Treatment Foster Care and relationships: Understanding the role of therapeutic alliance between youth and treatment parent

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Abstract

This study profiles the development of relationships between youths and treatment foster parents over the course of a year using a repeated measures design. While both youth and treatment parents report favorable therapeutic alliance, treatment parent alliance is generally higher than youth alliance. Both treatment parents and youth show a "honeymoon" affect in which therapeutic alliance ratings decrease, followed by a gradual increase. The number of previous placements, diagnosis, severity of problem behaviors and resistance associate with different alliance growth trajectories for youth. In addition, treatment parent race and the presence of biological children in the home also associate with different alliance trajectories. These findings are discussed in terms of the implications for policy, training and supervision, research and practice in treatment foster care.

Key words: therapeutic alliance, treatment foster care, relationships

Introduction

Although specialized foster care has been in existence since the 1960s, there have been few empirical investigations about the nature of the relationship between the treatment parent and the youth. How do youth, many of whom have histories of maltreatment, abandonment and serious emotional disturbance form an alliance with an adult acting in both a parental and treatment role? Can youth form alliances and what changes in the relationship occur over time? These youth are some of the most vulnerable in the child welfare system, yet little is known about a fundamental therapeutic process – forming a therapeutic alliance with a trained treatment parent. This investigation was designed to begin addressing this gap in knowledge.

Specialized foster care, often called treatment foster care (TFC), falls within a comprehensive range of care between facility and home based treatment and was developed as an alternative to facility-based care. It is considered to be the least restrictive form of out-of home treatment for youth with serious emotional disturbance who are at risk of, or returning from residential treatment (U.S. DHHS, 1999). There are variations in practice (Farmer, Burns, Dubs & Thompson 2002), but the model characteristically has trained treatment parents to provide

specialized and individualized treatment and care to a youth within their home. The intent is to provide behavioral health treatment in a normalized and nurturing environment, thus combining the elements of foster family care and residential treatment (Bryant, 1980; Hawkins, Meadowcroft, Trout, & Luster 1985; Meadowcroft, 1989, Stroul, 1989; Bryant, 2004).

In the United States there is great enthusiasm about TFC because it is one of the few evidence-based treatments for emotionally and behaviorally troubled youth in out of home care. Although great gaps in what we know about treatment foster care exist, the findings from research have been generally positive (Farmer, 2005). Results from clinical trials of Multidimensional Treatment Foster Care have demonstrated positive outcomes such as lower recidivism and reduced re-arrests and a greater success in returning youth home after treatment (Chamberlain et al., 1996; Chamberlain & Reid, 1998; Chamberlain and Reid, 1994). At the same time, residential care in the United States, the United Kingdom and Western Europe has come under scrutiny and criticism for its potential for institutional abuse and victimization, separation from family, exposure to deviant peers and cost (Whittaker, in Press; Barth, 2002; Polnay, Glaser, & Dewhurst, 1997). There is also the paucity of research: no conclusive evidence exists to support the effectiveness of residential services over other service types (Kutash & Robbins Rivera, 1996, p. 121). For all of these reasons, treatment foster care is increasingly being seen as one of the most viable treatment options for seriously troubled youth in out of home care.

Although it is estimated that 19, 553 youth in the United States are currently receiving TFC services in 27 states (phone conversation, M. Coles, Foster Family Treatment Association, October 19, 2004), little research exits on the effects of the quality of the relationship between the treatment parent and youth. A literature search of scholarly journals from 1987 using PsychINFO© yielded 13 published articles, most only tangentially addressing the quality of the foster parent-youth relationship. The influence of biological parent-child relationships is well-established: a healthy relationship between children and their biological parents is thought to buffer children from stress and to promote resilience (Masten & Coatsworth, 1998; Rutter, 1990), promote pro-social behavior and prevent delinquency (Reid & Hendricks, 1973; Solnick, Braukmann, Bedlington, Kirigin & Wolf, 1981) and provide a positive foundation for peer-relationships (Harrist, Pettit, Dodge & Bates 1994). Longitudinal studies of competent children and adolescents who have experienced severe adversity strongly indicate the importance of caregiver relationships for successful adaptation (Masten, 1994). Can youth form positive relationships with treatment foster care parents and what is the nature of this relationship? Does a close and positive bond with a treatment foster care parent have a similar positive effect, for children experiencing a disruption in their living situation? These are important questions for youth experiencing a disruption in their living situations and uncertain permanency.

While establishing a positive relationship is important, it is not an easy task. The role of a treatment foster parent is complex, providing treatment along with shelter, nurturance and care, while also acting as part of a treatment team (Wells, Farmer, Richards & Burns, 2004). In order to have a positive treatment impact on the youth, a treatment parent must be able to engage the youth. Yet, children and adolescents do not voluntarily engage in foster care. Children typically enter treatment foster care because adults in their lives recognize the need for out-of-home intervention and/or biological parents are unable to provide this treatment. Establishing a relationship with a treatment parent may be at odds with an adolescent's developmental task of establishing independence and autonomy from adults (Oetzel & Scherer, 2003; DiGiuseppe, Linscott & Jilton, 1996). Alternately, the youth may believe that they already have a "family" and feel no need to engage with a treatment foster parent. Youth may have experienced life situations such as abuse and neglect which may negatively impact their ability to form relationships (Doucette, Rauktis, Boley & Pleczowski, 2004; Eltz, Shirk & Sarlin, 1995). All of these factors highlight the need for further study of the relational context of TFC (Wells, Farmer, Richard & Burns, 2004; James & Meezan, 2001).

One relational or context variable is therapeutic alliance. Therapeutic alliance is the working relationship between a client and therapist in terms of the emotional bond between the client and the therapist, agreement on therapeutic tasks and the goals of treatment as well as the perceived

openness and truthfulness of the relationship (Doucette and Bickman, 2001b). While therapeutic alliance has been widely studied in adults, child psychotherapy research for children has "lagged behind its adult counterpart" (Shirk & Karver, 2003, p. 452; Russell & Shirk, 1998). However, a recent meta-analysis of 23 studies (Shirk and Karver 2003) found that therapeutic relationship was modestly associated with outcomes, not only across different types of treatment, but also across levels of child development. Meta-analyses of adults have been more conclusive suggesting that therapeutic alliance is one of the most consistent predictors of treatment outcomes. (Horvath & Symonds, 1991; Martin, Graske & Davis, 2000; Wampold 2001, 2000). Moreover, research has shown that the quality of the relationship is related to premature termination (Horvath & Symonds, 1991; Martin, Graske, & Davis, 2000). Failure to establish a relationship may lead to premature termination of treatment: estimates of premature termination for youth range from 40% to 60% (Armbruster& Kazdin 1994). In one of the few studies in this area, Hawley and Weisz (2002) found child caregiver-therapist alliance associated with greater persistence in therapy (fewer drop outs) and more family participation for children being seen in out-patient community mental health centers.

There are some youth characteristics that have been associated with the ability to form alliances. A history of maltreatement and abuse is one common characteristic of many youth in treatment foster care. Eltz, Shirk and Sarlin (1995) found that maltreated adolescents who did not form alliances with their therapist over time appeared to have the poorest outcomes. They concluded that the process of forming a relationship in therapy may be especially critical for maltreated adolescents because it may moderate the link between the experience of maltreatment and therapeutic outcome (Eltz, Shirk and Sarlin, 1995, p. 429). Similar research has not been conducted to date in treatment foster care, despite the prevalence of youth entering care with histories of physical and sexual abuse, neglect and abandonment (Takayama, Wolfe, & Coulter, 1998).

Thus, there is a critical gap in the body of research about treatment foster care. While much research has focused on looking at effectiveness of specific models of treatment foster care, little systematic inquiry has been made into the process by which treatment occurs. Treatment foster care occurs within a relationship between the youth and the treatment parent. Given that favourable alliance has been found to be a consistent predictor of positive outcomes for adults in therapy (Garcia & Weisz, 2002; Wampold, 2001; Horvath & Symonds, 1991) and for youth (Shirk & Karver, 2003; Hawley & Weisz, 2002; Hawley, Garland & Selijan, 2004), extending this research to the treatment foster care setting is appropriate. The purpose of this research is to examine: the level of alliance between youths and treatment foster care parents; whether youth and treatment parents have similar perceptions about their relationship; if perception of the relationship changes as youth and the treatment parent spend more time together and if it changes, are there different growth trajectories. Is alliance associated with youth and treatment foster parent characteristics? Finally, what is the relationship between youth alliance and resistance? These are important questions to answer since the development of one empirically based model of TFC that is internationally applicable for all youth is not likely. We need to improve our collective knowledge of the common factors that associate with good outcomes for TFC. Thus, efforts should be spent researching factors such as therapeutic alliance that are believed "to mediate outcomes that apply across most therapeutic modalities and theories" (Bickman, 1999: p. 973).

Method

This study profiles and describes the trajectory of how relationships between youth and treatment foster care parents develop over the course of a year. A repeated measures design is used, and the data are dyadic (treatment parent and youth). The youth and treatment foster care parents participating in the study are from the PRYDE[1] program (Pressley Ridge Youth

Development Extension), a treatment foster care program located in the Eastern State of Delaware in the United States. The Delaware PRYDE program is a new program that was created in response to the developing system of care in the State. Because this was a new program, we had the unique experience of collecting alliance data on a cohort of youth entering the PRYDE program and treatment home. In addition, many of the treatment parents were new to foster care and represent a cohort of new parents as well. All of the treatment parents and the youth in the program were asked to participate. At the time, 24 youth and 21 primary treatment parents were active in the Delaware program. Cumulatively, the Delaware program had served 34 youth since its inception.

Description of the program

PRYDE is an intensive, individualized and flexible treatment approach in a family setting using professional treatment foster parents. The model has evolved from the "Teaching Family Model" (Wilner et al., 1977) to become a model in which trained treatment parents use specific interventions from multiple theories such as behavioral theory (applied behavioral analysis), social learning theory (ecological interventions) and interpersonal (building a therapeutic alliance). Other services are provided in the home such as parent respite, 24 hour crisis and telephone support. Youth can receive psychological counseling and other supportive services outside the home. Treatment parents are carefully screened and trained using a manualized pre-service curriculum and are regularly supervised (weekly) by a treatment coordinator. Treatment parents have a dual role: to provide the care and nurturance as a substitute parent and to provide treatment to an emotionally disturbed youth. The treatment parents and PRYDE treatment coordinators work with the youth and the biological family or kin to create a plan, and to identify or develop a permanent home that best meets the needs of the youth. The PRYDE model includes working with the youth's biological family in order to maintain sibling and parental relationships, even if the youth cannot return to the custody of his/her biological parent.

The following guiding principles form the basis of the PRYDE model: The most troubled youth can succeed with intensive treatment; Treatment is teaching and the most successful treatment occurs in the settings of everyday living; The treatment parent is the primary change agent, the frontline counselor for the youth in their care; Our commitment is unconditional – we do not give up on our youth; Discharge is planned and to the least restrictive setting possible; Every child deserves a safe and permanent home; PRYDE programs succeed when youth show positive change; Excellent services require the practice of excellent business (Hasselman & Rauktis, 2004). All PRYDE programs are monitored every quarter using indicators of these Principles (Hasselman & Rauktis, 2004).

While not considered to be an "evidence-based" model, the PRYDE model contains elements of Multidimensional Treatment Foster Care, the evidence based foster care model developed at the Oregon Social Learning Center in the United States (Chamberlain et al., 1996; Chamberlain & Reid, 1998; Chamberlain & Reid, 1994). A small number of foster youth in the home, formal training of the parent, close treatment parent supervision of the youth, frequent supervision of the treatment parent, and fostering good treatment parent/child relationships are part of the PRYDE model. These model factors have been associated with positive outcomes for youth such as fewer runaway episodes, reduced delinquent acts and behavioral improvement (Chamberlain & Reid, 1991; Chamberlain & Reid, 1998; Farmer, 2005).

Description of the youth

All youth were asked to participate in this study and received a small gift card to thank them for their participation. If a youth left the program e.g. went to a residential program or an-

other agency, went back home to parents or extended family, or achieved independence we did not continue to collect data. If a youth transferred homes within the program, we continued to collect data, noting that there was a change in treatment parent. We were able to collect alliance data for three or more time periods from 25 of the youth. On average, youth of this PRYDE program are 15 years old (range between 12-18 years of age). Fifty-six percent of the youths are male, 16 percent are Hispanic and 56 percent are African American. Nine percent of youth had been sexually abused, 16 percent were sexual offenders. Most youth (68%) have multiple diagnoses. Fifty-five percent of them have two separate diagnoses, 14 percent have three or more. Mood disorder is the most commonly diagnosed disorder (55%), followed by ADHD (50%), oppositional defiant (41%), and depression (23%). Fifty-eight percent of the youths had multiple foster family placements before coming getting into the PRYDE program (range between 2 to 19 previous placements).

Description of the treatment parents

All of the parents were asked to participate, and like the youth, received a small gift card. All of the parents agreed to partipate. On average, foster parents of this PRYDE program are African American (72%), female (77%), 41 years old. Fifty-eight percent of these parents have at least one biological child living in the foster home. There is only one foster child per home. Seventy-two percent of the foster families make less than $ 35,000 per year, 28 percent have High-School education and 16 percent have a Bachelor's or a Master's degree.

Measures

Therapeutic Alliance Scale (TAS)

Doucette and Bickman have developed a multi-respondent, youth-focused Therapeutic Alliance Scale (TAS) (Doucette & Bickman, 2001a). The TAS has two respondent forms, youth, and treatment parent, and there are Spanish and English versions of both forms. The initial scale consisted of 35 items. Subsequent psychometric analyses reduced the final scale to 30 items. The TAS uses a 3-point response scale (disagree, somewhat agree, agree).

Initial Rasch analyses, using principal components analysis revealed two dimensions: (1) a dimension comprised of items characterizing the therapeutic relationship; and (2) resistance/an unfavorable outlook on therapy in general. The therapeutic relationship dimension measures the mutuality and empathic qualities of the relationship as well as the collaborative working rapport. Examples of the items under each respective dimension are provided below:

1. Therapeutic Alliance
   (a) Mutuality/Empathic Qualities
   My Treatment Parent respects me
   I like my Treatment Parent.
   (b) Collaborative Relationship (Working Rapport)
   My Treatment Parent and I work on my problems as a team.
   My Treatment Parent listens to changes I want to make in what I do in this home.
2. Resistance/Unfavorable outlook on therapy
   If I had a choice I would not be in this home.
   I can easily fool my Treatment Parent.

The therapeutic alliance (TA) score is the combination of the mutuality/empathic subscale and the collaborative relationship subscale. In the findings, when TA scores are reported, it is the combination of the mutuality and collaborative subscales. The resistance subscale is considered and reported separately. The reliability (Cronbach's alpha) reported for the TAS subscales (resistance, mutuality and collaborative relationship) is well within acceptable ranges

of .83, .88 and .90 respectively. Both the youth and the treatment parent completed forms at the same time periods (usually every month).

Child and Adolescent Measuring System (CAMS)

Doucette and Bickman (2001b) have developed a measure of child well-being. The Child and adolescent measuring system is an assessment of youth well-being with five subscales: acuity, social competence, and hopefulness, internalizing and externalizing problems and victimization. Internalizing items assess anxiety, fear and depression whereas externalizing items assess aggression, anger, conduct disorder and externalizing behaviors. Total problem scores are the sum of internalizing and externalizing scores. Acuity is assessed using a dichotomous scale (yes/no) and includes questions about self-harm, harm to others, drug and alcohol use and running away. Social competence and hopefulness refer to the degree that the youth feels comfortable in social interactions and hopefulness items captures optimism and hope. Finally, the victimization scale captures past sexual and physical abuse as well as being the object of bullying and random violence. There are three versions of the CAMS: youth, parent/caregiver and professional. The CAMS was completed every three months by the treatment parent and the youth.

Results

How is the alliance between youths and treatment parents? Does the relationship change?
From September 2003 to November 2004, 288 alliance ratings were collected from 25 youth and 26 treatment parents, averaging 5 to 6 ratings per each individual. Both youth and treatment parents report having a positive relationship, average monthly ratings during 14 months of data collection, ranged from 2.1 to 2.8 respectively (ratings between 1.8 and 2.4 are considered neutral ratings and above 2.4 are considered favorable ratings). Figure 1 shows youth and treatment parent average monthly alliance ratings. Youth ratings show an interesting pattern, high at the beginning of the relationship, decreasing while youth adjusted to the new treatment home and the parent, and then improving when both treatment parents and youth have shared more time together. This suggests there was a "honeymoon effect", at the beginning (Mean alliance ratings = 2.8, StdDev = 0.36). In the following months when youth got settled down in their new foster homes, youth ratings deteriorated. Ten months after these youth were placed in therapeutic foster, youth ratings started to improve significantly ($p = 0.01$).

Do youth and treatment parents have similar perceptions about the relationship? Does the perception of the relationship change over time?
Ratings from treatment parents are on average higher than youth ratings (0.18 TA points higher; $p = 0.001$) suggesting that parents and youth see their relationship differently. Parents are more optimistic when reporting about the relationship than youth. Treatment parent ratings are also more stable over time, even when youth reported a deteriorated alliance (April-June 2004) parents ratings were significantly higher than youth's. Overall, treatment parents and youth reported having good relationships but each group has a different perspective of their relationship, and their overall correlation was only 0.47 ($p = 0.01$).

If alliance changes, are there different trajectories of change?
Since alliance does not appear to be static, a clustering procedure was done to see if there were groups of youth who had different alliance growth trajectories (Figure 2). Although the size of the sample did not allow the power to detect statistical differences, there appears to be three distinct groups: youth whose alliance is moderately high and relatively stable (blue);

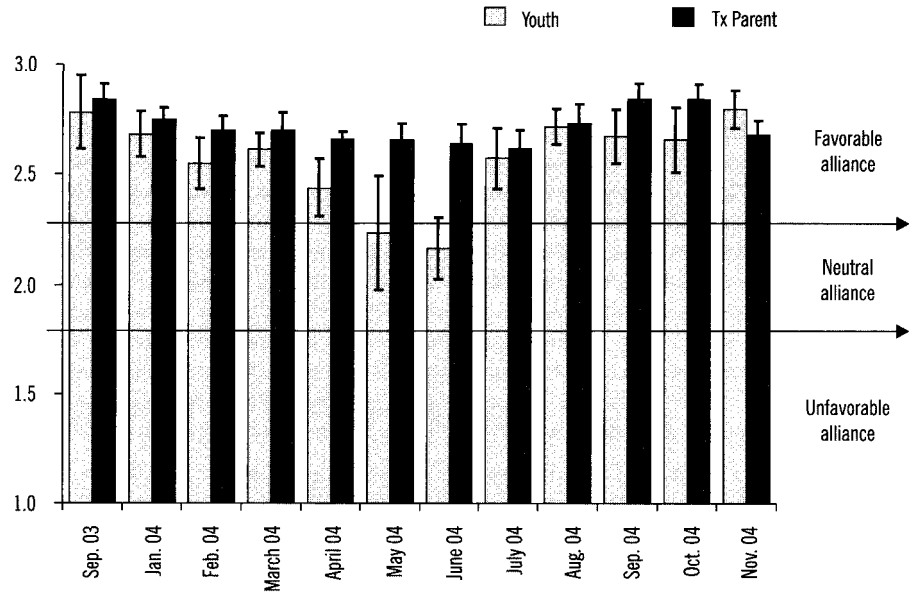

Figure 1
Average Monthly Youth and Treatment Parent Therapeutic Alliance Scores

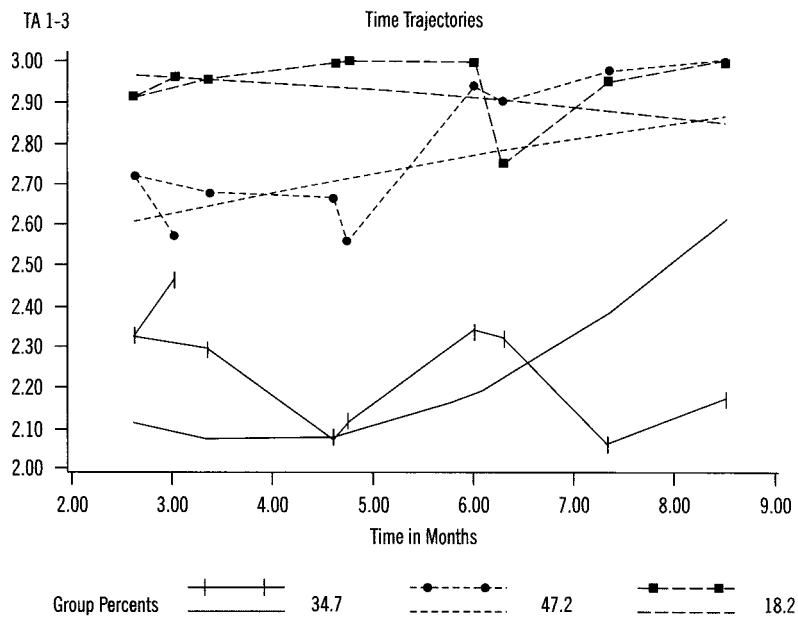

Figure 2
Youth Therapeutic Alliance Growth Trajectories

youth with decreasing alliance that improved over time (green); youth who reported unstable alliance (red).

Are there youth or treatment parent characteristics that associate with patterns of alliance development?

Previous alliance research suggests that there are demographic and clinical variables that may affect alliance (Bickman et al., 2004; Eltz, Shirk & Sarlin, 1995; Rauktis, Andrade & Doucette, In Press; Rauktis, Doucette & Andrade, 2004). To answer this question, we examined youth alliance growth curves looking at parent and youth factors. The parent characteristics examined were: the presence of biological children in the home and parent race; youth factors were age, gender and the number of placements, mental health diagnosis (such as oppositional defiant disorder, mood disorder, depression, and ADHD disorder), youth's total problem behavior.

In general, the presence of biological children living at home does not prevent youths from developing favorable alliance with their foster parents. Figures 3 show the youth alliance trajectories for families with and without biological children living at home; the trajectory of those living with biological children show a steeper and more positive slope and more stability (less dispersion) than other children living with families without biological children. This suggests that the presence of biological children in the home may positively influence the youth's alliance with the treatment parent.

Figure 4 shows the youth alliance trajectories by family racial composition. Youth placed in families of a different race or culture e.g. Caucasian youth placed in African-American families, Hispanic youth placed in Caucasian or African-American families and vice-versa, reported neutral to favorable TA ratings. However, the pattern of ratings shows more variability (higher variance) and a tendency to deteriorate over time Cultural and racial perceptions and adjusting to living with treatment parents of a different culture may be influencing youth alliance.

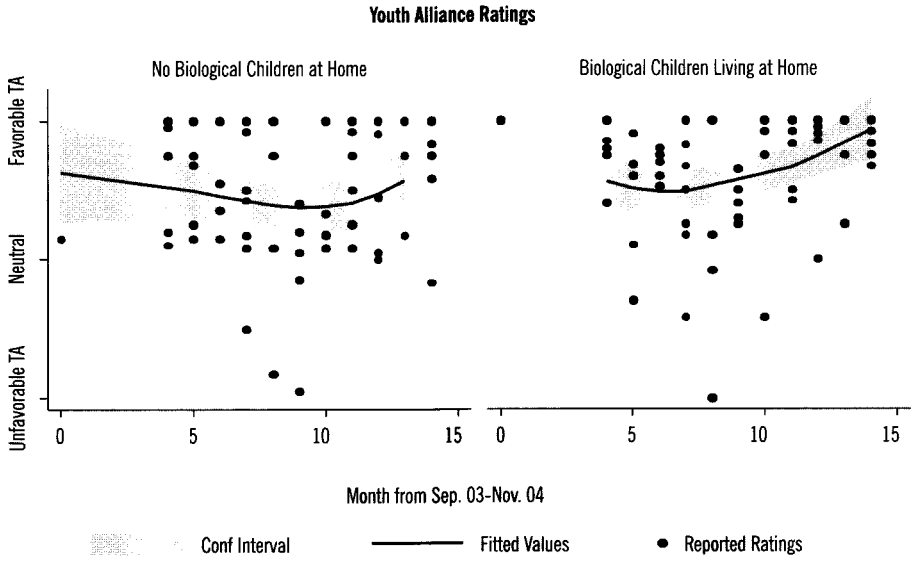

Figure 3
Youth Alliance: Biological Children in the Home

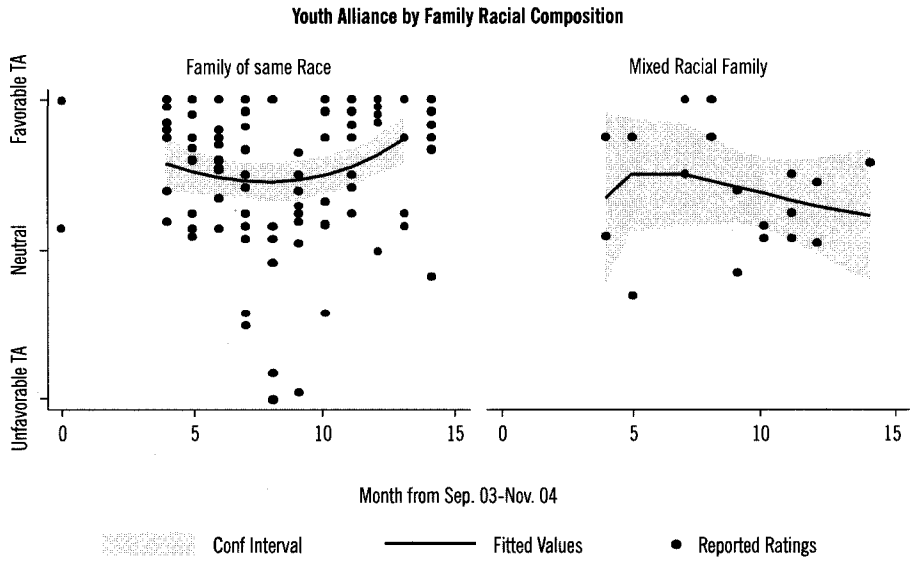

Figure 4
Youth Alliance: Living with Families of different Race

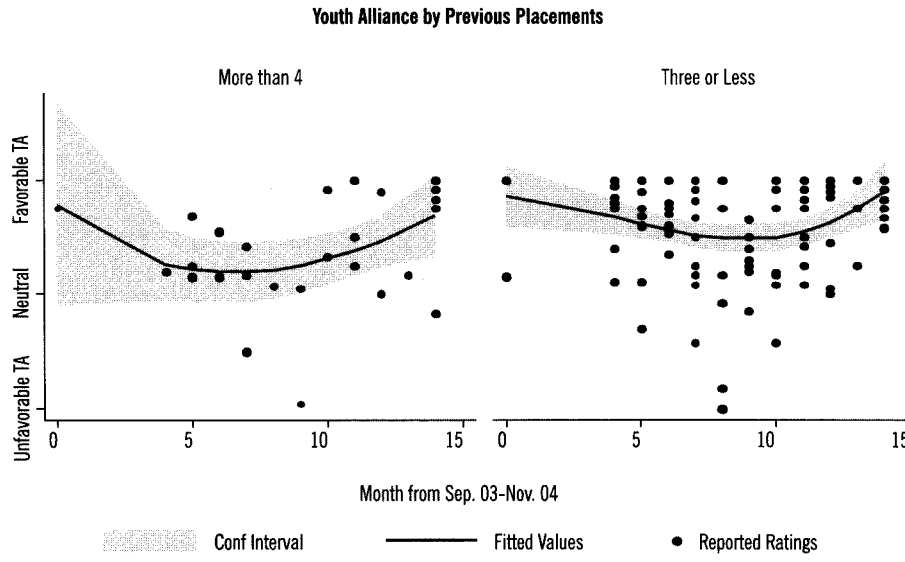

Figure 5
Youth Alliance: Number of Previous Placements

Youth age and gender did not impact patterns of alliance. Alliance growth curves by age groups and gender were very similar (curves are omitted due to space limitations).

The number of different placements that youth has had seems to influence how youth form relationships. Figure 5 displays youth alliance ratings by the number of previous placements. Placements included foster care, treatment foster care, kinship care and residential care. Youth with fewer previous placements (three or less) have more stable alliance growth curves (higher scores, flatter curve) while youth with more placements (four or more) have lower alliance scores. A history of being moved from home to home or into and out of different residential treatment facilities appears to make it harder for youth to form a relationship with a treatment parent.

The type of disorder or diagnosis that the youth has appears to influence how youth form relationships. Youth with oppositional defiant disorder have more unstable relationships: the alliance curve is "U" shaped, decreasing in the first 10 months of being in the home and then later improving (see Figure 6). Youth with ADHD, mood disorder, depression did not show major differences in their alliances patterns over time. It is not surprising that youth who are negative, hostile and argumentative and defiant with adults, would have a more difficult time forming an alliance with a treatment parent. However, what is encouraging is that over time, the youth begins to develop an alliance with the treatment parent.

Figure 7 shows alliance growth curves by problem level. Problem scores are the combined internalizing and externalizing behavior subscale scores from the CAMS and for this analysis were divided into lower problem and moderate to higher problem levels. Youth with mild problems have very favorable and stable alliance ratings over time. Youth with moderate to serious problems have more difficulty forming alliances especially at the beginning of the relationship. The good news is that later on, after 6 months of living in the foster home, youth seem to be able to improve their alliance level. This suggests that youth with more serious to moderate behaviors and problems are in need of more time to adjust to their new home and form relationships with the treatment parent.

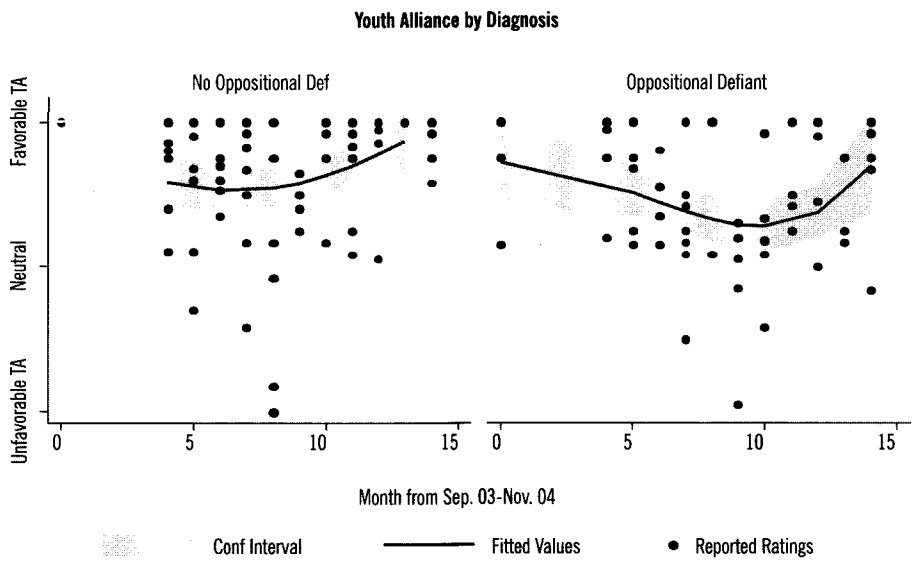

Figure 6
Youth Alliance: Youth Diagnosis

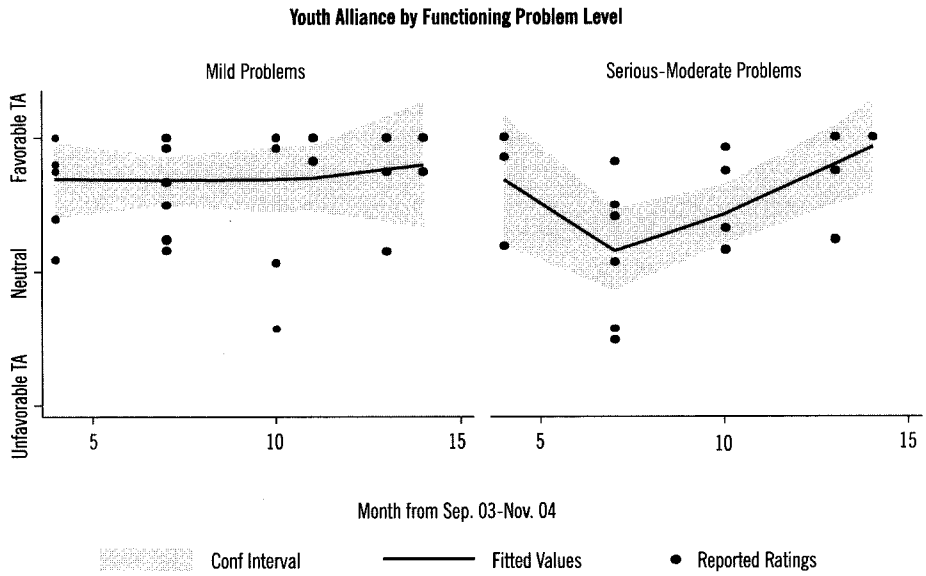

Figure 7
Youth Alliance: Youth Total Problem Score

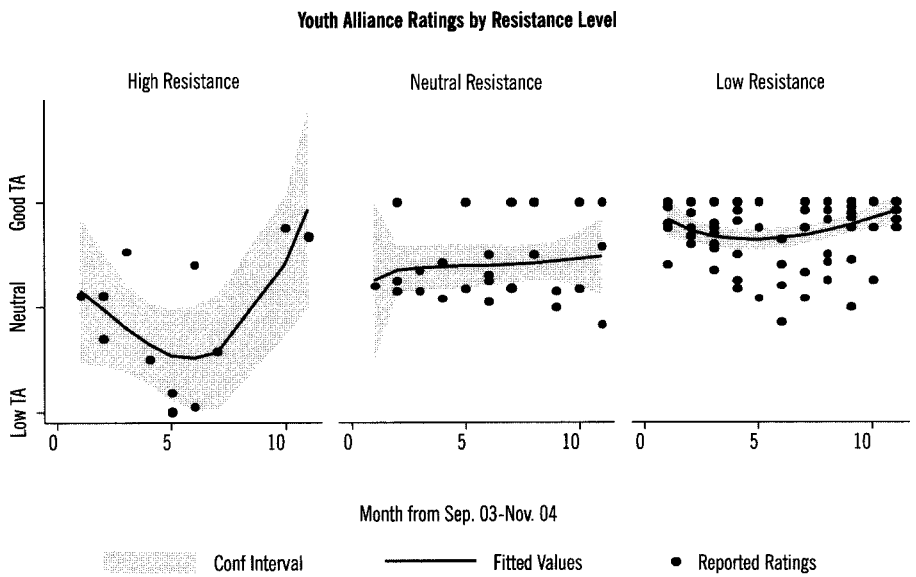

Figure 8
Youth Alliance and Resistance

What is the relationship between alliance and resistance?
Lower resistance correlates with good youth reported alliance. Figure 8 shows that youth reporting lower resistance are also the ones reporting better relationships and youth reporting higher resistance are the ones having more difficulty building good relationships ($r = 0.65$, $p < 0.001$).
Parents also reported higher alliance when the youth is less resistant ($r = 0.61$, $p = 0.001$). However, this correlation changes for parents. At the beginning of the relationship, parents who sensed lower youth's resistance reported higher alliance. However, after living with the youth, this correlation between youth resistance and alliance decreased to .47.

Discussion

More than a half a million children currently reside in out-of-home placements in the United States, with more than a quarter million entering foster care each year (U.S. DHHS, 2003). The proportion of children in foster care with significant mental health problems has expanded as the number of children in care in the United States has increased (Kortenkamp & Ehrle, 2002; Leslie et al., 2000). It is estimated that as many as 80% of children and adolescents in the American child welfare system experience significant emotional or behavioral problems (Landsverk & Garland, 1999). Treatment foster care can be a viable alternative to facility-based placements for youth with both permanency needs as well as mental health challenges. One factor that has been little researched is the relationship between the treatment parent and the youth living in their home. The reminder of this paper discusses the findings and what this means for treatment, policy and further research.
The findings suggest that youth in treatment foster care for the most part, report favorable alliance with the treatment parent. The perception of higher alliance reported by treatment parents has also been observed in other studies of alliance in day treatment/educational and therapeutic wilderness camp settings. (Bickman et al., 2004; Rauktis, Andrade and Doucette, in press). Helping adults generally rate their alliance with the youth higher than the youth rates their alliance with the adult. It is unclear why this difference exits: it may be the result of differences in cognitive functioning due to age or developmental level. An alternate explanation is that the adults, particularly treatment parents, may be reluctant to disclose negative feelings about their relationship with the youth. The fact that adults are more optimistic may serve a protective function: when you are living with a youth with mental health and behavioral challenges, being a little optimistic (although not oblivious) about the relationship may help the parent to persevere during the difficult periods.
The "honeymoon" period observed in Figure 1 was confirmed by treatment parents. When this data was shared with parents, one commented that "every child and parent has a honeymoon – how long it lasts is different – but you had better be prepared ahead of time for when it ends". This observation has implications for training, supervision and pre-placement planning. Having individualized, and pre-planned contingencies built into a plan and knowing who will do what and when and what additional resources can be added normalizes the situation and reduces the chances of making poor decisions during a crisis: pre-planning makes this a normal and expected event rather than a crisis.
Psychologically preparing or "inoculating" treatment parents may also help: treatment parents suggested role playing with experienced parents as an effective training tool. In fact, after reviewing the data, parents suggested pairing an experienced treatment parent with a professional when doing pre-service training for new parents, as well as experienced parents mentoring unseasoned parents.
The two parent factors that appear to influence how youth develop therapeutic alliance with their treatment parents are the presence of biological children in the home and the race of the parent. Having biological children in the treatment home may provide a role model for the

youth in terms of how to have a relationship with a parental figure. An alternate explanation is that individuals who are currently parenting can better foster youth alliances because of their personal experiences. The variability in alliance when a youth was placed in a home with a parent of a different race or culture suggests that supervisors work with youth and treatment parents in helping both to understand and value each other's unique cultural experiences. Treatment parenting is no more "culture neutral" than any other service provided to children, and not addressing these issues could be problematic for the development of the relationship.

Several youth factors seem to affect the pattern of alliance. Youth with a history of more placements had a different trajectory than youth with fewer placements. The lower alliance scores and steeper curve for these youth suggests that while they experienced initial difficulty forming an alliance with their treatment parent, over time, they were able to develop alliance. Youth with oppositional behaviors, and a greater degree of problem behaviors also had different shaped curves, suggesting a longer and more difficult course of developing alliance. Another factor in youth forming alliances is their degree of resistance. When youth are highly resistant, the development of youth alliance is more likely to be characterized by a pattern of neutral to low alliance, followed by increasing alliance.

One important difference seen in this study is worth noting. In an earlier study of teachers at the Pressley Ridge school/partial hospital program, teachers reported lower alliance when the youth was highly resistant and this perception did not change over time. (Rauktis, Andrade, Doucette, In Press). In contrast, treatment parents, after living with the youth seem to learn that that the youth can be resistant to the parent yet also have a relationship.

Persisting in the relationship despite resistance or reactance (Beutler, Moleiro & Talebi, 2004) is something most parents of adolescents live through. However, unlike a biological parent, in TFC the parent has the option of asking for the child to be removed from his/her home. Recent work done by the Chapin Hall Center for Children on residential care in the state of Illinois (Budde et al., 2004) and research by Pecora and associates on placement stability (Pecora et al., 2005; Herrick, Williams & Pecora, 2004) highlights how critically important preventing placement instability at earlier points in time during a child's foster care experience is to positive long term outcomes. Training treatment parents in overcoming resistant and reactant states and providing close professional supervision, support and respite in the home during difficult periods may help to maintain the placement. It also suggests careful assessment and planning are needed when placing a child with one or more of these factors into a treatment home. In other words, a child with a history of many placements, with a diagnosis of oppositional and defiant disorder who has many problematic behaviors and is resistant will take longer to develop a therapeutic alliance with their treatment parent. This parent may need additional support, mentoring and resources and this should be in the plan *before* the youth enters the treatment home.

Youth in treatment foster care have complex social, emotional, educational and legal needs and they are placed in homes of treatment parents with their own histories, families, and needs. To add to the complexity, the mental health, child welfare, educational and judicial systems are involved and they play a role in treatment decisions and placement changes. These preliminary results suggest that alliance alone is probably not the only contributor to placement stability and improvement, but is one important factor in a complex system.

The limitations of this study include the small size of the sample and the descriptive and preliminary nature of the information. This data is from one program: it is possible that there is something different about this program or the youth or treatment parents compared to other treatment foster care programs. We were also not able to obtain TA scores on all children from the day they first entered into the treatment home. In addition, the TAS was revised from a measure that was used in a residential and day school/partial setting.

Like most preliminary work, this research raises more questions than it answers. What are the trajectories of alliance in cases where the treatment parents ask to have the child removed? Are trajectories different when the goal is to reunify the child with his/her parents than if the child is to be adopted or the goal is independent living? What is the role of alliance in a suc-

cessful discharge from treatment foster care? Does it play a direct or indirect role? Does it matter, or are there other more powerful effectors? Can data on alliance be useful in supervising the parent and guiding treatment and transfer decisions? Is it possible to profile youth in terms of their trajectory of alliance and match them with treatment parents? We have the opportunity to observe how TFC models translate to new practice settings and cultures as more countries begin to include treatment foster care in their systems of care. We also hope that this preliminary work will encourage others to also research alliance in treatment foster care using longitudinal and repeated measure design so that these and other important questions can be answered.

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Note

1. PRYDE is a registered trademark.

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