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The need to do it all: Exploring the ways in which Treatment Foster Parents enact their complex role

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1. Introduction

There is a distinct tension and complexity in out-of-home treatment for youth with mental health problems. On one hand, out-of-home placements are designed to provide a safe setting for youth, many of whom have experienced high levels of violence, abuse, and neglect (Dorsey, et al., 2012). In line with this approach, youth need to have adult caregivers in these settings who can provide nurturing, trusting, age-appropriate relational "parenting" that facilitates youth development. On the other hand, many of these youth come into such placements with elevated levels of problem behavior, psychiatric diagnoses, and various developmental delays that require comprehensive, focused, and structured behavioral interventions to make it possible for the youth to achieve and maintain appropriate behavior and interactions. The challenge for individuals who are working with these youth is that they must simultaneously enact multiple roles – both parent substitute/caregiver and treatment professional.

While there is clearly overlap in these two approaches and perspectives, there are also a range of challenges and contradictions that underlie this role. To dramatically over-simplify the potential conflict and complexity in juxtaposing these roles, the role of a treatment professional is conventionally viewed (and assessed) as a worker's ability to effectively implement intervention strategies, many of which focus on behaviorally-focused discipline and structure, to produce relatively short-term measurable outcomes in line with a treatment plan, model, and/or protocol. From this perspective, both the intervention and the outcomes are often very behaviorally driven and defined. The role of a parent/caregiver is, of course, also concerned with providing discipline and structure to encourage short-term success. However, the focus of parenting also includes relational elements such as providing a nurturing environment and maintaining a close, accepting, and supportive parent-child relationship. Parents are also focused on long-term outcomes, focusing on helping youth

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successfully navigate developmental tasks, and producing a functioning individual who internalizes key mores and character qualities that benefit both the youth and the society in which they live. All youth need both behavioral support and relational support as they grow. However, for youth in out-of-home treatment, the focus is often explicitly on the treatment/ behavioral aspects, while providers struggle to figure out how and to what extent they can/ should provide the more "relational" aspects of caregiving (Wells, Farmer, Richards, & Burns, 2004).

The current paper brings together previous theoretical and empirical findings from the literature on parenting with conceptual and descriptive results from the treatment literature to propose a broader view of the domains that need to be considered when examining the implementation and effectiveness of treatment foster care and other out-of-home placements for youth. Previous work has suggested that treatment foster parents recognize the tension between being a parent and a treatment professional (Wells & D'Angelo, 1994; Wells, et al., 2004). This qualitative work showed that treatment parents were very diverse in how they experienced their role. Some viewed it as strongly treatment based while others viewed it primarily as "mothering" (Wells, et al., 2004). The remaining treatment parents reported complicated and conflicting views of how they experienced the challenges and rewards of the role. However, little is known about what treatment parents actually do to meet these complementary, yet sometimes competing, dimensions of the role and needs of the youth. Our goal is to a) provide a broad framework that outlines the potential dimensions of the treatment foster parent role and b) to use this framework to examine the various roles and behaviors that treatment foster parents use when working with work with youth in their care.

2. Conceptual Underpinnings

In this paper, we looked to both the treatment and parenting literatures to provide guidance into potential dimensions of roles and specific behaviors that treatment parents may engage in as part of their role. The literature on parenting and treatment is widespread, based in various theoretical frameworks, and much too complex to simplify easily. Thus, the following discussion is intended to provide guidance into potential dimensions of the treatment parent role, not to provide a comprehensive synthesis of all that is known about parenting or treatment. In line with this, some broad generalizations and overly simplified "ideal types" of treatment vs. parenting are utilized to provide a heuristic scheme for broadening understanding of how treatment parents view and enact their role.

2.1 Treatment Foster Care Literature

In its most well-articulated model, Treatment Foster Care (TFC) is often seen as a very behavioral approach to intervention (Chamberlain, 2002). The best-known and longest-standing evidence-based version of TFC is Chamberlain's Multidimensional Treatment Foster Care (e.g., Chamberlain, 1994, 2002; Chamberlain & Mihalic, 1998; Chamberlain & Moore, 2002; Chamberlain, Leve, & DeGarmo, 2007; Harold, et al., 2013; Kerr, Leve, & chamberlain, 2014; Leve, Chamberlain, Smith, & Harold, 2012; Rhoades, Chamberlain, Roberts, & Leve, 2013). This model builds from a coercive family process model (e.g., Patterson, 1975; Patterson & Forgatch, 1987; Reid & Eddy, 1997) to develop an intervention

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approach that is firmly rooted in behavioral principles, points-and-levels, proactive teaching-oriented discipline, and a comprehensive/coordinated system that structures and reinforces appropriate behavior (Chamberlain & Mihalic, 1998; Chamberlain, 2002). MTFC, in its ideal form, is also a relatively short-term intervention, with a goal of working with youth and their families (or other post-discharge caregivers) to create systems, approaches, and strategies that work in the TFC setting but also facilitate the transition back "home." MTFC clearly recognizes the complexities of the foster parent role (Chamberlain, 2002), but the core elements remain firmly grounded in behavioral principles.

Other work in the field suggests that TFC, as it is widely practiced, does not adhere closely to the well-articulated model of MTFC. Rather, in "usual care," TFC shows moderate levels of conformity to national standards of care (FFTA, 1995, 2004) and resembles a very "watered down" version of MTFC (Farmer, et al., 2002). In particular, there is much less focus on proactive behavioral strategies and a less delineated underlying model or treatment paradigm. In this "usual care" implementation, treatment parents often receive much less intensive training, coaching, and consultation than is standard in MTFC, and they are, in many ways, left to their own devices (with minimal levels of supervision and support) to live with and deal with very difficult-to-treat youth.

The only other currently recognized evidence-supported model of TFC, Together Facing the Challenge (TFTC) (Farmer, et al., 2009; Farmer, et al., 2010; Murray, et al., 2010; Murray, et al., 2014; Murray, et al., 2015), explicitly recognizes the dual roles required of treatment parents, but remains firmly grounded in behavioral approaches to intervention. In an attempt to recognize some of the complexities of the role treatment parents play, TFTC incorporates domains in its training and supervision that expand the role to emphasize more relational aspects. This includes, for instance, incorporating some elements taken from Trauma-Focused Cognitive Behavioral Therapy (particularly a focus on helping treatment parents understand the interplay of behavior, emotions, and thoughts). TFTC also explicitly recognizes the importance of helping youth (and the agencies/sectors that serve them) think about long-term plans and trajectories, rather than just focusing on current behavior, functioning, and crisis minimization. It also directly addresses the importance of incorporating activities that bring "family fun" to the forefront and helping the treatment parent prioritize their own well-being and "taking care of self," both as an approach to reduce burnout and to model for youth the importance of healthy lifestyles and choices (Murray, et al., 2010; Murray, et al, 2014). Despite this attempt to broaden and recognize the multiple domains and demands that treatment parents must address, nearly 75% of TFTC training is devoted to developing competence in behavioral approaches to address problem behaviors (Murray, et al., 2015).

2.2 The Parenting Literature

Beyond TFC, the broad literature on parenting also supports a behavioral approach to working with youth. Inconsistent parental discipline and rewards, such as failure to set limits and standards of behavior and follow through to reinforce them, has been associated with an increased risk of child problem behavior (Edens, Skopp, & Cahill, 2008; Halgunseth et al., 2013; Patterson et al., 1987). Parents are central socializing agents for children, and children

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learn to identify acceptable behavior through their interactions with them (Bandura, 1986). Clear external standards of conduct, and consistent limits and rewards, may help children foresee consequences for their behaviors and over time, develop their own internal standards of conduct (Halgunseth et al., 2013). In contrast, when parents use inconsistent discipline and reward systems, youth may perceive that there are few consequences for their behaviors, and may fail to internalize prosocial norms (Bandura et al., 1996). In addition, providing structured developmentally-appropriate supervision is also important for child development (Lippold, Greenberg, Collins, 2013; Stoolmiller, 1994). Parents who closely monitor and observe their children's behavior may be more likely to notice and set limits on inappropriate behavior and to praise prosocial behavior. A lack of supervision has been associated with an increased risk of delinquency and substance use (Lippold et al., 2013, 2014; Stoolmiller, 1994). Thus these behavioral domains of supervision and discipline may be an effective part of a treatment approach, as well as parenting more generally.

The parenting literature points to many other behaviors that may be important for ensuring healthy child development in the relational domain. For example, a large body of work suggests that the affective domain of parenting is also important for ensuring youth development. Youth with parents who are warm, supportive, and empathic are more likely to have positive outcomes, while those who experience conflictual, harsh, or dismissive parenting may be at risk for a host of negative outcomes, including both internalizing and externalizing problems (Bornstein, 2006; Greenberg & Lippold, 2013). Youth self-perceptions may be highly influenced by their perceptions of how others view them, in particular their parents (Baldwin, 1992; Bandura, 1986). Therefore, a cold or dismissing parent-child relationship may be linked to low youth self-esteem and depression, whereas a warm relationship with parents may boost a youth's self-concept. Further, strong emotional bonds with parents may promote the internalization of prosocial norms (Catalano & Hawkins, 1996) that may be protective against both externalizing and internalizing problems (Branje, Hale, Frijns, & Meeus, 2010; Catalano & Hawkins, 1996). Similarly, low parental empathy towards their child and difficulty understanding their child's perspective and feelings has been linked to increased risk of parental maltreatment (Rodriguez, 2013) as well as low empathy and less prosocial behavior in their children (Farrant et al., 2012).

Other relational aspects of parenting have also been associated with positive outcomes for youth. For example, effective parent-child communication has been identified as an important element of parenting, with implications for both internalizing and externalizing problems (Racz and McMahon, 2011). Parent-child relationships marked by high amounts of child disclosure about their experiences and high parental knowledge about youth activities have been associated with positive outcomes for youth (Lippold et al, 2013, 2014). Effective parent-child communication may provide opportunities for youth to access parental guidance, support, and problem-solving support when facing developmental challenges. Time with children may also be important, at least during adolescence, with a recent study finding that more engaged parent-child time during adolescence was linked to reductions in problem behaviors such as substance use and delinquency (Milke et al., 2015). Other studies have found that quality of time with parents may also be important, with engaged activities such as eating meals together and leisure activities being linked to positive youth emotional well-being (Offer et al., 2013).

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This Study

Treatment foster parents must navigate the dual role of being a parent substitute and front-line treatment provider. Hence, they are asked to play a role with youth that includes both the intensive behavioral intervention approaches traditionally associated with treatment, as well as affective and relational elements viewed as critical in the broader parenting literature. The current paper provides descriptive data on how treatment foster parents may navigate this dual role of treatment provider and substitute parent. Using the behavioral and relational domains outlined above, the paper examines three primary research questions. First, how do treatment parents view their role, as more of a treatment professional, more of a parent, or a mix of these two heuristic ideal types? Second, to what extent do treatment foster parents utilize various behaviorally- and relationally-oriented approaches to working with youth in their homes? Third, does use of these various strategies vary systematically by characteristics of the treatment parent and/or of the youth? Given that this study is primarily exploratory and descriptive, we did not posit specific hypotheses about the behaviors used by treatment parents.

3. Material and Methods

3.1 Broader Study

Data come from a broader randomized trial that assessed effectiveness of a treatment foster care program, Together Facing the Challenge (TFTC) (Farmer, et al., 2009; Farmer, et al., 2010).. The broader study included longitudinal data collection with treatment parents, youth, agency staff, and post-discharge caregivers for 247 youth served by 14 agencies across a southeastern U.S. state (see Farmer, et al., 2010 for a description of the broader study and effectiveness of TFTC).

Data for the current analyses focus on “usual practice” TFC. Therefore, they include only data from the baseline interviews with treatment parents (collected before the intervention group received Together Facing the Challenge training). Thus, all participating treatment parents were actively working with youth who had been placed in their homes by one of the participating TFC agencies. All treatment parents had completed state-required training by their TFC agencies and were licensed to provide TFC. Hence, these data capture what occurs in “usual practice” TFC across a range of licensed agencies.

The sample included treatment parents from 14 agencies across the participating state. The majority of agencies were private non-profits (n=12). Participating TFC agencies had been in operation for 2–15 years and had 13–50 licensed homes at the time of baseline data collection. In “usual care” TFC, treatment parents are viewed as key participants in the youths’ treatment; 90% of treatment parents indicated that they had signed off on their current youth’s treatment plan, nearly all went to treatment team meetings, and most also met with their TFC supervisor at least monthly. Treatment parents reported high levels of satisfaction with the supervision and support they received from their TFC agency; 88% indicated that their supervisor understood their needs and challenges as a treatment parent “very well,” and 95% endorsed the two highest levels of satisfaction (4–5 on a 5-point scale) for their relationship with their supervisor.

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Baseline data collection occurred when families entered the TFTC study. Therefore, data are included here from all participating treatment parents (n=247) in the broader study, implementing TFC as they did before completing the specific TFTC training. Interviews were conducted by trained study-employed interviewers in treatment parents' homes. Interviews lasted, on average, 60–90 minutes, and all procedures and measures were approved by the IRB of the lead university. Approximately 85% of eligible treatment parents in the participating agencies participated in the study.

3.2 Sample

Treatment parents in this study were, on average, middle aged (mean=48.5, s.d., 10 years), though there was considerable variation (range = 22–77 years). Nearly all of the treatment parents who identified themselves as the youth's "primary" treatment parent (i.e., the person who was most responsible for the youth) were female (90%). Of these, 59% were married. Nearly 75% of the sample was African American. This is much higher than the percentage of African American adults in the focal state's population. In terms of educational achievement, the most common response was "some college" (49.6%), followed by a high school diploma (27.5%). Approximately 20% had completed college (with 4.9% of the sample holding a graduate degree).

At the time of the baseline interview, the focal TFC youth had been in the TFC home with their current treatment parents for an average of 20 months (with a range of less than 1 month to over 12 years). The majority of youth (77%) entered their current TFC home from another out-of-home placement. Forty percent moved into their current TFC home from another TFC home, 18% had been in a group home, 10% had been in foster care, and 10% had been living in more restrictive institutional settings (e.g., hospital, correctional facility). Nearly half of the youth were girls (45.3%) and slightly more than half were African American (56.7%). Youth were a wide range of ages (2–21 years), but the majority of youth (86%) were between 10 and 17 years old. The majority of youth were in state custody (84.4%) and records data suggest that parental rights had been terminated for most of these youth.

3.3 Measures

Our study builds from literature in both treatment foster care and the broader parenting literature. From this background, we identified 8 potentially core categories that cover the complex role that foster parents are asked to play. These include behaviors from the behavioral domain as well as the relational domain of parenting. Categories capturing the behavioral domain of the TFC role include supervision/monitoring, approaches to discipline, and consistent responses to behaviors. Categories from the relational domain of the TFC role include time together, amount of adult-child conflict, positive affect towards the TFC child, perspective taking, and communication.

We identified items from the broader TFC study that could help create measurement scales to capture treatment parent-reported behaviors in these 8 categories. In creating our measurement scales, we used items from the broader study, including items from the following measures: the Parent Daily Report (PDR) (Chamberlain & Reid, 1987), Trusting

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Relationship Questionnaire (TRQ) (Mustillo, Dorsey, & Farmer, 2005), and the Conflict Behavior Questionnaire (CBQ) (Prinz, et al., 1979). Questions were also drawn from previous work on use of behavioral interventions from Project KEEP (Price, et al., 2009). In addition, to examine treatment parents' recognition of the multiple components of their role, a single item was included in the study that asked treatment parents about their own view of their role.

3.4 Analysis

First, we identified the appropriate items to include in each of our measures to assess our 8 categories (supervision/monitoring, time together, amount of adult-child conflict, positive affect, perspective taking, communication, approaches to discipline, and consistent responses to behaviors). In examining conventional or previously used scoring approaches, it was clear that while some items within the original study measures mapped on to our identified domains well, conventional scoring algorithms combined items that appeared to tap dimensions that we were conceptually separating. Therefore, in order to develop the scales for this study, we utilized the standardized measures, but used both conceptual guidance and face validity as well as exploratory factor analysis to identify items for each of our 8 conceptual categories. Using this approach, we developed a set of items for each of the included domains and, where appropriate, a composite measure of each overall domain. Given the exploratory nature of this line of inquiry, we used descriptive statistics to shed light on how frequently TFC parents engaged in behaviors in each of these domains. Then, we examined if treatment parents' behaviors in our eight categories differed by various characteristics of the child or treatment parent. Correlations, t-tests, chi-squares, and OLS regression were used to examine relationships between our 8 categories, characteristics of the child (i.e., age, sex, race, custody, time in home) and treatment parent (i.e., age, sex, race, education, marital status, household size/composition, experience). Given our interest in treatment parents' roles and their view of these roles, we also examined whether view of role was significantly related to any of the other conceptual categories. Missing data were minimal on the included variables (2–10% of sample). Hence, analyses were run on available data and no imputation was used.

4. Results

Results focus on three questions: How do treatment parents view their role, how do they enact their role (i.e., what do they actually do in the behavioral and relational domains), and does this role enactment vary systematically among and across treatment parents and/or youth?

4.1 View of Role

Given the complex role that treatment parents are asked to play, we were interested in how they saw themselves. Hence, they were asked, "If we had a continuum with 'treatment professional' at one end and 'parent' at the other, where would you put yourself?" (scale ranged from 1 (treatment professional) to 5 (parent). Responses were heavily skewed towards the "parent" side of the continuum. Fewer than 10% of treatment parents put themselves on the "treatment professional" side of the continuum (scored less than a 3),

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approximately 30% saw their role as equally balanced between the two roles, and over half (54%) placed themselves on the "parent" end, with 34% putting themselves at the highest level, indicating that they identified almost exclusively with the parent portion of the role.

4.2 Behavioral Domain

4.2.1 Monitoring/Supervision—In the current sample of youth in TFC, there were very high levels of supervision/monitoring and so little variation that it was not included in subsequent analyses. Overall, treatment parents reported that 83% of youth spent no time involved in activities without adult supervision, and those who had engaged in such activities did so for less than 45 minutes in the previous 24 hours. Only 7% of youth had been out the previous evening without an adult along, and treatment parents reported that all of these youth had their explicit permission to do this (and treatment parents reported that they knew where the youth was). Hence, with available data treatment parents appear to be providing high levels of supervision and there was insufficient variation in this construct to include it in future analyses. Note that these data come from reports of treatment parents, but concordance with youths' reports was quite high and also suggested insufficient variation for analysis.

4.2.2 Discipline and Consistent Responses to Youth Behavior—Treatment parents were asked a variety of questions about their efforts to effectively intervene with their treatment foster child's behaviors. Table 2 shows their responses when they were asked about the most effective approach to disciplining their current treatment foster child. Based on these responses, treatment parents said that the most effective approaches were removing privileges (37.6%) and discussing/talking (29%). All other approaches were endorsed by fewer than 10% of treatment parents. However, in more open-ended follow-up questions, when asked what responses they had actually used in the past month for problematic behaviors, privilege removal was mentioned much less frequently than discussing/talking, rewards, praise, and time out. While these latter results are not easy to quantify, responses suggest that what treatment parents view as "effective" and what they actually do may not be perfectly matched.

The Parent Daily Report was utilized to assess occurrence of both specific problematic behaviors and specific positive behaviors. When a treatment parent reported that a type of behavior had occurred in the past 24 hours, they were then asked "Did you or anyone else do anything in response to that?" As seen in Figure 2, treatment parents reported much more consistent responses to problem behaviors than to positive behaviors. Nearly 50% of treatment parents reported that they had some type of response/consequence for 80% or more of problem behaviors. Only one-quarter (27.5%) of treatment parents reported such a consistent response to positive behaviors by their treatment foster child.

4.3 Relational Domain

4.3.1 Time Together—On average, youth spent an average of 2–2.5 hours of one-on-one time with their primary treatment parent during a day. As noted in Table 3, though, this varied widely. To include this dimension in the composite for this domain, we created a

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dichotomous indicator of whether the treatment parent spent more than the median (i.e., 2 hours) of one-on-one time with the youth – 42% of the sample did so.

Other indicators in this domain looked at whether the youth and treatment parent did an activity (beyond eating a meal) together during the day – 62% had. We also examined the extent to which youth participated in family activities. Overall, it appears that most youth were involved in family activities, over half rated such involvement at the highest level of participation and less than 10% rated it in the lowest 2 categories.

Given the different metrics for the 3 indicators in this domain, each indicator was dichotomized to indicate whether the dimension was strongly evident. The resulting composite showed that 19% of respondents reported high levels of time together, 67% reported moderate levels of time together, and few showed no indicators of significant time together (13.6%).

4.3.2 Treatment Parent-Child Conflict—A more general assessment of adult-child conflict was tapped via 6 items from the Conflict Behavior Questionnaire. Fewer than 30% of treatment parents indicated that any individual item was a problem, but overall, approximately half (49%) indicated that at least one of the conflict items was present in their relationship with the focal child. The most commonly identified problems were getting angry with each other frequently (28.6%), arguing a lot about rules (28.3%), and arguing about little things (25.2%). As noted in the composite measure, approximately 2/3 of treatment parents reported little or no conflict (0 or 1 problems), but a small group (6.3%) experienced nearly all (5–6) of these problems.

4.3.3 Positive Affect Toward the TFC youth—Positive affect was assessed using 3 items from the Trusting Relationship Questionnaire: sharing things you like about the child with him/her; talking positively to others about the child; and enjoys spending time with the child. TRQ items can be scored from 1–5, with low scores indicting less positive affect. Overall positive affect was quite high among this group of treatment parents – means above 4 on each indicator and 4.17 on the composite.

4.3.4 Perspective Taking—This domain was somewhat difficult to assess using available data. However, it suggests a bidirectionality in the relationship that may be important for both modeling of appropriate behavior and encouraging recognition and internalization of empathy in youth. Two items from the TRQ were used to assess this: Telling the child when he/she (child) did something to hurt the treatment parent; telling child that the treatment parent is sorry for something. Means for this domain are lower than for positive affect, and the composite mean is 3.69.

4.3.5 Communication—This domain assesses the challenges in communication between the treatment parent and youth. Using the included 4 items, over half of treatment parents reported some level of communication difficulty (58%). The majority of these parents reported that the child was "defensive" and/or impatient during talks. A quarter of treatment parents reported that talking to the child was "frustrating." Forty percent of treatment parents

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reported that 2 or more communication problems were present in their relationship with their treatment foster child.

4.5 Variation by Characteristics of the Child and Treatment Parent

There was considerable variation in how treatment parents viewed themselves and enacted their role. This section of this paper explores whether such variations were randomly distributed in the sample or varied systematically by characteristics of the treatment parents and/or youth in their care.

4.5.1 Relationship between Youth Characteristics and Role Dimensions—Youth characteristics in these analyses included basic demographics (age, sex, race) as well as level of problem behavior at the baseline data collection (as reported by parents using the Parent Daily Report). Analyses suggested that each of these youth-level factors was significantly related to at least one of the 8 core categories of treatment parent behaviors.

Youth's age was related to several of the behavioral and relational dimensions. For older youth, treatment parents reported significantly less time spent together ($r=-.17$, $p<.01$), less positive affect towards the youth ($r=-.25$, $p<.001$), and lower levels of consistency in responding to both positive ($r=-.24$, $p<.001$) and negative ($r=-.17$, $p<.01$) behaviors. These results held even when controlling for youth's level of problem behavior.

Youth's race and sex showed fewer and weaker relationships with the 8 core domains of the TFC role. Youth's race and sex were each marginally related to significant differences on just one assessed dimension. Treatment parents reported slightly higher levels of conflict in their relationships with girls ($r=.13$, $p<.05$) than boys. Perspective taking varied systematically by the youth's race: treatment parents reported higher levels of perspective taking with white youth than with African American youth ($r=0.14$, $p<.05$). Given that participating agencies placed youth with similar-race treatment parents ($r=0.66$, $p<.001$), it is difficult to assess whether this is truly related to the youth's race or to the treatment parent's race.

4.5.2 Relationships Between Treatment Parent Characteristics and Role Dimensions—There were few relationships between treatment parent demographics or their broader household descriptors and the 8 core categories of the TFC role. Race and experience were related only to the treatment parents' view of their role. African American treatment parents were more likely than other treatment parents to view themselves as more closely aligned with the role of "parent" than of "treatment provider" ($t=3.6$, $p<.001$). Only 4% of African American treatment parents placed themselves on the "treatment professional" end of the continuum (score of 1 or 2), while 14% of White/Other treatment parents identified at these levels. On the other end, 59% of African American treatment parents placed themselves on the "parent" side, compared to 40% of white/other treatment parents. In a similar way, treatment parents whose pre-treatment parent experience had included only parenting their own children or working as a "regular" foster parent (with no mental health-related experience) were more likely to see their role as exclusively parenting ($t=3.08$, $p<.01$).

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Of the included household descriptors, only the number of other TFC children in the home was related to any of the assessed dimensions. Here, the number of TFC youth placed in the home was negatively related to one-on-one time with the treatment parent ($r=-0.17$, $p<.01$). Other measures of household size or composition (including marital status, number of other non-TFC children, youth's length of stay in the home) were not significantly related to any of the examined dimensions.

4.5.3 View of TFC role and parenting behaviors—How treatment parents viewed their role (e.g., as a treatment professional, or parent) was related to two examined dimensions. Treatment parents who viewed themselves as more closely aligned with the "parent" end of the continuum showed somewhat higher levels of perspective taking ($r=0.14$, $p<.05$) and positive affect for the child ($r=0.15$ $p<.05$). Multivariate regression models suggested that this relationship between the treatment parent's view of their role and the parenting dimensions remained significant when race or experience, both of which were shown to be related to a higher likelihood of identifying as a "parent," were included in the model.

5. Discussion

Treatment parents are asked to engage in many different roles – both as treatment professionals and as substitute parents. As such, they may engage in numerous behaviors. Some are more behaviorally-oriented approaches that may be focused on treatment: providing structure, supervision, monitoring, and consistent discipline. Other treatment parent behaviors may be more relationally-oriented such as developing a positive relationship and affect towards with the treatment child, minimizing conflict with the treatment child and encouraging effective communication. This paper provided an initial glimpse at the potential range of behaviors that treatment parents use in their complex role and investigated whether role enactment varies systematically by characteristics of the child and/or treatment parent

Overall, it appears that treatment parents view their role as both a treatment professional and a parent. In our data, nearly 2/3 of the foster parents in our study stated that they play a dual-role. However responses were clearly skewed towards seeing themselves as parents. This was especially apparent for African American treatment parents and for treatment parents whose pre-TFC lives had not included any experience with mental health problems or treatment. However, treatment parents' view of role appeared to be more important than demographics or previous experience in terms of their actual behaviors.

Many treatment parents were engaging in approaches from the behavioral domain. They were providing consistently high levels of supervision of youth's behavior and location. Treatment parents were also quite consistently addressing problem behaviors. However, they were less consistent in their responses to positive or prosocial behaviors. Interestingly, while treatment parents reported that behavioral approaches would hypothetically be most effective, many reported that they were actually addressing problem behavior with more relationally-oriented approaches (such as talking about it) than implementing behavioral approaches/systems (such as privilege removal or point charts). Such a finding suggests that

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many treatment parents regularly use relational approaches with their children, even in situations where the existing evidence-based versions of TFC would emphasize the appropriateness of using more behaviorally focused responses.

Treatment parents were engaging in many behaviors to create positive relationships with the TFC youth. There was more variation in the relational domain of their role, but the overall picture was encouraging. In general, composite scores showed means that were in the upper quartile of the potential range for continuous measures (i.e., positive affect, perspective taking), suggesting most treatment parents expressed positive affect towards the youth in their care and made efforts to understand their perspective. For summative indices, approximately half of treatment parents reported some level of problem on the relevant domains (i.e., time together, communication, conflict), but only a small group (2–13%) reported that all of the relevant indicators in the domain were problematic in their relationship with the youth. These findings suggest that many treatment parents were able to develop a positive relationship with the child in their care, and that they made effort to spend time together and minimize conflict. However, some treatment parents struggled with communication and conflict, in particular, and may benefit from increased training and/or support in these areas.

There were no specific characteristics of treatment parents, youth, or homes that overwhelmingly suggested either generalized excellence or concern. Rather, relationships among variables tended to be modest. This being said, there are a few characteristics of youth, treatment parents, and households that were systematically related to the approaches treatment parents enacted. Among the youth-level characteristics, child's age appeared to have the most robust relationships with treatment parent approaches. Younger children spent more one-on-one time with their treatment parents, were viewed with more positively by the treatment parents, and received more consistent feedback from their treatment parents in response to both problematic and prosocial behaviors. It is interesting that in our data, treatment parents were providing high levels of supervision and monitoring across all ages. However, this appeared to be less individualized (one-on one) among older youth. Further, even though they were providing supervision, treatment parents were less likely to engage in consistent discipline and responses to youth behavior with older youth. Such findings are somewhat concerning, as consistent discipline has been associated with positive outcomes for youth (Halgunseth et al., 2013). Yet, some of these findings may mimic age-related findings in the parenting literature. As youth move through adolescence, they spend less time with parents and more time with their peers, and this greater autonomy may result in less timely parental knowledge about the adolescents' behavior and, hence, less direct and immediate feedback to either correct or encourage behaviors (Lam, McHale, & Crouter, 2012; Keijers & Poulin, 2013). In the context of TFC, it is difficult to know whether these "normal" changes are appropriate. Youth are placed in TFC because their severity of problems suggests that they need a high level of structure, support, and intervention. Therefore, there may be an ongoing tension between the two roles that treatment parents are asked to play. Parenting an adolescent requires increasing levels of independence and autonomy, but treating a troubled adolescent requires vigilant monitoring, intervention, and supports. It appears that treatment parents are following a fairly typical parenting approach to adolescent development. Whether this meets criteria for appropriate levels of intervention

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is unknown in these data. Future research is needed to understand how these behaviors may relate to youth outcomes in TFC.

Household composition seems to matter little in enactment of the treatment parent role. Having multiple TFC children in the home was related to less one-on-one time for the focal youth and treatment parent, but otherwise household size or composition was unrelated to how treatment parents worked. Such findings are encouraging to help maximize the number of available TFC homes, as they suggest that characteristics of the household are largely unrelated to a treatment parents' ability or enactment of their role. It should be noted, however, that this variation occurred within state licensing standards, so dramatic variations in household size, number of youth, or resources were not observed.

Treatment parents' views of their role may be influential in how they play the role and have implications for training and supervision. Few treatment parents view themselves strongly as treatment professionals. Most see themselves more strongly as parents. How they see themselves is unrelated to many of the measured dimensions, but it does appear to be related to perspective taking and positive affect. The finding that African American treatment parents and those without pre-TFC mental health experience are more likely to place themselves firmly in the "parent" role may be useful both for "meeting new treatment parents where they are" in pre-service training and also for supporting and supervising them as they work with youth. Such a view of role, however, does not have universal implications for how treatment parents work with youth. It does not appear to change the extent to which they provide consistent feedback on behavior, challenges they may have in the relationship, or communication issues. Hence, knowing how a treatment parent views their role may be helpful in developing a shared sense of expectations and relationship for TFC supervisors, so that they can mesh their ways of approaching support and supervision to correspond with the treatment parents' self-concept and views. Future work on this dimension could also be informative to examine changes in treatment parents' view of their role across time and whether it is related to outcomes for youth.

5.1 Limitations

This work provides an initial glimpse into the ways in which treatment foster parents interact with and approach their role with youth. It included treatment parents from a variety of agencies, youth across a wide range of ages, and a larger sample than is typical of studies of TFC. However, it is clearly just a starting point for this type of work. First, measurement of the key constructs was developed post-data collection. The study collected many relevant measures and questions, but these were not initially selected to tap the broad range of dimensions that are relevant to the complex role that treatment parents play. Operationalization proceeded through a formalized process, but future studies would benefit from more focused and triangulated measures of the identified constructs. Second, these analyses do not examine implications of these baseline results for either improving practice or outcomes. Data came from pre-intervention phase of a randomized trial designed to improve training, supervision, and practice within TFC. Future analyses need to examine whether treatment parents who have different views of their own treatment parent role or who begin the process with various approaches to working with youth in their homes show

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differential "uptake" of the intervention (Together Facing the Challenge). In addition, do these variations noted at baseline affect outcomes for youth? This could occur either directly (treatment parents' view of their role and implementation of specific dimensions of their role affect child-level outcomes) or indirectly (variations in role and specific dimensions of their role at baseline affect implementation of Together Facing the Challenge which, in turn, affects outcomes). Longitudinal analyses will examine these possibilities. Third, both parenting processes and intervention approaches are extremely complex and intertwined constructs. We have heuristically separated them here into behavioral and relational domains to examine aspects that have not been previously explored within TFC. However, each consists of a much broader array of indicators that could be included here and it is likely that they interact in complex ways that are very difficult to identify and disentangle. Therefore, more focused work on relationships, interactions, and processes between these various treatment parent roles and behaviors and youth behaviors is needed to better capture and understand the complex phenomena involved. Such work will likely include more mixed methods approaches to adequately examine the complex bi-and multi-directional factors that affect how treatment parents enact their complex role, and the subsequent implications for youth outcomes.

6. Conclusions

Parenting and treatment implementation are complex activities. Treatment foster parents are asked to combine these two roles and activities in their work with youth who have serious mental health problems. This paper has begun to explore what the treatment parent role looks like, how much it varies, and whether different types of adults, youth, or settings are systematically related to how this complex role is played. Overall, the findings are encouraging. Treatment parents report relatively high levels of a range of core behaviors that cut across effective parenting and intervention approaches. There is evidence that treatment parents spend substantial time with the youth in their care, feel positively about these youth, and fairly consistently provide consequences for problem behaviors. However, there is also evidence that they experience substantial levels of conflict and communication difficulties in their relationships with the youth and show somewhat lower levels of perspective taking. While they are quite consistent in consequences for problem behaviors, they are much less consistent in encouraging positive behavior. So, while the overall picture is positive, there are clearly areas for improvement, both in our knowledge of what works in this setting and in how to help treatment parents systematically implement what works.

Future work should build from these findings to explore more fully the range of approaches that treatment parents (and other front-line providers) utilize in their work with youth. Findings suggest that treatment parents are much more focused on addressing problem behavior than in encouraging positive behavior. Relatively large amounts of time together and positive affect suggest a good spring board for working on issues related to communication and conflict. Differences in findings as youth age suggest the need for increased focus on balancing appropriate opportunities for age-appropriate growth with heightened needs for intensive involvement and intervention among these high-risk youth. Recognition of such issues could provide foci that could be integrated into ongoing in-service training and supervision for treatment parents.

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Treatment foster care is a tremendously appealing intervention approach, based on its ability to provide intensive intervention in a setting that allows for myriad opportunities for in-vivo development, relationships, and growth. Such opportunities, though, mean that treatment parents are working in relative isolation to complete a complex set of activities that fit this multi-dimensional role. Recognizing these complexities and understanding how treatment parents both view and play their role may be useful in more fully implementing TFC to fulfill its potential. Such information should also be critical for guiding appropriate supervision and support for treatment parents as they work in an incredibly complex, stressful, and potentially rewarding role. Future work should build from these findings to both more fully understand these phenomena and to understand how training, supervision, and supports can be more fully developed to enable treatment parents to successfully enact this role.

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Highlights

- Treatment foster parents play a complex role – combining aspects of front-line treatment providers with those of parents.
- Treatment parents show variation in enactment of most key examined dimensions (discipline/consistency, time together, parent-child conflict, positive affect, perspective taking, communication).
- For older children, treatment parents reported less time spent together, less positive affect towards the youth, and lower levels of consistency responding to both negative and positive behaviors.
- African American treatment parents were slightly more likely to view themselves as "parents" (rather than treatment professionals) compared to Caucasian parents.

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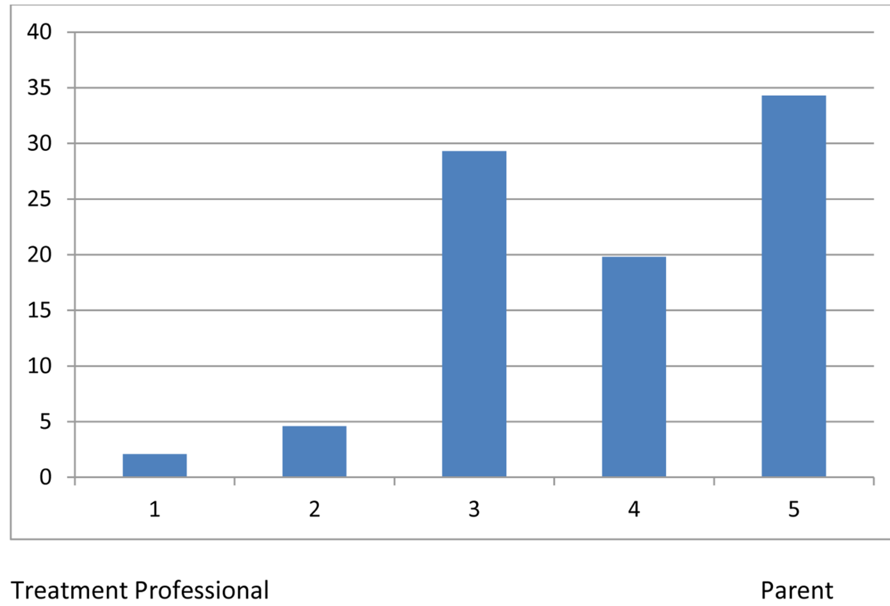

Figure 1.
View of Self: Treatment Professional=1 to Parent=5

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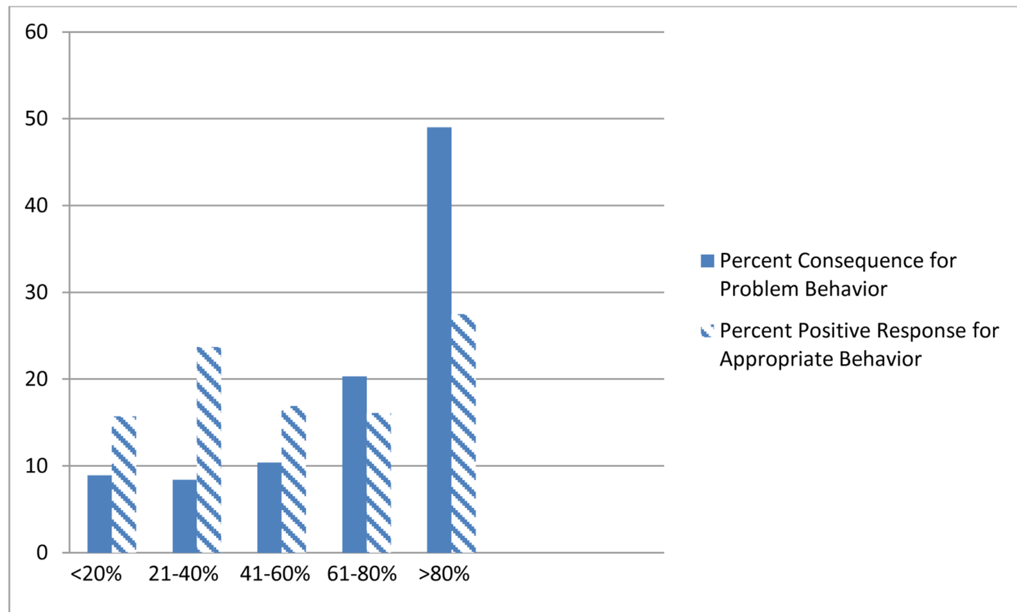

Figure 2.
Percent of Problematic and Prosocial Behaviors Responded to by Treatment Parents

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Table 1

Description of Youth and Treatment Parents

Variable	Percentage or Mean (s.d.)
Child Characteristics	
Age	12.9 (3.8)
Sex (female)	45.3
Race	
African American	56.7
White	33.2
Other	10.1
In State Custody	84.4
Length of Stay in TFC home	624.8 days (766.8)
Treatment Parent Characteristics	
Age	48.5 (10.0)
Sex (female)	90.2
Race	
African American	74.1
White	21.9
Other	4.0
Married	59.1
Education	
Less than high school	3.6
High school/GED	27.5
Some college	49.6
College graduate	14.3
Graduate/Professional	4.9
Household composition	
Has other TFC children	31.2
Has any other children	69.6
Experience	
As a Parent	86.9
As Foster Parent	28.2
With other TFC agency	21.9
As mental health provider	23.9
With family member’s MH problems	28.8

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Table 2

Most Effective Approach to Disciplining Current Child?

Approach	Percent endorsing
Ignore	7.3
Ground	6.8
Time Out	9.8
Discuss, Talk	29.0
Work chore	3.8
Privilege removal	37.6
Lose points	2.1
Physical punishment	2.6
Other	0.9

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Table 3

Scale Descriptions

Construct	Composite Score	Scale Range	Mean (std)	Frequency	Individual Items and Scoring
Time Together	Sum of 3 items	0–3	--	0=13.6% 1=32.9% 2=34.1% 3=19.3%	Individual items were dichotomized and summed. Individual items include: Parent Daily Report (PDR) 1-on-1 minutes in past 24 hours (0=*below median*; 1=*above median*), Activity together in past 24 hours (0=*no*; 1=*yes*), BERS "child participates in family activities" (0=*not at all like child to like child*; 1=*very much like child*).
Treatment Parent-Child Conflict	Sum of 6 items	0–6	--	0=51.4% 1=15.8% 2=12.0% 3=9.1% 4=5.4% 5=4.2% 6=2.1%	Individual items were coded as 0=*no*, 1=*yes* and summed. Items include: Treatment Parent (TP) and child never seem to agree, TP and child get angry at each other (> 3×/week), Child often seems angry at TP, TP and child generally do not get along well, TP and child argue about little things, TP and child argue a lot about rules.
Treatment Parent Positive Affect Towards Child	Mean of 3 items	1–5	4.17 (0.62)	--	Individual items were coded from 1–5 (1=*never* to 5=*very frequently*) and averaged. Items include: TP shares things they like about child with him/her, TP talks to others positively about child, TP enjoys spending time with child.
Treatment Parents Perspective Taking/ Empathy Building	Mean of 2 items	1–5	3.69 (0.82)	--	Individual items were coded from 1–5 (1=*never* to 5=*very frequently*) and averaged. Items include: TP tells child when child did something to hurt TP, TP tells child when TP is sorry.
Difficulties with Communication	Sum of 4 items	0–4	--	0=42.3% 1=17.6% 2=18.8% 3=11.3% 4=10.0%	Individual items were coded as 0=*no*, 1=*yes* and summed. Items include: Child almost never understands TP's side of argument, Child is defensive when TP talks, Child acts impatient when TP talks, Talks between TP and child are frustrating.

Note. Frequencies are presented for composite variables that were calculated as the sum of individual items. Means are presented for composite variables that were created by taking the average of individual items.