“And Then Every Time I Fell Back, I had my Friends to Help Me”

Exploring the Role of Peer Relationships for Adolescents in Alternative Care:

A Systematic Review and Grounded Theory Study

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Doctorate in Clinical Psychology

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DClinPsychol Declaration of Own Work

Name: Sonal Haddow

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A Systematic Review and Grounded Theory Study

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“Of course, one person's garden of riches is another's tangled forest, waiting to trap the unwary. This might be especially true for novice researchers and those attempting grounded theory methodology for the first time.”

Linda Liska Belgrave & Kapriskie Seide

Research Portfolio Abstract

Background. The positive impact of attachment relations with adults for young people in alternative care is well documented. However, more understanding of parental and peer relationships for young people in alternative care, particularly the potential role of peers in fulfilling attachment needs in this population, is needed. **Objectives.** Research objectives are addressed across two studies. In article one, a systematic review searched the existing quantitative evidence base to investigate the research question, how do positive peer relationships influence psychological variables related to coping and resilience in young people in alternative care? In article two, an empirical paper used a grounded theory methodological approach to explore the principle research question, how do young people in alternative care conceptualize parental and peer relationships? **Participants and Setting.** This research portfolio investigated adolescents living in alternative care, of any setting. The systematic review targeted literature relating to adolescents aged ten to eighteen, and the empirical paper included fourteen participants aged fourteen to eighteen, who were still in contact with a birth parent. **Methods.** In article one, a systematic search of the literature for studies of psychological resilience-based variables and peer relationships led to the inclusion of ten papers. These were assessed using standardized quality criteria and a narrative synthesis of the methodology and findings are presented. In article two, semi-structured interviews were transcribed and analysed, to propose a grounded theory model. In line with a constant comparative approach, data collection and analysis occurred simultaneously. **Results.** Article one highlights four key themes, (1) Perceived satisfaction with peer relationships; (2) The impact of peer group processes; (3) Positive attachments in adolescence and; (4) The role of social skills. Article two presents the five key themes of (1) Trust (2) Unresolved trauma (3) Feeling different to peers (4) A need to put others first and

(5) A dismissive coping style, associated with anger and self-reliance. These are proposed to be interrelated to a non-linear process model and contextualized within a resilience framework. **Conclusions.** Relationships are a complex and non-linear process for this population, that is likely to impact on normative developmental processes in relation to others, including peers. Implications for clinical practice and research are highlighted across both articles. Article one emphasizes a need to investigate a positive developmental rhetoric, using standardized measures for variables of resilience and peer attachment directly. Article two presents a need to further explore the nuances of the proposed relationship process presented, in relation to both peers and services, and promotes the value of directly involving young people in this endeavour. It emphasises the importance of trauma informed practice and puts forward relationships as a starting point to interventions with this population.

Research Portfolio Lay Summary

It is estimated that in Scotland, there are about 15,000 children and young people who are no longer living with their birth parents. Instead, they stay in 'alternative care' settings, which can include living with other family members, foster carers or in residential units supported by staff. Young people are normally living in these settings because they have had difficult early experiences, such as being neglected or abused by birth parents. Research suggests that these experiences, and the impact of being brought up in alternative care, can affect how young people develop relationships with others.

In general, relationships with our main caregivers, usually a parent, have a significant impact on how we develop through childhood. When we become teenagers, peers start to play a more important role in our lives. How we are able to connect with peers is thought to be related to our important early relationships. Therefore, if these relationships have been difficult, it can make it harder to go through normal relationship processes with others, like peers. Equally however, as young people in alternative care have had difficult relationships with adults in the past, it could be that this is an important time when peers can take on some of the developmental tasks adults would normally fulfill. With this idea as a starting point, this research portfolio aimed to investigate this further.

In article one it reviewed existing publish research to look at studies that explored the links between peers and positive factors related to coping in this population. Using set criteria to look at the evidence in a methodical way, ten papers were identified and analyzed in more detail. From this, four key themes emerged and these are discussed, highlighting how these findings can support future research with this group. In article two, fourteen teenagers aged fourteen to eighteen, who didn't live with a birth parent but was still in contact with them, were interviewed. They talked about important relationships in their life and factors related to these, that they wanted to share and highlight. These interviews were then analyzed in a systematic and comparative way, to draw together emerging key ideas. From this process, a model to better understand how young people in alternative care make sense of and navigate relationships with their parents and with their peers was put forward. Difficulties with trust was found to be the main theme highlighted. Other factors included the challenges of managing relationships in the context of previous traumatic experiences, feeling different to peers, needing to put others needs before their own and a dismissive style of coping, that was associated with being self-reliant and appearing angry to others. The article used these findings to suggest ways of further researching this topic. It also proposed some ways in which the findings could be used by those supporting young people in alternative care, to help them to develop successful relationships.

Both chapters have been prepared for submission to: *Child Abuse and Neglect: The International Journal* (see Appendix A). The author has adapted these guidelines where appropriate, to meet the submission requirements for a thesis to the University of Edinburgh Doctorate of Clinical Psychology programme.

Overall Portfolio Word Count (includes all abstracts and main body of text, excludes title pages, references and appendices): **20,419**

The Influence of Positive Peer Relationships on Psychological Variables Related to Coping and Resilience in Young People in Alternative Care:

A Systematic Review

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Abstract

Background: The positive impact of attachment relationships with adults for young people in alternative care is well documented. The potential role of peers in fulfilling attachment needs in this population warrants further investigation. **Objective:** This paper presents a systematic review of existing quantitative evidence exploring the research question - How do positive peer relationships influence psychological variables related to coping and resilience in young people in alternative care? **Participants and Setting:** This review targeted literature relating to adolescents aged ten to eighteen living in alternative care. **Methods:** A systematic search of the literature for studies of psychological resilience-based variables and peer relationships led to the inclusion of ten papers. An assessment of the studies using methodological quality ratings is presented. **Results:** Four key themes are discussed (1) Perceived satisfaction with peer relationships; (2) The impact of peer group processes; (3) Positive attachments in adolescence and; (4) The role of social skills. **Conclusions:** This review highlights the need to investigate more positive outcomes using standardized measures for variables of resilience and peer attachment directly in this population. It summarizes the current evidence and lays the foundation for future robust longitudinal studies exploring peer relationships and resilience variables directly. It puts forward the need for a positive developmental rhetoric, drawn directly from the strengths of this group.

KEYWORDS:

adolescent; alternative care; resilience; peer; relationships

Abstract Word Count: 215

1. Introduction

1.1 Definitions and Prevalence

Throughout the world children living out-with the home of their birth parents can be observed. This phenomenon is defined in multiple ways across academic literature. The United Nations Convention on the Rights of the Child (UNCRC) adopt the definition of children in alternative care, to describe children who have no parental care, inadequate parental care, when parental care has been abandoned or parents have relinquished a child (UNCRC, 2010). In addition, terms such as in care, out of home care, or describing specific settings (e.g. in foster care) are used. It is difficult to accurately assess the number of children that fall into this category worldwide. A recent review spanning 142 countries estimated approximately 2.7 million children between 0 and 17 could be living in residential or foster care (Petrowski, Cappaa, & Gross, 2017). Unfortunately, long-term outcomes for children in alternative care remain poorer than their peers in areas including education (Department for Education, 2018), mental health (Audit Scotland, 2010; Bazalgette, Rahilly, & Trevelyan, 2015) and interpersonal functioning (Meadows et al., 2011).

Different positions defining resilience across research fields have been put forward (see reviews by Aburn, Gott, & Hoare, 2016; and Shean, 2015). These include viewing resilience as a trait designed to protect individuals adversity (Maltby, Day, & Hall, 2015; Ong, Bergeman, Bisconti, & Wallace, 2006; Werner, 1984) or by an absence of psychopathology (Alim et al., 2008; New et al., 2009). This paper adopts an understanding of resilience as the demonstration of positive function or adaptation in response to adversity (Luthar, Cicchetti, & Becker, 2000; Masten, 2001; Rutter, 2006). Rather than viewing this as a static or fixed quality, resilience can be understood as a process related to protective characteristics such as self-esteem (Schofield & Beek, 2005), that is developed and influenced by a combination of individual, family and community based factors (Daniel & Wassell, 2002).

Despite the widespread adoption of this understanding of resilience, it is recognised there are some inconsistencies with this perspective and how resilience is captured within research (Hu, Zhang, & Wang, 2015). For example, due to the nature of this interpretation of resilience, its presence is often inferred (Luthar & Zelazo, 2003), by for example the absence of negative outcomes (e.g. Shpiegel, 2016). Given the early adversity and poorer outcomes associated with this population, exploring the concept of resilience within research in this area is pertinent (Furnivall & Grant, 2014; Masten, 2006), and this review aimed to provide a necessary systematic exploration of the current evidence base of the potential role of peer relationships within this area.

1.2 Attachment Relationships with Adults

Attachment relationships often provide the setting within which the developmental tasks of adolescence can be resolved (Allan & Manning, 2007; Rice, 1990). It is well recognised in the literature that insecure attachment can have a significant negative impact on psychological variables in young people, demonstrated for example by an increased risk of the development of psychopathology (Brumariu & Kerns, 2010; Rosenstein & Horowitz, 1996). Conversely, there is widespread recognition that positive relationships with at least one safe adult can improve outcomes, such as educational successes (Strolin-Goltzman et al., 2016) and emotional adjustment (Rice, 1990). Moreover, the presence of an engaged and consistent adult who is genuinely interested in their needs, has been highlighted within a multi-agency English care sector report as paramount by young people in alternative care(The Care Enquiry, 2013b). A clear link between positive adult relationships and positive psychological variables is recognised in the literature and represented in alternative care guidelines. The National Institute for Health and Care Excellence (NICE) puts forward that warm, nurturing care is an essential quality standard for this group (NICE, 2017). They suggest that good quality training and support for carers of young people should be prioritised in order to achieve attachments with an adult within which a young person can feel safe, valued and protected. In addition, understanding and promoting relationships for these young people have been put forward as the lens through which all future intervention should be developed, by agencies and stakeholders directly involved in supporting this population (The Care Enquiry, 2013a).

The potential positive impact of a supportive relationships with a responsible adult for a young person in alternative care is well recognised (see review by Lou, Taylor, & Di Folco, 2018). A predictable and healthy relationship over time can support children to redefine their internal working models, the templates they have developed to understand the world (Bowlby, 1969). Evidence has shown that alongside observable changes in behaviour, sensitive and responsive caregiving can impact children at a biological level, reversing abnormal stress hormone responses (Dozier et al, 2006). Despite this, factors such as feeling let down by adults in the past (Bazalgette et al., 2015) can mean children who have experienced early adversity can find it difficult to fully trust or connect with safe adults. Wigley et al. (2011) suggested reasons for this include a recognition from young people that it is the paid job of the adult to be there for them, particularly in residential care settings; inconsistent care reinforcing earlier experiences of loss and rejection; and a felt sense of powerlessness in influencing the decisions adults made about the young person's own future.

1.3 An Argument for Peer Attachment

Normative peer relationships are recognised as one of the most important factors related to adolescent resilience (Mann-Feder, 2018). Longitudinal evidence has put forward that differentiated attachment styles to parents and friends are seen in adolescence (Doyle, Lawford, & Markiewicz, 2009), suggesting that young people are able to relate in different ways to the people in their lives. Although difficulties developing and sustaining friendships has been highlighted as more complex for this population (Emond, 2014; Rutman & Hubberstey, 2016), in line with their non looked-after peers young people in alternative care make use of a range of different people to meet their social, emotional and psychological needs, including other young people (McMahon and Curtin, 2013). Despite carers expressing concerns over social isolation, this population can describe being satisfied with their friendships overall (Blower et al., 2004), and that given the transient nature of other relationships in their life, these friendships are highly valued (Ridge & Millar, 2000).

The potential influencing role of peer relationships on factors related to resilience is currently vastly under researched, and often only briefly referred to in reports and guidelines promoting the importance satisfying relationships for this population. For example, NICE (2017) quality standards state that children in alternative care should have support to explore and make sense of identity and relationships, and that supportive peer networks are an outcome within this. Further elaboration as to why, and how to explore and facilitate peer relationships specifically however, is lacking. This review puts forward that it is important to look at not only ways of promoting positive relationships with adults, but also peer relationships as a potential avenue through which these young people can have their attachment needs met.

An individual's peer group may act as either a risk or a protective factor depending on several factors (Aguilar-Vafaie et al., 2011; Leve, Fisher, & Chamberlain, 2009). Across the literature for this population, a focus on negative symptomatology (e.g. deviant behaviour, poorer long-term outcomes) is often seen, and this same trend can be observed for peer influence. In response to criticism focussing on outcomes based on what this population do not achieve, rather than what their needs are (Coman & Devaney, 2011; Devaney, 2008), emerging research exploring resilience-based factors (i.e. what might be supporting young people to adapt to and manage adversity) is taking place. This has allowed for a better understanding into why many children in alternative care who experience high levels of adversity, demonstrate positive emotional, social and behavioural adjustments and that these occur through the same basic adaptational systems utilised by all young people (Masten, 2001).

Preliminary evidence highlights the importance of peer relationships in providing both emotional (Hiles et al., 2013) and practical (Perez and Romo, 2011) support for care leavers. Although relationships with other young people in alternative care have been suggested to be problematic, young people also describe a closeness arising from their shared experiences, particularly if they perceive an associated external stigma to their care status (Mann-Feder, 2018). Leve et al. (2009) reported findings from randomised clinical trials investigating the impact of a strength-based intervention, which offered bespoke support to the system around the child with the aim of promoting resiliency in children and adolescents exposed to early adversity. They found that individuals who engaged in this program were more successful at forming positive peer relationships and moreover, that these peer relationships were a significant mediator of the intervention effects on delinquency in both male and female samples. Similarly, Rogers (2017) found that in a context of feeling stigmatised and devalued, forming meaningful and supportive relationships with other fostered peers demonstrated an adaptive responsive, which served a protective function to these negative factors.

1.4. Research Question

To the authors' knowledge, there are no current systematic reviews looking specifically at the links between peer relationships and psychological variables related to resilience in a population of young people in alternative care. As such this review aims to address the following review question: How do positive peer relationships influence psychological variables related to coping and resilience in young people in alternative care?

2. Method

2.1 Protocol

A review protocol, following PROSPERO guidance, can be accessed at http://www.crd.york.ac.uk/PROSPERO/display_record.php?ID=CRD42018085188 (see Appendix B). This outlines the main research question, sources, search terms and inclusion and exclusion criteria.

2.1.1 Review question. This question was developed following literature scoping exercises to help determine a focus for review. The focus on psychological variables specifically, was to differentiate from research relating to more general descriptors of functioning, and the use of the terms coping and resilience were felt to be broad enough to encompass a wide range of variables. Wider search terms referencing being in care were included.

2.1.2 Search terms. The literature search was conducted in two phases, and updated in September 2019 (phase 3). Three databases; Ovid, ProQuest and Cinahl plus were used. The sources included, date parameters and number of studies found are summarised in table 1.

In phase one, conducted in July 2017, the search terms "looked after" OR "foster care" OR "residential care" OR "kinship care" were used to identify articles related to an alternative care population. The terms "children" OR "adolescents" OR "young*" OR "teen*" OR “youth” were used to capture research referring to young people in alternative care. The terms "attachment" OR "relationship*" OR "interpersonal" were used to capture interpersonal functioning, with “coping” OR “resilience” OR “protective” representing positive psychological variables.

Table 1: Summary of literature search of phase one

Database	Sources included	Number of studies identified in phase one	Number of studies identified in phase two
Ovid (anywhere in article)	Embase - 1980 to 2017 week 30 Medline (R) - 1946 to July week 3 2017 PsychARTICLES Full text Psychinfo - 1806 to July week 3 2017	2, 691	243
Proquest (anywhere except full text)	Social Science ALL (including dissertations and theses global: Social Sciences)	828	11
Cinahl plus (anywhere in article)	Cinahl plus	666	219

In phase two, conducted in May 2019, population search terms were substituted to “alternative care” OR out of home care OR care-experienced and used alongside the existing search criteria described above. This second phase was added to increase the scope of this review in identifying potential studies for inclusion. Phase 3 combined the terms used in phases 1 and 2 to provide an updated search in September 2019. Figure 1 below summarises combined search strategies. For transparency, numbers retrieved at each stage are reported separately in the appendix (see Appendix C).

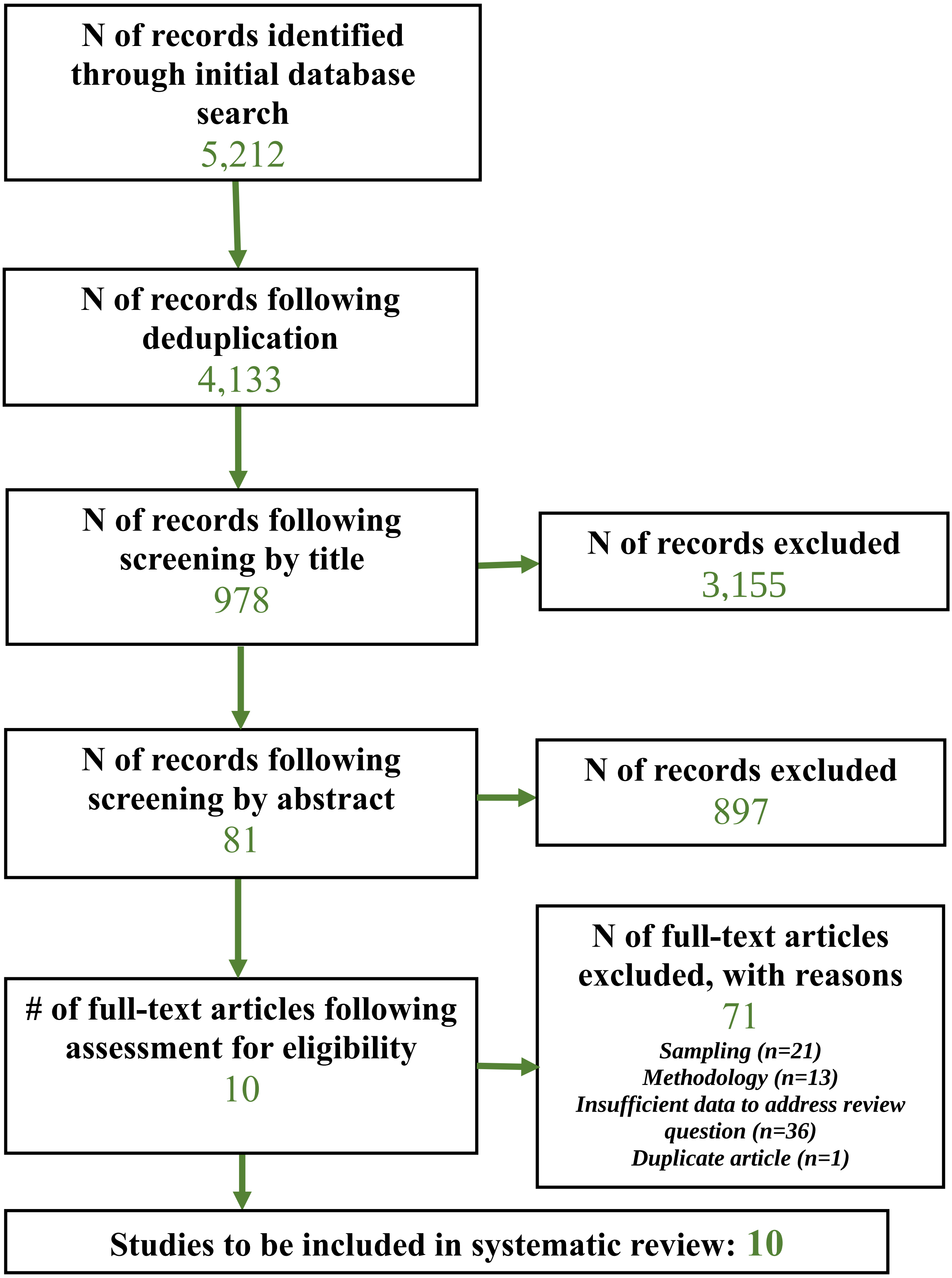


Figure 1: Flow chart detailing systematic review for combined search phases

2.1.3 Eligibility criteria. The PICOS framework was used to develop criteria. Young people in alternative care within the age range of 10-18 years, or with a mean age of over 10 years 0 months and less than 18 years 12 months (up until 19th birthday) if the age range was not reported, were included. Due to a known scarcity of research in this area, broad search terms were adopted to maximise the inclusion of appropriate studies. Therefore, studies that generally explored peer relationships and factors of resilience were included. As studies with this population often explore resilience as the absence of negative factors, studies that looked at negative outcomes (e.g. delinquent behaviour), but with the overall focus of the study related to understanding resilience factors, were included. Studies that explored a possible association (direct or indirect) between peer relationships and resilience factors (i.e. factors that related to young people adapting to and/or coping with their adversity) in this population were included. Given the highlighted variation in the way that the concept of resilience is adopted within the research literature, it was important to include these studies to meet this reviews aims of addressing the research question by providing a systematic and necessary synthesis of the current evidence base, including highlighting gaps within the literature. This review did not have a comparator group. Outcomes could be self-report, clinician-report, caregiver-report or a combination. Publications were limited to peer review journals and those with titles and abstracts published or translated to English. The review focused on studies that address the research question using quantitative methods.

2.2 Literature Search and Study Selection

Following an initial scoping exercise, it was decided that the Proquest search would exclude full text, due to the generation of an unmanageable number of unrelated articles. The phase one search yielded 4,185 results, reduced to 3,155 following de-duplication.

These were then screened by title, abstract and full text. Full text was screened hierarchically, first for sampling issues, then methodical issues and finally for insufficient data to address the research question, leading to the final inclusion of ten articles. This process was then repeated for phase two, which yielded 473 results, reduced to 458 results following de-duplication. Phase two led to the inclusion of one article, which was already identified by phase one. Figure one summarises these searches. Phase three yielded 554 results, reduced to 520 after deduplication, following which no further articles were included.

2.3 Quality Assessment of Studies

Data extraction PRISMA guidelines were followed (Moher et al., 2009). The full text of each article eligible for inclusion was read and relevant data was extracted, summarised and assessed. Quality criteria (see Appendix C) were developed using Scottish Intercollegiate Guidelines Network (SIGN) guidelines for cohort studies as a template (SIGN, 2017). Given that studies in this review explored associations between variables and not interventions, adaptations were made, to ensure quality criteria were appropriate and meaningful. This was done in consultation with published recommendations (Boland, Cherry, & Dickson, 2014; Centre for Reviews and Dissemination, 2009; NICE, 2013).

A selection of studies was co-rated by two independent reviewers, to ensure quality criteria demonstrated reduced assessment bias. As part of this process, quality criteria were refined and all studies were reviewed using updated quality criteria. In co-ratings using the finalised set of criteria, 78% of agreement was seen, with the strength of this agreement regarded as moderate (kw=0.58) (McHugh, 2012). Agreement between raters was sought for final reported quality ratings. Each quality criteria was assigned a category rating of Well Covered, Adequately Addressed or Insufficiently Addressed/Not Addressed. Had any quality criteria been rated as Not Known, attempts to contact the lead author for clarification would have been made for papers published in the last ten years. A summary of quality criteria ratings for each study can be seen in table 2.

Table 2: Quality ratings for included studies

Authors (Year)	**Research Questions**	**Selection of subjects**	**Assessment of study**	**Confounding factors**	**Data analysis and results**	**Overall generalisability of study**
1. Bender and Losel (1997)	AA	WC	AA	AA	WC	AA
2. Edmond, Auslander, Elze and Bowland (2006)	AA	AA	WC	WC	WC	AA
3. Erol, Simsek and Münir (2010)	AA	WC	WC	WC	AA	WC
4. Lee and Thomson (2009)	WC	AA	AA	AA	WC	IA/NA
5. Legault, Anawati and Flynn (2006)	WC	AA	AA	WC	WC	WC
6. Merritt and Snyder (2015)	WC	WC	WC	WC	WC	WC
7. Maurovic, Križanić and Klasić (2014)	WC	IA/NA	AA	AA	AA	AA
8. Mota and Matos (2013)	WC	AA	IA/NA	IA/NA	AA	AA
9. Perry (2006)	AA	WC	IA/NA	WC	WC	WC
10. Quisenberry and Foltz (2013)	WC	WC	AA	IA/NA	AA	AA

WC – Well Covered AA – Adequately Addressed IA/NA – Insufficiently Addressed/Not Addressed

Table 3: Summary of characteristics and findings of included studies

Authors (Year); Country	**Study Design**	**Sample and Sampling strategy**	**Sample characteristics**	**Peer Relationship outcomes**	**Resilience outcomes**	**Principle method of data analysis**	**Key findings**
Bender and Losel (1997); Germany	Longitudinal; Observational	27 residential institutions High risk adolescents, 55% with severe behavioural problems	N=146 at baseline, N=100 at 2 year follow-up. **Age**: 15 years at baseline **Gender**: 66% male	Bespoke measures of: size of social network; frequency of social support and satisfaction with social support	Problem behaviour – measure of aggressive and delinquent behaviour measured by the externalising scale of YSR from the CBCL	Hierarchical regression analysis (Males and females analysed separately)	Frequency of social support was significantly correlated with greater satisfaction with social support in both boys (r=.54, p<.001) and girls (r=.63, p<.001) at time 1. No individual peer factors significantly impacted problem behaviour rates across time for either gender. Significant negative effect of good friendships on problem behaviours in girls (β=0.36, p<.05). This finding was not replicated for boys.
Edmond et al. (2006); USA	Cross-sectional; Observational	Females who had experienced CSA only. Resilient Trajectories and Currently Symptomatic groups, defined by scores on YSR.	N=99 (Resilient trajectories n=49; currently symptomatic n=50); **Age:** 15-18, M=16.33; **Ethnicity:** 58% youths of colour; **Home environment:** 64% in congregate living, 36% in a home situation	Bespoke 13 question measure of three subscales: positive peer behaviour; Negative peer behaviour and Peer substance use	Future Orientation – combined items from LOT-R (related to optimism about life outcomes) and FTO (related to thinking about and being concerned	Chi-square; T-tests; Logistic regression	Resilient trajectory females showed significantly higher levels of positive peer influence compared to currently symptomatic females, on all three subscales of positive peer behaviour, negative peer behaviour, and peer substance use. Negative peer behaviour was found to be a significant predictor of resilience status (β=-1.01, p<.005)

					about the future). Education – bespoke measure to capture school status, school stability, school problems and plans for school		
Erol et al. (2010); Turkey	Cross-sectional; Observational	Probability cluster sampling from 12 institutions Control data was unrelated to this review question.	N=350 for adolescents **Age**: 11-18 years, M=14.6 years **Gender:** 46.6% male.	Social relations measured by YSR	Total problems scale (internalized and externalized problems subscales) on CBCL, designed to capture self ratings of emotional, behavioural, and social problems	Spearman correlation coefficient; Multiple regression	Good social relations significantly correlated with decreased internalizing problems (r= .16, p<.05) in institutional sample. However further bivariate analysis found the relationships between social relations and total problems to be non significant.
Lee and Thomson (2009); USA	Longitudinal; Observational	Retrospective longitudinal group care sample	N=744 **Age**: M=15.1 **Gender:** 60% male **Ethnicity:** 15.1% white Minimum 90 days in group care	Deviant peer density - proportion of deviant peers (diagnosis of ODD or CD) in a young person's	Bespoke measure of externalising behaviours (e.g. verbal aggression, physical	Trajectory Modelling	Deviant peer density was the strongest predictor of trajectory group membership after controlling for other background characteristics (χ^2=2.97, p<0.02). Similar behaviour patterns between individuals and their immediate

				immediate living environment Peer externalising behaviour rate - number of externalising behaviours recorded by staff divided by number of peers in that unit	aggression, property damage) Recorded by staff at three monthly points		peers is observed, though causality cannot be inferred. Statistical significance not tested. Youth with peer groups of no problem trajectories had a 98% probability of no problem or low problem trajectories themselves.
Legault et al. (2006); Canada	Cross-sectional; Observational	Sample drawn from longitudinal study of the implementation and outcomes of children in alternative care	N=220 **Age:**14-17 years, M=15.3 years **Gender:** 50% males 80% of sample lived in foster homes. On average six negative life events in addition to coming into care	Marsh Friendship Scale	Reduced anxiety and emotional distress; and physical aggression (defined by frequency of aggressive behaviours) on the NLSCY. General self-esteem scale measured by NLSCY. Bespoke scale of approach coping (more active and	Hierarchical multiple regression	Significant correlation between relationship variable and: -General self-esteem ($r = .34, p<.001$) -Approach coping strategies ($r= .29, p<.001$) -Avoidant coping strategies ($r= .27, p<.001$) -Anxiety ($r= -.38, p<.001$) -Physical aggression ($r= -.28, p<.001$) Taken together, high quality relationships with both female caregivers and friends, mediated the cumulative life events to anxiety relationship ($R^2 = .17, p<.001$). The mediation effect of these separately was not reported.

					problem solving based strategies) and avoidant coping strategies (more passive strategies)		
Merritt and Snyder (2015); USA	Cross sectional; Observational	Data from national longitudinal study of children under supervision of child welfare system due to maltreatment	N=727 **Age:** 11-17.5 years, M=13.72 years **Gender:** 51% male. **Ethnicity:** 34.23% white, 31.23% black, 27.59% Hispanic, 6.95% other	Perceived School Peer Connectedness assessed by Loneliness and Social Dissatisfaction Questionnaire for young children and DFSCA The Child Deviant Peer Affiliation Measure	Normative score on Youth Behaviour measure derived from CBCL. Accounts for behaviour across 8 categories (e.g. aggressive behaviour; withdrawn; thought problems) Social Skills (defined by prosocial skill development e.g. cooperation, assertion) as a covariate construct from SSRS	Full Logistic regression	High levels of peer connectedness in school settings overall Children significantly more likely to display normal (i.e. not borderline or clinical behaviours) if they: -Have fewer deviant peers (aOR = 2.07, p<.001) -Have better social skills (aOR = 1.94, p<.001) -Perceive strong peer connectedness (aOR = 1.52, p<.01)

Maurović et al. (2014); Croatia	Cross-sectional; Observational	Convenience sample from 7 residential homes Behavioural problems related to problematic family circumstances	N=118 **Age**: 14-18 years, M=16.47 years **Gender:** 74% boys	Bespoke measure: Caring relationship with friend(s)	Happiness (in general and in relation to others) measured by SHS	Kolmogorov Smirnov Test; Spearman correlation coefficient; Hierarchical regression	Caring relationships with friends rated as very satisfactory. Caring relationships with friends moderately correlated with happiness (r= .33, p value not reported). Though this was not found to be a significant individual contributor to the explanation of happiness.
Mota and Matos (2013); Portugal	Cross-sectional; Observational	Adolescents from 13 randomly contacted institutions Experienced loss of a parent or parents had inability to care for them due to poor socio-economic conditions Adolescents institutionalized for deviant behaviour excluded from study	N=109 **Age:** M=16.19 years **Gender:** 74.3% female 93.6% still in regular contact with family.	Peer version of the IPPA to measure peer attachment	Social Skills (e.g. cooperation; empathy) measured by SSQ Rosenberg's self-esteem scale Coping (categorized as active, internal and withdrawal coping) measured by CASQ	Structural Equation Modelling	Peer attachment had direct positive non-mediated effect on self-esteem (β=.23, p<.05) and social skills (β=.59, p<.05) Peer attachment had a positive effect on active coping (β=.14, p<.05), but this was shown to be mediated by social skills.
Perry (2006); USA	Cross-sectional; Observational	Telephone surveys from TAME-S foster care study; Comparison to general population	Foster Care sample (inc. kinship care) - N=154; **Age**:15-18 years, M=16.4 years;	Bespoke strength of peer network variable	Psychological Distress measured by a Depression variable using a modifed CES-D	Frequency distributions; Pearson's correlation; Chi-Square test;	Significantly less of foster care sample felt that their friends cared a lot about them (χ^2=60.20, df=1, p<.001).

		using longitudinal data from larger longitudinal study of adolescent health	**Gender:** 61% female; **Ethnicity:** 45.5% non-white Control sample - N=4,062; **Gender:** 50.8% female; **Ethnicity:** 37.7% non-white		Anxiety using psychological component of Langner index	Ordinary Least Squares regression	Study does not support the effectiveness of peer networks alone on psychological distress levels. Two or more social networks can significantly impact depression/anxiety levels, but not one on its own. This was found for all three network types. Perceived strength of foster care network had a greater influence on symptoms of depression than peer network. A significantly lower levels of depression when strong peer networks were combined with strong foster networks (b=-6.69, p<.001) and strong biological networks (b=-6.15, p<.01). Significance was not found on anxiety levels.
Quisenberry and Foltz (2013); USA	Cross-sectional; Observational	5 residential centres All participants had diagnosable mental health disorder	N=42 **Age**: 13-18 years, M=16 years **Gender:** 64% female **Ethnicity:** majority Caucasian Number of ACEs: M=4.71	Peer domain of ARQ	ARQ – designed to measure adolescent resiliency across five domains of self, peers, family, community, and school	Correlational analysis; Multiple regression	Peer domain of resiliency measure significantly correlated to positive youth development (r=.49, p<.001).

					Positive Youth Development (based on four universal growth values of belongingness, mastery, independence, and Generosity), measured by the Circle of Courage Questionnaire.		

Abbreviations:

NSCAW II - National Survey of Child and Adolescent Well-Being II; DFSCA – Drug Fee Schools Outcomes Study Questions; CBCL – Child Behaviour Checklist; SSRS – Social Skills Rating System; NLSCY – National Longitudinal Study on Children and Youth; SHS - Subjective Happiness Scale; YSR – Youth Self Report Questionnaire; IPPA – Inventory of Parental and Peer Attachment; SSQ - Social skills questionnaire; CASQ - Coping across situations questionnaire; ARQ - Adolescent resiliency questionnaire; LOT-R – Life Orientation Test – Revised; FTO – Future Time Perspective Inventory ; TAME-S - These Are my Experiences: A Survey of Foster Children ; CES-D – Centre for Epidemiological Studies – Depression Scale

3. Results

Methodology and reported findings of included studies are summarized in table 2. Across all 10 studies, the total number of participants was 3036, with 45% of these being male and 55% female. The age range of participants was 11-18 years with a mean age of 15.77 years.

3.1 Overall Strengths and Limitations of Studies

As expected, variation in the methodological quality of studies was seen, as outlined in table 2. Across the sample, studies were generally rated highly for research questions and data analysis and results (both well covered in six studies; adequately addressed in four studies). Generally, results related to research questions posed and appropriate statistical analysis was used to explore the data.

Initially all studies were rated as adequate in the selection of subjects criterion, highlighting that issues of sampling bias were present to some degree in all papers. Alongside recognising this as a weakness across the papers, well covered quality criteria were adapted to allow for more comparative ratings, leading to half the papers being defined as well covered using new criteria. Maurovic et al. (2014) was especially weak in this area due to an overall lack of consideration and description of sampling issues.

Assessment of study rating, which focuses on the use of outcomes, varied in quality across papers. Bespoke measures were utilised in six studies (Bender & Losel, 1997; Edmond et al., 2006; Lee & Thomson, 2009; Legault et al., 2006; Maurovic et al., 2014; Perry, 2006). These were usually well explained and developed based on existing measures, or had a clear theoretical reason for the development of items. Whilst levels of internal consistency were generally satisfactory, good external validation was not presented for any of the bespoke measures of interest in this review.

Issues with sampling impacted on generalisability. For example, the majority of the group care sample in Lee and Thomson (2009) entered care with behavioural problems in the clinical range. In contrast, Mota and Matos (2013) excluded all adolescents institutionalized for deviant behaviour, with no further information provided on how this definition was operationalized, limiting the generalisability of their findings to a wider alternative care population. Overall generalisability was well covered in four studies (Erol et al., 2010; Legault et al., 2006; Merritt & Snyder, 2015; Perry, 2006), largely due to considered sampling methods meaning that findings had greater external validity. Only two of the studies used control groups (Erol et al., 2010; Perry, 2006), one of which was unfortunately not related the question of this review (Erol et al., 2010). All studies in this review were observational, with half the papers drawing their data from existing research (Edmond et al., 2006; Lee & Thomson, 2009; Legault et al., 2006; Merritt & Snyder, 2015; Perry, 2006). The predominance of cross-sectional design was a consistent weakness. Confounding factors were addressed in design and analysis in five studies (Edmond et al., 2006; Erol et al., 2010; Legault et al., 2006; Merritt & Snyder, 2015; Perry, 2006). Two papers while discussing confounding factors, failed to sufficiently account for these in analysis (Mota & Matos, 2013; Quisenberry & Foltz, 2013).

3.2 Promoting Resilience Based Research

All the papers included in this study critique the dominance of research with this population being focussed on negative outcomes. Three papers (Maurovic et al., 2014; Mota & Matos, 2013; Quisenberry & Foltz, 2013) directly attempted to address this barrier in their methodological research design, focussing on more positive resilience-based outcomes only, and three papers did this partially (Edmond et al., 2006; Legault et al., 2006; Merritt & Snyder, 2015). Four of the papers focussed on negative outcomes only, in relation to problem behaviours (Bender & Losel, 1997; Erol et al., 2010; Lee &Thomson, 2009) or psychological distress (Perry, 2006). Thus, seven of the papers in this review utilized a framing of reduced negative outcomes as a marker of resilience within their research design.

Maurovic et al. (2014) suggest happiness and well-being to be an indicator of internal adjustment and predictor of future developmental outcomes. Their results indicated that satisfaction with peers correlated significantly to happiness ($r=.33$, p value not reported but significance indicated), though this was not found to be an individual predictor of happiness overall. Analysis of the structural equation model carried out by Mota and Matos (2013) demonstrated a positive effect of secure peer attachment and the psychological variables of self-esteem ($\beta=.23$, $p<.05$), social skills ($\beta=.59$, $p<.05$) and a mediated effect on active coping ($\beta=.14$, $p<.05$). Quisenberry and Foltz (2013) found that the peer domain on their measure of resiliency significantly correlated with positive youth development ($r=.49$, $p>.001$), as operationalized by four universal growth values related to the definition of resilience utilized in this study. However, there was no analysis to explore which of these four values was most indicated or to investigate if the peer domain associated with any other resilience factors within this measure.

3.3. Key Themes

This review aimed to systematically explore existing literature to better understand the potential influence of positive peer relationships psychological variables related to resilience and coping. Four key themes from the findings of these studies have been identified in relation to this. These were (1) Perceived satisfaction with peer relationships; (2) The impact of peer group networks; (3) Positive attachments in adolescence and; (4) The role of social skills. Each of these will be briefly discussed in turn.

3.3.1 Perceived satisfaction with peer relationships. As illustrated in figure 2, overall, it appeared that when positive beliefs and feelings about peers are present, young people had better resilience-based outcomes. High levels of peer satisfaction was a reoccurring theme across most of the papers, rated by psychological factors such as how well participants got on with their peers and their felt sense of connectedness and caring in these relationships (Legault et al., 2006; Maurovic et al., 2014; Merritt & Snyder, 2015; Mota & Matos, 2013; Perry, 2006). One study (Bender & Losel, 1997) combined perceived satisfaction with concrete factors (e.g. the number of friends a person had) and only one study (Erol et al., 2010) assessed peer satisfaction through concrete factors alone The dominance of psychological appraisal of peer relationships (as oppose to more arbitrary concrete indicators) as a measure of peer satisfaction across the papers is useful, as it lends support to the possibility that an overall positive sense of peer relationships may contribute to resilience within this population.

There were a few exceptions to this. Whilst findings from Perry (2006) did not discount the role of satisfaction with peer group, analysis found this only to be effective when combined with satisfaction from another relationship network (e.g. with strong foster networks, $b=-6.69$, $p<.001$). Mota and Matos (2013) suggested this positive impact was mediated by social skills ($z=3.546$, $SE=0.006$; $p=.000$). Bender and Losel (1997) using longitudinal data found that no individual peer factors had an impact on problem behaviour levels over time (e.g. social satisfaction for boys $R^2=.01$, $\beta=-.13$, ns), and that behaviour was more related to norms for that peer group (discussed below). Interestingly, Legault et al. (2006) found that satisfaction with peers correlated in the same direction for both positive ($r=.29$, $p<.001$) and negative ($r=.29$, $p<.001$) coping skills, suggesting that this factor does not play a role in resilience outcomes.

The dominance of cross-sectional design alongside other methodological limitations in these papers make it difficult to draw any firm conclusions in this area. However, taking the above into account it is proposed that how young people in alternative care appraise their peer relationships, as a possible moderating factor on their coping skills, is an area that warrants further exploration.

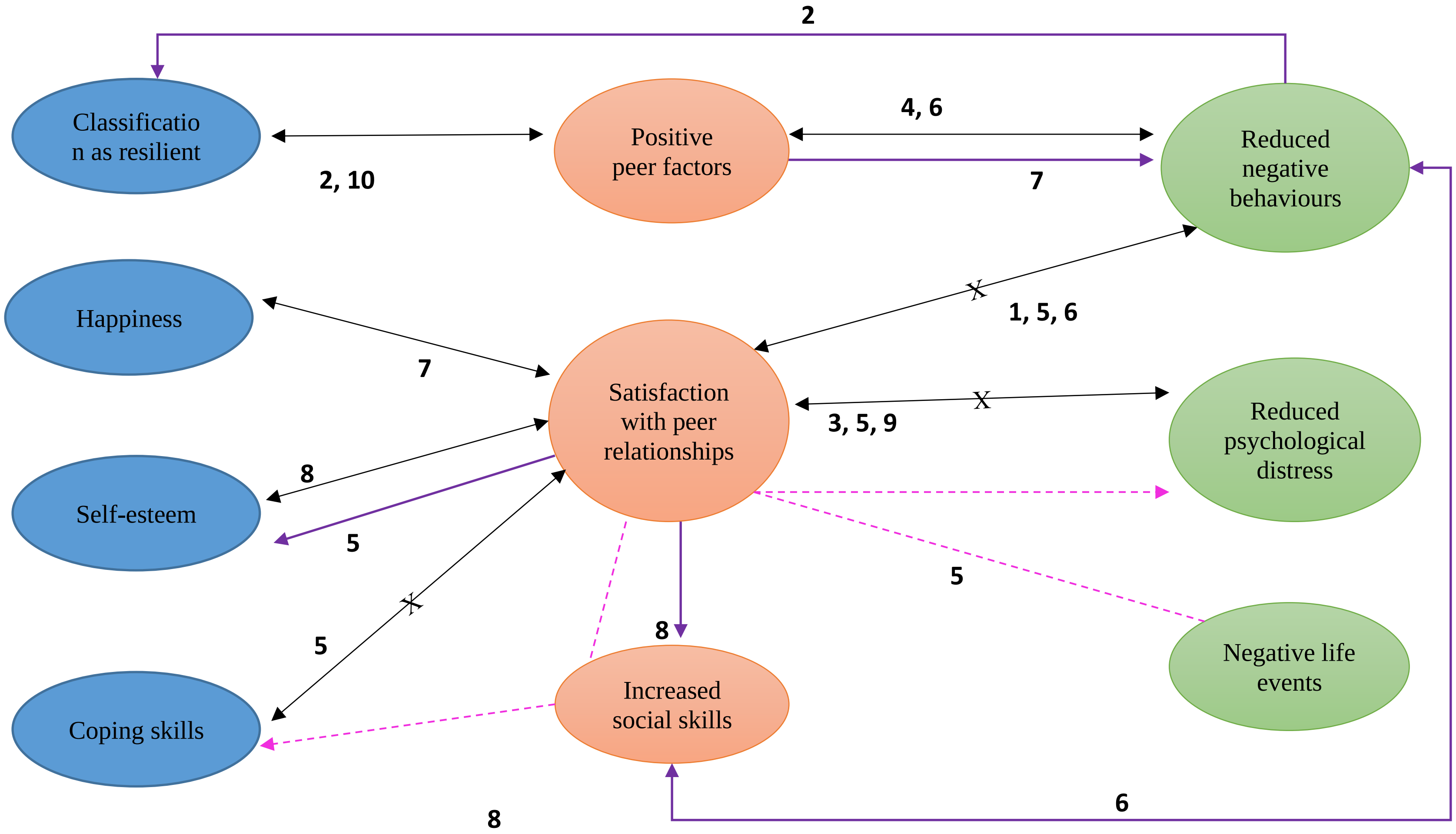
3.3.2 The impact of peer group networks. Four of the papers (Bender & Losel, 1997; Edmond et al., 2006; Lee & Thomson, 2009; Merritt & Snyder, 2015) explored the impact of exposure to peers. It could be put forward that due to normative socialisation processes, young people in alternative care may be motivated to align with their peers and minimise any differences between them. This psychological appraisal of their peer relationships may impact their coping-based behaviours. In line with this, Edmond et al. (2006) found that girls classed as having resilient trajectories, based on an absence of pathology and maladaptive behaviours, associated with peers that engaged in more positive peer behaviors ($x=2.2$, $p<.018$), less negative peer behaviors ($x=1.4$, $p<.001$) and less peer substance use ($x=1.3$, $p<.002$), than girls regarded as currently symptomatic.. Merritt and Snyder (2015) found that participants with fewer deviant peers were significantly more likely to demonstrate nonproblematic behaviours ($aOR=2.07$, $p<.001$). These studies suggest that an individual is likely to demonstrate similar behaviours to their peer group, and that this is true for both positive and negative outcomes. However, both studies make use of bespoke measures and although they both draw data from larger longitudinal studies, they only offer analysis at a cross-sectional level. The associations they put forward support this theory but evidence for causality beyond this cannot be inferred.

The two longitudinal papers of this review however, do provide further support for this proposition. Lee and Thomson (2009) explored the impact of peer contagion and suggested that exposure to deviant peers was a significant and strong predictor of problem behaviour trajectories in both directions (i.e. positive peers may also play a protective role) (χ^2=2.97, $p<0.02$). Bender and Losel (1997) found that although no specific peer factors had a significant effect across time points, there was some initial support to suggest peer factors may have an impact upon externalizing behavior rates over time, suggesting more investigation in this area is warranted. However, it may be that young people are naturally drawn to more similar peers.

3.3.3 Positive attachments in adolescence. As discussed earlier in this review, disrupted early attachments with caregivers sets a context within which research with this population has been developed. Whilst evidence suggests that the impact of this on interpersonal factors is often seen into adulthood, it has also been put forward that the development of peer relationships in adolescence can allow for an opportunity for young people to develop healthy and successful attachments. This theme is highlighted through discussion in five (Legault et al., 2006; Merritt & Snyder, 2015; Mota & Matos, 2013; Quisenberry & Foltz, 2013; Perry, 2006) papers of this review. Based on their experiences, children in alternative care may find external authority figures unsettling, instead seeking comfort and consistency in relationships with friends (Merritt & Snyder, 2015; Quisenberry & Foltz, 2013), with whom they often spend more time (Perry, 2006; Quisenberry & Foltz, 2013). Mota and Matos (2013) suggest that attachment functions can be transferred from parents to peers within peer relationships, including allowing for personal and social development. Their findings backed up this position, demonstrating that young people with higher levels of secure peer attachment are better able to develop empathy and assertion in their relationships ($\beta=.59$, $p<.05$). In addition, this study found a direct and positive effect of peer attachment on self-esteem ($\beta=.23$, $p<.05$) and active coping ($\beta=.14$, $p<.05$). This lends support to the possibility that successful peer relationships in adolescence could potentially allow for these young people to have the opportunity to build attachment relationships and the associated developmental outcomes, in a way that they were unable to in childhood. Furthermore, the association between peer attachment and self-esteem was upheld when social skills was introduced as a mediating factor, with the authors suggesting that it may be peer relationships fostering feelings of security that in turn increase adolescent self-esteem. However, due to methodological limitations, particularly in the areas of outcome measures and managing confounding variables, more robust evidence would be helpful to explore their proposition.

Legault et al. (2006) found strong peer networks in adolescence significantly correlated to reduced levels of anxiety ($r=-.38$, $p<0.001$) and physical aggression ($r=-.28$, $p<.001$), and also to increased general self-esteem ($r=.34$, $p<0.001$). Furthermore, when combined with relationships with a female caregiver, the impact of negative life events on anxiety levels was mediated by relationships with friends ($R^2=.17$, $p<.001$). In addition, Perry (2006) found that strong social networks in adolescence were shown to significantly reduce levels of distress, though this effect size was only significant for peer networks in addition to one other network (e.g. female caregiver), with no network demonstrating significance in isolation).=Despite the cross-sectional design of these studies, they highlight the potential of social networks in adolescence to reduce the negative impact of disruptive early attachments and support the proposition that newer networks can replace biological family support, without significant negative consequences to psychological distress.

3.3.4 The role of social skills. Social skills are highlighted as a possible impacting variable associated with peer relationships and resilience factors in five of the papers (Bender & Losel, 1997; Legault et al., 2006; Maurovic et al., 2014; Mota & Matos, 2013;



References: Bender & Losel, 1997[1]; Edmond et al., 2006[2]; Erol et al., 2010[3]; Lee & Thomson, 2009[4]; Legault et al., 2006[5]; Merritt & Snyder, 2015[6]; Maurovic et al., 2014[7]; Mota & Matos, 2013[8]; Perry, 2006[9]; Quisenberry & Foltz, 2013[10]

Figure Key:

🟩 Negatively framed resilience variables
🟦 Positively framed resilience variables
🟧 Peer factors
→ Direct effect
↔ Correlational relationship
⇢ Mediated relationship
↔x Mixed Findings

Figure 2: Summary of relationships between peer factors and resilience-based factors

Perry, 2006). Unfortunately, the two longitudinal papers of this review do not explore this relationship directly, so this is demonstrated by correlational associations only. It should be highlighted that social skills may be mediated by peer relationships, or these two factors could be bi-directional, or in fact more positive peer relationships may be a result of increased baseline resilience, rather than a factor that influences it. It is also plausible however, that social skills could be a psychological variable that is influenced by the role of peer relationships, which in turn have an impact on resilience-based outcomes.

When exploring social networks, Perry (2006) found that increased early levels of network disruption were associated with higher levels of later psychological distress, and that this relationship was mediated by the strength of current network domains. Thus, they suggested that the mechanism arising from early disruption may be an inability to develop and maintain sufficient networks (to replace previously lost networks), in adolescence. It is also suggested that due to the early difficulties experienced by this population, a lack of social skills may lead to peer rejection, which in turn can further reinforce a lack of social support leading to increased internalising and externalising problems (Bender & Losel, 1997). Unfortunately, this proposition was not further explored in this paper.

One paper (Mota & Matos, 2013) in this study looked at the mediating role of social skills directly in relation to peer relationships and the resilience factors of self-esteem and coping, in a sample of institutionalised adolescents. Their results suggested that young people with higher levels of peer attachment are better able to develop empathy and assertion (regarded as social skill outcome secondary variables) in their relationships. As reported above, while this paper demonstrated direct and positive effects of peer attachment on self-esteem and active coping, the relationship to active coping lost its significance once social skills as a mediating variable was introduced (this was upheld for self-esteem). This paper therefore suggests that social skills may be a key psychological variable in relation to resilience in looked after young people, as both a standalone and a mediating factor. In addition, it suggests that that the association between peer attachment and self-esteem is independent of this, with the authors suggesting that it may be peer relationships fostering feelings of security that in turn increase adolescent self-esteem. However, due to methodological limitations, particularly in the areas of outcome measures and managing confounding variables, more robust evidence would be helpful to explore their proposition.

Legault et al. (2006) show a significant correlation between relationships with friends and general self-esteem (r=.34, p<.001). They do however suggest that a level of self-esteem is required for young people to create bonds and build positive relationships with their peer group, which in turn could suggest that positive peer relationships are in fact the expression of resilience, affected by existing levels of self-esteem which impact on an individual's social skills. Maurovic et al. (2014) found the variable of individual resources to correlate most strongly with happiness (r=.44, p value not reported but significance indicated). It is suggested that this variable involves social skills but it does not measure this in isolation, so it is therefore not possible to extrapolate the influence of this factor alone. In contrast, Merritt and Snyder (2015) found that despite both social skills and perceived peer connectedness separately demonstrating significant differences to clinical and non-problem behaviours, the relationship between these two variables was not significant (r=.16, ns).

4. Discussion

Analysis of the literature demonstrated that addressing the research question of this review based on existing evidence is challenging. This is due to multiple factors, including a dominant focus on relationships with caregivers (as opposed to a focus specifically on peer relationships), the use of negative outcomes to demonstrate resilience and a reliance on cross-sectional data from which to draw findings. As such, the analysis presented should not be treated as conclusive findings, but as a good indicatorfor valid and necessary future focuses of research. This review therefore proposes an informative systematic preliminary analysis of an area of literature which while still in its infancy, offers an exciting and important foundation for building future knowledge that could have potentially powerful implications for this vulnerable group.

4.1 Key Findings

Four key themes have been presented as a result of this review. Despite interpersonal functioning being highlighted in the literature as an issue for this group, overall this review found that young people rated good levels of satisfaction with their peer relationships, and there was preliminary support for the proposition that this factor may be related to increased resilience factors. In line with this, this review puts forward that there is some cross-sectional evidence to support that peer relationships may be able to play a part, directly or indirectly, in mediating some of the negative effects of early disrupted attachments, a well-documented phenomenon in this population. Similarly, social skills have been highlighted as a factor that may be linked to the relationship between peer relationships and resilience-based outcomes. This theme lends itself well to possible future intervention-based research, for example offering young people the opportunity to improve and develop these skills specifically in relation to their peers and exploring the impact this has on psychological variables over time.

Finally, this review supports existing theories of peer contagion, suggesting that an individual's peer group is likely to impact them in both positive and negative ways, depending on the norms of their peers. Unfortunately, the review is unable to offer further insight into why this occurs. It does however highlight, that a rethinking of the way that data is collected within this population, to better understand the psychological mechanisms involved, is needed. Increased insight into this area would be particularly useful for clinical practice in more residential and institutionalised care facilities.

4.2 Review of the Evidence Base

Despite the broad search criteria of this review initially identifying a large number of articles and the inclusion of studies that used negative outcomes as a demonstration of an adaptive definition of resilience, only ten studies were identified for inclusion. This alone highlights the lack of specific academic research into resilience-based outcomes in relation to peer relationships for young people in alternative care. In addition, this review has also highlighted the variation in the way this this topic is currently explored in the literature. The heterogeneity in the studies, particularly in the way that outcomes are measured, makes it difficult to draw definitive conclusions, particularly as most of the studies employ a cross sectional design. Moreover, this review highlights a difficulty in capturing the adaptive, process orientated definition of resilience, which given the salience of resilience theories for this population is an important consideration for future exploration in this area.

NICE (2017) guidelines for research in this population put forward a need for robust studies that are carried out in controlled environments, that make use of standardised validated measures and that measure impact over time. Despite the limitations discussed, this review proposes emergent themes that offer interesting and useful contributions to the research question proposed, providing a foundation from which future research in line with these guidelines can develop.

4.3 Strengths and Weaknesses of Review

This review offers a methodologically rigorous and replicable exploration into a known gap in the academic literature. Following initial scoping exercises, it used broad search terms, updated (phase 3) and with additional terms (phase two) in order to maximise the potential to locate articles of relevance. Using existing guidelines, it adapted quality criteria to ensure a meaningful comparison of articles rather than a presentation of floor and ceiling effects.

The limitations of this review are primarily in relation to data restriction, which could have led to relevant papers being excluded. Although a range of international studies were seen, the review was limited to those with titles and abstracts available in English. In addition, whilst the inclusion of wider search terms and literature sources may have increased the international reach of this review, it was decided that that the chosen systematic exploration of peer reviewed data in this area, could provide a valid and necessary contribution to the existing evidence base, particularly in highlighting current research gaps. To allow for a feasible and valuable comparison of papers, qualitative papers were excluded, which could have potentially added further insight into the research question. The inclusion of peer reviewed articles only, meant that PHD studies and third sector reports for example were excluded. Furthermore, sampling issues were particularly weak, and the data highlighted a lack of both comparator groups and longitudinal data, with no studies offering data for more than two time points. In addition, the variation of quantitative data in these papers meant that a meaningful quantitative analysis was not an option, making it difficult to draw conclusions.

4.4 Implications

Several useful implications can be drawn from this review, with applicability in both research and clinical settings. Primarily, this review has highlighted some key areas for development within the research base, particularly in relation to methodological aims. Existing research has laid the foundation for more robust, longitudinal studies exploring peer relationships and resilience variables directly. Attention to sampling issues will help ensure that data generated can add necessary insight to the alternative care population. It is noteworthy that none of the papers included in this review used the same standardised measures for resilience and peer relationship variables, highlighting a need for consistency to facilitate good quality comparative research. This may require the development of new measures, or the adaptation of existing measures, specifically in relation to this population. Furthermore, a direct exploration of peer factors alongside resilience factors as a primary research question is lacking in the literature. As highlighted by the preliminary evidence in this study, this is an area that could potentially generate useful knowledge and understanding into the unique experiences of the alternative care population.

In addition, despite criticism within the literature a focus on negative outcomes appears to persist. By primary school age, looked after children are already acutely aware of the negative conations that accompany being referred to as looked after, and can articulate their frustrations towards this (Mannay et al., 2017). In contrast, this review recognises that peers can be a source of resilience and calls for future exploration of these issues to be centred upon resilience-based outcomes in their own right, rather than demonstrated by a lack of negative outcomes. It is important that we question the impact that the negative framing within the literature has on those working with young people and indeed, indirectly on young people themselves. In doing this, we can work towards developing a more positive and helpful rhetoric, drawn directly from the strengths of this group.

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"I'm Fending for Myself Right Now": A Grounded Theory Analysis of Parental and Peer Relationships for Adolescents in Alternative Care

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Abstract

Background. Increased understanding of parental and peer relationships for young people in alternative care, particularly in relation to adolescent attachment and identity, is needed. At a time when peers become more important, insight into how these relationships are appraised and navigated, from the voices of young people themselves, is a current research gap. **Objective.** This study addressed the question, how do young people in alternative care conceptualize parental and peer relationships? As a secondary aim it explored, how might the experience of being in care impact upon identity development in relation to peer relationships? **Participants and Setting.** A purposive sampling and theoretical saturation approach was taken. The predominantly female sample comprised of fourteen participants aged between fourteen and eighteen years (M=15.71, SD=1.20), living in alternative care settings and in contact with at least one birth parent. **Methods.** Semi-structured interviews, which included a relationship mapping exercise and the option to complete four self-report measures, were employed. A constant comparative approach based on grounded theory methodology was utilized during data collection and analysis. **Results.** Five key themes, two subthemes and a process model, contextualized within a resilience framework, is presented. **Conclusions.** Relationships are a complex and non-linear process for this population, that is likely to impact on normative developmental processes in relation to others. Trust, unresolved trauma, feeling different to peers, a need to put others first and a dismissive coping style, associated with anger and self-reliance, are important themes related to this. Implications for both research and clinical practice are discussed.

KEYWORDS: adolescent; alternative care; peer; parental; relationships; grounded theory

Abstract Word Count: 249

1. Introduction

1.1 Alternative Care: The Scottish Context

Chapter one presents an outline of the United Nations definition of alternative care, as it has been adopted in this paper. That is, to describe children and young people living out-with the home of their birth parents. Within Scotland, where this study was based, nearly 15 thousand children are estimated to be living in alternative care, with foster care being the most common form of care placement, followed by kinship care (Scottish Government, 2019).

Young people enter alternative care for a number of reasons, most commonly emotional abuse and neglect (Scottish Government, 2015a). Early attachment relationships to a nurturing caregiver are understood to be critical to social, emotional and psychological development with the quality of this attachment related to factors such as the caregivers abilities to attune to the needs of the child (Bretherton, 1992; Bowlby, 1969). Maltreated children are significantly more likely to display insecure attachments than their peers (e.g. review by Morton & Browne, 1998). Exposure to early trauma paralleled with the profound long term impact of disrupted attachment processes at a young age (Audit Scotland, 2010; Elsley, Backett-Milburn, & Jamieson, 2007; Scottish Government, 2015b) can prevent development of basic emotional and cognitive skills, alongside undermining these abilities in adolescents (Furnivall & Grant, 2014). Over two thirds of these children will have entered care before the age of eleven (Scottish Government, 2019). Given that these early years are critical for development it can be reasonably assumed that the trauma and disrupted attachments that occur during pre-care experiences, in-care experiences, and through the process of entering care itself, impact on the normative developmental processes for this population in a way that is distinct to their peers. This can be demonstrated in areas including affect regulation (Mikulincer, Shaver, & Pereg, 2003), risky behavior (Allen et al., 2008), interpersonal functioning (Johnson et al., 2002), development of self-concept (Cicchetti & Toth, 2005) and evidence that young people in alternative care are up to four times more likely than peers to develop mental health problems (Bazalgette, Rahilly, & Trevelyan, 2015). Disruption to normative development due to traumatic experiences, complex attachment relationships and a lack of care make children in alternative care a vulnerable group, the impact of which can often be seen well into adulthood (Audit Scotland, 2010).

1.2 Relationships Matter

1.2.1 Parental relationships. By the very fact that this population of young people are no longer primarily in the care of their birth parents, it can be assumed that in general, parental relationships in this population can be complex and varied in comparison to the majority of peers living at home (Furnivall, 2011). Research suggests the importance of maintaining these relationships held by young people in alternative care (Atwool, 2013; British Association of Social Workers (BASW), 2015), and the varying positive and negative impacts this can have (Moyers, Farmer, & Lipscombe, 2006).

In a relationship mapping exercise exploring adjustment to foster families, it was noted that despite a dilemma around feelings towards birth parents, they were still frequently placed in the circle representing central prominence in that child's life. This was often simultaneously accompanied by an account of negative experiences with that parent, or an absence of that parent from their present life (Heptinstall, Bhopal, & Brannen, 2001). Similarly, Fernandez's (2009) longitudinal study found that young people in care (for 8.2 years on average) consistently reported wanting to see their birth parents more often (63% for birth mothers; 78% for birth fathers) or the same (34% for birth mothers or 15% for birth fathers), with only a minority (3% for birth mothers; 7% for birth fathers) wanting to see them less. This pervasive desire to uphold relationships with birth parents in spite of adverse early experiences in relation to them, highlights not just the difficulty for services in negotiating this (Atwool, 2013), but the internal conflicts for young people themselves to navigate the difficult context within which their attachment relationships are based.

1.2.2 Peer relationships. Chapter one puts forward an argument for the importance of peer attachments in this population. While the positive impact of safe relationships with an adult involved in their care is well recognized (see review by Lou, Taylor, & Di Folco, 2018), the nature of these relationships as being embedded in an official role can also act as a barrier to young people engaging in them (Lindahl & Bruhn, 2017).

Adolescence is a time when peer relationships become more important than suggested in early childhood (Harrop & Trower, 2001; Jones et al., 2014; Pascuzzo et al., 2013), occupying a more central role in an adolescent's relational network (Helsen, Vollebergh & Meeus, 2000). Peer networks can provide social support in adolescence (Stanton-Salazar & Spina, 2005). Support from peers has been suggested to be protective against symptoms of depression in maltreated young people for example (Tanigawa et al., 2011), and this impact can be observed in longitudinal follow up of depression in adulthood (Powers, Ressler, & Bradley, 2009). Given that a depressive presentation can lead to increased social withdrawal and isolation, it is important to consider the potential impact of the role peer relationships could be playing in promoting healthy interpersonal functioning in this population.

While a focus on caregiver relationships dominates development literature, a fundamental change and evolution in how we understand attachment is put forward for adolescence (Allan & Manning, 2007). Classic attachment theory states that in childhood, internal working models create a blueprint of how relationships look (Bowlby, 1969). Many attachment theorists suggest that these are carried forward as the child develops and thus the attachment difficulties developed with primary caregivers can be seen beyond these early years (Cicchetti & Toth, 2005). Within the alternative care population, reported difficulties with peers are often seen (Meadows et al., 2011) and links between disrupted parental attachments and disrupted peer attachments, have been put forward (Malekpour, 2007). However, if adopting the position of Allan and Manning (2007) and viewing attachment from the perspective of adolescence rather than childhood, it may be that the relationship between childhood and adolescent attachment is less direct and predictive than previously suggested. These authors further suggest that an assessment of a child's caregiving system is not necessarily predictive of how an individual will go on to conceptualize other relationships in the future. Instead, a broadening of attachment templates in adolescence to integrate different important interpersonal experiences could be followed. This theory is particularly salient for young people in alternative care who are less likely to have had consistent attachment figures throughout their lives. Thus, an exploration of how parental and peer relationships might be conceptualized differently is an area that warranted further exploration.

1.2.3 The 'I' in the relationship. Developmental tasks in adolescence are often resolved within attachment relationships (Furnivall et al., 2012; Rice, 1990). Adolescence is an important time for young people to define who they are and what matters to them. Identity development has been put forward as a phased process (Erikson, 1980), the resolution of which leads to the forming of a coherent set of values, influenced by social, economic and cultural variants (Jones et al., 2014). This is an explorative enterprise, in which adolescents' question who they want to be and what their place is in the world (Meeus, Oosterwegel, & Vollebergh, 2002; Yeager et al., 2012). It begins in early childhood, when the child begins to separate themselves from their caregiver and develop an individual self-concept (Harrop & Trower, 2001; Mahler, 1975). In normative settings, adult attachment figures can provide children with a coherent and consistent narrative, from which emerging identity and autonomy can then develop (Furnivall et al., 2012), and good quality relationships between parents and adolescents foster this process (Meeus et al., 2002). Moreover in adolescence, young people typically develop the cognitive capacity to start to redefine themselves and their relationships (Nyarko, 2012).

A number of models of identity development in relation to attachment are present in the current literature. An innovative theory in this area, which highlighted the importance of adolescent development, was proposed by Blos (1967). While the authors acknowledge that this is now an older theoretical model, a number of its assumptions have been adopted in more contemporary perspectives, and this outlook can help add insight into the exploration of identity development in this population. This approach postulated that the separation-individuation process that begins in early childhood, can undergo a second phase in adolescence, allowing young people to shed earlier dependencies and move towards a position of adulthood (Doctors, 2000), in which peers take a more centralized role (Blos, 1967; Harrop & Trower, 2001). This identity development process is described as normative, adaptive and progressive (Steinwand, 1984). Successful completion of this process of development is linked to healthy psychological adjustment (Rice et al., 1995) and the construction of a clear personal identity (Grotevant & Cooper, 1985). It is experienced differently by each adolescent, as a result of the existing differences in their attachment styles and the interconnection of attachment and individuation processes (Doctors, 2000). Unstable attachment experiences and inconsistent care can have an impact on the normative progression of this process, and thus adolescents who have experienced adversity in their lives may find this process vulnerable to disrupted development (Blos, 1967; Boles, 1999). While reviews in this area have found that overall, good relationships with peers are positively relate to adolescent identity development, a need for increased peer reviewed research with this population is highlighted (e.g. Literature review by Ferguson, 2018; Systematic review by Ragelienė, 2016).

1.3 The Young Person's Voice

The ability of this group to articulate their views is well recognized, demonstrated for example by a multi-agency report by The Care Enquiry (2013) who found 94% of young people felt able to express their opinions about things which matter to them (TACT, 2015). Young people in alternative care have expressed themselves to in relation to areas such as reduced stigma (Young Minds, 2012), increased choice and decision making (Munro, 2001) and their need for a sense of belonging (BASW, 2015). The importance of supporting the exploration of personal identity and relationships is highlighted in National Institute of Health and Clinical Excellence (NICE) guidelines (NICE, 2015). Despite this, this area is dominated by the voices of adults (Hill, 1997), which can lead to young people feeling unheard and the views of young people themselves being underrepresented (Caldwell, McConvey, & Collins, 2019; Murray 2005).

1.4 Rationale for Current Study

In summary, existing literature tells us that young people in alternative care are able to articulate their needs and that using an attachment framework is a useful way to understand difficulties in this population. Similarly, while the link between adverse early experiences and attachment difficulties is well explored, there is a lack of research into how young people in alternative care conceptualize parental and peer relationships specifically, particularly in regards how they might be considered differently by the same young person. In addition, how identity development may play role in this interpersonal functioning is a novel area of research.

In line with NICE (2015) guidelines, this study puts forward a need for increased understanding of how parental and peer relationships are understood directly. It aimed to better understand the psychological mechanisms that might underpin current dialogue, particularly in relation to adolescent attachment and identity.

1.5 Research Questions

The principal research question for this study was: How do young people in alternative care conceptualize parental and peer relationships? As a secondary research question, the study explored: How might the experience of being in care impact upon identity development in relation to peer relationships?

2. Method

Due to the limited background literature in this area, grounded theory, a methodological approach focusing on the generation or discovery of theory (Glasser & Strauss, 1967) was utilized. Grounded theory can be described as flexible systematic guidelines that can be used to collect and analyze data, allowing the construction of theory from this data itself (Charmaz, 2014). This qualitative approach allows for the generation of rich and descriptive data not otherwise captured by quantitative methods (Corbin & Strauss, 2015). The comparative, interactive, reflective approach allows the construction of analytic categories (Charmaz, 2014) as oppose to the description of meaning that other qualitative methods are often focused on (Starks & Trinidad, 2007).

2.1 Sampling and Participants

2.1.1 Recruitment. Given that this population is underrepresented in current research, efforts were made to maximize the opportunity for young people to take part, such as flexibility on the timing, location of, and length of the research interview. In line with the exploratory nature of this study, a purposive sampling approach was adopted (Etikan, Musa, & Alkassim, 2016). As data collection and analysis developed, theoretical sampling was employed, to elaborate, clarify, test and develop categories and to focus analysis (Charmaz, 2014; Chun Tie, Birks, & Francis, 2019).

For inclusion, participants needed to be aged thirteen to eighteen and have already transitioned to high school (though not necessarily attending). They were to be living in alternative care out-with the home of their birth parents, but to still have some contact (e.g. phone, online) with at least one birth parent. This criterion was included to facilitate the direct exploration of parental relationships, in line with the primary research question. Young people in forensic care, non-English speakers or those with the presence of a severe learning disability that would impact on their ability to communicate and provide informed consent, were excluded.

Participants were recruited via professionals working in local authorities, youth services and an NHS Child and Adolescent Mental Health Service. An information sheet (see Appendix D) was shared with young people who met inclusion criteria. They could then volunteer to take part in the study by contacting, or consenting to be contacted by, the researcher directly. In line with the Gillick competence utilized in the UK national health service (NHS, 2019) young people could provide their own informed consent to participate. An adult information sheet (see Appendix E) was provided to all participants, to support them to facilitate a discussion about the study with an adult involved in their care if they wished to. If the interviewer had deemed the young person unable to provide capacity to consent to the process, any reasonable adjustments to support this would have been explored, for example reading out and discussing the information sheet if literacy levels were poor.

2.1.2 Demographic factors. Sixteen young people agreed to take part, with two withdrawing at the point of data collection. The final sample of fourteen participants were aged between fourteen years and eighteen years (M=15.71, SD=1.20). The sample consisted of ten young people who identified as female, two as male, one as transgender and one who preferred to descriptively self-define. Length of time in alternative care varied considerably and ten of the participants had lived in at least two different alternative care placements, with many of these having stayed in more than two. Time between first episode of care to present ranged from one year to ten years. This included a return to living with birth parents for a period within this time, for five participants. At the point they were interviewed five young people were living in foster care, four in residential care, three in supported independent care and two in kinship care.

2.2 Ethical Considerations

This study received ethical approvals from an NHS Research Ethics Committee, NHS R&D (see Appendix T), The University of Edinburgh (documentation available by request) and via senior managers for two local authorities (anonymized documentation available by request). Given the potential vulnerabilities of the research population and sensitivity of the topic, ethical considerations were a central part of research design processes. Staff were asked to only refer individuals they believed had the capacity to provide informed consent (see Appendix H) and data collection would not have taken place with any young person the researcher deemed as unable to provide this via the consent form (see Appendix F).

Due to early experiences of abuse and/or neglect, it was recognized that questions about parental attachment had the potential to trigger a traumatic response. As such, in order to maximize safe participation, interviewing was mindful of and flexible around the needs of each individual participant. The possibility of disclosure from participants (e.g. child protection issues) was also a consideration. During the study briefing, participants were encouraged to be thoughtful of the personal experiences they were sharing and reminded that they could choose not to answer questions during the interview. In addition, the standard briefing and debriefing process invited participants to think about safe adults from whom they could access support if they found the process difficult. A list of helplines and online resources was also provided to each participant at the end of the interview (see Appendix H).

Boundaries of confidentiality in line with local NHS policy, were explained and any concerns regarding disclosure were discussed with the clinical research supervisor and any other relevant professionals as required. In addition, it was made explicit to participants that they were free to withdraw their participation at any time and that this would have no impact on the care they receive from any service.

2.3 Procedure

The principal researcher carried out all semi-structured interviews between May 2019 and September 2019. Participants were screened to ensure inclusion criteria was met and to obtain informed consent. All interviews were audio recorded and took place within a private space at a service familiar to the participant. Length of interview ranged from 35 to 150 minutes (M=85.21, SD=28.44). Participants were offered breaks throughout and three young people opted to participate over multiple meetings. On completion of the research interview, young people were debriefed, thanked for their participation and given a small financial token of gratitude (funded by the University of Edinburgh). Thirteen participants opted to receive a summary of the study's findings (see Appendix S) and were invited to give feedback on these (See Appendix Q). Though the intention was to factor this into analysis, feedback was unfortunately not received from any participants.

The interview included the use of four self-report questionnaires (described below). A broad interview schedule (see Appendix G) was developed to encourage participants to discuss important relationships in their life and psychological factors in relation to these. However, in line with the principles of grounded theory, data collection was flexible and strongly guided by the content the young person brought to the interview. It was intended that this loosely structured flexible approach would allow the lived experiences of participants to emerge, with the interviewer seeking to clarify meaning and generate real life examples throughout (Charmaz, 2014). A brief relationship mapping exercise, similar to those used within interpersonal therapy with adolescents (Law, 2016; Mufson et al., 2004), was used as an engagement tool. This allowed participants to map out key relationships in their life, allowing for more detailed discussions to develop and facilitate theory construction. The final interview questions gave participants an opportunity to discuss anything they felt was important that hadn't been covered in the interview. This approach was piloted and audio recorded with one individual via role-play, which was discussed and refined in collaboration with the second author. This refined interview was then piloted with a second individual via role-play, who provided feedback on this.

Data collection continued until it was felt that theoretical saturation had occurred, in that the key theoretical categories could be understood with no novel explanations being generated by further data (Birks & Mills, 2015; Charmaz, 2014). The initial themes described below had emerged by the fourth interview. However, further interviews were required to refine, develop and highlight these amongst other emerging ideas, and ensure data saturation.

Following data collection audio recordings were transcribed verbatim by the first author, and identifying information was removed to ensure confidentiality. In line with a social constructionist approach to grounded theory (Charmaz, 2014), written memos and reflective accounts were kept. These helped to ensure quality by documenting inherent processes involved in data collection and analysis (Chun Tie et al., 2019). In addition, they helped the lead researcher acknowledge their own experiences and consider their role in relation to these processes (Birks & Mills, 2015; Charmaz, 2014; Stern, 2007). For transparency, examples can be found in Appendix P.

2.3.1 Self-report measures. Participants were asked to fill in four self-report measures, to be analyzed qualitatively alongside transcribed interview data. It was hoped that by asking specific standardized questions in areas such as attachment and interpersonal functioning, an enhanced understanding of the research questions would be generated. From a qualitative purist position, it could be put forward that this introduced constructs in a way that contradicts the foundational approach of grounded theory, as a methodology that is critical of the idea of preexisting and universal explanations (Suddaby, 2006). In response, this study adopts a more pragmatic perspective, following the rationale of mixed grounded theory (Johnson & Walsh, 2019). This approach advocates for the use of mixed data in a “creative and strategic merging of these traditions on a study-by-study basis” (Johnson & Walsh, 2019: 8). This contemporary approach is in line with the justification of combined data types, that has been presented by the grounded theorists from the outset

(Glasser & Strauss, 1967). Given that it is known that this population is difficult to recruit (Caldwell et al., 2019; Jackson et al., 2012), and the ethos of this paper is to directly hear the voices of young people, methodology was developed with the intention of facilitating the collection of multiple types of useable data from the same individual, which could then be converged to offer some triangulation (Creswell & Plano Clark, 2018) to emergent theoretical ideas. By combining a more flexible explorative interview approach with standardized questions known to target issues related to the research question, opportunity to capture the young person’s story was maximized. Thus, the inclusion of measures was intended to enhance qualitative data collection.

Questionnaires were predominantly completed collaboratively, discussing responses and drawing examples from participants’ lives. One young person opted not to complete the questionnaires, with a further two choosing only to complete one. In line with the ethical approach of this study, giving young people the option to opt out of aspects of the research was important, particularly if this supported them to engage in the rest of the research interview. Each self-report measure is briefly described below. As these were not intended for quantitative statistical analysis, psychometric properties are not detailed here. However, alongside factors discussed below, the robustness of these measures was considered prior to selection to ensure that these measures were well suited to, and validated in, exploring the research questions. Psychometric details properties of these measures can be found in the study protocol (Appendix O**).**

The Self-Perception Profile for Adolescents (Harter, 2012): This multidimensional measure was developed specifically for young people aged thirteen to eighteen, to better understand self-evaluation related to this developmental stage. Global self-worth and domain specific subscales of social competence and close friendship were utilised, making fifteen items in total.

The Experiences in Close Relationships-Relationship Structures questionnaire (ECR-RS) (Fraley et al., 2011): This nine item self-report measure looked at attachment styles across parental and peer relationships and. As this study is assessing parental and peer relationships comparatively, presentation was adapted to allow rating of these two groups at the same time, rather than consecutively. Despite some limitations to this abbreviated measure, it allowed for a conscience comparison in a way that directly addressed the principle research question.

Psychosis Attachment Measure (PAM) (Berry et al., 2006): This continuous sixteen item self-report measure comprised of questions relating to avoidant and insecure attachment styles. While this measure was developed specifically for a psychosis population, there are clear parallels to the research population of this study, including early adversity, traumatic life events and the experience of being in care itself (Gumley et al., 2014). The phrasing of this questionnaire makes it more accessible than alternatives, given the typically lower educational outcomes in alternative care populations (Scottish Government, 2015b).

The Inventory of Interpersonal Problems - 32 item shortened version (IIP-32) (Barkham, Hardy, & Startup, 1996): This abbreviated measure is put forward as a viable alternative to the extensively used longer version (Hughes & Barkham, 2005). It has been widely used in research with vulnerable adolescents, including inpatient samples (Hagerty et al., 2013) and young people displaying psychopathology (Wright, Briggs, & Behringer, 2005).

2.4 Data Analysis

The instructive revised text on constructionist grounded theory from Kathy Charmaz (2014) was used as a key reference for analysis. In line with this approach, the interactive interview process, alongside factors such as tone, tempo and the use of silence were all considered during analysis. NVivo 12 qualitative data analysis software was used to facilitate analysis and provide an audit trail. Monthly meetings with the second author were held throughout data collection and analysis to support the interviewer to reflexively acknowledge and consider their role in this process.

2.4.1 Data coding. Data analysis was carried out by the first author between May 2019 and October 2019. This process occurred simultaneously alongside data collection and memo writing, to facilitate the generation rich data through a constant comparative method (Birks & Mills, 2015; Charmaz, 2014), remaining open and curious to different theoretical possibilities throughout (Belgrave & Seide, 2019). Line by line initial coding using the participants own language was employed for the first six transcripts. This process allowed for an initial linking between the data and potential theories, promoting consideration of the larger analytic story that may be emerging from the young peoples' narratives (Charmaz, 2014). At this point, the six initial transcripts were divided between the three co-authors (three each) to allow for data triangulation (Flick, 2018), and a collaborative meeting to discuss emerging categories and reflections was held.

Focused coding was then introduced, clustering reoccurring related initial codes that related to the research question. This allowed for an initial tentative categorization of the data, to facilitate the development of emerging theory (Charmaz, 2014). Focused codes were utilized for the remaining eight interviews. At the end of this process, the initial six interviews were revisited to code for any new categories that had emerged. Following this, theoretical coding was used to group focused codes into semantic categories (Glasser & Holton, 2005; Stern, 2007), to sort and integrate related codes towards theory development (Hernandez, 2009) (see Appendix N for an example of this). An example of this process across all levels of coding is provided in the Appendix to further illustrate this methodology (see Appendix M). This analysis was carried out within constant comparative method framework, allowing for the research questions to be explored using a theoretical blueprint that emerged directly from the data itself (Charmaz, 2014; Glasser & Holton, 2005).

2.4.2 Self-report measure data. Self-report measure data responses offered self-report information alongside transcribed narrative. This allowed for some data triangulation to occur, within the grounded theory methodological framework (Johnson & Walsh, 2019). Subscale responses were calculated and recorded on IBM SPSS Statistics 5 software. These were then coded and categorized into the existing coding structure of qualitative data within Nvivo 12, at the focused coding stage for each interview (see Appendix O for an example of this process). It was hoped that collecting this information would enhance the development of thematic categories and understanding in relation to the research questions.

During analysis, self-report measure responses were explored alongside qualitative data in line with the constant comparative methodical approach of the study overall (Charmaz, 2014). It was found that generally, these responses corresponded with narrative content, adding evidence to the grounded theory put forward. As such, the next section of this paper focuses on presenting the qualitative data collected, using the voices of young people to illustrate the themes and process proposed. Some further consideration of the use of self-report measures is provided in the discussion section.

3. Results

This study aimed to present a grounded theory of how young people in alternative care conceptualize parental and peer relationships. A secondary aim was to better understand how the experience of being in care had impacted upon identity development in relation to peers. All participants are referred to by pseudonyms. Figure 1 summarizes the grounded theory that emerged from data analysis. It presents a summary of how parental relationships and peer relationships were conceptualized. Contextualized within a resilience framework the left-hand side of the model proposes five key themes (denoted in bold text) andtwo subthemes (denoted by underlined text). The right-hand side of the model puts forward a process model, aimed to capture the changeability and non-linearity of relationship experiences that emerged from the data. It is suggested that this is an interactional model at all stages (denoted by the yellow arrows between these two sides) with current relational experiences influencing these factors.

Difficult and traumatic early encounters with parents appeared to filter into the present-day narrative of young people, in a way that felt uncontained and unresolved. Peer relationships were interrelated with a sense of young people identifying as different to their peers. Drawing on experiences of relationships more broadly, a difficulty trusting others was the most central emerging theme, with a need to put others first proposed as a central theme. A dismissive coping style emerged as a further central theme, with anger and self-reliance as proposed subthemes within this. An underpinning resilience formed the key contextual factor within which the themes of the study can be considered.

Furthermore, through analysis of memos and reflecting with co-authors, a generalized narrative used when young people described their relationships was noted. At times many participants were, with prompting, able to offer more specific examples. In

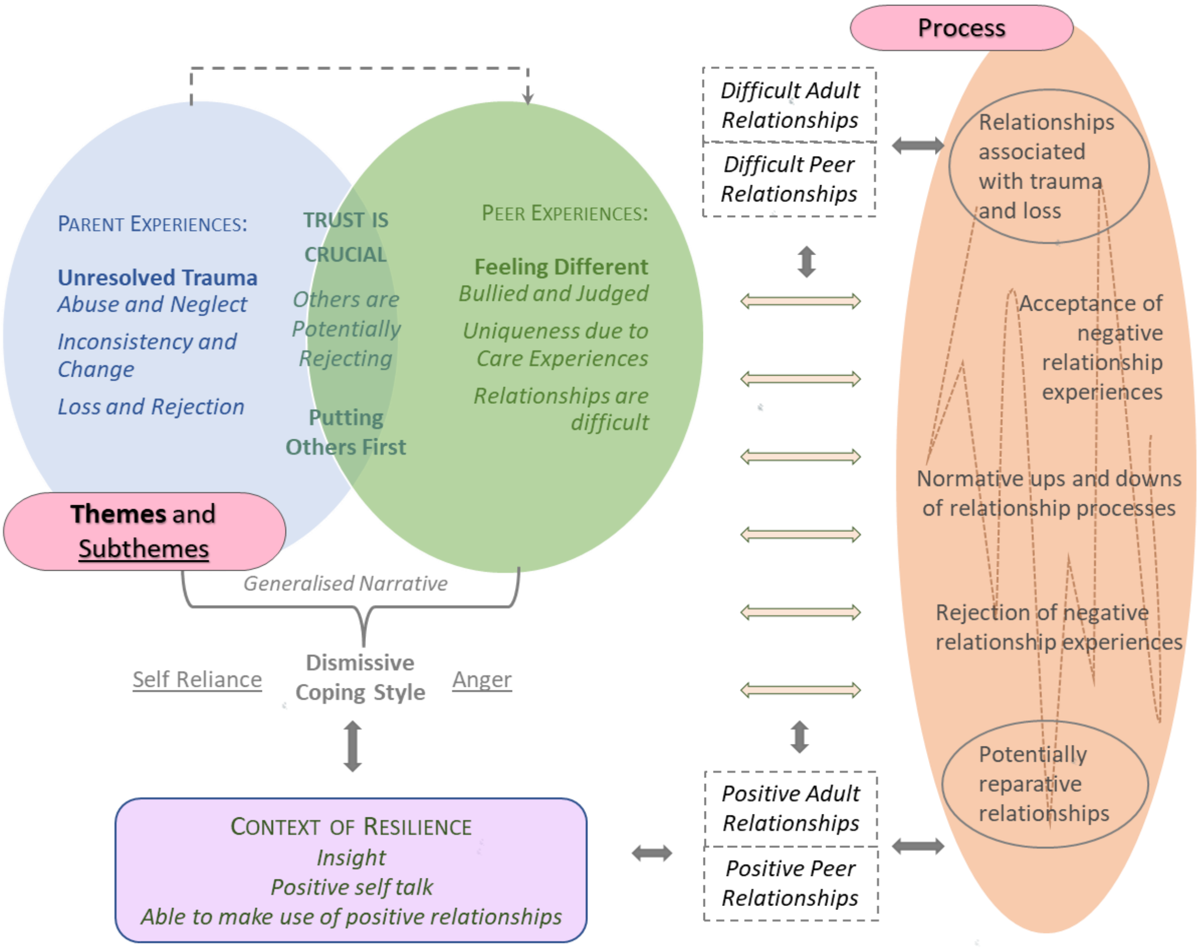

Figure 1: A grounded theory model of parental and peer relationships in young people in alternative care

general however, they presented a more overall statement that what we were discussing frequently occurred, such as “ *Like I can't think of a time, but I know I am with certain people” (Katie)* and *“I ken that's how it happened (…) I cannae mind them, I just know that it's there” (Connor).* This is considered further in the discussion section of this article.

Moreover, an attachment-based process, by which participants appeared to be navigating between traumatic and potentially restorative relationships is proposed. This was complex and non-linear, and appeared to have an interactional relationship with the themes put forward. All participants referred to both positive and difficult ongoing relationships with peers and adults (including parents, family members and staff involved in their care), and these experiences are suggested to influence the proposed theory, in a continual and interactive way. All elements of this grounded theory model shall now be discussed in turn.

3.1 Trust is Crucial

When thinking about relationship qualities, trust was clearly the overarching theme, or *"main thing" (Sally)* that arose from the data. Young people described this as "*a weird one. It's like the most important but the most difficult" (Jane)*. This quality was portrayed as the foundation to relationships, in relation to both parental and peer relationships. When describing what they meant by trust, participants predominantly explained this as "*being able to tell something personal to someone and knowing that they won't share it with others" (Freya),* believing "*the person I'm trusting is reliable enough to not spread what I tell them about" (Greg)*. Being able to depend on others and not being judged by others also related to this.

A number of the young people described having *"trust issues" (Annie),* suggesting *"anyone can be a potential threat" (Greg)* and *"If I trust you then you should feel privileged, cause it's not every day that I do" (Connor).* They attributed finding it hard to trust others to their trust being broken in past relationships, by both parents and by peers, and could provide numerous examples of this. Furthermore, they viewed this as a barrier to current relationships. This difficulty was often the case even when describing positive relationships. Despite this, all participants were able to describe at least one person that they could trust; "*And we started opening up to each other, and I started being honest with her like I let her in, I started trusting her and that. And I don't trust many people" (Freya).* Knowing this person for a long time, them having similar experiences or them having been dependable or consistent in the past, were factors associated to this.

3.2 Unresolved Trauma

Given that this was not the focus of this research, no individual was asked directly about their early trauma or why they were placed in alternative care. Despite this, all participants referred to difficult traumatic experiences in earlier life. Alongside transcribed verbal examples of this (e.g. of sexual abuse, physical abuse and substance misuse), memos documented a strong felt sense from the interviewer that this trauma was unresolved, with young people making connections to this throughout the interviews, often linking this to current interpersonal difficulties. It appeared that this was a lens through which they now viewed their relationships.

Key to this for most participants, was a perception of their parental relationships as rejecting. This was both in practical terms (e.g. relating to contact), and more generalized feelings based on previous experience; *"they would pick you up and they would drop you when it suited them. Like they would want you and then they wouldnae want you" (Lewis).* For the nine participants who described a birth parent as an important person in their lives at present, this observation was upheld. Moreover, eleven participants drew connections between difficulties with parental relationships in earlier childhood, and difficulties with current relationships, primarily, in relation to the overarching theme of finding it difficult to trust others:

> *"Even though she's my best friend and she's never ever broke my trust. I just, I don't know what it is I just can't trust friends (…) I think that when my mum broke my trust that would have been what it was (…) deep down I know that's probably what it is yeah." (Annie)*

3.3. Feeling Different to Peers

Feeling different to peers was a central theme related to how participants saw themselves, that emerged from this data. Young people described believing that "*I have to look a certain way, I have to present myself a certain way" (Lewis),* with some worrying that "*they are like judging me and stuff"* directly causing them to feel *"insecure" (John).* This often created a barrier to young people engaging with their peers. In addition, young people described a uniqueness to their peers based on their care experiences, proposing that they had an awareness of the complexity of adult problems and difficulties that they perceived other young people to have been sheltered from. There was a sense of feeling *"very different because it's just like I've had to go through a lot more" (Sally)*, that related to ***"****people in care have got a lot more understanding then folk that are in like a normal house. Cause we learn what the world is actually about. It's not like a nice wee world that yous like. And that your mum and dad is trying to protect you from" (Connor).*

In addition, reinforcing earlier experiences of rejection, participants expressed that they had been treated unfairly by peers for being different. Frequent examples of being bullied and feeling judged directly in relation to their family circumstances were present in the dataset. Young people described being told "*at least I have a mum and a dad" (Olivia); "no wonder that your grandad killed himself (…) no wonder your mum doesn't want you, or your gran" (Bianca)* and *"Ha you're in care, your mum and dad don't want you" (Lucy)*. These situations frequently occurred after the young person telling personal information to *"a really close friend actually"* (Greg), often leading to further rejecting experiences.

3.4 Putting Others First

Young people described being strongly motivated to use their relationships as a way help others. This theme came through in the narrative when participants were referring to both their past and their present and to both parental and peer relationships. Focusing on others' problems to avoid thinking about their own difficulties was one suggested motivation, for example with Harriet stating, *"Like if I'm sitting speaking to someone about their problems it's all good, cause it means I don't have to worry about my problems".* Predominantly however, finding it rewarding that *"I've made them happy" (John),* or making use of their experiences to prevent others undergoing the same difficulties, "*to try and make a difference in folks' lives*" *(Connor)*, were the main motivations. This appeared to be associated with a needing to give to others what, as a result of their experiences, had perhaps been missing in some of their key relationships. This may in turn have provided feelings of validation for participants.

In relation to this, participants described a sense of lost childhood. They suggested missing out on *"the right care and nutrients and development for your childhood" (Jane), b*y having had to grow up quickly. Examples of this included exposure to difficult experiences from a young age or needing to play a parental role to younger siblings, or other family members. The majority of participants in this position described dissatisfaction with their current contact with those they previously had a role in looking after, contributing to their ongoing experiences of rejection and loss:

> *"I didn't have a childhood or anything at all, cause I was always looking after my brothers and sisters. So like I hardly got to school cause like I was looking after my brothers and sisters, I never got fed cause I was feeding them before I fed myself. Like I'd have to eat like cat and dog food and that, because I didn't have anything for myself." (Harriet)*

Ten participants gave examples of this theme specifically in relation to giving money to others. Eight of these stated being taken advantage of financially, by both peers and adults, including parents. In spite of this, and although they recognized that this often left them without enough money for themselves, they *"would do it again cause I would think of somebody else I won't think of myself" (Bianca)* as *"if one of my friends hasnae got, like obviously I'm going to give them, like I would give them my last" (Lewis).* Participants also described feeling this way to numerous different people in their lives, and that *"I don't really care about like what I need to do for myself. Or how to make me feel better, it's always about other people." (Lucy)*, this prioritizing others at the expense of their own needs. On occasion, participants referred to their own needs more directly. However, even when this occurred, a prioritization of the needs of others was a theme across all interviews. When discussing his own needs, Greg suggested *"I still rank them highly"* but that they were "*Not as important as other people's".* It may be that given their experiences, opportunities to prioritize their own needs throughout their lives were lacking, leading to them feeling unable to do this in current relationships.

3.5 But it's Fine: A Dismissive Coping Style

With the exception of one participant, laughter, humor or a sarcastic tone appeared to be used as ways of deflecting from the topic being discussed, or a response intended to manage painful emotions associated with their relationships, as a form of self-protection. Examples of this were extracted during analysis, and this was the most frequently observed focused code:

> *"Like my own parents didn't even love me when I was little so <laughs>…*
> *I dunno. I'm not very helpful am I? <laughs>" (Lucy)*

These strategies appeared to be aimed at minimizing difficult encounters and relationships. This was experienced by the interviewer as a clear communication from young people that such occurrences were normal for them and a sympathetic or problem-solving response was not desired, perhaps as this is what they usually received from others. The interviewer noted perceiving individuals as particularly vulnerable during these times.

> *"It's annoying but like I'm used to it <laughs>. I've done it for so many years (...) Like I never want sympathy from anyone." (Harriet)*

> *"<laughs> Others kind of pity me. Like oh it's alright, you don't need to cry, everything will be alright <sarcastic tone> (...) But they <birth parents> don't care <pause>, they don't care about me the way they should (...) I'm like pfft, I don't care anymore. Like I've dealt with it for so many years." (Katie)*

In several participants, this dismissiveness appeared more entrenched in their overall approach to relationships. Issues of impermanence related to their care arrangements was a possible related factor. In individuals currently or previously accommodated in residential care for example, a pattern of managing rejecting experiences by a reluctance to form new relationships emerged, due to an expressed belief that relationships were transient:

> *"You get used to it <describing previous care history involving multiple high schools changes>…That's why I'm not the type of person to settle down cause there's no point. I'm just gunna move again (...) I think it's harder cause like obviously people are going to judge you for being in care. Cause obviously I move all the time so I don't see any point in making friends cause I'll just have to move, probably." (Lucy)*

> *"I don't want relationships (...) I'm moving away, I'm not having any relationships I just want to be by myself...I actually don't have any relationships. I've got <staff member> and that's it." (Georgina)*

Georgina’s example was particularly illustrative of this as she completed the research interview over two occasions. On the first meeting Georgina was able to list multiple positive relationships in her life, which included peers, family members and multiple staff involved in her care. The above quote is taken from the second interview a few days later, following an incident at her residential unit. When this change was highlighted to Georgina, she reiterated *“they don't count anymore none of those people…cause I’m moving away so I won't see them anymore”*.

Furthermore, the use of sarcasm appeared to be a form of self-protection aligned more to anger (considered further below), though still in the context of young people managing their feelings of pain:

> *“She'd (birth mother) be bringing up the gem of <sarcastic tone> 'I fought for you for five years' to my social worker and it’s been very annoying to me. Like I've heard that so many times. And I'm like <sarcastic tone> wow you were in a custody battle for 5 years…hmmm guess neither of you were that good of an option then if it took that long <laughs>.” (Sally)*

In addition, it could be put forward that the generalized narrative observed across the research interviews could also be understood as a way of young people protecting themselves against potentially distressing conversations (considered further below). In relation to this overall dismissive coping style theme, subthemes of self-reliance and anger shall now be briefly outlined.

3.5.1 Self-reliance. Related to this theme was a need for participants to cope on their own. . Young people described it being *“just easier not to speak to people about things” (Harriet)*, with a clearly articulated preference to “*just manage everything myself, that's what I'm used to*” (Lucy). Finding it hard to open up to others, there was a message that “*I've got my own back, I don't want to depend on others” (Annie).* The use of these strategies in relationships can also be interpreted as resilient functioning. By protecting themsleves from further rejecting or negative relational experiences, it may be allowing them to continue interacting with others to fulfil their relational needs, demonstrating an ability to adapt to the situation in spite of prior adversity. There did however appear to be some overlap between this strategy as adaptation avoidance.

3.5.2 Anger. Within their narrative, participants referred to different emotional responses to their interpersonal situations with parents and peers. Anger emerged as distinct within this. Across all interviews it appeared that anger was a way of coping with potentially triggering or distressing past and present relational experiences. Eleven of the participants articulated this emotion clearly, including through sarcasm (as highlighted above). Memos demonstrated a strong felt sense of this with the remaining three participants, experienced as more passive, but still clearly present. In Georgina’s interview for example, aggressively toned statements such as *“I cannae be bothered”, “This is too much effort*”, or describing the questions she was being asked as *“stupid”*, appeared to be more linked to *“I dunnae like it, I don't ken you. I dunnae like being with folk I don't ken”*, and thus the angry tone used appeared to be in response to her struggling to manage the interaction.

Awareness of anger being used in this way varied across the sample. Some young people demonstrated good insight; “*Yeah...like if I get <pause> like if I find something like difficult, like upsetting, I'll usually mostly like, get angry or annoyed” (Katie),* and could make sense of this based on their experiences; “*It just kind of culminated into me being angry 24/7, the slightest thing I would jump on (…) I would actively look for those little things to get mad at her <birth mother> at, so there would be an argument, because I felt more* *comfortable in that. And that just kind of continued" (Sally).* Others described a lack of control around their anger being activated; "*Well my anger goes from like 0 to 1000…Like I blow. Like ken how fast a gunshot goes. It goes at 0.6 seconds when the trigger is pulled. That is how fast my anger is." (Connor).* Participants also described clearly communicating their feelings of anger to others, often through behaviors that impacted on their relationships or had got them into trouble in to past:

> *"I'm a really nice person till I'm annoyed. And when I'm annoyed I don't hold back (…) I just melt down, I see red and I can say some really nasty things I don't mean (…) I've been chucked out of two schools (…) there's been videos of me fighting and stuff on the internet before, so I do have a reputation for myself." (Annie)*

3.6 Resilience

The findings discussed appeared to be underpinned by an inner resilience, defined as an ability to adapt and succeed in spite of prior negative experiences. Young people were able to reflect on their ability to *"always manage to get through" (Jane)* difficult periods, making use of experiences as survival tools; *Everything made me stronger (Harriet)*. Furthermore, they showed insight into their difficulties, demonstrating a capacity to reflect on and make links between their early parental relationships and their present:

> *"Umm, I don't view my mother as a mother, I don't view my father as, I don't even view myself as having a father really because he's just not been there… <pause> So...um...so, I wouldn't be surprised if it's something attachment based cause I don't really have those kind of um, I guess, um, what's the word I'm looking for, I guess those kind of automatic attachments (…) Because like, once you've got context, once you can*

> *contextualize how someone acts, it's a lot easier to understand them. So the more someone knows about me, the more they can contextualize how I am. And understand why I am like that" (Sally)*

Of key importance, despite their difficult experiences all participants described some positive relationships in their life, and moreover, could reflect on why these were important to them. These included with peers, but also with family members (siblings in particular) and staff involved in their care:

> *"Like with <friend> and stuff it's like totally different (...) she's not one of the people that will come near me when, like she'll come near me when I have nae money do you know what I mean (...)*
> *I'm so thankful for <name>." (Lewis)*

3.7 A Complex Process

Alongside these overarching themes, emerged a non-linear, idiosyncratic and complex attachment process that young people appeared to be navigating. As proposed in figure 1, there appeared to be a sense of back and forth in the way that young people described their relationships. This felt complex and interconnected with the highlighted themes, in a continual and heterogeneous way. As highlighted in excerpts above, young people showed an understanding of negative aspects of their relationships. Their desire to offer more positive and nurturing relationships to others, alongside their insight into factors that have been missing in their relationships (particularly parental relationships) demonstrate this. However, there also appeared to be an ongoing pulling back towards rejecting relationships, especially with birth parents. Even when there was clear articulation from the young person that they understood the traumatic impact of these relationships, or in some cases expression that did not want to continue their interactions with that person, the complex dynamics of these relationships and associated emotions and coping strategies appeared to be having an ongoing impact. It was apparent that interpersonal functioning for this sample was not linear or straightforward and the process model section within this grounded theory model aimed to capture and reflect this complexity.

Positive attachment relationships have the potential to play a restorative role, to the damage caused by disrupted attachment experiences in earlier life. This process involves the rejecting of relationship experiences that are not acceptable, such as being mistreated by others. Across the sample there appeared to be a strong pull back towards these relationships, particularly with parental figures, in a way that appeared distinct from normative relationship processes at this stage of adolescence. Despite a clear awareness of the negative and rejecting aspects of these relationships, a tolerance of them was observed. In regards to parental relationships, this seemed underpinned by the fact that *“they're your parents, you want them to care about you” (Lucy)* and although young people could articulate the difficulties of that relationship, *“I'll always care about her cause I'll be hers you know what I mean? And she'll always be my mum cause you only get one” (Annie).* With peers, a fear of further potential loss and rejection in relationships appeared to be related; *“I didn't want to have no friends, I didn't want to loose like the only person that actually would spend time with me <laughs>” (Jane).*

4. Discussion

4.1 Consideration of Findings

Using a grounded theory approach, the narratives of fourteen young people were analyzed to better understand how young people in alternative care make sense of their relationships with birth parents and peers. This led to the development of a data driven model proposing key themes, subthemes and an interactional process. This model demonstrates the complex and non-liner context within which this population navigate relationships. It promotes an attachment-based, trauma informed understanding of some of the outcomes often associated with these young people. It highlights the fundamental importance and challenges of relational experiences and proposes a framework from which those supporting this group can offer support.

4.1.1 The process of relationships. An attachment-based process, by which participants maneuvered between traumatic and potentially restorative relationships is put forward. This was complex and non-linear, and appeared to have an interactional relationship with the themes put forward. All participants referred to both positive and difficult ongoing relationships with peers and adults (including parents, family members and staff members involved in their care), and these experiences are suggested to influence the proposed theory, in a continual and interactive way.

Interestingly, it was observed that the grounded theory model put forward has many similarities with the dual process model of coping with bereavement. This proposes an oscillating process through which an individual learns to process the grief of their loss and works towards the development of a new identity and relationships (Stroebe & Schut, 1999). This paper acknowledges that there are distinct differences between bereavement and other forms of loss. Despite this, viewing the loss experienced by this population as a bereavement of kind (Harrop & Trower, 2001) in line with this framework, can help add understanding to the back and forth dynamic that appeared to take place by participants. In contrast to bereavement, this sample had ongoing contact with birth parents, repeatedly associated with ongoing experiences of rejection. This may have resulted in individuals being unable to fully grieve their feelings of loss and rejection, leading to a non-linear and complex navigation of the normative processes associated with coping with loss. This proposition is in line with the theory of ambiguous loss, which suggests that the unknown nature of loss from inconsistent contact with birth parents in this population can in some cases be even more distressing than absolute losses (McWey, Acock, & Portera, 2010) as it represents an ongoing relational trauma, associated with uncertainty and no clear resolution (Boss, 2006; Bruner & Thompson, 2018).

In parallel to this, the majority of young people in this sample were lacking the secure base (Bowlby, 1969) required to successfully undergo a normative process of secondary individuation (Blos, 1967). This process involves a rejecting and de-idealization of parental attachments, developing bonds with peers as a way of managing the distress of this process (Harrop & Trower, 2001). As part of this process of adolescence, a diminishing of dependency on the family would be expected in relation to normative identity development (Blos, 1967; Furnivall, 2011). Successful navigation of this process can support adolescents to build satisfying relationships with others, including peers (Harrop & Trower, 2001). These relationships can potentially fulfil the tasks of attachment relationships, such as providing comfort and proximity seeking (Allan & Manning, 2007).

It is important to acknowledge that difficulties navigating identity development are seen for all adolescents. However, adopting the viewpoint that successful completion is dependent on an adaptable working model of relationships based on attachment experiences (Fraley & Davis, 1997), it is reasonable to assume that this process could be particularly challenging for this population. The rejecting nature of their experiences is highlighted in this study. It may be that as a result of these, young people are unable to give up their idealization of birth parents, perhaps due to a fear that this could lead to further rejecting experiences, particularly if peers, who would normally take on this role in normative developmental process (Harrop & Trower, 2001), have been critical and rejecting. Alternatively, it could be that given early traumatic experiences this idealized view of birth parents is no longer present for this population. Thus, they are not able to undergo this process in the same way as their peers. Moreover, given these experiences, perhaps depending on others to fulfil their attachment-based needs feels intolerable. A potential consequence of an interaction between this and an adaptive dismissive coping style could be that young people are pulled back towards negative relationships, as the shift required to engage in potentially reparative relationships, for example with peers, feels unsafe.

4.1.2 Feeling different in relation to others. Peer perceptions are of paramount importance in adolescence, with peer validation in relation to care status having a particularly influential impact on identity development (Kools, 1997). In identifying as different to their peers, a sense of uniqueness emerged. This had a subtle hierarchical tone, a sense of knowing more about life than their peers. It could be that this had a protective quality, as having this perspective could help to manage and avoid attention to the potential distress caused by the differences in their relational experiences, both past and present. It could also be that this is an outlet of their frustration at the unfairness of their life experiences in comparison to others (Coram Voice, 2015) which appeared to be predominantly contained in everyday life through a dismissive coping style (Downes, 2019).

In line with the study's methodological approach, attention was paid to the relational experience of the interviewer during data collection. Reflective memos highlighted that difficult attachment experiences and early trauma felt both unresolved and often uncontained across the sample. This was observed in the narrative of young people (for example recalling specific details of their abuse) as well as the felt sense of the interviewer. In order to engage in effective interactions with others in adolescence, a capacity to access and interpret both our own mental states, and those of others is required (Bleiberg, 2013). While this experience may have been noted in interviews in part due to the fact that this sample were familiar with sharing their stories with professionals, (e.g. Sarah stating *"I've got my script"*), it may also be that their peers have similar, potentially overwhelming, relational encounters. If so, a lack of insight and ability for participants to manage their affect (Fonagy & Luyten, 2009), could potentially be contributing to the difficulties described in this study with young people feeling their trust has been broken. Feeding back into the overall oscillating relationship process, this would be particularly difficult to manage given that rejection from peers in adolescence can itself be viewed as a traumatic event associated with high levels of psychological distress (Lev-Wiesel, Nuttman-Shwartz, & Sternberg, 2006).

4.1.3 Resilience as a relational process. Different positions defining resilience have been put forward (see Shean, 2015) but generally, this concept is defined as the demonstration of positive function or adaptation in response to adversity (Luthar, Cicchetti, & Becker, 2000; Masten, 2001; Rutter, 2006). Of significance is that despite the challenges highlighted, young people could and had built successful relationships with peers. They were reflective of difficulties in different relationships and could make links between these and their prior attachment experiences.

Given that disrupted attachment processes are so instrumental in research with this population, and that the process of resilience is likely to differ for different groups of adolescents (Cicchetti & Rogosch, 2002; Zolkoski & Bulloc, 2012), rather than simply stating that this ability demonstrates resilience, this paper supports the argument that attachment theory can be used to explain the resilience process itself (Atwool, 2006). It puts forward that figure 1 could be demonstrating resilience in action for this sample. From this viewpoint, the ability of individuals to adapt in relation to others could be regarded as the foundation for their resilience, from which skills and behaviors often defined as resilient outcomes, can develop (Luthar, Cicchetti, & Becker, 2000). This adaptive resilience is likely to have been imperative to young people in earlier life. The overlap of this with relationship difficulties now could be that when presented with the opportunity for safer, potentially reparative relationships, this mechanism may inadvertently now act as an obstacle to this process. Thus, the themes and process presented in this paper, support an adaptive model of resilience for young people in alternative care, that is based on the idea of relational processes as a starting point for this (Bifulco et al., 2017).

4.2 Self-Report Measures as a Facilitator of Data Collection

As discussed, the inclusion of self-report measures allowed for some triangulation of data to occur. Given the methodological focus of this paper (highlighted above) and the fact that correspondence with narrative responses was seen, these results have not been detailed. However, a consideration of the inclusion of these as a tool to facilitate data collection is presented here. Alongside being mindful of the potential data influencing role of inclusion of self-report measures (Suddaby, 2006), it can be argued that thoughtfully selected measures that directly relate to the research questions can help to access the narrative of these topics, thereby enhancing data collection (Johnson & Walsh, 2019). Given that research with younger children routinely uses a more structured approach in order to better capture research data (Murray, 2005), this approach is particularly salient when researching a population that is suggested to be functioning at a developmental level below that of their peers (Audit Scotland, 2010; Scottish Government, 2017).

Of importance, self-report measures were used in a flexible, participant led way intended to trigger conversations and the generation of qualitative data. It could be argued that the use of measures contributed to difficulties to generate specific examples, as their structure encourages more generalized thought. However, this difficulty was observed during interviews prior to the inclusion of questionnaires. In addition, standardized questions frequently prompted the sharing of specific examples and reflections from young people, and thus could be viewed as a facilitator, rather than an obstacle, in this area. In addition, careful attention was paid to this facilitated narrative alongside numerical responses. When completing the ECR-RS (Fraley et al., 2011) for example, many young people commented that they weren't worried about being abandoned by their birth parents (question 8), or that their birth parents didn't care about them (question 7), *"cause I know <emphasised> they don't" (Sally).* This is fundamentally different to young people that reported similar numerical values but related this to a positive relationship with a parent at that time. This narrative arose directly from the inclusion of this questionnaire, demonstrating its function as an additional tool for exploration of the research questions.

4.3 Critical Appraisal of Study

4.3.1 Strengths. This study adds to understanding of the complexities of relationships in this population, particularly in relation to peers. It directly addresses an important research gap by utilizing the underrepresented voice of young people themselves (Caldwell et al., 2019; Hyde & Kammerer, 2009). Variation within the study sample is representative of the complexity of alternative care journeys of this population. As detailed above, this study has adopted a rigorous and transparent qualitative methodology (Belgrave & Seide, 2019; Birks & Mills, 2015; Charmaz, 2014), enhanced by the use of self-report measure data to offer some triangulation to findings (Johnson & Walsh, 2019). A flexible needs-based approach to data collection helped to maximize inclusion (Hill, 1997). The sharing of findings and opportunity to provide feedback on results was in line with the study's overall ethos to be grounded within the young person's narrative.

4.3.2 Limitations. A strength of this methodological approach is that is allows for a more bespoke, data led development of theory (Chamaz, 2014; Corbin & Strauss, 2015; Glaser & Strauss, 1967), However, it is not possible to capture and report the full range of narrative idiosyncrasies within the confines of this paper. By the very nature of synthesizing content, there lies a risk of losing the individual voice of the participant (Hill, 1997), the perspective that this study has aimed to promote the importance of. Furthermore, variation in the use of outcome measures limited methodological consistency across interviews. In addition, while frequency and level of contact with, and attitudes towards, parental relationship were varied with this sample, it did not include young people whom no longer had any contact with birth parents. This is likely to limit the overall transferability of the study, though perhaps appropriately so, as it is likely that the narratives of young people no longer in touch with birth parents could look quite different. In addition, though the approach of this research was not comparative, this study in isolation is not able to demonstrate specific differences between this population and a more normative sample of young people. Furthermore, the majority of participants identified as female.

In line with ethical guidance, recruitment to this study was only possible through staff members (of varying professional backgrounds). As such, a degree of selection bias may have occurred. This was primarily in relation to issues of staff gate-keeping (Heptinstall, 2000; Murray, 2005). It is likely that key reasons for this related to a non-prioritization of supporting research within a context of under-resourced services (Gilbertson & Barber, 2002) and a reluctance to put forward participants who were perceived as particularly vulnerable (Berrick, Frasch, & Fox, 2000; Heptinstall, 2000).

4.4 Implications of Study.

4.4.1 For research. The focus of this paper was on parental and peer relationships but during discussions, the importance of other family member as important attachment figures was clear. These included siblings, grandparents and siblings of birth parents. In addition, alongside highlighting the challenges of inconsistent care (Hyde & Kammerer, 2009), young people in this study recognized that services played a specific role in their lives. It could be that given their experiences, children in alternative care have an awareness of the often conditional and temporary context of their attachment relationships, an idea illustrated by this quote from Lewis describing a staff member involved in his care; *"You've got your life, like you get to go home at night, you've got your own house and everything else and it's just your job".* Investigating if this has an impact on the strong, often demonstrated, desire to remain connected to birth family (Atwool, 2013; BASW, 2015), is an area that is beyond the focus of this paper, but warrants further exploration.

Moreover, this paper has used the voices of young people to put forward the complicated, interactional and non-linear process of relationships for this population. From this starting point further investigation in need to unpick the nuances of this process. In relation to this, research aimed at separating unique factors of identity development and autonomy in this population from normative adolescent secondary individuation would add to the initial findings of this paper. Given the profound importance of reparative attachment relationships for young people in alternative care (Atwool, 2006), increased understanding of this is put forward as a research priority, particularly in relation to navigating difficulties with trust and feeling different to peers.

Furthermore, this study noted a generalized narrative across the interviews. It may be that this was due to cognitive factors related to how this population memorize and recall difficult experiences (Fry, Langley, & Shelton, 2017; Leslie et al., 2005). It could also be however, a way of young people protecting themselves against conversations that might touch upon early attachment experiences, in a way that could be potentially triggering or retraumatizing. It is important for research with this population to be mindful of balancing these two factors. There is a need for a strategy that can break down an over-rehearsed account, but which also scaffolds the conversation for young people who, as a result of early traumatic experiences or disrupted attachments, might have an incoherent or non-logical narrative.

4.4.2 In practice. Calls for more implementation of trauma-informed support within services for this population have been made for a number of years (Beyerlein & Bloch, 2014; Milne & Collin-Vézina, 2015). The need for service wide, integrated, trauma-informed understanding and intervention in this population is now well recognized (Fratto, 2016; Greeson et al., 2011; NICE, 2015) and implementation of this is slowly improving, particularly within Scotland (Gilliver, 2018) with encouraging preliminary observations of the potential impact of this (Bunting et al., 2019). The difference between services being trauma aware and trauma informed have been previously highlighted in literature, with the latter reflecting a more holistic and integrated approach that uses a trauma lens to understand present interactions, focusing on supporting empowerment, strength and resilience (Sweeny & Taggart, 2018; Wall, Higgins & Hunter, 2016). This paper puts forward a direct association between unresolved early traumatic experiences and current relationships. It highlights a clinical need to understand relational processes for these young people directly through a framework of trauma and loss. This understanding has the potential to support young people to explore this process, enhance their self-awareness and build upon their resilience factors in a meaningful way (Barton, Gonzalez, & Tomlinson, 2012).

The combination of a dismissive coping style and generalized narrative appeared to be a way of young people protecting themselves and navigating their way through the complexities and difficulties of relationship processes. As this is a common feature across the sample, this highlights support for the ongoing clinical need to really mentalize these young people, being curious about what is going on for them internally and paying close attention to how they make sense of and manage different relationships (Jacobson, Ha, & Sharpe, 2015; Taylor 2012). Furthermore, the findings of this paper demonstrate that in spite of numerous developmental obstacles, young people are able to develop supportive and potentially reparative relationships with their peers. Supporting young people to manage their feelings of difference, understand and address their difficulties with trust and navigate ongoing negative and rejecting experiences, will be important to support them to engage in this. This more nurturing approach to peer relationships can help to address the current shortcomings of the care system to offer sufficient management and intervention to facilitate positive peer relationships for this population (Bazalgette et al., 2015; Furnivall, 2018).

Increased vulnerability of this population to further abuse, exploitation and re-traumatization is well recognized (Bazalgette et al., 2015; Luke et al, 2014). This study found a tolerance of these experiences, despite knowing they are negative, related to both an acceptance of this as normal and a fear of rejection of losing these relationships. Working with young people to explicitly explore what their relationships needs are and how they can address these is therefore put forward as an important clinical implication. This requires a shift to viewing relationships as a starting point to interventions, as a foundation for resilience, rather than a factor related to it (Atwool, 2006). Furthermore, this paper puts forward the need for exploring and enhancing peer attachments within this, as the significant role that peers play in the lives of this population has been clearly articulated by the participants of this study.

4.5 Conclusions

This study has proposed a grounded theory model to increase understanding of parental and peer relationships in alternative care. A clear methodological framework has been described, and findings have developed directly from the voices of young people themselves. An argument for viewing resilience as a non-linear and complex relational process has been proposed. This has highlighted a back and forth dynamic process, impacted by ongoing experiences of rejection and loss in relation to parental and peer relationships, often reinforcing earlier trauma. The model presented includes a direct exploration of peer relationships specifically, and the role they can play in being potentially reparative attachments. Adolescence as a position from which to approach attachment and viewing relationships themselves as a position from which to understand resilience, is put forward. Implications for research and clinical practice have been discussed. These include a need to further explore specific nuances of the of the process proposed, such as the specific ways in which identity development in this population differs from more normative processes, and ensuring interventions are relational and trauma informed.

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Appendix A: Guidance for Publication in Child Abuse and Neglect (relevant sections)

The current study has followed the author guidelines for Child Abuse and Neglect: The International Journal. The author has adapted these guidelines where appropriate, to meet the submission requirements for a thesis to the University of Edinburgh Doctorate of Clinical Psychology programme.

Child Abuse and Neglect: The International Journal

Description. Child Abuse & Neglect is an international and interdisciplinary journal publishing articles on child welfare, health, humanitarian aid, justice, mental health, public health and social service systems. The journal recognizes that child protection is a global concern that continues to evolve. Accordingly, the journal is intended to be useful to scholars, policymakers, concerned citizens, advocates, and professional practitioners in countries that are diverse in wealth, culture, and the nature of their formal child protection system. Child Abuse & Neglect welcomes contributions grounded in the traditions of particular cultures and settings, as well as global perspectives. Article formats include empirical reports, theoretical and methodological reports and invited reviews.

Audience. Includes but is not limited to: Economists, Historians, Planners, Political Scientists, Ethicists, Legal Scholars, Political Theorists, Theologians Psychologists, Lawyers, Psychiatrists, Nurses, Social Workers, Sociologists, Public Health Workers, Law Enforcement, Educators, Pediatricians and Anthropologists.

Impact factor. 2017: 2.899

Types of Contribution. 1. Research Article: Child Abuse and Neglect publishes quantitative, qualitative, and mixed-method research. Particular focus will be placed on thorough and appropriate methods, strong data analysis and discussion of implications for the field. 2. Reviews: Authors with plans for proposed review articles (systematic, meta-analytic, scoping) are invited to first submit a draft outline to the Editor-in-Chief for review. Please send proposals to chiabu@elsevier.com. The editors may also commission reviews on specific topics. Reviews submitted without invitation or prior approval may be returned.

Language (usage and editing services). Please write your text in good English (only American usage is accepted, as dictated by APA style).

Length and Style of Manuscripts. Full-length manuscripts should not exceed 35 pages total (including abstract, text, references, tables, and figures), double spaced with margins of at least 1 inch on all sides and a standard font (e.g. Times New Roman) of 12 points (no smaller). Instructions on preparing tables, figures, references, metrics, and abstracts appear in the Publication Manual of the American Psychological Association (6th edition).

Article structure. Subdivision: Divide your article into clearly defined sections. Three levels of headings are permitted. Level one and level two headings should appear on its own separate line; level three headings should include punctuation and run in with the first line of the paragraph.

Introduction: State the objectives of the work and provide an adequate background, avoiding a detailed literature survey or a summary of the results.

Essential title page information: Title - Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible. Author names and affiliations- Please clearly indicate the given name(s) and family name(s) of each author and check that all names are accurately spelled. You can add your name between parentheses in your own script behind the English transliteration. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lowercase superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name and, if available, the e-mail address of each author. Corresponding author - Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. This responsibility includes answering any future queries about.

Methodology and Materials. Ensure that the e-mail address is given and that contact details are kept up to date by the corresponding author. Present/permanent address - If an author has moved since the work described in the article, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Abstract. Abstracts should follow a structured format of no more than 250 words including the following sections: Background, Objective, Participants and Setting, Methods, Results (giving specific effect sizes and their statistical significance), and Conclusions.

Keywords. Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

Formatting of funding sources. List funding sources in this standard way to facilitate compliance to funder's requirements. If no funding has been provided for the research, please include the following sentence: This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Footnotes. The use of footnotes in the text is not permitted. Footnoted material must be incorporated into the text. Table footnotes - Indicate each footnote in a table with a superscript lowercase letter.

Figure captions. Ensure that each illustration has a caption. Supply captions separately, not attached to the figure. A caption should comprise a brief title (not on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

Tables. Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules and shading in table cells.

References. Citation in text: Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication. Web references: As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list. References in a special issue: Please ensure that the words 'this issue' are added to any references in the list (and any citations in the text) to other articles in the same Special Issue. Reference style: Text - Citations in the text should follow the referencing style used by the American Psychological Association (view the APA Style Guide). You are referred to the Publication Manual of the American Psychological Association, Sixth Edition, ISBN 978-1-4338-0561-5. List - references should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters 'a', 'b', 'c', etc., placed after the year of publication.

Submission checklist. The following list will be useful during the final checking of an article prior to sending it to the journal for review. Please consult this Guide for Authors for further details of any item. Ensure that the following items are present:

One author has been designated as the corresponding author with contact details:

- E-mail address
- Full postal address
- Phone numbers

All necessary files have been uploaded, and contain:

- Keywords
- All figure captions
- All tables (including title, description, footnotes)

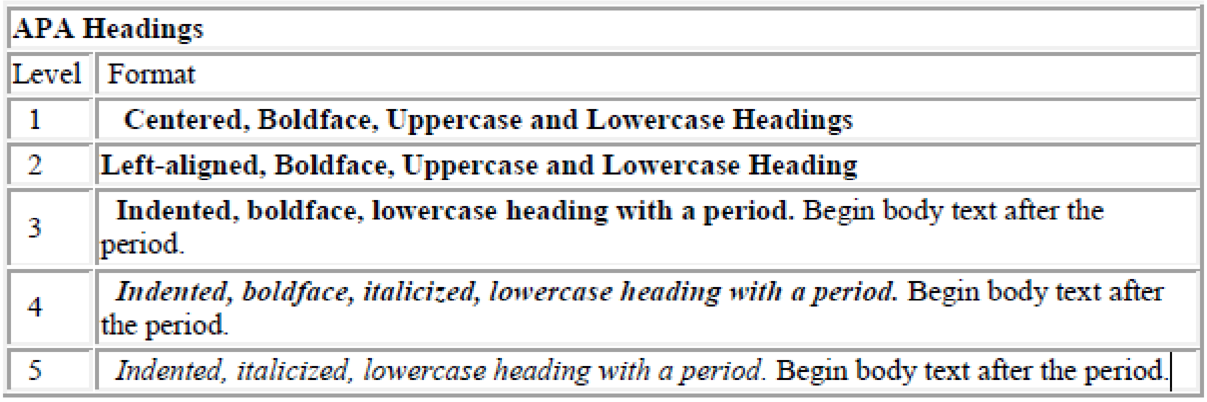
Further considerations:

- Manuscript has been 'spell-checked' and 'grammar-checked'
- References are in the correct format for this journal
- All references mentioned in the Reference list are cited in the text, and vice versa
- Permission has been obtained for use of copyrighted material from other sources (including the Web)

- Color figures are clearly marked as being intended for color reproduction on the Web (free of charge) and in print, or to be reproduced in color on the Web (free of charge) and in black-and-white in print
- If only color on the Web is required, black-and-white versions of the figures are also supplied for printing purposes For any further information please visit our customer support site at http://service.elsevier.com.

Authors are responsible for ensuring that manuscripts conform fully to the Publication Manual of the American Psychological Association (6th ed.), including not only reference style but also spelling (see, e.g., the hyphenation rules), word choice, grammar, tables, headings, etc. Spelling and punctuation should be in American English.

APA Style Guide. Spelling: In APA style, American English is used. Spelling should conform to the Merriam-Webster's Collegiate Dictionary (2005). Abstract: An abstract is a brief, comprehensive summary of the contents of the manuscript and should consist of approximately 250 words. Parentheses: APA does not allow back-to-back parentheses. So instead of (GLM)(Fryer, 1986), it should be (GLM; Fryer, 1986). In-text citations: There is no comma before "et al." (Ex: Marsh et al., 2006); If there are 6 or more authors, list only the first author followed by et al. (e.g., Margo et al., 2009). References: Double space throughout; Use a hanging indent; Do not include issue numbers unless the journal is paginated by issue. Headings:

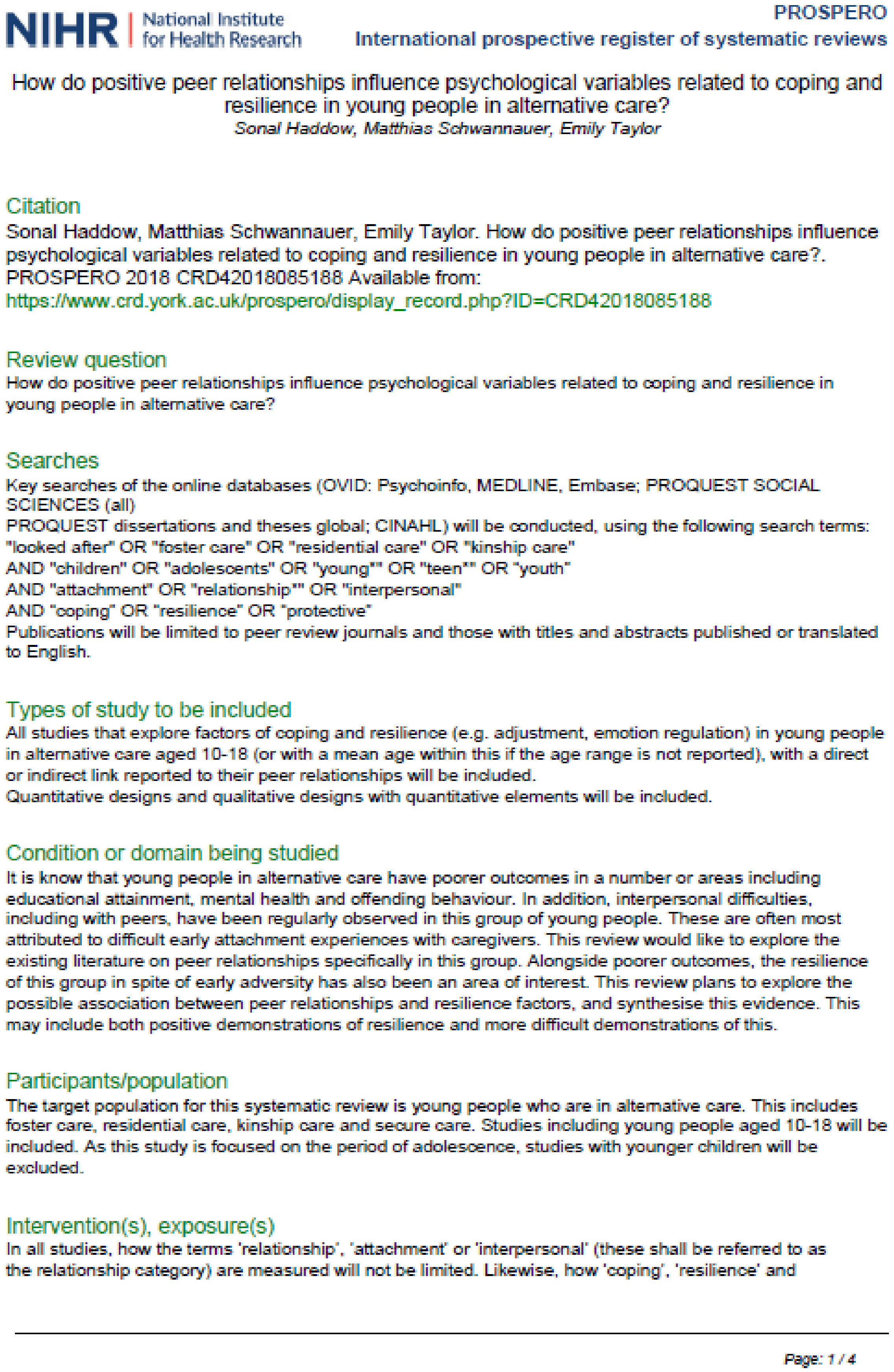


APA Headings

Level	Format
1	**Centered, Boldface, Uppercase and Lowercase Headings**
2	**Left-aligned, Boldface, Uppercase and Lowercase Heading**
3	**Indented, boldface, lowercase heading with a period.** Begin body text after the period.
4	***Indented, boldface, italicized, lowercase heading with a period.*** Begin body text after the period.
5	*Indented, italicized, lowercase heading with a period.* Begin body text after the period.

Commas: A comma should be included before the conjunction in lists (e.g., red, white, and blue; Don, Smith, & Jenkins, 2008); Put a comma before the conjunction if separating two complete sentences (e.g., I went to the park, and I went to the store.) Do not use a comma otherwise (e.g., I went to the park and then the store.). Statistics: p-values should be italicized, with a space before and after the “=” or “<” symbol (e.g., p < .006); Chronbach’s alpha should be reported using the symbol, e.g., (α = .70) When denoting an entire sample, use N. When reporting a subsample, use n. Quotation marks: Do not use quotation marks to identify the anchors of a scale. Instead, use italics (e.g., always, never); Only use single quotation marks when within double quotation marks to set of material that in the original source was enclosed in double quotation marks. Other issues: The use of while should be limited to its temporal meaning (i.e., to link events occurring simultaneously). When that is not what is meant, the terms although, whereas, and, or but should be substituted in its place; Do not use contractions (e.g., can’t)

Appendix B: Prospero Systematic Review Protocol



NIHR | National Institute for Health Research

PROSPERO
International prospective register of systematic reviews

How do positive peer relationships influence psychological variables related to coping and resilience in young people in alternative care?

Sonal Haddow, Matthias Schwannauer, Emily Taylor

Citation

Sonal Haddow, Matthias Schwannauer, Emily Taylor. How do positive peer relationships influence psychological variables related to coping and resilience in young people in alternative care?. PROSPERO 2018 CRD42018085188 Available from: https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42018085188

Review question

How do positive peer relationships influence psychological variables related to coping and resilience in young people in alternative care?

Searches

Key searches of the online databases (OVID: Psychoinfo, MEDLINE, Embase; PROQUEST SOCIAL SCIENCES (all)
PROQUEST dissertations and theses global; CINAHL) will be conducted, using the following search terms:
"looked after" OR "foster care" OR "residential care" OR "kinship care"
AND "children" OR "adolescents" OR "young*" OR "teen*" OR "youth"
AND "attachment" OR "relationship*" OR "interpersonal"
AND "coping" OR "resilience" OR "protective"
Publications will be limited to peer review journals and those with titles and abstracts published or translated to English.

Types of study to be included

All studies that explore factors of coping and resilience (e.g. adjustment, emotion regulation) in young people in alternative care aged 10-18 (or with a mean age within this if the age range is not reported), with a direct or indirect link reported to their peer relationships will be included.
Quantitative designs and qualitative designs with quantitative elements will be included.

Condition or domain being studied

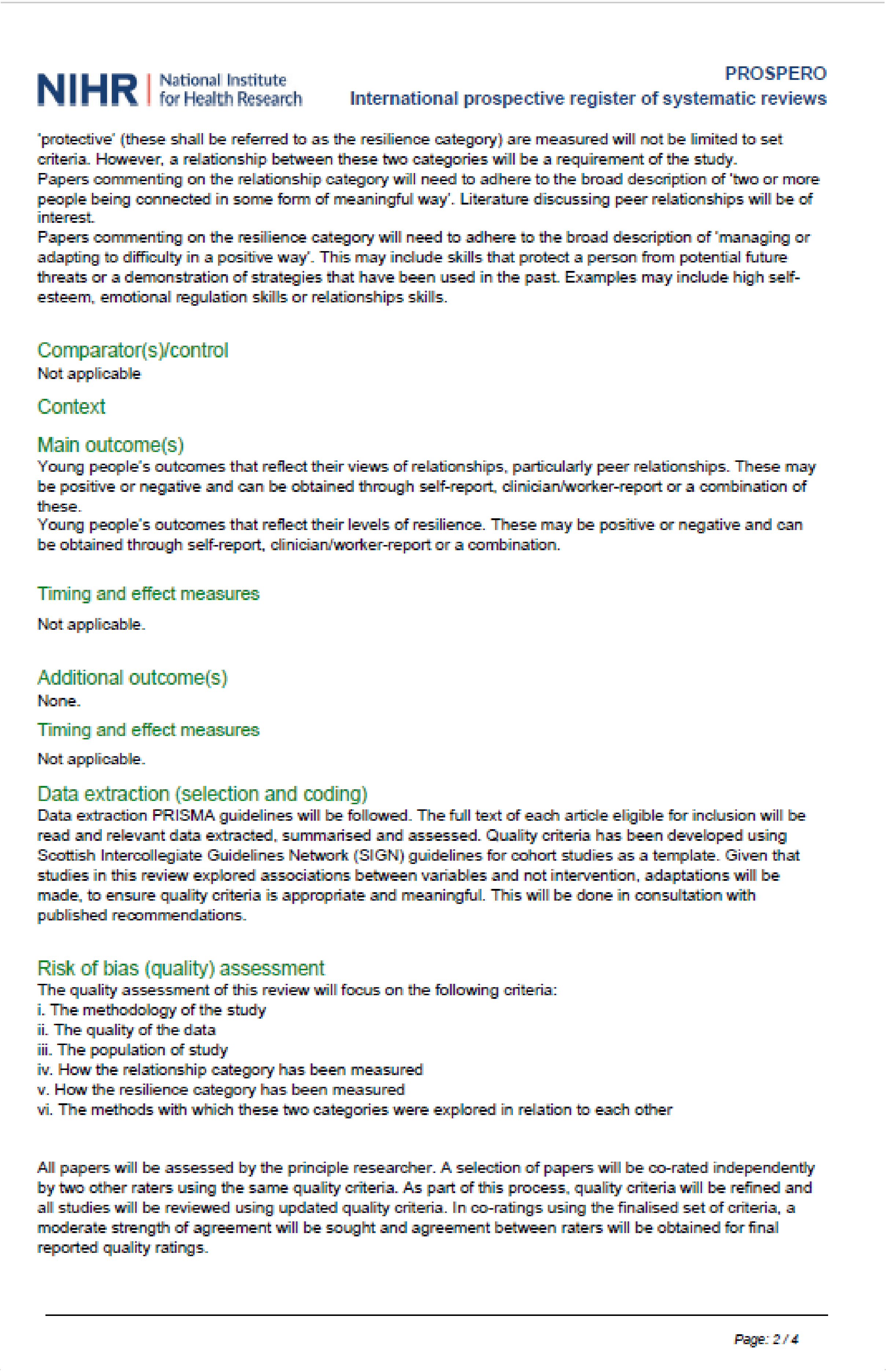
It is know that young people in alternative care have poorer outcomes in a number or areas including educational attainment, mental health and offending behaviour. In addition, interpersonal difficulties, including with peers, have been regularly observed in this group of young people. These are often most attributed to difficult early attachment experiences with caregivers. This review would like to explore the existing literature on peer relationships specifically in this group. Alongside poorer outcomes, the resilience of this group in spite of early adversity has also been an area of interest. This review plans to explore the possible association between peer relationships and resilience factors, and synthesise this evidence. This may include both positive demonstrations of resilience and more difficult demonstrations of this.

Participants/population

The target population for this systematic review is young people who are in alternative care. This includes foster care, residential care, kinship care and secure care. Studies including young people aged 10-18 will be included. As this study is focused on the period of adolescence, studies with younger children will be excluded.

Intervention(s), exposure(s)

In all studies, how the terms 'relationship', 'attachment' or 'interpersonal' (these shall be referred to as the relationship category) are measured will not be limited. Likewise, how 'coping', 'resilience' and



'protective' (these shall be referred to as the resilience category) are measured will not be limited to set criteria. However, a relationship between these two categories will be a requirement of the study.

Papers commenting on the relationship category will need to adhere to the broad description of 'two or more people being connected in some form of meaningful way'. Literature discussing peer relationships will be of interest.

Papers commenting on the resilience category will need to adhere to the broad description of 'managing or adapting to difficulty in a positive way'. This may include skills that protect a person from potential future threats or a demonstration of strategies that have been used in the past. Examples may include high self-esteem, emotional regulation skills or relationships skills.

Comparator(s)/control

Not applicable

Context

Main outcome(s)

Young people's outcomes that reflect their views of relationships, particularly peer relationships. These may be positive or negative and can be obtained through self-report, clinician/worker-report or a combination of these.

Young people's outcomes that reflect their levels of resilience. These may be positive or negative and can be obtained through self-report, clinician/worker-report or a combination.

Timing and effect measures

Not applicable.

Additional outcome(s)

None.

Timing and effect measures

Not applicable.

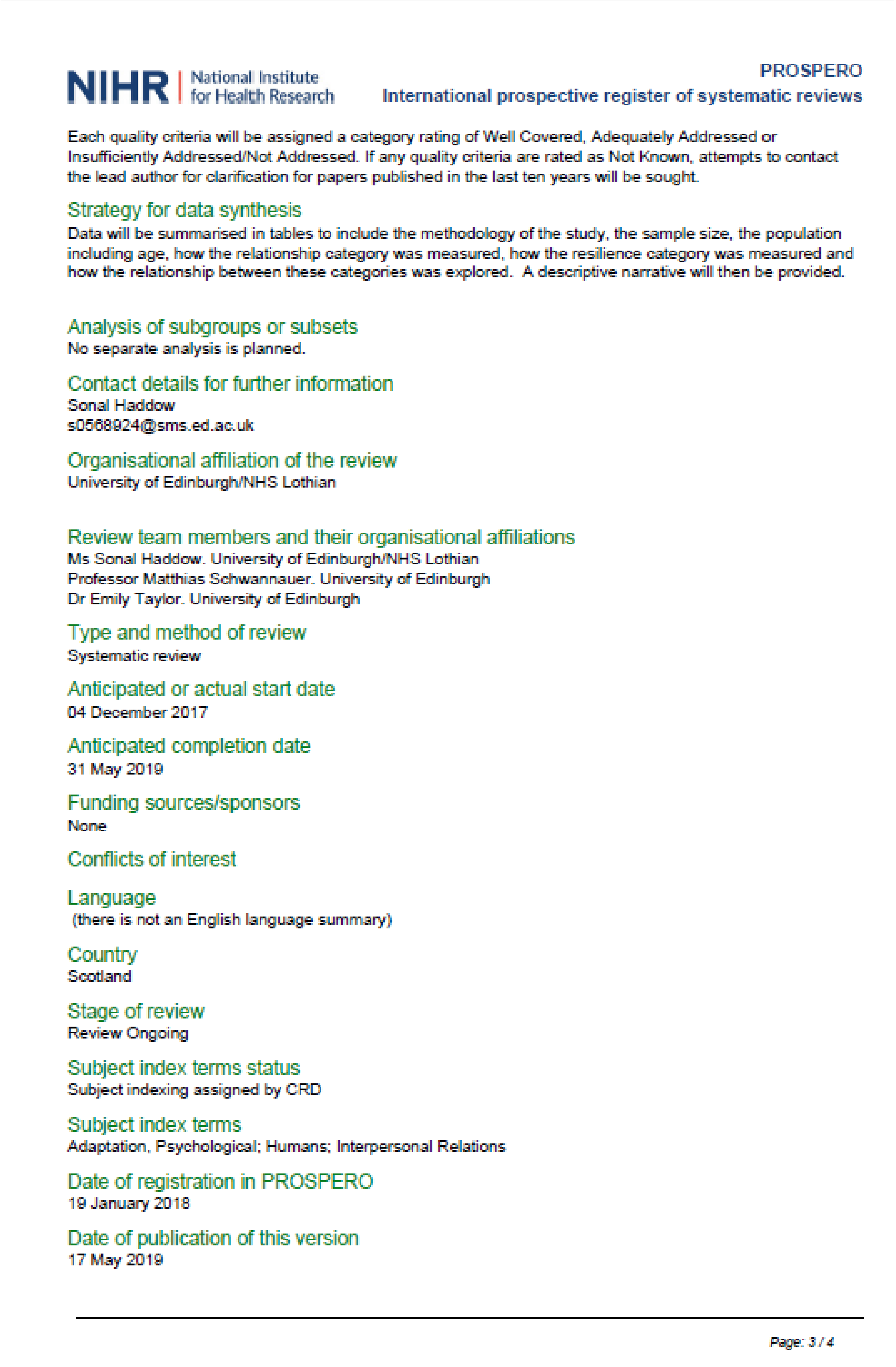
Data extraction (selection and coding)

Data extraction PRISMA guidelines will be followed. The full text of each article eligible for inclusion will be read and relevant data extracted, summarised and assessed. Quality criteria has been developed using Scottish Intercollegiate Guidelines Network (SIGN) guidelines for cohort studies as a template. Given that studies in this review explored associations between variables and not intervention, adaptations will be made, to ensure quality criteria is appropriate and meaningful. This will be done in consultation with published recommendations.

Risk of bias (quality) assessment

The quality assessment of this review will focus on the following criteria:
i. The methodology of the study
ii. The quality of the data
iii. The population of study
iv. How the relationship category has been measured
v. How the resilience category has been measured
vi. The methods with which these two categories were explored in relation to each other

All papers will be assessed by the principle researcher. A selection of papers will be co-rated independently by two other raters using the same quality criteria. As part of this process, quality criteria will be refined and all studies will be reviewed using updated quality criteria. In co-ratings using the finalised set of criteria, a moderate strength of agreement will be sought and agreement between raters will be obtained for final reported quality ratings.



Each quality criteria will be assigned a category rating of Well Covered, Adequately Addressed or Insufficiently Addressed/Not Addressed. If any quality criteria are rated as Not Known, attempts to contact the lead author for clarification for papers published in the last ten years will be sought.

Strategy for data synthesis

Data will be summarised in tables to include the methodology of the study, the sample size, the population including age, how the relationship category was measured, how the resilience category was measured and how the relationship between these categories was explored. A descriptive narrative will then be provided.

Analysis of subgroups or subsets

No separate analysis is planned.

Contact details for further information

Sonal Haddow
s0568924@sms.ed.ac.uk

Organisational affiliation of the review

University of Edinburgh/NHS Lothian

Review team members and their organisational affiliations

Ms Sonal Haddow. University of Edinburgh/NHS Lothian
Professor Matthias Schwannauer. University of Edinburgh
Dr Emily Taylor. University of Edinburgh

Type and method of review

Systematic review

Anticipated or actual start date

04 December 2017

Anticipated completion date

31 May 2019

Funding sources/sponsors

None

Conflicts of interest

Language

(there is not an English language summary)

Country

Scotland

Stage of review

Review Ongoing

Subject index terms status

Subject indexing assigned by CRD

Subject index terms

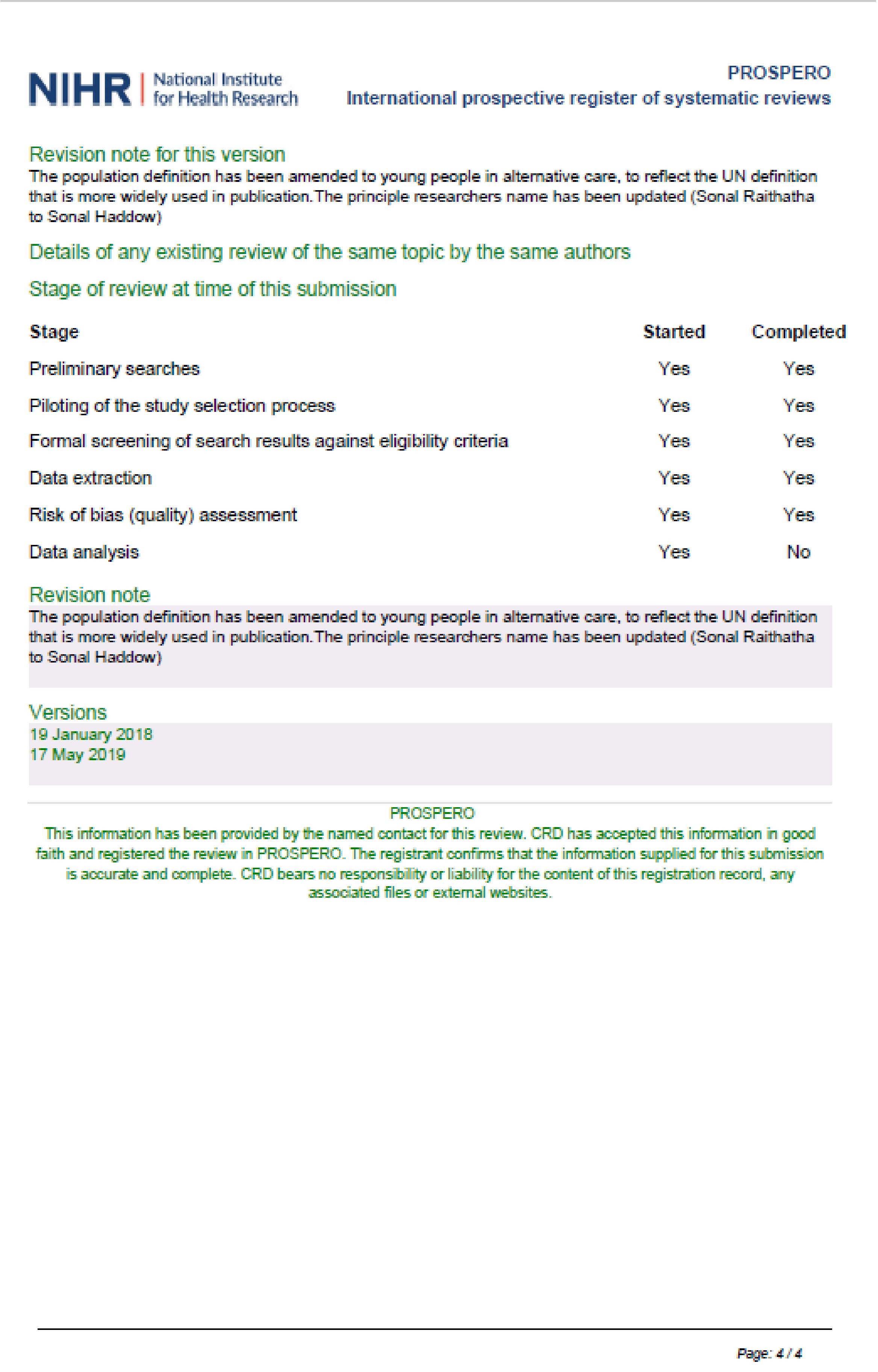
Adaptation, Psychological; Humans; Interpersonal Relations

Date of registration in PROSPERO

19 January 2018

Date of publication of this version

17 May 2019



Revision note for this version

The population definition has been amended to young people in alternative care, to reflect the UN definition that is more widely used in publication.The principle researchers name has been updated (Sonal Raithatha to Sonal Haddow)

Details of any existing review of the same topic by the same authors

Stage of review at time of this submission

Stage	Started	Completed
Preliminary searches	Yes	Yes
Piloting of the study selection process	Yes	Yes
Formal screening of search results against eligibility criteria	Yes	Yes
Data extraction	Yes	Yes
Risk of bias (quality) assessment	Yes	Yes
Data analysis	Yes	No

Revision note

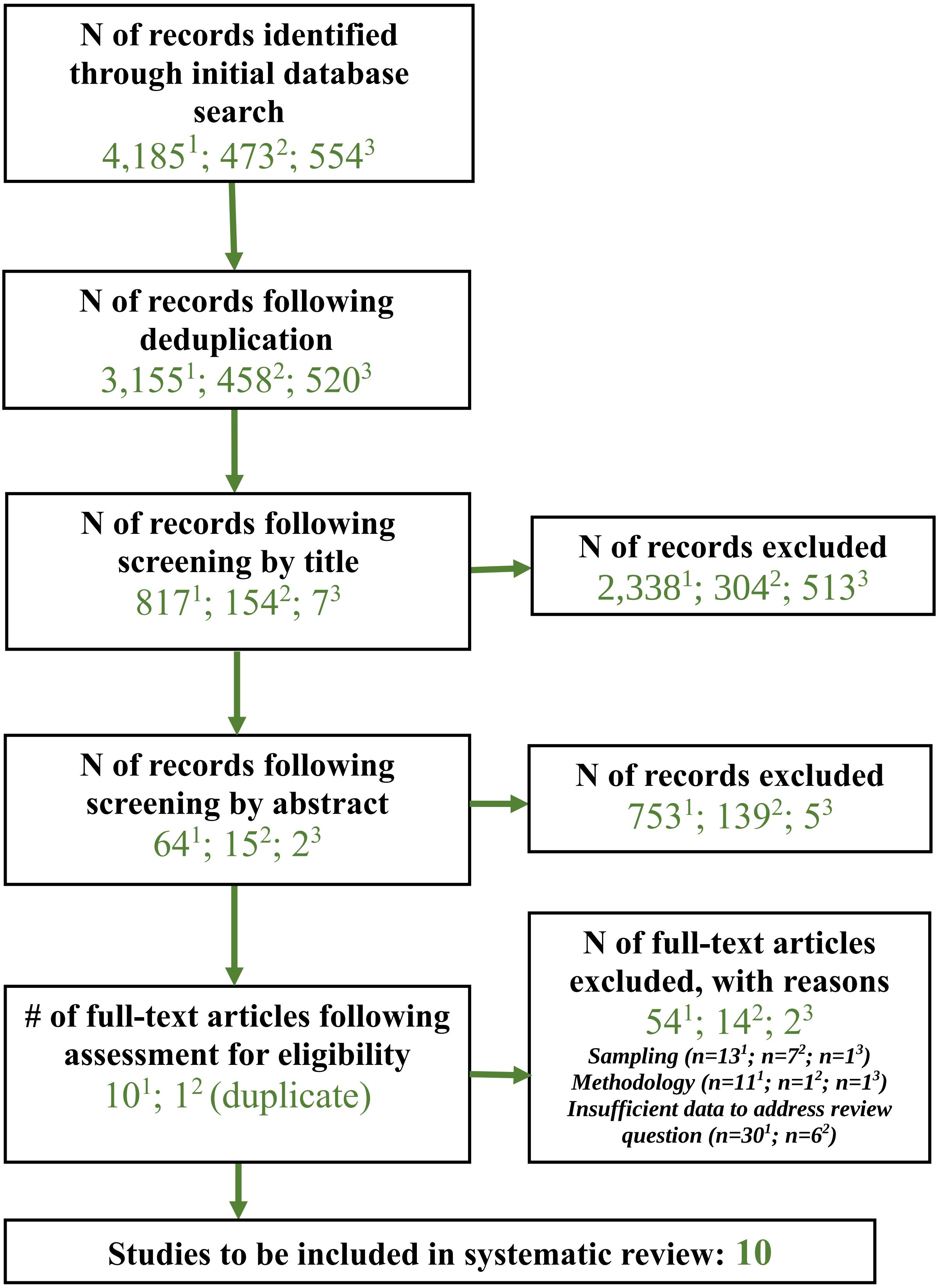
The population definition has been amended to young people in alternative care, to reflect the UN definition that is more widely used in publication.The principle researchers name has been updated (Sonal Raithatha to Sonal Haddow)

Versions

19 January 2018
17 May 2019

Appendix C: Systematic Review Phased Search Strategies

Phase 1^1, Phase 2^2 and Phase 3^3 search strategies:



Appendix D: Systematic Review Quality Criteria

Quality Criteria	Well covered	Adequately addressed	Insufficiently addressed / Not addressed	Not Applicable / Not known
1. The study addresses an appropriate and clearly focused question	Main aims/research questions of study are clearly stated and focused (I.e. not just generalized question(s) about the research area) Background information presented justifies the rationale for the study. The research question(s) give also specify and expected direction of results, defined by specific factors.	Main aim(s)/research question(s) of study are stated and appropriate to background information presented. The research question(s) are more generalized and/or do not offer an expected direction of results.	The study does not have any clear research questions(s) and/or the research question(s) presented is unfocussed and unrelated to the background information of the study	There is insufficient information to rate this criteria or this criteria is not applicable to this study
2. Selection of subjects	Study sample representative of wider LAC population with clear consideration given to maximize inclusion of participants and manage sampling issues. Study participants are selected from source populations that are comparable in all respects other than the factor(s) under investigation Selection bias is not present. The study indicates how many of the people asked to take part did so, in each area of the study and there is discussion of and acceptable justification of any sampling changes made Attrition bias discussed if applicable.	Sample somewhat representative of population of interest with some consideration given to maximize inclusion of participants and manage sampling issues. Sampling issues are discussed but detail and management of these issues is lacking e.g. only some issues are addressed or issues are only partially managed.	Sampling strategy is poorly described and/or sampling process does not adequately address sampling issues. Overall sampling strategy is poor.	There is insufficient information to rate this criteria or this criteria is not applicable to this study

	e.g. What percentage of individuals dropped out and at which stage of the study this occurred; Comparison and identification of any differences between full and partial participants and how this may impact analysis and results			
3. Assessment of study	The outcomes and the criteria used for measuring them are clearly described and are relevant and meaningful to both the intervention and evaluation When comparing groups of participants, the degree of detail collected and method of data collection is comparable for all participants Evidence from other sources is used to demonstrate that the method of outcome assessment is valid and reliable Outcomes are assessed more than once e.g. a variety of measures or at different time points.	Outcome measures are appropriate to research questions and study design, but do not meet all the criteria in the well covered category. Study may include a mix of validated and bespoke measures, provided that bespoke measures are well described, with a clear rational for their development. A measure of internal consistency should be reported and all key measures represent an acceptable level of consistency e.g. Cronbach's alpha value greater than 0.7. If this is not reported, suitable rationale for they the measure is included must be clearly provided.	At least one key measure of the study is not externally validated or well described, or demonstrates poor internal consistency.	There is insufficient information to rate this criteria or this criteria is not applicable to this study
4. Confounding factors	The main potential confounders are identified. At least two potential confounders are taken into account in both the design and analysis (e.g. gender, age, ethnicity, previous history) The report of the study should indicate which potential confounders have been considered, and how they have been assessed, controlled or allowed for in the analysis.	The main potential confounders are identified and some efforts have been made to manage and record these and this has been discussed in the paper. At least one potential confounder is taken into account in both design and analysis.	Key potential confounders are not sufficiently discussed or addressed in the study e.g. potential confounders are accounted not for in both design and analysis.	There is insufficient information to rate this criteria or this criteria is not applicable to this study

5. Data analysis and results	The study meets all the following criteria: a. Results of study relate directly to research question(s) b. Statistical analysis adopted is appropriate to data available and reasons for this choice are discussed c. Results are reported clearly with an appropriate level of information for that analysis (e.g. effect sizes, confidence intervals) d. The relationship between all variables explored in analysis is reported and discussed	Criterion a is met and overall, analysis adds to understanding of research questions. Statistical analysis is appropriate but there is a lack of discussion regarding the choice of statistical design. Overall results are reported but additional information is lacking.	Analysis and reporting of data is poor. Study lacks the use of appropriate and well justified statistical analysis.	There is insufficient information to rate this criteria or this criteria is not applicable to this study
6. Overall generalisability of study	Taking into account clinical considerations, evaluation of the methodology used, and the statistical power of the study, there is good evidence of an association between factors investigated and outcomes. Findings can be generalized to a wider LAC population with reasonable confidence.	Taking into account clinical considerations, evaluation of the methodology used, and the statistical power of the study, there is some evidence of an association between factors investigated and outcomes. Findings may be applicable to a wider, but more specific population e.g. girls in residential care, YP with externalizing behaviour symptoms.	The study design makes it difficult to generalize to a wider population. Conclusions drawn should be treated with caution and contextualized within the study's limitations.	There is insufficient information to rate this criteria or this criteria is not applicable to this study

Appendix E: Participant Information Sheet

Relationships Matter for Young People in Care: An Exploration of Interpersonal Functioning in Looked After and Accommodated Children during Adolescence.

You are being asked to take part in a research study as you are a young person in care who is currently attending Child and Adolescent Mental Health Services (CAMHS). Please read the information sheet below and take time to decide whether or not you wish to take part. You can decide to take part yourself but you may also find it helpful to share the adult information sheet with an adult whom you trust and is responsible for your care in some way.

What is the study about?

Young people in care may feel like they have different experiences to other people their age. You can help adults understand more about how you see the world, what can feel difficult and what your needs are. Although taking part in the research will take up some of your time, the more that young people in care speak to us, the more we can learn about how to best understand and support you. This study would like to listen to young people who are in care aged 13-18, who have already started high school, and who still have some contact with a birth parent.

What will happen if I take part?

We will meet somewhere you are comfortable with and that feels safe to you. Any travel costs you have to pay to take part will be refunded. To say thank you for taking the time to speak to me, you will be provided with a £10 token of appreciation.

The study will take up to 2 ½ hours in total but we can divide this up into shorter meetings if you prefer. You will be asked to fill in some questionnaires and then we will have a chat about your views on things like friendships. I will audio record this chat. Remember it is ok if there are some things you don't want to talk about. It is completely up to you what you choose to share with me.

A list of resources that can offer support will be provided. I will ask you to complete and sign a consent form, to show that you have understood what is being asked of you and that you are happy to take part. You can also opt in to receive a summary of the study, once it is completed.

The personal information you tell me will be kept confidential. It will be stored in a safe place until the project is complete, in line with ethical research procedures. Your CAMHS team will be told that you are taking part in the study, but not what we talk about. If you tell me something that makes me worried about you, or someone else, I might have to tell someone, even if you don't want me to. The reason for doing this is to keep you and others safe. If this happens I will always try to speak to you about it first.

Do I have to take part?

No, it is completely your choice if you wish to take part. If you do choose to take part and change your mind later, that's fine too. If you decide not to take part you do not have to tell me why. Your choice will have no impact on the care you receive from CAMHS.

How do I get in touch?

If you would like to take part in the study, or have any questions I would love to hear from you! My name is Sonal Raithatha and I'm a Trainee Clinical Psychologist.
You can email me on, myvoicematters@ed.ac.uk or call or text me on 07547307126.
I hope to hear from you soon.

Other information:

The study is being carried out as part of my thesis, a research project for the University of Edinburgh that forms part of my clinical psychology training. It is supported by NHS Lothian. It is hoped that the study will be completed December 2019. The project has received ethical approval from The University of Edinburgh, NHS Health Research Authority and relevant local agencies. The research team for this study is:

Sonal Raithatha

Prof. Matthias Schwannauer

Dr. Fiona Duffy

Dr. Emily Taylor

If you would like to contact an academic supervisor of the study, please contact:

If you would like to discuss the study with someone independent of the study team please contact:
Dr. Angus Macbeth
School of Health in Social Science, The University of Edinburgh
Rm 3.06A, Doorway 6, Medical Quad, Teviot Place
Edinburgh. EH8 9AG
Tel: 0131 650 3893 Email:

If you wish to make a complaint about the study please contact NHS Lothian:
Patient Experience Team, NHS Lothian
2nd Floor, Waverley Gate 2-4 Waterloo Place
Edinburgh. EH1 3EG
Tel: 0131 536 3370 Email: feedback@nhslothian.scot.nhs.uk

Please feel free to ask any questions.
Thank you for taking the time to read this information sheet.

Appendix F: Responsible Adult Information Sheet

Relationships Matter for Young People in Care: An Exploration of Interpersonal Functioning in Looked After and Accommodated Children during Adolescence.

You have received this information sheet as you are an adult responsible in the care of a looked after and accommodated young person aged 13-18. They have been asked to take part in a research study and invited to share this information sheet with you. Please discuss any thoughts you might have about participation with the young person. Contact details for further information are also provided.

What is the study about?

This study wants to understand more about the experiences of young people who are looked after and accommodated. It is hoped that by speaking to young people, we can understand more about how they see the world, what can feel difficult and what their needs are. The study is being carried as a research project for the University of Edinburgh and is supported by NHS Lothian. It is hoped that the study will be completed by December 2019.

Why are you asking this young person to take part?

Young people who are looked after and accommodated have often had different experiences to other young people. I am interested to learn more about these directly from young people themselves. This study is recruiting young people aged 13-18 who have already transitioned to high school and who still have some contact with their birth parent(s).

Does the young person have to take part?

No, participation in this study is on a voluntary basis. Non participation will have no impact on the care they currently receive. The young person will only be asked to share information they are comfortable with sharing, and are free to withdraw their participation at any point during the study.

What will happen if they take part?

I will meet the young person at a place that they feel comfortable and safe. I will ask them to sign a consent form. The study will take up to 2 ½ hours in total but can be divided into shorter meetings. They will be asked to complete some questionnaires and then we will have a chat about their views on things like friendships, thinking about how being in care might be important to these discussions. I will audio record this chat. They will be reminded that it is their choice what they share with me and they do not have to talk about anything they don’t want to.

A list of resources that can offer support will be provided at the end of the study. To say thank you for taking the time to be a part of the study, the young person will be provided with £10 as a token of appreciation and any travel costs will be refunded.

What happens to the information they give you?

The personal information the young person tells me will be kept confidential. It will be stored in a safe place until the project is complete, in line with ethical research procedures. The young person's CAMHS team will be told that they are taking part in the study, but not what we talk about. If I am told something that makes me worried about the young person, or someone else, I might have to tell someone, even if they don't want me to. The reason for doing this is to keep the young person and others safe. If this happens I will always try to speak to them about this first. Any concerns will be discussed with my clinical supervisor, who is a clinical psychologist within NHS Lothian. The project has received ethical approval from The University of Edinburgh, NHS Health Research Authority and relevant local agencies.

What will happen to the results of the research project?

Once the study is complete, I will share the findings to try and make sure people interested in this topic can read it if they wish to. All efforts will be made to make sure that the young person cannot be identified. The young person will also be offered the opportunity to receive a summary of the results.

Contact for further information

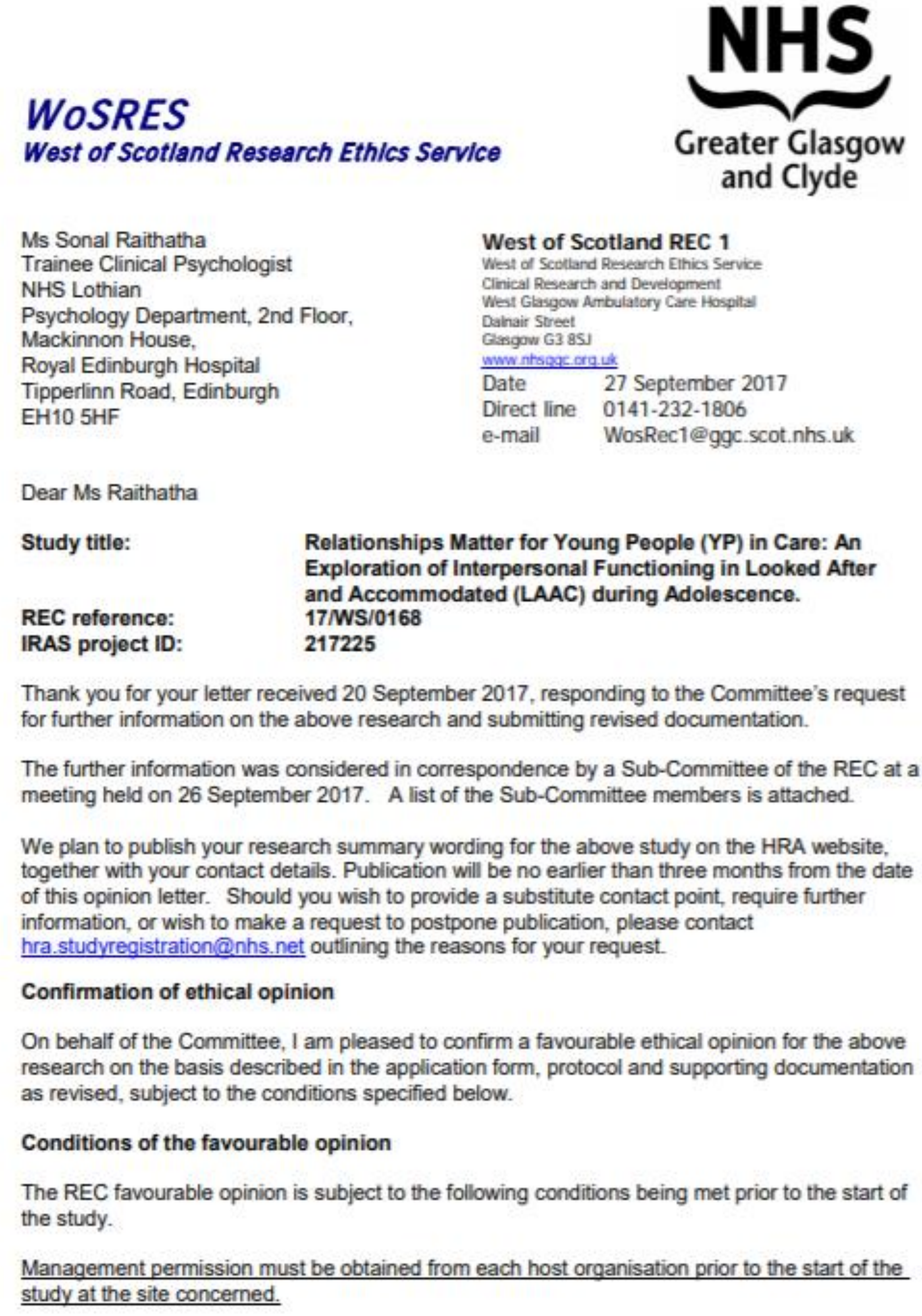
If you have further questions about the study please contact myself, Sonal Raithatha (Trainee Clinical Psychologist) on myvoicematters@ed.ac.uk or <*research mobile number*>.

If you would like to contact an academic supervisor of the study, please contact:
or
If you wish to discuss the study with someone independent of the study team please contact:
Dr. Angus McBeth
School of Health in Social Science,
The University of Edinburgh, Rm 3.06A, Doorway 6,
Medical Quad, Teviot Place, Edinburgh. EH8 9AG
Tel: +44 (0)131 650 3893
Email:

If you wish to make a complaint about the study please contact NHS Lothian:
Patient Experience Team, NHS Lothian
2nd Floor, Waverley Gate, 2-4 Waterloo Place,
Edinburgh. EH1 3EG
Tel: 0131 536 3370
Email: feedback@nhslothian.scot.nhs.uk

Thank you for taking the time to read this information sheet.

Appendix G: Ethical Approvals for Empirical Study



WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow
and Clyde

Ms Sonal Raithatha
Trainee Clinical Psychologist
NHS Lothian
Psychology Department, 2nd Floor,
Mackinnon House,
Royal Edinburgh Hospital
Tipperlinn Road, Edinburgh
EH10 5HF

West of Scotland REC 1
West of Scotland Research Ethics Service
Clinical Research and Development
West Glasgow Ambulatory Care Hospital
Dalnair Street
Glasgow G3 8SJ
www.nhsggc.org.uk

Date	27 September 2017
Direct line	0141-232-1806
e-mail	WosRec1@ggc.scot.nhs.uk

Dear Ms Raithatha

Study title:	**Relationships Matter for Young People (YP) in Care: An Exploration of Interpersonal Functioning in Looked After and Accommodated (LAAC) during Adolescence.**
REC reference:	**17/WS/0168**
IRAS project ID:	**217225**

Thank you for your letter received 20 September 2017, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a Sub-Committee of the REC at a meeting held on 26 September 2017. A list of the Sub-Committee members is attached.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

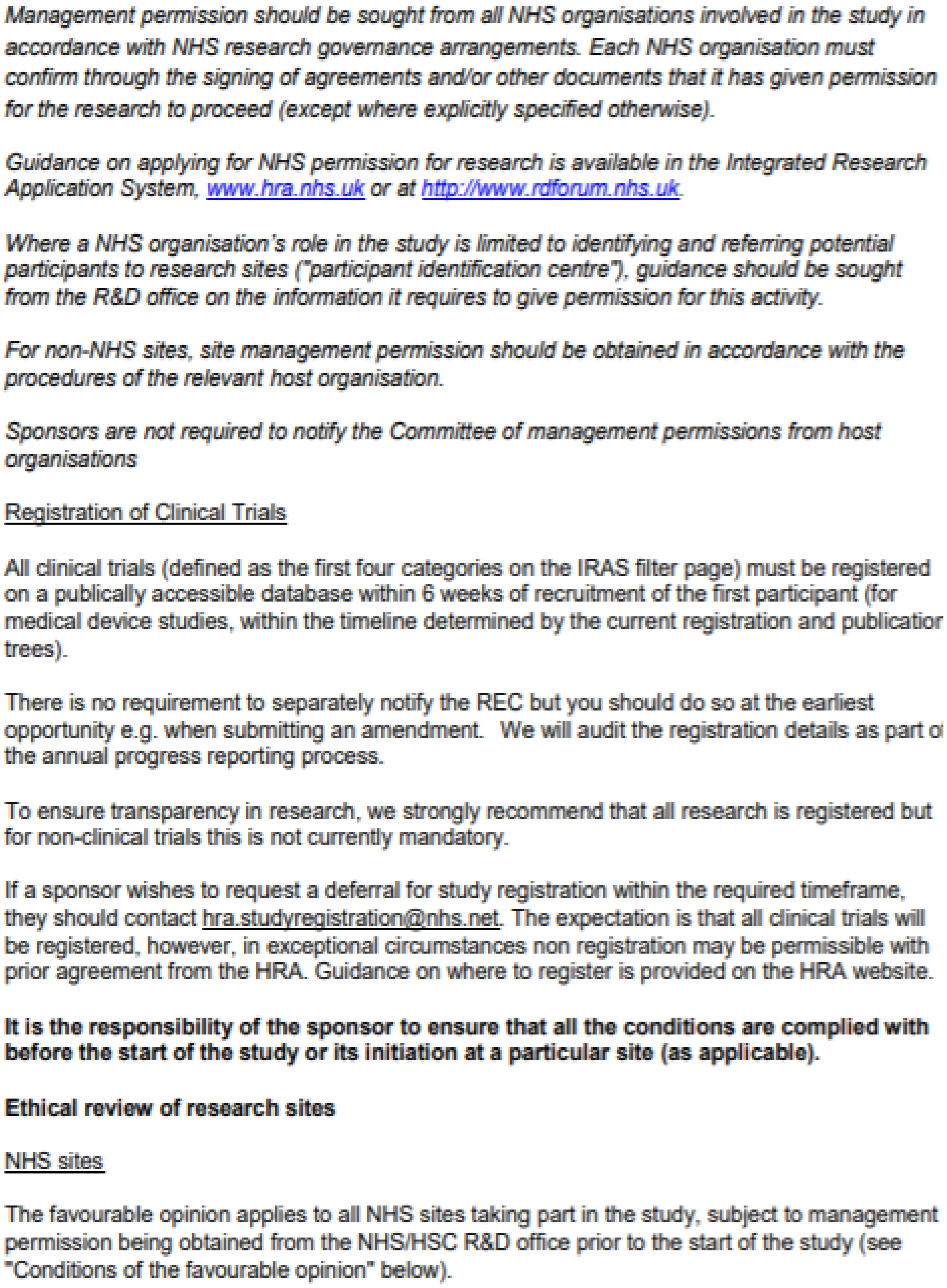
Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.



Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publicatio trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part o the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Interpersonal functioning in LAAC adolescents, CAMHS Recruitment Poster, V1, 23.06.17]	1	23 June 2017
Copies of advertisement materials for research participants [Interpersonal functioning in LAAC adolescents, CAMHS Information Leaflet, V1, 23.06.17]	1	23 June 2017
Covering letter on headed paper [17/WS/0168 response cover letter]	1	17 August 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Certificate of Employers' Liability Insurance]		31 July 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [PL Confirmation]		21 July 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Clinical Trial Liability]		25 July 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional Indemnity Insurance]		25 July 2016
GP/consultant information sheets or letters [Interpersonal functioning in LAAC adolescents, CAMHS Staff Information Sheet, V1, 23.06.17]	1	23 June 2017
GP/consultant information sheets or letters [Interpersonal functioning in LAAC adolescents, CAMHS Staff Participation Letter, V1, 23.06.17]	1	23 June 2017
GP/consultant information sheets or letters [Interpersonal functioning in LAAC adolescents, Capacity Flowchart, V1, 23.06.17]	1	23 June 2017
Interview schedules or topic guides for participants [Interpersonal functioning in LAAC adolescents, Interview Schedule, V1, 23.06.17]	1	23 June 2017
Interview schedules or topic guides for participants [Interpersonal functioning in LAAC adolescents, Interview Schedule, V1, 23.06.17]	1	23 June 2017
Letters of invitation to participant [Interpersonal functioning in LAAC adolescents, Participant Cover Letter, V2, 17.08.17]	2	17 August 2017
Participant consent form [Interpersonal functioning in LAAC adolescents, Participant Consent Form, V3, 20.09.17]	3	20 September 2017
Participant information sheet (PIS) [Interpersonal functioning in LAAC adolescents, Participant Information Sheet, V3, 20.09.17]	3	20 September 2017
Participant information sheet (PIS) [Interpersonal functioning in LAAC adolescents, Responsible Adult Information Sheet, V3, 20.09.17]	3	20 September 2017
REC Application Form [REC_Form_11072017]		11 July 2017
Research protocol or project proposal [Interpersonal functioning in LAAC adolescents, Study Protocol, V2, 17.08.17]	2	17 August 2017
Response to Request for Further Information [17/WS/0168 response cover letter September 2017]		
Summary CV for Chief Investigator (CI) [Chief Investigator CV]		
Summary CV for supervisor (student research) [Supervisor CV]		
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Interpersonal functioning in LAAC adolescents, CAMHS Recruitment Flowchart, V2, 17.08.17]	2	17 August 2017
Validated questionnaire [Inventory of Interpersonal Problems - 32 item version (IIP-32)]		
Validated questionnaire [Psychosis Attachment Measure (PAM)]		

Document	*Version*	*Date*
Validated questionnaire [The Experiences in Close Relationships-Relationship Structures questionnaire (ECR-RS)]		
Validated questionnaire [The Self-Perception Profile for Adolescents]		

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

17/WS/0168	**Please quote this number on all correspondence**

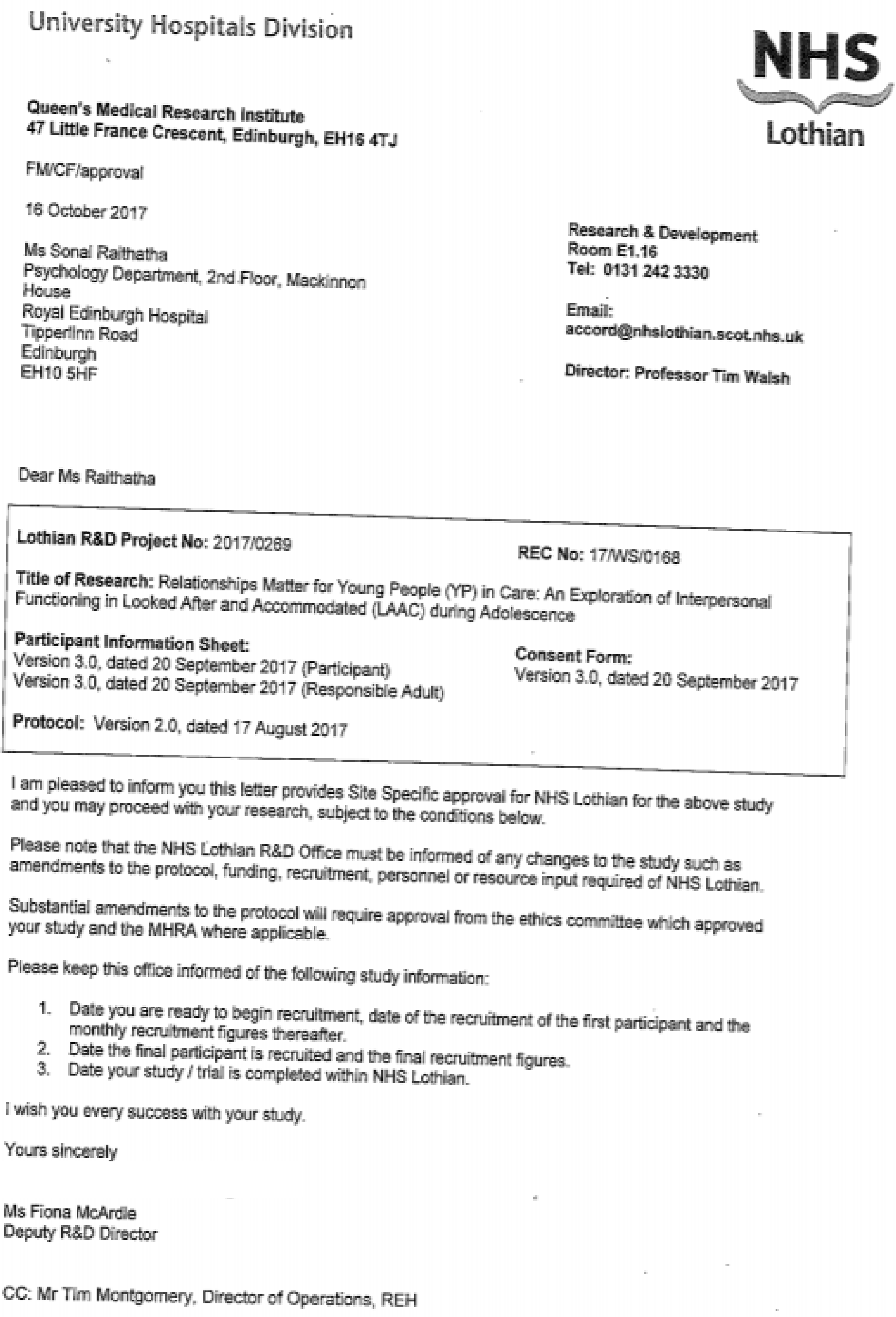
With the Committee's best wishes for the success of this project.

Yours sincerely

On behalf of
Dr Malcolm Booth
Chair

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*
"After ethical review – guidance for researchers"

Copy to: *Ms Charlotte Smith*
Ms Melissa Taylor, NHS Lothian Research and Development Office



University Hospitals Division

NHS
Lothian

Queen's Medical Research Institute
47 Little France Crescent, Edinburgh, EH16 4TJ

FM/CF/approval

16 October 2017

Ms Sonal Raithatha
Psychology Department, 2nd Floor, Mackinnon House
Royal Edinburgh Hospital
Tipperlinn Road
Edinburgh
EH10 5HF

Research & Development
Room E1.16
Tel: 0131 242 3330

Email:
accord@nhslothian.scot.nhs.uk

Director: Professor Tim Walsh

Dear Ms Raithatha

Lothian R&D Project No: 2017/0269

REC No: 17/WS/0168

Title of Research: Relationships Matter for Young People (YP) in Care: An Exploration of Interpersonal Functioning in Looked After and Accommodated (LAAC) during Adolescence

Participant Information Sheet:
Version 3.0, dated 20 September 2017 (Participant)
Version 3.0, dated 20 September 2017 (Responsible Adult)

Consent Form:
Version 3.0, dated 20 September 2017

Protocol: Version 2.0, dated 17 August 2017

I am pleased to inform you this letter provides Site Specific approval for NHS Lothian for the above study and you may proceed with your research, subject to the conditions below.

Please note that the NHS Lothian R&D Office must be informed of any changes to the study such as amendments to the protocol, funding, recruitment, personnel or resource input required of NHS Lothian.

Substantial amendments to the protocol will require approval from the ethics committee which approved your study and the MHRA where applicable.

Please keep this office informed of the following study information:

1. Date you are ready to begin recruitment, date of the recruitment of the first participant and the monthly recruitment figures thereafter.
2. Date the final participant is recruited and the final recruitment figures.
3. Date your study / trial is completed within NHS Lothian.

I wish you every success with your study.

Yours sincerely

Ms Fiona McArdle
Deputy R&D Director

CC: Mr Tim Montgomery, Director of Operations, REH

WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow
and Clyde

Ms Sonal Raithatha
School of Health in Social Science, University of Edinburgh,
Rm 3.06A, Doorway 6, Medical Quad,
Teviot Place, Edinburgh.
EH8 9AG

West of Scotland REC 1
West of Scotland Research Ethics Service
Clinical Research and Development
West Glasgow Ambulatory Care Hospital
Dalnair Street
Glasgow G3 8SJ
www.nhsggc.org.uk

Date	16 April 2019
Direct line	0141-232-1806
e-mail	WosRec1@ggc.scot.nhs.uk

Dear Ms Raithatha

Study title:	**Relationships Matter for Young People (YP) in Care: An Exploration of Interpersonal Functioning in Looked After and Accommodated (LAAC) during Adolescence.**
REC reference:	**17/WS/0168**
Amendment number:	**1;28.03.19 (REC Ref AM01)**
Amendment date:	**04 April 2019**
IRAS project ID:	**217225**

The above amendment was reviewed on 15 April 2019 by the Sub-Committee in correspondence. This amendment proposed that alongside the written summary of the study's results participants will be offered the opportunity to engage in a short feedback exercise with the primary researcher, to reflect on the findings of the study

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

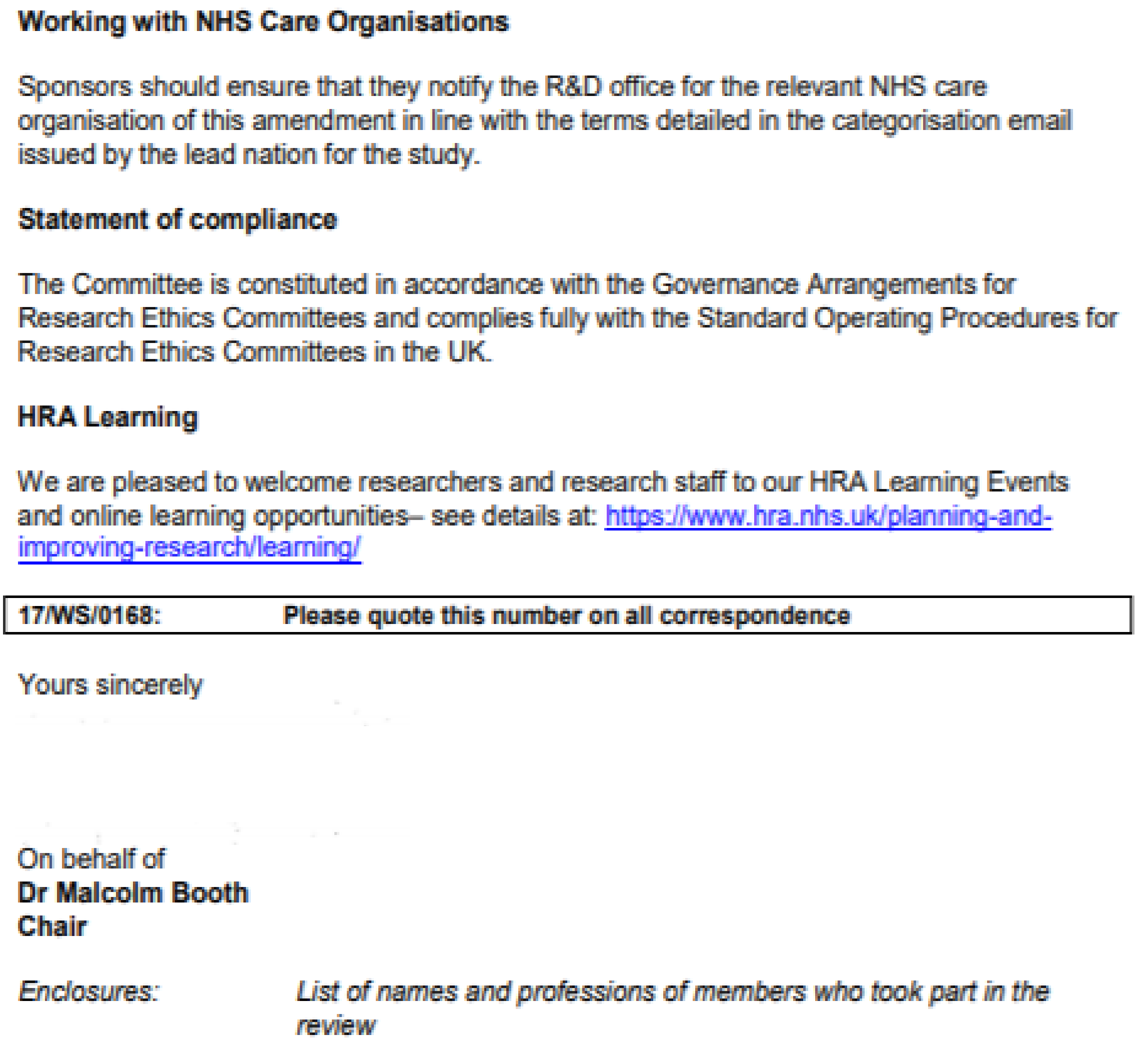
Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Notice of Substantial Amendment (non-CTIMP)	1Ï¼28.03.19 (REC Ref AM01)	04 April 2019
Other [Email clarification re Protocol version number]		09 April 2019
Participant consent form [Follow Up]	1	28 March 2019
Participant information sheet (PIS) [Follow Up]	1	28 March 2019
Research protocol or project proposal	4	28 March 2019

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.



Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

HRA Learning

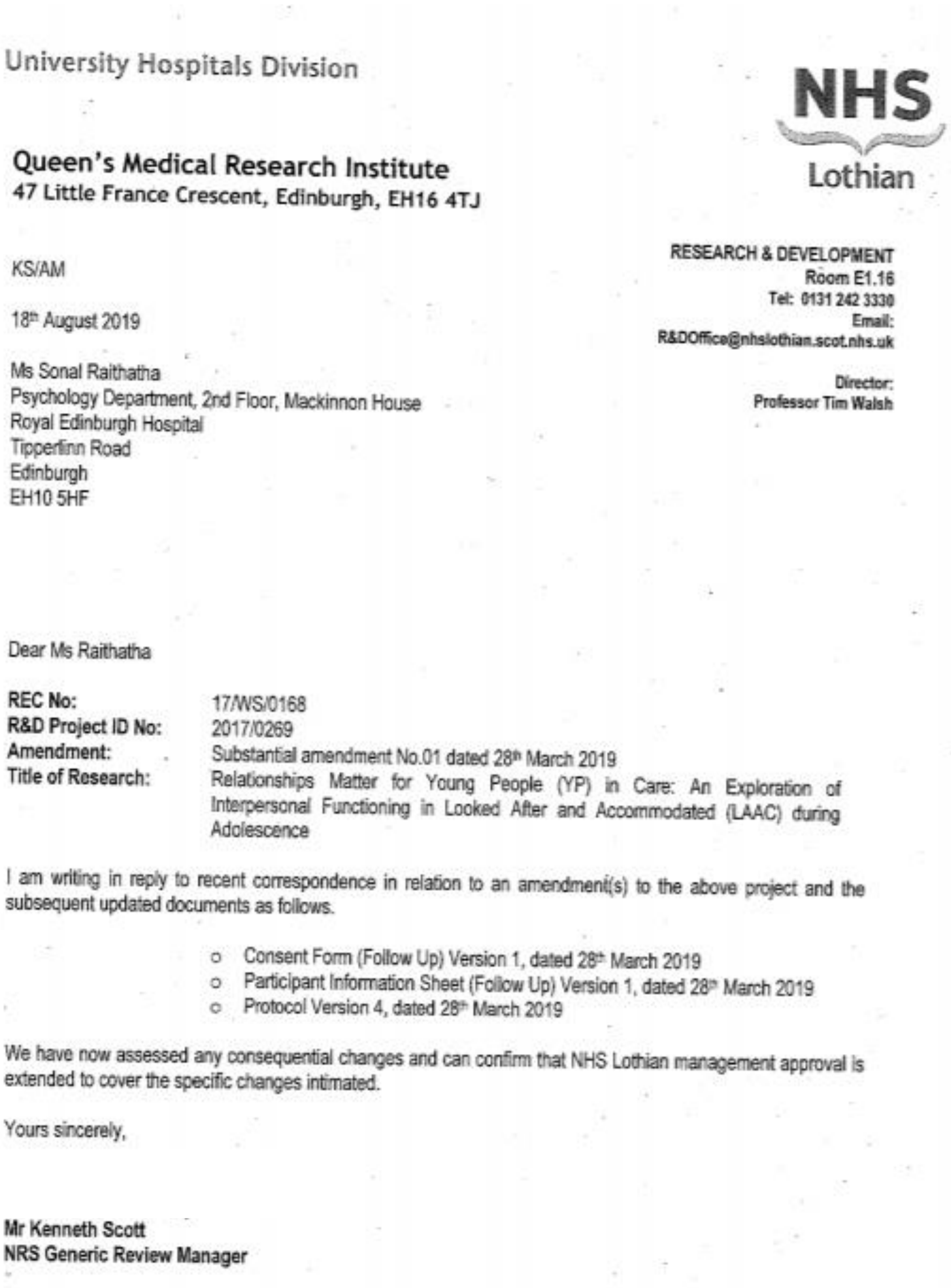
We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

17/WS/0168:	**Please quote this number on all correspondence**

Yours sincerely

On behalf of
Dr Malcolm Booth
Chair

Enclosures:	*List of names and professions of members who took part in the review*



University Hospitals Division

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Room E1.16
Tel: 0131 242 3330
Email:
R&DOffice@nhslothian.scot.nhs.uk

Director:
Professor Tim Walsh

KS/AM

18th August 2019

Ms Sonal Raithatha
Psychology Department, 2nd Floor, Mackinnon House
Royal Edinburgh Hospital
Tipperlinn Road
Edinburgh
EH10 5HF

Dear Ms Raithatha

REC No:	17/WS/0168
R&D Project ID No:	2017/0269
Amendment:	Substantial amendment No.01 dated 28th March 2019
Title of Research:	Relationships Matter for Young People (YP) in Care: An Exploration of Interpersonal Functioning in Looked After and Accommodated (LAAC) during Adolescence

I am writing in reply to recent correspondence in relation to an amendment(s) to the above project and the subsequent updated documents as follows.

- Consent Form (Follow Up) Version 1, dated 28th March 2019
- Participant Information Sheet (Follow Up) Version 1, dated 28th March 2019
- Protocol Version 4, dated 28th March 2019

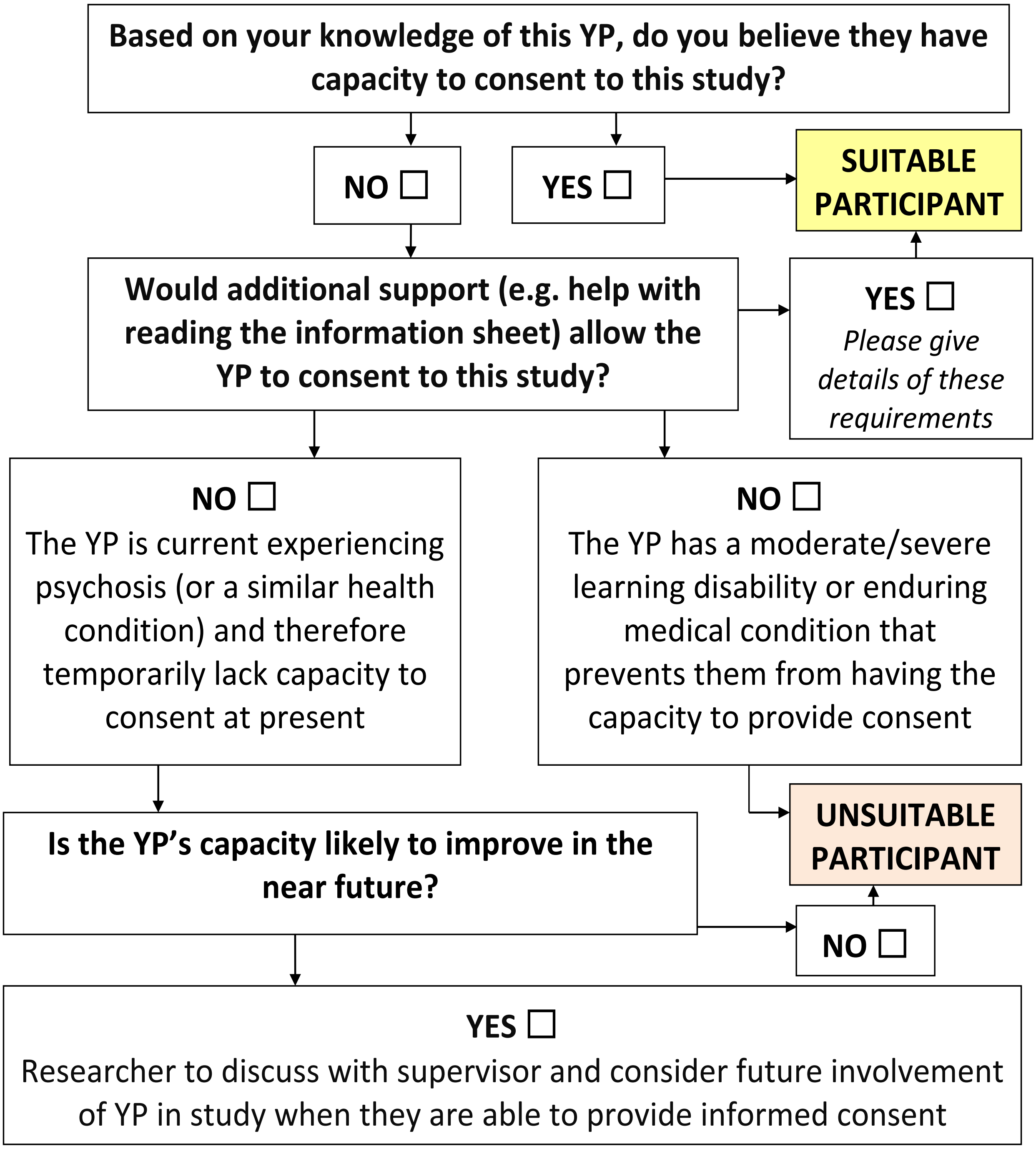
We have now assessed any consequential changes and can confirm that NHS Lothian management approval is extended to cover the specific changes intimated.

Yours sincerely,

Mr Kenneth Scott
NRS Generic Review Manager

Appendix H: Participant capacity flowchart for clinicians

This capacity pathway is intended to help assess a young person's suitability to provide their own informed consent for research. Please use the check boxes provided and sign and date the form below.



Based on your knowledge of this YP, do you believe they have capacity to consent to this study?

NO ☐

YES ☐

SUITABLE PARTICIPANT

Would additional support (e.g. help with reading the information sheet) allow the YP to consent to this study?

YES ☐
Please give details of these requirements

NO ☐
The YP is current experiencing psychosis (or a similar health condition) and therefore temporarily lack capacity to consent at present

NO ☐
The YP has a moderate/severe learning disability or enduring medical condition that prevents them from having the capacity to provide consent

UNSUITABLE PARTICIPANT

Is the YP's capacity likely to improve in the near future?

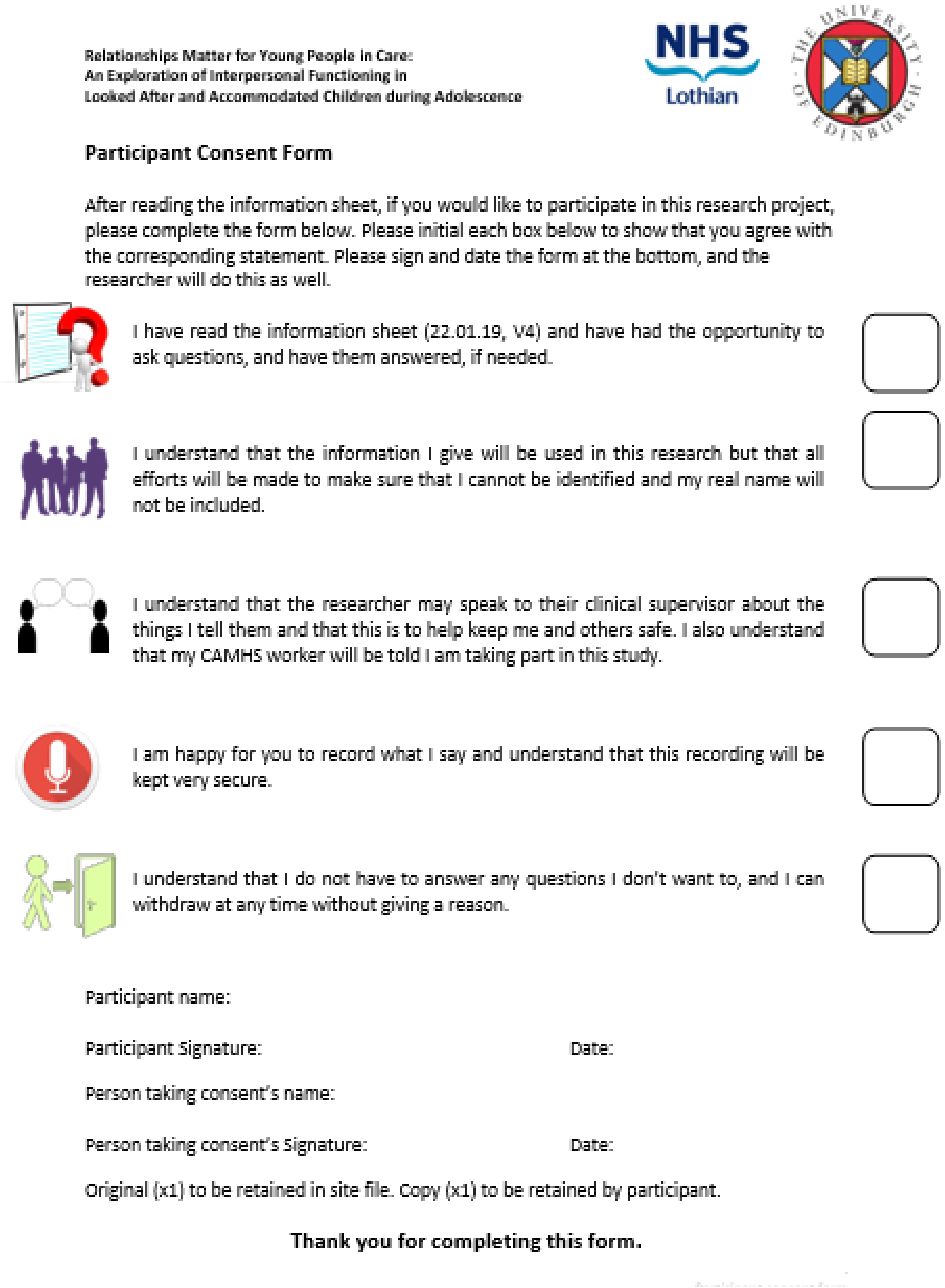
NO ☐

YES ☐
Researcher to discuss with supervisor and consider future involvement of YP in study when they are able to provide informed consent

Pathway completed by (name, job title):

Signed: Date:

Appendix I: Participant Consent Form



Relationships Matter for Young People in Care:
An Exploration of Interpersonal Functioning in
Looked After and Accommodated Children during Adolescence

Participant Consent Form

After reading the information sheet, if you would like to participate in this research project, please complete the form below. Please initial each box below to show that you agree with the corresponding statement. Please sign and date the form at the bottom, and the researcher will do this as well.

I have read the information sheet (22.01.19, V4) and have had the opportunity to ask questions, and have them answered, if needed. ☐

I understand that the information I give will be used in this research but that all efforts will be made to make sure that I cannot be identified and my real name will not be included. ☐

I understand that the researcher may speak to their clinical supervisor about the things I tell them and that this is to help keep me and others safe. I also understand that my CAMHS worker will be told I am taking part in this study. ☐

I am happy for you to record what I say and understand that this recording will be kept very secure. ☐

I understand that I do not have to answer any questions I don't want to, and I can withdraw at any time without giving a reason. ☐

Participant name:

Participant Signature: Date:

Person taking consent's name:

Person taking consent's Signature: Date:

Original (x1) to be retained in site file. Copy (x1) to be retained by participant.

Thank you for completing this form.

Appendix J: Debrief Support Sheet

Where can I go for extra support?

If you feel that you need extra support here are some places you could try:

Safe Adults - are there any safe adults around you that you could talk to, such as a family member or a social worker?

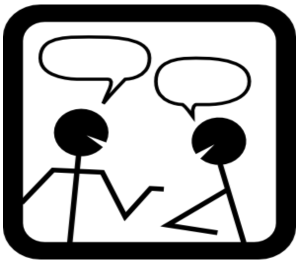
Childline – the childline website www.childline.org.uk has lots of helpful information. You can also arrange email support or access a 1-2-1 counsellor support online chat. You can access this on www.childline.org.uk. You can also call 0800 1111 at any time to speak to someone.

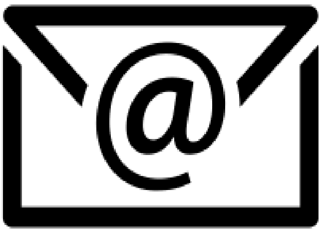
Samaritans are open 24 hrs a day and your call will be answered by a trained advisor on 116 123. Their website is www.samaritans.org or you can e-mail them at jo@samaritans.org

Breathing Space is a free helpline for people in Scotland. You can speak to a breathing space advisor from 6pm-2am Monday to Thursday, and 24 hrs a day from Friday evening to Monday morning on 0800 83 85 87. There is also lots of information on their website www.breathingspacescotland.co.uk

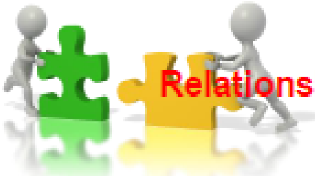
NHS 24 is a general medical helpline on short code 111. Or you can visit www.nhs24.com

Mental Health Assessment Service (MHAS) based between the Royal Edinburgh Hospital (REH) and the Edinburgh Royal Infirmary (ERI). This service operates 24 hrs per day, 365 days of the year. If you feel in crisis, call 0131 537 6000 to speak to someone who can help.

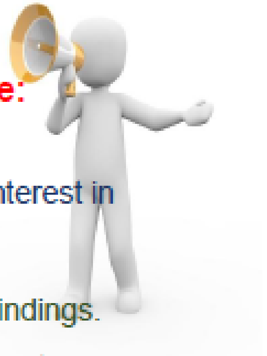




Appendix K: Feedback Follow up Participant Results Summary Sheet



Relationships Matter for Young People in Care: A Reserach Study



Thank you again for taking part in this study and for your interest in the findings. This is a summary of those findings.

It would be great to hear any thoughts you have on these findings.

Please read the information sheet if you are interested in doing this.

This study spoke to 14 young people who have different experiences of living in care. Here are some of the main themes that came from these conversations overall:

Relationships with people the **same age** can be hard. These can sometimes lead to **feeling judged or bullied**

As a result of **different life experiences**, care-experienced young people are **unique** to their peers. This can sometimes lead to feeling **different** to others

Some really **difficult and traumatic experiences** have happened in the past. Understandably, this can still **have an impact** on relationships today

Relationships with **birth parents are complicated.** This is normally the case whether or not they feel positive overall

Difficult past experiences, especially with **birth parents,** can make it feel **hard to trust people**

Feelings of **anger** can happen a lot and these can sometimes be **hard to control.** This can also be **linked to other emotions,** such as feeling upset.

Trust is key! It is the most important thing in relationships, but often the most difficult. Trust is about knowing that **someone won't tell others things they have been told in confidence,** and feeling able to depend on them not to be judgemental

Difficult early experiences can **impact on current relationships.** There was **good awareness and understanding** of this link.

Helping others and putting **others needs first** can often happen

Explaining opinions and feelings to others can feel difficult, even if the **feeling itself is really strong**

Coping with problems alone, rather than needing to depend on others, is preferable.

When it has been **hard to depend on others** in the past, it can be hard to want to build new relationships

Humour or sarcasm are often used when describing difficult thoughts and feelings. This might make it feel easier to talk about certain things

While some relationships feel difficult, others can feel **more positive.** These can be with people like friends, siblings or trusted adults.

Taking part in this study felt important because by **going through lots of different experiences,** there was a desire to be able to **help others** who might be going through similar things.

There were examples of reflections on **personal strengths** and **ways of coping really well.** This was both currently and in the past.

Making use of **positive relationships with** others, can help to **meet different needs,** in different ways

Appendix L: Feedback Follow up Participant Information Sheet

Relationships Matter for Young People in Care: An Exploration of Interpersonal Functioning in Looked After and Accommodated Children during Adolescence:

FOLLOW UP

You recently took part in a research study. I asked you about your experiences and about important people in your life. I used your words and those of other young people to look for patterns and common experiences. I have written a report to help adults understand more about ways to support people in care. You asked to receive some information about the results of the study once it was completed. These have been supplied with this sheet.

I would now like to invite you to take part in a feedback exercise about these results. This will involve you answering a few short questions about what you think of the results. It should take no longer than 20 minutes of your time. We can meet in person, or chat over the phone if you prefer. Just like before, all your information will be kept very secure and all efforts will be made to make sure that you cannot be identified. This feedback exercise is to help get a sense of if the study's findings feel meaningful and relevant to young people. Findings from this will be included in the final study report.

It is completely your choice if you wish to take part. If you do choose to take part and change your mind later, that's fine too. If you decide not to take part you do not have to tell me why. Your choice will have no impact on the care you receive from any service, or in your previous involvement in the study.

If you are happy to take part, you can email me on myvoicematters@ed.ac.uk or call or text me on 07547307126. These are the same contact details as before.

Sonal Raithatha
Trainee Clinical Psychologist

If you would like to contact an academic supervisor of the study, please contact:

If you would like to discuss the study with someone independent of the study team please contact:
Dr. Angus Macbeth
School of Health in Social Science, The University of Edinburgh, Rm 3.06A, Doorway 6
Medical Quad, Teviot Place, Edinburgh. EH8 9AG
Tel: +44 (0)131 650 3893. Email: angus.macbeth@ed.ac.uk

If you wish to make a complaint about the study please contact NHS Lothian:
Patient Experience Team, NHS Lothian, 2nd Floor, Waverley Gate
2-4 Waterloo Place, Edinburgh. EH1 3EG
Tel: 0131 536 3370 Email: feedback@nhslothian.scot.nhs.uk

Please feel free to ask any questions.
Thank you for taking the time to read this information sheet.

Appendix M: Interview Schedule

INTERVIEW SCHEDULE

Themes to explore:

- Important people in the young person’s life
- The relationship qualities young people value
- How young people see themselves in relation to their peers
- How satisfied YP are with their current relationships
- How young people describe similarities and differences between parental and peer relationships
- Identity development in relation to peer relationships
- How young people relate differently to their parents and peers

Example opening questions:

Can you tell me a bit about the relationships you have with others in your life at the moment?

What qualities are important to you in a friend/parent?

Could you give me an example of a time when you have found a relationship difficult?

Do you think you see your friends in the same way you see your parents?

Do you see yourself as similar or different to your peers? In what ways?

Are you happy with the relationships in your life at the moment? Why?

How do you think your experiences with your parents affects how you relate to other young people?

Example follow-up questions:

That sound interesting, could you tell me some more about it?

How do you feel when you talk about that?

What helps you to manage x?

Are there any things about x that you would change?

That sounds quite important to you. Would you mind explaining this idea in more detail?

Example ending Questions:

We’ve spend some time talking about x. Is there anything about this that you would like to reflect on further?

Is there anything else you think we should talk about, so that I can understand how you feel about this area better?

How do you think your experiences influence how you feel about others?

How have you found talking about these things today? Did it make you think about anything you haven’t considered before?

What do you think are the most important points from what we talked about today?

Is there anything that we have talked about today that makes you feel worried?

We have talked about some personal areas today which might have been difficult. Do you feel you need any extra support?

Are there any questions you would like to ask me?

Do you have anything you would like to tell me about how you have found participating in this study?

Appendix N: Examples of Reflective Memo Writing

Reflective memo written August 2019

Reflecting on these interviews, I realize how difficult it is for me to strike the balance between being a clinician and a researcher. While I understand my role in these interviews and the function of them is different to clinical work, it is hard for me to not sometimes slip into that more clinical role when presented with such vulnerability. I have found this to some degree in all the interviews so far, but particularly with Lewis and Freya. Perhaps because their trauma felt more uncontained and present to me in the room. I find that I am automatically starting to build a picture of the young persons life, and a formulation of their difficulties in relation to this. It is important for me to take a step back from this to ensure that I am not hindering data collection. I remind myself why I am doing this research project and that while staying in the 'researcher' position can feel counter intuitive at times, it is important to allow me to really hear what the young people are saying. It is important that this interview feels different to them to clinical support appointments they have had in the past, or are having currently.

Memo written while transcribing Lucy's interview

When listening back to this interview I am struck once again by how dismissive Lucy is. In the room I noticed a real felt sense to push me away from her, to make sure she didn't share too much. It was at these times she felt most vulnerable. I also wonder about my multiple attempts to ask for examples, met throughout by 'I don't know'. Is this her saying that she doesn't want to, or feel able to, tell me? Or does she not know because it is hard for her to link together how she thinks and feels, with experiences in her life. This feels like a pattern with many of the interviews, particularly with participants Georgina and John. Despite this though, she is able to offer a clear explanation for this – that she keeps people at a distance because all relationships end so ‘what’s the point’. Have examples led to her developing this insight and now holding those examples at the forefront of her memory is too difficult, so she just holds onto the meaning she has made? Or has this come from input from professionals around her? Either way, it feels like she really connects to this belief and uses this to get by day to day. It feels like this interview is a snapshot into her interactions with others, and I am left wondering if others experience this barrier in the same way, and if this coping mechanism (as I perceive it) stops her being able to access any meaningful attachment bonds with others.

Memo written after completing Connor’s interview

This interview has really made me reflect on ASD as a potential diagnosis for a number of young people that have taken part so far. Five of the 11 young people have made reference to this diagnosis, as something that has been suggested to them by professionals, with one young person being given this diagnosis. In the majority of these interviews I can see traits of these characteristics and understand why this has been suggested. However, with the exception of one young person, I am also struck by which the level to which all of these participants present clearly to me as young people who have experienced complex trauma. From these interviews there appears to be a drive in this population for the young people to understand why they are the way they are. On the whole, they seem to have made links between their early attachment experiences and their interpersonal functioning now. I wonder about the role diagnosis could have on this. The one young person with this diagnosis made links throughout their interview with their difficulties and this being due to their autism, rather than their early attachment experiences. I find myself wondering if there is a danger of diagnosing trauma as a neurodevelopmental difficulty, rather than an adaptive response to adverse events? Or could this highlight the overlap between early trauma and neurodevelopmental damage? Or do my own research interests in trauma influence me in a way that means I see the trauma before the potential neurodevelopmental difficulty?

Memo written during reflection on focused coding in September 2019

I have categorized this set of examples as positive rather than dismissive, largely due to the felt sense when they were said. They felt different to other examples where young people have said ‘they don't care’, but it really felt like they did, it felt more vulnerable. If reading these alone in the transcripts they could potentially be coded in this same way. So these particular examples are coded, in part, in line with the interaction with me as the interviewer. It is important to be mindful of this. I wonder how this plays out in everyday interactions. How do services etc react to this? Does this link to feeling let down by services vs. them feeling helpful? E.g. Sally – she is quite matter of fact in her requests and feels that services meet specific needs. vs. Lucy who has a very dismissive attachment style, is very negative about her experience of services but always saying ‘I'm fine, I don't mind’ vs. Annie who is very angry towards services for not meeting her needs.

Appendix O: Empirical Study Protocol (Updated Version)

Title: Relationships Matter for Young People (YP) in Care:
An Exploration of Interpersonal Functioning in Looked After
and Accommodated Children (LAAC) during Adolescence.
Researcher: Sonal Raithatha (Trainee Clinical Psychologist)*
Academic Supervisors: Dr. Emily Taylor (Lecturer in Clinical Psychology) and Dr. Matthias Schwannauer (Professor of Clinical Psychology)
Clinical Supervisor: Dr. Fiona Duffy (Consultant Clinical Psychologist)
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List of Abbreviations

YP – Young People
LAAC – Looked After and Accommodated
IIP -32 - The Inventory of Interpersonal Problems – 32 item shortened version
PAM - Psychosis Attachment Measure
ECR – RS - The Experiences in Close Relationships-Relationship Structures questionnaire
NHS – National Health Service
CAMHS – Child and Adolescent Mental Health Service

Summary

This research project proposes a mixed methods study to better understand how looked after YP conceptualize parental and peer relationships and the role this can play in identity development. Relationships are a key area of functioning for adolescents, with suggested links to positive well-being, good mental health and resilience factors. Currently, there is a significant lack of rigorous research in this area, despite the well documented difficulties with interpersonal functioning in this population. LAAC young people will be asked about their experiences of parental and peer attachments. The study will adopt a mixed methods approach, making use of qualitative grounded theory methodology and four validated outcome measures. A clear consideration of methodological and ethical procedures is presented.

Introduction

It is estimated that there are 15,404 LAAC children within Scotland (Scottish Government, 2015a). Disrupted attachment processes at a young age have a profound and long term impact on later functioning in a number of areas throughout life (Audit Scotland, 2010; Elsley *et al.,* 2007; Scottish Government, 2015b). These include affect regulation (Mikulincer *et al.*, 2003), risky behaviour (Allen *et al.,* 2008), interpersonal functioning (Johnson *et al.*, 2002), development of self concept (Cicchetti & Toth, 2005) and this group are up to four times more likely than peers to develop mental health problems (Bazalgette *et al.*, 2015). This there is a clear need to understand the complex psychological mechanisms that apply to functioning in this at risk population, in order to ensure that our interventions are effective and relevant.

An emphasis is often placed on addressing attachment in LAAC YP, due to an increased risk of attachment related difficulties (National Institute for Health and Care Excellence (NICE), 2015) and a positive relationship with an attachment figure in adolescence can increase functioning in a number of key areas (Mastern *et al*., 1990; Rice, 1990) including mental health (Furnivall, 2011) interpersonal functioning (Meadows *et al*., 2011) and psychological adjustment (Noom et al., 1999). As developmental tasks in adolescence are often resolved within attachment relationships (Rice, 1990), difficulties in this area can have a global impact on functioning and the link between insecure attachment and increased risk of the development of psychopathology is well supported (Brumariu & Kerns, 2010; Johnson *et al*., 2002; Mikulincer & Shaver, 2007; Rosenstein & Horowitz, 1996). Identity development begins in early childhood, when an individual begins to distance themselves from their caregiver and develop a separate self concept (Mahler, 1975). This separation-individuation process that begins in early childhood, can undergo a second phase in adolescence (Blos, 1967), allowing YP to shed earlier dependencies and move towards a position of adulthood (Doctors, 2000). Unstable attachment experiences and inconsistent care can disrupt the identity development process. While normative identity development is linked to healthy psychological adjustment (Rice *et al.,* 1995), disruption can lead to difficulties in emotional regulation (Boles, 1999), mental distress (Boles, 1999) and challenging behaviour (Blos, 1967).

Classic attachment theory states that in childhood, internal working models create a blueprint of how relationships look (Bowlby, 1969). These are carried forward as the child develops leading to attachment difficulties in adolescence, (Cicchetti & Toth, 2005; Malekpour, 2007), a time when this group occupies a more central role in YP's relational network (Helsen et al., 2000). However, longitudinal evidence suggests that differentiated attachment styles to parents and friends are seen in adolescence (Doyle et al., 2009), suggesting that YP are able to relate in different ways to the people in their lives. This theory is particularly salient for LAAC populations who are less likely to have had consistent attachment figures throughout their lives. As we do not yet know to what extent and in what ways peer relationships in LAAC YP are influenced by parental attachment experiences, an exploration of this area clearly warrants further exploration.

Existing literature tells us that LAAC YP are able to articulate their needs and that using an attachment framework is a useful way to understand difficulties in this population. In fact, opportunities to explore and make sense of identity and relationships is put forward as a NICE (2013) quality standard for this population. While a number of reports express the views of YP, more data demonstrating how relationships are understood directly within this group is needed. Existing literature does not adequately investigate the psychological mechanisms that might be underpinning the discourse captured in current reports, particularly in relation to adolescent attachment and identity. Similarly, while the link between adverse early experiences and attachment difficulties is well explored, how LAAC YP conceptualize parental and peer relationships specifically, particularly in regards how they might be considered differently by the same young person, has not been adequately explored. In addition, how identity development may be playing a role in this interpersonal functioning is a novel area of research.

This study will aim to address the outlined research and knowledge gap. The principal research question for this study is 'how do LAAC YP conceptualize parental and peer relationships?' As a secondary research question, it will investigate 'how has the experience of being in care impacted upon identity development in relation to peer relationships?'

Methodology

This study proposes a mixed methods approach. Qualitative interviews, analyzed within a grounded theory framework will explore emerging themes and gather information developed from the YP's own understanding and experiences. Four quantitative standardized outcome measures will be utilized. Quantitative data collected in the study will be coded alongside qualitative data in line with the process and principles of grounded theory. The descriptive information obtained from the quantitative outcome measures will be used alongside qualitative data to explore themes that emerge from the data. This will add to the richness of the data obtained for each participant, better informing the study and helping to directly address the research questions.

Data collection will take place in an outpatient CAMHS clinic setting, or a location identified as familiar and convenient to the young person, and a safe environment in which to carry out this study. Data will be stored according to NHS Lothian and University of Edinburgh policy. Total participation time for the whole study, including obtaining informed consent is expected to be no longer than 2.5 hours.

Design

The study can be completed in one session, or split over multiple sessions. This will be collaboratively decided with the participant, based on their needs. Difficulty concentrating for an extended period of time, fitting participation around other the individual's other commitments and participant preference will all be factored into this, and the researcher will be flexible in order to accommodate participation. If splitting participation time, all data collection for that participant will be completed within one month.

The interview it is an opportunity to establish rapport with the young person, to ensure they feel at ease to share their thoughts with the researcher in a way that is safe and contained. Some basic normative information regarding the level and type of contact they currently have with their birth parent(s) will be gathered. Outcome measures will be given to the young person to complete. Following this, a qualitative interview based on a grounded theory methodology will be undertaken.

Methods

Participants

An optimal sample size for grounded theory research remains a debated issue (Baker & Edwards, 2012). It is contingent on a number of issues including the range of data offered by participants (Starks & Trinidad, 2007), the research area of interest itself (Charmaz, 2014) and practical considerations such as time, available resources and the views of stakeholders involved in support the research (Baker & Edwards, 2012). A review of 100 articles that employed a grounded theory approach found that the range of total participants was 5 – 114, with 25 being the average number, leading to the suggestion of 30 participants as a suitable reference point (Thomson, 2011). Suggestions offered specifically for students have been put forward, with 20 suggested for an MA thesis (Baker & Edwards, 2012). In an exploration of data saturation to attempt to answer this question, Guest and colleagues (cited in Charmaz, 2014) concluded that 12 interviews are sufficient for most researchers. Taking into account available resources and the timescales, this project shall therefore hope to achieve a sample size of 12 – 20 participants, aiming for the upper end of this range to allow for some attrition if this occurs. Given the individualized nature of this population, it is hoped that this will allow for some consensus of findings to allow a valid contribution to the evidence base to be put forward.

It is anticipated that all data will be collected from YP currently residing within Lothian. This will include the City of Edinburgh, East Lothian, Midlothian and West Lothian regions. An equal distribution from these areas will not be a requirement of the design. NHS recruitment will take place through the NHS Lothian CAMHS service.

Using the most recent statistics published by the Scottish government (2015a), the estimated number of LAAC children, excluding those looked after at home by their parents, is 1740 across Lothian. This has been calculated using the figures available for each of the four local authorities (with all calculations rounded to the nearest whole number). Using statistics for age breakdown of LAAC children across Scotland, it has been further calculated that approximately 41% of the total number fall into the 12-17 age category, suggesting that there is currently an estimated 713 LAAC young people (excluding at home care) aged 12-17 across Lothian. This figure excludes 18 year olds as they fall into the 18-21 category and data is not available to calculate those eligible for this study separately. Taking the midpoint of the target sample size of 12-20, and the estimate of 713 LAAC YP, approximately 2.25% of this population would be required to take part in the study to achieve a total sample of 16 participants.

There are a number of barriers in obtaining participants from this population, including reluctance from carers to support participation in the research (Thomas & O'Kane. 1998). In addition, it is expected that exclusion criteria will affect this 2.25% figure, as a number of the potential pool of 713 participants will not be eligible to participate. Due to a lack of data, it is not possible to calculate this figure accurately. For example, approximately 10% of this population (calculated based on an average of figures available for the four Lothian regions) fall into the category of addition support needs (Scottish Government, 2015a). However this has a wide definition that includes categories such as mental health difficulties, and therefore while it is expected that some of this 10% will meet exclusion criteria, many of this group will still be eligible to participate.

Inclusion criteria:
The young person must have already transitioned to high school (though they not need to be actively attending) and be no older than 18 years of age (i.e. they can participate up until the day before their 19th birthday). They must have some contact with their birth parents from whom they have been removed. This may be supervised or unsupervised, and could take the form of face to face direct contact, phone contact, online contact, or a mixture of these. There is no minimum requirement of time that they have been looked after and accommodated. Young people who are looked after in foster care placements (temporary or permanent), secure units, residential units and in kinship care placements are all eligible for this study.

Exclusion criteria:
YP looked after at their birth parent(s) home will be excluded. This is because this study is researching relationships specifically in YP who have been removed from their birth parents. This study is exploring the research questions in a non forensic population and as such, YP in young offenders units will be excluded. The presence of a severe learning disability will lead to exclusion due to potential issues with communication and informed consent. It is important that the YP has the ability to respond to written questionnaire items and verbal questions. These will require a particular level of cognitive function to answer. In addition, the researcher will use their clinical judgement to identify if a participant's vulnerability is at a level that it is believed that participation in the study would be harmful. This includes participants for whom there is a significant level of distress or risk, for whom participation may impact on their current safety.

Measures

The approach of this interview is exploratory. Principles of intensive interviewing will be adopted, facilitating an open-ended, shaped but emergent approach. An interview schedule outlines a flexible structure. It highlights themes addressing the research questions in the hope that data will emerge organically through the interview process. A relationship mapping exercise will be used to help engage YP in the interview. This will involve the YP drawing a diagram to represent who is in their lives and how they see their relationships with these people to be. It is anticipated that this tool will allow for more detailed discussions to develop. The four outcome measures involved in this study are detailed below.

- The Self-Perception Profile for Adolescents (Harter, 2012)

This outcome measure was chosen as it offers a valid and representative approach to capture how adolescents specifically define themselves. It was developed specifically for adolescents and a slightly adapted version yielded an 80% response rate on a large sample of YP from the Lothian region (Hoare et al., 1993). While a shortened version of this questionnaire is not supported by the author, it is suggested that entire subsets can be excluded. Based on the research questions put forward in this study, the global self-worth subscale shall be used alongside the domain specific subscales of social competence and close friendship. In total, this makes 28 items. Two statements are presented to the young person, of which they pick the one they most agree with. These are then scored as ‘really true for me’ or ‘sort of true for me’, via a tick box. Each question is scored along a continuum of 1 to 4. Cronbach’s alpha values of internal reliability fall between 0.77 and 0.9, representing good reliability (Harter, 2012). This paper also found that convergent validity demonstrated correlations of 0.68 between the social competence subscale and Marsh’s peer relations subscale and of 0.56 between the global self-worth subscale and Marsh’s general self-concept subscale.

- The Experiences in Close Relationships-Relationship Structures questionnaire (ECR-RS) (Fraley et al., 2011)

This 9 item self report measure looks at attachment styles across four different types of relationships: mother, father, romantic partner, and best friend. YP will be asked to use the 9 item measure to rate parental relationships (as a whole) and peer relationships (as a whole). As this study is assessing parental and peer relationships comparatively, the presentation of this will be adapted from the original measure to have separate columns to allow rating of these two groups at the same time, rather than consecutively. This method will be piloted with a service user group. While there are some limitations to this abbreviated measure, it allows for a comparative measure of parental and peer relationships in a way that directly contributes towards the research questions. Furthermore, it is relatively short which is an important consideration when assessing the demand placed on participants to engage.

- Psychosis Attachment Measure (PAM) (Berry et al., 2006)

The PAM is a continuous 16 item self report measure comprised of 8 questions relating to avoidant attachment and 8 items to insecure attachment, with higher overall scores indicating higher levels of insecure attachment. It has good psychometric properties, with Berry and colleagues (2006) reporting good concurrent validity against the Relationships Questionnaire (Bartholomew & Horowitz, 1991) and good internal consistency with cronbach’s alpha calculations of 0.82 for anxiety dimensions and 0.75 for avoidance dimensions. In addition, positive associations between non-clinical psychotic phenomena (including self concept and interpersonal functioning) and insecure attachment were found. While this measure was developed specifically for a psychosis population, there are clearly parallels between the experiences of a psychosis population and a LAAC population, including early adversity, traumatic life events and the experience of being in care itself (Gumley et al., 2014). The phrasing of this questionnaire makes it more accessible than alternatives, given the typically lower educational outcomes in LAAC populations (Scottish Government, 2015b). The measure is relatively easier to administer than alternatives in this area and has been used with success in previous research, in a population of vulnerable Scottish adolescents (M. Schwannauer, personal communication, 31 May 2016).

- The Inventory of Interpersonal Problems – 32 item shortened version (IIP-32) (Barkham et al., 1996)

This measure aims to capture the interpersonal strategies of an individual, in particular difficulties due to under or overdeveloped approaches. The IIP-32 (Barkham et al., 1996) was developed within the UK and is suggested to function comparably to the longer version it was developed from, being easier to administer and score, and overall providing a viable alternative to the more cumbersome earlier versions (Hughes & Barkham, 2005). It includes 32 items in which individuals state how much they agree with a statement on a 5 point scale. An overall score, composed of 8 subscales can be obtained. Overall reliability analysis for this scale is good (α=0.86) with an effect size of 0.91 (Barkham et al., 1996). Unfortunately, the scale was not validated against any external measures during its development. In regards to recent research, the IIP-32 has been used with vulnerable adolescents in a number of studies, included inpatient samples (Hagerty *et al.,* 2013) and YP displaying psychopathology (Wright *et al.*, 2005).

Procedure

The process by which participants will undertake the study is outlined below. This refers to participants recruited from NHS Lothian CAMHS.

1a. Potential participants identified and contact through Trak alert:
The researcher will use the existing Trak looked after children alert, to generate a list of looked after YP who are open to CAMHS at that time. This will include YP who are on the treatment waiting list and YP who have active caseholders. The CAMHS workers of YP who fall within the age parameters of this study will be contacted to highlight the individual that could be a potential participant in the study. If they feel the YP has capacity to consent to the study, they will be asked to share the participant cover letter and participant information sheet with the YP. While YP are able to consent for themselves to this research study, they are encouraged to share the responsible adult information sheet with an adult responsible for their care. This recruitment strategy has been approved by the NHS Lothian CAMHS clinical lead.

1b. Potential participants who learn of study through posters/CAMHS worker:
Posters/leaflets will be made available in CAMHS waiting rooms. CAMHS workers may also approach YP to discuss the study.

2. YP identifies their interest in the study.
This can be done either through their CAMHS worker, who can make contact with the researcher on the YP's behalf, or the YP can contact the researcher directly. Participants will be briefly screened at this stage to identify if they meet inclusion/exclusion criteria. This can be done directly with the YP directly, or with their CAMHS worker if they have the information required for this. If the YP does not have access to the information sheet and responsible adult information sheet, all attempts will be made to make this available to them prior to the next stage of the procedure.

3. Researcher meets with YP
The researcher will meet with the YP to discuss the study and the informed consent process. The researcher will introduce themselves and explain that they are a trainee clinical psychologist, attending the University of Edinburgh and employed by NHS Lothian. If the YP has not been provided with an information sheet prior to this stage, they will be given this for a minimum of 24 hours before undertaking the next stage of the study. It will be checked that they meet the inclusion/exclusion criteria for this study and are able to provide informed consent. If it is felt

that the young person does not have capacity to consent to the process, any reasonable adjustments to support this will be explored. If following this they are still unable to provide consent, they will be excluded from further stages of the study. If they are likely to be able to provide this in the future, this will be monitored by the researcher. Prior to commencing data collection with a participant, it will be confirmed in writing that the individual's CAMHS worker has no concerns about their capacity to consent to the study.

4. Informed consent form
   YP are able to provide their own informed consent for this study, so long as it is felt by the researcher and their keyworkers that they are competent to understand the research proposal and thus able to make an informed decision of whether or not they would like to participate. NHS Lothian confidentiality practices will be followed and the limits of this (e.g. if the YP is believed to be at immediate risk) will be highlighted. Provided that the YP has seen the information sheet for a minimum of 24 hours, the YP will be asked to initial and sign the informed consent form. They will have the opportunity to ask any questions about the study and be reminded that their participation is voluntary, can be withdrawn at any time without stating a reason and will have no direct impact on the care that they receive from CAMHS services. YP will also be reminded that that this interview will involve talking about their personal experiences. They will be encouraged to be mindful of what they are sharing and reminded that they do not need to talk about anything which they do not want to. In addition, it will be explained that participants can take a break if they need to. If this is felt beneficial to data collection in the course of the interview, the researcher may also initiate this.
5. Participation in study
   The audio recorder will be switched on and the YP will be reminded that this data will be securely stored in line with an approach approved by ethical review. The YP will be informed that the study should take no longer than 2.5 hours in total. They will be reminded that they can choose to do this all in one session, or multiple sessions within a month as required. They will be asked to answer some background questions about themselves and their contact with their birth parent(s). This is to help establish a rapport between the researcher and the YP, and allow data on the level and type of parental contact to be obtained. They will be asked to fill in the four self report measures discussed in this section. They can choose to fill these in without assistance, or in collaboration with the researcher. The researcher will aim to ensure that no responses are accidently missed from these measures, to help control for missing data. The YP may however choose not to fill in any items or questionnaires if they wish. The interview will then follow the format of the interview schedule. It is intended that the loosely structured flexible approach will allow the lived experiences of these YP to emerge.
6. Debrief
   Once the YP has completed the above stages, they will be thanked for their time and participation in the study. They will be offered a small financial token of gratitude, to acknowledge the effort taken to participate in the research and to symbolise appreciation for their time given. They will be given a sheet of support numbers and told that they can refer to this sheet if they feel they require any extra support following their participation. This sheet will be given to all participants as standard practice. If it is felt by the researcher that additional immediate support is required, the same risk management procedures that operate within a CAMHS setting will be adopted in this study.
   If participants are completing the study on a separate occasion, this will be arranged collaboratively with the YP on an individual basis. When this occurs, they shall be shown their consent form and asked to verbally reconfirm their informed consent to the study. Participants will be reminded that the same boundaries of confidentiality apply, and that they are still free to withdraw their participation at any time without stating a reason. They will also be reminded that their participation will not influence the care they receive from CAMHS in any way. Extra copies

of the support numbers sheet will be available following each meeting and YP will be reminded that they can refer to this if they feel they require any extra support following their participation.

Analysis

Grounded theory is the key method of analysis in this study. It can be described as flexible systematic guidelines that will be used to collect and analyze data, allowing the construction of theory from this data itself (Charmaz, 2014). While some of the specific methods of grounded theory have been developed and adapted over time (Barker *et al.,* 2016), the aim of grounded theory to 'generate or discover a theory' (Glaser & Strauss, 1967) remains. Other qualitative methods including interpretative phenomenological analysis were considered, but it was felt that the chosen method would best address the research questions posed. While there is some limited background literature in the area of investigation, psychological theory investigating the ways in which this specific population conceptualize their relationships is lacking. As such, an approach that focuses on the development of theory was required.

A qualitative approach allows for rich detailed data to be collected and it is hoped that adopting a grounded theory methodology within this will help to address the research aims put forwards. The comparative, interactive, reflective approach allows the construction of analytic categories (Charmaz, 2014) as oppose to the description of meaning that other qualitative methods are often focused on (Starks & Trinidad, 2007). Outcome measure data will be coded and categorized alongside verbal data. By asking specific standardized questions in areas such as attachment and identity, it is hoped that these responses will generate an enhanced understanding of the research questions. The instructive revised text from Kathy Charmaz (2014) will be used as a key reference for the implantation of this analysis. Adopting a constructionist approach, the interactive process alongside factors such as tone, tempo and the use of silence will all be considered during analysis (Charmaz, 2014).

NVivo qualitative data analysis software, for which the University of Edinburgh have an ongoing subscription for use by students, will be used to facilitate analysis.

Ethical concerns

As this project is collecting data from a vulnerable group, it is important to offer an overview of the consideration of ethical issues in the development of this research design.

A clinician capacity flowchart has been developed, to allow CAMHS clinicians to raise any concerns that they have regarding a young person's capacity to consent to the study. In addition to this, data collection will not take place with any young person who it is believed is unable to provide informed consent to participate. As there is a potential for the study to be triggering, consideration of the location and timing of interviews is important to ensure the personal safety of both researcher and participants. Data collection will take place at time when other professionals are accessible within the building and the timing of interviews will be mindful of times when the YP may be more at risk due to a lack of access to support staff. It is expected that this will vary based on participant and interviewing will be flexible around the needs of the YP in order to maximize safe participation.

Due to the research focus, there is the possibility of disclosure from participants. This may take the form of issues to do with child protection, concerning behaviour from staff or carers or issues related to risk to themselves (e.g. self harm, suicidal ideation) or others (including criminal activity). At the end of each interview, as part of the standard debriefing process all YP will be invited to think about who they may wish to contact if they found the process difficult. A list of organisations that the young people can access if they wish will also be provided. Boundaries of confidentiality, in line with NHS Lothian policy, will be clearly explained in the briefing of the study. This will specify that anything discussed that is related to child protection policies, or which makes the researcher concerned for the safety of the participant or the safety of others, may need to be reported to an appropriate person or agency. If there is felt to be an increased risk as the interview progresses, participants will be reminded of this to allow them to make a more informed decision regarding any disclosures they may choose to make. Any concerns regarding disclosure shall be discussed in the first instance with the clinical supervisor of this project.

Data Storage

Identifiable patient information from Trak

In order to carry out the recruitment strategy indicated, patient information will be obtained from Trak. All information generated from this will be stored in a password protected document on the researcher's NHS Lothian secure home drive. This data will not leave NHS Lothian. This information will be destroyed on the researcher's completion of their Clinical Psychology Doctorate, anticipated to be December 2019.

Participant information

Once a YP has indicated their interest in the study, they will be able to contact the researcher via their University of Edinburgh email address, or the research mobile phone for this study. Their information will be stored on with the University server in the researcher's secure space or on their NHS Lothian secure home drive. This information will be destroyed on the researcher's completion of their Clinical Psychology Doctorate, anticipated to be December 2019.

Data generated during the study

Interviews will be audio recorded using encrypted devices. These recordings will be uploaded directly to Datastore using the University of Edinburgh's shared secure network and accessed from here by the researcher. Original recordings will then be deleted. Interviews will be transcribed and stored within the researcher's secure space within the University server. Identifying information will be removed and these files will be named according to the unique identifiers assigned to that participant. Once anonymized, these files will be shared via the secure network with named academic supervisors on OneDrive, and managed as described above.

Hard copies of outcome measure data will be stored in a locked filing cabinet at the University of Edinburgh's Health in Social Science department. They will be transferred to this site in a tamper proof bag, contained within a combination locked bag. Only the researcher and the academic supervisors of the project will have access to these. A spreadsheet of outcome measure responses will use a unique identifier for each participant. A separate password protected spreadsheet will be kept to with the participant's name and their unique identifier, and this will be stored on the University server in the researcher's secure space. In order to share the anonymized spreadsheet with the named academic supervisors, this will be uploaded to OneDrive via the secure server and shared with them directly via their University email addresses. Any downloaded versions of this will be stored on their secure space within the University server, and data will be transferred back via OneDrive.

Audio recordings stored on datastore will be destroyed following completion of the researcher's viva assessment. Hard copies of outcome measures will be destroyed following successful completion of the researcher's clinical psychology doctorate viva assessment, anticipated to be December 2019 . The database containing anonymized outcome data and anonymized transcripts will be kept beyond this date, to allow for the researcher to disseminate the study. Access will be limited to the research team and be destroyed before 2025.

Dissemination

The final report of this project shall reflect on findings from this mixed methods approach in the discussion section. This project is due to be submitted to the University of Edinburgh as a Doctorate level thesis in December 2019. A key priority of research is that it is shared with relevant stakeholders (British Psychological Society, 2015). As such, the researcher intends to share findings with link agencies, either in the form of a written summary or presentation to staff. In addition, YP who participated in the study can opt in to receive a short written summary of the research once it has been completed. Alongside this, they will be invited to take part in a short feedback exercise reflecting on this summary, if they wish to and consent to this. The purpose of this exercise is to obtain direct service user feedback of the themes that emerged, to help to assess if these feel meaningful and relevant to young people. It will also aim to capture any other thoughtful reflections that can further enhance the validity and applicability of the findings beyond this study.

This project will be written up as a journal article with the aim to submit the findings to relevant journals (e.g. Child Abuse and Neglect) in order to disseminate the findings beyond the local area. It is hoped that a poster of the key approaches and findings of this study will be developed and submitted to relevant conferences as the project develops. Furthermore, findings will be accessible through the University of Edinburgh thesis depository.

Conclusions

This study is directly addressing a clear gap in the current evidence base, in line with identified priorities for this population. Due to the existing lack of information in this area, an exploratory approach has been suggested, to generate theory from the starting point of young people themselves. Potential risk has been considered and the research will be carried out in line with existing safety procedures in this population. The proposed methodology maximizes the opportunity for this underrepresented group to participate in research.

Key References

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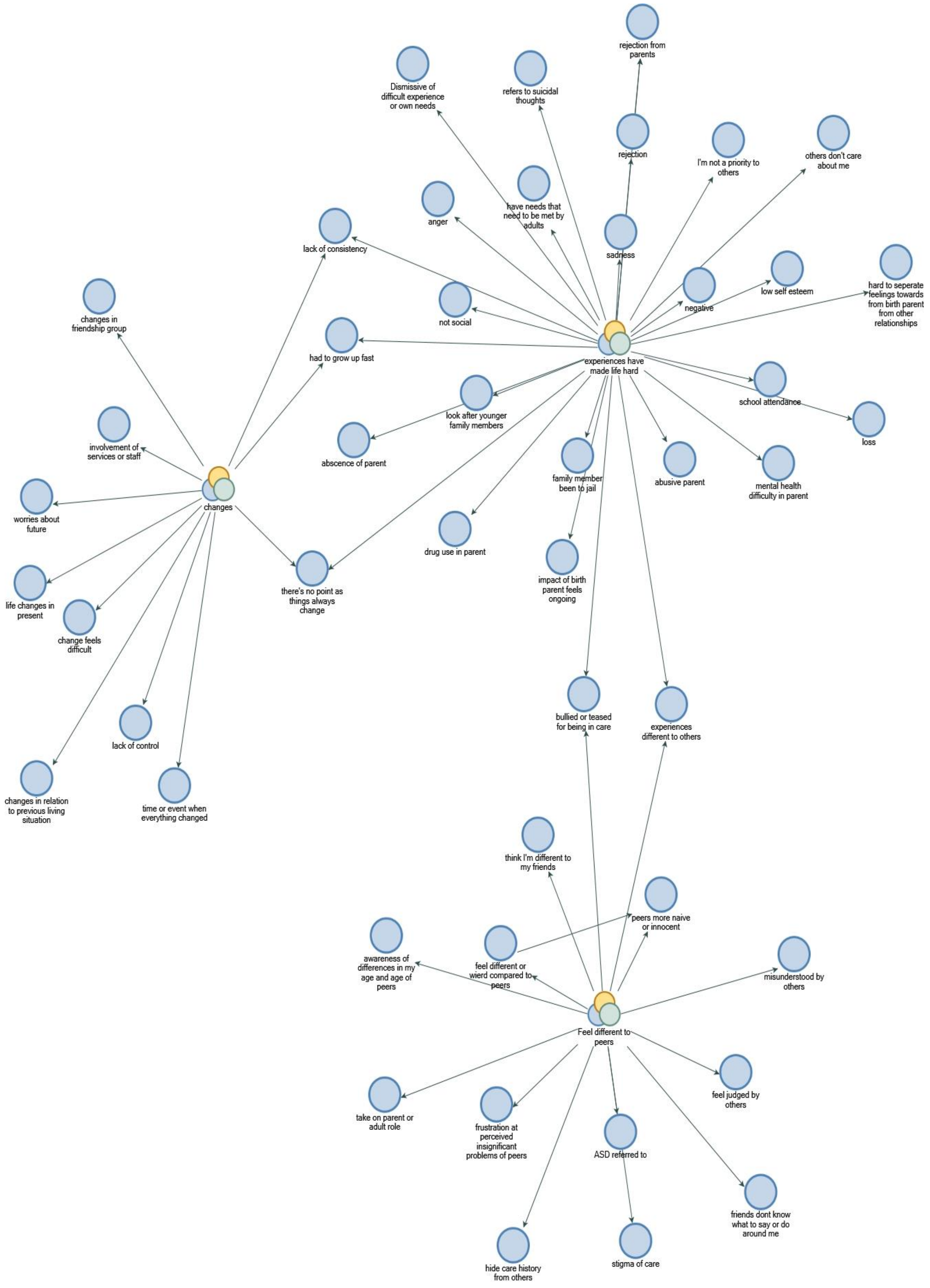
Appendix P: Nvivo Example Map to Illustrate Theoretical Code Clustering



Appendix Q: Example of Coding and Analysis

Extract taken from minute 32 of interview with Bianca (pseudonym):	Initial Coding	Focused Coding	Theoretical Coding	Relates to overall theme
Interviewer: So connecting with her <mum> now is really hard? Bianca: Yeah. Not just that, like she did other stuff that I just don't forgive her. Like she's at <town> with her boyfriend cause I was looking after <nieces names> and she promised, she promised me that she would help me. And then her boyfriend and her had an argument, He went down to <town> and she followed him. So I was like thanks mum <sarcastic tone> <laughs>. So I fell out with her cause of that. Cause she promised me	-Can't forgive mum for what she did -Looking after nieces -Mum broke promise -Mum left to be with boyfriend -Sarcastic/ Laughs	-Refers to difficult experience or trauma -Looking after younger relatives -Humour or laughter or sarcasm in relation to difficult topic	-Difficulties in parental relationship -Dismissive of difficult experience or own needs -Rejection and Loss	Unresolved Trauma Dismissive Coping Style

that she would help. And that impacted me as well. Cause I needed to go to school and I didn't. And then when I did I'd come back and <niece's> nappy was full, like full. She was crying and even sitting in her basket once my gran wasn't paying attention to her. <Older niece> was just sitting watching TV, didn't have anything to eat. She looked ill. And as soon as I came in I'd drop like everything I had and quickly just do everything round the house. My gran never, well she could cook but she could never be bothered cooking for me and my sister. And when she did she would just make it cold and disgusting. And she would the same for <nieces> too.	-Impact on me -Missed school to take care of nieces -Nieces not looked after properly by adults -Drop everything to help nieces -Gran didn’t look after me or us	-Rejected by birth parent -Let down -School attendance -Prioritized others needs -Looking after younger relatives -Caring -Prioritized others needs -I’m not a priority to others	-Others needs prioritized -I need to look after others -Own needs aren’t important	Hard to trust others I need to put others first

Appendix R: Sample of Outcome Measure Coding Examples

Measure	Subscale	Response	Context	Focused Codes
IIP-32	Non-assertive	≥8 (Scale range: 0-16). Interpersonal difficulty overall viewed as Moderately / Quite a bit / Extremely	Difficulties being assertive/firm when communicating with others	○ Hard to articulate needs to others ○ Avoid confrontation ○ Communication difficulties: Assertiveness ○ Taken advantage of
IIP-32	Non-assertive	≤8 (Scale range: 0-16). Interpersonal difficulty overall viewed as Not at all / A little bit	Able to be assertive/firm when communicating with others	○ Can ask people to stop doing something ○ Don’t do things I don’t want to ○ Stand up for myself
Self-Perception Profile for Adolescents	Close friends	≥15 (Scale range: 5-20). In general, more adaptive statement chosen as either sort of true for me or really true for me	Ability to make and share personal information with friends	○ Can speak to friends about difficulties ○ Easy to make friends ○ Have online friends ○Trust