PERSPECTIVES OF PROFESSIONALS ON TREATMENT FOSTER CARE SUCCESS

By

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Dedication

To my wonderful husband Brent, for supporting me through the process.

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Perspectives of Professionals on Treatment Foster Care Success

Abstract

by

KELLY DAVIS

Treatment foster care is designed to serve children involved with the child welfare system who have complex needs. The current study was an exploration of successful treatment foster families from the perspective of professionals. Concept mapping, a mixed methods research design which involves participants generating ideas and stating the relationship between those ideas, was utilized in this study. Data collection occurred in two phases, idea generation and statement structuring. Participants included professionals employed with a private, not-for-profit agency who provide support to treatment foster families as part of their regular job duties. There was a total of 33 participants in the idea generation phase of data collection and 21 participants in the statement structuring phase of data collection The Concept Systems CS Global MAX ™ proprietary software was used to collect and analyze the data. Findings of this study suggest that professionals view treatment foster family success as a combination of the treatment foster parents' parenting skills, qualities the treatment foster family possesses, supports the foster youth needs from the treatment foster family, supports the treatment foster family needs from others, and the match between the foster youth and treatment foster family. Additional research regarding treatment foster family success is needed and future research should include the perspectives of treatment foster families and treatment foster youth.

CHAPTER 1

Statement of the Problem

Family Foster care (aka foster care) is an integral part of the child welfare system in the United States and exists to provide safety to a child when the primary family is unable to provide adequate care (Child Welfare League of American [CWLA], 1995). Foster care is designed to be a temporary family into which a child can be placed until it is either safe for the child to return to their primary family, or in cases where the primary family is unable to ensure the safety of the child, a permanent placement can be found for the child, generally in an adoptive home. The foster family agrees to provide the care necessary to meet the child's physical, emotional, developmental, social, educational and spiritual needs while the child is residing with the foster family. Foster care generally refers to placement in a non-relative home that is licensed and monitored; when a child is placed in a relative home, it is considered kinship care.

According to the U.S. Department of Health and Human Services Adoption and Foster Care Reporting System (U.S. Department of Health and Human Services [DHHS], 2015), on September 30, 2014 there were 415,129 children residing in out-of-home care in the United States (DHHS, 2015). Out-of-home care includes children residing in pre-adoptive homes, non-relative family foster homes, relative foster homes or kinship placements, group homes, institutional facilities, supervised independent living arrangements, and children who have run away from out of home care. Of the 415,129 children residing in out of home care on September 30, 2014, 190,454 (46%) of children were residing in non-relative family foster homes (DHHS, 2015). The mean age of children residing in foster care was 8.7 years, and the median age was 8.0 years (DHHS,

2015). The number of children in out-of-home care has steadily declined over the past decade. According to Child Welfare Outcomes 2010-2013 Report to Congress (DHHS, 2014), the number of children residing in out of home care decreased by 23.3% from 524,000 in 2002 to 402,000 in 2013. Still, a significant number of children are placed nonrelative foster family care each year.

The needs of children residing in foster care vary, and as a result different types of foster care have emerged to meet the varying needs of children in the child welfare system. Traditional family foster care primarily serves children with minimal emotional, behavioral, developmental, and/or medical problems who are in need of a safe and stable living environment until the children can be reunified with primary family members or other permanency plan is made. Traditional foster homes typically serve children with less complex needs such as younger children and/or children in their first placement in foster care. According to Turner and Macdonald (2011), traditional foster care does not "typically provide interventions designed specifically to address the complex emotional, psychological, and behavioral needs of young children placed; nor do they provide caregivers with the skills and support services needed to implement them" (p. 501).

Not all children placed in foster care can have their needs adequately met by a traditional foster home, so specialized types of foster care exist to meet the needs of these children. Children with specialized medical needs are often placed into homes with families who have received additional training targeted to care for children with medical needs. These homes are generally referred to as medically fragile foster homes or specialized medical needs foster homes.

Children with more complex emotional, behavioral, and/or mental health problems are typically served in treatment foster homes. Treatment foster care, also known as therapeutic or specialized foster care, combines the stability of home life with psychosocial treatment (Dore & Mullin, 2006). Treatment foster parents typically received additional training and support to meet the specialized needs of children placed into their care. The different types of foster care will be discussed further in subsequent chapters.

Foster care is an integral part of the child welfare system, and the foster family is one of the most critical elements in the foster care system. Foster families are tasked with providing safe, stable, and nurturing environments to children to whom they are not biologically related. The conditions under which children enter foster care are traumatizing as children are being removed from their primary family, and children are generally removed from their primary family because they have suffered some form of maltreatment in the form of abuse and/or neglect. Given that children enter foster homes under difficult circumstances, it is critical that foster families are competent and able to successfully meet the needs of the various foster children placed in their care to avoid further traumatization of the children. In the treatment foster care system, having competent treatment foster families who are able to successfully meet the needs of the children placed in their care is even more critical because the family is the primary source of treatment.

Despite the critical role that the foster family plays in the child welfare system, little is known about foster families, and even less is known about what makes a foster family successful. Much of the research focuses on foster placement disruption or

breakdown. Foster placement disruption refers occurs when a child is removed from a foster home, and can occur at the request of the foster family, the determination of the child's social worker, or, in some cases, at the behest of the child. The research related to foster placement breakdown focuses heavily on child factors and is deficit focused. For example, numerous studies have been conducted on the relationship between child behavior problems and foster placement disruption (Barber & Delfabro, 2003; Chamberlain, Price, Reid, Landsverk, Fisher, & Stoolmiller, 2006; Eggertsen, 2009; James, Landsverk, & Slymen, 2004; Leathers, 2006; Lindhiem & Dozier, 2007; Newton, Litrownik, & Landsverk, 2000; Strijker, Knorth, & Knot-Dicksheit, 2008; Rubin, O'Reilly, Luan, & Localio, 2007). Study results on the relationship between foster youth behavior problems and foster placement disruption are inconsistent; it is unclear whether behavior problems increase the risk of placement disruption or if placement disruption increases the likelihood of behavior problems.

Over four decades ago, Madison and Shapiro (1970) identified the negative focus of foster care research and the emphasis on placement failure rather than placement success as problematic. Early foster care researchers identified that characteristics of the foster family are more important than characteristics of the child when predicting placement success (Kraus, 1971), and that child behavioral problems are not a reliable factor in predicting placement success (Cautley & Aldridge, 1975). Yet, four decades later, little research on foster family success exists. This project focuses on what treatment foster family characteristics maintain foster placements and promotes positive behavior in foster children. The purpose and history of foster care will be explored, the current literature related to foster family success will be reviewed, and differences

between traditional and treatment foster care will be discussed. A family systems theoretical frame with a stress-and-coping model will be utilized for exploring foster family characteristics that promote success. The impact of the family life cycle and family functioning on foster family success will be explored.

CHAPTER 2

Current Knowledge

History of Foster Care

Dealing with orphaned, abandoned or at-risk children is an issue for all societies. (The term 'dependent child' will be used here as a short-hand means of describing all these children). In Colonial America, the most common means for dealing with dependent children was indenture contracts in children were contracted to masters who agreed to provide food, clothing, shelter, and to provide skills training (Hacsi, 1995). Indenture contracts were often arranged by public officials but contracts could be entered into without official involvement of the government (Hacsi, 1995). Indenture was seen as a practical economic arrangement in which children were prepared for adulthood and work (Hacsi, 1995).

Children's Aid Society

In the United States, the history of a formalized response to the needs of dependent children can be traced back to the 19th century. The Children's Aid Society of New York was founded by Charles Loring Brace in 1853 and incorporated in 1856 (Brace, 1872). The Children's Aid Society was founded to alleviate the impacts of poverty and crime on children living in New York City (Brace, 1872). One year after its founding, the Children's Aid Society of New York opened a "lodging house" for homeless or "street-boys" (Brace, 1872). In his 1872, writing "The Dangerous Classes of New York and Twenty Years' Work Among Them", Brace commented on the strengths of the street-boys, including their willingness to work, loyalty to other street-boys, and good nature. Because of initial suspicion on the part of the boys, the lodging house did

not offer any religious or educational services, only safe lodging and food. As the boys became more engaged with the lodging house and were less suspicious, the lodging house began to offer additional programs, including "evening school" to teach the boys to read and write (Brace, 1872).

The number of boys served by the lodging house increased substantially over time. Between 1854 and 1856 the lodging house served 408 boys; five years after opening, between 1859 and 1860, the lodging house served 4,500 boys and between 1870 and 1871 the lodging house served 8,835 boys (Brace, 1872). While the boys did pay a nominal fee towards their room and board, their contributions did not cover all costs and the lodging house depended on charity from the community to operate; however, according to Brace (1872) the "Lodging-houses repay their expenses to the public ten times over each year, in preventing the growth of thieves and criminals" (p. 106). In addition to providing lodging and other services to the boys, five years after opening, the lodging-house began reunifying boys with families and locating permanent homes for boys (Brace, 1872). In the first 18 years of operation, the Children's Aid Society lodging-house reunified 7,278 boys with friends and located homes for 5,126 boys (Brace, 1872).

In addition to establishing lodging houses for homeless boys in the city, the Children's Aid Society established schools for those living in poverty in New York City (Brace, 1872). The schools were established not to replace public schools but to supplement the education provided by the schools; however, Brace (1872) indicated that often children served by the Children's Aid Society were so negatively impacted by poverty that they were unable to function in the traditional public school setting. The

schools provided assistance to those living in poverty but Brace asserts that since the assistance was provided in conjunction with education, complete dependence upon assistance was not created.

Brace and members of the Children's Aid Society came to believe that while schools and lodging houses provided assistance to children living in poverty, placement with rural families was the best option for dependent children (Brace, 1872). In his 1872 work, Brace wrote "The founders of the Children's Aid Society early saw that the best of all Asylums for the outcast child, is the *farmer's home*," (p. 225). Rural farm families were seen as an ideal place for dependent children for many reasons. There was a constant need for labor to work the land on farms and the demand for labor exceeded the available supply (Brace, 1872). Generally, there was an abundance of food and resources available to farm families, so feeding an extra child would not be a drain upon the family (Brace, 1872). The culture and structure of the farm family was such that the help on the farm must live with and function as members of the farmer's family (Brace, 1872). These conditions lead the Children's Aid Society to see the value of placing homeless children from New York City in the homes of farmers in rural areas (Brace, 1872).

Initially questions arose regarding how to recruit such families and how to ensure that appropriate placements were being made (Brace, 1872). This Children's Aid Society began recruiting farm families by sending circulars and placing advertisements in rural newspapers. This method of recruitment was successful, and the Children's Aid Society received hundreds of applications for children in response to their advertisements (Brace, 1872). Initially the Society made attempts to provide the applicants with exactly the type of child requested; all families wanted attractive and well-mannered children (Brace,

1872). The Society shortly came to realize that they could not accommodate specific requests for certain characteristics, and that families could not receive exactly the child that they requested (Brace, 1872).

The second approach to placement taken by the Children's Aid Society involved sending groups of children in need of placement to rural villages on trains (Brace, 1872). The children interacted with families from the community and then families made applications to have the children placed in their homes (Brace, 1872). Receiving families included those who were childless and wanted to adopt children, families who were looking for farm labor, and families who decided to apply to accept a child after interacting with the children (Brace, 1872). If they had the means, families either paid for the child's fare to the village or made a donation to the Children's Aid Society (Brace, 1872).

The Children's Aid Society faced criticism of its program of placing poor and dependent children from New York City in rural farming communities (Brace, 1872). Poor families were suspicious of the program and rumors circulated that the program was a proselytizing scheme to convert children to Protestantism, that children were being sold as slaves, that the placing agency was profiting from the placement of children, and that the names of children were being changed once they moved which meant that related children could possibly meet and marry as adults (Brace, 1872). Wealthy opponents accused the Children's Aid Society of "scattering poison over the country" (Brace, 1872, p. 235) and argued that poor children needed to be placed in an Asylum or detention facility for "purification" and preparation for adult life (Brace, 1872).

Brace and the Children's Aid Society viewed children in need of placement not as criminals but as poor and homeless children who were victims of their circumstances who often had no other option than to engage in criminal activity for survival (Brace, 1872). Brace (1872) countered criticisms by asserting that placing children with farm families or offering services through schools and lodging houses cost a fraction of what maintaining a child in an Asylum cost. Children placed in families learned practical skills that prepared the child for adulthood (Brace, 1872). Brace argued that Asylum life poorly prepared a child for adulthood, created an "institutional child," and "the longer he is in the Asylum, the less likely he is to do well in outside life," (Brace, 1872, p. 236).

The Children's Aid Society made an effort to collect data regarding how the children faired after their placement (Brace, 1872). The first data collection effort began in 1859, five years after the start of the placement program, and found that overall children did well after being placed with families (Brace, 1872). The data suggested that children who were placed with families at a younger age did better than children who were placed at older ages, with those children placed at age 14 or younger doing best (Brace, 1872). It was estimated that only 2% of children placed under the age of 15 had problems and that 4% of children placed between the ages of 15 and 18 had problems (Brace, 1872). It was found that as adults many of the children placed at younger ages had farms, shops, or trades of their own, and had sent donations to the Children's Aid Society or took in poor children to raise themselves (Brace, 1872).

Brace (1872) estimated that between 20,000 and 24,000 children had been placed by the Children's Aid Society. Brace acknowledged that it was a "loose" arrangement and that children could leave or be put out by the family if either party were not satisfied,

but overall Brace considered the endeavor to be successful. According to the Children's Aid Society (2012), the program, which came to be known as The Orphan Train Movement, continued until the early 1900's and more than 120,000 children were placed in 45 U.S. states, in Canada, and in Mexico. The Orphan Train Movement is considered to be the beginning of foster care in the United States (Children's Aid Society, 2012).

The work of Charles Loring Brace, the CAS, and other programs that engaged in placing-out has been criticized. Brace's program of placing-out has been criticized as anti-urban and anti-immigrant (Hacsi, 1995). Families living in poverty have always been at greater risk of having their children removed and placed in institutions or the homes of others (Cook, 1995; Hacsi, 1995). The practice of placing children in the families of rural farmers was criticized for being a means of protecting children from the urban environment and from parents who were unable to properly raise their children (Hacsi, 1995). Brace was criticized for being anti-urban, anti-immigrant, and anti-Catholic (Hasci, 1995). Typically, children placed via the Orphan Trains were treated differently based on age; younger children were more likely to be taken in as members of the family while older children were expected to work. In a small qualitative study, Cook (1995) interviewed 25 individuals who were placed-out by the CAS or the New York Foundling Home late in the placing-out program. Participants interviewed reported that the primary reason for placement was poverty, that the quality of the homes in which they were placed was questionable, that they faced prejudice in the communities into which they were placed, that there was no monitoring after the placement occurred, and that they were treated more like slaves providing unpaid labor than family members (Cook, 1995).

Foster care changed little through the late 1800's and into the early 1900's. In 1893 the Board of Children's Guardians was established, and had, among other things, the right to place children in the homes of families (Modell & Haveren, 1973). In 1904 the U.S. Census Bureau reported that there were 93,000 children in children's homes and orphanages in the United States, and it was estimated that there were another 50,000 dependent children in private homes (either as boarders or adopted), and 25,000 children in institutions for juvenile delinquents (Modell & Haveren, 1973).

The 1909 Conference of the Care of Dependent Children had a significant impact on the development of foster care through the early 20th century. The 1909 Conference on the Care of Dependent Children established the Federal Children's Bureau, the primary responsibility of which was to investigate and report on all matters related to the welfare of children. According to the Proceedings of the Conference of the Care of Dependent Children (1909), children should not be deprived of a home life, as the home was "the great molding force of mind and of character," (p.9). It was asserted in the proceedings that children should never be removed from their primary families for reasons of poverty alone, and should only be removed because of ineffective parents. Children should be placed into foster homes which were carefully selected by skilled professionals, and agencies placing children should secure information about children placed and their parents, monitor the status of the birth parents of the children placed in foster care at least annually, and provide supervision of the children until the children are returned to their primary family, adopted, or until it is clear that they no longer require supervision (Modell & Haveren, 1973).

The major federal legislation to impact the development of modern foster care was the 1935 Social Security Act. The 1935 Social Security Act Aid to Dependent Children provided States with a means to care for children whose parents were unable to provide care because of death, disability, or abandonment (Ross, 1985). With the passage of the Social Security Act, the Federal Government took on the responsibility of helping States care for vulnerable children in homes rather than in institutions (Ross, 1985). Tile V, part 3 of the Social Security Act, provided states with $1.5 million annually to establish child welfare services for the protection and care for dependent children (Oettinger, 1960). Funds could be utilized for many purposes, including the training of social workers and for foster care per diem payments.

The momentum if foster care development established by the Social Security Act of 1935 continued through the 1940's and 1950's (Oettinger, 1960). This was a period of program building in which adoption, foster care, and services to children in their own homes further developed, and training of child welfare workers continued. The number of children in foster care increased dramatically. In 1933 there were 49,000 children in foster care in the United States, and by 1955 that number grew to 123,000 children in foster care (Oettinger, 1960). Funds made available by the Social Security Act of 1935 were used to help fund the expansion of child welfare services (Oettinger, 1960).

Traditional or Family Foster Care

The Child Welfare League of America (CWLA) publishes Standards of Excellence for Family Foster Care Services (CWLA, 1995). The standards are intended to be utilized as goals for improving foster care services provided to children, and are useful in service planning, establishing foster care licensure requirements, education and

professional development of foster families and foster care staff, and in the promoting of understanding of how services can best meet the needs of children (CWLA, 1995). It should be noted that the CWLA Standards of Excellent for Foster Care Services have not been updated in more than 21 years and that much has changed in American society since the Standards were written. The CWLA Standards are included for discussion here because they are a comprehensive overview of family foster care and the CWLA continues to circulate the Standards as desirable practices in family foster care services.

The CWLA (1995) defines family foster care as "an essential child welfare service for children and their parents who must live apart from each other for a temporary period of time because of physical abuse, sexual abuse, neglect, or special circumstances necessitating out-of-home care" (p. 11). Foster care should only be used when it is determined that a child's parents, family, or kin cannot provide protection and care to the child; that it is necessary to remove the child temporarily from the care of the parents; and, when a family setting is the best setting to meet the needs of the child (CWLA, 1995). Foster care is designed to be a temporary support service for families until the problems that lead to the need for out-of-home care can be solved, or it the problems cannot be solved, while appropriate permanency arrangements are made for the child (CWLA, 1995). The CWLA standards address the following areas family foster care: the foundations, practices, staffing of services, the administration and organization of services, and community-based support for family foster care.

The foundation of family foster care defines family foster care and its values, outlines the rights of children in family foster care, the rights of parents of children in family foster care, the responsibilities of all parties involved with foster care, the placing

agency, and the agency with which the placing agency contracts for family foster care services (if applicable). In addition, the purposes for which family foster care should be used and the essential characteristics of family foster care programs are defined. The rights of children in foster care focus primarily on ensuring safety, promoting development, and maintaining connections to their primary family (CWLA, 1995) as long as it is the best interest of the child to do so. For example, unless contraindicated children in family foster care have the right to maintained continued connections with their primary and extended family members as well as others with whom they have close connections, and they have the right to be returned to their family of origin or to be placed with another permanent family as quickly as possible (CWLA, 1995). The rights of parents of children in family foster care focus on the right to treatment, support services, and maintaining contact with their child(ren) (CWLA, 1995). Reasonable efforts must be made to prevent unnecessary removal of children from their parents, and reasonable efforts must be made to support the parent in meeting the conditions of the case plan to have children reunified (CWLA, 1995).

The CWLA states that placement of a child in family foster care does not remove the responsibility for the child from the parent, and that the parent has a continued role in the process to return the child home safely. Parents of children in foster care are responsible for working towards goals on their case plan, maintaining regular contact with their child, keeping the agency informed of any significant changes in their lives or circumstances, and for making a financial contribution to the child's care if possible (CWLA, 1995).The placing agency responsibilities are primarily concerned with providing protection and care for the children placed in family foster care, providing

services to assist the birth family with meeting the conditions of their care plan, selecting the most appropriate foster family to provide care for the child, and thoroughly assessing the needs of the biological family (CWLA, 1995). If an agency utilizes another agency to provide foster care services, the agency with which the child is placed is responsible for the care and supervision of the child in foster care, coordination of services with the placing agency, and for providing high quality casework services to the child and family (CWLA, 1995).

An assessment should be conducted to determine if foster care is appropriate for a child and their family, and if it is determined that foster care is the most appropriate service, what level (traditional, specialized or treatment) of family foster care would best meet the needs of the child (CWLA, 1995). Foster care can be used for emergency shelter care, diagnostic assessment purposes to develop an appropriate treatment plan for a child, specialized or treatment foster care for children who require intensive or specialized services, teen parent services to support young mothers and their children, respite care to provide short term relief so that children can be maintained with their families, foster family adoption or preparation for nonrelative adoption for children who cannot be reunified with their primary families, planned long-term foster care for children who cannot return to primary family but who cannot be adopted for legal or other reasons, and preparation of young adults for independent living (CWLA, 1995). Foster care should ensure that comprehensive community-based services are made available to children and their families, support the relationship between children and their families, and utilize an interdisciplinary team approach that involves the caseworker, foster parent, and other professionals involved with the care of the child including those in the fields of

education, health, mental health, and the law (CWLA, 1995). Children and their families should be educated about the service planning process and should be encouraged to participate fully in the service planning and treatment process (CWLA, 1995).

The CWLA (1995) practice standards address the referral, intake, and assessment process, case planning, service provision, monitoring of services, permanency planning, and discharge planning. The CWLA goals for family foster care:

> are to protect and nurture children who are placed with agency-approved foster families; meet the physical, mental health, developmental, social, and educational needs of children in family foster care; support the relationship between children and their families; and plan for permanency, that is, undertake planning to connect children to safe and nurturing relationships intended to last a lifetime (CWLA, 1995, p. 23).

The practice standards address the methods by which the goals are met.

Public child-placing agencies should have referral and intake policies and procedures that outline the circumstances under which a referral could lead to the utilization of family foster care services (CWLA, 1995). Placement of children in foster care can be involuntary; that is, the outcome of an investigation reveals that the emergency removal of a child is necessary to ensure his/her safety. Placement can also be voluntary, that is the results of an investigation does not indicate or substantiate abuse and/or neglect but that the investigation reveals that there are other conditions that make placement in foster care is appropriate, so the family voluntarily agrees to foster care services (CWLA, 1995). Referrals for family foster care can also be made by the court system, mental health agencies, public health agencies, schools, and by families (CWLA,

1995). Except in an emergency situation, the placing agency is responsible for the completion of an assessment to determine if placement in family foster care is appropriate. Once a referral for family foster care is deemed appropriate, the placing agency is responsible for ensuring that an appropriate placement is secured (CWLA, 1995). If a provider agency is utilized for family foster care services, the provider agency should be selected based on the agency's ability to meet all needs of the child, provide access to the child's parents and other family members, engage the family in service provision, and demonstrates a commitment to culturally competent interdisciplinary service provision (CWLA, 1995). The placing agency is responsible for searching for extended family members or kin to participate in the intake and assessment process, and if it is determined that a child is Native American or Alaskan Native, the placing agency is responsible for turning the case over to the child's tribal social service agency (CWLA, 1995) or securing permission from tribal agencies to treat the child. The assessment process should be individualized to meet the child and his/her family, should be culturally competent, and should take into account the sociocultural context of the strengths and needs of the child and his/her family (CWLA, 1995). A team approach that involves all agencies, the child's parents and other family members, the foster family, and the child should be utilized in the assessment process (CWLA, 1995). Placement agreements between the child's parents and the agency and between the foster family and agency should be completed at the time of placement (CWLA, 1995). Placement agreements should reflect the rights and responsibilities of all parties (CWLA, 1995). As previously stated, the agency has the responsibility to select the most appropriate foster family for a child. The following considerations should be made in the selections of an appropriate

foster family: the child's age, gender, culture, the strengths and abilities of the foster family especially as they relate to the family's ability to meet the specific needs of the child, the total number of children in the home, the ability of the foster family to work with the child's primary family, the geographic location of the foster family to ensure continuity and continued contact between the child and his/her family, the foster family's assessment of their ability to meet the needs of the child, and the foster family's ability to access community resources to meet the needs of the child (CWLA, 1995). Whenever possible, siblings should be place together, and if placement together cannot occur, efforts to maintain regular contact between siblings should be made (CWLA, 1995). The foster family should be provided with adequate information about a child, and assistance should be provided to the foster family so that they may make an appropriate determination of whether or not a child would be an appropriate fit for the foster family (CWLA, 1995).

The foster family and caseworker are responsible for meeting the emotional and developmental needs of children placed in family foster care (CWLA, 1995). This includes the foster parent and social worker working together to help prepare the child for placement and to develop relationships between the child, his/her parents, and the foster family (CWLA, 1995). In addition, it is important to remember that children who enter foster care have experienced abuse and/or neglect severe enough to warrant removal from their birth home. It is the responsibility of the social worker and foster parent to help children manage the impact of trauma from abuse and neglect (CWLA, 1995). This is done by referral to appropriate mental health resources, helping children process their feelings and understand what happened to them, and also by regularly assessing children

for the effects of abuse such as developmental delays and emotional problems (CWLA, 1995). If it is determined that a child is experiencing delays or emotional problems as a result of the abuse or neglect he/she experienced or as a result of a child's separation from his/her family. The service plan should include services to address all the issue (CWLA, 1995). The service plan and all service provided should be regularly reviewed for appropriateness and should track progress made by the child and his/her family (CWLA, 1995).

Foster families and agency social workers are responsible for arranging medical, dental, psychological, developmental, and educational assessments, and assessments should be completed within 30 days of placement in foster care (CWLA, 1995). Foster families and social workers should collaborate to ensure that all appropriate services to meet the medical, dental, psychological, developmental, and educational needs are arranged and provided (CWLA, 1995). Foster families are responsible for providing appropriate discipline that takes a positive approach and is mindful of the child's age, developmental level, and abuse history. Agencies should ensure that inappropriate discipline, including corporal punishment, does not occur (CWLA, 1995). Foster families and social workers are responsible for ensuring that a foster child attends services regularly and that all educational needs of the child are being met (CWLA, 1995).

Service plans for children placed in foster care must address permanency planning (CWLA, 1995). The service plan should be reviewed at least every six months to determine if family foster care remains an appropriate service, the compliance of all parties with the service plan, what services are needed to facilitate the permanency plan

for the child, and a target date for when permanency will be achieved (CWLA, 1995). Steps should be taken and services should be provided to support a permanency goal of reunification (CWLA, 1995). Regular assessment of a parent's capacity for reunification that takes into consideration the circumstances that lead to the placement of the child in family foster care, the parent's ability to accept and utilize formal and informal supports, and the parent's ability to recognize and provide for the needs of the child should be conducted (CWLA, 1995). Foster parents should support reunification efforts by preparing a child for contact with their primary family, assisting the child with coping with feelings after contact with primary family, and supporting the strengths of primary family members (CWLA, 1995). Should reunification not be a realistic permanency option, other permanency options including placement with kin, adoption by foster parent, and non-family adoption should be explored (CWLA, 1995). Members of the team, including foster parents, are responsible for supporting permanency planning (CWLA, 1995).

The CWLA (1995) staffing standards address foster parent qualifications, social worker qualifications, foster parent and staff training and development, caseload size, and recruitment and retention plans. The standards assert that children in family foster care should be served by foster parents and social workers who have the necessary qualifications to meet the developmental, social, treatment, education, physical, mental health, cultural, spiritual and permanency needs (CWLA, 1995). Agencies have the responsibility to have an on-going recruitment and retention plan for recruiting and maintaining currently licensed family foster care homes (CWLA, 1995).

Prior to licensing a foster home, the agency should complete a full background check on all applicants, including a criminal records check and a child abuse and neglect records check (CWLA, 1995). Applicant should attend orientation and pre-service training prior to licensure, and training should cover areas such as the agency mission and organizational structure; agency policies, including policies regarding discipline, safety procedures, and role of the foster parent in the treatment team; the differences between foster parenting and other kinds of parenting; foster parent responsibilities and rights; the importance of cultural competence; and, the impact of fostering on families (CWLA, 1995). A thorough home study assessment should be completed that takes into account the health and mental health status of all family members, the applicants motivation and willingness to become foster parents, personal references, and the conditions of the foster home (CWLA, 1995). The CWLA standards state that certain interpersonal qualities are desirable in foster parents, including personal maturity and life experiences that prepare them to be foster parents.

The CWLA (1995) outlines rights and responsibilities of foster parents. Foster parents have the responsibility to provide all day-to-day care for a child placed in the foster home and to keep their agency informed of any significant changes in the household (CWLA, 1995). Foster parents have to right to refuse to accept a child into their home if they feel they are unable to meet the needs of the child, to be informed of and educated regarding their role in the treatment team, to be provided information about children in their care, the right to be treated with courtesy and respect by agency staff, the right to receive support from their agency, and the right to be considered as permanent family option for a child placed in their home if it is appropriate (CWLA, 1995). Foster

parents should be provided with regular respite care and opportunities for on-going training once licensed (CWLA, 1995).

The CWLA (1995) standards outline two levels of social worker competencies. Level I is considered entry level and generally requires a B.S.W. degree. Level II is considered an experienced worker and generally requires and M.S.W. degree. Agencies should not employ social workers who have substantiated reports of child abuse or neglect, and should not employ social workers who have a history of any violent crime (CWLA, 1995). As with foster parents, certain interpersonal qualities are desirable in family foster care social workers, including personal maturity and life experiences that prepare them to effectively handle all responsibilities in their role as family foster care social workers (CWLA, 1995). Social workers should receive adequate training and clinical supervision, and a development plan that assesses a social worker's strengths and growth areas should be completed with input from the social worker and his/her supervisor (CWLA, 1995). Social worker caseload size should range between 12 and 15 children, depending on the needs of the child and the experience level of the social worker (CWLA, 1995).

The CWLA (1995) standards outline the organization and administration of family foster care services. The organization and administration standards address the authorization of service; the responsibilities of the public agency board, public agency director, and voluntary agency chief executive officer; licensing responsibilities of agencies; contracting between public and voluntary agencies; public and voluntary agency policies; and, the financing of family foster care services (CWLA, 1995). Agencies providing family foster care services have the responsibility to maintain

standards of practice and should have a quality improvement process that evaluates agency service provision (CWLA, 1995). Agencies should collect and maintain data regarding their service provision, and have the responsibility to remain current on research finding in the field of family foster care (CWLA, 1995). Agencies have the responsibility to maintain client records and to ensure confidentiality of those records (CWLA, 1995).

The CWLA (1995) standards regarding community-based support for foster care services addresses the need for agencies to develop support from the community to which the agency provides foster care services. The agency should provide community education that provides information about the agency mission as well as information regarding foster care as a child welfare service (CWLA, 1995). Should the agency become aware of any unmet service needs in the community, the agency should provide education to the community regarding those needs (CWLA, 1995). Agencies have the responsibilities for maintaining relationships with other agencies that provide child welfare and family services in the community, and should maintain positive relationships with other community stakeholders that provide service and support to families (CWLA, 1995).

Specialized Medical Foster Care

Prior to the early 1980's few resources existed for abused and neglected children with serious medical problems (Davis, Foster, & Whitworth, 1984). A population of children with serious and complex medical problems exists who are well enough to leave the hospital, but whose parents are unable to maintain at home because of the complexity of the children's medical needs (Hochstadt & Yost, 1989). As a result, children

languished in the hospital for longer periods of time than necessary (Davis et al., 1984; Hochstadt & Yost, 1989; Yost & Hochstadt, 1987). Children languishing in the hospital receive a higher level of care than what is necessary which is costly, both in monetary terms and in regards to the well-being of children (Davis et al., 1984; Hochstadt & Yost, 1989; Yost & Hochstadt, 1989). Maintaining a child in the hospital is expensive which is usually funded through public funds such as Medicaid (Yost & Hochstadt, 1989). Children who languish in the hospital often suffer developmentally as their emotional, educational, and social needs cannot be adequately met in a hospital setting (Davis et al., 1984; Yost & Hochstadt, 1989). In addition, the psychosocial needs of the child's family are rarely met when the child is hospitalized for lengthy periods of time (Hochstadt & Yost, 1989).

Special medical foster care, also known as medical foster care, developed to meet the needs of children with complex medical needs whose biological parents were unable to maintain at home. Children served by special medical foster care have a vast array of health problems including but not limited to prenatal drug exposure, HIV infection (Cohon & Cooper, 1993), spina bifida, cleft palate, Pierre Robin syndrome, tracheostomy, bronchopulmonary dysplasia, (Hochstadt & Yost, 1989), failure-to-thrive syndrome, skull fracture, and history of injuries resulting from severe burns or chemical ingestion (Davis et al., 1984). Reasons for families' inability to meet the needs of this population of children vary; abuse and/or neglect may be a factor, or families may simply be unable to meet the complex needs of a seriously medically ill child (Davis et al., 1984). In the 1980's several medical foster care programs developed throughout the

United States to meet the previously unmet needs of these children with complex medical needs.

The Children's Medical Services program developed in Florida in the early 1980's, and was designed to meet the medical needs of children who were victims of abuse and/or neglect (Davis et al., 1984). Foster families licensed under this program met all of the Florida foster care licensing criteria, as well as additional requirements including that the primary caretaker of the child be a licensed Registered Nurse in Florida, that the family only accept one foster child, and the foster family had to be willing to work with the biological family to provide education, advocacy, and modeling in how to care for the child (Davis et al., 1984). Medical foster families received additional training as well as additional financial support over and above the typical reimbursement for caring for a foster child (Davis et al., 1984). The goal of the program was to return the child to the child's biological family or in cases where it was impossible to return the child to his/her biological family, to locate a suitable adoptive home for the child (Davis et al., 1984). Evaluation of the program determined that maintaining children in medical foster care was more cost effective than long term hospitalization (Davis et al., 1984).

The Medical Foster Parent Program (MFPP) was a grant-funded program that developed through a partnership between a children's hospital and a child welfare agency in Illinois (Hochstadt & Yost, 1989). Similar to the Children's Medical Services Program, foster parents in the MFPP program received additional training; however, MFPP did not require that the primary caretaker be a Registered Nurse (Hochstadt & Yost, 1989). MFPP foster parents were recruited from the general population and from a

pool of existing foster parents, and they received an 8 session training program that focused on caring for medically complex children (Hochstadt & Yost, 1989). MFPP foster parents received additional child specific medical training prior to the placement of a foster child in the home (Hochstadt & Yost, 1989). Similar to the Children's Medical Services program, evaluation of the program determined that medical foster care was a cost effective alternative to long term hospitalized for children with complex medical needs (Hochstadt & Yost, 1989).

In 1988 the Children's Aid Society of New York City (CAS) developed the Medical Foster Care program (MFC) in response to the growing number of infants with serious medical needs being abandoned at hospitals (Diaz et al., 2004). Similar to other programs, foster parents in the MFC program received training required of all foster parents, as well as additional training specific to caring for medically complex children and child specific medical training prior to the placement of a child with complex medical needs (Diaz et al., 2004). Similar to other programs, foster parents in the MFC program received higher than average reimbursement; typically, MFC per diems were three times higher than per diems paid for typical foster care placements (Diaz et al., 2004).

Special medical foster parents serve children with HIV infection and/or drug exposed children, and there is an overlap between the two populations (Groze, Haines-Simeon, & Barth, 1994). In the early 1990's the increased need for services for children with HIV infection and/or drug exposed children placed a burden on the child welfare system (Groze et al., 1994). According to the U.S. Department of Health and Human Services (Macrosystems Inc, 1989), in 1989 there were 806 HIV infected children in

foster care in the United States. In 1991, there were 1,149 children born to HIV positive mothers placed in foster care (Cohen & Nehring, 1994). In 1989 it was estimated that between 16% and 22% of children in the United States who were HIV infected would be placed in foster care at some point (Macrosystems Inc, 1989). HIV infected children were primarily minority children from poor families (Macrosystems Inc, 1989).

Children with HIV infection have special healthcare, developmental, and educational needs (Groze, McMillen, & Haines-Simeon, 1993), as well as special psychosocial and emotional concerns for this population (Cohen & Nehring, 1994). In a 1991 survey of the United States, Washington D.C., Puerto Rico, American Samoa, the U.S. Virgin Islands, and Guam, only 38.2% of states had foster care policies that were specific to the care of children with HIV infection (Cohen & Nehring, 1994). The majority of states (83.6%) had requirements that foster families caring for children with specialized needs, including children with HIV infection, have specialized foster care licenses (Cohen & Nehring, 1994).

There are challenges associated with specialized medical foster care that are universal to foster care in general, and unique to specialized medical foster care. Clearly there is a need for foster parents who can care for children with complex medical needs, but recruiting foster parents to care for children who are medically complex, drug exposed, or HIV+ is difficult (Cohon & Cooper, 1993). Specialized medical foster families face challenges over and above those faced by typical foster families. For example, Hochstadt and Yost (1989) found that role confusion was an issue for special medical foster parents because the family must incorporate multiple caregivers into the family as many children with complex medical needs have multiple healthcare providers,

some of whom provide care in the home. In addition, the healthcare providers faced the challenge of providing healthcare services in the foster home (Hochstadt & Yost, 1989). The role confusion often manifested itself in power struggles amongst the foster parents and healthcare providers, and lead to foster parents having difficulty defining their complex roles as medical foster parents (Hochstadt &Yost, 1989). Despite these challenges, specialized medical foster care has continued to develop since the 1980's, and continues to serve children with complex medical needs in the child welfare system.

Treatment Foster Care

Treatment foster care, also referred to as therapeutic or specialized foster care, is designed to serve children involved with the child welfare system that have more complex needs. Treatment foster care combines the stability of home life with psychosocial treatment, and arose primarily as the result of three conditions (Dore & Mullin, 2006). First, those in the child welfare system began to acknowledge that there was a need for a more therapeutic level of foster family as the link was recognized between childhood trauma of abuse and neglect and later functioning (Dore & Mullin, 2006). Second, the juvenile justice system began moving away from focusing primarily on punishment and containment, recognizing that delinquent youth often have extensive mental health needs (Dore & Mullin, 2006). A step-down option was needed for youth exiting the juvenile justice system and re-entering the community (Dore & Mullin, 2006). Third, managed care systems began reducing the length of stay in psychiatric hospitals and restricted funding for long-term residential treatment (Dore & Mullin, 2006). The need arose for a community based alternative to residential treatment for children with

severe emotional and behavioral problems (Dore & Mullin, 2006; James & Meezan, 2002).

The Foster Family-Based Treatment Association (FFTA) was established in 1988 by treatment foster care agencies and was formed to define and set standards for treatment foster care (FFTA, 2013). Members of the FFTA embrace a set of core values and principles that include the following: normalization is an important component in treatment and family living is a normalizing influence, kinship is important in identity formation and the development of feelings of self-worth, having a permanent family is the right of all children and that efforts to ensure stable and long-term living arrangements are crucial, the importance of cultural diversity and cultural competence, the importance of taking whatever steps are necessary to ensure that a child can live in a family setting and community successfully, and the importance of documentation and service evaluation (FFTA, 2013).

The FFTA (1991, 2004, 2013) publishes program standards for treatment foster care. These program standards are periodically reviewed for continued appropriateness. If it is determined that no revisions are necessary, the standards remain unchanged. Standard revisions have been published three times since the initial publication in 1991; first in 1995, again in 2004, and most recently in 2013. The updates to the standards were based on information gathered from treatment foster care experts, public officials, administrators, as well as treatment foster parents. The standards have been utilized as a means to define and operationalize treatment foster care by researchers, accrediting bodies, and treatment foster care agencies (FFTA, 2013).

In the FFTA (2013) treatment foster care program standards there are 78 individual standards divided into three sections; the program, treatment parents, and children, youth, and their families. Standards related to the program covers areas such as a program mission statement, program performance, the qualifications and responsibilities of program supervisors, and the qualifications and responsibilities of the program caseworkers. Standards related to treatment parents cover the responsibilities of the treatment parents, treatment parent qualifications, selection of treatment parents, treatment parent training, and treatment parent support. Standards related to children, youth, and their families address placement, support services made available to the children, youth and families, trauma-informed care, primary family involvement, and well-being for children and youth.

The FFTA (2013) recognizes that it is possible for a treatment foster care program to operate without meeting all standards; however, FFTA asserts that the standards outlined are the qualities which define treatment foster care services. The first section of the FFTA (2013) program standards addresses the program, including the responsibilities of the program and the program staff. According to the FFTA (2013), a treatment foster care program,

> is created when services and supports are organized in a coherent manner for a common purpose. It is the program context that creates and supports the framework necessary for effective service delivery. A clear Program Statement, a commitment to measuring Program Performance, and attention to Program Staff qualifications, roles, and supports are all required to define a program of Treatment Foster Care (p. 7).

The program standards in the section address the need for each treatment foster care program to have a program statement that describes the program's "mission, organizational structure, services, policies, record-keeping and evaluation procedures" (p. 7).

Program standards outlined in the FFTA (2013) treatment foster care standards stress the importance of evaluating program performance. According to the FFTA (2013), program evaluation is a critical piece in a treatment foster care program for reasons of accountability and program improvement. The treatment foster care program standards assert that at minimum a treatment foster care program should have a means to document service delivery, should document individualized treatment plans that regularly track the progress of the foster child, should have a means to evaluate both staff and treatment foster parent performance, and should document program outcomes at least annually (FFTA, 2013). Program outcomes should be designed to assess safety, permanency, and well-being of children and youth and address areas such as placement stability, whether or not the youth achieved permanency at discharge, child well-being as measured through standardized assessments, progress towards treatment goals at discharge, employment status, graduation rates, community and educational involvement, and services received by youth (FFTA, 2013). The standards encourage programs to utilize evidence-informed practices, collaborate in the process of moving promising and innovative practices to evidence-based practices, and have processes in place to support data-based decision making (FFTA, 2013).

The FFTA (2013) program standards also address staffing issues, including supervisor and caseworker qualifications, supervisor and caseworker role in the treatment

team, caseload size, and supervisor to caseworker ratio. It is expected that caseworkers and supervisors meet minimum education and experience standards and that caseworkers carry small caseloads. For example, the FFTA recommends that the supervisor have at least a minimum of a graduate degree in a human services field and a minimum of 2 years of experience with the placement and treatment of children and families, and that caseworkers have a master's degree in a human services field. It is acceptable for a caseworker to have a Bachelor's degree in a human services field and a minimum of 2 years working with children and families. The supervisor oversees the treatment team and participates in treatment planning with the caseworker, and the FFTA recommends that supervisor to caseworker ratio not exceed 1 to 5. The FFTA recommends small caseloads with an ideal ratio being no more than 8 children assigned to one worker; however, depending on the severity of the children's needs, caseload sizes may be larger but should never exceed 12 children to one worker.

In addition to recommendations regarding employee qualifications and caseload size, the FFTA (2013) treatment foster care program addresses the role of the caseworker in the treatment team. The caseworker is expected to have regular contact with the foster child at least twice a month, and should spend time meeting alone with the foster child to address any specialized concerns the child may have, and to monitor the health, safety, and well-being of the child (FFTA, 2013). The caseworker is expected to function as an advocate for the child in both the community and educational system, and should provide regular consultation and support to foster children, treatment foster parents, and families of the children served in the program (FFTA, 2013). Both the caseworker and supervisor are expected to be available for crisis-on-call support to the foster child and treatment

foster family 24 hours a day, seven days a week (FFTA, 2013). In selecting program staff, treatment foster care programs are expected to abide by equal opportunity employment standards and to select program staff that is culturally competent or willing to become culturally competent in areas of the populations served (FFTA, 2013). Regular training should be provided to program staff in a variety of areas including crisis prevention, grief, loss, attachment, and trauma issues, the importance and value of birth and extended families, permanency planning, cultural competence and culturally responsive services, working with children with specialized needs including children with emotional and/or behavioral problems, and treatment interventions designed to meet the specialized needs of any population served in the program (FFTA, 2013).

The second section of the FFTA treatment foster care program standards addresses the role, responsibilities, selection, and qualifications of the treatment foster parent (FFTA, 2013). According to the FFTA (2013), the treatment foster parent "serve as both caregivers for children and youth with treatment needs (the fostering role) and as active agents of planned change (the treatment role)," (p. 25). The treatment foster parents are expected to serve as active members of the treatment foster care team and are viewed as members of the professional team (FFTA, 2013). The primary functions of the treatment foster parents "are to provide safety, help build children's social and emotional well-being, and assist in moving the child to permanency," (p. 25).

The FFTA (2013) treatment foster care program standards require that the program provide all treatment foster parents with a description of the duties of the treatment foster parents that clearly identify the responsibilities associated with their roles as treatment foster parents. Responsibilities of the treatment foster parent include

functioning as an active member of the treatment foster care team (FFTA, 2013). Like the caseworker, the treatment foster parent is required to participate in treatment planning, treatment team meetings, are required to document the services that they provide in their role as treatment foster parents (FFTA, 2013). The treatment foster parent is expected to enhance and support a positive relationship between the foster child and his/her birth family by facilitating contact with the child's birth and extended family members, providing updates on the child's progress towards his/her treatment goals to the primary family and providing assistance in the permanency planning process (FFTA, 2013). Treatment foster parents are expected to function as advocates for the child, and are expected to foster positive relationships with members of the extended treatment team in the community and school system (FFTA, 2013). If a treatment foster parent feels that they must ask for the removal of a foster child placed in their home, it is expected that the treatment foster parent provide at least 30 days' notice of the request to allow for a planned transition into a new setting (FFTA, 2013).

Qualifications and selection guidelines for treatment foster parents are outlined in the FFTA (2004) treatment foster care program standards. It is expected that treatment foster parents who are recruited to the program accept the treatment philosophy of the treatment foster care program be willing to carry out all responsibilities related to their role as the treatment foster parent (FFTA, 2013. According to the FFTA (2013), parents with certain qualities should be sought as treatment foster parents. These qualities include

> commitment, positive attitude, willingness to implement treatment plans and follow the Program's treatment philosophy, a sense of humor, enjoyment of

> children and youth, flexibility, tolerance and the ability to adjust expectations concerning the achievement and progress to the children's individual needs and capabilities. Treatment families must express openness to children and youth regardless of culture, language, socioeconomic status, race, ethnic background, religion, gender, political affiliation, gender identity, sexual orientation and ability (p. 28).

In addition, a treatment foster family must be emotionally and financially stable and have a reliable support network (FFTA, 2013).

Treatment foster care programs should have a recruitment and training program that is specifically designed to meet the needs of the population that is served by the program, and may include targeted recruitment efforts to meet the needs of children with very specific special needs (FFTA, 2013). Treatment foster care programs should conduct a thorough assessment of all potential treatment foster parents that includes background and reference checks, and assessment for other required qualifications including the need for treatment foster parents to meet minimum age requirements, be healthy enough to provide care to the children served by the program, have access to reliable transportation, to have reliable and appropriate alternate child care that is able to meet the needs of the children served by the program, and to refrain from corporal/ physical punishment (FFTA, 2013). Before becoming licensed, treatment foster parents must participate in at least 30 hours of primarily skill-based preservice training that prepares the family to meet the needs of the children served by the treatment foster care program, and once licensed treatment foster parents must receive a minimum of 24 hours of on-going training annually (FFTA, 2013). Training topics should be designed to

increase competency and develop skills needed to meet the needs of the foster children placed in the home of the treatment foster parent (FFTA, 2013).

In addition to pre-service and on-going training, treatment foster care programs should offer treatment foster parent support (FFTA, 2013). Support services include full information disclosure regarding the foster children placed in the treatment foster home, planned and crisis respite services, crisis counseling to cope with any issues cause specifically by the foster child placed in the treatment foster home, financial and social support, and professional liability coverage (FFTA, 2013). Treatment foster care programs should have written statements regarding the rights of treatment foster parents which should include but are not limited to the right of the treatment foster parent to be treated with dignity and respect, the right of the foster parent to have input into decisions about placement of children into their home, the right to have adequate access to respite services, and the right to have access at all times to a staff member from the program (FFTA, 2013). A formal grievance process should exist should the treatment foster parent feel their rights are violated (FFTA, 2013). Limits should be placed on the number of foster children placed into a treatment foster home, and should not exceed two children without justification for the placement of additional children (FFTA, 2013). Justification may include the accommodation of a sibling group in one home, and the abilities of treatment foster family to meet specific needs of a child (FFTA, 2013).

The third section of the FFTA (2013) treatment foster program standards address the needs of children, youth, and their families. Children and their families that are served by a treatment foster care program have the right to receive treatment to meet their specific needs and to be matched with a treatment foster family that is best suited to meet

the child's needs (FFTA, 2013). When possible, pre-placement activities such a day and overnight visits should occur to allow the child and family to become familiar with each other (FFTA, 2013). Children and their families should be asked about their specific placement requests, and a matching process that includes careful consideration of a treatment foster family's ability to meet the needs of a child (FFTA, 2013). The program should maintain a record on a child that includes but is not limited to the child's treatment, educational, medical, family, and social history, as well as current assessment and treatment documentation (FFTA, 2013). Children should have access to agency staff on a regular basis and in emergency situation, and should be provided with a handbook that details their rights and provides the child with contact information for the agency (FFTA, 2013). Children placed in treatment foster programs should have regular contact with their families as deemed appropriate by the child's treatment plan, and unless a court or the custodial agency prohibits it, the treatment foster care program should actively support the enhancement of the child's relationship with his/her primary family (FFTA, 2013).

According to the FFTA (2013), children placed in treatment foster care programs have the right to receive and participate in treatment planning services that address the child's cognitive, emotional, physical, and developmental needs. Upon placement into a treatment foster care program, a preliminary treatment plan should be developed to address goals for the child's first 30 days of placement (FFTA, 2013). Within 30 days of placement a comprehensive treatment plan that builds upon the child's strengths and addresses the child's growth areas should be developed (FFTA, 2013). The plan should outline measurable short-term treatment goals, and address the anticipated length of stay,

discharge plans, permanency plans, and anticipated discharge service needs (FFTA, 2013). Treatment plans should be reviewed at least monthly and revised as needed, and quarterly progress reports that outline the child's progress towards treatment goals should be completed (FFTA, 2013). The child's treatment should address the permanency plans and goals for the child, and transition planning that includes respite planning, discharge planning, and aftercare planning should occur (FFTA, 2013). Documentation of the child's progress should occur quarterly, and discharge report that details progress and recommended future treatment should be prepared upon discharge from the program (FFTA, 2013).

Early Foster Care Research

Published research on foster care using social science methodology dates back more than five decades and covers a range of topics. Early foster care researchers described the characteristics of children placed in foster care and their families (Fanshel & Mass, 1962), permanency (Mass & Engler, 1959), the value of foster care when compared with institutional care (De Fries, Jenkins, & Williams, 1965), the value of long-term foster care as a permanency plan (Madison & Schapiro, 1970), predictors of foster placement success (Kraus, 1971), and predictors of success in new foster parents (Cautley & Aldridge, 1975).

Taylor and Starr (1967) conducted a review of the existing foster care literature related to foster parenting. The review included clinical writings as well as descriptive, exploratory, and experimental studies. The review was conducted because the researchers believed that there was a lack of a comprehensive knowledge base of foster parenting and there had been little effort by researchers to build upon the work of past

research (Taylor & Starr, 1967). Areas of review included recruitment, foster parent selection, motivation to become foster parents, foster parent characteristics, caseworker/ foster parent relationship, foster parent training, and foster parent role performance adequacy (Taylor & Starr, 1967). The review suggested inconsistent findings and revealed gaps in the literature which lead Taylor and Starr to propose a series of questions for future research.

In regards to foster parent recruitment problems, one problem identified early was that the demand for foster parents exceeded supply (Taylor & Starr, 1967). Reasons cited for the shortage in the supply of foster parents included a shortage of people in the age range from which foster parents are recruited; an abundance of well-paying jobs available to those in the groups from which foster parents are recruited; and, in African American communities, poor economic situations, a high rate of maternal employment outside of the home, lack of adequate housing, and a general distrust of social service agencies (Taylor & Starr, 1967).

Problems recruiting foster families may be due to a general lack of knowledge about the functions of foster care and foster parenting amongst the general population. Public awareness campaigns would increase foster parent recruitment; however, the authors (Taylor & Starr, 1967) noted that of the four studies that suggest public awareness campaigns as a means to improve recruitment (Bohman, 1957; Ougheltree, 1957; Rawley, 1950; Simsarian, 1964:), only Ougheltree (1957) offers evidence that public awareness campaigns work (Taylor & Starr, 1967). Other reasons cited as reasons for potential foster parents not wanting to foster include families having children of their

own, agencies expecting too much from foster parents (Dick, 1961) and inadequate reimbursement (Glover, 1965).

After recruitment, other issues emerge in foster care as subjects of early research. In regards to foster parent selection, three main areas are covered; homestudy requirements, matching foster youth with foster families, and qualities sought in foster parents (Taylor & Starr, 1967). Primary areas of consideration in the homestudy are related to the social and emotional situation and the relationship of family members with other members of the family (Taylor & Starr, 1967). The authors note that the model on which the homestudy is based is the diagnostic assessment that is utilized in child and family agency settings; however, there is no evidence to support the need for such an assessment in the placement of foster children. Findings of studies cited are inconsistent. For example, two studies suggested that typical foster homes could serve both children with special medical needs as well as children with emotional and behavioral problems, and that agency support and resources are the most important factor in whether or not a family can successfully foster a child (Cochintu & Mason, 1961; Kaplan & Turitz, 1964).

Studies reviewed by Taylor and Starr (1967) indicated that specific characteristics are desirable, and found that the temperament of the foster mother (Murphy, 1964 as cited in Taylor & Starr, 1967, p. 374) and the age range desired by the foster family was associated with foster parent success (Babcock, 1965). The authors indicated that the best evidence regarding matching and foster parent success suggests that it is an interaction between the foster child's age, the foster parents' ability to tolerate certain behaviors, and the support received from the community and agency that best predict success (Taylor & Starr, 1967).

Although the need to examine the motivation of a family to foster was emphasized, the relationship between motivation and successful foster parenting was not clear (Taylor & Starr, 1967). One study found that foster parents who expressed altruistic reasons for fostering were significantly more successful with at-risk boys, and that foster parents who began fostering because they wanted a companion for their own child were unable to care for foster children once the foster children were no longer infants (Colvin, 1962). Clinical writers asserted that the reported motivation should only be used as a starting point for assessment purposes, and argue that it is not merely the motivation given for fostering that should be of concern, rather how the motivation for fostering will be translated into the relationship with any foster children placed in the home (Babcock, 1965). Taylor and Starr suggest that further research explore the relationship between husband and wife in foster families, specifically focusing the impact that the relationship between the husband and wife may have on the foster family's relationship with the agency.

The relationship between the agency caseworker and foster parent is complicated, and typically resembles a supervisor/staff relationship more than a caseworker/client relationship (Taylor & Starr, 1967). The nature of the relationship is typically hierarchical as it focuses on education, supervision, and support, and the hierarchical nature of the relationship can be problematic (Babcock, 1965). The authors suggest that the unclear relationship between the caseworker and the foster parent is problematic, and that previous research and clinical writing does not adequately address the problematic nature of the relationship. Based on their review of the literature, Taylor and Starr (1967) suggest that future researchers explore roles and responsibilities of the case worker and

foster parent, and how agencies can provide clarification regarding the role of the caseworker and foster parent to foster parents.

Foster parents encounter challenges and problems related to their role as foster parents (Taylor & Starr, 1967). Some of the issues most commonly reported are related to discipline (Ambinder & Sargent, 1965) and sharing the foster child with his/her primary family (Gaffney, 1965). These issues can be addressed through foster parent training. Taylor and Starr reviewed training methods, specifically the role of the group process in foster parent training. Benefits of training foster parents in a group setting include allowing foster parents to realize that other foster parents experience similar problems (Kohn, 1961), allowing the foster parents to discuss feelings and issues that are not addressed in individual meetings with caseworkers (Kohn, 1961), and providing role clarification (McCoy & Donahue, 1961). The argument was also made that the group process increases foster parent identification with the agency by providing role clarification, education that helps the foster parents fulfill their role more successfully, and by making the relationship between the agency and foster parent more collegial as opposed to a hierarchical supervisor/ supervisee relationship (Taylor & Starr, 1967). It was unclear if a group training process improved the care provided to foster children (Taylor & Starr, 1967), but there was evidence to suggest that group training did increase foster parents' understanding of difficult behaviors and encouraged more appropriate responses to difficult behaviors (Soffen, 1962). Following a review of the literature related to foster parent training, Taylor and Starr proposed that additional research be conducted to determine what educational backgrounds should be required of foster

parents since they function in a semiprofessional role, and what the specific content and sequence of on the job training should be provided to foster parents.

The definition of the foster parent role and the adequacy of foster parent role performance are the two major issues related to foster parent role performance (Taylor & Starr, 1967). It is argued that in order for a foster parent to effectively perform their role, the foster parent must have a clear understanding of what their role is, and there are discrepancies between how the foster parent sees their role and how the agency sees the foster parent role (Taylor & Starr, 1967). After reviewing the literature, Taylor and Starr indicate that many foster parents are unable to successfully fulfill their role as foster parents.

The literature review conducted by Taylor and Starr (1967) suggests that the most adequate foster parents are younger (Colvin, 1962), use words such as love and give to describe their motivation to foster (Kinter & Otto, 1964), show warmth when relating to foster children (Fanshel, 1966), and can accept that foster children's primary families are important to children (Hunter, 1964). The least adequate foster parents are older (Colvin, 1962), utilize the word take when discussing their motivation for fostering (Fanshel, 1966), have low parental competency scores (Fanshel, 1966), place a strong emphasis on academic performance (Hunter, 1964), and report a strong preference for fostering only preschool age children (Babcock, 1965). The authors caution that with few exceptions, the characteristics desirable in foster parents were based on the judgments of social workers (Taylor & Starr, 1967). The authors suggest that future research explore whether or not agencies have realistic expectations for foster parents and what alternate expectations might be, and the role that agency expectations play in defining the role of

foster parents, the selection of foster parents and training of foster parents (Taylor and Starr, 1967).

Subsequent researchers have identified limitations and difficulties related to research on foster families. A common limitation pointed out by researchers is an overall lack of research regarding foster parents/ foster families (Cautley, 1980; Cautley & Aldridge, 1975; Green, Braley, & Kisor, 1996; Hampson & Tavormina, 1980; Orme & Beuhler, 2001; Redding, Fried, & Britner, 2000; Taylor & Starr, 1967; Wiehe, 1983). Cautley and Aldridge (1975) asserted that the need for research on foster families had been emphasized for years yet there had been little progress in building the knowledge base. Researchers have identified the lack of knowledge regarding characteristics of foster families (Hampson & Tavormina, 1980; Orme & Beuhler, 1980) and the lack of knowledge regarding successful foster child/ foster family matching despite its importance as problematic (Green et al., 1996.; Redding et al., 1967). Orme and Beuhler (2001) assert that there is a lack of information regarding the marital functioning and mental health of foster caregivers, and cite the overall lack of synthesis of the literature related to foster families and failure to build upon the knowledge base as problematic.

Issues around the framework used to conduct research on foster families also have been identified. Madison and Shapiro (1970) point out that many of the studies related to foster families has been negative and focused on failure, not success. Other researchers point out that there has been a lack of conceptual framework related to foster parent research (Redding et al., 2000), and that there is a lack of linkage of the literature regarding foster families to the larger body of research on families in general (Orme & Beuhler, 2001).

In addition, challenges in conducting research on foster families have been identified. Researchers point out that there are issues related to how to define success in research on foster families (Cautley & Aldridge, 1975; Kraus, 1971; Redding et al., 2000; Rowe, 1976). The definition of foster parent success in early foster care research is vague (Cautley & Aldridge, 1975) and researchers assert that defining foster parent success is difficult because there are several criteria that can be used to assess success (Rowe, 1976) and because there are many factors that impact interactions among family members which can be related to foster family success (Cautley & Aldridge, 1975). Success generally refers to the fulfillment of a specific goal or goals, and one challenge in defining success as it relates to foster families is that different stakeholders may have different goals (Cautley, 1980). There are goals of the foster care system, which generally refer to meeting the needs of the family to whom the system is providing help and ensuring the long-term permanency needs of the child, and goals of the placement, which generally refer to the provision of appropriate parenting to a child who is unable to remain with his/her parents and possibly the amelioration of the impact of abuse and/or neglect that the child may have experienced prior to placement in foster care (Cautley, 1980). It has been argued that a typical measure of foster placement success, the continuation of a placement, is inadequate and shouldn't be the only measure of placement success (Cautley & Aldridge, 1975) and that the length of a foster care placement provides no information on family adjustment or child functioning (Redding et al., 2000).

Despite gaps in the literature discussed, there is some research regarding what makes foster families successful. The negative impact of foster placement disruptions in

the child and child welfare system has been of concern to researchers for decades (Kraus, 1971; Mass & Engler, 1959) and the role of foster parents in placement stability is documented (Cautley & Aldridge, 1975; Hampson & Tavormina, 1980; Kraus, 1971; Orme & Beuhler, 2001). Researchers have examined a multitude of factors that impact foster parent outcomes including demographic variables (Kraus, 1971; Rowe, 1976), motivations for fostering (Hampson & Tavormina, 1980; Kraus, 1971), family constellation and decision making style (Cautley & Aldridge, 1975), the match between foster parent and foster youth temperaments (Doelling & Johnson, 1990; Green et al., 1996), and a combination of these variables (Cautley & Aldridge,1975; Kraus, 1971). Since the focus of this project is what makes foster families successful, the existing literature regarding foster family success is reviewed.

One early study that explored factors contributing to foster placement success found that characteristics of the foster parents and foster home were more important in predicting foster placement success than characteristics of the foster child (Kraus, 1971). Kraus (1971) asserted that placement stability was the most important criterion of placement success. Placement stability is critical for reasons related to both the well-being of the child and the well-being of the child welfare system (Kraus, 1971). Stability is important in the social and emotional well-being of children. In addition, foster placement disruptions place a strain on an already overstressed child welfare system, and disruptions discourage foster parents from continuing to foster (Kraus, 1971), not to mention the negative impact they have on child psycho-social development when a foster placement disputes. Kraus' study revealed that combinations of factors, not a single factor, were related to foster placement success. Factors that predicted success included a

foster mother who was age 46 or older, foster parents who have 2 children of their own, another foster child being placed in the home, and foster parents who were motivated to foster by either a general interest in caring for children or the desire to foster a specific child (Kraus, 1971). The motivation to foster had the strongest relationship with success, and no relationship was found between placement success and the age, sex, or intelligence level of the foster youth (Kraus, 1971).

Hampson and Tavormina (1980) in a later study supported the relationship between foster parent success and motivations for fostering. Foster mothers who had longer term placements were more likely to report a desire to foster for "social" reasons such as a love of children, a desire to help, and overall interest in the well-being of children (Hampson & Tavormina, 1980). Foster mothers who had shorter term placements were more likely to report "private" motives for fostering such as wanting a companion for their own child (Hampson & Tavormina). The researchers report that motivations of foster mothers who had shorter term placements "universally involved the fulfillment of need for the foster mother," (Hampson & Tavormina, 1980, p. 110).

Similar to research conducted by Kraus (1971), Cautley and Aldridge (1975) found that there was a combination of factors that predicted placement success. In an effort to identify factors that predicted placement success amongst new foster families, the researchers interviewed 963 foster care applicants, and subsequently followed 145 couples who were approved to foster children between the ages of 6 and 12 years old (Cautley & Aldridge, 1975). Since it was felt that the continuation of a placement should not be the only measure of foster placement success, the researchers used additional criteria to measure success including case worker assessment of how the placement was

going and the case worker's assessment of the foster parent's skill level in managing the child's major issues (Cautley & Aldridge, 1975). In addition, foster parents were interviewed regarding to gather information regarding the child's behavior, the interactions between the parent and the child, and the experiences, feelings, and adjustments of the foster parents (Cautley & Aldridge, 1975). They found that the behavior of the foster child was not a predictor of placement success; the most successful and least successful placements had both children with very difficult behavioral issues and children with no behavioral issues (Cautley & Aldridge, 1975). The ideal family constellation for success was for the foster child to be the youngest child in the home (Cautley & Aldridge, 1975). Having a social worker with more years of experience and the foster parents' experience level with caring for foster children were both positively associated with placement success (Cautley & Aldridge, 1975). A foster family with a democratic decision making style in which the foster mother and father made major family decisions jointly were positively associated with placement success (Cautley & Aldridge, 1975). A foster mother who viewed the children as individuals who were separate from herself was positively related to placement success (Cautley & Aldridge, 1975). The foster father's flexibility, willingness to allow the social worker into the home regularly, willingness to accept feedback from the social worker, extent to which he had changed to meet the needs of his biological children and the level of concern shown for the foster youth were all positively associated with placement success (Cautley & Aldridge, 1975). The presence of preschool aged children in the home had a negative impact on placement success; as the number of preschool age children in the home increased, the negative impact on the placement increased (Cautley & Aldridge, 1975).

High levels of formal religiousness were also negatively correlated with placement success (Cautley & Aldridge, 1975).

In a subsequent study, Cautley (1980) found that the majority of new foster mothers interviewed reported that the foster parent role was different than they expected, and that they were unprepared for how different parenting foster children was than parenting their own biological children. Foster mothers reported that parenting foster children required more effort than anticipated, and some were unprepared for the behaviors exhibited by foster children placed in their care (Cautley, 1980). When interviewed three months into their first placement, new foster mothers who expressed dissatisfaction with their role as foster mothers were discouraged by their perception that the foster child(ren) were not making progress and feeling as if they were not helping the child (Cautley, 1980). It became clear that the longer the foster child was in the home; the foster parents began to more fully realize the depth of the impact of early abuse/ maltreatment on the foster child's functioning (Cautley, 1980). The ultimate measure of success was whether the child got better during their foster placement, and as with previous studies, there was no single factor that predicted success (Cautley, 1980). Some factors associated with success included families who were more adaptable/ flexible, families in which the foster mother had more experience caring for children in general as well as more experience in caring for children who were not her own, and families in which the foster father was open to working with the social worker (Cautley,1980).

Foster parent attitudes and expectations regarding child behavior are important in examining outcomes (Rowe, 1976). Foster parent performance was assessed through a review of foster family files and an eight item measure developed by the researcher that

was completed by the case worker and included questions regarding the degree of harmony in the foster home, the foster parent's level of responsiveness to the child, the foster parent's ability to tolerate acting out behavior from the child, and the case worker's overall rating of the competence of the foster home (Rowe, 1976). Study results indicated that age of the foster mother, the number of siblings, the foster mother's number of biological children, and the foster family's fostering preferences related to age, sex, and number of foster youth that they wished to foster were not related to success (Rowe, 1976). The socioeconomic status of the foster family was also unrelated to success (Rowe, 1976). However, parental attitudes and expectations were related to foster parent success; foster families who were tolerant of behaviors and values that differed from their own were more successful foster parents (Rowe, 1976).

Current Foster Care Research

The most recent foster care research has explored successful foster parents or foster placement success from multiple perspectives. Several studies have focused on success from the perspective of foster parents (Brown, 2008; Brown & Campbell, 2007) and foster youth (Miller & Collins-Camargo, 2015), qualities of foster parents (Berrick & Skivenes, 2012), or strategies to ensure foster youth successfully adapting to a new foster care placement (Jones, Rittner, & Affronti, 2016). Other studies have explored the role of matching foster youth and foster families on placements success (Brown, George, Sintzel, & St. Arnault, 2009; Doelling & Johnson, 1990; Green et al., 1996; Sinclair & Wilson, 2003), using a variety of research designs but all focus on traditional foster care, not treatment foster care.

Brown and Campbell (2007) utilized a mixed-method approach to explore foster parents' opinions of what makes a foster care placement successful. They found six distinct themes related to placement success emerged: the foster youth experiences security and safety in the placement, the foster parents are able to connect with the youth, a good relationship exists between the foster family and the foster youth, the placement has a positive impact on the foster family, there is seamless involvement of the child welfare agency, and the child experiences positive growth/development while in the placement. Foster parents in the study placed emphasis on the importance of a positive relationship between the foster family and the foster youth's primary or biological family (Brown & Campbell, 2007). Foster parents viewed the involvement of the primary or birth family throughout the placement as an indicator of placement success (Brown & Campbell, 2007).

Brown (2008) expanded this study, focusing on what foster parents felt they needed in order for a placement to be successful. Using a mixed-method design, foster parents indicated that they needed to have the right skills and personality, identifying traits such as open-mindedness, flexibility, kindness, patience, and self-awareness as important (Brown, 2008). Foster parents also reported needing adequate information about the child, a positive relationship with the agency, support and resources from the community, and personalized services to support the placement to ensure success (Brown, 2008). Foster parents also indicated they needed the opportunity to network with other foster families, a supportive extended family, and the need to practice good self-care as a foster parent (Brown, 2008).

Rather than focusing on the foster parent, Miller and Collins-Camargo (2015) sought to define foster placement success from the perception of foster youth. Thirty foster youth between the ages of 14 and 18 participated. According to foster youth, social workers were perceived to contribute to foster placement success through being responsible for making sure a foster care placement is adequate, listening to the foster youth, and trying to understand what foster care is like for youth. Foster parents were perceived to contribute to foster placement success not behaving differently in front of social workers than at home and supporting the foster youth in participating in after-school activities (Miller & Collins-Camargo, 2015). Foster youth perceived that they were responsible for placement success in that it is the foster youth's responsibility to ensure they successfully prepare themselves for a transition into adulthood. In general, youth viewed open communication and mutual accountability across all members of the foster care team as predictive of foster placement success.

Expanding beyond the U.S., Berrick & Skivenes (2012) explored qualities of exemplary foster parents in a qualitative study of 141 foster parents in the United States (n=87) and Norway (n=54). Exemplary foster parents were identified by agency workers; as providing high quality foster care to explore whether successful foster parents require only skills and qualities needed to successfully parent general population children or if exemplary foster parents must also go above and beyond good parenting to meet the specialized needs of children placed in foster care, what researchers referred to as "Parenting +" (Berrick & Skivenes, 2012). Findings suggest that high quality foster parents not only need to have more than just good parenting skills, they need to take a "Parenting +" approach. There are three dimensions to "Parenting +": the ability to

successfully integrate a foster child into the family, the ability to manage the complexities of the relationship between the foster youth, the foster youth's primary family, and the foster family, and the ability to meet the developmental and specialized needs of the foster youth. Exemplary foster parents take steps to ease the transition of a foster youth into the family and are able to successfully integrate a foster child into the family in a way that makes the foster child feel like a part of the family. Successful foster parents have empathy and respect for the youth's primary families and are able to manage the complexities of the relationship between the foster youth, foster family, and the youth's primary family. In addition, successful foster parents take a child-centered approach to parenting and advocate for the services foster youth need to meet their developmental and specialized needs.

One study sought to identify how foster parents support youth in adapting to a new foster care placement (Jones et al., 2016). Focus groups and interviews were conducted with 35 experienced foster parents living in both rural and urban areas to explore what foster parents do to support foster youth in successfully adapting to their homes. Some common themes which emerged were similar to findings from the study conducted by Berrick and Skivenes (2012). For example, Jones et al. (2016) found that foster parents who are able to help youth successfully adapt to placement are advocates for services needed to help the foster youth successfully adapt to their new school and neighborhood, and are able to manage the complexities of the relationship between the foster youth, foster family, and the youth's primary family by being respectful of the primary family and helping youth manage complex feelings about their primary family. Study findings also suggest that foster parents who are able to support successful

adaptation to the foster home help the youth settle in by making tangible accommodations for the youth such as allowing the youth to personalize his/her bedroom and accommodating the youth's food preferences. Other factors that support successful adaption to placement include the foster parent establishing a routine for the youth and exhibiting claiming behaviors such identifying the youth as their child and not a foster youth.

Much of the research related to successful foster care placements over the past 25 years has focused on the role of matching in foster placement success. Two studies explored success by examining the temperament of the foster parents and foster youth, and how well the foster youth matched with the foster family in terms of temperament (Doelling & Johnson, 1990; Green et al., 1996). Doelling and Johnson (1990) focused on children ages 5 to 10 while Green et al. focused on adolescents. Both studies measured the temperaments of foster parent and foster children, and assessed the family environment with input from the case workers and foster parents. Green et al. also utilized input from the adolescent foster youth when assessing the home environment. The results of the studies were similar. In children ages 5 to 10, study results indicated that when children whose temperament ratings indicated a negative mood were placed with mothers whose temperament ratings indicated inflexibility, placement outcomes were poorer (Doelling & Johnson, 1990). In these cases, there were greater levels of conflict and lower levels of maternal satisfaction, the case worker ratings of placement success were lower (Doelling & Johnson, 1990). When adolescent foster youth whose temperament ratings indicated a positive mood were matched with temperamentally similar parents, higher rates of family functioning and better adjustment to foster care

were reported (Green et al., 1996). When adolescents whose temperament ratings indicated a negative mood were placed with mothers whose temperament ratings indicated rigidity, ratings of family functioning were poorer (Green et al., 1996).

Sinclair and Wilson (2003) explored the role of matching, foster child factors, foster parent factors, and the interaction between the foster youth and foster parent in placement success in a sample of 495 foster children (Sinclair & Wilson, 2003). The researchers defined the placement as successful when the foster child, foster parent, and the child's caseworker all said that the placement had gone very well from the child's point of view. The mixed methods study indicated that foster children want to be placed in homes in which the foster parents are loving, encouraging, respectful of the individuality of the foster child, and that were able to treat the foster child as their own without creating divided loyalties between the foster family and the foster child's biological family (Sinclair & Wilson, 2003). Caseworkers stressed the importance of the foster families' ability to create an environment of case, stability, and love, to be persistent in managing the foster child's behaviors, treat the foster youth as a member of the family, and the ability to set limits with the foster child (Sinclair & Wilson, 2003). The researchers explored the foster families' overall parenting ability as assessed by a measure designed to quantify the foster parents' ability to create a caring, accepting, and encouraging environment for the child, the foster families' levels of child orientation, that is the number of things that the family would regularly with the foster child that would be enjoyable for the child, the foster parents' level of acceptance or rejection of the foster child, and behavioral difficulties of the foster child (Sinclair & Wilson, 2003). Results indicated that child orientation was significantly associated with parenting ability,

placement success, and the absence of disruption (Sinclair & Wilson, 2003). In foster families with low levels of child rejection, children with greater numbers of behavioral problems were not more likely to disrupt from the placement and were not less likely to be successful (Sinclair & Wilson, 2003). In foster families with high levels of child rejection, children with greater numbers of behavioral problems were more likely to disrupt from the placement, and the placement was less likely to be successful (Sinclair & Wilson, 2003).

Only one study explored foster parents' perceptions of the benefits of matching foster parents and foster youth based on cultural factors (Brown, George et al., 2009). Foster parents identified several benefits of matching based on culture including the foster parents' ability to expand on values held by the foster youth's primary family and community of origin, an enhanced sense of safety and security for a foster child when placed in a home that is culturally similar to his/her primary family, it being easier for a child to make a smooth transition into a foster home if there is shared culture between the foster youth and foster family, the foster parent experiences a lower level of stress because it is easier for the foster parents to make a connection with and parent a child with a similar cultural background, and a sense of commonality between the foster parent and foster youth facilitates communication and is less likely to create friction in the household (Brown, George et al., 2009).

In summary, researchers have explored traditional foster placement success from the perspective of the foster parent (Berrick & Skivenes, 2012; Brown, 2008; Brown & Campbell, 2007; Brown, George et al., 2009; Jones et al., 2016) and the perspective of foster youth (Miller & Collins-Camargo, 2015). Common themes emerged across

studies. Findings of several studies suggest a good match between the foster youth and foster family (Brown, George et al., 2009; Doelling & Johnson, 1990; Green et al., 1996; Miller & Collins-Camargo, 2015) and the relationship between the foster youth and foster family are important (Brown & Campbell, 2007; Miller & Collins-Camargo, 2015). Research also suggests that the involvement of the primary family is an indicator of success (Brown & Campbell, 2007) and discuss the importance of foster parents being able to navigate the complexities of the relationship between the foster youth, foster family, and biological family (Berrick & Skivenes, 2012; Jones et al., 2016). The role of support in placement success was a common theme, both in terms of the need for foster families to have a support network (Brown, 2008) and for the foster family to provide support to foster youth (Berrick & Skivenes, 2012; Jones et al.2016; Miller & Collins-Camargo, 2015). All of these studies focused on traditional foster care, not treatment foster care.

Treatment Foster Care Research

As previously discussed, treatment foster care developed to meet the needs of children involved with the child welfare system who have more complex needs. Early researchers identified concerns with treatment foster care research. In 1997, Reddy and Pfeiffer conducted a review of 40 treatment foster care studies published between 1974 and 1996 and found that overall treatment foster care had a positive impact on treatment foster youths' social skills and placement stability; however, the researchers pointed out that the studies reviewed generally lacked methodological rigor so results had to be interpreted with caution (Reddy & Pfeiffer, 1997). Other concerns identified by Reddy and Pfeiffer included a lack of consensus on what success in treatment foster care means,

a lack of clearly defined interventions, a lack of information about treatment strength or dosage, and a lack of studies related to treatment foster care outcomes, a concern identified earlier by Dore and Eisner in 1993. In 2008, Dorsey, Farmer, Barth, Greene, Reid, and Landsverk expressed concern about the lack of research related to training programs for treatment foster parents, noting that lack of research in this area means that there is little empirically based information to guide even the improvement of foster parent training.

A review of the literature indicates research related to placement success in treatment foster care is absent. No studies exploring successful treatment foster care placements or successful treatment foster placements could be located. Table 1 presents an overview of key empirical studies related to foster placement success. Because of the absence of research related to treatment foster placement success, all studies presented in the table are related to traditional foster care.

Table 1

Table of Key Empirical Studies

Author & Date	Data Source	Population/Sample Size
Berrick & Skivenes (2012)	Primary Data	International sample of 141 foster parents, 87 in the United States and 54 in Norway
Brown & Campbell (2007)	Primary Data	61 Canadian foster parents
Brown (2008)	Primary Data	63 Canadian foster parents
Cautley & Aldridge (1975)	Administrative Data	145 couples approved as first time foster caregivers for children ages 6-12.
Cautley (1980)	Administrative Data	115 newly licensed Wisconsin foster families fostering their first foster youth.
Doelling & Johnson (1990)	Administrative Data	51 foster children between ages 5 and 10 and their foster families in seven north Florida counties.

Green et al. (1996)	Administrative Data	40 foster families that resided in urban areas of Virginia and West Virginia with adolescent foster youth.
Hampson & Tavormina (1980)	Administrative Data	34 currently active foster mothers in central Virginia
Jones, Ritter, & Affronti (2016)	Primary Data	35 experienced foster parents in rural and urban areas of Western New York
Kraus (1971)	Administrative Data	157 children age 6 and older in their 1st foster care placement with no siblings residing on the same foster home.
Miller & Collins-Camargo (2015)	Primary Data	30 foster youth ages 14-18 in Kentucky
Rowe (1976)	Administrative Data	60 foster mothers from currently active and recently closed foster homes in Boulder, CO.
Sinclair & Wilson (2003)	Administrative Data	492 foster youth and their foster families in two London boroughs.
Author & Date	Outcome Variable	Covariates
Berrick & Skivenes (2012)	Qualities of exemplary foster parents	None
Brown & Campbell (2007)	Foster parent perception of placement success	None
Brown (2008)	Foster parent needs for placement success	None
Cautley & Aldridge (1975)	Placement success	Foster parent demographics (age, education level, occupation), reason for becoming a foster parent, anticipated difficulties of fostering, which spouse 1st expressed interest in fostering, attitude of other spouse towards fostering, reported pleasures and challenges of raising own children, manner in which couple makes major decisions, family background of each spouse, support from social worker, extent of foster youth's reported "difficult" behavior, level and involvement of foster youth's primary family, social worker's experience level, foster youth's background, family constellation including ages and number of other children in the home.

Cautley (1980)	Placement success as measured by whether or not the child improved while in placement.	Foster parent demographics (age, race, education level), number of biological children, level of adjustment foster mothers reported having to make, degree of difficulty of foster child's behavior, involvement of the foster child's own family, report of change in the foster child, foster mother's satisfaction with the placement, role of the foster father in the family, foster mother's attitude regarding the placement.
Doelling & Johnson (1990)	Placement success as measured by foster care worker rating.	Foster parent demographics (age, income, education level,), number of parents in the home, number of children in the home, length of placement, foster parent temperament, foster youth temperament.
Green et al. (1996)	Placement success as measured by family adjustment.	Foster parent demographics (race, income, education level, age), foster parent temperament, foster youth temperament, case worker rating of placement, family adjustment.
Hampson & Tavormina (1980)	Placement success as measured by placement lasting for 2 years or more	Foster parent demographics (income, age), motivation for fostering, number of biological children, number of foster children, length of time child has been in foster care, rewards and problems related to fostering, resources, modes of discipline used.
Jones, Rittner, & Affronti (2016)	Successful adjustment of foster youth to a placement	None
Kraus (1971)	Placement success as measured by continuation of placement for at least 6 months.	Foster youth age, gender, Wechsler Intelligence Scale for Children of Wechsler Intelligence Scale for Adults full-scale IQ score, date of placement, and date of placement termination (if applicable). Foster parent religion, age, occupation, number of natural, adopted, or foster children (excluding present foster youth), income, reason for wanting to foster, preferences for foster youth age and gender, number of children in the household within 2 years in age of the foster youth, number of people living in the home, number of rooms in the home, crowding index, and caseworker's assessment of foster parents' ability to manage foster youth behavior problems.
Miller & Collins-Camargo (2015)	Foster youth perceptions of placement success	None
Rowe (1976)	Placement success	Foster parent demographics (education and occupation), SES of foster family, foster parent's level of acceptance of early adult behavior, poor academic performance, level of encouragement of religious observance, parent discipline practices.

Sinclair & Wilson (2003)	Placement success	Foster child's wish to stay in the placement, pro-social behavior (foster child), behavioral difficulties (foster child), parenting score (level of warmth, persistence, and ability to set limits), parent rejection scores, parent/ child interaction.
Author & Date	Methodology	Summary of Findings
Berrick & Skivenes (2012)	Qualitative, analytical and conceptual strategy	Exemplary foster parents need qualities above and beyond what is required to successfully parent general population children, referred to as "Parenting +" by the researchers.
Brown & Campbell (2007)	Mixed-methods, concept mapping	Foster parents viewed placement success in terms of security for the child, family connects with the foster youth, good relationship between foster family and foster youth, positive family change, seamless agency involvement, and the child grows.
Brown (2008)	Mixed-methods, concept mapping	Foster parents reported needing the right personality and skills, information about the child, a strong relationship with the foster care agency, personalized services, support from the community, opportunities to network with other foster families, a supportive family, and the ability to practice good self-care.
Cautley & Aldridge (1975)	Multiple regression	Behavior of the child was not a predictor of success; involvement of foster youth's primary family did not impact the care of the foster youth; the presence of preschool age children negatively impacted placement success with negative impact increasing as the number of preschool age children increased; high formal religiousness negatively correlated with success. Factors associated with success included social worker having more years of experience; higher levels of familiarity of child care; democratic decision making style; father's willingness to allow social worker in the home and willingness to accept feedback; father demonstrating flexibility in the care of his biological children; higher levels of concern shown for the foster youth's well-being by the foster father; foster mother who views children as individuals separate from herself.
Cautley (1980)	Multiple regression	Factors positively associated with success included: families who were more adaptable/ flexible, foster mothers with more child care experience, foster mothers with more experience caring for a child who is not her own, families who were more willing to work with the social worker.
Doelling & Johnson (1990)	Multiple regression	Placement of a negative mood child with an inflexible mother was more likely to result in greater conflict, lower maternal satisfaction, and lower case worker success rating.

Green et al. (1996)	Regression analysis	Foster youth with positive mood temperament placed with similar temperament foster parents had higher rates of family functioning and placement adjustment. Foster youth with negative mood temperament placed with rigid foster mothers associated with poorer family functioning.
Hampson & Tavormina (1980)	Chi-square distribution	Foster mothers who reported social motives (love of children, interest in children's well-being, desire to help someone else) for fostering had longer term placements. Foster mothers who reported private motives for fostering (wanting a companion for own child, wanting a child to care for) had shorter term placements.
Jones, Rittner, & Affronti (2016)	Qualitative, grounded theory	Major themes that emerged included the foster parent taking steps to help the youth settle in, demonstrating claiming behaviors, establishing routines, helping youth adjust to the neighborhood and school, and managing complex relationships between the foster youth, foster family, and foster youth's primary family.
Kraus (1971)	Chi-square distribution	No relationship between placement success and the foster youth age, gender, or intelligence level. The motivation for fostering had the strongest association with placement success, with a desire to care for a child or desire to foster a specific child being associated with success. Other factors positively associated with success include a foster mother age 46 or older, foster parents having 2 children of their own, presence of another foster youth in the home, and total number of people in the home greater than or less than 4.
Miller & Collins-Camargo (2015)	Mixed-methods, concept mapping	Foster youth viewed placement success in terms of responsibilities of the social worker, foster parents, foster youth, and foster care agency.
Rowe (1976)	Multiple regression	Social class was not related to success. Factors associated with success were foster parents who were more accepting of early adult behavior, poor academic performance, difficult social behavior, and who don't require strict religious observance.
Sinclair & Wilson (2003)	Mixed methods, Chi square	Child orientation associated with parenting scores, placement success, and absence of disruption. In foster families with low levels of rejection, child behavior problems not related to placement disruption and not less likely to be successful. When rejection scores were high, behavior problems associated with increased likelihood of disruption and placement was less likely to be successful.

Theoretical Perspectives

The ABCX Model

Family systems theorists have studied the impact of stress on the family system for more than 6 decades (Hansen, 1965; Hill, 1949; Lavee, McCubbin, & Olson, 1987; Lavee, McCubbin, & Patterson, 1985; Lightburn & Pine, 1996; McCubbin, 1979; McCubbin & Patterson, 1982; Olson & McCubbin, 1982; Olson, Russell, & Sprenkle, 1983). In his 1949 study of the impact of separation and reunification on American families, Rueben Hill explored the responses of 135 families to stress by examining the impact of the removal of the father from the family because of military service during World War II and then the process of the father returning to the family. Hill (1949) viewed the family system as a closed system which behaved much like a living organism. According to Hill (1949), the study was "a search for the characteristics and processes which set of successful from unsuccessful families," (p.7).

The way a family copes with stress can be predicted in part by how a family coped with a stressful situation in the past (Hill, 1949). According to Hill (1949), there are three factors that determine whether or not a situation is a crisis. First, the hardship or difficulty of the situation; second, the resources the family has to cope with the event including their past history with crisis management; and third, whether or not the family sees the situation as a threat to their goals, status, and objectives as a family. An important component of whether any situation is a crisis or manageable is how the family defines the event, or the family's cognitive appraisal of the situation. These three factors came to be known as the ABCX model (Hill, 1958). The "A" or hardship event interacts with "B" the resources of the family, which interacts with "C" the definition the family

gives to the situation to produce the "X" which is a manageable situation or the crisis (Hill, 1958). Successful management of a crisis situation generally leads to a strengthening of a family system, while unsuccessful management of a crisis situation can have a negative impact on a family, resulting in a range of negative effects from increased family conflict to family disintegration (Hill, 1958).

Crisis situations can often lead to changes in family structure by impacting the roles and duties of various family members (Hill, 1949). Crisis situations can lead to family breakdown, which can then lead to disruption of family roles, and reassignment of family roles, followed by a period of confusion and uncertainty while new family roles are being learned (Hill, 1949). In Hill's study, the removal of the father from the family because of military service lead to the reassignment of roles previously managed by the father to other family members. When the father returned to the family once his military service was complete, role reassignment reoccurred in many families to accommodate the father back into the family. According to Hill, family traits of adaptability or flexibility can be useful during a crisis situation (Hill, 1949).

Hill (1949) found that certain family characteristics impacted a family's adjustment to separation and reunification. The most influential factors in a family's adjustment to the separation of the father were the resources of the family, and the hardship of the separation experience including the adequacy of communication during the separation and the severity of the hardship created by the separation (Hill, 1949). Hill found that the more the separation impacted the day-to-day family experiences, the stronger the impact it had on family adjustment to separation. For example, the adaptability of a family, the level of family integration, and the skills and resources a

family had available to manage the separation were influential in determining how a family managed the separation of the father, while factors such as the number of years marriage, the number of years of parenting experience, the courtship history of a couple, and a couple's readiness for marriage at the time of marriage had little to no influence on a family's adjustment to separation (Hill, 1949). Similarly, Hill found that the resources of the family and the level of hardship created impacted a family's ability to adjust to the reunification with the father. The most influential factor in determining the success of a father's reintegration into a family was the level of focus that individual family members had on the interest of the family and the level of identification with the family; those families with a high level of focus on the interests of the family and a high level of family identification were more likely to experience successful reunification than those families with lower levels of focus on family interest and lower levels of family identification (Hill, 1949).

According to Hill (1949) the best predictor of how a family will behave during a crisis event is the family's behavior during past stresses. Hill determined that some families are more likely to define a hardship as a stressful event which he referred to as crisis proneness. Crisis proneness appeared to be more common in families with low family adequacy, and Hill hypothesized that crisis proneness could run in families.

Not all crises are the same; families experience different types of crisis. An extra-family crisis results from a factor outside of the family, while an intra-family crisis results from an event occurring within the family (Hill, 1949). Intra-family crisis includes family dismemberment that results from death of a family member or separation of a family member; accession which includes the addition of a family member such as a

foster-child entering the family; demoralization includes a family member being unfaithful or refusing to provide support to the family; or, demoralization plus dismemberment or accession which includes illegitimacy, divorce, or a family member being imprisoned (Hill, 1949).

In the decades since Hill introduced the ABCX Model, family systems researchers have built upon Hill's ideas and original model. In the early 1980's two notable models were introduced; the Double ABCX Model (Patterson & McCubbin, 1983) and the Circumplex Model of family functioning (Olson & McCubbin, 1982). Both models will be explored further.

The Double ABCX Model

Patterson and McCubbin (1983) expanded upon Hill's original ABCX model to develop the Double ABCX Model. When a family faces a stressful situation, in many cases not only does the family have to cope with the stressful event, the family must cope with stressors related to changes that occur in the family in an effort to cope with the stressful situation. Patterson and McCubbin (1983) use the term "pile-up" to describe the initial stressor that the family faces as well as the stressors that result from changes that occur within the family as a result of the stressful event. Ambiguity is a contributing factor to stressors experienced by the family. Ambiguity can include uncertainty about the future or the unclear and/or absence of norms related to how a family behaves the situation. The "pile-up" is the Double A in the Double ABCX Model (Patterson & McCubbin, 1983).

When presented with a stressful situation, a family will not only draw upon available resources in an effort to prevent the family from entering a crisis state, the

family may develop and/or strengthen resources in an effort to cope with the crisis event. Resources can be personal characteristics (psychological, social, material, and interpersonal) of family members that can be drawn upon to reduce tension, meet the needs of family members, and manage conflicts (McCubbin & Patterson, 1982). At the individual level resources can include education, emotional stability, independence, and competency (McCubbin & Patterson, 1982). At the family level resources can include flexibility, cohesiveness, organization, expressiveness, and religion (McCubbin & Patterson, 1982). At the environmental level resources can include a family's social support network and formal services such as medical and psychological services as well as social policies (McCubbin & Patterson, 1982). The resources available to the family in combination with resources that may be developed or strengthened to cope with the crisis is the Double B in the model (Patterson & McCubbin, 1983).

When faced with a stressful event the family not only has an initial perception of the stressor event but the family also develops a perception of the crisis; this includes the meaning the family assigns to the crisis situation as a whole including the family's view of the stressor, the pile up of the events, and the related hardship. Religious beliefs can provide meaning to the situation encountered by a family that can help the family redefine the event (McCubbin & Patterson, 1982). The combination of the family's perception of the initial stressful event and the family's perception of the crisis situation as a whole is the Double C in the ABCX Model (Patterson & McCubbin, 1983).

To test the Double ABCX Model, 100 families with at least one child with cystic fibrosis were participants in a 1983 study (Patterson & McCubbin, 1983). The researchers utilized the Family Inventory of Life Events (FILE) developed by McCubbin,

Wilson, and Patterson to explore the concept of pile-up as it related to the Double A. The FILE includes 171 self-report items that assess the life events and changes within a family in each 6-month period of the previous year and it includes 8 categories: family development and relationships, family and extended family relationships, family and work, family management and decisions, family and health, family and social activities, family and finances, and family and law. The focus of the FILE is on change alone, and did not take into account whether a change could be perceived as positive or negative. For each occurrence of items on the FILE in the previous year the researchers assessed whether the change was anticipated, the amount of adjustment required by the family, and whether the family had finished adjusting to the event or if the adjustment was completed (Patterson & McCubbin, 1983). The researchers found an association between the number of life changes experienced by a family and a change in the health status of the family member with cystic fibrosis, which the researchers considered support for their hypothesis that the pile-up of life events was a factor in how a family reacts to stress (Patterson & McCubbin, 1983).

As a theoretical perspective, the Double ABCX Model (Patterson & McCubbin, 1983) has been utilized to explore family functioning and response to stress in a wide range of situations. Researchers have utilized the model to explore functioning in families facing economic pressure (Vandsburger & Biggerstaff, 2004), divorce (Tschann, Johnston & Wallerstein, 1989), issues related to blended families/ step-families (Crosbie-Burnett, 1989), families relocating to foreign countries for employment purposes (Caligiuri, Hyland, Joshi, & Bross, 1998; Lavee et al., 1985), families raising children diagnosed with developmental disabilities (Jones & Passey, 2004; Saloviita, Italinna &

Leinonen, 2003; Trute, Benzies, Worthington, Reddon, & Moore, 2010) or autism spectrum disorders (Bristol, 1987; Pakenham, Samios, & Sofronoff, 2005), primary caregivers of elderly family members diagnosed with dementia (Rankin, Haut, & Keefover, 1992) or family members experiencing other physical and/or cognitive impairments (Lee, 2009), and adult children of alcoholics (Easley & Epstein, 1991). The model has been demonstrated to be useful in that it provides a framework for understanding a wide range of potential responses by families to various stressors.

Several studies provide support for a relationship between the double A or "pile-up" of events and a family's overall response or adaptation to a stressor. For example, a study of caregivers of family members diagnosed with dementia found that the number of stressful life events faced by a family in the preceding year predicted a significant portion of the strain experienced by the caregiver (Rankin et al., 1992). In a study of Army families relocated to a foreign country found that the "pile-up" of demands negatively influenced family adaptation to the move to the foreign country (Lavee et al., 1985). Those families who experienced move related stressors and who experienced demands unrelated to the move that were not resolved prior to moving experienced more difficulty adjusting to being relocated to a foreign country (Lavee et al., 1985). In a study of the functioning of families with a child diagnosed with autism or other communication disorders, Bristol (1987) found that in parents reported being more depressed and less happily married who also experienced a greater pile-up of stressors.

Several studies also demonstrate relationship between the double B, or a family's resources, and a family's overall response and/ or adaptation to a stressor. For example, in a study of parents of children with Asperger syndrome, a negative relationship was

found between the quality of social support that a parent received and the level of anxiety experienced by the parent (Pakenham et al., 2005). However, in some studies (Lavee et al., 1985; Vandsburger & Biggerstaff, 2004) resources such as social support played more of a buffering role in a family's response/ adaptation to a stressful situation. For example, in a study of families experiencing economic pressure, researchers found that economic pressure was negatively associated with family functioning but that family resiliency factors such as family hardiness and social support were positively associated with family functioning (Vandsburger & Biggerstaff, 2004). When resiliency factors were taken into account, economic pressures faced by families did not negatively impact family functioning; the effects of economic pressure on family functioning were mediated by the resiliency factors of family hardiness and social support (Vandsburger & Biggerstaff, 2004). In a study of Army families who were relocated to West Germany, social support did not enhance a family's adaptability to the move to West Germany; however, social support played a buffering role in that those families who reported more social support and friendships interpreted the situation more positively, and those families who interpreted the situation more positively adapted better to the move (Lavee et al., 1985).

Research has explored the relationship between the resources available to a family (Double B) and a family's perception of the stressful event (Double C). In a study of Army families who were relocated to West Germany, results indicated that intrafamily resources were related to the ability of a family to cope with stress (Lavee et al., 1985). Families, who were more cohesive, were better able to communicate support to one another, and who were more flexible were better able to deal with the "pile-up" of

stressors (Lavee et al., 1985). Resources in the form of social support from the community and friends had more of a buffering role (Lavee et al., 1985). The study indicated that social support did not enhance a family's adaptability to the move to West Germany; however social support played a buffering role in that those families who reported more social support and friendships interpreted the situation more positively, and those families who interpreted the situation more positively adapted better to the move (Lavee et al., 1985). The family's perception of the external environment had more of an influence than the internal environment of the family (Lavee et al., 1985).

A family's perception or cognitive appraisal of a situation is a critical concept in the Double ABCX model (McCubbin & Patterson, 1982). The perception of the crisis includes the family's view of the stressor, the related hardships that develop as a result of the stressful event, and the meaning that the family makes of the whole situation (McCubbin & Patterson, 1982). In their study of military families coping with separation induced by the Vietnam War, McCubbin and Patterson assert the perceptions that a family has of the stressor appear to involve religious believes, how the situation is defined, and the how the family assigns meaning to the situation. The ability of a family to make sense of a situation is impacted both by the negative experiences/ pile-up of demands, and the positive experiences of the social environment (Lavee et al., 1985).

A few studies have found indirect support for the relationship between whether a family has a negative or positive cognitive appraisal of a situation, the double C, and how a family responds to the stressor. For example, in families of children diagnosed with developmental disabilities, how positively parents view their situation is related to their level of adaptation (Bristol, 1987; Jones & Passey, 2004; Pakenham et al., 2005; Saloviita

et al., 2003; Trute et al., 2010). In a study of families with children diagnosed with developmental disabilities and behavior problems, those families who focused on maintaining family integration, cooperation, and optimism experienced less stress related to family cohesiveness, parental satisfaction related to caring for their child, and concerns about the child's future (Jones & Passey, 2004). In a study of 237 families with children diagnosed with intellectual and developmental disabilities, mothers who reported higher level of family adjustment tended to have a more positive appraisal of the impact of the child's disability on the family through improved family values, improved sensitivity to others, and/or increased spirituality (Trute et al., 2010). A study of families with children diagnosed with Asperger syndrome found that families with more positive maternal adjustment had increased levels of social support and coping by positive reinterpretation of the situation (Pakenham et al., 2005). In a study of families with children diagnosed with Autism or other communication disorders, mothers who interpreted their child's diagnosis negatively or who blamed themselves or another family member for the child's diagnosis had poorer levels of adaptation (Bristol, 1987). Saloviita et al. (2003) found that among parents of children with intellectual disabilities, the way that the parents defined the situation was the strongest predictor of parental stress, with those parents who defined having a child with an intellectual disability as a "catastrophe" reporting higher levels of stress.

The impact of positive cognitive appraisal does not appear to be limited to families facing stress related to raising children with physical and/or intellectual disabilities. In a study of families who relocated to a foreign country for employment, families who perceived the move to be more positive adjusted better to living in a new

country than families with negative perceptions of the move (Caligiuri et al., 1998). Similarly, Army families who were stationed in West Germany adjusted better to the move when the move was interpreted positively (Lavee et al., 1985). A study of typically functioning families found that those families who have the ability to reframe or view problems faced by the family as solvable adjust better than those families who were unable to do so (Lavee et al., 1987).

The Circumplex Model of Families

Central to the Circumplex Model are three dimensions of family functioning: family cohesion, family adaptability, and family communication (Olson, McCubbin, et al., 1983). Olson and McCubbin assert that the model is useful in that the "circumplex model provides a viable framework for bringing together theorists, researchers, and practitioners involved in the analysis, study, and treatment of families under stress," (Olson & McCubbin, 1982, p. 48). Family cohesion is the emotional bond between family members. Family adaptability is the ability of the family system to change roles, rules, and the structure of power within the family in response to stress. In the Circumplex Model, family communication facilitates the other two dimensions and allows family members to share with one another what they need in relation to cohesion and adaptability (Olson, McCubbin et al., 1983). Positive communication skills include supportive comments, empathy, and reflection and negative communication strategies include criticism and double messages (Olson, McCubbin et al., 1983).

Four levels of family cohesion and four levels of family adaptability exist (Olson, McCubbin et al., 1983). The levels of family cohesion include disengaged (very low), separated (low to moderate), connected (moderate to high), and enmeshed (very high)

(Olson, McCubbin et al., 1983). Levels of family adaptability are rigid (very low), structured (low to moderate), flexible (moderate to high), and chaotic (very high) (Olson, McCubbin et al., 1983). These four levels of family cohesion and four levels of family adaptability combine to form 16 different types of marital systems; however, the researchers determined that there were three basic groups of family types (Olson, McCubbin et al., 1983). The Balanced type family functions at the two central levels on dimensions of family cohesion and adaptability; the Extreme family type is extreme on both family cohesion and adaptability; and, the Mid-Range family is extreme on only one level (Olson, McCubbin et al., 1983). According to Olson, Russell, & Sprenkle (1989) families that function in the mid-range of family cohesion and family adaptability tend to function more adequately when compared with families that function in the extreme ranges of family cohesion and family adaptability. In later developments of the model based on cultural diverse families, Olson and colleagues conclude that there is not one type of family style better than another style. What is most important is if the family is able to accomplish their tasks of living so that everyone in the family gets his or her needs met.

Normative Processes and Crisis in Foster Families

A foster family is a unique type of family. It is constructed for the purpose of caring for a child who is (usually) not biologically related to the parents. It is an intervention to provide family care to a child (or children) whose birth parents are unable or unwilling to safely provide them care. Foster care is designed to be a temporary family until it is either safe for the child to return to the primary family, or in cases where the primary family is unable to ensure the safety of the child, become a permanent

placement through adoption. By design foster families regularly experience accession and dismemberment. When a foster child is placed in a foster home, a family member is added and the family experiences accession. When a foster youth leaves the foster home to return to primary family or enter an adoptive home that is not the foster family, the family experiences dismemberment.

In addition to regularly experiencing accession and dismemberment, the introduction of foster children into the family may alter the family life cycle. Similar to individuals, families move through different developmental stages throughout the life cycle of the family. The family life cycle is a concept that is central to the Circumplex Model, as families may move through different levels of family cohesion and family adaptability as the family moves through various life cycles (Olson, McCubbin et al., 1983). A more concrete example follows.

In considering the developmental stage of the family, the age of the oldest child, the amount of transition required to meet the changing needs of the family members as they entered into different developmental stages, and changes in family goals or direction were accounted for (Olson, McCubbin et al., 1983). The researchers identified seven stages in the family life cycle; young couples without children, childbearing families and families with children in the preschool years, families with school-age children, families with adolescents living in the home, launching families, empty nest families, and families in retirement (Olson, McCubbin et al., 1983).

The focus and goals of the family change as the family moves through the life cycle. Young couples without children are in the process of negotiating individual and family goals, and during this stage the couple is not dealing with the demands of having

young children in the family (Olson, McCubbin et al., 1983). In families with the oldest child being in the preschool years, the family is child centered, the child (or children) spend most of their time in the home, and the focus of the family is on the nurturing of the child (or children) (Olson, McCubbin et al., 1983). Families with school-age children have the socialization and education of the child (or children) as their primary goal (Olson, McCubbin et al., 1983). Families with adolescents in the home are focused on preparing the child to leave the home, and this stage of the life cycle is difficult for many families because dealing with adolescents is challenging (Olson, McCubbin et al., 1983). Launching families are faced with changing roles and rules related to parenting, as the primary focus of the family is on supporting older adolescents/ young adults in successfully leaving the family (Olson, McCubbin et al., 1983) Empty nest families are characterized by an absence of children in the home, the couple becoming more focused on the needs of the couple, and the establishment of differentiated roles with children and grandchildren (Olson, McCubbin et al., 1983). Families in retirement are families who have raised their children, have completed their major career responsibilities, and are primarily focused on relationships, both between the couple and with members of extended family and friends (Olson, McCubbin et al., 1983).

The addition of a foster child or children to a family potentially alters the life cycle of the family. For example, the addition of a child who is older than the child (or children) currently living with a family would change the age of the oldest child in the family, and depending of the needs of the foster child (or children) placed into the family, the level of adjustment required of existing family members to meet the changing needs of the family could be considerable. The addition of an adolescent to a family whose

oldest child had been preschool age could require considerable adjustment on the part of the family as the family would move from the preschool-age child stage of the family life cycle to the adolescent stage in the family life cycle instantly. Notably, Olson, McCubbin et al. (1983) found that levels of family cohesion and adaptability vary at differing times in the family life cycle in their study of 1140 healthy/ non-clinical families in all stages of the family life cycle. Study results indicated that family cohesion was highest in early stages of the family life cycle, dropped during the adolescent and reached the lowest level in the launching phase, and then increased again as the family entered into the empty nest and retirement phases (Olson, McCubbin et al., 1983). Family adaptability followed a pattern similar to what was noted with family cohesion; family adaptability was highest in the early stages of marriage, husbands' assessment of adaptability reached the lowest point in the adolescent stage, while wives' assessment of adaptability reached the lowest point in the launching stage, and scores for both husbands' and wives' increased in the empty nest and retirement stages (Olson, McCubbin et al., 1983).

A review of the literature reveals that the family life cycle of foster families has not been addressed; however, researchers have explored the family life cycle of the adoptive family. Rosenberg (1992) explored the life cycle of the adoptive family in terms of the developmental tasks that birth families, adoptive parents, and adoptees must face. The phases of the adoptive family life cycle focusing on the developmental tasks of the adoptive parents are: phase 1, the couple decides to adopt; phase 2, the adoption process; phase 3, an adoptive family is born; phase 4, the adoptive family with a preschool age child; phase 5, the adoptive family with a school age child; phase 6, the

adoptive family with an adolescent; phase 7, the adoptive family with a young adult; and phase 8, the adoptive family later in life (Rosenberg, 1992). The phases of the adoptive family life cycle focusing on the developmental tasks of the adoptee are: phase 1, the circumstances of conception, pregnancy, and birth; phase 2, the postpartum period; phase 3, infancy; phase 4, preschool years; phase 5 school years; phase 6, puberty and adolescence; phase 7, young adulthood; phase 8, adulthood; and phase 9, later life (Rosenberg, 1992). The developmental tasks faced by adoptive parents and adoptees will be reviewed as they are some commonalities between adoptive and foster families. The phases related to young adulthood, adulthood, and later life will not be discussed as it is highly unusual for foster families to foster children beyond adolescence.

In many cases the adoptive family life cycle begins with a couple's traumatic realization of infertility (Rosenberg, 1992). After this traumatic realization of infertility, a couple enters phase 1 when the couple makes the decision to adopt. According to Rosenberg couples in this phase must grieve the loss of fertility; however, the grief process is often not recognized or validated by others (Rosenberg, 1992). Couples must deal with relationship and sexual issues that arise in their own relationship, and must cope with difficult feelings that may be triggered by being around children and other families with children (Rosenberg, 1992). A couple's race, culture, class, and religion will impact how the couple meets the developmental tasks in this phase, as race, culture, class, and religion all impact the couple's own feelings regarding adoption, as well as the willingness of the adoptive couple's extended family to accept a child into the family who is not biologically related to the family (Rosenberg, 1992).

Infertility issues lead some families to foster parenting. Becoming a foster to adopt family allows a family to foster a child/ children before making the commitment to adopt a child which is appealing to some families. Finances may be a factor in making the decision to foster with some families, as in some cases families who commit to foster parenting can receive an adoptive homestudy for free or at a reduced cost. For these reasons, some families find the foster to adopt process appealing and make the choice to become foster families with the intent to adopt. Families who seek to become foster parents with the intent to adopt because of infertility issues would face similar developmental tasks to adoptive families in phase 1 of the adoptive family life cycle.

The second phase of the adoptive family life cycle faced by adoptive parents is phase 2, the adoption process (Rosenberg, 1992). During this phase, if infertility is a factor, the couple must publicly reveal their issues with infertility (Rosenberg, 1992). During this phase a couple must say goodbye to their fantasy child and cope with the hurtful and insensitive comments and actions of others (Rosenberg, 1992). Further complicating this phase is the fact that a couple must deal with the very critical and confusing adoption process in which the couple must submit to scrutiny from an adoption agency in which factors such as the couple's age, finances, and the quality of the marital relationship are assessed (Rosenberg, 1992). The homestudy process for adoptive families and foster families are very similar, and in some states those wishing to become foster parents are subjected to more scrutiny than those wishing to adopt. Foster families would face similar developmental tasks as adoptive families during this phase, as both foster and adoptive families must navigate the confusing and critical homestudy process

in which the families as assessed for appropriateness to parent a child that is not biologically related to them.

The third phase of the adoptive family life cycle begins when the adoptive placement occurs and the adoptive family is born (Rosenberg, 1992). During this phase the adoptive family is aware of the birth family, at least at some level, and recognizes that while it is a happy occasion for the adoptive family, the birth family is grieving (Rosenberg, 1992). The adoptive family becomes an instant family, and likely experiences excitement and apprehension during this phase (Rosenberg, 1992). During this phase the family must again cope with insensitive and hurtful comments and behaviors from others (Rosenberg, 1992). Despite the challenges of becoming an instant family without the physical presence of a fetus or outward signs of pregnancy for social confirmation of becoming a parent, the adoptive family must assume complete responsibility for a child that is not biologically their own (Rosenberg, 1992). Although the circumstances are different, and foster families are generally accepting a child for temporary, not permanent placement, some similarities exist between foster and adoptive families when a child is initially placed. When a child is placed into a foster family, whether the child is coming from their biological family or from another foster family, loss is involved and the situation is generally difficult. Like adoptive families, foster families become instantly responsible for a child to whom they are generally not biologically related, and foster families must deal with the presence of the birth family.

In phases 4 and 5, the adoptive family with a preschool child and the adoptive family with a school-age child, one of the primary developmental task of adoptive parents is facing the child's changing understanding of what adoption means, and challenges

related to when, how, and under what circumstances to disclose the adoption to the child (Rosenberg, 1992). In phase 5 adoptive families must deal with issues related to insensitivity from the school system and the child making comparisons with other children who are not adopted (Rosenberg, 1992). During phase 5 the child may fear that the adoptive parent will give the child back, or they may fantasize that their birth family will want them back (Rosenberg, 1992). As school age children develop a deeper understanding of what it means to be adopted and struggle with fears and fantasies about their birth and adoptive families, children may begin to act out and test the relationship (Rosenberg, 1992). In these situations, adoptive parents may have difficulty accepting that the adopted child is not their ideal child, and the adoptive parents many have difficulty making a permanent commitment to the child (Rosenberg, 1992).

Although the developmental tasks are not identical, foster families face some similar issues as adoptive families when parenting pre-school and school age children. As children grow older, their understanding of what it means to be in foster care will change and deepen. Like adoptive families, foster families must face challenges related to the school system and the child making comparisons between themselves and children who are not in foster care. In some cases, these issues may be more pronounced because a child in foster care is not a permanent member of the foster family, and they may be struggling with feelings about their primary family that develop as a result of their deeper understanding of what it means to be in foster care. Relationship testing in an issue that foster families face frequently with children of all ages, and it may be difficult for foster families to parent a child who is acting out and to whom they have not made a permanent commitment.

Most families find parenting adolescents challenging. Rosenberg (1992) asserts that parenting an adolescent who is adopted is especially challenging as there are additional challenges that adoptive families must face. The developmental task of adolescence is separating from the family of origin, and adoptive parents may be particularly sensitive to an adolescent's attempts to separate from the family. Since separation from the family is the central developmental task and adolescents are struggling to form their own identity, the adolescent may assert that the adoptive parent is not the "real" parent which may trigger insecurity within the adoptive parent (Rosenberg, 1992). It is not uncommon for adolescents who have been adopted to "float" attachments to other adults in their lives such as teachers and coaches (Rosenberg, 1992). Sexual development occurs in adolescence and because the family is composed of non-biologically related individually, a heightened sense of sexual boundaries between family members may develop (Rosenberg, 1992). Working through the additional challenges faced by adoptive families and laying the groundwork for a relationship into adulthood become the developmental task that the adoptive family must face (Rosenberg, 1992).

As with adoptive families, foster families parenting adolescents face the typical challenges faced by families parenting adolescents, as well as the issues that are unique to children being parented by adults who are not their biological parents. Issues related to sexual development and sexuality can be of concern to foster parents because, particularly if there are other non-biologically related adolescents in the household. In addition, some children in foster care have been victims of sexual abuse, which may lead to sexually reactive behavior. A heightened awareness of sexual boundaries will be an issue faced by foster families parenting adolescents. It is not uncommon for children in

foster care to have attachment difficulties, whether the issues are related to trauma experienced while living with birth families, or related to many moves through the foster care system. The separation and identity formation process faced by adolescents may be complicated by existing attachment issues.

The phases of the adoptive family life cycle focusing on the developmental tasks of the adoptee are also relevant to foster families. The first developmental tasks faced by the adoptee are the circumstances related to the adoptee's conception, pregnancy, and birth (Rosenberg, 1992). How the child was conceived is relevant. For example, was the child conceived in a committed relationship, from a casual encounter, or as the result of violence (Rosenberg, 1992)? The first piece of autobiographical information that an adoptee may have is that they were a mistake or not wanted (Rosenberg, 1992). Genetics may be a factor, particularly if mental health issues, substance abuse issues, or personality issues are present (Rosenberg, 1992). The impact of the mother's behavior during pregnancy is also a factor, including substance abuse, poor nutrition, and poor prenatal care (Rosenberg, 1992). Similar to adoptees, children in foster care may experience less than ideal circumstances related to their conception, their mother's pregnancy, and their birth.

During the postpartum period the adoptee is separated physically and emotionally from their mother (Rosenberg, 1992). The child may experience multiple placement moves prior to being placed in the adoptive home, which may exacerbate the trauma experienced by the physical and emotional separation of the child from his/her birth mother and any prenatal trauma that the child may have experienced (Rosenberg, 1992). How well the child recovers from the trauma may depend on the child's temperament and

the quality of the environment in which the child is placed (Rosenberg, 1992). Children in foster care experience similar trauma, particularly if the child is placed in foster care shortly after birth, if the child experiences multiple placement moves, or if the child experiences trauma in the form of abuse and/or neglect while living with their birth family during the postpartum period. According to Rosenberg, children in the postpartum phase need a nurturing environment to help them recover from the trauma related to prenatal stress and the physical and emotional separation from their birth mother. The same would be true for children in foster care.

According to Rosenberg (1992) the circumstances under which a child enters an adoptive placement may determine the level of well-being the child experiences during infancy. In addition, the infant's temperament may be a factor, as some children may be difficult to comfort or soothe (Rosenberg, 1992). Rosenberg asserts that the quality of the match between the infant and his/her adoptive parents is important during the infancy phase, as the bonding process may be impacted by the match between the temperament of the child and the adoptive parents. Whether or not the adoptive parents have come to terms with their own infertility may impact the adoptive parents' ability to accept that adopting is not the same as raising one's biological child (Rosenberg, 1992). As with adoption, the match between the foster family and the foster child's temperament is important to the success of the placement. As previously discussed, couples may seek to foster because of infertility issues. If infertility is an issue, as with adoptive parents, whether or not the parents have dealt with their infertility issues may impact their ability to parent a child that is not biologically related to them.

The cognitive development of a child during the preschool years impacts their ability to understand the concept of adoption (Rosenberg, 1992). During this developmental phase, children experience magical thinking, and are generally unable to think abstractly, so understanding a conception as complex as adoption is a challenge (Rosenberg, 1992). As previously discussed, parents during the preschool years may struggle with when, how, and under what circumstances to disclose the adoption (Rosenberg, 1992). As with preschool age adoptees, a child's ability to understand their placement in foster care and the circumstances surrounding it will be impacted by their cognitive development. Children during this phase may engage in magical thinking and misunderstand the reasons for their placement in foster care.

According to Rosenberg (1992), children of school age will rework their understanding of their adoption as they are able to think more logically. During this developmental phase children will be able to understand that they have two sets of parents, and issues related to identity and belonging may arise (Rosenberg, 1992). School age children tend to believe that fault must be assigned if something bad happens, and an adoptee may develop fantasies about their birth family in which they attempt to sort out issues related to fault and blame (Rosenberg, 1992). Children in foster care may deal with similar issues as adoptees. Children in foster care often experience divided loyalties between their foster families and their birth families, which may lead to issues related to belonging and identity. In addition, children in foster care may assign blame either to their parents or to themselves for their placement in foster care.

As previously discussed, adoption issues may exacerbate normal adolescent difficulties (Rosenberg, 1992). The process of separation and identity formation may

have different meaning for adoptees in that they may view the separation from the adoptive family as a second abandonment or they may fear that the end of the adoptive parents' active childrearing may mean the end of the relationship (Rosenberg, 1992). Normal adolescent identity formation and questions about self may be complicated for adoptees as they wonder if they are like their birth parents in some way (Rosenberg, 1992). Similarly, foster youth may struggle with issues related to separation and abandonment. Adolescents in foster care face additional issues related to moving into adulthood, as many children aging out of the foster care system do not have the safety net of a permanent family to rely upon.

In addition to these family processes, foster youth sometimes exhibit behaviors that could potentially be crisis producing. Foster care is an integral part of the child welfare system. Yet foster care is not always successful. Researchers have examined the problem of foster placement breakdown or disruption for decades; at the most basic level foster placement breakdown means moving a child from their current foster home placement. However, little research has been conducted on what makes a foster family successful. Much of the research related to foster placement breakdown or disruption focuses on the child, not the foster family or the service system. In addition, much of the research takes a deficit approach, focusing on what leads to breakdown or disruption but not the factors that support successful foster care placement. The Double ABCX Model developed by Patterson and McCubbin (1983) may be a useful model to explore foster family success.

When a child is placed in a foster home the family experiences a period of adjustment as the addition of a family member leads to changes to the family unit.

Ambiguity may result as family members adjust to the addition of a new household member, a child who is unknown and may have an unknown history, and clarity is obtained regarding the roles within the new family system. The ability to tolerate ambiguity may be one of the most important factors in foster parent success.

A review of the literature reveals little in regards to the adjustment following the addition of family members in foster care; however, research has been done regarding the process of family adjustment following the addition of a family member through adoption (Pinderhughes, 1995, 1998). Pinderhughes (1995) developed a four phase model of family readjustment and relationship formation following the adoptive placement of a child into a family. The four phases of adjustment and relationship formation are anticipation, accommodation, resistance, and stabilization. There are five domains of functioning that are critical to the adjustment and relationship formation process; cognitions, resources, stressors, coping, and relationship representation (Pinderhughes, 1995). Pinderhughes' research focuses on the adoption of older children, most of who are adopted from the child welfare system. Since the focus of the research is on children who have previously been in the child welfare system, the experiences of the children in Pinderhughes' research are similar to children in foster care. For this reason, the model can be helpful in understanding adjustment and relationship formation process that occurs in a family following the placement of a foster youth.

According to Pinderhughes (1998), adopting a child over the age of five is challenging because of the prior experiences the child brings to the relationship, including the child's potentially negative experiences with their birth family and experiences with other foster families. The child must adapt to a new family, a new

community, a new school, and to new peers, and the child's prior experiences in a family and their need to adjust to new situations impacts the adjustment and relationship building process (Pinderhughes, 1998). Children in a new foster care placement would experience similar challenges to an older child being placed into an adoptive home.

The first phase of adjustment and relationship formation is the anticipation phase (Pinderhughes, 1995). During this phase, cognitions of both the adoptive family and the adoptee regarding the placement, potential problems, and potential positives are salient (Pinderhughes, 1995). The family prepares for the addition of a new family member by making concrete preparations such as preparing bedroom space, and through forming expectations regarding how the addition of the new family member will impact existing birth order, family activities, and existing family relationships (Pinderhughes, 1995). The adoptive family and the adoptee likely have different experiences in families, so there are likely discrepancies regarding expectations of how families function, how relationships are formed, and how problems are solved (Pinderhughes, 1995). These differences impact the cognitions and expectations that are formed by the adoptive family and the adoptee during the anticipation phase.

Once placement occurs, the family moves into the accommodation phase in which all family members develop perceptions of one another, and test these perceptions based on their own past experienced (Pinderhughes, 1995). New roles and boundaries are explored and tested, expectations are confirmed and/or denied, and perceptions of the situation are adjusted (Pinderhughes, 1995). During this phase, expectations of the family members are compared with reality, and family members assess and reassess the developing roles and relationships in terms of the expectations that they brought to the

situation (Pinderhughes, 1995). During this phase a "honeymoon" period may occur in which the interactions are more positive than what was anticipated; the "honeymoon" period may be masking underlying problems in the adjustment and relationship development which may lead to deterioration in the relationship (Pinderhughes, 1995). If there are early negative interactions between family members or if there are great discrepancies between expectations and reality, the family may fall into a pattern of being stuck and not being able to negotiate new relationships (Pinderhughes, 1995). The inability to negotiate new relationships may lead to ambivalence and deterioration in the relationship (Pinderhughes, 1995). However, if family members are able to be flexible and resolve the differences between expectation and reality, the family may be able to successfully negotiate relationships (Pinderhughes, 1995). Whether a family responds with flexibility or immobility during this phase will impact the family's ability to incorporate the new family member (Pinderhughes, 1995).

The third phase of adjustment and relationship formation in Pinderhughes' (1995) model is the resistance phase. The exploration that occurs in the accommodation phase leads to a confirmation of or a denial of the expectations held by family members (Pinderhughes, 1995). Both the adoptive parents and the adoptees may experience ambivalence during this phase; the parents may have second thoughts about the adoption and the ambivalence experienced by the adoptees may be reflected in an increase in negative behaviors as the adoptee becomes more attached to the family (Pinderhughes, 1995). The ambivalence forces choice and family members must decide their level of commitment and their willingness to accommodate and make changes necessary to make the adoption work (Pinderhughes, 1995). Stress is evident during this phase, and the

availability of resources is important (Pinderhughes, 1995). The attributions the family makes regarding the source of the stress or "problem" are critical; if the adoptee is blamed and seen as the source of the "problem", the adoptee is expected to change to fit into the family, but if the placement is seen as the source of the "problem", the family members are more likely to share a sense of responsibility and be more willing to make changes (Pinderhughes, 1995). How the family copes with the resistance during this phase is an important factor in the outcome and likelihood of success. Proactive steps taken to solve problems may lead to healthy restabilization, while avoidance of problem solving may lead to the disruption of the adoption or an unhealthy incorporation of the adoptee into the family (Pinderhughes, 1995).

The fourth phase of family adjustment and relationship formation is restabilization, and there are three possible outcomes to this phase; healthy incorporation, dysfunctional incorporation, or disruption (Pinderhughes, 1995). If family members are able to resolve differences between expectation and reality, build a relationship that is mutually supportive, and if a healthy balance between independence and dependence on relationships between family members can be achieved, healthy incorporation can be achieved (Pinderhughes, 1995). If the family is able to make a commitment to the adoption, but family members are unwilling or unable to make changes and/or compromises, the adoptee may become incorporated but the incorporation is dysfunctional (Pinderhughes, 1995). If dysfunctional incorporation occurs family may expect that the adoptee changes to fit the family, which may lead to scapegoating of the adoptee (Pinderhughes, 1995). Disruption of the adoption occurs when the pain

experienced by the family is so significant that the family has to get rid of the negative influence by expelling the adoptee from the family (Pinderhughes, 1995).

Although they are not identical, there are similarities between the adjustment and relationship formation processes in foster and adoptive families. Pinderhughes (1995) asserts that one of the challenges adoptive families face when adopting a child over the age of five is dealing with the impact that the potentially negative experiences a child had in his/her birth family or other foster families prior to placement in the adoptive home. Foster families would face similar challenges as families adopting children over the age of five. Unless a child enters foster care immediately after birth, which is relatively uncommon in the child welfare system, prior to being placed in a foster home a child has lived with another family or families. The child's previous experiences will shape the child's expectations, interactions, and behaviors. A similar anticipation phase would be experienced, as both the foster family and foster child would develop expectations about the placement and the expectations of both the foster family and foster child would be shaped by their past experiences with family interaction. In the modern child welfare system, foster care placements often happen quickly so the anticipation phase for both foster families and foster children would be abbreviated.

Once a foster child is placed with a family, as in Pinderhughes' (1995) model, a foster family must move through an accommodation process in which limits are tested, new boundaries and roles are negotiated, and expectations are confirmed or denied. A "honeymoon" phase frequently occurs in foster care placements in which the placement appears to be going better than anticipated. As with the adoptive process of adjustment, how a foster family responds in the accommodation phase is important to the success of

the placement. A family's ability to respond with flexibility and to negotiate new roles successfully may determine how well the foster child is incorporated into the foster family.

A phase similar to the resistance phase described by Pinderhughes (1995) may occur in a foster family after the placement of a foster child. As with the resistance phase with an adoptive placement, attributions about the source of any problems that may arise are important, and if blame is placed upon the child the placement may be at risk. According to Pinderhughes, resources that the family has access to during the resistance phase is important, and the lack of external resources for the family to draw upon can be problematic. Foster families who have a support network to rely upon, and who can engage in proactive problem solving with their agency, may be more likely to successfully cope with the challenges that may be present in this phase.

It is likely that foster families move through a process that is similar to the restabilization phase described by Pinderhughes (1995). In Pinderhughes' model there are three possible outcomes; healthy incorporation, dysfunctional incorporation, or disruption. Similar outcomes are also possible with foster care placements. As with adoptive placements, a child may be incorporated in a healthy manner into the family, or unhealthy incorporation may occur. It is not uncommon for foster families to expect that a child adjusts to the foster home, and not be willing to make adjustment to meet the needs of the child. If this occurs, it would not be unusual for scapegoating of the foster child to occur. The disruption process is similar with adoption and foster placements. According to Pinderhughes, disruption occurs when the pain experienced by the family is

so great that the family must get rid of the negative influence and expel the child from the family system. This process may occur in foster families as well.

It is important to note that a foster care placement by design is temporary in nature. Families who adopt a child are making a life-long legal commitment to a make a child a permanent member of their family, while foster families make a commitment to provide a stable home for a child until he/she can either be safely reunified with primary family, or if necessary, until an adoptive placement can be located for the child. The difference in commitment levels between foster and adoptive families differ, so while the adjustment and relationship formation process may be similar to the model proposed by Pinderhughes (1995), differences in the levels of commitment between adoptive and foster families will impact the adjustment and relationship formation process. It is plausible that the lower level of commitment required by foster families may either increase or decrease the likelihood that a family disrupts a child. A foster family may be more tolerant and willing to maintain a difficult placement because they know the placement is temporary, which could reduce the likelihood of disruption. However, it is also possible that the lower level of commitment required of foster families could increase the likelihood of disruption as the family has not agreed to make a child a permanent member of the family.

Adoption Success: Implications for Foster Care Success

A review of the literature reveals little research in the area successful foster families; however, research has been conducted in the area of adoptive family success. Commonalities between adoptive families and foster families exist, so it is appropriate to

utilize the literature on adoptive family success as a starting point for the exploration of foster family success.

Although the study primarily focused on adoption disruption, researchers Barth and Berry (1988) explored factors that could distinguish stable adoptions from disrupted adoptions. The model utilized viewed adoption adjustment occurring in three key areas; the child, the parent/ household and family interactions (Barth & Barry, 1988). A fourth key component of the model is the agency response to and services available to address the child, parent/ household and family interactions (Barth & Barry, 1988). The researchers analyzed a full model that included variables from all four areas (child, parent/household, family interactions, and agency services), as well as sub-models for each of the four areas (Barth & Barry, 1988).

Analysis revealed that the most powerful model for predicting intact versus disrupted adoptions was the model related to parent/household characteristics that included the placement type (foster parent adoption vs. new adoption placement), family constellation (presence of other adoptive children in the home), and informal social support available to the family (Barth & Barry, 1988). The model found that placements in families with other adoptive children in the home and non-foster parent adoptions were at highest risk for disruption (Barth & Barry, 1988). Based on 82 cases, the parent/household sub-model correctly predicted 77% of stable placements, 75% of disruptions, and it had the highest overall accuracy score of 77% (Barth & Barry, 1988). Analysis of the full model revealed that the top four discriminating variables were related to family/household characteristics which were the number of relatives living within driving distance of the family, the number of other adoptive children in the home, a foster

parent vs. non-foster parent adoption, and the frequency of church attendance by the family (Barth & Barry, 1988). The full model based on analysis of 62 cases predicted 70% of stable placements, 60% of disruptions, and 68% of all placements (Barth & Barry, 1988).

Barth and Barry (1988) did not utilize Hill's (1949) ABCX Model or the Double ABCX Model developed by Patterson and McCubbin (1983) to interpret their results; however, it is noteworthy that two of the top four discriminating variables could be related to support available to the family (number of relatives within driving distance and frequency of church attendance). Frequency of church attendance could also relate to the family's perception of the event. McCubbin and Patterson (1982) assert that perceptions of crisis appear to involve religious beliefs and findings from their longitudinal study of military families who experience war-induced separation "suggest that religion and/or religious beliefs enabled these families to ascribe an acceptable meaning to their situation," (p.36).

A review of the literature related to adoption from the public system is even more relevant to foster care, because in many cases issues faced by families who adopt children from the public child welfare systems are similar to issues foster families face. There is no set definition for the term special needs, but in relation to adoption, the State of Ohio considers any child who is awaiting adoption for whom it may be difficult to locate an adoptive home to be special needs. According to the Ohio Administrative Code 5101:2-1-01 Children services definition of terms for the purposes of state adoption subsidy determination, a child meets the criteria for special needs if he/she meets one of the following criteria: is a member of a sibling group who should be placed together, is age 6

or older, is a member of a minority ethnic group, has been in the permanent custody of a public children services agency or private child placement agency for more than one year, has a medical or physical disability, has a developmental disability, has emotional or behavioral problem, has a social or medical history that places a child at risk for developing future medical disorder, physical or developmental disability, or emotional disorder, has experienced previous adoption disruptions, or has been in the home of the prospective adoptive parent as a foster care placement for at least a year and removing the child from the placement would cause damage to the child because of the child's emotional ties to the family (http://codes.ohio.gov/oac/5101%3A2-1-01).

Groze (1996) explored characteristics of families who successfully adopted special needs children. The longitudinal study included a random sample of subsidized adoption cases and data were collected over a 4-year period. The study assessed children's behavior as well as family functioning. To assess family functioning, family cohesion, or feelings of closeness among family members, and family adaptability, or the family's ability to change and adapt to stress, were measured (Groze, 1996). Families participating in the study showed a statistically significant decrease in mean adaptability scores over the four-year study period; however, even with the statistically significant drop in adaptability scores, mean scores at the end of the 4-year study period were still higher than normed family adaptability scores (Groze, 1996). Similarly, a statistically significant decrease in mean cohesion scores was observed over the 4-year study period, but mean cohesion scores at the end of the 4-year study period were comparable to norms for families with adolescents (Groze, 1996). Overall, families participating in the study

were more adaptable and cohesive than normative families (Groze, 1996). So, greater adaptability and greater cohesiveness results in higher likelihood of success in adoption.

Lightburn and Pine (1995) utilized the Double ABCX Model to explore characteristics of families that adopted children with developmental disabilities. The researchers assumed that a family who adopts a child with a developmental disability or chronic medical problem would face on-going and repeated stressors including the hospitalization of the child, dealing with educational barriers and needs, and inconsistent information from medical professionals (Double A) (Lightburn & Pine, 1995). The resources available to the family, or the Double B, could include income, the family's support network, communication among family members, and family cohesion. The researchers were most interested in "how a family uses its resources to mediate the potential impact of stressors," (Lightburn & Pine, 1995, p. 141). The researchers assert that the belief system of the family is a key influence in determining the Double C, or the family's perception of the situation and meaning assigned to the adoption. Of the 52 families who participated in the study, all adoptions were still intact, and 79% of families reported being very satisfied with the decision to adopt and reported that they would adopt again, which suggests positive adoption outcomes and family adaptation (Lightburn & Pine, 1995). Study findings indicated that resources available to the families did play a role in outcomes; families who participated in the study were found to be better than average problem solvers and financial supports in the form of adoption subsidies and medical coverage for the children predicted overall parental satisfaction related to the adoption (Lightburn & Pine, 1995).

As should be apparent, foster families play a critical role in the child welfare system by providing a safe and stable living environment to a child when child welfare professionals determine that it is no longer safe for a child to continue living with his/her own primary family. Children involved in the child welfare system who have more complex needs are generally served by treatment foster families. Treatment foster families provide psychosocial treatment in a stable home environment to children with emotional, behavioral, and/or mental health issues (Dore & Mullin, 2006). The role that the treatment foster family plays in the child welfare system is even more critical because the family is the treatment. Despite the critical role that foster families play in the child welfare system, little is known about what makes foster families successful, and less is known about what makes treatment foster families successful. Much of the foster care research takes a deficit approach, and focuses on placement disruptions, not placement success. Much of the disruption research focuses on the child system, and not the family system. In addition, there is a lack of an organized theoretical framework used in foster family research.

Theoretical models such as the ABCX Model (Hill, 1949), Double ABCX Model (Patterson & McCubbin, 1983), and the Circumplex Model (Olson, McCubbin et al., 1983) have been used to explore family stress and coping for decades. The ABCX Model was used to explore the impact of stress on families by examining the impact of the removal of a father from the family because of military services during World War II and then the process of the father returning to the family (Hill, 1949). Family stress can result from dismemberment and/or accession. Dismemberment refers to the removal of a family member (Hill, 1949), such as a father separating from a family for military service

or the removal of foster child from a family, and accession refers to the addition of a family member (Hill, 1949), such as a father rejoining his family upon return from military service or the addition of a foster child to a family. Hill found that the more the separation of the father impacted the family's day-to-day family functioning, the greater the impact was on the family. Hill also found that certain family characteristics such as adaptability and the level of family integration impacted a family's adjustment to the separation and reunification of the father. Families whose individual members were more focused on family interests and had higher levels of identification with the family adjusted better to reunification with the father (Hill, 1949).

The Double ABCX Model (Patterson & McCubbin, 1983 has been used to examine a variety of family stressors including families with children diagnosed with serious chronic illnesses (Patterson & McCubbin, 1983), functioning in families facing economic pressure (Vandsburger & Biggerstaff, 2004), divorce (Tschann et al., 1989), issues related to blended families/ step-families (Crosbie-Burnett, 1989), families relocating to foreign countries for employment purposes (Caligiuri et al., 1998; Lavee et al., 1985), families raising children diagnosed with developmental disabilities (Jones & Passey, 2004; Saloviita et al., 2003; Trute et al., 2010) or autism spectrum disorders (Bristol, 1987; Pakenham et al., 2005), primary caregivers of elderly family members diagnosed with dementia (Rankin et al., 1992) or families experience other physical and/or cognitive impairments (Lee, 2009), and adult children of alcoholics (Easley & Epstein, 1991). The model has been demonstrated to be useful in that it provides a framework for understanding a wide range of potential responses by families to various stressors. The model's proven track record as a framework for understanding a family's

response to a wide array of stressors indicates that it may be a model useful for understanding how a family might respond to stressors it may encounter in its role as a foster family.

The Circumplex Model focuses on three dimensions of family functioning: family cohesion, family adaptability, and family communication (Olson, McCubbin et al., 1983). Family cohesion refers to the bond between family members, family adaptability refers to a family's ability to change roles, rules, and power structure when faced with a stressor, and family communication facilitates the other two dimensions in that is allows family members to communicate what they need in relation to cohesion and adaptability (Olson, McCubbin et al., 1983). The family life cycle is a concept that is central to the Circumplex Model (Olson, McCubbin et al., 1983). A family's life cycle stage is determined by the age of the family's oldest child, and levels of adaptability and cohesion change as families move through different stages of the family life cycle (Olson, McCubbin et al., 1983). Family cohesiveness is highest during the early stages of the family life cycle, drops in adolescence, reaches the lowest level during the launching phase, and then increases again as a family enters the empty nest and retirement phases (Olson, McCubbin et al., 1983). Family adaptability follows a similar pattern with levels of adaptability being highest in the early stages of the family life cycle, dropping in the adolescent and launching phases, and then increasing in the empty nest and retirement phases (Olson, McCubbin et al., 1983).

Research on successful adoptive families indicates that greater adaptability and greater cohesiveness results in higher likelihood of success in adoption (Groze, 1996). The limited body of research on successful foster families indicates that there could be a

relationship between family adaptability and foster placement success. Cautley and Aldridge (1975) found a combination of factors to be associated with greater likelihood of foster placement success, two of which are related to family adaptability. Families in which the father demonstrates high levels of flexibility and in which the mother and father take a joint approach to decision making were more likely to have successful foster placements. Two studies indicated that foster families with inflexible/ rigid temperaments were less likely to have successful foster placements (Doelling & Johnson, 1990; Green et al., 1996). Foster families in which the mothers had inflexible/ rigid temperaments were less likely to have successful foster placements when fostering children with similar temperaments (Doelling & Johnson, 1990; Green et al., 1996). One early foster care study suggests a possible relationship between the family life cycle and foster placement success. Cautley and Aldridge (1975) found that the ideal family constellation for foster placement success was a family in which the foster child was the youngest child in the home. Since the stage of the family life cycle is determined by the age of the oldest child in the family, a family constellation in which the foster child is the youngest child in the home would mean that the placement of the foster child did not alter the life cycle of the family.

Child welfare practitioners working in the foster care field currently have little research-based knowledge on which to draw in recruiting treatment foster families who are likely to be successful. Such knowledge would be helpful in making placements decisions that would maximize success. Past research on successful adoptive families, successful foster families, and families who are able to successfully deal with stress in

general suggests that a relationship may exist between the family life cycle and foster placement success, and between family functioning and foster placement success.

Research Questions

The primary purpose of this study is to obtain a conceptual representation of characteristics and actions of successful treatment foster families from the perspective of professionals who provide support to treatment foster families. In addition, the relationship between family life cycle and placement success will be explored.

The following research questions are proposed.

1. How do professionals providing support to treatment foster families conceptualize successful treatment foster families?

2. What do professionals providing support to treatment foster families identify as family factors that are most important for placement success?

This study is exploratory in nature and the purpose is to seek a foundational conceptualization of successful treatment foster families from the perspective of professionals providing support to treatment foster families. The desired end result for research question one is a concept map that represents participants' perspective of treatment foster family success. For this reason, no hypotheses for research question one will be stated.

CHAPTER 3

Methodology

Concept Mapping as a Methodology

This chapter begins with a general overview of concept mapping, the methodological approach utilized in this study, followed by a detailed discussion of the design of this study following.

Overview.

A concept map or conceptual diagram is a picture that depicts suggested relationships between concepts, ideas and/or variables (Hager & Scheiber, 1997). Concept mapping is a generic term which refers to any process which results in ideas represented in the form of a picture or map (Kane & Trochim, 2007). The term concept mapping as used here describes the mixed methods research approach described by Trochim (1989) in his seminal article on the topic; concept mapping uses a set of structured steps to organize the ideas of a group of people and represent those ideas in a format which is easily understandable. The information can be used for a variety of purposes including program planning and evaluation (Trochim, 1989).

Concept mapping is a research design that involves the collection and analysis of both qualitative and quantitative data (Palinkas, Aarons, Horwitz, Chamberlain, Hulburt, & Landsverk, 2011). In concept mapping, ideas are generated and the relationships between those ideas are stated by research participants (Kane & Trochim, 2007). The approach uses multivariate statistical techniques in which multidimensional scaling and cluster analysis are completed and the results are represented in the form of a diagram or picture to participants (Kane & Trochim, 2007) that shows the interrelationship of ideas

(Johnsen, Biegel, & Shafran, 2000). In other words, concept mapping takes ideas and through a standardized structured process that follows specific steps, results in a picture that demonstrates how the ideas are connected, according to how participants view those relationships. One you have the picture, you can begin to determine how to use these ideas in planning a program or changing the policies and practices of an organization.

Concept mapping has been used for a variety of purposes including designing a theory-driven approach to program evaluation (Rosas, 2005), scale development (Rosas & Camphausen, 2007), program planning (Miller, Rhema, Faul, D'Ambrosio, Yankeelov, & Clark, 2012), program development (Ridings et al., 2008; Ridings et al., 2010; Miller et al., 2012), curriculum development and strategic planning in relation to curriculum changes (Cash, Smith, Mathiesen, Graham, & Barbanell, 2006), identifying facilitators and barriers to the implementation of evidence-based practices in community mental health (Aarons, Wells, Zagursky, Fetes, & Palinskas, 2009), and theory development (Burke, O'Campo, Peak, Gielen, McDonnell, & Trochim, 2005). In the child welfare field, concept mapping has been utilized in research related to traditional foster care and adoption. Miller and Collins-Camargo (2015) used a concept mapping approach to explore foster care placement success from the perspective of foster youth. Concept mapping studies have also been utilized to explore foster parent perspectives on the needs of foster parents (Brown & Calder, 2000), what constitutes a successful placement (Brown & Campbell, 2007), factors needed for successful foster care placements (Brown, 2008), challenges faced by foster parents (Brown & Calder, 1999), factors that contribute to placement breakdown (Brown & Bednar, 2006), challenges faced in fostering youth with disabilities (Brown & Rodger, 2009), and cultural issues related to foster parenting

(Brown, George et al., 2009; Brown, Sintzel, St. Arnault, & George, 2009; Brown, St. Arnault, George, & Stinzel, 2009). Ryan and Nalavany (2003) utilized a concept mapping approach to explore challenges faced by youth who have been adopted, supports the youth utilize, and barriers to accessing support. In each of these studies the perspective of those with direct experience with the topic of interest was the focus of the research. All of the studies of foster care have focused on traditional and not treatment foster care/specialized foster care.

As an approach, concept mapping has many benefits. Concept mapping translates a complex set of ideas into a visual representation which can be understood by many people (Rosas, 2005), it engages many stakeholders (Riding et al, 2008), it can assist with the identification of measureable program outcomes (Ridings et al., 2008; Rosas, 2005), and it can be used to describe and operationalize constructs for research purposes (Brown & Calder, 2000). Because it is done in phases and it doesn't require participants to agree to participate in all phases of the research process, it can help overcome some of the traditional barriers to participating in research such as demands on participants' time (Ridings et al., 2008). Since it allows for the engagement of multiple stakeholders, concept mapping allows for the involvement of subject matter experts such as service providers (Rosas & Camphausen, 2007) and service recipients (Ridings et al., 2008; Ridings et al., 2010) in the processes.

The Concept Mapping Process

The process of concept mapping described in this paper was first outlined by Trochim (1989). The process was expanded on by Kane and Trochim (2007) to include updated descriptions of the methodology, including additional information regarding data

collection and analysis using the CS Global MAX ™ data collection and analysis web-based software specifically designed for concept mapping. There are six steps in the concept mapping process: preparation for the project, generating ideas by participants, structuring the statements, analysis, interpretation of the maps, and utilization of the maps (Trochim, 1989: Kane & Trochim, 2007). An overview of the concept mapping process is provided in Table 2 and details of each of these steps are providing in the narrative which follows.

Table 2

Steps in the Concept Mapping Process

Steps in the Concept Mapping Process	Critical Elements for the Step
Step 1: Preparation phase	The focus of the project is developed • Prompts or statements are created for brainstorming • Participants are selected
Step 2: Idea Generation	Participants generate ideas through brainstorming after reading statements
Step 3: Structuring the Statements	Statements generated during brainstorming are: • Sorted by participants • Rated by participants
Step 4: Analysis	Data are analyzed using: • Multidimensional Scaling (MDS) • Hierarchical Cluster Analysis (HCA) • Maps or diagrams are created
Step 5: Interpretation of the Maps	Interpretation of the concept maps created during analysis.
Step 6: Utilization of the Maps	Maps are used for their intended purpose

In concept mapping idea generation and structuring of statements can be done through face-to face-interaction between the researcher and participants, through web-based software in which all activities are done on-line, or through a multimethod approach in which researchers gather information through a combination of paper forms, web-based means, and face-to-face interaction. In their review of 69 concept mapping studies, Rosas and Kane found that the multimethod approach was most common (50.7% of studies), followed by web-based method (34.8% of studies), and with face-to-face information gathering comprising the smallest number of studies (14.5%).

Preparation for the Project

The first step of the concept mapping process is the preparation or planning phase. During this phase the researcher determines the desired outcome of the study and then

uses the desired outcome to guide the planning of the remaining steps in the concept mapping process (Trochim, 1989). An important task in the preparation phase is the development of the focus prompt. A focus prompt is a question, a directive statement, or an incomplete statement completed by a research subject/participant. The focus prompt is used to elicit ideas from participants during the idea generation phase (Step 2) of the study; participants are asked to brainstorm ideas based on the prompt. For example, in their concept mapping study exploring foster parents' perceptions of factors that lead to foster placement breakdown, Brown and Bednar (2006) used the following focus prompt to elicit ideas from participants: "What would make you consider ending a foster placement?" (p. 1502). Miller and Collins-Camargo (2016) used the following directive statement as a focus prompt in their study of foster youth perspectives of foster placement success: "Come up with statements that describe successful foster care," (p. 66). Ridings et al. (2010) used the following focus prompt in the form of an incomplete statement to identify culturally relevant interventions which could be used in the development of a Latino youth program: "A specific strategy that will help Latino youth in your community stay in school is…" (p. 40). While focus prompts in any of these forms are acceptable, Kane and Trochim (2007) advise using an incomplete sentence format as it usually elicits content-focused ideas from participants in a format that is easy for the researcher to work with in later phases of the project.

Once the focus prompt is developed the researcher decides on a ratings prompt (Kane & Trochim, 2007). A ratings prompt is the process when participants rate the ideas generated by the focus prompt (Kane & Trochim, 2007). When developing ratings prompts the researcher should consider the type of information that would be useful for

the purposes of the study (Trochim, 1989). Participants can be asked to rate ideas based on things such as importance, priority, preference, or feasibility—the researcher determines which is most relevant to the study (Kane & Trochim, 2007). For example, in their study of challenges faced by youth who have been adopted, Ryan and Nalavany (2003) asked participants to rate statements on a 7-point Likert scale using the following ratings prompt: "How hard have these challenges been?" (p. 36). In their 2008 concept mapping study of a community building effort related to at-risk African American youth, Ridings et al. (2008) asked participants to rate statements on prevalence and severity of the ideas generated during the brainstorming process.

During the preparation phase the researcher also identifies who the desired participants are for the study (Kane & Trochim, 2007). Participants are generally chosen because they are knowledgeable about the topic being explored during the study (Kane & Trochim, 2007); they are often referred to as key informants in community assessments. The purpose of the study drives the selection of participants. For example, because of the dearth of research regarding success in foster care, particularly from the perspective of foster youth, Miller and Collins-Camargo (2016) recruited foster youth ages 14 to 18 in their concept mapping study. Ridings et al. (2008) were seeking a variety of perspectives in their study of community building efforts, so participants included representatives from a variety of community populations including law enforcement, education, business, medical, faith, human service, residents, and potential service recipients.

The number of participants can vary widely from study to study and participants do not have to participate in all phases of the concept mapping process (Kane & Trochim, 2007). In their study analyzing 69 concept mapping studies, Rosas and Kane (2012)

found a range of 20-649 participants across the studies. It is not uncommon for there to be a larger number of participants during the idea generation phase and smaller number of participants in the rating and sorting phase (Kane & Trochim, 2007). After the preparation stage, the project moves to the idea generation phase.

Idea Generation

The second phase or step of the concept mapping process is the idea generation phase (Kane & Trochim, 2007). During this phase, the focus prompt is used for brainstorming (Kane & Trochim, 2007). Participants are presented with the focus prompt and asked to generate as many ideas as they would like in response to the prompt (Kane & Trochim, 2007). During brainstorming it is beneficial for participants to be able to see ideas which have already been contributed (Trochim, 1989). There is no limit on the number of statements which can be generated; however, the end result should yield a manageable number of statements as participants will later sort and rate the statements in the next phase (Trochim, 1989). In their analysis of 69 concept mapping studies, Rosas and Kane (2012) found the average number of statements generated during this phase was 96.32 (*SD*=17.23) with a range of 45 to 132 statements.

Because of the need for a manageable number of statements, it may be necessary to edit the statements generated during brainstorming (Trochim, 1989). After the ideas are generated the ideas are then reduced utilizing a process known as idea synthesis (Kane & Trochim, 2007). The goal of idea synthesis process is to produce a manageable number of statements for the next phase of the study through the elimination of redundant or irrelevant ideas; the recommended maximum number of statements is 100 (Trochim, 1989; Kane & Trochim, 2007). The researcher or members of the research team review

and decide upon which statements should be removed and which statements need to be clarified (Kane & Trochim, 2007). For example, in a study of foster parents' perceptions of placement success, Brown (2008) utilized a process in which Brown and two other raters selected by Brown, a graduate student and a teacher, reviewed the statements separately to remove redundant items and edit statements for clarity. The raters then came together to compare statements removed and edits made to the group of statements, and to come to agreement on each statement (Brown, 2008).

After statements are generated during the brainstorming phase of data collection statements must edited through a process known as idea synthesis (Kane & Trochim, 2007). Idea synthesis is important because ideas presented in the sorting and rating phase should be clear to participants to ensure the sorting and rating phases are successful in the concept mapping process (Kane & Trochim, 2007). According to Kane and Trochim the four main purposes of the idea synthesis process are:

- To obtain a list of unique ideas, with only one idea represented in each statement
- To ensure that each statement is relevant to the focus of the project
- To reduce the statements to a manageable number for the stakeholders to sort and rate
- To edit statements for clarity and comprehension across the entire stakeholder group. (p. 59).

Kane and Trochim (2007) provide guidelines for conducting the idea synthesis process. Choosing keywords in the set of brainstormed statements allows the researcher to sort and evaluate ideas which may be redundant and organizing ideas allows the

researcher to group the ideas so that the ideas may be reduced based on concepts or keywords (Kane & Trochim, 2007). Ideas should be edited for clarity in the idea synthesis process so that the idea can be understood by a wide group of people; however, once edited the idea should still reflect the participant's original idea (Kane & Trochim, 2007). Finally, statements which contain two or more distinct ideas should be split so that only one component part is represented in the statement (Kane & Trochim, 2007). It is not uncommon for there to be a significant reduction in the number of initial statements during idea synthesis. For example, in a study of foster parents' perceptions of foster placement breakdown, 194 statements were generated during brainstorming but researchers ended with a statement set of 61 after idea synthesis (Brown & Bednar, 2008). Idea generation and synthesis leads to the next stage of structuring the statements.

Structuring the Statements

The third phase of the concept mapping process is structuring the statements (Kane & Trochim, 2007). The structuring process involves two steps: sorting the statements and rating the statements (Trochim, 1989). Sorting is an unstructured process in which participants are asked to sort the set of statements created during the idea generation phase into piles or groups which make conceptual sense to them (Rosas & Kane, 2012). Participants cannot place all statements into the same group or create a group for each individual statement (Kane & Trochim, 2007); however, it is acceptable to place some statements by themselves (Trochim, 1989). When sorting, participants are asked to assign a label or name to each conceptual group that they create and which the researcher will later use during the analysis process as suggestions for cluster names (Brown & Campbell, 2007). Once a sort is completed then they are rated by participants.

During the rating process participants are asked to rate the statements based on a relevant dimension determined by the researcher. Ratings are generally done on a Likert-type response scale (Kane & Trochim, 2007). During rating, participants are presented with the complete list of statements with the corresponding Likert-type response scale and instructions for rating the statements (Kane & Trochim, 2007). The researcher can ask the participants to rate the statements on more than one dimension; if participants rate statements on more than one dimension, each statement is rated separately for each dimension. For example, in a study evaluating a pilot program in social work education, participants were asked to rate statements on three dimensions: the importance of each statement, the practicality of each statement, and the participants' level of interest in learning related to each statement (Cash et al., 2006). The researchers provided participants three separate ratings instruments, one for importance, one for practicality, and one for interest in learning, and each ratings instrument contained a complete list of statements with a corresponding Likert-type rating scales for each statement (Cash et al., 2006). While a researcher can ask participants to rate statements on multiple dimensions, since each rating is done separately attrition can occur between each rating. Rosas and Kane (2012) found in their analysis of 69 concept mapping studies that the average number of participants completing the rating portion of the study dropped from 81.8 for the first rating to 65.8 for the second rating. After statements are sorted and rated, the analysis phase begins.

Analysis Phase

The fourth phase of the concept mapping process is the analysis phase (Kane & Trochim, 2007). Data analysis involves multivariate analysis and cannot be done

manually; the use of a computer program for analysis is required (Kane & Trochim, 2007). General multipurpose statistical analysis program can perform the analysis required (Kane & Trochim, 2007); however, there is a proprietary software program, The Concept System CS Global MAX ™ software was developed specifically for the purpose of managing and conducting analysis in concept mapping projects (Concept Systems Inc., 2016). A review of concept mapping studies indicates multiple studies have utilized a version of The Concept System software for data analysis. For example, Aarons et al. (2009), Brown (2008), Brown & Calder (1999), Jackson & Trochim (2002), Miller et al. (2012), Ridings et al. (2008), and Ryan & Nalavany (2003) all used a version of The Concept System proprietary software for data analysis in their studies. The CS Global MAX™ system can be utilized for both data collection and analysis, or simply for analysis. If the system is only utilized for analysis, the researcher must enter the data into the system prior to analysis.

In the first step of the analysis process a similarity matrix is created. The similarity matrix shows how the statements created during the idea generation phase of the study were sorted together during statement structuring. In a similarity matrix, there are as many rows and columns as there are number of statements included in the analysis (Trochim, 1989). During analysis a similarity matrix is first created for each participant who completed the sorting task. The matrix is a binary matrix as it indicates whether or not the statements were sorted together by the participant (Kane & Trochim, 2007). Next, a similarity matrix is completed which combines data from all of the sorts by adding all of the sort matrixes together (Jackson & Trochim, 2002). Again, this matrix has as many rows and columns as there are statements, but with this matrix each cell

indicates the number of participants who sorted those statements together (Kane & Trochim, 2007). A high value indicates more people sorted the two statements together while a low value indicates fewer people sorted the statements together (Brown & Bednar, 2006).

Multidimensional scaling (MDS). Multidimensional scaling (MDS) is a multivariate analysis process which uses data from the similarity matrix and iteratively puts the data on a map until a fair representation of the data is found (Kane & Trochim, 2007). MDS uses a two dimensional solution and places each statement on an X-Y graph (Brown & Bednar, 2006) known as a point map (Rosas, 2005). Each idea is represented by a single point on the map (Concept Systems Inc., 2016). Statements which are located closer together on the map are sorted together by participants more frequently, while statements which are farther apart on the map are sorted into different groups more frequently (Brown & Bednar, 2006).

Stress value. An important statistic in MDS is the stress value (Kane & Trochim, 2007). The fit between the original similarity matrix and the distance matrix created during MDS is measured through the stress value (Petrucci & Quinlan, 2007). According to Kane and Trochim (2007),

> A high stress value implies that there is a greater discrepancy between the input matrix data and the representation of those data on the two-dimensional array, and that the map does not represent the input data well; a low stress value suggests a better overall fit. (p. 97).

If the participants' sorts during statement structuring are very different, there is a poorer fit between the original similarity matrix and the distance matrix; this is indicated by a

higher stress value (Petrucci & Quinlan, 2007). Rosas and Kane conducted a pooled analysis study in which they examined 69 concept mapping studies and found the average stress value was 0.28 (*SD*=0.04) with a range of 0.17 to 0.34.

Hierarchical cluster analysis (HCA). Hierarchical cluster analysis (HCA) organizes statements on a map in a meaningful way (Johnsen et al., 2000). In concept mapping HCA partitions the statements on the map so that statements in the same cluster are close or next to each other on the map (Kane & Trochim, 2007). Statements or ideas are represented in sets of discrete categories or clusters (Goodyear, Lichtenberg, Tracey, Claiborn, & Wampold, 2005) and clusters are reflective of similar concepts (Rosas, 2005). The end product of HCA is a cluster map which illustrates how the points on the map are grouped (Rosas, 2005). The placement of a cluster on the map is not indicative of the cluster's importance, it represents the relationship of the ideas presented on the map to one another (Ridings et al., 2010). Clusters found closer to the middle of the map reflect concepts which are related to many other regions of the map, while clusters found more towards the outside of the map are more clearly defined conceptually (Ridings et al., 2010).

There is no single right number of clusters and no mathematical method for automatically selecting the number of clusters (Kane & Trochim, 2007; Rosas, 2005). The researcher must use his/her knowledge and discretion to select the final number of clusters (Kane & Trochim, 2007; Trochim, 1989). In studies with 100 statements or fewer, the number of clusters can range from three to twenty (Trochim, 1989). Generally, if the desired outcome of the concept mapping process is to produce high-level representation of a concept there is typically a fewer number of clusters; however, if the

desired outcome is seeking more detail for the purpose of operation planning a concept map with more clusters might be desirable (Kane & Trochim, 2007).

Selecting the final number of clusters. Kane and Trochim (2007) provide guidance for selecting the number of clusters on a concept map. The suggested approach is to decide on the upper and lower limits for the desired number of clusters for the concept map, then review the concept map from the highest number of clusters to the lowest number of clusters to determine what number of clusters produces a map which is most useful and has the appropriate level of detail (Kane & Trochim, 2007). As the person conducting the analysis moves from one cluster solution to the other, he/she should examine the statements which are grouped together to determine if those groupings make sense conceptually (Trochim, 1989). As the number of clusters is decreased, the researcher may find that the lower number of clusters merges concepts which make more sense when kept distinct from one another (Kane & Trochim, 2007). When deciding upon the final number of clusters, it is generally better to err on the side of more clusters than fewer (Trochim, 1989). Kane and Trochim (2007) point out that the underlying map remains the same regardless of the number of clusters selected so more weight should be given to the map than the way clusters are created from the points on the map.

Naming the clusters. When participants sort ideas during the statement structuring phase they assign names to each group (Kane & Trochim, 2007). The researcher uses the names assigned by the participants as suggestions for cluster names (Brown & Campbell, 2007); however, it is the role of the researcher to provide a descriptive label for the cluster (Brown & Calder, 2000). The CS Global Max ™

software has a proprietary mathematical algorithm which will select a name for each cluster; however, the researcher can select another name if it is determined that the name assigned by the system does not adequately reflect the cluster concepts (Kane & Trochim, 2007).

Bridging analysis. The bridging value shows the relationship between a statement to other statements on a map (Brown, 2008) and rages from 0 to 1 (Concept Systems, Inc., 2016). The bridging value shows whether a point on the map was sorted with points on the map which are close to it or points on the map which are further away from it (Concept Systems Inc., 2016). A lower bridging value indicates a statement is a better indicator of the meaning of a particular area of the map than statements with a higher bridging value (Concept Systems Inc., 2016).

Pattern matching. Pattern matches use a ladder graph to represent the relationship of average cluster ratings between two variables (Kane & Trochim, 2007). The pattern matching report "displays absolute or relative cluster ratings between two cluster sets, such as different demographic groups, points in time, importance or feasibility," (Concept Systems Inc., 2016, p. 7).

Go-zones. Go-zones are graphs which depict the average ratings for each statement within a cluster and are tools for exploring within cluster detail (Kane & Trochim, 2007). The average rating for each statement in a cluster is plotted on an X-Y graph which is divided into quadrants above and below the mean of each rating variable within a cluster (Concept Systems Inc., 2016). The upper right quadrant of the graph shows which statements have an average rating value above the mean for each variable

(Kane & Trochim, 2007). Statements in the upper right quadrant generally show the most actionable items in each cluster (Kane & Trochim, 2007).

Interpreting the Concept Maps

During the fifth phase of the concept mapping process lists and concept maps are interpreted (Kane & Trochim, 2007). There are two types of lists for interpretation; a statement list and a cluster list, both of which are generated by the analysis program (Kane & Trochim, 2007). The statement list is a list of the ideas brainstormed during the idea generation phase with a corresponding number which is assigned to the statement as an identifier (Kane & Trochim, 2007). The cluster list is a list which shows how the statements were grouped together during HCA and it lists which statements were assigned to which cluster (Kane & Trochim, 2007). The CS Global MAX ™ system creates several visual representations of the data analysis results. The first visual representation of the analysis is the Point Map which must be created before any other maps can be created (Concept Systems Inc., 2016). The Point Map is the result of MDS. Once the point map is created, a Cluster Map, Point Rating Map, and Cluster Rating Map can be created (Concept Systems Inc., 2016). The Cluster Map is the result of HCA. The Point Rating Map and the Cluster Rating Map incorporate ratings data into the analysis. The Point Map and Cluster Map are two dimensional, while the inclusion of the ratings data into the Point Rating Map and the Cluster Rating Map introduce a third dimension; the height of the point or cluster represents the ratings of each (Johnsen et al., 2000).

Figures 1 through 4 give examples of what each map can look like. Examples are from CS Global Max ™ software guide (Concept Systems Inc, 2016).

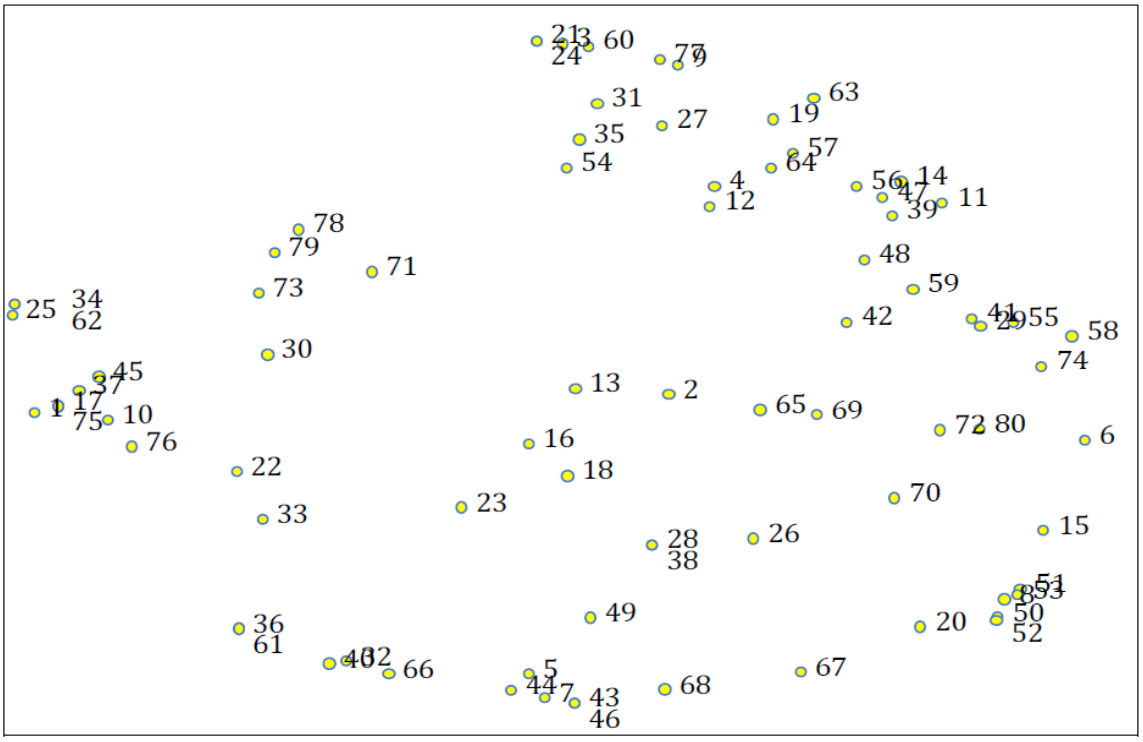

Figure 1. Example of a Point Map (Concept Systems Inc, 2016, p. 3).

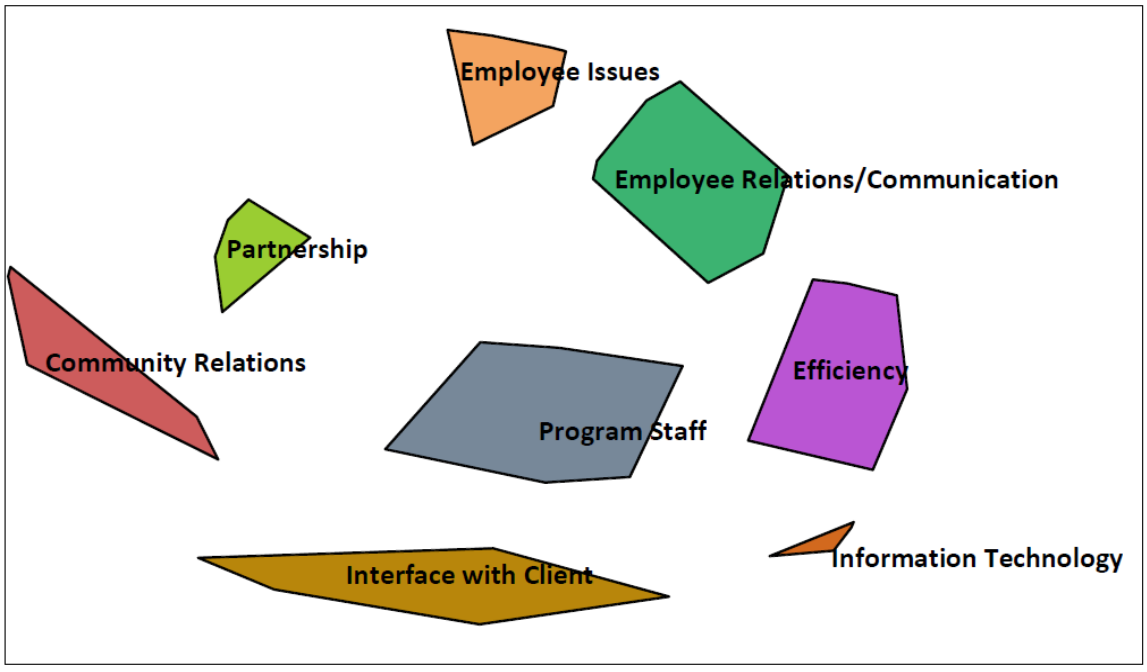

Figure 2. Example of a Cluster Map (Concept Systems Inc, 2016, p. 5).

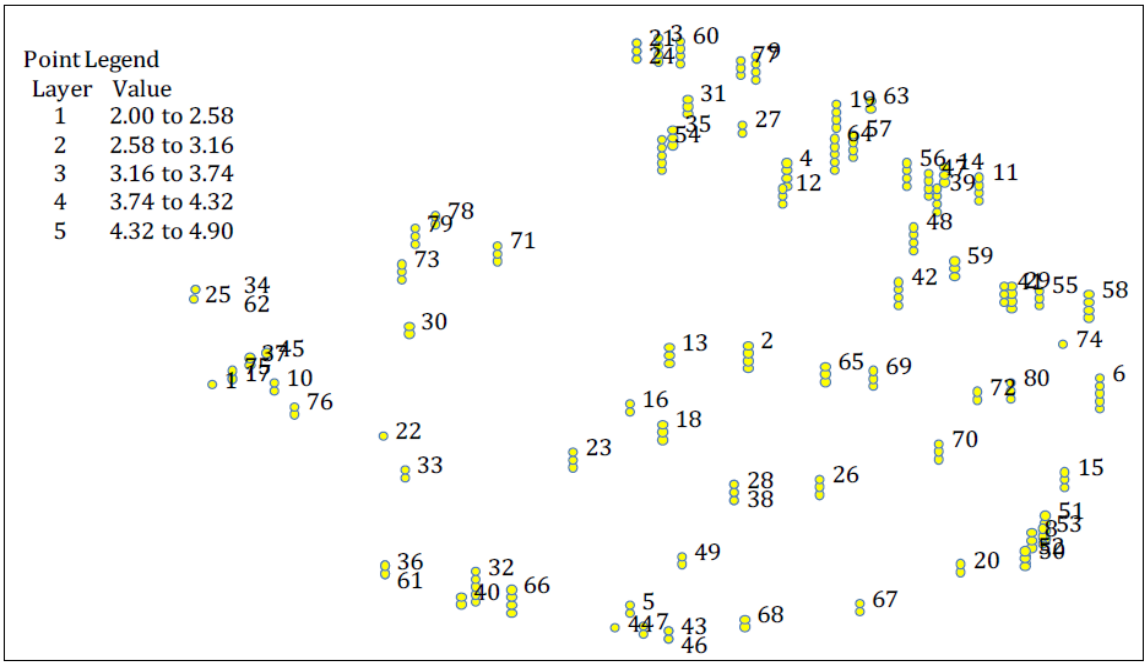

Figure 3. Example of a Point rating map (Concept Systems Inc, 2016, p. 4).

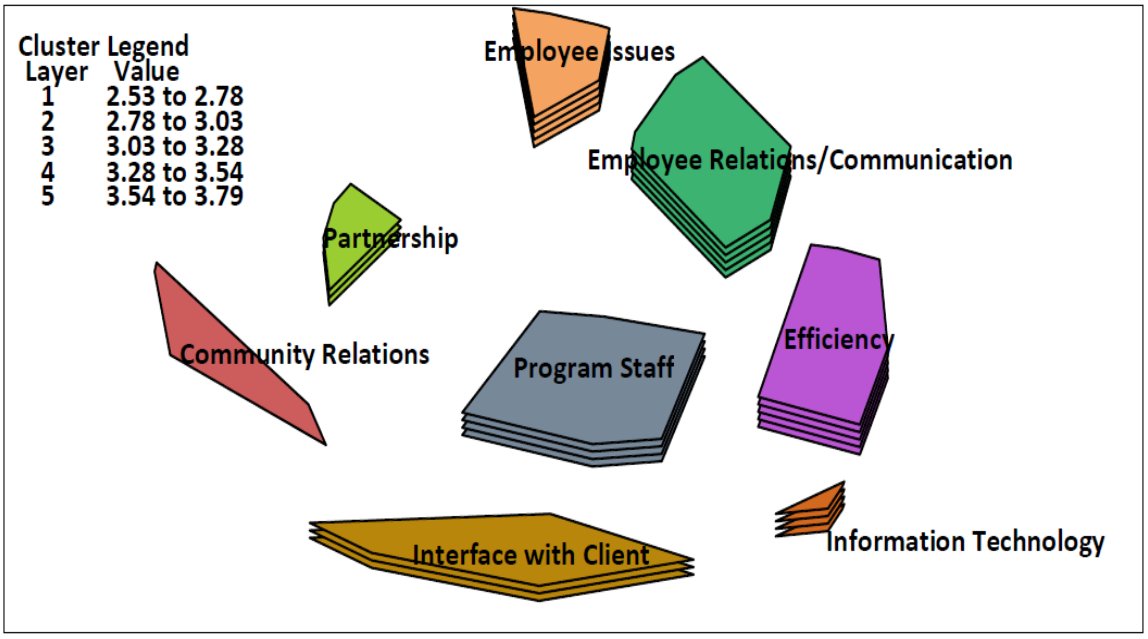

Figure 4. Example of a cluster rating map (Concept Systems Inc, 2016, p. 6).

There are two additional types of results that can be obtained from the analysis: pattern matches and go-zones (Kane & Trochim, 2007). Pattern matches show comparisons of cluster ratings across different things such as participants groups and ratings variables in a ladder graph format (Kane & Trochim, 2007). Go-zones depict values of ratings variables within a cluster in bivariate graph form (Kane & Trochim, 2007). More detail regarding interpretation of the maps is provided in the data analysis portion of this paper. Examples from the Concept Systems Inc. CS Global MAX™ (2016) software guide of a pattern match graph and a go-zone are provided in figures 5 and 6. After the concept maps are developed, the next step is to use the maps.

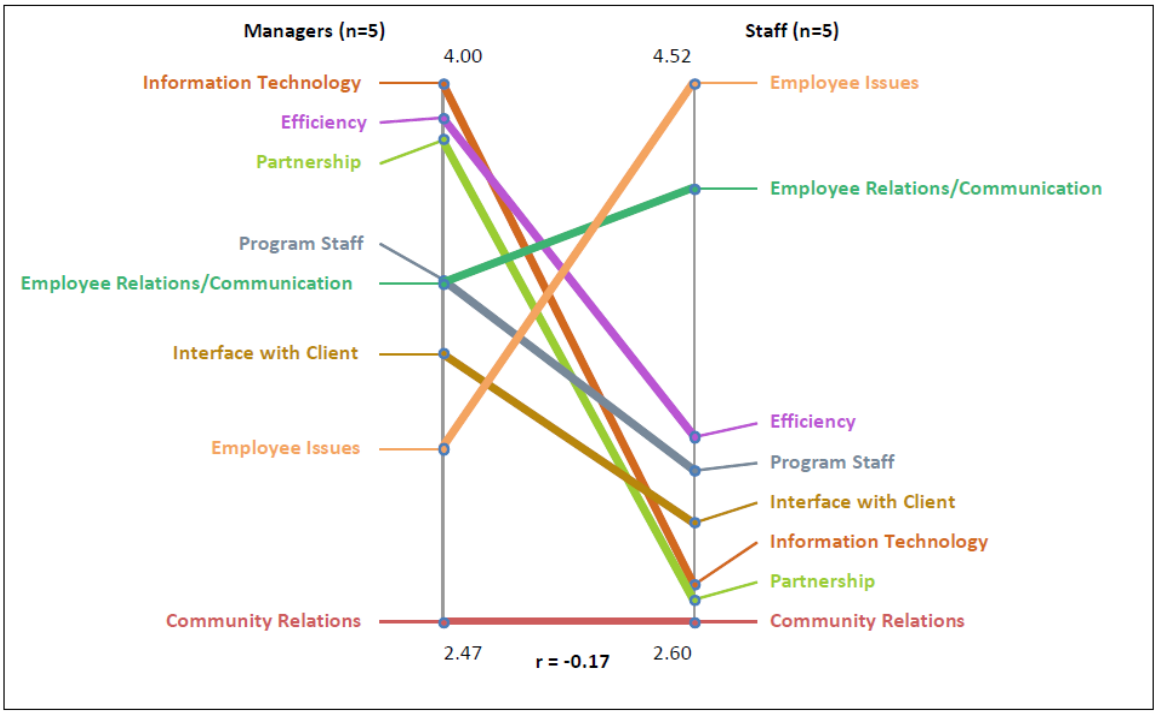

Figure 5. Example of a pattern match (Concept Systems Inc, 2016, p. 7).

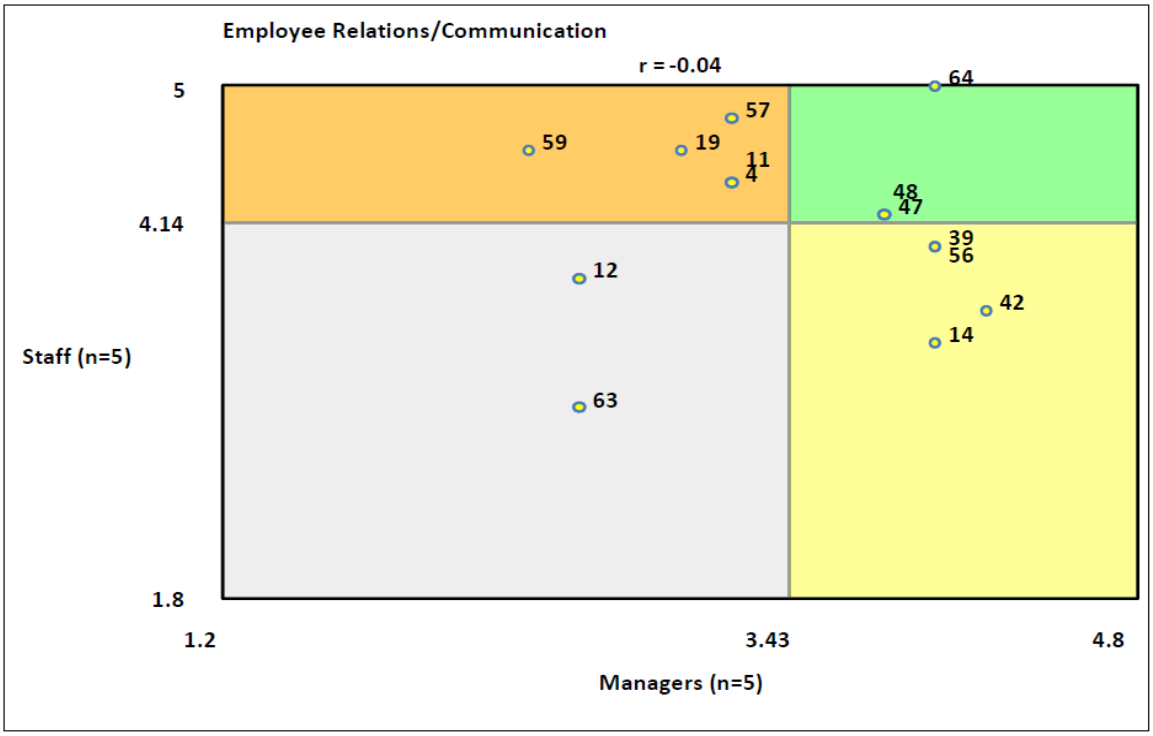

Figure 6. Example of a Go-zone (Concept Systems Inc, 2016, p. 8)

Utilization of the Maps

The final stage of the concept mapping process is the utilization phase (Kane & Trochim, 2007). During this phase the researcher determines how the concept maps will be utilized (Kane & Trochim, 2007). The maps can be utilized for any number of purposes and how they are utilized generally relates back to the original purpose of completing the concept map (Trochim, 1989). Maps can be utilized in planning a program or service, program evaluation, or survey development. Once they are generated maps are generally shared with participants (Trochim, 1989). In some cases, simply having a visual representation of the conceptualization process can be the desired end result of the process and how the map is utilized (Brown & Calder, 2000).

Current Study Design and Process

Preparation Phase.

Preparation for this study included multiple steps such as determining the method used for data collection, the identification of potential participants, development of the focus and rating prompts, and the development of additional questions to be used during analysis. Approval for this study was given from the Case Western Reserve University Institutional Review Board IRB-2013-609.

For this study, the decision was made to conduct data collection and complete data analysis in the CS Global MAX ™ data collection and analysis web-based software specifically designed for the concept mapping process. The CS Global MAX ™ software is a proprietary software program which allows a researcher to facilitate a concept mapping process and analyze data (Concept Systems Inc., 2016). This method for data collection and analysis was chosen because it is convenient for participants as they can log on to participate in their own time, they do not have to complete tasks in one sitting, and participation can be done from anywhere as long as the participants have access to a device which can connect to the internet.

Participants. Foster care workers providing support to treatment foster families as part of their regular job duties employed with a not-for-profit agency family services agency were identified as potential participants. The agency has approximately 550 employees, serves 1200 youth in treatment foster care, and operates in eight states across the Midwest, Southern, and Western regions of the United States.

Foster care workers were identified as potential participants for a variety of reasons. Foster care workers are required to have either a Bachelor's or Master's degree

in social work, psychology, counseling, marriage and family therapy, or another related field and are required to receive on-going professional education to remain in compliance with agency policy as well as best practices in child welfare. This educational background and on-going professional training combined with the foster care workers' professional experience providing support to foster families and foster youth ensures that foster care workers are knowledgeable about this area of study. Foster care workers provide support to multiple treatment foster families and youth so they have the opportunity to see both successful and unsuccessful treatment foster placements. Foster care workers employed with the agency are all provided with their own computer and internet access, so they are able to easily access the CS Global MAX ™ system. In addition, past difficulties recruiting foster parent participants were unsuccessful so the decision was made to focus recruitment efforts on foster care workers who may be more likely to participate.

Inclusion criteria for participants are as follows:

- Employed as a foster home worker with the identified agency for a minimum of six months.
- Job responsibilities include providing on-going support to foster families.
- Has a current caseload with treatment level foster youth.

A report of all agency employees was generated for those who support foster families professionally as part of their job. The report included the employees' start date so the researcher was able to determine potential participants' length of employment. Foster care workers who have been employed with the agency longer than six months and who provide support to foster families as part of their normal job duties were contacted via

their agency email address and invited to participate in the brainstorming portion study. The email included a link to the project home page in the CS Global MAX ™ system. Foster care workers were instructed to click the link for additional information about the project. The project home page included a brief description of the project and instructions for participating in the study. The informed consent document was located in the CS Global MAX™ platform and foster care workers who elect to participate were not be able to begin the brainstorming process without giving consent. The brainstorming portion of the process was anonymous.

Foster care workers eligible to participate were recruited via agency email. Participants were told that they would participate on-line and at their own pace in the CS Global MAX ™ system. The recruitment email included a link to the CS Global MAX ™ data collection and analysis web-based software.

Focus Prompt. As previously discussed the focus prompt is important as it is the means by which ideas are elicited during the brainstorming phase of the study (Kane & Trochim, 2007; Trochim, 1989). Since data were being collected in the CS Global MAX ™ system, participants were provided with some background about the study and instructions for completing the task, also known as the preamble to the focus prompt. The preamble and focus prompt is as follows.

Preamble:

The goal of this project is to identify and articulate characteristics and actions of a treatment foster family that leads to a successful treatment foster placement. Success can be viewed from multiple perspectives such as: foster youth functioning, the outcome of the foster placement, and/or family functioning and characteristics.

Please read the focus prompt below and then complete the sentence. When responding to the prompt, consider the multiple factors that have reflected on successful treatment foster placements in your experience.

Given that this is a multi-faceted issue, we want you to feel free to generate as many ideas as possible in response to the statement below. You may also wish to review others' responses below. This may help you think of additional factors, characteristics, and actions. Your experience and voice is the foundation of this project.

In the text box below, type a statement that completes or answers the focus prompt below. You may add as many statements as you wish. Please keep each statement brief, just one thought and then click the button "add this statement." Then you may enter your next idea.

Each statement will then be saved and added to the list of collected statements at the bottom of the page. Please review the other statements to see if your idea is already there. You may also search this list of collected statements using the search function below.

Focus Prompt:

Something that contributes to a treatment foster placement being successful in a family is…

Idea Generation

The brainstorming phase of the project was open for four weeks and five days. A total of 77 potential participants received invitations to participate in the brainstorming portion of the study. Participants did not have to complete the process all in one sitting and had the option of saving their work and re-entering the system to add responses as

long as the brainstorming session was open. After the participants received the initial email inviting them to participate, regular emails were sent to remind them about the project and inviting them to participate. A total of five reminder emails were sent after the initial email. At any point during the brainstorming period if a potential participant responded to an email stating they were not interested in participating in the project any longer, no further emails inviting them to participate were sent for the remainder of the project. Since the brainstorming phase of the project was anonymous the researcher had no way of knowing which participant completed the brainstorming task. The researcher received responses from some participants to reminder emails indicating they had already participated. If the researcher was notified by a participant that he/she had completed the task, no further reminder emails regarding the brainstorming phase were sent.

During the brainstorming phase of the study, information about the research project was included in the agency newsletter, posted on the company intranet, and provided to supervisors. The information included a brief description of the study, information about who was eligible to participate, how long the brainstorming phase of the study would continue, and contact information for the researcher should potential participants have questions.

Idea Synthesis:

At the completion of the brainstorming phase there were 65 statements generated. Idea synthesis was completed utilizing guidelines established by Kane and Trochim (2007). The statements were downloaded from the CS Global MAX™ system into a Word document for ease of editing. First, keywords in each statement were highlighted. Once the keywords were highlighted it became clear that many statements contained

multiple concepts. Examples of statements with multiple concepts included "The foster parent being nurturing, compassionate, and consistent with the youth," "consistency, support, and security," "When a foster parent is flexible, non-judgmental, and willing to work with primary family," and "openness, judgement-free, loving, kind, strong, and willing to work through difficult times."

Second, statements in which multiple ideas were represented were split so that only one idea was represented in each statement. For example, the statement "The foster parent being nurturing, compassionate, and consistent with the youth" contained three distinct ideas so the statements were split into the following three separate statements: "The foster parent is nurturing," "the foster parent is compassionate," and "the foster parent is consistent with the youth." At the completion of separating statements with multiple ideas represented were split into statements which reflected only one idea each, there were 120 statements.

Finally, the statement list of 120 statements was reviewed to reduce the number of statements by eliminating redundant ideas. Kane and Trochim (2007) advise that the final set of statements include 100 or fewer statements so the number of statements for the sorting and rating phase is manageable. In a pooled analysis study of 69 concept mapping studies, the average number of statements was 96.32 (*SD*=17.23) with a range of 45-132 statements (Rosas & Kane, 2012). In order to reduce the statement set to a manageable number, statements were reviewed and statements representing similar ideas were grouped together. For example, there were two statements related to the key concept of the foster parent accepting the child: "foster parents who accept the child for who he/she is," and "foster parents can accept the child." These three statements were

edited to include only one statement, “accepting the child for who he/she is.” Other concepts which had multiple related statements include the concept of the foster parent providing security/ a secure environment (four statements), the foster parent being consistent with the youth (three statements), the foster parent having support (four statements), the foster parent being non-judgmental (three statements), and the need for foster parents to understand that children in foster care have experienced trauma (five statements). In each case were multiple statements reflected one concept or idea, the statement that most clearly and succinctly expressed the concept was chosen, and the other statements were eliminated.

After completing idea synthesis, a set of 86 final statements was obtained. A complete list of statements is located in the results section of the paper. The edited statements were entered into the CS Global MAX ™ system for the sorting and rating phase of the project.

Statement Structuring

Sorting and rating was open roughly for seven weeks. A total of 89 potential participants received invitations to participate in the sorting and rating portion of the study. This was a longer period of time than initially planned because three holidays fell during the sorting and rating period, the agency was closed for holidays five days during the time period, and many employees took time off during the time period. Foster care workers again were contacted via agency email and invited to participate in the sorting and rating portion of the study. The email included a link to the sorting and rating portion of the project in the CS Global MAX ™ platform as well as instructions for navigating the CS Global MAX ™ system. Participants were eligible to participate in the

sorting in rating portion even if they did not participate in the brainstorming portion of the project. Participants could elect to complete only the sorting or only the rating portion of the project. This portion was not anonymous and participants registered using their email address.

Consent was obtained again during this phase of data collection because the previous phase was anonymous. Participants were not able to begin the process until consent was given. Participants could save their work at any time and go back into the system to complete the process at a later time. The CS Global MAX™ system included detailed instructions for completing the sorting and rating process. Reminder emails were sent to potential participants regularly during the sorting and rating phase. After the initial invitation email was sent a total of eight reminder emails were sent. Since this phase was not anonymous and participants registered using their email address, any participant who completed all the sorting and rating tasks were not sent reminder emails. If a potential participant initiated the sorting and rating tasks but did not complete them, reminder emails continued to be sent. As with the brainstorming phase of the study, if a potential participant indicated they were not interested any time after they began the process, no further emails were sent. If a potential participant did not meet the criteria of six months' employment with agency at the start of the sorting and rating phase but they reached six months of employment with the agency any time during the seven-week period, they were sent an email inviting them to participate.

As with the brainstorming phase of data collection, during the sorting and rating phase of data collection information about the research project was included in the agency newsletter, posted on the company intranet, and provided to supervisors. The

information distributed included a brief description of the study, information about who was eligible to participate, how long the sorting and rating phase of the study would continue, and contact information for the researcher should potential participants have any questions.

Before beginning the sorting and rating process participants were asked two questions to gather information for later use in data analysis.

1. How long have you worked in a position in which you have provided support to foster families?
    - Less than 2 years
    - 2-5 years
    - 5-10 years
    - 10-15 years
    - 15-20 years
    - Greater than 20 years
2. In your experience, treatment foster placements are most successful when the placement has been (choose the option that best reflects your experience):
    - Older than the family's oldest child
    - Same age as the family's oldest child
    - Younger than the family's older child
    - Family does not have other children

After answering the questions, the participant began the sorting and rating process. For the sorting process, the participant was instructed to sort the final list of statements from the idea synthesis phase into conceptual categories which make sense to

them. Participants were also asked to give each category a title which the participant felt represented the category.

Participants who chose to participate in the rating process were asked to rate each statement on a five point Likert scale in response to 1) importance of each statement to a successful placement (1- not at all important, 2- slightly important, 3- neutral, 4- important, and 5-very important), and 2) frequency of occurrence with a successful placement (1- never, 2- rarely, 3- occasionally, 4- frequently, 5-very frequently). Participants can could the rating in their own time and can save work and come back to it later if needed. Once collected, data were analyzed in the CS Global MAX ™ system utilizing the steps described previously in this chapter. More detail regarding data analysis are provided in the following chapter.

CHAPTER 4

Data Analysis and Results

The purpose of this study was to explore characteristics of successful treatment foster families. Characteristics and qualities/traits of treatment foster families which contribute to a successful treatment foster placement was explored from the perspective of professionals providing support to treatment foster families as part of their regular job duties.

Participants

A total of 77 potential participants received invitations to participate in the brainstorming phase of the study. Of those 77, four indicated they were not interested in participating so they were not sent any further email invitations, and the researcher learned that six potential participants' employment with the agency ended at some point during the brainstorming phase. The final potential number of participants excluding staff no longer at the agency or not interested was 67. Of the 67, 33 staff participated in the brainstorming phase. Since participation in the brainstorming phase of data collection was done anonymously, no demographic data regarding participants are available.

A total of 89 potential participants received invitations to participate in the sorting and rating phase of the study. Of those 89, two indicated they were not interested in participating so they were not sent any further email invitations, and the researcher learned that seven potential participants' employment with the agency ended at some point during the sorting and rating phase of the study. The final potential number of participants excluding staff no longer at the agency or not interested was 81.

Because participants choose their level of participation in the study, the number of participants for the structuring phase of the study varies by activity. Of the 81 potential participants, 21 staff created an account in the CS Global MAX ™ software system and participated in some form of the structuring phase of the study which included sorting statements, rating statements on two dimensions, and responding to two questions. Total number of participants for each portion of the structuring phase of the study are as follows: 21 responded to the first question presented in the CS Global MAX™ system, 20 responded to the second question presented in the CS Global MAX™ system, 13 completed the sorting portion of the study, 13 completed the first rating, and 11 completed the second rating.

Length of employment with the agency varied widely among those invited to participate in the study, ranging from 23 years to 6 months. Agency policy requires that all employees providing professional support to foster parents have at least a BA/BS degree. All participants had either a Bachelor's (*n*=9) or Master's degree (*n*=12). Participants were from five of the agency's nine states; two of the states are in the southern region of the United States, two are in the Midwestern region of the United States, and one state is in the western region of the United States. Additional demographic information available for participants is found in table 3.

Table 3

Demographic Information for Participants (N=21)

Category	Percentage and Number
Gender	
Male	9.5% (n=2)
Female	90.5% (n=19)
Race	
Caucasian	80.9% (n=17)
African American	9.5% (n=2)
Asian	4.8% (n=1)
Unknown	4.8% (n=1)
Length of Employment with the Agency	
Less than 1 year	28.57% (n=6)
1 year	19.05% (n=4)
3 years	9.52% (n=2)
5 years	14.29% (n=3)
6 years	4.76% (n=1)
8 years	4.76% (n=1)
14 years	9.52% (n=2)
18 years	4.76% (n=1)
23 years	4.76% (n=1)

A Pearson chi square test was computed with demographic variables that were categorical to determine if there was a difference in terms of educational level, gender and race comparing those employees who elected to participate in the study and those who did not. When conducting a chi square test, the frequency in each cell should be at least five (Agresti & Finlay, 1997). To meet this requirement race was divided into two categories: Caucasian and non-Caucasian. Because of the small number of males eligible to participate in the study, the minimum frequency of five in cell required for a chi-square test could not be met. For this reason, a Fisher's exact test was used to determine if there was a difference in terms of gender between those who elected to participate in the study and those who did not. There were no significant differences noted between participants

and non-participants in terms of education level, race, or gender. Analysis results are presented in Table 4.

Table 4

Demographic Characteristics Comparisons (N = 81)

Characteristic	Non-Participants Number & Percentage	Participants Number & Percentage	χ^2	*df*	*p*
Education Level					
BA	21 (35%)	9 (42.9%)	0.412	1	.521
MA	39 (65%)	12 (57.1%)			
Race					
Caucasian	39 (65%)	18 (85.7%)	3.201	1	.074
Non-Caucasian	21 (35%)	3 (14.3%)			
Gender [a]					
Male	6 (10%)	2 (9.5%)		1	.0659
Female	54 (90%)	19 (90.5%)			

Note. [a] Fisher's exact test was utilized.

Because length of employment with the agency does not necessarily capture the number of years' experience participants have providing support to treatment foster families as participants may have provided support to treatment foster families while employed with other agencies, the following question was asked of participants: How long have you worked in a position in which you have provided support to foster families?

- Less than 2 years
- 2-5 years
- 5-10 years
- 10-15 years
- 15-20 years
- Greater than 20 years

As previously reported a total of 21 participants responded to this question. Number of years' experience providing support to foster families in a professional capacity varied widely. While the greatest frequency of participants responding to this question had less than 2 years' experience (*n*=9), there were an equal number of participants (*n*=9) responding to this question with 10 or more years' experience providing support to foster families in a professional capacity. Participants responses are found in Table 5. Number of years' experience providing support to foster families in a professional capacity was not available for non-participants, so no comparison for sample bias could be done.

Table 5

Length of time participants have worked in a position supporting foster families (n=21)

Number of years	Percentage & Number
Less than 2 years	42.85% (*n* = 9)
2-5 years	4.76% (*n* = 1)
5-10 years	9.52% (*n* = 2)
10-15 years	23.81% (*n* = 5)
15-20 years	14.29% (*n* = 3)
Greater than 20 years	4.76% (*n* = 1)

In order to address the research question related to the impact of family life cycle state on treatment foster placement success, participants were asked the following question:

In your experience, treatment foster placements are most successful when the placement has been (choose the option that best reflects your experience):

- Older than the family's oldest child
- Same age as the family's oldest child
- Younger than the family's oldest child
- Family does not have other children

Half (50%, *n*= 10) of all participants responding to this question indicated that in the participants' experience treatment foster placements were most often successful when the treatment foster youth was younger than the treatment foster family's oldest child, 45% (*n*=9) of participants indicated that in their experience treatment foster placements were most often successful when the treatment foster family had no other children, and 5% (*n*=1) of participants indicated that in their experience treatment foster placements were most often successful when the treatment foster youth was older than the treatment foster family's oldest child.

Generating the Ideas

As discussed in the previous chapter, idea generation was completed in the CS Global MAX™ on-line software system. The brainstorming portion of this study resulted in a finalized list of 86 statements. The statement and their corresponding numbers are listed in Table 6. The list of statement and corresponding numbers found in Table 6 will be referenced throughout this chapter.

Table 6

Final Statement List (N=86)

#	Statement
1	the foster parent continue training hours that truly focuses on the needs of the youth in care.
2	the foster parent needs to have support of at least one other adult who is not a worker such as a friend, family member, or fellow foster parent.
3	the foster parent is compassionate.
4	providing foster parents with as much information as possible about the child's history and issues before placement.
5	goodness of fit between family and child.
6	unconditional regard.
7	support and guidance from the treatment team for the foster parents.
8	understanding that most of the children in foster care have some type of trauma experience that they will need to work through.
9	setting reasonable expectations for the foster children coming into the home.
10	the foster parents experience.
11	recognizing that everyone has good and bad days, every child and adult alike.
12	the foster parent is mentally stable.
13	being able to provide some normalcy in the child's life.
14	understanding that foster parents do not come from a clinical background.
15	effective listening.
16	not assuming that the child already knows something, the child may or may not know what is being asked of them.
17	accepting the child for who he/she is.
18	all team members being sensitive and respectful of the youth's biological family.
19	the foster family is willing to work with the goals that are put in place for the child.
20	that foster parents understand that their parental approach with foster children may be different than how the foster parents raised their biological children.
21	the understanding of clear expectations.
22	foster parent(s) do not internalize constructive criticism or feedback as an insult.
23	commitment.
24	the foster parents working together as a team.
25	willingness to learn from the children.
26	family cohesiveness.
27	being able to accept and trust the family.
28	being open to new experiences in dealing with foster children.

29	when a foster family doesn't try to push their own set of values, morals, and beliefs on to the foster child.
30	the foster parents reassure the foster child that they are there to support them.
31	when a foster parent spends more time trying to catch the foster child being "good" rather than dwelling on what the foster child does as "bad."
32	when a foster parent is able to recognize that acting out behaviors from a foster child is a result of fear.
33	when a foster parent doesn't take things that a foster child says to them personally.
34	when a foster parent recognizes the importance of establishing a positive and trusting relationship with the foster child first, before expecting anything in return from the foster child.
35	when a foster parent is flexible.
36	when the case worker not only works with the foster youth but also has contact with primary family members.
37	emotionally regulated foster parents.
38	open communication.
39	foster parent self-awareness.
40	the foster parent being willing to love the foster child.
41	helping youth with homework.
42	willingness to own up to parental mistakes or misunderstandings to build the relationship.
43	providing a caring environment.
44	treating youth as a member of family.
45	openness.
46	when the foster child feels that they can express themselves.
47	when the foster child is included in family activities.
48	working with the child and the family together to resolve conflicts.
49	well educated foster parents who have an understanding of mental health diagnoses and the traumatic experiences affecting foster children.
50	ensuring the foster family understands they may need to take advantage of mental health treatment to moderate the effects of secondary trauma.
51	ensuring the child has community support.
52	allowing the child and foster family time to get to know each other when possible.
53	an empathetic spirit.
54	understanding of life situations
55	meeting the child where he/she is.
56	when the foster parent is consistent with the youth.
57	support and guidance from the treatment team for the child.
58	the foster parents being aware that trauma can cause behavioral and emotional issues in the home.
59	recognizing that no one is perfect.

60	recognizing it may take a child longer or shorter to understand something than another child.
61	all team members are respectful of the child's history.
62	all team members are respectful of how the child was taught.
63	understanding change takes time and will not happen overnight.
64	the foster family is willing to implement suggested interventions.
65	the foster family is creative with their own interventions.
66	foster parents follow through with the expectations set for the foster child.
67	foster parents can use constructive criticism or feedback for the benefit of the child(ren) in their home.
68	being open to new learnings in dealing with foster children.
69	when a foster parent is non-judgmental.
70	when a foster parent is willing to work with the foster child's primary family.
71	when the foster parents use a strength based approach.
72	foster parents who can find small successes.
73	honest communication.
74	communication without blame.
75	advocating for the foster youth when needed.
76	providing a nurturing environment.
77	providing a consistent environment.
78	kindness.
79	willingness to work through difficult times.
80	strength.
81	when foster children are in an environment where they feel that others understand them.
82	when the foster child is included in family decisions as much as is appropriate.
83	when the child feels that he/she is emotionally safe.
84	when the child feels that he/she is physically safe.
85	facilitating relationship building so that the child is effectively integrated into the family.
86	ensuring the child feels comfortable in all settings

Structuring the Statements

Statement structuring was completed using the process as defined in the previous chapter. Participants sorted the statements into categories which made sense to them and rated the statements in two dimensions: importance and frequency. As previously reported 13 participants completed the sorting, 13 participants completed the first rating

for importance, and 11 completed the second rating for frequency of occurrence. Participant attrition between first and second ratings in concept mapping research is not uncommon. In their study of 69 concept mapping studies Rosas and Kane (2012) found that the second rating is generally completed by fewer participants as attrition may occur because of participant fatigue or knowledge level. Attrition between the first rating and second rating was highest in web based data collection studies (Rosas & Kane, 2012). On average, the first rating was completed by 65.87% (*SD*= 20.24) of those who began the rating task and by 51.64% (*SD*=20.84) for the second rating (Rosas & Kane). In this study there was attrition of 2 of the 13 participants (15.38%) between the first and second ratings.

For importance, participants were asked "On a scale of 1 - 5 with 1 being not at all important and 5 being very important, how important do you think the following statements are to a successful treatment foster placement?" with 1 being not at all important, 2 being slightly important, 3 being neutral, 4 being important, and 5 being very important. A total of 13 participants completed the rating for importance. Mean ratings for each statement ranged from 3.4615 to 4.8462. Statement 10 *the foster parent experience* had the lowest mean rating at 3.4615. There were 4 statements with the highest mean rating of 4.8462: statement 56 *when the foster parent is consistent with the youth*, statement 69 *when a foster parent is non-judgmental*, statement 76 *providing a nurturing environment*, and statement 77 *providing a consistent environment.* Table 7 provides the statement list with the mean importance rating for each statement.

Table 7

Statement List with Mean Importance Rating

Statement Number	Statement	Mean rating: Importance
1	the foster parent continue training hours that truly focuses on the needs of the youth in care.	4.7692
2	the foster parent needs to have support of at least one other adult who is not a worker such as a friend, family member, or fellow foster parent.	4.6154
3	the foster parent is compassionate.	4.7692
4	providing foster parents with as much information as possible about the child's history and issues before placement.	4.6923
5	goodness of fit between family and child.	4.4615
6	unconditional regard.	4.6154
7	support and guidance from the treatment team for the foster parents.	4.7692
8	understanding that most of the children in foster care have some type of trauma experience that they will need to work through.	4.6923
9	setting reasonable expectations for the foster children coming into the home.	4.6923
10	the foster parents experience.	3.4615
11	recognizing that everyone has good and bad days, every child and adult alike.	4.0769
12	the foster parent is mentally stable.	4.7692
13	being able to provide some normalcy in the child's life.	4.4615
14	understanding that foster parents do not come from a clinical background.	4.0769
15	effective listening.	4.6154
16	not assuming that the child already knows something, the child may or may not know what is being asked of them.	4.0769
17	accepting the child for who he/she is.	4.6154
18	all team members being sensitive and respectful of the youth's biological family.	4.2308
19	the foster family is willing to work with the goals that are put in place for the child.	4.4615
20	that foster parents understand that their parental approach with foster children may be different than how the foster parents raised their biological children.	4.4615
21	the understanding of clear expectations.	4.5385
22	foster parent(s) do not internalize constructive criticism or feedback as an insult.	4.0769

23	commitment.	4.6923
24	the foster parents working together as a team.	4.6154
25	willingness to learn from the children.	4.0769
26	family cohesiveness.	4.3077
27	being able to accept and trust the family.	4.4615
28	being open to new experiences in dealing with foster children.	4.3846
29	when a foster family doesn't try to push their own set of values, morals, and beliefs on to the foster child.	4.3846
30	the foster parents reassure the foster child that they are there to support them.	4.4615
31	when a foster parent spends more time trying to catch the foster child being "good" rather than dwelling on what the foster child does as "bad."	4.2308
32	when a foster parent is able to recognize that acting out behaviors from a foster child is a result of fear.	4.1538
33	when a foster parent doesn't take things that a foster child says to them personally.	4.3846
34	when a foster parent recognizes the importance of establishing a positive and trusting relationship with the foster child first, before expecting anything in return from the foster child.	4.6923
35	when a foster parent is flexible.	4.3846
36	when the case worker not only works with the foster youth but also has contact with primary family members.	3.8462
37	emotionally regulated foster parents.	4.6923
38	open communication.	4.5385
39	foster parent self-awareness.	4.6923
40	the foster parent being willing to love the foster child.	4.6154
41	helping youth with homework.	4
42	willingness to own up to parental mistakes or misunderstandings to build the relationship.	4.3846
43	providing a caring environment.	4.6923
44	treating youth as a member of family.	4.6923
45	openness.	4.5385
46	when the foster child feels that they can express themselves.	4.6154
47	when the foster child is included in family activities.	4.6923
48	working with the child and the family together to resolve conflicts.	4.7692
49	well educated foster parents who have an understanding of mental health diagnoses and the traumatic experiences affecting foster children.	4.0769
50	ensuring the foster family understands they may need to take advantage of mental health treatment to moderate the effects of secondary trauma.	4.2308

51	ensuring the child has community support.	4.3077
52	allowing the child and foster family time to get to know each other when possible.	4.2308
53	an empathetic spirit.	4.5385
54	understanding of life situations	4.4615
55	meeting the child where he/she is.	4.5833
56	when the foster parent is consistent with the youth.	4.8462
57	support and guidance from the treatment team for the child.	4.6154
58	the foster parents being aware that trauma can cause behavioral and emotional issues in the home.	4.7692
59	recognizing that no one is perfect.	4.3846
60	recognizing it may take a child longer or shorter to understand something than another child.	4.3846
61	all team members are respectful of the child's history.	4.5385
62	all team members are respectful of how the child was taught.	4.3077
63	understanding change takes time and will not happen overnight.	4.6923
64	the foster family is willing to implement suggested interventions.	4.5385
65	the foster family is creative with their own interventions.	4.1538
66	foster parents follow through with the expectations set for the foster child.	4.5385
67	foster parents can use constructive criticism or feedback for the benefit of the child(ren) in their home.	4.6154
68	being open to new learnings in dealing with foster children.	4.6923
69	when a foster parent is non-judgmental.	4.8462
70	when a foster parent is willing to work with the foster child's primary family.	4.1538
71	when the foster parents use a strength based approach.	4.4615
72	foster parents who can find small successes.	4.5385
73	honest communication.	4.7692
74	communication without blame.	4.6923
75	advocating for the foster youth when needed.	4.6923
76	providing a nurturing environment.	4.8462
77	providing a consistent environment.	4.8462
78	kindness.	4.7692
79	willingness to work through difficult times.	4.7692
80	strength.	4.5385
81	when foster children are in an environment where they feel that others understand them.	4.6154
82	when the foster child is included in family decisions as much as is appropriate.	4.1538
83	when the child feels that he/she is emotionally safe.	4.7692

84	when the child feels that he/she is physically safe.	4.7692
85	facilitating relationship building so that the child is effectively integrated into the family.	4.6154
86	ensuring the child feels comfortable in all settings	4.4615

Table 8 provides the mean rating for frequency of occurrence with a successful treatment foster placement for each statement. For frequency of occurrence participants were asked *"On a scale of 1 - 5 with 1 being never and 5 being very frequently, how frequently do the following occur with a successful treatment foster placement?"* with 1 being never, 2 being rarely, 3 being occasionally, 4 being frequently, and 5 being very frequently. A total of 11 participants completed ratings for frequency of occurrence with a successful treatment foster placement. Mean ratings ranged from 3.7273 to 4.6364. Statement 41 *helping youth with homework* had the lowest mean rating for frequency of occurrence with a successful treatment foster placement at 3.7273. Statement 83 *when the child feels he/she is emotionally safe* had the highest mean rating for frequency of occurrence with a successful treatment foster placement at 4.6364.

Table 8

Statement List with Mean Frequency of Occurrence Rating

Statement Number	Statement	Mean rating: Frequency
1	the foster parent continue training hours that truly focuses on the needs of the youth in care.	4.1818
2	the foster parent needs to have support of at least one other adult who is not a worker such as a friend, family member, or fellow foster parent.	4.1818
3	the foster parent is compassionate.	4.4545
4	providing foster parents with as much information as possible about the child's history and issues before placement.	4.3636
5	goodness of fit between family and child.	4.3636

6	unconditional regard.	4.2727
7	support and guidance from the treatment team for the foster parents.	4.3636
8	understanding that most of the children in foster care have some type of trauma experience that they will need to work through.	4.4545
9	setting reasonable expectations for the foster children coming into the home.	4.1818
10	the foster parents experience.	4
11	recognizing that everyone has good and bad days, every child and adult alike.	4
12	the foster parent is mentally stable.	4.3636
13	being able to provide some normalcy in the child's life.	4
14	understanding that foster parents do not come from a clinical background.	4
15	effective listening.	4.3636
16	not assuming that the child already knows something, the child may or may not know what is being asked of them.	4
17	accepting the child for who he/she is.	4.1818
18	all team members being sensitive and respectful of the youth's biological family.	3.8182
19	the foster family is willing to work with the goals that are put in place for the child.	4.2727
20	that foster parents understand that their parental approach with foster children may be different than how the foster parents raised their biological children.	4.4545
21	the understanding of clear expectations.	4.1818
22	foster parent(s) do not internalize constructive criticism or feedback as an insult.	4.1818
23	commitment.	4.4545
24	the foster parents working together as a team.	4.4545
25	willingness to learn from the children.	4
26	family cohesiveness.	4.1818
27	being able to accept and trust the family.	4.3636
28	being open to new experiences in dealing with foster children.	4.0909
29	when a foster family doesn't try to push their own set of values, morals, and beliefs on to the foster child.	4.1818
30	the foster parents reassure the foster child that they are there to support them.	4.2727
31	when a foster parent spends more time trying to catch the foster child being "good" rather than dwelling on what the foster child does as "bad."	4.4545
32	when a foster parent is able to recognize that acting out behaviors from a foster child is a result of fear.	4.1818

33	when a foster parent doesn't take things that a foster child says to them personally.	4.1818
34	when a foster parent recognizes the importance of establishing a positive and trusting relationship with the foster child first, before expecting anything in return from the foster child.	4.4545
35	when a foster parent is flexible.	4.3636
36	when the case worker not only works with the foster youth but also has contact with primary family members.	4.2727
37	emotionally regulated foster parents.	4.4545
38	open communication.	4.4545
39	foster parent self-awareness.	4.3636
40	the foster parent being willing to love the foster child.	4.4545
41	helping youth with homework.	3.7273
42	willingness to own up to parental mistakes or misunderstandings to build the relationship.	4.0909
43	providing a caring environment.	4.3636
44	treating youth as a member of family.	4.4545
45	openness.	4.3636
46	when the foster child feels that they can express themselves.	4.4545
47	when the foster child is included in family activities.	4.5455
48	working with the child and the family together to resolve conflicts.	4.5455
49	well educated foster parents who have an understanding of mental health diagnoses and the traumatic experiences affecting foster children.	4.0909
50	ensuring the foster family understands they may need to take advantage of mental health treatment to moderate the effects of secondary trauma.	3.9091
51	ensuring the child has community support.	3.9091
52	allowing the child and foster family time to get to know each other when possible.	4.0909
53	an empathetic spirit.	4.1818
54	understanding of life situations	4.2727
55	meeting the child where he/she is.	4.2727
56	when the foster parent is consistent with the youth.	4.2727
57	support and guidance from the treatment team for the child.	4.3636
58	the foster parents being aware that trauma can cause behavioral and emotional issues in the home.	4.3636
59	recognizing that no one is perfect.	4.2727
60	recognizing it may take a child longer or shorter to understand something than another child.	4.2727
61	all team members are respectful of the child's history.	4.4545

62	all team members are respectful of how the child was taught.	4.2727
63	understanding change takes time and will not happen overnight.	4.3636
64	the foster family is willing to implement suggested interventions.	4.3636
65	the foster family is creative with their own interventions.	4.1818
66	foster parents follow through with the expectations set for the foster child.	4.4545
67	foster parents can use constructive criticism or feedback for the benefit of the child(ren) in their home.	4.1818
68	being open to new learnings in dealing with foster children.	4.1818
69	when a foster parent is non-judgmental.	4.2727
70	when a foster parent is willing to work with the foster child's primary family.	4.1818
71	when the foster parents use a strength based approach.	4.4545
72	foster parents who can find small successes.	4.5455
73	honest communication.	4.4545
74	communication without blame.	4.2727
75	advocating for the foster youth when needed.	4.3636
76	providing a nurturing environment.	4.5455
77	providing a consistent environment.	4.5455
78	kindness.	4.5455
79	willingness to work through difficult times.	4.5455
80	strength.	4.4545
81	when foster children are in an environment where they feel that others understand them.	4.2727
82	when the foster child is included in family decisions as much as is appropriate.	4.0909
83	when the child feels that he/she is emotionally safe.	4.6364
84	when the child feels that he/she is physically safe.	4.5455
85	facilitating relationship building so that the child is effectively integrated into the family.	4.4545
86	ensuring the child feels comfortable in all settings	4.3636

Concept Mapping Analysis

Data analysis to create the concept maps was conducted in the CS Global MAX™ proprietary software system. The first step in the analysis process was to create a sort matrix which is comprised of all of the sorts completed by participants. A total of 13 participants completed the sorting task. According to Jackson and Trochim (2002)

between 10 and 12 sorters are needed for a reliable concept map, so 13 sorters meets the established criteria for a reliable concept map.

The sort matrix is comprised of all of the sorts completed by participants and contains as many columns and rows are there are statements (*n*=86). The value in each cell of the sort matrix indicates how many times the two statements were sorted together by participants. Since there were 13 sorts completed in this study, the value in each cell could range from zero (the two statements were not sorted together) to 13 (the two statements were sorted together by every participant).

Table 9 depicts a portion of the overall sort matrix for this study for illustrative purposes. Statements were sorted together at various rates. The two statements sorted together most frequently were statement 2 *the foster parent needs to have the support of at least one other adult who is not a worker such as a friend, family member, or fellow foster parent* and statement 7 *support and guidance from the treatment team for the foster parents.* These statements were sorted together by 12 of the 13 participants completing sorting. Other statements were not sorted together by any participants. For example, statement 4 *providing foster parents with as much information as possible about the child's history and issues before placement* and statement 6 *unconditional regard* were not sorted together at all. These examples are highlighted in yellow in Table 9. The sort frequencies ranged from zero to twelve in this study.

Table 9

Portion of the Overall Sort Matrix for Illustrative Purposes

Statement Index	1	2	3	4	5	6	7	8
1		2	1	4	1	1	2	8
2	2		1	3	1	0	12	1
3	1	1		1	2	9	1	2
4	4	3	1		3	0	3	5
5	1	1	2	3		3	1	1
6	1	0	9	0	3		0	1
7	2	12	1	3	1	0		1
8	8	1	2	5	1	1	1	
9	4	0	4	2	2	2	0	4
10	2	0	6	1	1	4	0	1
11	3	0	3	0	3	4	0	5

Multidimensional Scaling (MDS)

Once the sort matrix is completed, the next step in the analysis process is to complete multidimensional scaling (MDS) using the similarity matrix as input. MDS computes x and y coordinates for each of the statements so the statements can be plotted on a map. The x and y coordinates Table 10 provides a list of statements with their corresponding x and y coordinates. The x and y coordinates are used to plot the statements on a two-dimensional map.

Table 10

Statement Number, Statement, x coordinate, and y coordinate

Statement Number	Statement	X	Y
1	the foster parent continue training hours that truly focuses on the needs of the youth in care.	-0.183	1.817
2	the foster parent needs to have support of at least one other adult who is not a worker such as a friend, family member, or fellow foster parent.	-2.316	-0.188
3	the foster parent is compassionate.	0.689	-1.17
4	providing foster parents with as much information as possible about the child's history and issues before placement.	-1.961	0.8
5	goodness of fit between family and child.	-1.169	0.497
6	unconditional regard.	0.799	-1.248
7	support and guidance from the treatment team for the foster parents.	-2.264	-0.205
8	understanding that most of the children in foster care have some type of trauma experience that they will need to work through.	0.234	1.594
9	setting reasonable expectations for the foster children coming into the home.	0.976	0.558
10	the foster parents experience.	0.02	-1.824
11	recognizing that everyone has good and bad days, every child and adult alike.	0.823	0.907
12	the foster parent is mentally stable.	0.682	-1.533
13	being able to provide some normalcy in the child's life.	0.903	-0.391
14	understanding that foster parents do not come from a clinical background.	-1.245	1.516
15	effective listening.	0.247	-1.635
16	not assuming that the child already knows something, the child may or may not know what is being asked of them.	0.587	1.283
17	accepting the child for who he/she is.	0.917	0.409
18	all team members being sensitive and respectful of the youth's biological family.	-1.587	-0.294
19	the foster family is willing to work with the goals that are put in place for the child.	1.17	0.184
20	that foster parents understand that their parental approach with foster children may be different than how the foster parents raised their biological children.	0.857	1.021
21	the understanding of clear expectations.	1.017	1.127

22	foster parent(s) do not internalize constructive criticism or feedback as an insult.	-0.799	-1.445
23	commitment.	0.763	-1.34
24	the foster parents working together as a team.	-0.276	-0.147
25	willingness to learn from the children.	0.086	-0.933
26	family cohesiveness.	-0.843	-0.899
27	being able to accept and trust the family.	-1.239	0.23
28	being open to new experiences in dealing with foster children.	1.308	0.372
29	when a foster family doesn't try to push their own set of values, morals, and beliefs on to the foster child.	-0.061	0.534
30	the foster parents reassure the foster child that they are there to support them.	0.788	0.706
31	when a foster parent spends more time trying to catch the foster child being "good" rather than dwelling on what the foster child does as "bad."	0.744	0.329
32	when a foster parent is able to recognize that acting out behaviors from a foster child is a result of fear.	0.355	1.438
33	when a foster parent doesn't take things that a foster child says to them personally.	0.831	-0.147
34	when a foster parent recognizes the importance of establishing a positive and trusting relationship with the foster child first, before expecting anything in return from the foster child.	0.759	1.203
35	when a foster parent is flexible.	0.488	-1.132
36	when the case worker not only works with the foster youth but also has contact with primary family members.	-2.061	-0.564
37	emotionally regulated foster parents.	0.762	-1.024
38	open communication.	-0.532	-1.366
39	foster parent self-awareness.	1.004	-1.129
40	the foster parent being willing to love the foster child.	1.136	-0.344
41	helping youth with homework.	-0.189	0.763
42	willingness to own up to parental mistakes or misunderstandings to build the relationship.	1.33	0.159
43	providing a caring environment.	0.948	-0.092
44	treating youth as a member of family.	0.606	0.817
45	openness.	-0.102	-1.576
46	when the foster child feels that they can express themselves.	-1.058	1.142
47	when the foster child is included in family activities.	-0.464	1.142
48	working with the child and the family together to resolve conflicts.	-1.752	-0.74

49	well educated foster parents who have an understanding of mental health diagnoses and the traumatic experiences affecting foster children.	-1.045	-0.989
50	ensuring the foster family understands they may need to take advantage of mental health treatment to moderate the effects of secondary trauma.	-0.879	1.409
51	ensuring the child has community support.	-1.59	0.106
52	allowing the child and foster family time to get to know each other when possible.	-1.457	0.786
53	an empathetic spirit.	0.396	-1.403
54	understanding of life situations	-0.1	-0.888
55	meeting the child where he/she is.	0.499	0.404
56	when the foster parent is consistent with the youth.	1.22	0.62
57	support and guidance from the treatment team for the child.	-2.105	-0.388
58	the foster parents being aware that trauma can cause behavioral and emotional issues in the home.	-0.145	1.744
59	recognizing that no one is perfect.	0.337	-0.75
60	recognizing it may take a child longer or shorter to understand something than another child.	0.101	1.65
61	all team members are respectful of the child's history.	-1.535	-0.498
62	all team members are respectful of how the child was taught.	-1.616	-0.426
63	understanding change takes time and will not happen overnight.	0.316	1.664
64	the foster family is willing to implement suggested interventions.	0.141	0.382
65	the foster family is creative with their own interventions.	1.316	-0.423
66	foster parents follow through with the expectations set for the foster child.	1.151	0.467
67	foster parents can use constructive criticism or feedback for the benefit of the child(ren) in their home.	0.538	-0.226
68	being open to new learnings in dealing with foster children.	1.317	0.303
69	when a foster parent is non-judgmental.	0.615	-1.136
70	when a foster parent is willing to work with the foster child's primary family.	-0.803	-0.425
71	when the foster parents use a strength based approach.	1.124	-0.252
72	foster parents who can find small successes.	1.227	-0.55
73	honest communication.	-0.054	-1.301
74	communication without blame.	0.211	-1.206
75	advocating for the foster youth when needed.	-0.107	-0.255
76	providing a nurturing environment.	0.818	-0.249
77	providing a consistent environment.	1.252	-0.171

78	kindness.	0.46	-1.42
79	willingness to work through difficult times.	-0.292	-1.164
80	strength.	0.536	-1.395
81	when foster children are in an environment where they feel that others understand them.	-0.948	1.053
82	when the foster child is included in family decisions as much as is appropriate.	-0.306	0.782
83	when the child feels that he/she is emotionally safe.	-1.15	1.613
84	when the child feels that he/she is physically safe.	-0.95	1.498
85	facilitating relationship building so that the child is effectively integrated into the family.	-0.697	0.751
86	ensuring the child feels comfortable in all settings	0.476	1.099

Once the x and y coordinates are computed through MDS, the coordinates are used to create a point map; see Figure 7 for the point map for this study. MDS analysis created a point map with a final stress value of 0.3041 after 12 iterations. Sturrock and Rocha (2000) created a stress evaluation table based on 587,200 random similarity matrices of varying sizes calculating the upper stress limit for various sizes and dimensions. For a two-dimensional MDS where 86 objects were scaled the upper stress limit value is 0.391 (Sturrock & Rocha, 2000). This means that if the stress value of the MDS is less than 0.391 there is a 1% chance that there is no structure in the configuration or the configuration is random (Sturrock & Rocha, 2000). The stress value of 0.3041 for the point map for this study falls below the upper limit and is acceptable.

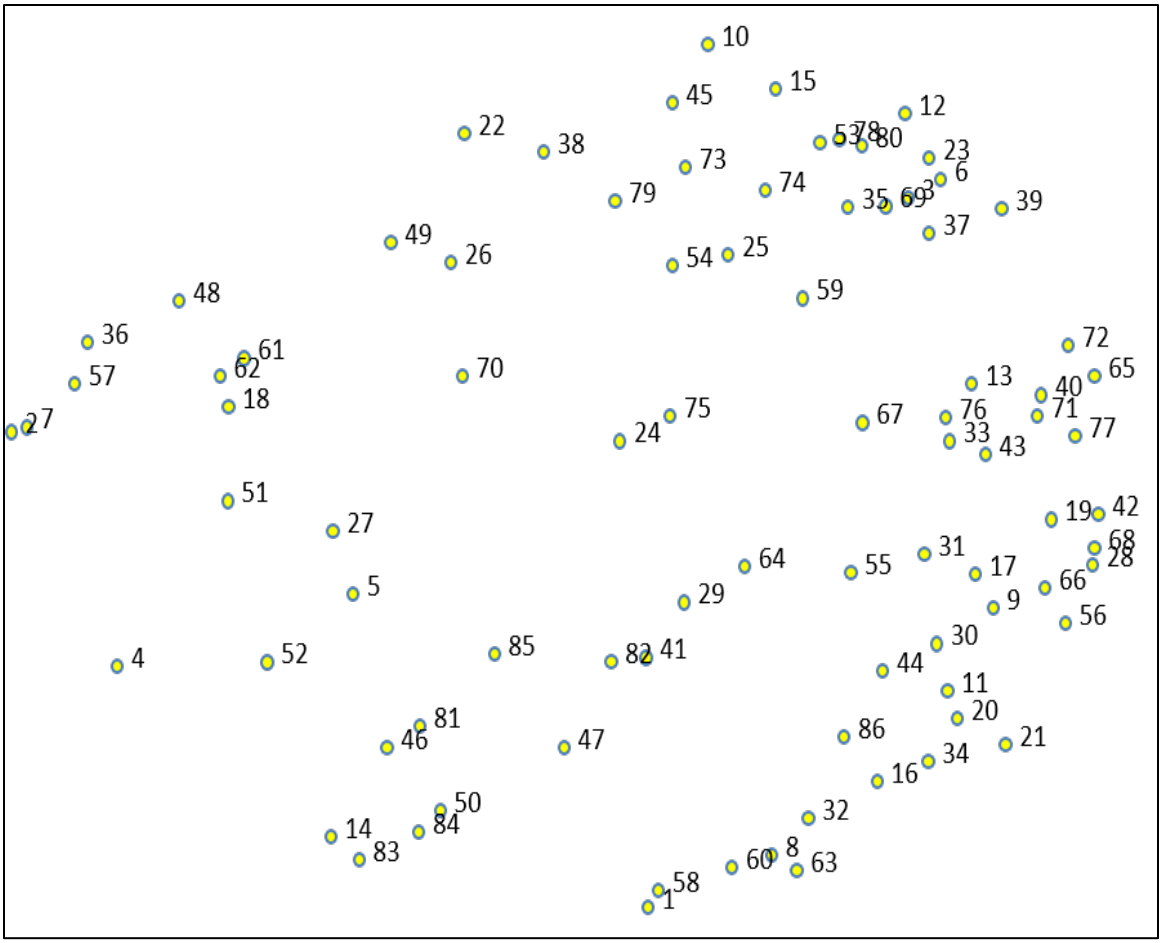

Figure 7. Point Map

Hierarchical Cluster Analysis (HCA)

Once the point map is created through MDS, the cluster map was created using hierarchical cluster analysis (HCA) as presented in Figure 8. As previously noted, there is no single correct number of clusters and no mathematical method for determining the appropriate number of clusters (Kane & Trochim, 2007; Rosas, 2005) so it is necessary for the researcher to use his/her knowledge and discretion to select the final number of clusters (Kane & Trochim, 2007; Trochim, 1989). In general, if the desired outcome of the concept mapping process is to produce high-level representation of a concept there is

typically a fewer number of clusters; however, if the desired outcome is seeking more detail for the purpose of operation planning a concept map with more clusters might be desirable (Kane & Trochim, 2007).

As suggested by Kane and Trochim (2007), upper and lower limits were established for the analysis for this study. Since the purpose of this study was to explore characteristics of successful treatment foster families, that is obtain a high level representation of the concept of successful treatment foster families, the decision was made to explore solutions with fewer clusters. For this reason, an upper limit of seven and a lower limit of four was decided upon. As suggested by Kane and Trochim (2007) concept maps were reviewed from the upper limit to the lower limit to determine which solution is most useful. A seven cluster solution was ruled out after the initial review as the seven cluster solution had separate clusters for concepts which clearly belonged together as there were two clusters which included statements which were related to qualities or traits of foster families. For example, one cluster assigned the preliminary name "Qualities of Exceptional Foster Parents" by the CS Global MAX™ system contained statement 3 *when the foster parent is compassionate*, statement 35 *when a foster parent is flexible,* and statement 53 *an empathetic spirit,* while statement 15 *effective listening,* statement 38 *open communication,* and statement 45 *openness* were in a separate cluster assigned the preliminary name "Traits" by the CS Global MAX™ system. Since the statements found in these two clusters were both associated with the concept of qualities or traits of successful foster parents and could be appropriately combined into one cluster, it was determined that a seven cluster solution was not the best fit for this study.

Concept maps with six, five, and four cluster solutions were carefully examined and a preliminary determination was made that a five cluster solution was the best fit for this study; however, prior to finalizing results preliminary results were reviewed with participants to determine which solution was the best fit for this study. In concept mapping it is common to obtain feedback from participants to ensure the results of the study make sense conceptually and are an accurate representation of the participants' perceptions. In order to obtain feedback from participants, the 21 participants who took part in the structuring phase of this project were contacted and invited to participate in a remote meeting to review preliminary results. Of the 21 participants contacted, two participants elected to participate in the preliminary results review. Participants were shown concept maps with six, five, and four cluster solutions and the corresponding statements associated with each cluster in each of these solutions and invited to offer their feedback about which solution was the best representation of the participants' perceptions. Participants were not told which solution was determined to be the best fit during preliminary analysis. Both participants reported that the five cluster solution made the most sense to them and was an accurate representation of their perceptions. Since the participants' selection of a five cluster solution as the best fit was consistent with preliminary results, a final determination was made that the five cluster solution was the best fit for this study.

Each cluster was examined to see if the name assigned by the CS Global MAX™ system accurately reflected the concepts in the cluster. The cluster names assigned by the CS Global MAX™ system were also reviewed with the two participants who elected to participate in the preliminary results review. Based on the review conducted by the

researcher and participant feedback, modifications were made by the researcher to the cluster names to better capture the concepts represented in each cluster. The five clusters are: Cluster 1 Foster Youth Needs, Cluster 2 Optimal Environment, Cluster 3 Foster Parent Support Needs, Cluster 4 Foster Parent Required Qualities, and, Cluster 5 Effective Parenting Skills. The finalized Cluster Map is presented in Figure 8.

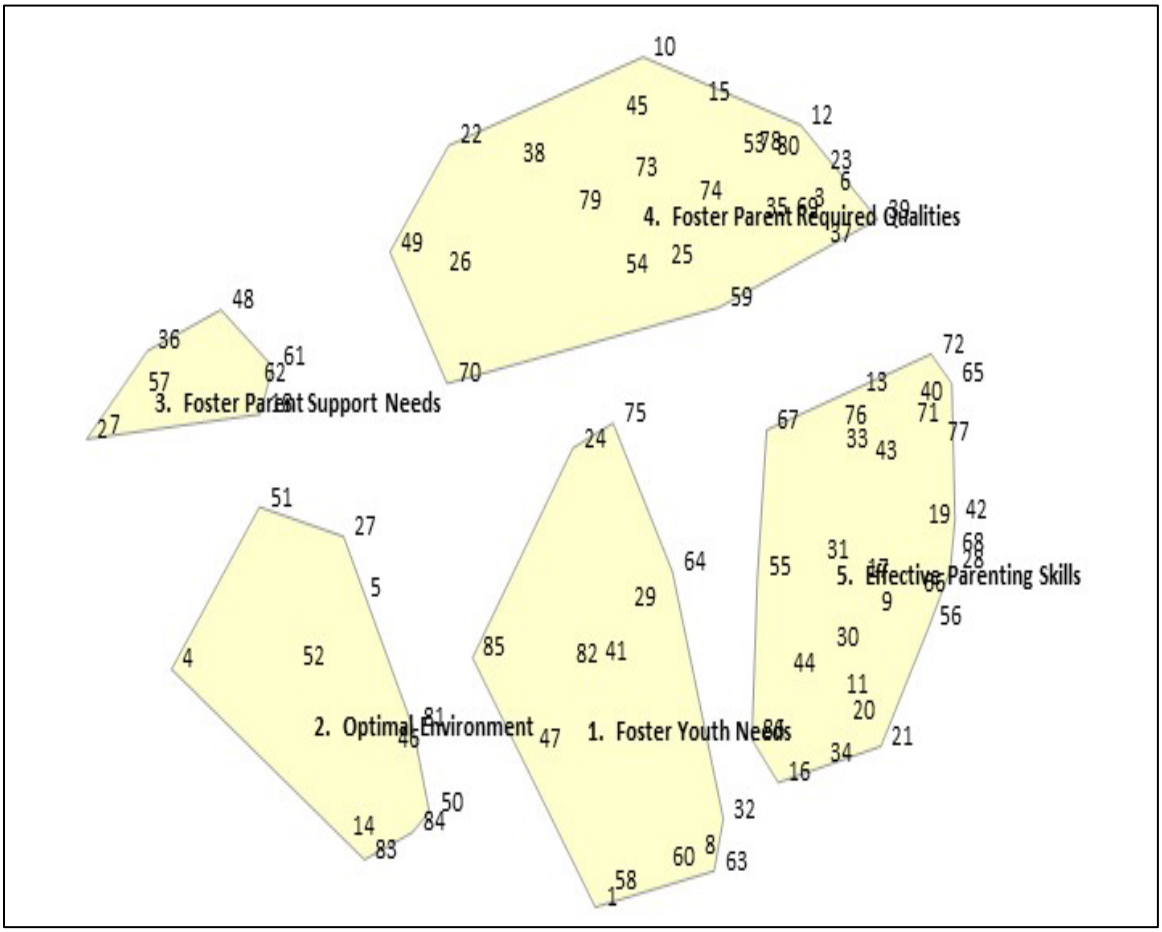

Figure 8. Cluster Map

Bridging Values

As previously discussed, bridging values show the relationship between a statement to other statements on a map (Brown, 2008) and can range from 0 to 1 (Concept Systems, Inc., 2016). A lower bridging value means there is more cohesion in a cluster. A list of statements organized by cluster with bridging values are found in Table 11. Mean bridging values for this study ranged from 0.14 to 0.65. The cluster with the lowest bridging value in this study was *Effective Parenting Skills* at 0.14, meaning that this cluster was the most cohesive or that statements in this cluster were sorted together more frequently by participants. The cluster with the highest bridging value in this study was *Optimal Environment* at 0.65, meaning that this cluster was the least cohesive or that statements in this cluster were sorted together less frequently by participants.

Table 11

List of statements organized by cluster with bridging values

Cluster		Statement	Bridging
Cluster 1: Foster Youth Needs			
	64	the foster family is willing to implement suggested interventions.	0.15
	75	advocating for the foster youth when needed.	0.19
	29	when a foster family doesn't try to push their own set of values, morals, and beliefs on to the foster child.	0.21
	24	the foster parents working together as a team.	0.22
	41	helping youth with homework.	0.23
	82	when the foster child is included in family decisions as much as is appropriate.	0.25
	32	when a foster parent is able to recognize that acting out behaviors from a foster child is a result of fear.	0.26
	85	facilitating relationship building so that the child is effectively integrated into the family.	0.33

	47	when the foster child is included in family activities.	0.37
	8	understanding that most of the children in foster care have some type of trauma experience that they will need to work through.	0.38
	60	recognizing it may take a child longer or shorter to understand something than another child.	0.42
	58	the foster parents being aware that trauma can cause behavioral and emotional issues in the home.	0.46
	63	understanding change takes time and will not happen overnight.	0.47
	1	the foster parent continue training hours that truly focuses on the needs of the youth in care.	0.52
		Mean Bridging Value for Cluster 1	**0.32**
Cluster 2: Optimal Environment			
	84	when the child feels that he/she is physically safe.	0.5
	46	when the foster child feels that they can express themselves.	0.5
	81	when foster children are in an environment where they feel that others understand them.	0.53
	5	goodness of fit between family and child.	0.53
	51	ensuring the child has community support.	0.57
	83	when the child feels that he/she is emotionally safe.	0.59
	27	being able to accept and trust the family.	0.62
	50	ensuring the foster family understands they may need to take advantage of mental health treatment to moderate the effects of secondary trauma.	0.66
	14	understanding that foster parents do not come from a clinical background.	0.81
	52	allowing the child and foster family time to get to know each other when possible.	0.81
	4	providing foster parents with as much information as possible about the child's history and issues before placement.	1
		Mean Bridging Value for Cluster 2	**0.65**
Cluster 3: Foster Parent Support Needs			
	57	support and guidance from the treatment team for the child.	0.37
	36	when the case worker not only works with the foster youth but also has contact with primary family members.	0.39
	7	support and guidance from the treatment team for the foster parents.	0.45
	62	all team members are respectful of how the child was taught.	0.47
	61	all team members are respectful of the child's history.	0.48

	48	working with the child and the family together to resolve conflicts.	0.51
	2	the foster parent needs to have support of at least one other adult who is not a worker such as a friend, family member, or fellow foster parent.	0.52
	18	all team members being sensitive and respectful of the youth's biological family.	0.56
		Mean Bridging Value for Cluster 3	**0.47**
Cluster 4: Foster Parent Required Qualities			
	3	the foster parent is compassionate.	0
	69	when a foster parent is non-judgmental.	0.02
	80	strength.	0.04
	23	commitment.	0.04
	78	kindness.	0.05
	37	emotionally regulated foster parents.	0.07
	6	unconditional regard.	0.07
	35	when a foster parent is flexible.	0.07
	53	an empathetic spirit.	0.13
	74	communication without blame.	0.14
	59	recognizing that no one is perfect.	0.15
	12	the foster parent is mentally stable.	0.15
	25	willingness to learn from the children.	0.17
	39	foster parent self-awareness.	0.17
	15	effective listening.	0.18
	73	honest communication.	0.23
	54	understanding of life situations	0.25
	45	openness.	0.28
	70	when a foster parent is willing to work with the foster child's primary family.	0.39
	79	willingness to work through difficult times.	0.4
	10	the foster parents experience.	0.42
	38	open communication.	0.43

	26	family cohesiveness.	0.56
	22	foster parent(s) do not internalize constructive criticism or feedback as an insult.	0.74
	49	well educated foster parents who have an understanding of mental health diagnoses and the traumatic experiences affecting foster children.	0.81
		Mean Bridging Value for Cluster 4	**0.24**
Cluster 5: Effective Parenting Skills			
	43	providing a caring environment.	0.04
	76	providing a nurturing environment.	0.04
	33	when a foster parent doesn't take things that a foster child says to them personally.	0.05
	31	when a foster parent spends more time trying to catch the foster child being "good" rather than dwelling on what the foster child does as "bad."	0.06
	17	accepting the child for who he/she is.	0.06
	9	setting reasonable expectations for the foster children coming into the home.	0.07
	67	foster parents can use constructive criticism or feedback for the benefit of the child(ren) in their home.	0.07
	66	foster parents follow through with the expectations set for the foster child.	0.1
	44	treating youth as a member of family.	0.1
	13	being able to provide some normalcy in the child's life.	0.11
	86	ensuring the child feels comfortable in all settings	0.14
	55	meeting the child where he/she is.	0.15
	19	the foster family is willing to work with the goals that are put in place for the child.	0.15
	30	the foster parents reassure the foster child that they are there to support them.	0.15
	77	providing a consistent environment.	0.16
	71	when the foster parents use a strength based approach.	0.16
	11	recognizing that everyone has good and bad days, every child and adult alike.	0.18
	68	being open to new learnings in dealing with foster children.	0.18
	40	the foster parent being willing to love the foster child.	0.18
	65	the foster family is creative with their own interventions.	0.19

	42	willingness to own up to parental mistakes or misunderstandings to build the relationship.	0.19
	28	being open to new experiences in dealing with foster children.	0.19
	34	when a foster parent recognizes the importance of establishing a positive and trusting relationship with the foster child first, before expecting anything in return from the foster child.	0.19
	72	foster parents who can find small successes.	0.2
	16	not assuming that the child already knows something, the child may or may not know what is being asked of them.	0.22
	56	when the foster parent is consistent with the youth.	0.22
	20	that foster parents understand that their parental approach with foster children may be different than how the foster parents raised their biological children.	0.25
	21	the understanding of clear expectations.	0.3
		Mean Bridging Value for Cluster 5	**0.14**

Figure 9 is the Cluster Bridging Map and it supplements Table 11. The mean bridging values are depicted in the third dimension. Clusters with fewer layers are clusters which are more cohesive when compared with clusters on the map which have more layers. For example, the cluster *Optimal Environment* at 0.65 had the highest bridging value, and on the Cluster Bridging Map below is has four layers, while the clusters with the lowest bridging values, *Foster Parent Required Qualities* at 0.24 and *Optimal Environment* at 0.14 have only one layer on the Cluster Bridging Map below.

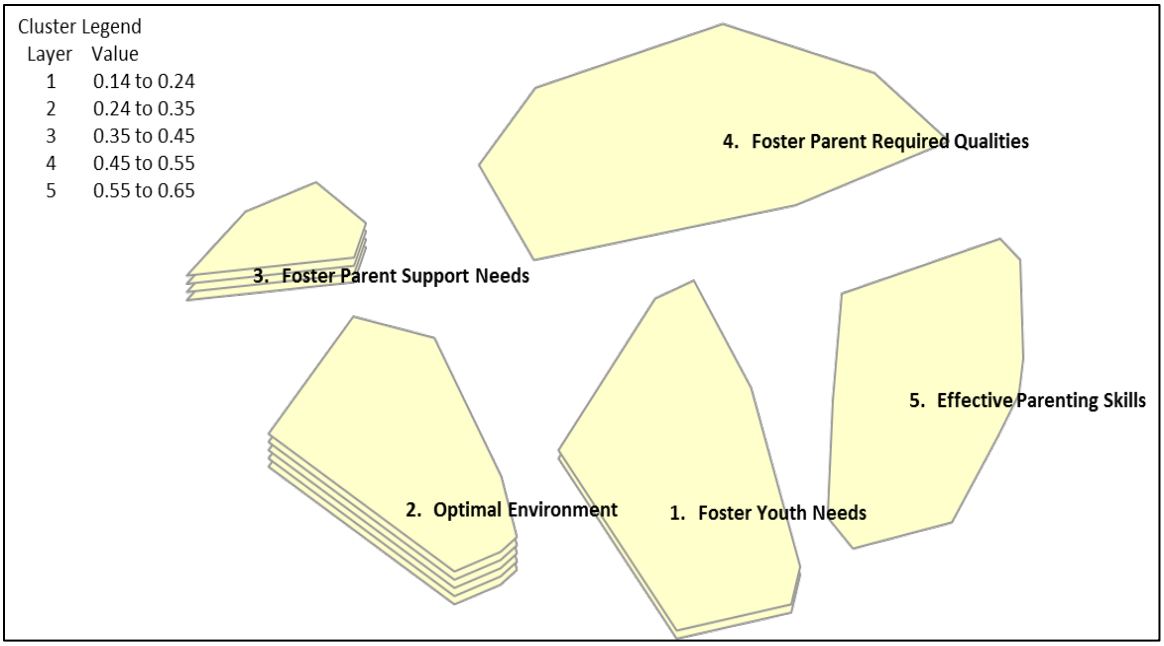

Figure 9. Cluster Bridging Map

Point Rating Maps

Once point and cluster maps were created, ratings data were incorporated into the analysis. As previously discussed, there were two ratings in this study, the first for importance to a successful treatment foster placement and the second for frequency of occurrence in a successful treatment foster placement. Point Rating Maps are based on the Point Map presented previously in this chapter and depict the average rating for each statement (Kane & Trochim, 2007). Figure 10 depicts the Point Rating Map for importance to a successful treatment foster care placement and Figure 11 depicts the Point Rating Map for frequency of occurrence with a successful treatment foster care placement. Taller columns of points represent statements which were rated as more important to a treatment foster care placement in Figure 10 and statements which were

rated as occurring more frequently with a successful treatment foster care placement in Figure 11.

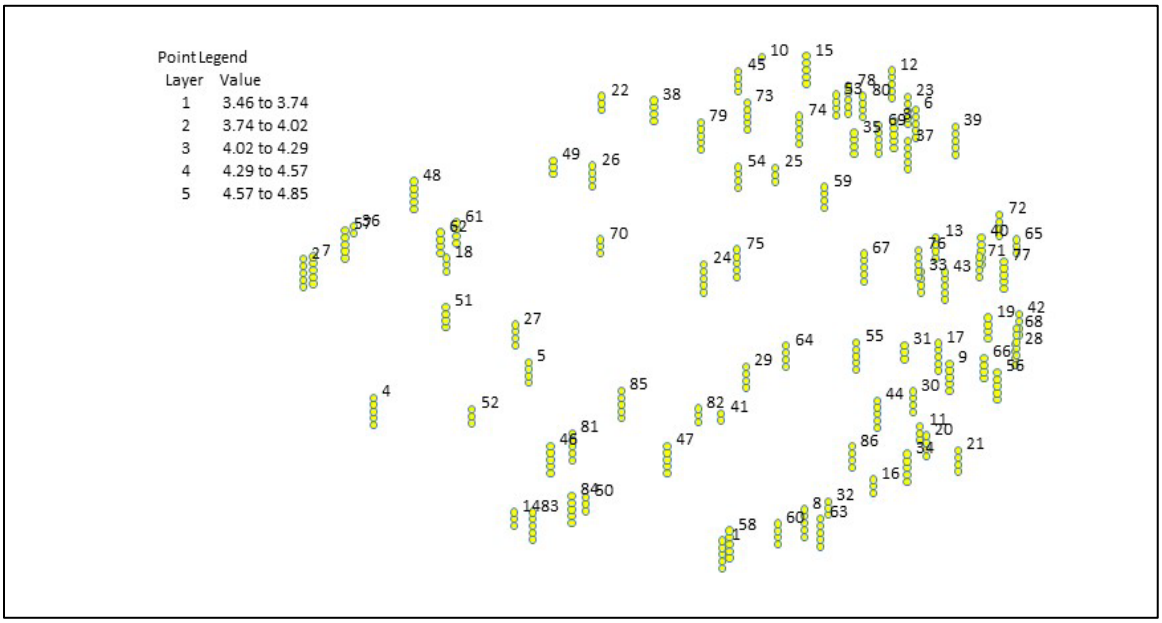

Figure 10. Point Rating Map for Importance

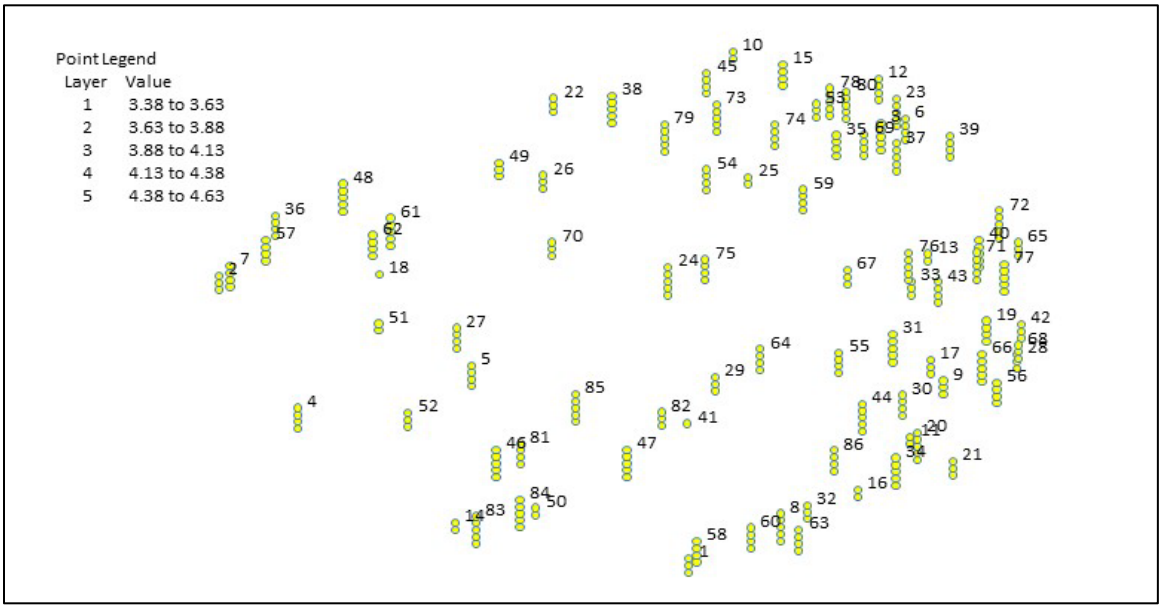

Figure 11. Point Rating Map for Frequency

Cluster Rating Maps

Cluster Rating Maps are similar to Point Rating Maps in that they incorporate ratings data into the maps, but instead of showing average ratings for each point that represents a statement, Cluster Rating Maps depict the mean rating for the statements in each cluster. On the Cluster Rating Map more layers represent higher average ratings for the cluster. In Figure 12, clusters with more layers indicate higher ratings for importance to a successful treatment foster care placement. In Figure 13, clusters with more layers indicate higher ratings for frequency of occurrence with successful treatment foster care placements. In Figure 12, Cluster 1 *Foster Youth Needs* and Cluster 5 *Effective Parenting Skills* had the most layers, indicating that participants rated these clusters as most important to a successful treatment foster care placement. In Figure 13, Cluster 4 *Foster Parent Required Qualities* had the most layers, indicating that participants rated this cluster as occurring most frequently with a successful treatment foster care placement.

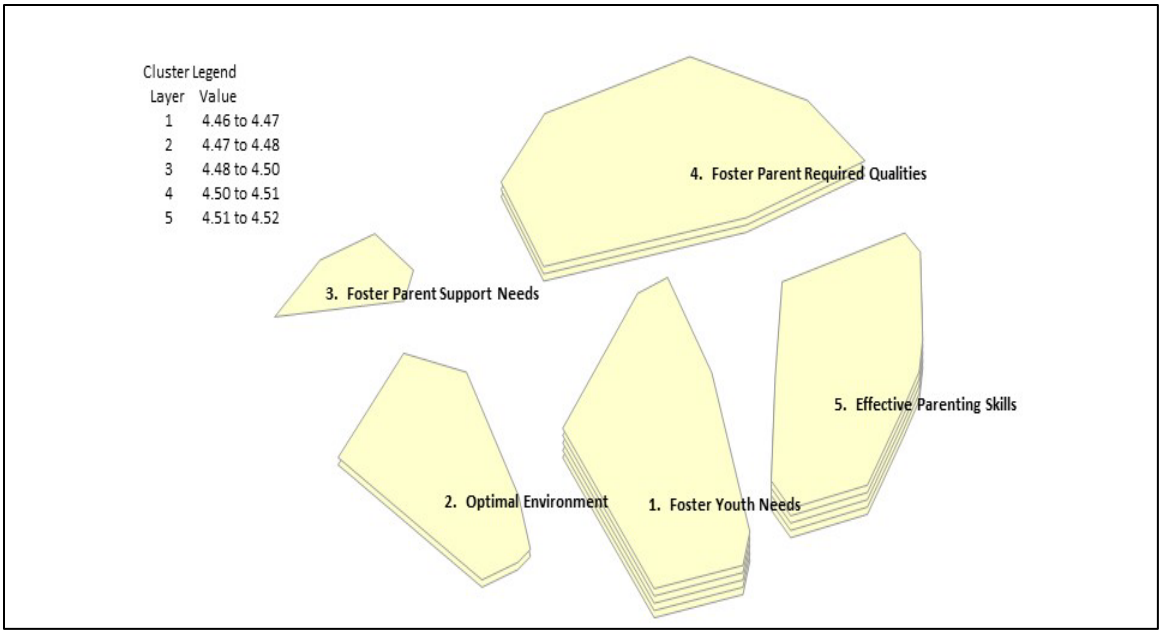

Figure 12. Cluster Rating Map for Importance

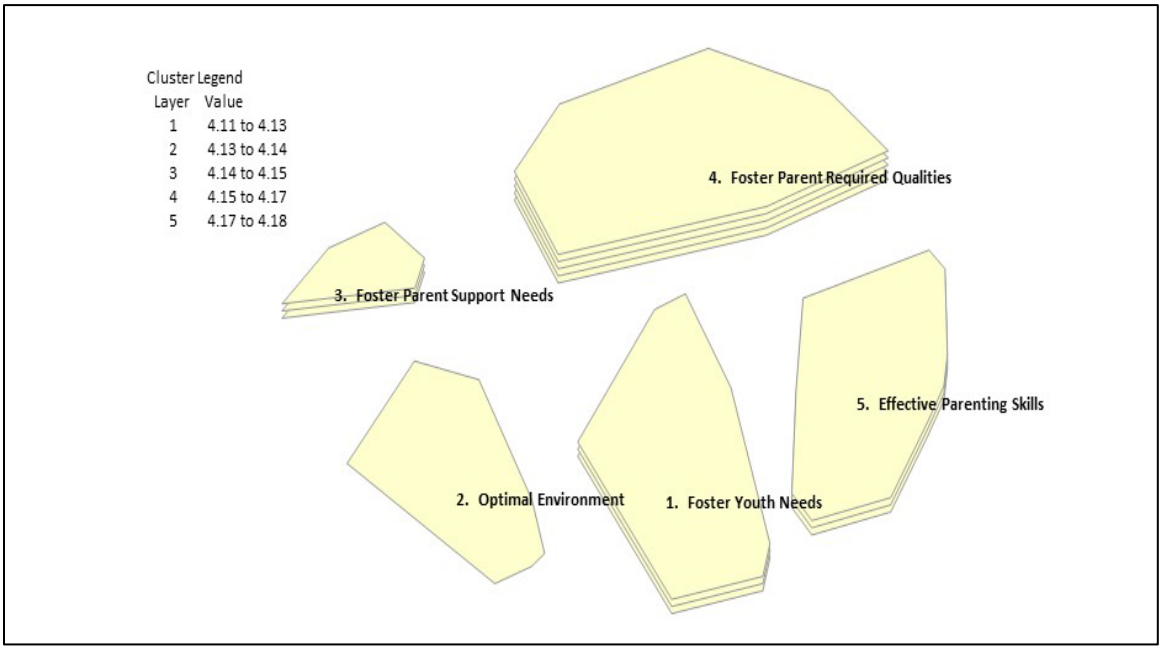

Figure 13. Cluster Rating Map for Frequency of Occurrence

Pattern Match

A pattern match is computed to show the relationships between ratings variables in concept mapping studies and are depicted in the form of a ladder graph (Kane & Trochim, 2007). The pattern match is constructed as follows: average cluster ratings for one dimension, in this study for importance, are depicted on the left side of the ladder graph and average ratings for the dimension being compared, in this study frequency of occurrence, are depicted on the right side of the ladder graph (Kane & Trochim, 2007). Clusters listed towards the top of the ladder graph are rated higher for the respective dimension by participants, while clusters listed lower on the ladder graph are rated lower for the respective dimension by participants (Kane & Trochim, 2007). A straight line is then drawn between the same cluster on each side of the graph to illustrate the relationship between the average ratings for the clusters on each dimension (Kane & Trochim, 2007). A Pearson product moment correlation or "*r*" value is computed to show the strength of the correlation between patterns of ratings on the two dimensions (Kane & Trochim, 2007).

For this study, a pattern match was created to show the relationship between the two ratings variables of importance and frequency and are presented in Figure 14. For importance, *Effective Parenting Skills* was rated highest by participants, followed by *Foster Youth Needs, Foster Parent Required Qualities, Optimal Environment*, and finally *Foster Parent Support Needs*. For frequency of occurrence, *Foster Parent Required Qualities* was rated the highest by participants, followed by *Effective Parenting Skills*, Fo*ster Youth Needs, Foster Parent Support Needs*, and finally *Optimal Environment*. The ladder graph shows that there is a low relationship between the ratings of importance

and frequency of occurrence on all clusters, this is supported by a low overall correlational value between the two dimensions for all cluster ratings of r=0.26.

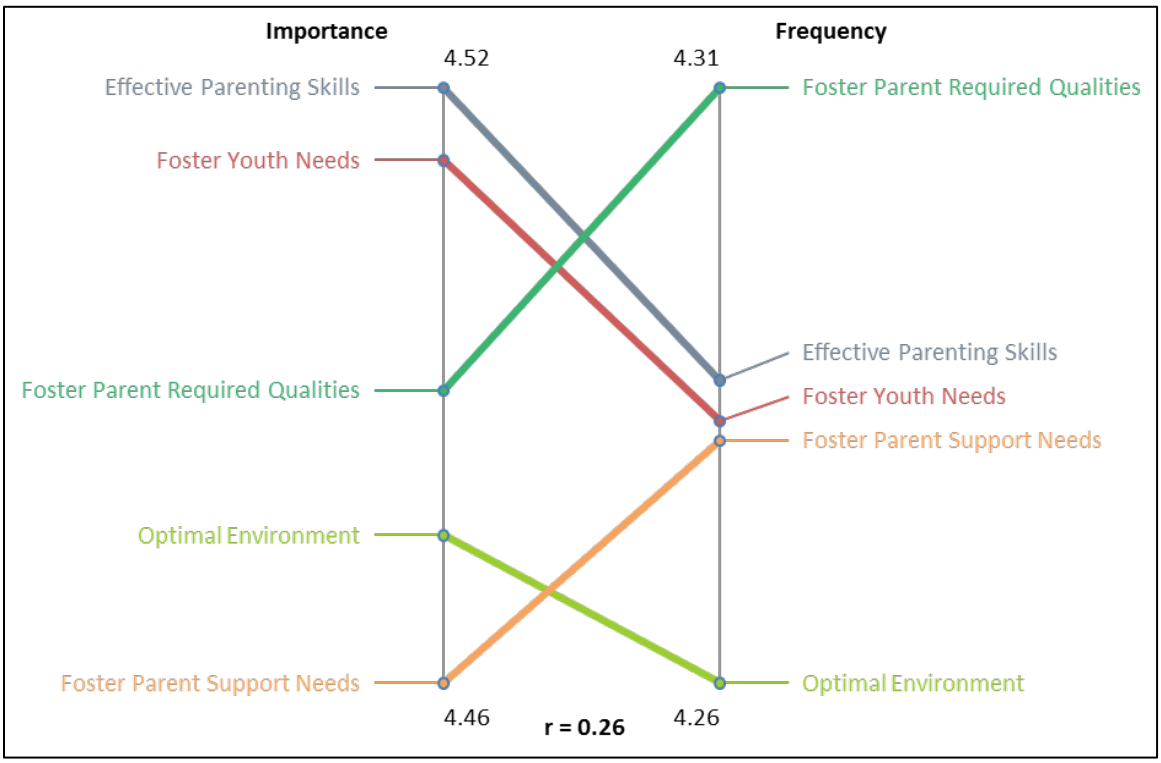

Figure 14. Pattern Match Between Importance and Frequency of Occurrence

Go-Zone Graphs

For this study, go-zones were calculated for each cluster. In go-zone maps computed for this study, the vertical line shows the mean rating for importance for each cluster, and the horizontal line shows the mean rating for frequency of occurrence. Statements which fall in the upper-right quadrant fall in to the go-zone, that is those statements are rated above the mean rating for both importance and frequency of occurrence. These statements were rated by participants as both most important to and most frequently occurring in successful treatment foster care placements. Those

statements which fall in the upper-left quadrant of the go-zone maps represent those statements which were rated higher than the mean rating for frequency of occurrence but lower for importance. Statements which fall in the lower-right quadrant were rated higher than the mean for importance but lower for frequency of occurrence. Statements which fall in the lower-left quadrant were rated lower than the mean for both importance and frequency of occurrence.

The go-zone graph for Cluster 1 is presented in Figure 15. In Cluster 1 *Foster Youth Needs*, statement numbers 8 *understanding that most the children in foster care have some type of trauma experience that they will need to work through*,24 *the foster parents working together as a team*, 47 *when the foster child is included in family activities*, 58 *the foster parents being aware that trauma can cause behavioral and emotional issues in the home*, 63 *understanding change takes time and will not happen overnight*, 64 *the foster family is willing to implement suggested interventions*, 75 *advocating for the foster youth when needed*, and 85 *facilitating relationship building so that the child is effectively integrated into the family* fell into the upper right quadrant or go-zone. This means that these statements were rated higher on both dimensions than the mean rating in this cluster indicating that participants viewed these statements as the most actionable items in the *Foster Youth Needs* cluster.

Statements which fell into the lower-left quadrant were rated lower than the mean for both importance and frequency of occurrence in the *Foster Youth Needs* cluster include statement numbers 29 *when a foster family doesn't try to push their own set of values, morals, and beliefs on to the foster child*, 32 *when a foster parent is able to recognize that acting out behaviors from a foster child is a result of fear*, 41 *helping*

youth with homework, 60 *recognizing that it may take a child longer or shorter to understand something than another child,* and 82 *when a foster child is included in family decisions as much as is appropriate.* This means that these statements were rated lower than the mean rating in this cluster indicating that participants viewed these statements as the least actionable items in the *Foster Youth Needs* cluster.

Statement 1 *the foster parent continue training hours that truly focuses on the needs of the youth in care* falls in the lower-right quadrant, indicating it was rated higher than the mean for importance yet lower than the mean for frequency of occurrence in the *Foster Youth Needs* cluster. No statements fall into the upper-left quadrant for the *Foster Youth Needs* cluster indicating that no statements were rated higher than the mean for frequency of occurrence but lower than the mean for importance.

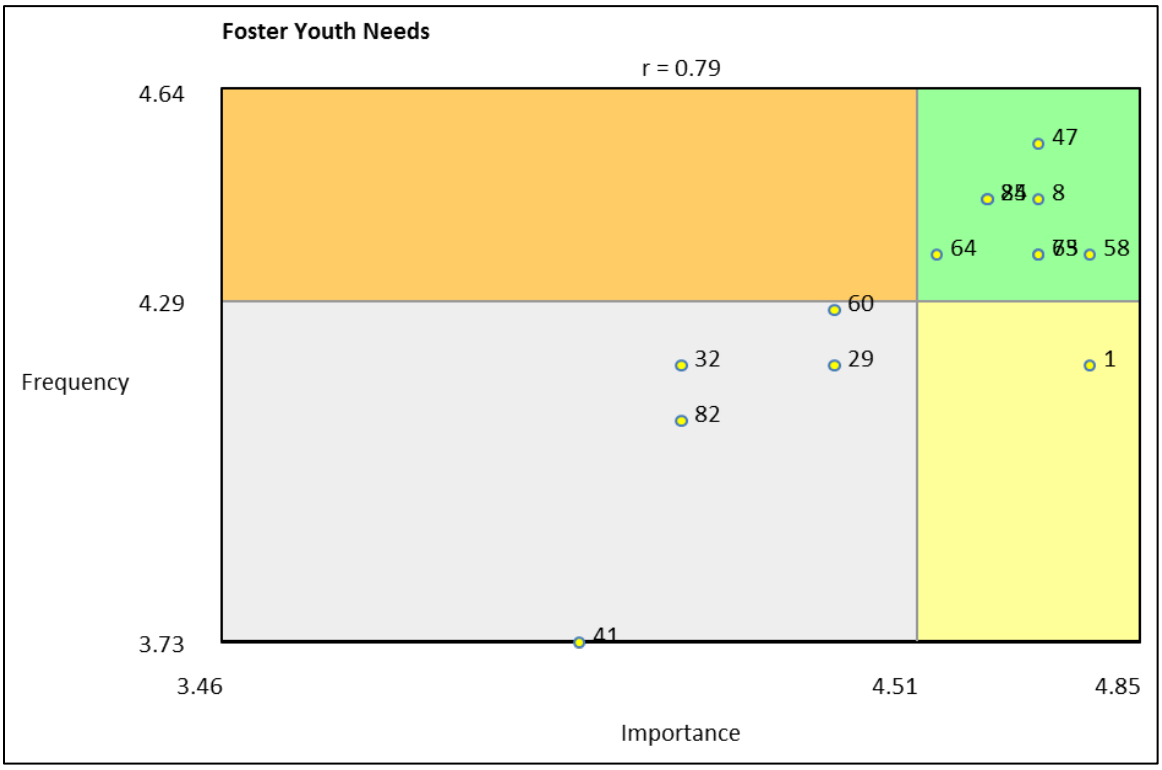

Figure 15. Go-zone Graph for Cluster 1 Foster Youth Needs

The go-zone graph for Cluster 2 is presented in Figure 16. In Cluster 2 *Optimal Environment,* statement numbers 4 *providing the foster parents with as much information as possible about the child's history and issues before placement,* 46 *when the foster child feels that they can express themselves,* 81 *when foster children are in an environment where they feel that others understand them,* 83 *when the child feels that he/she is emotionally safe,* and 84 *when the child feels that he/she is physically safe* were in the go-zone. This means that these statements were rated higher than the mean rating for both importance and frequency of occurrence in this cluster indicating that participants viewed these statements as the most actionable items in the *Optimal Environment* cluster.

Statements which fell into the lower-left quadrant in the *Optimal Environment* cluster include statements 14 *understanding that foster parents do not come from a clinical background,* 50 *ensuring the foster family understands they may need to take advantage of mental health treatment to moderate the effects of secondary trauma,* 51 *ensuring the child has community support,* and 52 *allowing the child and foster family time to get to know each other when possible* were rated lower than the mean on importance and frequency of occurrence for this cluster. This indicates that participants viewed these statements as the least actionable items in the *Optimal Environment* cluster.

No statements fall in to the lower-right quadrant indicating that no statements were rated higher than the mean for importance but lower than the mean for frequency of occurrence in this cluster. Statements 5 *goodness of fit between family and child* and 27 *being able to accept and trust the family* fell in to the upper-left quadrant indicating these

statements were rated higher than the mean for frequency of occurrence but lower than the mean for importance in the *Optimal Environment* cluster.

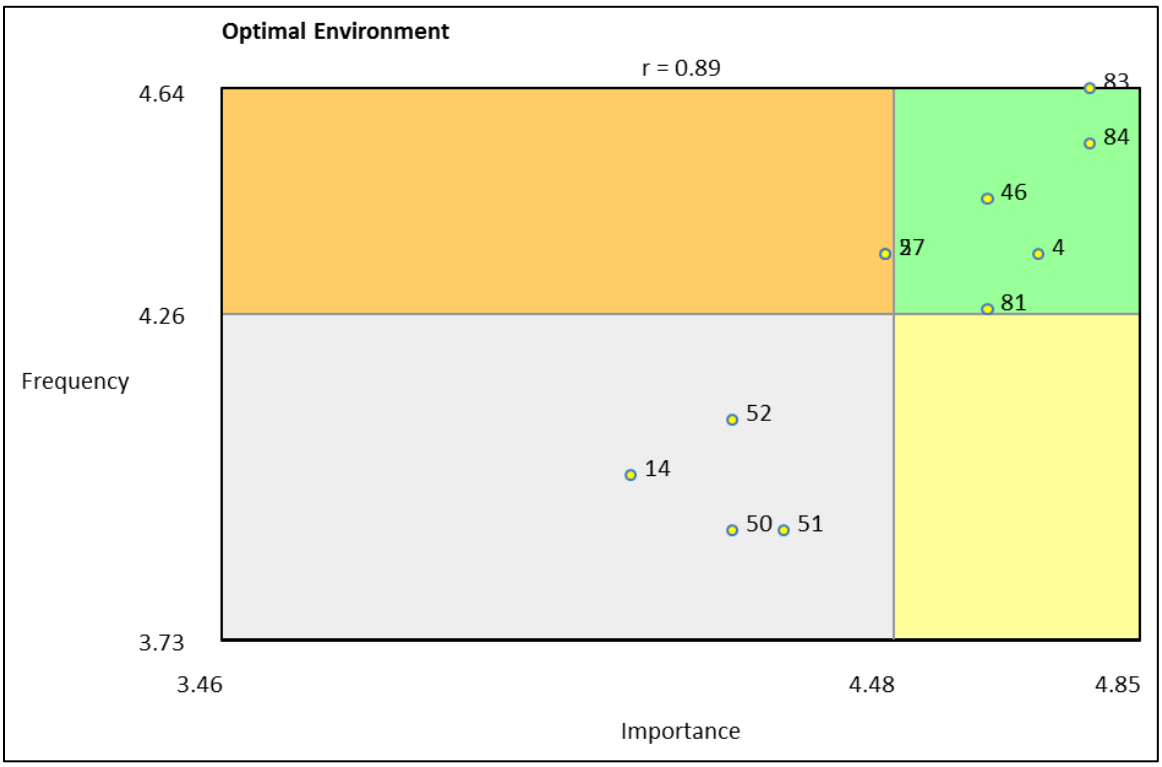

Figure 16. Go-zone Graph for Cluster 2 Optimal Environment

The go-zone graph for Cluster 3 is presented in Figure 17. In Cluster 3 *Foster Parent Support Needs*, statement numbers 7 *support and guidance from the treatment team for the foster parents*, 48 *working with the child and family together to resolve conflicts*, 57 *support and guidance from the treatment team for the child*, and 61 *all team members are respectful of the child's history* were in the go-zone. This means that these statements were rated higher than the mean rating for both importance and frequency in this cluster indicating participants viewed these statements as the most actionable items in the *Foster Parent Support Needs* cluster.

Statements which fell in to the lower-left quadrant in the *Foster Parent Support Needs* cluster include statements 18 *all team members being sensitive and respectful of the youth's biological family*, 36 *when the caseworker not only works with the foster youth but also has contact with primary family members,* and 62 *all team members are respectful of how the child was taught.* This indicates that participants viewed these statements as the least actionable items in the *Foster Parent Support Needs* cluster.

Statement 2 *the foster parent needs to have support of at least one other adult who is not a worker such as a friend, family member or fellow foster parent* fell into the lower-right quadrant indicating this statement was rated higher than the mean for importance but lower than the mean for frequency of occurrence in this cluster. No statements fell into the upper-left quadrant indicating there were no statements in the *Foster Parent Support Needs* cluster that were rated higher than the mean for frequency but lower than the mean for importance.

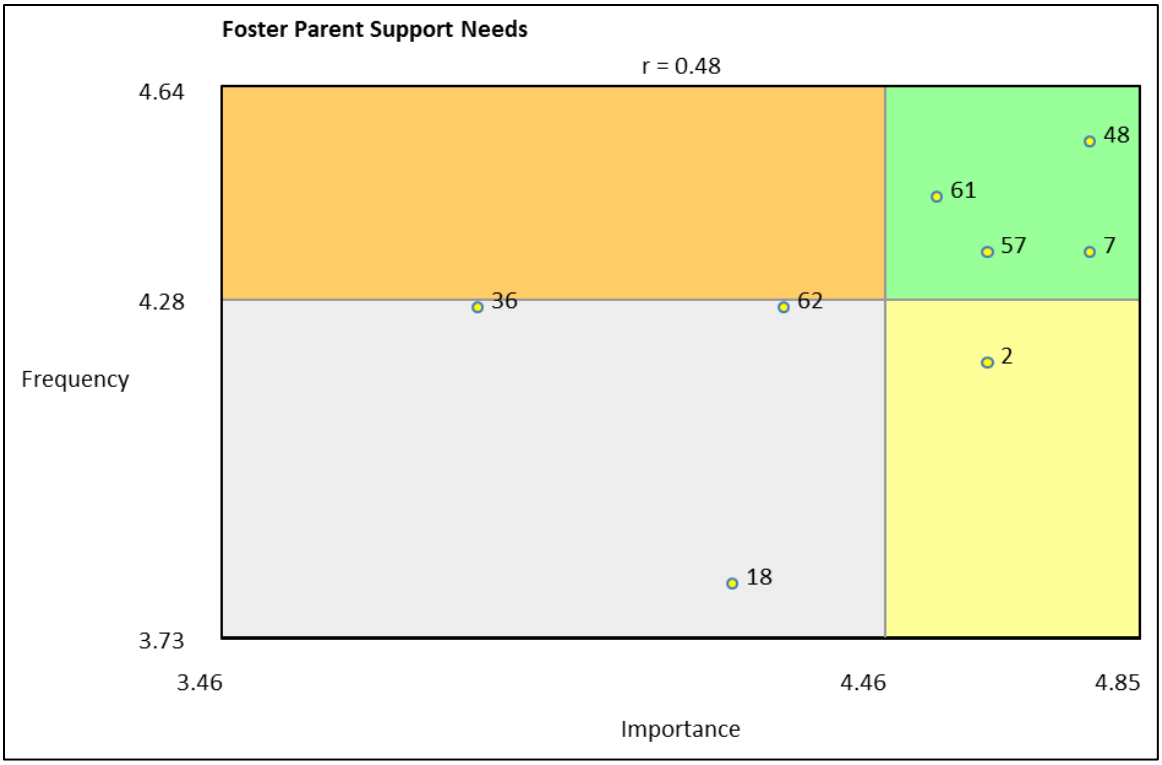

Figure 17. Go-zone Graph for Cluster 3 Foster Parent Support Needs

The go-zone graph for Cluster 4 is presented in Figure 18. In Cluster 4 *Foster Parent Required Qualities,* statement numbers 3 *the foster parent is compassionate,* 12 *the foster parent is mentally stable,* 15 *effective listening,* 23 *commitment,* 37 *emotionally regulated foster parents,* 38 *open communication,* 39 *foster parent self-awareness,* 45 *openness,* 73 *honest communication,* 78 *kindness,* 79 *willingness to work through difficult times,* and 80 *strength* were in the go-zone. This means that these statements were rated higher than the mean rating for both importance and frequency of occurrence in this cluster. This indicates participants viewed these statements as the most actionable items in the *Foster Parent Required Qualities* cluster.

Statements 10 *the foster parents experience,* 22 *foster parent(s) do not internalize constructive criticism or feedback as an insult,* 25 *willingness to learn from*

the children, 26 *family cohesiveness*, 49 *well educated foster parents who have an understanding of mental health diagnoses and the traumatic experiences affecting foster children*, 54 *understanding of life situations*, 59 *recognizing that no one is perfect*, and 70 *when a foster parent is willing to work with the foster child's primary family* fell in to the lower-left quadrant. This indicates participants viewed these statements as the least actionable items in the *Foster Parent Required Qualities* cluster.

Statements which fell into the lower-right quadrant include statements 6 *unconditional regard*, 53 *an empathetic spirit*, 69 *when a foster parent is non-judgmental*, and 74 *communication without blame*. This indicates these statements were rated by participants as higher than the mean for importance but lower than the mean for frequency of occurrence in this cluster. Statement 35 *when a foster parent is flexible* fell into the upper-left quadrant indicating that participants rated this statement higher than the mean rating for frequency of occurrence but lower than the mean rating for importance.

Figure 18. Go-zone Graph for Cluster 4 Foster Parent Required Qualities

The go-zone graph for Cluster 5 is presented in Figure 19. In Cluster 5 *Effective Parenting Skills*, statement numbers 34 *when the foster parent recognizes the importance of establishing a positive and trusting relationship with the foster child first, before expecting anything in return from the foster child*, 40 *the foster parent being willing to love the foster child*, 43 *providing a caring environment*, 44 *treating youth as a member of family*, 66 *foster parents follow through with the expectations set for the foster child*, 72 *foster parents who can find small successes*, 76 *providing a nurturing environment*, and 77 *providing a consistent environment* were in the go-zone. This means that these statements were rated higher than the mean rating for both importance and frequency of occurrence in this cluster, indicating that participants view these statements as the most actionable items in the *Effective Parenting Skills* cluster.

Statements which fell into the lower-left quadrant include statements 11 *recognizing that everyone has good and bad days, every child and adult alike,* 13 *being able to provide some normalcy in the child's life,* 16 *not assuming the child already knows something, the child may or may not know what is being asked of them,* 19 *the foster family is willing to work with the goals that are put in place for the child,* 28 *being open to new experiences in dealing with foster children,* 30 *the foster parents reassure the child that they are there to support them,* 33 *when a foster parent doesn't take things that a foster child says to them personally,* 42 *willingness to own up to parental mistakes or misunderstandings to build the relationship,* and 65 *the foster family is creative with their own interventions*. These statements had ratings lower than the mean for both importance and frequency of occurrence, indicating these statements are viewed as the least actionable items for the *Effective Parenting Skills* cluster.

Statements 9 *setting reasonable expectations for the foster children coming into the home,* 17 *accepting the child for who he/she is,* 21 *the understanding of clear expectations,* 55 *meeting the child where he/she is,* 56 *when the foster parent is consistent with the youth,* 67 *foster parents can use constructive criticism or feedback for the benefit of the child(ren) in their home,* and 68 *being open to new learnings in dealing with foster children* fell into the lower-right quadrant indicating that these statements were rated higher than the mean rating for importance but lower than the mean rating for frequency of occurrence. Statements 20 *that foster parents understand that their parental approach with foster children may be different than how they foster parent raised their biological children,* 31 *when a foster parent spends more time trying to catch the foster child being "good" rather than dwelling on what the foster child does as "bad",* 71 *when the foster*

parents use a strengths based approach, and 86 *ensuring the child feels comfortable in all settings* fell in to the upper-left quadrant. This means these statements were rated higher than the mean rating for frequency of occurrence but lower than the mean rating for importance in the *Effective Parenting Skills* cluster.

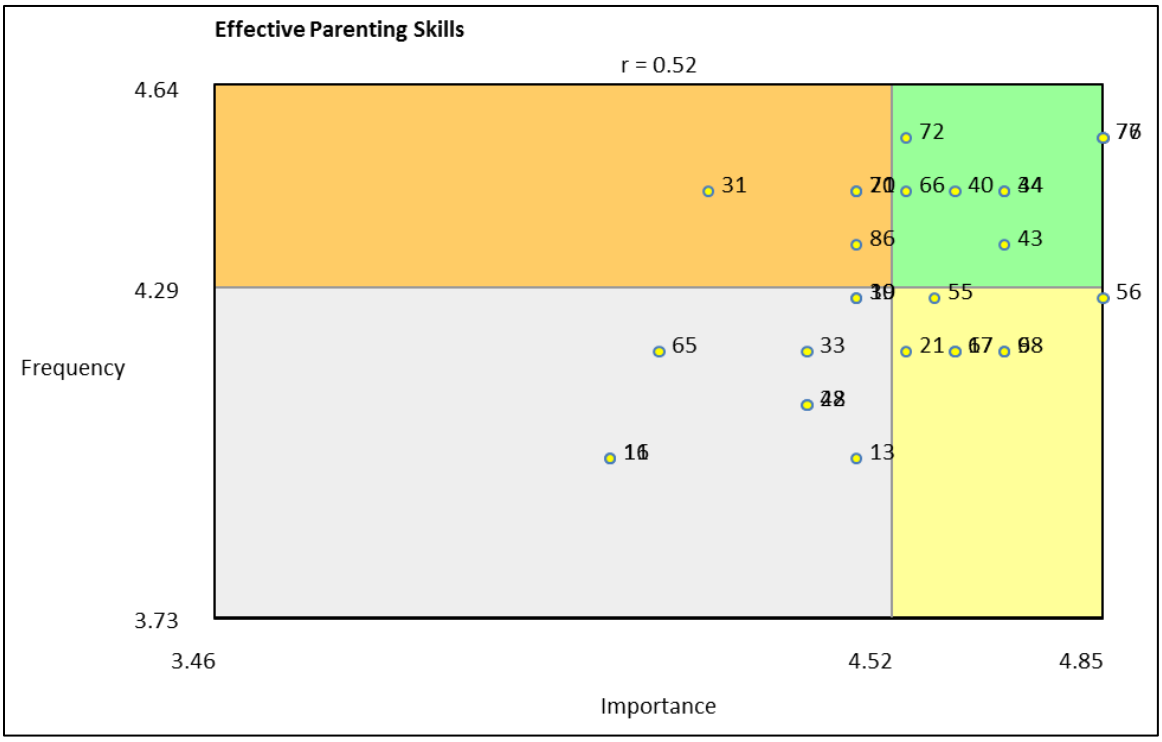

Figure 19. Go-zone Graph for Cluster 5 Effective Parenting Skills

Results of this study provide a conceptualization of treatment foster family success from the perspective of professionals. During the brainstorming phase of the study participants generated 86 ideas in response to the focus prompt "*Something that contributes to a treatment foster placement being successful in a family is…*". Participants then structured the 86 ideas during the sorting and rating phase of this study. The results of the concept mapping analysis yielded five distinct clusters: *Foster Youth*

Needs, *Optimal Environment*, *Foster Parent Support Needs*, *Foster Parent Required Qualities,* and *Effective Parenting Skills*. Bridging values indicate that the most cohesive cluster was *Effective Parenting Skills* meaning that the statements or ideas in this cluster were sorted together more frequently by participants. In terms of cohesiveness, *Effective Parenting Skills* was followed by *Foster Parent Required Qualities*, *Foster Youth Needs*, *Foster Parent Support Needs,* and finally *Optimal Environment*.

The *Effective Parenting Skills* cluster and the statements comprising the cluster represent the skills treatment foster parents should possess and actions treatment foster parents should take to ensure a successful placement. The *Foster Parent Required Qualities* cluster and statements represent qualities foster parents should possess to be successful. *Foster Youth Needs* cluster and statements center around what foster youth need from the treatment foster family for a placement to be successful. The *Foster Parent Support Needs* cluster and statements focus on the supports, both informal and formal, foster parents need for a treatment foster placement to be successful. The *Optimal Environment* cluster and statements center around an environment which is a good fit for the youth, both in terms of the foster home being a good match for the foster youth going in to the placement and how the youth feels in the foster home environment.

Professionals rated each of the statements based on importance and frequency of occurrence in successful treatment foster placements. In terms of importance to placement success, professionals rated the *Foster Youth Needs* cluster as most important, followed by the *Effective Parenting Skills* cluster. In terms of frequency of occurrence, professionals viewed *Foster Parent Required Qualities* as most important. Go-zone graphs for each cluster provide insight into which statements were viewed as both most

important for a successful placement and which statements occurred most frequently with successful treatment foster care placements.

This study also explored what family life cycle stages are most frequently associated with success. Professionals providing support to treatment foster families report in their experience treatment foster placements are most often successful when the foster youth is younger than the oldest child in the treatment foster family or when the treatment foster family has no other children.

Findings of this study suggest that professionals view treatment foster family success as a combination of the treatment foster parents' parenting skills, qualities the treatment foster family possesses, supports the foster youth needs from the treatment foster family, supports the treatment foster family needs from others, and the match between the foster youth and treatment foster family. Findings also suggest professionals view certain family life cycle stages as more conducive for treatment foster placement success.

CHAPTER 5

Discussion and Implications

The purpose of this research project was to explore characteristics of successful treatment foster families from the perspective of professionals providing support to them as part of their regular job duties. Results of this study were detailed in the previous chapter. This chapter provides interpretation of the results, discusses the relationship of the results to the existing literature related to foster care success, explores implications for policy, practice, and research, and identifies the limitations and strengths of the study.

Foster care is designed to provide a temporary family for a child whose birth parent(s) are unable or unwilling to provide care for the child safely; by design treatment foster families face a variety of stressors on a regular basis. One type of stressor faced by treatment foster families is the potential for the frequent addition and removal of family members as children enter and leave the foster family. Treatment foster families must adapt to these experiences. Even when trained and having had previous experiences, there is still the anxiety of getting to know a troubled child, understanding how to best parent that child, building a relationship not only with the child but the child's birth parent(s) and their foster care worker, and managing the demands for providing the best care for the child. When a child leaves the treatment foster family, there is anxiety about what will happen to the child, feeling sadness at the loss of child, and preparing for the next fostering experience. The entry and exit of foster children make the foster family experience unique.

Treatment foster families are also required to care for children with trauma histories. The primary reason a child enters foster care is because they have experienced

maltreatment, usually in the form of abuse and/or neglect, or because of the primary/birth family is unable to care for the child for reasons such as parental incarceration, mental illness, mental retardation or substance abuse. Children enter foster care after traumatizing experiences and sometimes experience trauma in the form of placement in multiple foster homes. Integrating a child who has experienced trauma into the foster family is stressful. Traumatized children often have emotional, behavioral, and/or mental health issues; treatment foster families provide a stable home environment while therapeutic services are used to provide mental health treatment to the child (Dore & Mullin, 2006). Meeting the needs of children with complex emotional, behavioral, and/or mental health needs often requires multiple services to meet those needs. In addition to acting as the primary change agent by providing stability, love and family structure, treatment foster families are tasked with navigating the complex child welfare and mental health systems. This potentially involves multiple appointments with different organizations at different locations. Treatment foster families are also often required to receive on-going training to maintain their treatment foster care license. Treatment foster families have significant demands placed on their time and regularly deal with challenges related to the children, the educational system, the child welfare system and the mental health system.

In addition to the stressors that treatment foster families can anticipate and prepare for in advance, treatment foster families face stressors that are unpredictable. In some cases, the information about a foster youth's history and an accurate assessment of their needs is not complete at the time of a foster placement. Also, it is not uncommon for youth to exhibit behaviors not previously known about after being placed in a

treatment foster home. In the case of behaviors which may present safety issues for the foster youth or other members of the treatment foster family, such as self-injurious behaviors, aggressive behavior, or problem sexual behavior, the treatment foster family could be required to make considerable adjustments to the way the entire household functions. Other unanticipated stressors treatment foster families may potentially face include, but are not limited to, foster youth being suspended from school, unpredictable changes in visitation with primary family members, and unanticipated changes to a foster youth's permanency plan.

Some treatment foster families manage these challenges/stressors and are successful in their role regardless of the stressors or challenges that are presented to them. Findings of this study suggest there are three essential factors which impact treatment foster family success. One, treatment foster parents should have effective parenting skills. Two, treatment foster parents need to possess certain qualities. Three, treatment foster parents need to have adequate support and resources to deal with the stress associated with being a treatment foster family. This combination of skills, qualities, and resources combine to support treatment foster families in facilitating successful treatment foster care placements. Each of these are discussed in the following section.

Characteristics of Successful Treatment Foster Families

Effective parenting skills are viewed as the linchpin for success. According to professional staff, parents who are able to balance flexibility and cohesion with the ability to set clear expectations are more likely to be successful. It is important for treatment foster parents to adjust their parenting style to meet the needs of the treatment foster youth placed in their care, which requires flexibility. One professional stated that it is

important for foster parents to "understand that their parental approach with foster children may be different than how the foster parents raised their own child." Professionals also cited the need for the treatment foster family to integrate the foster youth into the family and to treat the foster youth as a member of the family. Accomplishing this task requires a level of flexibility to integrate the youth into the family and family cohesion to create an emotional connection with the youth for all family members. In addition, professionals identified the need for treatment foster parents to be able to set clear expectations and provide consistency for foster youth. Foster youth need to know concretely what is expected, that there are rewards for meeting expectations and consequences for not meeting expectations or violating family rules. This combination of parenting skills—flexibility, cohesion, and structure—appears to be more likely to result in success in treatment foster care.

The Circumplex Model of the Family (Olson et al., 1982) can serve as a theoretical framework for understanding these variables identified by professionals as important to placement success. As previously discussed, the Circumplex Model of the Family (Olson et al., 1982) views family functioning in terms of three dimensions: adaptability, cohesion, and communication. In terms of adaptability, findings suggest treatment foster families need to be adaptable enough to adjust parenting approaches to meet the needs of the treatment foster youth placed in the home, while structured enough to provide clear expectations and consistency. In terms of cohesion, integrating the treatment foster youth effectively into the family requires the creation of an emotional bond between the treatment foster youth and members of the family. It requires assimilating youth into the family, having her/him participate in all family activities from

the mundane of chores to family vacations and events, and helping the child to feel that they belong. At the same time, they have to prepare the youth to either return to their birth family, move to an adoptive family (unless they adopt him/her) or for living in another family as he or she gets better and does not need treatment foster care. Communication that this clear, consistent, continuous and kind becomes the pivotal skill—not only with the foster youth but the foster care worker, treatment providers and the birth family (when appropriate).

These results are consistent with results of previous research. Brown (2008) reported that foster parent flexibility was important for placement success. Multiple studies have associated foster placement success with a youth being treated like a member of the family (Affronti, Ritter, & Jones, 2015; Miller & Collins-Camargo, 2015; Sinclair & Wilson, 2003), foster parents taking steps to successfully integrate a foster youth into the family (Berrick & Skivenes, 2012; Jones et al., 2016), and foster parents being intentional in their approach to parenting so the needs of the foster youth can be met (Affronti et al., 2015; Berrick & Skivenes, 2012). Brown and Calder (1999) found that foster parents needed open communication in the family to be successful. Foster youth identified the need to feel understood as important for success (Miller & Collins-Camargo, 2015).

A second finding of this study suggests there are certain foster parent qualities are associated with treatment foster placement success. According to professionals, treatment foster parents need to communicate openly and honestly, listen effectively, and demonstrate emotional stability. For example, professionals associated "emotionally regulated foster parents," "foster parent self-awareness," and "communication without

blame" with successful placements. In addition, foster parent qualities such as having an empathetic spirit, being non-judgmental, demonstrating compassion, commitment, and kindness are associated with treatment foster placement success. One way to facilitate understanding and empathy for foster youth is for the treatment foster parents to understand of trauma and the impact of trauma on the foster youth. As one professional stated, treatment foster parents should understand "that trauma can cause behavioral or emotional issues in the home." This understanding of trauma may help treatment foster parents not take a foster youth's behaviors personally, another quality identified by professionals as important for a successful treatment foster parent to possess. The trauma perspective is relatively new to child welfare services and few studies have specifically identified it.

The third major finding is that to be successful, treatment foster families should have adequate resources and support to manage the challenges associated with being a treatment foster family. Professionals identify the need for treatment foster families to have at least one informal social support in the form of a family member, friend, or other foster parent. Informal support can positively impact how a family copes with stress. For example, quality social support has been found to decrease anxiety in parents caring for children with Asperger syndrome (Pakenham et al., 2005) and act as a moderator or buffer to families experiencing various types of stress (Lavee et al., 1985; Vandsberger & Biggerstaff, 2004). If treatment foster parents have quality social support, it can assist them with managing the stress associated with their role.

Treatment foster parents also need formal support and guidance from the treatment team. One form of support provided by the treatment team is ensuring there is

an appropriate match between the treatment foster family and the youth prior to placement. Professionals cited the importance of providing "foster parents with as much information as possible about the child's history and issues," and ensuring there is "goodness of fit between family and child." Previous research on traditional foster care suggests that foster parents want adequate information about a child prior to placement (Brown, 2008; MacGregor, Rodger, Cummings, & Lescheid, 2006) and that a good match between the foster youth and foster family is important for a successful placement (Brown et al., 2009; Doelling & Johnson, 1990; Green et al., 1996). Adequate information about the foster youth prior to placement helps foster parents decide if there is a good match between the needs of the youth and their home (Brown, 2008). Successful matching can support the youth in adapting more successfully to foster care (Green et al., 1996), facilitate a smoother transition into the home (Brown et al., 2009), while a poor match has been associated with poorer outcomes for youth (Doelling & Johnson, 1990).

Professionals associated placement support with specific actions taken by the treatment team. These actions included facilitating relationship building between the child and treatment foster family, ensuring the foster youth has adequate community support, and working with the foster youth and treatment foster family together to resolve conflicts. Most studies focusing on traditional foster care, report a relationship between resources and placement success. Foster parents report needing support in the form of access to community resources such as counseling and educational services to meet the specialized needs of the foster youth placed in their care (MacGregor et al., 2006). Lack

of support and problems with the relationship with their foster care agency are most likely to result in placement breakdown (Brown & Bednar, 2006).

The provision of on-going training opportunities that are targeted to the needs of the treatment foster family promote placement success. One professional indicated the need for foster parents to receive "training hours that truly focus on the needs of the youth in care." Quality training for treatment foster families is important for a variety of reasons. Children placed in treatment foster care generally have specialized needs and treatment foster families benefit from targeted training designed to increase their competency and capacity to meet the needs of youth. As previously discussed, children enter foster care under traumatic circumstances and likely experienced trauma prior to entering foster care. Increased knowledge about trauma, the impact it has on children's functioning, and strategies for successfully parenting children who have experienced trauma can support treatment foster parents in meeting the needs of the youth. Previous research on traditional foster care indicates foster parents value training, particularly training that is targeted to the needs of foster youth such as autism and abuse (MacGregor et al., 2006). One study found that foster parents would consider ending a placement because of insufficient training (Brown & Bednar, 2006).

In addition to having access to these supports and resources, professionals providing support to treatment foster families also indicated it was important for treatment foster families to be open to the support offered. For example, professionals identified the need for treatment foster parents to be open to learning, both from the foster youth and from support professionals. An openness to implement suggested interventions and an ability to not personalize or view feedback as negative were also

cited as important to success in treatment foster placements. As previously discussed, treatment foster families may need to adapt their parenting approaches to meet the needs of the foster youth placed in their care. Treatment foster families who are open to feedback and willing to implement suggested interventions may be able to make these adjustments more easily than those families who are not. There is some evidence in previous research that suggests treatment foster parents who are more open and willing to implement suggested interventions promote placement success (DeGarmo, Chamberlain, & Leve, 2009). In a study of a foster parent intervention training program, when foster parents were more engaged in the training, that is they demonstrated a high level of participation in training sessions, completed training related homework assignments, and showed an openness to suggested interventions, the foster youth placed with the foster family benefitted more from the intervention program (DeGarmo et al., 2009).

The Double ABCX Model (McCubbin & Patterson, 1982) can serve as a theoretical framework for understanding factors important to treatment foster placement success. Factors identified by professionals as important for treatment foster placement success are focused mainly on the Double B, or the resources available to the family. This suggests that professionals view a treatment foster family's ability to successfully manage a crisis is heavily associated with the family having adequate resources. Professionals identified both informal support in the form of support from family and friends, as well as formal support in the form of concrete support from the treatment team such as conflict resolution and training as important to placement success. It is unclear if the only reason professional identified this as a factor is because this is how they trained or if it is really the only factors that matter. Many foster care workers have not been

trained to think from a family system perspective and, if they are not social workers, have not been training to think ecologically. This finding points to the need to further explore the influence of academic background and agency training on how foster care workers view the treatment foster family as an ecological family system.

In addition to these three issues, this project explored the relationships of family life cycle stage to placement success. The family life cycle is a concept that is central to the Circumplex Model of the Family (Olson, McCubbin et al., 1983). The family life cycle is dependent upon the age of the oldest child in the family. As previously discussed, a treatment foster family is a unique type of family. The placement or removal of a treatment foster youth could mean the treatment foster family moves regularly from one family life cycle stage to another. For example, if a treatment foster family has a preschool age child and accepts the placement of an adolescent, that family would move from the life cycle stage of a family with a preschool age child to the life cycle stage of a family with an adolescent living in the home. In this case, the placement of a treatment foster youth would be a stressor because it changes the family life cycle. This brings an additional stressor to the family, independent of the other stressors already identified.

Participants responded to a question regarding the age of a foster youth related to the age of a treatment foster family's children and the impact that has on placement success. Half (n=10) of the respondents indicated that in their experience, placements were most often successful when the treatment foster youth was younger than the treatment foster family's oldest child. Almost half (45%, n=9) of participants indicated that in their experience treatment foster placements were most often successful when the treatment foster family had no other children, and 5% (n=1) participant indicated that in

their experience treatment foster placements were most often successful when the foster youth was older than the treatment foster family's oldest child. The placement of a foster youth younger than the treatment foster family would not disrupt the family life cycle stage, thus no adjustment related to a new family life cycle stage would be required. The placement of a foster youth into a treatment foster family who does not have children would alter the family life cycle stage; however, it would require adjustment only on the part of the parents as there are no children to be impacted. The majority of participants (95%, *n*=20) indicated placing a foster youth in a treatment foster family is most successful when no adjustment related to family life cycle stage is required for any children residing in the family, suggesting a potential relationship between family life cycle stage and placement success.

Study Limitations

A small sample size was one limitation present in this study. In the first phase of data collection 33 professionals providing support to treatment foster families participated. This phase was anonymous so it is impossible to test for sample bias. In the second phase of data collection 21 participants responded to the first question, 20 participants responded to the second question, 13 completed the sorting activity, 13 responded to the first rating, and 11 responded to the second rating. While there was no sample bias detected and the sample size of participants completing the sorting activity was adequate, above the recommended minimum of 10-12 participants completing sorts for a reliable concept map (Jackson & Trochim, 2002), the sample was small when compared with other concept mapping studies. A review of 69 concept mapping studies indicating that the average number of total participants ranged from 20 to 649 with an

average number of participants of 155.78 (Rosas & Kane, 2012). The small sample size limits the generalizability of the results and the concept maps in this study should be interpreted with caution as the findings reflect the viewpoint of a small sample of professionals providing support to treatment foster families.

It is common in concept mapping studies to review preliminary analysis results with participants to ensure that the outcome of the analysis is a true representation of the participants' thinking. This is done because the final concept maps should be a visual representation of the participants' perception of relationships between ideas. In this study, the 21 participants who participated in the second phase of data collection were invited to participate in a web-based meeting to review the preliminary results of the study and provide feedback. Only participants from the second phase of data collection were invited to participate because participation in the first phase of data collection was anonymous and no information was available about those participants. Of the 21 participants invited to review preliminary results, only 2 participated. While both participants who reviewed preliminary results and provided feedback agreed that the results were accurate representations of their perceptions of the relationship between ideas, they represented only a small portion of participants who participated in the second phase of data collection. The small sample size of participants willing to review preliminary results is a further limitation of the study.

While there are many professionals who work with treatment foster families in some capacity, this study focused only on professionals who provide on-going support to treatment foster families in the role of a foster home worker. This study did not include other professionals who work with treatment foster families such as licensing specialists,

foster parent recruiters, foster parent trainers, or supervisors. The decision was made to focus on this population because of the foster home workers' combination of educational background and on-going professional training combined with professional experience providing support to foster families and foster youth. This ensured that potential participants were knowledgeable of the area of study. Foster care workers provide support to multiple treatment foster families and youth so they have the opportunity to see both successful and unsuccessful treatment foster placements. While limiting the study population to this group ensured study participants were knowledgeable of the subject matter, it limited the generalizability of the findings. The results of this study should be interpreted with caution as the findings reflect only the viewpoint of foster home workers providing support to treatment foster families.

In addition to a small sample size, this study utilized a convenience sample. Foster care workers at one private not-for-profit agency were recruited for this study to facilitate data collection. This study did not include participants from the public sector or from other treatment foster care agencies; therefore, results represent only foster home workers from one specific agency.

Finally, when presented with the focus prompt during the idea generation phase of the study, participants did not receive a clearly defined operational definition of treatment foster placement success. The instructions simply stated that success can be viewed in terms of youth functioning, the outcome of the foster placement, and/or family functioning and characteristics. As a result, the ideas generated during the brainstorming phase represent what participants think is important for success and not an operational definition of treatment foster placement success established by the researcher.

Study Strengths

As previously discussed, research regarding treatment foster care is lacking. This study is the first study to explore successful treatment foster care from the perspective of professionals providing support to treatment foster families. Because of their combination of education, professional training, and experience of providing support to multiple treatment foster families, participants brought a unique perspective regarding factors that impact treatment foster placement success that has not been captured before. Previous research has explored foster care success from the perspective of foster youth (Miller & Collins-Camargo, 2015), foster care alumni (Affronti et al., 2015), and from the foster parent (Brown, 2008; Brown & Bednar, 2006; Brown & Campbell, 2007); however, none of these studies explored foster care success from the perspective of professionals and all of these studies focused on traditional, not treatment foster care.

While generalizability of the findings in this study are limited because of a small sample size and inclusion of professionals only serving in one capacity, the findings are consistent with previous research conducted on foster care success from the perspective of foster youth, foster care alumni, and foster parents. For example, the need for treatment foster parents to integrate the youth in to and treat the youth like a member of the family was a theme found in this study. This finding is similar to findings of a study of exemplary foster families which found that successfully integrating the child into the foster family was central to success (Berrick & Skivenes, 2012) as well as another study in which foster youth viewed foster care as successful when foster parents treat foster youth the same as biological children and like a member of the family (Miller & Collins-Camargo, 2015).

Relevance to Social Work Policy and Practice

As previously discussed, treatment foster care developed to meet the needs of children involved with the child welfare system who have more complex needs including children with mental health issues, behavioral issues, developmental issues, and special medical needs. While treatment foster care provides service to some of the most vulnerable children involved with the child welfare system, research regarding treatment foster care is lacking. Almost 20 years ago, researchers identified concerns related to treatment foster care research, including studies lacking in methodological rigor, a lack of consensus on what success in treatment foster care means, a lack of clearly defined interventions, a lack of information about treatment strength or dosage, and a lack of studies related to treatment foster care outcomes (Reddy & Pfeiffer, 1997). In addition to these identified issues, research on characteristics of successful treatment foster families and factors which contribute to placement success in treatment foster families is absent.

Youth placed in treatment foster care generally receive a variety of services to meet their specialized physical and mental health needs; however, the treatment foster parents are the primary service providers and the treatment foster family is the primary treatment setting (FFTA, 2013). Because the family is the treatment, having information about what makes a treatment foster family successful is critical.

Having research supported information about characteristics of successful treatment foster families and factors that contribute to treatment foster placement success benefits social work practitioners in many ways. Increased knowledge of family characteristics which contribute to placement success allows foster care recruiters and licensing specialist to engage in targeted recruitment efforts in order to identify and

license families which are most likely to be successful treatment foster families. If recruitment is targeted to specific families, resources are targeted. Funding is limited in the child welfare sector, and having licensing staff target recruitment on families which are more likely to be successful means less resources are spent on licensing families which are less likely to be successful. For example, findings of this study suggest that a treatment foster family in which the foster youth is younger than the family's oldest child or in which the family has no other children is associated with placement success. This information can support social workers in better identifying which family composition and life cycle stage would best meet the needs of the children being served by the treatment foster care program. If there is a high need for treatment foster families to serve adolescents, recruiting families which are empty nesters might be a good option.

The findings of this study suggest the Circumplex Model of Families may be useful for understanding treatment foster families. The Circumplex Model of Families is a family systems model that uses three dimensions: adaptability, cohesion, and communication (Olson, McCubbin et al., 1983). Adaptability is the ability of a family to change (Olson & Gorall, 2006) and cohesion refers to the emotional bond between family members (Olson, McCubbin et al., 1983). Communication facilitates the ability of families to be adaptable and cohesive (Olson, Russell et al., 1983). Positive communication includes empathy, reflective listening, and supportive comments (Olson, Russell et al., 1983).

As previously discussed, professionals providing support to treatment foster families view the ability of a treatment foster family to demonstrate flexibility, cohesion, and utilize positive communication as factors impacting placement success. This

suggests the Circumplex Model may be useful in gaining a deeper understanding of treatment foster families. Using a model to understand treatment foster families may also improve the assessment of treatment foster families. A search of the California Evidence-Based Clearinghouse for Child Welfare (http://www.cebc4cw.org/) reveals there are no evidence-based practices for completing home studies, the primary approach utilized to assess foster families. In the absence of evidence-based practices, practitioners should use research evidence to inform their practice. Improved knowledge of what makes treatment foster families successful could improve the assessment of treatment foster families. Knowing what family characteristics lend themselves to placement success allows social work practitioners make more informed decisions about assessment tools to use with potential treatment foster families. For example, Social work practitioners might consider utilizing research-based measures during the assessment process. The Family Adaptability and Cohesion Scales IV (FACES IV) is a clinically relevant, reliable, and valid measure which assesses family adaptability and cohesion (Olson, 2011).

Knowing what makes treatment foster families successful can help social work practitioners be more targeted with development and support efforts. As previously discussed, there is a lack of empirical evidence regarding training programs for treatment foster parents (Dorsey et al., 2008). Having knowledge about factors which contribute to placement success can improve foster parent training efforts and assist practitioners with identifying ways to provide for targeted support. For example, findings of this study suggest that integrating a youth into the treatment foster family is a factor that contributes to placement success. Providing treatment foster parents with development opportunities

to help them successfully integrate a foster youth into the family such as training, coaching, and mentoring could increase the chances of placement success. In addition, social workers could target support to the treatment foster family and the foster youth at the time of placement to help facilitate the integration of the foster youth into the treatment foster family.

Findings of this study may have implications for the training, development, and supervision of social workers. As previously discussed, professionals providing support to treatment foster families placed a heavy emphasis on the role of concrete supports available to the family in the family's ability to successfully manage stress related to being a treatment foster family. While resources do play a role in a family's ability to manage stress, there are other factors related to family functioning and family systems factors that also impact the ability to manage stress that were not as clearly identified by professionals participating in this study. It is unclear if professionals' focus on these concrete resources is because concrete resources play a more significant role in a treatment foster family's ability to manage stress, or if professionals focused on resources because heavy emphasis is placed on resources in training and supervision of social workers. In addition, interventions which target building resources in families are less complex and require less skill than interventions which target family functioning and family systems issues. Placing more emphasis on family functioning and family systems issues in the training, development, and supervision of social workers who provide support to treatment foster families may impact the manner in which social workers view and support successful treatment foster placements.

Most importantly, increased knowledge about successful treatment foster families helps social workers improve services provided to youth involved with the child welfare system. When children enter the foster care system they are removed from their primary family, generally because they have suffered some form of maltreatment in the form of abuse and/or neglect. Given that children enter foster homes under difficult circumstances, it is critical that foster families are competent and able to successfully meet the needs of the various foster children placed in their care to avoid further traumatization of the children. Improved recruitment, assessment, development, and support for families would increase the likelihood that treatment foster parents are competent and able to support the needs of youth placed in their care. This in turn could support better treatment and outcomes for youth.

Social work policy makers benefit from increased knowledge of factors which impact placement success. Currently policy makers at the state and local level define requirements and criteria families must meet to become licensed as treatment foster families. In general, requirements focus on safety standards such as having adequate space, heat, lighting, and working appliances, require that foster parents be healthy enough to care for children, and that the family have adequate income to meet the basic needs of the family (Child Welfare Information Gateway [CWIG], 2014). Beyond the basic standards, requirements to become a foster parent vary widely by state. For example, age requirements for foster parents widely; in five states the minimum age is 18, in 2 states minimum age is 19, and in 36 states the minimum age is 21 (CWIG, 2014). Improved knowledge of factors that impact placement success would provide policy

makers information which can be used to establish consistent and meaningful foster parent licensing standards.

As previously discussed, research evidence regarding training programs for treatment foster families is lacking (Dorsey et al., 2008). This lack of knowledge regarding training programs for treatment foster families impacts policy makers as well as practitioners. Requirements for training hours needed to become a foster parent vary widely by state. For example, while 44 states do require some form of training to become licensed as a foster parent, 6 states do not (CWIG, 2014). Only 24 prescribe a specific course of training (CWIG, 2014). Number of training hours required vary widely and range from 6 hours in Minnesota to 36 hours in Ohio (CWIG, 2014). Not only are the wide number of hours required to become a foster parent an issue, the content of the training for treatment foster parents is especially problematic. The two most commonly used training curriculum for treatment foster parents are Model Approach to Partnerships in Parenting or MAPP (Children's Alliance) and Parent Resources for Information Development and Education or PRIDE (CWLA, 1995). Despite MAPP and PRIDE being the most commonly used training curriculum for treatment foster parents, there is no empirical support for their efficacy (Dorsey et al., 2008). This is especially problematic since treatment foster parents are the primary treatment provider and rely on training to prepare them to be the primary treatment provider. Improved knowledge regarding factors impacting placement success in treatment foster care could lead to improved training for treatment foster parents.

Recommendations for Future Research

Results of this study yielded a concept map with five distinct clusters of factors which impact placement success: *Foster Youth Needs, Optimal Environment, Foster Parent Support Needs, Foster Parent Required Qualities,* and *Effective Parenting Skills*. A deeper examination of these clusters suggest that resources available to a family as well as family functioning, specifically adaptability, cohesion, and communication, may impact placement success. Results also suggest a potential relationship between the family life cycle stage and placement success, specifically that professionals providing support to treatment foster families indicate that placements are most often successful when a foster youth is younger than the treatment foster family's oldest child or when the treatment foster family has no other children. While these results provide some information which can be used by practitioners and policy makers to improve recruitment, training, and support to treatment foster parents in an effort to improve services and outcomes for youth in treatment foster care, this study was small and results must be interpreted with caution. Since this study is the only known study of characteristics of successful treatment foster families, it does provide some direction for future research. Recommendations for future studies are as follows:

- The concept mapping approach utilized in this study is an effective format for future studies as the web-based participation allows for the collection of data from participants in multiple geographic locations and places minimum demands on participants in terms of time. This study could be replicated with other professionals providing support to treatment foster parents such as foster parent recruiters, licensing specialists, foster parent trainers, and supervisors.

Utilization of the same study design, including the same focus prompt, would allow for the comparison of responses across different populations of professionals.

- While previous researchers have explored foster care success from the perspective of foster youth (Miller & Collins-Camargo, 2015), foster care alumni (Affronti et al., 2015), and from foster parent (Brown, 2008; Brown & Bednar, 2006; Brown & Campbell, 2007), these studies have focused exclusively on traditional, not treatment, foster care. Concept mapping has been used with foster youth (Miller & Collins-Camargo, 2015) and foster parents (Brown, 2008; Brown & Bednar, 2006; Brown & Campbell, 2007) and has proven to be an effective format for conducting research with foster youth and foster parents. The concept mapping approach appears to be a useful methodology for engaging reluctant research participants, possibly because web-based participation places limited demands on participants' time and the approach allows participants the phases of data collection in which they would like to participate. Concept mapping studies could be utilized to explore the perspectives of treatment foster youth and treatment foster parents in terms of successful treatment foster families.
- Treatment foster families serve children with a variety of complex issues including mental health issues, behavioral issues, developmental issues, and medical issues. The definition of a successful treatment foster placement may be different depending on the specific needs of the treatment foster youth. In addition, family characteristics that support a successful treatment foster

placement may differ depending on the needs of the treatment foster youth. For example, treatment foster placement success for a medically fragile youth may be different than treatment foster placement success for a youth with an autism spectrum disorder. Future studies could explore treatment foster placement success in terms of specific foster youth needs.

- This study suggests that the Circumplex Model of Families (Olson, McCubbin, et al., 1983) may be a useful theoretical framework for understanding treatment foster families. Findings of this study suggest relationships between family functioning (adaptability and cohesion) and treatment foster family success, as well as a relationship between family life cycle stage and treatment foster family success. Future studies could explore the role of family functioning and family life cycle stage in placement success.

Summary

Foster care is an integral part of the child welfare system in which foster families provide safe, stable, and nurturing environment to children to whom they are not biologically related. A foster family is a temporary family a child can be placed with until the child can safely returned to his or her family, or in cases where a child cannot be safely returned to the primary family, a permanent placement such as an adoptive home can be found. Treatment foster care is a specialized type of foster care which is designed to serve children involved with the child welfare system who have more complex needs.

Despite the critical role that foster parents play in the child welfare system, little is known about foster families and even less is known about treatment foster families.

Much of the foster care literature is focused on placement disruption or breakdown, and is focused on the foster child, not the foster family. Numerous studies have been conducted on the relationship between child behavior problems and foster placement disruption (Barber & Delfabro, 2003; Chamberlain et al., 2006; Eggertsen, 2009; James et al., 2004; Leathers, 2006; Newton et al., 2000; Rubin et al., 2007; Strijker et al., 2008; Lindhiem & Dozier, 2007). Despite the number of studies, it remains unclear whether behavior problems increase the risk of placement disruption or if placement disruption increases the likelihood of behavior problems.

When a child is placed with a treatment foster family, the treatment foster family is entrusted with the care of one of society's most vulnerable children. Treatment foster families are tasked with providing a stable and nurturing environment to a traumatized child with complex emotional, behavior, and/or mental health needs to whom the family is not biologically related. Parenting children under these circumstances is challenging at best.

Currently, the knowledge base regarding treatment foster families is inadequate. This means that social workers are tasked with making decisions about the recruitment, training, licensure, and support of treatment foster families without adequate research-based information to guide their decision making. If social workers do not have an adequate knowledge base that is grounded in research, it is difficult to ensure that the families and children receive the best care.

Children enter foster care because their primary families are unable or unwilling to care for them. It is the responsibility of the child welfare system and social work practitioners to ensure that children receive the highest quality care and are not re-

traumatized by the system. It is also the responsibility of the child welfare system and social work practitioners to ensure treatment foster families receive the preparation and support needed to provide the highest quality of care to treatment foster youth. These are not responsibilities that should be taken lightly. It is impossible to ensure that the needs of families and children served in the treatment foster care system receive the highest quality care in the absence of an adequate knowledge based to support practice decisions. While this study does provide a conceptualization of successful treatment foster families from the perspective of professionals, it is critical that research regarding successful treatment foster families continue so that the child welfare system and social work practitioners are able to uphold our responsibilities to families and children.

Appendix

Appendix A. Informed Consent Document

INFORMED CONSENT DOCUMENT

The Impact of Family Functioning on Treatment Foster Family Success

You are being asked to participate in a research study about characteristics of successful treatment foster families. You were selected as a possible participant because you are a SAFY employee providing on-going support to foster families.

Researchers at Case Western Reserve University are conducting this study. As part of the requirement to complete her doctoral degree at the Mandel School of Applied Social Sciences, Kelly Davis is completing this study in collaboration with Victor Groza, Ph.D.

Background Information

The purpose of this research is to explore the relationship between family and child characteristics and treatment foster family success.

Procedures

You have received this consent form because you are a SAFY employee who provides on-going support to foster parents as part of your job duties. You are being invited to participate in this research study. We are requesting that you read this form carefully and, if you agree to participate in this study, please provide your consent by clicking accept at the end of this form. If you agree to be a participant in this research, we would ask you to do the following things:

1. Participate in a brainstorming activity in which you generate responses to a focus prompt on-line in CS Global MAX ™ website in your own time.
2. Sort statements generated in the brainstorming portion of the study into conceptual groups on-line in the CS Global MAX ™ website in your own time.
3. Rate statements generated in the brainstorming portion of the study in terms of importance and/or frequency of occurrence.

You may participate in the entire project or any one aspect of the project. If you agree to be a participant in this research, we would also ask you to provide some information about yourself. Information collected will include length of time employed with SAFY and number of years working in the child welfare field. This information will be kept private and confidential.

Risks and Benefits to Being in the Study

There are no known risks to participating in this study; however, if you choose to participate in this study you will be investing time in participating. There are no direct benefits to you for participating in this study. An indirect benefit of your participation will be providing information that will eventually help to educate professionals in the fields of social work and child welfare regarding characteristics of successful foster families.

Compensation

You will not receive compensation for participating in this study.

Confidentiality

The records of this research will be kept private and confidential. In any sort of report that may be published, we will not include any information that will make it possible to identify you. Research records will be stored on the CS Global MAX ™ server. The server is located in a locked facility with restricted access. All functional areas of the CS Global MAX ™ web application have access restrictions and access to research records stored within the CS Global MAX ™ web application will be limited to the researchers, the University's review board responsible for protecting human participants, and regulatory agencies. Once all data are collected, all identifying information is removed for analysis. All records related to this project will be destroyed after five years, or three years after the last published journal article, whichever time period is longer.

Voluntary Nature of the Study

Your participation in this study is voluntary. If you choose not to participate, it will have no affect your current or future relationship with Case Western Reserve University or SAFY of Ohio. There is no penalty or loss of benefits for not participating in the study or for discontinuing your participation. You may withdraw your consent to participate at any time during the data collection portion of this study.

Contacts and Questions

The researchers conducting this study are Professor Victor Groza, Ph.D. and Kelly Davis, MSW, LISW-S, doctoral candidate, Mandel School of Applied Social Sciences, Case Western Reserve University. You may ask any questions that you have now. If you have additional questions, concerns or complaints about the study, you may contact Kelly Davis at (937)903-4885, davisk@asfy.org or kelly.davis@case.edu.

If the researchers cannot be reached, or if you would like to talk to someone other than the researcher(s) about: (1) questions, concerns, or complaints regarding this study, (2) research participants' rights, (3) research-related injuries, or (4) other human subjects issues, please contact Case Western Reserve University's Institutional Review Board at (216)368-6925 or write: Case Western Reserve University, Institutional Review Board; 10900 Euclid Ave.; Cleveland, OH 44106-7230.
You will be given a copy of this form for your records.

Statement of Consent

I have read the above information. I have received answers to questions I have asked. I consent to participate in this research. I am at least 18 years of age.
If you consent to participate in this study, please click accept to indicate your consent.

Appendix B. Recruitment Letter Phase 1

Dear (Staff Person Name)-

I am writing to tell you about a research projecting being conducted by researchers at Case Western Reserve University in conjunction with SAFY. The purpose of this research study is to explore characteristics of successful foster families. You are eligible for this study because you are a worker employed with SAFY whose job responsibilities include providing on-going support to SAFY foster families.

It is important to know that this email is not to tell you to join this study. It is your decision. Your participation is voluntary. Whether or not you participate in this study will have no effect on your relationship with SAFY or Case Western Reserve University.

The link below will take you to a website which will provide you with additional information about the study. Please take the time to review the information. If after reviewing the information you decide to participate in the study, please follow the instructions provided on the website.

https://conceptsystemsglobal.com/impactfamilyfunctiontreatmentfosterfamily/brainstorm

If you would like to talk to someone directly about this research project, you may contact Kelly Davis at (937) 903-4885 or davisk@safy.org. Thank you for your consideration.

Appendix C. Recruitment Letter Phase 2

Dear (Staff Person name),

I am writing to tell you about a research projecting being conducted by researchers at Case Western Reserve University in conjunction with SAFY. This email is regarding the second phase of data collection for this research project. The purpose of this research study is to explore characteristics of successful foster families. You are eligible for this study because you are a worker employed with SAFY whose job responsibilities include providing on-going support to SAFY foster families.

It is important to know that this email is not to tell you to join this study. It is your decision. Your participation is voluntary. Whether or not you participate in this study will have no effect on your relationship with SAFY or Case Western Reserve University.

The link below will take you to a website which will provide you with additional information about the study. Please take the time to review the information. If after reviewing the information you decide to participate in the study, please follow the instructions provided on the website.

https://conceptsystemsglobal.com/impactfamilyfunctiontreatmentfosterfamily/sort/rate

Instructions for participating in the project are also attached to this email.

If you would like to talk to someone directly about this research project, you may contact Kelly Davis at (937) 903-4885 or davisk@safy.org. Thank you for your consideration.

Appendix D. Instructions for Sorting and Rating

Instructions for Sorting, Rating, and Participant Questions in the Concept System© Global Max© Software System

Create an Account

When you click the participation invitation link you will be prompted to create an account. You only need to enter an email address/ user name and password to create an account. The other fields are not required.

Once you create an account you will be taken to the project home page. There will be a list of links for the project in the middle of the page. Links are also along the left side of the project home page.

Sorting Instructions

To begin sorting click the sorting tab located on your screen. An instructions box for completing the sorting task will appear on the screen of the sorting page. You may close the instructions by clicking the "x" icon at the top right of the instruction box or minimize the instructions by clicking the (-) icon at the top right of the instruction box. If you close the instruction box and want to re-open it, click the (?) questions icon on the toolbar.

The statements you will be sorting are located vertically along the left side of your screen. To the right of the statements is an open space known as the "table-top". To sort the statements click and drag the statement into the open area to form piles of conceptually related statements. Each time you create a new pile you will be asked to give the pile a name which makes sense to you. After a pile is created you can drag and drop statements into the existing piles or you can create new piles. You will drag and drop statements until you have sorted all of the statements into conceptual piles. Statements cannot go into more than one pile. You can save your work and return to it at any time by logging back into the system. To save your work click the save icon located on the toolbar at the top of the page.

Rating Instructions

There are 2 ratings for this project; rating by importance and rating by frequency. To begin rating click either the importance or the frequency tab and you will be taken to the rating page for whichever rating you choose to do first. Instructions will appear at the top of the screen. Statements will appear in a list below the instructions with the numbers for the rating scale to the right of each statement. To rate each statement choose the number that corresponds to your answer. Once you've completed the rating click save rating information. Repeat this process for the second rating.

Participant Questions

You will be asked to answer two multiple choice questions. To answer the questions click the participant questions link. Select your answer to the 1st question then click the continue icon which will take you to the 2nd question. Select your answer to the 2nd question and the activity will be complete.

Instructions adapted from The Concept System© Global Max© Software Guide, © 2015 Concept Systems Incorporated.

Appendix E. Recruitment Letter for Preliminary Results Review

Dear (Participant Name)-

Thank you for participating in the research project conducted by researchers at Case Western Reserve University in conjunction with SAFY. All data for this study have been collected and preliminary results are available. At this time the researchers would like to share and get participant input on the preliminary results before finalizing the results of the study.

This email is to invite you to participate in a meeting held remotely via Go To Webinar in which Kelly Davis will share the preliminary results with participants and ask for participant feedback. You are eligible to participate in this meeting because you participated in some portion of the second phase of data collection for this study. The meeting should take no more than an hour of your time. The meeting will be offered on two occasions: Monday June 13th at 10AM Eastern and Tuesday June 14th at 3PM Eastern.

It is important to know that this email is not to tell you to participate in a meeting to review preliminary results and provide your input. It is your decision. Your participation is voluntary. Whether or not you participate in this meeting will have no effect on your relationship with SAFY or Case Western Reserve University.

Please read the attached informed consent document carefully. If after reading the attached informed consent document you are interested in seeing preliminary results and providing your input, please register for the Go To Webinar invitation for the date and time of your choice using the links below. If you are interested in seeing preliminary results and providing your input but are unable to attend one of the meeting times offered, please contact Kelly Davis and she will schedule a separate time to review the information with you. Clicking on the link to register for and participate in a remote meeting constitutes your consent. If you would like to talk with someone directly about this research project, you may contact Kelly Davis at 937-903-4885 or davisk@safy.org. Thank you for your consideration.

Join us for a webinar on Jun 13, 2016 at 10:00 AM EDT.
Register now!
https://attendee.gotowebinar.com/register/6492526377160565249

Join us for a webinar on Jun 14, 2016 at 3:00 PM EDT.
Register now!
https://attendee.gotowebinar.com/register/6336957576458188033

Appendix F. Informed Consent Document for Preliminary Results Review

INFORMED CONSENT DOCUMENT

The Impact of Family Functioning on Treatment Foster Family Success

You are being asked to participate in a research study about characteristics of successful treatment foster families. You were selected as a possible participant because you are a SAFY employee providing on-going support to foster families who participated in a previous phase of data collection for this research project.
Researchers at Case Western Reserve University are conducting this study. As part of the requirement to complete her doctoral degree at the Mandel School of Applied Social Sciences, Kelly Davis is completing this study in collaboration with Victor Groza, Ph.D.

Background Information
The purpose of this research is to explore the relationship between family and child characteristics and treatment foster family success.

Procedures
You have received this consent form because you are a SAFY employee who provides on-going support to foster parents as part of your job duties who participated in a previous phase of data collection for this research project. We are requesting that you read this form carefully. If you agree to be a participant in this research, we would ask you to participate in a meeting conducted remotely via Go To Webinar to review preliminary results of the research project and provide your input regarding preliminary results. If you are unable to participate in a scheduled meeting but would still like to review preliminary results and provide input, one of the researchers, Kelly Davis, will schedule a separate time to review the information with you. If you consent to participating in this portion of the research project, please register for and attend one of the scheduled meetings through the link provided in the email this form was attached to. Your registration for and participation in a remote meeting constitutes your consent.

Risks and Benefits to Being in the Study
There are no known risks to participating in this study; however, if you choose to participate in this study you will be investing time in participating. There are no direct benefits to you for participating in this study. An indirect benefit of your participation will be providing information that will eventually help to educate professionals in the fields of social work and child welfare regarding characteristics of successful foster families.

Compensation
You will not receive compensation for participating in this study.

Confidentiality
The records of this research will be kept private and confidential. In any sort of report that may be published, we will not include any information that will make it possible to identify you. Research records will be stored on the CS Global MAX ™ server. The server is located in a locked facility with restricted access. All functional areas of the CS Global MAX ™ web application have access restrictions and access to research records stored within the CS Global MAX ™ web application will be limited to the researchers, the University's review board responsible for protecting human participants, and regulatory agencies. Once all data are collected, all identifying information is removed for analysis. All records related to this project will be destroyed after five years, or three years after the last published journal article, whichever time period is longer.

Voluntary Nature of the Study
Your participation in this study is voluntary. If you choose not to participate, it will have no affect your current or future relationship with Case Western Reserve University or SAFY of Ohio. There is no penalty or loss of benefits for not participating in the study or for discontinuing your participation. You may withdraw your consent to participate at any time during the data collection portion of this study.

Contacts and Questions
The researchers conducting this study are Professor Victor Groza, Ph.D. and Kelly Davis, MSW, LISW-S, doctoral candidate, Mandel School of Applied Social Sciences, Case Western Reserve University. You may ask any questions that you have now. If you have additional questions, concerns or complaints about the study, you may contact Kelly Davis at (937)903-4885, davisk@asfy.org or kelly.davis@case.edu.
If the researchers cannot be reached, or if you would like to talk to someone other than the researcher(s) about: (1) questions, concerns, or complaints regarding this study, (2) research participants rights, (3) research-related injuries, or (4) other human subjects issues, please contact Case Western Reserve University's Institutional Review Board at (216)368-6925 or write: Case Western Reserve University, Institutional Review Board; 10900 Euclid Ave.; Cleveland, OH 44106-7230.

You will be given a copy of this form for your records.

Statement of Consent
I have read the above information. I have received answers to questions I have asked. I consent to participate in this research. I am at least 18 years of age.

If you consent to participate in this study, please register for and attend one of the remote meetings conducted via Go To Webinar through the links in the email this document was attached to.

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