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JADE H. REDFERN BSc Hons

**CARING FOR TRAUMATISED LOOKED-AFTER CHILDREN:
THE COSTS AND GAINS OF CARING.**

Section A: Child Welfare Professionals: The psychological impact of caring for traumatised looked-after children. A literature review

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The costs and gains of caring.

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A thesis submitted in partial fulfilment of the requirements of
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SEPTEMBER 2013

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

CANTERBURY CHRIST CHURCH UNIVERSITY
Doctorate in Clinical Psychology (D.Clin.Psychol.)

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(e.g. Clinical Portfolio Part 1, Child PPR, QIP)

Major Research Project

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SUBMISSION DATE

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Summary of the MRP portfolio

Section A is a review of the literature on the psychological impacts experienced by child welfare professionals working with traumatised looked-after children. Relevant theories are explored and discussed in relation to burnout, secondary trauma/ compassion fatigue, vicarious trauma, compassion satisfaction and post-traumatic growth. Limitations of the literature and suggestions for future research are included.

Section B explores foster parents' lived experiences of caring for traumatised looked-after children and the impact the young person's trauma may have on the foster parents and their families using Interpretative Phenomenological Analysis. Semi-structured interviews were carried out with eleven foster parents. The master- and sub-themes from the results are presented and discussed, taking account of prior research findings. Clinical and research implications are also deliberated.

Section C is a critical appraisal of section B, offering reflections on the research process including research skills learned, future learning needs, what could have been done differently, and both clinical and future research implications emanating from the study.

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JADE H. REDFERN BSc Hons

Section A:

Child Welfare Professionals: The psychological impact of caring for traumatised looked-after children. A literature review

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Abstract

Section A provides a definition of looked-after children (LAC) in the UK, the mental health difficulties they often experience and the role of child welfare professionals (CWPs). CWP is an American term used in this paper to encompass all social workers and child protection workers who work with LAC. The aim of this paper is to review the literature and key conceptualisations of the psychological impact of trauma in LAC on CWPs. The 30 empirical studies included in this review explored the concepts of burnout; secondary trauma/ compassion fatigue; vicarious trauma; compassion satisfaction; and post-traumatic growth. LAC have complex emotional needs that significantly impact on professionals caring for them. Overall the research suggests that working with LAC has both positive and negative impacts on CWPs, including a marked impact on their psychological wellbeing. Overall, research in this area suggest that CWPs suffer high stress levels, which may lead to significant difficulties with burnout, compassion fatigue and vicarious trauma, despite experiencing high levels of personal accomplishment or satisfaction with their work. Limitations of the literature and suggestions for future research are included.

Introduction

Looked-after children

The Children Act 1989 defines looked-after children (LAC) as “a child looked-after by a local authority if he or she is in their care or is provided with accommodation for more than 24 hours by the authority” (p. 29). LAC live either in foster placements (placement of a child by a local authority with a foster parent/ family), kinship care (placed with a relative or next of kin), or residential homes.

Residential homes for LAC in the UK, either private or run by local authorities, provide for around 12% of children in care (Department of Education, 2011), attending to LAC’s physical, psychological and behavioural difficulties (Watson, 2003).

Mental health needs of LAC

LAC enter care for a variety of complex reasons, most commonly physical abuse; sexual abuse; neglect; incarceration of a parent without another relative to care for them; and abandonment (Meltzer, Gatward, Goodman, & Ford, 2002). LAC often have histories of recurrent interpersonal trauma caused by their caregivers, often early in life. This is referred to as complex trauma, causing a diverse range of reactions (Greeson et al., 2011). According to Burns et al. (2004) around three-quarters of LAC show significant social and behavioural difficulties. LAC frequently experience mental health difficulties as a result of complex trauma (Naughton, 2008). Post-traumatic stress disorder (PTSD); abuse-related trauma; behavioural disorders (including conduct disorder and attention-deficit hyperactivity disorder); depression; and substance abuse appear to be among the most prevalent conditions (Landsverk, Burns, Stambaugh, & Rolls-Reutz, 2006).

LACs’ mental health problems are complex and poorly conceptualised and current diagnostic tools are not always able to capture the multifaceted nature of the impact the trauma has on them (Tarren-Sweeney, 2008). Compared with other types of trauma, LAC with complex trauma histories have much higher rates of internalisation, PTSD and clinical diagnoses (Greeson et al., 2011); although not all meet the criteria for a PTSD diagnosis. A large-scale survey of 2,500 LAC in the UK found 45% suffered from a mental health disorder: 37% had clinically significant conduct disorder;

12% experienced emotional disorders – anxiety and depression; and 7% were highly hyperactive (Meltzer et al., 2002).

Child welfare professionals

The broad term child welfare professionals (CWPs) used in this paper is also found within the literature, describing the professionals working with LAC (e.g. Janoski, 2010). The term CWPs includes a wide range of professionals, including social workers, residential child care workers and child protection professionals (these terms often used interchangeably), whose work is immersed in the care and protection of LAC.

CWPs may become traumatised by their experiences at work, either directly via LACs' externalising behaviours, or indirectly through hearing and reading about their traumatic pasts (Meyers & Cornille, 2002). The high turnover of CWPs has large financial consequences for the state, increased burden on the remaining workforce and clients in terms of discontinuities of services, which can exacerbate negative outcomes and feelings of helplessness, abandonment and rejection (Meltzer et al., 2002). Empathy and attachment, two vital ingredients required for this work, can make CWPs' role both satisfying and emotionally exhausting (Pines & Aronson, 1988).

Conceptualisations in the literature: psychological impact of working with trauma

A number of terms are used in the literature to describe the psychological impact of working with trauma. This paper attempts to define these concepts and describe the key theoretical underpinnings found within the literature. However, it is important to note that the concepts known as burnout, secondary trauma/ compassion fatigue, vicarious trauma, compassion satisfaction and post-traumatic growth are used interchangeably and are based on numerous theories.

Burnout is used to describe a state of exhaustion through excessive demands being placed on an individual that gradually depletes their energy, strength and resources (Schaufeli, 1999). Burnout describes the emotional consequences for professionals working intensely with other people's problems (Maslach, 1982) and is characterised as a form of emotional exhaustion (EE). The helper experiences a reduced sense of personal accomplishment (PA) and increased depersonalisation (DP).

Burnout develops gradually but if unrecognised or ignored, may get progressively worse (Figley, 1995).

There are several theories posited within the literature, which are used interchangeably to understand the antecedents of burnout and its range of symptoms, including affective (e.g. depressed mood), cognitive (e.g. thoughts of hopelessness and powerlessness), physical (e.g. headaches, nausea, fatigue), behavioural (e.g. impulsive or in contrast indecisive) and motivational symptoms (e.g. lack of enthusiasm) (Schaufeli & Enzmann, 1998). Burnout theories appear to be rooted mainly in general stress theories, emphasising the interaction between the work characteristics (i.e. large caseloads) and the employee (Schaufeli & Enzmann, 1998). However, commonly used is the Person-Environment-Fit Theory (PE-Fit theory) (French, Caplan, & Harrison, 1982). This suggests that an imbalance between demands and opportunities in one's job, and the employee's skills and expectations are likely to cause stress, and potentially burnout. In addition to this, Lazarus and Folkman (1984) suggested a more interactive process, which addressed people's appraisals of stressful situations and their perceptions of their ability to manage these.

Secondary trauma (ST) is described by Figley (1995) as the emotional duress experienced by persons having close contact with a trauma survivor, especially concerned family members trying to help a person suffering. The transfer of trauma symptoms can pass from the victim to those who have close and prolonged contact with them (Motta, Kefer, Hertz, & Hafeez, 1999). This process occurs as a direct result of hearing emotionally shocking material from or about a client (Iliffe & Steed, 2000). Figley (1995, 2002a, 2002b). Others have suggested ST and burnout symptoms overlap (e.g. Jenkins & Baird, 2002; Nelson-Gardell & Harris, 2003; Stamm, 2002). However, Figley (2002b) stated that ST differs from burnout; particularly as the onset of ST symptoms emerge suddenly with little warning.

Figley (1995) began using the less stigmatising term compassion fatigue (CF) to describe ST symptoms, both of which are used interchangeably within the literature. The symptoms fall under the same clusters as PTSD: flashbacks; sleep disturbance; nightmares; hyperarousal; irritability; anxiety; and perceived loss of control (Pearlman & Saakvitne, 1995).

Vicarious trauma (VT) also describes the impact on mental health professionals working with trauma victims, when the symptoms transfer from the trauma survivor to the professional (Kassam-Adams, 1999; Schauben & Frazier, 1995). McCann and Pearlman's (1990) Constructivist Self-Development Theory (CSDT) is used as a framework for understanding the aetiology of VT. The CSDT outlines five personality aspects affected by VT: frame of reference; self-capacities; ego resources; psychological needs and related cognitive schemas; and memory and perception. According to CSDT, people construct their reality through the development of cognitive structures, which are then used to interpret events in pursuit of meaning. Trauma can disrupt a person's cognitive schemata in one or more of five fundamental need areas: safety; trust/dependency; esteem; control; and intimacy. These significant psychological effects, if untreated, can persist for months or years and modify the meanings used to interpret events in their life and others (McCann & Pearlman, 1990).

Compassion satisfaction (CS) describes the pleasure derived from helping others, including positive feelings about colleagues, contributions to the work setting, or even the greater good of society through working with LAC. CS relates to workers' perceived success and support offered by colleagues to achieve their aims (Conrad & Kellar-Guenther, 2006).

Post-traumatic Growth (PTG) is described in the literature (e.g. Regehr, Hemsworth, Leslie, Howe, & Chau, 2004) as the positive impact experienced following a traumatic event, including an increase in the appreciation of others, self-efficacy, social and personal resources, new coping skills and self-knowledge (Tedeschi & Calhoun, 1996). The positive psychological impact of working with LAC might provide helpful changes to CWPs' lives and may even mitigate the potential for developing burnout, CF or VT.

Aims of Review

Taking this context into account, it is fundamental to the health and wellbeing of LAC to better understand the experiences and wellbeing of CWPs. They are required to develop relationships with LAC and their families. However, if unable to sustain their own emotional wellbeing, which is conducive to the care they can offer, these relationships are likely to break down, exacerbating the rejection and traumatic disturbances LAC experience (Meyers & Cornille, 2002). This review looks

systematically at the empirical research, exploring burnout; ST/CF; VT; CS and PTG, in order to understand the psychological impact LACs' trauma has on CWPs.

Review

A systematic search of electronic databases (PsycINFO, Cochrane Database, Medline, ASSIA) was conducted to identify qualitative and quantitative research exploring the psychological impact of working with traumatised LAC on CWPs (see Appendix A for full details of the databases, search terms and inclusion/ exclusion criteria). Thirty papers met the inclusion criteria. These were critically evaluated, drawing on the recommendation of Greenhalgh (1997a; 1997b; 1997c) and Yardley (2000).

Study categorisation

The studies were categorised according to key conceptualisations found within the literature, pertaining to the impact working with traumatised LAC can have on CWPs, including burnout, secondary trauma (ST)/ compassion fatigue (CF), vicarious trauma (VT), compassion satisfaction (CS) and post-traumatic growth (PTG). Several studies were included in more than one category since they explored more than one key concept. Further to this, some studies were discussed in relation to qualitative data, which may not have investigated quantitative measures of these concepts but explored qualitatively the impact of working with LAC – discussing the stresses, strains and gains of the CWPs' work.

Burnout

Burnout can occur as a result of working with any client group (Ilfie & Steed, 2000). However, it has been suggested that burnout is more common among CWPs compared to other social workers, such as those working in adult mental health (Ballew, Salus, & Winett, 1979). Twenty studies explored the concept of burnout in CWPs. Of these, 14 measured burnout using the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1986), a 22-item questionnaire designed to measure the criterion variables of emotional exhaustion (EE), depersonalisation (DP) and personal accomplishment (PA) separately. Two studies used the MBI-Human Service Survey (MBI-HSS; Maslach, Schaufeli, & Leiter, 2001), three studies used the Professional Quality of Life Survey

(ProQOL; Stamm, 2006), whilst one study used the Compassion Satisfaction/Fatigue Self-Test (CSFT; Figley & Stamm, 1996) (see table 1).

Table 1: Studies measuring burnout

Study	Burnout measurement used
Jayaratne, Chess, & Kunkel (1986)	MBI
Anderson (2000)	MBI
Bennett, Plint, & Clifford (2005)	MBI
Boyas & Wind (2010)	MBI
Boyas, Wind, & Kang (2012)	MBI
Savicki & Cooley (1994)	MBI
Smith & Clark (2011)	MBI
Bhana & Haffejee (1996)	MBI
Jayaratne & Chess (1986)	MBI
Reagh (1994)	MBI
Mann-Feder & Savicki (2003)	MBI
Drake & Yadama (1996)	MBI
Savicki (1993)	MBI
Manlove (2010)	MBI
Kim (2011)	MBI-HSS
Stevens & Higgins (2002)	MBI-HSS
Van Hook et al. (2008)	ProQOL
Sprang, Craig, & Clark (2011)	ProQOL
Eastwood & Ecklund (2008)	ProQOL
Conrad & Kellar-Guenther (2006)	CSFT

High levels of burnout were reported by several studies. Jayaratne et al. (1986) found 'high' levels of burnout, which appeared related to symptoms of depression, anxiety, irritableness and lower marital satisfaction. However, no differences were found between marital satisfactions of the CWPs' husbands. A causal relationship could not be established since the extent to which marital problems affected job performance was not measured. This study's high use of statistical testing increased the likelihood of chance findings. Boyas and Wind (2010) found high levels of burnout, particularly among younger, less experienced workers. However, causal relationships were not identifiable and without longitudinal data, there remains a lack of understanding regarding how burnout manifests over time. Bennett et al. (2005) reported that 13.5% of CWPs presented with high levels of burnout, from a sample of 126 current workforce and 13 former members. They did not differentiate between the scores of current or former CWPs. However, two thirds of the current workforce suggested they had considered resigning and former members cited primarily 'burnout' and 'job stress' as reasons for leaving. Furthermore, Sprang et al. (2011) found CWPs reported significantly higher burnout compared to other professional groups.

Emotional Exhaustion (EE), Depersonalisation (DP) and Personal Accomplishment

(PA): Some studies differentiated between the three constructs of burnout, as measured by the MBI. Anderson (2000) reported 62% (n=151) of veteran¹ CWPs scored within the high range on EE, the moderate range on DP and the low end of the moderate range on PA. CWPs' scores were higher than those of other professionals. This research used a large sample, with a high response rate. However, no data were gathered for non-respondents and the findings relied upon self-report measures. Savicki and Cooley (1994) support the notion that, as EE and DP increase, PA decreases. However, causality remains unidentifiable. In contrast, Bhana and Haffejee (1996) found 62% (n=29) of CWPs in South Africa experienced 'moderate' EE, whilst 14% experienced 'high' EE. More concerning was the 86% experiencing 'high' DP, despite scoring high on PA, suggesting PA may not protect against burnout. However, these results should be interpreted with caution since both used relatively small sample sizes, without control groups or validated measures, possibly producing biased results. Smith and

¹ two years or more experience

Clark (2011) used a large sample (n=1001) of CWPs and found high levels of EE (44%) but only 19% reported high levels of DP and 24% reported low PA. Stevens and Higgins (2002) found CWPs (n=44) displayed high levels of EE and DP (100%), and low levels of PA (75%), suggesting high levels of burnout, despite several demonstrating a high level of PA. These studies suggest that the psychological impact might vary between individuals, with many CWPs remaining positive despite experiencing burnout.

In contrast, three studies reported CWPs were not at high risk of developing burnout (Mann-Feder & Savicki, 2003; Conrad & Keller-Guenther, 2006; Van Hook et al., 2008). Participants scored highly on either PA or compassion satisfaction, demonstrating professionals that maintain a sense of meaning from their work are perhaps protected from burnout (Savicki, 2002). Alternatively, three studies have suggested that CWPs with increased burnout may retain job satisfaction (Reagh, 1994; Bhana & Haffjee, 1996; Bennett et al., 2005). Although, this contradicts the view that high levels of PA or satisfaction might prevent burnout, these studies suggest that burnout may still exist but perhaps exhibit less impact on those maintaining a sense of meaning from their work.

Burnout, related to job stress was explored in six studies, which attempted to differentiate between the impact that role ambiguity², role conflict³ and workload can have on CWPs. Harrison (1980) found high degrees of role conflict and role ambiguity and low levels of job satisfaction in CWPs compared to social workers not working with LAC. Similarly, Manlove (2010) found high role conflict and role ambiguity predicted higher levels of both EE and DP and lower levels of PA. Jayaratne and Chess (1986) reported high levels of role conflict, role ambiguity and workloads significantly predicted DP, which appeared to predict low PA. However, neither contributed toward EE. In contrast, both Savicki and Cooley (1994) and Boyas et al. (2012) suggested work pressures increased EE and decreased feelings of PA, whereas job stress increased DP. However, it was not clear exactly what constituted 'work pressures' or 'job stress,' and how the LACs' trauma impacted upon them.

² role expectations lack clear definitions

³ incompatibility between role requirements and expectations

Kim (2011) found CWPs experienced greater workloads, role conflict and DP, with low PA compared to other social workers, but with similar unmet expectations and EE. These findings may not generalise to the UK since the research was carried out in California. Although the large sample size and the use of validated measures increased the reliability and validity of these results, the findings might be compounded by the possibility that burnout may affect the professional's perceptions of their working environment.

Intentions to leave and job exits were considered as a potential consequence of working with LAC (Bennett et al., 2005; Hopkins, Cohen-Callow, Kim, & Hwang, 2010; Drake & Yadama, 1996; Smith & Clark, 2011) if the psychological impact on CWPs becomes overwhelming. Hopkins et al. (2010) suggested that the potential consequences of unrecognised burnout might manifest in more subtle forms than intending to or actually leaving one's job. CWPs, particularly younger (<40) men, highly stressed, with more work experience with LAC showed high levels of withdrawal (e.g. absenteeism) and disengagement from work, without resigning. Nonetheless, their findings suggested that the probability of resigning was higher in those experiencing more stress. However, Smith and Clark (2011) found most respondents continued in their jobs despite high levels of EE. Still, CWPs who had left their jobs were, on average, experiencing greater burnout. It is possible that differences found within these results are somewhat attributable to the differences in the measurements of burnout used.

Secondary trauma/ Compassion fatigue

CWPs' attempts to repair attachments and empathise with LAC to bring about therapeutic change, might place them at greater risk of internalising the child's trauma and developing ST symptoms (Figley, 1995). Six studies (Cornille & Meyers, 1999; Nelson-Gardell & Harris, 2003; Conrad & Kellar-Guenther, 2006; Eastwood & Ecklund, 2008; Van Hook et al., 2008; Sprang et al., 2011) have attempted to measure ST/CF in CWPs. Cornille and Meyers (1999) found that 37% (n=205) experienced clinical levels of emotional distress associated with ST. They measured ST using the Impact of Events Scale-Revised (Weiss & Marmar, 1997) and the Symptom Checklist-90-R (SCL-90-R; Derogatis, 1975) to assess psychological distress symptoms. CWPs reported greater

symptomatology compared to the general population but less than outpatient psychotherapy clients. In support of this, Conrad and Kellar-Guenther (2006), used the Compassion Satisfaction/ Fatigue Self-Test (Figley & Stamm, 1996) and found 50% (n=363) reported “high” or “very high” levels of CF. However, without any longitudinal data, these results do not take into account any CF symptoms in professionals prior to entering the field.

Eastwood and Ecklund (2008) agree that CF might be a ‘specialised form’ of burnout (Figley, 2002b). Their findings suggest that burnout levels might be a significant component in the etiological understanding of CF. However, these cross-sectional data do not allow the determination of causality. The psychological impact of working with LAC is perhaps more complicated than these psychometric measures demonstrate, following only a linear model of understanding. Nonetheless, the literature has attempted to address in more detail certain risk factors that might increase or decrease the likelihood of CWPs developing CF (see table 2).

Table 2: Risk factors associated with CF

Study	Factors associated with secondary trauma/compassion fatigue					
	Age	Gender	Experience level	Personal trauma history	Hours	Direct vs. indirect contact
Van Hook et al. (2008)	Younger age	Female CWPs	-	-	-	Direct contact
Sprang et al. (2011)	Younger age	Male CWPs	-	-	-	-
Manlove (2010)	Younger age (<40 years)	-	-	-	-	-
Boyas & Wind (2010)	Younger age (<40 years)	-	Less experience	-	-	-
Boyas et al. (2012)	Younger age (<40 years)	-	-	-	-	-
Nelson-Gardell & Harris (2003)	No difference	-	-	Personal trauma	Greater number of hours (40hrs+)	-
Cornille & Meyers (1999)	-	Female CWPs	Greater experience	Personal trauma	-	-
Horwitz (2006)	-	-	No difference	-	-	No difference
Savicki (1993)	-	-	-	-	-	Mixed findings
Stevens & Higgins (2002)	-	-	-	Personal trauma	-	-

Table 2 outlines the potential risk factors associated with ST/CF for CWPs. With the exception of Nelson-Gardell and Harris (2003), studies have consistently found that younger CWPs are more at risk of developing ST/CF than older (typically dichotomised at 40 years) CWPs. The reasons for this are unclear. One possibility is that older CWPs have developed better coping strategies through greater experience of working in this field. Studies exploring the relationship between amount of experience and ST/CF however, have found mixed results, possibly reflecting the

disparity in the range of measures used. Studies of gender as a risk factor are inconclusive, with half reporting that male CWPs are at greater risk, and half reporting female CWPs.

CWPs with a history of personal trauma appear to be at greater risk of experiencing ST/CF. However, these professionals might be exhibiting residual or recurrent symptoms emanating from their original primary trauma. More longitudinal or qualitative data is needed to explore these experiences in more detail. This is also true for studies looking at the number of hours worked by CWPs, with one study suggesting working over 40-hours a week increases the risk of developing CF. However, no differentiation was made between frontline and non-frontline professionals. In terms of the amount of direct versus indirect contact with LAC, there were again mixed findings, with one study reporting that CWPs working directly with LAC, compared to supervisors with indirect contact, were at greater risk of developing CF. In contrast, Horwitz (2006) found that vicarious events were reported as frequently as direct events and appeared to have an equally negative impact on caseworkers and supervisors. Another study reported mixed findings that suggested that CWPs in 'continuous contact' with LAC experienced more freedom with authority and supervisory support, but experienced greater stress levels.

Vicarious trauma

According to the Constructivist Self-Development Theory (CSDT; McCann & Pearlman, 1990) VT describes the impact of working with victims of trauma on mental health professionals, by altering their cognitive schemata: frame of reference; self-capacities; ego resources; psychological needs and related cognitive schemas; and memory and perception.

There is a lack of research exploring VT in CWPs. However, Jankoski (2010), using a qualitative approach, explored the cognitive changes experienced by CWPs. Following initial analyses of 24 focus groups and a further 65 one-to-one semi-structured interviews (n=270), Jankoski (2010) concluded that burnout was not the main impact causing workers to leave, since burnout symptoms have a gradual onset, and workers new to the field reported devastating effects as a result of their work. Jankoski (2010) suggested that the experiences described appeared to go beyond those described by CF and seemed deep-rooted and not easily ameliorated. Through further analyses the

transcripts appeared to more closely match the theory and behaviour changes described by the CSDT – all five aspects (frame of reference; self-capacities; ego resources; psychological needs and related cognitive schemas; and memory and perception) were found within the transcripts. Participants expressed how the organisation, the LAC and their own experiences contributed to their feelings of distress. Examples given from the transcripts include “no matter what I do and how hard I try, nothing changes;” “We don’t live in a safe world; I keep my kids close;” “I don’t care about myself anymore, what I look like. I just don’t care anymore;” “Nobody in my family understands what I go through;” “I go home at night and drink myself to sleep.” Also observed in the focus groups were symptoms that mirrored PTSD, including intrusive images, startled responses, multiple triggers and avoidance of certain places.

Jankoski (2010) utilised a large sample size and a team of researchers to discuss all aspects of the analyses and to identify reliable and valid themes. The analyses focused on 17 focus groups and three one-to-one interviews; the researchers selected informants who they felt had provided the richest information and had articulated their concerns well. This method might have produced biased results, since the research team appeared to be looking for whether CF or VT impacted upon CWPs’ experiences. This may have led them to select those who confirmed some of their original assumptions. Nonetheless, the CWPs’ experiences reported upon shed light on the potential negative impact working with LAC might have on professionals.

Compassion satisfaction

To understand the “costs of caring,” we must also explore the potential “benefits.” The literature describes many CWP experiences as positive and rewarding. However, only three studies measured the potential positive psychological impact of working with LAC on CWPs (Van Hook et al., 2008; Conrad & Kellar-Guenther, 2006; Eastwood & Ecklund, 2008). No studies explored the concept of post-traumatic growth with CWPs.

Conrad and Kellar-Guenther (2006) reported that CWPs have a good potential for CS. Those with higher levels of CS also showed lower levels of both CF and burnout. However, contradicting these findings Eastwood and Ecklund (2008) found that CS levels ameliorated burnout but not CF

levels. Van Hook et al. (2008) found CS did appear to reduce levels of both burnout and CF. These studies support the notion that gaining a sense of meaning from one's job may protect against potential burnout (Savicki, 2002). Differences found in these studies' findings may be due to the different measures used and the varied participant samples, with some including only frontline caseworkers (Eastwood & Ecklund, 2008) and others combining frontline and supervisors, managers and clerical staff (Conrad & Kellar-Guenther, 2006; Van Hook et al., 2008). There appears to be a significant lack of research exploring the potential benefits experienced by CWPs from the work they do with LAC.

Further psychological impacts

Three further studies explored the psychological impact of working with LAC on CWPs, the results of which are not fully captured by the constructs of burnout, CF, VT or CS (Reagh, 1994; Gold, 1998; Boverhof, 2006).

Reagh (1994) conducted a naturalistic study on CWPs, using a grounded theory approach. CWPs described how entering the field was motivated by 'being needed' and wanting to 'make a difference,' suggesting they 'find meaning' in their work. Participants shared overwhelmingly negative experiences, yet the successes appeared to keep them in the job and "made it all worthwhile." Using a qualitative approach enabled in-depth analyses of personal experiences.

Gold (1998) interviewed 40 female CWPs in focus groups regarding the positive and negative impacts of their work. Positive aspects included feeling proud of their work; it was rewarding, exciting and challenging, especially seeing positive change in children; good support from trusted co-workers and flexible supervisors. Negative aspects included impossible expectations; high workloads; no control over caseload size; unpredictability of the work; lack of control over court decisions and insufficient resources; feeling disempowered, despite being perceived by parents and foster parents as holding all the power; lack of organisational recognition and praise; low salary; role strain, role ambiguity, and role conflict. They expressed the distress they experienced at work, as "it's being day-to-day, hour-to-hour, minute-to-minute, face-to-face with human suffering" and "you have all this pain coming at you, and it keeps hitting you and hitting you and hitting you. That's the root of the

stress.” Participants also reported significant negative effects on their physical health as a result of stress, such as colds, flus, chest infections, headaches and stomach upsets. Many stated they felt “chronically exhausted” and “emotionally exhausted.” They experienced mood swings, anger, depression, fearfulness, anxiety, low self-esteem, and nightmares – one woman attributed her “nervous breakdown” to work pressures. Several women described feeling “pessimistic,” “cynical” and “jaded,” with a profound mistrust of others and overprotective of their own children. These findings appear to reflect some changes to their cognitive schemas, put forward by the CSDT – although the authors do not relate their findings to VT.

Participants expressed gratitude for the opportunity to talk and felt this validated their mixed feelings about their experiences. Frontline caseworkers, supervisors and managers with different roles and responsibilities all participated. However, their roles were not differentiated between in the results of this study. Also, no measure of burnout or stress was taken to validate participants’ perceptions. Nonetheless, the findings were rich and in-depth and the process was positively experienced by all participants.

Boverhof (2006) compared experiences of novice and experienced front-line workers, via open-ended, semi-structured focus groups. The purposive sample of 13 CWPs reported episodes of feeling physically ill at the thought of going into work and each reported some level of stress, trauma and burnout. Some expressed anger about situations they had endured. However, standardised or validated measures were not used. Nonetheless, the perceptions given by the workers spoke about the physical and emotional impact working with LAC had on them, both in and out of work.

Summary and Conclusions

This review aimed to explore the psychological impact LACs’ trauma may have on CWPs, including burnout; secondary trauma/ compassion fatigue; vicarious trauma; and compassion satisfaction. Furthermore, qualitative data were included which explored CWPs’ experiences further. Overall, the research findings suggest that working with LAC has a significant impact on CWPs. However, this impact can be both positive and negative. Several studies measured a range of constructs, including burnout and CF. However, they often neglected to examine the positive aspects

of the work and perhaps whether or not these positives outweighed the negative impacts of burnout, CF or VT. Nonetheless, research has found significant results, suggesting that many CWPs suffer high stress levels, leading to significant difficulties with burnout, CF and VT, despite experiencing high levels of personal accomplishment or satisfaction with their work.

Clinical implications

Working with LAC appears to provide many with job satisfaction and a sense of purpose. However, it can also have a significant negative impact on CWPs' psychological wellbeing. Services must continue to find ways to monitor and reduce these negative effects, since the turnover of CWPs is costly, both financially to the state, and emotionally to all those involved in the care system. Nonetheless, the evidence to suggest whether symptoms of burnout or CF contribute toward high turnover remains inconclusive.

CWPs' burnout scores were often higher than those of other professionals (e.g. Anderson, 2000). Several studies suggested that CWPs suffering from high emotional exhaustion and symptoms of depersonalisation also suffered from reduced personal accomplishment. However, the methodological designs prevented conclusions being made regarding the causality of the correlational data. Nonetheless, it is pertinent for services to evaluate CWPs levels of distress and potentially low personal accomplishment to improve their emotional wellbeing and ability to carry out a stressful job. In turn, this may enable a better service for traumatised LAC to recover and thrive. This may also moderate the turnover of professionals and further reduce instability and change experienced by LAC, lessening their distress and feelings of abandonment and rejection.

Furthermore, if CWPs, both young and old, novice and experienced can suffer the devastating effects of burnout, CF or VT, despite also experiencing compassion satisfaction, what might the psychological impact on foster/adoptive parents of traumatised LAC be? Foster parents care for LAC seven days a week, often with little respite (Murray, Tarren-Sweeney, & Frances, 2010). If they suffer similar or worse psychological impacts, what effect might the spread of trauma have on them and their families? If foster parents' emotional wellbeing was reduced and more stresses and strains were experienced, the LAC's placement may break down. This may necessitate yet another change for the

LAC, increasing their feelings of abandonment and rejection and make any therapeutic change unlikely (Meltzer et al., 2002).

Research implications

The research included in this review enabled a greater understanding about the different psychological impacts of working with LAC on CWPs. However, there remains a lack of clarity in the definitions of the psychological impacts being measured, which makes it difficult for future research to build on. Also many of the findings came from correlational data, which prevent identifying causal relationships. Without longitudinal data, there remains a lack of understanding regarding how burnout manifests over time. Some studies neglected to differentiate between the scores of those who remained in the workforce and those who had left, which again limits firm conclusions. The research often relied upon self-report measures alone, guiding the findings and limiting the exploration of in-depth experiences. The majority of the research was carried out in either America or Canada, therefore may not generalise to other geographical areas, such as the social care system and National Health Service in the UK.

Overall, the research offered a good insight into the psychological impact of working with LAC on CWPs, including the positive impact of compassion satisfaction. Large sample sizes, both quantitative and qualitative data suggest a multitude of different experiences. The research often did not differentiate between frontline CWPs and those working indirectly with LAC. The studies that did differentiate revealed that both frontline and non-frontline staff were negatively affected by the traumatic material they are exposed to.

Future research should continue to differentiate between the different professionals and job responsibilities, and conduct more qualitative investigations to ascertain in more detail the professionals' experiences. This research may help develop more sensitive tools to assess and inform targeted interventions and prevention strategies for all those working in foster care.

Following a wider search of the literature, including the terms 'foster parents,' 'foster carers' and 'adoptive parents,' there appears to be a gap in the research on foster/adoptive parents' experiences and the possible psychological impact on them and their families from working with

traumatised LAC. The measures to date have been designed to assess the impact of working with trauma on mental health professionals (e.g. Jenkins & Baird, 2005) and not for foster parents. Adoptive/ foster parents care for traumatised LAC every day of the week, with little respite and yet research has not explored their experiences. Also the terms CF and VT for example continue to be used interchangeably and with poor theoretical understandings. Nonetheless, if CF or VT affects foster parents in similar ways to CWPs, then understanding this is paramount for both the wellbeing of foster parents and the LAC they care for. Future research might require qualitative research approaches, to gain a sense of the meaning foster/adoptive parents' make of their experiences, since their roles and responsibilities are quite different to that of other allied health professionals.

References

- Anderson, D. G. (2000). Coping strategies and burnout among veteran child protective workers. *Child Abuse & Neglect*, 24, 839-848.
- Ballew, J. R., Salus, M. K. & Winett, S. (1979). Supervising child protective service workers (DHEW Publication No. [OHDS] 79-30197). Washington, DC: National Center on Child Abuse and Neglect.
- Bennet, S., Plint, A. & Clifford, T. J. (2005). Burnout, psychological morbidity, job satisfaction, and stress: a survey of Canadian hospital based child protection professionals. *Archives of Disease in Childhood*, 90, 1112-1116.
- Bhana, A. & Haffejee, N. (1996). Relation among measures of burnout, job satisfaction and role dynamics for a sample of South African child-care social workers. *Psychological Reports*, 79, 431-434.
- Boverhof, H. A. E. (2006). Front-line child welfare experiences of work related stress, trauma, and burnout: Is experience a mediating factor? (Master's thesis, McMaster University). Retrieved from <http://digitalcommons.mcmaster.ca/opendissertations/4843/>
- Boyas, J. & Wind, L. H. (2010). Employment-based social capital, job stress, and employee burnout: A public child welfare employee structural model. *Children and Youth Services Review*, 32, 380-388.
- Boyas, J., Wind, L. H. & Kang, S. (2012). Exploring the relationship between employment-based social capital, job stress, burnout, and intent to leave among child protection workers: An age-based path analysis model. *Children and Youth Services Review*, 34, 50-62.
- Burns, B.J., Phillips, S.D., Wagner, H.R., Barth, R.P., Kolko, D.J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43, 960-970.

- Children Act 1989, ch. 41. Retrieved from <http://www.legislation.gov.uk/ukpga/1989/41/contents>
- Conrad, D. & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse and Neglect*, 30, 1071-1080.
- Department of Education. (2011). Children looked after by local authorities in England, including adoption. Retrieved from <https://www.gov.uk/government/publications/children-looked-after-by-local-authorities-in-england-including-adoption>
- Derogatis, L. (1975). Brief symptom inventory. Baltimore: Clinical Psychometric Research.
- Drake, B. & Yadama, G. N. (1996). A structural equation model of burnout and job exit among child protective services workers. *Social Work Research*, 20, 179-187.
- Eastwood, C. D. & Ecklund, K. (2008). Compassion fatigue risk and self-care practices among residential treatment center childcare workers. *Residential Treatment for Children & Youth*, 25, 103-122.
- Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorders in those who treat the traumatized*. New York: Brunner/Mazel.
- Figley, C. R. (2002a). Compassion fatigue: psychotherapists' chronic lack of self care. *Journal of Clinical Psychology*, 58, 1433-1441.
- Figley, C. R. (2002b). *Treating compassion fatigue*. New York: Brunner-Routledge.
- Figley, C. R. & Stamm, B. H. (1996). Psychometric review of Compassion Fatigue Self Test. In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 127-130). Lutherville, MD: Sidran Press.
- French, J. R. P., Caplan, R. D., & Van Harrison, R. (1982). *The mechanisms of job stress and strain*. New York: Wiley.
- Gold, N. (1998). Using participatory research to help promote the physical and mental health of female social workers in child welfare. *Child Welfare*, 77, 701-724.

- Greenhalgh, T. (1997a). How to read a paper. Getting your bearings (deciding what the paper is about). *British Medical Journal*, 315, 243–246.
- Greenhalgh, T. (1997b). How to read a paper. Statistics for the non-statistician. I: Different types of data need different statistical tests. *British Medical Journal*, 315, 364–366.
- Greenhalgh, T. (1997c). How to read a paper. Statistics for the non-statistician. II: “Significant” relations and their pitfalls. *British Medical Journal*, 315, 422–425.
- Greeson, J. K. P., Briggs, E. C., Kisiel, C. L., Layne, C. M., Ake, G. S., Ko, S. J, et al. (2011). Complex trauma and mental health in children and adolescents placed in foster care: Findings from the national child traumatic stress network. *Child Welfare*, 90, 91-108.
- Harrison, D. W. (1980). Role strain and burnout in child-protective service workers. *Social Service Review*, 54, 31-44.
- Hopkins, K. M., Cohen-Callow, A., Kim, H. & Hwang, J. (2010). Beyond intent to leave: Using multiple outcome measures for assessing turnover in child welfare. *Children and Youth Services Review*, 32, 1380-1387.
- Horwitz, M. J. (2006). Work-related trauma effects in child protection social workers. *Journal of Social Service Research*, 32, 1-18.
- Iliffe, G., & Steed, L. (2000). Exploring the counselor’s experience of working with perpetrators of domestic violence. *Journal of Interpersonal Violence*, 15, 393-412.
- Jankoski, J. A. (2010). Is vicarious trauma the culprit? A study of child welfare professionals. *Child Welfare*, 89, 105-120.
- Jayaratne, S. & Chess, W. A. (1986). Job stress, job deficit, emotional support, and competence: their relationship to burnout. *The Journal of Applied Social Sciences*, 10, 135-155.
- Jayaratne, S. Chess, W. A. & Kunkel, D. A. (1986). Burnout: Its impact on child welfare workers and their spouses. *Social Work*, 31, 53-59.

- Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress*, 15, 423-432.
- Kassam-Adams, N. (1999). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators* (2nd ed., pp. 37-47). Lutherville, MD: Sidran Press.
- Kim, H. (2011). Job conditions, unmet expectations, and burnout in public child welfare workers: How different from other social workers? *Children and Youth Services Review*, 33, 358-367.
- Landsverk, J. A., Burns, B. J., Stambaugh, L. F., & Rolls Reutz, J. A. (2006). *Mental Health Care for Children and Adolescents in Foster Care: Review of Research Literature*. Seattle, WA: Casey Family Programs. Retrieved from <http://www.casey.org/Resources/Publications/MentalHealthCareChildren.htm>
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.
- Manlove, E. E. (2010). Conflict and ambiguity over work roles: The impact on child care worker burnout. *Early Education & Development*, 5, 41-55.
- Mann-Feder, V. & Savicki, V. (2003). Burnout in Anglophone and Francophone child and youth workers in Canada: A cross-cultural comparison. *Child & Youth Care Forum*, 32, 337-354.
- Maslach, C. (1982). *Burnout: The cost of caring*. Englewoods Cliffs, NJ: Prentice Hall.
- Maslach, C., & Jackson, S. E. (1986). *Maslach Burnout Inventory Manual*, 2nd edition. Palo Alto, CA: Consulting Psychologists Press.
- Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology*, 52, 397-422.
- McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: a framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3, 131-149.

- Meltzer, H., Gatward, R., Goodman, R., & Ford, T. (2002). Mental health of children and adolescents in Great Britain. London: The Stationary Office.
- Meyers, T. W., & Cornille, T. A. (2002). The trauma of working with traumatised children. In C. R. Figley (Ed.). *Treating compassion fatigue* (pp. 39-56). New York: Brunner-Routledge.
- Motta, R. W., Kefer, J. M., Hertz, M. D., & Hafeez, S. (1999). Initial evaluation of the secondary trauma questionnaire. *Psychological Reports*, 85, 997-1002.
- Murray, L., Tarren-Sweeney, M. & Frances, K. (2010). Foster carer perceptions of support and training in the context of high burden of care. *Child and Family Social Work*, 16, 149-158.
- Naughton, M. (2008). Every child every chance: *A good childhood is in everyone's best interests*. Retrieved from Victoria, Australia: Department of Human Services website: <http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/reportspublications/good-childhood-is-in-everyones-best-interests-mick-naughton>
- Nelson-Gardell, D., & Harris, D. (2003). Childhood abuse history, secondary traumatic stress, and child welfare workers. *Child Welfare*, 82, 5-26.
- Pearlman, L. A. & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W. W. Norton.
- Pines, A. & Aronson, E. (1988). *Carer burnout: Causes and cures*. New York: Free Press.
- Reagh, R. (1994). Public welfare professionals – those who stay. *Journal of Sociology and Social Welfare*, 21, 69-78.
- Regehr, C., Hemsworth, D., Leslie, B., Howe, P. & Chau, S. (2004). Predictors of post-traumatic distress in child welfare workers: a linear structural equation model. *Children and Youth Services Review*, 26, 331-346.
- Savicki, V. (1993). Clarification of child and youth care identity through an analysis of work environment and burnout. *Child & Youth Care Forum*, 22, 441-457.

- Savicki, V. (2002). *Burnout across thirteen cultures: Work, stress, and coping in child and youth care workers*. Westport, CT: Praeger.
- Savicki, V. & Cooley, E. J. (1994). Burnout in child protective service workers: a longitudinal study. *Journal of Organizational Behavior*, 15, 655-666.
- Schauben, L., & Frazier, P. (1995). Vicarious trauma: The effects on female counsellors of working with sexual violence survivors. *Psychology of Women Quarterly*, 19, 49-64.
- Schaufeli, W. (1999). Burnout. In J. Firth-Cozens & R. Payne (Eds.), *Stress in health professionals. Psychological and organisational cause and interventions* (pp.17-32). New York: John Wiley & Sons Ltd.
- Schaufeli, W., & Enzmann, D. (1998). *The burnout companion to study and practice: A critical analysis*. London: Taylor & Francis.
- Smith, R. J. & Clark, S. J. (2011). Does job resource loss reduce burnout and job exit for professionally trained social workers in child welfare? *Children and Youth Services Review*, 33, 1950-1959.
- Sprang, G., Craig, C. & Clark, J. (2011). Secondary traumatic stress and burnout in child welfare workers: A comparative analysis of occupational distress across professional groups. *Child Welfare*, 90, 149-168.
- Stamm, B. H. (2002). Measuring compassion satisfaction as well as fatigue: Developing history of the compassion satisfaction and fatigue test. In C. R. Figley (Ed.), *Treating compassion satisfaction* (pp. 107-119). New York: Brunner-Routledge.
- Stamm, B. H. (2006). *The ProQOL Manual. The Professional Quality of Life Scale: Compassion Satisfaction, Burnout, Compassion Fatigue/Secondary Trauma Scales*. Institute of Rural Health Idaho State University.
- Stevens, M. & Higgins, D. J. (2002). The influence of risk and protective factors on burnout experienced by those who work with maltreated children. *Child Abuse Review*, 11, 313-331.

- Tarren-Sweeney, M. (2008). The mental health of children in out-of-home care. *Current Opinion in Psychiatry*, 21, 345-349.
- Tedeschi, R., & Calhoun, L. (1996). The post-traumatic growth inventory: measuring the positive legacy of trauma. *Journal of Traumatic Stress*, 9, 455-471.
- Van Hook, M. P., Rothenberg, M., Fisher, K., Elias, A., Helton, S., Williams, S., ... & Gregory, A. (2008). Quality of life and compassion satisfaction/ fatigue and burnout in child welfare workers: A study of the child welfare workers in community based care organisations in central Florida. Paper presented at the North American Association of Christians in Social Work Convention, Orlando, FL. Retrieved from <http://www.nacsw.org/Publications/Proceedings2008/VanHookMQuality.pdf>
- Watson, D. (2003). Defining quality of care for LAC: frontline workers' perspectives on standards and all that? *Child and Family Social Work*, 8, 67-77.
- Weiss, D. & Marmar, C. (1997). Impact of event scale revised. In J. Wilson & T. Keane (Eds.), *Assessing psychological trauma and post traumatic stress disorder*. New York: Guildford Press.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15, 215-228.

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Section B:

Foster parents' lived experiences of caring for traumatised looked-after children:

The costs and gains of caring.

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Abstract

Research has evidenced variously the impact on those caring for traumatised people, such as wives of distressed police officers, partners of war veterans and trauma counsellors. However, there is a lack of research exploring the impact on foster parents (FPs) caring for traumatised looked-after children (LAC). This study aimed to explore FPs' experiences of caring for traumatised LAC, including their understanding of the impact the trauma has on the young person and on themselves and their biological family. Eleven FPs were interviewed to elicit their personal experiences of caring for traumatised LAC and its impact on them, the young people and the FPs' families. Transcripts were analysed using Interpretative Phenomenological Analysis (IPA). Six master-themes emerged from the data: emotional impact on foster parents, cognitive impact on foster parents, impact from the wider fostering system, impact on foster parents' family and friends, foster parent coping and perceived understanding of the impact of trauma on LAC. These themes were linked to previous research and existing theoretical constructs, such as secondary trauma (ST), vicarious trauma (VT) and compassion satisfaction. Whilst all related experiences within each of the themes, participants differed between which themes dominated. FPs experience a variety of complex negative impacts from caring for traumatised LAC, that warrants further investigation and development of screening tools to measure potential ST/VT symptoms. However, several FPs reported a wealth of positive experiences from their role, which may or may not counteract these symptoms.

Introduction

Research has shown that those caring for traumatised others are at risk of becoming traumatised themselves, (Kassam-Adams, 1999) but perhaps with the right knowledge/ support may also thrive from their experiences (Conrad & Kellar-Guenther, 2006). The Children Act 1989 defines looked-after children (LAC) as “a child is looked-after by a local authority if he or she is in their care or is provided with accommodation for more than 24 hours by the authority” (p. 29). LAC can live in foster placements (child placed by a local authority with a foster parent/family); kinship care (placed with a relative or next of kin); or residential homes. According to the Department for Education (2012), on 31 March 2012, 50,260 children were living in foster placements, nearly four-fifths (79%) of the 63,450 LAC in the UK.

According to Pearlman and Saakvitne (1995), psychological trauma is an individual experience of an event or enduring conditions whereby the individual experiences overwhelming emotional distress, experiencing a (subjective) threat to life. This study did not restrict its definition of trauma using post-traumatic stress disorder (PTSD) criteria from the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000). LAC with histories of severe and multiple interpersonal traumas commonly exhibit a complex array of trauma symptoms, not fully captured by such a narrow diagnosis (Greenson et al., 2011).

Traumatised LAC

Traumatised LAC⁴ commonly experience physical abuse, sexual abuse, neglect, and several forms of abandonment prior to, and sometimes during, their time in care. Many have experienced early-life complex trauma, involving recurrent interpersonal difficulties with their caregivers, resulting in a diverse range of reactions (Greenson et al., 2011). Mental health difficulties (Naughton, 2008) including PTSD; abuse-related trauma; behavioural disorders (including conduct disorder and attention-deficit hyperactivity disorder); depression; and substance abuse appear to be among the most prevalent conditions (Landsverk, Burns, Stambaugh, & Rolls Reutz, 2006).

⁴ From here on traumatised LAC will be referred to as LAC

LACs' mental health difficulties are complex and poorly conceptualised. Current diagnostic tools are not always able to capture the multi-faceted nature of the impact their trauma has on them (Tarren-Sweeney, 2008). Compared with other types of trauma, LAC have much higher rates of internalisation, PTSD and clinical diagnoses (Greeson et al., 2011); although not all meet criteria for a PTSD diagnosis. A large-scale survey of 2,500 LAC in the UK found 45% suffered from a mental health disorder: 37% had clinically significant conduct disorder; 12% experienced emotional disorders – anxiety and depression; and 7% were significantly hyperactive (Meltzer, Gatward, Corbin, Goodman, & Ford, 2002).

Foster parents

There is a growing shortage of foster placements, especially for the most traumatised adolescents, with significant behavioural difficulties (Harber & Oakley, 2012). Authorities are experiencing trouble in recruiting new foster parents (Colton, Robert, & Williams, 2008). Worryingly, a high number of foster parents (FPs) are dropping-out altogether (Rodger, Cummings, & Lescheid, 2006). Wilson, Sinclair and Gibbs (2000) reported that FPs experience various stressful events, including placement disruption, allegations, challenges with the child's birth parents, adverse impacts of the placement on the foster family and disagreements with social services. These experiences all appeared to influence FPs to discontinue fostering.

Local Authorities rely heavily on FPs to have the knowledge and skills to care for LAC who are experiencing emotional and behavioural difficulties (Berridge, 1997). However, Bonfield, Collins, Guishard-Pine and Langdon (2010) found that 49% of LAC with mental health problems received no support from child and adolescent mental health services (CAMHS). Children with enduring and severe mental health difficulties are perhaps more likely to access CAMHS, if problems are identified by FPs. Bonfield et al. (2010) reported that FPs understanding and attitudes toward mental health, including their mental health literacy ('knowledge and beliefs about mental disorders, which aid their recognition, management or prevention,' Jorm et al., 1997, p. 182) and education level often affect their ability to seek CAMHS' support.

Theoretical underpinning: how LACs' trauma might impact those who care

Secondary trauma (ST)/ compassion fatigue (CF) are terms used interchangeably within the literature to describe the emotional duress experienced by persons having close contact with trauma victims, especially concerned family members (Figley, 1995). The transfer of trauma symptoms can pass from victims to those with close and prolonged contact (Motta, Kefer, Hertz, & Hafeez, 1999). It occurs as a direct result of hearing emotionally shocking material from or about a client (Iliffe & Steed, 2000). ST symptoms fall under the same clusters as PTSD: flashbacks; sleep-disturbance; nightmares; hyperarousal; irritability; anxiety; and perceived loss of control (Pearlman & Saakvitne, 1995).

ST research has predominantly looked at mental health professionals working with trauma survivors, in which symptoms may spread from the survivor to the professional (Kassam-Adams, 1999; Pearlman & Maclan, 1995; Schauben & Frazier, 1995). Studies have demonstrated ST in family members of military officers, war veterans (Suozzi & Motta, 2004), and the general population (Motta, Newman, Lombardo, & Silverman, 2004). Dwyer (2005) found evidence of ST among wives of distressed police officers following traumatic work experiences. Figley (1983, 1995) states that being a member of a family and caring deeply makes us emotionally vulnerable to the impact of each other's catastrophes. Hence research is essential to study how LACs' trauma might impact FPs and their families.

FPs risk developing ST as they use empathy, to understand and support LAC, but carers over-empathising may risk of internalizing the LACs' trauma (Regehr, Goldberg, & Hughes, 2010). Other risk factors include insufficient recovery time, since many FPs experience a lack of respite or support from those around them (Sinclair, 2005). Also unresolved personal trauma may become re-activated when hearing about LACs' experiences (Turner & Lloyd, 1995). FPs may feel powerless to change or prevent vulnerable children experiencing trauma, making them feel vulnerable and at risk of developing ST (Figley, 1995).

Another commonly cited construct within the literature is the term **vicarious trauma (VT)**, the impact on mental health professionals working with trauma victims. McCann and Pearlman's

(1990) Constructivist Self-Development Theory (CSDT) is used as a framework for understanding its aetiology. The CSDT outlines five personality aspects affected by VT: frame of reference; self-capacities; ego resources; psychological needs and related cognitive schemas; and memory and perception. According to CSDT, people construct their reality through the development of cognitive structures, which are then used to interpret events in pursuit of meaning. Trauma can disrupt a person's cognitive schemata in one or more of five fundamental need areas: safety; trust/ dependency; esteem; control; and intimacy. These significant psychological effects, if untreated, can persist for months or years and modify the meanings used to interpret events in their life and others (McCann & Pearlman, 1990). However, no research to date has developed a measure or assessed VT specifically for FPs.

Burnout describes the emotional consequences for professionals working intensely with other people's problems (Maslach, 1982), characterised as a form of emotional exhaustion (EE). However, it seems reasonable to suggest that FPs might be affected by burnout during times of emotional distress. According to Figley (1995) burnout develops gradually but if unrecognised or ignored may progressively worsen. Carers experience a reduced sense of personal accomplishment (PA) and increased depersonalisation (DP), worsening when role conflict (conflicting or incompatible expectations) or role ambiguity (unclear or vague expectations) increases (Manlove, 2010).

Research, though focused on the negative impacts, has demonstrated many positive experiences that may protect against the adverse effects described above (Eastwood & Ecklund, 2008). **Compassion satisfaction** (CS) describes the pleasure derived from caring, including positive feelings about colleagues, contributions to the work setting and general society through working with LAC. CS relates to workers' perceived success and support offered by colleagues to achieve their aims (Conrad & Kellar-Guenther, 2006). However, this concept has not yet been explored with FPs.

FPs caring for LAC without respite endure many strains and satisfactions in their work (Sinclair, 2005), which have been poorly researched. FPs receive a child into their families, endeavouring gradually to form caring interpersonal relationships with them, often absent in their early years. This may create tension for both FPs and their family, learning to handle a variety of

emotional and behavioural difficulties resulting from the LACs' trauma. Crucial to LACs' development is the capacity of the FPs to reliably regulate their emotional states (Tronick, 2007), which can be satisfying but potentially traumatic.

Sinclair (2005) reported that the number of abused children needing foster care has steadily increased since the 1980's and pose more complex challenges for carers. If vulnerability to ST is similar to partners of war veterans or mental health professionals, then screening FPs is paramount. Lipton (1997) investigated ST experienced by families of sexually abused LAC, suggesting that the family's reaction to disclosure and the emotional functioning of mothers impacts upon the emotional wellbeing of the child. As a FP's role is uniquely different to other professions it is vital we learn more about their experiences, good and bad. Using Interpretative Phenomenological Analysis (Smith, Flowers, & Larkin, 2009), we may learn from those currently fostering and willing to share their experiences of caring for LAC. This method explores differences in experience and, in this study, attempts to capture the richness of FPs' experiences, instead of reducing them to particular measures of ST or VT.

Summary and Aims

ST and VT are not exclusive to therapists or partners of war veterans. Figley (1983, 1995) noted the vulnerability of caring family members. However, there is a paucity of research regarding FPs' experiences and a lack of a clear understanding about the impact LACs' trauma has on FPs and their families. Research often omits to consider the potential positive impacts. Therefore, this study aimed to investigate the following research questions:

- (1) How do foster parents experience looking after traumatised looked-after children?
- (2) How do foster parents understand the possible impact the looked-after child's trauma has on:
 - (a) the young person;
 - (b) themselves as foster parents;
 - (c) their family

To address these questions, the qualitative approach IPA was used in an attempt to understand FPs' lived experiences of caring for traumatised LAC (Elliott, Fischer, & Rennie, 1999). Putting the voices of FPs at the heart of this study might enable their experiences to influence service design and delivery, tailoring resources to the diverse needs of both FPs and the LAC themselves.

Method

Interpretative Phenomenological Analysis (IPA) was utilised to explore the meanings people make from the experiences they live through (Smith et al., 2009). IPA aims to obtain a rich picture of 'what it feels like' for someone and is a way of examining and striving to comprehend lived experiences. IPA's hermeneutic stance is one of inquiry and meaning-making. Its ideographic focus aims to offer insights into how a given person, in a given context, makes sense of a given phenomenon usually of personal significance (Smith et al., 2009). It was for these reasons that IPA was chosen to explore the different meanings foster parents attach to their experiences.

Design

An interview-based study using IPA was utilised attempting to answer the research questions above. The research questions were grounded in an epistemological position consistent with IPA, since they are directed at exploring foster parents' lived experiences (Smith et al., 2009).

Participants

Eleven participants were recruited following IPA's suggestion that a relatively small homogenous sample was required to examine convergence and divergence in people's experiences (Smith et al., 2009). All participants met the following criteria:

- (1) Had cared for, currently or previously, a LAC (aged 5-17 at the time of the interview) who had experienced significant trauma(s) prior to the current foster placement
- (2) The primary caregiver, with a minimum of six months experience of fostering the child prior to the interview, allowing for initial adjustment to the placement and experiences with the LAC
- (3) The LAC or FP is currently involved with a clinician in the target National Health Service (NHS) team, relying on clinicians to identify LAC who are significantly traumatised

(4) LAC had no diagnosed disability (e.g. severe physical/learning disability) that would impact upon homogeneity

Participants' demographic characteristics are displayed in Table 1 below.

Table 1.

Participants' demographic characteristics

	Characteristics	Number of participants
Gender	Male	0
	Female	11
Age	30-40 years	2
	40-50 years	4
	50-60 years	5
Ethnicity	White British	6
	Black British Caribbean	3
	Black British	1
	Black African	1
Duration of fostering	1-4 years	6
	5-8 years	1
	9-12 years	0
	13-16 years	3
	>16 years	1

Age of young person	8-12 years	8
	14-17 years	6

Recruitment

Participants were recruited from a LAC NHS team. A clinician, member of the multi-disciplinary team, known to the FP was contacted to gain verbal consent for the researcher to contact them regarding their participation. A recruitment clinic letter (Appendix B) and FP information sheet (Appendix C) were provided via email or post. FPs who expressed interest in taking part (n=13) were contacted by the researcher via telephone or email to answer questions, discuss the research in more detail, explaining expectations of them. For those who consented to take part (n=11) an interview appointment was arranged. Two FPs declined an interview because they were ‘too busy and had very little time to offer.’

Interview Schedule

The interview schedule (Appendix D) was carefully designed following the researcher’s attendance at a FP forum in a neighbouring site to the NHS research site. The development of the questions remained as open as possible, reducing the amount of researcher bias and ensuring that the wording used was accessible and the questions raised pertinent issues for FPs of LAC. The schedule consisted of three key open-ended questions, the first two inviting participants to share some experiences of fostering and a little about the LAC they cared for. The third question aimed to gain insight into FPs’ understanding of the impact LACs’ trauma had on the young person, themselves and their family. Several open-ended prompt questions were used to follow-up what was said and develop a greater understanding of their experiences and the psychological impacts of fostering LAC.

Ethical Considerations

The relevant NHS Research Ethics Committee and local research department gave full approval for the study to be carried out (Appendix E). The British Psychological Society (BPS) code of human research was adhered to throughout (BPS, 2010).

Interview Procedure

All eleven participants were interviewed in a private clinical room at the NHS site. Participants were given an opportunity to ask questions, each declined, expressing willingness to continue. Confidentiality and its limits were discussed, followed by participant and researcher signing the consent form (Appendix F). Interviews lasted between 45 minutes and one hour. No participant requested a meeting with a clinician to discuss any issues following their interview. Most reported that they had found the interview process ‘therapeutic’ and ‘supportive.’ Participants did not request a copy of their transcript. However, all participants wished to receive a summary of the findings (Appendix G).

Data Analysis

Two transcripts (see Appendix H for an example transcript), considered to contain the richest data, were read and re-read in line with IPA, noting initial thoughts regarding descriptive, linguistic and conceptual issues, and recording emergent themes (Smith et al., 2009). The remaining transcripts were then analysed using the same approach, connecting themes and emerging patterns within the data, as recommended for larger samples (Smith et al., 2009). The resultant master- and sub-themes were constructed following the recording of similarities and differences between the transcripts and the emerging themes (Appendix I details this theme development process).

Quality Assurance

To allow for reflexivity (Yardely, 2000), the researcher was interviewed prior to conducting this study, in order to ‘bracket’ her assumptions (Smith et al., 2009) (Appendix J), and used a reflective research diary throughout the project (Appendix K).

Yardley’s (2000) guidelines (see Appendix L) were used throughout ensuring the researcher remained aware of her own ‘sense-making’ and difference in experience, or lack of, of working with traumatised young people. The ‘double hermeneutic’ of the researcher’s interpretation of participants’ perceptions are emphasised strongly in IPA. During the detailed analysis, transcripts were coded in order to keep track of developing themes (Smith et al., 2009), coding excerpts from the transcripts that supported each sub-theme (Appendix M). A supervisor analysed two transcripts independently, to

enable ‘commitment and rigour’ and ‘transparency and coherence’ in the development of the resultant themes (Yardley, 2000). Overall, these methods allowed for the findings to be grounded with examples and credibility checks (Elliott et al., 1999).

Results

Six master-themes emerged from the data, displayed in Table 3, which will be explored with example quotations (see Appendix M for further illustrative quotations).

Table 2.

Master-themes and sub-themes

Master-themes	Sub-themes
Emotional Impact on Foster Parents	Overwhelming Reaching threshold Attachment – difficulties letting go Rewarding
Cognitive Impact on Foster Parents	Doubts/ questioning ability to effect change Change in perspective Sense of injustice Satisfaction and pride
Impact from the Wider Fostering System	High responsibility of care without parental control Support and understanding Continued rejection/neglect Ambiguous and conflicting professional/carer roles
Impact on Foster Parents’ Family and Friends	Strained relationships Growing understanding

Foster Parent Coping	Need for support and reassurance
	Distancing, breaks and respite
	Search for meaning
	Sense of duty
Perceived Understanding of the Impact of Trauma on LAC	Search for meaning
	LACs' past experiences
	Foster parents' past experiences

Emotional Impact on Foster Parents

This master theme encapsulates both the positive and negative emotional impacts on FPs caring for traumatised LAC. FPs' use of empathy may also cause themselves distress, '*In my role as a carer you have to have empathy but this is distressing*' (P5, 2, 214)⁵; and potentially increase their vulnerability to negative emotional impacts.

Overwhelming. FPs expressed a variety of negative emotions, including sadness, frustration and anger when caring for LAC. Almost all suggested that their role was emotionally challenging, describing it as a roller-coaster, reflecting the breadth of emotions experienced:

'It is an emotional roller coaster' (P1, 1, 20); and *'I've gone through all the emotions'* (P3, 7 243).

Several FPs described stressful situations that impacted negatively on their lives:

'It has put me through a lot of stress they have turned my life upside down' (P10, 4, 147).

⁵ P (x, x, x) Participant name, page number, line number.

FPs commonly experienced anxiety and fear, *'It was like walking around on egg shells'* (P10, 6, 201); and *'I was on tenterhooks the whole time'* (P3, 1, 19).

Many FPs voiced feelings of sadness regarding their experiences, *'Often I would just come here and cry because I can't deal with, how am I supposed to deal with this?'* (P11, 8, 302); whilst others expressed feeling angry, *'It just really angered me'* (P10, 7, 272).

For some these negative emotions seemed to have impacted significantly on FPs' physical health:

*'I felt physically sick, I felt shaky (...)'*⁶ I dreaded it when they would come home from school (...) *it just built up and up. I felt that I was feeling ill myself'* (P10, 5, 193).

Also striking was the FPs' expressions of horror on discovering, in their roles as carers, the traumas LAC experienced prior to entering care, *'It's wholly horrific'* (P4, 5, 171).

Some FPs showed greater awareness than others that LACs' trauma directly affected their personal wellbeing:

'Just listening to it (...) his night terrors, he was re-living it, and it affected me so much' (P10, 7, 247).

Reaching threshold. Many FPs reflected on the constantly demanding nature of caring for LAC, not part-time but a full-time role, *'As a carer you are there 24/7, it is not a part-time job'* (P2, 2, 66). Another FP illustrated that even when not physically caring for the children, she was still attending meetings regarding their care, *'I was constantly thinking about them (...) social worker appointments, counselling appointments, LAC reviews, so you are constantly talking about them'* (P10, 6, 228).

FPs described a sense of filling up with negative emotions, with little respite to allow for processing these emotional impacts, resulting in many feeling they had reached their threshold, *'It became too much'* (P11, 8, 315).

Attachment – difficulties letting go. Some FPs expressed strong attachments, feeling unable or unwilling to let go of the LAC, which then impacted negatively on FPs' emotional wellbeing:

⁶ (...) Material omitted for clarity or confidentiality.

'It is not easy. It still hurts (...) they moved her from me' (P5, 10, 389)

FPs forming good attachments with LAC has long been understood as a fundamental therapeutic tool for young people. However, these attachments may have a negative impact when the placement ends, whether planned or unplanned. Supporting FPs to 'let go' and move on from painful placement endings seemed important:

'The foster carers should be given so much more information (...) it is so hard that you don't know (...) give you some kind of closure' (P6, 11, 535).

Rewarding. Despite these negative emotional impacts, the FPs continued to foster and several described many positive experiences impacting on their emotional wellbeing. The most common seemingly rewarding nature of their work, observing positive changes in LACs' lives:

'But (...) it is really rewarding when you see them move on with their lives' (P4, 1, 21).

For some FPs the rewards were not immediate and the positive emotional impact only felt on reflection, *'What a difference I've made to her life, but I didn't feel it at the time (...) things like that make me feel really good'* (P4, 11, 466).

Cognitive Impact on Foster Parents

Caring and supporting LAC trying to make sense of their traumatic experiences appeared to impact on FPs' thought processes. This master-theme captures the cognitive impact expressed by almost all FPs, suggesting that their experiences affected their thinking in a number of ways, illustrated with each sub-theme below.

Doubts/ questioning ability to effect change. All FPs at some point during their experience had doubted their ability to continue fostering:

'So after that I had contemplated not doing it anymore' (P11, 2, 54).

FPs often questioned their ability to cope and to affect positive change in the LACs' lives:

'Am I good enough for this, am I getting too old?' (P1, 6, 229).

Several FPs questioned their qualifications to deal with the demands placed upon them, 'Where you have more trained professionals *who know how to deal with these types of behaviours*' (P8, 7, 248).

Change in perspective. Almost all FPs described a change in perspective, developing over time. Commonly, FPs in the early stages expressed that experiences differed from expectations:

'We never knew when we went and picked up them two little boys what we were picking up' (P6, 14, 676). Another FP suggested that, 'You have your own script about how it is going to go and it *doesn't work like that* (P2, 1, 30).

FPs' experiences also appeared to change their perception of others and the world:

'I think I've learnt a lot of what goes on in the world that I didn't really know about' (P3, 7, 242).

These cognitive changes seemed to affect the way FPs viewed their future experiences, 'I'm a lot more cautious of the types of issues and experiences the young person has had prior to the *placement*' (P8, 11, 436) and perceptions of life and others around them, 'It did affect everybody a lot *more than anybody thought it was going to affect them*' (P1, 12, 476).

These changes in perspective included a realisation that bad things happen and perhaps skewed perceptions of others, in terms of threats to their personal safety:

'I felt like everyone I went past was going to jump out with a gun' (P6, 6, 270).

These changes appeared to have a lasting cognitive impact, resulting from hearing about LACs' trauma:

'But that still stays with me, in terms of how traumatic' (P2, 1, 23).

Sense of injustice. The LACs' backgrounds of neglect and abuse understandably stirred negative cognitions for FPs, with some developing a strong sense of injustice:

'They shouldn't be having children; they shouldn't go on to have children. You can't say lock them up I know' (P7, 6, 210).

Some FPs expressed a wish to avenge the LAC, despite acknowledging that this would be wrong:

'I think if someone had done that to a child, I mean I shouldn't say this but I don't even think they should have contact with her' (P11, 5, 180).

In contrast, some FPs empathised with the biological parents, *'I try and see that her mum had a raw deal as well (...) I try to help her not blame her mum'* (P5, 4, 130), whereas another FP suggested, *'It is not for me to avenge her'* (P8, 5, 180).

Satisfaction and pride. Despite these negative cognitive impacts some FPs experienced many positives, which appeared to give them a sense of satisfaction and pride from fostering, *'I was very proud'* (P1, 4, 128). Another FP suggested her experiences had enabled her to appreciate things she previously took for granted:

'It was nice to realise that sometimes things you take for granted and has a big impact' (P8, 1, 30).

Enjoyable experiences were described by many FPs, which seemed to give them a sense of satisfaction in fostering, *'There are very enjoyable moments (...) full of love and affection (...) has been really enjoyable'* (P1, 1, 35). These experiences appeared to extend to realisations of the positive difference one can make in children's lives:

'I like being needed by the family (...) you don't even realise the changes (...) they tell you about what a difference you've made in their lives' (P4, 1, 11).

Impact of the Wider Fostering System

All FPs relayed challenges they experienced with fostering, some of which reflected the impact that the wider fostering system had on them as FPs.

High responsibility of care without parental control. FPs described having huge responsibilities caring for LAC but with limitations, in particular, not having overall parental control. One FP expressed several difficult experiences with the LAC's social worker, *'She didn't like that I had saved all of (...) money for her and she said well what are you going to do with the money? (...)*

and she went well it is not up to you' (P3, 10, 391). Others shared this frustration, illustrating the complex nature of the systems involved around fostering LAC, which FPs work with:

'You are answerable to all these other people (...) you have to be careful what you say' (P4, 13, 541).

One FP explained that even social services do not always have the final say, *'The courts can only make that decision'* (P9, 12, 456).

Support and understanding. All FPs expressed the importance of being supported and understood by the system and other professionals, reporting both positive and negative experiences of support. Several FPs expressed gratitude to services and professionals who had helped them:

'We have worked through that with the help of CAMHS' (P1, 1, 41).

In contrast, others described negative experiences with professionals apparently neither supporting nor providing the help they required:

'I couldn't get no help and no one was listening' (P5, 6, 222).

These negative experiences appeared to significantly impact on FPs' wellbeing:

'Having a horrible child social worker, who just came in and just completely floored me' (P3, 10, 385); and *'It was only me (...) I was (...) losing control of my home, my life'* (P10, 11, 418).

Continued rejection/ neglect. FPs gave many examples of how the wider fostering system did not always meet the needs of the LAC, perceiving that it even contributed to LACs' continued trauma of rejection and neglect:

'She never got the help she needed (...) even the school didn't want her' (P5, 6, 228); and *'These children have gone from pillar to post, they have been let down by various people'* (P10, 7, 245).

One FP appeared to blame herself for causing further distress to the LAC by ending the placement:

'The way that it ended is the fact that I have now added (...) she's had a lot of movement, I've now added to that' (P8, 11, 440).

FPs expressed determination not to become another person failing the LAC. One FP suggested that to not fight decisions she disagreed with would make her an abuser, *'I'm not an abuser, so I took the whole lot on'* (P5, 7, 244).

Ambiguous and conflicting professional/carer roles. FPs appeared to have different perceptions as to whether they viewed themselves as professionals or not. Several clearly viewed themselves as professional, *'I am a professional'* (P8, 5, 179). Others appeared more ambiguous, *'You have to keep it a bit professional (...) but sometimes that's difficult because it's in your own home environment'* (P4, 13, 552), whilst some stated that they were not the professional, *'I might not be a professional but I know this child'* (P5, 6, 241).

Several FPs suggested that people working within the fostering system had different agendas:

'Sometimes it is difficult because their agenda is, is different to the carer's agenda' (P2, 2, 77).

Others appeared more frustrated, perceiving some professionals caring more for the parents' needs than the LAC's, *'I couldn't understand (...) how people could sit there and pander to the parents' needs (...) and let them get away with what they've done'* (P10, 7, 259).

FPs talked about the rules and boundaries they must comply with, which at times made their role challenging:

'He gives me hugs and kisses but there is still a boundary, whereas my children can jump into my bed' (P9, 14, 541).

This was illustrated by some FPs' uncertainty around their disclosures during our interviews, *'Am I allowed to tell you?'* (P6, 3, 105).

Impact on Foster Parents' Family and Friends

All FPs gave examples of the impact their LACs' trauma had on family members and on their friends and social networks. These impacts varied between FPs, some expressing more negative impacts, whilst others also described positive experiences, in relation to the impacts on family and friends.

Strained relationships. Some FPs reported the negative impacts fostering had on their biological children, such as ‘There have been times when I have thought I cannot continue with this because there is an impact on my children’ (P9, 7, 262). The same FP even suggested her children had changed as a result, ‘My children’s personalities have changed’ (P9, 13, 511).

These impacts on their family then affected the FPs themselves, some appearing to feel guilty for the time given to fostering LAC:

‘Your birth children could turn around and say ‘I had a really bad childhood, we had foster children and my parents neglected us’ (P9, 7, 276).

These experiences were perceived to affect the whole family unit, ‘It put a strain on the whole family’ (P6, 5, 244); and also impacting on FPs’ friends, ‘It did put a strain on my friendships and my family (...) they have attacked my friends. They have attacked my family’ (P10, 4, 138).

Understandably FPs social lives were affected, ‘We’d stopped visiting our friends’ (P6, 12, 553), in particular through concern for the safety of those around them, ‘My main issue was keeping those around me safe’ (P8, 9, 346). This included fearing allegations made by LAC, ‘You’ve always got to be wary there could be an allegation’ (P4, 13, 544), which many FPs reported having experienced both against themselves and their friends and family.

One FP reported other children at school having been significantly affected by the LAC’s trauma:

‘Children have gone home and told their parents and they are having nightmares about what she said (...) so it has a knock on effect’ (P11, 3, 104).

This FP also noted the effect she thought working with LAC might have had on their social worker, ‘That social worker was absolute rubbish (...) I guess she wasn’t able to cope with the nature of her work’ (P11, 9, 345).

Growing understanding. In contrast, some FPs described examples of positive impacts on their families. One FP perceived her son as benefitting, ‘He is getting a growing understanding, a lot more patience’ (P1, 11, 438). Several FPs felt strongly that LAC become part of the family, ‘She will

always be there as part of our family unit' (P3, 9, 334). However, some acknowledged the challenge of maintaining a balance between caring for their biological children and LAC:

'It's difficult when you are a foster carer trying to keep that balance' (P11, 7, 259).

Foster Parent Coping

FP coping was not a focus of the research questions or the interview schedule. Nonetheless FPs reflected on their coping abilities, which appeared fundamental to understanding FPs' experiences.

Need for support and reassurance. FPs commonly expressed the need to feel supported and reassured by others, not only by their family and friends, *'My family, they've helped'* (P3, 3, 104); but also by professionals:

'Training within the company (...) helped me prepare myself for what I could hear or what I could receive' (P8, 5, 164).

Reassurance, *'You need to be told that you are doing okay'* (P2, 2, 75) and being understood by others, *'You've got to talk to somebody, somebody that understands and hear them pick out the positives for you'* (P1, 7, 263) are two vital ingredients enabling FPs to feel supported.

Distancing, breaks and respite. All FPs spoke about the importance of respite; though managing these breaks varied, with some taking breaks following each placement, *'I took breaks in between'* (P2, 1, 9). Others ensured they used their social networks and respite carers, *'I need to make use of my network because I need time-out'* (P11, 10, 362).

In contrast, several FPs expressed a need to distance themselves from the LAC, explaining that they needed to be emotionally close but not too close:

'Supporting her and being personable but still distancing myself' (P8, 5, 182).

Other FPs appeared to maintain distance by taking the 'non-expert' role, but seemed unaware that this was what they had been doing:

'I don't know I am not an expert' (P7, 8, 208).

Some FPs appeared to strive for closeness, expressing a stronger sense of being their ‘parent,’ ‘*We are mummy and daddy*’ (P1, 3, 84). Nonetheless, all FPs agreed that there is a need for respite and they have experienced times when this has not been there when they have needed it most, ‘*You just can’t get away and we all need a break*’ (P9, 14, 531). This includes the biological family also needing time-out, ‘*I would have to give my children some respite.*’ (P9, 12, 480).

Search for meaning. All FPs seemed to search for a meaning, to make sense of their experiences, ‘*It felt as if, and maybe I am wrong, but as I reflect on it*’ (P2, 1, 33). FPs desire to comprehend LACs’ behaviours and experiences, striving to understand and empathise seemed to be a coping resource:

‘*Step back and look at why he was behaving like that and that is how I had to deal with it*’ (P11, 8, 303).

Sense of duty. A strong commonality amongst FPs seemed to be their sense of duty, feeling compelled to ‘do what is right’ for vulnerable children, no matter what the cost is to them, ‘*Even if it is getting the better of me sometimes, or getting me down, I will stick with that young person*’ (P5, 1, 10).

Their sense of duty seemed to give FPs a strong determination to be responsible and not to treat them the way they have been mistreated by others, ‘*They are my responsibility (...) I’ve agreed that I am going to have them long-term (...) I’ve got to stick with that*’ (P10, 5, 184).

All FPs shared a strong desire to ‘make a difference’ in LACs’ lives, which also seemed to fuel their sense of duty, ‘*Knowing that you are giving two children a bit of stability and as normal a family life as you can*’ (P9, 14, 538). Also fuelling their sense of duty maybe a ‘need to be needed’, as several FPs talked about wanting to help others:

‘*I am giving something back. I’m helping a child*’ (P11, 1, 13).

Perceived Understanding of the Impact of Trauma on LAC

This theme encapsulates the similarities and differences found between FPs’ perceived understandings of the impact of trauma on LAC.

Search for meaning. Almost all FPs expressed a significant lack of knowledge about the LACs' background and previous experiences, *'I knew there was something more than what I was being told'* (P5, 3, 97). Nonetheless, FPs strived to make sense of these experiences, despite not having answers, *'How do you make sense of a child experiencing that?'* (P11, 2, 78). One FP illustrated this further by questioning her understanding of the traumas experienced:

'What is it, what it means, what does trauma mean' (P2, 9, 353).

FPs appeared to be divided on whether or not they should receive further information about LAC. One suggested, *'The foster carer should be given so much more information (...) is so hard that you don't know'* (P6, 11, 535). Another FP stated, *'The different levels of information sharing needs to be addressed, definitely when there has been extreme trauma'* (P8, 13, 523).

In contrast, one FP said, *'I think if I had been told that she had been sexually abused, I am not sure I would have gone there because I just find the whole thing horrifying'* (P11, 2, 61).

LACs' past experiences. FPs expressed a desire to understand LACs' behaviour often by referring to the knowledge gained about the children's past experiences, *'They do have behaviour problems of course because of their experiences'* (P4, 8, 340). FPs described how their understanding developed over time, again within the context of learning about LACs' pasts:

'It took me a while to work it out then suddenly (...) 'oh my god' food was a rarity in his house where he came from' (P2, 4, 131).

Foster parents' past experiences. FPs often illustrated using personal experiences, such as their own childhood, in an attempt to understand LACs' trauma and their behaviours:

'I know what it is to hear my mother being beat for no reason. And so I got a bit of insight' (P7, 9, 357).

Discussion

This study's aim was to explore FPs' experiences of caring for LAC and how they understand the impact the trauma has had on the young person, on them as FPs and on their family. The results suggest, that despite FPs' mixed experiences, there is a significant emotional and cognitive impact on

them and their family. These findings are discussed below in relation to the research questions and previous research. Theoretical, clinical and research implications are also explored.

The 'emotional impact on foster parents' master-theme provides information both about FPs' experiences and the emotional impact the LAC's trauma might have on FPs. These findings support Figley's (1995) concept of ST, suggesting that emotional duress may result, especially in concerned family members, from having close contact with trauma survivors. However, there was evidence of positive emotional impacts, which previous research has often neglected to explore. These positive experiences, such as feeling 'proud' seemed to give FPs a sense of satisfaction and of 'being needed.' This supports the concept of compassion satisfaction, suggesting that pleasure is derived from helping others (Conrad & Kellar-Guenther, 2006).

The 'cognitive impact on foster parents' theme encapsulates further the impact LACs' trauma might have on FPs. All FPs seemed to have experienced an altered view on others, the world and their perceptions of the future. These findings are in line with McCann and Pearlman's (1990) Constructivist Self-Development Theory (CSDT), supporting the concept of VT. In relation to the CSDT, FPs commonly described changes in their cognitive schemas, such as 'the world is a bad place' linked to the realisation that bad things happen to innocent children. CSDT also supported the sub-theme 'threshold' encapsulated by the 'emotional impact on FPs' master-theme, as FPs described the depletion of their self-capacities and ego resources and reaching their 'threshold'.

Almost all FPs recounted the stresses and strains, as well as the positive support received from the 'wider fostering system.' This theme provides information regarding FPs' experiences of fostering and how this impacted on them and their families. In support of Wilson et al. (2000), FPs shared how important feeling supported and understood by other professionals was to their wellbeing. FPs experienced heightened stress when they felt their role to be ambiguous or in conflict with other professionals. This finding supports the opinion that role conflict and role ambiguity may contribute to feelings of burnout (Manlove, 2010).

The 'impact on foster parents' family and friends' master-theme encapsulates how LACs' trauma impacts on others and how this further impacts on FPs themselves. Often FPs expressed

feeling isolated with little social support, feeling compelled to consider the safety of others, for example wishing to protect others from potential threats or allegations. This is in keeping with previous research findings (e.g. Sinclair, 2005). It is possible that FPs' altered cognitive schemata negatively impacts on some of their 'fundamental need areas,' in particular 'safety' and 'control' (McCann & Pearlman, 1990). In contrast, some FPs talked about positive impacts on family, such as developing a greater understanding and empathy for others, perhaps supporting the notion that positive impacts may mitigate the adverse effects of ST (Eastwood & Ecklund, 2008).

The 'foster parent coping' theme reflects the meanings and understandings FPs make of their experiences of caring for LAC, despite not being a direct question within the interviews. In support of Lazarus and Folkman's (1984) Coping Skills Theory, FPs made sense of their experiences using all four main stages of the coping process: 'appraisal' could be linked to the sub-theme 'search for meaning,' as FPs strive to understand the LAC's behaviour and the meanings they attribute to the situation; 'assess coping resources' is perhaps encapsulated by the sub-theme 'distancing, breaks and respite' as FPs seemed more able to access their coping resources by using a level of 'distancing' and 'respite' from the LAC; 'carry out coping strategy' was evidenced by FPs describing ways they had coped, such as using professional and personal support networks, although these were often not available and; 'evaluate coping efforts' was perhaps captured by the sub-theme 'need for support and reassurance,' with FPs consulting with others whether or not they were doing a good job. In addition, FPs showed a 'sense of duty,' which seemed to compel them to continue fostering despite the challenges and adverse impacts of their work.

FPs' 'perceived understanding of the impact of trauma on LAC' provides information about FPs' 'search for meaning' to understand LACs' traumatic experiences and how these have impacted on them. Some FPs wished to know more about the LACs' histories, whereas others expressed difficulty with hearing about their pasts and how this affected them. FPs demonstrated two different ways of understanding, either using LACs' past experiences, or using their own personal experiences to comprehend the LACs' difficulties. FPs found this process challenging trying to understand LACs' traumatic experiences and the resultant impacts, with insufficient information prior to the start of each

placement. However, some FPs felt that too much information regarding the nature of the abuse previously experienced might have prevented them from fostering that LAC. This might also be a form of ‘distancing,’ a cognitive coping strategy described earlier, that may be understood in relation to ‘experiential avoidance,’ which potentially worsens symptoms of PTSD (Boeschen, Koss, Figueredo, & Coan, 2001). Perhaps FPs ‘search for meaning’ in the LACs’ experiences, rather than blocking out the painful memories acts to protect against the harmful impact of trauma. This supports previous findings with child welfare professionals working with LAC (Savicki, 2002).

Several FPs talked about the challenges associated with attachment and loss, some suggesting it takes time to form a good relationship with the LAC, whilst others talked more about the ‘difficulties of letting go’ when the placement, planned or unplanned, ended. FPs’ attempts to attune to LACs’ needs and develop secure attachments may be seen as ‘an emotional dance’ (Goldsmith, 2010). FPs seemed to experience strongly conflicting emotions, striving for closeness and security with the LAC, yet, for themselves maintaining a safe emotional distance.

Study limitations and future research

Using a qualitative approach allowed for in-depth exploration of FPs’ experiences. However, this limited the study’s ability to measure more specifically the impact of trauma, comparing measures of burnout, ST and VT. This method also limited the study’s findings regarding whether positive emotional and cognitive impacts may or may not protect FPs against the negative impacts of, for example, ST. Future studies could adapt current quantitative measures of ST and VT, in order to determine the extent to which FPs might be at risk of developing such symptoms. Further research could measure resilient factors, which might protect against the negative impacts of trauma, such as ‘search for meaning.’ This study was limited by the definition of child trauma, since it used an inclusive definition and relied upon clinicians to identify LAC who had experienced significant complex trauma, not relying on a formal PTSD diagnosis.

Another limitation of this study was that it did not allow for a longitudinal approach to observe how trauma impacts FPs over a longer period of time (the cut-off was a minimum of six months). Future longitudinal research could attempt to understand how LACs’ trauma impacts on FPs

and their families, whilst also evaluating whether these negative impacts, in turn, adversely affect the LAC. For example, if FPs had reached their ‘thresholds’ too often, had a lack of social support, and viewed the world and others as ‘unsafe,’ how might these impacts be experienced by LAC?

This study was limited by its sampling of FPs currently fostering and engaged with CAMHS, neglecting those families not engaged with or been identified by CAMHS. Research focusing on those who had recently left fostering might elucidate further the potential impacts of working with LAC and help suggest ways to prevent placement breakdowns and retain healthier, happier FPs and families. This study’s findings suggest that future research could look into the experiences of FPs’ families, to enable a more holistic approach to the wellbeing of vulnerable children, including fostered and biological children. Perhaps, a quantitative approach could be taken to measure secondary trauma and vicarious trauma in foster parents and whether these negative impacts might be experienced alongside protective factors such as personal resilience or compassion satisfaction. Research could compare and contrast those who have been fostering for a relatively short period of time and those who have been fostering for longer. A group of foster parents currently fostering could also be compared to those who have recently resigned or taken a break from fostering. These ideas would allow the research questions to move from an exploratory position to an attempt to explain how and why diverse impacts affect foster parents differently. Furthermore, this research could explore why some FPs continue to foster despite the high demands, stresses and strains placed on them and their families, whilst others do not cope and some even resign from fostering altogether.

Clinical implications

Despite FPs describing many positive experiences and illustrating a wealth of coping resources, this study’s findings suggest that the impact of LACs’ trauma on FPs has potentially significant consequences for their wellbeing. Furthermore, these impacts extend to affect FPs’ families and friends. Despite the limitations of this study, it feels safe to conclude that FPs experiencing detrimental effects to their physical and emotional health due to ST and VT symptoms, may, in turn, have the potential to impact on the wellbeing of LAC. Clinical psychologists (CPs) have a role and responsibility to screen and monitor the psychological wellbeing and outcomes (i.e. school

achievements) of LAC. These findings reinforce the need to extend this responsibility to screening and monitoring the wellbeing of foster families as a whole, allowing them greater access to support. This consideration of the impact of fostering LAC has on personal support networks may prevent potential placement breakdowns, improving therapeutic outcomes for LAC. CPs' roles include assessment and formulation and using psychological thinking with others who are not trained in this way. Therefore access to CPs should be made more readily available for FPs to develop a greater understanding of the impact of trauma on the young person and on themselves and their family. Perhaps the role and responsibility of CPs could be extended to offer support and training to supervising social workers with regards to the potential impact of ST and VT on FPs.

Conclusions

A search of the literature into the experiences of adoptive/ foster parents caring for traumatised LAC suggested a large gap in the research. This is the first study exploring FPs' lived experiences of caring for traumatised LAC, examining the psychological impacts on FPs and their families using rigorous qualitative methodology. The emotional impact on FPs suggests there may be the potential for FPs to develop ST symptoms. The cognitive impact on FPs suggests there may be the potential for FPs to develop VT symptoms. Overall, the negative and positive impacts experienced by FPs and their family and friends warrant further investigation. It is evident that a variety of complex negative impacts may result from caring for LAC. However, a wealth of positive impacts were reported, which may or may not protect against the development or worsening of ST/VT symptoms. The findings add to the emergent ST/VT literature, extending this to FPs, a different population to caring professionals previously studied. The findings provide evidence for the need for future research. They have implications for CPs working with foster families and important clinical implications for LAC services, inviting clinicians to pay close attention to FPs' wellbeing and develop ways to screen for ST and VT.

References

- American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text rev.). Washington, DC: Author.
- Berridge, D. (1997). Foster care: A research review. London: The Stationary Office.
- Boesch, L. E., Koss, M. P., Figueredo, A. J., & Coan, J. A. (2001). Experiential avoidance & post-traumatic stress disorder. A cognitive mediational model of rape recovery. *Journal of Aggression, Maltreatment and Trauma*, 4, 211-245.
- Bonfield, S., Collins, S., Guishard-Pine, J., & Langdon, P. E. (2010). Help-seeking by foster-carers for their 'looked-after' children: The role of mental health literacy and treatment attitudes. *British Journal of Social Work*, 40, 1335-1352.
- British Psychological Society. (2010). Code of human research ethics. Retrieved from http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf
- Children Act 1989, ch. 41.
- Colton, M., Robert, R., & Williams, M. (2008). The recruitment and retention of family foster-carers: An international and cross-cultural analysis. *British Journal of Social Work*, 38, 865-884.
- Conrad, D. & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse and Neglect*, 30, 1071-1080.
- Department for Education. (2012). Children looked after in England (including adoption and care leavers) year ending 31 March 2012 (Statistical First Release SFR 20/2012). London: Author. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167451/sfr20-2012v2.pdf.pdf

- Dwyer, L. A. (2005). An investigation of secondary trauma in police wives. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 66, 2816.
- Eastwood, C. D. & Ecklund, K. (2008). Compassion fatigue risk and self-care practices among residential treatment center childcare workers. *Residential Treatment for Children & Youth*, 25, 103-122.
- Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.
- Figley, C. R. (1983). Catastrophes: An overview of family reactions. In C. R. Figley & H. McCubbin (Eds.), *Stress and the family: Volume II: Coping with catastrophe*, (pp 3-20). New York: Brunner/ Mazel.
- Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress in those who treat the traumatized*. New York: Brunner/Mazel.
- Goldsmith, D. F. (2010). The emotional dance of attachment. *Clinical Social Work Journal* 38, 4-7.
- Greeson, J. K. P., Briggs, E. C., Kisiel, C. L., Layne, C. M., Ake, G. S., Ko, S. J, et al. (2011). Complex trauma and mental health in children and adolescents placed in foster care: Findings from the national child traumatic stress network. *Child Welfare*, 90, 91-108.
- Harber, A., & Oakley, M. (2012). *Fostering aspirations. Reforming the foster care system in England and Wales*. London: Policy Exchange.
- Iiffe, G., & Steed, L. (2000). Exploring the counselor's experience of working with perpetrators of domestic violence. *Journal of Interpersonal Violence*, 15, 393-412.
- Kassam-Adams, N. (1999). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators* (2nd ed., pp. 37-47). Lutherville, MD: Sidran Press.

- Landsverk, J. A., Burns, B. J., Stambaugh, L. F., & Rolls Reutz, J. A. (2006). *Mental Health Care for Children and Adolescents in Foster Care: Review of Research Literature*. Seattle, WA: Casey Family Programs. Retrieved from <http://www.casey.org/Resources/Publications/MentalHealthCareChildren.htm>
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.
- Lipton, M. (1997). The effect of the primary caretaker's distress on the sexually abused child: A comparison of biological and foster parents. *Child and Adolescent Social Work Journal*, 14, 115-127.
- Manlove, E. E. (2010). Conflict and ambiguity over work roles: The impact on child care worker burnout. *Early Education & Development*, 5, 41-55.
- Maslach, C. (1982). *Burnout: The cost of caring*. Englewoods Cliffs, NJ: Prentice Hall.
- McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: a framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3, 131-149.
- Meltzer, H., Gatward, R., Goodman, R., & Ford, T. (2002). *Mental health of children and adolescents in Great Britain*. London: The Stationary Office.
- Motta, R. W., Kefer, J. M., Hertz, M. D., & Hafeez, S. (1999). Initial evaluation of the secondary trauma questionnaire. *Psychological Reports*, 85, 997-1002.
- Motta, R. W., Newman, C. L., Lombardo, K., & Silverman, M. A. (2004). Objective assessment of secondary trauma. *International Journal of Emergency Mental Health*, 6, 67-74.
- Naughton, M. (2008). *Every child every chance: A good childhood is in everyone's best interests*. Retrieved from Victoria, Australia: Department of Human Services website: <http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/reportpublications/good-childhood-is-in-everyones-best-interests-mick-naughton>

- Pearlman, L. A., & MacIain, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, 26, 558-565.
- Pearlman, L. A. & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: Norton.
- Regehr, C., Goldberg, G., & Hughes, J. (2010). Exposure to human tragedy, empathy, and trauma in ambulance paramedics. *American Journal of Orthopsychiatry*, 72, 505-513.
- Rodger, S., Cummings, A., & Lescheid, A. W. (2006). Who is caring for our most vulnerable children? The motivation to foster in child welfare. *Child Abuse & Neglect*, 30, 1129-1142.
- Savicki, V. (2002). *Burnout across thirteen cultures: Work, stress, and coping in child and youth care workers*. Westport, CT: Praeger.
- Schauben, L., & Frazier, P. (1995). Vicarious trauma: The effects on female counsellors of working with sexual violence survivors. *Psychology of Women Quarterly*, 19, 49-64.
- Sinclair, I. (2005). *Fostering now: Messages from research*. Jessica Kingsley Publishers: London.
- Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: theory, method and research*. London: Sage.
- Suozzi, J. M. & Motta, R. W. (2004). The relationship between combat exposure and the transfer of trauma-like symptoms to offspring of veterans. *Traumatology*, 10, 17-37.
- Tarren-Sweeney, M. (2008). The mental health of children in out-of-home care. *Current Opinion in Psychiatry*, 21, 345-349.
- Tronick, E. (2007). *The neurobehavioral and social-emotional development of infants and children*. New York: W.W. Norton & Company.
- Turner, R. J., & Lloyd, D. A. (1995). Lifetime traumas and mental health: The significance of cumulative adversity. *Journal of Health and Social Behavior*, 36, 360-376.

Wilson, K., Sinclair, I., & Gibbs, I. (2000). The trouble with foster care: The impact of stressful 'events' on foster carers. *British Journal of Social Work*, 30,193-209.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15, 215-228.

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Section C:
Critical Appraisal

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SALOMONS
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1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

Prior to the commencement of my clinical psychology training my research experience had predominantly involved using quantitative methods, including my undergraduate psychology dissertation. I gained minimal knowledge of using thematic analysis as a qualitative approach to research in my role as an assistant psychologist, researching the experiences of adults with acquired neurological conditions. During training my quality improvement project also used thematic analysis to examine service-users' experiences of a new service-user group/forum. I was keen to develop my qualitative research skills, using the more rigorous qualitative method Interpretive Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009) for my major research project.

From the beginning I discovered both the challenges and satisfactions of designing my own research project in an under-researched area. I also experienced the challenge of gaining National Health Service (NHS) ethics approval. Despite the lengthy application process I feel the effort was worthwhile, since I value strongly the research role of clinical psychologists in the NHS. One of my greatest challenges was relying on members of a very busy team to recruit participants, at least in terms of identifying those who met the inclusion criteria and eliciting their initial interest to take part. I discovered the importance of communication, developing strong relationships within the team and how key this was in developing a mutual understanding and commitment to carrying out the research. I feel that I facilitated this by attending a team meeting, in which I was able to present my proposed research project and answer any questions from team members. I kept in regular contact with both the clinicians and the team leader and since completing my research project, I have thanked the team personally via email, sending them a summary of my findings including, in particular, the clinical implications. I feel it was important to acknowledge their support, helping to maintain their interest and desire to assist or even conduct their own research in the future.

Using IPA for my study enabled me to engage with foster parents' experiences of working with traumatised looked-after children (LAC). I was able to learn about the underpinnings of IPA and engage at a deeper level with participants' experiences. My learning came from reading IPA text-

books and papers, as well as forming part of an IPA trainee-study group at Salomons, which I found both interesting and helpful. Also I organised an extra teaching seminar with a tutor who has specialist knowledge and experience in using IPA.

From the outset I was aware that the research was likely to have an impact on me. However, I had underestimated the extent to which the participants' stories and experiences did affect me, both personally and professionally. I was emotionally moved by their experiences, which I reflected on with my supervisors and confidentially with my friends and family. Professionally, the participants taught me a lot about valuing the small changes one can make in others' lives, not expecting to change everything but to improve small parts of a one's life, which whilst this might be challenging it is 'worth the fight.' The foster parents I interviewed were both empathic and tenacious and I felt privileged to hear their stories.

My learning to date is far from complete and I hope to develop my qualitative research experiences. In particular I am keen to broaden my experience in using grounded theory (Strauss & Corbin, 1990) and narrative (Riessman, 1993) methodologies. After completing my training I would like to develop my quantitative research skills also, since I think it is vital for clinical psychologists to maintain their empiricist position and retain skills in both quantitative and qualitative research methodologies.

2. If you were able to do this project again, what would you do differently and why?

My initial ideas for this project partly came from personal experience of a traumatic event in my life and observing the way that others responded to my experience and how their responses, in turn, impacted on me and on my recovery. Also this project was strongly influenced by my clinical experiences prior to my current training, working with traumatised young people, observing the impact this work had on both my supervisor (a consultant clinical psychologist) and the children's parents/ foster parents. I feel, therefore, that I had a lot invested personally in this project. I am extremely glad that I kept a research diary (see appendix K) and completed a bracketing interview (see appendix J) that has enabled me to keep track of my thoughts and feelings regarding this project and its findings (Fischer, 2009). However, I feel that I would have benefited by completing a second

bracketing interview to explore any changes in my thinking with regards to this research, following the completion of all the interviews and the analysis of the results.

Also if I were able to do this project again, I would perhaps gather further information regarding the foster parents' backgrounds, experiences of fostering to date and their motivations to start fostering. As the interviews progressed it quickly became apparent that the participants had different motivations for fostering young people. Also each of them seemed to come from quite different backgrounds and brought a variety of different life-experiences with them prior to and during their work as a carer.

In addition, if I knew then what I know now (the benefit of hindsight!) I might have thought more carefully about the wording of some of my interview questions. Asking foster parents about the 'impact' of the looked-after children's trauma on them seemed to invite predominantly negative responses. It is possible that by sampling my participants from within a child and adolescent mental health service (CAMHS) created some pre-conceptions for the foster parents, as CAMHS is often the service accessed to discuss problems they are experiencing. However, it was clear also that foster parents had many positive experiences they wished to share and by using a semi-structured interview. I was able to follow up the reports of positive experiences with further questions, gathering more information and insight.

3. Clinically, as a consequence of doing this study, would you do anything differently and why?

Personally, carrying out this research project has taught me a great deal more about the effect working with trauma has on me and on the clinical work that I do. Self-reflection is fundamental in the research process (Bell, 1998) and to my clinical practice. I have learnt more about what I bring to my therapy sessions with clients and the need to keep myself safe and well, in order to continue providing the best care possible. However, I have learnt how easy it is, despite writing a thesis about the impact of working with trauma on others, to 'lose myself' in the process of caring for my clients. During this period, whilst working to strict deadlines, with multiple demands from my clinical work, university and searching for future employment, writing my thesis has required me to pull on many of

my coping resources, which have recently felt somewhat depleted. It has taught me to continue my self-reflection during both research work and in my clinical work. This will enable me to monitor how my clients' experiences impact on me and help me to think flexibly about how I can continually find ways to increase my coping resources before they become depleted. I wish to continue my sports and organising of social events and fundraisers, which offer me great relief from the stresses and strains of my clinical work in highly emotive situations, with vulnerable and distressed people.

In my future clinical practice I hope to have the opportunity to work with parents/ foster parents/ adoptive parents. In particular I would like to offer groups to explore secondary trauma (ST) and vicarious trauma (VT) and the meaning carers make from the LACs' trauma they have experienced. I feel that I have gained knowledge about the vast experiences, both good and bad, of foster parents caring for traumatised LAC. I hope to continue with this learning and to consult with services, in particular supervising social workers, in order to share some of this knowledge. I feel that this might enable teams to work creatively with foster parents, to consider new ways forward, in order to better meet their needs and in turn the LACs' needs, whilst remaining transparent about the current cut backs and limited resources all services are currently faced with. In addition to this, I would like the opportunity to work with LAC teams and encourage them to self-reflect more on the highly emotive and stressful roles they have within their teams, considering ways to protect themselves from the potential effects of ST and VT. I believe this may help to build resilience in workers but also help others to recognise when their personal resources are depleting and take steps to enable their repletion. The overall aim would be to improve staff morale and well-being, in order to protect themselves, reduce sickness and staff-turnover, aiming ultimately to better meet the needs of our most vulnerable young people.

4. If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

Whilst conducting this research project and on reflection since its completion, I have developed several ideas for future research, some I hope to be able to follow through with. Firstly,

whilst writing my review in Section A I was surprised by the lack of consideration of the potential positive impacts of working with LAC. This piece of work also highlighted for me the lack of clarity in the constructs (e.g. ST/ VT) or valid measures of these psychological impacts on professionals and foster/ adoptive/ biological parents caring for traumatised young people. My project's findings warrant the need for further research in a number of areas, in particular research to develop/ adapt current measures of ST and VT, assessing the impact on FPs caring for LAC.

The experience of foster parents who are considering leaving fostering, or those who have recently resigned requires further exploration. This research could increase our understanding of the potential negative psychological impacts of working with traumatised LAC and in particular, shed light on why some do not cope and how to offer better support to foster parents in these difficult situations. IPA methodology would be an appropriate methodology to explore these issues.

My study's findings suggest that foster parents may experience symptoms of ST and VT, which may be detrimental to their health and wellbeing. However, currently there are no validated measures specifically designed to screen for ST or VT in foster parents. I would like to adapt current measures of ST (e.g. Secondary Traumatic Stress Scale; Bride, Robinson, Yegidis, & Figley, 2004) and VT (e.g. TSI-Belief Scale; Pearlman, 1996) by asking foster parents within a multitude of support/ training groups to tailor the wording of each question to better suit the role of a foster parent, as opposed to a social worker, or psychotherapist. I would then validate these adapted measures on foster parents, by recruiting both foster parents who are currently fostering traumatised LAC and those who have recently resigned or taken a break from fostering. I would aim to recruit a minimum of 100 foster parents, a similar sample size to Jenkins and Baird's (2005) secondary traumatic stress and vicarious trauma validation study, with sexual assault and domestic violence counsellors. These findings would be informative to NHS services and perhaps private fostering agencies, in particular to those caring for our most traumatised LAC, endeavouring to maintain and support foster parents in the difficult work that they do. I believe that by caring more for our foster parents, we will be caring more for our most vulnerable children.

References

- Bell, S. (1998). Self-reflection and vulnerability in action research: Bringing forth new worlds in our learning. *Systemic Practice and Action Research*, 11, 179-191.
- Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C. R. (2004). Development and validation of the secondary traumatic stress scale. *Research on Social Work Practice*, 14, 27-35.
- Fischer, C. T. (2009). Bracketing in qualitative research: Conceptual and practical matters. *Psychotherapy Research*, 19, 583-590.
- Jenkins, S. R. & Baird, S. (2005). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress*, 15, 423-432.
- Pearlman, L. A. (1996). Psychometric review of TSI Belief Scale Revision. In B. H. Stamm (Ed.), *Measurement of stress, trauma and adaptation* (pp. 127-130). Lutherville, Md: Sidran Press.
- Riessman, C. K. (1993). *Narrative analysis*. Newbury Park, CA: Sage.
- Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: theory, method and research*. London: Sage.
- Strauss, A. & Corbin, J. (1990). *Basics of qualitative research: Grounded Theory procedures and techniques*. Newbury Park, CA: Sage.

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Section D:

Appendices of supporting material

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Appendix A: Literature search methodology for Section A

Search strategy

Electronic databases were searched from the earliest year of publication up to the end of December 2012: PsycINFO (1806-present), Medline (1948-present), ASSIA (2005-present) and Cochrane databases (2005-present).

Key words LOOKED AFTER CHILD* or FOSTER CHILD* or CHILDREN IN CARE and CHILD WELFARE PROFESSIONAL or SOCIAL WORK* or CHILD PROTECTION were combined with the following: VICARIOUS TRAUMA*, SECONDARY TRAUMA*, BURNOUT, COMPASSION FATIGUE, STRAIN, STRESS, COMPASSION SATISFACTION, POST TRAUMATIC GROWTH.

Inclusion criteria

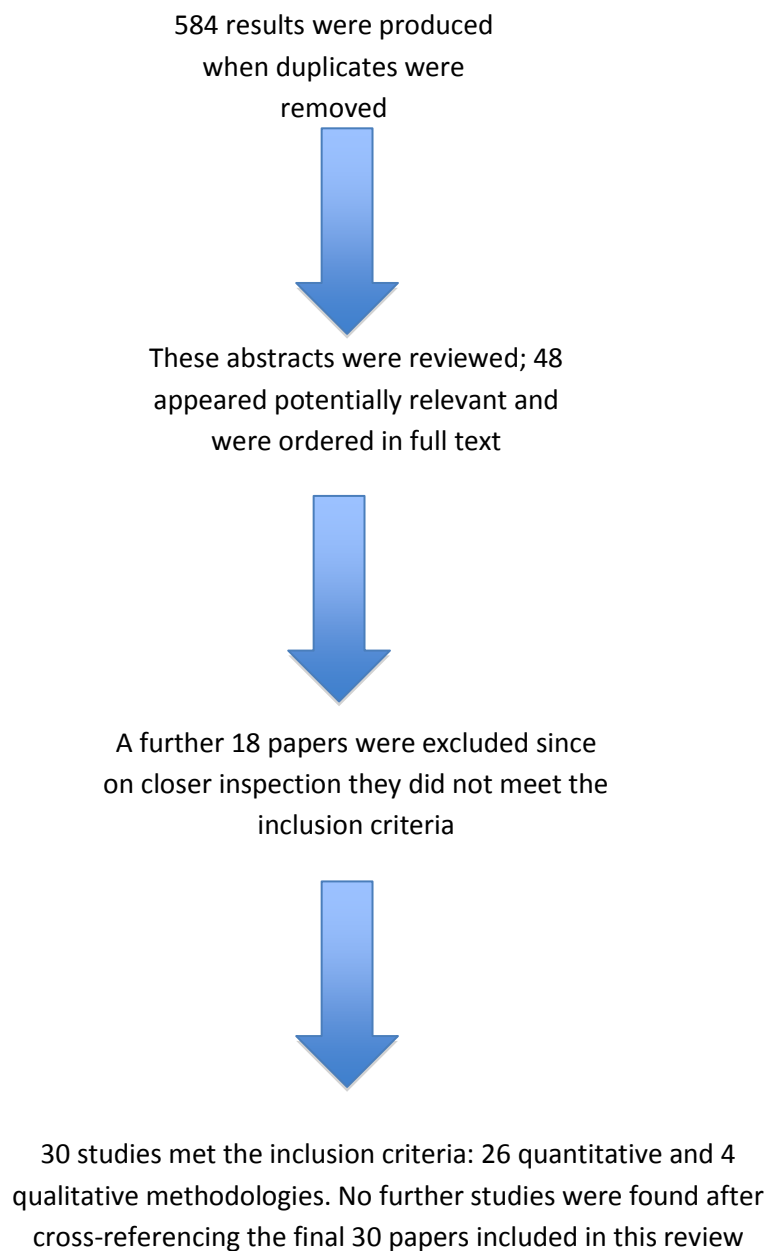
Quantitative and qualitative studies that explored the psychological impact (both positive and negative) of caring for traumatised looked-after children (LAC) on child welfare professionals (CWPs) were included.

Exclusion criteria

Studies exploring the experiences of trauma counsellors or psychotherapists working with looked-after children were excluded, since their roles and responsibilities were deemed a separate issue and it was outside the scope of this review to be exploring this. Also not included were studies whereby participants were a mixture of CWPs and other professionals, such as psychotherapists, unless the results of CWPs and other professionals were analysed and reported on separately. Studies that focused on support needs/ coping strategies of CWPs rather than the psychological impact of their work were also excluded.

Study selection

Abstracts were screened for relevance and full articles were retrieved when the inclusion criteria appeared to be met. Following this the full article was read and either included or excluded again depending on whether the criteria were met. For those who met the criteria, references were checked for additional studies not found in the original searches. Thirty studies met the inclusion criteria and were included in the review (see diagram below for methodological process).



Appendix B: Recruitment Clinic Letter



Canterbury Christ Church University
Department of Applied Psychology
Broomhill Road
Tunbridge Wells
TN3 0TG

Dear

I (Jade Redfern, Trainee Clinical Psychologist) would like to invite you to participate in an interview about your experience of looking after traumatised looked-after children.

I am contacting you via the Child and Adolescent Looked After Service [REDACTED], who are supporting the project and helping me find foster parents like yourself who would like to take part. The project is based at the Child and Adolescent Looked After Service [REDACTED], in a private clinic room to carry out the interview.

The research project aims to find out what it is like for foster parents to look after traumatised looked-after children. There has been very little research carried out to date in this area.

The enclosed information sheet will tell you about the project. The consent form enclosed is what you would need to sign if you decide to take part in an interview.

The clinic will have asked you if it's OK for me to telephone/email you. I will contact you in a few weeks to answer any questions you may have and see if you are happy to meet me and discuss your experience of looking after traumatised children.

If you would like to contact me, or if you have changed your mind and do not want to discuss taking part, please contact me either by telephone or email:

j.h.redfern4@canterbury.ac.uk

01892 507667

Yours sincerely,

Jade Redfern

Trainee Clinical Psychologist

Canterbury Christ Church University

Dr [REDACTED]

Clinical Psychologist

Appendix C: Foster parent information sheet

FOSTER PARENT INFORMATION SHEET

Exploring Foster Parents' lived experiences of caring for traumatised children

This research study is being sponsored by the Department of Applied Psychology at Canterbury Christ Church University (CCCU). I (Jade Redfern) would like to invite you to take part in this research study. Your participation is completely voluntary, if you decide you are not going to take part this will not affect your family's ongoing care at the clinic in any way. Before you decide I will go through this information sheet with you and answer any questions you may have.

Purpose of the study

Young people who have experienced trauma(s) in their lives can lead to various different difficulties, behaviours, emotions and ways of coping. As a foster parent your roles are varied and complex, in terms of caring for traumatised foster children. There is a significant lack of research in the area of foster care, in particular the experience of the foster parent. The joint guidance from NICE and the Social Care Institute for Excellence (SCIE) is supported by a principle of putting the voices of young people and their families at the heart of service design and delivery, and ensuring services are tailored to the individual and diverse needs.

You have been invited to take part in this study because you have experience of looking after a young person who has experienced significant trauma(s) in their past and we would like to learn about what this experience has been like for you. Your participation is voluntary.

What will you be required to do?

You will take part in an interview with me (Jade Redfern), which will last for up to an hour and a half. You will be asked questions about:

- How long you have been a foster carer for and what you might enjoy the most about this experience
- Talk about the young person, about their likes and dislikes for example.
- What understandings you may or may not have about the young person's past trauma(s)
- How you might have experienced caring for traumatised young people, whilst thinking about them, yourself and perhaps your family as a whole.

The interview will be voice recorded so that the interview can be written down afterwards, and then the recordings will be erased.

To participate in this research you must:

- Have cared for currently or in the past a foster child or adolescent (aged 5-17) who has past experience of significant trauma(s) in their lives
- Be the primary care giver for the young person
- Be currently involved with a clinician or on the caseload known to the Child & Adolescent Looked After Service [REDACTED]

What are the benefits and risks of your participation?

You will have an opportunity to contribute to research the experience of foster care with traumatised young people. You can choose what you want to tell me, and you do not have to answer questions if you do not want to. If you choose to discuss sensitive topics regarding your experiences you may become upset. You are free to stop the interview at any time, or take a break. I will be available to answer any of your concerns after the interview, and/or a member of the clinical team at the Child & Adolescent Looked After Service [REDACTED] will also be available within a week of the interview if required.

Expenses

Travel expenses of up to £10 can be claimed to contribute to the cost of travel to the interview.

Confidentiality

If you take part, the clinical team at the Child & Adolescent Looked After Service [REDACTED] will be told that you are coming for an interview. The local authority is in agreement for this research and the project has been through thorough ethical scrutiny to ensure that confidentiality is not breached. You do not have to mention any child's name during the interview if you choose not to. The contents of the interview will remain confidential unless you tell me something that makes me worry about your safety or the safety of others. In this case I may need to discuss the issue with the clinical team, and you. Data will be stored securely within CCCU premises and the chief investigators office in accordance with the Data Protection Act 1998 and the University's own data protection requirements. The anonymised transcripts of the interviews will be accessed only by me (Jade Redfern) and two research supervisors. Your name and contact details will be stored separately to the printed copy of the interview. After completion of the study, all data will be made anonymous (i.e. all personal information associated with the data will be removed).

Feedback and Dissemination of results

You will be sent a brief summary of the findings of the study.

The Child & Adolescent Looked After Service [REDACTED] will also be sent a summary of the findings of the study and the research study will be written up as an article, and submitted to an academic journal for publication. Participants' names and other identifying information will not be included in any dissemination of the results. I may want to quote something you had said to me but no-one will be able to tell that it was you who said it.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect the interests of participants. This study has been reviewed and given favourable opinion by the [REDACTED] Research Ethics Committee. The study has also been approved by the Department of Applied Psychology at Canterbury Christ Church University (CCCU).

Deciding whether to participate

If you have any questions or concerns about the nature, procedures or requirements of the study please discuss these with me. Should you decide that you are going to participate in the study, you will be free to withdraw from the study at any time without having to give a reason. Your family's treatment or support from the Child & Adolescent Looked After Service [REDACTED] will not be affected in any way.

Any questions? Please contact Jade Redfern (Trainee Clinical Psychologist):

j.h.redfern4@canterbury.ac.uk or 01892 507667

Canterbury Christ Church University, Salomons Campus at Tunbridge Wells

Broomhill Road, Southborough. Tunbridge Wells, Kent, TN3 0TG

If you are unhappy with the research project or the care you have received please talk to the researcher and/or the Child & Adolescent Looked After Service [REDACTED] and we will do our best to solve the problem. There are also two other options available to you.

The Patient Advice and Liaison Service (PALS) provide a confidential service to help patients get the most out of the NHS. If you would like to get advice or more information you can contact them:

Telephone: [REDACTED]

Email: [REDACTED]

Write: PALS, [REDACTED]

[REDACTED]

If would like to make a formal complaint you can contact the complaints department:

Telephone: [REDACTED]

Email: [REDACTED]

Write: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Appendix D: Semi-structured interview schedule

Interview Schedule

- Explain rationale and procedure
 - Check participant has signed consent form
 - Ask if they have any questions about the research project
1. I wondered if you could start by telling me a bit about yourself, perhaps about how long you have been a foster parent for and what you might enjoy the most about this experience?

 2. I wondered if you could tell me a little bit about [young person]?
Prompts: What does he/she like or dislike? What does he/she find easy or difficult?

 3. I understand that [young person] was first placed with you [X months/years ago] and he/she has had some past experiences of traumatic events in their life. Can you tell me a bit more about your understanding of this?

Prompt Questions:

And how did this make you feel?

Can you tell me a bit more about what you have personally experienced whilst caring for [young person]?

And how do you think this may have affected [young person]?

Can you tell me a bit more about some difficult times you have experienced together? So, what happened?

Can you tell me a bit more about some better times you have experienced together? So, what happened?

And how do you think this may impact on you as a foster parent?

Can you tell me what comes to mind when thinking about caring for [young person] and the rest of your family?

4. Is there anything that you think I should have asked that I didn't ask?

Debrief

'Those were all my questions'

Do you have any questions about what we've been talking about?

How are you feeling?

Do you feel I need to talk to anyone about how you are feeling?

Give contact details of local authority for them to contact if they wish they need to talk to someone about how they are feeling after the interview has finished. Alternatively, give them my contact details.

Appendix E

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Appendix F: Consent form



CONSENT FORM

Title of Project: Exploring foster parents’ lived experiences of caring for traumatised looked-after children

Name of Researcher: Jade Redfern

Contact details:

Address:

Canterbury Christ Church University
 Salomons Campus at Tunbridge Wells
 Broomhill Road
 Southborough, Tunbridge Wells
 Kent, TN3 0TG

Tel:

01892 507667

Email:

j.h.redfern4@canterbury.ac.uk

Please initial box

1. I confirm that the above study has been explained to me by the researcher.
2. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and this will not affect the treatment I, or my looked-after child receive at the clinic in any way.
4. I agree to the interview being voice recorded.
5. I understand that any personal information that we provide to the researchers will be kept strictly confidential
6. I agree to my taking part in take part in the above study.

Name of Foster Parent

Date

Signature

Name of Researcher

Date

Signature

Copies: 1 for foster parent
 1 for researcher

Appendix G: End of study letter and summary for participants



Canterbury Christ Church University

Department of Applied Psychology

Broomhill Road

Tunbridge Wells

TN3 0TG

24th June 2013

Dear

Firstly I would like to say a big thank you for taking part in my research project. I interviewed 11 foster parents who have experience of caring for traumatised looked-after children, and the project has now been completed.

I am sending you a summary of the research findings. If you would like any further details, or would like to receive a copy of the study once it is published, please contact me before the end of September 2013 by email or telephone:

j.h.redfern4@canterbury.ac.uk

01892 507667

Kind regards,

Jade Redfern

Trainee Clinical Psychologist

Canterbury Christ Church University

Dr [REDACTED]

Clinical Psychologist

Summary of findings: Foster parents' lived experiences of caring for traumatised looked-after children: The costs and gains of caring

June 2013

Background

There is a significant lack of research exploring the impact on foster parents caring for traumatised looked-after children (LAC). The aim of this study was to explore foster parents' experiences of caring for LAC, including their understanding of the impact the trauma has had on the young person and on themselves and their biological family.

What did I do?

I interviewed 11 foster parents, exploring their personal experiences of caring for traumatised LAC and its impact on them, the young people and the foster parents' families. Transcripts were analysed using Interpretative Phenomenological Analysis (IPA) to produce key themes emerging from the data.

What did I find?

I found six key themes:

Emotional impact on foster parents

Many foster parents talked about the 'emotional rollercoaster' and wealth of emotional experiences you have while caring for LAC. These significant emotional impacts at times have felt overwhelming. However, some of you also talked about feeling proud and a sense of satisfaction with making a difference in their lives.

Cognitive impact on foster parents

There appeared to be a significant change in foster parents' perceptions and expectations, often resulting from not quite knowing what to expect in the beginning. Some of you talked about how you

had at times questioned whether or not you were able to continue fostering. However, you also talked about positive thoughts regarding fostering.

Impact from the wider fostering system

All foster parents talked about the challenges of working within a complex system around the child, with some professionals offering greater support than others. These support networks appeared to have a huge impact on foster parents' wellbeing.

Impact on foster parents' family and friends

Many of you talked about how fostering traumatised LAC also had a significant impact on your social lives. This seemed to be due to many factors, including trying to keep others safe from potential allegations and protect them from the aggressive behaviours exhibited by the young people.

However, some foster parents also experienced positive impacts on others, such as learning more about what others have been through and increasing ones understanding and empathy.

Foster parent coping

All of you talked about the many coping skills and resources you have developed over time, including taking breaks and respite; support from others; searching for meaning in what you do; and feeling a sense of duty to the children you look after.

Perceived understanding of the impact of trauma on LAC

All of you showed ways of searching for meaning in the young person's behaviour and the impact that the trauma has had on them. However, this was made difficult by the lack of information you were given regarding their histories. Most of you either used the knowledge you did have about the young

person's past, or your own childhood experiences to help you understand the impact the trauma has had on them.

Summary

These findings are really important to all those involved in the care and supervision of traumatised looked-after children. Increasing awareness of the impact this work can have on foster parents may inform services and hopefully assist in the decisions made regarding provisions of care.

These findings will be sent to the Journal of Clinical Child Psychology and Psychiatry (which is like a magazine for findings of projects like this) so that others can read about foster parents' experiences of caring for traumatised looked-after children. As we talked about, the findings will be written about anonymously, so no-one will be able to identify who took part or the young people you talked about in your interviews.

Jade Redfern

Trainee Clinical Psychologist

Canterbury Christ Church University

Appendix I: Table documenting the theme development process

Master theme	Sub-theme	Initial theme related to sub-theme	Participants with initial theme	Total number of references to initial theme
Emotional impact on foster parents	Overwhelming	Empathy is needed but distressing	2, 5, 7, 8	4
		An emotional rollercoaster – overwhelming emotions	1, 2, 3, 4, 11	5
		Anxiety, fear and shock	1, 2, 3, 4, 6, 7, 8, 9, 10, 11	10
		Anger	1, 3, 4, 5, 8, 10, 11	7
		Sadness	3, 4, 6, 10, 11	5
		Negative emotions impact upon foster parents' physical health	3, 6, 8, 10	4
		Reaching threshold	24/7 – not a part-time job	1, 2, 7, 8, 9, 10
		Feeling full-up of emotions	1, 3, 4, 11	4
		Draining	2, 4, 5, 8, 10, 11	6
	Attachment – difficulties letting go	Cannot let go of the young people	1, 3, 5, 6, 8, 9, 10, 11	8
		Sense of loss when the LAC leave	3, 5, 6, 8, 11	5
		Fear losing the young people	7, 9, 10	3
		Lack of closure from one placement to the next	3, 6, 8, 10	4
	Rewarding	Rewarding	1, 4, 6, 7, 8, 10, 11	7
		Feelings of pride	1, 3, 7, 8, 10	5
		Sense of satisfaction	1, 4, 8, 10, 11	5
Making a difference feels good		2, 3, 4, 6, 8, 9	6	
Cognitive impact on foster parents	Doubts/ questioning ability to affect change	Doubting their abilities to continue fostering – thinking about giving up	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11	11
		Feeling de-skilled	1, 2, 3, 4, 6, 7, 8, 11	8
		On-going impact of trauma on foster parents	1, 2, 3, 5	4
	Change in perspective	Fear, apprehension and shock	1, 2, 3, 4, 6, 7, 8, 9, 10, 11	10

		Not as expected	1, 2, 5, 6, 7, 8, 9	7
		Different views/ changing views	1, 2, 3, 4, 6, 7, 8, 9	8
	Sense of injustice	Cruelty to children – sense of right and wrong	3, 5, 6, 7, 9, 11	6
		A wish to avenge the young person vs it is not up to us to avenge them	1, 10 vs 8	2 vs 1
	Satisfaction and pride	Sense of satisfaction and pride	1, 3, 4, 7, 8, 10, 11	7
		Glad they chose to stick at fostering	1, 4, 8	3
		A new appreciation for things	8, 9	2
Impact of the wider fostering systems on foster parents	High responsibility of care without parental control	Powerlessness	1, 4, 5, 6	4
		Lack of control	3, 4, 5, 6, 7, 11	6
		Not our decision	3, 4, 5, 7, 9, 10, 11	7
	Support and understanding	Importance of being understood	1,4,5,7,8,9,11	7
		Experiences of being supported vs not being supported	1, 3, 4 vs 3, 5, 6, 8, 9, 10, 11	3 vs 7
		Experiences of being heard and listened to vs not having a voice	1, 2 vs 3, 5, 7, 10	2 vs 4
	Continued rejection/ neglect	Continued rejection by others including services	1, 3, 4, 5, 10, 11	6
		Experiences of several placement moves	1,2, 3, 5, 7, 8, 9, 10, 11	9
	Ambiguous and conflicting professional/ carer roles	I'm a professional vs I'm not a professional	3, 4, 8, 9, 11 vs 5, 7, 10	5 vs 3
		Different agendas	2, 3, 4, 7, 9, 10, 11	7
Rules and boundaries		4, 5, 6, 9, 10	5	
Impact on foster parents' family and friends	Strained relationships	Difficulty finding a balance	2, 8, 10, 11	4
		Lack of social life	1, 4, 5, 6, 8, 9, 10	7

		Fear for others/ need to protect others	4, 5, 6, 8, 9, 10, 11	7
	Growing understanding	Become a part of the family	3, 10, 11	3
		Greater understanding	1, 4, 6, 11	4
		Develop good relationships	3, 6, 10	3
Foster parent coping	Need for support and reassurance	Support	1, 2, 3, 4, 5, 7, 8, 10, 11	9
		Reassurance	1, 2, 6, 8, 10, 11	6
	Distancing, breaks and respite	Distancing	2, 4, 5, 6, 7, 8, 9, 11	8
		Breaks/ time-out	1, 2, 4, 5, 6, 8, 9, 10, 11	9
	Search for meaning	Search for meaning as a way of coping	1, 2, 7, 8, 9, 10, 11	7
	Sense of duty	Motivation/ determination	1, 2, 9, 10, 11	5
		Desire to make a difference	2, 3, 4, 7, 8, 9, 11	7
Need to be needed		1, 5, 11	3	
Foster parents' perceived understandings of the impact of trauma on the young people	Search for meaning	Search for understanding	1, 2, 4, 6, 7, 8, 9, 11	8
		Lack of information	5, 6, 8, 9, 10	5
	LAC's past experiences	Attachment and love	1, 7, 8, 10	4
		Context – young person's background	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11	11
	FPs' past experiences	Personal/ childhood experiences	1, 3, 4, 7, 8, 10, 11	7
		Traumas are complex, repetitive and on-going	1, 4, 5, 7, 8, 9	6

Appendix J

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Appendix K

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Appendix L: Characteristics of good qualitative research (Yardley, 2000)

Reproduced from Yardley (2000)

Sensitivity of context

The interpretations made are sensitive to the data, taking into account the social context and relationships through which the data emerged.

Commitment and rigour

This accounts for thorough data collection and in-depth engagement with topic; depth and breadth of analysis and methodological competence.

Transparency and coherence

Transparent methods and presentation of data; clarity and power of description/ arguments; fit between theory and method; reflexivity.

Impact and importance

Theoretical utility (enriching understanding); socio-cultural context; practical (usefulness) for community, health service, policy makers.

Appendix M: Example quotes from transcripts supporting each sub-theme

Emotional Impact on Foster Parents

Overwhelming

‘The biggest challenge is getting over the emotional side’ (P10, 11, 414)

‘It was distressing’ (P2, 6, 230)

‘I mean sometimes the fostering I have found stressful’ (P3, 3, 101)

‘I was just disgusted’ (P10, 7, 256)

‘The experiences that she has had, I myself have found it quite traumatic’ (P11, 2, 50)

‘I was on tenterhooks the whole time’ (P3, 1, 19)

‘It was frightening’ (P11, 7, 276)

‘I am not sure (...) but it is quite unnerving’ (P9, 3, 96)

‘I was getting really angry and I was hurt for her’ (P5, 6, 228)

‘I find it really upsetting (...) I’m quite tearful sometimes’ (P4, 4, 169)

‘and when they did that I cried and cried’ (P6, 10, 491)

Reaching threshold

‘It then just became a bit too much’ (P8, 8, 324)

‘It was at one point for about two weeks, it was a daily basis. It was just draining’ (P8, 8, 306)

‘And it is too much (...) I just feel pretty useless’ (P5, 11, 385)

‘It got to a point as well for myself as for her the environment just wasn’t safe (...) so I gave notice.’
(P8, 6, 217)

‘I told CAMHS I didn’t want this anymore and it was just like, it became too much’ (P11, 8, 288)

Attachment – difficulties letting go

‘But I can’t let things go’ (P5, 9, 338)

‘I don’t let go, so I hold on, I just hold on to her’ (P5, 11, 414)

‘They had their final hearing (...) that meant they weren’t going back to their mother. And that was an anxious time for me’ (P7, 2, 47)

‘I am quite anxious (...) about them coming and saying to me ‘the kids are going today’ and take them out of the house, which would be traumatic for us and traumatic for the children’ (P9, 12, 449)

‘I was choked up and I was sad to say goodbye to him’ (P6, 11, 516)

‘I want to email the school and check he’s alright’ (P6, 11, 533)

‘We are still in contact (...) there is still a connection there, still a thread there’ (P8, 11, 419)

Rewarding

‘I just find it really rewarding’ (P6, 1, 20)

‘But it is very rewarding’ (P7, 2, 74)

‘She is now achieving merits (...) so it is very rewarding’ (P8, 2, 62)

‘I enjoy the fact that I have got control over my own time, my home and my family (...) I enjoy looking after the children. I enjoy the family life side of things’ (P10, 1, 10)

‘It is really really nice. When things are good, it’s really really good’ (P10, 11, 401)

‘There are lots of rewarding bits’ (P10, 11, 430)

‘I feel pleased and happy and so glad that I’ve chosen to do this (...) I feel good about myself’ (P4, 11, 443)

Cognitive Impact on Foster Parents

Doubts/ questioning ability to affect change

‘Will it work, or won’t it?’ (P2, 1, 13)

‘Did I actually help those children?’ (P2, 1, 38)

‘I was then thinking do I really want this (...) I was covered in bruises (...) is this what I want to do’ (P1, 6, 221)

‘Is he ever going to settle?’ (P2, 2, 58)

‘What am I doing, you know, what good am I doing?’ (P4, 1, 20)

‘I thought I don’t know whether I am able to actually deal with what she had been through’ (P11, 4, 132)

‘I don’t really know if I am cut out to deal with someone who is traumatised with sexualised behaviour’ (P11, 4, 144)

‘But there have been, really to the point of do I want to foster care’ (P1, 1, 39)

‘In the beginning I thought ‘oh’ and I was sort of what have I done?’ (P7, 2, 74)

‘I thought no I can’t do this’ (P9, 7, 247)

‘I must admit it does make me feel like what on earth am I doing?’ (P10, 5, 172)

‘It just makes me think please leave my house so I can shut the door and lock myself in, and go and live with somebody else’ (P10, 5, 181)

‘It put a few weeks doubt in my mind’ (P10, 9, 337)

‘I wasn’t sure I wanted to be a long-term carer’ (P11, 2, 72)

Change in perspective

‘I just took it for granted that he would be here for Christmas and we would enjoy it (...) it didn’t work out’ (P7, 1, 32)

‘Sometimes that can surprise me’ (P7, 3, 96)

‘And it was what I had never thought about was those sorts of incidences’ (P8, 10, 375)

‘I didn’t realise how it would affect my support network’ (P8, 10, 389)

‘You don’t know what you are getting’ (P9, 7, 272)

‘And when my mum was fostering, we had never come across it’ (P10, 4, 130)

‘Why do these foster carers want to go on holiday and not take the children with them? But (...) I fully understand them now why they need a break’ (P3, 1, 25)

Sense of injustice

‘Well you just want to (...) I think you want to do the same to them’ (P7, 6, 208)

‘These children, it is cruelty what is going on’ (P7, 6, 224)

‘And I did for a moment feel for her and as much as I have no feelings for that woman one bit (...) to me she is not even a, no’ (P7, 11, 422)

‘A lot of very very inappropriate behaviour from so-called adults’ (P8, 4, 147)

‘And let them get away with what they have done’ (P10, 7, 262)

‘But really I think how can your mum and dad love you if they have done something like that’ (P10, 8, 276)

‘And again it just made me furious because I thought she has got no idea of how to look after them, or how to treat them’ (P10, 8, 287)

‘And I just think oh my God how can someone do that to a child?’ (P11, 3, 84)

‘How can someone do that to a child, how can they put a little girl through that?’ (P11, 4, 153)

‘There are wicked people out there, how can they put a child through that?’ (P11, 5, 168)

‘I know children are neglected. But you think we have moved on. But hearing we haven’t (...)’ (P2, 6, 227)

Satisfaction and pride

‘It is nice to see (...) the change in them (...) I have got to hold on to that’ (P10, 12, 431)

‘I have had to learn to accept that she is always going to see him in a better light than me’ (P1, 9, 350)

‘I am glad we persevered’ (P1, 12, 467)

‘It has been a learning curve for me (...) I didn’t know about attachment theory until I came into fostering’ (P3, 7, 253)

‘It is really rewarding when you see them move on with their lives’ (P4, 1, 16)

‘What a difference I have made to her life’ (P4, 11, 410)

Impact from the Wider Fostering System

High responsibility of care without parental control

‘I was really annoyed they’d actually let him go into the contact (...) I felt like social services hadn’t helped him enough (...) no matter what I did I just couldn’t help him’ (P6, 5, 231)

‘His mum would say one thing to him, his dad would say one thing to him and (...) I got the brunt of it because he would say to me you can’t tell me what to do’ (P11, 7, 280)

‘And social services said well it is not up to you’ (P3, 10, 394)

‘They knew what was going on (...) I would go to the social worker, to school and it would be me having to say things because the social worker wouldn’t (...) I was hurt for her because she never got the help she needed and there was nothing I could do about it’ (P5, 6, 193)

‘Nobody was doing nothing about it so I phoned the police and said look she has been missing and they said well it is nothing really to do with you so I phone social services (...) they said that they cannot do nothing ‘cause they don’t know where she is’ (P5, 10, 358)

Support and understanding

Positive:

‘My own link worker really supported me’ (P3, 10, 387)

‘I’m not a psychologist so that is why I am so glad he comes to see people’ (P4, 3, 124)

‘I had some on my team, on my side. I had some really good workers there, which supported me’ (P5, 5, 173)

Negative:

‘I was left to get on with it’ (11, 9, 343)

‘I felt quite unsupported because at the time her social worker never visited’ (P11, 9, 337)

‘I felt like social services hadn’t helped him enough’ (P6, 5, 233)

‘You don’t really get any feedback about what’s going on’ (P6, 10, 481)

‘All the social worker kept saying was show them more love, show them more love’ (P10, 6, 219)

Continued rejection/neglect

‘She has just been plucked from one place to another’ (P11, 2, 67)

‘We are the only consistent person in that child’s life because every other professional is going to change at some point’ (P1, 14, 459)

‘She was given carers who didn’t really have no time for her but wanted the brother (...) Even though they looked after her, they never cared about her. And then she went to another foster home, which is even worse because she is an alcoholic, the foster carer’ (P5, 2, 56)

‘I was hurt for her because she never got the help she needed’ (P5, 6, 198)

‘Her social worker never visited’ (P11, 9, 308)

Ambiguous and conflicting professional/carer roles

‘I keep it professional’ (P3, 3, 91)

‘I don’t know I am not an expert’ (P7, 6, 225)

‘Why are they having contact with their parents...they shouldn’t be having contact with their parents after having all that traumatic experience’ (P2, 8, 299)

‘I am not in agreement with services (...) going to see their parents (...) I am not in agreement with that’ (P7, 11, 409)

‘They said they can’t tell you what it is (...) I am thinking why I am the carer, so I should know’ (P11, 3, 92)

‘I am not sure if the local authority saw it the same way as I did’ (P2, 1, 33)

‘Immigration are planning one thing and social services want to plan something else, so there is a bit of a clash’ (P9, 6, 213)

‘It really annoyed me and it annoyed me that the whole system worked like that’ (P10, 7, 269)

‘I’m not allowed to shout, I’m not allowed to do this and that’ (P4, 8, 324)

Impact on Foster Parents’ Family and Friends

Strained relationships

‘There was always a lot of jealousy as well because of what you taking my mum and dad away’ (P2, 7, 275)

‘She’s absolutely awful a lot of the time and that has quite an impact on my birth children’ (P4, 9, 355)

‘My kids have had stuff over the years stolen off of them’ (P4, 8, 307)

‘But the older ones, teenagers, impact more on the lives on my children’ (P4, 9, 343)

‘The whole family (...) they’re not trained as foster carers’ (P4, 8, 303)

‘My son was really angry’ (P4, 12, 489)

‘She felt that I neglected her in a sense that I had this little boy (...) she told me she felt left out’ (P11, 7, 250)

‘Hurting my son ‘cause my son is crying and telling him to stop’ (P9, 2, 79)

‘He’s got to be moved (...) it’s not fair for the rest of the family’ (P4, 12, 493)

‘I think my daughter finds it frustrating because she likes to tell tales’ (P11, 2, 42)

‘It was hurting his feelings’ (P6, 7, 303)

‘The children at school had become quite upset because of what she said’ (P11, 9, 327)

‘He is absolutely disgusted. And sometimes he is more shocked than I am’ (P7, 9, 348)

‘There would be less strain if he wasn’t here (...) made other people feel uncomfortable (...) it stops your social life because you can’t put other people through that’ (P6, 12, 551)

‘I knew what some of the impact could be on me. I didn’t know, realise how it would affect my support network’ (P8, 10, 388)

‘It has caused issues between me and my family’ (P10, 4, 131)

‘So it did put a strain on what we was going to do in the future’ (P10, 4, 138)

Growing understanding

‘They are very protective of each other’ (P3, 9, 341)

‘They do enjoy it’ (P4, 9, 345)

‘My eldest son (...) built up quite a rapport with him’ (P6, 1, 43)

‘My family ‘cause we are a family’ (P10, 1,11)

‘He really worries about them (...) He has took to them, he has really took to them’ (P10, 10, 367)

‘So my daughter was sympathetic to that’ (P11, 6, 238)

Foster Parent Coping

Need for support and reassurance

‘We support each other’ (P4, 1, 39)

‘I’ve got my sister who is a foster carer and my other friend who’s a foster carer (...) I can talk in a language that you can’t talk to a social worker’ (P4, 7, 258)

‘I had some really good workers there, which supported me through the placement’ (P5, 5, 174)

‘The only person I can really talk to is my husband’ (P7, 8, 308)

‘We have got support groups (...) where we can again share information but also with somebody who understands’ (P8, 5, 194)

Distancing, breaks and respite

‘They said ‘Mum’ which we were trying to hold back on a bit really’ (P2, 2, 55)

‘I have to say she is not my daughter, she is my foster daughter’ (P5, 6, 208)

‘I thought we’d have a little break and start back in January’ (P8, 12, 465)

‘I actually only had to take a two-year break but I took a four-year break’ (P6, 1, 7)

‘I think we would have a break from fostering for a while. I think we couldn’t take another placement for a few months. I think just readjusting’ (P9, 12, 476)

‘I kept saying leave him (...) I’m thinking don’t keep getting your feelings hurt’ (P6, 7, 302)

‘I was relieved he was going’ (P6, 11, 516)

‘It was a relief that they went to bed. It was a relief that they was at school or out of the house’ (P10, 5, 192)

‘Then I had to take a step back’ (P11, 4, 154)

‘I need to make use of my network because I need time-out as well’ (P11, 10, 361)

‘It is important as a carer to take time-out and do things with your family, do things without the foster child, as well as it is important to do things with them’ (P11, 10, 368)

‘Then I had to accept that I can be angry, just take time out’ (P11, 8, 306)

‘For the carer, it is like taking it slowly’ (P2, 3, 115)

‘Let me just think it’s a job, I’m getting paid for doing this’ (P4, 12, 507)

‘Initially I did not want to go and see dad, I just thought it was a bit too much for me’ (P9, 4, 136)

Search for meaning

‘We have tried to kind of figure out’ (P9, 3,108)

‘I keep thinking well all children should be with their parents but not all parents can look after children’ (P9, 10, 392)

‘Once you are aware (...) explore it more, so it is really about looking within yourself and preparing yourself for that’ (P8, 5, 171)

‘Well I couldn’t understand and a lot of the professionals around her couldn’t understand what the triggers were’ (P8, 6, 222)

Sense of duty

‘They have been let down by various people in the past and it is the only thing that has made me want to keep them here’ (P10, 7, 246)

‘I stuck with him’ (P11, 8, 283)

‘I’m not ready to give up on her yet (...) I couldn’t do that to her’ (P1, 7, 248)

‘Thinking you must go on, you must go on’ (P2, 9, 339)

‘It was the right thing for me to do’ (P6, 1, 15)

‘Then I thought but this child needs looking after. And not just looking after, he needs educating’ (P7, 2, 78)

‘I would hate to give up on them’ (P9, 7, 272)

‘But I still wanted to keep them here’ (P10, 4, 140)

Perceived Understanding of the Impact of Trauma on LAC

Search for meaning

‘We try to work out what it is’ (P2, 2, 63)

‘It took me a while to work it out’ (P2, 4, 134)

‘She doesn’t want to communicate, maybe she doesn’t understand what she is feeling I don’t know (...) it could be fear, it could be anger, it could be anxiety’ (P8, 3, 97)

‘They all say no matter what these children love their parents. And it is very strange for me to understand that’ (P7, 4, 150)

‘Part of me is thinking I’m wondering if it is that’ (P9, 13, 491)

LACs’ past experiences

‘You just have to remind yourself why he’s doing this (...) and what he’s been through’ (P4, 6, 244)

‘You have to sort of ignore because they’re from (...) because of their past’ (P4, 7, 286)

‘She is like the way she is because of her mum’ (P5, 3, 106)

‘He’d been in such a bad place, he’s been through so much that you know this is not personal’ (P6, 7, 337)

‘I do always (...) think they’ve had such a hard experience you’ve got to realise they’ve had such a bad time and try and keep that in perspective’ (P6, 9, 411)

‘A lot of arguments between mum and dad (...) so he always thought it was his fault (...) because he couldn’t run away from his dad fast enough’ (P10, 3, 101)

‘When she came here she reverted back to a really small child because she had a lot of responsibilities when she was with mum and dad’ (P10, 3, 106)

‘I don’t know what he is feeling inside; he might have had to learn to be like that (...) His whole life was built around fear’ (P7, 4, 135)

‘He is always drawn to the violent headlines or the violent pictures (...) that is what he has been around isn’t it’ (P7, 7, 243)

‘(...) has had some traumatic incidences in his life as a baby (...) I am sure the screaming and the crying is a part of that’ (P9, 9, 361)

‘She was like an outsider almost and not really a family member (...) that was extremely difficult for her’ (P1, 4, 154)

‘And again it is about the trauma and neglect he has experienced’ (P2, 4, 131)

‘She has witnessed all those things. She has seen things and it has affected her, she used to dream every night and have nightmares’ (P3, 5, 175)

‘Being overly familiar with people, which stems from (...) the experiences that she has had’ (P11, 1, 21)

‘How she has presented herself now is through learnt behaviour from her mum, because there were no boundaries’ (P11, 3, 109)

FPs’ past experiences

‘I have been through a lot myself and I have been around a lot of friends (...) who have been in very unfortunate situations (...) a lot of life experience (...) as well as (...) theoretical training’ (P8, 4, 159)

‘My mum was a foster carer so we grew up with foster children’ (P10, 1, 7)

‘My personal opinion I think (...) some underlying issues (...) I feel it has prevented her moving forward’ (P8, 5, 185)

‘I would say from my experience’ (P3, 5, 201)

‘I sometimes think how would I feel at that age going to someone else’s house (...) knowing they’re paid to care for you’ (P4, 13, 531)

‘When I grew up’ (P7, 6, 217)

‘Cause my father beat my mother, so I have grown up around violence’ (P7, 9, 351)

‘I know what it is to hear my mother being beat for no reason. And so I got a little bit of insight’ (P7, 9, 357)

Appendix N: End of study report: 11/LO/1901

End of study report – June 2013

Full title of study: Foster parents' lived experiences of caring for traumatised looked-after children:

The costs and gains of caring

REC reference number: 11/LO/1901

Background

Secondary trauma (ST) describes the emotional duress experienced by persons having close contact with a trauma survivor, especially concerned family members (Figley, 1995). ST research has predominantly looked at mental health professionals working with trauma survivors, in which symptoms may spread from the survivor to the professional (Kassam-Adams, 1999).

Foster parents (FPs) risk developing ST due to their necessary use of empathy, to understand and support looked-after children (LAC), but this may place carers at risk of internalizing the LACs' trauma (Regehr, Goldberg, & Hughes, 2010). Other risk factors may include insufficient recovery time, since many FPs experience a lack of support or respite from those around them (Sinclair, 2005).

Another commonly cited construct within the literature is the term vicarious trauma (VT), describing the impact on mental health professionals working with trauma survivors. According to McCann and Pearlman's (1990) Constructivist Self-Development Theory (CSDT) trauma can disrupt a person's cognitive schemata in one or more of five fundamental need areas: safety; trust/dependency; esteem; control; and intimacy. These significant psychological effects, if untreated, can persist for months or years and modify the meanings used to interpret events in their life and others (McCann & Pearlman, 1990). However, no research to date has developed a measure or assessed VT with FPs.

In summary, research has evidenced a variety of ways the impact on those who care for traumatised people, such as wives of distressed police officers, partners of war veterans and trauma counsellors. However, there is a lack of research exploring the impact on FPs caring for traumatised LAC.

Research aims

Given that no studies have rigorously examined the impact on FPs' caring for traumatised LAC, this study aimed to examine foster parents' understanding of this impact, and the impact that the trauma has on the LAC themselves and the FPs' families.

Method

Eleven FPs caring for LAC who met the study inclusion criteria were interviewed. Interpretative Phenomenological Analysis (IPA) was selected as it is concerned with how people make sense of their life experiences (Smith, Flowers & Larkin, 2009).

Findings

Six master themes were identified: ‘emotional impact on foster parents’, ‘cognitive impact on foster parents’, ‘impact from the wider fostering system’, ‘impact on foster parents’ family and friends’, ‘foster parent coping’ and ‘perceived understanding of the impact of trauma on LAC’.

Many FPs talked about the ‘emotional rollercoaster’ and wealth of emotional experiences they had while caring for LAC. However, some FPs also talked about feeling proud and a sense of satisfaction with making a difference.

There appeared to be a significant change in FPs’ perceptions and expectations, often resulting from not quite knowing what to expect in the beginning. Some talked about how they had at times questioned whether or not they felt able to continue fostering. However, they also talked about positive thoughts regarding fostering.

Many FPs talked about how fostering traumatised LAC had a significant impact on their social lives. They also talked about coping skills and resources they had developed over time, including taking breaks and respite; support from others; searching for meaning in what they do; and feeling a sense of duty to the children they look after.

All participants showed ways of searching for meaning in the LAC’s behaviour and the impact that the trauma has had on them. However, this was made difficult by the lack of information FPs were given regarding the LACs’ histories. FPs either used the knowledge they did have about the young person’s past, or their own childhood experiences to help them understand the impact of the trauma.

These findings are perhaps transferable to the wider population of FPs engaged with child and adolescent mental health services, and therefore support the clinical psychologist’s role within these teams. Clinical psychologists may have a role in supporting FPs, in particular those who care for our most traumatised LAC, which could be done directly or indirectly by training supervising social workers that support FPs on a more regular basis.

Feedback to participants

Participants were sent a 'Thank you' letter for taking part in the study and a brief summary of the research findings. Copies of these documents are included with this report.

Publication and dissemination of findings

The findings of this study will be disseminated to the NHS research site and will be submitted to the Journal of Clinical Child Psychology and Psychiatry for publication.

References

Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress in those who treat the traumatized*. New York: Brunner/Mazel.

Kassam-Adams, N. (1999). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators* (2nd ed., pp. 37-47). Lutherville, MD: Sidran Press.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: a framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3, 131-149.

Regehr, C., Goldberg, G., & Hughes, J. (2010). Exposure to human tragedy, empathy, and trauma in ambulance paramedics. *American Journal of Orthopsychiatry*, 72, 505-513.

Sinclair, I. (2005). *Fostering now: Messages from research*. Jessica Kingsley Publishers: London.

Smith, J., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis: theory, method and research*. London: Sage

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Appendix O: Publication guidelines for journal chosen for publication –

Journal of Clinical Child Psychology and Psychiatry

Retrieved from: <http://www.uk.sagepub.com/msg/ccp.htm#MANUSCRIPTSTYLE>

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2. Article types

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7. Acknowledgements

Any acknowledgements should appear first at the end of your article prior to your Declaration of Conflicting Interests (if applicable), any notes and your References.

All contributors who do not meet the criteria for authorship should be listed in an Acknowledgements section. Examples of those who might be acknowledged include a person who provided purely technical help, writing assistance, or a department chair who provided only general support. Authors should disclose whether they had any writing assistance and identify the entity that paid for this assistance.

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The text should be double-spaced throughout and with a minimum of 3cm for left and right hand margins and 5cm at head and foot. Text should be standard 10 or 12 point.

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The title, keywords and abstract are key to ensuring readers find your article online through online search engines such as Google. Please refer to the information and guidance on how best to title your article, write your abstract and select your keywords by visiting SAGE's Journal Author Gateway Guidelines on [How to Help Readers Find Your Article Online](#).

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Provide full contact details for the corresponding author including email, mailing address and telephone numbers. Academic affiliations are required for all co-authors. These details should be presented separately to the main text of the article to facilitate anonymous peer review.

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For guidance on the preparation of illustrations, pictures and graphs in electronic format, please visit SAGE's [Manuscript Submission Guidelines](#).

Figures supplied in colour will appear in colour online regardless of whether or not these illustrations are reproduced in colour in the printed version. For specifically requested colour reproduction in print, you will receive information regarding the costs from SAGE after receipt of your accepted article.

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