

11-12-2025

Telemental Health Utility: Working Toward Foster Carer Role Satisfaction and Placement Stability

Carlos David Ortiz
Walden University

Follow this and additional works at: <https://scholarworks.waldenu.edu/dissertations>

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Allied Health

This is to certify that the doctoral dissertation by

Carlos David Ortiz

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee

Dr. Denise Horton, Committee Chairperson, Psychology Faculty

Dr. Reba Glidewell, Committee Member, Psychology Faculty

Chief Academic Officer and Provost

Sue Subocz, Ph.D.

Walden University
2025

Abstract

Telemental Health Utility: Working Toward Foster Carer Role Satisfaction and

Placement Stability

by

Carlos David Ortiz

MS, Walden University, 2018

MA, Yeshiva University, 2011

BS, Nyack College, 2007

Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

October 2025

Abstract

Approximately 400,000 children in the Child Welfare System have an average of more than three placement disruptions while in care in what is termed placement instability (PI). PI is a known toxin to children's neurodevelopment that predisposes them to a life of poor behavioral outcomes. Previous research shows that foster parents dissatisfied with their carer role contributed to PI by quitting or terminating a child's placement. However, an important gap remains in the PI literature about the ability of telemental health (TMH) to provide adequate support to foster parents, to increase satisfaction in the carer role and potentially decrease the rates of PI. Therefore, the main purpose of this quantitative study was to explore the role of TMH utility among foster parents for its contributions to carer role satisfaction and placement stability using a survey design. A second goal was to explore the role of caregiver orientations on TMH utility among foster parents in the United States using the Caregiver System Scale (CSS). A convenient sample of 77 foster parents who have used in-person and TMH services were recruited with the help of community partners. A multivariate regression analysis was used on survey data to explore whether TMH utility is associated with placement stability; and a one-way MANOVA was used to explore mean differences in TMH utility among caregiving orientations. Findings from this research clarify how TMH utility contributes to placement stability with the aim of developing a service delivery model. This is an important contribution to the existing literature and enhances social change initiatives through the development of a TMH praxis that helps to reduce PI and protect the neuropsychological development of cared-for children.

Telemental Health Utility: Working Toward Foster Carer Role Satisfaction and
Placement Stability

by

Carlos David Ortiz

MS, Walden University, 2018

MA, Yeshiva University, 2011

BS, Nyack College, 2007

Proposal Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Clinical Psychology

Walden University

October 2025

Dedication

This dissertation is dedicated to God, who made all things possible; to my late mother, whose endless, prayerful support sustained me through this process; to my sister, Dr. Monica Ortiz, who was a second mother to me and inspired me to pursue my own doctorate; to my father who taught me about hard work; to my late best friend, Dr. Pedro Laureano, who relentlessly encouraged and challenged me to reach for more; to my mentor and spiritual father, Dr. Derek Suite, whose countless contributions shaped me into the clinician that I am today; to my two beautiful sons, David and Jonathan, for their contributions and for believing in me; to my oldest sister, Diane, who was a constant sounding board, counselor and safe haven; and to the rest of my “familia” for their unconditional love and support. The final dedication belongs to my beautiful wife, Karen, whose support, contributions and fervent faith in me carried me across the finish line.

Acknowledgments

I would like to acknowledge the incredible support that I received during my journey at Walden University. The university's clinical psychology program has been life-changing and the faculty's commitment to fostering a safe and stimulating learning environment has left a profound imprint on both my academic and personal attainments. Pairing me with Dr. Denise Horton as my chair was a perfect match for someone as distractable as myself. Her guidance has been invaluable in navigating this challenging path, providing clarity and direction when it was most needed. More importantly, Dr. Horton was more than a chair, at times reaching out to me to keep me on track and to motivate me through serious medical and personal challenges. Her own health challenges were a constant testament to me when I thought I wouldn't make it through the program. I am equally grateful to Dr. Reba Glidewell, whose guidance was critical to completing my dissertation, and more fondly, whose disarming laughter made the whole process more bearable.

Table of Contents

List of Tables	v
List of Figures	vii
Chapter 1: Introduction to the Study.....	1
Introduction.....	1
Background.....	2
The Perils Of Aging Out Of Foster Care	2
Funding and Administration	2
Outcomes of Institutional Rearing and PI.....	3
Injuries To Children’s Attachment System.....	4
Lack Of Foster Parent Support Services, Foster Parent Retention And PI.....	5
Foster Parents’ Personal Attributes And PI	6
Problem Statement	6
Purpose of the Study	7
Research Questions and Hypotheses	10
Theoretical Foundation	10
Nature of the Study	11
Definition of Terms.....	12
Assumptions.....	13
Scope and Delimitations	14
Limitations of the Study.....	16
Significance of the Study	16

Summary	18
Chapter 2: Literature Review	21
Introduction.....	21
Literature Search Strategy.....	21
Theoretical Foundation	22
Andersen (1995) Behavioral Model of Health Services Use.....	22
Caregiving Behavioral System (CBS) and Caregiving Strategies	23
Placement Instability (PI)	24
The Psychiatric Sequela of PI.....	25
Child Characteristics And Placement Disruptions.....	25
Difficult Parent Experiences And Placement Disruptions.....	26
Child And Adolescent Needs And Strengths (CANS) Assessment And PI.....	26
Placement Types and PI.....	27
Meta-Analysis On Putative PI Risk Factors	27
Foster Youth Vs Non-Foster Youth And PI	27
Profiles Of Stability Vs Instability.....	28
Carer Role Satisfaction (CRS) and PI.....	28
Carer Role Satisfaction And Foster Parent Retention.....	29
Parenting Stress.....	30
Trauma-Informed Parent Training and Foster Parent Satisfaction	31
Foster Parents as a Distinct Group.....	32
Measures of Carer Role Satisfaction (CRS)	33

Telemental Health (TMH)	34
TMH and PI	34
TMH Utility	36
Live Parent Training Through TMH Utility	37
TMH and Attendance.....	37
Satisfaction With TMH Utility	38
COVID-19 and TMH.....	39
Scholars’ Views On TMH Utility.....	39
Summary.....	40
Chapter 3: Research Method.....	43
Introduction.....	43
Research Design and Rationale	43
Methodology.....	44
Population	44
Sampling and Sampling Procedures	45
Procedures for Recruitment, Participation, and Data Collection.....	46
Instrumentation and Operationalization of Constructs	47
Data Analysis Plan.....	51
Threats to Validity	55
Ethical Procedures	58
Summary.....	59
Chapter 4: Findings.....	60

Introduction.....	60
Data Collection	62
Demographics	62
Sample Vs Population Comparison	68
Results69	
Telemental Health (TMH) Survey	69
RQ1: Multiple Linear Regression.....	80
RQ2: MANOVA.....	88
Summary.....	94
Chapter 5: Discussion	97
Introduction.....	97
Interpretation of the Findings.....	99
Limitations of the Study.....	101
Recommendations.....	103
Implications.....	104
Conclusion	105
References.....	107
Appendix A: Survey Invitation.....	115
Appendix B: Online Telemental Health Survey	116

List of Tables

Table 1. Respondent Age Statistics	62
Table 2. Respondents' Sex.....	62
Table 3. Respondents' Education	63
Table 4. Respondents' Years Fostering	64
Table 5. Respondents' Care Training	64
Table 6. Respondents' Use of Telehealth	65
Table 7. Child's Age.....	66
Table 8. Level of Behavioral Problems (LBP)	67
Table 9. Length of Child's Placement (LOP).....	68
Table 10. Child Descriptive Statistics.....	68
Table 11. Item 1	70
Table 12. Item 2	71
Table 13. Item 3	72
Table 14. Item 4	73
Table 15. Item 5	74
Table 16. Item 6	74
Table 17. Item 7	75
Table 18. Item 8	76
Table 19. Item 9	77
Table 20. Item 10	78
Table 21. Item 11	79

Table 22. Item 12	79
Table 23. Descriptive Statistics.....	80
Table 24. Correlations.....	80
Table 25. Model Summary	81
Table 26. ANOVA	81
Table 27. Model Summary	82
Table 28. ANOVA	82
Table 29. Coefficients.....	83
Table 30. Rotated Component Matrix	86
Table 31. Respondents' CSS Category Membership.....	89
Table 32. Predisposing Factors	90
Table 33. Enabling/Disabling Factors.....	91
Table 34. Need Factors	92
Table 35. TMH Utility	94

List of Figures

Figure 1. Histogram	83
Figure 2. Scatterplot.....	84
Figure 3. Proposed Survey Framework	85
Figure 4. Behavioral Model For TMH Service Utilization.....	93

Chapter 1: Introduction to the Study

Introduction

Placement instability (PI) results from unplanned changes or disruptions in a foster child's placement home that does not lead to an adoption or a reunification with his/her biological parents (Chateauneuf et al., 2022; Fisher et al., 2013; Konijn et al., 2019). The current 24-month average per child is three or more placement disruptions in the child welfare system (CWS) but any disruption to a child's placement may cause harm to their attachment system (Cicchetti, 2016; Leathers et al., 2019; Vreeland et al., 2020). The high incidence rate of PI is a major concern to Child Welfare System (CWS) administrators in most western countries (Chateauneuf et al., 2022; Rice et al., 2017) due to the lifelong threat the effects of PI pose to children's physical and mental wellbeing (Fisher et al., 2013; Gypen et al., 2017; Konijn et al., 2019;). Although PI is a complex phenomenon, it commonly starts with carer role dissatisfaction, which occurs when foster parents are not able to lovingly connect with their foster children (Hanlon et al., 2021).

For instance, unmitigated child-behavioral problems combined with a lack of CWS support tend to frustrate and disincentivize foster parent's commitment to the carer role (Barnett et al., 2018; Gypen et al., 2017; Hanlon et al., 2021; Konijn et al., 2019). Dissatisfaction with the carer role often translates to premature placement terminations as well as foster parent retention problems, both of which contribute to PI (Hanlon et al., 2021; Leathers et al., 2019). The damaging effects of PI are mostly caused by unplanned placement changes, which lead to attachment disorders in children (Bederian-Gardner et al., 2018). The cumulative neurological effects of PI are associated with disinhibition and

impulsivity which cause lifelong challenges such as a lack of educational attainment, poor relational outcomes, early pregnancy, substance use, detachment from the labor market, homelessness and difficulties with the law (Fisher & Mannering, 2015; Hernandez & Lee, 2020; Konijn et al., 2019).

Background

The Perils Of Aging Out Of Foster Care

Every year an estimated 21,000 youth are at-risk for aging-out of the foster care system and losing government support (Hernandez & Lee, 2020). Unlike most other American youth, many foster youth who transition out of the system (e.g., are emancipated) are forced to become self-sufficient at 18 years of age; many with poor educational attainment as well as a dearth of independent living skills (Hernandez & Lee, 2020). Most require some level of support but over 55% of these youth struggle with one or more serious challenges in their transition to independence, including “homelessness, unemployment, early parenthood, or incarceration” (Hernandez & Lee, 2020, p160). Regarding the latter, higher rates of PI in adolescence were found to be correlated with increased odds of “an adjudicated felony” in adulthood in one study.(Crawford et al., 2018, p.455).

Funding and Administration

The complexity, scope and implications of PI make it a driving factor in CWS. However, Hernandez and Lee (2020) explain that despite a history of significant federal funding, large gaps exists in the availability of support services across the United States. According to these authors, transitioning out of care was originally funded by a 1986

amendment to Title IV-E of the Social Security Act that included the Independent Living Program (ILP; Hernandez & Lee, 2020). The ILP made funding available to prepare youth for independent living at the age of 18 (Hernandez & Lee, 2020). In 1999, Congress found ILP to be ineffective to improve the outcomes of youth transitioning and passed the Foster Care Independence Act (FCIA), which according to Hernandez and Lee, essentially doubled available funding from 70 to 140 million dollars.

While Collins (2019) appreciates the contributions of the FCIA, the researcher also agrees with Hernandez and Lee (2020) regarding the disparate availability of services across the U.S., which Collins believes is due to the insufficiency of funds. Hernandez and Lee point out that another problem has been a history of difficulty with tracking funding at the state level. For instance, state and local-level initiatives targeting permanency vary significantly from state to state with dissemination efforts often failing to account for the disparate availability of resources across the U.S. (Collins, 2019). Moreover, many “eligible youth report not using these services” (Collins, 2019, p. 234). Thus, not only has the number of emancipated youth remained unacceptably high, but sadly, many youth are emancipated without ever having experienced a permanent home (Crawford et al., 2018). The latter is particularly troubling because these youth have likely experienced PI.

Outcomes of Institutional Rearing and PI

In addition to the immediate perils of PI when aging out of the foster care system, it is also important to note that every year there are more than 400,000 children in foster care (AFCARS, 2022), most at risk for PI (Bederian-Gardner et al., 2018; Chateaufneuf et

al., 2022). They mostly come from disadvantaged communities and have experienced inconsistent parenting marked by domestic violence, substance use, neglect, sexual abuse and/or physical abuse (Bederian-Gardner et al., 2018; Gypen et al., 2017). Their entry into the foster care system is marked by the trauma of family dissolution usually followed by internalized guilt for reporting maltreatment (Bederian-Gardner et al., 2018; Cicchetti, 2016; Konijn et al., 2019). This compromises their ability to trust themselves or others; and are thus, already emotionally fragile upon entry into the system (Bederian-Gardner et al., 2018; Cicchetti, 2016; Konijn et al., 2019).

Once in the child welfare system (CWS) they may experience increased supervision and complete isolation from all that they once knew, including their home, their family, pets, friends, teachers, and anything else in the environment that may be significant to them (Bederian-Gardner et al., 2018; Font et al., 2018; Konijn et al., 2019). This places an undue demand on emotionally fragile children to adjust to their new surroundings without much say, eroding their sense of autonomy (Bederian-Gardner et al., 2018; Font et al., 2018; Konijn et al., 2019).

Injuries To Children's Attachment System

According to Humphreys et al. (2017), two attachment disorders, Reactive Attachment Disorder (RAD) and Disinhibited Social Engagement Disorder (DSED), are common outcomes of "institutional rearing" (p. 675). RAD and DSED are thought to arise during a child's developmental years due to compromised early attachments. Among the researchers' key findings was that the number of placement disruptions predicted the presence of attachment disorders in children (Humphreys et al., (2017).

Ultimately, once removed from their family of origin, a child has likely sustained one of the greatest traumas they will ever face with immediate damage evident in their inability to trust or attach (Bederian-Gardner et al., 2018; Cicchetti, 2016; Konijn et al., 2019). The current average is more than three placement disruptions per child in the system but any placement change beyond the initial removal of a child from their home further damages their attachment system and increases the probability that they will suffer from the psychiatric and psychosocial sequela associated with PI (Cicchetti, 2016; Leathers et al., 2019; Vreeland et al., 2020).

Lack Of Foster Parent Support Services, Foster Parent Retention And PI

The compromised emotional state referenced above is often what foster parents initially face in their foster children (Hanlon et al., 2021). Hanlon et al.'s review of factors affecting foster parent retention indicates that the most stressful challenge they face is child-externalizing behaviors. While the researchers did not find a direct correlation between these behaviors and foster parent retention rates, the former is associated with placement disruptions or premature placement terminations by the foster parent, which ultimately contribute to PI (Leathers et al., 2019).

Hanlon et al. (2021) also identified a host of other factors that do affect foster parent retention rates. For instance, the most perpetuating factors affecting retention rates are outcomes of foster parents' relationship with CWS such as lack of support from the agency, agency staff turnover and lack of information of child's emotional needs (Hanlon et al., 2021). Hanlon and colleagues point out that the accumulation of stressors, over and above a child's externalized behavioral problems prevent foster parents from lovingly

connecting to their child, which ultimately increases foster parents' dissatisfaction with the carer role.

Foster Parents' Personal Attributes And PI

Moreover, Hanlon et al. (2021) found that personal attributes “such as flexibility, confidence and motivation” do contribute to foster parent retention (p. 293). Relatedly, McKeough et al. (2017) found that parents with high general stress, parental distress and anxiety reported higher levels of stress from challenging behaviors, time management, lack of control, and lack of support. Thus, current CWS support inadequately accounts for diverse caregiving orientations amongst foster parents, which according to Hanlon and colleagues, contributes to overall foster parent retention problems.

Problem Statement

Notwithstanding current efforts to provide support for foster families in crisis, researchers do agree that timeliness and availability of interventions and support services are needed in order to increase carer role satisfaction (CRS) and to promote placement stability (PStability; Barnett et al., 2018; Barnett et al., 2019; Garcia et al., 2015; Gypen et al., 2017; Hayes et al., 2015; Konijn et al., 2019). Yet, to date there are no known studies that examine telemental health (TMH) utility for its potential to satisfactorily support foster parents in their carer roles with appropriate mental health services.

Research shows that TMH utility has been found comparable in quality to in-person services, convenient, accessible, cost effective and equally satisfying to child and parent (Madigan et al., 2021). Early TMH researchers, Comer and Myers (2016) readily recognized the viability of TMH technology to provide adequate services to the children

and family population. They urged the research community to find applications and to develop guidelines for emerging technologies (Comer & Myers, 2016). However, many years later, contemporary researchers are still documenting a dearth of development, particularly in the area of guidelines for the application of TMH services to the child maltreatment population (Racine et al., 2020).

Despite the relative nascence of TMH utility in foster care settings (Racine et al., 2020), understanding how TMH utility is related to carer role satisfaction (CRS) is essential for the development of an effective TMH praxis that endeavors to support foster parents and protect children from the effects of PI. Research also indicates that personal attributes are implicated in foster parent retention rates (Hanlon et al., 2021; McKeough et al., 2017). Thus, an effective TMH praxis would also support foster parents of diverse caregiving orientations. This research addresses these gaps in TMH utility by focusing on the perspectives of foster parents who have received both in-person as well as TMH services. The results of this study will help policy makers understand when a TMH approach is indicated in a foster care context. To this end, this study's background, purpose, nature, theoretical framework, guiding research questions as well as a comprehensive definitions of terms are provided later in the chapter. In addition, this study's parameters including limitations, significance, assumptions, scope, and delimitations are also subsequently addressed in a similar fashion.

Purpose of the Study

The main purpose of this quantitative, cross-sectional study was to examine the relationship between telemental health satisfaction (TMHsat), carer role satisfaction

(CRS), and placement stability (PStability). A secondary purpose was to examine whether foster parents' mean measures of TMH utility (TMHsat, CRS and PStability) differ among the four caregiving orientations (e.g., optimal, anxious hyperactivation, avoidant deactivation and ambivalent disorganized) as measured by the Caregiving System Scale (CSS).

The main measurement instrument in this study was originally an 8-item, 2-dimensional (e.g., support/connection/availability and consumer satisfaction), TMH utility survey by Tse et al. (2021). To represent a foster care context (vs a general population context), the instrument was amended by: (a) relabeling the 'support/connection/availability' dimension (e.g., survey items 1-3) as 'TMHsat'; (b) relabeling the 'consumer satisfaction' dimension (survey items 4-7) as 'carer role satisfaction (CRS)' and rephrasing these items to reflect a foster care context ; and (c) adding a third dimension (survey items 8-12) by incorporating foster parents' measures of placement stability (PStability).

The purpose of adding a third dimension was to measure the contributions of TMHsat and CRS toward PStability along the positive antipodes of PI. This new dimension followed the same form and style as the original survey items in the Tse et al. (2021). Total changes to the survey resulted in a 12-item, 3-dimensional measure of TMH utility (e.g., TMHsat, CRS and PStability). All changes to the instrument were approved by the authors of Tse et al. (Appendix B).

The caregiver system scale (CSS) was the second instrument. It is a 20-item orthogonal measure of caregiving orientation that yields 4 categories of caregiving

strategies (e.g., optimal, anxious hyperactivation, avoidant deactivation and ambivalent disorganized) and is part of Bowlby's attachment theory (Shaver et al., 2010b).

The predictor variables in the first part of the study were TMHsat and CRS. TMHsat was hypothesized as a measure of satisfaction with TMH utility along the criteria of support, connection, and availability. CRS was hypothesized as a measure of satisfaction with TMH utility along the criteria of comfort with medication and treatment options for the foster child; relevance of treatment in terms of specific goals for the foster child; sensitivity of staff to difficult parenting experiences; and foster parent's quality of parenting experiences. The dependent variable was PStability, which was hypothesized as a measure of TMH satisfaction in this study along the criteria of role support, quality of parenting, stress of parenting, and connection with foster child. These reflect the positive antipodes of PI factors identified in the literature (Chateaufneuf et al., 2022; Konijn et al., 2019).

In the second part of the study, the three dimensions of TMH utility (e.g., TMHsat, CRS and PStability) were the independent variables. The dependent variables were four caregiving orientations (e.g., optimal, anxious hyperactivation, avoidant deactivation and ambivalent disorganized) as measured by the CSS. These were associated with distinct caregiving orientations that varied in levels of emotional adjustment, relational outcomes, life-satisfaction and perceptions of health among caregivers (Reizer & Hetsroni, 2015).

Research Questions and Hypotheses

Research Question 1 (RQ1): Based on subjective ratings by foster parents in America, what is the relationship between measures of TMHsat, CRS and PStability?

Null Hypothesis (H_01): Based on subjective ratings by foster parents in America, there is no relationship between TMHsat, CRS and PStability among foster parents in America.

Alternative Hypothesis (H_11): Based on subjective ratings by foster parents in America, there is a positive correlation across the variables (TMHsat, CRS and PStability) such that higher TMHsat is correlated with higher CRS, and higher CRS is correlated with higher PStability.

Research Question 2 (RQ2): Based on subjective ratings by foster parents in America, is there a difference in foster parents' TMH utility (e.g., TMHsat, CRS and PStability) among the four caregiving orientations (e.g., optimal, anxious hyperactivation, avoidant deactivation and ambivalent disorganized) as measured by the CSS?

Null Hypothesis (H_02): Based on subjective ratings by FPs, there is no difference in TMH utility among CSS categories.

Alternative Hypothesis (H_12): Based on subjective ratings by FPs, there is at least one difference in TMH utility among CSS categories.

Theoretical Foundation

The proposed framework applied to this study was Andersen (1995) Behavioral Model of Health Services Use (BMHSU). Andersen developed the model in the 1960s, which has now gone through four revisions (Anderson, 1995). The purpose of this

framework is to evaluate health systems for their ability to deliver services effectively and to develop a model that provides measures of access to health care (Anderson, 1995). As it pertained to this study, the BMHSU was used to help conceptualize relevant factors in the delivery of TMH services to the foster parent population.

Shaver et al. (2010a) caregiving behavioral system (CBS) was the proposed lens. The CBS is an extension of Bowlby's Attachment Theory; Attachment Theory and CBS provided a lens by which the results of this study can be interpreted. Shaver et al. (2010a) posited that the caregiving system evolved to help and protect loved ones. But in response to failures in caregiving goals (e.g., help and protect the other) the caregiving system is hypothesized to reject normal strategies and engage in non-optimal caregiving strategies (e.g., hyperactivation or deactivation), which are characterized by caregiving dysfunction to varying degrees (Shaver et al., 2010a). In that vein, the caregiving system scale (CSS), measures caregiving strategies (Shaver et al., 2010b) and presented an opportunity to explore any resulting associations between CSS measures and TMH utility that would be added to a TMH user profile.

Nature of the Study

I used a survey in this quantitative, cross-sectional study. I used the cross-sectional aspect to collect multiple data points on the target population at one point in time. I used the SPSS environment to carry out multiple methods of analysis, including multivariate regression to examine the relationship between the two predictor variables (e.g., TMHsat and CRS) and an the outcome variable (PStability); a one-way MANOVA for the comparisons of foster parents' mean measures of TMHsat, CRS and PStability

among the four CSS categories (e.g., optimal, anxious hyperactivation, avoidant deactivation and ambivalent disorganized); and, a confirmatory factor analysis (CFA) on the amended survey to examine factor loading on the intended outcome variables of the survey (TMHsat, CRS and PStability).

Definition of Terms

Carer Role Satisfaction (CRS): The term “carer role” was introduced by McKeough et al. (2017) to describe foster parents’ roles as caregivers (p. 10). The study examined the relationship between “foster carer stress, role specific challenges, placements, organizational support and training, and satisfaction” among foster carers (McKeough et al., 2017, p. 10). The results highlighted the need to improve training and support for the carer role to increase placement stability and reduce carer attrition (McKeough et al., 2017, p. 10). Hanlon et al., (2021) suggested that foster parents are satisfied with their parenting roles when they were able to connect lovingly with their foster children. However, a lack of support from CWS prevents or diminishes the quality of this connection (Hanlon et al., 2021). Thus, the receipt of relevant support services in the care of foster children is a top concern for foster parents and a major contributor to CRS.

Placement Instability (PI): PI is a term given by Fisher et al. (2013) to describe the status of children who are moved from one temporary home to another temporary home. PI is a major concern to child welfare administrations due to the toxic effects it has on children’s development (Chateauneuf et al., 2022).

Placement Stability (PStability): PStability was a term used in literature to describe the positive antipodes of PI (Chateaufneuf et al., 2022; Konijn et al., 2019).

Support/connection/availability (TMHsat): TMHsat was a measures of TMH satisfaction along the criteria of support, connection, and availability among foster parents (Tse et al., 2021).

Telemental Health (TMH): “Telemental health (also called telehealth, teleservices, and telemedicine) includes the use of video-conferencing utilizing “real time” audio and video technology that is administered through a secure and encrypted connection.” (Jones et al., 2014). Using the term ‘telemental health’ vs ‘telehealth’ helps to differentiate mental health services from amongst the many healthcare fields that offer telehealth services. This is particularly useful for the participants in this study, who may correlate the term ‘telehealth’ with other services such as those that are medical in nature.

Assumptions

Several assumptions were necessary to complete this study. Primarily, in this study I assumed that a representation of the foster parent population across the United States was properly achieved in the sample. Albeit convenient, I deemed that using a community partner was appropriate because it would have helped me ensure the respondent’s qualifications for the study. This method was used in conjunction with snowball sampling, which hypothetically also reduced biases by following the recommendations of past participants (Ungvarsky, 2023).

I also made two final assumptions: that a representative portion of foster parents would have used TMH services, and that participants would have understood the

questions asked of them and would have answered them truthfully. To encourage truthful responses, I assured participants that their identities would be protected. Survey Monkey was the main method for data collection. And, neither the instruments nor methods used for this study collect any identifying information nor IP addresses. Respondents were prompted to follow a link where they could consent to participate or decline without consequence. The results of the survey were then sent directly to this researcher's webpage after consent was obtained and the survey has been completed. Results of data analysis were reported at the aggregate level. Safe storage of data is achieved using a 128-bit encrypted hard drive. In compliance with Walden University's requirements, all data will be destroyed by computer deletion after 5 years.

Scope and Delimitations

This quantitative study was a cross-sectional survey design. I examined the foster parent population in the U.S. and their use of telemental health (TMH) as a means of support during the care of foster children. I also explored and evaluated the multivariate relationships between caregiver system strategies (CSS), an extension of Bowlby's Attachment Theory, and TMH utility among the foster parent population.

I targeted a gap in foster parent literature on the use of TMH technology. The effects of PI were well documented and widely studied among foster care populations worldwide (Chateaufneuf et al., 2022). However, a review of the literature revealed that TMH utility had never been studied for its potential to increase carer role satisfaction (CRS) among foster parents nor for its potential to reduce placement instability (PI). Neither had an examination of the correlations between foster parent TMH utility and

CSS been conducted. Therefore, it was the hope of this researcher that the outcome of this study would contribute to the current literature with a special aspirational goal of affecting PI incidence rates and supporting foster parents in their valuable societal roles.

Additionally, the exploratory nature of this study was indicated due to the lack of research on TMH utility among the foster parent population. The theoretical framework was comprised of: (a) Andersen (1995) Behavioral Model of Health Services Use (BMHSU) to help analyze the efficiency of TMH services ; and (b) Shaver et al. (2010a) caregiving behavioral system, which was used as an attachment lens to help analyze foster parent's use of TMH services for predictable patterns.

I conducted a power analysis to determine sample size using Cohen (1988) formula for multivariate regression. I determined that a sample size of 77 was adequate to regress the two predictor variables in RQ1 using an alpha = .05, power = .80, and a medium size effect = .13. For RQ2, I determined that a sample size of 48 – 62 was sufficient for k=4 groups, power = .70, and an alpha = .05 using the recommendations in Warner (2013). Therefore, a sample size of 77 will be adequate to answer both research questions.

I using self-report instruments typically applied in this study's subject matter. The methods of analysis included the use of a multivariate regression, a principal component analysis (PCA), a confirmatory factor analysis (CFA), and a one-way MANOVA. As noted earlier, recruitment occurred solely among the United States foster parent population using a community partner and snowball sampling, which precludes generalization to foster parents beyond the United States

Limitations of the Study

The findings and conclusions of this study may be impacted by the limitations inherent in its design. For instance, this study adopted specific self-report measures for data collection; and data collection only occurred in a manner consistent with the constructs being measured. Therefore, any additional constructs of interest that were not targeted for data collection were not assessed. However, participants were afforded an opportunity to enter comments at the end of the survey.

Additionally, due to the study's quantitative/correlation design, complex descriptive narratives about the study's participants were outside of the study's purview. The development of TMH services is extensive, cuts across many disciplines, and was only marginally relevant to the goals of this study. Therefore, an exhaustive account of these services was also well beyond the scope of this study's literature review. Finally, generalization of findings beyond the United States foster parent population was not possible because foster parents elsewhere were not sampled.

Significance of the Study

PI is toxic to children's brain and physical development with potential lifelong psychiatric sequela and commensurate poor psychosocial functioning (Konijn et al., 2019). It is physically dangerous because it increases children's impulsivity sometimes putting themselves in harm's way (Konijn et al., 2019). PI also increases the risk for disorders of substance use, attachment, and impulse control (Konijn et al., 2019). Finally, PI is associated with poor educational, career and relational outcomes, substance abuse,

premature pregnancy as well as problems with the law (Konijn et al., 2019). Thus, the potential impact of PI on the quality of life of each child merits researchers' attention.

TMH utility also warrants researchers' attention because the science and technology involved have implications for the delivery of mental health services to a vulnerable population, namely children and youths. During the implementation of Covid-19 social distancing policies, TMH became the most viable replacement for the receipt of in-person mental health services because of its efficacy and its ability to adapt and meet diverse mental health needs (Barnett et al., 2019). TMH services have many benefits including accessibility, reduced costs, improved attendance, and reduced treatment times (Racine et al., 2020). TMH has also been used in foster care settings to treat trauma (Racine et al., 2020), where according to Engler et al., (2022) the highest rates of children with mental health disorders exist.

TMH is not likely a unilateral choice for service delivery to children despite its technological advances. Instead, TMH utility is likely to take on any number of mediating and moderating roles (Comer & Myers, 2016, p. 296). Racine et al. (2020) similarly noted that the limitations to TMH services are numerous but nevertheless underscored the urgency to identify evidence-based practices expeditiously. More germane to foster care, Barnett et al. (2021) and Tolou-Shams et al. (2021) noted a similar urgency for the development of a TMH praxis to support children and their families. Thus, there is a clear and urgent need to develop evidenced based practices for TMH utility that are tailored for the foster care population.

As it pertains to the foster care population, TMH utility may be instrumental to researchers interested in the intersection of foster care and PI because of the many proximal and distal risk factors to a child's development (Konijn et al., 2019). Research suggests that supporting the foster parent with relevant services (e.g., trauma informed and psychoeducation) mitigates caregiver role dissatisfaction and adds stability to the placement (Barnett et al., 2018; Barnett et al., 2019; McKeough et al., 2017). Mitigating PI with support delivered via TMH, therefore, seems logical, ethical, and a research-worthy exploration.

Finally, elements of attachment theory were employed in this research design. The use of attachment theory in foster care research is common (Alexander, 2021). However, foster care research using Bowlby's (1982) caregiving systems scale (CSS) could not be found by this writer. The CSS is comprised of two orthogonal measures (e.g., hyperactivation and deactivation) which in turn is subsequently expressed in four categories of caregiving strategies (e.g., optimal, anxious hyperactivation, avoidant deactivation and ambivalent/disorganized; Shaver et al., 2010b). Measures of the relationship between caregiving strategies and TMH utility may offer insight into foster parent selection and is also research-worthy for its potential contributions to the literature on PI.

Summary

PI is a complex phenomenon of serious, direct, and enduring consequences to all children in foster care and to some extent, society at large. A neurological injury sustained or partially sustained while in government care is negligent and arguably

iatrogenic, but ignoring it is surely unconscionable. CWS was originally instituted to protect children but close to four decades of federal funding through programs such as the ILP and the FCIA have been spent in failed attempts to stem the flow of emotionally crippled youth into American society (Hernandez & Lee, 2020). The fact is that year after year more than 21,000 youth are at immediate risk of facing emancipation from institutional care many with neurological injuries (Hernandez & Lee, 2020).

Additionally, many more hundreds of thousands of children in the CWS are at risk for suffering the same injuries, which may predispose them to a life of abject failure marked by a lack of educational attainment, detachment from the labor market, substance abuse, lack of sustainable income, inability to form lasting relationships and problems with the law (Hernandez & Lee, 2020). Therefore, the failures that these youths experience due to the quality of care they receive are also society's failures.

But how can this course be corrected? According to Hanlon et al. (2021), the American foster parent is the linchpin of CWS; and without them, the system will fall apart. Yet, Hanlon and colleagues note that retention efforts are inadequate even while the matter has become a national crisis. They are quick to point out that foster parenting is a difficult and stressful job; and that dwindling numbers in the foster parent population mean more children will experience placement disruptions while in care (Hanlon et al., 2021). Ultimately, Hanlon and colleagues conclude, declining rates of CRS translate to declining foster parent retention rates.

TMH utility is a potential solution to declining rates of CRS among foster parents who care for children with dysregulated behavior. Some of the more salient benefits

associated with TMH utility are immediacy of support, reduced costs associated with mental health services, reduced wait times, better connection to care team and greater availability of services (Madigan et al., 2021). Can TMH utility really increase CRS? TMH utility has never been studied for its potential to increase CRS and reduce the risk for PI. However, TMH services are ubiquitous and commonplace today among the helping professions. Moreover, the delivery of TMH services to the foster care population is also commonplace. What is missing is the research, the development of protocols and the proper mechanisms for disseminating the findings (Comer & Myers, 2016).

Chapter 2: Literature Review

Introduction

According to Hernandez and Lee (2020), each year approximately 21,000 youth turn 18 years old putting them at-risk for aging-out of the foster care system and losing government support. Only 52% of these youth manage to complete high school or attain a GED and just 3% go on to access higher education (Hernandez & Lee, 2020). Many have histories of neglect as well as a history of multiple placements in the foster care system (Hernandez & Lee, 2020). They are characterized as ill-prepared for adulthood, have poor attachment to the workforce, are at risk for homelessness, incarceration, drug involvement, mental health issues and early childrearing (Hernandez & Lee, 2020).

The toxicity of subjecting children to multiple foster care placements in what is termed placement instability (PI) is well established (Chateauneuf et al., 2022). The associated literature is reviewed here to provide background, to establish a theoretical framework and to operationalize constructs related to the current study. Additionally, the literature search method, the rationale for this study's theoretical framework as well as an examination of the constructs of placement instability (PI), carer role satisfaction (CRS) and telemental health (TMH) utilization are provided below.

Literature Search Strategy

I searched for relevant, peer-reviewed articles between the years of 2017 and 2022 primarily through Walden University's online library and other online resources. However, some articles included were older than 5 years due to their import as seminal work or to substantiate a critical element in this study. In general, selected articles related

to the effects of placement instability, non-optimal caregiving, foster parent role dissatisfaction and the utility of telemental health were included here. The keywords searched were: *attachment, caregiving, measure of caregiving, telemental health, telehealth, telemental health satisfaction, user satisfaction, telepsychiatry, access, availability, utilization, mental health utilization, needs, foster care, foster parent, foster parent satisfaction, parenting, parental role, role dissatisfaction, child welfare services, placement instability and placement disruptions* in the databases, which included EBSCOHOST, APA PsycINFO, APA PsycArticles, SAGE Journals, ProQuest Central, SocINDEX, ScienceDirect and Walden Dissertations.

Theoretical Foundation

Andersen (1995) Behavioral Model of Health Services Use

The proposed framework applied to this study was Andersen (1995) Behavioral Model of Health Services Use (BMHSU). The purpose of this framework was to develop a model that provides measures of access to health care (Andersen, 1995). A 2005 revision of the model included both societal and individual determinants of service utilization (Andersen & Newman, 2005). However, this study only focused on the individual determinants of service utilization as they apply to the foster parent population. The individual model conceptualizes that service utilization at the individual level is determined by predisposing, enabling, and need factors (Anderson, 1995).

In this study, TMH utility was hypothesized to be a reliable and valid medium for the delivery of foster parent support services. According to Andersen (1995), an effective TMH service delivery model can be developed by determining what the predisposing,

enabling and need factors are for the foster parent population. Predisposing factors are those that motivate foster parents to use the services including, “demographic, social structural, and attitudinal beliefs”; enabling factors are those that give the individual the “ability to secure services including, income, health care access and sources, health insurance, rural/urban environment, etc.”; and need factors include individual illness level, “perceived or evaluated” (Luo et al., 2022, p. 4).

Caregiving Behavioral System (CBS) and Caregiving Strategies

The proposed lens applied to this study was Shaver et al. (2010a) Caregiving Behavioral System, which is an extension of Bowlby’s Attachment Theory. Attachment Theory and the caregiving behavioral system (CBS) provided a lens by which the results of this study can be interpreted. The authors posited that the caregiving system evolved to help and protect loved ones. When the system works properly, caregiving strategies benefit both the caregiver and the recipient. However, in response to failures in caregiving goals (e.g., help and protect the other) the CBS is hypothesized to reject normal strategies and engage in non-optimal caregiving strategies. The caregiving system scale (CSS) measures caregiving strategies and yields four categories (e.g., optimal, anxious hyperactivation, avoidant deactivation and ambivalent disorganized) that range from effective to dysfunctional caring strategies of varying degrees.

One secondary goal of this study was to explore to what degree do foster parents engage in non-optimal caregiving strategies, and whether these patterns are correlated with TMH utility. For instance, the literature on carer role satisfaction (CRS) indicates that personal attributes are associated with CRS among foster parents; and that CRS is

hypothesized to be key in preventing placement disruptions (Hanlon et al., 2021). Thus, it is likely that personal attributes may partially explain TMH utility among foster parents.

The search for moderating factors such as CSS measures in child TMH utilization was a gap identified by early TMH researchers in Comer and Myers (2016). It was a clarion call that ushered in a new focus of research. Specifically, the researchers noted that the viability of TMH technology had already been established and that researchers should pivot toward developing praxis guidelines (Comers & Myers, 2016). That is, the authors urged the research community to determine when and for what population was TMH utility indicated (Comers & Myers, 2016). In that vein, this study represented an opportunity to explore any resulting associations between CSS measures and TMH utility that could be added to a TMH user profile.

Placement Instability (PI)

Placement instability (PI) is a term that describes when unplanned placements of a foster child do not end with an adoption or reunification with biological parents (Fisher et al., 2013). PI is a major concern for child welfare administrators due to the lifelong risks that it poses to children's psychosocial development (Chateauneuf et al., 2022).

Unplanned placements disrupt children's attachment to their foster families as well as to many other primary figures (such as siblings, friends, teachers and doctors) in their environment during key developmental stages (Vreeland et al., 2020). The cumulative effect of repeated disruptions to a child's attachment system during development leads to permanent neurological damage to a child's memory, ability to learn as well as his or her

ability to self-regulate (Fisher et al., 2013) or to trust authority figures (Griffith et al., 2023).

The Psychiatric Sequela of PI

The psychiatric sequela associated with PI is extensive but more germane to this study are those noted by Fisher et al. (2013) review of the associated neuroscientific literature, which included 59 studies. The study's conclusion provided an important translational perspective of the neurological damage associated with PI, specifically, that PI is associated with:

[...] disrupted development of the brain's prefrontal cortex, which is involved in executive functioning. [...] which] is implicated in elevated risk for ADHD, disruptive behavior disorders, substance abuse, and other forms of disinhibitory psychopathology (Fisher et al., 2013, p. 9).

Child Characteristics And Placement Disruptions

Researchers have studied PI in diverse ways such as examining the influence of settings, child characteristics, parenting styles, measurement instruments and predictive variables. For instance, Font et al. (2018) examined the quality of placements changes (i.e., reason for end of last placement; and, fit of subsequent placement). The authors reviewed the records of 23,760 children in the Texas foster care system categorizing them into "progress moves" or "non-progress moves". Progress moves were distinguished as a "safe setting that is least restrictive (most family like) and most appropriate setting available and in close proximity to the parent's home" whereas non-progress moves "occur when a placement is no longer able or willing to meet a child's needs, or when a

child moves to an environment that is less preferable” (p. 249). The authors sought to identify predictive variables or child characteristics associated with PI.

Font et al. found that child characteristics were key determinants for stability of placement. For instance, children who only had progress moves and children who had no moves shared similar individual and family characteristics (Font et al., 2018). These were children who were younger when they entered foster care, spent less time in care, had less cognitive disabilities, had better mental health, had few behavioral problems, and had caring parents when compared to those with more non-progress moves (Font et al., 2018).

Difficult Parent Experiences And Placement Disruptions

Seeking foster parents’ perspectives, Leathers et al. (2019) explored correlations between foster parent experiences and placements disruptions using the determinants of parenting model. The determinants of parenting model takes into consideration child characteristics and foster parent stress as well as the need for support services to assess for risk of placement disruption. The researchers interviewed 139 foster parents who took care of children ages 8-14 in midwestern state in the U.S. The authors found that difficult parenting experiences predicted placement disruptions (behavior problem $r = .28$; risk to others $r = 0.22$; low support $r = 0.18$; stress $r = 0.19$).

Child And Adolescent Needs And Strengths (CANS) Assessment And PI

Focusing on instrumentation, Vreeland et al. (2020) explored the utility of the Child and Adolescent Needs and Strengths (CANS) assessment to identify risks for placement disruptions. The records of 8,853 children, ages 5 to 19 (mean = 13.1, 44% female) in the Tennessee Department of Children Services were examined, including

demographic and placement information as well as CANS results. The researchers found the CANS could identify the risks of PI and targets for intervention that include, “child internalizing and externalizing symptoms, school difficulties, youth affect dysregulation, and child age” (Vreeland et al., 2020, p.1).

Placement Types and PI

On the other hand, Chateauneuf et al. (2022) focused on placement settings. The authors distinguished between three types of placements (non-relative foster care, NRFC; kinship foster care, KFC; and, foster-to-adopt family, FAF) to differentiate their effect on placement stability. In their study of 361 Canadian children ages <12 (mean = 4.64, female = 49%), the researchers found that, while the NRFC group had “significantly more problems” than the FAF and KFC groups, it also included more boys than girls (NRFC boys = 59 %). In turn, the FAF group faced less placement changes, where younger and female (FAF girls = 62 %; Chateauneuf et al., 2022, p. 1).

Meta-Analysis On Putative PI Risk Factors

Taking a broader view, Konijn et al. (2019) conducted a meta-analysis, including 42 studies (1990-2017) exploring putative risk factors contributing to PI. The researchers found medium size effects for behavioral problems ($r = 0.35$), non-kinship care ($r = 0.31$), and parenting ($r = 0.29$) as well as smaller size effects for age of child ($r = 0.25$), placement with(out) sibling ($r = 0.16$), and history of maltreatment ($r = 0.14$).

Foster Youth Vs Non-Foster Youth And PI

Finally, Bederian-Gardner et al. (2018) examined the connection between instability, mental health problems and attachment in foster youth vs non-foster youth of

low SES. Using a structural equation, the researchers found that instability was associated with posttraumatic stress in foster youth but not in non-foster youth.

Profiles Of Stability Vs Instability

Even though behavioral problems tend to be associated with PI, this body of literature suggests that PI may result from one or a confluence of many factors, some of which include child behavior, child characteristics, history of maltreatment, placement setting, parenting style (Konijn et al., 2019; Leathers et al., 2019), time in foster care (Font et al, 2018), and low support and foster parent stress (Leathers et al., 2019).

In general, the younger the child enters foster care, the greater the placement stability; however, the longer a child's stays in foster care the higher the risk for PI, though many youth do age-out of the CWS with the effects of PI (Bederian-Gardner et al., 2018; Chateauneuf et al., 2022). Younger children and females with no disabilities appear to fare the most stable placements (i.e., kinship or foster-to-adopt families), whereas older children and males with behavioral problems experience the greatest level of PI in non-kinship foster families (Chateauneuf et al., 2022).

Carer Role Satisfaction (CRS) and PI

Foster parents are seen as a critical component in reducing the PI incidence rate (Konijn et al., 2019). The term "carer role" is introduced by McKeough et al. (2017) to describe foster parents' roles as caregivers (p. 10). The study examined the relationship between "foster carer stress, role specific challenges, placements, organizational support and training, and satisfaction" among foster carers (McKeough et al., 2017, p. 10). Therefore, foster parents' satisfaction with their carer roles is hypothesized to be key in

preventing placement disruptions. Unfortunately, the demands of the job are such that the average foster parent lasts under a year (Hanlon et al., 2021). Today there is a nationwide shortage of foster parents which has a profoundly negative impact in the lives of tens-of-thousands of children (Hanlon et al., 2021).

As the literature is reviewed, it is important to note that the nomenclature for the designated primary caretaker may change. In general, where comparisons are made between groups of parents, these distinctions will be made clear, for example, between foster, adoptive, kinship, and foster-to-adopt parents. However, (McKeough et al., 2017) introduced the term foster carer and carer role to specifically reference foster parents and their roles as caregivers.

Carer Role Satisfaction And Foster Parent Retention

Regarding the present body of literature, the construct of carer role satisfaction is complex and does not easily lend itself to formulaic equations. For instance, Hanlon et al. (2021) conducted a review of studies between 1989 and 2018 that identified factors affecting retention of foster parents. Hanlon and colleagues found that foster parent satisfaction was related to retention, particularly when they were not able to experience loving interactions with their child. However, the authors note two salient points: (a) that the average foster parent only served 8-14 months; and (b) that foster parents' relationship with the child welfare system was the most cited problem in retention, followed by material resources (or finances), personal attributes such as "flexibility, confidence and motivation", training, and peer support (p. 2903).

Hanlon et al. (2021) concluded that: job satisfaction for the average foster parent is difficult to achieve given the overwhelming demands, both material and emotional; PI that resulted from foster parent turnover was very burdensome to the child welfare system (CWS); and, that contrary to other findings, child characteristics or behaviors were not significantly connected to foster parent retention.

Parenting Stress

Despite these findings, child externalizing behaviors and those that increase the risk to others are very stressful (Konijn et al., 2019; Leathers et al., 2019; Vreeland et al., 2020). Foster parents managing these externalizing behaviors often find themselves dissatisfied with their carer roles (McKeough et al., 2017). For instance, in a two-part study McKeough et al. (2017) examined stress associated with parenting roles.

In study A, McKeough and colleagues sought to measure role-specific stress among 87 foster parents in Australia attending a national carer conference. The participants who had a mean age of 47.5 years (SD = 9.9) and a mean of 4.7 (SD = 4.3) years as foster parents were administered a survey and the Depression Anxiety Stress Scales (DASS). Results were significantly skewed with most foster parents (60%) having reported normal levels of stress as indicated by DASS stress scores (i.e., 0-7), 28% of foster parents reported mild to moderate DASS stress levels (i.e., 8-12) and 13% reported severe to extreme DASS stress levels (i.e., 13-21). To understand which parenting roles were the most stressful, carer role-specific challenges were ranked according to stress levels (0-4) with higher number indicating more stress: allegations of misconduct (mean

= 3.6, SD = 1.5), challenging behaviors (mean = 3.4, SD = 1.1), sexualized behaviors (mean = 3.0, SD = 1.4).

In study B, McKeough and colleagues again examined general stress and stress from role-specific difficulties as well as psychological wellness in a sample of 46 fulltime foster parents with a mean of 9.2 years of service (SD = 5.4) and a mean of 50.1 years of age (SD = 9.4). This time, comparisons were made between foster parents with general foster children (GFC) and children with high CAT (Children's Assessment Tool) scores (4-6), which designated children with high behavioral, health and developmental needs as well as high trauma comorbidities.

Results indicated that foster parents with high CAT scoring children reported significantly more dissatisfaction with the parent-child relationship than GFC foster parents. Moreover, there were significant correlations between dissatisfaction with parent-child relationship and misbehaviors ($r = 0.45$) as well as with a perceived lack of control on behalf of the foster parent ($r = .38$). Parents with high general stress, parental distress and anxiety also reported higher levels of stress from challenging behaviors ($r = 0.32$), time management ($r = 0.29$), lack of control ($r = 0.47$), and lack of support ($r = 0.30$).

Trauma-Informed Parent Training and Foster Parent Satisfaction

Given that the management of externalizing behaviors was associated with the most stressful part of parenting (McKeough et al., 2017), and that foster parent role satisfaction is a critical factor in the reduction of the PI incidence rate (Hanlon et al., 2021), researchers have also explored the role of foster parent training that targets child

behavior. For instance, Barnett et al. (2019) examined whether trauma-informed child welfare services (TI-CWS) and trauma-informed mental health services (TI-MHS) moderated the relationship between children's behavioral health needs and satisfaction and commitment (SFC) in foster and adoptive parents. The researchers conducted a federally-funded, state-wide survey of foster and adoptive parents with 512 respondents. The name of the state was withheld to protect confidentiality, and the motive was also not articulated.

However, the results demonstrated that TI-MHS moderated foster parents SFC ratings (but not for adoptive parents) such that as TI-MHS ratings increased, the associations between child behavioral health needs and SFC ratings diminished to non-significant status. TI-CWS did not moderate the relationship for either group. Managing behavioral health needs was rated as the greatest role challenge to either group. Significant and inverse relationships were found in the: foster parent group between education and SFC ratings such that the greater the education of the foster parent the lower their SFC ratings; and the adoptive group between income and SFC ratings such that the greater the reported income the lower their SFC ratings.

Foster Parents as a Distinct Group

The above study is notable in several ways. First, the researchers found that their proposed solution to carer satisfaction (i.e., trauma informed services) is not uniformly valued across parent groups (foster and adoptive parents). Second, the adoptive parent group's SFC ratings were not mediated by either service, indicating that neither service (TI-MHS nor TI-CWS) is related to adoptive parents' satisfaction or commitment to their

children. Therefore, it is likely that foster and adoptive parents are two distinct groups, each with unique needs (Barnett et al., 2019). This is an important distinction that is relevant for the current study since it focuses solely on foster parents. It also indicates that foster parents really value the extra training. This may bode well for this study since it seeks to support foster parents in managing child behavioral problems.

Measures of Carer Role Satisfaction (CRS)

The carer satisfaction literature substantiates both the effect of child externalizing behaviors on carer role satisfaction (CRS; McKeough et al., 2017) and the relevance of CRS in the reduction of PI (Hanlon et al., 2021) such that increasing CRS will hypothetically decrease PI. However, measures of carer satisfaction in the literature reviewed were informed by diverse factors, which if not controlled in the current study may dilute measures of satisfaction with TMH utility. For instance, among the most cited factors in the literature are problems with the CWS, inadequate material resources (or finances), personal attributes, lack of training, and peer support (Hanlon et al., 2021).

However, it was noteworthy that in Barnett et al. (2019) foster parents' dissatisfaction with CWS did not seem to eclipse their positive valuation of the mental health services they received. A similar mediating effect of TMH utility on foster parent satisfaction is sought after in the current study. For instance, although the type of service mediated through TMH is not controlled for in this study, attitudes about treatment/medication as well as the foster child's mental health needs are measured. Thus, the relevancy of the interventions and their effect on levels of satisfaction will be measured indirectly via the survey. Specificity for measures of satisfaction with TMH

utility will be achieved using a survey designed by Tse et al. (2021) that directly compares the receipt of in-person services with the receipt of TMH services. This design will limit the influence of extraneous factors that may dilute findings of satisfaction, specifically with the TMH services they received.

Telemental Health (TMH)

TMH is the delivery of mental health or psychological services via technological means such as “video conferencing, telephone or texting” (Madigan et al., 2021, p. 6). The delivery of mental health services (MHS) through technology has a long history. As far back as 1973, interactive television was used as a means for psychiatric consultation in what was termed “telepsychiatry”; and from the years 2000 to 2014 hundreds of scientific articles were published referencing some form of telehealth (Comer & Myers, 2016). Since the inception of COVID-19 pandemic social distancing policies, there has been a rapid expansion of telehealth services into many major health disciplines (Bearss et al., 2018) including mental health, such that today evidenced-based interventions are routinely delivered “via smartphone, tablet or laptop” (Tolou-Shams et al., 2021 p. 4).

TMH and PI

An exhaustive account of the development of TMH services is well beyond the scope of this literature review. What is relevant about TMH in the current study is that TMH potentially offers foster parents an effective means to receive MHS and support for children with behavioral problems. Because of the associations between child externalized behaviors and low CRS (McKeough et al., 2017), and between low CRS and placement instability (PI; Hanlon et al., 2021), finding a way to support foster parents in

their carer roles is essential in mitigating the PI incidence rate. The psychiatric sequela notwithstanding (Fisher et al., 2013), foster parents' dissatisfaction is also associated with declining retention rates for foster parents, which also contributes to PI (Hanlon et al., 2021).

Once a child has been moved to a non-permanent home, PI dynamics begin and are reinforced with multiple moves as in Reactive Attachment Disorder (RAD) and Disinhibited Social Engagement Disorder (DSED; American Psychiatric Association, 2013; Humphreys et al., 2017). That is, a typical course is evidenced with children becoming more behaviorally-difficult to handle with each move (Humphreys et al., 2017). The underlying neurological damage to the child's executive functioning (EF) and attachment system (Fisher et al., 2013) impedes children from developing trust in caregivers and from exhibiting adequate impulse control (Fisher et al., 2013).

Since neurological damage is not readily observable, a child's externalizing behavior is likely to disturb a foster parent. According to Baumgart (2020), parents of children who suffer from RAD or DSED often experience chronic stress, sleep deprivation, confusion, feelings of being overwhelmed, poor physical and mental health. The literature indicates that without support foster parents in similar situations may ultimately become dissatisfied with their carer role, and either terminate placement or quit their jobs as a foster parents (Hanlon et al., 2021; McKeough et al., 2017). When a placement is terminated, foster children are moved to new ones but unless stability is achieved, they will likely age-out of the foster care system with a poor outlook for life (Wilson Spigner, 2021).

The hypothesized role of TMH in this scenario is to be a means for effective, accessible, and prompt support to a caregiver who is tasked with the difficult job of providing a safe and stable placement to a dysregulated child (Bearss et al., 2018). Appropriate TMH services would be particularly welcomed by foster parents, who in turn, may feel more secure and satisfied with the greater accessibility and immediacy of support of TMH over conventional (in-person) services (Madigan et al., 2021).

TMH Utility

Comer and Myers (2016) warned that the actual practice of child telemental health had outpaced research and development of guidelines that inform evidenced-based practices. The authors noted that the viability of delivering TMH services to children and families was no longer in question and urged researchers to focus instead on when these services are indicated and for what populations. The early TMH researchers shared their vision of the future of child TMH services, however, cautioning against comparing TMH with in-person response rates for an overall best format, noting that each format may, in fact, target different populations.

Many years later, the paucity of children and family TMH utility literature continues. Nonetheless, articles included in this review (from 2017 to 2022) are comprised of a two trial runs of children and family TMH services, one trial of TMH services to a community clinic, three commentaries, and one umbrella review, which is not specific to child and family TMH but useful nonetheless for baseline comparisons.

Live Parent Training Through TMH Utility

In the first trial, Bearss et al. (2018) used TMH to deliver a live, therapist-led, Parent Training (PT) program, designed by Research Unit on Behavioral Interventions (RUBI) to 14 parents of disruptive children with Autism Spectrum Disorder (ASD) ages 3-8. Results indicated: “13 of 14 (92.9 %) completed, 91.6 % of sessions attended, with 98% fidelity to treatment, measurements at 24 weeks indicated that 11 of 14 children (78.6) were rated much/very improved” (p. 1020). Parents expressed feeling comfortable with the technology, rated TMH utility as acceptable and would recommend it to others.

TMH and Attendance

The second trial was conducted by Tolou-Shams et al. (2021) who detailed a rapid roll-out of TMH services in response to COVID-19 social distancing policies at one urban safety-net hospital’s psychiatric clinic. The authors cited the inadequacy of the published guidelines in response to COVID-19 conditions by the American Academy of Child and Adolescent Psychiatry (AACAP) as a motivation for their study. The authors argued that the pandemic had firmly established the need for emergency psychiatric practices to include TMH service availability. Tolou-Shams et al. administered a follow-up survey to providers to measure perceptions of quality-of-service provision and utilization for the purposes of informing recommendations for the emergency implementation of TMH services.

The clinic served approximately 3000 publicly and uninsured children and families through conventional in-person services. As a historically underserved community with respect to social services, these marginalized populations were

additionally and severely affected by the pandemic in terms of mortality and loss of services. However, the authors note that the no-show rates for TMH utility (e.g., telephone sessions were 23 %, and 14 % for video) were lower than the historical 30%-60% rates for in-person services, which firmly substantiated the need of TMH availability.

Satisfaction With TMH Utility

The final trial was conducted by Tse et al. (2021) whose study of a rapid roll-out of TMH services into a community behavioral health agency featured the results of a patient TMH-user satisfaction survey (also used in the current study). The authors argued that the study was needed in light of an increased risk to people with serious mental illness (SMI) during COVID-19 due to a “combination of comorbid conditions and adverse social determinants of health (e.g., housing instability, economic hardship, and social isolation”); Tse et al., 2021, p. 654).

Survey invitees were diverse and included an age range of 5-93; 233 out of 6,546 were minors; invitees were mostly Black (60%), Hispanic (22%); White (3%); and Asian (1%). Invitees were also stratified by social services and mental health programs offered to patients of this agency. Finally, most participants had a history of serious mental illness (i.e., psychotic disorders, 39%, mood disorders 41%). Survey respondents totaled 1482 (22.6%) across treatment, outreach, and housing programs. Results showed that >80% reported that they could connect, receive support, and make appointments as well or better than before. Most (80%) expressed interest in continuing via TMH but most of those (83%) preferred a mixture of TMH and in-person services.

COVID-19 and TMH

The COVID-19 pandemic was a watershed moment for TMH. Due to the enacted social distancing policies and effects of social isolation, there was an exponential demand for virtual appointments in many health-related fields, particularly in mental health (Barnett et al., 2021). To capture the state of TMH utility, Barnett et al. (2021) conducted a rapid umbrella review that included 19 systematic reviews on various issues (i.e., clinical effectiveness, implementation, acceptability, cost effectiveness, and guidance). The authors found significant underdevelopment of TMH services in certain catchment areas (the child and youth population), and some reviews to be of low quality. However, they also found significant evidence that TMH is a viable means of service delivery.

Scholars' Views On TMH Utility

There are many scholars who believe similarly about TMH utility despite having significant concerns about it. Grieco-Page et al. (2021) has concerns about those left behind in the digital divide such as immigrants, low-income families and those who struggle with digital literacy. These are populations that are already marginalized but will be further excluded from the potential gains of the technology (Grieco-Page, 2021). Racine et al. (2021) celebrates the gains made by TMH technologies but has significant concerns about treating children with trauma via TMH; noting that it is not the optimal setting to detect issues with emotion and attention regulation in children; or that sessions at home may create privacy issues for children; or that children at home may be forced to spend more time with perpetrators due to COVID restrictions. Madigan et al. (2021) are even more cautious, noting that the fragility of some patients such as psychotic or

suicidal patients contra-indicates TMH services. Contraindications notwithstanding, scholars agree TMH technology is a viable means to continue delivering mental health services as it was during the pandemic (Grieco-Page et al., 2021; Racine et al., 2021; Madigan et al., 2021)

Summary

The PI phenomenon is a deleterious neuropsychological event (Fisher et al., 2013) that threatens every foster child's pursuit of happiness (Wilson-Spigner, 2021).

Disruptions to the attachment system begin when foster children are moved from one non-permanent placement to another (Fisher et al., 2013). Forming trusting relationships for these children becomes increasingly difficult with each new home (Bederian-Gardner et al., 2018).

Placement disruptions take a toll on children's executive functioning (EF), which will likely predispose them to disinhibited behavior and a lifetime of poor decision making (Fisher et al., 2013). As a result, children who are moved to new non-permanent placements are likely to manifest behavioral disturbances and may pose risks to themselves and to others, which foster parents commonly identify as being the most stressful aspects of parenting (Barnett et al., 2019; McKeough et al., 2017).

The stress associated with parenting a behaviorally-dysregulated child takes a toll on the foster parent (McKeough et al., 2017). Foster parents often find themselves anxious, overwhelmed and dissatisfied with their job (McKeough et al., 2017). Their psychological wellbeing is significantly impacted in negative ways by their perceived lack of control (Hanlon et al., 2021; McKeough et al., 2017). Parenting in the foster care

system is additionally stressful due to problems with CWS such as lack of support and training among other factors (Hanlon et al., 2021; McKeough et al., 2017). The carer satisfaction literature indicates that diverse factors related to the job are significant stressors and that satisfaction is indeed associated with retention (Hanlon et al., 2021). The average foster parent only serves 8 – 14 months, therefore, retention problems are burdensome to CWS and a major contributor to PI (Hanlon et al., 2021).

Taken as a whole, PI is a phenomenon that arises out of the difficult task of taking care of maltreated children. Those on the front lines (foster parents) have significant concerns about the CWS but more than anything, they need help providing a stable home for these children (Barnett et al., 2019; Hanlon et al., 2021; McKeough et al., 2017). They look forward to “loving interactions” with their child but they often feel helpless and confused by their child’s dysregulated behaviors (Hanlon et al., 2021, p.). TMH has the capability to be a readily available source of effective support to these parents (Barnett et al., 2021; Bearss et al., 2018; Tolou-Shams et al., 2021; Tse et al., 2021).

However, as Comers and Myers (2016) noted, TMH utility has outpaced research and development of guidelines. Moreover, the TMH literature reviewed indicated that technology is well past its nascent stages and currently in use in diverse capacities. Therefore, the next logical step is to determine when and with what population is TMH utility indicated (Comer & Myers, 2016).

The purpose of this study is, therefore, to examine the role of TMH utility in providing foster parents effective, readily-accessible support; and, whether that utility has an impact on carer role satisfaction (CRS) and on placement stability (PStability). A

secondary goal of this study is to determine whether caregiving system strategies (Shaver et al., 2010b) have some moderating effect on TMH utility.

Chapter 3: Research Method

Introduction

The main purpose of this quantitative, cross-sectional study was to examine the relationship between foster parents' measures of telemental health satisfaction (TMHsat), carer role satisfaction (CRS) and placement stability (PStability). A secondary purpose was to examine whether foster parents' mean measures of TMHsat, CRS and PStability differ among the four caregiving orientations (e.g., optimal, anxious hyperactivation, avoidant deactivation and ambivalent disorganized) as measured by the Caregiving System Scale (CSS: Shaver et al., 2010b).

The methodology for the study was outlined in this chapter in detailed fashion to facilitate the reader's understanding of the procedures and justifications for the study. This section includes descriptions of the selected population, the sampling technique used as well as the recruitment procedures; followed by the instrumentation, data collection, analysis, threats to validity as well as any ethical concerns related to the study.

Research Design and Rationale

The proposed quantitative approach was a cross-sectional survey design in alignment with the research questions and with the exploratory nature of this study. In this vein, the use of a survey instrument for data-collection was appropriate given the dearth of literature on the subject. The cross-sectional design allowed for the observation and gathering of the multiple desired data points providing a snapshot view of the foster parent population at one point in time (e.g., 2023). The data analysis for this study required several methods. For instance, a multivariate regression was used to examine the

relationship between the two predictor variables (e.g., TMHsat and CRS) and an outcome variable (PStability). A one-way MANOVA was indicated for the comparisons of foster parents' mean measures of TMHsat, CRS and PStability among the four CSS categories (e.g., optimal, anxious hyperactivation, avoidant deactivation and ambivalent disorganized). And a confirmatory factor analysis (CFA) was conducted on the amended survey to examine factor loading on the latent variables (TMHsat, CRS and PStability). Finally, a theory was used as a foundational lens to help interpret the results of the analysis.

Methodology

Population

This study was targeted at the United States (US) foster parent population (e.g., in relative and non-relative homes settings) in the US who had used both in-person mental health services as well as TMH services in the care of their foster children. The size of this population for 2023 was $n = 227,454$ (AFCARS, 31, 2025). However, this population is in a national retention crisis since the average foster parent serves just 8-14 months due to low CRS (Hanlon et al., 2021). Thus, the size of the population is in question from year to year.

Foster parents were the subject of study because the literature reviewed in Chapter 2 indicated that foster parents contributed to PI in two main ways: through declining retention rates (Hanlon et al., 2021), which limits how many children are placed; and because of low CRS (Hanlon et al., 2021) among foster parents, which leads to premature placement terminations (Leathers et al., 2019). The gap in the literature indicated that no

studies had been conducted where the role of TMH is evaluated for its ability to increase CRS among foster parents who care for children and to increase PStability as perceived by the foster parent.

Sampling and Sampling Procedures

The sampling technique proposed was snowball sampling (a convenience sampling method). Snowball sampling allows for the recruitment of research participants through referrals of past participants (Ungvarsky, 2017). It is particularly useful when identifying potential respondents from the population is difficult (Ungvarsky, 2017). One drawback of snowball sampling is that it may limit generalizability (Ungvarsky, 2017). However, it is appropriate for this study because the use of TMH in the foster parent population may not be uniform across the child welfare system (CWS). Exclusionary criteria applied to all foster parents who: had not worked in the United States CWS in the last six years; and had not received TMH services in the care of their foster child.

I conducted a power analysis to determine sample size using the Cohen (1988) formula for multivariate regression. I determined that a sample size of 77 was adequate to regress the two predictor variables in RQ1 using an alpha = .05, power = .80, and a medium size effect = .13. For RQ2, I determined that a sample size of 48 – 62 was adequate for k=4 groups, power = .70, and an alpha = .05 using Warner (2013) recommendations. Therefore, I determined that a sample size of 77 was adequate to answer both research questions.

Procedures for Recruitment, Participation, and Data Collection

Participants were recruited via known community partners who provided support to families in the foster care system. The community partners forwarded the survey link to foster parents interested in participating in the survey. Some participants, in turn, forwarded the invitation to other known foster parents. In addition, I posted notices on social media platforms and other online portals to recruit respondents who met the requirements for this study. The community partners asked respondents to support the study by forwarding the survey invitation or online link to other potential respondents who met the selection criteria. The survey was accessible through social media portal links to Survey Monkey. Survey Monkey was the main mechanism for data collection, which I estimated to occur between April 2024 to April 2025. The survey was anonymous, collected no personal data, and the respondents were free to stop participating any time without any consequence.

Research participants received informed consent forms (See Appendix B) detailing the voluntary nature of the study as well as their rights as participants. The informed consent detailed inclusion criteria, a description of the questions that were asked, the estimated time to completion as well as a description of the study's purpose. Finally, the informed consent detailed both the potential benefits of the study as well as the potential risks to participants.

Instrumentation and Operationalization of Constructs

TMH survey

The main instrument used was a survey specifically designed by Tse et al. (2021) to measure satisfaction with TMH utility vs in-person services along two dimensions: (1) support/connection/availability of treatment team; and (2) consumer satisfaction. Tse and colleagues reported first using the survey in 2018 and again in 2020 as part of an organizational effort to track patient experiences. The survey asked participants to make mental comparisons between two modes of receipt of mental health services (e.g., in-person vs TMH) and then rate how much TMH service is better or worse for each statement (e.g., “Using TMH I can get support when I need it”) using a 5-point Likert-type scale (1- A lot less, 2- A little less, 3- The same, 4- A little more and 5- A lot more; Tse et al., 2021, p. 656).

The first dimension (e.g., support/connection/availability) of the TMH utility survey measured a participant’s perception of being supported by the treatment team, of being connected to the treatment team, and of the availability of the treatment team using items 1-3 (Tse et al., 2021). The second dimension (consumer satisfaction) of the TMH utility survey measured a participant’s satisfaction with the receipt of TMH services with items 4-7; the participant was asked to compare levels of comfort, relevancy of interventions, the sensitivity of treatment team, and whether their lives are subjectively improving with the receipt of mental health services before and after the availability of TMH services (Tse et al., 2021). The 8th and final item was rated by a staff member, who asks the participants for levels of distress before and after the pandemic (Tse et al., 2021).

However, to better reflect the goals and context (foster care) of this study design, several changes to the Tse et al.'s TMH survey were made with the authors' expressed permission (Appendix B). The changes are detailed below, which include relabeling the 'support/connection/availability' as 'TMHsat' and 'consumer satisfaction domain' as carer role satisfaction (CRS) and customizing the phrasing on 5 of the survey items to better reflect a foster care context.

And finally, a third dimension of TMH utility (i.e., PStability) was added with the aid of four additional survey items. The total proposed structural and verbiage changes to the TMH survey will result in a 12-item, three-dimensional survey measure of TMH utility in foster care settings that includes foster parent ratings for: TMHsat (items 1-3), CRS (items 4-7) and PStability (items 8-12).

As noted above, the structural changes to the survey include the addition of four new items (e.g., item 9 – “I feel supported for my role as a foster parent”; item 10 - “The quality of my parenting improves”; item 11 – “The task of foster parenting improves”; and item 12 - “I feel connected to my foster child”). Items 9-12 are measuring placement stability (PStability) along the positive antipodes for known PI risk factors. For instance, Konijn et al. (2019) found that behavioral problems and quality of parenting were correlated with PI ($r = 0.35, 0.29$, respectively). Additionally, Leathers et al. (2019) found that behavioral problems, low foster parent support, and parenting stress were also associated with PI ($Bs = 0.28, 0.18, 0.19$, respectively). Understanding how these factors affect TMH utilization was essential to the nature of this study, which explored TMH

utility in foster care settings for its potential to: support caregivers, lower carer role dissatisfaction and ultimately mitigate placement instability.

In item 9, participants were asked to compare levels of foster parent support with ‘in-person’ services vs with TMH services. In item 10, participants were asked to compare their ability to parent with ‘in-person’ services vs with TMH services. In item 11, participants were asked about their parenting stress with ‘in-person’ services vs with TMH services. In item 12, participants were asked to compare their connection with their foster child with ‘in-person’ services vs with TMH services. The additional four items were meant to provide direct measures of placement stability as a function of TMH utility. Finally, the additional four items followed the same form, style and scoring structure of the original survey, a 5-point Likert-type scale (1- A lot less, 2- A little less, 3- The same, 4- A little more and 5- A lot more; Tse et al., 2021, p. 656).

To complete customization of the survey for foster care settings, the following 5 changes in verbiage were made:

Item-1 (“I am connected to my care team”; Tse et al., 2021, p. 656) changed to, “I am connected to my foster child’s care team”.

Item-5 (“Staff talk to me about specific goals for my health”; Tse et al., 2021, p. 656) changed to, “Staff talk to me about specific goals for my foster child’s mental health”.

Item-6 (“Staff are sensitive to my traumatic or difficult experiences”; Tse et al., 2021, p. 656) changed to, “Staff are sensitive to my traumatic difficult parenting experiences”.

Item-7, “The quality of my life is improving”; Tse et al., 2021, p. 656) be changed to, “The quality of my relationship with my foster child is improving”.

Item-8 (“Staff, please assess the degree to which your client is experiencing distress because of the pandemic”; Tse et al., 2021, p. 656) changed to a self-rated item with wording to reflect, “I can manage my foster child’s behavior”.

Caregiving System Scale

The Caregiving System Scale (CSS) was the second measurement instrument for data collection included in the survey. It is a 20-item instrument that measures non-optimal caregiving strategies using a 7-point Likert scale (Shaver et al., 2010b). It is a valid and reliable measure of caregiving functioning, developed, tested, and revised in multiple studies (George & Solomon, 2008; Reizer & Mikulincer, 2007; Shaver et al., 2010a). The CSS yields two orthogonal measures (e.g., hyperactivation and deactivation) that determine participants’ non-optimal caregiving strategies according to four categories (e.g., optimal, anxious hyperactivation, avoidant deactivation and ambivalent disorganized). The CSS is free to use in educational settings (Appendix B).

Finally, important contextual information is gleaned from demographic data. Finding for instance, whether foster parent training or length of service was associated with higher levels of foster parent satisfaction, or whether personal attributes (e.g., CSS measures) are associated with age, relational status or level of education would be valuable additions to the literature. Therefore, important data points collected included length of service as a foster parent, foster parent training, foster parent age and gender as well as more generic demographic data points such as level of education, household income and marital status.

Additional and important data points collected were length of foster child placement, age, and gender of foster child. Categorical variables were coded in the following manner: foster parent and child genders were measured at four levels: 1 = cis male, 2 = cis female, 3 = trans male, 4 = trans female and 5 = prefer not to answer; foster parent relational status was measured at five levels: 1 = single, 2 = married, 3 = divorced, 4 = separated, 5 = widowed; foster parent training was measured at three levels: 1 = parenting, 2 = trauma-informed parenting, 3 = other and 4 = no training; and level of behavioral problems was measured at four levels: 1 = none, 2 = mild, 3 = moderate, 4 = severe. A comment box was also provided for foster parents to include details about the child's behavior. The combined instruments for this study took about 12 minutes to complete.

Data Analysis Plan

This study leveraged the SPSS computing environment for data analysis. This computing environment allowed for the estimation of a factor analysis, multivariate regression and a MANOVA research design that was critical to evaluating the two key research questions of this project:

Research Question 1 (RQ1): Based on subjective ratings by foster parents in America, what is the relationship between measures of TMHsat, CRS and PStability?

Null Hypothesis (H_0): Based on subjective ratings by foster parents in America, there is no relationship between TMHsat, CRS and PStability among foster parents in America.

Alternative Hypothesis (H_11): Based on subjective ratings by foster parents in America, there is a positive correlation across the variables (TMHsat, CRS and PStability) such that higher TMHsat is correlated with higher CRS, and higher CRS is correlated with higher PStability.

Research Question 2 (RQ2): Based on subjective ratings by foster parents in America, is there a difference in foster parents' TMH utility (e.g., TMHsat, CRS and PStability) among the four caregiving orientations (e.g., optimal, anxious hyperactivation, avoidant deactivation and ambivalent disorganized) as measured by the CSS?

Null Hypothesis (H_02): Based on subjective ratings by FPs, there is no difference in TMH utility among CSS categories.

Alternative Hypothesis (H_12): Based on subjective ratings by FPs, there is at least one difference in TMH utility among CSS categories.

As noted above, multivariate regression was used to test the relationship between the independent and dependent variables identified in RQ1. This approach allowed for the estimation of the relationship between TMHsat, CRS and PStability for foster parents after accounting for potential confounding variables such as gender or marital status of the foster parent that may influence the outcome variables. By including these potentially confounding covariates this design isolated the relationship between the key independent variables and outcome variables of interest. The rationale for the inclusion of these potentially confounding covariates in this correlational analysis was to account for alternative predictors and thus isolate the true amount of variation of the dependent variable accounted for by the main explanatory variable of interest.

For RQ2, an examination of potential differences in mean measures of TMH utility (TMHsat, CRS, and PStability) of foster parents among the four caregiving orientations (e.g., optimal, anxious hyperactivation, avoidant deactivation and ambivalent disorganized) required a one-way multivariate analysis of variance (MANOVA). According to (Warner, 2013), a one-way MANOVA compares “mean scores on multiple quantitative outcome variables for participants with membership across two or more groups” (p. 778).

This type of analysis accounts for intercorrelations among the outcome variables in its summary of group differences (Warner, 2013). Therefore, a MANOVA was appropriate for RQ2 because measures of TMH utility (TMHsat, CRS, and PStability) were expected to have some intercorrelation because they all included some measure of TMH satisfaction. For instance, TMHsat is a measure of TMH satisfaction along criteria of support, connection and availability. CRS is a measure of satisfaction with TMH utility along the criteria of comfort with medication and treatment options for the foster child; relevance of treatment in terms of specific goals for the foster child; sensitivity of staff to difficult parenting experiences; and foster parent’s quality of parenting experiences; and, PStability is a measure of TMH satisfaction in this study along the criteria of role support, quality of parenting, stress of parenting, and connection with foster child.

Finally, one of the contributions of this study was to test a new measure of telehealth satisfaction that expanded the measure traditionally used in the literature developed by Tse et al. (2021) by including four additional questions (survey items) to

this measure. The inclusion of these items was evaluated using confirmatory factor analysis (CFA) to assess the validity or contribution of each of the amended items as well as the four new items to the desired latent variables (e.g., TMHsat, CRS and PStability). The CFA was intended to explain how much of the proportional variance would be explained in a model that included the new questions vs one that did not. In addition, the CFA was intended to measure some facet of telehealth satisfaction that improved the explanation of the variance in the underlying data used to measure these latent concepts.

Data cleaning was performed in SPSS to evaluate the relationship between the explanatory variables of interest and the outcome variables. The main predictor variables TMHsat, CRS and PStability were measured using a revised 12-item survey modified from Tse et al. (2021), and group membership in the 4 caregiving orientations will be measured using the standard Caregiving System Scale (CSS) 20-item question battery from Shaver et al. (2010b). The battery for telehealth utility was coded on a 5-point Likert scale from: 1-a lot less, 2- a little less, 3- the same, 4- a little more, and 5- a lot more; this will be reflected in the data cleaning process of this study. By contrast, the second battery measuring caregiving orientation using the CSS scale was coded and cleaned on a 7-point scale.

Demographic variables collected, such as the gender of the foster parent, were cleaned using the discrete coding technique noted above. The variables were included as multivariate factor control variables in the regression models to account for potential non-linear relationships between the demographic variables and the outcome variables. This

approach allows the design to measure any statistically significant effect, for example, that gender may have on CRS or PStability.

Results were interpreted using standard ordinary least squares (OLS) regression coefficient point estimates articulating how a one-unit change in the independent variable correlates with a change in the dependent variable, standard errors conveying uncertainty around these parameter events, confidence intervals conveying the substantive magnitude of the uncertainty around the point-estimated, and p-values for continuous interpretation of statistical significance. These results were also interpreted in the form of graphical figures, with the linear prediction of the dependent variable on the y-axis of the figure and observed values of the independent variable on the x-axis.

Threats to Validity

The validity of a study allows a researcher to deduce meaningful inferences from its findings (Creswell & Creswell, 2017). However, there are potential threats to a study's validity that may undermine the significance of the findings. According to Creswell and Creswell (2017) the types of validity that may come under threat in this study are internal validity, external validity, and construct validity.

Research procedures are the main source of threats to internal validity. Improper procedures diminish a researcher's ability to arrive at valid conclusions from the study's findings (Creswell & Creswell, 2017). Thus, the following key areas were examined for possible sources of errors:

1. Instruments – The main instrument used in this study was a survey adopted from a previous similar study in telemental health utility (Tse et al., 2021). The authors

designed the survey specifically for keeping track of clients' experiences using telehealth at their outpatient community mental health clinic. The authors used the instrument in 2018 and again in 2020 across program types, publishing the results in their study (Tse et al, 2021). Thus, it had been found to have consistently reliable results. The appropriateness of this instrument for the current study is rooted in that it measures satisfaction with telemental health while comparing it to in-person services. This survey was a good fit for this study since the premise of this study was that telemental health is a better option for supporting foster parents than in-person services. The second instrument is the Caregiving System Scale (CSS). The CSS is part of Caregiving Behavioral System, an extension of Bowlby's Attachment Theory (Colledani et al., 2022). It is a time-tested, valid and reliable measure of caregiving orientations (Colledani et al., 2022).

2. Learned responses - Internal validity may also be compromised if respondents become familiarized with testing materials or with the expected outcomes of the study. According to Creswell and Creswell (2017), respondents may seek to memorize expected responses for use later during testing. However, the survey construction did not provide respondents with an opportunity for memorization, nor did it cue respondents to answer in any particular manner. Survey questions simply asked respondents to rate their experiences with telehealth along a 5-point Likert scale.

3. Participants - Participant selection was conducted through a community partner who interacted with foster parents, and through snowball sampling. The combination of these methods were intended to exclude participation by unqualified respondents.
4. Elapsed time – In line with cross-sectional studies, all data was collected at a particular point in time. This prevents the effects of elapsed time to diminish findings.

External validity is compromised when researchers “draw incorrect inferences from the data to other persons, other settings and past or future situations” (Creswell & Creswell, 2017, p. 169). For the purposes of this study, sample and setting characteristics were considered:

1. Sample characteristics – The population studied was foster parents in America who have used telemental health in the care of their foster children. This is a population with unique characteristics that are not generalizable to all foster parents who do not meet that criteria.
2. Setting characteristics – In this study, no pre- or post-test procedures were conducted that could have an impact on the collected data. Additionally, the same instruments for data collection was given to all respondents, and all data was collected at once.

Finally, construct validity is contingent upon whether the constructs of study are truly being measured by instrumentation (Creswell & Creswell, 2017). For the purposes of this study, construct validity was achieved with well-established measures of telemental health satisfaction and caregiving orientations (as measured by CSS). Therefore, to the extent possible, the construct of interest was faithfully measured.

Ethical Procedures

The nature of this study was to examine the relationship between the use of telemental health and placement stability, and whether caregiving orientations have some effect on telemental health use by foster parents in America. To this end, it is possible that respondents recalled memories that caused discomfort given that foster parenting is exceedingly stressful, and for some, an injurious experience. However, no memories were cued or reviewed in this study. Thus, abstaining from this line of questioning reduced the likelihood of emotional injury.

Beyond emotional injury, the observance of privacy, respect for values, diversity, dignity, and autonomy of participants are pre-requisites to fulfill the ‘do no harm’ ethical mandate by the American Psychological Association. To this end, the following protocols were followed:

1. Privacy – Confidentiality and integrity are of primary concern to this researcher.

Therefore, no identifying information or IP addresses was collected. Respondents were prompted to follow a link where they could consent to participate or decline without consequence. The results of the survey were then sent directly to this researcher’s webpage after consent had been obtained and the survey had been completed. Results of data analysis were reported at the aggregate level. Safe storage of data was achieved by using a 128-bit encrypted hard drive. In compliance with Walden University’s requirements, all data will be destroyed by computer deletion after 5 years.

2. Inclusion – There were no restrictions for participation in this study based on age, gender, race, ethnicity, or sexual orientation. All members of the population being studied had access to participate.
3. Social responsibility – Adherence to ethical standards was achieved through oversight and approval from Walden University’s Institutional Review Board (IRB; *approval number here*) and by ensuring that the methods used in this study posed no harm to research participants. Although precautionary steps were taken in this vein, risks to participants may have existed. To that end, participants were offered free resources such as counseling from the IRB to help address any distress from participation in this study.

Summary

As noted above, the primary purpose for this quantitative, cross-sectional study was to examine the relationships between foster parents’ measures of telemental health satisfaction (TMHsat), carer role satisfaction (CRS) and placement stability (PStability) among foster parents in the United States. The secondary purpose was to examine the mean differences of foster parents’ TMH utility among caregiving orientations (as evidenced by their CSS categories). Multivariate regression, a one-way MANOVA, and CFA were the chosen methods for data analysis. The reasoning for the proposed methodology has been provided in detailed fashion throughout this chapter to provide the reader with a thorough understanding of the justification for the study and to provide guidance in how to conduct this research study. Research results and findings from the data collected will be provided in the next chapter.

Chapter 4: Findings

Introduction

The main purpose of this study was to examine the role of telemental health (TMH) utility in mitigating placement instability (PI). To that end, this study was guided by the following research questions and hypothesis:

Research Question 1 (RQ1): Based on subjective ratings by foster parents in America, what is the relationship between measures of TMHsat, CRS and PStability?

Null Hypothesis (H_01): Based on subjective ratings by foster parents in America, there is no relationship between TMHsat, CRS and PStability among foster parents in America.

Alternative Hypothesis (H_11): Based on subjective ratings by foster parents in America, there is a positive correlation across the variables (TMHsat, CRS and PStability) such that higher TMHsat is correlated with higher CRS, and higher CRS is correlated with higher PStability.

Research Question 2 (RQ2): Based on subjective ratings by foster parents in America, is there a difference in foster parents' TMH utility (e.g., TMHsat, CRS and PStability) among the four caregiving orientations (e.g., optimal, anxious hyperactivation, avoidant deactivation and ambivalent disorganized) as measured by the CSS?

Null Hypothesis (H_02): Based on subjective ratings by FPs, there is no difference in TMH utility among CSS categories.

Alternative Hypothesis (H_12): Based on subjective ratings by FPs, there is at least one difference in TMH utility among CSS categories.

The findings from the study are presented here in the following order: First, the sociodemographic data (i.e., participant characteristics) are presented as described in Chapter 3, that is, following the format originally prescribed. Where indicated, demographic data may include measures of central tendency and/or dispersion and/or percentiles/rankings. A population/sample comparison was also provided.

Following an initial description of our sample respondents (e.g., demographics), an analysis of their opinions and attitudes about TMH utility are presented in the order listed: (1) TMH satisfaction survey; (2) a multiple regression in the service of answering RQ1; and (3) and post-hoc principal component analysis (PCA) and confirmatory factor analysis (CFA) on the revised 12-item TMH satisfaction survey.

In the service of answering RQ - 2, the results of analysis conducted are presented in the order listed: (1) application of the caregiving system scale (CSS) to sample population; and (2) a one-way MANOVA examining potential differences in mean measures of TMH utility (TMHsat, CRS, and PStability) of foster parents among the four caregiving orientations (e.g., optimal, anxious hyperactivation, avoidant deactivation and ambivalent disorganized).

Finally, the telemental health service delivery model will be presented according to the Anderson (1995) behavioral model of health service utilization (BMHSU) specifications.

Data Collection

Data collection was achieved by means of a survey, which ran on Survey Monkey from May of 2024 to April of 2025. Respondents were recruited from foster care and community-based organizations in the southwest of the U.S with the aid of community partners. There were N=89 foster parents sampled in this survey, with n=77 comprising total usable responses. Their responses are presented here:

Demographics

The sample of 77 foster parents was composed of n = 12 males (15.6%), n = 63 females (81.8%), n=1 trans females (1.3%) and n =1 other (1.3%). The average age of foster parents in this study is 48.83 ($SD = 11.27$), the minimum = 28, the maximum = 74, the mode = 62 and the range = 46.

Table 1

Respondent Age Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
R's age	77	28.00	74.00	48.8312	11.27807
Valid N (listwise)	77				

Table 2

Respondents' Sex

	Frequency	Percent	Valid Percent	Cumulative Percent
Cis male (male at birth)	12	15.6	15.6	15.6
Cis female (female at birth)	63	81.8	81.8	97.4
Trans female	1	1.3	1.3	98.7
Other	1	1.3	1.3	100.0
Total	77	100.0	100.0	

Respondents' Care-Taking Background

Most of the respondents n=45 (58.4%) reported being foster parents for '4 or more years', whereas others, n = 16 (20.8%) reported '3 years of service', n = 11 (14.3%) reported '2 years of service, n = 4 (5.2%) reported 1 year of service and only n = 1 (1.3%) reported less than 1 year as a foster parent. More than half of respondents, n = 40 (51.9%) reported having received 'parenting training, nearly a third, n = 24 (31.2%) reported having received 'training for special populations', a smaller group, n = 10 (13%) reported having received 'other training' and just n=3 (3.9%) reported receiving 'no training'.

Table 3

Respondents' Education

	Frequency	Percent	Valid Percent	Cumulative Percent
Less than high school diploma	6	7.8	7.8	7.8
High school diploma or equivalent	10	13.0	13.0	20.8
Some college	38	49.4	49.4	70.1
Bachelor's degree	19	24.7	24.7	94.8
Graduate degree	4	5.2	5.2	100.0
Total	77	100.0	100.0	

Respondents' Personal Background

Most foster parents reported either being married, n = 33 (42.9%) or single, n=24 (31.2%) with a minority reporting either being divorced, n = 7 (9.1%), widowed n = 7 (9.1%) or cohabitating n = 6 (7.8%). Nearly half of foster parents (n = 38; 49.4%) had some college education, nearly a fifth (n = 19; 24.7%) had a bachelor's degree, and just n = 4 (5.2%) reported having a graduate degree or higher with; the rest n = 16 (20.8%)

reporting a high school diploma or less. Only n = 4 (5.2%) reported making over \$150k in income; others, n = 14 (18.2%) reported making between \$100k and \$150k, n= 14 (18.2%) reported making between \$75k and \$100k, n = 24 (31.2%) reported making between \$50k and \$75k, n = 11 (14.3%) reported making between \$30k and \$50k, n = 5 (6.5%) reported making between \$15k and \$30k and n=5 (6.5%) reported making less than \$15k.

Table 4

Respondents' Years Fostering

	Frequency	Percent	Valid Percent	Cumulative Percent
less than 1 year	1	1.3	1.3	1.3
1 year	4	5.2	5.2	6.5
2 years	11	14.3	14.3	20.8
3 years	16	20.8	20.8	41.6
4 or more years	45	58.4	58.4	100.0
Total	77	100.0	100.0	

Table 5

Respondents' Care Training

	Frequency	Percent	Valid Percent	Cumulative Percent
Parenting training	40	51.9	51.9	51.9
Training for special populations (e.g., trauma, autism, other special needs, etc.)	24	31.2	31.2	83.1
Other training	10	13.0	13.0	96.1
No training	3	3.9	3.9	100.0
Total	77	100.0	100.0	

Table 6*Respondents' Use of Telehealth*

	Frequency	Percent	Valid Percent	Cumulative Percent
Approximately once monthly	37	48.1	48.1	48.1
Approximately twice monthly	24	31.2	31.2	79.2
Approximately three times monthly	8	10.4	10.4	89.6
Approximately four times monthly	8	10.4	10.4	100.0
Total	77	100.0	100.0	

Respondents' Use Of Telemental Health (TMH)

Whereas almost all respondents reported that they own the technology necessary to use telemental health (TMH), $n = 70$ (90.9%), a small minority, $n = 7$ (9.1%) reported borrowing technology. Use of TMH varied. Most foster parents, $n = 37$ (48.1%) reported using TMH once a month and many, $n = 24$ (31.2%) reported using TMH twice a month. Some, $n = 8$ (10.4%) reported using TMH three times a month, and the same number of respondents, $n = 8$ (10.4%) reported using TMH four times a month.

An ad hoc analysis yielded a significant, moderate but negative correlation between R's use of TMH and R's age, $r(75) = -.31, p = .007$, such that younger foster parents used TMH services significantly more than older ones. An additional, near-significant, moderate but negative correlation $r(75) = -.22, p = .059$, was found between R's use of TMH and R's years fostering, suggesting that dependence on TMH services wanes moderately with experience or age or perhaps as an interaction of various factors.

Respondents' Foster Children

Respondents reported fostering children in all age categories: n = 21 (27.3%) reported fostering an 'infant to three years old' child; n = 16 (20.8%) reported fostering a 'four to six years old' child; n = 19 (24.7%) reported fostering a 'seven to twelve years old' child; n = 20 (26%) reported fostering a 'thirteen to eighteen years old' teenager; n = 1 (1.3%) reported fostering a 'nineteen to twenty-one years old' individual. Of the n = 77 reported children, a third, n = 26 (33.8%) were male and n=51 (66.2%) were female.

Table 7

Child's Age

	Frequency	Percent	Valid Percent	Cumulative Percent
Infant to three years old	21	27.3	27.3	27.3
Four to six years old	16	20.8	20.8	48.1
Seven to twelve years old	19	24.7	24.7	72.7
Thirteen to eighteen years old	20	26.0	26.0	98.7
Nineteen to twenty-one years old	1	1.3	1.3	100.0
Total	77	100.0	100.0	

Levels Of Behavioral Problems (LBP)

The level of behavioral problems (LBP) associated with these children ranged from 'no behavioral problems, n = 13 (16.9%) to 'severe behavioral problems', n = 8 (10.4%). Most foster parents, n = 42 (54.5%) reported 'moderate behavioral problems' while a lesser amount, n = 14 (18.2%) reported 'mild behavioral problems'. An ad hoc analysis found that LBP and child's age were positively and moderately correlated, $r(75) = .22, p=.05$.

Length Of Child's Placement (LOP)

Length of child's placement (LOP) and level of LBP and were also positively and moderately correlated, $r(75) = .24, p = .05$. Thus, increasing age and LOP were risk factors to children's increasing negative behavioral outcomes. Considering those risk factors, it makes sense that a low percentage of foster parents, $n = 9$ (11.7%) reported an extended placement (e.g., 'until emancipated'). Notwithstanding, the LOP varied significantly across foster parents; while most, $n = 50$ (64.9%) reported a long term of 'more than 2 years', some, $n = 11$ (14.3%) reported a medium, '7 – 11 months' placement; and others, $n = 7$ (9.1%) reported a short '4-6 month' placement.

Table 8

Level of Behavioral Problems (LBP)

	Frequency	Percent	Valid Percent	Cumulative Percent
No behavioral problems	13	16.9	16.9	16.9
Mild behavioral problems (e.g., occasional problems that are easily corrected)	14	18.2	18.2	35.1
Moderate behavioral problems (e.g., established patterns of poor behavior that require direct and frequent interventions but are not dangerous.	42	54.5	54.5	89.6
Severe behavioral problems (e.g., established patterns of poor behaviors that can be dangerous to the child and others.	8	10.4	10.4	100.0
Total	77	100.0	100.0	

Table 9*Length of Child's Placement (LOP)*

	Frequency	Percent	Valid Percent	Cumulative Percent
4-6 months	7	9.1	9.1	9.1
7-11 months	11	14.3	14.3	23.4
more than 2 years until emancipated	50	64.9	64.9	88.3
Total	77	100.0	100.0	100.0

Sample Vs Population Comparison

Official data on foster parents is scarce. The Adoption and Foster Care Analysis and Reporting System (AFCARS) seems to be the best official source of information on all things having to do with foster care though it cites no direct information on foster parents. Nevertheless, according to AFCARS #31 (FFY 2023), 45% or $n = 79,644$ placements occur with both licensed relatives and licensed, non-relative foster families, which is an approximation of the US foster parent population that we sampled ($n=77$) in this study.

Table 10*Child Descriptive Statistics*

	Mean	Mode/Percent/Years	Std. Deviation	N
Child's age	2.5325	6 ½ years	1.18748	77
Child's sex	1.6623	female = 51 (66%)	.47601	77
Level of behavioral problems	2.5844	3 (moderate)	.89370	77
Length of child's placement	3.7922	4 (until emancipated)	.76670	77

The average age of a child in US foster care in 2023 was more than 8 years old and the gender division was 51% boys and 49% girls. On the other hand, the average age

of our sample was 6.5 years of age, a third of the sample, $n = 26$ (33.8%) were male and two-thirds, $n=51$ (66.2%) were female (Table 10).

All children who left foster care in 2023 had spent an average of nearly 22 months (1.8 years) in care (AFCARS, 2023). The average LOP in this sample was 3.8 on our Likert scale (Table 10), which is ‘more than 2 years’ but less than emancipation age. In 2022, 23% of the US population of foster youth stayed in care from 0-5 months, 19% stayed from 6 – 11 months, 49% stayed between 1-5 years, and 9% stayed until they were emancipated (AFCARS, 2023). In our sample, $n = 7$ (9.1%) were placed for 4 - 6 months, $n = 11$ (14.3%) were placed for 7 – 11 months, $n = 50$ (64.9%) were placed for more than 2 years and $n = 9$ (11.7%) of foster youth were placed until emancipated (Table 10).

Results

Telemental Health (TMH) Survey

The respondents completed a modified 12-item version of the Tse et al (1995) TMH survey. The questions prompted respondents to make mental comparisons about their experiences with telemental health vs their in-person experiences. The twelve-item survey was redesigned to measure telemental health satisfaction (e.g., TMHsat = items 1-3 of the survey) as well as the new dimensions of carer role satisfaction (CRS = items 4 – 7 of the survey) and placement stability (PStability = items 8 - 12). The questions used a five-point Likert Scale, rating how much better or worse the experience in question was via telehealth than in-person (e.g., 1= A lot less, 2= A little less, 3 = The same, 4 = A little better or 5 = A lot better).

Telemental Health Satisfaction (TMHsat)

As noted above, telemental health satisfaction (TMHsat) was measured using items 1-3 in the survey. Answer frequency Tables 11-13 (items 1-3, respectively) are listed below.

For services rendered in item 1 (Table 11), n = 32 (41.6%) of respondents said that the TMH services they received were ‘The same’ as in-person services, n = 18 (23.4%) of respondents said they received ‘A little more’ and n = 6 (7.8%) of respondents said ‘A lot more’. Therefore, n = 56 (72.8%) of respondents said that the TMH services offered were the same or better than the services received ‘in-person’ compared to n=9 (11.7%) of respondents who said that the TMH services they received were ‘A little less’ plus n = 12 (15.6%) who said the services they received were ‘A lot less’ than the services they received in-person. Thus, n = 56 (72.8%) were satisfied with TMH services vs n = 21 (27.2%) who were not satisfied.

Table 11

Item 1

	Frequency	Percent	Valid Percent	Cumulative Percent
A lot less	12	15.6	15.6	15.6
A little less	9	11.7	11.7	27.3
The same	32	41.6	41.6	68.8
A little more	18	23.4	23.4	92.2
A lot more	6	7.8	7.8	100.0
Total	77	100.0	100.0	

Table 12*Item 2*

	Frequency	Percent	Valid Percent	Cumulative Percent
A lot less	9	11.7	11.7	11.7
A little less	10	13.0	13.0	24.7
The same	20	26.0	26.0	50.6
A little more	31	40.3	40.3	90.9
A lot more	7	9.1	9.1	100.0
Total	77	100.0	100.0	

For services rendered in item 2 (Table 12), n = 20 (26%) of respondents said that the TMH services they received were ‘The same’ as in-person services, n = 31 (40.3%) respondents said they received ‘A little more’ and n = 7 (9.1%) said ‘A lot more’. Therefore, n=58 (75%) of respondents thought that the TMH services they received were the same or better than in-person services, compared to n = 10 (13%) of respondents who said the TMH services they received were ‘A little less’ plus n = 9 (11.7%) of respondents who said the TMH services they received were ‘A lot less’ than the in-person services they received. Thus, n = 58 (75%) were satisfied with TMH services vs n = 19 (25%) who were not satisfied with TMH.

Table 13*Item 3*

	Frequency	Percent	Valid Percent	Cumulative Percent
A lot less	3	3.9	3.9	3.9
A little less	8	10.4	10.4	14.3
The same	28	36.4	36.4	50.6
A little more	26	33.8	33.8	84.4
A lot more	12	15.6	15.6	100.0
Total	77	100.0	100.0	

For services rendered in item 3 (Table 13), n = 28 (36.4%) of respondents said that the TMH services they received were ‘The same’ as in-person services, n = 26 (33.8%) respondents who said the service they received were ‘A little more’ and n = 12 (15.6%) said ‘A lot more’. Therefore, n=66 (85.7%) of respondents thought that the TMH services they received were the same or better than in-person services compared to n = 8 (10.4%) of respondents who said the TMH services they received were ‘A little less’ plus n = 3 (3.9%) of respondents who said the TMH services they received were ‘A lot less’ than the services they received in-person. Thus, n= 66 (85.7%) of respondents were satisfied with the TMH services they received vs n=11 (14.3%) of respondents who were not satisfied. Altogether, average satisfaction/dissatisfaction percentages for items 1-3 comprising TMHsat are 78% satisfied vs 22% dissatisfied with TMH services.

Caregiver Role Satisfaction (CRS)

Caregiver role satisfaction (CRS) was measured with items 4-7 of the survey. For services rendered in item 4 (Table 14 below), n = 44 (57.1%) of respondents said that the

TMH services they received were ‘The same’ as in-person services, n = 11 (14.3%) of respondents said ‘A little more’ and n = 13 (16.9%) said ‘A lot more’. Therefore, n= 68 (88.3%) of respondents said that the TMH services they received were the same or better than in-person services, compared to n = 8 (10.4%) of respondents who said the TMH services they received were ‘A little less’ plus n = 1 (1.3%) of respondents who said the TMH services they received were ‘A lot less’ than the in-person services they received. Thus, n = 68 (88.3%) were satisfied with TMH services vs n = 9 (11.7%) who were not satisfied.

Table 14

Item 4

	Frequency	Percent	Valid Percent	Cumulative Percent
A lot less	1	1.3	1.3	1.3
A little less	8	10.4	10.4	11.7
The same	44	57.1	57.1	68.8
A little more	11	14.3	14.3	83.1
A lot more	13	16.9	16.9	100.0
Total	77	100.0	100.0	

For services rendered in item 5 (Table 15 below), n = 41 (53.2%) of respondents said that the TMH services they received were ‘The same’ as in-person services, n = 16 (20.8%) of respondents said, ‘A little more’ and n = 6 (7.8%) said, ‘A lot more’. Therefore, n= 63 (82%) of respondents said that the TMH services they received were the same or better than in-person services, compared to n = 10 (13%) of respondents who said the TMH services they received were ‘A little less’ plus n = 4 (5.2%) of

respondents who said the TMH services they received were ‘A lot less’ than the in-person services they received. Thus, n = 63 (82%) were satisfied with TMH services vs n = 14 (18%) who were not satisfied.

Table 15

Item 5

	Frequency	Percent	Valid Percent	Cumulative Percent
A lot less	4	5.2	5.2	5.2
A little less	10	13.0	13.0	18.2
The same	41	53.2	53.2	71.4
A little more	16	20.8	20.8	92.2
A lot more	6	7.8	7.8	100.0
Total	77	100.0	100.0	

Table 16

Item 6

	Frequency	Percent	Valid Percent	Cumulative Percent
A lot less	2	2.6	2.6	2.6
A little less	10	13.0	13.0	15.6
The same	39	50.6	50.6	66.2
A little more	15	19.5	19.5	85.7
A lot more	11	14.3	14.3	100.0
Total	77	100.0	100.0	

For services rendered in item 6 (Table 16 above), n = 39 (50.6%) of respondents said that the TMH services they received were ‘The same’ as in-person services, n = 15 (19.5%) of respondents said, ‘A little more’ and n = 11 (14.3%) said, ‘A lot more’. Therefore, n= 65 (84.4%) of respondents said that the TMH services they received were

the same or better than in-person services, compared to n = 10 (10.4%) of respondents who said the TMH services they received were ‘A little less’ plus n = 2 (2.6%) of respondents who said the TMH services they received were ‘A lot less’ than the in-person services they received. Thus, n = 65 (84.4%) were satisfied with TMH services vs n = 12 (15.6%) who were not satisfied.

Table 17

Item 7

	Frequency	Percent	Valid Percent	Cumulative Percent
A lot less	4	5.2	5.2	5.2
A little less	13	16.9	16.9	22.1
The same	27	35.1	35.1	57.1
A little more	21	27.3	27.3	84.4
A lot more	12	15.6	15.6	100.0
Total	77	100.0	100.0	

For services rendered in item 7 (Table 17 above), n = 27 (35.1%) of respondents said that the TMH services they received were ‘The same’ as in-person services, n = 21 (27.3%) of respondents said, ‘A little more’ and n = 12 (15.6%) said ‘A lot more’. Therefore, n= 60 (78%) of respondents said that the TMH services they received were the same or better than in-person services, compared to n = 13 (16.9%) of respondents who said the TMH services they received were ‘A little less’ plus n = 4 (5.2%) of respondents who said the TMH services they received were ‘A lot less’ than the in-person services they received. Thus, n = 60 (78%) were satisfied with TMH services vs n = 17 (22%) who were not satisfied. Altogether, average satisfaction/dissatisfaction percentages for items 4-7 comprising CRS are 83% satisfied vs 17% dissatisfied with TMH services.

Placement Stability (PStability)

Placement stability (PStability) was measured with items 8-12 of the survey. For services rendered in item 8 (Table 18 below), n = 25 (32.5%) of respondents said that the TMH services they received were ‘The same’ as in-person services, n = 21 (27.3%) of respondents said, ‘A little more’ and n = 12 (15.6%) said ‘A lot more’. Therefore, n= 60 (78%) of respondents said that the TMH services they received were the same or better than in-person services, compared to n = 13 (16.9%) of respondents who said the TMH services they received were ‘A little less’ plus n = 4 (5.2%) of respondents who said the TMH services they received were ‘A lot less’ than the in-person services they received. Thus, n = 60 (78%) were satisfied with TMH services vs n = 17 (22%) who were not satisfied.

Table 18

Item 8

	Frequency	Percent	Valid Percent	Cumulative Percent
A lot less	4	5.2	5.2	5.2
A little less	15	19.5	19.5	24.7
The same	25	32.5	32.5	57.1
A little more	21	27.3	27.3	84.4
A lot more	12	15.6	15.6	100.0
Total	77	100.0	100.0	

For services rendered in item 9 (Table 19 below), n = 41 (53.2%) of respondents said that the TMH services they received were ‘The same’ as in-person services, n = 10 (13%) of respondents said, ‘A little more’ and n = 15 (19.5%) said ‘A lot more’.

Therefore, n= 66 (85.7%) of respondents said that the TMH services they received were

the same or better than in-person services, compared to n = 8 (10.4%) of respondents who said the TMH services they received were ‘A little less’ plus n = 3 (3.9%) of respondents who said the TMH services they received were ‘A lot less’ than the in-person services they received. Thus, n = 66 (85.7%) were satisfied with TMH services vs n = 11 (14.3%) who were not satisfied.

Table 19

Item 9

	Frequency	Percent	Valid Percent	Cumulative Percent
A lot less	3	3.9	3.9	3.9
A little less	8	10.4	10.4	14.3
The same	41	53.2	53.2	67.5
A little more	10	13.0	13.0	80.5
A lot more	15	19.5	19.5	100.0
Total	77	100.0	100.0	

For services rendered in item 10 (Table 20 below), n = 24 (31.2%) of respondents said that the TMH services they received were ‘The same’ as in-person services, n = 22 (28.6%) of respondents said, ‘A little more’ and n = 15 (19.5%) said ‘A lot more’. Therefore, n= 61 (79.2%) of respondents said that the TMH services they received were the same or better than in-person services, compared to n = 9 (11.7%) of respondents who said the TMH services they received were ‘A little less’ plus n = 7 (9.1%) of respondents who said the TMH services they received were ‘A lot less’ than the in-person services they received. Thus, n = 61 (79.2%) were satisfied with TMH services vs n = 16 (20.8%) who were not satisfied.

Table 20*Item 10*

	Frequency	Percent	Valid Percent	Cumulative Percent
A lot less	7	9.1	9.1	9.1
A little less	9	11.7	11.7	20.8
The same	24	31.2	31.2	51.9
A little more	22	28.6	28.6	80.5
A lot more	15	19.5	19.5	100.0
Total	77	100.0	100.0	

For services rendered in item 11 (Table 21 below), n = 27 (35.1%) of respondents said that the TMH services they received were ‘The same’ as in-person services, n = 18 (23.4%) of respondents said, ‘A little more’ and n = 16 (20.8%) said ‘A lot more’. Therefore, n= 61 (79.2%) of respondents said that the TMH services they received were the same or better than in-person services, compared to n = 11 (14.3%) of respondents who said the TMH services they received were ‘A little less’ plus n = 5 (6.5%) of respondents who said the TMH services they received were ‘A lot less’ than the in-person services they received. Thus, n = 61 (79.2%) were satisfied with TMH services vs n = 16 (20.8%) who were not satisfied.

For services rendered in item 12 (Table 22 below), n = 28 (36.4%) of respondents said that the TMH services they received were ‘The same’ as in-person services, n = 16 (20.8%) of respondents said, ‘A little more’ and n = 14 (18.2%) said ‘A lot more’. Therefore, n= 58 (75.3%) of respondents said that the TMH services they received were the same or better than in-person services, compared to n = 15 (19.5%) of respondents who said the TMH services they received were ‘A little less’ plus n = 4 (5.2%) of

respondents who said the TMH services they received were ‘A lot less’ than the in-person services they received. Thus, n = 58 (75.3%) were satisfied with TMH services vs n = 19 (24.7%) who were not satisfied.

Table 21

Item 11

	Frequency	Percent	Valid Percent	Cumulative Percent
A lot less	5	6.5	6.5	6.5
A little less	11	14.3	14.3	20.8
The same	27	35.1	35.1	55.8
A little more	18	23.4	23.4	79.2
A lot more	16	20.8	20.8	100.0
Total	77	100.0	100.0	

Table 22

Item 12

	Frequency	Percent	Valid Percent	Cumulative Percent
A lot less	4	5.2	5.2	5.2
A little less	15	19.5	19.5	24.7
The same	28	36.4	36.4	61.0
A little more	16	20.8	20.8	81.8
A lot more	14	18.2	18.2	100.0
Total	77	100.0	100.0	

Altogether, average satisfaction/dissatisfaction percentages for items 8-12 comprising PStability are 79.5% satisfied vs 20.5% dissatisfied with TMH services; and average satisfaction/dissatisfaction rates for the all twelve-items in the survey are 80.16% satisfaction vs 19.83% dissatisfaction in favor of TMH.

RQ1: Multiple Linear Regression

To test the hypothesis that there is a positive correlation across the variables TMHsat, CRS and PStability (Table 23 below), I conducted a multiple linear regression analysis. TMHsat and CRS were entered into the regression equation as predictor variables, and PStability as a dependent variable.

Table 23

Descriptive Statistics

	Mean	Std. Deviation	N
PStability	16.6494	4.78970	77
TMHsat	9.6494	2.65452	77
CRS	13.0909	3.08298	77

Table 24

Correlations

		PStability	TMHsat	CRS
Pearson Correlation	PStability	1.000	.518	.687
	TMHsat	.518	1.000	.562
	CRS	.687	.562	1.000
Sig. (1-tailed)	PStability	.	<.001	<.001
	TMHsat	.000	.	.000
	CRS	.000	.000	.
N	PStability	77	77	77
	TMHsat	77	77	77
	CRS	77	77	77

A Pearson correlation coefficient was calculated to examine the relationship between the predictors (Table 24 above). The coefficient, $r = .562$, suggested that the

assumption of multicollinearity was not violated. Moreover, neither tolerance (.684) nor variance inflation factor (1.46) indicated a violation of this assumption (Table 29 below).

Table 25

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.706 ^a	.498	.484	3.43946	1.973

a. Predictors: (Constant), CRS, TMHsat

b. Dependent Variable: PStability

Table 26

ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	868.121	2	434.061	36.692	<.001 ^b
	Residual	875.411	74	11.830		
	Total	1743.532	76			

a. Dependent Variable: PStability

b. Predictors: (Constant), CRS, TMHsat

Results of the regression analysis show a significant effect on PStability, $F(2,74) = 36.69$, $p < .001$ (Table 26 above); and $R^2 = 0.498$, suggesting that 49.8% of the variance in PStability is predicted by the combination of CRS and TMHsat (Table 27 below). The predictor variable of carer role satisfaction (CRS) comprised of items 4-7 of the survey was a strong, significant predictor of placement stability (PStability), $B = .900$, $t(76) = 5.82$, $p < .001$ (Table 29). This means that PStability increases by .9 points on the survey scale with every point increase in CRS (Table 29). However, TMHsat did not reach significance as a predictor at $p (.05)$ level, $B = .347$, $t(76) = 1.93$, $p = .057$ (Table 29

below). This means that there is a positive correlation but that an increase in TMHsat does not significantly increase PStability as measured on survey. The predicted PStability score is: $1.517 + 0.9 (\text{TMHsat}) + .347 (\text{CRS})$ for every point increase in on each scale. Thus, the null hypothesis that there is no relationship across these variables is rejected.

Table 27*Model Summary*

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.706 ^a	.498	.484	3.43946	1.973

a. Predictors: (Constant), CRS, TMHsat

b. Dependent Variable: PStability

Table 28*ANOVA*

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	868.121	2	434.061	36.692	<.001 ^b
	Residual	875.411	74	11.830		
	Total	1743.532	76			

a. Dependent Variable: PStability

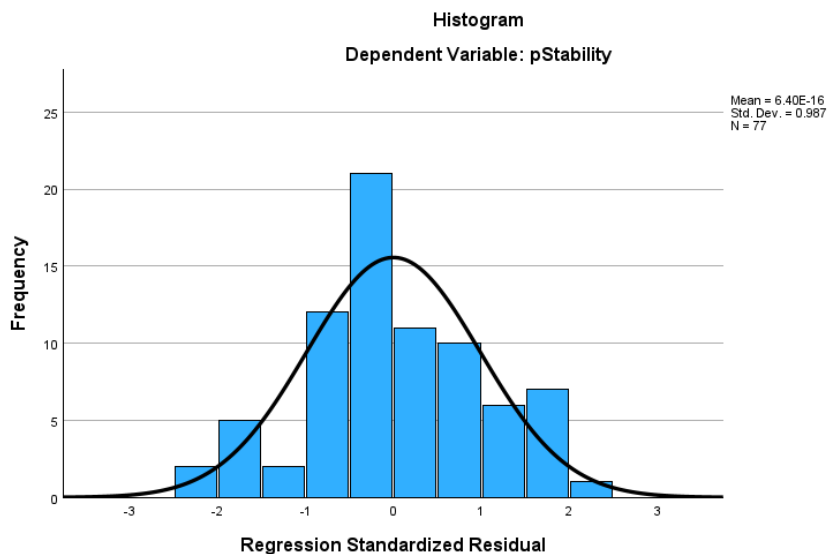
b. Predictors: (Constant), CRS, TMHsat

A Durbin-Watson statistic (1.97) was calculated to assess that the values of the residuals are independent, which suggested that this assumption had not been violated (Table 27 above). A histogram of the residuals below suggested a normal distribution (Figure 1 below).

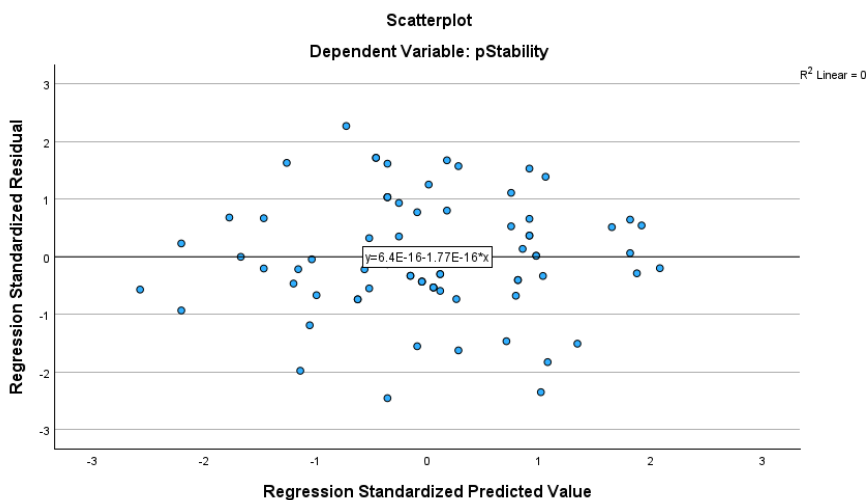
Table 29*Coefficients*

Model	Unstandardized Coefficients		Standardized Coefficients		Sig.	Collinearity Statistics	
	B	Std. Error	Beta	t		Tolerance	VIF
1 (Constant)	1.517	1.821		.833	.408		
TMHsat	.347	.180	.193	1.934	.057	.684	1.461
CRS	.900	.155	.579	5.817	<.001	.684	1.461

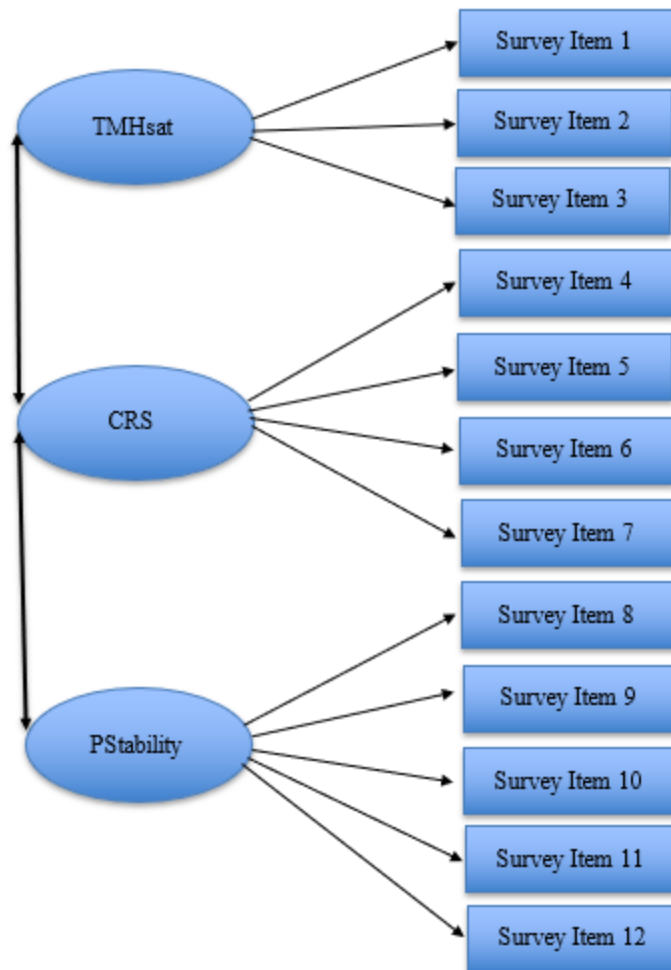
a. Dependent Variable: PStability

Figure 1*Histogram*

A scatter plot (Figure 2 below) shows that the variance of the residuals was constant (homoscedasticity); thus, the assumption was not violated.

Figure 2*Scatterplot****Principal Component Analysis (PFA)***

As noted in Chapter 3, one of the contributions of this study was to test a new measure of telehealth satisfaction that expanded the measure traditionally used in the literature developed by Tse et al. (2021). The survey was originally an 8-item, 2-component (telemental health satisfaction and customer satisfaction) survey. The expanded model (Figure 3 below) included 4 additional survey items, totaling twelve, researched-based survey items, designed to measure 3 latent variables, TMHsat, CRS and PStability. Details of the amended survey are found in Chapter 3 under ‘Instrumentation and Operationalization of Constructs’.

Figure 3*Proposed Survey Framework*

A principal component analysis (PCA) was performed on the model above (Figure 3) using SPSS. The data was checked for missing values using pairwise deletion. Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was .824, indicating that the data was a great for factor analysis. Bartlett's Test of Sphericity was significant, $\chi^2 (55) = 560.4$, $p < .001$, indicating that the correlation matrix is significantly different from an identity matrix. The extraction value was set at an eigenvalue > 1 which resulted in the

retention of 2 out of the 3 components (latent variables). The first component (PStability) explained 53.7% of the variance and the second (TMHsat) 11.6%, with a cumulative explained variance of 65.3%. The rotation method used was Varimax with Kaiser Normalization. Factor loadings ($>.50$) are presented in Table 30 below.

Table 30

Rotated Component Matrix

	Components	
	PStability	TMHsat
item10	.890	
item11	.865	
item9	.823	
item12	.722	
item8	.653	
item6	.598	
item4	.595	
item2		.841
item3		.784
item5		.736
item7		.705

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.^a

a. Rotation converged in 3 iterations.

Confirmatory Factor Analysis (CFA)

To test whether a one-factor solution for PStability fits the data, a confirmatory factor analysis (CFA) was conducted using Amos. The factor loadings were examined; however, model fit indices did not suggest a good fit. The Chi-square value for the default model was significant, $\chi^2(43) = 136.6, p = .000$, with a CMIN/DF ratio of 3.2,

indicating a poor fit relative to the degrees of freedom. The Goodness of Fit Index (GFI) was .762, which does not suggest a good fit between the model and the data. The comparative fit Index (CFI) and the Normed Fit Index (NFI) were .827 and .771, respectively, indicating a poor model fit. Additionally, the Root Mean Square Error of Approximation (RMSEA) was .169 with a 90% confidence interval of .138 to .202, and a PCLOSE value of .000, suggesting that the model does not fit well in terms of error approximation. Overall, these indices do not support a one-factor solution for explaining the underlying factors that influence PStability. Neither did the data suggest a good fit for a two-factor solution for PStability, as originally proposed (Figure 32 above).

These results were adequately addressed in the Discussion section. Critically, however, a CFA with a sample $n < 200$ is not recommended because it skews fit indices (Lam, 2017). Notwithstanding, the PCA and CFA performed herein were primarily informative in line with the exploratory nature of this study as cited in Research Design and Rationale of Chapter 3. For instance, because of these analyses, two components were identified (Table 4.8b); one robust measure, PStability, was supported by 53.7% of the data as well as by strong factor loadings for seven survey items ($>.05$, Table 4.8b). Thus, a case could be argued in support of an independent measure for PStability as a starting point for future studies.

Caregiving System Scale (CSS)

The caregiver system scale (CSS) is a 20-item instrument that measures caregiving orientations. Using a 7-point Likert scale, participants are asked to rate how much they agree/disagree with ten hyperactivating items totaling from 10 to 70 points

(e.g. 10 questions x 7-point Likert scale) and ten deactivating items totaling from 10 to 70 points. The hyperactivation and deactivation scales are orthogonal measures, which are each split into high and low creating 4 distinct categories (e.g., optimal, anxious hyperactivation, avoidant deactivation and ambivalent disorganized).

Our sample, $n = 77$ survey volunteers, were screened with the CSS. Respondents' memberships in CSS categories are provided in Table 34 (below) and are listed here in percentiles: Most respondents, $n = 48$ (62.3%), fit into the 'optimal' category, which is comprised of low scores (< 36) on both hyperactivation and deactivation scales. The second largest group, $n = 14$ (18.2%), fit into the 'anxious hyperactivation' category, which is comprised of high hyperactivation (> 35) and low deactivation (< 36) scores. The third group, $n = 11$ (14.3%), fit into the 'ambivalent disorganized' group, which is comprised of high (>35) activation and deactivation scores. The final group, $n = 4$ (5.2%), fit into the 'avoidant deactivation' group, which is comprised of low hyperactivation (< 36) and high deactivation (> 35) scores.

RQ2: MANOVA

To test the hypothesis that there was at least one mean difference in TMH utility among CSS categories a one-way MANOVA was performed. CSS categories containing 4 categories of caregiving systems (Table 34) were entered as the independent variable. TMH utility, containing 3 measures of satisfaction (TMHsat, CRS and PStability) were entered as the dependent variable. However, respondents' membership in CSS categories (Table 4.9b) was uneven across groups (e.g., optimal $n = 48$, anxious $n = 14$, disorganized $n = 11$ and, avoidant $n = 4$); and, Box's M test of equality of covariance

matrices was significant, $\chi^2(43) = 136.6, p = .000$, indicating that covariances were not equal as a function of unequal group membership. Because this finding precludes a valid MANOVA, the results are not included. Thus, the RQ2 null hypothesis was accepted that there is no mean difference in TMH utility among Respondents' membership in CSS categories.

Table 31

Respondents' CSS Category Membership

	CssCategory	Mean	Std. Deviation	N
TMHsat	Anxious	10.5000	1.60528	14
	Avoidant	11.7500	.50000	4
	Disorganized	8.9091	.83121	11
	Optimal	9.3958	3.11987	48
	Total	9.6494	2.65452	77
CRS	Anxious	14.2143	4.09838	14
	Avoidant	12.2500	.50000	4
	Disorganized	13.0909	2.73695	11
	Optimal	12.8333	2.93427	48
	Total	13.0909	3.08298	77
PStability	Anxious	17.2857	6.16976	14
	Avoidant	15.0000	.00000	4
	Disorganized	18.0000	3.25576	11
	Optimal	16.2917	4.83761	48
	Total	16.6494	4.78970	77

Anderson (1995) Behavioral Model of Health Services Utilization

The proposed framework applied to this study was Andersen (1995) Behavioral Model of Health Services Utility (BMHSU). The purpose of the BMHSU is to evaluate health systems for their ability to deliver services effectively and to develop a model that

provides measures of access to health care (Anderson, 1995). According to Andersen (1995), an effective TMH service delivery model can be developed by determining what the predisposing, enabling, and need factors are for the foster parent population. These factors help explain how the system works. As it pertained to this study, the BMHSU helped conceptualize all relevant factors in the delivery of TMH services to foster parent populations.

Table 32

Predisposing Factors

	N	Range	Min.	Max.	Mean	Mode	Std. Deviation
R's age	77	46.00	28.00	74.00	48.8312	62 yrs	11.27807
R's sex	77	4.00	1.00	5.00	1.9091	2 (female =82%)	.56619
R's education	77	4.00	1.00	5.00	3.0519	3 (some college)	.93042
R's marital status	77	4.00	1.00	5.00	2.5714	3 (married = 43%)	1.27143
Child's age	77	4.00	1.00	5.00	2.5325	1 (1 -3 years old)	1.18748
Child's sex	77	1.00	1.00	2.00	1.6623	2 (female = 66.2%)	.47601
Valid N (listwise)	77						

Predisposing factors (PF)

Predisposing factors (Table 32 above) are those that motivate foster parents to use the services including, “demographic, social structural, and attitudinal beliefs” (Luo et al., 2022, p. 4). For the purposes of this study, the PF studied were limited to age, sex, education and marital status for respondents, and for children, sex and age. For example,

in our sample, the average respondent foster parent was a 48-year-old, married female with some college education, fostering a six and a half year-old female child.

Table 33

Enabling/Disabling Factors

	N	Range	Min	Max	Mean	Mode	Std. Deviation
R's age*	77	46.00	28.00	74.00	48.8312	62 yrs	11.27807
R's education	77	4.00	1.00	5.00	3.0519	2 (female =82%)	.93042
R's income	77	6.00	1.00	7.00	4.2338	4 (\$75K)	1.52950
R's years fostering	77	4.00	1.00	5.00	4.2987	5 (>4 yrs)	.98762
R's technology	77	1.00	1.00	2.00	1.0909	1 (own tech = 90.9%)	.28936
R's care training*	77	3.00	1.00	4.00	1.6883	1 (parenting = 52%)	.84697
Child's age	77	4.00	1.00	5.00	2.5325	2 (6.5 yrs)	1.18748
Valid N (listwise)	77						

*disabling factors: $p < .01$

Enabling/Disabling Factors

Enabling factors (Table 33 above) are those that give the individual the “ability to secure services including, income, health care access and sources, health insurance, rural/urban environment, etc.” (Luo et al., 2022, p. 4). In our sample, our average adult TMH user with \$75k in household income and owned her own technology for TMH use (90.9%). On the other hand, disabling factors were respondents’ age and care-training, which were negatively correlated with the use of TMH, $r = -.306$, $p = .007$ and $r = -.298$,

$p = .008$, respectively. Thus, most respondents had enabling factors though some also had disabling factors.

Table 34

Need Factors

Level of behavioral problems		
N	Valid	77
	Missing	0
Mode		3.00
Mean		2.58
Range		3.00
Minimum		1.00
Maximum		4.00
Std. Deviation		.8937

Need Factors

Need factors include individual illness level, “perceived or evaluated” (Luo et al., 2022, p. 4). Helping foster children adjust to their new surroundings is challenging and often evidenced by unwanted internalized and externalized behaviors. However, level of behavioral problems (LBP) reported may be influenced by other factors. For instance, in our sample TMH system, the need factor is children’s LBP, which ranged from mild-to-moderate (mean = 2.58, Table 34 above). However, both respondents’ education and a child’s age were factors that were positively correlated with a child’s LBP, $r = .295$, $p = .009$ and $r = .224$, $p = .05$, respectively. Thus, LBP reported appeared to increase with child’s age, and respondents’ reports of LBP appeared to increase with respondents’ education.

Figure 4

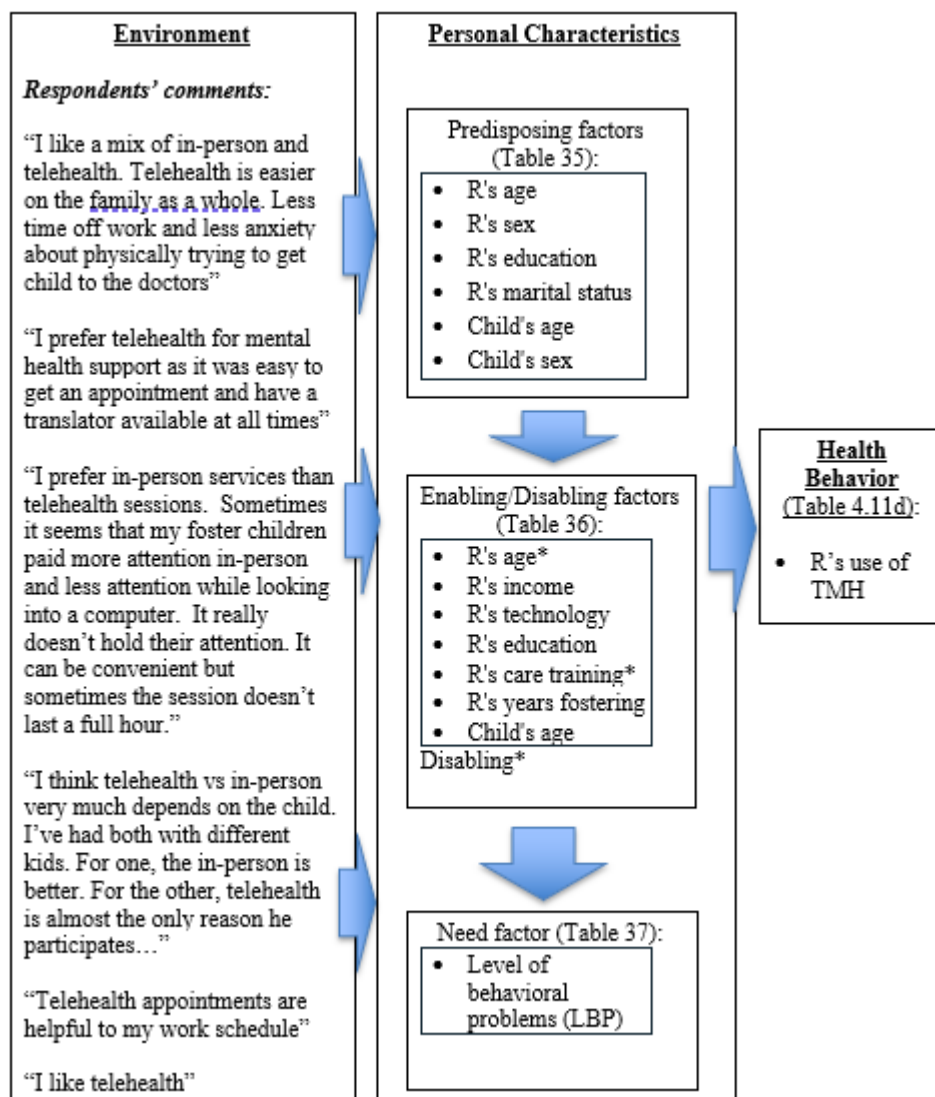
Behavioral Model For TMH Service Utilization

Table 35*TMH Utility*

R's use of telehealth		
N	Valid	77
	Missing	0
Mean		1.8312
Median		2.0000
Mode		3
Std. Deviation		.99211
Range		3.00
Minimum		1.00
Maximum		4.00

TMH Utility

The average respondent in our sample was a 48-year-old, married female, who used her TMH system nearly twice (mean = 1.8, Table 35 above) a month and was fostering six and a half year-old, female child with mild-to-moderate LBP.

Summary

Although the data collection took an extended amount of time (approximately one year), the precaution was necessary to ensure that only qualified individuals were included in the sample. To a reasonable extent, the sampling of this study achieved similar overall statistics to the US foster parent population. Additionally, the sample displayed similar overall trends found in the literature such as a correlations between age of child and level of behavioral problems (LBP) or length of placement and LBP. Thus, a representative sample was likely achieved.

Regarding the findings, the mixed outcomes of this study were expected due to the exploratory nature of the study. For instance, the results of the TMH survey indicated

overwhelmingly that TMH services are the same or better than in-person services, 80.16% vs 19.83%, respectively. Relatedly, the results of a multiple linear regression conducted in the service of answering RQ1 concluded that a positive relationship exists across the variables of interest (e.g., TMHsat, CRS and PStability) and that the null hypothesis could be rejected. Preliminary analysis indicated mean group differences but a one-way MANOVA in the service of answering RQ2 was not possible due to unequal group membership. Thus, the null hypothesis that there is no difference in TMH utility according to group membership in CSS categories was accepted. The implications of these findings were further explored in the next chapter, including the future of using CSS categories.

Post-hoc tests also gave mixed results. For instance, a principal component analysis (PCA) identified that only two (TMHsat and PStability) of the three proposed survey components were responsible for 65.3% of the variance in the data with the third component (CRS) remaining unexplained by the data. But a subsequent confirmatory factor analysis (CFA) found that this model was not a good fit for the data either. While the CFA is not valid with sampling $n < 200$, together these analyses reveal that the construct of CRS as well as a significant percentage of the data (34.7%) remain unexplained. On the other hand, the construct of PStability emerged as a possible standalone measure, or as a springboard for future TMH research, which was an issue addressed in chapter five.

Finally, framing the data using Anderson (1995) Behavioral Model of Health Service Utilization was critical to understand how the respondents used TMH services to

support the care of their foster children. Specifically, categorizing factors in terms of predisposing, enabling/disabling and needs was instrumental in understanding what and how population characteristics affect TMH utilization and offers points for interventions.

As noted in Chapter Two, foster children's behavioral problems prevent foster parents from connecting with them, which often leads to early placement terminations and placement instability (PI). To prevent PI, this data supports that TMH utility was as good or better than in-person services for support and guidance on children's LBP. The importance of this model and what our data suggests is further explained in the following chapter.

Chapter 5: Discussion

Introduction

The main purpose of this study was to gain insight into telemental health (TMH) utility as a means of support to foster parents. The study accomplished this by gathering foster parents' attitudes and behaviors about TMH utility through an online survey. The study's secondary purpose was to explore the possibility that foster parents' caregiving attitudes (e.g., CSS categories) influence TMH utility in significant ways. An analysis of the data gathered was recorded in Chapter 4 and is discussed herein.

The main purpose of the study as stated above was accomplished. This is evident by the rejection of the null hypothesis in RQ1 but in more pragmatic terms, through the results of the survey. The null hypothesis in RQ1 posited that no relationship existed between the variables of interests (e.g., TMHsat, CRS, and PStability), which was proven untrue in this study. According to the findings, the positive relationship that exists across the variables in the survey predicts that as the ratings of the services offered in survey items 1-7 increase (TMHsat and CRS), so do the ratings of items 8-12, which represent the construct of placement stability (PStability). Additionally, the survey results indicated that TMH was as good as or better than in-person services, 80.16% satisfaction vs 19.83% dissatisfaction. Altogether, TMH utility was found to be a preferred and effective means of providing support to foster parents, which can have an added effect of placement stabilization.

However, not all aspects of the study could be completed; a MANOVA needed to answer RQ2, and a post-hoc confirmatory factor analysis (CFA) on the hypothesized

survey model could not be completed for reasons that will be addressed later in this section. Moreover, carer role satisfaction (CRS), the second independent variable in the hypothesized solution for PStability, remained undefined, according to a post-hoc principal component analysis (PCA) on the survey model.

The four factors (e.g., survey items 4-7) representing carer role satisfaction (CRS) were found undifferentiated from the rest of the data by a principal component analysis (PCA) and were instead loaded under the other two components (TMHsat and PStability). In the absence of a defined CRS variable, the PCA suggested a one-factor solution for PStability, which a subsequent confirmatory factor analysis (CFA) found to be a poor model fit. Though it is likely that the CFA findings were skewed due to inadequate sample size, the fundamental problem with the survey model was that CRS remained undefined. Because the study lacked a guiding theoretical framework, the model for CRS was borrowed from Tse et al.'s customer satisfaction model with modifications to reflect a foster care setting. But these results signal that more research is required to define CRS if it is to be used as hypothesized in this study.

The concerns for the survey model notwithstanding, the analyses were productive in terms of solutions for PI. For instance, PStability emerged as a strong, standalone measure, which can be used independently or may be used in further development. PStability is a measure of TMH satisfaction along the positive antipodes of PI. Thus, PStability as defined by the PCA (e.g., survey items 4, 6, 8-12) can be used independently to measure TMH satisfaction if placement stability is the goal.

RQ2 asked if there was a mean difference in TMH utility between CSS categories. This question required a MANOVA to consider the three variables of TMH as defined in this study (e.g., TMHsat, CRS, and PStability) and the four CSS categories (e.g., optimal, anxious hyperactivation, avoidant deactivation and ambivalent disorganized). Unfortunately, this question could not be answered due to unequal group membership in CSS categories.

The final task of this study was to frame the findings using Anderson (1995) Behavioral Model of Health Service Utilization (BMHSU). Application of the BMHSU to this study's findings allowed me to contextualize the average TMH user's experience in this sample population.

Interpretation of the Findings

This study entertained an aspirational goal of finding ways to reduce placement instability (PI). Thus, the finding that TMH utility can help meet that goal can only be considered as a success. The study made other notable contributions, for instance, in terms of establishing the validity of TMH utility in a foster care setting as well as establishing a valid metric for PStability.

As far as this study's main parameters are concerned, the sampling was representative of the US foster parent population. The data took one year to collect to limit participation by unqualified respondents. A detailed population/sample comparison was provided in Chapter 4 – Demographics. But as another point of validation, the data collected exhibited statistical trends noted in Chapter 2's literature review.

There is scarce information on foster parents, which precludes a valid comparison to this sample. However, describing the study's sample in terms of a TMH behavioral model as outlined by Anderson (1995) BMHSU helps to contextualize the findings. For instance, the average respondent in my sample was a 48-year-old, married female, with some college education, and a household income of approximately \$75k. She owned her own technology and used her TMH system nearly twice a month while fostering a 6 ½ - year-old, female child with mild-to-moderate LBP.

The foster child is a valid point for comparison against the US foster care population. For instance, the average child in this sample was 6.5 years old, while the average child in the US foster care system was approximately 8 years old in 2022. How that age average has changed in 2025 is unknown. Statistically, these ages are not the same, but they do represent adjacent or similar developmental stages. Moreover, the average age difference is less of a concern as you consider that the age range of children in this sample vs the US foster care system was nearly identical with children's ages ranging from 1-to-21 years in both contexts.

More germane to foster care dynamics, some key statistics noted in Chapter 2's literature review were also evidenced in the sample. For instance, I found correlations between child's age and level of behavioral problems, and length of placement and level of behavioral problems. Regarding these correlations, Konijn et al. (2019), cited in Chapter 2, noted that the likely cause of those correlations is that older children entering the foster care system have more of a history of maltreatment with their biological families than younger ones. And, it was Vreeland et al., (2020), also cited in Chapter 2,

who noted when older children act out, their placements are shorter when compared to younger children. So, it seems that younger children's behavioral problems are better tolerated (e.g., reported less) when compared to older children, which leads to longer placements that last until the behavioral problems become riskier with older age.

Additionally, older children entering CWS are more likely to have a greater accumulation of familial trauma, which will likely lead to increasing behavioral problems over time.

Thus, increasing behavioral problems over placement time is a trend seen both in the sample and in the literature.

But this study also documented trends not found elsewhere in the literature, particularly in the key area of TMH utility. For instance, an ad hoc analysis yielded a significant, moderate but negative correlation between respondents' use of TMH and respondents' age such that younger foster parents used TMH services significantly more than older ones. An additional near significant moderate but negative correlation was found between respondents' use of TMH and respondents' years fostering, suggesting that dependence on TMH services wanes moderately with age and/or experience. Another explanation is that some older foster parents have established stability and a secure attachment with their foster children consequently using TMH services less.

Limitations of the Study

This study was conducted with respondents from the southwest part of the US. As such, generalizability of this study's findings to the greater US foster parent population is limited. Specifically, attitudes and more importantly health utilization behaviors may be different. In-person services may be preferred over TMH services in other areas of the

US. The identified barriers to TMH utilization of this sample may not apply to others. Similarly, the predisposing, enabling, and needs profile may change according to the socioeconomic conditions of another area in the US.

Another limitation of this study is its unmet goals, which would have shed further light on the intersection of foster parenting and TMH utility. For instance, in the absence of a guiding theory, carer role satisfaction (CRS), an important construct in this study, remained psychometrically undefined. CRS represents the overall satisfaction felt when fostering children, and therefore, it is important to foster parent retention problems as well as placement instability (PI).

Additionally, the caregiving system scale (CSS) could not be examined for its possible correlations to TMH utility. In my opinion, the CSS has predictive potential and could also offer suggestions to help foster parents engage in effective parenting skills. Unfortunately, unequal group membership prevented an analysis that could have helped determine how predictive CSS membership is. In a similar vein, it would have been interesting to see if CSS has any cultural implications; the notion of mental health, in general, and culture have had historical correlations such as aversions to mental health treatments: these correlations may extend for TMH utility. Nevertheless, when I designed this study, I considered the construct of culture to be extraneous to this study's goals, which were mainly centered on the intersection of TMH utility and placement instability. For future studies, however, the intersection of culture and TMH utility may offer insights worthy of exploration.

Recommendations

The construct of PStability is psychometrically sound and can be presently used to measure TMH satisfaction with its metrics. But a recommended course would be for researchers to develop solutions for PStability that include a metric for CRS. CRS is in a nascent stage but represents the satisfaction that most foster parents are looking for when caring for children. Psychometrically defining CRS is a critical first step in addressing foster parent retention problems, and by extension, PI.

As far as this researcher is aware, this is the first time the CSS has been used in the context of TMH utility. Therefore, there is no baseline comparison for group membership in a foster parent population. That is, there is no way to determine whether the unequal membership is due to the sample size or whether the observed percentages are characteristically found in the US foster parent population. Thus, further research is recommended to fully investigate the nature of CSS membership in foster parent populations.

Nevertheless, the construction of the CSS is sound and can detect valid trends that may impact TMH utility. Konijn et al., (2019) found that the third largest cause for placement instability was low quality parenting. Within the context of TMH utility, those in the category 'anxious hyperactivation' may overuse and tax a TMH system due to anxious tendencies but those in the category 'avoidant deactivation' may trend in the opposite direction, signaling possible neglect. Therefore, having a predictive model will help develop interventions for group dynamics and ensure that a TMH system operates properly.

Regarding TMH content and interventions, I think foster parents should have the ability to select or engage in individual training, courses, certificate programs, interactive resources or continuing education, which can be incentivized with foster parent licensing requirements. But on a very basic level, foster parents just need fast and effective TMH services such as being able to consult with mental health professionals within a reasonable timeframe.

Implications

Although TMH utility is a common mode of service, the literature is virtually non-existent for foster parenting. However, this study finds that TMH utility can help to reduce PI. As an aspirational goal for this study, this finding adds value to the literature. Additionally, this is also one of the first studies to target the intersection of TMH utility and placement instability. Another unique aspect of this study is the establishment of a new measure of placement stability, PStability. This is a valid and statistically sound measure that can be used to target foster parent populations with reliable TMH services. The measure also offers valid points of treatment measures that can be used to track services rendered. This may be a very valuable tool to administrators of a TMH system who could then maintain quality control or offer a range of services.

And, to the best of my knowledge, this study is also the first to use CSS within a foster care setting to predict TMH utility. Although this goal was not accomplished with this sample, further attempts should be made to quantify caregiving attitudes in this vein. A preliminary analysis displayed in Table 34 was promising in terms of yielding mean

differences if it were not for sample size. Thus, CSS categories continue to offer a potential predictive model for TMH utility.

Conclusion

That TMH utility is the same or better than in-person services may not necessarily constitute news, but literature-wise, it establishes what is already part of the Zeitgeist. TMH utility was once considered a marginal service just a few years ago but it is clearly mainstream now. Today, face-to-face calls among friends and family are common; virtual calls are common in many professional settings; likewise, telehealth visits have become an expected option in many healthcare settings, including mental health.

What is more meaningful is that this is a very strong opinion from this study's target population, which has significant implications for the development of resources to combat PI. As noted elsewhere in the literature: technology has been developed and is currently in use. This study established that TMH technology is preferred. And, in no uncertain terms, the next step is to develop a praxis and/or content that specifically combats PI.

In addition to the recommendations made above, points of intervention can be developed at various stages in foster care. For instance, foster parents can consult with mental health professionals during a TMH session about what to expect regarding child behaviors. This consultation can be done at regular intervals as is typically mandatory with annual psychological evaluations. Contextualizing a child's behavior this way can help the foster parent understand, empathize, and connect; thereby stabilizing the placement.

The relevance of TMH utility to PI is that foster parents need the availability of support services to be at their fingertips because what they do is very stressful. Fostering carries huge implications for the lives of children and their foster parents. Foster parents generally enjoy and feel good about their jobs and supporting them to do a very difficult job is accomplished by establishing a TMH system that addresses their needs. This is a low-cost, low-maintenance solution for PI.

References

- AFCARS. The AFCARS Report (28). U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Retrieved from: <https://acf.gov/cb/report/afcars-report-28>
- AFCARS. The AFCARS Report (31). U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Retrieved from: <https://acf.gov/cb/data-research/adoption-fostercare>
- Alexander, D. K. (2021). Foster Parents' Experience of Placement Disruptions for Youths in Foster Care [Psy.D., Walden University].
<https://www.proquest.com/pqdtlocal1005747/docview/2592980510/abstract/74C401804C5E45DDPQ/3>
- Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, 36(1), 1–10.
- Andersen, R., & Newman, J. F. (2005). Societal and Individual Determinants of Medical Care Utilization in the United States. *The Milbank Quarterly*, 83(4).
<https://doi.org/10.1111/j.1468-0009.2005.00428.x>

- Barnett, E. R., Cleary, S. E., Butcher, R. L., & Jankowski, M. K. (2019). Children's behavioral health needs and satisfaction and commitment of foster and adoptive parents: Do trauma-informed services make a difference? *Psychological Trauma: Theory, Research, Practice, and Policy*, *11*(1), 73–81.
<https://doi.org/10.1037/tra0000357>
- Barnett, E. R., Jankowski, M. K., Butcher, R. L., Meister, C., Parton, R. R., & Drake, R. E. (2018). Foster and adoptive parent perspectives on needs and services: A mixed methods study. *The Journal of Behavioral Health Services & Research*, *45*(1), 74–89. <https://doi.org/10.1007/s11414-017-9569-4>
- Barnett, P., Goulding, L., Casetta, C., Jordan, H., Sheridan-Rains, L., Steare, T., Williams, J., Wood, L., Gaughran, F., & Johnson, S. (2021). Implementation of Telemental Health Services Before COVID-19: Rapid Umbrella Review of Systematic Reviews. *Journal of Medical Internet Research*, *23*(7), e26492.
<https://doi.org/10.2196/26492>
- Baumgart, A. (2020). The Lived Experiences of Caregivers of Children with Reactive Attachment Disorder [Ph.D., Walden University]. In ProQuest Dissertations and Theses.
<https://www.proquest.com/pqdtlocal1005747/docview/2426153210/abstract/55E0086863D64EBBPQ/29>

- Bearss, K., Burrell, T. L., Challa, S. A., Postorino, V., Gillespie, S. E., Crooks, C., Scahill, Lawrence., Bearss, K., Burrell, T. L., Challa, S. A., Postorino, V., Gillespie, S. E., Crooks, C., & Scahill, L. (2018). Telehealth Caregiver Satisfaction Survey: Feasibility of parent training via telehealth for children with autism spectrum disorder and disruptive behavior: A demonstration pilot. *Journal of Autism and Developmental Disorders*, 48, 1020–1030.
- Bederian-Gardner, D., Hobbs, S. D., Ogle, C. M., Goodman, G. S., & Cordon, I. M. (2018). Instability in the lives of foster and non-foster youth: Mental health impediments and attachment insecurities. *Children and Youth Services Review*. <https://doi.org/10.1016/j.chilyouth.2017.10.019>
- Chateauneuf, D., Poitras, K., Simard, M.-C., & Buisson, C. (2022). Placement stability: What role do the different types of family foster care play? *Child Abuse & Neglect*, 130, 105359. <https://doi.org/10.1016/j.chiabu.2021.105359>
- Cicchetti, D. (2016). Developmental Psychopathology. In Developmental Psychopathology: Vol. 3: Maladaptation and Psychopathology (3rd ed.). John Wiley & Sons, Inc.
- Colledani, D., Meneghini, A. M., Mikulincer, M., & Shaver, P. R. (2022). The Caregiving System Scale: Factor structure, gender invariance, and the contribution of attachment orientations. *European Journal of Psychological Assessment*, 38(5), 385–396. <https://doi.org/10.1027/1015-5759/a000673>

- Collins, M. E. (2019). Transitioning from Foster Care to Independence: Lessons from Recent Research and Next Steps. *Child Welfare, 97*(5), 233–240.
- Comer, J. S., & Myers, K. (2016). Future Directions in the Use of Telemental Health to Improve the Accessibility and Quality of Children’s Mental Health Services. *Journal of Child and Adolescent Psychopharmacology, 26*(3), 296–300.
<https://doi.org/10.1089/cap.2015.0079>
- Crawford, B., Pharris, A. B., & Dorsett-Burrell, R. (2018). Risk of serious criminal involvement among former foster youth aging out of care. *Children and Youth Services Review, 93*, 451–457.
<https://psycnet.apa.org/doi/10.1016/j.childyouth.2018.08.027>
- Fisher, P. A., Mannering, A. M., Van Scoyoc, A., & Graham, A. M. (2013). A Translational Neuroscience Perspective on the Importance of Reducing Placement Instability among Foster Children. *Child Welfare, 92*(5), 9–36.
- Font, S. A., Sattler, K. M. P., & Gershoff, E. T. (2018). Measurement and correlates of foster care placement moves. *Children and Youth Services Review, 91*, 248–258.
<https://doi.org/10.1016/j.childyouth.2018.06.019>
- Griffith, R.L., Nowalis, S., Zax, A., Fite, P.J., & Gudiño, O.G. (2023). Justice-Involved Youths’ Perceptions of Placement Instability and Adjustment Related Outcomes. *Residential Treatment for Children & Youth, 40*, 387 - 403.
<https://www.tandfonline.com/doi/epdf/10.1080/0886571X.2023.2186307?needAccess=true>

- Hanlon, R., Simon, J., Day, A., Vanderwill, L., Kim, J., & Dallimore, E. (2021). Systematic Review of Factors Affecting Foster Parent Retention. *Families in Society: The Journal of Contemporary Social Services*, 102(3), 285–299. <https://doi.org/10.1177/1044389420970034>
- Hernandez, P. M., & Lee, J. (2020). Outcomes of Young Adults Aging out of Foster Care: A Latent Class Analysis. *Child Welfare*, 98(3), 145–166. <https://www.jstor.org/stable/48623668>
- Humphreys, K. L., Nelson, C. A., Fox, N. A., & Zeanah, C. H. (2017). Signs of reactive attachment disorder and disinhibited social engagement disorder at age 12 years: Effects of institutional care history and high-quality foster care. *Development and psychopathology*, 29(2), 675–684. <https://doi.org/10.1017/S0954579417000256>
- Jones, A. M., Shealy, K. M., Reid-Quñones, K., Moreland, A. D., Davidson, T. M., López, C. M., Barr, S. C., & de Arellano, M. A. (2014). Guidelines for Establishing a Telemental Health Program to Provide Evidence-Based Therapy for Trauma-Exposed Children and Families. *Psychological Services*, 11(4), 398–409. <https://doi.org/10.1037/a0034963>
- Konijn, C., Admiraal, S., Baart, J., van Rooij, F., Stams, G.-J., Colonesi, C., Lindauer, R., & Asink, M. (2019). Foster care placement instability_ A meta-analytic review, 96, pp 483-499. <https://doi.org/10.1016/j.chilyouth.2018.12.002>
- Lam, Eddie. (2017). Re: What is the minimum sample size for factor analysis? Retrieved from: <https://www.researchgate.net/post/What-is-the-minimum-sample-size-for-factor-analysis/5902a39a48954c96a655689e/citation/download>.

- Leathers, S. J., Spielfogel, J. E., Geiger, J., Barnett, J., & Vande Voort, B. L. (2019). Placement disruption in foster care: Children's behavior, foster parent support, and parenting experiences. *Child Abuse & Neglect*, 91, 147–159.
<https://doi.org/10.1016/j.chiabu.2019.03.012>
- Luo, Y., Li, Q., & Cheatham, L. (2022). Associated Factors with Electronic Personal Health Records Use among Older Cancer Survivors: An Application of Anderson's Behavioral Model of Health Services Use to eHealth Services. *Online Journal of Nursing Informatics*, 26(1), 1–1.
- Madigan, S., Racine, N., Cooke, J. E., & Korczak, D. J. (2021). COVID-19 and telemental health: Benefits, challenges, and future directions. *Canadian Psychology/Psychologie Canadienne*, 62(1), 5–11.
<https://doi.org/10.1037/cap0000259>
- McKeough, A., Bear, K., Jones, C., Thompson, D., Kelly, P., & Campbell, L. (2017). Foster carer stress and satisfaction: An investigation of organizational, psychological and placement factors. *Children and Youth Services Review*, 76, 10–19. <https://doi.org/10.1016/j.childyouth.2017.02.002>
- Racine, N., Hartwick, C., Collin-Vézina, D., & Madigan, S. (2020). Telemental health for child trauma treatment during and post-COVID-19: Limitations and considerations. *Child Abuse & Neglect*, 110, 104698.
<https://doi.org/10.1016/j.chiabu.2020.104698>

- Reizer, A., & Hetsroni, A. (2015). Does helping others impair caregivers' health? Associating caregiving, life satisfaction, and physical health. *Social Behavior and Personality: An International Journal*, 43(2), 255–267.
<https://doi.org/10.2224/sbp.2015.43.2.255>
- Rice, S., Cotton, S., Moeller-Saxone, K., Mihalopoulos, C., Magnus, A., Harvey, C., Humphreys, C., Halperin, S., Scheppokat, A., Mcgorry, P., & Herrman, H. (2017). Placement instability among young people removed from their original family and the likely mental health implications. *Shanghai Archive of Psychiatry*, 29(2).
- Shaver, P. R., Mikulincer, M., & Shemesh-Iron, M. (2010a). A behavioral-systems perspective on prosocial behavior. In *Prosocial motives, emotions, and behavior: The better angels of our nature*. (2009-08941-004; pp. 73–91). American Psychological Association. <https://doi.org/10.1037/12061-004>
- Shaver, P. R., Mikulincer, M., & Shemesh-Iron, M. (2010b). Caregiving System Scale. *PsycTESTS*. <https://doi.org/10.1037/t02054-000>
- Tolou-Shams, M., Folk, J., Stuart, B., Mangurian, C., & Fortuna, L. (2021). Rapid creation of child telemental health services during COVID-19 to promote continued care for underserved children and families. *Psychological Services*.
<https://doi.org/10.1037/ser0000550>

Tse, J., LaStella, D., Chow, E., Kingman, E., Pearlman, S., Valeri, L., Wang, H., & Dixon, L. B. (2021). Telehealth Acceptability and Feasibility Among People Served in a Community Behavioral Health System During the COVID-19 Pandemic. *Psychiatric Services*, 72(6), 654–660.

<https://doi.org/10.1176/appi.ps.202000623>

Ungvarsky, J. (2023). Snowball sampling. In Salem Press Encyclopedia. Salem Press.

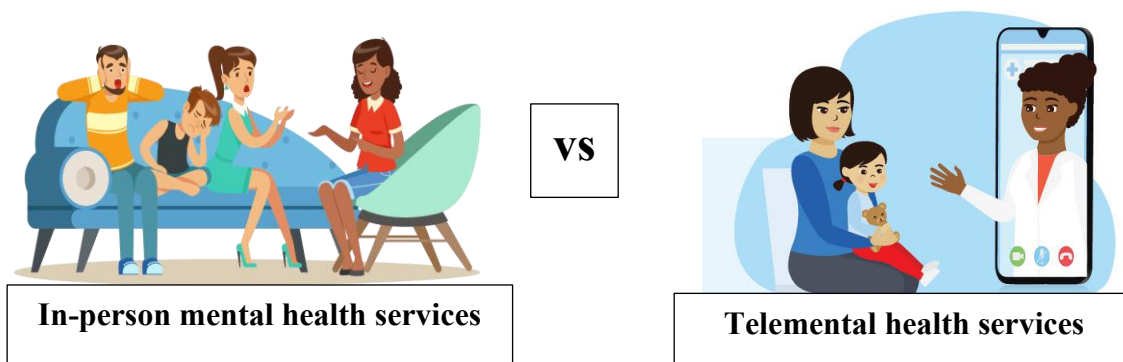
Vreeland, A., Ebert, J. S., Kuhn, T. M., Gracey, K. A., Shaffer, A. M., Watson, K. H., Gruhn, M. A., Henry, L., Dickey, L., Siciliano, R. E., Anderson, A., & Compas, B. E. (2020). Predictors of placement disruptions in foster care | Elsevier

Enhanced Reader. <https://doi.org/10.1016/j.chiabu.2019.104283>

Warner, R. M. (2013). *APPLIED STATISTICS: From Bivariate Through Multivariate Techniques* (2nd ed.). SAGE Publications, Inc.

Appendix A: Survey Invitation

Online survey study seeks foster parents in the U.S. who have used both telemental health (telehealth) and in-person mental health services to care for their foster children.



There is a new study about the use of telemental health services by foster parents to receive support while caring for their foster children. You are invited to complete a 12-minute, anonymous, survey.

Seeking volunteers that meet these requirements:

- Be or have been a licensed foster parent who has cared for a foster child in the last six years.
- Have used both '**in-person**' and '**telemental health**' (telehealth) services to receive mental health support services in the care of their foster children.

This study is part of the doctoral program for Carlos D. Ortiz, a doctoral student at Walden University. The survey will be open until the end of April 2025. Questions should be directed to carlos.ortiz2@waldenu.edu.

Please copy and paste the link below on to you browser and follow the prompts:

<https://www.surveymonkey.com/r/HM8DPVD>

Appendix B: Online Telemental Health Survey

Procedures:

- Part I collects demographic information to provide context.
- Part II is a survey that measures satisfaction with 'telemental health' vs 'in-person' services.
- Part III is the Caregiving System Scale (CSS), which measures caregiving orientations.
- It takes between 20-30 minutes to complete the online survey.

Survey Instructions:

Compare times when you've received 'in-person' mental health services vs 'telemental health' services for the care of your foster child. Then complete each statement below by filling in the blank with the answer that best reflects your opinion (e.g., 1,2,3,4 or 5).

Part One: Demographics

- (a) What is your gender ___?
0. Cis male
 1. Cis female
 2. Trans male
 3. Trans female
 4. Prefer not to disclose.
- (b) Please state your age ___
- (c) What is the highest level of education you have completed or the highest degree you have received ___?
0. Less than high school diploma
 1. High school diploma or equivalent (e.g., GED)
 2. Some college but no degree
 3. Associate's degree (2 years undergrad)
 4. Bachelor's degree
 5. Master's degree
 6. Doctorate degree
- (d) What is your relational status ___?
0. Single
 1. Cohabiting
 2. Married
 3. Separated

4. Divorced

5. Widowed

(e) How long have you served as a foster parent ___?

0. < 1 year

1. 1 year

2. 2 years

3. 3 years

4. 4 or more years

(f) Which of the following best describes your household income ___?

0. \$0-25 thousand

1. \$26-50 thousand

2. \$51-75 thousand

3. \$76-100 thousand

4. Over \$100 thousand

(g) Which best describes the training you have received as a foster parent ___?

0. Parenting training

1. Parenting for special populations (e.g. trauma, autism, other special needs, etc.)

2. Other training

(h) Please choose what technology you have used for a telemental health session:

0. My own computer, tablet or cellphone.

1. Someone else's computer, tablet or cellphone

(i) As a foster parent, how often have you used telemental health services in the care of your foster child?

0. One time monthly
1. Two times monthly
2. Three times monthly
3. Four times monthly
4. Greater than four times monthly

(j) Length of child placement in your home ____?

0. 0-3 months
1. 4-6 months
2. 7-11 months
3. 1 - 2 years
4. More than 2 years
5. Until emancipated.

(k) What was the age of the child when first assigned to you ____?

0. From infancy to three years old.
1. From four to six years old.
2. From seven to twelve years old.
3. From twelve to eighteen years old.
4. From nineteen to twenty-one years old.

(l) What is the gender of your foster child ___?

- 0. Cis male
- 1. Cis female
- 2. Trans male
- 3. Trans female
- 4. Prefer not to disclose.

(m) What level of behavioral problems did your foster child have ____?

- 0. None
- 1. Mild
- 2. Moderate
- 3. Severe

(n) Please describe your child's behavior:

***** End of Part I *****

Part Two: Telemental Health Survey

Survey Instructions:

Mentally recall and compare a time when you received **‘in-person’** mental health services vs **‘telemental health’** services for the care of your foster child. Then complete each statement below by filling in the blank with the answer (e.g., 1,2,3,4 or 5) that best reflects your opinion. The higher the number you choose, the greater your preference for telemental health services. The lower the number you choose, the greater your preference for in-person services.

a) Compared to using in-person mental health services, when I use telemental health services, I am connected to my foster child’s care team ____.

1. A lot less
2. A little less
3. The same
4. A little more
5. A lot more

b) Compared to using in-person mental health services, when I use telemental health services, I can get support when I need it ____.

1. A lot less
2. A little less
3. The same
4. A little more
5. A lot more

c) Compared to using in-person mental health services, when I use telemental health services, I can get an appointment when I want ____.

1. A lot less
2. A little less
3. The same
4. A little more
5. A lot more

d) Compared to using in-person mental health services, when I use telemental health services, I am comfortable asking about treatment and medication options for my child ____.

1. A lot less
2. A little less
3. The same
4. A little more
5. A lot more

e) Compared to using in-person mental health services, when I use telemental health services, staff talk to me about specific goals for my foster child's mental health ____.

1. A lot less
2. A little less
3. The same
4. A little more
5. A lot more

- f) Compared to using in-person mental health services, when I use telemental health services, staff are sensitive to my difficult parenting experiences ____.
1. A lot less
 2. A little less
 3. The same
 4. A little more
 5. A lot more
- g) Compared to using in-person mental health services, when I use telemental health services, the quality of my relationship with my foster child is improving ____.
1. A lot less
 2. A little less
 3. The same
 4. A little more
 5. A lot more
- h) Compared to using in-person mental health services, when I use telemental health services, I can manage my foster child's behavior ____.
1. A lot less
 2. A little less
 3. The same
 4. A little more
 5. A lot more

- i) Compared to using in-person mental health services, when I use telemental health services, I feel supported in my role as a foster parent ____.
1. A lot less
 2. A little less
 3. The same
 4. A little more
 5. A lot more
- j) Compared to using in-person mental health services, when I use telemental health services, the quality of my parenting improves ____.
1. A lot less
 2. A little less
 3. The same
 4. A little more
 5. A lot more
- k) Compared to using in-person mental health services, when I use telemental health services, the task of foster parenting improves ____.
1. A lot less
 2. A little less
 3. The same
 4. A little more
 5. A lot more

l) Compared to using in-person mental health services, when I use telemental health services, I feel connected to my foster child ____.

1. A lot less
2. A little less
3. The same
4. A little more
5. A lot more

***** End of Part II *****

Part Three: Caregiving Strategy Scale (CSS)

Please think about situations in which other people need help, without focusing on a specific person, and **rate each item on a scale of 1 to 7;** with **1 representing the lowest level of agreement** with each statement, and **7 representing the highest level of agreement** with each statement.

Deactivation items

1. When I see people in distress, I don't feel comfortable jumping in to help ____.
2. I sometimes feel that helping others is a waste of time ____.
3. I often don't pay much attention to other people's discomfort or distress ____.
4. I don't invest a lot of energy trying to help others ____.
5. Thinking about helping others doesn't excite me very much ____.
6. I don't often feel an urge to help others ____.
7. I have no problem helping people who are troubled or distressed ____.
8. When I notice that someone seems to need help, I often prefer not to get involved ____.
9. It's hard for me to work up much interest in helping others ____.
10. I feel uncomfortable when I'm required to help others ____.

Hyperactivation items

1. When helping people, I often worry that I won't be as good at it as other people are ____.
2. When I'm unable to help a person who is in distress, I feel worthless ____.
3. I feel bad when others don't want my help ____.
4. I sometimes try to help others more than they actually want me to ____.
5. When people don't want my help, I still sometimes feel compelled to help ____.
6. I often get anxious when I think nobody needs my help ____.
7. I often worry about not being successful when I try to help others who need me ____.
8. When I decide to help someone, I worry that I won't be able to solve the problem or ease the person's distress ____.
9. I sometimes worry that I try to help others more than they want me to ____.
10. I sometimes feel that I intrude too much while trying to help others ____.

Optional comments:

Please feel free to leave any comments or suggestions about your experience taking this survey or about your experience as a foster parent that may relate to this study.

***** End of Survey *****