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What's the Relationship Got to do with It? Understanding the Therapeutic Relationship in Therapeutic Foster Care

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Even as evidence based practice has become the *sine qua non* of good social work practice in the mental health service arena, translating the evidence into effective real-world practice remains a complex endeavor (Burns & Hoagwood, 2002; Drake *et al.*, 2001; Hoagwood *et al.*, 2001). Research on common factors that operate across treatment modalities promises to at least partially elucidate these complexities (Jensen *et al.*, 2005). Understanding how common process factors within interventions affect treatment outcomes is an important adjunct to the focus on identification and dissemination of evidence based practices (Bickman, 2005). Kazdin & Nock (2003) propose that evidence based practices can be improved in terms of clinical applicability in real world settings, by studying discrete mechanisms of therapeutic change within the constellation of factors that constitute the intervention model. They suggest this approach in order to extend current research toward an understanding of why and how evidence based approaches work. This is a critical link in moving evidence based practice from the research to the service arena. Understanding how process factors within a best practice intervention work will contribute to the ability to generalize evidence based practice into usual care settings (Brekke *et al.*, 2007).

Of the process factors or mechanisms common to many if not all child mental health treatments, the therapeutic relationship is increasingly recognized as important to understanding how process variables in best practices contribute to treatment outcomes (Karver *et al.*, 2005). In this paper, we examine the therapeutic relationship between children with serious emotional and behavioral disorders and their treatment providers in an intensive, community based setting. We report on the association of specific relationship measures with child outcomes in the context of an observational study of *Therapeutic Foster Care*. Therapeutic Foster Care (TFC) is a family-based, residential mental health treatment intervention for children with severe emotional and behavioral disorders that is emerging as an important and widely disseminated evidence-based practice (Chamberlain, 2002). TFC provides an appealing option for providing intensive individualized treatment within the context of a family and community setting. Evidence from randomized trials has shown that TFC reduces problematic behavior, increases pro-social behavior, and leads to better outcomes post-discharge. This evidence is based almost exclusively on research of well-implemented short-term TFC (i.e. 6–9 months) conducted by Chamberlain and colleagues at the Oregon Social Learning Center (Chamberlain, 2003; Farmer *et al.*, 2004). The current study built on this evidence base, to extend knowledge of TFC by examining implementation, use and outcomes of TFC in 'real world' practice (Farmer *et al.*, 2003).

The core processes of TFC include extensive pre-service training and in-service supervision/training for the on-site providers, called treatment parents, and planned treatment that combines treatment technologies from more restrictive settings with an emphasis on daily interactions with treatment parents and others in a less restrictive setting (Chamberlain, 2002; Farmer, Burns, *et al.*, 2002a). A key feature of a therapeutic foster care intervention is the treatment

parents, who provide care and treatment for troubled youth in their home on a 24/7 basis. The treatment parent in TFC fulfills dual roles: (1) the parent role of nurturing and taking care of the child's basic needs; and (2) the treatment role, directly implementing treatment interventions with the youth (Wells *et al.*, 2004). An underlying assumption of TFC is that the relationship between the treatment parent and child is a therapeutic one. Establishing a positive relationship is considered a core process of the Therapeutic Foster Care intervention (Chamberlain, 2003). It is critical to examine the treatment parent-child relationship in TFC because it operates both as a common process factor and as a core component of this particular intervention.

The therapeutic relationship in child treatment is generally understood as functioning to produce an environment or condition that facilitates change on the part of youth in treatment (Shirk & Saiz, 1992). Decades of theory development and empirical investigation have shown that development of a positive, trusting and collaborative relationship has a positive effect on treatment outcome (Horvath, 2005). Although the majority of this research has been done on adult populations, the importance of a positive, high quality relationship in the mental health treatment of children and youth is beginning to be systematically examined (Karver *et al.*, 2006; Shirk & Russell, 1996). The empirical evidence demonstrates that the relationship between youth and their treatment providers is significantly associated with treatment outcomes (Bickman *et al.*, 2005; Kazdin *et al.*, 2005; Robbins *et al.*, 2003; Shirk & Karver, 2003).

Shirk & Karver (2003), in a meta-analysis of the association between relationship variables and treatment outcomes, established that the effect was overall modest, leading them to conclude that "the therapeutic relationship has a modest but consistent, association with outcomes" (p. 461) in child treatment. This association held regardless of type of treatment or child developmental levels. Child age, gender or race did not have a moderating effect on the relationship between alliance and treatment outcomes. Type of primary problem did mediate the association. The association between the relationship and outcomes was significantly stronger for children with externalizing symptoms than for children with predominantly internalizing symptoms.

Studies of youth being treated specifically for behaviors related to externalizing disorders report that those youth who showed improvement in therapeutic alliance scores had more improvement in externalizing symptoms (Hogue *et al.*, 2006). A study of adolescent boys adjudicated delinquent who are being treated in community based setting found that for youth whose alliance with their treatment provider grew stronger over treatment had decreased externalizing behaviors and lower crime recidivism (Florsheim *et al.*, 2000). Rauktis and colleagues (Rauktis *et al.*, 2005) reported similar findings in a descriptive examination of the role of the relationship in therapeutic foster care. They observed that youth with higher externalizing symptoms had lower initial alliance scores but showed improved alliance scores by six months in TFC. These findings are particularly salient for children served in Therapeutic Foster Care, where externalizing behaviors are one of the major targets of the intervention (Farmer, Compton, *et al.*, 2002).

The effect of the relationship on youth behavior over time seems to be a unique feature of the therapeutic relationship in child treatment. In studies of adults, alliance measured earlier in the psychotherapeutic process is more predictive of treatment outcomes, as opposed to measures in the middle or end of therapy (Horvath & Symonds, 1991). Shirk and Karver (2003) found, however, that in child studies the later alliance measures more reliably predicted outcomes. A related finding was that change in alliance was predictive of changes in symptom related outcomes. This pattern was especially evident for youth with histories of maltreatment. Eltz, Shirk & Sarlin (1995) found that for youth who had a history of maltreatment, change of alliance

during treatment was more predictive of outcome than early alliance level. Adolescents who had a history of maltreatment had less positive therapeutic alliance scores in initial phases of therapy but overtime, showed a pattern of improved alliance, comparable to children without histories of maltreatment. This association was not explained by child characteristics such as emotional or functional differences in the youth, gender or symptom severity. Notably, they found that youth who had consistently low alliance scores had the worst outcomes.

While evidence of the importance of the relationship in child treatment as a therapeutic process factor is expanding, current evidence has some major limitations. First, little of the research is based on treatment in intensive, community based settings, such as Therapeutic Foster Care. Likewise, the literature on parent-child relationships, which has clearly demonstrated the importance of a quality relationship to positive emotional, psychosocial and academic functioning (O'Connor, 2002; Prevatt, 2003), does not address the therapeutic role of the relationship between treatment parent and troubled youth. In addition, the abundance of different measures used to assess of the therapeutic relationship presents both conceptual and methodological challenges. For instance, Shirk and Karver (2003) noted the lack of consistency of measurement strategies employed to examine the relationship process in child treatment literature. Of 23 studies, only two scales were used more than once, and measures ran the gamut from single item to extensive scales, which measured highly variable aspects of the youth-provider relationships. This concern has led to calls for examining the therapeutic relationship within a conceptual framework of the role of the therapeutic relationship in child treatment that incorporates more specificity in which processes and variables are measured and how they are measured (Karver et al, 2005). This paper specifically addresses these limitations by explicitly examining the therapeutic relationship in TFC, drawing on a conceptual model that is based on previous empirical and theoretical work.

Karver et al (2005, 2006) argue that understanding how the relationship operates as a therapeutic factor requires examining the provider-child relationship within a conceptual framework that includes youth and therapist pre-treatment characteristics, treatment implementation, and youth-provider relationship characteristics. In this study we examine one specific construct of the therapeutic relationship, the quality of the treatment parent-child relationship, which we contend operates as a mediating factor in a Therapeutic Foster Care intervention (Kazdin & Nock, 2003). We use a valid and reliable measure of the provider-youth relationship, the *Trusting Relationship Questionnaire* (TRQ) (Mustillo *et al.*, 2005), to examine the association of the therapeutic relationship to child emotional and behavioral functioning outcomes, in the context of an evidence based intervention implemented in a real world setting.

Figure 1 illustrates the conceptual framework that we have adapted from Karver et al (2005) for this analysis. We examine pre-treatment characteristics of the child and parent along with program and provider characteristics as controls, and then examine the therapeutic relationship's effect on child functional and behavioral outcomes. We test the mediating effect of the therapeutic relationship on child emotional and behavioral functioning within the context of a specific treatment intervention, Therapeutic Foster Care, where the relationship is both a process factor and a feature of the intervention. The hypothesis we test in this analysis is that the relationship, as measured by the TRQ, will be significantly related to the child's behavioral and functional outcomes, over and above the effect of the provider and program characteristics and pre-treatment characteristics of both treatment parent and child.

Methods

Participants

Data for this study were drawn from an NIMH-funded statewide study of TFC (Farmer et al., 2003). The sample included youth with both psychiatric disorders and aggressive behavior who

resided in TFC from June 1999 through May 2001. The sampling frame is based on Willie M. class members in North Carolina, which includes, “seriously emotionally, neurologically, or mentally handicapped youth who are violent or assaultive” (Behar 1985, 1986). The Willie M. program provided state-level funding for all the class members (approximately 1,200 – 1,500 at any point in time) and services were managed and provided (directly or via contract) through local Area Mental Health programs.

Procedures

The sampling strategy included both an incidence and prevalence approach. State of North Carolina Management Information System data for the Willie M. program were used to identify youth eligible for participation. All Willie M. youth residing in TFC during the first month of recruitment or who entered during the recruitment period were eligible for inclusion. This resulted in a sample that represented a wide range of lengths of stay at the time of the baseline interviews (range = 2 months to 10 years). Seventy-six percent of eligible youth were recruited ($N=183$). Comparisons using available state data showed no significant differences on age, demographics, or diagnosis between participating and nonparticipating eligible youth.

In-person baseline interviews were completed with TFC parent respondents at study entry. The TFC parent interview included inquiries about various aspects of the youth's behavioral and emotional functioning, characteristics of the TFC intervention, and relationship processes. The TFC parent respondent in two-parent homes was the individual who self-identified as the ‘primary treatment parent.’ While treatment parent interviews were obtained for the entire sample ($N = 183$), complete data was missing on 3% of the interviews. Therefore, the analysis reported here was conducted on 97% of respondents ($n=177$).

Measures

Pre-Treatment Characteristics

Child and treatment parent demographic and pre-treatment variables were employed as controls. We controlled for child race (black or white), treatment parent race (black or white), and child age and gender. White is used as the comparison group for both child and parent race, and child age was coded into three categories (4–12, 13–15, and 16–19, with 4–12 used as the comparison group in analyses). Pre-treatment variables of the child included mental health status at intake using a Brief Psychiatric Rating Scale for Children (BPRS-C) total score (J. Vance *et al.*, 2002) and length of stay in the current therapeutic foster care setting prior to the baseline interview for this study. Both of these measures were available from centralized state MIS files. The BPRS-C had 6.5% missing data, which we imputed using a stochastic imputation procedure (Rubin, 1996; Schafer, 1998). The imputation model had adequate fit and explanatory power, and the mean of the imputed variable did not differ significantly from the mean of the unimputed variable.

Treatment parent pre-treatment characteristics included whether they had previous parenting experience, whether they had any prior experience as a treatment parent, and their view of their role in the treatment foster care setting. The parent's view of their role was measured by asking parents to rate how they viewed their role as a treatment provider on a continuum from 1= “primarily a treatment professional” to 5= “primarily a parent”. The results of the likert scale were collapsed into three categories, (1) primarily professional (responses 1–2), (2) mixed parent and professional (response 3), and (3) primarily parent (responses 4–5) for descriptive analysis, but left as an interval variable for the inferential analysis.

Program Characteristics

Characteristics of the TFC program were measured using three variables related to training and adherence to model specifications, measured at the Treatment Parent level. These variables were amount of specialized TFC related training received, whether they had regular meetings with their agency TFC supervisor, and how satisfied they were with their relationship with their supervisor. The amount of specialized training was a continuous variable, measured as the hours of training the treatment parent received in the past year. Whether they had regular meetings with their supervisor was a dichotomous yes/no measure. A regular meeting was operationalized as at least once a month. Level of satisfaction was measured with a 5-item likert-type scale from very dissatisfied (1) to very satisfied (5).

Relationship Factors

The *Trusting Relationship Questionnaire* (TRQ) was designed to assess the affective quality of the relationship between youth and the adult caregivers involved in their care in an intensive community setting (Mustillo, et al, 2005). It was particularly designed for use in non-clinical residential settings (E. Vance & Sanchez, 1997). The Trusting Relationship Questionnaire (TRQ) consists of 18 items on the parent-report version that assesses the quality of the relationship based on the caregiver's perceptions. Respondents indicate on a 5-point continuum (1 = "never" to 5 = "very frequently") how each item characterizes their relationship with the target individual. Previous psychometric analysis of the TRQ suggests good reliability and validity. The TRQ possess acceptable levels of internal consistency and inter-rater reliability. In previous psychometric analysis, the entire parent response version of the TRQ was factor analyzed and two factors were identified (Mustillo et al., 2005). The first factor measures the parent's perception of the child's feelings about the relationship, and the second factor measures the parent's own perception of or feelings about the relationship. Cronbach's alpha for Factor 1 and Factor 2 were .87 and .80, respectively. Given the two factor structure, these subscales were analyzed separately in the study reported here. Scale scores were determined by summing the items and dividing by the number answered.

Child Behavioral and Emotional Functioning

Child behavioral and emotional functioning, assessed with the *Behavioral and Emotional Rating Scale* (BERS), was the dependent variable in this analysis. The TFC parent was administered the BERS to measure emotional and behavioral strengths of their foster child. The BERS consists of 52 items and includes five subscales: interpersonal strengths, family involvement, intrapersonal strengths, school functioning, and affective strengths. Research has shown the reliability and validity of the BERS to be sound. The BERS meets acceptable levels of test-retest and inter-rater reliability, internal consistency, and convergent and discriminate validity (Epstein *et al.*, 1999; Epstein *et al.*, 2004). In the current sample, the alpha coefficient for the BERS was .74. We include the total score in this analysis. Higher scores on the BERS represent better functioning.

Data Analysis

First, we present descriptive statistics on all study variables. Next we present the bivariate and multivariate models used to assess the varying levels of importance of program characteristics and parent-child relationship on child BERS scores, controlling for child and parent demographics, and pre-treatment characteristics. Because the BERS was a continuous variable with an approximately normal distribution, we used OLS regression for multivariate analysis.

Results

Descriptive statistics of the study sample are provided in Table 1. The youth in this study were primarily late adolescent, white males. Forty-one percent of the sample was black and almost three-quarters (74%) were male. Ages of the youth in TFC ranged from 4–19, with the majority of youth being in the 13–15 and 16–19 age groups. The majority of the youth in this study had been in their current TFC placement for an extended period. The mean length of time in the index foster care home was 1.5 years (18 months), with a range of a few months to a decade. The mean intake BPRS-C total scale score was 66.3, which is in the moderate range of clinical-level psychopathology (Gale *et al.*, 1986; Lachar *et al.*, 2001). The BERS mean score was 87, which is approximately a standard deviation below the mean for a general population sample, but corresponds with prior sample means for youth with SED (Epstein & Sharma, 1998).

In terms of treatment parent characteristics, half were black (51%), one quarter had previous TFC experience and the vast majority (88%) had previous parenting experience. About half of the treatment parents (49%) viewed their role as primarily that of a parent, while only 14% viewed the treatment parent role primarily as professional. The treatment parents received a mean of 27 hours of TFC training in the past year. About three-quarters of the parents reported having regular meetings with their TFC placement supervisor, and a majority (88%) were satisfied or very satisfied with their relationship with their supervisor.

Table 2 shows the bivariate relationship of the study variables regressed on the youth's BERS score. Race of the child was significantly associated with the BERS; white youth had significantly lower BERS scores than black youth. White parents had treatment foster children with significantly lower BERS scores (this was expected as previous analysis had shown that white parents were most likely to get matched with white children). Child's age was positively associated with BERS scores. The treatment parent's satisfaction with their relationship with the agency therapeutic foster care supervisor and endorsement of their role as more of a parent versus a professional were also significantly associated with better child functioning. Finally, both factors of the parent-child relationship measure were significantly associated with higher BERS scores.

Results of our examination of the effect of the study variables on child functioning, using a multivariate regression model (see Table 3), revealed that the only variables to significantly predict child functioning were the parents' view of their role as parent versus professional, and the first Factor of the TRQ, the parent's perception of the child's view of the quality of the therapeutic relationship. Specifically, youth with treatment parents who rated themselves more as parents than as professionals, and who rated the quality of the therapeutic relationship above the mean, had higher BERS scores. The treatment parent's level of satisfaction with their TFC supervisor was marginally significant, in the direction of more supervision being associated with higher BERS scores.

Discussion

The research presented in this paper provides a unique perspective on the relationship between children in Therapeutic Foster Care (TFC) and their treatment parents and begins to address the paucity of evidence of the role of the therapeutic relationship in intensive, community-based residential services. Our findings suggest that the quality of the relationship between the treatment parent and youth in a Therapeutic Foster Care setting is significantly associated with better emotional and behavioral functioning for the youth. It appears from these findings that the quality of the relationship between the youth and treatment parent in a TFC setting is at least one of the mechanism or process factors that contribute to improved functioning for the youth. This finding is in accordance with the developmental, socio-cognitive model explicated

by Shirk and Saiz (1992), where they identified the central role of the therapeutic relationship in treating children as “the affective quality of the relationship between child and therapist that enabled the child to work purposefully on resolving problems” (p. 715). In other words, a strong, high quality relationship would effect cognitive beliefs about how one can use a relationship to facilitate change or growth. One interpretation of this finding then would suggest that the development of a strong therapeutic relationship between the treatment parent and youth would indicate improved interpersonal functioning on the part of the youth, which then may have a positive effect on development of more adaptive behaviors, e.g. improved emotional and behavioral functioning (Shirk & Russell, 1996).

A surprising finding was the weak relationship between program characteristics and child functioning. One possible explanation is that the structural features of this best practice intervention are necessary but not sufficient to establish an effect on the child's emotional and behavioral functioning. Further research is necessary to ascertain if there were unmeasured program factors that explain the effect of the relationship processes on child outcomes, and how the relationship operates in conjunction with other intervention features. Longitudinal intervention research examining the impact of enhancements to training and clinical supervision provided to therapeutic foster parents will allow us to examine the effect of the relationship on outcomes over time in an enhanced treatment context. In particular we will be able to examine whether improved treatment will result in improvements in the parent/child relationship, and in turn, will directly improve child outcomes.

An interesting finding in this study was that the treatment parent's satisfaction with their relationship with the agency supervisor was marginally significant in the multivariate model. This would suggest that the parallel relationship process between the treatment parent, who is a paraprofessional in an intensive community setting, and their primary agency supervisor, is an important factor in this intervention. This is consistent with our finding that youth with foster parents who viewed their role as being that of a parent more so than that of a professional demonstrated higher functioning. Understanding the therapeutic relationship in community based, intensive settings, must take into account the particular demands of those treatment settings, and how they affect the relationship when the treatment provider is a paraprofessional caregiver who functions in the dual roles of parent and treatment provider (Wells, et al, 2005).

Another finding that needs additional examination is the association between the length of the therapeutic relationship (e.g. length of stay in the current TFC placement) and child functioning. Tenure in the foster home was not a significant predictor of child functioning. This is an important area to examine for two reasons. Previous analysis has shown that youth remain in TFC for extended periods of time. In particular, instead of being a transitional placement from restrictive to less restrictive care, it appears that TFC in usual-care functions more often as a long term placement. Moreover, previous studies have found that, in contrast to findings in adult studies, measures of relationship later in the duration of treatment with children have been shown to have stronger associations with outcomes than measuring the relationship early in treatment (Shirk & Karver, 2003, Rauktis, et al, 2005). Longitudinal research is needed that explicitly measures the effect of the stage of the relationship as a moderating factor of the effect of the quality of the therapeutic relationship on the child's functioning.

A major strength of this study is that it allowed us to measure therapeutic alliance in an intensive community-based residential treatment setting that is being rapidly disseminated as a best practice. It provides the first glimpse of the measured constructs in ‘usual care’ TFC. Data were available on a diverse and representative sample of youth and treatment parents in multiple programs across a state. As such, it provides a foundation for research on ‘usual care’ TFC as well as therapeutic alliance in residential settings. Despite these strengths, the study also has

limitations. The primary limitation is that because the relationship and functioning were measured cross-sectionally in the current analyses, we were not able to establish causal linkages between the relationship measures and child outcomes. This will be corrected with future longitudinal research.

Despite these limitations, the study represents a step forward in a growing research area. Understanding how the therapeutic relationship functions in family-based and intensive treatment settings is challenging given the many actors involved. More research is needed to unpack the salient components of therapeutic relationships in these complex settings, while also identifying commonalities within the alliance construct across varying therapeutic contexts (Bickman, et al., 2004).

Implications for Social Work practice in Therapeutic Foster Care treatment settings

In the context of a Therapeutic Foster Care intervention, it appears that the relationship is at least one of the mechanism or process factors that contribute to improved functioning. This understanding provides important clues to the social work professional who is involved in the treatment of the child in a therapeutic foster care setting, whether as a supervisor for the treatment parent or as a direct service provider to the child. This study reinforces the importance of supporting the treatment foster parent to understand the impact of the relationship between themselves and their foster youth as an important component of the change process in the TFC setting (Chamberlain, 2002). Further, it provides clues to the parallel processes of the parent-child relationship and the supervisor-paraprofessional relationship. How these two relationship processes effect outcomes of children in TFC requires further study.

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Figure 1.
Conceptual Model of Therapeutic Relationship in TFC

Table 1
Descriptive statistics of study variables

	% or m(sd)
Client Characteristics	
Black	40.98%
Male	74.32%
Age 4–12	23.5%
13–15	39.34%
16–19	37.16%
Time in TFC (years)	1.5(1.5)
BPRS-C	66.27 (17.67)
Parent Characteristics	
Parent race = Black	51.1%
Parent View of Role	
Primarily professional	13.69%
Equally professional and parent	36.9%
Primarily parent	49.41%
Previous Parenting experience	87.69%
Previous TFC experience	26.52%
Program Training/Adherence Characteristics	
Hours of In-Service Training	26.72(24.65)
Regular meetings with supervisor	75.56%
Satisfaction with supervisor	
Dissatisfied	7.82%
Neither Satisfied or Dissatisfied	4.47%
Satisfied	87.71%
Parent-Child Relationship	
Perception of Child's Feelings	3.47 (0.77)
Perception of Own Feelings	3.84 (0.62)
Child Functioning	
BERS Total Score	86.98(24.32)

Table 2
Bivariate models: Regressed on Child BERS scores N = 177

		b	se	
Child Characteristics				
Race	White	-5.16	2.6	*
	Black	6.28	3.69	+
Male		-4.8	4.13	
Age	4-12	-3.33	4.3	
	13-15	-4.98	3.73	
	16-19	7.6	3.73	*
Time in TFC		0.0035	0.0032	
BPRS		-0.14	-0.11	
Treatment Parent Characteristics				
Parent race	White	-7.86	3.63	*
Parent race	Black	6.21	3.63	+
Previous Parenting experience		2.51	5.66	
Previous TFC experience		1.15	4.09	
Parent vs professional		3.72	1.84	*
Program Training/Adherence Characteristics				
Hours of training		2.79	7.59	
Meetings with supervisor		-2.14	4.24	
Satisfaction with supervisor		7.09	1.64	**
Parent-Child Relationship				
TRQ - F1		17.4	2.01	**
TRQ - F2		15.14	2.79	**

⁺ ≤ .10

* ≤ .05

** ≤ .01

TABLE 3

Multivariate Model, Regressed on Child BERS Score

	b	se	t	95% CI
Child Characteristics				
Black	5.12	4.48	1.14	-3.71 13.96
Male	-2.25	3.49	-0.64	-9.14 4.64
Age	2.06	2.03	1.02	-1.94 6.06
Time in TFC (days)	0.002	0.003	0.80	-0.003 0.007
BPRS-C	-0.130	0.093	-1.41	-0.314 0.053
Parent Characteristics				
Parent race = black	2.84	4.43	0.64	-5.91 11.6
Previous TFC experience	0.51	3.58	-0.39	-6.5 7.58
Parenting experience = none	-0.48	4.77	-0.10	-9.9 8.94
Parent or professional	4.13	1.50	2.74	1.16 7.11
Program Training/Adherence Characteristics				
Hours of training in past year	-1.64	1.44	-1.14	-4.5 1.2
Meetings with supervisor	-2.11	1.25	-1.69	-4.57 0.355
Satisfaction w/ supervision	3.09	1.56	1.98	0.007 6.17
Relationship				
TRQ - F1	18.46	2.90	6.37	12.74 24.19
TRQ - F2	-2.84	3.82	-0.74	-10.37 4.7
Adj R ² = .36				
Constant	19.22	15.96	1.2	-12.29 50.75

* ≤ .05

+ ≤ .10

** ≤ .01

*** ≤ .001