Feeling the same or feeling different? An exploratory analysis of the experience of young people in foster care

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This thesis is dedicated to the nine young people who met with me and to all young people in foster care

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Thesis abstract

Due to competing claims in the literature regarding the relationship between self-esteem and being 'looked-after', and the implicated ethical and clinical issues, a systematic review of the literature was carried out. Ten articles met inclusion criteria for review. The majority of studies made a limited contribution to the review due to poor study quality, and the ethical, clinical and research implications of this are discussed. In addition, anecdotal evidence suggests that young people in care do not want to be made to feel different to others but there appears to be an absence of empirical research confirming this. Interviews were carried out with nine 12-16 year olds currently residing in foster care to explore their representations of 'feeling the same or feeling different'. Interpretative Phenomenological Analysis (IPA) guided how data was analysed, and resulting super-ordinate themes were identified. The research paper reports on one of these themes: 'difference', which is explored through four sub-ordinate themes. These relate to participants not wanting others to know they were in care, feeling alienated due to their foster care status, perceiving that others viewed them differently and, at times, noticing differences themselves. Findings are considered in relation to the extant literature on foster care and identity development and practice and research implications are discussed. A second super-ordinate theme: 'making sense' is presented in the 'extended results' which is explored through five sub-ordinate themes. Representations involved participants making sense of why their birth parents could not care for them, conflicting feelings towards both birth parents and foster parents, and a desire to feel a sense of agency in their lives.

1 Systematic literature review[1,2]

Title: The relationship between being 'looked after and accommodated' and self-esteem: A systematic review of the literature.

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[1]Produced according to submission guidelines of **British Association of Adoption and Fostering (BAAF) Journal (SAGE guidelines)** (see appendix 1 of thesis)
[2] Numbering of titles has been included in this review for continuity with the thesis but has not been included for submission. Additionally tables are included within text as per instructions in the _University of Edinburgh/ NHS (Scotland) Clinical Psychology Training Programme 3 year Full Time and Specialist Training Handbook_ , but will be formatted for submission as per _BAAF_ guidelines.

1.1 Abstract

Due to competing claims in the literature regarding the relationship between self-esteem and being 'looked-after', and clinical and ethical implications thus entailed, a systematic review of the literature was carried out. Due to the paucity of published peer review articles available on the subject, included in the review were; English language peer reviewed papers reporting the use of a measure of self-esteem with Looked After and Accommodated Children (LAC) 21 years or younger. In total ten articles met the inclusion criteria for review. Six studies failed to reveal a significant difference between the self-esteem of LAC and the comparison group. One found that LAC had significantly more positive self-perceptions than non LAC and another found that LAC had significantly lower self-esteem than the control group. Internal and external validity of the studies were extremely limited however. Other patterns in the data are discussed; the importance of non parental adults as a social support is highlighted. Many limitations of the studies and the current review are highlighted. For example, difficulties with self-report, the lack of a standardised measure of self-esteem, the varied conceptualisations of self-esteem (and lack of operational definitions) and the heterogeneous nature of the population mean that any inferences to the source population are problematic. Further, the cross-sectional nature of most of the studies limits causal inferences. Implications for future research are discussed.

Key Words: Self-esteem, looked after children, heterogeneity

1.2 Introduction

1.2.1 Self-esteem

Self-esteem refers to an individual's evaluation of self (Bachman *et al,* 2008) and is a widely studied construct in the social sciences. It includes how we feel about ourselves as well as thoughts and beliefs, for example 'I am worthy' (Hewitt, 2009). Varying definitions are prolific however and there has been much disagreement in nomenclature (Butler and Gasson, 2005) with a plethora of badly defined and confounding labels such as self worth, self belief, self concept and self regard (McGuire, 1994). Despite the lack of an accessible and universal definition, Butler and Gasson (2005) differentiate between the various labels asserting that evident themes in the literature point to how self-esteem represents the *evaluative* aspect of self worth (Blascovich and Tomaka, 1991; Butler and Green, 1998).

Self-esteem has long been viewed as a crucial part of healthy development, central to the adaptive functioning of individuals (Harter, 1990) and as a personal resource vital for social development and inclusion (Scottish Executive, 1999). Erikson (1963), states that self-esteem is a part of psychosocial development and a component of healthy identity and Maslow (1943) conceptualised self-esteem as one of the basic human needs in his influential 'hierarchy of needs'. However there have been debates about the importance and role of self-esteem (Ellis, 2005) and its predictive utility with regards to psychological health (Baumeister *et al*, 2003; Debois and Tevendale, 1999).

These debates have included questions regarding the benefits of 'high self-esteem'. Some research (Kernis *et al,* 2008) has explored how 'high' self-esteem is different from 'healthy' self-esteem, further that people with 'secure' high self-esteem are less verbally defensive that people with 'fragile' high self-esteem. This, along with other research highlighted in the current systematic review indicates how the construct of self-esteem is multi-faceted thus requiring sophisticated conceptualisation. Kernis and colleagues (2008) explored how high self-esteem can actually be associated with aggressive behaviours and that people with high self-esteem can be very unlikable if their egos are threatened. This research complements the multi-dimensional approaches to measuring self-esteem. Specifically that even with 'high' self-esteem, there are multiple forms, only some of which relate to positive psychological functioning. Baumeister *et al,* (2003) report that objective measures have disconfirmed that high self-esteem is related to better relationships and likability, that 'narcissists' can alienate others and that self-esteem has now been shown to predict the quality or duration of relationships.

1.2.2 The origins of self-esteem

Attachment refers to the behavioural propensity to seek contact and proximity to an attachment figure in times of stress or anxiety (Bowlby, 1984). Bowlby defines attachment as the 'building blocks' of children's development and discusses how this relationship teaches children to manage their emotions, soothe themselves and relate to others. He holds that this relationship influences how children form concepts of themselves, others and the world. A child's internal mental representation of self develops through interactions with their attachment figure (Fonagy and Target, 1997). Fonagy and colleagues (1994) discuss how a secure base facilitates exploration and increases reflective functioning and self-esteem. Early relationships are thus

thought to be critical to the development of future self-esteem. Researchers have however also emphasized that the formation of self develops over time and in response to social environments in a more transactional process (Gauntlett, 2007). Peer acceptance, for example, can be associated with high self-esteem whereas rejection from peers can be associated with low self-esteem (Leary and Baumeister, 2000) and academic success or failure can promote or hinder positive self-esteem development (Crocker *et al,* 2003).

1.2.3 What do we know about self-esteem in adolescents?

A broad and diverse literature regarding self-esteem and adolescence suggests that high self esteem is positively, though not necessarily causally, associated with psychological health (Gonzales *et al,* 2007; Keyes, 2006), goals, expectancies, coping mechanisms and behaviours that facilitate productive achievement (Bachman *et al,* 2008). Self-esteem has been negatively associated with depression (MacAphee and Andrews, 2006), substance abuse and anti-social behaviour (Niregi, 2006), suicidal ideation (Harter, 1993; Rosenberg, 1979), academic achievement (Hattie, 1992) and loneliness and peer rejection (Ammerman *et al,* 1993). There are competing claims as to whether or not self-esteem is a stable or changing concept, (Myers *et al,* 2011) however Robins and colleagues (2002), using cross-sectional data on more than 326, 600 participants suggest that self-esteem changes over the life-span and is particularly critical during adolescent development when it is likely to decline. Emler (2001) has highlighted an association between self-esteem and a number of troubles in young people, arguing that such individuals tend to treat themselves badly and may invite undesirable treatment from others.

Self-esteem has been linked to a wide range of psychopathologies. A search of the Diagnostic Statistical Manual IV-TR revealed that the term 'self-esteem' appears in 24 different diagnostic contexts as a criterion for disorder and as an associated feature of disorders (Kernis, 2005). This did not include the appearance of over 50 'self' terms that had meanings overlapping with self-esteem. Despite its apparent centrality to various aspects of psychological functioning inconsistent findings are found in self-esteem literature (Kernis, 2005). Baumeister and colleagues (2003) found that self-esteem was not a strong predictor of objective outcomes such as school achievement, occupational success, drug abuse and criminality. Causality in disorders is unclear but it is plausible that high self esteem could to some extent offset childhood problems resulting in difficulties of a less severe nature (Pope *et al*, 1988). Furthering understanding of the role of self esteem in psychological functioning may therefore aid the promotion of psychological wellbeing and be clinically relevant.

1.2.4 How is self-esteem measured?

Krause and colleagues (2011) claim that a variety of reliable explicit self-esteem measures are available but it is widely acknowledged that this vast variety can be problematic and it has been argued that most measures are of debatable quality (Wylie, 1961). Blascovitch and Tomaka (1991) suggested that at least 200 measures of self esteem have been developed. Butler and Gasson (2005) carried out a systematic review of the 14 most frequently cited self-esteem/self concept scales for children and adolescents. They claim that there now appears to be both theoretically and psychometrically an acceptance of multi-dimensionality with respect to the self, with the latest scales designed around this notion. Though historically this was not the case and

the Rosenberg Self-esteem Scale (Rosenberg, 1965) and the Coopersmith Self-Esteem inventory (1967) are considered more one-dimensional in nature.

Self-esteem is typically assessed using a self-report inventory yielding a score on a continuous scale from low to high self-esteem. The inconsistent findings in the literature as well as difficulties establishing self-esteem as a predictor of objective outcomes have emphasized the incomplete picture of the role of self-esteem in psychological and interpersonal functioning (Kernis, 2005). Due to these problems and limitations associated with social desirability, measures of implicit self-esteem have begun to emerge (Bosnan *et al,* 2003). Researchers have also been exploring contingent self-esteem (Crocker and Wolfe, 2001) and stability of self-esteem (Kernis and Golman, 2002; Kernis, 2005) in order to promote a more complete picture of the role that self-esteem plays in psychological functioning. There have been issues with suboptimal levels of reliability in implicit self-esteem measures but Krause and colleagues (2011) suggest that these are improving.

1.2.5 Difficulties associated with self-report

There are assumptions that self-esteem is both a phenomenological and reflexive process, whereby an individual perceives characteristics of self and has awareness of the judgments they place on themselves (Butler and Gasson, 2005). Thus, self-report is by far the most frequency used methodology adopted in assessment. Many difficulties with this approach have however been highlighted (Brinthaupt and Erwin, 1992; Wylie, 1961; Purkey, 1970; Roy *et al,* 1989). They assume verbal competence; self-awareness; are potentially influenced by an individual's

motivational and affective state; can be biased by social desirability and can disregard different cultural philosophies where collective aspects of self are more relevant than individual notions of self.

1.2.6 Self esteem and Looked after and Accommodated Children

'Looked after' is a term that refers to all children in public care; children in foster or residential homes and children still living at home with their parents or family members but subject to care orders (Department of Health, 1989). It has been widely documented that mental health problems are more prevalent in 'Looked after and accommodated Children' (LAC) in comparison to the normative population (Utting *et al,* 1999; Richardson and Joughin, 2000; Orme and Buehler, 2001; Blower *et al,* 2004), for example depression, anxiety and behavioural problems (Harman *et al*, 2000). This has been accounted for by the fact that LAC are more likely to have experienced risk factors that predispose to development of mental disorders (Richardson and Lelliott, 2003). These experiences may include; abuse and neglect, family dysfunction, disability, parental illness or disability, family in acute stress, socially unacceptable behaviour, low income and absent parenting, socio-economic disadvantage, poverty and homelessness (Richardson and Lelliott, 2003). Despite this compelling evidence some studies have shown that some fostered young people demonstrate good psychological adjustment and positive outcomes in some life domains (Flynn and Biro, 1998; Flynn *et al,* 2004). However, these early adversities can continue to affect self-esteem (Schofield and Beck, 2005).

LAC may have experienced care giving that is rejecting and neglectful thus may develop negative working models of themselves (Hodges, 2003) and may lack enabling role models

through which to support the development of positive identities (Lasson, 2002). As well as the impact of negative working models on identity development, Kim and Cicchetti (2009) discuss how the ability to emotionally regulate is crucial in terms of developing positive peer relationships. Difficulties in relationships could exacerbate low self-esteem in LAC. Multiple placements can also reinforce attachment difficulties and have been found to negatively correlate with young people's reported self esteem in relationship to their peers (Fernandez, 2008). As well as internal working models the absence of a stable attachment figure can affect a child's ability to enter new situations and relationships with a capacity to trust (Andersson, 2005). Maslow's hierarchy of needs (1943) suggests that self-esteem develops subsequent to when more basic needs have been met; physiological needs, security needs and social needs; needs which may have been compromised in LAC.

Previous research on the relationship between being 'looked after' and self esteem is however sparse and of varying quality with very few published peer reviewed studies. Cook compared the adult well-being of 107 former foster children with a control group of 12,910 adults. The results indicated that former foster children reported lower levels of self esteem. However, Buehler *et al.* (2000) found that former foster children did not differ in depressed affect and self-esteem from either a random sample of their age mates or a sample matched to the former foster youth. The reasons for the differences between these findings are unclear (Farrugia *et al,* 2006). As Faruggia and colleagues (2006) highlight, research on former foster children typically has not taken into account their psychological well-being before the transition from foster care to independence. Hence, it is unclear if foster care youth have lower levels of well-being prior to leaving care or whether such differences first emerge at the point when foster youth no longer

have the supports provided by the foster care system. Research on resilience in LAC has however identified self-worth as a key dimension of resilience for foster care youth (Flynn *et al,* 2004; Schofield and Beek, 2005).

1.2.7 Rationale and explicit aims of the review

Due to competing claims in the literature concerning the relationship between being 'looked after' and self-esteem further examination is necessary; if measures of self-esteem are failing to capture significant or reliable results, there are ethical implications for continuing with their use in both clinical and research settings. Additionally, critically appraising current literature may provide a more sophisticated understanding of the role of self-esteem in the lives of LAC and/or illuminate areas for future research and considerations for clinical practice. Therefore the aims of this review are twofold; firstly to establish if there is a significant difference in the self-esteem levels of LAC in comparison to the normative population and secondly to explore any other patterns in terms of the role that self-esteem plays in the lives of LAC.

1.3 Methods

1.3.1 Search strategy

A literature search using the following databases was carried out in November 2012: Applied Social Sciences Index and Abstracts (ASSIA) (1987 until present) MEDLINE (1980 until present), PsycInfo (1980 until present), Behavioural and Science Collection (1980 until present) and Social Services Abstracts (1979 until present). The following search terminology was used:

(foster care OR foster child* OR looked after chil*) AND (self esteem OR self-esteem). The search was augmented with use of terminology common to the United States of America as follows; (out-of-home care OR child welfare) AND (self esteem OR self-esteem). A further search using the 'self-esteem' measures was carried out. The following search terms, chosen due to their prevalence in the self-esteem literature; Rosenberg Self-Esteem Scale; Harter Self-Esteem Questionnaire; Self-Esteem Scale and Coopersmith Self Esteem Inventory. Finally a search using the internet search engine 'Google' was carried out and reference lists from articles were reviewed.

1.3.2 Inclusion and exclusion criteria

Articles that specified the use of a measurement of self esteem (or a measurement with self esteem as a component of the measure) with young people who were 'looked after and accommodated' and 21 years and younger were included. Due to the limited amount of articles available the author chose to widen the search to 'looked after children' as opposed to children solely in 'foster care', to include young people up to the age of 21 and not to exclude articles based on study quality. The search was limited to journals in the English language and to articles published in peer-reviewed journals. Due to the lack of journal articles directly comparing the self-esteem levels of looked after children and non-looked after children, articles were also included that explored the role that self-esteem plays for looked after children.

1.3.3 Critical Appraisal

Article quality was graded using a pro forma based on a quality appraisal checklist recommended by the National Institute of Clinical Excellence (NICE) (2012). Scores were given for the following: representativeness of the source population and the eligible population, the presence of a control or comparison group, provision of a sound theoretical basis, use of a valid and reliable outcome measure, sample size and power, appropriate analyses and internal and external validity. Individual items were scored out of 2 so the overall maximum score was 20.

1.4 Results

1.4.1 Search results

The search strategy initially identified a total 518 publications (170 from ASSIA, 278 from PsycInfo, 59 from Social Services Abstracts, 11 from MEDLINE). The author read the titles/abstracts to identify articles that met inclusion criteria. Following removal of duplicates and reading relevant full text articles eight articles were identified that met inclusion criteria. The second search using American terminology identified 176 articles. The author read all of the titles/abstracts, removed duplicates and identified one further article. Following removal of duplicates the final search using self-esteem scale terminology identified one more article. The internet search engine and the review of reference lists failed to reveal any peer review journal articles that had not already been identified. Figure 1 depicts the search process in a flow chart.

Initial search

518 publications

Search using American terminology

176 publications

Search using self-esteem measure terminology

7 publications

Abstracts and relevant full articles read and duplicates removed

Exclude = 507

Abstracts and relevant full articles read and duplicates removed

Exclude = 174

Abstracts and relevant full articles read and duplicates removed

Exclude = 6

To include in review

N = 8

To include in review

N = 1

To include in review

N = 1

Figure1. Flow chart to depict the search process

1.4.2 Overview of reviewed studies

An overview of study characteristics and brief summaries of the findings are provided in Table 1. The majority of studies (n=8) employed a cross-sectional design, one a combined qualitative and qualitative two-stage (uncontrolled) prevalence study and one an experimental matched subjects design. A variety of statistics were used; statistics of association such as regression or correlation analyses and *t* tests. Three of the studies did not carry out any statistical analyses. Four of the studies took place in the United States of America, three in the United Kingdom, two in Canada and one in Belgium. The sample sizes range from 10-340. The ages of participants range from 7-21. Table 2. depicts the varying levels of reliability and validity of the measures of self-esteem or measures with self-esteem as a component of the measure that were used. The table illustrates how many different measures of self-esteem have been used; eight different measures in only ten studies.

1.4.3 Critical appraisal of study quality

The studies will now be grouped and critically appraised under the following three categories; those failing to find a significant difference in self-esteem levels of LAC and the control or comparison group, studies suggesting there is a significant difference and studies exploring patterns rather than differences. The overall quality of the studies was poor (see table 3 for the quality appraisal scores of all ten studies). The second author graded four of the papers and there was 100% agreement in 90% of the ratings. The minor discrepancies in grading were discussed and resolved. None of the differences were more than one point apart.

Table 1. Study characteristics and brief summaries of findings

Authors	Year	N	Country	Study Design	Age	Measures Used	Summary of Findings
Flynn, Ghazal, Legault, Vandermeulen & Petrick	2004	340 (5539 in comparison group)	Canada	Cross sectional	10-15	Assessment and Action Record, with 4-item self-esteem component	On the measure of general self-esteem, there was virtually no difference in how the young people in care and those in the general population saw themselves
Legault, Anawati & Flynn	2006	220	Canada	Cross sectional	14-17	Assessment and Action Record, with 4-item self-esteem component	Lower anxiety was significantly associated with higher self-esteem. The were significant associations between less frequent physical aggression higher self-esteem. Greater use of approach coping strategies, and less frequent use of avoidant coping strategies offered further empirical evidence that positive relationships with peers and positive self-esteem are associated with psychological adjustment
Farruggia, Greenberger, Chen & Heckhausen	2006	163 (163 in comparison group)	United States of America	Cross sectional	17-20	Rosenberg Self-Esteem Scale	Foster care youth had significantly higher levels of work orientation, but lower grades in school and lower educational expectations and aspirations than comparison group. No differences were found for depressed mood, self-esteem, and problem behaviour,
Gil and Bogart	1982	100	United States of America	Cross sectional	8-18	Coopersmith Self-esteem Inventory	While all the foster children were somewhat lower than the norm in self-esteem, the children in foster family homes were higher in self-esteem than the children in group homes.
Hicks and Nixon	1989	10 (10 in comparison group)	United Kingdom	Experimental matched subject design	8-12	Reparatory Grid Technique	The results were significant suggesting that children in foster care have lower self-esteem than children living with their natural parents. Children in foster care have significantly fewer positive constructs and significantly more negative constructs

							about themselves than do the Control Group children.
Honey, Rees & Griffey	2011	51 (99 in comparison group)	United Kingdom	Cross sectional	11-15	LAC questionnaire with self-esteem component	LAC tended to report more positive self-perceptions than the comparison sample. This was particularly noticeable in the ratings given for: how much the pupil likes school; home-support with schoolwork; self-esteem; and reaching potential in education and life.
Denwaleare	2007	96 (96 in comparison group)	Belgium	Cross sectional	10-21	Rosenburg self-esteem scale	Both aspects of self-worth, the amount of self-esteem and self-efficacy, and the amount of internalizing anxiety-depressive symptoms did not differ significantly between sample of foster children and birth children The self-esteem of foster children was more strongly affected by support and conflict processes in the foster family than the self-esteem of birth children in the same family.
Blower et al	2004	58	United Kingdom	Combined qualitative and quantitative, two-stage uncontrolled prevalence study	7-17	The modified Harter self-esteem questionnaire	35 of 48 participants had lowered self-esteem on at least one subscale, and 11 displayed lowered global self-esteem. However, the average scores for the sample across domains , including global self-esteem were at, or above the midpoint for the scale. 25 had lowered self-esteem in the domain of behaviour whereas only 4 had lowered social self-esteem.
Lyman and Bird	1996	58 (1385 in comparison group)	United States of America	Cross sectional	12-19	The Offer Self-image questionnaire	Failed to reveal a significant difference between the global self-image score for the sample of foster care youths and the normative population of male adolescents. Comparison of the scores revealed that the foster care sample scored significantly higher on the social relationships subscale and significantly lower on both the family relations and emotional health subscales.

Saluha-Din	1994	116	United States of America	Cross sectional	11-15	The Baltimore Self-Esteem Scale (a 6-item Guttman scale) (Rosenberg, 1979)	Self-esteem of youth with lower identification with birth family tends to be lower that that of youth who had higher identification with their birth families.

Table 2. Details of Self Esteem Measures/ Measures with self esteem as component

Measure	Study	Details of Measure	Reliability (internal consistency [IC], test retest) and Validity
The Modified Harter Self-esteem Scale	Hoare, Elton, Greer, & Kerley, (1993)	36 item self-completed questionnaire which measures global self esteem as well as 5 separate subscales; scholastic performance, social acceptance, athletic competence, physical appearance and behaviour.	The high Cronbach values for reliability between the subscales alpha 0.72-0.83. No independent measure of self-esteem so construct validity not known (Hoare et al., 1993).
Coopersmith Self-esteem Inventory	Coopersmith, S. (1967). *The antecedents of self-esteem*. San Francisco: Freeman.	50 items using forced-choice (like me or unlike me) format.	Test-retest reliability was .88 for a sample of 30 5th graders at a 5 week interval and .70 for a different sample of 56 children after a 3 year interval (Coopersmith, 1967). Roberson & Miller (1986) explored construct validity. 1397 middle school students. Found 7 fairly well defined sub constructs confirming to some extent the 5 originally hypothesized subscales. But 13 of 26 items on General Self Construct were excluded. Empirical evidence for 5 factors and the magnitude of correlation among related constructs supportive of construct validity. Further research needed.
The Rosenberg Self Esteem Scale	Rosenberg,M. (1965). *Society and the Adolescent Self-Image*. Princeton University Press, Princeton, NJ.	Adolescents responded to statements such as, "I feel that I have a number of good qualities" with responses ranging from 1=*strongly disagree* to 4=*strongly agree*.	This scale had high internal consistency for both the foster care sample (α =.80) and the comparison sample (α =.87) (Faruggia *et al.* 2006) Chronbachs alpha .86 for birth children and .85 for foster children (Denuwaleare, 2007) The original sample for which the scale was developed consisted of 5,024 participants from 10 randomly selected schools in New York State and was scored as a Guttman scale. The scale generally has high reliability: test-retest correlations typically in the range of .82 to .88, and Cronbach's alpha for various samples are in the range of .77 to .88 (Blascovich and Tomaka, 1993; Rosenberg, 1986).

| The Offer Self-image questionnaire | Offer, D., Ostrov, E. & Howard, K. I. (1989). The Offer Self-Image Questionnaire for Adolescents. Chicago:Michael Reese Hospital. | A self-descriptive personality test that is designed to measure self-image in adolescents in a number of specific domains. 130 item instrument | alpha coefficients reported in the manual (.38 to .87 for younger adolescents, and .36 to .88 for older adolescents)

Moderate discriminant validity (Laukkanen et al., 1998 |
|---|---|---|---|
| The Baltimore Self-Esteem Scale | Rosenberg (1979) Concieving the Self. New York: Basic Books. | A 6 item Guttman scale | Coefficient of re-producibility of 93 per cent and a coefficient of scalability of 76 per cent (Rosenberg, 1979) |
| Reparatory Grid Technique | Hicks and Nixon. The use of a modified repertory grid technique for assessing the self-concept of children in local authority foster care (1989). *British Journal of Social Work, 19, 203-216.* | The measure involves presenting eight pictorial elements and eight bipolar constructs to participants and asking them to rank them in order according to their perception of each construct. | Authors acknowledge that there are theoretical problems with establishing conventional reliability and validity for repertory grid (Lund, 1987; Bannister and Fansella, 1977) |
| The General Self Esteem Scale (part of the assessment and action record (AAR) – Canadian adaptation) | Flynn et al (2004): Looking after children: good parenting, good outcomes, assessment and action records (second Canadian adaptation). Centre for Research on Community Services, University of Ottowa and HMSO. | Part of the AAR which is a structured interview to assess seven developmental dimensions. The General Self Esteem part of the interview consisted of 4 questions measuring the young person's overall sense of self. Fostered young people answered on a 5 point Likert scale ranging from false to true. | The self-esteem scale had an internal consistency (Cronbach's alpha) of 0.82 in the in-care sample and 0.73 in the Canadian comparison sample (Flynn et al. 2003) |
| Looked After Children Questionnaire | Not reported (Honey et al., 2011) | Three questions designed to measure self-esteem on a 5 item Likert Scale | No information on reliability or validity reported or available |

1.4.4 Studies suggesting no significant difference in self-esteem of LAC and comparison group

Farruggia and colleagues (2006) compared a group of 163 17-20 year olds in foster care for at least one year with a matched sample of 163 comparison youth. The population were fairly representative of 'looked after' young people, although the narrow age range limits inferences to the source population. They used a random sample of foster care youth, unlike many previous studies. A high percentage (78%) of the eligible population participated in the study. A matched sample of 163 comparison youth was used, which is a significant strength of this study design in

terms of minimizing potential confounding factors. The comparison group were selected from a larger group of 1183 youth and were matched to the foster care sample on age, gender and ethnicity. Self-esteem was assessed by the 10-item Rosenberg Self Esteem Scale (1965) which, as already highlighted is widely documented as a reliable measure, with a high internal consistency, specifically $\alpha = 0.80$ for the foster care sample and $\alpha = .87$ for the comparison sample in the current study. No information is given on study power. The aims of the study are clearly stated and the statistical analyses chosen are appropriate. Independent-samples *t* tests were conducted to compare the two groups; appropriate when comparing two separate samples and paired-sample *t* tests were used for within-sample comparisons. Finally, confirmatory factor analyses were carried out to investigate the measurement models of the outcome variables. It was found that foster care youth did not differ from the comparison sample on the self-esteem measure, $p > .05$. A potential limitation is the sole reliance on self-report and due to the cross sectional nature of the study no claims of causality can be made.

Table 3. Quality appraisal scores

Criteria	Denu-waleare (2007)	Legault et al. (2006)	Faruggia et al. (2006)	Hoeny et al. (2006)	Blower et al. (2004)	Flynn et al. (2004)	Lyman et al. (1996)	Saluha-Din and Bollman (1994)	Hicks and Nixon (1989)	Gil and Bogart (1982)
1.1 Is the population representative of the source population?	1	1	1	1	1	1	0	1	1	1
1.2 Do the participants represent the eligible population?	0	0	2	2	1	1	0	1	0	0
2.1 Was there a control /comparison group?	1	0	2	1	0	1	1	0	2	0
2.2 Sound theoretical basis?	1	0	1	0	0	0	1	1	0	0
3. outcome measurements reliable?	2	1	2	0	1	1	0	1	0	2
4.1 sample size and power?	0	0	0	0	0	0	0	0	0	0
4.2 appropriate analysis?	2	2	2	2	0	0	2	2	0	0
5.1 internally valid?	1	1	1	0	0	1	0	0	0	0
5.2 externally valid?	1	1	1	0	0	1	0	0	0	0
Total score out of 20	**10**	**7**	**13**	**6**	**3**	**6**	**4**	**6**	**3**	**3**

Denuwaleare and colleagues (2007) carried out a study comparing a group of foster children with non-fostered children. The study failed to find a significant difference between the two groups in terms of self-esteem levels using the Rosenberg Self Esteem Scale (Rosenberg, 1965). Participants were in foster homes with foster parents who had at least one birth child between the age of 10 and 21, and with both a foster mother and father in the family. As well as determining whether or not there were significant differences between the two groups in terms of wellbeing, the study also looked at the affect of 'support and conflict' on the foster children compared to birth children. The strict inclusion criteria limit inferences to foster families without birth children, or single parent foster families.

Another limitation was the low response rate. The presence of the comparison group represents one strength of the study design. However, given the strict inclusion criteria, the group was not matched so, again caution must be exercised when interpreting the results. The authors clearly outline the study aims and appropriate statistical analyses are adopted. Due to the foster children and birth children reporting on their experiences in the same family, the data were not independent so a repeated measures ANCOVA was used. This allowed some potential confounds to be controlled for; age of foster child, gender composition, absolute age difference, and birth order. Self-esteem levels did not differ significantly between the sample of foster children and birth children. Again, due to the cross sectional design, causal conclusions cannot be made.

A study examining resilient outcomes in young people in care was conducted by Flynn and colleagues (2004). In terms of self-esteem they found virtually no difference in how the young

people in care and those in the general population saw themselves. Participants were 340 young people and ages ranged from 10 to 15. Participants were referred by 'Children Aid Societies' but it is unclear how many of them exist; hence it is difficult to establish how representative the participants are of the source population. The current study also involved a group of 132 5-9 year olds, who were too young to complete the self-esteem aspect of the study. So their sample comprised 472 of a potential 663 young people. Strength in the current study lies in the use of a comparison group, comprised of 5539 10-15 year olds.

The study used the General Self-Esteem scale which was part of the Assessment and Action Record. During the interview the caregiver and child welfare worker participated which, together with the sensitive nature of some of the items, may have given rise to demand characteristics that could have biased answers. There is no evidence that any confounding factors were controlled for, other than the use of the comparison group. No statistics are reported here, which makes it difficult to make any accurate inferences. The authors compare the scores of the two groups and offer basic percentage of scores as well as bar charts. As stated the authors found virtually no difference in how the young people in care and those in the general population saw themselves. Over two-thirds of the young people in care (72%) were classified as either resilient or highly resilient on the self-esteem component of identity. The authors acknowledge that selection effects may have accounted for part of the resilience observed on the various outcomes.

Lyman and Bird (1996) carried out a study attempting to determine differences between 58 male adolescents in foster care and their peers in the normative population. Participants were recruited

from a privately run state-licensed residential home in the United States, limiting how representative they were. No information is provided on how many participants were invited to participate. A non-matched comparison group was used, composed of 1,385 adolescents used to establish the norms for the Offer Self-Image Questionnaire (OSIQ) (Offer *et al,* 1982). The group home counselors administered the measure, potentially biasing results, if the young people were concerned about any impact on their home life. A major flaw in the current study is that the outcome measure used is not adequately reliable ($\alpha = .38$ to $\alpha = .87$ for younger adolescents, and $\alpha = .36$ to $\alpha = .88$ for older adolescents). Another limitation is that no confounds were controlled for. The authors did however, clearly state their research aims and used appropriate statistical analyses; *t*-test and multiple regression analysis. The authors report that the *t* tests failed to reveal a significant difference between the global self-image score for the sample of foster care youths (M = 49.31, SD = 10.92) and the global score for the normative population of male adolescents (M = 50, SD = 15). They found that foster care youth scored significantly higher than the normative population on the 'social relationships' subscale ($p < .05$) and significantly lower on the 'family relations' and 'emotional health' subscales ($p < .01$). The authors state that the study does suggest that foster children are affected by the pattern of loss they experience but that this is not reflected in global self-esteem but rather in the separate domains of self image.

Gil and Bogart (1982) interviewed 100 children in foster care, 50 lived in foster families and 50 in group homes. Due to non-reporting it is unclear to what level the participants represent the eligible population as no information is given on recruitment. The Coopersmith Self-esteem inventory, one of the more reliable measures was used, illustrating one of the few strengths of the study. There is no control group used and no confounds are controlled for. The authors report

that while all the foster children were 'somewhat lower' than the norm in self-esteem, the children in foster family homes were higher in self-esteem than the children in group homes. However, due to the lack of precision in terms of levels of difference, it is impossible to make any accurate conclusions regarding significance of findings. For the present systematic review this study does not make a valuable contribution.

Blower and colleagues (2004) carried out a study aimed at assessing mental health needs of LAC. They interviewed 48 out of 61 children and young people who were accommodated by one local authority in foster care, children's homes and residential schools. The variety of settings the participants are from represent the source population well but the small number is limiting. No comparison group was used. The modified Harter Self-Esteem Questionnaire was used. Due to non-reporting it is impossible to conclude how valid and reliable this measure is (see table 2 for information on this). The midpoint of each subscale was used to differentiate 'high' from 'low' self-esteem. The authors state that 'self-esteem was preserved to a variable extent across different domains'. Twenty-five had lowered self-esteem in the domain of behaviour whereas only 4 had lowered social self-esteem. The average scores for the sample across every domain, including global self-esteem, were at or above the midpoint for the scale. No statistical analyses are present so it is impossible to determine how significant these findings are. Internal and external validity are extremely limited.

1.4.5 Studies that found a significant different in self-esteem between LAC and comparison

group

Hicks and Nixon (1989) carried out a study aiming to compare the self-perceptions and self-esteem of children in local authority care using a marched subject design. Participants were 10 young people randomly selected from 126 children in local authority foster care. Five participants were male and five were female with ages ranging from 8-12 years of age. The control group were matched with the experimental group on the following; age, sex, racial origin and intellectual ability. Strength lies in the use of a matched control group and their random selection. However, the very small-scale nature of the study, severely limits how representative the group are of the eligible population as well as the extent to which generalisations can be made. The modified repertory grid task was used to measure self-esteem, which involves presenting 8 pictorial elements and 8 bipolar constructs and asking the subjects to rank order the elements according to their perception of each construct. As stated, the validity and reliability of this measure is limited. Aims of the study were however clearly stated and appropriate analyses were carried out. The results indicated that children in local authority care a) have significantly lower self-esteem scores, (t=2.25, p<0.025) and b) have significantly fewer positive constructs about themselves overall (x2 = 7.07, p<0.01).

Honey and colleagues (2011) carried out a cross-sectional study investigating self-perceptions and resilience in LAC. They recruited 51 LAC (22 boys and 29 girls) who represented the complete cohort of pupils in years 7-10 of secondary school accommodated by one local authority (with the exception of 4 pupils). Therefore the eligible population are represented well. Participants also represent the source population well, no exclusion criteria are stated. However,

the small number of participants is problematic. The measure used in this study was a 'Looked After Children Questionnaire' but no information is reported on validity or reliability. The comparison group included 99 young people (56 boys and 43 girls) who were not in care and attended years 7-10 of a neighbouring high school. Authors carried out a series of univariate t-test analyses and found that LAC reported more positive self-perceptions than the comparison sample (t (147) = 2.54, p < 0.01). The authors do not report controlling for confounds.

1.4.6 Patterns rather than differences

Legault and colleagues (2006) carried out a study exploring factors favouring psychological resilience among fostered young people in Canada. The authors hypothesized that fostered young people would report lower levels of anxiety and physical aggression if they had a higher level of general self-esteem and if they used approach coping strategies more frequently and avoidant coping strategies less frequently. Results supported the hypotheses and revealed significant associations between lower levels of anxiety and higher self-esteem (and higher quality relationships with the female caregiver, a greater number of close friendships). Less frequent physically aggressive behaviour was also associated with higher self esteem. Participants comprised 220 young people in foster care between the ages of 14 and 17. It was difficult to assess representativeness due to under-reporting. The authors state the 26 Children's Aid Societies (CASs) participated in a longitudinal study from which the participants were recruited, but does not say how many CASs there are in total. They also state that some CASs participated 'fully' and others 'partially'. However the authors did state that only 220 people participated out of a potential 839 and the narrow age range of 14-17 years of age also limits the extent to which the sample represents the source population.

No control or comparison group was used. Aims were however stated clearly and appropriate analyses were performed. For example prior to analysis data were examined for accuracy of data entry, missing values and fit between their distributions and the assumptions of multivariate analysis. The authors state that all variables were normally distributed and no outliers were identified. Some confounds were controlled for; age, gender and the number of primary caregivers on the outcome variable. However, the cross sectional design limits causal inferences. Another limitation is the presence of the caregiver and child welfare worker during interview which could have caused demand characteristics.

Saluha-Din and Bollman (1994) examined the relationship between identification with birth family and the ability to develop a self-identity and positive self-esteem. 116 participants aged 11-15 who had resided in foster care for one year or longer completed the Baltimore Self-Esteem Scale (RSSE); a 6-item Guttman scale (Rosenberg, 1979). They were a random sample. A total of 326 youth out of a population of 709 was drawn. 116 questionnaires were returned; limiting how representative the participants are of the eligible population. The identification with birth family was measured using a scale consisting of four open ended questions. It is unclear how valid or reliable this scale is and the theoretical basis is not clear. A correlation was found between identification with birth family and self-esteem, r =.27 at the .01 significance level. Results of the one-way analysis of variance also reflected a significant relationship between identification with birth parents and self-esteem, $F_{(2,87)} = 3.1113$, $p < .05$. Post hoc analysis was used to make group comparisons which suggested that adolescents with high identification (mean, 1.6533) had significantly higher self-esteem the youth with low identification (mean,

1.4600). The authors do not report controlling for confounds and fail to consider any other possible explanations for the results.

1.5 Discussion

1.5.1 Lack of evidence for significant difference in self-esteem scores between groups

Six of the ten studies failed to reveal a significant difference between self-esteem levels of LAC and either the comparison, control group or norm (Farruggia *et al,* 2006; Denuweleare *et al,* 2007; Flynn *et al,* 2004; Lyman and Bird, 1996; Gil and Bogart, 1982; Blower *et al,* 2004). Honey and colleagues (2011) actually found that LAC had more positive self-perceptions but the lack of information available on reliability and validity make these findings inconsequential. Hicks and Nixon (1989) were the only authors to state that LAC had lower self-esteem than the control group, but again the significant issues with external validity due to the small scale of the research, make these findings negligible in terms of the current review's conclusions. One must be cautious with the conclusion that there is no difference in the two groups however for a number of reasons.

As stated there are numerous limitations, in terms of the varied use, and varying levels of reliability and validity, of outcome measures, the small sample sizes and lack of power and the extent to which participants represent LAC in general. Crucially there are also issues with self-report and with the lack of a standardised 'operational definition' of self-esteem. Further, due to the cross-sectional design of the majority of the studies included, no causality can be implicated in the conclusions. Some of the research was however based on careful sampling and

comparisons and thus the possibility of a more balanced perspective to foster care should be borne in mind. Farrugia and colleagues (2006) state that the previous emphasis in research on the dysfunctional nature of foster youth leads to a deficit model which can present a one sided notion that foster youth are headed for maladjustment. Whilst this may be the case, empirical evidence is lacking in terms of justifying any conclusive assertions about similarities or differences in levels of self-esteem of LAC and the general population.

1.5.2 Patterns observed in the studies

Legault and colleagues (2006) found that lower anxiety levels and less physical aggression were significantly associated with high self-esteem and Saluha-Din (1994) found a significant association with identification with birth family and higher self-esteem. However due to the limitations already outlined and the significant lack of consideration of confounding factors the results are deemed negligible for the current reviews purposes. Faruggia and colleagues (2006) found that for foster youth important non-parental adults represent a significant social support which can offset risks and Denuwaleare and colleagues (2007) found that self-esteem of foster children was more strongly affected by support and conflict processes in the foster family than the self-esteem of birth children. Both of these studies emphasize how important relationships outside of the birth family are for LAC.

1.5.3 Difficulties with self-report

As stated numerous authors have written about difficulties with self-report (Wylie, 1961; Purkey, 1970; with some authors of the current studies acknowledging inherent problems with its

application (Farruggia, 2006; Hicks and Nixon, 1989) Some specific difficulties that LAC might have reporting on their own 'self-esteem' also need to be considered. One problem with self-report is that participants may only reveal information they consider desirable or acceptable and even this can be governed by the degree of insight and awareness that the subject has (Wylie, 1961). We therefore might find out more about how participants wish to appear than how they truly feel (if they are even aware of this). Roy and colleagues (1989) argue that people designated as having high self-esteem are simply those who display a readiness to endorse favourable statements about the self. Research indicates that adolescents in care, who feel devalued by others, may attempt to protect from further devaluation by others (Kools, 1997). It is possible that young people may respond in a way that prevents further 'separation' between themselves and the 'normative' cohort, thus biasing results. Hicks and Nixon (1989) also highlight that for individuals who have experienced trauma questions can consequently be highly sensitive, making self-report even less useful. Another problem is that the minimum age has to be restricted; hence findings cannot be generalized to younger LAC (Denuwaleare, 2007). Gil and Bogart (1982) report that even with some of the older participants, difficulties with reading and writing meant that an adult had to assist thus compromising the young person's anonymity; making social desirability an obvious issue. Finally, reflective functioning, which is associated with positive early attachment relationships (Fonagy and Target, 1997) may be compromised in young people who have experienced abuse and neglect and thus bias results.

1.5.4 Heterogeneity

The fact that self-esteem is conceptualised so differently in the literature makes it difficult to generalise about research findings. Authors have been warning of the dangers of there being so

many different self-esteem measures available for some time (Wylie, 1961). Further the group labelled as 'looked after' will have a variety of early life experiences and varied levels of reflective functioning. Schofield and Beek (2005) write about resilience in children in long-term foster care and discuss how the child interacts with complex environments and environments interact with each other across time in ways that defy measurement – but in ways we must attempt to make sense of. They cite Rutter (1987) who emphasizes the importance of processes and mechanisms rather than simply focusing on factors or characteristics.

1.5.5 Further problems with the available measures

A further complication in terms of relying on the available self-esteem measures is the lack of information regarding theoretical underpinnings of the measures (Butler and Gasson, 2005). Some scales were initially designed with research or screening purposes in mind, yet more recent versions allude to the measures being used clinically. Harter (1999) emphasizes the need to examine individual profiles carefully in the clinical setting and Butler and Gasson (2005) recommend that measures are not used as diagnostic tools.

1.5.6 Possible explanations for the lack of difference found between the two groups

Many factors have been outlined that may be leading to inaccurate inferences regarding LAC having positive self-esteem levels. Another possibility is that LAC do not differ in self-esteem levels to their peers. However, when research is failing to establish significance, and 'self-esteem' does not seem to be a construct that is adding anything helpful to the evidence base it is important to question the ethics of continuing to carry out research in the area. The benefits of

researching this area further need to be considered and it is imperative to consider whether doing so is likely to advantage LAC or not. Although there is a well documented higher prevalence of mental health problems in LAC, it appears something is not being captured or detected in the self-esteem research. Perhaps there are two options; either higher quality rigorous research is done on a larger scale with sufficient power or research needs to focus on other areas in the lives of LAC.

1.5.7 Future research

Farruggia and colleagues (2006) steer future research toward the examination of resilience in fostered young people; specifically in the context of important non-parental adults who can offer important social support. Denuwaleare and colleagues (2007) recommend further research on the numerous environments surrounding LAC and how they influence their well-being, such as individual characteristics, school and peer experiences, leisure activities and the quality of social work (Kelly and Gilligan, 2000). They also suggest that qualitative research has an important role in exploring in more detail the ways in which foster children make sense of their family experiences.

1.5.8 Robustness of synthesis/limitations of review

Inclusion criteria pertaining to solely peer reviewed journal articles and to English language studies could have been potentially restrictive. Another potential limitation is the rigid criteria used. Although criteria aid a systematic and transparent process, if for example a high score is given for appropriate analyses yet the outcome measure was not reliable; scores can be

misleading. Highly appropriate analyses do not necessarily lead to meaningful findings. Thirdly, the inclusion of studies with a variety of outcome measures represents a limitation. Operational definitions of self-esteem vary and the lack of standardisation of measures makes comparing and synthesizing the results challenging. Due to the scarcity of articles identified however, stricter inclusion criteria, whilst promoting easier assimilation of results, would have resulted in too few studies to carry out the review. Fourthly, as discussed the term 'looked after' refers to a very heterogeneous population and some of the studies only included for example foster children. Again assimilating the results is therefore limited. Finally, as stated, inclusion of largely cross-sectional studies means that causal inferences cannot be made.

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2. Journal Article

Before the journal article is presented, an example of the author's reflective log will be presented to aid transparency in terms of the researchers' stance.

Reflective log (rough notes) to evidence the process

September 2012

Personal experiences that shape my preconceptions?

I have cousins who have been fostered and adopted. It is possible that hearing about their experiences from a young age has influenced my interest in this field. During this process I have spent time trying to honestly reflect on the preconceptions and beliefs that these experiences have led me to hold. I suppose I feel aware of the distress that is involved for young people when they lose their attachment figures. I am aware that abuse and neglect can predispose people to experience difficulties in forming future relationships and I am aware of the challenges foster carers may experience. I have heard my cousin talk about not wanting to be treated differently and about how people had lower expectations of her and how she wishes this was different. I have always wondered about this and about how it must feel joining another family. It is very likely that these experiences shaped my interest in this field.

- But my preconceptions? that young people don't want to be treated differently? that experiences with birth family can be extremely traumatic and that this can have long standing effects, that young people are extremely resilient and can come across in a very confident manner and whether or not this is always really how they feel?

Did speak to cousin who talked about definitely feeling like a family member treated her differently etc, and that it was ok to include this, and that thinking back actually perhaps it was appropriate to be treated differently because of the different experiences and stuff that was going on etc. but that yes, this definitely at the time was something that bothered her.

October 2012

My reflections on the process thus far

- her spontaneously bringing up re: feeling different early on in the interview
- interesting about her saying about not wanting people to feel sorry for her, really made me think about whether or not my behaviour implies that I convey sympathy versus empathy???

- blown away by her insight
- esp. into the fact that she is sensitive, and her ability to connect that to having to be so tuned into her dad
- so mature
- feel excited about the research

December 2012

I am astounded by how much I have started considering issues of 'power' and 'interpretation' not only in terms of the thesis but also in terms of my therapeutic work with patients. I have been thinking how much my interpretations of patient's experiences are based on my experiences and knowledge, and how although I try to be careful in terms of 'collaboratively' formulating with patients, that actually I do a great deal of 'suspicious' interpretation, in terms of patient's difficulties being conceptualized within theories and models that I am aware of. I found myself checking out more with patients i.e., 'is this something you find meaningful', and being much more tentative about my interpretations of patients experiences etc. Having so much power is a huge responsibility.

I also had an experience on the train, it seems trivial, but a man and his child were sitting opposite me. I was thinking how wonderful childhood is, as the child was exclaiming 'oh! Wow! A doggy!', 'are we going through a tunnel etc'? and I realized the rest of the family were sitting separately. I offered to swap seats so that they could sit together. The dad was very grateful but said 'have we made you suitably uncomfortable?'. I found this really interesting. He had interpreted my moving away as me feeling uncomfortable, and needing to escape. Or perhaps he was just joking. But I felt really misunderstood and really like I wanted him to know that it was quite the opposite. I was experiencing being near the child as joyful and beautiful, not in the slightest as an uncomfortable experience. I then started thinking that if I could feel so 'miss-understood' by someone's interpretations of my actions, just by a stranger on a train, how it would be horrible to feel like people were 'miss-interpreting' your behaviuors, thoughts, feelings, experiences etc. I feel a little overwhelmed at the moment with regards to how I am going to be interpreting the experiences of the young people. I am interested in re-applying to the ethics panel to ask whether or not I can meet with some of the young people I am interviewing to offer them a chance to hear about my interpretations and see what they think? What feels meaningful etc?

REFLECTIONS ON STARTING INTERPRETATION;

How difficult it is not to approach the data as psychologist/clinician, e.g., thinking about hiding away, contributing to isolation, and low mood, and thinking about how low self-esteem and attachment find it

difficult to accept anything positive. I.e. participant no. 7 talking about her foster carer thinking she is a nice person and she is not able to accept this. My interpretation is that she is unable to accept this love, but she might just not like him for example. THIS IS SO HARD TO LISTEN TO (first day back after xmas etc, less defended against content? REALLY DIFFICULT TAKING ROLE AS RESEARCHER AS OPPOSED TO CLINICIAN. I.e., taking a step back as observer, no hope that I can help, implement any change etc).

I am finding it heartbreaking and so sad. The language used such as 'dump, waste, rubbish' etc, feels so emotive and powerful and it is painful to think about the experiences and shame that these young people have experienced. On the other hand there is so much around, 'agency' and the idea of being able to do something about your experiences. I wish I could help. Being about to DO something, and have choice and control, feels REALLY important following these interviews. It doesn't feel like it is just a recommendation in guidelines. It feels really important. The accumulative aspect of everything is what I find striking. I.e. Loss of attachments, which will already likely predispose to difficulties (bracket this?), then at times the neglect causing difficulties at school, causing difficulties with self esteem, and difficulties in friendships, and the vicious cycle etc. importance of BUFFERING. Of at least one constant, like interviewee 1 talked about. If there is at least one constant. Young people need help to externalize their experiences and to know that there was nothing wrong with them but with the support/lack of, that they received. I wonder about even the participants who are doing well, how much pain they are defended against, but this feels a bit patronizing, and like I should bracket this part of my knowledge? Speak to Ethel about this. My response of being heartbroken, makes me feel like there are young people (int 1) who wouldn't want people to feel like this. They don't want sympathy, they want people to understand.

the relationship between identity and how you feel others perceive you, 'if other people view you as different, you are different, threes nothing you can do about it"
 and relationship between "positive role models for developing positive self-image, i.e. foster carers who encourage you to be 'who you are' a etc' positive encouragement to 'be who you are' from foster carers - encouragement to be individual etc.

2.1 Journal Article[1,2]

Title: Feeling the same or feeling different? An exploratory analysis of the experience of 12-16 year olds in foster care

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[1]Produced according to submission guidelines of **British Association of Adoption and Fostering(BAAF)Journal (SAGE style guidelines)** (see appendix 1 of thesis)
[2] Numbering of titles has been included in this review for continuity with the thesis but has not be included for submission.

2.2 Abstract

Various conceptualisations of identity development emphasise the internal world of adolescents whilst others place more emphasis on the social world. Previous findings highlight the impact of stigmatization and how this may hinder positive identity development in adolescents in foster care; the significance of peer interactions has been underlined. Anecdotal evidence suggests that young people in care do not want to be made to feel different to others but there appears to be an absence of empirical research confirming this. Interviews were carried out with nine 12-16 year olds currently residing in foster care to explore their representations of 'feeling the same or feeling different'. Interpretative Phenomenological Analysis (IPA) guided how data was analysed and super-ordinate themes were identified. The current paper reports on one of these themes: difference. This is explored through four subordinate themes which relate to participants not wanting others to know they were in care, feeling alienated due to their foster care status, perceiving that others viewed them differently and, at times, noticing differences themselves. The dynamic nature of these experiences is emphasized and the findings are considered in relation to the extant literature. Practice and research implications are discussed.

2.3 Introduction

2.3.1 Adolescent identity development

The period of adolescence is considered a particularly crucial time in the development of identity (Erikson, 1968; Flavell, 1985; Marcia, 1966) and adapting to the cognitive, social and physical changes occurring in adolescence can be challenging. Koepke and Denissen (2012) reviewed identity development literature and concluded that the most frequently referenced model remains the psychosocial life-span model offered by Erikson (1968).This model presents identity formation as the main task of the developmental stage of adolescence, which involves the resolution of conflict between identity synthesis and confusion. Identity synthesis refers to the extent to which various aspects of one's identity fit together and is proposed to predict psychosocial functioning. Identity confusion, refers to feeling 'mixed up' and lacking a clear sense of direction (Erikson, 1968). McKinney (2011) discusses how Erikson's model implies behaviours are an overflow of one's inner self and attributable to the individual, that the source of self is innate, predetermined and discovered over time within a person's mental life.

Criticisms of Erikson's theory are that it represents a Western, male, middle class ideological pathway to adult identity paying too little attention to socialization, the significance of interpersonal relationships and the variety of family constellations (Gilligan, 1982; Sorrell and Montgomery, 2001). As a consequence it has been proposed that identity formation is less linear (Biggart and Walther, 2006), multidimensional rather than one-dimensional, disparate rather than coherent and fluid rather than static (Brekhus, 2008). Similarly, Bosma and Kunnen (2001) emphasize the dynamic nature of identity and argue that previous conceptualisations are too

cognitivist and static. It has been proposed that rather than being pre-existing and discovered over time, selves are formative and develop (McKinney, 2011) in a more transactional process (Bruner, 1990; Gauntlett, 2007).

Woodhouse (1996) emphasises how adolescents develop identity through comparisons between themselves and others. This is reminiscent of the symbolic interactionists who claimed that identity is contingent upon the reactions and behaviours of others (Cooley, 1902 as cited in McMurray *et al*, 2008). As McAdams (2001, p 116) states; "the person and the person's social world co-author identity". Young people are also more vulnerable to these social interactions due to the re-wiring of the brain that occurs in adolescence (Perry, 2006). Specifically for groups of adolescents who may feel marginalized or stereotyped (Kools, 1997; McMurray *et al*, 2008) by their peers and society, the impact on identity development may be significant. Children in foster care may represent one of these groups.

2.3.2 Impact of foster care

For young people in foster care, adverse experiences such as abuse and neglect, family dysfunction, low income and attachment difficulties are prevalent and have an impact on development (Richardson and Lelliott, 2003). Physical and psychological abuse in early life have been associated with neuropsychological changes (e.g. Perry, 2001), which, as with neglect (Miller *et al,* 2000), can have long lasting and profound effects on child development. Poor attachment formation, under stimulation, developmental delay, poor physical development and anti-social behaviour can result. These factors may generate various problems in behaviour and

educational performance, which can affect peer-group friendships and may result in social isolation (Kerfoot, 2005).

Attachment refers to the behavioural propensity to seek proximity to an attachment figure in times of anxiety (Bowlby, 1984) and the attachment relationship teaches children to regulate emotions and to relate to others. A child's internal mental representation of self develops through interactions with this attachment figure (Fonagy and Target, 1997). Children in foster care who may not have experienced accepting and nurturing care-giving may have negative working models of themselves and lack enabling role models through which to support the development of positive identities (Lasson, 2002). Further, Kim & Cicchetti (2009) have described how the ability to emotionally regulate is crucial in the development of positive peer relationships. Multiple foster placements can reinforce attachment difficulties and have been found to negatively correlate with young people's reported self-esteem in relationship to their peers (Fernandez, 2008).

2.3.3 Foster care and identity development

Much less is known about identity development specifically for young people in foster care placements. A number of studies exist with foster children from ethnic minority backgrounds (e.g. White *et al*, 2008) but the potential confounds and predominant focus on ethnicity limit the generalisability of these findings. Winter and Cohen (2005) highlight the impact that lack of knowledge regarding personal histories, and the accompanying sense of loss, can have on identity development in children who are fostered. Kools (1997) interviewed adolescents in

group-homes who had experienced multiple placements in foster care and found that this had a negative impact on identity development. Specifically that the diminished status of foster care, and the stereotypical view of the foster child contribute to the devaluation of the adolescents' self by others. Sampling bias represents a significant limitation of this study and the experiences described are not representative of young people living solely in foster care. Vojak's analysis (2009) compliments some of Kool's findings, suggesting that in an individualistic society people tend to attribute responsibility for their predicaments to themselves rather than structural inequalities and that stigmatizing language can reinforce these inequalities.

McKinney (2011) carried out observations over four months of 23 young people in therapeutic foster care examining how identity is 'co-constructed' and highlighting the construct of a 'bad' social identity. While the methodology of this study limits the conclusions that may be drawn, McKinney highlighted the need for more research within the foster family setting. McMurray and colleagues (2011) interviewed 13 young people in care and their social workers and emphasized how identity is shaped by relationships, can be a protective mechanism, and can be deferred or put on standby, resembling Kools' (1997) and Vojaks' (2009) findings relating to 'rejection of identity that may lead to social stigmatization'.

Anecdotal evidence suggests that young people in care do not want to be made to feel different to others (e.g. Barnados, 2007; McMurray *et al*, 2011; Office For Standards and Teaching in Education, 2009) but there appears to be an absence of empirical studies confirming this. The current study contributes to our understanding of the impact of the context of foster care on

young people's representations of 'feeling the same or feeling different' and considers how this relates to the extant literature on identity development.

2.4 Method

2.4.1 Interpretative Phenomenological Analysis (IPA)

IPA was the chosen 'stance' (Larkin *et al,* 2004) to adopt due to its focus on sense-making activity (Smith *et al,* 2009), texture of experience (Willig, 2008) emphasis on the individual and because phenomenological approaches are recommended for exploring the lived experience of groups of people (Chenail, 2011). Guidelines specific to IPA (Smith, 2011) were followed as well as those for achieving rigour in qualitative research (Willig, 2008) to ensure transparency of the process as well as the stance of the researcher (Chenail, 2011). The aim is not to establish 'truths' but to make sense of the young peoples' representations of their experiences.

2.4.2 Ethics and inclusion criteria

Following ethical approval and an examination of the ethics involved in interpretation (Brinkman and Kvale, 2008; Holloway and Jefferson, 2005; Willig, 2012) nine 12-16 year olds in foster care were recruited through a social work service in Scotland. Young people were eligible for participation if they were; 12-16 years old, currently residing in foster care and considered competent to participate by their social worker. Young people in residential homes or with a diagnosis of a learning disability were excluded.

2.4.3 Participants

In total 23 young people were invited to participate and nine responded. Of the 23 people 9 were male and 14 were female. Of the nine participants, five were male and four were female. Eight were living in full time foster care at the time of interview and one was living in foster care during the week and with birth parents at the weekend. Placement length varied from between seven months and four years. Four participants discussed having experienced multiple placements.

2.4.4 Interviews

Prior to interviews, the researcher met with a care leaver who acted as a consultant to the study and provided feedback on the interview guide and procedural issues. The interviews lasted between 30 minutes and one hour and took place in social work premises. At the beginning of the interview the researcher clarified that the young person knew what participation involved and that they did not have to answer questions they did not want to. The researcher reminded the young person that the interview would be recorded, and in the write up of the research direct extracts would be used but anonymity would be ensured. Written consent was obtained from the young person, as parental or guardian consent is not a legal requirement in Scotland (Children Scotland Act, 1995; Medical Research Council, 2004). The interview guide included open ended questions and was used flexibly; if a participant led the conversation in an alternative direction, follow-up questions were asked. Subsequent to the interview an opportunity to de-brief was offered. Consistent with IPA, extensive field notes were made following interviews and supervision used to reflect and attempt to 'bracket' any expectations. Following analysis the

researcher offered the young people an opportunity to feedback if they found the themes meaningful.

2.4.5 Analysis

Following transcription, interviews were read and re-read alongside listening to the audio recordings. Descriptive, linguistic and conceptual comments were made (Smith, 2009) followed by documentation of identified emergent themes. Recurring themes, contradictions and particularly emotive parts of the interviews were noted. This was done for each case independently and then cross-case analysis took place. This process involved initially creating a separate document for each participant listing all potential themes and then creating another document listing every single potential theme for all nine participants. At this point certain themes naturally grouped together and others were discarded. This involved the researcher deciding which themes were most relevant in terms of answering the research question. This was discussed extensively with the academic and clinical supervisors. Smith (2011) proposes that with nine participants, themes should consist of three or four participants per theme.

2.5 Results

2.5.1 Overview of super-ordinate themes

Super-ordinate themes emerged regarding: participants' representations of feeling different; attempts to make sense of their experiences; the importance of predictability and the significance of relationships. A sense of agency was emphasized throughout and the dynamic nature of

experiences was evident. To address in detail the current research question one super-ordinate theme 'Difference' and its sub-themes will be presented (see Figure 1).

2.5.2 If they know I'm in care, what the hell can they say to me?

Six participants discussed current or previous concerns regarding others knowing they were in care. These appeared to relate to past experiences of being made fun of and feeling fearful of future responses. Participants discussed how sometimes when people did 'find out', what they feared may happen did not happen, but they appeared to discount this information. There was a sense that participants felt they had something to 'disclose'.
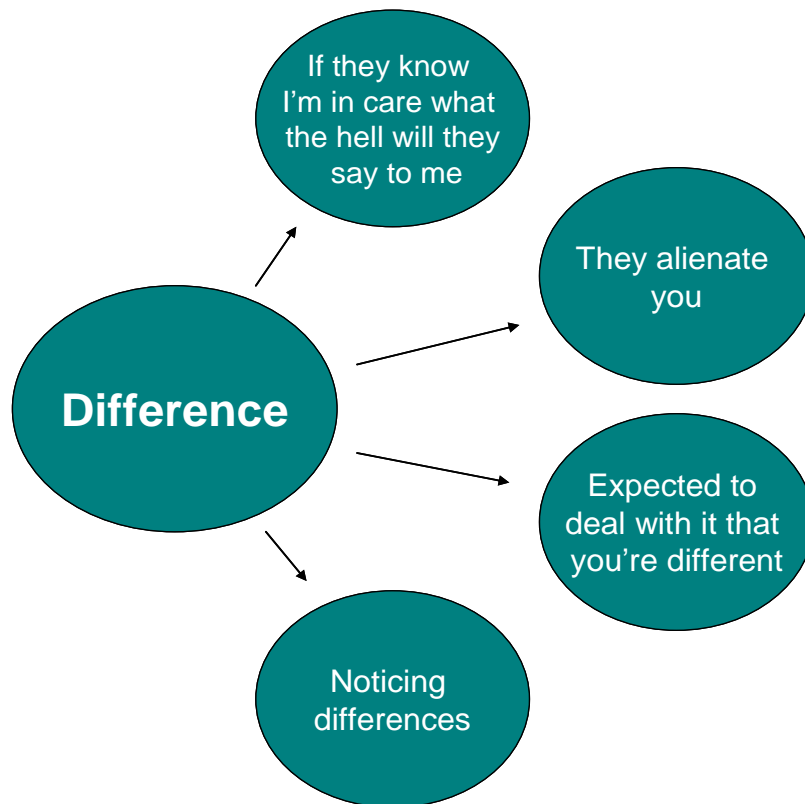

Figure 1. Diagram of the super-ordinate theme 'Difference' and the four sub-ordinate themes

Participant seven talked about referring to her foster father on a social networking site as 'dad' to prevent her friends from knowing she was in care and viewing her as a 'looked after child';

> '(they would think) like my mum's a bad mum…. there was a guy that joined our friends who had just been put into foster care and he told us all, and my pals were like "your life is totally fucking wasted now, you're not going to get to do nothing [sic]"…… it's just like '*oh no*', then I was put into care three weeks after, I was just like 'nah', if they can say that, then what the *hell* can they say to me' (Participant seven, line 555)

She described how the memory of her peer being told that his life was '*fucking wasted*' created unease for her and elaborated that because this happened to him it may happen to her. She appeared to anxiously anticipate this, finding difficulty in accepting the situation and at the same time contemplating a number of possibilities. Her stance of '*telling them nothing*' suggests that she needed to keep herself safe by withholding information about being in care and underlies the significance of peer interactions.

On being asked about her friends who did know she was in care, she stated that they 'were not bothered' but appeared to discount this information. Perry (2006) discusses stress responses and how the brain is naturally set at suspicion rather than acceptance, and more focused on threat rather than safety. Participant two also discussed how people did not respond in the way that he feared they might. He described how he used to be worried about people knowing he was in care but how this changed for him;

> 'I'm a lot more open with people like I didn't like to tell people about my life, to start off with 'cos I thought they'd just take the mince[1][sic], but I've grown in confidence and I could tell really anybody, and dinnae ken ey? [sic]........ cos I feel more secure, like in foster care, and if something did go wrong then I've got somewhere [sic] that I could tell' (Participant two, line 378)

He attributed this shift to an internal process, his growth in confidence as well as an increased sense of security in foster care. He explained that if something goes wrong he has got someone to tell and how "I could tell anybody really". His feelings of current security appeared to impact on concerns about rejection from others. This is in great contrast to the previous participant who appeared to dread people's responses and who went on to discuss lots of negative feelings about care. Participant two, however, reported being very happy in placement which may highlight the impact of context on participants' sense-making activities.

Participant two described what could be understood as the psychological 'secure base' (Ainsworth *et al,* 1978) in attachment literature (Bowlby, 1984). Fonagy and colleagues (1994) describe that with a secure base present one can explore the world with confidence. The secure base can be viewed as a 'blueprint' in the child's mind, which is known as an 'internal working model' (Howe, 2001). This mental representation of the caregiver enables children to broaden their attachments and develop healthy relationships (Hart and Blincow, 2007). Interestingly, the concept that something could go wrong is still present but his 'internal working model' appears to help him feel more able to cope. This is congruent with research suggesting that more positive attachment styles grow, but only *alongside* old patterns; new and more positive representations develop but do not automatically transform pre-existing representations (Hodges *et al,* 2003). The participant talked of his displeasure when people asked him questions about care and it is possible his sense of control relates to him choosing who to disclose information to (Perry, 2006). The desire to have a sense of control in their lives was common across participants and corroborates findings from other qualitative research with children in care (McMurray *et al,* 2011).

Participant three shared concerns about people knowing she was in care and was anxious about telling a friend in case she 'blurbs' it out to everyone because of previous experiences;

> 'at the start of high school this boy was saying I came from a dump and that I'm a rat, and stuff like that, just making really bad out of me, so I told (name of Foster Carer) and I went and told my guidance teacher and he has not said anything since' (Participant 3, line 274)

She also discussed how her friend having a 'different' living situation made it easier to talk about being in care, and how her response was positive. Again the participant appeared to discount this positive response and remain focused on future negative responses. It is possible that the participant felt that she and her friend both had something to hide together. Fearing her friend would 'blurb' it out to everyone suggests it is information she did not want to 'disclose'. Similarly participant nine talked about not wanting information about him being in care to be 'spreaded about'.

2.5.3 They alienate you

Seven participants talked about difficult interactions with other young people, having been bullied and witnessing others being bullied. Participant one talked about her perception that people alienated her for being in care;

> 'They alienate you, and like it's difficult for me to make friends, 'cos I used to get bullied a lot so I'm not really that confident when it comes to other kids, and it's been a real struggle, I had hardly any friends in first year, but now I've been able to make friends... I feel like they alienate you because we're in care but they don't make it obvious that it's because of that, 'cos were different' (Participant one, line 160)

She experienced it as a 'real struggle' not having friends and felt this impacted on her confidence with peers. She made sense of other people excluding her by attributing it to the fact that she was in care. She talked about being different. Although this appeared to relate to pre-care she used the present tense when she is talking, emphasizing that these feelings had continued into the present. She acknowledged that she may have played a role in excluding herself from others, this will be explored further under the heading 'noticing differences'. Participant three also talked about the emotional experience of being bullied;

> 'when people call me names, I don't know what to say back, I just start to cry, and they're like 'yeah I've made her cry I can do it again….and it's just like, I feel really small' (Participant three, line 1015)

It appears that she felt powerless and she elaborated that her response of crying was akin to a victory to the people calling her names and how the 'others' had 'won'. This appeared to be a painful representation for the participant who became distressed when talking. The concept of 'feeling small' was found in previous research on adolescent development with foster children (Kools, 1997) and was also discussed by participant two in relation to lacking in agency.

Participant eight described the time when children in school found out she was in care and started laughing at her. She said that she felt guilty as a result of this, because in the past she had laughed at people for being in care. She talked about how in the past she did not know what care was, that she used to think 'ha ha you're in care'. Throughout the interviews the young people placed emphasis on the limited understanding of other young people with regards to 'foster care'. Participant five was the only person who did not talk about 'not wanting people to know' or about bullying. There seemed to be a discrepancy between the participant's description of how

he was feeling and his facial expressions and affect. This may have related to his acknowledged difficulties in talking to adults. A similar theme discussed in research regarding identity with LAC (McMurray *et al,* 2008) was 'presented identity as a protective mechanism not the real them' which both social workers and participants discussed. Interestingly the male participants, with only one exception, did appear to differ from female participants in their responses. Male participants appeared to find more difficulty in terms of articulating their feelings.

2.5.4 People expect you to deal with it, that you're different

This theme highlights the young people not wanting people to treat or view them differently. Five participants discussed this topic. Participant one discussed her interpretations of peoples' responses to her;

> 'people *always* feel like sympathetic, I don't need sympathy, 'cos that kinda [sic] set me back, I need people to *understand* what I've been through but not kind of hold it against me, like 'oh what a shame, she's in care'
>
> 'mmm… you just want people to understand' (Interviewer)
>
> 'and just get on with it' (Participant one, line 682)

This discourse was highly emotionally charged and the participant appeared frustrated with people feeling sorry for her. Her perception that people were '*always* feeling sympathetic' emphasized how frequently she perceived this was happening. It was as though she wanted to be on an 'equal footing' and not to be 'set back' by people feeling sorry for her. Her perception of it being 'held it against' suggested that the fact she is in care becomes a 'thing' or a 'weapon' used by others against her, holding her back. It was as though she did not want it to be the 'thing' it

was and felt this would allow her to move forward. The idea of 'people not understanding' resurfaces.

Participant two described his representation that people were overly cautious and had a 'different mind set' around him, wishing they would just be 'normal'. He discussed teachers being more lenient with him and how he would prefer this not to happen. Participant three also experienced and disliked a friend being overprotective of her. Participant seven described teachers shouting at her and exposing her 'looked after' status to her peers;

> 'they said they can't properly exclude me because I'm a *looked after child*, but then kicked me out anyway and told me not to come back'
>
> 'so what did it feel like when they gave you that label then?' (Interviewer)
>
> 'I went mental…. I was like 'everybody's a *fucking* looked after child [very angry tone]' (Participant seven line 532)

She talked of hating the label 'looked after' and how she wished teachers would treat her in the same way as everyone else. Her representation was that her teachers and friends were looking at her 'like a looked after child'. Given that previously she talked about withholding information from her friends regarding being in care, and anxiety about their potential reactions, it is possible that when her teachers shared this information with her peers this caused her to feel out of control, exposed and scared.

Participant one talked of people at school thinking you are different and not normal due to living with non-family members and how this was a disadvantage of being in care, 'and people like just expect you to *deal* with that *you're* different' (Participant 1, lines 149-153). Her tone of voice

and language suggested frustration and anger at having to *'deal'* with being different. Her representation of 'others' is somewhat cold and unkind in this specific scenario; they expect her just to 'deal' with it. She discussed how she didn't see her life as 'bad', giving the impression that she perceived that others had done. This echoes participant seven's claims regarding others thinking your life is wasted.

There appeared to be something about 'being' what people view you to be. The excerpt above indicates that the young person felt that if people see her as different, she *is* different. She elaborated on this 'it's hard 'cos if people think you're different then *you're* different and there's nothing you can do about it' (Participant one line 776). The importance of peer responses in terms of developing identity seems apparent. The participant found this hard and reported that 'there is nothing you can do about it'. 'Self-agency' was a recurring theme for this participant so this was likely to be challenging for her. She then expressed opinions contrary to those she perceived her peers adopted; talking about how it is a positive thing to be different and important to be individual. She talked of her foster parents encouraging this; 'if they like you they like you, if they don't they know where the door is'. There was a real sense that she was attempting to make sense of who she was, of how people viewed her and her thoughts and feeling about this.

2.5.5 Noticing differences

Five participants discussed times when they felt different to others. Participant one discussed watching classmates' parents meeting them from school and being 'marched' off by her aunt and feeling upset and jealous and of being forced to grow up quickly and how she felt more mature

and sensitive than her peers. She attributed this to earlier experiences of having had to be constantly attuned to her birth father's mood to protect herself.

> 'I'm still so different…with what I've been through I'm a bit maturer [sic]… I've been forced to grow up that bit quicker, whereas they've been able to like grow up at their own stage…I wasn't allowed to be a child …and I don't find what they find funny funny so they think I'm weird and different and that also kinds of makes it worse because I'm in care as well' (Participant 1, line 225)

The significance of relationships is again emphasized. She described how she held herself back from people because she felt so different and elaborated on how this may have led them to conclude that she wanted to be left alone. As illustrated, she also discussed how due to her increased sensitivity, at times she would not find funny what others found funny and this made her peers think she was 'weird'. As well as being in care she noticed other aspects of her personality separating her from her peers. This participant stated on numerous occasions in the interview that she was no different then proceeded to say all the ways that she felt different.

Participant seven talked of feeling different to her peers because she did not live with her birth parents and how she felt 'weird' and 'not normal'. She also talked about feeling different to her foster parents and how she constantly felt 'out of place';

> 'it feels really weird...not normal...all my friends are with their family and can do things with their family and be happy and stuff... like when I went on holiday with my foster parents, it was weird, I just feel like out of place all the time... like they're posh and all that and I'm like more of a [2]chav…' (Participant 7, line 67)

As well as feeling emotionally out of place she felt physically out of place. She perceived she was 'dumped' with people she had never met before in a place she had 'never flipping heard of'

[2]chav; colloquial term to refer to working-class youth subculture in the United Kingdom

far away from her friends. The word 'dumped' suggests that she did not feel valued during the process of being placed in care and that it felt like something that was 'done to her' out with of her control.

The content of the discourse, as well as non-verbal cues suggested that beneath the anger lay intense sadness and fear. On a number of occasions the participant stated 'I don't want to talk about this anymore'. She reported not feeling included but how she distanced herself from others; by physically separating herself from them and by not making any effort with people. She reported having been let down her whole life and how this had made her cut herself off from people to avoid it happening again. She reported hating the loving things her carers said to her and how one of her carers told her positive things about her character but that 'I just think it's a load of shit'. She elaborated;

> 'I don't do well with positive stuff 'cos [sic] at school and like at home I've always been given like negative attention and been told negative stuff and so that's what I'm used to' (Participant 7, line 764)

She discussed how different she was to her carers. She had mixed feelings, recognising it was good that they were a support unit, because this was absent at home, but at the same time not wanting support. This ambivalence physically manifested when she tried to run away, but said she could not do this as her carers were too nice. She discussed ambivalence towards her friends as well;

> 'I get to the point where I'm like "my group of pals are a bunch of ³fannies", I'm kinda [sic] glad like I don't see them all the time, 'cos [sic] I'd just get roped into all their shit' (Participant 7, line 363)

³fanny; colloquial term meaning stupid person or wimp

She talked of how care gave her space to reflect on them being a bad influence. She appeared to feel different to her friends now she was in care, separate from her birth family and different to her carers; constantly 'out of place'. 'Belonging' represents the opposing end of the spectrum to feeling out of place and is emphasized in resilience literature (Hart and Blincow, 2007). A review of empirical literature proposes that 'belonging' is a pervasive motivation which represents a set of mechanisms that enable us to live our lives with at least some degree of predictability (Baumeister and Leary, 1995). It has been proposed that if a positive sense of belonging is not achieved, young people may seek to belong in relationships that do not serve them well (Hart & Blincow, 2007).

Other participants discussed representations of what life was like for young people living with birth parents and that they would be happier and that life would be easier because they did not have to adapt to new environments, talking about it being more 'natural'. The word 'natural' conjures up positive connotations which imply opposing notions of 'abnormality' and 'difference'. Three participants' however talked about how life for people with their birth parents was likely not too different from life in care.

Expressions of difference by other participants related to difficulties with schoolwork. Participant six talked about feeling stupid when he struggled with school work. He talked about how this could make him feel; 'like I'm hopeless, I'm stupid, I'm rubbish ... I can't be bothered doing it, I'm no good at it' (Participant six, line 608). He felt that there was a link between his

father's lack of support and his difficulties with schoolwork but the outcome was that he internalised this and concluded that he was hopeless, stupid and rubbish. For this participant the negative emotional impact of struggling with peer-appropriate tasks was powerful. Participant three also reported feeling ashamed of her educational ability when she entered care. She however report feeling extremely proud of her progress since entering care and reflected that it was not her fault because she missed so much school when living with her birth parents.

2.6 Discussion

2.6.1 Summary

Participants discussed representations of how being in care affected how others viewed them and their own sense of who they were. The emotional experiences associated with these representations were powerful. Feelings of powerlessness, sadness, anger, jealousy, hopelessness, feeling 'weird' and feeling out of place were described. It is important to acknowledge that this picture only reflects part of these young peoples' lives. Participants also discussed very positive friendships and foster care placements. The impact of 'feeling different' however was very evident and common across nearly all participants at some point in their journeys. These findings corroborate the anecdotal evidence that being made to feel different is a significant concern for young people in foster care.

2.6.2 Extant literature

The findings are also congruent with previous research regarding the presence of social stigmatisation (Kools, 1997; McMurray *et al,* 2011; Vojak, 2009) and with Kools' (1999) findings that young people in foster care guard their foster care status to avoid further devaluation by others. The significance participants appeared to place on interactions with others emphasizes the importance of interpersonal relationships and compliments the more dynamic and transactional conceptualisations of identity development (Bosma and Kunnen, 2001; McKinney, 2011; Gauntlett, 2007). The dynamic nature of the participants' experiences also compliment the less static and predetermined conceptualisations (McKinney, 2011). Further, the finding that, 'if people think you're different, you're different' illuminates the symbolic interactionists' theories regarding how identity is contingent upon the reactions and behaviours of others (Cooley, 1902 as cited in McMurray *et al,* 2008). Attachment theory clearly plays a significant role in how young people form representations of who they are (Fonagy *et al,* 1994) but the significance of social interactions appears also to be crucial. While early experiences may lay the foundation that either facilitates or jeopardizes identity development (Kools, 1997), identity appears to be socially bound (Harter, 1990).

2.6.3 Clinical and systemic implications

The lack of understanding regarding 'foster care' and lack of acceptance of 'difference' appeared to be prevalent in participants' peers, suggesting that more education and awareness are needed. Perry and Szalavitz (2006) explore how children, like adults, react badly to the unknown and that social rejection and bullying often begin with fear of the unfamiliar. They acknowledge that

social hierarchies are not always easy to influence but that adults, teachers and parents may have more influence than they realise. Especially with younger children who are more influenced by cues of rejection and acceptance from adults, these cues may set the tone for childrens' status systems;   teachers and parents can either minimize or maximize bullying by either strongly discouraging or tolerating the scape-goating of those who are 'different' (Perry and Szalavitz, 2006).   Additionally, providing opportunities for young people in foster care to meet with positive role models who are care leavers and to spend time with other young people in care may allow them to integrate their 'foster care status' into their identity and promote positive identity development. Smith (2011) writes about 'gems' in qualitative research, which are relatively rare utterances in the data that are particularly resonant. In relation to the current research question one participant talked about her foster care status in a celebratory and positive manner and exclaimed that she was 'a foster auntie!'. Something enabled this participant to integrate her foster care status into her identity and feel proud and positive about this. Future research examining these processes further would be valuable.

Health care professionals and foster carers need to be aware of the potential significance of 'feeling different', so that young people have opportunities to make sense of this, and so they can be encouraged to develop positive feelings about themselves. Some participants perceived that they had missed out on a great deal in comparison to their peers and subsequently may need to grieve. Children need to be supported to deal with others' responses to their care status. For children who are likely to have experienced neglect or abuse, imagining numerous ways of coping with situations may be difficult due to lack of development in the part of the brain responsible for this kind of cognition (Miller *et al.,* 2000; Perry *et al,* 1995). This may be even

more difficult when stress responses are activated during questioning by peers about care or being made fun of. Children need help to feel confident and more in control when managing these interactions.

2.6.4 Limitations

Despite attempts to bracket knowledge in the initial stages of analysis, the researcher's background in psychology, experience of clinical work with foster children and having family members who were fostered likely influenced how data was approached. However, IPA does acknowledge the researcher's perspective and knowledge as a strength in terms of making informed interpretations in the latter stages of analysis. The 'knowledge' this research generated was also limited by the fact that the interviews took place on only one occasion and would clearly have been influenced by the choice of questions. Upon reflection, there were also occasions when the researcher could have asked for more detail about the emotional texture of participants' experiences. A further limitation is that 15 of the young people invited to participate did not respond. It is possible too, that they may have had different perspectives regarding 'feeling the same or feeling different'. In future, the researcher would include in the initial letter to participants, a section offering the opportunity to outline reasons for not participating, to try and obtain a clearer understanding of this. Despite limitations, value lies in the involvement of a care leaver in the initial stages of the research and that the researcher offered participants an opportunity to feedback how meaningful they found the themes. The feedback that was provided suggested the themes were very relevant and meaningful although the majority of participants requested a written summary of the research rather than a face to face meeting to provide their own feedback.

2.6.5 Conclusions

Young people who are already likely to have experienced early trauma that can impact on their developing sense of self are further challenged by how systems around them respond to their foster care status. Health, social and educational settings have long been required to label groups of people and are structured in a way to facilitate *their* functioning; not necessarily the functioning of the groups being labelled. Young people in care need opportunities to develop a positive identity despite the challenges this process may entail. Promoting acceptance of 'difference', providing positive role models and offering opportunities for the young people to develop ways to cope with peer interactions may be valuable. Some young people clearly adapt well to their lives in foster care. Research examining this, specifically in relation to identity development, may provide a more sophisticated understanding of the role of resilience.

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3 Extended Results

The following section represents one additional super-ordinate theme; 'Making Sense'. This will be explored through five sub-ordinate themes (see Figure. 2)

Figure. 2 The super-ordinate theme 'Making sense' and the five sub-ordinate themes

3.1 Making Sense

This super-ordinate theme represents how participants attempted to make sense of their experiences of foster care. They discussed being removed from birth homes and adapting to life with new people. This involved making sense of why their birth parents could not care for them,

developing concepts of 'right and wrong', and managing conflicting feelings towards both birth parents and foster parents. Participants expressed throughout how important having a sense of control was in their lives. The five sub-ordinate themes will now be explored.

3.1.1 Is this better for me?

Eight participants discussed their understanding of why they went into foster care and their perceptions of whether or not it was 'better' for them. Seven expressed openly that foster care was a positive part of their lives, however one participant talked of how she knew it was positive for her in the long term but it did not feel positive now. What was discussed by six participants was having their basic needs met, such as enough and better food, clothes, and money in foster care. One participant talked about the process of accepting what had happened to her;

> I kind of learned to accept that although my birth family weren't the greatest there is good that's come out of the bad because now I know what I grew up in was wrong and I can now turn that around for myself (participant one, line 191)

She elaborated that her parents did not show her care in the way it *should* be shown. Crucially she linked the fact that she knew that what she grew up in was wrong to her ability to turn things around for herself. It is possible that her ability to grasp the abstract moral concepts of 'right and wrong' enabled her to externalize what had happened to her. This participant expressed strong emotions regarding wanting to prove to her father that she could make a good life for herself. She talked about 'acceptance' and how she 'now knows' that it was wrong; suggesting this entailed a *process* of discovery.

She perceived that foster care enabled her to focus on her school work more, due to the absence of stress, and that had she stayed with her birth family all her energy would have been taken up trying to cope with home life, impeding her school work. She proudly talked about being able to do really well in school now and about how she had been getting 'loads of gold awards and stuff'. It is possible that her belief about her parents being in the 'wrong' allowed her to externalize what had happened to her and provided her with a sense of agency. This, as well as her academic abilities, allowed her to work hard at turning her situation around for herself, and receive rewards and praise for doing so, in a positive cycle. Other participants discussed how foster care was better for them and how it taught them more about what was 'right and wrong'. Some also discussed how their parents were unable to look after them;

> people would say 'do you stay with your mum and dad' and I didn't want to talk about it, I was kind of emotional, just even saying it before could make me really upset, but like because at first, when I actually first came into care, I didn't know why I was in care, and now like I'm old enough and I've realised that obviously my mum and dad couldn't look after me and stuff (participant 3, line 308)

This participant also highlighted that there was a *process* at play, of understanding why she had been removed from her birth family and of the texture of the emotional experience this entailed. There was a time when she felt she did not understand why she was in care. She attributed her lack of understanding to her age. It is clear that age impacts on a child's ability to understand the incredibly complex experience of being taken into care, but it may also be the case that the system too either hinders or promotes the 'making sense' process. Participants two and nine also discussed their perceptions that their parents were not able to look after them.

Participants perceived that foster care was better for them because of the availability of food, clothes and money but also because foster carers were supportive and encouraging. It was also the case that they had people to talk to, were able to do well at school, that predictability and boundaries were present, that experiences and activities were richer, and that there was an absence of fear. Participants appeared to perceive that foster care would impact on their futures in a positive way. As well as foster care being a positive thing, they discussed how it had taught them about 'right and wrong', and how it had a positive impact on their behaviour. Participant nine mentioned his teachers noticing a 'big difference' in him and how it felt good to hear them say that. He elaborated on this;

> getting taught what is right, and if you do something wrong, well I never used to get disciplined for it, so I kept doing it, but when I went into care I started getting a [1]row for it and getting grounded, and then I started being good
>
> and what does it feel like to be good more often? (interviewer)
>
> happier (Participant 9, line 257)

He gave, as an example that he would feel embarrassed to see a video of himself behaving in the way that he used to. He talked about how his perceptions of his behaviour changed when he went into care and how his previous behaviour in school was 'terrible'. A number of participants echoed these experiences and talked about how their behaviour had improved and how they preferred there to be consequences for their bad behaviour. Participant seven however, said that although people told her that foster care was good for her, it did not feel good. She did state that although people may think your life is wasted, sometimes foster care can be better for you 'in the long run not in the short run'. She talked about how foster care gave her space to reflect on her life and how this made her feel sad. In her birth home she would be too distracted and would

[1]row; colloquial term for being 'told off'

never think about things, but foster care allowed her the time and space to reflect on what had happened, which included having witnessed and experienced violence.

3.1.2 More of a pal than a mum

For many respondents, birth parents were not only unable to fulfill their parenting roles but also wanted to position themselves as friends rather than parents:

> Like when I was at my own house, like my old house, my mum wanted to be more of like a pal, than a mum, like she couldn't really support me as a mum and there always like, sometimes when I was at my mum's there wouldn't be food in the fridge or that [sic] (Participant two, line 37)

He discussed the worry he experienced about where his next meal would come from and how his foster carers were 'more like how a mum and dad should be'. Participant three described how she had to adopt a caring role towards her mother;

> yeah because I was saying to my mum that I was sick 'cos [sic] I wanted to stay with her 'cos [sic] I was really worried about my mum 'cos [sic] my mum was on a lot of medication…… and sometimes basically she can't get to sleep so she's tired and my dad isn't really the best to ask, 'cos [sic] he doesn't help her… and so I was just really worried about her and if my mum said that I had to go to school, I would just say that I felt sick so that I could go home (participant three, line 650)

The worry that this participant experienced clearly impacted on her ability to feel calm and concentrate in school and at times was so overwhelming that she had to pretend to be sick to return home to look after her mum. She discussed how for a four-year period she barely attended school. Similarly participant one discussed how her mother had mental health problems and how she was unable to 'give us what we needed'. She talked about how her mother 'tried her best'

and feeling 'proud' of her mother for letting them go into care. These participants discussed feeling worried and proud in a manner that could be conceptualised as a 'role reversal' of child-parent relationships. The lack of availability of someone to parent and care for *them* was apparent and something that they appeared to have spent time reflecting on and attempting to make sense of.

3.1.3 Managing feelings towards foster carers and birth parents

Four participants explored conflicting feelings towards birth parents and foster parents and the tension that followed from this. Participant one also discussed how her feelings towards her birth parents had changed over time;

> It's quite hard, 'cos [sic] now when I do see them again I think it's going to be quite hard to actually be able to learn to trust them again, 'cos [sic] like with what I've been through, like I did trust them but then I didn't trust them and like now I understand more about what happened, it's going to be really hard for me to trust these people again (Participant one line 723)

She explored how her increased knowledge about her parents made it hard for her to continue a relationship with them. She talked about how her foster parents were more of a mum and dad to her, that they were more of a family and that to her a family was a place where you can trust and be listened to and supported. This participant appeared to feel guilty about having positive feelings towards her foster parents and was concerned about her birth mother knowing that she called her foster mother 'mum'. She also explored the tension that this had caused among her siblings who were in other foster care placements.

Anger towards birth parents resulted in them being blamed for things that went wrong (participant eight). This was also associated with feelings of guilt for the positive feelings she associated with her foster parents. Similarly participant six talked tentatively about how it was a 'wee bit better here than at my dads', and how he used to get shouted at all the time. He was very hesitant and appeared to find it extremely difficult to talk openly about his positive feelings about care. Participant seven acknowledged that in some ways foster care was better for her in the long run but that she also experienced very negative feelings about foster care and her carers:

> like, they give their opinions and advice but like, which I didn't have at home, but, I don't know…. it's just, sometimes I just don't want their opinion 'cos [sic] like of the mindset that like you've not got the right to give me your opinion, sort of like you can't tell me what to do... there was one time where she like tried to be my mum, I was like 'no, you're not my mum' (Participant seven, line 182)

While she acknowledged that their support was positive, and recognised that this was something that she missed in her birth family, she also felt that she did not want their advice.

3.1.4 You'll miss home, even if you're better off

Four participants expressed feelings of missing home and family. Participant one, who was extremely positive about her care experiences, stated that the only thing she did not like was the fact that she had been split up from people she loved. Participant three talked about how she wished her brother was at the same school as her and how she felt sad about this and about it being 'really hard' coming into care and not being able to see her mum. She would try and find comfort in telling herself that her mum had not 'just disappeared', but even so had moments

when she would cry. She appeared to find this difficult to talk about and quickly changed the subject. Participant seven discussed a similar experience;

> I don't like it… its 'cos [sic] like I'm like really family orientated and that and like I do everything for my sister and that... and then like I got a place in care and that all just stopped (participant 7, line 21)

There were echoes of how participant three discussed her mother 'disappearing' again, when participant seven said 'it all just stopped', emphasizing the sudden nature of the experience. Participant eight talked about how not being able to see her parents was upsetting for her; she said this was the only negative things about staying away from her mum and dad. No matter the quality of the lost attachment, the emotional loss can be significant. This can be experienced as a loss of security and safety no matter how limited the security and safety were (Ruston and Minnis, 2002).

3.1.5 I could do something about it

One theme that was extremely prevalent was the importance of having a sense of agency. For participant one this was reflected in her belief that foster care had impacted on her in a positive way;

> It helped me realise what was happening was wrong and I *could* do something about it, I *could* change what I wanted to do, I *could* become somebody that I was proud to be, not somebody I was ashamed to be. It gives me some control over my own life, I can make decisions for myself now. Even though I've got people supporting and guiding me along they're not saying 'you have to do this, you have to do that'. I can make decisions for myself now, whereas at home I didn't get to do that, I got told what to do and that was the end of it (participant one, line 753)

It was as though she felt empowered to be able to make changes in her life, and she discussed how being supported to make decisions, rather than being told what to do, provided her with a sense of control. She discusses feeling both pride in this but also shame about her birth father's behaviour. It is possible that her belief that her parents were in the wrong and her ability to externalize this impacted on her identity in a positive way. Participant six discussed what helped him when he was feeling low:

> er.... just thinking that I *can* do anything, like, like I'm no like terrible at things, I'm actually like good at things when I put my mind to it (Participant six, line 728)

Again, a sense of agency was important to this participant. Conversely, participant two described a time when he did not feel in control during a panel meeting. His understanding was that he was unable to do anything in the meetings;

> I still hate meetings, like at panels, I hate them cos its about me but ken it's just like I feel kind of dead small and like I cannae do much it's just like I need to sit here (participant 2, line 337)

The sense of feeling that there *is* something participants can do in their interactions with others appears to be imperative. Participant seven also discussed how difficult it was feeling out of control when she was placed in foster care:

> They're all like 'this is your home town now', but I don't see it as my home town... It's just weird, being taken out of your family home... and then dumped with strangers, and like 'aw, you're going to be for such and such a time' (participant 7, line 21)

This participant portrays being placed in care as something that 'happened to her', rather than something that she had any control over, and as a negative and difficult experience. She also talked about the lack of privacy in the foster home and wishing she had more control over this. On a more positive note she expressed that she liked how her foster carers gave her more independence and responsibility than the younger children on placement with her.

3.2 Summary

Young people who have been removed from their birth parents and placed in foster care are forced to have to attempt to make sense of the very complex experiences they have been through. Representations of this multifaceted process were explored by participants and involved; attempts to understand 'why' they have been taken away from birth parents, guilt when forming attachments to foster carers, sadness when missing birth families and attempts to manage conflicting feelings towards both foster carers *and* birth parents. The subsequent emotional experiences were varied and included happiness, sadness, guilt, anger, relief, pride, and shame. The dynamic nature of these processes was evident, and participants were mixed in terms of accepting or rejecting what they had been through. As well as having to make sense of being taken into care it appeared that foster care provided space to reflect on birth family life. When these experiences involved trauma, this was clearly challenging and painful.

3.2.1 An additional task of adolescence for young people in care

The process of 'making sense' in itself might be conceptualised as an additional developmental task of adolescence for young people in care. Difficulties with this process may impact on

cognitive, social, emotional and identity development, all of which may have clinical implications. It is therefore essential that the system surrounding young people in care responds in a sophisticated way that promotes rather than hinders this process to ensure healthy development is not compromised further. A participant who provided feedback subsequent to analysis, talked of how although you come to learn that 'what you grew up in was wrong' at first you cannot understand because it 'just felt normal' at the time. She talked about how this 'took its toll' on her friendships and prevented her from feeling relaxed and spontaneous and how it would regularly intrude on her thoughts. She described school as her 'saviour' and asserted that her school work had not been affected but she stated that she could imagine some young people may find it difficult to concentrate in school. She felt that this was an extremely meaningful theme in the analysis.

3.2.2 Clinical Implications

Providing young people with the opportunity to make sense of their experiences may be beneficial and have a positive impact on other areas of development. The time and space provided in foster care, may force young people to confront early traumatic experiences. Whilst talking therapies are widely recommended for the treatment of trauma (NICE, 2005) Perry and Salovitz (2006) discuss the implications of the neurological impact of trauma in terms of therapy. They discuss how the brain develops in a 'bottom-up' fashion with the cortical regions, responsible for abstract and concrete thought and affiliation developing the latest. For young people who have experienced trauma these areas can be undeveloped. Crucially, in relation to the current research finding, this may have implications in terms of 'making sense' activities but also for making use of 'talking therapies'.

They explore a 'neurosequential approach' which examines which regions and functions in the brain are underdeveloped or poorly functioning and then works to provide the missing stimulation to help the brain resume a more normal development. They discuss how these parts of the brain need repetitive and patterned stimulation which suggests that other forms of intervention, such as providing sensory stimulation, music therapy and play therapy may be beneficial and necessary before 'talking therapies'. More systematic research in these areas is needed. It is also important to acknowledge that these claims regarding the importance of brain development are not novel; there are existing theories of sensitive periods of development which have explored how important the early experiences are and the idea that a child's brain is particularly sensitive to certain stimuli or interactions at a certain stages (Montesorri, 1949). Despite these sensitive periods, and despite evidence indicating a 'neuro-sequential' approach to therapy, the brain maintains a level of plasticity and there exists a body of research evidencing the successful use of talking therapies with young people. Perry (1997) claims that children who have missed critical periods of brain development can be extremely insensitive to therapy however psychosocial treatments for children who have experienced trauma have been evidenced (Stallard, 2006) and trauma has been successfully treated with cognitive-behavioural approaches (Nixon *et al.,* 2012). Congruent with this, Silverman and colleagues (2008) conducted a systematic review of 21 studies and concluded that Trauma-Focused Cognitive-Behaviuoral Therapy was efficacious. A more balanced perspective must therefore be borne in mind.

Another important clinical implication is that young people need to feel empowered and to be provided with a sense of control in their lives. This finding is congruent with previous research

with young people in foster care (McMurray *et al.,* 2011). Foster carers need to be educated about how vital it is for young people to feel in control, especially for young people who have experienced trauma (Perry and Salovitz, 2006). Young people need to be supported to be agents in their own lives, decisions about their care need to be as collaborative as possible and therapists need to be aware of allowing young people to feel safe in therapy and in control of the therapeutic process.

3.2.3 Rejecting identity

Loxtercamp (2009) discusses the deleterious effect that contact with birth parents can have on young people in foster care or adoptive placements. He argues that professionals can sanitise the early experiences of young people in adoptive care, offering explanations such as 'she (birth mother) was poorly', or 'they loved you but they didn't know how to look after a child'. The way in which professionals explain to young people why they have been removed from their birth families may also be pivotal in terms of the young person's sense making activities. 'Life story work' is supposed to help young people make sense of who they are and where they come from (Ryan & Walker, 2003) and is considered a minimum standard within social care (BAAF, 2008). However, there appears to be an absence of research supporting its effectiveness (Baynes, 2008) and Loxtercamp argues that it can encourage an idealistic and sanitised version of events.

There appears to be little to help practitioners understand how a child's concept of time and illness affect their understanding of the possibility of their birth parents being able to provide an adequate home for them. There are clearly challenges in telling a young person in a

developmentally appropriate manner, the truth about why they were removed from their birth families to help them make sense of the need for them to be looked after by people other than their birth parents. Professionals physically remove young people from their birth parents but perhaps find it harder to communicate to young people why this happened. It is possible that professionals find this painful and are unable to manage this. Further, young people may pick up on this making it difficult for them to ask questions to make sense of what they have been through. This also may represent a missed opportunity to contain the young person's anxieties and sadness.

One participant in the current study directly linked the fact that she knew that what she grew up in was wrong to her ability to turn things around for herself. It is possible that this knowledge enabled her to externalize what had happened to her, thus encouraging positive identity development. Loxtercamp (2009) argues that in healthy identity formation, to disown what (one believes) ought to be disowned is as important in forming a secure identity as it is to endorse that which (one believes) ought to be endorsed. Further research examining how professionals explain to young people that they are care, in the context of identity development, would be extremely valuable.

4. Overall conclusion

4.1 Theoretical Perspectives

While a variety of theoretical models have relevance for the current research question, one in particular, 'dynamic nonlinear systems theory' is particularly relevant in relation to the research question and the results of the analysis. This theory is based on Bertalanffy's general systems theory (1950, as cited in Smith 2011) and suggests that every living organism is an open system that sustains itself in continuous inflow and outflow, exchanging matter with the environment in which it is embedded (Lin, 2002). Nonlinear dynamic systems theory builds on this by adding the three principles of 'complexity', 'continuity in time' and 'dynamic stability'.

'Complexity' refers to the way in which numerous interacting parts work together to produce a coherent pattern under particular conditions; implying there is no such things as unicausality (Thelen, 2005), and emphasizes that the environmental surround is always a part of a person's behaviour, including social, cultural and physical factors. 'Continuity of time', suggests that each moment is a product of all proceeding experience and all future moments are built on the present moment (Smith, 2011), implying that all interventions have to potential to make a difference to what comes after. 'Dynamic stability' refers to how some behaviours are so constrained by human structure and social systems that they are highly stable patterns, but only for a time, e.g., developmental stage may constrain choices but only for a time. This principle emphasizes the adaptability of the individual, as well as the potential of new experience or developmental capabilities to have impact on a person and on relationships.

Young people in care are part not only of the complex system of their birth family but their lives are closely entwined with a much wider system. The young people's representations illuminated this, their interactions with their social world, affected by the social work system, and the system of the foster family impacted on their thoughts, feelings and developing sense of self. 'Continuity of time' acknowledges that previous experiences have an impact on the individual, in the case of the current research, for example, internal working models, attachment, previous incidents of being bullied, to name a few. However, emphasis is also placed on the fact the present is important and influences the future; congruent with the young people discussing the positive impact that foster care was having on their lives. Further, highlighting how imperative it is that the systems around young people in care work in the 'present' and aim to promote positive identity development. Finally 'dynamic stability' illuminates how developmental stages impact on the individual.

4.2 Reflections on the process and contextualising the findings

The process of carrying out this research was enjoyable yet at times incredibly challenging emotionally. Given the nature of the discussions this seems obvious, but interestingly, and congruent with the 'sense of agency' theme, one of the most difficult things was having to adjust to the role of researcher as opposed to clinician; feeling at a loss to be able to *do* anything and having to take a step back, and think at a more conceptual level about these young people's lives. Engaging with some of the dialogue at such a deep level was hard; really considering the texture of the emotional experiences of being bullied, of feeling shameful, of yearning for lost attachments no matter the quality of those attachments, of young people feeling lonely and

lacking a sense of belonging. Authors have however warned of the dangers of emphasizing the negative aspects of the lives of young people in care (Faruggia *et al.,* 2006). This project hopes to have balanced this effectively. Whilst addressing the current research question it has also acknowledged that some participants in the cohort did clearly evidence strong friendships, positive social adjustments and secure placements.

As stated, engaging with the dialogue from the stance of a researcher was challenging. Similarly, clinical work, especially with young people who are discussing emotive and traumatic experiences, can be emotionally challenging. This has clinical implications and underscores the importance of, for example, using clinical supervision appropriately. A great deal of research has highlighted the emotional impact that trauma therapy can have on the therapist. McCann & Pearlman (1990) introduced the term 'vicarious traumatization', which refers to the transformation occurring within the therapist as a result of engaging empathically with clients' trauma experiences. Since then a number of studies have continued to establish a relationship between carrying out trauma work and experiencing trauma symptoms (e.g., Schauben & Frauzier, 1995; Pearlman & Mac-Ian, 1995). Pearlman & Saakvitne (1995) discuss the importance of training and supervision amongst trauma therapists and the imperative nature of supportive, confidential and professional relationships for therapists, to enable the processing of traumatic stories and images.

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Appendix 1 British Association of Adoption and Fostering Journal Style Guidelines

⑤SAGE

SAGE UK Style Guide

Version UK3/August 2011

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2. Article opening material

2.1 Headings
1. Headings should have an initial capital with everything else lowercase, unless proper names.
2. Italics can be included in A heads (H1) if needed, e.g. mathematical symbol or genus name.
3. Headings are unnumbered and formatted as below.
4. Where headings are referred to in the text use section names, as headings are not numbered.

A head (H1) (bold with initial cap, all the rest lowercase)

Introduction

The mucosa of the small and large intestines is the largest reservoir of tissue macrophages (Mφ) in both humans and mice.[1] Although Mφ possess various

B head (H2) (italic with initial cap, all the rest lowercase)

Human samples

Human specimens of normal large intestine were obtained from normal tissues of three patients with colon cancer who had their large intestine resected for

C head (H3) (same as B head, but set as first line of paragraph, full out; italic with initial cap, all the rest lowercase, followed by a full stop. Following text runs on)

Single nucleotide primer extension. The PCR product from bisulfite-created genomic DNA was cleaned with ExoSAP (USB) prior to SNuPE reaction. For calibra-

Headings for Abstract, Keywords, Funding, Acknowledgements, Conflict of interest (in that order), References, Appendices are same as A head but smaller font size

Acknowledgements
We thank Dr van Lookeren Campagne (Genentech) for providing blocking mAb against CRIg (clone 14G8) and isotype control mAb (anti-ragweed).

(CEs: where a template is being used there is no need to format these. Where no template is being used, please format as bold/italic, but there is no need to mark the font sizes, TS will format.)

2.2 Article types
Where a journal displays article types, these should appear on the first page of each article, left aligned above the horizontal rule, and in italics.

General technical or research papers should be classified as *Original Article* (with uppercase initial caps) for STM, and *Article* for HSS. (Check with the PE, as there is some variation between journals.)

Other usual paper types are as follows: *Review Article, Case Study, Technical Note, Case Report.* Individual journals may also have other paper types, as agreed with the Editor. Where no particular convention has been agreed, *Original Article* should be followed for STM, and *Article* for HSS.

2.3 Article title
Please format with an initial capital only and remaining words lower case, unless proper names. Italics can be included where necessary (e.g. genus name). Run on subtitle after colon, with initial capital after colon.

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2.4 Author names, affiliations, and corresponding address

Authors

List authors in the order that they appear on the manuscript. Authors' first name should be in full, middle names should be initials *without* full stops (e.g. Simon PS Sharma) and no spaces between multiple initials. No series comma before the 'and' before the final author name.

Affiliations

Affiliations should contain only the following: department or faculty, institution, country. Some HSS journals may have institution and country only. Do not include titles, positions, qualifications, street names, or postcodes/zip codes. Affiliations should *not* end in a full stop.

STM: author names should be annotated with superscripted numbers (CE: do not use automated endnotes against names and affiliations). If all authors are at the same affiliation no superscript numerals are required. Affiliations appear separately with the corresponding address at the bottom of the right column (see next page):

Mark A Creager[1], Reena L Pande[1] and William R Hiatt[2,3]

HSS: affiliations should directly follow each author name, as follows:

Mark A Creager

(Department of Engineering,) Southampton University, UK

Reena L Pande

(Department of Engineering,) Southampton University, UK

William R Hiatt

County Hospital, CA, USA; Harvard Medical School, USA

Multiple affiliations are separated by a semi-colon.

Corresponding author

The affiliations and corresponding author information is positioned as follows:
Bottom of the right column on the first page of each paper, separated from the text with a horizontal rule (some exceptions apply for specific journals).

Corresponding author:
John Smith, Department of Social Studies, South Bank University, 4 Sample Road, London SE17 9OP, UK
Email: john.smith@sbu.ac.uk

STM: Affiliations and corresponding author details should appear as follows, bottom of right column.
HSS: corresponding author appears in the same position, minus the affiliations.

[1]Research Center Borstel, Leibniz-Center for Medicine and Biosciences, Borstel, Germany
[2]Microbiology Department, Chemical Faculty, Gdańsk University of Technology, Gdańsk, Poland
[3]Novartis, Basel, Switzerland

Corresponding author:
Sven Müller-Loennies, Research Center Borstel Leibniz-Center for Medicine and Biosciences, Parkallee 22, D-23845 Borstel, Germany.
Email: sml@fz-borstel.de

Please remove any fax or telephone numbers, titles (e.g. Dr, Professor), positions (e.g. Senior Lecturer).

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Please note: 'Email' with cap E and without hyphen. Email should start a new line. There *should* be a full stop after the country in the corresponding address.

Affiliations and corresponding address text should be left aligned, not justified, to avoid irregular spacing between words.

2.5 Abstract and keywords
Abstract should appear in bold without a colon, text should start on the next line, with no indent.

Keywords (all one word) should appear in bold without a colon. The keywords should start on the next line, separated by commas only, not semi-colons. The first keyword should have an initial cap.

Abstract
Anaphylaxis related to drug therapy with 5-HT3 antagonists, in particular, palonosetron has not been reported frequently in the literature. Here a case is presented where the patient possibly had an anaphylactic reaction to palonosetron. In this case report, a 40-year-old female with ovarian cancer developed shortness of breath and hypotension after receiving her palonosetron as part of her premedication for chemotherapy. The patient recovered successfully with fluids and supportive care. This case demonstrates that even after successful treatment in the past with palonosetron a patient may later develop a hypersensitivity to the agent.

Keywords
Palonosetron, anaphylaxis, hypersensitivity, 5-HT3 receptor antagonist

In some journals, Abstracts have sub-headings, e.g. Methods, Conclusion etc. These should be formatted in bold with a colon in bold and each sub-heading should start a new paragraph. The text should run on after each heading with an initial capital.

Submitted/accepted dates
For journals that publish received/revised/accepted dates (applies to specific journals, if unsure please check with the PE), this should appear after the Keywords and be formatted thus:

Date received 29 July 2010; reviewed 30 August 2010; accepted 5 November 2010

2.6 Running heads
Recto: should be author surname(s), e.g. *Smith*, or *Smith and Jones*, or *Smith et al.* (for three or more authors, and et al. is also in italic).
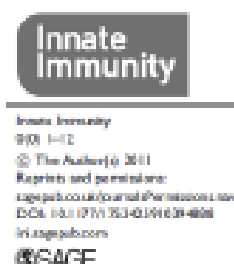Verso: full journal title in italic, followed by 0(0).
For IMechE journals: e.g. *J. Automobile Engineering 0(0)*, without the Proc. IMechE or journal letter).

Innate Immunity 0(0)

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3. General style and layout

3.1 Logo and imprint box

All papers in the standard SAGE design will have a journal logo in the top right with an imprint box underneath (although the logo may be missing on journals that are new to the SAGE design). The imprint box will contain the following information: journal name, vol/issue/page numbers (for papers in production, vol/issue are represented by 0(0), page numbers are the number of pages in the PDF, e.g. 1–9), copyright line, link to permissions web page, DOI, journal URL, SAGE logo:

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3.2 Figures

1. STM: All figures should have a key line (i.e. be enclosed in a box). HSS: figures have no key line.
2. Figures should be appropriately sized (done by the TS). They do not need to be a full column width or page width.
3. Figure permissions: any figures reproduced from another publication need permission. In cases where those publishers listed on the STM permission Guidelines page (http://www.stm-assoc.org/permissions-guidelines/), permission is not required and only the reference number need by present in the caption. Some publishers ask for certain text, e.g. Elsevier.
4. Source: in cases where permission is required and has been obtained, this should appear below the caption in the following form: Source: reproduced with permission from publisher, year, reference number (Vancouver), author, date (Harvard).
5. Any abbreviations needing to be spelled out should be listed after the caption, starting on the next line, in the following format: IC: internal combustion; PID: proportional–integral–derivative).
6. Captions are positioned below the figures and left aligned.
7. Captions should start, for example, **Figure 1.** (with a full point also in bold) and have a full point at the end. Where the text runs onto multiple lines, the captions need not be justified but should be aligned left.
8. Where figures have multiple parts, these should be labelled as (a), (b), (c), etc. (not A, B, C). Captions should contain subheadings for all parts if not present in the figure itself.
9. All figures should be numbered consecutively and cited in the text as Figure 1, Figure 2 etc. (Figure should be spelled out in full, not abbreviated).
10. Text citations: figures should be referenced in the text as follows: Figure 1, or Figures 1 and 2, or Figures 2 to 4, or Figure 1(a) and (b), or Figure 2(a) to (c). Where the figure citation is not part of the sentence it should be placed in parentheses.

Examples:
Please see Figure 2 for an illustration of the model used
The model used was an X3G standard type, exported from Germany (Figure 2 or see Figure 2).

3.3 Tables

1. Tables do not need to be a full column width or page width, but should be the appropriate width for the content. They will be laid out by the TS so no work is required by CEs on table layout, only on content.
2. Table headings should be left aligned, even when they relate to multiple columns, unless this creates confusion.

3. Tables should only have minimal horizontal rules for clarity, and no vertical rules (done by TS, no need for CE to format).
4. All tables should be numbered consecutively and cited in the text as Table 1, Table 2 etc. (Table should be spelled out in full, not abbreviated).
5. Table permissions: any tables reproduced from another publication need permission. In cases where those publishers listed on the STM permission Guidelines page (http://www.stm-assoc.org/permissions-guidelines/), permission is not required and only the reference number need by present in the caption. Some publishers ask for certain text, e.g. Elsevier.
6. Source: In cases where permission is required and has been obtained, this should appear below the table in the following form: Source: reproduced with permission from publisher, year, reference number (Vancouver), author, date (Harvard).
7. Any abbreviations needing to be spelled out should be listed under the table (smaller font, TS will format), in the following format: IC: internal combustion; PID: proportional–integral–derivative.
8. General notes to the Table should be positioned below the Table, typeset in a smaller font and should start 'Note:', and end in a full stop. Do not add the word 'Note:' unless needed for clarity.
9. Footnotes should be represented in the table by superscript letters a, b, c, etc., and appear below the Table (smaller font, TS will format). Each footnote should start a new line and end with a full stop. These notes should precede the source for the table, if included.
10. Captions are positioned above the table and left aligned.
11. Captions should start, for example, **Table 1.** (with a full point also in bold) and have a full point at the end. Where the text runs onto multiple lines, the captions need not be justified but aligned left.
12. Dates in Tables can be shortened to, for example, 4 Dec 10, if space is lacking. Do not use the form 04/12/10, as this could be confused as 12 April in US.
13. Normal text in columns should always be left aligned. Data in tables should be aligned on units if all the data in that column take the same units. Otherwise, the data should be left aligned. Units in table headings should be enclosed by parentheses, not square brackets (if any brackets are required at all).

3.4 Lists
1. For lists where items are not full sentences, use (a), (b), (c) etc. or bullet points (whichever is more appropriate) and separate items with semi-colons. Start list with a preceding colon and end list with a full stop.
2. For lists where items are full sentences or multiple sentences, use 1. 2. 3. Start list with a preceding full stop or semi-colon (whichever is more appropriate), and end list with a full stop.
3. List numbering/bullets should be full out and left aligned, with text indented and aligned. Lists should be separated from preceding/following text with a line space.
4. Where list items include headings, that heading should be italic, same size as text and end in a full stop. The following text should run on.

3.5 Maths/equations (see section 5, p. 14 for more details)
1. Equations should be left aligned with a 3 mm indent, *not* centred.
2. Equations can be broken at operator symbols (x, -, +, etc.), and continue on the next line, starting with the operator itself.
3. Equations should be separated from text above and below by at least one line space.
4. Any equation numbers should be enclosed in parentheses and right aligned, and aligned horizontally with the bottom line of the equation or equations, where multiple terms are covered by one equation number. (Not all equations need be numbered, see section 5).

General note: text following Figures, Tables, equations does not need to be full out with no indent. If the next block of text after any of these items is a new paragraph, then this may be indented.

3.6 Appendices
Maths notation list
1. Where present, notation should appear as Appendix 1, following the references. The heading *Notation* should be a B-head (not Notations; it is not plural).
2. Abbreviations list should be separated from mathematical notation under a separate B-head *Abbreviations*.

3. Notation should be listed in alphabetical order, English letters first, followed by Greek, followed by numbers, followed by symbols.
4. Subscripts and superscript should come under a separate C-head (italic and smaller font), and symbols should follow the same order as in point 2 above.
5. The Notation section does not need to be cited in the text, like other Appendices.
6. Notation list should be left aligned. Text in the notation section should be left aligned in general, not justified.
7. Please note that a notation list is not compulsory in mathematical papers, as long as all symbols are defined in the text.

Other appendices
1. Numbering of figures/tables/equations in Appendices should follow on from the numbering in the text.
2. All tables/figures should have captions.
3. All appendices should be cited in the text, e.g. (see Appendix 1). If they are not cited, authors need to be queried for a citation position.

3.7 Notes and footnotes
Textual notes
HSS
References: Vancouver style reference citations are represented as textual notes, as a numeral enclosed in a square bracket. Harvard style references are as follows (Smith, 1999).
Any other textual notes: are indicated by a superscript Arabic numeral placed after the punctuation. All textual notes should be collected and placed after the text and before the reference section with the heading Notes.

STM
References: Vancouver style reference citations are represented as textual notes, as a superscript Arabic numeral. Harvard style references are as follows (Smith, 1999).
Any other textual notes (whether references are Harvard or Vancouver) are indicated by a superscript Arabic letter and the corresponding footnote appears at the bottom of the relevant column.
In STM journals, footnotes should be edited into the text if appropriately and easily incorporated. However, please leave footnotes if this is not possible.

Authors' biographical notes
These should appear at the end of the paper with the heading Author biography (or biographies), in same font size as References/Funding etc. heading. Follow journal style.

3.8 Book reviews
Please check that the book details are given in this format at the top of each review.

Author, title, publisher: place, date of publication; 000 pp.: ISBN, price (hbk), ISBN, price (pbk)
Editor(s) (ed[s].), title, publisher: place, date of publication; 000 pp.: ISBN , price (hbk), ISBN, price (pbk)

4. Spelling, punctuation and formatting

4.1 Author style/voice
We will endeavour to keep the author's voice as much as possible:
1. Some authors write in the first person. CEs please note that we will not be taking articles out of the first person into the third person.
2. Where American authors have used American spellings, we should also endeavour to keep the author's grammar/punctuation, e.g. closed em-dashes instead of spaced en-dashes, single quotation marks within double, series comma etc.
3. Where UK authors have used –ise spellings throughout their papers in a consistent fashion, please do not change. Where there is inconsistency, use -ize.

4.2 General spelling rules
The general rules are as follows:
- UK spellings should be followed for European articles (-ise is acceptable)
- US spellings should be followed for North American articles
- Rest of the world – follow author style but make it consistent
- Canadian spellings should be standardized to UK or US, depending on author preference
- The following list shows some common exceptions to the '-ize' rule:

Samples							
advertise	arise	devise	enfranchise	expertise	merchandise	promise	surmise
advise	chastise	disenfranchise	enterprise	franchise	misadvise	reprise	surprise
affranchise	circumcise	disguise	exercise	improvise	premise	revise	televise
apprise	comprise	emprise	excise	incise	prise	supervise	treatise

Note also: analyse (for UK), catalyse, dialyse, paralyse.

Do not mix English and US spellings. Some common US variations in spelling:							
analyze	color	favor	fulfil	labor	license (noun)	program	traveler/traveling
behavior	counseling	fetus	gray	mold	pediatrics	practice (verb)	wilful

Follow author style regarding use of the possessive's for proper names ending in s. However, 's is not used for classical names, e.g. Socrates' philosophy.

The following books are recommended: *Hart's Rules*; *Fowler's Modern Usage*.

4.3 Punctuation and formatting
Commas
- Follow author style but make consistent
- Oxford or series comma are not generally used; only use an Oxford/series comma if essential for clarity

Parentheses
These can be used throughout. Double sets of parentheses are acceptable, e.g. (see Figure 2(a)). Do not use square brackets in the text, except in the following circumstances.

Square brackets are used only to enclose an author's comment within a quote, e.g. [sic], [emphasis added]. Square brackets are also used for equations and mathematical expressions within the text.

Quotes
Use single quotes, with double quotes within quoted material. (See section 4.1 for exceptions for articles written by US authors.)

Hyphenation
The basic rule is to follow author style but be consistent.

Use of upper and lower case

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Check the author's usage first, and make consistent. For specific titles use initial caps, for generic titles use lower case (useful pointers follow):

Institutions, movements, denominations, political parties:
- the Roman Catholic Church
- he has catholic tastes
- They were Bolsheviks
- bolshevism, communism

Titles, ranks:
- the President (referring to a particular one)
- the Spanish Foreign Minister
- a president
- several government ministers

Geographical names:
Capitalize politically defined or geographically named places, use lower case in all other instances.
- the West, the East
- western values, eastern culture
- South Africa
- the south of Scotland

Periods, events:
- Second World War
- rationing during the war

Article and book titles:
Follow the style used in the references.

Roman and Italic usage
- Anglicized words should be roman with no accents (common examples follow):

Samples			
ad hoc	coup d'etat	laissez faire	post mortem
a priori	de facto	nouveau riche	raison d'etre
a propos	elite	op. cit.	sine qua non
avant-garde	en masse	per annum	status quo
bona fide	en route	per capita	vice versa
bourgeois/bourgeoisie	et al.	per se	vis-a-vis
cafe	in situ	post hoc	

- Words in other languages – follow author style and make consistent.
- Keep author's own emphasized words or phrases (in italic), unless excessive.
- General: usual italic rules applies, e.g. genus, species, relevant mathematical symbols, x-axis, y-axis, journal/book/magazine names, etc.

Quoted text
Spellings and punctuation in quoted texts should not be altered. If they are obviously incorrect, query with author or insert [sic].

Undisplayed quotes:
Short quotations should be indicated by single quotation marks, with double quotation marks for quotation material within the quote. A full point (or other punctuation) follows the reference for the quote, e.g. '... is the most decisive and important' (Smith, 2003).

Displayed quotes:
Lengthy quotes (40 words or more) should be displayed and indented, with a line space above and below, separating it from the text – follow journal style. Font size will be smaller (TS to format).

SAGE UK Style Guide

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Appendix 2 Quality appraisal checklist

Section 1: Population

1.1 Is the eligible population or area representative of the source population or area? (are important groups under-represented?, e.g., are participants with co-morbidity excluded? is this described well?)

0) Poor or not described

1) Some information on the above or if some groups are under-represented

2) Comprehensive description of the above and no/very little under-representations of groups

1.2 Do the selected participants or areas represent the eligible population or area? (Was methods of selection well described? What percentage of selected individuals agreed to participate?)

0) Very limited information on the above or if there was a significantly small amount of eligible population who agreed to participate

1) Some information on the above available and a reasonable amount of the eligible population agreed to participate

2) Comprehensive description of inclusion/exclusion criteria, the methods of selection are well described and a significant number of eligible population agreed to participate

Section 2: Method of selection of exposure (or comparison) group

2.1 Was there a control/comparison group?

0) No, or no information given on this

1) yes, but unclear how well matched

2) Yes and well matched

2.2 Was the selection of explanatory variables based on a sound theoretical basis? (How sound was the theoretical basis for selecting the explanatory variables?)

0) Very limited information on the above or no sound theoretical basis

1) Some information on the above available and some evidence of a sound theoretical basis

2) Comprehensive description of the sound theoretical basis

2.3 How well were likely confounding factors identified and controlled? (Were there likely to be other confounding factors not considered or appropriately adjusted for?)

0) Very limited information on the above or no consideration of potential confounding factors

1) Some information on the above available and some acknowledgement of potential confounding factors

2) Comprehensive description of potential confounding factors

Section 3: Outcomes

3. Were the outcome measures and procedures reliable? (information regarding validity/reliability?)

0) Low validity/reliability or non-standardised measures

1) Acceptable validity and reliability

2) High validity and reliability

Section 4: Analyses

4.1 Sample size and power (Power calculation undertaken and reported using reasonable effect size estimation and sufficient numbers of participants in groups)

0) not reported or low,

1) acceptable

2) good

4.2 Appropriate analysis for outcome measures is used and confidence intervals, effect sizes and p-values are reported where appropriate

0) Poor method of statistical analyses used, not well described confidence intervals, effects sizes and p-values not reported for any analysis

1) Appropriate quantitative analyses used but less fully described and reporting of confidence intervals, effect sizes and p-values is less clear

2) Appropriate quantitative analyses used. Confidence intervals, effect sizes and p-values reported for every analysis

Section 5: Summary

5.1 Are the study results internally valid (i.e. unbiased)? (How well did the study minimise sources of bias (i.e. adjusting for potential confounders)? Were there significant flaws in the study design?)

0) Given if there were no measure taken to minimise sources of bias and if there were significant flaws in the study design

1) Given if some attempt was made to minimise sources of bias

2) Given if specific and focused attempts were made to minimise sources of bias

5.2 Are the findings generalisable to the source population (i.e. externally valid)? (Are there sufficient details given about the study to determine if the findings are generalisable to the source population? Consider: participants, interventions and comparisons, outcomes, resource and policy implications.)

0) Given if generalisability is extremely limited or if no information is given about this

1) Given if there is some information given about this and if the results are somewhat generalisable

2) Given if comprehensive account of information is given to determine generalisability and if the results are significantly generalisable

Appendix 3 University ethical approval

Re: **The same or different? – An exploratory analysis of the experience of
        12-16 year olds in foster care**

Application for Level 2-3 Approval
****

Thank you for submitting the above research project for review by the Section of Clinical
Psychology Ethics Research Panel. I can confirm that the submission has been independently
reviewed and was approved. Should there be any change to the research protocol it is
important that you alert us to this as this may necessitate further review.

With best wishes,

Yours sincerely,

Appendix 4 School of Health and Social Science approval

I confirm that the above named is currently a student with the University of Edinburgh. Ms Nugent is a full-time postgraduate student on the Doctorate in Clinical Psychology programme at the School of Health in Social Science, College of Humanities and Social Science. Ms Nugent started the programme on 1st October 2008 and her estimated maximum end date is 31st September 2013.

Ms Nugent's academic research supervisors are   and
Her research proposal has been fully approved by the School of Health in Social Science Ethics Committee and the School is happy to support this research.

A copy of the University Public Liability Insurance is attached.

If you require any further information, please do not hesitate to contact me.

Yours faithfully

Appendix 5 NHS management approval

Dear Ms Nugent

Project Title: 'The same or different?' An exploratory analysis of the experience of 12-16 year olds in foster care

Thank you for your application to carry out the above project. Your project documentation (detailed below) has been reviewed for resource and financial implications for   and I am happy to inform you that NHS permission for the above research has been granted on the basis described in the application form, protocol and supporting documentation. The documents reviewed were:

Document	Version	Date
E-mail from Social Work Dept confirming support & consent		18 January 2012
University Thesis Ethics Form (with comments)		5 June 2012
IRAS R&D Form	3.4	
CV		14 June 2012
IRAS SSI Form	3.4	14 June 2012
Appendix A – Information Sheet for Consultants	3	14 June 2012
Appendix B – Information for Social Work	3	14 June 2012
Appendix C – Information for young people	2	20 March 2012
Appendix D – letter explaining required number of participants recruited	1	14 February 2012
Appendix E – Consent Form	5	10 May 2012

The terms of the approval state that you are the Principal Investigator authorised to undertake this study within _____. I note that due to the fact that this study does not involve NHS patients and recruitment is undertaken via Social Work Department contacts, review by an NHS Research Ethics Committee has not been required.

The sponsors for this study are University of Edinburgh.

Appendix 6 Participant information sheet

You are being invited to take part in a project. Before you decide if you would like to take part please read this information very carefully. It tells you all about the project and what you will need to do, should you wish to take part.

What is the purpose of the study?

The researcher is interested in finding out about young people's experience of being in foster care; how young people view themselves and how they feel that other people view them too. The researcher thinks it is important for young people to get a chance to tell adults how they think and feel. The researcher hopes that the study will help adults who work with people in care understand more about what is important to young people. It is hoped that this might help young people in care get the kind of support they want.

The study is also part of an educational project.

Why have I been invited?

You have been identified by your social worker as someone who might want to participate.

Do I have to take part?

Absolutely not. It is entirely your choice to take part or not. It will not affect the care you receive in any way if you decide not to take part. If you do decide to take part you can contact the researcher and ask any questions you might have. At any point you can change your mind and decide to withdraw from the study.

What will happen to me if I take part?

You will meet with the researcher for approximately 20-90 minutes. This depends on how much you might have to say. You can stop the interview at any point and you do not have to

answer any questions that you do not want to. On page 3 of this information sheet there are some examples of the questions you may be asked. You can have a read of these beforehand. The researcher will record the conversation on a Dictaphone and will then type out the conversation on a computer and will delete the recording. The researcher will keep the information really safe, on a computer that only she will be able to use. The information that is printed out will be kept in a locked drawer. After the meeting, when the Dictaphone is turned off, there will be a chance for you to tell the researcher how you are feeling and how you felt the meeting went.

What are the possible disadvantages or risks of taking part?

The discussion may involve you talking about some difficult experiences (although you do not have to talk about <u>anything</u> you do not want to). If you become upset, you can take a break, miss out questions or withdraw from the study. If upset, you will also be given the opportunity to talk about this. The researcher can contact your social worker as well if she thinks that you need more support. To try and stop this happening the researcher has included some of the questions you might be asked at the end of this information. This way, you can know what to expect and tell the researcher if there is anything you do not want to talk about before the interview.

Will I definitely be asked to take part?

The researcher is hoping to meet with between 10 and 12 young people. If you contact us to express interest you will be contacted within 3 weeks, either with an invitation to take part or with a letter explaining the researcher does not need any more participants. If you would like the researcher can send some information to you about the findings of the study when it is finished.

What if you have questions or concerns?

If you have any questions or concerns you can call the researcher and she will do her best to answer your questions.

Will my taking part in this study be kept confidential?

When the study is written up no information identifying you will be included. Nobody reading the study will be able to tell that you were involved. The researcher might include, sometimes word for word things that you have said but this will not be linked to any information about you at all.

What if I want to take part?

If you would like to take part you can contact the researcher either by telephone on the numbers above or alternatively on _____.

Thank you

Examples of questions you might be asked

1. **Can you tell me a bit about what life is like?**
   - What does it feel like living where you live/going to school?
   - Can you think of examples of things you like/things you don't like about it?

2. **Can you tell me a bit about your friends?**
   - How do you think they would describe you?
   - What do you think life is like for your friends/people who live with their birth parents?
   - Do you feel that your friends understand you?

3. **Who do you think knows you best?**
   - How do you think they would describe you?
   - How would you describe yourself?

4. **How do you think your experiences of being in care have affected you?**
   - Can you think of any ways your experiences have affected you in a good way?
   - Can you think of any ways your experiences have affected you in a not so good way?
   - How do you think the public view young people in care?

Appendix 7 Social worker information sheet

What is the study about? I am planning on interviewing 10 young people who are currently in foster care and between the ages of 12-16. I am interested in finding out more from the young person's perspective about the experience of being 'looked after'. I am interested in the impact that foster care has on development. My study will explore issues such as 'identity' and the concept of 'feeling the same or feeling different'. A great deal of research highlights that 'feeling different' is an important issue for young people in care but no research systematically explores this concept.

Who fits the referral criteria? I was hoping that you might be able to identify any young people on your caseload who fit the following criteria:

- Between the ages of 12-16.
- Currently in a foster care placement.
- Someone you consider has the competence/ability to understand what participation will involve and to consent to participate them self.

Who does not fit the criteria? Due to the limited time I have to prepare documents suitable for young people with a diagnosis of a learning disability, I will not be including this group of people in the study. This does not include people with a 'learning difficulty'; only people with a formal diagnosis of a learning disability will be excluded. Looked after children in residential homes will not be included.

What do I need to do? If you can provide _____ Social Work Secretary, with the names and addresses of any potential participants then we can send information packs out to the foster carers/young people. If you could let the families know about the research so that they are expecting to hear from us that would be great but not essential. Aside from providing me with details of the young people, no further input is expected. The only other time that I might contact you is following the interview if any concerns are raised. (Head of Service) has approved the research and is happy for you to provide me with the required information.

What is involved for the young person? I will meet for one semi-structured interview with the young people. At the beginning of the meeting the researcher will again check that the young person understands why they are there, that participation is optional, that they do not have to answer any questions they do not want to and that they can stop the interview at any point. Limits of confidentiality will be outlined. The evaluator will tell the young person that if they have any concerns about their or anyone else's welfare that confidentiality will be broken. Then the semi-structured interview will take place. It will last between 20-90 minutes, depending on what the young person feels comfortable with. The researcher will have a number of potential questions, and follow-up questions in mind. However, the researcher will also respect the young persons' right to take the conversation in a different direction too. The conversation will be recorded using a digital Dictaphone. All of the information will be stored in a locked cabinet or on a password accessible computer.

When the research has been written up a full copy and a summary of the research findings will be made available to all participants, carers and social work staff.

If you have any questions please do not hesitate to contact me;

Thanks again

Appendix 8 Further ethical considerations

Concerns that young people might feel obliged to participate were addressed by not contacting the young people directly in the hope that they would find it easier to tell their social workers they did not want to participant rather than the researcher. Another concern was that the young people may find the interviews emotionally distressing, given the sensitive nature of the topics being explored. This was addressed by sending the young people example questions that they would be asked in the interview so that they were prepared and could decide against participating if they wished. Further, as stated, all young people were offered a chance to 'de-brief' following the interview. The researcher was able to ask about how the young person found the interview and make sure they did not seem distressed. The researcher planned on notifying foster carers and social workers if there were any concerns. The young people already had access to a system prepared to respond appropriately to distress.

Ethics of interpretation

Holloway and Jefferson (2005) warn that through interpretation one can 'individualise' and 'psychologise' the participant's words thus potentially creating a version of the participants personality that they may not recognise. Willig (2012) discusses how interpretation is an action. 'Interpretative violence' occurs when interpretations have consequences that hurt, damage or disadvantage those at the receiving end, and that this is unethical (Willig, 2012). It was vital throughout the current research to be morally responsible and reflective on how any interpretations may affect the participants. Willig recommends a number of strategies to promote this, which are as follows; 'keeping the research question in mind and being modest about what

the research can reveal', 'ensuring that the participants voice is not lost' and 'remaining open to alternative explanations'. The researcher followed these recommendations by being explicit about what kind of knowledge could be gained, about grounding interpretations solidly in the data and being explicit about when interpretations were more tentative and by attempting to 'bracket' any expectations of explanations and remain open to alternatives.

Brinkmann and Kvale (2008) encourage that as well as following guidelines researchers must do more. They must remain open to ethical dilemmas and respond to them on one's own ethical capabilities. An example of this happening in the current research was that the researcher was initially not planning on offering the young people an opportunity to respond to the themes, but during the interpretation stage, it felt un-ethical to make any interpretations without checking out with the young people if they were meaningful or not. The researcher therefore re-applied to the ethical panel who granted approval for the change in methodology and the young people were then offered the chance to voice their thoughts on how meaningful or not they found the themes.

Appendix 9 Interview guide

Can you tell me a bit about what life is like?

- What does it feel like living where you live/going to school?

- Can you think of examples of things you like/things you don't like about it?

Can you tell me a bit about your friends?

- How do you think they would describe you?

- What do you think life is like for your friends/people who live with their birth parents?

- Do you feel that your friends understand you?

Who do you think knows you best?

- How do you think they would describe you?

- How would you describe yourself?

How do you think your experiences of being in care have affected you?

- Can you think of any ways your experiences have affected you in a good way?

- Can you think of any ways your experiences have affected you in a not so good way?

- How do you think the public view young people in care?

Appendix 10 Transcribing process

Smith (2009) states that unlike with a conversational analysis, transcribing in IPA does not require a particularly detailed account of the prosodic aspects of the recordings, for example, exact lengths of pauses. This is because IPA is concerned mainly with interpreting the *content* of the participant's account. The researcher therefore recorded pauses and laughter in brackets but without exact lengths. The lines were numbered and wide margins used for ease of coding. Due to time constraints the researcher did not wait until all of interviews had taken to place to transcribe. No formal analysis took place until all interviews were completed, but it must be acknowledged that 'informal' interpretation is bound to take place. To avoid imposing preconceived ideas on the 'next' case, the researcher attempted to 'bracket' any interpretations and stay focused solely on what presented in the interview that was being transcribed.

Appendix 11 Example of initial coding process

Emergent Themes	Transcript	Exploratory comments
	P yeah, and she's married to (name) and they have a baby,	Identity? Pleased about the role of aunt?
	I oh lovely!	
Impact of role on identity?	P so Im a foster auntie!	
	I oh youre a foster auntie! lovely! whats the babies name?	integration of foster care status
	P (name)	
	I oh that's a lovely name!	
Routine	P yep, and Ive also got a foster nephew (name) and like a foster auntie and all that, we go round to theirs every (day of week) and that so weve got a routine and like I know they are there and I can be really open with my foster family. Whereas I really, (pause) its hard to explain, its really weird and scary at my real house, although I *love* my real family, its like Ive got a better future now that Im away from that, cos ive not got the stress of looking after my brothers and sisters	importance of routine, (talks about routine again)
Managing Conflicting Feelings		being able to be open
Better future		
	I ok. So theres really something there about having routine that's really important to you isn't there (name)?	Managing conflicting feelings re: birth family??
	P yeah	Lack of fear
	I and about not feeling scared. And like you say although you love your real family, there is something different about your future now that you feel is a bit more positive is that right?	
Relationship With school	P yeah, like Ive always liked school and Ive always taken great care in my work and that, but now that Ive no got the stresses of being at home, Ive been able to do really well in school and Ive been getting loads of gold awards and stuff like that.	Relationship between doing well at school and lack of stress at home, feelings of pride
	I well done!	

Appendix 12 Example of sub-theme coding

Participant	Sub-theme; 'if they know I'm in care what the hell will they say to me?'
One	
Two	I'm a lot more open with people like I did 'nae like to tell people about my life, to start off with 'cos I thought they'd just take the mince, but I've grown in confidence and I could tell really anybody, and dinnae ken ey?........ cos I feel more secure, like in foster care, and if something did go wrong then I've got somewhere that I could tell'
Three	Inerviewer (I) "what sort of things would you be worried that she would tell other people?" Participant (P) "like, maybe that I'm in care, 'cos I used to really, get made a fool out of cos I'm in care" I "Do you feel that you still don't want people to know that you are in care" P "yeah, because they might make a fool out of me, I don't really think that I actually need that" "at the start of high school this boy was saying I came from a dump and that I'm a rat, and stuff like that, just making really bad out of me, so I told (name of Foster Carer) and I went and told my Guidance Teacher' and he has not said anything since"
Four	P "well, not everyone knows" I "ok, and do you prefer it if people dont know that you are in care?" P "aye" I "yeah, you prefer it if people dont know... why is that you think?" P "i don't know, id just rather they didnae ken"....
Five	
Six	P "well, nobody's really said anything about me being in care, cos nobody really kens that I'm in care...it might be fine if they did know, but then they might take the mick out of me"

Seven	P "like some of my pals still don't know that I'm in foster care… I just told them that I moved in with my dad and my step mum" I "ok so is there something there about you just feeling like you don't want people knowing?" P "mm, when I got chucked out of school the school sort of labeled me a looked after child, so I just thought nah, I'm not telling them cos they'll just look at me as a 'looked after' child…so school sort of like *fucked* that up for me… and if I write something about my Carers on Facebook I just put 'my dad' and, some of my pals are like 'why are you putting that' and I'm like 'cos some of my pals don't know'" '(they would think) like my mum's a bad mum…. there was a guy that joined our friends who had just been put into foster care and he told us all, and my pals were like "your life is totally fucking wasted now, you're not going to get to do nothing"…… it's just like '*oh no*', then I was put into care three weeks after, I was just like 'nah', if they can say that, then what the *hell* can they say to me'
Eight	
Nine	P "usually if you tell someone something, that's not really about you, about someone else then it's always getting spreaded about" I "what kind of things would you not want to get spread about?" P "mmm, (pause) not really that I'm in care and that's about it" I "so you feel like you wouldn't want people to know that you are in care?" P "yeah. But most people do" I "why would you prefer people not to know?" P "because, like before this placement, there was other people making up names, and they didn't really bother me, but when they were doing it all the time it was quite annoying" I "too right so, when I said why would you not want people to know, it's because people have actually called you names because of it" P "yeah"

Appendix 13 Table to illustrate prevalence of sub-ordinate themes within 'making sense' super-ordinate theme

(Numbers illustrate how many times theme recurred during interview)

	Partipant One	Participant Two	Participant Three	Participant Four	Participant Five	Participant Six	Participant Seven	Participant Eight	Participant Nine
Is this bettter for me?	5	2	2		1	2	1	1	1
More of a pal than a mum	1	1	1						
Managing foster carers and birth parents	2					2	2	3	
You'll miss home, even if you're better off	1		3				2	3	
Control	4	2	1			3	4		