VOLUME I : RESEARCH COMPONENT

FOSTER CARER FACTORS WHICH PREDICT PLACEMENT SUCCESS FOR YOUNG PEOPLE AGED 12 – 18 YEARS

By

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OVERVIEW

This thesis consists of research and clinical components and is submitted as partial fulfilment of a doctorate degree in Clinical Psychology. Volume 1, the research component, comprises of a literature review, an empirical paper and a public domain paper. The literature review looks examines what facilitates the development of a secure relationship between a child and their foster carer. The empirical paper explores the role of the foster carer in promoting successful placements for foster children between the ages of 12 and 18 years old. Lastly, a public domain provides a summary of the empirical paper.

Volume II, the clinical component, contains clinical practice reports conducted within placements from adult, child, learning disability older adult specialties. The first report contains a cognitive and psychodynamic formulation of a 51 year-old who was suffering from depression and anxiety after being made redundant. The second report describes an evaluation of the completion risk assessments in three adult inpatient wards. The third report presents a case study of a 13 year old girl who was hearing a voice. The fourth report presents a single case experimental design concerning a behavioural approach to challenging behaviour displayed by a 17-year old with learning disabilities and autism. Finally, the fifth report is an abstract of an oral case presentation of a 63 year old female who was referred to a Psycho-Oncology service due to a fear of cancer recurrence.

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LITERATURE REVIEW

What Facilitates The Development Of A Secure Relationship Between A Child And Their Foster Carer? : An Attachment Perspective

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What Facilitates The Development Of A Secure Relationship Between A Child And Their Foster Carer? : An Attachment Perspective

Abstract

Children in foster care who experience stable placements have better developmental outcomes. One important dimension of placement stability is the quality of relationships between foster carers and children (Dozier & Lindheim, 2006). Ten studies quantifying the quality of an attachment relationship between foster carers and children were reviewed. Using attachment theory as a framework, the results generally indicated that later-placed children showed more insecure and unstable attachment behaviours. Although contestable, older children and those previously exposed to more severe maltreatment showed more unstable attachment behaviours. Foster carers' own attachment security, acceptance and motivations to foster also impacted on the attachment relationship with children in their care. Methodological and conceptual limitations are considered along with implications for clinical practice and further research.

What Facilitates The Development Of A Secure Relationship Between A Child And Their Foster Carer? : An Attachment Perspective

Removing children from adverse family and environmental circumstances is sometimes seen as a necessary step in safeguarding and promoting their wellbeing. The majority (70%) of children entering the care system will be placed in new families with Local Authority approved foster carers (Departement for Children, Schools and Families [DCFS], 2008). Although this transition may increase their safety, it does not necessarily guarantee positive psychosocial outcomes (Taussig, 2002). Compared to young people growing up in their birth families, many in foster care will be more likely to display emotional and behavioural problems (Newton, Litownik & Landsverk 2000), have fewer academic achievements (Zima, Bussig, Freeman, Yang, Belling & Forness, 2000), and struggle to develop satisfying interpersonal relationships (Unrau, Seita & Putney, 2008). Those experiencing multiple placement changes whilst in care are at even greater risk (Department of Health [DoH], 2002; Social Exclusion Unit 2003; Oosterman, Schuengel, Wim Slot, Bullens, & Doreleijers, 2007). As a result, the Government highlighted the importance of placement stability in improving outcomes for children in foster care in their white paper Care Matters: time for change (DCFS, 2007) and underpinned this guidance with a national achievement target for all Local Authorities in England. By the end of 2008, 80% of children aged 16 and under who had been in the care system for 2.5 years should have been in a stable placement for at least two years (DCFS 2008). Unfortunately, Local Authority returns fell short of the target (DCSF, 2008) and the majority of Children's Services Departments have been unable to identify

initiatives that will increase placement stability and improve the prospects of children growing up in foster care (Ofsted, 2009).

Underpinning the drive for stability is research indicating that young people are more likely to develop greater psychological well-being and attain personal, social and educational goals within the security of a stable, long-term placement. One important dimension of placement stability is the quality of the relationship between foster carers[1] and foster children[2] (Dozier & Lindheim, 2006; Milan & Pinderhughes, 2000). When the relationship is secure, valued and mutually satisfying, placements are less likely to disrupt (Brown, 2008). However relationships between carers and children are typically subject to many stressors. The majority (62%) of children enter the care system due to abuse, neglect or disruption in their families of origin (DCFS, 2008). These early traumatic experiences may impact detrimentally on their cognitive, emotional and behavioural development, leaving the child ill-equipped to manage the stressful transition from family to foster care (Golding, 2008). From the outset, children may appear disruptive, aggressive, withdrawn, needy or inconsolable when upset. Such behaviours can exert pressures on carers who can quickly become overwhelmed and feel that they lack the training and knowledge to manage the children's needs. In trying to deal with these challenges, many carers will draw on their previous experiences of raising their own children or being parented themselves but this may be insufficient or inappropriate when responding to the needs of a traumatised and/or highly dysregulated child. Even the most experienced carers can sometimes feel out of their depth as their training is often limited to an understanding of general child development (Golding, 2008). Allied to this

[1] The term carer and foster carer will be used interchangeably
[2] The term child and foster child will be used interchangeably

is the degree to which carers are prepared to persevere with the relationship, despite the challenges. Indeed, the level of investment and commitment between carers and children is likely to vary due to the transient nature of the relationships; something which will influence the formation of positive relationships and impact on the ultimate success or failure of placements (Dozier & Lindheim, 2006; Oosterman et al., 2007). The experience of placement breakdowns can affect children's ability to form new relationships with other carers and may fill carers with guilt and regret (Nutt, 2006; Wilson, Sinclair & Gibbs, 2000). For children, vicious cycles can emerge in which experiences of placement breakdowns can influence their willingness and ability to engage with future foster care provision. This means that their chances of encountering a secure and nurturing relationship, in which they can develop pro-social skills and achieve their developmental outcomes, will be greatly reduced (Milan & Pinderhughes, 2000).

Exploring what factors promote the formation of a positive relationship between carers and children may contribute something to our understanding of placement stability and provide a direction for future research and clinical initiatives. Attachment theory can provide a useful model for understanding the developing relationship between carers and children. It can also offer a rationale for the persistence of maladaptive behaviour, despite children's removal from earlier adverse conditions in their families of origin (Bates & Dozier, 2002; Golding, 2008).

The Importance of Attachments on Early Relationship Formation

Human infants are born with a biologically based drive to maintain a high level of proximity to their caregiver. This is intended to afford them with protection and comfort, thereby increasing their chances of survival (Cassidy & Shaver, 2008). Newborns instinctively show a preference to attend to human faces and voices and have the innate ability to elicit interest and care from others. As they develop, their behaviours become more complex and purposeful, discriminating between particular caregivers from whom they derive comfort and safety (Golding, 2008). Such attachment behaviours include signalling, which is used either to alert the primary caregiver[3] to the child's interest in interaction (e.g. smiling), or indicate distress (e.g. crying). Once the infant is mobile, their attachment behaviours can be active; with the child moving towards their primary caregiver to maintain physical closeness (e.g. proximity seeking) (Cassidy & Shaver, 2008). This attachment behavioural system ensures that the caregiver remains accessible and responsive (Bolwlby, 1973). Knowing that the caregiver is generally responsive and will provide protection and comfort if danger threatens allows the infant to gradually move away from the 'secure base' provided by the caregiver and fulfil his or her other instinctual drive to explore and learn (Golding, 2008).

Repeated interactions between an infant and the primary caregiver leads to the development of an 'internal working model' or attachment representation of how the child perceives and responds to their own and others' behaviours and emotions (Ackerman & Dozier, 2005; Cassidy & Shaver, 2008; Hodges, Steele, Hillman, Henderson & Kaniuk, 2003). From a neuro-developmental perspective, during sensitive

[3] A primary caregiver is usually the birth mother

periods of brain development, an infant's interaction with others stimulates the maturation of specific brain functions (Golding, 2008). Interactions with the primary caregiver have been shown to promote the maturation of both the right cerebral and orbito-frontal cortex and connections to the limbic system in the right hemisphere (Schore, 2001). These areas are central to social-emotional development, allowing the infant to process and manage feelings, to inhibit impulsive reactions and to think things through and plan before acting (Schore 2001).

Early Attachment Patterns

Different patterns of attachment have been defined based upon caregiver-child observed behaviours.

Secure attachment pattern. A secure attachment is more likely to develop when primary caregivers meet infants' needs in a reasonably reliable manner. Securely attached infants will develop internal working models of others as safe, predictable and available, and of themselves as worthwhile, loveable and effective in relationships. Allied to this, primary caregivers will be attuned to infants' internal states and consequently able to recognise and respond in a sensitive and supportive way to infants' emotional arousal. They will generally be able to regulate or manage infants' emotions through comforting touch, expression, intonation and so on. As infants grow older they will begin to internalise some of these adult responses and start to identify, tolerate and regulate emotions more independently, eventually developing self-regulatory strategies. Sensitive

and communicative relationships between primary caregivers and their children also allow children to understand more about the feelings of others (reflective function) and to predict others' responses (mentalisation) and act accordingly. This lays the foundation for positive interpersonal functioning throughout childhood and later life and the presence of at least one secure attachment relationship has been associated with prosocial behaviour, psychological well-being and higher levels of resiliency (Steele, Steele, Croft & Fogany, 1999).

Insecure and Disorganised-Disorientated attachment patterns. Infants can develop an insecure-ambivalent attachment style when they are unsure about their caregivers' availability to keep them safe and meet their needs. In this scenario, primary caregivers generally show repeated patterns of over-involvement interspersed with periods of rejection when their children express a high level of need. As a way of maintaining proximity to inconsistent caregivers, children often display intense and ambivalent behaviours when distressed, such as clinging and aggressively rebuffing caregivers at the same time. This makes them extremely difficult to comfort and pacify. Functioning in a state of emotional 'over-drive,' which includes an escalation in risky behaviours as the children grow older, is a way of ensuring that the caregivers' attention is captured and they remain predictably available. It puts the children in the driving seat, providing a sense of control (Golding, 2008).

If caregivers are consistently unresponsive and rejecting, their children often respond by minimising their attachment behaviours in order to reduce demands on the caregivers. The aim is to increase the likelihood that caregivers will be able to tolerate

their proximity and so maintain the attachment (Golding, 2008). In this insecure-avoidant style, children may appear passive, self-reliant or withdrawn; displaying little emotional distress and acting as if they do not need the caregiver. They may also show false positive affect or be overly helpful, often taking on the caregiver role in order to gain proximity, attention and approval.

In some extreme cases of maltreatment and trauma, caregivers may be experienced by children as frightening or frightened. This results in an unresolvable dilemma because caregivers are seen as both the source of potential security and fear. In this situation, infants are unable to organise a response and are likely to display odd behaviours, such as freezing, rocking and approach-avoidance in the presence of the caregivers. These children tend to be categorised as having a disorganised-disorientated attachment style (Main & Soloman, 1986 in Cassidy & Shaver, 2008).

Children who experience insecure (i.e. ambivalent/avoidant) or disorganised-disorientated attachments are likely to internalise negative messages about themselves and others, reflecting the poor quality of the interactions they have experienced with their primary caregivers. These children develop internal working models of themselves as unloveable, uninteresting, unvalued and ineffective, and of others as unavailable, neglectful, rejecting, unresponsive and hostile (Golding, 2008). Inconsistent, unresponsive, or frightened/frightening caregivers will be unable to regulate their children's emotions for them, and consequently over time, children will struggle to internalise self-regulatory strategies to cope with their own emotional arousal.

Attachment patterns can impact on children's development into adolescence and adulthood. Insecure attachment histories may place people at risk of developing anxiety

disorders, depression and conduct problems (Cassidy & Shaver, 2008). In addition, disorganised-disorientated attachments have been associated with an increased likelihood of experiencing dissociative states (Liotti, 1992), externalising problems (Lyons-Ruth, 1996) and later psychopathology (Carlson, 1998; Lyons-Ruth, 1996).

Rationale For Review

The relationship between carers and children is likely to be a fundamentally important factor in achieving placement stability, which has been shown to increase the chances of children growing up in care meeting their developmental goals (e.g. Newton, Litrownik, & Landsverk, 2000). However, children's early life experiences bring particular challenges to the task of caregiving and places the foster carer-child relationship under a unique level of stress. Consequently, this review aims to synthesise the empirical literature examining factors that influence the development of attachment security between children in the care system and their foster carers.

Method

Search Strategy

Using search terms focussing on foster care, foster carers and foster children, relations between foster carers and foster children, relationship formation and attachment, six databases (Web of Science, ASSIA, Social Services Abstracts, Sociological Abstracts, Psycinfo) were searched for reviewed journal papers written in English and published between 1998 and 2008 (see Appendix 1 for specific keyword searches used for each database). A total of 793 papers were retrieved using this strategy. The following selection criteria were then applied:

- Only papers where the quality of the attachment relationship between a foster child and their carer was assessed using a quantitative measure were included
- Studies in part or solely used this quantitative measure of attachment as an 'outcome' measure
- Studies simply comparing the attachment of foster children to another comparative sample (e.g. foster children and their biological mothers) were excluded
- Studies of children placed in permanent foster placements were excluded

This generated ten papers for the review. A manual check of each paper's bibliography did not identify any additional sources.

Results

The papers selected for the review are summarised in Table 1. To aid the reader's understanding of the key results, Table 2 provides an overview of the measures employed in the selected papers to quantify the quality of the specific attachment relationship between the foster carer and child. Factors promoting or inhibiting the development of attachment security between carers (usually the female caregiver) and their children will be highlighted and reference will be made throughout to important theoretical and practical considerations arising from the Attachment and Social Care literature. A methodological and conceptual critique will be presented in the discussion, alongside implications for future research and clinical practice.

Describing individual child and carer factors influencing the formation of relationships in a new care setting is only a starting point in understanding how to achieve greater stability and success for vulnerable young people in the Looked After population. However, it is also important to acknowledge that there are likely to be many complex interactions between these variables and other broader social and environmental influences, which have not as yet been fully explored within the empirical research, and are beyond the scope of this paper.

Table 1 – Summary of the reviewed papers

Study	**Aim**	**Participant Details**	**1. Measurement of carer-child attachment** **2. Overview of design and methodology**	**Findings**	**Strengths and limitations**
Ackerman & Dozier (2005)	To investigate whether the degree of carer's emotional investment of their foster child was related to the foster child's self and other representations and attachment security three years later.	39 foster mother- infant dyads Average age at placement = 9.7months. At initial interview average time in placement = 19 months. 21 children were male. 24 children in their 1st placement; 11 were in their 2nd and 4 in their 3-5th placement. All carers were female. Carer's average age = 45 yrs.	1. Separation Anxiety Test (SAT) 2. Cross-sectional study. 1st contact – Conducted 'This is My Baby Interview' when child was in placement for a minimum of 3 months and was on average 2 years old. 2nd contact – Conducted SAT when child was on average 5 years old. Child's self-esteem assessed using the Puppet Interview (Cassidy, 1988). Child's Intelligence assessed by WPSSI-R and behaviour by CBCL. Pre- placement risk factors from case records.	Children provided more constructive coping responses to imagined separation scenarios at 5yrs if their carers were more accepting of them when they were 2yrs old.	Non-randomised. Correlational analyses used therefore causality could not be inferred Participant samples split according to attachment categories so analyses conducted on even smaller samples Difficult to ascertain whether it was also child characteristics elicited certain feelings or responses in carergivers leading them to be more or less invested in their foster child. Pre-placement factors considered and child's intelligence and behaviour assessed. Two data points over relatively long period of 3 years
Bernier, Ackerman & Stovall (2004)	To examine the links between foster infants' attachment behaviours when initially placed and their later, consolidated attachment behaviours.	24 foster mother-infant dyads 14 infants were male. Age range = 6.5 -19 months (mean age = 12 months). 13 children in 1st placement, 7 children in their 2nd and 4 in 3rd to 5th placement.All carers were female. Carers' average age = 51 years.	1. Parent Attachment Diary (PAD) &Strange Situation Procedure (SS). 2. Longitudinal study. Time 1 – Carers completed PAD over 7 days, within the first month of placement. Time 2 - SS completed five months later.	Secure and avoidant diary scores from the Parent Attachment Diary related to the Strange Situation scores. The instability score from the diary discriminated between children who later developed organized versus disorganized attachment patterns.	Non-randomised. Correlational analyses used therefore causality could not be inferred Low number of children classified as presenting with avoidant / ambivalent patterns in SS thus severely restricting power of analyses Categorical analyses restricted to secure/insecure and organized/disorganized breakdowns thus impeding ability to predict different types of insecurity from diary Difficult to disentangle child's and mother's contributions to mother-reported child behaviours. No examination of impact of neonatal or early caregiving experiences. Potential parental report bias.

					Longitudinal data Measuring attachment over a number of data points enabled investigation of development of attachment
Bernier & Dozier (2003)	To examine the capacity of maternal mind-mindedness to account for the relation between adult attachment state of mind and infant attachment security.	64 foster mother – foster children dyads. 41 children were male. Average age at placement = 6.4 months. Children were between 6-30 months when maternal mindedness assessed and between 12-24 months when participating in the Strange Situation. 44 children in 1st placement, 13 in their 2nd and 7 in the 3rd - 5th. All carers were female. Mean age of carer = 47 years.	1. Strange Situation Procedure (SS) 2. Cross-sectional study. Caregiver's state of mind with regard to attachment was assessed using the Adult Attachment Interview (AAI) (specifically coherence). Maternal mind-mindedness was assessed using the 'This is My Baby Interview'. Infant's attachment to caregiver assessed using the SS.	The frequency with which foster carers described children in terms of the children's mental processes (mind mindedness) accounted for total predictive power between coherence in the AAI and security in the SS. A negative relation was found between mind-mindedness and attachment security suggesting that it is the appropriateness and accuracy of carers' references to children's mental processes, not their sheer number that predict children's attachment security.	Wide range of children's ages when TIMB was conducted. Several ways to conceptualise the interplay between mind-mindedness and attachment security, not all imply a direct causal relation. No objective external evaluation of the child's current functioning was made. Subjective recall and halo effects may have influenced answers given in AAI and TIMB Relatively large sample. Regression analyses used enabling predictive power to be tested
Stovall & Dozier (2004)	To investigate the development of attachment relationships over first 2 months of placement. For a subset (n=20) to investigate the relationship between the Parent Attachment Diary and the Strange Situation.	38 foster infant-caregiver dyads. Age range of 5-28 months at placement (mean age = 13 months). All carers were female. Average age of foster carer = 51 years.	1. Parent Attachment Diary (PAD) & Strange Situation Procedure (SS) 2. Longitudinal design. Time 1- Carers completed the PAD for 60 days over the first two months of placement. The Adult Attachment Interview (AAI) was completed within the first month of placement. Time 2 - The SS was conducted 3-4 months into placement.	Association between a decrease in the use of coherent attachment behaviours over the first 60 days and disorganized/disorientated attachment pattern measured by the SS 3-4 months later. Over the first 60 days of placement, infants with autonomous carers and infants placed at younger ages showed higher early and overall levels of secure behaviour, less avoidant behaviour and more coherent attachment strategies compared to infants placed with nonautonomous carers. Neither age at placement nor carer attachment predicted change in attachment behaviours over the first 60 days of placement. Significant concordance was found between PAD Scores and the SS for secure and avoidant behaviours.	Not clear if effects of age at placement reflect length of time in problematic care settings, age at which disruption occurs or age at which new attach is formed. Potential parental report bias. Issues which implicate ability to adapt to new home e.g. biological parent visit, respite, daycare not addressed. Subjective recall may have influenced answers given in AAI Longitudinal and multilevel diary data enabled multilevel regressions (hierarchical lonear modeling) to closely examine data
Stovall & Dozier (2000)	To investigate the developing attachment	10 foster children and 8 foster carers. At start of data collection, age	1. Parent Attachment Diary (PAD) & Strange Situation Procedure (SS) 2. Single case studies.	For 8 infants diary data revealed predominant patterns of attachment behaviour emerging within 2 months	Small sample. Lack of stable diary patterns: Not all children with disorganized

	relationships in 10 foster-caregiver dyads. To test the prediction that only infants placed early and with autonomous carers would form a secure attachment.	of infants ranged from 6 to 20 months (average = 11.9 months). 5 infants were females. All carers were female. Average age of carers = 54 years.	Carers completed PAD during first 60 days of placement and completed the Adult Attachment Interview (AAI) after a few weeks of starting to participate in the study. The SS was conducted after the diaries were completed and when children were at least 12 months.	of placement. In most cases, PAD data predicted attachment classification measured by the SS. The 3 children placed before 12 months with carers with autonomous states of mind were classified as having secure attachments. The 5 children placed after 12 months showed predominantly insecure attachment behaviours in the PAD and SS. Contingency analyses of behaviour sequences of carer and child reported in the PAD revealed that carers tended to complement children's attachment behaviours.	attachments show contradictory attachment behaviour – some show lapses in awareness and orientation – unlikely to be picked up in diary data. – but this behaviour may just be one part of an organized attachment. Maybe not enough time to form stable attachment patterns – possibly a longer data collection period required. Subjective recall may have influenced answers given in AAI Examination of behaviour exchanges between parents and children in PAD
Cole (2005)	To investigate the effects of types of motivation to foster on the security of attachment of infants.	46 participant dyads. 12 of the caregivers were related to the infants. Age of children ranged from 10-15 months. Mean age of children = 12.8 months.	1. Strange Situation Procedure (SS) 2. Cross-sectional . 2 contacts: 1st in home - Motivations for Foster Parenting Inventory administered. 2nd in lab – the SS.	Desire to increase family size and social concern for the community were significant predictors for secure attachment while reasons such as spiritual expression, adoption and replacement of a grown child were predictors of insecure attachment.	Infants' previous experience was not reported. Subjective recall and halo effects may have influenced answers given for Motivations for Foster Parenting Inventory. Large number of participant dyads
Cole (2005a)	To investigate the effect of relational and environmental factors affecting attachment security.	46 infants- carer dyads. Age of children ranged from 10-15 months. All children were placed with the carers within first 3 months of life and had been with their carer for at least 6 months.	1. Strange Situation Procedure (SS) 2. Cross-sectional. Two contacts with infant and caregiver – 1st contact at home, 2nd contact within first 3 months of life. 1st contact: measures to assess infant development (Caregiver Interview Form; Infant Toddler Symptom Checklist; Minnesota Infant Development Inventory) were completed. Support Functions Scale & Parenting Stress Index-Short Form to assess factors of caregiver support and stress previously associated with quality of parent-child attachments. Home environment was assessed using the HOME. 2nd contact: SS completed. Childhood Trauma Questionnaire completed to assess extent of any childhood trauma experienced by carers.	Organisation of foster home environment approached significance and access to appropriate learning materials predicted secure attachment. Carer childhood trauma and involvement predicted insecure attachment.	Did not investigate two variables; caregiver depression or assessment of caregiver internal model of attachment (Hipwell et al 2000). Comparability of sample to non-respondents couldn't be considered. Use of self-report measures may be biased. Subjective recall and halo effects may have influenced answers given to foster carer questionnaires Previous childhood experience of foster carers considered Large number of participant dyads
Dozier, Stovall, Albus & Bates (2001)	To investigate the concordance between foster carer's attachment	50 foster mother – infant dyads. Infants' age at placement was on average 7.7 months 29	1. Strange Situation Procedure (SS) 2. Cross sectional. Carer's attachment measured by the Adult attachment interview, conducted at some	Age at placement was not related to attachment quality. Infant's attachment security was concordant with carer's state of mind	Participant samples split according to attachment categories so analyses conducted on even smaller samples Subjective recall may have

	state of mind and foster infant's attachment quality.	children were males. 28 children were in their 1st placement, 17 were in their 2nd placement and 5 were in the 3rd-5th placement. All carers were female. Average age of carers = 47 years.	point between 31 months prior to child's placement and 10 months following placement. The SS was completed at least 3 months after placement when child was between 12 - 24 months.	at levels similar to biologically intact dyads. Age at placement was not a predictor between carer state of mind and infant security.	influenced answers given to AAI Large number of participant dyads.
Milan and Pinderhughes (2000)	To examine the influence of children's maternal and self representations on subsequent relationship with foster mothers and behavioural adjustment in foster care.	32 children. 18 children were female. All children were between 9 and 13 years old. Mean age = 11 yrs, 7 months. All had entered care for the first time and had been all had experienced at least one form of maltreatment from their biological mothers. IQ scores above 80 and mean IQ was 88.2	1. The Relatedness Scale & the Attachment Rating Scale 2. Cross sectional. 1st Contact: Children interviewed between 2nd and 3rd week in residential facility (all children remain in residential facility for 4 weeks when first entering care as part of standard procedure in county where study took place) Children completed Self-Perception Profile for Children, the Contingency, Competence, and Control Probes and the Rochester Child Resiliency Project Future Expectations Measure to measure internal representations of self. 2nd Contact: Children interviewed after residing with foster family for 1 month. Children completed the Relatedness Scale to measure internal representation of relationships with their biological mother and carer. Carers completed the Child Behaviour Checklist and the Attachment rating scale.	Upon entering foster care, children's maternal and self-representations were significantly related to each other and severity of maltreatment history. These representations significantly predicted children's subsequent views of their relationship with foster carers. Children who had more positive views about themselves, had strong, positive feelings about their biological mothers and wanted a close relationship with carers were also rated by carers as showing more relational behaviours e.g. spontaneous affection and caring regardless of any behavioural difficulties. Children who had been severely maltreated by their biological mothers showed less relational behaviour with carers and held more negative views about themselves. Children's representations of carers and carers' reports of children's relational behaviour, internalising and externalising symptoms did not differ by children's age, ethnicity gender or IQ, although girls had more internalising problems and boys had more externalising problems.	Sample size not large so question null hypothesis re. age at placement. Used inaduequately validated measures Subjective recall and halo effects may have influenced answers provided for the attachment rating scale and Child behaviour Checklist Older children enabling questionnaires to be administered to the children rather than relying on observation of behaviour to assess attachment security Relatively large age range of children in sample Considered impact of child's views of biological mother with regards to views of carer
Oosterman & Schuengel (2008)	To examine parental sensitivity in relation to clinical symptoms of	61 children and their foster caregivers. 39 were females. Mean age at placement = 12.11 months. 97% had experienced one or	1. Attachment Q-Sort Method (AQS). Symptoms of Reactive Attachment Disorder (RAD) & Secure Base Distortions. 2. Cross sectional.	No significant relations between symptoms of RAD and attachment security. Carer sensitivity was positively associated with attachment security,	Used behavioural checklist and telephone interviews rather than in person interviews. Correlational analyses used therefore causality could not be inferred

	attachment disorders and attachment relationship between the carer and child. Examined relation between attachment and presence of emotional and behavioural problems.	more previous placements. Mean time in placement = 35 months. 55 carers were female and 6 were male.	Carer-child dyads were observed twice within 3 weeks: once at home and once at a university. 1st contact : Carer and child were videotaped playing, enabling a trained observer to complete the AQS. Parental Sensitivity was measured by a 15 minute semi-structured caregiver-child interaction. 2nd contact: Carers completed the Disturbances of Attachment Interview; a semi-structured interview to measure symptoms of disordered attachment. Child Behaviour Checklist was also completed to measure the child's behavioural and emotional problems. 60 carers completed the CBCL and 47 teachers completed the Caregiver-Teacher Report Form (C-TRF).	but only if symptoms of disordered attachment were partialed out. Symptoms of RAD and secure base distortions predicted higher levels of externalizing and internalizing behaviour problems respectively. Regarding teacher reports of behaviour, security of attachment was negatively related to externalizing behaviour problems and symptoms of RAD and secure base distortions were related to more internalizing behaviour problems.	Child behaviour videotaped and rated by trained observer rather than relying on carer observations. For those children in kindergardten, teachers' ratings of child's behaviour sought as well as carers'. Relatively large age range of children in sample. Large number of participant dyads Included small number of male carers

Table 2 – Summary of attachment measures used to assess the quality of foster carer-child relationships

Attachment Measure	Method of Assessment	Psychometric Properties
Observational Measures:		
Strange Situation Procedure (Ainsworth et al., 1978)	Procedure places the carer and child together in an unfamiliar playroom. Two separations from the carer and an introduction of a stranger then follow placing the child under stress, activating attachment behaviours. The child's ability to both seek and receive comfort from its carer on reunification and the ability to return to play are assessed. Child's behaviours are classified as secure, avoidant or ambivalent. A later category of disorganized/disorientated was added by Main & Soloman (1986). Suitable for infants aged 12-24 months.	Inter-rater reliability was 1.0 for secure and insecure categories which fell to .86 when disorganized/disorientated category included. This reflects inter-coder agreement in other studies using the Strange Situation. Low stability of classification has previously been found (Ainsworth et al., 1978) reflecting sensitization of infants to procedure, although the Strange Situation has shown considerable stability across 3 to 6 months (Bretherton, 1985; Lamb, Thompson, Garner & Charnov, 1985).
Attachment Q-sort method (AQS; Walters & Deane, 1985)	Home-based observational measure. Appropriate for 12-48 month olds. Trained observers assess the observed relationship between carer and child. Cards are sorted into a forced distribution from 'most characteristic' to 'least characteristic'. This profile is compared to a secure attachment profile to determine overall security.	Inter-rater reliability was .70. A meta-analysis demonstrated good convergent validity with the Strange Situation and predictive validity with sensitivity measures (Van Ijzendoon et al., 2004)
Parent Attachment Diary (Dozier & Stovall, 1997)	The carer records the sequence of child and carer behaviours during a distressing incident by ticking items on a behaviour checklist and providing a short narrative account. Three incidents per day are recorded. Trained coders assess the diary data, summing scores for security, avoidance and ambivalence across the three daily situations, yielding one score for each category. Disorganised attachment behaviours are not captured by this measure although some studies quote a 'stability' or 'coherence' score.	Inter-rater reliability was .88 for secure behaviours, 1.00 for avoidant behaviours and .86 for ambivalent behaviours. Significant concordance has been found between the Parent Attachment Diary and Strange Situation for secure and avoidant behaviours.
Separation Anxiety Test (Hansburg, 1972; Klagsbrun & Bowlby, 1976; revised by Kaplan, 1985)	Child's verbal and affective responses to pictures about carer-child separations are used to obtain a measure of the child's emotional security and quality of coping responses. Four out of six scenarios were considered appropriate for foster children. Episodes were transcribed from videotape.	Inter-rater reliability for emotional security was .85 and for coping responses was .89.

	High emotional security reflects confidence in the motives and return of the carer. Low emotional security scores reflect a denial of the separation, an unwillingness to show vulnerability or demonstration of bizarre or disorganized behaviour. High coping scores reflect constructive or adaptive strategies such as social support or positive coping separation behaviours (e.g. playing with a friend). Low coping scores suggest no coping strategy (e.g. doing nothing) or maladaptive strategies (e.g. running away).	
Representational Measures:		
Relatedness Scale (Wellborn & Connell, 1987)	Completed by the child using four response options to items on two subscales: emotional quality (e.g. "when I am with X, I feel happy") and psychological proximity seeking (e.g. "I wish X understood me better"). High emotional quality scores and high proximity scores reflect strong, positive feelings and a greater desire for a closer relationship with the attachment figure, respectively.	Alpha reliability has ranged from .75 to .84 for emotional security and .86 to .88 for psychological proximity seeking (Lynch & Cicchetti, 1991)
Questionnaire – based Measures:		
Attachment Rating Scale (Barth & Berry 1988)	Carers rate the child's relational behaviours (e.g. shows spontaneous affection; cares whether parent approves) on a 3-point scale. Higher scores indicate stronger or more frequent relational behavour.	Alpha level was found to be .83
Disturbances of Attachment Interview (Smyke & Zeanah, 1999)	Semi-structured interview with the carers. Assesses child's behaviour, included subscales of emotional withdraw/inhibited attachment disorder, social/disinhibited attachment disorder and secure base distortions.	Inter-rater reliability was .86 for inhibited attachment disorder, .71 for disinhibited attachment disorder and .75 for secure base distortions.

Factors Affecting Attachment In Infants

Early attachment behaviours. According to attachment theory, infants who are placed into foster care at an earlier age, and who have been exposed to less adversity, are more likely to adapt to relationships with new caregivers and demonstrate attachment security (Egeland & Stroufe, 1981). Three studies (Bernier et al., 2004; Stovall & Dozier, 2000; 2004) looked at attachment behaviours when infants (ranging from 5 – 28 months) were first placed. They found that the infants' attachment categories, derived from the Parent Attachment Diary, were concordant with those observed three to five months later in the Strange Situation procedure. This suggests that the infants' early attachment behaviours remained stable during the first few months of the substitute placement, irrespective of the carers' parenting approach or the caregiving environment (Bernier et al., 2004). Another related finding suggesting consistency in infant attachment behaviours during the early months of placement, was that those infants ascribed a higher 'instability' score (i.e. displaying different attachment behaviours from day-to-day) by carers using the Parent Attachment Diary over a one week period, were more likely to be classified as disorganised in the Strange Situation procedure five months later (Bernier et al., 2004). Stovall & Dozier (2004) also asked carers to complete the Parent Attachment Diary but over a much longer period (60 days). They found that infants with higher initial instability scores, showed insecure attachment patterns when assessed in the Strange Situation three to four months later. Despite the fact that these findings demonstrate that infants displaying less stable attachment behaviours early in the placement continued to exhibit high levels of attachment insecurity several months later,

they do not indicate an association with disorganised attachment, unlike Bernier et al.'s (2004) study. This difference may be due to the low numbers of infants classified with a disorganised attachment pattern (n = 6) in the study, compared to Bernier et al. (2004) whose disorganised sample consisted of ten infants. However, Stovall & Dozier (2004) did find that infants who became increasingly inconsistent in their use of a particular attachment strategy over the first two months of placement, were more likely to be classified as exhibiting a disorganised/disorientated attachment patterns later in the Strange Situation procedure (Stovall & Dozier, 2004). This apparent breakdown in infants' attachment behaviours could be due to the overwhelming stress experienced following the removal from their original caregivers (Fisher, Gunnar, Chamberlain & Reid 2000), and/or a reaction to the demands of establishing a new relationship with a carer who may react in an unfamiliar and unexpected manner.

The above results suggest that young infants (aged 5 – 28 months at placement) generally display stable attachment behaviours over the first few months of a new placement. Theoretically, this is somewhat unexpected as attachment patterns are believed to be forming and reasonably fluid over the first 18 months of life (Dozier, Higley, Albus & Nutter, 2002). Bowlby proposed that attachments do eventually become stable and resistant to change but he did not specify a time-frame in which this process occurs (Cassidy & Shaver, 2008).

These findings may suggest that early attachment patterns of even young infants placed in care are reasonably well established and impervious to the interventions from carers and influences of the new caregiving environment. Another explanation could be that carers respond to these infants in a way that perpetuates the attachment tendencies

that they initially bring into the placement. Daniel Stern (1985) compared the interaction between an infant and its carergiver to a dance. If the child leads the dance and the carer falls into step, adjusting their own behaviour to match the child's expectations, the dyad start to re-enact and reciprocate an interactional pattern that the infant learnt within the context of their earlier relationships with primary caregivers. This is particularly concerning as many early relational experiences of infants coming into the care system are characterised by abuse, neglect and inconsistent parenting (DCSF, 2008). In line with this, some carers report that infants can elicit strong, uncomfortable and even abusive feelings from them (Hobday, 2002).

A carer's lack of attuned sensitivity to infants they are caring for may also explain the stability in attachment behaviours observed in the reviewed studies. Some carers may only respond to children's observable or expressed needs (e.g. their tendency to minimize distress), while neglecting their hidden needs for security and comfort. This could mean that infants classified as insecure or disorganized in their attachment style, who are less likely to display the usual signals of distress (i.e. crying, proximity seeking), may be overlooked, dismissed or even rejected by their carer. The carer's reactions may confirm the infant's previous experiences of adult caregivers as unable to meet their needs and perpetuate an insecure or disorganised attachment pattern.

Findings relating to infants' attachment behaviours observed in the early stages of a new foster placement suggest that carers need to be attuned and to respond sensitively to children's expressed and hidden needs, but also to be aware of not being drawn into a reciprocal interaction that mirrors the infants' early experiences with abusive, neglectful or inconsistent caregivers. The results also indicate that it is important for carers to

provide particularly sensitive, predictable and consistent care to infants who use different attachment behaviours; particularly those who become increasingly inconsistent during the early months of the placement. This can present significant challenges to many carers, as infants who exhibit unpredictable and inconsistent attachment behaviours may be perceived as particularly chaotic and hard to comfort (Bernier et al., 2004). If carers' responses are equally erratic, infants may be less likely to organise their attachment behaviours into a stable pattern (Bernier et al., 2004). Providing training to carers to educate them about the importance of identifying inconsistent attachment behaviours early in the placement and then offering timely interventions could facilitate the development of more secure attachment behaviours, and improve the prospects for placement stability and successful long-term developmental outcomes (Stovall & Dozier, 2004).

Age at placement. A number of the studies looked at differences in the quality of the attachment relationship between early-placed (before 12 months) and late-placed (after 12 months) children and their new carers. As suggested above, attachment theory would predict that infants who have been placed into foster care at an earlier age may have had less exposure to abusive, neglectful and/or inconsistent experiences with previous caregivers and, as a result, may be more likely to form secure attachments with their new carers (Egeland & Stroufe, 1981).

Based on recordings from the Parent Attachment Diary, Stovall & Dozier (2000; 2004) found that early-placed infants, aged less than 12 months old, were more likely to show secure attachment behaviours than later-placed infants (older than 12 months) over

the first 60 days in placement. Stovall & Dozier (2004) noted that the number of previous placement disruptions prior to entering the placement could not account for the difference between the groups. Age at placement remained significant even when the children's cumulative risk status (sum of risk factors indicated in case records; namely prior physical abuse, disruptions in care and prenatal drug exposure) was controlled for. They therefore concluded that age was a stronger predictor of early attachment behaviours during the first two months of placement than previous experience. In support of Stovall & Dozier's findings, Jill Hodges and colleagues (2003) found that 33 maltreated children, many of whom had suffered disruptions in care and had been placed into adoptive families at a later age (4-8 years) reported more avoidant and disorganised attachment themes in their Story-Stem narratives[4], than 31 children adopted when they were less than 12 months old. Although the development of relationships between children and adoptive parents may be conceptually quite different due to the permanent nature of adoption, compared to fostering, these findings do suggest that those late-placed children may have developed an internal working model predicting rejection and the inability of the carer to meet the child's needs.

Despite this, the finding that cumulative risk status was not a strong predictor of attachment status may be explained by a lack of variability in the relatively small sample (n = 38), as well as the over reliance on inaccurate or incomplete case notes in gathering background information. Stovall & Dozier (2004) did however find that children with a higher cumulative risk status showed a breakdown in consistent attachment behaviours (as measured by the Parent Attachment Diary) over the first two months in placement.

[4] Story-stem narratives are used to assess children's mental representations of attachment relationships. The beginnings of stories are told using props and the children's responses are videotaped and rated.

This result indicates that although the age at which infants move into placement is an important factor affecting their initial attachment behaviours towards carers, a history of maltreatment can result in some children becoming increasingly chaotic and unstable in their interactions with carers when distressed. Sinclair, Baker, Wilson, & Gibbs (2005) indicate that carers sometimes refer to a honeymoon period of stability when children are first placed but this can quickly breakdown as children have to cope with the demands of their new relationship and environment.

During the first two months of placement early-placed infants appeared to exhibit more consistent patterns of attachment behaviours (whether that be secure, avoidant or ambivalent) when distressed compared to late-placed infants (Stovall & Dozier, 2004). This consistency makes it easier for carers to know how to respond sensitively and predictably to children's needs, which in turn, increases the likelihood of children in their care organising their attachment behaviours into a secure and stable pattern (Golding, 2008).

Nevertheless, this age effect disappeared as the length of time in placement increased. Stovall & Dozier (2004) found that although earlier-placed infants showed higher levels of secure behaviours than their late-placed counterparts when they first entered a placement, after three months, age was no longer significantly associated with the infant's attachment patterns assessed in the Strange Situation procedure. Late-placed infants were equally as likely to display secure patterns as early-placed. Hodges et al., (2003) found that one year after adoption, although internal working models of attachment relationships were "far from transformed," some positive changes had occurred for late-placed maltreated children. Specifically, adults were represented as

being more helpful, able to set limits and aware when children needed help. However, at the same time, adults were also still represented as being aggressive or rejecting, so although new and more positive internal working models or attachment representations develop, these do not automatically transform the already established representations.

Given these findings, it seems that carers who offer placements to older infants and children (>12 months) need to demonstrate perseverance and expect that there may be more difficulties in forming attachments in the early stages of the placement than there would be with younger children. These placements may also require additional support from Social Care and other professionals in the early phases.

Children's maternal and self representations. Research with older children has looked more closely at the relationship between their internal working models or attachment representations and the development of relationships with new carers. Children with negative internal representations of themselves and others are believed to be more likely to hold negative expectations of new relationships (Bowlby, 1982 in Cassidy & Shaver, 2008). In seeking to examine this, Milan and Pinderhughes (2000) interviewed 9-13 year olds, all of whom had been maltreated (e.g. physical abuse, sexual abuse, neglect) by their biological mothers and were entering foster care for the first time. Before being placed with carers, the children were given a battery of measures assessing their feelings of relatedness/attachment to their biological mothers and their internal representations of themselves. They were assessed again one month after the transition into foster care. However, this time their feelings of relatedness towards their carers were explored, along with the carers' views about the children's adjustment to the new

placement. The carers completed measures of their children's behavioural and emotional functioning and the frequency with which explicit relational behaviours were displayed in the placement (more details of the measures employed in this study are described in Table 1). A regression analysis indicated that children who reported higher self-worth and held more positive attachment representations of their biological mothers, tended to have more positive attachment representations of their relationships with carers. However, there was no significant association between children's attachment representations of their birth mother and the frequency of relational behaviours displayed towards the carer. Relational behaviours in the placement were influenced more by current constructions of the child-carer attachment than by previous relational experiences. This is supported by the finding that children with more positive attachment representations of their carers were rated as displaying more relational behaviours, such as spontaneous affection and caring; a result that remained constant regardless of any emotional and behavioural difficulties exhibited by the children.

In addition, this study found that children with more severe maltreatment histories showed less attachment-related behaviours towards their carers. The association between maltreatment severity and the children's representations of their attachment to their carer was mediated by their attachment representations of the relationship with their biological mother. This result can be partly explained using attachment theory, which would suggest that a maltreated child would develop an internal working model of others as frightening, uncaring, and untrustworthy and they would use this model in navigating all other interpersonal relationships. Therefore, the maltreated children in this study were likely to view their new carers in the same light as their biological mothers and hold negative

expectations about the relationship. Despite the detrimental influence of their early relational experiences, most of the children reported having a positive emotional connection with their biological mothers, characterised by love, warmth and happiness. Milan & Pinderhughes (2000) suggested that these positive representations result from a cognitive bias or 'defensive exclusion' that protects the children's psychological integrity (Bowlby, 1982 in Milan & Pinderhughes, 2000). They hypothesised that considering the full implications of the maltreatment inflicted by their mothers would be too emotionally overwhelming for the children. While this type of defense may initially be a protective factor when forming a relationship with a new carer, in the long-term, denial of negative information about parents has been linked to maladjustment (e.g. Cole-Detke & Kobak, 1996).

Despite the study's results being open to social desirability and defensive biases due to the use of self-reports, they do suggest that carers need to be sensitive to the constructions that children hold of their attachment relationships with their biological mothers. Indeed, such representations may influence their approach to forming new relationships with carers, even when there is a background of severe maltreatment. Social Care professionals must be aware of these dynamics when negotiating contact arrangements between children in care and their biological families, and wherever safeguarding allows, they should promote positive family connections as this may bolster the quality of the foster care experience (Alpert & Britner, 2005).

Carer's own attachment security. One of the strongest predictors of attachment security in typical mother-child relationships is the parents' own attachment security

(Van IJenzdoorn, 1995). It is believed that the development of attachment patterns in childhood is influenced by a process of trans-generational transmission; secure parents are more likely to raise secure children (van IJenzdoorn, 1995). Four studies examined the role of foster carers' own attachment style in the carer-child relationship (Bernier & Dozier, 2003; Dozier et al., 2001; Stovall & Dozier, 2000; 2004). Foster carer attachment security was measured using the Adult Attachment Interview (AAI; George, Kaplan & Main, 1996), which examines the respondent's concepts of their own attachment experiences and relationships; referred to as 'attachment state of mind'. The studies demonstrated that carers' attachment state of mind was associated with infant attachment security as measured by the Strange Situation (Bernier & Dozier, 2003; Dozier et al., 2001) and the Parent Attachment Diary (Stovall & Dozier, 2000; 2004), although Stovall & Dozier (2000) found this to be the case only for those infants placed before the age of 12 months. Dozier et al. (2001) found concordance levels similar to biologically-related dyads (Van IJenzdoorn, 1995) and proposed that this provided evidence that it is carers' characteristics, that primarily determine children's attachment strategies in substitute care. However, children's attachment was not measured before they entered the placement, so causality cannot be inferred. Stovall & Dozier (2004), stated that the association between carer attachment state of mind and infants' security was robust for those classified as either secure or avoidant, but no association was found for those displaying ambivalent attachment behaviours. This finding may be an artefact of low participant numbers in the ambivalent group. Stovall & Dozier (2004) also commented on the association between carers' attachment state of mind and the stability of the infants' attachment behaviours. They found that children placed with carers

classified as 'autonomous' by the AAI (i.e. those who processed attachment related thoughts, feelings and memories and valued attachments), started to use consistent patterns of attachment behaviours (whether that was secure or avoidant behaviours) earlier into the placement. It was argued that autonomous carers were able to provide more consistent and nurturing care because their own attachment state of mind does not interfere with their ability to focus on the child's needs (Dozier, Hingley, Albus & Nutter, 2002). The association between carers' attachment state of mind and the consistentcy of children's attachment behaviours is particularly important, as those exhibiting inconsistent attachment behaviours early in the placement are more likely to be classified as disorganised five months later and to present a greater management challenge (Stovall & Dozier, 2004). These children may be at increased risk of experiencing a placement breakdown (Oosterman et al., 2007), and tend to achieve poorer psychosocial outcomes in the long-term (Lyons-Ruth, 1996).

Bernier & Dozier's (2003) looked at the role of 'maternal mind-mindedness' in mediating the relationship between the carer and infant attachment quality. Maternal mind-mindedness indicates the carer's tendency to describe their child in terms of mental attributes (e.g. will, mind, imagination, interest, intellect, wishes, desires, emotions), and was measured by assessing responses to the question "Could you describe (child's name) for me, what is he or she like?" Maternal attachment was assessed by examining the coherence of their discourse in the AAI. Coherence was chosen because it has been shown to be the single most powerful predictor of infant attachment security (Van Ijzendoorn, 1995). The study found that mind-mindedness explained most of the variance in the relation between carer and infant attachment security. However, it was

not merely the number of references to the child's mental processes that predicted security, rather the age-appropriateness of the descriptions (Bernier & Dozier, 2003). If carers described infants in terms of mental processes beyond their developmental stage, it reflected a lack of attunement and insensitivity, which appeared to hinder the development of a secure attachment (Bernier & Dozier, 2003).

Carers showing a lack of coherence in processing attachment information tend to either dismiss the importance of attachment experiences, are caught up in their own attachment experiences or experience a lapse in reasoning when they talk about a trauma or a loss (Dozier et al., 2002). Consequently, such carers are unlikely to provide sensitive care to their children resulting in insecure or disorganised attachments being formed (Van Ijzendoorn, 1995). The implications here are that the foster carers' own attachment style may be important to assess as part of the Local Authority approval process.

Caregiver sensitivity. From the above, it seems carergiver sensitivity is essential in developing secure carer-child relationships. According to attachment theory, a sensitive carer is likely to be attuned and responsive to the child's needs, promoting the formation of a secure attachment. Oosterman & Schuengel (2008) examined carer sensitivity by observing caregiver-child dyads to assess the degree of positive regard, emotional support provided, and the extent to which carers recognised and respected the children's motives and perspectives. They measured attachment security using the AQS (Waters, 1995) and two other non-standardized measures, namely Symptoms of Reactive Attachment Disorder (RAD) and Secure Base Distortions. Symptoms of RAD were used to assess extremely diffuse, undifferentiated or highly inhibited attachment behaviours,

whereas Secure Base Distortions were used to explore the extent to which the carer-child relationship differed from a typical secure pattern.

Oosterman & Schuengel (2008) surprisingly found that carer sensitivity was not associated with children's attachment security, as measured using the AQS, but when secure base distortions were taken into account, sensitivity was positively associated with higher attachment security. No correlation was found between carer sensitivity and symptoms of RAD. This was not to be entirely unexpected, as sensitive care-giving may be less effective for children with extreme attachment difficulties. Oosterman & Schuengel (2008) argued that secure base distortions tapped into relational constructs with a preferred caregiver and reflected disturbances in that specific relationship, whereas symptoms of RAD indicated the absence of an attachment relationship with a caregiver and were specifically related to early childhood experiences, existing "within the child."

Cole (2005) also assessed carer sensitivity using the Home Observation for Measurement of the Environment (HOME; Caldwell & Bradley, 1984). This measure involved an in-home observation/interview which looked at the quality and quantity of stimulation and support available to children in substitute care (Bradley, 1994). Sub-scales of responsivity, acceptance and involvement were used to obtain a measurement of caregiver sensitivity. Cole found, surprisingly, that caregiver sensitivity was negatively correlated with attachment security as measured by the Strange Situation. Further analysis of the sub-scales indicated that this was due to 'parental involvement,' which measured carers' attentiveness to the infants' needs. Carers displaying high 'parental involvement' were deemed to be hypervigilent and anxiously monitoring infants in their care. Rather than being attuned to children's needs, these hypervigilient and anxious

carers were over-reactive, controlling and over-protective. These characteristics have previously been associated with the development of disorientated/disorganised attachment patterns (Main & Goldwyn, 1998 in Cole, 2005). Although not reporting how many carers had experienced childhood trauma, Cole (2005) found carers' own experiences of childhood emotional and sexual abuse approached significance in predicting infants' insecure attachment. Cole suggested that carers who had suffered childhood trauma themselves were more likely to have an insecure attachment style, making them more likely to perceive their environment as threatening and to respond in an anxious and hypervigilent manner to protect their infants from perceived danger. Cole also suggested that carers' hypervigilience and over-anxious parenting style may be due to children's possible medical or developmental difficulties or to perceived scrutiny from external agencies increasing the carer's desire to 'get it right'.

Using the HOME measure, Cole also looked at the caregiving environment and found that availability of 'appropriate learning materials' was significantly associated with children's attachment security and 'organisation of the environment' approached significance. It seems that a well organised home, with access to age-appropriate materials, promotes the development of secure attachments. These associations could be explained by caregiver's own attachment security (Hipwell, Goossens, Melhuish & Kumar, 2000), which despite being proposed to influence the measured variables, was not measured in the study. Cole suggested that carers with secure attachments are more focused and sensitive to children's needs, enabling them to organise their home environment around the children and demonstrating their understanding of children's developmental needs.

Sensitive carers are more likely to show positive regard towards the children in their care, to provide emotional support, recognise and respect the children's motives and perspectives, and provide an enriching environment. All of which appear to promote the development of secure relationships. However, 'overly-sensitive' carers who are hypervigilent and over-involved, create more insecurity for children who have already experienced significant disruption and/or trauma in early childhood.

Caregiver Acceptance. Carers have been found to vary widely in the degree of emotional investment they place in their foster child (Bates & Dozier, 2002). One aspect of emotional investment is 'caregiver acceptance', which may be important in motivating carers to provide sensitive care. To measure caregiver acceptance, Ackerman & Dozier (2005) used the 'This is my baby' interview (TIMB); a semi-structured interview tapping into aspects of carers' emotional investment, i.e. acceptance of the child, commitment to parenting the child, and the belief in their ability to influence the child's development. They found that if carers showed more acceptance of their two-year old children; describing them in positive terms, demonstrating enjoyment in caring for them, as well as respecting their individuality, children were better able to cope with separations, which indicates greater attachment security.

More accepting carers are believed to interact with their children in ways that promote the development of a positive internal working model in which children perceive themselves as being accepted, valued and cared for, and that others are responsive, accepting and caring (Ackerman & Dozier, 2005).

Caregiver motivation. Individuals chose to become carers for a variety of reasons which may impact on the development of children's attachments security (Cole, 2005a). Cole (2005a) examined caregiver's initial motivation for fostering using the Motivations for Foster Parent Inventory (Yates, Lekies, Stockdale & Crase, 1997). When grouping both kinship and unrelated carers together, those carers motivated to foster for reasons such as increasing family size and social concern for the community were more likely to have secure attachments with their children as measured using the Strange Situation. Those carers desiring a bigger family may be more accepting of children, engendering children's sense of belonging and promoting a secure attachment. The reason why social concern for the community is a predictor of secure attachment could be because many of these carers were older and were exclusively committed to the ethos of short-term fostering: providing a "good bridge" for infants who would ultimately move on to adoptive families or back to their birth families (Cole, 2205a). However, attachment difficulties may be less likely to emerge in very short-term placements and carer and child may remain in the honeymoon period (Sinclair et al., 2005).

It was found that spiritual expression, adoption and replacement of a grown child predicted insecure attachments. Cole stated that caregivers with such motivations were unable to put the children's needs above their own concerns, making it difficult to become attuned to infants' cues and respond sensitively. A number of specific criticisms can be levelled at this study, for example, the sample was self-selected and carers were asked to remember what their motivation to foster was at least a year after the event. Consequently, more motivated carers may have been attracted to the study and their accounts could have been affected by poor recall or changing perceptions. Also, the

study does not specifically state at what stage in the placement the Strange Situation Procedure was conducted, which makes it difficult to draw conclusions about the impact of carer motivation on children's attachment status over time.

These findings perhaps highlight the need to assess carers' motivations before they are approved for fostering. Prospective carers need to examine their own motivations to foster, particularly as the reality of fostering may not necessarily match their expectations. This can result in novice carers being overwhelmed by the challenges of looking after highly dysregulated and traumatised children, whose behaviour is beyond the experience of most parents and families.

Discussion

It is hard to disentangle the disparate and variable evidence arising from the reviewed studies. However, in general, it seems that early attachment patterns are relatively stable and that later-placed infants show more insecure and unstable attachment behaviours than those placed earlier in life. The impact of early trauma remains contestable but it appears that older maltreated children, and those who have been exposed to more severe abuse, are likely to exhibit unstable attachment behaviours and hold negative expectations of new caregiver relationships. Added to this, foster carers' own attachment security can also affect the development of the relationship, particularly for early-placed infants. Their degree of sensitivity to children's needs, as well as their reasons for fostering and the degree of acceptance they demonstrate, all impact on the attachment relationship with children in their care. However, these results need to be considered in light of a number of methodological and conceptual limitations.

Research looking at attachment relationships between carers and their children is limited, having been conducted by only a handful of researchers. Indeed, participants from at least six of the studies (Ackerman & Dozier, 2005; Bernier et al., 2004; Cole 2005; Cole 2005a; Stovall & Dozier, 2000; 2004;) were part of an ongoing longitudinal programme, possibly drawing on the same sample pool. Although this could have implications for the variability of the findings, it is hard to verify from the research papers.

The participants in the majority of reviewed studies were less than two years old and assessed over relatively short periods in placement, therefore findings may not be relevant to other age groups and for those in longer-term care. It is difficult to draw

conclusions about the experiences of older children, as studies sampling older participants (e.g Milan & Pinderhughes, 2000) used measures that had not been adequately validated.

None of the studies used randomised sampling methods and sample sizes were generally small, reducing the power of significant findings (e.g. Milan & Pinderhughes, 2000). Participant samples were often split according to attachment categories and analyses were thus conducted on even smaller participant numbers, particularly for insecure sub-samples, thus potentially inflating type II error rates and again reducing the generalisability of any significant findings (e.g. Ackerman & Dozier, 2005; Bernier et al., 2004, Dozier et al., 2001). Also the issue of causality was often not addressed, as many of the studies relied on correlational analyses (Ackerman & Dozier, 2005; Bernier et al., 2004, Oosterman & Schuegenel, 2008). For studies using foster carer rated measures and assessing foster carer attachment style, there may be a number of important influences to consider, such as halo effects and subjective recall.

It is impossible to say with any confidence whether the children's attachment behaviours changed after entering the placement or whether they simply reflected attachment patterns formed with previous caregiver (usually the biological mother), since none of the studies measured children's attachment before being placed. There are likely to be many factors influencing the development of new relationships between carer and chid which no single research study has comprehensively captured. For example, the influence of neonatal or early care-giving experiences (Bernier et al., 2004), or current influences, such as children's ongoing contact with their family of origin (Stovall & Dozier, 2004), were not included. Where previous experiences were considered,

information was often collected through case file reviews, which can be unreliable and inaccurate (Milan & Pinderhughes 2000).

Attachment was often measured within the first month of placement (e.g. Bernier et al., 2004; Milan & Pinderhughes, 2000; Stovall & Dozier, 2000; 2004). However, over such a short time period, it is hard to discern whether it is actually short-term adaptation to a new caregiving environment that is being assessed or attachment quality. For some children, especially those with a history of severe maltreatment, the first couple of months in placement are characterised by behaviours indicative of a disorganised/disorientated attachment pattern, as children process the stress of the transition. Given a little more time, children may settle and display more organised attachment behaviours. Reliance on the Strange Situation procedure to measure attachment so early within the placement could also be questioned, as the separation-reunion procedure may not be valid for infants who are just adapting to a new caregiver. Given these points, the impetus for more longitudinal research initiatives in this area seems clear (see Dozier and her colleagues).

Further consideration also needs to be given to the credibility of attachment measures employed within the reviewed studies. Both the Strange Situation and the AQS, and to a lesser degree the Separation Anxiety Test, are reported to have well-established good psychometric properties (e.g. Van Ijzendoorn et al., 2004). However, the other attachment measures were not well standardised, with only statistics for inter-rater reliability cited within the literature. This reflects the general lack of quality control and standardisation among attachment measures (O'Connor & Byrne, 2004). Debate also continues regarding which approach is best suited for capturing individual attachment

differences. It has been suggested that reliance on attachment categories fails to capture the unique behavioural and affective components of individuals' attachment systems, and that focusing on the behaviours displayed within the Strange Situation, such as avoiding contact, proximity seeking and maintaining contact with the caregiver may provide a richer and more accurate description for researchers (Kochanska & Coy, 2002).

A critical evaluation of the studies reviewed here suggests that future research looking at the quality of foster carer-child relationships needs to take greater account of important background information about the children being placed. This should include details of the children's early developmental history and their exposure to maltreatment, derived from multiple sources to increase its validity. The time period for study and the quality of the measures employed also needs careful consideration. Multi-method approaches, describing individual attachment behaviours over key developmental stages, may also be particularly beneficial in advancing the current knowledge-base.

This review also highlights a number of critical issues for recruiting and supporting foster carers. Attuned and sensitive caregiving appears to be particularly important in enabling older children and those who have been exposed to more extreme maltreatment to display predictable and organised attachment behaviours. Foster carers also need to demonstrate persistence in gently challenging insecure and chaotic attachment behaviours. Training, consultation and direct work with carers and children may all be beneficial in increasing placement stability and improving the quality of the carer-child relationship (Golding, 2008). For example, helping foster carers develop skills to respond consistently to infants' cues may improve the quality and sensitivity of the care provided (Dozier et al., 2002), as well as promoting attachment security (van den

Boom, 1995). Furthermore, in addition to developing and delivering evidence-based training to carers, psychological interventions need to provide carers with a space to reflect on the personal impact of caring for traumatised and troubled children (Lipton, 1997). This has been shown to reduce carers' parenting stress and improve their sensitivity to their foster child's needs (Golding, 2008). Allied to this, foster carers' motivations and their own attachment security should be carefully assessed in the recruitment process, as these factors seem to be closely associated with children's attachment behaviours within the placement. Indeed, gaining an understanding of carers' own attachment status is recommended and advocated in a number of intervention programmes (e.g. Dozier et al., 2002; Liberman, Weston & Pawl, 1991).

Despite a number of developments in clinical approaches to working with foster carers, there is still a belief that those providing substitute care are isolated and overlooked within the social care system (Fisher, Gibbs, Sinclair & Wilson, 2000). In response to the failures of services to train and support carers, Government policy (DfES, 2006) has highlighted the need for a tiered, competency-based training programme that recognises fostering as a career, with opportunities for progression and financial reward.

Long-term outcomes for children growing up in foster care are generally poor, compared to their peers (e.g. Cicchetti & Toth, 2000; Newton, et al., 2000). However, the development of a positive, enduring relationship with a foster carer can act as a protective buffer and provide the platform from which children can go on to achieve their developmental potential (e.g. Zima et al., 2000). This review has highlighted a range of interacting factors related to both the child and carer that influence the quality of this fostering relationship. Nevertheless, despite the importance of this area of research in

improving outcomes for children in care, the evidence is far from convincing and the need for more robust designs is paramount.

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EMPIRICAL PAPER

Foster carer factors that promote placement success for young people aged 12-18 years old

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Foster carer factors that promote placement success for young people aged 12-18 years old

Abstract

Children placed in foster care are at increased risk of poorer outcomes (e.g. Meltzer, 2004). This risk is increased further, if multiple placement breakdowns occur; something which older children are more likely to experience (Smith, Stormshak, Chamberlain & Bridges-Whaley, 2001). Successful placements offer young people stable and secure environments, helping them meet their developmental goals (e.g. Newton, Litrownik, & Landsverk, 2000). This study examined the role of foster carers in promoting placement success for young people aged between 12 and 18 years old. It specifically examined the degree of commitment, 46 carers demonstrated towards the young person, their parenting self-efficacy and their general well-being. No significant relationships were found between any of the carer variables and placement success, although a significant positive association was found between carer commitment and self-efficacy. Methodological limitations of the study were discussed, together with some recommendations for future research and clinical practice.

Foster Carer Factors That Promote Placement Success For Young People Aged 12-18 Years Old

Of the 59,500 children growing up in Looked After Services in the UK, the majority (71%) are placed with foster carers[1] (Department for Education and Skills, 2008). Epidemiological research has shown that these children are likely to achieve poorer emotional, behavioural and educational outcomes than their peers who have never been in the care system (e.g. Newton, Litownik & Landsverk 2000). One of the reasons for these statistics is that the transition into foster care is invariably precipitated by stressful life events, such as abuse, neglect, family dysfunction and parental illness (Kools, 1997). Such events can place a huge emotional burden on a child, potentially leading to the development of significant psychosocial difficulties. Although moving into foster care allows children to escape traumatic family environments, this is a time of uncertainty and distress (Unrau, Seita & Putney, 2008), which is often further compounded by having to leave behind friends, extended family and school (Chipungu & Bent-Googley, 2004). Allied to this, children who have experienced early trauma and neglect in their families of origin may lack the skills and/or trust to build new relationships with their foster carers and to use these relationships as a source of support to buffer the stress of the transition (Howe & Fearnley, 2003; Milan & Pinderhughes, 2000). Consequently, they may be at increased risk of developing internalising (e.g. anxiety or depression) and externalising (e.g. aggressive or antisocial) difficulties which,

[1]A foster placement provides care in a family home environment for a child whose birthparents are deemed unable to meet the child's needs. This is mandated by child welfare services and can be a temporary or long-term arrangement.

in time, may jeopardise the stability of the placement (Oosterman, Schiengel, Wim Slot, Bullens & Doreleijers, 2007). A vicious cycle can thus develop, as a placement breakdown can exacerbate the young person's difficulties, which then serve to increase the risk of future placement failure. Foster placement breakdowns are particularly commonplace amongst adolescents living within the care system (Barth, Lloyd, Green, James, Leslie & Landsverk, 2007). They are much more likely to engage in violent and high risk behaviours than younger children (Taussig, 2002), therefore making the challenge of fostering even harder (Oosterman et al., 2007).

A successful placement can offer a young person a stable and secure environment in which they are able to meet their developmental goals. Indeed, children who remain longer in placements do better academically (Zima, Bussig, Freeman, Yang, Belling, & Forness, 2000) and exhibit fewer behavioural problems than those who experience multiple placement moves (Newton et al., 2000). Therefore, to improve outcomes for children growing up in foster care, research needs to consider potential risk and protective factors affecting placement success. Factors related to the child, the carer, the quality of the caregiving relationship, as well as the availability of support from external agencies have all been identified as playing a part in determining the success or failure of a placement (Oosterman et al., 2007). In this study, the role of the foster carer in promoting placement success was explored. The degree of commitment carers demonstrated towards the young person they were caring for, their sense of parenting self-efficacy and their psychological well-being were all proposed as important correlates of placement success.

Foster Carer Commitment

Commitment can be defined as the caregiver's commitment to an enduring relationship with his or her child (Bates & Dozier, 1998; Dozier & Lindheim, 2006). In most mother-infant dyads, although differences may exist in the degree of warmth, acceptance and sensitivity shown, parents are generally strongly committed to their infants (Bradley, Whiteside-Mansell, Brisby, & Caldwell, 1997; Corwyn & Bradley, 1999). Parental commitment has previously been associated with positive developmental outcomes. However, for those charged with looking after other people's children, commitment may be more variable (Dozier & Lindhiem, 2006). Indeed, foster carer commitment has been found to vary according to the age at which child is placed, with greater commitment demonstrated towards younger children (Dozier & Lindheim, 2006). Carer experience has also been found to be an important mediating factor. Experienced carers who have looked after many children during their careers demonstrated lower levels of commitment (Dozier & Lindheim, 2006), possibly as a result of developing stronger defenses to protect themselves from the grief and loss of children frequently moving on.

Foster carer commitment has been shown to predict placement stability (Dozier & Lindhiem, 2006) and to promote greater psychosocial achievements for children in care (Lindheim & Dozier, 2007). However, these findings only relate to infants and young children. No studies have directly examined the relationship between foster carer commitment and placement outcomes for adolescents. Dozier and Lindheim (2006) have

suggested that experience may be more important than commitment when fostering older children. Indeed, Chamberlain, Moreland and Reid (1992) found that foster carer experience was particularly important when caring for adolescents who present with challenging behaviours, although no comparisons were made with carer commitment. Given the scarcity of research, the relationship between foster carer commitment and successful outcomes in adolescent placements warrants further examination.

Carer Well-being

Verini (2003) found that foster mothers of children between the ages of 3 months and 12 years who reported higher levels of commitment, perceived parenting as less stressful and more satisfying. The presence of parenting stress and parental psychological problems, even at a sub-clinical level, has been shown to have an adverse effect on children's socio-emotional and cognitive development (Ramchandani, Stein, Evans & O'Connor, 2005), which is attributed to the parents' inability to provide sensitive and responsive caregiving during periods of distress (Gotlib & Goodman 2002 in Cole & Eamon, 2007). Although relatively unexamined, similar effects have been found in research involving foster carers. Farmer, Lipscombe and Moyers (2005) looked at well-being in carers who were fostering adolescents. They found that emotional stress levels experienced by foster carers prior to or during the placement influenced their parenting practices and impacted on placement outcome. Carers who experienced higher levels of distress generally disliked the young people they were caring for, demonstrated less sensitive parenting, and were more dissatisfied with the placement from the

beginning. Carer stress was directly linked to placement outcome, as young people placed with emotionally stressed carers showed less improvement in their own well-being, had greater levels of unmet needs and experienced more placement disruption. On the basis of these preliminary findings, it seems that foster carer well-being may be an important dimension of placement success for adolescents. However, more research is needed to verify this conclusion.

Carer Self-Efficacy

Research with birth parents has linked well-being to self-efficacy, which refers to the belief in one's ability to successfully perform a particular behaviour (Bandura, 1977). A parent who is low in mood, may also be expected to have low self-efficacy (Cutrona & Troutman, 1986; Teti & Gelfand, 1991), and hold more negative perceptions of their child's functioning (Halpern, Anders, Coll & Hua, 1994).

An individuals' level of self-efficacy can have a significant affect on their emotional, motivational, behavioural and cognitive reactions when faced with a demanding task. People with a high sense of self-efficacy trust their own abilities and tend to think of problems more as challenges rather than threats. They also experience less negative emotional arousal during a challenging task and are more likely to persevere (Jerusalem & Mittag, 1995). Parental self-efficacy refers to a parent's beliefs in their ability to influence their child and their environment in order to promote the child's well-being and success (Ardelt & Eccles, 2001; Coleman & Karraker, 1998; Jones & Prinz, 2005). Parents with high parenting self-efficacy have been shown to be more competent

and to use positive parenting practices, strategies and behaviours (Coleman & Karraker, 1998). Self-efficacy is also an important variable in parental role satisfaction and appears to influence parental perceptions (Coleman & Karraker, 2000). For example, high maternal self-efficacy has been consistently associated with a relative absence of perceived child behavioural problems (Johnston & Mash, 1989), as well as with greater parental acceptance of their child's behavioural problems (Coleman & Karraker, 1998). Whereas low maternal self-efficacy has been associated with a number of factors including depressive symptoms (Cutrona & Troutman, 1986), increased parenting stress (Gross, Fogg & Tucker, 1995), actual child behaviour problems (Hassel, Rose & McDonald, 2005), and maternal perceptions of child difficulty (Halpern et al., 1994). However, despite the wealth of research on birth parents, there appears to be a gap in the literature regarding self-efficacy beliefs of foster carers looking after other people's children. This study thus proposed to examine the impact of foster carer self-efficacy beliefs on placement success.

Aims Of The Study

It is important to identify factors that may promote foster placement success, particularly for adolescents who generally experience the highest rates of breakdown. Young people growing up in a stable foster care environment are more likely to achieve good psychosocial outcomes and to go on to become more fulfilled in adulthood (Unrau et al., 2008). Although there are likely to be multiple correlates of placement success, this study focused specifically on foster carer factors. In particular, it examined the

extent to which carer commitment, self-efficacy and well-being predicted placement success. A successful placement was defined as one in which the young person was stable and was achieving age appropriate social, emotional and behavioural targets. It was expected that:

1. Those young people placed with foster carers who show greater carer commitment, higher levels of self-efficacy, and a greater sense of well-being would experience more successful placements (as measured by the Every Child Matters Outcomes Framework and the Strengths and Difficulties Questionnaire).
2. Those young people placed with foster carers who show greater carer commitment, higher levels of self-efficacy, and a greater sense of well-being would experience more stable placements (as measured by the length of time in placement).
3. Carer experience (number of years a carer has been fostering and number of children the foster carer has fostered) would be a stronger predictor of placement success than carer commitment.
4. Lower carer self-efficacy would be associated with lower general well-being.

METHOD

Design

This exploratory study used a within subjects, cross-sectional design to examine the impact of carer commitment, self efficacy and well being on placement success. Placement success was measured by the length of time in placement, outcomes of the foster carer rated SDQ measure, and whether the young person was meeting their targets in the five outcome domains outlined in the Every Child Matters Outcomes Framework. Using Cohen's (1992) conventions for describing effect sizes it was calculated that 76 participants were required to maintain a power of 0.8 to detect a medium sized effect for a multiple regression/correlational analysis and significance tests at $\alpha = .05$.

Method

Participants.

A convenience sample of foster carers was recruited from two Children's Services Departments in the West Midlands. All of those approached were looking after young people aged between 12 and 18 years old who had been placed with the carers for at least six months. Neither kinship carers nor those who did not speak English fluently were approached. The final sample comprised forty-six, non-kinship foster carers. Response rates and demographic/background details for foster carers and young people are presented in the results section.

Measures

Background & Demographic Questionnaire (Appendix 1): A number of factors related to the young person, carer and placement (e.g. time in placement, number of biological children / other foster children in the placement) were collected from the participating foster carers and Children's Services' records. Items included in the background and demographics questionnaire had previously been shown to influence foster placement outcome (Oosterman et al., 2007).

Carer-related measures: Commitment- This is My Baby Interview TIMB (Bates & Dozier, 1998) (Appendix 2): This nine question interview was used to assess foster carers' commitment towards the young people in their care. During the interview, the carers are asked to describe their feelings about the young people, such as, "How much would you miss the young person if he or she were to leave your care?" Foster carers responses were audio recorded and coded. Commitment was rated on a 5-point scale, where 5 = high commitment and 1 = low commitment. Scoring guidelines written by the authors of TIMB were used and are included in Appendix 3. The TIMB has been shown to have high inter-rater reliability calculated as a Spearman Brown correlation of .90. In this study, a validity coefficient was calculated to be r = .97 by comparing 10% of interviews, which were randomly selected and coded from both the audio recording and from written transcripts. The recordings and transcripts were counter-balanced to avoid the influence of carryover effects. This sub-sample was also rated by the researcher and an

experienced clinical psychologist working with children in the care system. Inter-rater reliability from this sub-sample was calculated to be r = .70.

Self-efficacy subscale - Parenting Sense of Competence Scale (PSOC; Gibaud-Wallston, 1978 in Johnston & Mash, 1989) (Appendix 4): This 7 item scale measured the degree to which foster carers believed they had acquired the skills and understanding to be a good carer, e.g. "If anyone can find the answer to what is troubling my foster child, I am the one". The measure was adapted by replacing the term 'parent' with 'foster carer' and 'foster child' was used instead of 'child.' Foster carers responded to each item using a 6 point scale, ranging from 1= strongly agree to 6= strongly disagree (this scale was then reverse scored for the purposes of analysis). The PSOC has been shown to have good internal reliability (α = .77), and test-retest reliability coefficients for the PSOC scale over a six-week period have ranged from r= .46 to .82 (Gibaud-Wallston & Wandersman, 1978 in Johston & Mash, 1989). The internal validity of the PSOC in this study was calculated to be α = .89.

Well-being - General Health Questionnaire, Version 12 (GHQ-12; Goldberg, 1992; see Appendix 5): The GHQ-12 was completed by the foster carers to give a measure of their psychological well-being. It has been widely used with both general and clinical populations and has been shown to have high internal consistency (α range of 0.82 to 0.90), and test-retest reliability of r = .73 (Goldberg & Williams, 1988). Internal validity of the GHQ-12 in this study was calculated to be α = .91.

Measuring Placement Success. The study measured placement success using three variables.

Length of time in placement: The date of entry to the current placement was collected enabling the calculation of the length of time the young person had been in the placement at the time the interviews with foster carers were conducted.

Every Child Matters Outcomes Framework (West Midlands Children's Commissioning Partnership, 2008; Appendix 6): The Outcomes Framework was derived from the Every Child Matters (2004) 5 key outcome indicators of well-being and personal achievement in childhood: be healthy, stay safe, enjoy and achieve, making a positive contribution and achieving economic well-being. By examining the current and previous statutory Looked After Review minutes, evidence of the young person's progress was assessed and entered onto the Outcomes Framework. For each factor a numerical value was ascribed to indicate whether the young person was doing better, as well as, or worse than at their previous Review[2]. Inter-rater reliability was obtained for 10% of the sample and cross-informant correlation was calculated to be $r = .80$. The internal validity for this measure was calculated to be $\alpha = .74$.

Strengths and difficulties questionnaire: teacher/parent version (Goodman, 1997; Appendix 7): Foster carers were asked to complete this 25 item measure assessing the emotional and behavioural functioning of the young person in their care. They were asked to answer 'not', 'somewhat' or 'certainly true' to each item. Responses were

[2] All foster children under the age of 18 years have a multi-agency statutory Look After Review every six months to ensure their needs are being met. An Independent Reviewing Officer chairs the meeting and the proceedings are formally minuted.

assigned a score of 0, 1 or 2 (see Appendix 7 for scoring sheet). A total difficulties score was then calculated. The questionnaire assessed the behaviour of the young person over the last 6 months and the 25 items were divided into five scales looking at emotional, conduct, hyperactivity/inattention, peer relationship problems and prosocial behaviour. The SDQ has been shown to have satisfactory reliability with internal validity ($\alpha = .73$), cross-informant correlation ($r = .34$), and retest stability after 4-6 months ($r = .62$). In this study, internal validity was calculated to be $\alpha = .76$. Appendix 8 denotes the cut off scores for both the total difficulties score and sub-scales which correspond to 'normal', 'borderline' and 'abnormal' categories.

Procedure

Ethical approval was obtained from the School of Psychology Human Research Ethics Committee at the University of Birmingham (Appendix 9) and Research and Development approval was granted by the participating Children's Social Services Departments. Advance notice of the study was advertised both through articles in local Fostering Newsletters and by the researcher attending foster carer and supervising social worker meetings. Potential participants, meeting the study's inclusion criteria, were identified from Children's Services records and sent an information sheet (Appendix 10) and covering letter (Appendix 11) through the post. The covering letter included a response slip which foster carers were asked to complete and return in a prepaid envelope if they did not want to be contacted by the researcher. Those who did not return the

response slip within two weeks were contacted again and asked if they were interested in taking part in the study.

As all of the measures of placement success and the demographic questionnaire relied on information about young people, it was essential to secure their informed consent before proceeding with the foster carer interviews. Consequently, all the young people being cared for by those who had agreed to participate were sent an information sheet about the study (Appendix 12) and a consent form granting the researcher access to their statutory Looked After Review records (Appendix 13). If a young person refused to give consent, the foster carer was thanked for their interest in the study but no further action was taken. For any young people under 16 years who did consent, further permission to proceed was sought from representatives of the relevant Children's Services Department holding parental responsibility for them.

Before the interviews commenced, written consent was obtained from the foster carers (Appendix 14) and their right to withdraw was stressed. Interviews and questionnaire completion took approximately 50 minutes, after which the foster carers were given a debriefing sheet (Appendix 15) and an opportunity to ask any questions about the study. The young person's Looked After Review minutes were accessed at the Children's Services departments where they were kept. Due to the variable quality of information available in the Review minutes, the young person's Social Worker was contacted in some cases to obtain more detailed information in order to complete the Every Child Matters Outcomes Framework measure. Written information was stored in a locked cabinet and details were stored in password protected computer files. After audio recordings had been coded they were deleted from the audio equipment.

Results

Response Rates

Of the 86 foster carers approach to participate in this study, 52 (53.5%) agreed to take part and 34 (39.5%) declined. Some foster carers did not offer a reason for their refusal, whereas others stated that they were not interested, or that they were unable to participate due to time constraints or family illness. Of those who expressed an interest in taking part, a further 6 (7%) were unable to be interviewed because the young person did not give consent for the researcher to access at their statutory Looked After Review records. Table 1 compares the demographics of the young people who were being cared for by foster carers who agreed to participate against those from non-participating carers.

Table 1 – Comparison of the young people's demographics of those foster carers who were interviewed and those foster carers who did not take part.

	Participants	*Non Participants*
Young person's details		
Male	26 (56.5%)	18 (45%)
Female	20 (43.5%)	22 (55%)
Average age of YP (yrs)	15.6 (SD=1.6)	15.0 (SD=2.0)
Average time in current placement (mean in yrs)	4.8 (SD=3.1)	3.7 (SD=2.4)

Independent t-tests showed no statistical differences between participants and non-participants with regards to the young people's gender, (t (84) = 1.06, p = .29) age (t (84) = 1.42, p = .16) or time spent in the current placement (t (84) = .10, p = .07). It was thus concluded that the participant sample was representative of the total sample pool.

Participant Demographics and background information

Tables 2 and 3 present the background details and demographics of foster carers and young people, respectively.

Table 2 – Background details / demographics of the Foster Carers

Gender		
Male	12	(26.1%)
Female	34	(73.9%)
Ethnicity		
White British	38	
Asian British	2	
Black African Caribbean	4	
Mixed White & Asian	0	
Mixed White & Black African Caribbean	0	
Mixed heritage	2	
Age in years (mean)	55.0 (SD =7.6)	
Marital Status		
Married	39	(84.8%)
Single	3	(6.5%)
Cohabiting	2	(4.3%
Widowed	2	(4.3%)
Number Of Years Fostering (mean)	14.7 (SD = 7.8 ; range 4-37)	
Number Of Children Fostered (Excluding Respite, Emergency Care)		
1-5	5	(10.9%)
6-10	12	(26.1%)
11-25	5	(10.9%)
26-99	14	(30.4%)
100-199	8	(17.4%)
200+	2	(4.3%)
Number Of 12-18 Yr Olds Previously Fostered		
0	8	(17.4%)
1-5	8	(17.4%)
6-10	7	(15.2%)
11+	23	(50.0%)
Number Of Other Birth Children / Adopted Children In The Home		
0	20	(43.5%)
1	19	(41.3%)
2	4	(8.7%)
3	3	(6.5%)
Number Of Other Fostered Children In The Home		
0	13	(28.3%)
1	11	(23.9%)
2	17	(37.0%)
3	5	(10.9%)
Previous Number Of Placement Breakdowns		
0	11	(23.9%)
1-5	20	(43.5%)
6-10	13	(28.3%)
11+	2	(4.3%)

Table 3 – Background details /demographics of the Young People

Gender		
Male	26	(56.5%)
Female	20	(43.5%)
Ethnicity		
White British	37	(80.4%)
Asian British	2	(4.3%)
Black African Caribbean	1	(2.2%)
Mixed White & Asian	2	(4.3%)
Mixed White & Caribbean	2	(4.3%)
Mixed heritage	2	(4.3%)
Age		
12-13	8	(17.4%)
14-15	15	(32.6%)
16-17	20	(43.5%)
18	3	(6.5%)
Years in Placement (mean)	4.8	(SD=3.2)
Number Of Placements (Including Current)	2.50	(range 1-8)
Previous Types Of Placements		
Foster care	32	
Kinship care	2	
Residential	5	
Adoption	1	
Other	1	
Age In Years At Entry Into Foster Care (mean)	9.7	(SD=11.8)
Total Time In Years In Foster Care (mean)	7.5	(SD=3.9)
Type Of Care Order		
Full care order	40	(87.0%)
Voluntary (Section 20)	4	(8.7%)
Interim care order	1	(2.2%)
Other	1	(2.2%)
Number With Statement Of Educational Needs	11	(23.9%)

One-sample Kolmogorov-Smirnov anlayses were carried out to test the distribution of the key variables. The results (see Appendix 16) indicated that all the variables, except for the Outcomes Framework variables, were normally distributed.

Carer Commitment

Carer commitment scores ranged from 1.5 to 5 (maximum score). The mean score was 3.9 (SD = 1.0) which indicates that moderate to high carer commitment was

demonstrated. This compares to previous studies which reported means of 3.3 (SD=1.0) (Dozier & Lindhiem, 2006), 3.5 (SD=1.0) (Ackerman & Dozier, 2005) and 3.3 (SD=1.1) (Lindhiem & Dozier, 2007); scores closer to moderate commitment. Appendix 17 denotes the number of carers who achieved each score.

Carer Self-Efficacy

The mean total self-efficacy score was 33.6 (SD=6.50) which indicates high self-efficacy since the highest possible self efficacy score is 42. This compares to a previous study measuring parental self-efficacy which reported means of 27.7 (SD=7.22) (Lovejoy, Verda & Hays, 1997). There was no significant difference between foster carer self-efficacy and gender (Chi-squared = 16.2, df =18, p= .58). Appendix 18 shows the mean scores for each question, ranging from 6 = strongly agree to 1 = strongly disagree (reversed scores).

Carer Well-Being

The mean total score on the GHQ-12 was 10 (SD=5). Although the Likert scoring method used to score the GHQ-12 does not report cut-offs a mean total score of 10 would suggest foster carers reported good general well-being and indicates low probability of clinical disorder. The responses score 0, 1, 2, and 3 was transformed to the scoring 0, 0, 1 and 1 in order to detect casesness (Goldberg, 1992). Seven carers (14.2%) exceeded a total score of 3 and therefore the cut-off threshold for psychiatric disorder.

However such cut-offs may need to be raised to take account of those respondents with somatic symptoms. Farmer et al. (2005) used the GHQ-28 (Goldberg & Hiller, 1979), finding that 29% foster carers scored in the sub-clinical or clinical range.

Measures Of Success In Placement

SDQ scores. Differences in SDQ total or sub-scale mean scores according to a young person's age or gender were investigated. When age was categorized into groups (12-13yrs; 14-15yrs; 16-17yrs; 18yrs), one-way ANOVA tests found that the both the total SDQ scores and subscale scores did not differ significantly with regards to the young person's age or gender (see Appendix 19 for statistical results). Table 4 shows the mean scores for the sample and compares this to the British means for 11-15 year olds. The mean scores from the study were higher for all the subscales, except prosocial (which was calculated by reverse scoring the items in this subscale). Higher scores in the emotional, conduct, hyperactivity and peer subscales and lower scores in the prosocial subscale indicate greater difficulties.

Table 4 – Means and standard deviations for current study and norms of a British sample of 11-15 year olds

	Current Study		*SDQ Norms for British sample 11-15 year olds*	
	Mean	*SD*	*Mean*	*SD*
Emotional	3.0	2.6	1.9	2.0
Conduct	3.3	2.8	1.6	1.7
Hyperactivity	5.5	3.0	3.5	2.6
Peer	3.0	2.3	1.5	1.7
Prosocial	7.3	2.3	8.6	1.6
TOTAL	14.7	7.9	8.4	5.8

Scores on the SDQ were categorized and the number of young people in each category for each subscale and total SDQ score is presented in Table 5. For the hyperactivity and peer problems subscales there were nearly as many young people rated in the abnormal range compared to the normal range. More young people were rated in the abnormal range regarding peer problems. None of the young people were rated in the abnormal range for the conduct subscale.

Table 5 – SDQ category scores

	Normal n (%)	*Borderline n (%)*	*Abnormal n (%)*
Emotional	30 (65.2)	6 (13.0)	10 (21.7)
Conduct	24 (47.1)	2 (3.9)	20 (39.2)
Hyperactivity	25 (54.3)	5 (10.9)	16 (34.8)
Peer Problems	17 (33.3)	9 (19.6)	20 (39.2)
Prosocial	37 (80.4)	3 (6.5)	6 (13.0)
TOTAL	20 (39.2)	9 (17.6)	17 (33.3)

Grouping the total SDQ score data according to the three SDQ categories (normal, borderline or abnormal) a one-way ANOVA found no significant differences between these categories according to the continuous variables of young person's, age, time in current placement, number of previous placements, the foster carer's age, number of years fostering, their total self-efficacy score, their total GHQ score or their commitment score and chi-squared tests found no difference with regard to either the young person or foster carers' gender (see Appendix 20).

Every child matters outcome framework measure. Median and inter-quartile ranges for the total outcomes score and the five subscale scores are presented in Table 6.

Table 6 – Median and inter-quartile ranges for the total and subscales of the ECM outcomes framework measure

	Total	*Being Healthy*	*Staying Safe*	*Enjoying & achieving*	*Positive Contribution*	*Economic Wellbeing*
Median	14	3	3	3	3	3
Inter-quartile range	13 -15	3-3	2-3	3-3	2-3	2.5-3

The total and subscales of the Every Child Matters outcomes framework measure were correlated with the total score and subscales on the SDQ. The correlation matrix is presented in Appendix 20. No significant correlations were found between the Outcomes Framework total score and the SDQ score. However, some of the subscales on the two measures were significantly associated with each other. Interestingly, positive contribution was significantly associated with the SDQ prosocial scale (rho = .40, $p<.05$) and staying safe had a significant negative association with both the SDQ conduct (rho = -.47, $p<.01$) and SDQ hyperactivity scales (rho = -.30, $p<.05$).

Spearman's rho correlations were performed to examine the relationships of the key independent variables of carer commitment, self-efficacy, wellbeing, number of years fostering and number of children fostered on the dependent variables of total SDQ score, time in current placement and the total outcomes framework score (ECM total) (see Table 7).

Table 7 – Correlations between key variables

	Commitment	*Self-efficacy (total)*	*Well-being (total)*	*Number of children fostered*	*Number of years fostering*
SDQ total[#]	-.03	-.07	.15	.18	.16
Time in current placement[#]	.28	.04	-.05	.04	.17
ECM total[~]	-.23	-.20	-.21	-.00	-.27
Commitment[#]	-	.36*	-.12	-.20	-.15
Self-efficacy (total)[#]	.36*	-	-.26	-.14	-.15
Well-being (total)[#]	-.12	-.26	-	.16	-.08

$p < .05$
Pearson's correlations
~ Spearman's rho correlations

Hypothesis one and two:

The correlation matrix presented in Table 7 indicated that there were no significant associations were found between foster carers' commitment, self-efficacy well-being and placement success for adolescents (as measured by the Every Child Matters Outcomes Framework, the Strengths and Difficulties Questionnaire and length of time in placement).

Hypothesis three:

It was expected that carer experience (number of years a carer has been fostering) would be a stronger predictor of placement success than carer commitment. This hypothesis was not supported by the results. As Table 7 illustrates, no significant associations were found between any of the foster carer factors and placement success, which precluded any further analysis to identify predictor variables.

Hypothesis four:

Contrary to expectation, carers' self-efficacy was not significantly associated with general well-being (see Table 7). However a significant positive correlation was found between self-efficacy and carer commitment.

Discussion

This exploratory study aimed to examine the extent to which foster carer commitment, self-efficacy and well-being were associated with placement success for adolescents in foster care aged between 12 and 18 years old. Contrary to expectations, none of the hypotheses were supported.

Previous research has shown foster carer commitment to be positively associated with placement stability and better developmental outcomes for infants and younger children (Dozier & Lindheim, 2006; Lindheim & Dozier, 2007). However, no significant relationship was evident for the foster carer-adolescent dyads participating in this study. Like Dozier & Lindheim (2006), this study employed the "This is My Baby Interview" to assess carer commitment. Although this measure was specifically developed with infants and young children in mind, it does not refer to babies per se. However, its validity with foster carers looking after adolescents could be questionable, as carer commitment may be conceptually different with this older age group. Despite this, its use in this study was endorsed by Mary Dozier (personal communication) and mean scores on the TIMB were similar to those found by Lindhiem & Dozier (2007), Ackerman & Dozier (2005) and Dozier & Lindhiem (2006). In comparison to young children, adolescents in care are likely to be less dependent on their foster carers, to have experienced multiple placement moves, to be looking to move into independent living, or for those entering care for the first time, to have more established relationships with their birth families. Given this, foster carer commitment may be less meaningful to adolescents and have less impact on their overall functioning within the placement. Dozier & Lindheim (2006) suggested that foster carer experience may have greater influence over placement outcomes for older

children and adolescents than commitment. Nevertheless, this study did not find a significant relationship between either the number of years a carer had been fostering or the number of children they had looked after and placement success for the adolescents in the sample.

Previous research has indicated that greater parenting self-efficacy is associated with an increase in the use of positive parenting strategies and a reduction in child behavioural problems (Coleman & Karraker, 2003). Although this research had largely been conducted with birth parents and their young children, similar effects were expected with foster carers looking after adolescents. However, no significant relationship was found between self-efficacy and placement success in this study. Like commitment, the influence of carer self-efficacy as children reach adolescence may diminish. Carers may feel that however confident they are in their parenting skills, other sources of influence such as peers and family of origin may have a greater impact on the young person's behaviour and the success of the placement (Oosterman et al., 2007). Foster carer self-efficacy was measured using an adapted version of the PSOC (Parenting Sense of Competence). Although the word changes from 'parent and child' to 'foster parent and foster child' were not piloted, the internal consistency for the measure with the foster carer sample was high ($\alpha = .89$) and comparable with previous research, although the mean score for the foster carers in this study was higher (33.6) than that found with birth parents (Lovejoy, Verda & Hays, 1997). This may suggest that foster carers perceive themselves as having higher parenting self-efficacy than birth parents. Further analysis, did not find any relationship between foster carers' experience and parenting self-efficacy. It is difficult to explain the null results but they this may also reflect a social

desirability bias, as foster carers may be highly motivated to portray themselves as competent professionals (Rostill-Brookes, Larkin, Toms & Churchman, in press). This methodological consideration could apply equally to all of the foster carer rated measures in this study. Another issue related to the measurement of parenting self-efficacy, was the construction of one of the items on the PSOC, which presented many of the foster carers with a dilemma. They perceived the following, "Being a good foster carer is manageable, and any problems are easily solved" to be two distinct statements, to which they were asked to assign one rating. This may have compromised the validity of the scale.

One significant finding of note was that parenting self-efficacy was positively associated with foster carer commitment. It seems that the more carers feel skilled and confident in their ability to care for their foster child, the more they are able to invest in a stronger, enduring relationship. Although no causal pathway can be determined from this association, foster parent training is based on the premise that increasing carers' skills and knowledge will enhance the quality of the carer-child relationship (see Turner, Macdonald & Dennis, 2007).

Farmer et al. (2005) found that foster carers' emotional stress levels influenced their parenting practices and impacted on placement outcome for adolescents. However, this finding was not supported here. Like Farmer et al. (2005), foster carers' psychological well-being was assessed using the General Health Questionnaire and placement success was determined (in part) through scores on the SDQ, so it is difficult to determine why no significant effects were found in this study. The sample employed by Farmer et al. (2005) was marginally larger (n=68) compared to (n=46), which may

account for the differences. The GHQ may not be the most sensitive measure for assessing emotional stress in foster carers and it could have been prudent to use a tool specifically designed to assess parenting stress (e.g. the Parenting Stress Index). However, this measure would have required significant adaptation to be appropriate for use with substitute carers. By using the GHQ it was possible to detect caseness in the current sample (n=7). This may have some clinical utility for identifying those most in need of support from external agencies. Further research with larger sub-samples may be warranted to determine the relationship between caseness and the other variables explored in this study. Both foster carer-informant and multi-agency perspectives (as recorded from the review minutes on the Outcomes Framework measure) were used to assess placement success. This is a relative strength of the study but there are a number of limitations that should be considered. While the SDQ has recently been accepted as a general outcome measure for Looked After Children in England (DfES, 2008), it has not been standardized for use with this population and may produce ceiling effects (Meltzer et al., 2002). The young people indicated greater difficulties in all the SDQ subscales which is in line with Meltzer et al. (2002), who found that children in care have greater difficulties than children living with their birth families.

However, this study compared reasonably well to the mean scores for a British sample of 11-15 year olds (Meltzer, Gatward, Goodman, & Ford, 2000). It is worth noting that in Britain, the SDQ has been standardized for use with young people up to the age of 15 years, although in the US it has been standardised with young people up to the age of 18 and 17 in Australia (Mellor, 2005). The SDQ is used by Local Authorities with those up to care leaving age (16-18 years) and with young people up to 18 years in Farmer et al.'s

(2005) study. One of the other measures employed to assess placement success was the Outcomes Framework based on the Every Child Matters core attainment factors for children (2004). This measure was developed by a collaboration of Local Authorities in the West Midlands to provide an ecologically valid measure of a young person's current functioning in a substitute care environment. The measure was completed through a file review process, and as such was subject to considerable variability, dependent on the quality of the information available. Whilst efforts were made to follow-up missing data with individual's Social Workers, some gaps remained. To improve confidence in this measure inter-reliability was calculated and found to be reasonably high (r=0.80). Although the total score of this measure did not correlate with the SDQ total score, some of the subscales were correlated with some of the SDQ subscales. For example, the positive contribution scale correlated with the prosocial scale which makes sense and thus may suggest some validity in this measure. Unfortunately, this measure is not particularly sensitive to the level of success a young person demonstrates across the five core factors as it does not distinguish numerically between young people who are making progress between Reviews and those that remain the same over time. Although this may be sufficient for Children's Services' outcome evaluation, it has obvious implications for the variability in the data collected here and adds support to the inclusion of other measures (SDQ and length of time in placement) to assess placement success in this study. The final measure of placement success was length of time in placement. This is used by the Government as an indicator of stability. In order to allow for the development of a relationship between foster carers and young people in this study, a minimum of six months in placement was set as an inclusion criterion. Based on advice

from Social Care professionals supporting the study, this approach significantly reduced the available sample pool. However, ensuring that carers and young people had some chance to build a relationship seemed important when assessing factors such as commitment.

One of the main limitations of this study was its lack of power. Despite the significant efforts employed to increase the sample size by attending both supervising social worker and foster carer meetings, advertising in the fostering newsletters and using an opt-out procedure to contact carers with advance notice of the study, it was not possible to recruit the 76 participants required for a medium effect size. A post-hoc power analysis was not calculated. However, in a study looking at the relationship between foster carer well-being and placement outcome, Farmer et al. (2005) found significant results at the $p<0.05$ level with a sample size of $n=68$. This suggests that with more participants the results may have achieved significance. It may have been worthwhile recruiting other Children's Services' Departments into the study, although the difficulties with obtaining the required sample size did not become apparent until a late stage in the research procedure. Any replication of this study would need to ensure a broad pool of Departments to recruit from. This may also improve the generalisability of any findings. Albeit that all efforts were taken to ensure that the sample here was representative of the foster carers employed by both participating Children's Services Departments.

Despite the lack of significant findings, the cross sectional design employed in this study could have been a particularly limiting factor. Future research should ideally employ longitudinal designs but the inherent practicalities of recruiting large enough

samples of foster carers may limit this avenue of research. If these difficulties could be overcome by mainstreaming research programmes within Children's Services, it may be possible to identify causal pathways contributing to placement success. Given the association between placement success and long-term positive psychosocial outcomes for young people, it seems that further multi-agency investment in research in this area is warranted. With sufficient resource, future research could explore multiple perspectives and factors associated with improving placement outcomes for adolescents. Taking this research forward should ideally involve major stakeholders within the social care system and not just foster carers, for example young people in foster care, their social workers and birth families (Brown & Bednar, 2006).

The lack of significant findings in this study limits the extent to which meaningful clinical recommendations can be made. However, it is important to continue to support foster carers and young people to achieve a positive placement experience (Barth et al., 2007). One contributing factor in promoting placement success has been the provision of training for foster carers, often based on cognitive-behavioural approaches (Turner et al., 2007). Although these interventions appear to increase carers' satisfaction with their role and reduce their stress levels, they have only had a small to moderate impact on the range and severity of social, emotional and behavioural problems exhibited by young people in care (Golding, 2008; Turner et al., 2007). The evidence base for individual or family/systems work with foster carers and adolescents is also extremely limited (Oosterman et al., 2007). This again suggests the need for further research to understand what works for young people in care and how to support them in achieving their developmental potential.

Although this study produced few significant results, the aim of identifying factors promoting placement success remains valid, particularly for adolescents who experience the highest rates of placement breakdowns within the care system (Barth et al., 2007). Hopefully, applying this positive psychology approach to future research initiatives will allow treatment interventions to be developed from what works well already and applied early within the placement process to produce greater stability and better psychosocial outcomes for young people.

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PUBLIC DOMAIN BRIEFING PAPER

Foster Carer Factors Promoting Placement Success In Young People Aged 12-18 Years

This research was conducted by Nicola Taylor as partial fulfilment of the Doctorate in Clinical Psychology at the University of Birmingham. Research supervision was provided by Dr Helen Rostill (University of Birmingham) and Dr Marie Kershaw (Dudley & Walsall Mental Health Partnership Trust).

Overview

The research is divided into two parts: a literature review and the main research paper.

The literature review aimed to look at what facilitates the development of an attachment relationship between a foster carer and their child. Using attachment theory as a framework, studies quantifying the quality of an attachment relationship between the foster carer and child were examined. The results, in general, indicated that early attachment patterns are relatively stable and later-placed infants show more insecure and unstable attachment behaviours than those placed earlier in life. It appears that older maltreated children, and those who have been exposed to more severe abuse, are likely to show unstable attachment behaviours and hold negative expectations of the new caregiver relationships. Added to this, foster carers' own attachment security can also affect the development of the relationship, particularly for early-placed infants. Their degree of sensitivity to children's needs, as well as their reasons for fostering and the degree of acceptance they show, all impact on the attachment relationship with children in their

care. However, these results need to be considered in light of a number of methodological and conceptual limitations.

The research study examined the role of foster carers in promoting placement success for young people aged between 12 and 18 years old, specifically looking at carer commitment, self-efficacy and well-being. Contrary to expectations, neither foster carer commitment, self-efficacy nor well-being were associated with placement success.

Background: Children placed in foster care account for 71% of the 59,500 children in Looked After Services in the UK (Department for Education and Skills, 2008). Many children, particularly adolescents experience frequent placement changes. This instability is likely to have further negative implications for children who may already be experiencing difficulties relating to a history of abusive and neglectful caregivers. Research has shown that children who experience placement stability do better academically (Zima et al., 2000) and experience fewer behavioural problems (Newton, Litrownik, & Landsverk, 2000). Examining both risk and protective factors related to placement success, particularly for adolescents in foster care is therefore important as this age group has been shown to suffer increased numbers of placement breakdowns (Barth et al., 2007).

Method: Fifty-two foster carers were recruited for the study. Of those, six young people did not give their consent for the researcher to view their Looked After Review minutes, therefore 46 foster carers were interviewed. The interviews consisted of a number of questionnaires assessing the foster carers' self-efficacy, their general well being and

background and demographic factors related to the foster carer and young person which have been previously shown to be associated with placement stability (Oosterman et al., 2007). Carer commitment was assessed by a semi-structured interview which was audio-recorded and later coded by the researcher. Interviews took approximately 50 minutes after which the carers were given a debrief sheet. Placement success was assessed in a number of ways. The length of time the young person had been in placement was calculated, a carer-rated measure of the young person's emotional and behavioural functioning was completed and a measurement of young person's well-being and personal achievement was completed by examining their Looked After Review minutes.

Results: Contrary to expectations, carer commitment, self-efficacy and well-being were not associated with placement success, although a significant association was found between carer commitment and self-efficacy.

Limitations of the study: There were a number of methodological limitations which could have contributed or explained the lack of significant findings. The study did not recruit the required number of participants for a medium sized effect, therefore lacked power. Social desirability could have biased the results and the validity and sensitivity of using some of the measures with this population was questioned.

Conclusion: The lack of significant findings limits the clinical implications and recommendations which can be made. However, it is important to continue to support dimensions of placement success, particularly with regards to adolescents in foster care

(Barth et al. 2007). Future research should ideally use larger participant samples, employing longitudinal designs. Studies should incorporate multiple perspectives including those of the young people in, their social workers and the young people's birth families and focus on developing standardised measures, specific to the Looked After adolescent population.

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LITERATURE REVIEW APPENDICES

Appendix 1:

SEARCH STRATEGY

SEARCH TERMS Database searched	Search strategy used	Inclusion / Exclusion Criteria specific to database	Number of hits
PSYCINFO 1987 to December Week 3 2008 & Ovid MEDLINE 1996 to December Week 3 2008	KEYWORDS: Foster care 'exp' OR foster parents 'exp' OR foster children 'exp' OR "foster care*" OR (child* or adolescent* or 'young person' or 'young people' or infant* or parent* or mother* or father* or placement*) adj3 ('foster care*' or foster * or 'looked after*' or 'in care' or 'in substitute care' or placement*)) AND Parent child relations 'exp' include mother child relations or father child relations OR 'parent* child relation*' OR 'mother child relation*' OR 'father child relation*' OR 'carer child relation*' OR (relation* or bond* or connection*) adj3 (mother* or father* or parent* or 'foster carer*' or carer* or foster parent* or child* or adolescent* or 'young person' or 'young people' or infant* or 'looked after') AND Attachment theory 'exp' OR attachment behaviour 'exp' OR attachment theory 'exp' OR attach* or 'attachment behavio*r' OR (develop* or establish* or form* or emotional) adj3 (bond* or connection* or relation*)	EXCLUSION CRITERIA: Methodology: literature review, systematic review INCLUSION CRITERIA: Year: 1998-2008 Publication types: Peer-reviewed or Peer-reviewed status unknown	62
WEB OF SCIENCE (ISI) Science Citation Index Expanded (SCI-EXPANDED) Social Science Citation Index (SSC-I)	TOPIC: "foster care*" OR (child* or adolescent* or 'young person' or 'young people' or infant* or parent* or mother* or father* or placement*) SAME ('foster care' or foster* or 'looked after' or 'looked-after' or 'in substitute care' or 'in care' or 'placement*') AND 'parent* child relation*' OR 'mother child relation*' OR 'father child relation*' OR 'parent*-child relation*' OR 'father-child relation*' OR 'mother-child relation*' OR 'carer child relation*' or 'carer-child relation*' OR 'foster parent child relation*' OR 'foster-parent child relation*' OR 'foster-carer child relation*' OR 'foster carer child relation*'(relation* or bond* or connection*) SAME (mother* or father* or mother* or parent* or carer* or 'foster-carer*' or 'foster-parent*' or child* or adolescen* or 'young person' or 'young people' or infant* or 'looked after' or 'looked-after') AND Attach* or 'attachment behavio*r' or 'attachment theory' or (develop* or establish* or form* or emotional) SAME (bond* or connection* or relation*)	INCLUSION CRITERIA: Document type: article Subject: psychology, developmental; psychiatry; paediatrics; social work; family studies; nursing; psychology, clinical; psychology, multidisciplinary; psychology, educational; psychology, social; rehabilitation; psychology; sociology; behavioural sciences; neurosciences; health policy & sciences; health care sciences & services;	601

		social issues; social science, interdisciplinary; psychology, applied; psychology, psychoanalysis; genetics & heredity; substance abuse; psychology, experimental, psychology, biological; developmental biology; multidisciplinary sciences Language: English Year: 1998 to 2008	
ASSIA	DESCRIPTORS: Foster care OR foster young people OR foster carers OR foster children OR long term foster care OR private foster care OR temporary foster care OR kinship foster carers or professional foster carers OR ANYWHERE: "foster child*" or "foster adolescent*" or "foster mother*" or "foster father*" or "foster placement*" or "looked after placement*" or "looked-after placement*" or "looked after child*" or "looked-after child*" or "looked after adolescen*" or "looked-after adolescen*" OR "in care" or "in substitute care" OR "foster care*" or "foster parent*" AND DESCRIPTORS: "child rearing" or "fathering" or "mothering" or "parent-adolescent communication" or "parent-adolescent interaction" or "parent-adolescent relationship" or "parent-adult child relationship" or "parent-child communication" or "parent-child interactions" or "parent-child relationships" or "parent-infant communication" or "parent-infant interactions" or "parent-infant relationships" or "parental attachment" or "parental bonding" or "parenting" or "reparenting" OR ANYWHERE: "parent child relation*" or "parent-child relation*" or "mother child relation*" or "mother-child relation*" or "father child relation*" or "father-child relation*" or " carer child relation*" or "carer-child relation*" AND DESCRIPTORS: attachment OR bonding OR "maternal attachment" or "paternal attachment" OR ANYWHERE: attach* or "attachment behavio*r" or "attachment theory"	INCLUSION CRITERIA: English Journal articles 1998-2008	9
SOCIAL SERVICES ABSTRACTS & SOCIOLOGICAL	DESCRIPTIORS: foster care OR caregivers OR foster children OR placement OR ANYWHERE: "foster child*" or "foster adolescent*" or "foster mother*" or "foster father*" or "foster placement*" or "looked after placement*" or "looked-after placement*" or "looked after child*" or "looked-after child*" or "looked after adolescen*" or "looked-after adolescen*" OR	INCLUSION CRITERIA: English Journal articles 1998-2008	184

ABSTRACTS via ASSIA	"in care" or "in substitute care" OR "foster care*" or "foster parent*" AND DESCRIPTORS: parent child relations OR ANYWHERE: "parent child relation*" or "parent-child relation*" or "mother child relation*" or "mother-child relation*" or "father child relation*" or "father-child relation*" or " carer child relation*" or "carer-child relation*" AND DESCRIPTORS: attachment OR ANYWHERE: attach* or "attachment behavio*r" or "attachment theory"		

Appendix 2:

INSTRUCTIONS TO AUTHORS

EMPIRICAL PAPER APPENDICES

Appendix 1:

BACKGROUND AND DEMOGRAPHIC QUESTIONNAIRE

CHILD RELATED FACTORS						
Age of child						
Gender (please circle		Male Female				
Ethnicity (please state using sheet)						
Date entry in current placement (month:year)						
Initial reason for placement into foster care (tick all that apply)				Yes	No	Unknown
		Abuse : Emotional				
		Physical				
		Sexual				
		Parental Illness				
		Parental Substance abuse				
		Abandonment				
		Parental incarceration				
		Inadequate housing				
		Family instability				
		Other (please state)				
Placement history	Age at entry into care (yrs:mnths)					
	Total time in care (yrs: mnths)					
	Type of placement:	Foster	Kinship foster	Residential	Adoption	Other (please state)
	Number of placements:					
Does the child have a SEN?		Yes		No		

FOSTER CARER FACTORS										
DoB of foster carer										
Gender of foster carer	Male Female									
Marital status	Married	Cohabiting	Separated	Divorced	Single				Widowed	
Ethnicity										
Who's living in the home?	Carer's partner (please circle)				Yes			No		
	Carer's birth children				1st	2nd	3rd	4th	5th	
				Gender (M / F):						
				Age (yrs):						
	Other children placed in the carer's home				1st	2nd	3rd	4th	5th	
				Gender (M / F):						
				Age (yrs):						
Experience of carer	Total number of years fostering									
	Total number of children (including children currently fostering)									
	Experience of fostering 12-18 year olds (please circle number children)				None	1 -5	6-10	11+		
	Training level (please circle)				Level 1		Level 2		Level 3	
Type of care order	Voluntary		Interim care order		Full Care order			Other		
Does the child have contact with birth parents?	Type of contact (please circle):		Face to face unsupervised	Face to face supervised	Phone		Letter		None	
	How often?:									
Does the child have contact with birth siblings?	Type of contact (please circle):		Placed together	Face to face	Phone		Letter		None	
	How often?:									
Number of previous fostering breakdowns? (please circle)				0	1 – 5			6 +		

Appendix 2:

THIS IS MY BABY INTERVIEW

This is my baby interview (Bates & Dozier, 1998)

1. I would like to begin by asking you to describe (Child's name). What is (his/her) personality like?
2. Do you ever wish you could raise (child's name)?
3. How much would you miss (child' name) if (he/she) had to leave?
4. How do you think your relationship with (child's name) is affecting (him/her) right now?
5. How do you think your relationship with (child's name) will affect (him/her)? In the long-term?
6. What do you want for (child's name) right now?
7. What do you want for (child's name) in the future?
8. Is there anything about (child's name) or your relationship that we've not touched on that you'd like to tell me?
9. *I'd like to end by asking a few basic questions about your experience as a foster parent.*
    a. *How long have you been a foster parent?*
    b. *How many foster children have you cared for in all?*
    c. *How many foster children do you currently have?*
    d. *How many biological children and/or adopted children are currently living in your home?*

Appendix 3:

SCORING GUIDELINES FOR COMMITMENT IN THIS IS MY BABY INTERVIEW

Commitment

This scale assesses the degree of maternal commitment to the child and to the mother-child relationship. Conceptually, commitment anchors one end of the commitment-indifference continuum. In general, high levels of commitment are scored based on the presence of maternal behaviors, thoughts, or feelings about the child that suggest strong maternal emotional investment in the child. High levels of commitment reflect a clear desire and willingness to parent the child. Lower levels of commitment (i.e., higher levels of indifference) are indexed by a lack of maternal affective involvement with the child, as well as apathy regarding continued involvement in the child's life.

The core construct being rated is the extent to which the mother views the child as "my baby." More specifically, it captures the degree to which the mother: (1) views the child as her own while the child is living with her, (2) has permitted the formation of a mother-child attachment without emotionally holding back or otherwise limiting the strength of that bond, (3) provides evidence of a willingness to commit physical or emotional resources to promote the child's growth and development, or (4) gives evidence that parenting this child is important to her. The key to scoring commitment is the *degree* to which the mother has "psychologically adopted" the child. The central question being asked is: Is the mother emotionally invested in *this* child and in being his or her parent? Or, is the mother indifferent to whether she continues to parent the child?

Indices of high levels of commitment may include, but are not limited to:

1. Expression of the desire or wish to adopt the child (Note: This point is further explained below).
2. Expression of the desire to parent the child as long as the child remains in care or is benefiting from the mother's care.
3. Evidence that the mother has allowed herself to become fully attached to the child without withholding feeling or putting up barriers to limit the extent of attachment (Note: This point is further explained below).
4. Statements indicating that the mother would deeply miss the child if he or she were removed from the home.
5. Evidence that the child is fully integrated into the family and viewed as a family member.
6. Evidence of commitment of emotional resources (e.g., pride in the child's accomplishments) or physical resources (e.g., working with the child at home; advocating for services) in fostering the child's growth and development.

Lower levels of commitment are suggested by, but are not limited to, indices such as:

1. Indifference as to whether the child remains in the mother's care or expression of a hope or desire that the child will be placed elsewhere.
2. Evidence of withholding feelings or putting up guards to limit the strength of the mother-child affective bond.
3. Maternal statements indicating that the child would not be missed very much if he or she were removed from the home.
4. Evidence that the child is not treated as a family member.

***Adoption*:**

It is NOT required that the mother expresses the intent to adopt the child in order to receive a high commitment score. Again, the construct being assessed is "psychological adoption" as opposed to actual physical adoption. For example, the parent who says, "We wish we could keep her because we love her so, but we know it is impossible, so while she's here we are doing the best we know how," would receive a very high commitment score (assuming the rest of the interview does not contradict this perspective).

In contrast, the mother who responds to the question of whether she has thought about adopting the child by saying, in an offhand manner, "Yeah, yeah, I've thought about it, just because we've had her since she was a day old and I've raised her the way I like," would receive a much lower score based on the lack of convincing evidence of emotional investment in the child and because of her indifferent tone. The key here is the *degree* to which the mother's answer reflects an emotional investment in and commitment to parenting the child.

***Withholding*:**

Although not seen in every transcript, some mothers mention withholding emotions, putting up guards to limit what they feel, or participating in physical activities designed to limit the development of an attachment with the child (e.g., not holding the baby very much). When present, maternal withholding behaviors are an important component in deriving the commitment scores. These activities suggest a reluctance or unwillingness to fully emotionally engage the child or to emotionally invest in the child. Therefore, they are a reflection of limited maternal commitment.

There are at least four possible degrees of withholding:

1. The mother provides no evidence of holding back; she does not say she wants to hold back and provides no evidence of holding back during the interview. This is the optimal situation, indicating a high level of maternal commitment.
2. The mother says she tries to hold back but cannot help but "fall in love" with the child and give the child her all; or, the mother says she tries to hold back but her descriptions of her thoughts and feelings about the child, and her descriptions of her behavior with the child suggest she does not hold back.
3. The mother feels torn between wanting to give her all to the child yet being afraid to do so. The mother provides some evidence that she struggles with the issue of holding back and sometimes may hold back, yet she may still provide a "good enough" level of emotional care for the child (but not necessarily the best she is capable of providing); or, the mother may relate concerns that her holding back may affect the child's development. In essence, the mother says she holds back, provides some evidence that at times she may hold back, yet she struggles with the issue.
4. The mother clearly states that she DOES hold back and acknowledges that she does not think it is harmful; or, the mother fails to acknowledge that she holds back while concurrently providing evidence the she does. This is the worst situation, indicating a low level of maternal commitment.

When assigning a rating, it is important to keep in mind the degree to which the mother was convincing when speaking of her level of commitment to the child. Points to consider include:

1. When describing her emotional investment in the child and in parenting the child, was the mother's voice confident, assertive, or empathic? Or, was her tone monotone, perfunctory, or bland? In essence, was there affective warmth present in her description?
2. Were descriptions of the mother's level of investment in the child and in parenting the child congruent with how the mother described her behavior with the infant? (Note: Not all mothers describe their behavior. Mothers should NOT be scored down for failing to describe their *behavior* as they are not specifically asked to do so.)
3. How complete and well thought out were the mother's answers? Did she give evidence that she is thinking actively and carefully about what it means to raise this particular child? Or, were her answers limited, perfunctory, or scripted?

There are many ways in which a mother can show high, moderate, or low Commitment. Therefore, the descriptions of scale points listed on the following page should be viewed as only a limited number of possible pathways to each score. It is highly unlikely that any individual mother will fulfill each of the descriptive phrases. The final score assigned should reflect a consideration of all the evidence presented in the interview, and a balancing of positive and negative indices of commitment.

Commitment ratings are as follows:

5. High Commitment: the mother provides evidence of a strong emotional investment in the child and in parenting the child; multiple indices of high levels of commitment are present throughout the interview; descriptions of the child and the mother-child relationship clearly reflect a strong attachment to the child with no evidence of mental or physical activities designed to limit the strength of the mother-child affective bond; there is evidence of the mother committing resources to promote the child's growth, or other indices of psychological adoption of the child; the child is fully integrated into the family; although the mother may acknowledge that the child will eventually leave her home (e.g., to return to the biological parent) she considers the child as hers while the child is in her home.

3. Moderate Commitment: the mother provides evidence of investment in the child, but this is not nearly as marked as a mother scoring high on commitment; although there may be some indices of high levels of commitment, there may also be evidence suggesting that the child has not been psychologically adopted by the mother; the mother may state she would miss the child if her or she left, but this is more of a matter-of-fact statement and lacks the strong affective component seen in mothers high in commitment; if the mother speaks of limiting the psychological bond with the infant, she also gives evidence of struggling with this issue; the child may be only partially integrated into the family (i.e., is placed in respite care only when the family goes on vacation); overall, the coder may conclude that the child is adequately cared for and nurtured, but not to any special degree.

1. Low Commitment: the mother provides virtually no evidence of a strong and active emotional investment in the child or in parenting the child; there are few, if any, indices of high levels of commitment; the mother may be indifferent to whether the child remains in her care or may actually state the she hopes/desires that the child will be removed; there may be little evidence that the mother would miss the child if he or she leaves; the mother may provide evidence of participating in physical or mental activities designed to limit the strength of the mother-child bond; the child has not been psychologically adopted by the mother, and may not be fully integrated into the family (e.g., is routinely placed in respite care); the child may seem to be more of an unwelcome guest than a member of the family, or may be viewed as only one of a series of children passing through the mother's home.

Appendix 4:

PARENTING SENSE OF COMPETENCE SCALE: SELF-EFFICACY SUBSCALE

Parenting Sense of Competence Scale; Self efficacy subscale (Gibaud – Wallston & Wandersman, 1978)

For each of the 7 statements below, please consider if it applies to you. Then for each statement please tick **one** box only from **A** to **F** to indicate how much you agree or disagree with it.

Strongly Agree. Agree. Slightly agree. Slightly disagree. Disagree. Strongly disagree.
A **B** **C** **D** **E** **F**

		A	**B**	**C**	**D**	**E**	**F**
1.	The problems of taking care of a foster child are easy to solve once you know how your actions affect the child. I have acquired this understanding.	☐	☐	☐	☐	☐	☐
2.	I would make a fine model for a new foster carer to follow so that she/he could learn to be a good foster carer.	☐	☐	☐	☐	☐	☐
3.	Being a good foster carer is manageable, and any problems are easily solved.	☐	☐	☐	☐	☐	☐
4.	I meet my own personal expectations in my ability to care for my foster child.	☐	☐	☐	☐	☐	☐
5.	If anyone can find the answer to what is troubling my foster child, I am the one.	☐	☐	☐	☐	☐	☐
6.	Considering how long I've been a foster carer, I feel thoroughly familiar with this role.	☐	☐	☐	☐	☐	☐
7.	I honestly believe that I have all the skills necessary to be a good foster carer to my foster child.	☐	☐	☐	☐	☐	☐

Appendix 5:

GENERAL HEALTH QUESTIONNAIRE 12

Appendix 6:

EVERY CHILD MATTERS OUTCOME FRAMEWORK MEASURE

BEING HEALTHY

Is the young person healthier than or at least as healthy as, before the last review?

TOTAL YES …./3

Aspect	Yes / No / Not enough information	Examples	Examples
Medical Care Is the young person healthier than or at least as healthy as, before the last review?		• Going to GP • Medication	Appropriate weight for age and height Maintains reasonable personal hygiene Can use any necessary aids/adaptations most of the time without prompting (glasses, hearing aid etc.) Takes any prescribed medications most of the time without prompting
Self Care Is the young person healthier than or at least as healthy as before the last review?		• Self management of medical routines • Development of self care skills • Dignity and privacy • Health routine	Goes to bed and gets up on time with reasonable support Understands and manages contraception appropriately
Well being and relationship Is the young person healthier than or at least as healthy as, before the last review		• Healthy living – diet/exercise • Friendships • Someone to talk to • Fun activities • Culturally sensitive lifestyle	Uses alcohol responsibly Reduces or abstains from smoking Abstains from solvent and drug use

STAYING SAFE

Is the young person safer than, or at least as safe as, or before the last review?

TOTAL YES…… / 3

Aspect	Yes / No / Not enough information	Examples	Prompts
Self preservation Is the young person safer than, or at least as safe as, or before the last review?		• Self awareness • Health, safety and protection • Someone to ask for help • Personal, social and health education • Self-responsibility for health and safety	The young person does not get involved in criminal activity The young person can accept boundaries and instructions that are in place to protect them The young person can and does use the complaints procedure appropriately The young person reports bullying issues to an appropriate person
Safety with others Is the young person safer than, or at least as safe as, or before the last review?		• Feeling safe • Someone to talk to about others • Bullying • Health and safety of others • Child Protection & risk assessment	The young person show signs of settling into the placement The young person doesn't behave in an anti-social manner The young person doesn't discriminate against other people The young person doesn't attempt to harm themselves or others The young person isn't abusive, threatening or intimidating to adults or others The young person reads their files, corrects errors and adds personal statements
Safety in the environment Is the young person safer than, or at least as safe as, or before the last review?		• Risks and dangers • Health and safety in placement • Out in the community • Individual behaviour plan / safety plan where appropriate	Reduce or abstain from absconding The young person can deal with difficulties and frustrations effectively The young person understands and reduces their vulnerability to maltreatment, violence or sexual exploitation

ENJOYING AND ACHIEVING

Is the young person enjoying life and achieving more than or at least as much as before the last review?

TOTAL YES ……/ 3

Aspect	Yes / No / Not enough information	Examples	Prompts
Fulfilling aspirations and needs Is the young person enjoying life and achieving more or at least as much as before the last review?		• Expression of personal aspirations • Doing favourite activities • Making choices • Having own needs met • Doing things independently/with support • Celebration of success • Satisfactory attendance for particular individuals	The young person builds positive relationships The young person accesses additional educational resources The young person attends school/college/education/training The young person engages in education and is expected to achieve appropriate educational and vocational qualifications The young person takes part in their PEP meetings
Attainment Is the young person enjoying life and achieving more or at least as much as before the last review?		• Personal growth milestones achieved • National curriculum level attained • Examinations attained • Other educational attainments	The young person attempts to achieve targets set in their PEP The young person participants in planning for and engaging in leisure activities
Achievement Is the young person enjoying life and achieving more or at least as much as before the last review?		• Personal achievements related to all aspects of life e.g. physical, emotional, leisure • Awards for achievements • Access to recreational activities • Access to community resources	The young person takes part in cultural and sporting activities The young person takes part in extra curricular activities The young person's attainment is in line with their abilities The young person has individual goals and ambitions for life

MAKING A POSITIVE CONTRIBUTION

Is the young person making a greater positive contribution, or at least as much as before the last review?

TOTAL YES ……. / 3

Aspect	Yes / No / Not enough information	Examples	Prompts
Rights and citizenship Is the young person making a greater positive contribution, or at least as much as before the last review?		• Human rights • Having a say and being listened to • Dignity being respected • Personal and private space • Home and culture values	The young person accesses local amenities The young person interacts appropriately with peers and Adults The young person is aware of racial, social, cultural and spiritual issues The young person takes a lead in developing care or pathway plans
Responsibilities Is the young person making a greater positive contribution, or at least as much as before the last review?		• Carrying out responsibilities • Caring for the environment • Helping others	The young person participates positively in review, planning meeting, house meetings etc. The young person has positive contact with significant adults/peers/siblings etc. The young person attends and plays an active role in education, in particular Personal Development Studies The young person is able to accept changes in staff
Roles and relationships Is the young person making a greater positive contribution, or at least as much as before the last review?		• Speaking up for others • Respecting others' opinions • Fulfilling roles in placement/community • Being part of a team	The young person advocates for others The young person does not bully or discriminate against others

ACHIEVING ECONOMIC WELLBEING

Is the young person overcoming socio-economic disadvantages to achieve their full potential better than or at least as well as before the last review?

TOTAL YES …… / 3

Aspect	Yes / No / Not enough information	Examples	Prompts for professionals
Equity in resources and activities Is the young person overcoming socio-economic disadvantages to achieve their full potential better than or at least as well as before the last review?		• Personal resources and equipment e.g. wheelchairs/computers • Access to communal resources and equipment e.g. spot/leisure • Activities in the community • Benefits • Pocket money • Fair share of funding	The young person can be of smart appearance and be punctual The young person has a network of support for i.e. family, friends, carers, advocates The young person takes part in social activities The young person accesses careers service
Preparation for adult life Is the young person overcoming socio-economic disadvantages to achieve their full potential better than or at least as well as before the last review?		• Handling money / understanding benefits • Work experience • Post-school placement • Transition plan • Family involvement in transition • Acquiring basic skills and life skills	The young person has job seeking skills for i.e. can completes a job application form, can deal with interviews The young person has practical and social and emotional skills which are age appropriate for i.e. is financially literate, can access public transport, can prepare and cook a healthy diet, can communicate effectively with others
Self-determination and confidence Is the young person overcoming socio-economic disadvantages to achieve their full potential better than or at least as well as before the last review?		• Self-determination at key points of life • Self confidence in the placement • Confidence in the community • Knowing when to seek support • Acquiring basic skills	The young person accepts support from family members. The young person has a positive attitude to education/ employment/ training The young person plays an active role in planning for their future.

Appendix 7:

STRENGTHS AND DIFFICULTIES QUESTIONNAIRE PARENT VERSION & SCORING SHEET

Interpreting Symptom Scores and Defining "Caseness" from Symptom Scores

Although SDQ scores can often be used as continuous variables, it is sometimes convenient to classify scores as normal, borderline and abnormal. Using the bandings shown below, an abnormal score on one or both of the total difficulties scores can be used to identify likely "cases" with mental health disorders. This is clearly only a rough-and ready method for detecting disorders – combining information from SDQ symptom and impact scores from multiple informants is better, but still far from perfect. Approximately 10% of a community sample scores in the abnormal band on any given score, with a further 10% scoring in the borderline band. The exact proportions vary according to country, age and gender – normative SDQ data are available from the web site. You may want to adjust banding and caseness criteria for these characteristics, setting the threshold higher when avoiding false positives is of paramount importance, and setting the threshold lower when avoiding false negatives is more important.

	Normal	Borderline	Abnormal
Parent Completed			
Total Difficulties Score	0 - 13	14 - 16	17 - 40
Emotional Symptoms Score	0 - 3	4	5 - 10
Conduct Problems Score	0 - 2	3	4 - 10
Hyperactivity Score	0 - 5	6	7 - 10
Peer Problems Score	0 - 2	3	4 - 10
Prosocial Behaviour Score	6 - 10	5	0 - 4
Teacher Completed			
Total Difficulties Score	0 - 11	12 - 15	16 - 40
Emotional Symptoms Score	0 - 4	5	6 - 10
Conduct Problems Score	0 - 2	3	4 - 10
Hyperactivity Score	0 - 5	6	7 - 10
Peer Problems Score	0 - 3	4	5 - 10
Prosocial Behaviour Score	6 - 10	5	0 - 4

Generating and Interpreting Impact Scores

When using a version of the SDQ that includes an "Impact Supplement", the items on overall distress and social impairment can be summed to generate an impact score that ranges from 0 to 10 for the parent-completed version and from 0-6 for the teacher-completed version.

	Not at all	Only a little	Quite a lot	A great deal
Parent report				
Difficulties upset or distress child	0	0	1	2
Interfere with HOME LIFE	0	0	1	2
Interfere with FRIENDSHIPS	0	0	1	2
Interfere with CLASSROOM LEARNING	0	0	1	2
Interfere with LEISURE ACTIVITIES	0	0	1	2
Teacher report				
Difficulties upset or distress child	0	0	1	2
Interfere with PEER RELATIONSHIPS	0	0	1	2
Interfere with CLASSROOM LEARNING	0	0	1	2

Responses to the questions on chronicity and burden to others are not included in the impact score. When respondents have answered "no" to the first question on the impact supplement (i.e. when they do not perceive the child as having any emotional or behavioural difficulties), they are not asked to complete the questions on resultant distress or impairment; the impact score is automatically scored zero in these circumstances.

Although the impact scores can be used as continuous variables, it is sometimes convenient to classify them as normal, borderline or abnormal: a total impact score of 2 or more is abnormal; a score of 1 is borderline; and a score of 0 is normal.

Appendix 8:

CUT OFF SCORES FOR THE STRENGTH AND DIFFICULTIES QUESTIONNAIRE

	Normal	Borderline	Abnormal
Total Difficulties Score	0-13	14-16	17-40
Emotional Symptoms Score	0-3	4	5-10
Conduct Problems Score	0-2	3	4-10
Hyperactivity Score	0-5	6	7-10
Peer Problems Score	0-2	3	4-10
Prosocial Behaviour Score	6-10	5	0-4

Appendix 9:

LETTER OF ETHICS APPROVAL

Appendix 10:

FOSTER CARER INFORMATION SHEET

Foster carer factors that promote placement success for young people aged 12-18 years old

I would like to ask you for your help in understanding more about the way foster placements contribute to young people's well-being and success.

Why is this study been done?
As you know, there are many factors which determine how successful[1] a placement is. These can include issues relating to the young person, the carers, and their relationship together, as well as the availability of support from external agencies. A successful placement may mean that the young person is able to stay in the foster placement for longer and break the vicious cycle between placement breakdown and escalation of the young person's difficulties. So far, research has tended to concentrate on very young children and has neglected the needs of adolescents. This is a serious oversight as adolescents have been shown to experience many more placement breakdowns than younger children. The effects of this can be devastating and challenging for both the young person and carers.

What are the benefits of taking part?
Looking at factors which help to promote successful placements is really important. It can improve role satisfaction for the carer and promote better developmental outcomes for young people. There may not be any direct benefit from taking part but it is hoped that the results of the study will help focus support and possible future training for foster carers who are looking after adolescents.

Why am I being asked to take part?
Your name was identified by the Children's Services as someone who is a foster carer looking after a young person between 12 and 18 years old and I thought that you might be interested in taking part in this study.

What will I be asked to do?
The research will involve asking you questions about your relationship with the young person you are fostering, for example how you get along together. This part of the interview will be audio recorded. There will also be some questionnaires for you to complete which will ask you questions about how confident you feel about looking after an adolescent, your own emotional well-being (using a psychological measure) and how well you think the young person you are caring for is doing. All this should take no longer than 50 minutes.

Do I have to take part?
You do not have to take part. If you choose not to take part, this will not affect the services that you, or the young person receive in any way. If you do decide to take part you can withdraw from the study at any time.

[1] A successful placement is one where the young person is meeting their developmental goals and needs

What do I have to do if I want to take part?
If you are interested in taking part, I would be grateful if you could let me know by phoning the number or sending me an email (see details below) and leaving your contact details. If you prefer you could let your Fostering Link Worker know you are interested in taking part and they can pass your name and contact details onto me. I will then give you a call to arrange a time and place to meet that is convenient to you. This could be at your home or another venue.
If you have any questions about the study please feel free to get in touch with me. If you would like, I can arrange a time to meet with you to discuss any queries you may have about taking part.

Will all information be kept confidential?
The information you give will be kept confidential. As with any research or contact with health or social care workers, the only exception when confidentiality may be broken is if you tell me that you have acted in a way that is harmful to the child in your care or that the child is at risk of hurting themselves or someone else. You will be given a participant code so that any identifiable information is anonymised. Information relating to your code number and contact details will be held on a password protected computer database. Once audio recordings have been coded, the recording will be destroyed. All written information e.g. questionnaires will be kept in a locked cabinet.

What are the possible disadvantages and risks of taking part?
All of the questions will be very general. It is unlikely but if you do find any questions upsetting we can stop the interview at any point, return to the interview at a later time or you can decide not to continue. If you wish to talk to someone after the interview, I can put you in contact with Clinical Psychologists working in local services.

What happens when the research stops?
I will send you an anonymised summary of the findings of the study. They will be published in Fostering Newsletter and may also be published in a journal.

Contact details:

Nicola Taylor,
Trainee Clinical Psychologist,

Address: School of Psychology,
Department of Clinical Psychology,
University of Birmingham,
Edgbaston,
Birmingham,
B15 2TT

Email:

Thank you for your help

Appendix 11:

EXAMPLE OF A COVERING LETTER FOR FOSTER CARERS

Appendix 12:

YOUNG PERSON INFORMATION LETTER

[redacted]

Foster carer factors that promote placement success for young people aged 12-18 years old

I would like to ask you for your help in understanding more about how foster placements may be linked to how well a young person is doing.

Why is this study been done?
As you might know yourself, if a placement is successful, young people are more likely to be happier, do better at school and have fewer problems. They are also more likely to stay in the placement for a longer time. Young people who have lots of foster placement changes are more likely to have more difficulties. Many things might effect how successful a placement is. These can be things relating to the carer, the young person or the services that support them. It is really important to try and work out what makes foster placements successful as this can effect how the young person is doing. We want to look at some factors about foster carers, which we think might effect how successful a placement is and how well a young person does when they are in their care.

What are the benefits of this research?
Looking at factors which help to make foster placements successful is really important. It can help make the role of being a foster carer better for the carer, and also make the lives of young people in foster care better too.
It is also hope that the results of the study will help us work out what training might be helpful to foster carers who are looking after young people.

What am I being asked to do?
I am asking you if it is OK to look at the two latest sets of your Looked After Review minutes. I would like to look at the review minutes to get an idea of how well you are doing.

Do I have to agree to let you look at my records?
You do not have to agree. If you do not want me or another researcher (Amapreet Chahal) to look at your records it will not affect the services or care you get.

What do I have to do if I want to agree to let you look at my records?
I would be grateful if you could fill in the consent form.
If you would like any help filling in the form please ask your Foster Carer or your Social Worker to help you. You could also contact me for help. If you do not have the consent form please let me know by contacting me (see my contact details in the box on the next page) or you could ask your Foster Carer or Social Worker to contact me.
If you have any questions about the study please contact me. If you would like, I can also arrange a time to meet with you to talk about the study.

What does the research study involve?
I will be interviewing your Foster Carer. I will be asking your foster carer questions about how you both get on, how confident they feel about looking after a young person and how they are feeling in general. I also hope to look at the review minutes to get an idea of how well you are doing.

Will all information be kept confidential?
All the information will be kept confidential. The only time I may need to share information with someone else is if you tell me anything that makes me think that you are at risk of getting hurt, or someone else is at risk of getting hurt. All identifiable information relating to the foster carer and young person will be anonymised. Every Foster Carer who is interviewed and information relating to the young person they are looking after will be given a code number which we will use instead of their names. All written information will be kept in a locked cabinet.

What happens when the research stops?
I will send you a summary of what we have found. The results of the study will be published in Fostering Newsletter and may also be published in a journal.

Contact details:

Nicola Taylor,
Trainee Clinical Psychologist,

Address: School of Psychology,
University of Birmingham,
Edgbaston,
Birmingham,
B15 2TT

Email: _____

Telephone: _____ _____ _____ _____ _____ _____

Thank you for your help

Appendix 13:

YOUNG PERSON CONSENT FORM

Consent / Assent Form to access records:

Title of Research: Foster Carer Factors that Promote Placement Success for Young People aged 12-18 years

Name of Researcher: Nicola Taylor

Name of Project Supervisors: Dr Helen Rostill
Consultant Clinical Psychologist – Dudley PCT
Senior Academic Tutor – The University of Birmingham
Dr Marie Kershaw
Clinical Psychologist – Dudley PCT

Name of young person:

Please Tick Boxes

1. I have read and understood the information sheet about the study ☐
2. I agree to let the researchers look at my Looked After Review minutes ☐
3. I understand that all information will be stored securely e.g. and any identifiable information will be anonymised e.g. information will not have my name on it ☐

Name of young person **Date** **Signature**

……. ……. …….

Thank you for your help

Appendix 14:

FOSTER CARER CONSENT FORM

[redacted]

[redacted]

Foster Carer's Consent Form:

Title of Research: Foster Carer Factors that Promote Placement Success for Young People aged 12 –18 years old

Name of Researcher: Nicola Taylor

Name of Project Supervisors: Dr Helen Rostill
Consultant Clinical Psychologist – Dudley PCT
Senior Academic Tutor – The University of Birmingham
Dr Marie Kershaw
Clinical Psychologist – Dudley PCT

Name of Foster Carer: **……**

Please Tick Boxes

1.I confirm that I have read and understood the information sheet about the above study ☐

2.I agree to take part in the study ☐

3.I understand that participation in the study is voluntary and that I can withdraw at any time, and I do not have to provide any reason for withdrawal. The services which I or the young person I am fostering receive will not be affected in any way ☐

4.I consent for part of the interview to be audio taped and I understand that this and paper questionnaires will be stored safely and any identifiable information will be annonymised ☐

5.I understand that the tape recordings will be destroyed after the information has been coded ☐

Foster carer's name	**Date**	**Signature**
…….	…….	…….

Thank you for your help

Appendix 15:

DEBRIEFING SHEET

Thank you for taking part in the study

The study is looking at a number of factors, such as how confident foster carers feel about looking after an adolescent, how they are currently feeling in general, their relationship with the young person they are looking after and how these factors might be related to placement success. Looking at factors that help to promote successful placements is really important. It can improve role satisfaction for the foster carer and promote better developmental outcomes for young people.

It is also hoped that the results of the study will help to focus support and possible future training for foster carers who are looking after adolescents.

What will happen to the responses I have given?
You will be assigned a participant code so all your responses will be anonymised. Your contact details will be stored separately. The part of the interview I recorded onto tape will be analysed and given a number according to your responses to the questions. This number, together with the answers you gave to the questionnaires will be entered onto a password protected database. The tape will be wiped and the paper questionnaires will be kept in a locked cabinet for one year, after which they will be destroyed.
I will look at the data to see if any of the factors are related to each other and to see which factors are related to how the young person is doing in the placement.
The results of the study will be written up and possibly published in a journal.

Do I need to do anything now?
If you know of any other foster carers looking after a young person between the ages of 12-18 who you think may wish to take part, you could let me know yourself or ask them to contact me directly. I can give you an information sheet for you to give to them if they would like to know more about the study.

If any issues have arisen as a result of taking part in the study, is there anyone I can talk to?
If you would like to discuss any issues raised as a result of taking part in the interview please let me know and I can put you in contact with Clinical Psychologists who work in the local services. You can also speak to your supervising Social Worker or ask me to get in contact with them on your behalf.

If you have any further questions or know someone who may wish to take part in this study please contact:

Nicola Taylor,
Trainee Clinical Psychologist,

Address: School of Psychology, Dept. Clinical Psychology,
University of Birmingham,
Edgbaston,
Birmingham,
B15 2TT

Appendix 16:

KOLOMORGOV-SMIRNOV ANALYSES

One-Sample Kolmogorov-Smirnov Test

		YP time in current placement (months)	FC number of children fostered	FC number of years fostering	COMPUTE SDQ_total_1=SDQ_tot_emotional + SDQ_tot_conduct + SDQ_tot_hyperactivity + SDQ_tot_peerprobs	SE total redone	GHQ total	TIMB Commitment	Total outcomes
N		46	46	46	46	46	46	46	37
Normal Parameters[a]	Mean	58.07	44.09	14.70	14.8261	33.61	9.80	3.880	13.43
	Std. Deviation	37.619	47.855	7.834	7.93671	6.496	4.490	.9955	2.128
Most Extreme Differences	Absolute	.104	.190	.139	.100	.185	.180	.190	.281
	Positive	.104	.190	.139	.100	.098	.180	.130	.231
	Negative	-.096	-.184	-.086	-.083	-.185	-.099	-.190	-.281
Kolmogorov-Smirnov Z		.706	1.288	.940	.678	1.253	1.219	1.286	1.708
Asymp. Sig. (2-tailed)		.702	.072	.340	.748	.086	.102	.073	.006

a. Test distribution is Normal.

Appendix 17:

COMMITMENT SCORES

Commitment Score	1.5	2	2.5	3	3.5	4	4.5	5
Number	2	1	3	7	6	6	10	11
Percentage of total sample	4.3	2.2	6.5	15.2	13	13	21.7	23.9

Appendix 18:

SELF-EFFICACY SCORES

		Mean	Standard Deviation
Item 1	The problems of taking care of a foster child are easy once you know how your actions affect the child. I have acquired this understanding.	4.91	1.24
Item 2	I would make a fine model for a new foster carer to follow so that she/he could learn to be a new foster carer.	5.15	1.07
Item 3	Being a good foster carer is manageable, and any problems are easily solved.	3.89	1.37
Item 4	I meet my own personal expectations in my ability to care for my foster child.	5.11	1.14
Item 5	If anyone can find the answer to what is troubling my foster child, I am the one.	4.09	1.43
Item 6	Considering how long I've been a foster carer, I feel thoroughly familiar with this role.	5.26	0.98
Item 7	I honestly believe that I have all the skills necessary to be a good foster carer to my foster child.	5.20	1.03

Appendix 19:

DIFFERENCES IN MEAN SDQ SCORES ACCORDING TO YP AGE AND GENDER

One-way ANOVA (Age in categories)

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Sdq emotional2	Between Groups	20.563	3	6.854	1.023	.392
	Within Groups	281.350	42	6.699		
	Total	301.913	45			
SDQcon2	Between Groups	39.289	3	13.096	1.749	.172
	Within Groups	314.450	42	7.487		
	Total	353.739	45			
SDQ Hyper2	Between Groups	11.146	3	3.715	.392	.759
	Within Groups	398.267	42	9.483		
	Total	409.413	45			
SDQ peer2	Between Groups	21.153	3	7.051	1.347	.272
	Within Groups	219.825	42	5.234		
	Total	240.978	45			
SDq Prosocial2	Between Groups	36.876	3	12.292	2.628	.063
	Within Groups	196.450	42	4.677		
	Total	233.326	45			
SDQ total 2	Between Groups	302.778	3	100.926	1.693	.183
	Within Groups	2504.092	42	59.621		
	Total	2806.870	45			

Independent Samples *t* Test (YP Gender)

Group Statistics

	YP gender numbered	N	Mean	Std. Deviation	Std. Error Mean
Sdq emotional2	Female	20	3.4000	2.92719	.65454
	male	26	2.6154	2.29916	.45090
SDQcon2	Female	20	3.5000	3.25253	.72729
	male	26	3.1538	2.46077	.48260
SDQ Hyper2	Female	20	5.3000	2.84882	.63702
	male	26	5.5769	3.18965	.62554
SDQ peer2	Female	20	2.9500	2.21181	.49458
	male	26	3.0769	2.43184	.47692
SDq Prosocial2	Female	20	6.7500	2.46822	.55191
	male	26	7.6923	2.07402	.40675
SDQ total 2	Female	20	15.1500	8.71946	1.94973
	male	26	14.4231	7.36572	1.44454

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Sdq emotional 2	Equal variances assumed	.900	.348	1.019	44	.314	.78462	.77007	-.76735	2.33658
	Equal variances not assumed			.987	35.275	.330	.78462	.79482	-.82850	2.39773
SDQcon2	Equal variances assumed	2.428	.126	.411	44	.683	.34615	.84170	-1.35019	2.04250
	Equal variances not assumed			.397	34.354	.694	.34615	.87284	-1.42699	2.11930
SDQ Hyper2	Equal variances assumed	.564	.457	-.306	44	.761	-.27692	.90630	-2.10345	1.54960
	Equal variances not assumed			-.310	42.955	.758	-.27692	.89280	-2.07748	1.52363
SDQ peer2	Equal variances assumed	.405	.528	-.182	44	.856	-.12692	.69579	-1.52919	1.27534
	Equal variances not assumed			-.185	42.702	.854	-.12692	.68707	-1.51280	1.25896
SDq Prosocial 2	Equal variances assumed	.684	.413	-1.406	44	.167	-.94231	.67001	-2.29263	.40802
	Equal variances not assumed			-1.374	36.958	.178	-.94231	.68560	-2.33152	.44691
SDQ total 2	Equal variances assumed	.400	.530	.306	44	.761	.72692	2.37301	-4.05556	5.50941
	Equal variances not assumed			.300	37.090	.766	.72692	2.42655	-4.18933	5.64317

Appendix 20:

DIFFERENCES IN CATEGORY SDQ TOTAL SCORES ACCORDING TO YP AND FC DEMOGRAPHICS

ANOVA re. SDQ total (categories)

		Sum of Squares	df	Mean Square	F	Sig.
YP_age_yrs	Between Groups	13.358	2	6.679	2.951	.063
	Within Groups	97.312	43	2.263		
	Total	110.670	45			
YP time in current placement (months)	Between Groups	2871.063	2	1435.532	1.015	.371
	Within Groups	60813.741	43	1414.273		
	Total	63684.804	45			
YP number of previous placements	Between Groups	16.142	2	8.071	1.968	.152
	Within Groups	176.315	43	4.100		
	Total	192.457	45			
FC age in yrs	Between Groups	101.790	2	50.895	.872	.425
	Within Groups	2510.220	43	58.377		
	Total	2612.010	45			
FC number of years fostering	Between Groups	181.508	2	90.754	1.512	.232
	Within Groups	2580.231	43	60.005		
	Total	2761.739	45			
SE Total Self efficacy score	Between Groups	52.969	2	26.484	.617	.544
	Within Groups	1845.988	43	42.930		
	Total	1898.957	45			
GHQ total	Between Groups	45.518	2	22.759	1.136	.331
	Within Groups	861.721	43	20.040		
	Total	907.239	45			
TIMB Commitment	Between Groups	2.812	2	1.406	1.447	.246
	Within Groups	41.780	43	.972		
	Total	44.592	45			

YP Gender

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.191[a]	2	.909
Likelihood Ratio	.191	2	.909
N of Valid Cases	46		

a. 1 cells (16.7%) have expected count less than 5. The minimum expected count is 3.91.

FC Gender

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	2.213[a]	2	.331
Likelihood Ratio	2.102	2	.350
N of Valid Cases	46		

a. 2 cells (33.3%) have expected count less than 5. The minimum expected count is 2.35.

Appendix 21:

CORRELATION MATRIX BETWEEN SDQ AND ECM OUTCOME FRAMEWORK SCORES

			Total outcomes	being healthy	staying safe	enjoying & achieving	making a positive contribution	achieiving ec. wellbeing
Spearman's rho	SDQ emotional symptoms scale	Correlation Coefficient	.092	.242	.056	.164	-.061	.086
		Sig. (2-tailed)	.59	.11	.71	.29	.72	.60
		N	37	44	46	43	38	40
	SDQ total conduct category	Correlation Coefficient	-.338*	-.074	-.470**	-.319*	-.488**	.028
		Sig. (2-tailed)	.04	.63	.01	.04	.00	.86
		N	37	44	46	43	38	40
	SDQ hyperactivity scale	Correlation Coefficient	-.220	-.013	-.303*	-.202	-.307	.015
		Sig. (2-tailed)	.19	.93	.04	.19	.06	.93
		N	37	44	46	43	38	40
	SDQ peer problems scale	Correlation Coefficient	-.064	.237	-.144	.043	-.225	-.086
		Sig. (2-tailed)	.71	.12	.34	.79	.18	.60
		N	37	44	46	43	38	40
	SDQ prosocial scale	Correlation Coefficient	.222	.111	.209	.196	.397*	.019
		Sig. (2-tailed)	.19	.47	.16	.21	.01	.91
		N	37	44	46	43	38	40
	SDQ_total	Correlation Coefficient	-.217	.099	-.392**	-.139	-.401*	.039
		Sig. (2-tailed)	.20	.52	.01	.37	.01	.81
		N	37	44	46	43	38	40

Appendix 22:

INSTRUCTIONS TO AUTHORS