

Portfolio including Thesis

Volume 1 of 2

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Learning from foster carers: their experience of fostering and mental health service provision

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WRITTEN EXERCISE 1

Name: Joanna Mary

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Title: “Age and treachery will always overcome youth and skill”. How does one get old, wise and treacherous? Discuss the continuities and discontinuities in psychological development and human experience across the lifespan. Examine how this could impinge on psychological problems in old age and how you might come across and address these as a clinical psychologist.

Psychological knowledge and research concerned with the problems that older adults face has been rapidly developing over recent decades. This area has traditionally been given relatively little focus. From a theoretical point of view this is seen as having stemmed from the fact that predominant theories from the psychoanalytic tradition (e.g. Freud, 1905/1953) viewed old age as a time in which there was little scope for psychological change, and, therefore, older adults as a relatively uniform population. However, subsequent research suggests that this is by no means the case and that, like other clinical populations, intervention for mental health problems in older adults is both needed and possible.

Observations indicate that psychotherapists often feel unequipped and personally inexperienced to work with older adults (Knight, 1996). Theories from a lifespan developmental perspective have been shown to offer much in terms of both understanding the problems that older adults face and designing effective interventions. Lifespan development approaches are concerned with the interaction of physical, cognitive and personal stability and change throughout life, and how this is shaped by factors such as genetic predisposition, life experiences and age. In this respect they advocate the importance of earlier development and experience when conceptualising psychological problems in old age.

This essay explores some of the perspectives lifespan development theories have assumed with regard to personality and psychosocial development, although it is recognised that this does not occur in isolation from cognitive and physical development. However, theory and research in the area of personality development across the life span has much to offer in terms of understanding older clients' psychosocial contexts and their individual values and coping mechanisms. This has far-reaching implications for clinical practise with older clients. The essay begins with a discussion of the life stage theories of personality development. Studies of attachment and individual differences in patterns of development across the life span are then explored. This is followed by a review of the recent research into subjective experience and self-concept over the life course. Finally, the practise implications of these theories for the Clinical Psychologist will be evaluated.

Life Stage Theories of Development

Traditionally, theories of personality offered detailed accounts of development during the childhood years and little attention was paid to developmental issues after that time. Over the last few decades, however, lifespan developmental approaches have attempted to make sense of personal experiences across the whole of life. Life stage theories are orderly accounts of personality development. They conceive the lifespan as consisting of a sequence of qualitatively different age-related stages during which personality is modified and developed. Probably the most influential theory from this perspective is that of Erikson (see Erikson, 1963, 1980). Erikson viewed life stages as a series of different psychosocial “crises” which come about because of the changing demands that society places on the ego. The ultimate psychosocial crisis occurs in old age during which an individual can achieve “integrity”. To achieve integrity means that the individual has reached the highest form of self-acceptance and realisation through life review. Thus, by virtue of the extent of their experience, they possess a wisdom that individuals of a younger age cannot surpass. Unresolved crises at the time of old age might involve the individual being preoccupied by feelings of regret and despair about the life they have led, and therefore they are likely to be prone to psychological problems such as depression (Coleman, 1994). Studies of personality in old age have revealed similar findings to Erikson’s concept of the integrity/despair crisis. For example, in a study of men between the ages of 55 and 84 years, Reichard et al (1962) defined five personality types reflecting differing adjustment styles to the changing circumstances of old age. The most desirable personality type was given to those individuals who were constructive and flexible in their coping style. Very like the idea of integrity, they were described as having successfully accepted their lives and place in the world. The other four personality types involved firstly, those who viewed old age as a time for relaxation and dependence on others; secondly, those who aimed to preserve their active approach to life at all costs; thirdly, those who blamed others for their situation; and lastly, those who blamed themselves. The last two personality types could be compared to Erikson’s idea of unresolved crises in old age.

Erikson's theory is very useful in understanding people in late life for a number of reasons. Firstly, it postulates that self-development occurs in old age unlike some other psychodynamic theories that view old age as a time of ego rigidity and stagnation (eg. Freud, 1905/1953). Secondly, Erikson's theory implies that an older person is best understood in the context of their whole life history and how successful they have been in resolving previous psychosocial crises. Psychological problems in old age might be understood and dealt with in terms of focusing on these earlier unresolved conflicts.

Finally, Erikson's theory recognises that personal development involves an interaction between the individual and societal influences. Another important life stage theory that takes this view is that developed by Levinson in the 1970s (see Levinson et al, 1978). Based on retrospective interviews with forty men between the ages of 35 and 45 years, Levinson explored the interactions between self and environment at different stages of life, and theorised that all individuals pass through a series of "phases" and "transitions" during which they are confronted with "developmental tasks". He is best known for his account of the transition of middle adulthood which is popularly referred to as the "mid-life crisis". At this transition (between the ages of 40 and 45 years), due to changing environmental circumstances, individuals are confronted with the tasks of accepting that they are no longer young; achieving increased independence and sense of self, coming to terms with their own mortality and readdressing their sexuality and gender role. Successful resolution of these tasks involves some emotional upheaval, but results in significant personal change. Further transitions and change are assumed to occur over the age of 65 years. However, Levinson does not comment on the nature of these changes due to the lack of research data on the older age group. His theory also fails to account for the massive individual variation in timing of experiences that occurs from person to person. In terms of the mid-life crisis, he proposes a time span of only five years to allow for individual differences.

Erikson and Levinson's theories can both be criticised on a number of points. Firstly, although personal change is not seen as occurring in isolation from societal and environmental influences, neither theory pays attention to the idea that personal change is affected by a multiplicity of factors, for example, genetic predisposition and gender differences. For example, a longitudinal study of personality development in men and women from the age of 7 to 60 years by Haan et al (1987) found gender differences in organisation of personality across the lifespan. In particular, the transition into later life involved more reorganisation of personality for women than men.

Secondly, both theories are limited in that they reflect a life course set within a particular point in history. They fail, therefore, to take into account differences in experience across different cohorts of individuals (Sugarman, 1986). Thirdly, Erikson and Levinson's theories are also culture-specific. Anthropological studies carried out by Gutmann (1980, 1987) indicate that experiences in old age differ across cultures and the extent to which older individuals from non-Western cultures show the personality attributes described by Erikson differs to those from Western societies. Finally, and somewhat related to the last point, Erikson and Levinson's theories can be criticised for advocating a conformist view of society (Roazen, 1976). Their theories do not pay attention to the idea of intentional action – that each individual is motivated to and capable of shaping and changing their own experience and life path independent of societal structure (Dannefer, 1989).

In summary, therefore, although the life stage theories might help practitioners working with older people to conceptualise a link between psychological problems of old age and earlier life experience, they can be criticised for neglecting the extent of individual variation in experience throughout life.

From this viewpoint, Coleman (1994) points out that by virtue of the fact that they have lived the longest, the older an age group is, the more heterogeneous they will be. Therefore, an understanding of the psychological problems of older adults requires an appreciation of the individual differences in their development and previous experience. Recent research investigating mental health difficulties in older adults have emphasised the importance of differential attachment experiences in early life.

Attachment and Pathways of Development.

Attachment was a concept first described by Bowlby (see Bowlby, 1969). In his theory, attachment was taken to illustrate the interaction between a mother and her child. He hypothesized that between six months and the age of around two or three years, the infant, having developed a discriminatory capacity, instinctively selects an attachment figure whom he/she has a “secure base” from which to explore. In subsequent years, during increasingly complex cognitive development, the child develops a mental representation of this first attachment relationship (an internal working model), characterised by feelings of security and a sense of worth from which the child can build future relationships and can become increasingly independent.

Research consistently indicates that close, confiding relationships akin to this first attachment relationship are indeed important and protective, particularly in times of stress, throughout the life span (Rutter and Rutter, 1993). Studies have, therefore, been concerned with the psychosocial development of individuals who have not had an opportunity for attachment in early life. For example, the development of children who were raised in institutions where a consistent care-giver was unlikely to have been present has been investigated (e.g. Hodges and Tizard, 1989b; Quinton and Rutter, 1988).

Other studies have been concerned with the identification of insecure attachment in early life, and subsequent experience (e.g. Sroufe, 1983; Parks et al, 1991). As illustrated in a review by Rutter and Rutter (1993), these studies raise a number of important implications. The studies showed that individuals with poor attachment experiences in early life went on to show social difficulties with peers through childhood and into adulthood. However, the quality of subsequent experience in childhood and adulthood affected the extent to which individuals went on to develop emotional problems and then continue to have difficult experiences. This implies that personal development involves complex interactions between cognitive and environmental mechanisms. The internal working model that the individual has developed from early attachment experiences will thus influence their subsequent psychosocial experiences, but it is also possible that later experience that is very different from the earlier attachment experience can change an individual's cognitive model of relationships and thus change their subsequent behaviour and experience. Research has also found an association between infant temperament and security of attachment (e.g. Belsky and Rovine, 1987). This suggests that genetic factors are also involved in attachment and psychosocial development.

In summary, therefore, studies suggest both continuity and discontinuity of attachment difficulties across the life span based on an interaction of underlying cognitive, environmental and genetic mechanisms. Unresolved attachment difficulties render an individual vulnerable to stressful events or transitions later in life. Therefore, in conceptualising psychological problems in old age, it is important to concentrate on the interplay of vulnerability and protective factors across the life span. For example, Gagnon and Hersen (2000) illustrate how individuals who have unresolved child sexual abusive experiences might be interpersonally and psychologically vulnerable to the stressful life events of old age, such as loss of social support and roles as well as the developmental task of life review. Vulnerabilities resulting from an unresolved childhood sexual abusive experience might involve longstanding attachment difficulties, poor coping strategies, low self-esteem, helplessness and poor social skills.

Studies of the effect of traumatic experience during the life course are also useful for understanding the development of psychological problems. A review by Weintraub and Ruskin (1999) indicated that the vulnerability and protective factors an individual shows before and after the traumatic event, (e.g. level of social support, experience of parenting in early life) are important for evaluating risk of further psychological problems in old age. In this respect, they view old age as a time in which the detrimental effects of previous trauma might resurface if an individual is particularly psychologically vulnerable.

Finally, research on vulnerability and protective factors across the life span by Brown et al (1990) have focused particularly on the role of self-concept in personal development. Their findings highlight the reciprocal interaction between self-concept and experience. Thus, experience effects self-concept and self concept can affect subsequent experience. From this perspective Brown and Harris' conceptualisation of depression involves an individual showing low self-esteem resulting from early difficult experiences which then puts them at an increased risk of developing depression when faced with further negative experiences. Self concept across the life span and its role in coping with the changing circumstances that accompany old age has been increasingly studied in recent times (see Coleman, 1999).

Self Concept and Subjective Experience across the Life span.

Research concerned with adjustment in old age has emphasised the importance of self-esteem as an influential component for successful adaptation in this part of life (e.g. Lund, 1989). However, it should be noted that studies have also revealed that self-esteem is remarkably resilient in the face of adverse experience in old age. An individual's self concept is important to understand in terms of its protective role in stressful or changing circumstances. It can be seen as being particularly relevant to the time of old age when the developmental task is to review one's past life and experiences.

Furthermore, studies indicate differences in objective and subjective indicators of continuities and discontinuities across the life span (e.g. Bengtson et al, 1985; Woodruff and Birren, 1972).

Lifespan developmental theories concerned with self-concept explore an individual's understanding of who they are, how they have become who they are and what they need and want in their life. Dittman-Kohli (1990) refers to an individual's cognitively based, subjective view of life as the "personal meaning system" and she views an individual's life path as consisting of actions and goals based on their meaning systems. The self is not, therefore, viewed as a passive recipient of experience during life, but as active and intentional. This perspective is echoed in Dannefer and Perlmutter's theory of development (Dannefer and Perlmutter, 1990). Their theory views development as consisting of three processes – "physical ontogeny" (which involves biological changes and the role of gene factors); "habituation" (learning from and adapting to the surrounding environment); and "cognitive generativity" (active and intentional processing and shaping of one's life history and experience).

Studies of self concept across the lifespan suggest that individuals strive to achieve continuity in the global aspects of self and identity. In his theory of self-concept over the life course, Atchley (1989) postulates that individuals are motivated to achieve continuity of self through times of change, such as those encountered in old age. Continuity is taken to mean bringing about change in the context of a basic, stable understood structure of self. An individual does this through "subjective perception" (perceiving changes as linked to their past history); "internal continuity" (remembering aspects of their inner personality such as temperament, skills and preferences) and "external continuity" (behaving and living in familiar environments).

With respect to self concept in old age, Dittman-Kohli (1990) found that older adults reported more positive attitudes towards themselves than younger adults and that they were more concerned with their current situation and self as opposed to the goals of further self realisation which younger adults reported. Given these findings, it seems that an important factor in adapting to change in old age, is the extent to which an individual can maintain a coherent sense of identity. This can be seen as being linked to Erikson's concept of integrity in old age. Understanding an individual's subjective experience of their life and the meaning they give to it in old age can, therefore, be a significant indicator of well-being (Coleman, 1986). However, a more complete understanding of an older person's psychological problems would be gained from a combination of subjective and objective evaluation of their past experiences utilising the different perspectives on lifespan development already discussed. An examination of the various ways these theories can be used in clinical practise will now follow.

Practise Implications of the life span development approach for Clinical Psychologists.

Theories adopting a lifespan developmental approach all point to the importance of appreciating individual variation in experience. Therefore, it is fundamentally important that a practitioner assuming this perspective is aware of their own values and assumptions about development and experience. Sugarman (1986) emphasises the need for practitioners to assume the role of "interviewer" as opposed to "expert", for practitioners to try to understand the developmental issues particular to each individual. When working with older adults, it is important for a practitioner to address their own views of ageing and possible negative stereotypes of ageing they may hold as these hinder the process of understanding the problems a client presents with from their own perspective.

Assessing psychological problems in older adults.

If a practitioner is to understand the psychological problems of older adults from a lifespan developmental perspective, an assessment must incorporate an account of life history as well as current situations. This in itself seems an overwhelming task for practitioners working with older adults whose lives are of course the longest of all clinical populations (Knight, 1996). However, an examination of the various theories of lifespan development points to the need for practitioners to structure their assessments so that they can obtain relevant and meaningful information. Firstly, life stage developmental theories imply that practitioners need to be aware of age-related normative experiences. If a client then reports a non-normative experience at a particular age, the practitioner might hypothesise difficulties with regards to the corresponding life stage conflict and subsequent personality development. Secondly, practitioners should pay attention to adverse experience in early childhood as this might have predisposed the client to attachment difficulties in later life, and thus interpersonal vulnerabilities, such as poor coping and social skills. Thirdly, an appreciation of the client's social context throughout their life is useful in terms of highlighting the extent of protective factors such as social support. Finally, theories advocating the importance of subjective experience and personal constructs have much to offer the practitioner in terms of understanding how the client perceives their life and previous experiences. However, a practitioner should also assume an appropriate degree of realism and sensitivity when carrying out an assessment of life experiences. Retrospective accounts of life history are prone to inaccuracy due to factors such as poor memory for the experience and an unwillingness to talk about or confront a particular experience. McInnis-Dittrich (1996) illustrates this point with regards to older adults with experiences of childhood sexual abuse. Having little memory of their abusive experience might serve an important protective function for some clients. Therefore, McInnis-Dittrich stresses that practitioners should be cautious when addressing these issues. It may be detrimental to a client's well-being to explore these distressing memories with them. Furthermore, if memories are incomplete, a practitioner runs the risk of suggesting false memories to the client.

When an older adult gives an account of their experience, a practitioner needs to be able to place that experience in its appropriate historical context. Knight's Contextual Cohort Based Maturity/Specific Challenge model has much to offer in this respect (see Knight, 1992, 1993). Knight proposes that a practitioner working with older adults needs to acquire knowledge about contextual and value differences across cohorts. He discusses this point with regards to a number of factors (see Knight, 1996). In terms of language use, older cohorts both understand aspects of language differently and express themselves in different ways to younger cohorts. When discussing a psychological problem with an older client, the practitioner will, therefore, need to be aware of these differences. Knight also advocates for knowledge of prevailing normative values for different cohorts, using the example of divorce – a phenomenon that is much more usual in the parents of children today than when older clients were in their childhood. Finally, a knowledge of the impact of major historical events on individuals is necessary. Probably the most important event of this kind for current cohorts of older adults is World War II (see Davies, 1997 for a review of the psychological impact of World War II experiences and its clinical implications). A practitioner would, therefore, need to consider what age an individual client would have been during World War II, and how it shaped their development and subsequent experience.

A final point that needs to be emphasised with regards to the assessment of psychological problems in older adults concerns the complex work that might be involved. In light of these complexities, it is suggested that it is important for a Clinical Psychologist to work in a multidisciplinary way with older adults (e.g. Dick et al, 1999).

Implications for Intervention

Conceiving problems in terms of lifespan development issues implies that the therapist encourages the client to view change positively. Lifespan developmental theories can aid the practitioner in designing appropriate and effective interventions with older adults to suit their individual needs.

Of all the interventions carried out with older adults, life review therapy uses the lifespan developmental approach most explicitly. Life review therapy was first conceptualised by Butler (see Lewis and Butler, 1974). It involves helping clients to understand their life and their self concept. Although initially based on Erikson's life stage theories (life review was considered a means by which a person achieves integrity), life review therapy has since been further developed to incorporate biological and sociological as well as intrapsychic perspectives (e.g. Bengston and Allen, 1993). Bengston and Allen emphasise how biological ageing can influence the self concept, as can an individual's awareness of the differences in life of later born cohorts. They also propose that changing family and age-linked roles can have an impact on self-concept. Life review therapy involves asking a client about each stage of life so that themes can be identified in relation to work, relationships, bereavement, fear, religion, sex and school (Burnside and Haight, 1994). In this way, current forms of life review therapy can be seen as echoing the principles of the self-concept theories of lifespan development (e.g. Atchley, 1990; Dittman-Kohli, 1990). The focus is on emphasising previous adaptive and coping strategies for dealing with current challenges as well as formulating new ones.

Knight (1996) highlights several uses of life review therapy with older adults. Firstly, it can be used to help clients confront and deal with developmental issues from their past. Clients with long-term psychological or personality problems might benefit from such an intervention. Secondly, it can help clients who are having difficulties adjusting to the challenges of old age. Thirdly, it is helpful with grieving clients who need to come to terms with their self-concept after their loss. However, in theorising about his concept of integrity, Erikson pointed out that life review is not always a positive experience in that it can create feelings of depression and despair (Erikson, 1963, 1980). Haight, Coleman and Lord (1995) also point out that life review therapy needs to be carried out sensitively and that it takes time.

McInnis-Dittrich (1996) highlighted the uses of life review therapy with older individuals who had unresolved experiences of child sexual abuse. However, she outlined a number of adaptations that were necessary for this client group.

Recognising that verbal expression of memories that have never been explored before might be extremely difficult for the client, nonverbal expression was seen as a more effective and appropriate tool. Also, given that confrontation with the perpetrators of the abuse was unlikely because they would probably have already died, role play was seen as an adequate substitute. Finally, when carrying out life review therapy with any client, she emphasised the importance of allowing the client choice in what and how far they wanted to explore at all stages of treatment.

Some of the ideas of life review are echoed in schema-change therapy which was developed by Jeff Young (see Young, 1990). Schema-change therapy is an adapted form of cognitive therapy concerned with changing core beliefs and maladaptive cognitive schemas. Its uses lie in working with people with longstanding psychological problems and personality difficulties. In this respect it can be useful with older adults who have chronic problems and developmental issues. Schema-change therapy involves helping the client to identify how they developed core beliefs about themselves in childhood. The client is then encouraged to systematically reflect on significant life events in their past and to identify how their core beliefs were active in shaping their experience and interpretations of these events. Eventually, work is done with the client around reformulating maladaptive core beliefs and schemas, using techniques such as role-play and paying particular attention to the therapeutic relationship to illustrate the impact of maladaptive schemas. Given its complex and radical nature, schema-change therapy is carried out over a relatively long period of time.

Life review can be also carried out using a personal construct approach. Narrative therapy (see Kropf and Tandy, 1998) focuses on a client's stories with the aim of deconstructing existing meaning systems and creating more functional ones.

Conceptualisation of an individual's life story involves them giving it personal meaning (derived from personal experiences and identity) and social meaning (experiences that are socially constructed). This is done by helping the client to externalise their experiences thus making them easier to change.

Coleman (1999) points to the idea of indirect intervention, suggesting that it is important to give information to service providers about how life review and reflection for older people helps them to preserve their self concept in the face of stressful experience.

Implicit in all the assessment and intervention techniques discussed, is the assumption that practitioners using a lifespan developmental approach to working with older adults need to develop some specialist skills and knowledge. Given the long-standing and complex nature of therapy concerned with developmental issues, it is also desirable that practitioners receive adequate support and supervision in their work.

Conclusions

The study of personality and psychosocial development across the life span has been given relatively recent attention and is a growing area of research. Traditionally, theories of personality development into adulthood assumed a life stage approach. Their concepts are still widely used today in terms of understanding the psychological problems of older individuals. However, they are mostly viewed as incomplete and generalisations of development. They fail to take into account the interplay between various mechanisms and factors that make for individual differences in patterns of development and experience. The focus, therefore, of more current research has been on individual subjective meaning and identity over the life course. This has been shown to have considerable relevance to old age in terms of providing a fuller understanding of the continuities and discontinuities that an individual experiences throughout life. It also forms the basis of current intervention techniques concerned with life review.

Life span developmental approaches have implications for psychological assessment of problems in old age. They point to important psychological processes that need to be considered during a clinical assessment and in conceptualising formulations. In terms of intervention, life span theories offer much hope for successful and positive change. However, practitioners need to be sensitive and realistic about the appropriateness and productiveness of their aims in therapy. In this respect, life review, schema-change therapy and narrative therapy are most useful for older clients who have long-standing problems or who have developmental issues, perhaps resulting from traumatic experience earlier in life that they would like to confront and deal with. Multidisciplinary working is particularly important given the complex nature of the approach. The concept of life review also has training implications for service providers in terms of helping them recognise the importance of preservation of identity in later life.

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WRITTEN EXERCISE 2

Name: Joanna Mary

Date: October 2002

Year: 2

Title: In the recent Government White Paper, “Valuing People” (2001), the definition of Learning Disability specifically excludes adults with autism who have average or above average intelligence. Do you agree? Critically discuss.

Being the most important plan in the field for thirty years, the Government White Paper “Valuing People” (Department of Health, 2001) sets out a national strategy for services for people with a learning disability. It is based on four principles – rights, independence, choice and inclusion and it advocates that services use a person-centred approach to supporting people with a learning disability and their carers. The role of Learning Disabilities professionals is therefore seen as viewing service-users as people first, enabling them to access mainstream services, which they may have previously been denied. This can be seen as a further development of the principles of normalization proposed by Wolfensberger (1972), which was the prevailing philosophy behind the development of community care, advocating that services should strive to provide an existence for people with a learning disability that was as close to normal living conditions as possible.

In outlining to whom the new strategy applies, “Valuing People” provides the definition of learning disability as

including the presence of a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood, with a lasting effect on development. (Department of Health, 2001).

Impaired intelligence in this definition is seen as an IQ below 70 (i.e. two standard deviations below the mean). Adults with autism who have average or above average intelligence are not seen, therefore, as being part of this definition. This raises questions about the nature of disability, the classification and diagnosis of autism and the type of services people with autism who have average or above average intelligence should receive.

This essay begins by focusing on the concept of a learning disability and how it evolved in the context of service provision. The problems inherent in defining intelligence and social functioning are then examined.

This is followed by a review of psychological theories of autism and research into the pattern of abilities that autistic individuals show. The debate as to whether autism with average or above average intelligence should be viewed as a learning disability is then explored. Finally, the implications of “Valuing People” for learning disabilities services and services for people with autism who have average or above average intelligence will be evaluated.

History of the concept of learning disability and service provision

A review of the history of descriptions of the concept of a learning disability reveals that it has always been bound up in the prevailing views and policies of society. As such, the concept of a learning disability is a socially constructed term meaning that over time and in different societies, what it represents, who it has applied to and how they have been treated has differed somewhat (Trent, 1995; Wright & Digby, 1996).

In the UK, prior to the industrial revolution, classification and services for people who would have had a learning disability were not universally identified and their identities within village communities varied (e.g. from being ridiculed and exploited to being revered for their difference) (see Race, 1995). As a result of the industrial revolution and subsequent urbanisation, people who had low competence in the areas of education and employment began to stand out more and became more of a “problem” for society. Then, due to developments in science and the medical profession, prevailing societal views about disability changed. By the turn of the century, genetic theories viewed people with organic impairment as untreatable and qualitatively different from the rest of society. Furthermore, at that time, psychological theories saw intelligence as hereditary and static throughout life and tests for measuring people’s intelligence were developed. Thus, “mental deficiency” became quantifiable and people classified in this way were segregated from society.

In the 1950's researchers began to show that people with below average intelligence could develop their skills with appropriate support and education (e.g. Clarke et al, 1958; Clarke and Clarke, 1959).

Scientific measures of "adaptive behaviour" were also being developed as theorists debated whether people with intellectual impairment were capable of independent living (e.g. Doll, 1953).

However, it was not until the 1970's, with the development of principles of normalisation (Wolfensberger, 1972) that the effect of "labelling" was emphasised and that terms that are and have been used to classify the concept now known as "learning disability" were value-laden.

As such, therefore, from a social constructionist viewpoint, the concept of learning disability can be seen as having evolved from an attempt by powerful groups in society to exclude and undermine less powerful groups (Clements, 1998). Clements (1998) considers that learning disability is currently most commonly constructed as a long-lasting difference in cognitive processing with biological and/or early environmental origins that can be influenced to some extent with environmental input.

Definition of learning disability

In line with current constructions of learning disability, today, classification of learning disability within service settings usually depends on the availability of services and the particular needs of the individual (e.g. BPS, 2001).

It is generally accepted that measures should be obtained of both intelligence and social functioning in order to define a learning disability. Historical evidence should also be provided on the presence of these impairments before the age of 18 years.

However, there are a number of problems inherent in the concepts of both intelligence and social functioning that make the definition of a learning disability an inexact science. These will now be explored.

Intelligence

Measurement of intelligence on the basis of IQ tests relies on the validity and reliability of the tests in question. To this end, intelligence tests have many shortcomings (e.g. Barnett, 1986). For example, tests results for one individual can vary according to their mood, motivation and fatigue among other factors. Tests in general are biased in terms of the type of education that individuals have received. Furthermore, the tests are framed within Western cultures, and so their applicability with people from other ethnicities becomes problematic. In general, when employing intelligence tests, psychologists are required to differentiate between performance which is due to ability and that which might be affected by other factors (BPS, 2001). Furthermore, the employment of intelligence testing to differentiate impairment according to a statistically derived cut-off point (i.e. an IQ of 70 or below, representing two or more standard deviations below the mean) is seen by some as arbitrary (O'Brien, 2001). Identification of impairment becomes particularly problematic due to the idea that a standard error of measurement surrounds any IQ score. If, therefore, a person obtains an IQ of 70, their score falls in the range above and below the cut-off for impairment. A general IQ score may also mask significant differences in ability, for example between verbal and nonverbal skill.

Current cognitive research has moved away from focusing on the concept of general intelligence and is now more focused on looking at the effects of specific areas of functioning. For example, individuals may have specific difficulties in language, executive functioning, social cognition, motor skills, or perceptual functioning (see Clements, 1998), which can all affect development, performance and the environmental input received. IQ tests do not adequately reflect these differences and so may not identify the specific needs of individuals.

Recent studies have highlighted the individual differences in the development of specific skills in relation to environmental input (e.g. Karmiloff-Smith, 2000) representing a move away from viewing domain specific skills or impairments as having a universal ontogeny. These studies suggest that new cognitive assessment tools should be developed so that individual differences in information processing can be better identified.

Social Functioning

Similar to measures of intelligence, the measurement of social or adaptive functioning can also be seen as problematic. An individual's performance in this area is context dependent and related to their age and socio-cultural expectancies (O'Brien, 2001). Furthermore, tests of social functioning are varied and focus on different aspects of this area to the exclusion of others. In their guidelines to psychologists evaluating level of social functioning, the British Psychological Society do not specify one single recommended assessment tool for this (see BPS, 2001), but caution is advised in making sure assessment of social functioning is tailored for the individual being evaluated.

In line with the principles of "Valuing People" which aims to focus on the abilities of people with a learning disability rather than their disabilities, research is being conducted into new classification systems. One such system is the World Health Organisation document "The International Classification of Impairments, Activities and Participation (ICDH-2)". The ICDH-2 aims to record how different personal difficulties and social influences serve to either enhance or diminish the activities of which the individual is capable, that in turn affect their participation in society. Classification systems which incorporate these aspects may, therefore, improve assessment in this area.

Psychological theories of autism

The above discussion has focused on the difficulties in defining a learning disability and the implications of using that label. This has relevance for individuals with autism and the characteristics they show. The condition of autism will now be discussed and research into this area will be reviewed.

In explaining autism, theorists have identified a number of biological causes. Szatmari & Jones (1991) identified three aetiological groups – those caused by exogenous factors (e.g. prenatal accidents), autosomal recessive genetic causes, and x-linked genetic causes. The characteristics of autism are identified as becoming evident before the age of three years. Individuals with autism have been found to show a variety of different behavioural manifestations, although three core features have been identified as being universal.

These are in the areas of socialization (showing difficulties with social reciprocity and understanding), communication (where difficulties range from no speech and no use of gestures through to fluent speech together with problems with the pragmatic use of language) and imagination (obsessional interests in things that are narrow and circumscribed in nature).

In addition, there are a number of other characteristics, which are not universal to autism but are typical. These are impaired intelligence; superior nonverbal abilities to verbal abilities on IQ tests; savant abilities in music, drawing or calculation; motor stereotypies and the desire for the preservation of sameness. Psychological theories propose that autism is defined by a characteristic style of cognitive processing. Thus, the idea of a “final common pathway” has been proposed in which different biological causes may affect the same specific component of the brain, resulting in autism, although researchers have not agreed on the critical pathway or area of brain that is affected (see Happe, 1994).

An influential theoretical proposition for the cognitive processing style seen in autistic individuals has been the Theory of Mind hypothesis. Theory of Mind is seen as a social cognition skill - the ability to think about thoughts and to understand that people have mental states; that they have beliefs and desires about the world, which determine how they behave (Happe, 1994). Autistic individuals are thought to have a deficit in theory of mind, which explains their difficulties in the areas of socialization, communication and imagination. Various tests of theory of mind, such as false belief tasks, have been developed to assess this skill in autistic individuals (e.g. Wimmer & Perner, 1983). False belief tasks are designed to test a person's ability to understand and predict someone's behaviour based on a false belief. Numerous studies investigating the theory of mind abilities of children by evaluating their performance on differing levels of false belief tasks have been conducted. They have shown that children without developmental disorders acquire theory of mind abilities around the age of four years (see Happe, 1994).

Many other studies have been conducted into theory of mind abilities in children with autism and those without autism, using evidence other than that shown on false belief tests. For example, Attwood et al (1988) found that autistic children showed gestures towards others to get their needs met, but not gestures that would influence mental states in others. Other studies have focused on recognition of mental states or emotions in others (e.g. Baron-Cohen, 1992; Baron-Cohen et al, 1993a).

However, theory of mind research has also raised a number of questions as to its accuracy and applicability to the cognitive processing of autistic people. For example, some autistic adults with good verbal abilities have been found to pass false belief tasks (e.g. Frith, Morton and Leslie, 1991). This raises the question of whether some autistic people do eventually acquire a theory of mind, which would have implications about whether their difficulties with theory of mind represent a distinct disorder of autism or not. However, it is also not known whether or not these people are able to generalise their theory of mind abilities to real-life social situations.

Furthermore, theory of mind does not explain some of the other characteristics seen in autism such as desire for sameness, stereotyped behaviours, savant skills and self-injurious behaviour (Happé, 1994). There has been some debate, therefore, about whether theory of mind actually represents the primary, core deficit in autism or not, and other theories have been developed. These will be reviewed in relation to discussions about autism and intelligence.

In general, theory of mind has, however, greatly increased understanding of individual differences in ability within the field of learning disabilities and objectives for the specialist support for adults with autism and impaired intelligence are set out in the “Valuing People” paper.

However, as implied by the success rates on false belief tasks of more able autistic individuals, the pattern of abilities of autistic individuals who do not have impaired intelligence has been less clear.

The concept of high functioning autism

In the 1950s and 1960s, the focus of research on autism was on those individuals with autism who had impaired intelligence on IQ tests. However, it was recognised that a small group of individuals displayed the behavioural characteristics of autism but they did not have impaired intelligence (e.g. Everard, 1976). This group of individuals have become known as having high functioning autism.

Earlier studies into the characteristics shown by high functioning autistic individuals varied in terms of the IQ criteria they used to define normal intelligence. Some studies based their criterion on Full-scale IQs and other studies on Performance IQs. Furthermore, cut-off points in these early studies ranged from an IQ of 60 to an IQ of 80 (see Tsai, 1992).

A study by Bartak and Rutter (1976) in which the cut-off score was a Performance IQ of 70, showed that the low functioning autistic children showed more severely delayed language development, more self-injurious behaviours and stereotyped hand and finger movements, greater difficulty with environmental change, a higher rate of epilepsy and poorer “outcome” overall than the high functioning autistic children in their study. The high functioning children showed more pronominal reversal, undue sensitivity to noise and rituals. A further study by Freeman et al (1981), also using a Performance IQ of 70 as the cut-off score supported these findings. Although it is difficult to conclude the findings of these early studies because of the differences in IQ criteria, there was certainly some indication that high functioning autistic individuals may show different behaviours and a greater potential for adaptation than low functioning autistic individuals.

It should be noted that studies investigating IQ test scores in high and low functioning autistic individuals have found that both these groups sometimes show unusually uneven profiles (a peak performance on Block Design and a trough on the Comprehension subtest) (e.g. Shah & Frith, 1993). This raises the possibility that IQ tests might be less valid for autistic people anyway and calculation of general IQ on the basis of their test profile might be misleading.

In general, therefore, the studies on IQ in autism suggest that making a distinction between people with autism who have average and above average intelligence (defined as an IQ above 70) and people with autism with impaired intelligence is problematic if the IQ tests used to assess them are not valid. Furthermore, there are no clear conclusions from studies that compare autistic individuals on the basis of IQ alone. Therefore, individuals with differing IQ scores may show similar behavioural characteristics but would not be accessing the same services according to the criteria set out in the “Valuing People” White Paper.

A recent article by Baron-Cohen (2000) takes a different perspective on the concept of high functioning autism by focusing on the behavioural characteristics, social adaptation and cognitive processing styles of this group in which he also includes people with Asperger's syndrome. Here children are classified as having high functioning autism if they have an IQ above 70. Children with Asperger's syndrome are seen as showing the characteristics of high functioning autism but without a history of language delay.

Baron-Cohen gives the following behaviours as examples of the diagnostic features seen in high functioning autistic children and children with Asperger's syndrome. These are: being more involved with objects and physical systems than with people; less communication than other children; a tendency to follow their own beliefs and desires as opposed to the desires and beliefs of others; showing relatively little interest in either what the social group is doing or being part of it; showing strong, persistent interests; showing accuracy in perceiving details of information; noticing and recalling things that other people may not; views of what is relevant and important in a situation not coinciding with others' views; being fascinated by patterned material and systems; having a strong drive to collect categories of objects or categories of information; and having a preference for experiences that are controllable rather than unpredictable.

These characteristics are seen as representing a difference in cognitive style that people with high functioning autism and Asperger's syndrome show rather than a "disability". The term disability is seen here as being a value-laden judgement which could have the effect of stigmatising individuals with high functioning autism or Asperger's syndrome.

Instead of focusing on the postulations of the theory of mind hypothesis, which regards individuals with autism as having a "deficit" in theory of mind abilities, Baron-Cohen focuses on two theories of cognitive processing "styles", which construe ability along a dimension or continuum.

Firstly, the folk psychology-folk physics model is proposed in which people with high functioning autism and Asperger's syndrome are seen as having intact or superior folk physics skills and impaired folk psychology skills. Folk psychology is seen as involving an understanding of how people work, whereas folk physics is seen as involving an understanding of how inanimate things work. It is suggested that people who show good folk psychology but poor folk physics are not regarded as having a disability, so it seems logical not to label people who have the impairments seen in high functioning autism and Asperger's syndrome as having a disability.

Secondly, Baron-Cohen refers to the central coherence model, proposing that the differences in behaviour shown in high functioning autistic individuals and individuals with Asperger's syndrome are a result of weak central coherence. Central coherence is seen as the tendency to integrate information into its context, whole, or gestalt, which people who do not have autism are thought to have (Happé and Frith, 1996). Having weak central coherence means that greater attention is paid to local details relative to global information and as such just represents a different way of attending to things rather than a disability. Weak central coherence is seen as accounting for a number of behaviours that autistic people show in general. For example, it explains the unusual perceptual abilities seen in autism (e.g. superior performance on the Block Design subtest where the testee is required to make a whole out of abstract parts). Evidence of verbal ability is shown in a study that investigated autistic individuals' performance on memory tasks (Hermelin & O'Connor, 1967). Autistic subjects did not show better memory for sentences than unconnected word strings in a recall task suggesting that they did not make use of semantic relations (e.g. words from the same category) or grammatical relations (e.g. sentences rather than word lists). This would be because weak central coherence means that autistic individuals do not integrate verbal information into context or meaning. These examples illustrate that the abilities of autistic individuals are seen on a continuum of weak versus strong central coherence and do not imply a disability.

In further arguing against the idea of high functioning autistic individuals and Asperger's syndrome individuals being seen as having a disability, Baron-Cohen examines research into neural differences. He concludes that although neural abnormalities in individuals with high functioning autism and Asperger's syndrome indicate neurological differences, there is no evidence to show that these differences are any better or worse than brains of individuals who do not have autism.

In general, therefore, Baron-Cohen's article advocates that the social skills of individuals with autism who have average or above average intelligence are only construed as impaired or as a disability because of the environmental expectations of the society we live in. Furthermore, his proposed theories take the perspective of looking at individual difference in cognitive style rather than qualitative differences in general IQ. From these viewpoints, therefore, excluding adults with autism who have average or above average intelligence from the definition of learning disability outlined in "Valuing People" is positive in terms of including these individuals within mainstream society. Although "Valuing People" proposes eventual inclusion in mainstream society for people with a learning disability and viewing these people in a holistic way, it is still based on a construction of disability, which involves assessing performance on tests of IQ and social functioning.

In contrast to the above argument, Baron-Cohen does however make an important point arguing for the definition of high functioning autism and Asperger's syndrome as a disability. This is when it is viewed from the point of view of carers of people who are showing extreme behaviours related to their desire for predictability in their environment, their inflexibility or their lack of interest in the beliefs and desires of others around them. From a service point of view, obtaining a definition of disability is the current way for carers to obtain practical, specialist and financial help and support in dealing with the difficult behaviours that a person with high functioning autism or Asperger's syndrome might show.

Indeed, as adults with autism who have average or above average intelligence are excluded from the “Valuing People” objectives for people with a learning disability, it raises the question as to how support for these people will be organised.

In writing about the history of service provision for adults with autism, Morgan (1996) outlines how normalisation was perceived as a problem for many of their carers. From their viewpoint, the prevailing language was so focused on individual rights, inclusion, choice and independence, that people were unfocused and ineffective in providing the practical aspects of support that adults with autism and their carers may have needed.

Furthermore, Morgan goes on to argue that the process of self-empowerment requires, in current society, the ability to appreciate the feelings, beliefs and desires of other people and to tolerate unpredictability and change. He, therefore, proposes that autistic people will need specialised support in empowerment. Currently, the wealth of knowledge and expertise about autism may rest in learning disabilities services. The implication of the exclusion of adults with autism who have average or above average intelligence from learning disabilities services is that other services should be trained in specialist knowledge of how best to support an individual with autism who may need to access services. Studies have shown that high functioning autistic individuals are at risk for developing mental health problems due to poor emotional control, concrete thinking and immature beliefs and naivete (e.g. Rumsey et al 1985).

Hare and Flood (2001) outline the difficulties and differences inherent in providing interventions for people with Asperger’s syndrome and highlight the need for mental health professionals to be aware of the needs of this particular client group. For example, in establishing a therapeutic relationship with a person with Asperger’s syndrome, it may not be useful to initially focus on making an empathic relationship with them since problems in empathic inter-subjectivity may be part of their social difficulties. Use of visual imagery in therapy is also advocated as are forms of personal construct therapy with these individuals.

Conclusions

The exclusion of adults with autism who have average and above average intelligence from the definition of a learning disability set out in the new Government White Paper “Valuing People”, raises a number of important debates.

Firstly, although “Valuing People” advocates inclusion, rights and independence for people with a learning disability, definitions of disability are still bound up with ideas about general intelligence, and IQ testing. Yet IQ tests are often not valid and reliable enough to meet a person’s individual needs. Research into the cognitive abilities of people with autism has shown that measures of general IQ may be less valid than with other groups of people because of the uneven profile of skills that they show. An understanding of their abilities as being along a continuum of cognitive styles celebrates their difference and avoids value-laden terms such as disability. It also enables understanding of the more complex cognitive processes involved and of individual need.

Secondly, current measures of social functioning fall short of encompassing the interactive nature an individual has with their environment. New classification systems such as the ICDH-2, proposed by the World Health Organisation have tried to address this.

Not viewing adults with autism who have average or above average intelligence as having a disability, means important support needs that they have may be overlooked and that other services may not currently have the expert knowledge to cope effectively with these needs. For example, adults with autism may need support in the self-empowerment process of independence, inclusion into mainstream society and increased rights and choice. Furthermore, they may be at risk for developing mental health problems and it would, therefore, be important for mental health professionals to understand how best to support them through that.

Finally, as Baron-Cohen notes at the end of his paper, there is the viewpoint that further change is needed at the societal level towards total acceptance of difference in others.

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SMALL SCALE RESEARCH PROJECT

Name: Joanna Mary

Date: May 2003

Year: 3

Placement: Adult Mental Health

Title: “An investigation into the effectiveness of mindfulness meditation as a group therapy programme for outpatients with anxiety disorder.”

Abstract

Currently, there is a growing trend towards acceptance of meditation techniques as a therapeutic tool in the clinical psychology profession. In particular, there has been increasing interest in the application of “mindfulness meditation” in the clinical setting. Mindfulness meditation has its roots in traditional Buddhist literature and psychological texts. It involves cultivating non-judgemental, moment to moment awareness of conscious experience. Preliminary research has shown mindfulness meditation to be effective in reducing psychological symptoms in patients with a range of psychological difficulties. More recently, research in the USA has shown mindfulness meditation to be clinically useful with patients with anxiety disorder and to have implications for cost effectiveness in terms of relapse prevention and the fact that it can be applied on a group basis.

The current study aimed to establish the effectiveness of a pilot group therapy programme of mindfulness meditation for adult outpatients with anxiety disorder referred to an Adult Mental Health Clinical Psychology service. Case profiles of four participants’ scores on a variety of outcome measures were obtained over a five week baseline period, eight weekly group based therapy sessions, and a five week follow-up period to investigate the effect of mindfulness meditation on their experience of anxiety and their sense of control over their anxiety. The results suggested that for all cases the mindfulness meditation sessions had immediate benefits in terms of reducing their feelings of anxiety. However, none of the cases showed clear patterns of improvement in the level and frequency of their anxiety over the course of the therapy or follow-up periods. Two of the cases showed a slight increase in their perceived control over their anxiety at follow-up. Qualitative reports about the usefulness of the therapy programme also raised implications for running this type of intervention as part of the service in the future.

Introduction

Over recent years, there has been an increasing interest in the application of meditation techniques within the clinical psychology profession. Research into the psychological benefits of practising meditation techniques was initially focused on non-psychiatric populations (see Delmonte, 1985). In particular, several studies showed meditation to be effective for patients with difficulties with anxiety although these were not formally delineated using psychiatric diagnostic criteria (Benson et al, 1978; Girodo, 1974; Goldberg, 1982; Raskin et al, 1980).

This project was focused on one particular type of meditation technique, “mindfulness meditation” because of the increasing interest and research into it’s various benefits in the clinical setting and more specifically with patients with anxiety disorder.

The practice of mindfulness meditation has been extensively described in traditional Buddhist literature and psychological texts (see Thera, 1962). The term “mindfulness” refers to a state in which an individual cultivates non-judgemental, moment-to-moment awareness of their conscious experience. Unlike relaxation techniques and some other meditation techniques, mindfulness meditation does not advocate restricting attention to one single object or focus (for example, focusing on achieving a state of relaxation or on a mantra). Instead, it emphasizes attending to and acknowledging any and all thoughts, feelings and bodily sensations, whether those experiences are pleasant, unpleasant or neutral, and sustaining this mode of attention over time. Kutz et al (1985) described how through mindfulness, one becomes “a detached observer of one’s own mental activity, so that one thereby may identify its habits and distortions”. Therefore, the practice of mindfulness meditation is seen as a “way of being” which facilitates awareness of potential mental health difficulties and an enhanced sense of control over one’s experiences.

A large body of research investigating the application of mindfulness meditation in clinical settings has been conducted in the USA. A leading researcher in the field, Kabat-Zinn, developed a “Stress Reduction Program” in which patients were taught mindfulness meditation techniques on a group basis (see Kabat-Zinn, 1982 & 1990). His early studies suggested that this program was effective in reducing a range of psychological symptoms and in facilitating coping with pain in patients with both physical and psychological difficulties (Kabat-Zinn, 1982; Kabat-Zinn et al, 1985; Kabat-Zinn et al 1986). Another study showed mindfulness meditation, as an adjunct to psychotherapy, to be effective in reducing psychological symptoms in individual patients with a wide range of psychological difficulties (Kutz et al 1985). As well as showing an immediate positive effect on psychological symptoms, the above studies on mindfulness meditation also suggested that this improvement was sustained over time (e.g. Kabat-Zinn et al 1986 demonstrated sustained improvement over a four year period).

In general, the studies also indicated that mindfulness meditation as a clinical intervention had implications for cost effectiveness both in terms of its efficacy in relapse prevention and when applied on a group basis. However, a limitation with all of these studies was the lack of a comparison and/or control group. More recently, Astin (1997) aimed to address this limitation by conducting a controlled study to investigate the effectiveness of a group intervention based on Kabat-Zinn’s stress reduction program. The study showed the program to be effective both in reducing psychological symptoms and increasing participants’ sense of control immediately after intervention and at six-month follow-up. However, the study was limited in that none of the participants were from a clinical population.

Conversely, two recent studies (Kabat-Zinn et al, 1992; Miller et al, 1995) investigated the effect of using Kabat-Zinn’s stress reduction program with patients with anxiety disorder as defined by DSM-III-R criteria, using a repeated measures design.

The program was shown to be effective in reducing symptoms of anxiety in these patients and to have long-term benefits in that patients showed sustained improvement and compliance with practising the meditation techniques over a three year period.

In Britain, research on mindfulness meditation in the clinical setting has been shown to be effective with patients with depression when used in conjunction with cognitive therapy techniques (see Segal, Williams & Teasdale, 2002).

In summary, the above studies provide preliminary research evidence that mindfulness meditation has clinical usefulness for patients with a range of psychological symptoms. More specifically, exploratory research from the USA has shown that mindfulness meditation taught on a group basis is effective for patients diagnosed with anxiety disorder. However, there is a need for continued research to support the full acceptance of this technique within the field of clinical psychology.

Context of the Current Study

The current study grew out of an interest in further developing a Community Adult Mental Health Clinical Psychology service, by offering mindfulness meditation as a group intervention for outpatients with anxiety disorder. This type of intervention had not been offered before at the service. The study also aimed to expand on previous research on the effectiveness of a mindfulness meditation as an intervention for outpatients within a British clinical setting.

Research Questions

The aim of the current study was to evaluate whether mindfulness meditation taught on a group basis with adult outpatients diagnosed as having anxiety disorder would be effective in reducing their symptoms of anxiety and in improving their overall sense of control over anxiety.

More specifically, therefore, the study aimed to explore the following questions:

1. Whether there would be an immediate effect on participants' anxiety levels after each group therapy session.
2. Whether participants would show a reduction in the frequency of their anxiety symptoms over the time of the group therapy programme.
3. Whether participants would show an improvement in general anxiety and an increased sense of control over their anxiety at a five-week follow-up.

Methodology

Design

The current project was a pilot study using an experimental case study A-B-A design to evaluate the effectiveness of a group based therapy programme of mindfulness meditation for outpatients with anxiety disorder.

The therapy programme took the form of eight consecutive weekly group based sessions. Case profiles of each participant's scores on a variety of measures were obtained on three separate occasions during the baseline period (at five weeks, three weeks and one week before therapy), on a weekly basis during the eight week therapy programme and on three separate occasions during the follow-up period (at one week, three weeks and five weeks after therapy) to assess the effectiveness of the intervention.

Participants

Participants in the current study were initially selected from the waiting list of referrals at the Adult Mental Health Clinical Psychology service on the basis that they were between the ages of 18 and 65 years, that they had a primary diagnosis of anxiety disorder, and that they were living independently in the community. Referrals that indicated diagnoses of both anxiety and depression but with predominant difficulties with anxiety were also considered.

Selected referrals were then contacted about the study and those who expressed an interest in taking part were sent an information sheet about the study (see appendix 1), a consent form (see appendix 2) and a participant information questionnaire (see appendix 3). This questionnaire was designed for the purpose of this study in order to obtain information about participants' individual situations and to screen for appropriateness for taking part in the study. It was considered inappropriate for participants who reported to be experiencing an acute life crisis at that time to be included in the study.

Following the selection and screening procedures, four participants consented to taking part in the study.

Case 1:

This participant was a 57 year old Caucasian woman who was referred to the Clinical Psychology service by her GP due to her having experienced difficulties with anxiety for around four years. She reported to experience acute episodes of anxiety that would occur without warning and would cause her digestive problems. Since the start of her difficulties with anxiety, she had become increasingly avoidant of social situations because of her resulting digestive problems. She also reported to worry about the future, her family and about getting older. She reported to not have experienced mental health problems prior to her current difficulties with anxiety. She said that she found it difficult to talk about her feelings and that she felt anxious about attending therapy.

This participant lived at home with her husband. She suffered from ventricular tachycardia and she had undergone an operation to be given a defibrillator eight years previously. She was taking beta blockers at the time of the study. She reported, however, that her difficulties with anxiety were not related to her heart problems. She had not practised meditation techniques before.

Case 2:

This participant was a 64 year old Caucasian woman who was referred to the Clinical Psychology service by her GP due to her experiencing acute anxiety when driving. This had been occurring ever since her involvement in a road traffic accident one year and nine months previously and she reported to have become avoidant of driving long distances because of her difficulties with anxiety.

This participant was divorced and lived on her own. She worked as a manager of a care home. She reported that she had lived with her husband, who was physically abusive towards her, for many years. She reported to not have experienced mental health problems prior to her current difficulties with anxiety, although she had previously attended counselling at a community mental health service to come to terms with her divorce. In terms of her physical history, she had undergone an operation for breast cancer several years previously and she also suffered from pain due to osteoarthritis. She had not practised meditation techniques before.

Case 3:

This participant was a 48 year old Caucasian woman who was referred to the Clinical Psychology service by her GP due to concerns about her chronic difficulties with anxiety. She reported to have suffered from anxiety and depression since the age of 20 years but that she was currently experiencing particular difficulties with chronic worrying and feelings of anxiety. She also had a history of alcohol and tranquilliser abuse, although she had not used either substance for nine months prior to the start of the study.

This participant had a long history of contact with mental health services and she had undergone several courses of psychotherapy both on a group and individual basis. She had lived with her partner for two years and she felt that the stability of that relationship had helped her face some of her difficulties. She also suffered from diabetes. At the time of the study, she was taking SSRI medication (Citalopram) for her mental health problems and medication for her diabetes. She reported to have practised yoga occasionally in the past.

Case 4:

This participant was a 35 year old Caucasian woman who was referred to the Clinical Psychology service by her GP due to her having phobias about travelling on planes, tube trains and driving. She reported that she began to have these difficulties after she suffered a nervous breakdown six years previously, which she felt had had a detrimental effect on her self-esteem. She reported to not have experienced any mental health problems prior to her breakdown, she did not have any physical health problems and she was not taking any medication.

This participant lived on her own and she was in full-time employment. She reported to have regularly attended yoga classes for a short period several years ago, which she had found beneficial.

Outcome Measures

1. Weekly Anxiety Questionnaire:-

This questionnaire was designed for the purposes of this study to monitor participants' ongoing experience of anxiety before, during and after the group therapy programme. The questionnaire measures participants' ratings of the presence, frequency and intensity of a number of thoughts, feelings and behaviours associated with anxiety that they have experienced over the preceding week plus a rating of life events that could have influenced their thoughts, feelings and behaviour over the preceding week (see appendix 4).

Participants were asked to complete this measure five weeks, three weeks and one week before the start of therapy, before the start of each therapy session, and one week, three weeks and five weeks after completion of therapy.

2. *State Anxiety Rating*:-

This measure was designed for the purposes of this study in order for participants to rate their level of state anxiety (see appendix 5). They were asked to complete this rating five weeks, three weeks and one week before the start of therapy and five weeks, three weeks and one week after completion of therapy. During the therapy programme, participants were asked to complete this rating once before each therapy session and once after each therapy session in order to measure the immediate effect of therapy on their anxiety levels.

3. *State-Trait Anxiety Inventory (STAI) (Spielberger, 1983)*:-

This questionnaire measures participants' ratings of anxiety symptoms they experience generally (trait anxiety) as well as their experience of anxiety at the time of completing the measure. Participants were asked to complete this questionnaire five weeks before the start of therapy and five weeks after completion of therapy in order to measure the effect of group therapy on participants' general anxiety.

4. *Anxiety Control Questionnaire (ACQ) (Rapee et al, 1996)*:-

This questionnaire measures participants' ratings of their perceived control over their symptoms of anxiety. They were asked to complete this questionnaire five weeks before the start of therapy and five weeks after completion of therapy in order to measure the effect of group therapy on participants' perceived control over their anxiety.

5. Group Therapy Evaluation Questionnaire:-

This questionnaire was designed for the purposes of this study for participants to provide qualitative feedback on how beneficial they found the group therapy programme to be (see appendix 6). They were asked to complete it one week after completion of therapy.

See appendix 7 for the full schedule of measures.

Procedure

Pre-therapy evaluation:-

The first two baseline assessments (at five weeks and three weeks before the start of the therapy programme) were conducted by post. Participants were then invited to a twenty minute individual evaluation session with the researcher for the third baseline assessment (within one week before the start of the therapy programme).

Group therapy programme:-

Group sessions were held on a weekly basis for eight consecutive weeks. Each group session lasted for one hour and fifteen minutes and was run by two Clinical Psychologists who were trained in mindfulness meditation techniques and who worked at the service. The group sessions involved learning, practice and discussion of mindfulness meditation and yoga techniques and the completion of the intervention measures. Participants were also asked to practise techniques at home between sessions.

The session plan was designed using aspects of the manualised mindfulness meditation techniques developed by Segal, Williams and Teasdale (2002) in conjunction with yoga. These techniques involve “stilling the body” in a number of postures or “asanas”, and observing breathing and emotional experience.

In the first and last group sessions, time was built into the session plan for the relevant information giving and feedback. In general, however, each group session followed a standard structure:

- 15 mins.: Completion of relevant assessment measures.
- 10 mins.: Feedback from last session and introducing session plan.
- 5 mins.: Sukhasana (a conditioning asana posture).
- 15 mins.: Three asanas – Talasana (standing), Yoga Mudra (Sitting), Hhujangasana (lying down on the stomach).
- 15 mins.: Breath meditation.
- 10 mins.: Feedback and questions.
- 5 mins.: Completion of relevant assessment measures.

Post-therapy evaluation:- For the first follow-up assessment, participants were invited to attend an individual evaluation session with the researcher within one week of completion of the therapy programme. The second and third follow-up assessments (at three weeks and five weeks after the completion of the therapy programme) were conducted by post.

Ethical Considerations

Ethical approval for this project was granted by the local Research Ethics Committee before the study began (see appendix 8).

Other ethical issues were addressed as follows:

1. All participants were offered individual psychology therapy for their difficulties independent of the current study. Furthermore, in the event that a participant might have experienced adverse effects as a result of the group therapy programme of mindfulness meditation, it was arranged that immediate individual psychology support from a Clinical Psychologist would be offered to them.

2. All completed questionnaires were treated as confidential and were not used for any other purpose other than research analysis.

Results

Cases 1, 2 and 3 participated in the duration of the study whereas Case 4 decided to discontinue with the study at session 6 of the therapy programme due to her feeling that the group had generally not met up to her expectations. However, it was not possible to obtain a complete set of assessment results for any of the cases due to their not being able to attend some sessions due to illness or other life circumstances.

Immediate effects of mindfulness meditation on state anxiety

Figure 1 shows the change in state anxiety that each case reported before and after each therapy session that they attended.

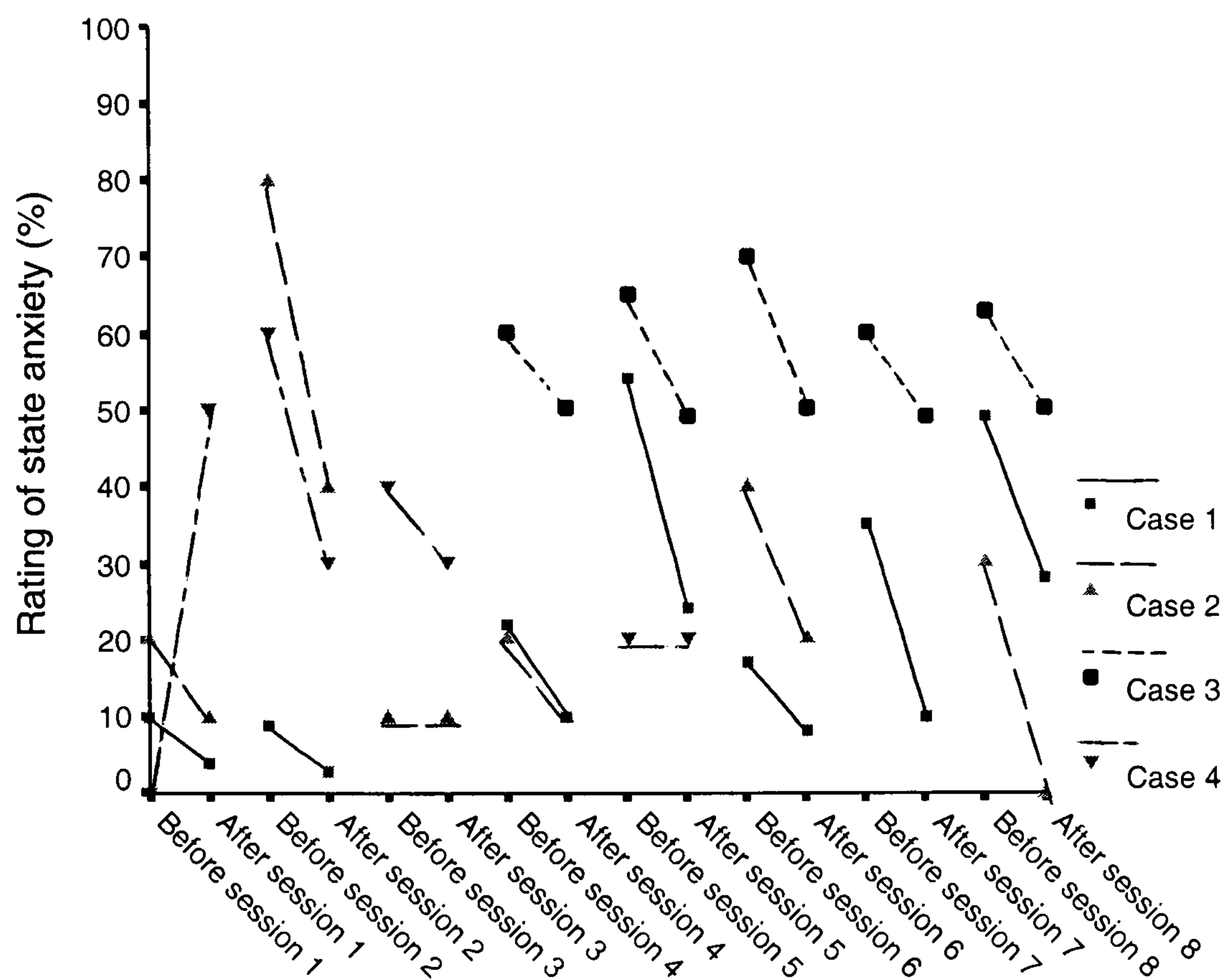


Figure 1.

Table 1 shows the mean ratings of state anxiety for each case before and after each session and the mean amount of reduction in state anxiety they showed after each of these sessions.

	Case 1	Case 2	Case 3	Case 4
State Anxiety Rating (%) before session	Mean: 28, sd: 18	Mean: 33, sd: 25	Mean: 64, sd: 4	Mean: 30, sd:26
State Anxiety Rating (%) after session	Mean: 12, sd: 10	Mean: 15, sd: 14	Mean: 50, sd: 1	Mean: 33, sd: 13
Reduction in State Anxiety (%) after session	Mean: 16, sd: 10	Mean: 18, sd: 15	Mean: 14, sd: 4	Mean: -3, sd: 34

Table 1

Cases 1, 2 and 3 did not report an increase in their state anxiety after any of the sessions that they attended and on nearly all occasions, they reported considerable reductions in their state anxiety after each session. The levels and variation of ratings in state anxiety reported by Cases 1 and 2 before and after each session were fairly similar, as was their mean amount of reduction in state anxiety relative to the extent to which these reduction amounts varied. Case 3, however, reported relatively higher levels of state anxiety before and after each session and there was much less variation in both her state anxiety ratings and the amount of reduction in her state anxiety for each session. It is possible that the different patterns of ratings seen in Cases 1 and 2 as compared to Case 3 reflect the fact that Case 3's difficulties with anxiety were much more pervasive and chronic than for Cases 1 and 2, who had reported more sporadic difficulties.

Case 4 reported an increase in her anxiety after her first session. This was felt to be due to her reporting in the first session that she felt uncomfortable and unsure about attending the group and using mindfulness meditation as a new technique

In the subsequent sessions that she attended, she did not report an increase in her state anxiety, and after all but one of these sessions, she reported varying amounts of reduction in her state anxiety.

In summary, the results suggested that for each case overall, mindfulness meditation did have immediate benefits in terms of reducing their feelings of anxiety.

Level of state anxiety over the study period

Figure 2 shows the ratings of state anxiety for each case over the course of the study period.

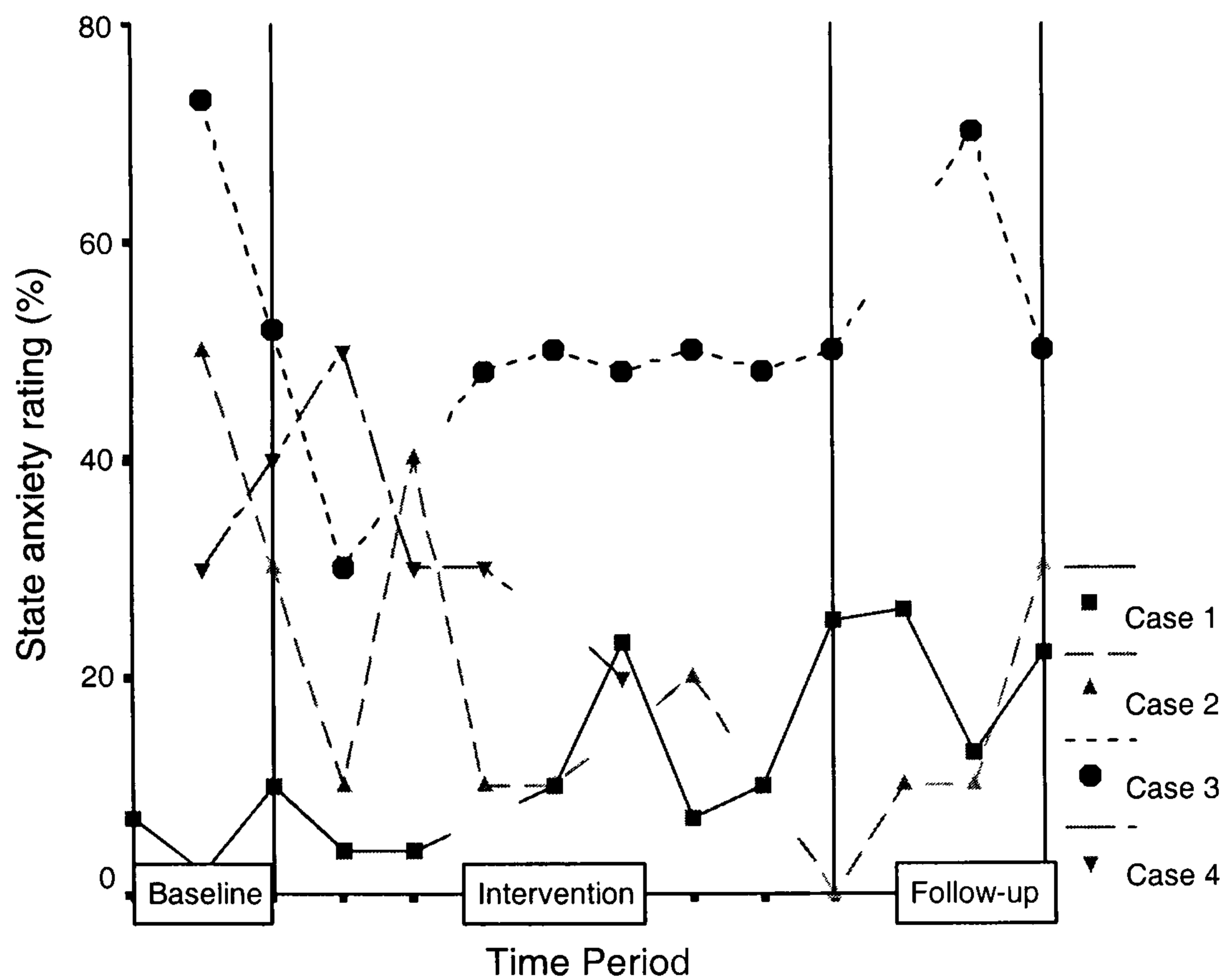


Figure 2.

Table 2 shows the mean ratings of state anxiety for each case.

State Anxiety Rating	Baseline	Intervention	Follow-up
Case 1	Mean: 6, sd: 4	Mean: 12, sd: 9	Mean: 20, sd: 7
Case 2	Mean: 40, sd: 14	Mean: 15, sd: 14	Mean: 17, sd: 12
Case 3	Mean: 63, sd: 15	Mean: 46, sd: 7	Mean: 60, sd: 14
Case 4	Mean: 35, sd: 7	Mean: 33, sd: 13	

Table 2.

The patterns of results differed considerably for each case with regards to their ratings of state anxiety over the study period. Case 1 showed low levels of state anxiety, which increased slightly over the course of the study. Case 2 showed fluctuating levels of state anxiety, which tended to decrease towards the end of the therapy programme. However, these gains were not maintained during the follow-up period, where her state anxiety showed a gradual increase. Case 3 initially showed a relatively high level of state anxiety, which decreased substantially during the baseline period and at the start of the therapy programme. However, her state anxiety level then increased slightly and then remained constant throughout the rest of therapy. The initial decrease in Case 3's anxiety may therefore have been due to the fact that joining the study had had a positive effect for her because it gave her expectations for change. During the follow-up period, Case 3's level of state anxiety did, however, increase sharply. She reported that this was due to her experiencing a difficult life event during that time, which had caused her anxiety and had affected her ability to practise mindfulness meditation techniques after the therapy programme had finished. Although Case 4's level of state anxiety increased during the baseline period and at the start of therapy, possibly due to the fact that she felt apprehensive about the intervention, her anxiety then began to decrease before she withdrew from the study.

In general, the results did not suggest any clear improvements in any of the cases' level of state anxiety over the therapy programme and at follow-up.

Frequency of symptoms of anxiety over the study period

No clear improvements were observed in any of the cases with regards to their reported frequencies of symptoms of anxiety over the course of the study period (see appendix 9).

Perceived control of anxiety and trait anxiety over the study period

Figure 3 shows changes in Cases 1, 2 and 3's perceived control over their anxiety, as measured by the Anxiety Control Questionnaire (ACQ), at the first baseline assessment and the last follow-up assessment.

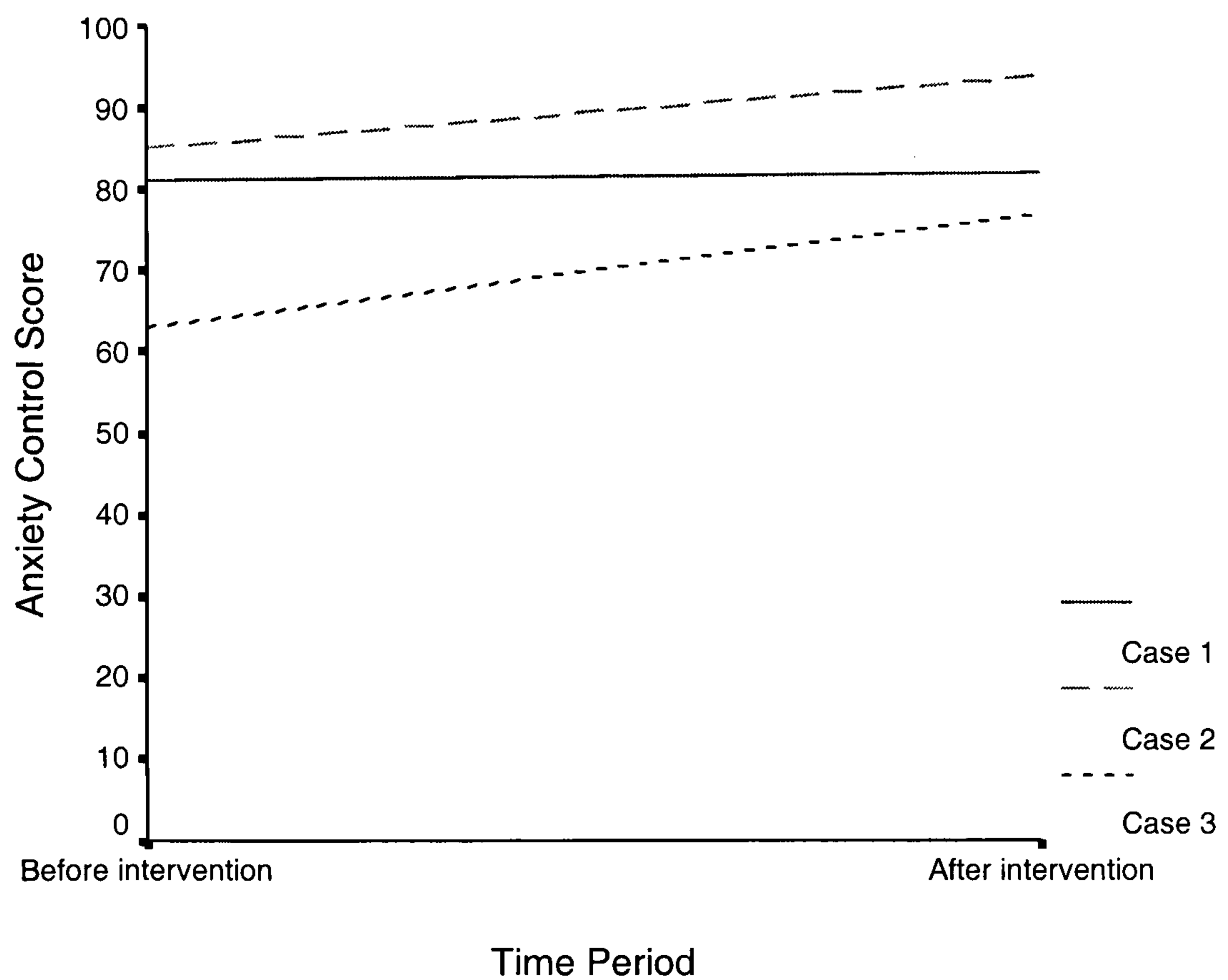


Figure 3.

There was a slight increase in Case 2 and 3's total scores on the ACQ over the course of the study period, suggesting that they showed a slight increase in their perceived control of their anxiety at follow-up as compared to before the therapy programme. Case 1's scores on the ACQ suggested that her perceived control of her anxiety remained constant over the course of the study.

It is possible, therefore, that the mindfulness meditation group therapy programme was effective in increasing two of the cases' perceived control over their anxiety.

Due to the fact that Cases 1 and 2 failed to fully complete the baseline measure of trait anxiety on the State Trait Anxiety Inventory (STAI), it was not possible to observe any changes for them on this outcome measure (see appendix 10).

Group Evaluation Questionnaire

All three cases who completed the Group Evaluation Questionnaire reported that they felt that they might have benefited from a few more group therapy sessions and that they would not have liked to have participated in larger group of patients. They also reported to have found it easier to learn and apply the meditation techniques as compared to the yoga that was taught. Individual subjective reports about the therapy programme included the following:

Case 1: This participant reported to have learnt and to be practising ways of dealing with anxiety using mindfulness meditation in her everyday life as a result of attending the therapy sessions. However, she felt that she needed further psychological help to deal with her specific anxiety episodes. In terms of her experience of therapy, she commented that she had not always found the dynamics within the group as being conducive to learning the meditation techniques.

Case 2: This participant reported to have learnt and to be practising mindfulness meditation when she felt nervous about driving. She also reported to have benefited from using mindfulness meditation in other life situations that were anxiety provoking. She felt, however, that she needed further psychological help to come to terms with her fear of driving.

Case 3: This participant reported to have had a good experience of therapy, although she also commented on having sometimes found it difficult to learn the meditation techniques on a group basis. She reported to find mindfulness meditation useful for controlling her feelings of anxiety. However, she reported to have found it particularly difficult to practise the meditation techniques outside of the group sessions and she did not feel that she had benefited in terms of dealing with her difficulties with worrying.

Discussion

The results of the current study suggest that for each of the four cases who took part, mindfulness meditation taught on a group basis had immediate benefits in terms of reducing their level of state anxiety. However, there were no clear patterns of improvement shown for any of the cases over the therapy period or at a five week follow-up in their general level of state anxiety or in the frequency of their symptoms of anxiety. Cases 2 and 3 did show a slight improvement in their perceived control over their anxiety at the five week follow-up as compared to before the therapy programme although these gains were minimal. It is possible, however, that mindfulness meditation does have a positive effect on perceived control over anxiety for patients who suffer from anxiety disorder.

In terms of the individual cases in the current study, there was some heterogeneity in their presentations. In particular, Case 3 reported to suffer from long-standing and pervasive difficulties with anxiety as compared to the other cases who reported experiencing more acute anxiety in specific areas of their lives which was of a much more recent onset. Case 3 also reported to have additional difficulties with depression. On the measures of state anxiety and symptom frequency, Case 3 consistently reported higher levels relative to the other cases in the study. Case 3 also differed from the other cases in that she reported to have experienced a difficult life event during the follow-up period of the study, which she felt restricted the potential benefits of the therapy programme and had affected her ratings on the follow-up measures.

Individual feedback after the therapy programme had finished, on the Group Evaluation Questionnaire, also yielded some interesting qualitative data with regards to firstly, the usefulness of mindfulness meditation for different types of anxiety difficulty; secondly, the design and monitoring of the therapy schedule; and thirdly, the issues involved in teaching mindfulness meditation on a group basis.

In terms of the areas in which mindfulness meditation was useful, it was interesting to note that Cases 1 and 2, who experienced anxiety in specific areas of their life, reported using and finding benefit from the techniques in their everyday life to combat general feelings of anxiety. Case 2 did report mindfulness meditation to be beneficial in reducing her feelings of anxiety when driving. However, both these cases felt that they needed further psychological intervention to help them come to terms with their specific episodes of anxiety. These results suggest, therefore, that for these cases, mindfulness meditation techniques were most usefully applied as general life coping strategies for anxiety. In terms of the clinical implications of using this type of intervention in the service in which this study was set, it would be important to collect further data on how useful mindfulness meditation techniques are for different types of anxiety difficulty.

Whereas Cases 1 and 2 reported to be regularly practising the mindfulness meditation techniques outside of the sessions, Case 3 reported that she had found this difficult to do. Furthermore, all three cases reported to find it more difficult to learn and regularly use the yoga that was taught in the sessions. Based on this feedback, it was felt that the therapy schedule was limited in two ways. Firstly, it appeared that teaching of the techniques might have been more effective if more focus had been given to ensuring that they were easier and more relevant to application in everyday life. Given the feedback from the cases in the study, it was also felt that meditation techniques might be more relevant and therefore effective than the yoga techniques. Secondly, the therapy schedule was seen to lack any systematic monitoring of practice of the techniques outside of the sessions, which could have been an important factor in improving the benefits of the techniques over the therapy and follow-up periods.

With regards to the therapy sessions themselves, it was interesting to note that all the cases reported that they would not have liked the group to be larger in participants than it was. Cases 1 and 3 also reported to find that difficult group dynamics sometimes prevented their achieving maximum benefit from the sessions. It is possible, therefore, that another factor that could have affected the results in the current study was the make-up of the personalities within the group itself. This raises the issue that if the group therapy programme was to be run on a regular basis within the service, it might be important to ensure less case heterogeneity than in the current group. However, this could be difficult to achieve given the large variation in referrals to the service. It would also not be possible to totally control for difficult group dynamics within the sessions. Furthermore, it could prove impractical for the service to run future groups with a maximum of only four participants due to the high number of referrals to the service. In general, it would be important to continue to evaluate any groups that were run at the service to weigh up the potential benefits of teaching mindfulness meditation on a group basis.

Summary and Conclusions

The current study provided evidence that teaching mindfulness meditation on a group basis with outpatients with anxiety disorder at an Adult Mental Health Clinical Psychology Service produced immediate benefits in their reported feelings of anxiety after each therapy session. There was a slight suggestion that the therapy programme may have also been effective in increasing participants' perceived control over their anxiety. The therapy programme was reported to be most useful for helping patients to develop further strategies to cope with their anxiety in everyday life with particular respect to using meditation techniques.

It was felt that due to the preliminary nature of the current study, it would be important to continue to run and evaluate further group therapy programmes of this kind run in the service before making further conclusions about the benefits of offering this intervention package to outpatients with anxiety disorder.

Based on the findings in the current study, when running future groups, it would be important to revise the therapy schedule to make it more focused on meditation techniques and on applying these techniques within everyday life. It would also be interesting to monitor participants' use of the techniques outside of the sessions more closely and to evaluate the potential benefits of this on their reported levels of state anxiety, symptoms of anxiety and perceived control over their anxiety. Finally, it would be interesting to evaluate the effectiveness of running the therapy programme with a less heterogeneous group of participants as compared to the current study. Conversely, it might also be interesting to evaluate the effectiveness of teaching mindfulness meditation techniques to outpatients with other types of mental health difficulty, for example, depression or obsessive compulsive disorder.

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APPENDICES

1. Participant Information Sheet
2. Consent Form
3. Participant Information Questionnaire
4. Weekly Anxiety Questionnaire
5. State Anxiety Rating
6. Group Evaluation Questionnaire
7. Schedule of Measures
8. Letter of Ethical Approval
9. Graphs for Frequencies of Symptoms of Anxiety
10. Graph of Trait Anxiety Scores

APPENDIX 1

INFORMATION ON THE MINDFULNESS MEDITATION GROUP THERAPY STUDY.

The current study involves research into the effectiveness of mindfulness meditation as a group therapy for individuals with anxiety problems, who have been referred to the psychology department in

As you have been referred to the psychology department, we would like to invite you to take part in this study.

Mindfulness Meditation

Mindfulness meditation is a type of meditation technique that involves learning to acknowledge and become more aware of personal experience. Practice of this technique has been shown to be helpful with anxiety problems.

What the study involves

The study will involve attending eight weekly 1¼ hour-long group sessions of therapeutic mindfulness meditation. During these sessions you will have the opportunity to learn, discuss and practise the techniques of mindfulness meditation in relation to your anxiety difficulties. The number of people attending the group will be between 4 and 10.

The group sessions will be held at ..., and will run **every ... at** The first session will be held on

As part of the study we will also ask you to complete a number of short questionnaires related to your experience of anxiety on three occasions in the weeks leading up to the therapy programme, at the start and end of each therapy session and on three occasions after the therapy programme has finished. This is so we can evaluate the effectiveness of the therapy programme.

Five weeks before the start of the therapy programme we will send you these questionnaires and ask you to complete them and send them back to us as soon as possible in a pre-paid envelope. We will then ask you to do the same again three weeks before the start of the therapy programme.

We will then ask you to attend a twenty minute assessment session at North Place one week before the start of the therapy programme. During this session, you will meet with ..., Clinical Psychologist in Training, who will ask you to complete some more questionnaires. You will then be invited to attend another twenty minute assessment session at North Place one week after the therapy programme has finished. Once again, you will meet with ... and you will be asked to complete some questionnaires.

Then, three weeks after the therapy programme has finished, we will once again send you some questionnaires and ask you to complete them and send them back to us as soon as possible in a pre-paid envelope. Finally, we will ask you to do the same again five weeks after the therapy programme has finished.

In all, therefore, we will ask you to attend ... on **ten occasions** over a period of **ten weeks**.

Therapeutic Procedures

The group therapy programme will be run by ..., Clinical Psychologist. During the eight weekly group therapy sessions, you will have the opportunity to learn mindfulness meditation, which includes breath meditation, yoga meditation and body awareness. In between the sessions you are required to practice the techniques for about 20 minutes per day for a minimum of 5 times per week. An audiotape will be provided to help you with this.

During your last assessment session, after the therapy programme has finished, you will have an opportunity to receive individual feedback on your progress in the group, and to ask any questions you may have.

Participation

Participation in this study is entirely voluntary and if you decide not to take part, this will not affect your current or future treatment. You will also be free to withdraw from the study at any stage, without giving a reason, and this will also not affect your current or future treatment in any way.

After the course has finished you will be offered further individual psychology sessions if/when required.

Confidentiality

All identifying information you give out in relation to the assessment will be treated as privileged and confidential and will not be used for any other purpose other than research analysis. We will, however, write a standard letter to your GP at the end of your contact with the psychology department summarising your progress in therapy but not drawing on any of the information you gave for research purposes.

Contact Names and Addresses

If you have any inquiries, you can contact the following people:

...,

Clinical Psychologist

(Address)

Tel.no: ...

...

Clinical Psychologist in Training

(Address)

Tel no: ...

APPENDIX 2

MINDFULNESS MEDITATION GROUP THERAPY STUDY – CONSENT FORM

1. Explanation of the Programme

You will be asked to attend 8 weekly sessions of group based therapy involving learning and practising mindfulness meditation techniques for dealing with anxiety problems. You will also be asked to attend two 20 minutes assessment sessions one week before and one week after the group therapy programme. Finally, you will be sent and asked to complete a number of short questionnaires five weeks and three weeks before the therapy programme and three weeks and five weeks after the therapy programme. A clinical psychologist will facilitate the group sessions. A clinical psychologist in training will carry out the assessments.

2. Assessments

The assessments will consist of:

- a)* A questionnaire asking you to monitor your anxiety over the period of the study which you will be asked to complete at all the times specified above (including at each therapy session).
- b)* A general rating of your anxiety level which you will be asked to do at all the times specified above (including at each therapy session).
- c)* A questionnaire asking you about your general experience of anxiety and a questionnaire asking you about your feelings of control over your anxiety, both of which you will be asked to complete once before the therapy programme and once after the therapy programme.
- d)* A questionnaire asking you about your general health and life situation which you will be asked to complete at the first stage of the study.
- e)* A questionnaire asking you to give your views on the therapy programme which you will be asked to complete in the assessment session one week after the therapy programme.

3. Benefits to be expected

Mindfulness meditation is increasingly being recognised as a useful tool in the treatment of psychological and emotional difficulties. Evidence suggests that participation in a group programme for people with anxiety difficulties may help coping more effectively with the symptoms of anxiety and the effects of anxiety on general functioning in day-to-day life.

4. Responsibilities of the Participants

- a) to attend eight 1¼ hour group sessions
- b) to practice a meditation tape in between sessions for at least 5 times per week
- c) to attend two 20 minute pre and post assessment sessions
- d) to return postal assessment questionnaires, twice before the group starts and twice after the group has finished

5. Confidentiality

Any information that is obtained for assessment purposes will be treated as privileged and confidential. The information obtained will be used for statistical analysis of the group effectiveness with your right to privacy retained. At the end of your contact with the psychology department, we will write a standard letter to your GP summarising your progress in therapy.

6. Inquiries

Any questions about the programme are welcome. If you have any doubts or queries, please contact us for further explanation.

7. Freedom of Consent

Your decision to engage in this study is voluntary and if you decide not to take part, this will not affect your current or future care. You are free to deny consent if you wish to, now or at any time in the future, again without this affecting your treatment here.

8. Continued psychological care

After completion of the group session further individual psychological treatment will be offered to you.

I acknowledge that I have read this form in its entirety or had it read to me and I understand the purpose of the study in which I will be engaged. I accept my responsibilities as participant as outlined above. Knowing these and having had an opportunity to ask questions which have been answered to my satisfaction, I consent to participate in this study.

Signature of Participant _____ Date: _____

APPENDIX 3

PARTICIPANT INFORMATION QUESTIONNAIRE

Name:.....

Date:.....

Participation in the group therapy programme involves commitment to attending ten weekly sessions over a ten week period and practising techniques at home over the therapeutic period. Therefore, we would ask you to think about whether participating in this study would fit into your current lifestyle (e.g. if you are currently experiencing a major life event, this type of therapy may not be suitable for you at this present time).

If you would like to participate in the group therapy programme, please would you take the time to answer the following questions. The information you give will enable us to cater for your needs throughout the programme.

1. Are you currently taking any medication? If so, please state the type and dose.

2. Do you have any physical health problems? If so, please give details.

3. Do you suffer from pain and/or joint problems?

4. Have you received treatment for mental health related difficulties in the past? If so, please give details.

5. Have you been through any major life changes that are still currently relevant for you? Please give details.

6. Have you practised and/or read about meditation or yoga in the past? If so, please give details.

7. What are your expectations of the group therapy programme?

APPENDIX 4

WEEKLY ANXIETY QUESTIONNAIRE

Name:.....

Date:.....

Session Number:.....

Instructions:

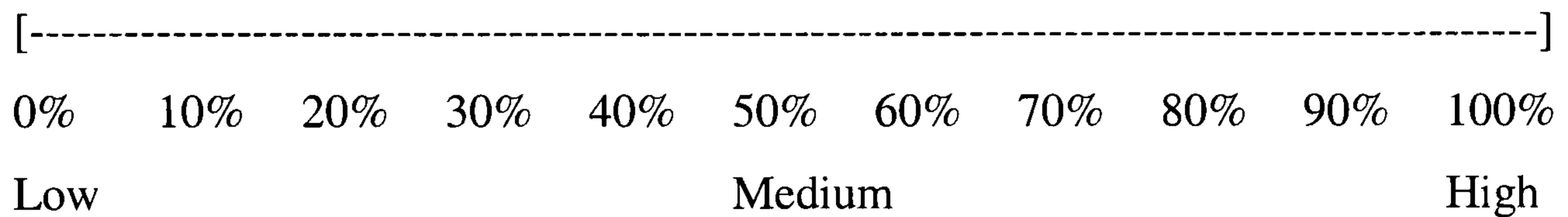
Please indicate how often you have experienced each of the following symptoms during the *past week including today* by choosing one of the responses shown and marking the box above it.

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Fear of the worst happening.	Not at all	Less than 2 times/ week	2-4 times/ week	5-8 times/ week	Over 8 times/ week
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Fear of losing control	Not at all	Less than 2 times/ week	2-4 times/ week	5-8 times/ week	Over 8 times/ week
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Fear of not being able to cope.	Not at all	Less than 2 times/ week	2-4 times/ week	5-8 times/ week	Over 8 times/ week

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Avoided stressful situations.	Not at all	Less than 2 times/ week	2-4 times/ week	5-8 times/ week	Over 8 times/ week

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Feelings of nervousness and/or physical sensations as a result of anxiety.	Not at all	Less than 2 times/ week	2-4 times/ week	5-8 times/ week	Over 8 times/ week

Please rate generally the level of intensity of symptoms of anxiety that you experienced *over the past week including today* by placing a cross on the line below.



Did any of the following events/situations affect your feelings of anxiety in the last week?

Stress at work	Yes	No
Relationships	Yes	No
Health	Yes	No
Medication	Yes	No
Home life	Yes	No
Other (please state below)	Yes	No

APPENDIX 5

STATE ANXIETY RATING

Name:..... Date:..... Session Number:.....

Please rate the degree to which you are experiencing anxiety *right now* by placing a cross on the line below.

[-----]
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Not at all. Moderately so. Very much so.

APPENDIX 6

GROUP EVALUATION QUESTIONNAIRE

Thank you for taking the time to complete this questionnaire. The information collated will assist in our review of the group and help plan future groups.

Name:..... Date:.....

1. Please rate the following aspects of the group:

- Information provided prior to the group. Excellent Good Satisfactory Poor Unsatisfactory

- Time that the group was held. Excellent Good Satisfactory Poor Unsatisfactory

- Number of sessions. Excellent Good Satisfactory Poor Unsatisfactory

- Length of group (i.e. 1¼ hours) Excellent Good Satisfactory Poor Unsatisfactory

- Format of sessions. Excellent Good Satisfactory Poor Unsatisfactory

Comments:

2. Did attending the group change the way you experience and/or manage your anxiety?
Please give details.

3. Did the group meet your expectations? Yes No Unsure

Please comment.

4. What did you find most useful about attending the group?

5. What did you find least useful about attending the group?

6. Do you still feel the need to continue with individual psychology sessions? Yes No Unsure

7. Any other comments.

APPENDIX 7

Baseline 1 (By post 5 weeks before therapy)	Baseline 2 (By post 3 weeks before therapy)	Baseline 3 (Assessment session 1 week before therapy)	Intervention 1 (1 st weekly group therapy session)	Intervention 2 (2 nd weekly group therapy session)	Intervention 3 (3 rd weekly group therapy session)	Intervention 4 (4 th weekly group therapy session)	Intervention 5 (5 th weekly group therapy session)	Intervention 6 (6 th weekly group therapy session)	Intervention 7 (7 th weekly group therapy session)	Intervention 8 (8 th weekly group therapy session)	Follow-up 1 (Assessment session 1 weeks after therapy)	Follow-up 2 (By post 3 weeks after therapy)	Follow-up 3 (by post 5 weeks after therapy)
STAI	Weekly anxiety quest.	Weekly anxiety quest.	Start of session: Weekly anxiety quest	Start of session: Weekly anxiety quest	Start of session: Weekly anxiety quest	Start of session: Weekly anxiety quest	Start of session: Weekly anxiety quest	Start of session: Weekly anxiety quest	Start of session: Weekly anxiety quest	Start of session: Weekly anxiety quest	Weekly anxiety quest	Weekly anxiety quest	STAI
ACQ	Level of state anxiety	Level of state anxiety	Start of session: Level of state anxiety	Start of session: Level of state anxiety	Start of session: Level of state anxiety	Start of session: Level of state anxiety	Start of session: Level of state anxiety	Start of session: Level of state anxiety	Start of session: Level of state anxiety	Start of session: Level of state anxiety	Level of state anxiety	Level of state anxiety	ACQ
Weekly anxiety quest.			End of session: Level of state anxiety	End of session: Level of state anxiety	End of session: Level of state anxiety	End of session: Level of state anxiety	End of session: Level of state anxiety	End of session: Level of state anxiety	End of session: Level of state anxiety	End of session: Level of state anxiety	Group therapy evaluation questionnaire		Weekly anxiety quest.
Level of state anxiety													Level of state anxiety

APPENDIX 8

Dear ,

Re: : An investigation into the effectiveness of mindfulness meditation as a group therapy programme for outpatients with anxiety disorder

I am pleased to advise you that at a sub-committee meeting on 4th September 2002 your application for approval of the above research was approved.

The Committee will look forward to receiving an annual report and a copy of the results of your research when it is completed.

Yours sincerely

Administrator -

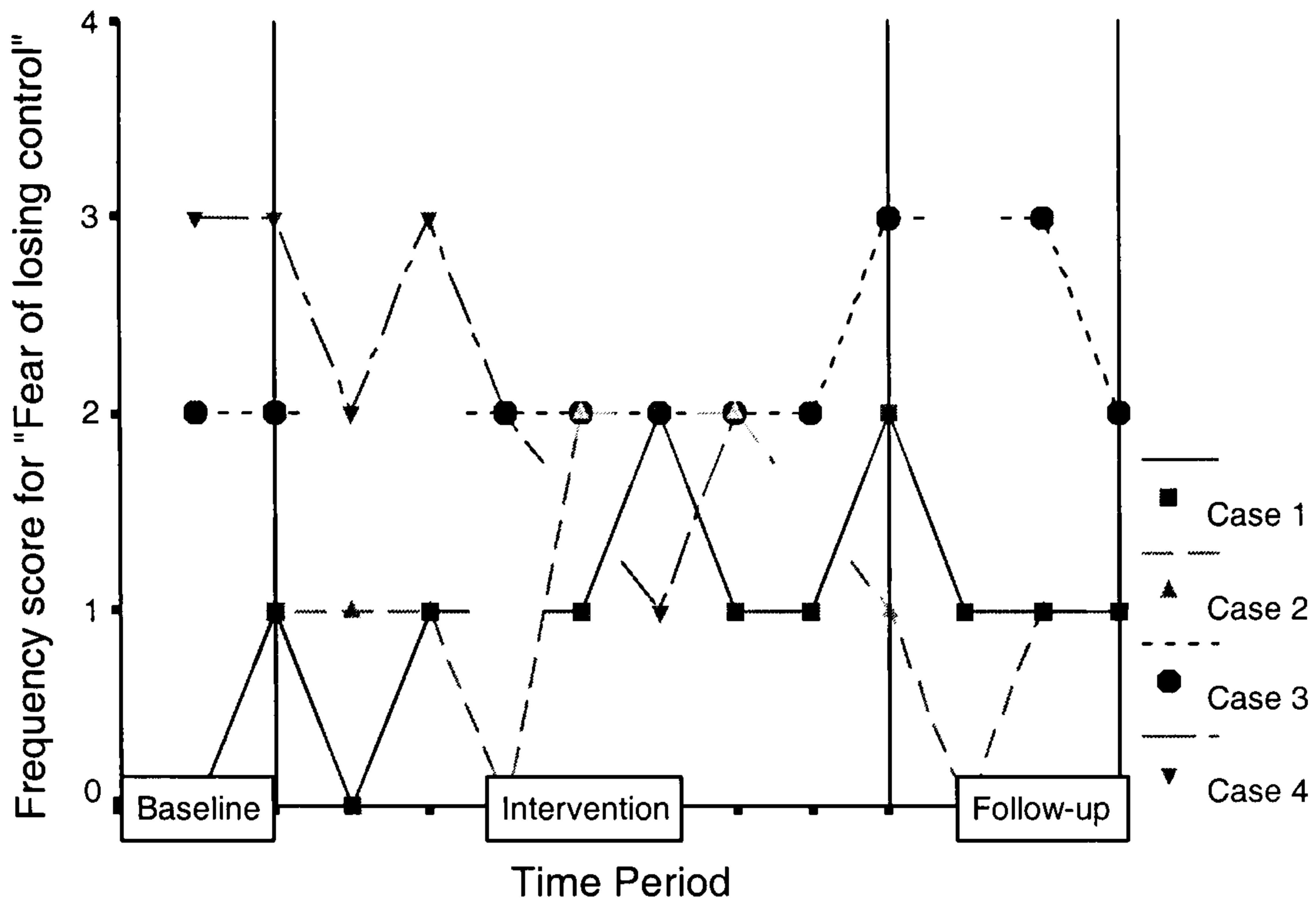
LREC

cc

R & D,

APPENDIX 9

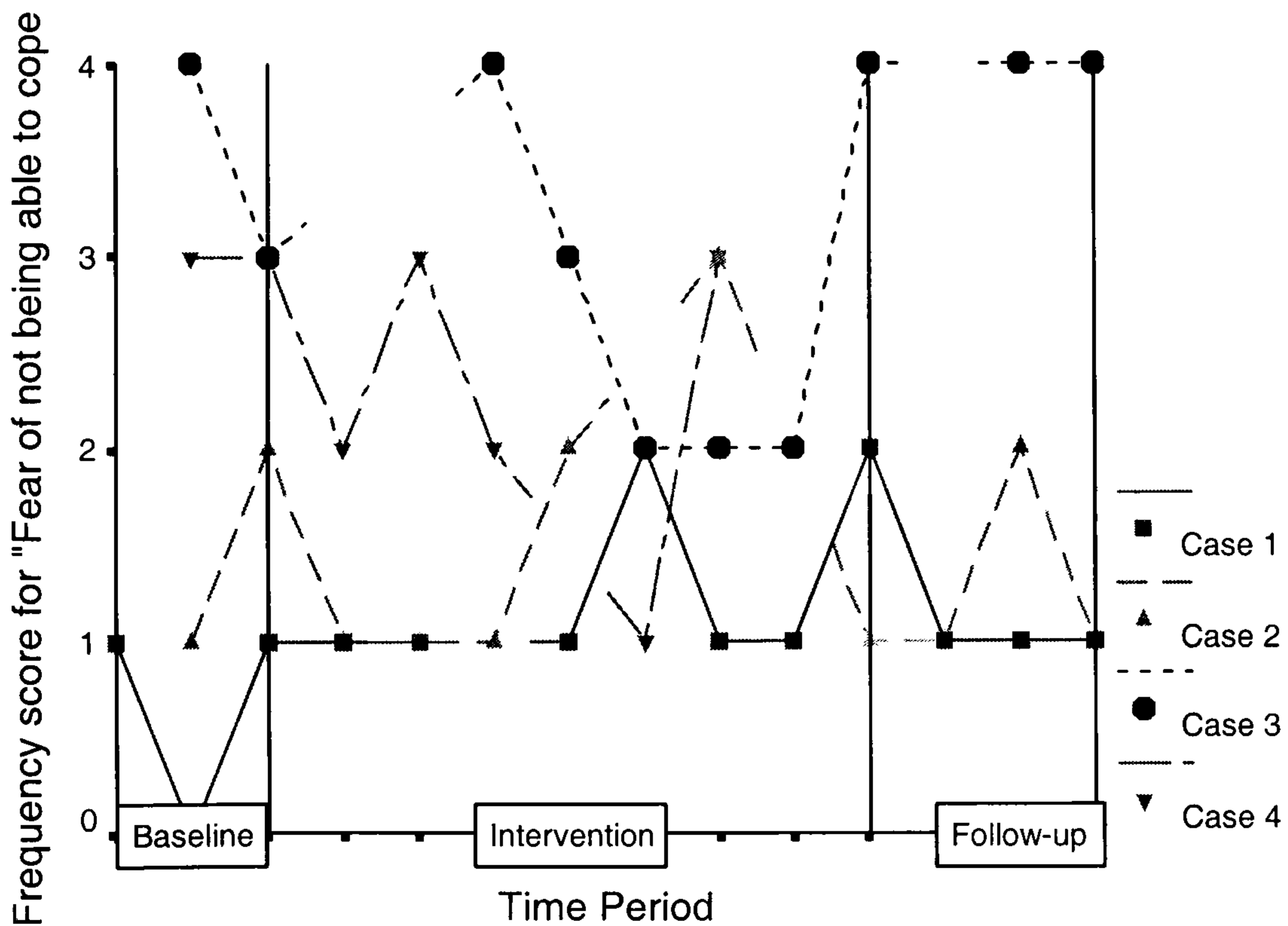
Reported frequencies of "Fear of losing control" symptom



0 = Not at all; 1 = Less than twice/week

2 = 2-4 times/week; 3 = 5-8 times/week; 4 = >8 times/week

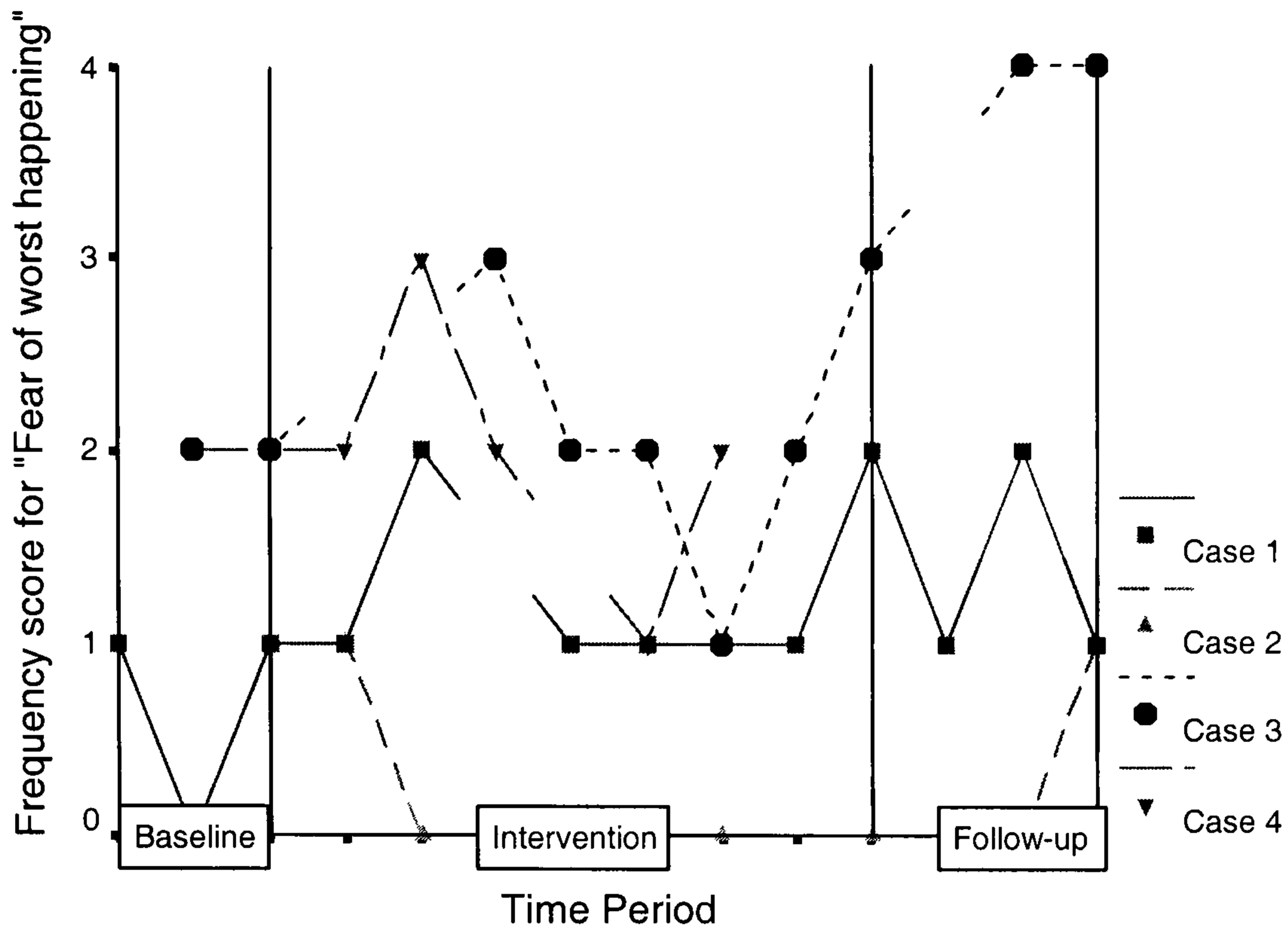
Reported frequencies of "Fear of not being able to cope" symptom



0 = Not at all; 1 = Less than twice/week

2 = 2-4 times/week; 3 = 5-8 times/week; 4 = >8 times/week

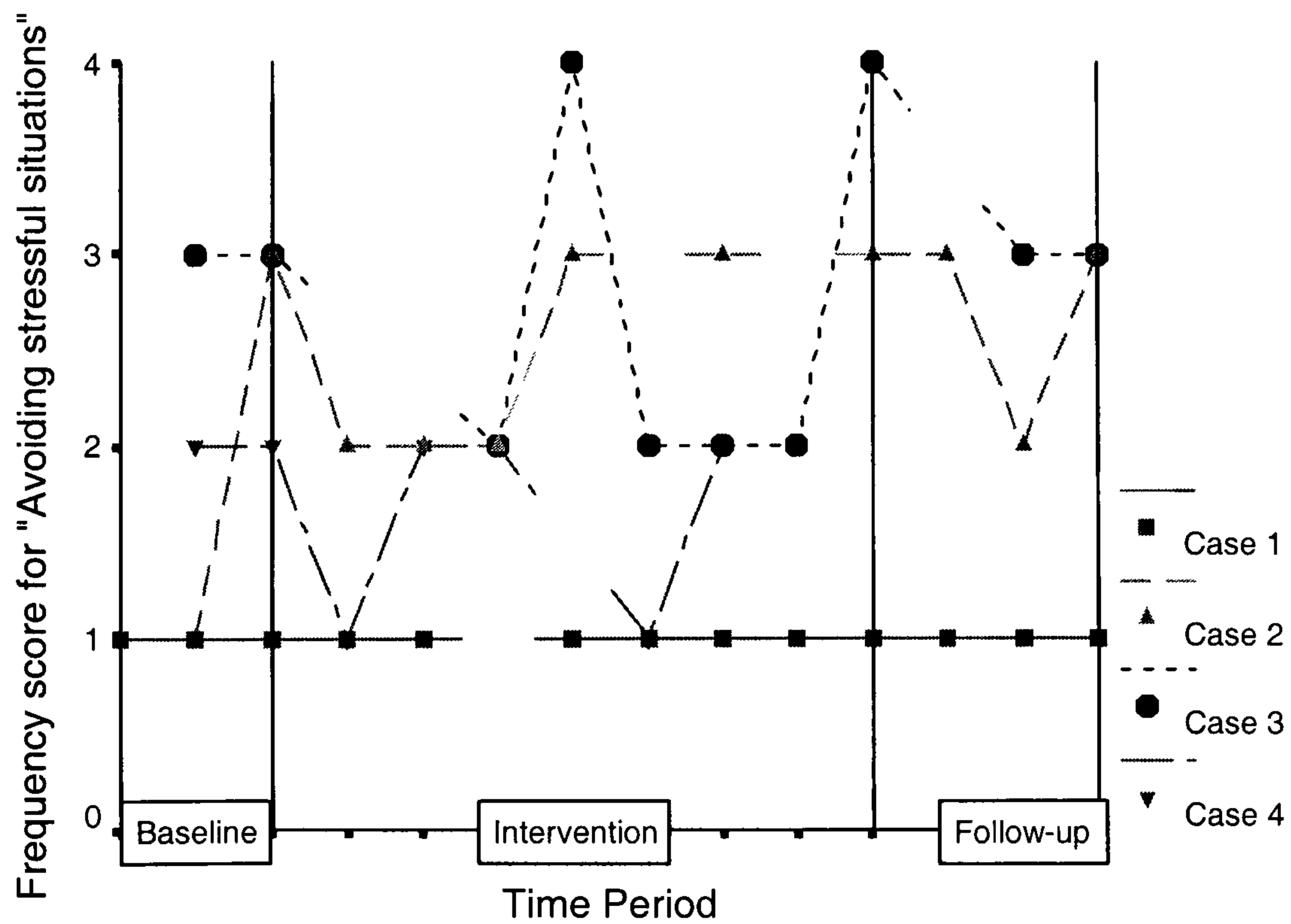
Reported frequencies of "Fear of the worst happening" symptom



0 = Not at all; 1 = Less than twice/week

2 = 2-4 times/week; 3 = 5-8 times/week; 4 = >8 times/week

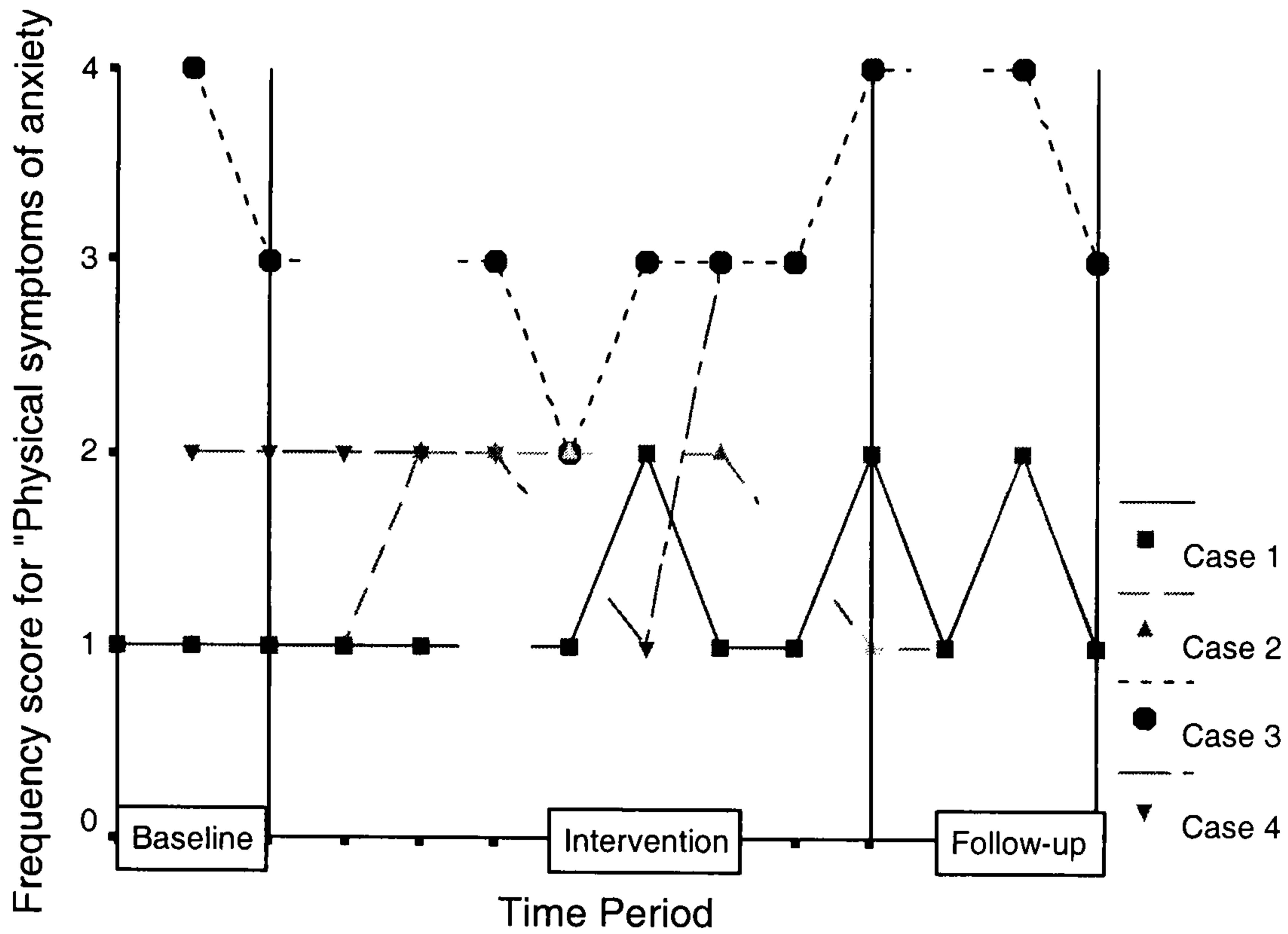
Reported frequencies of "Avoidance of stressful situations" symptom



0 = Not at all; 1 = Less than twice/week

2 = 2-4 times/week; 3 = 5-8 times/week; 4 = >8 times/week

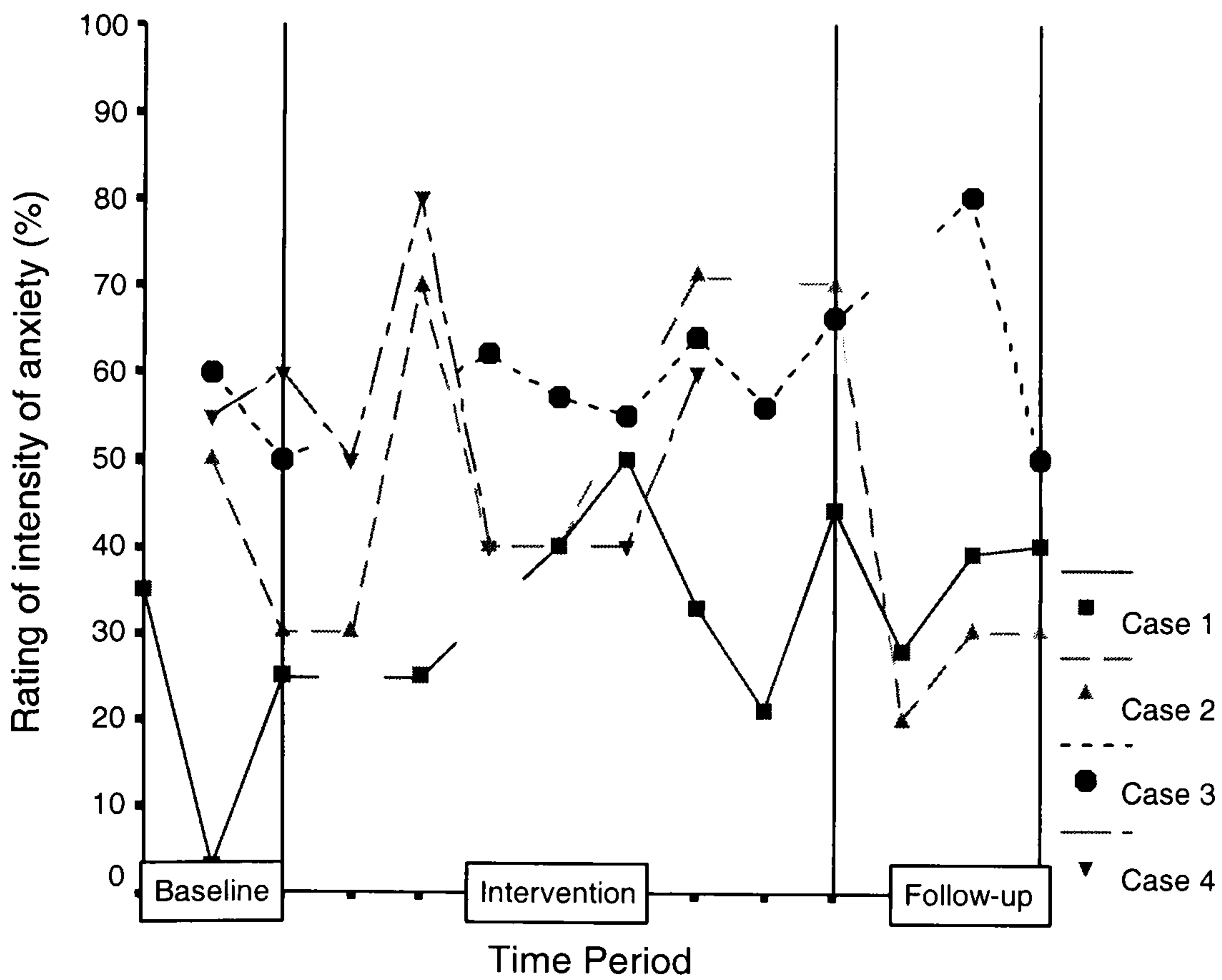
Reported frequencies of "Feelings of nervousness/physical sensations of anxiety" symptom



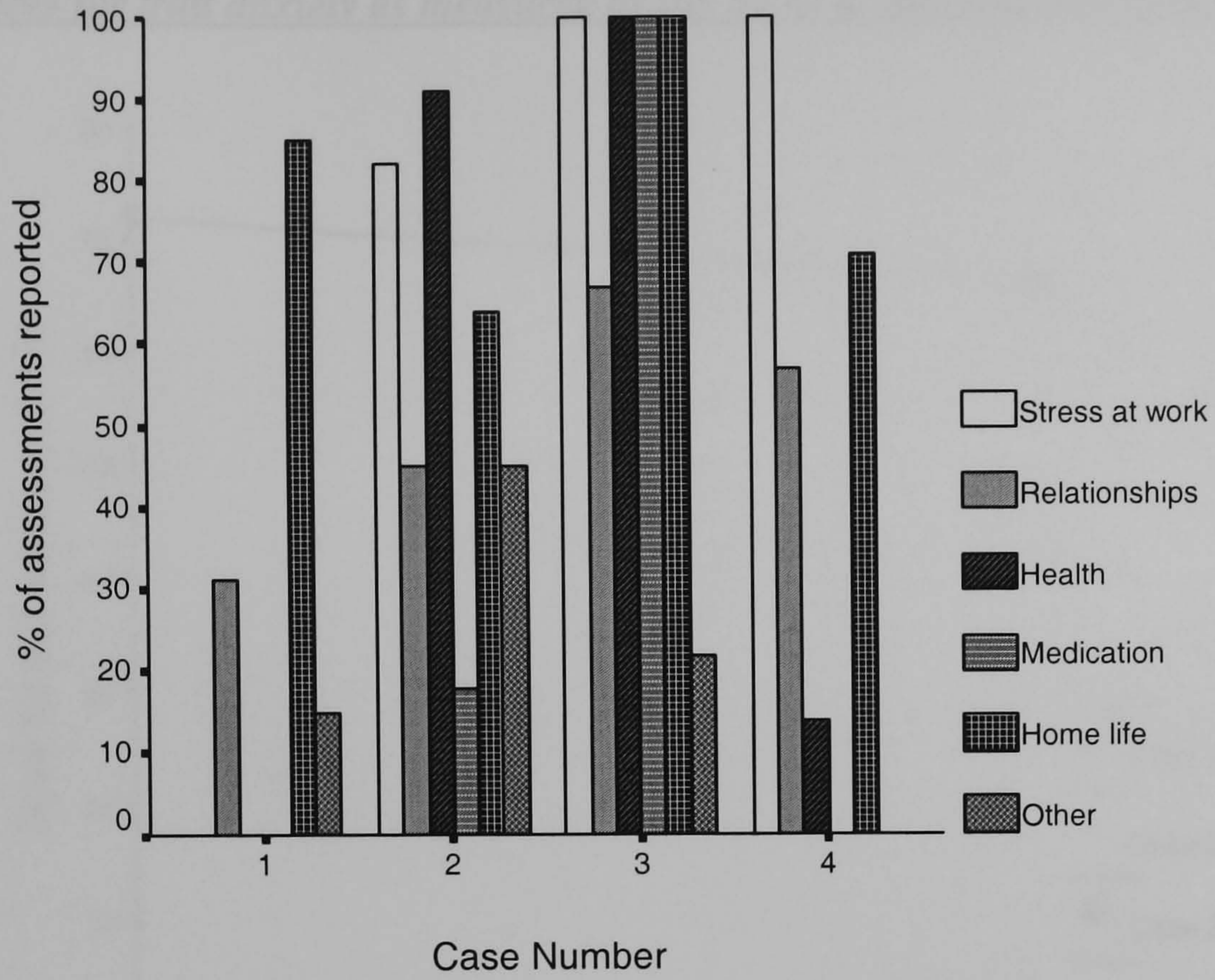
0 = Not at all; 1 = Less than twice/week

2 = 2-4 times/week; 3 = 5-8 times/week; 4 = >8 times/week

Reported ratings of intensity of anxiety symptoms

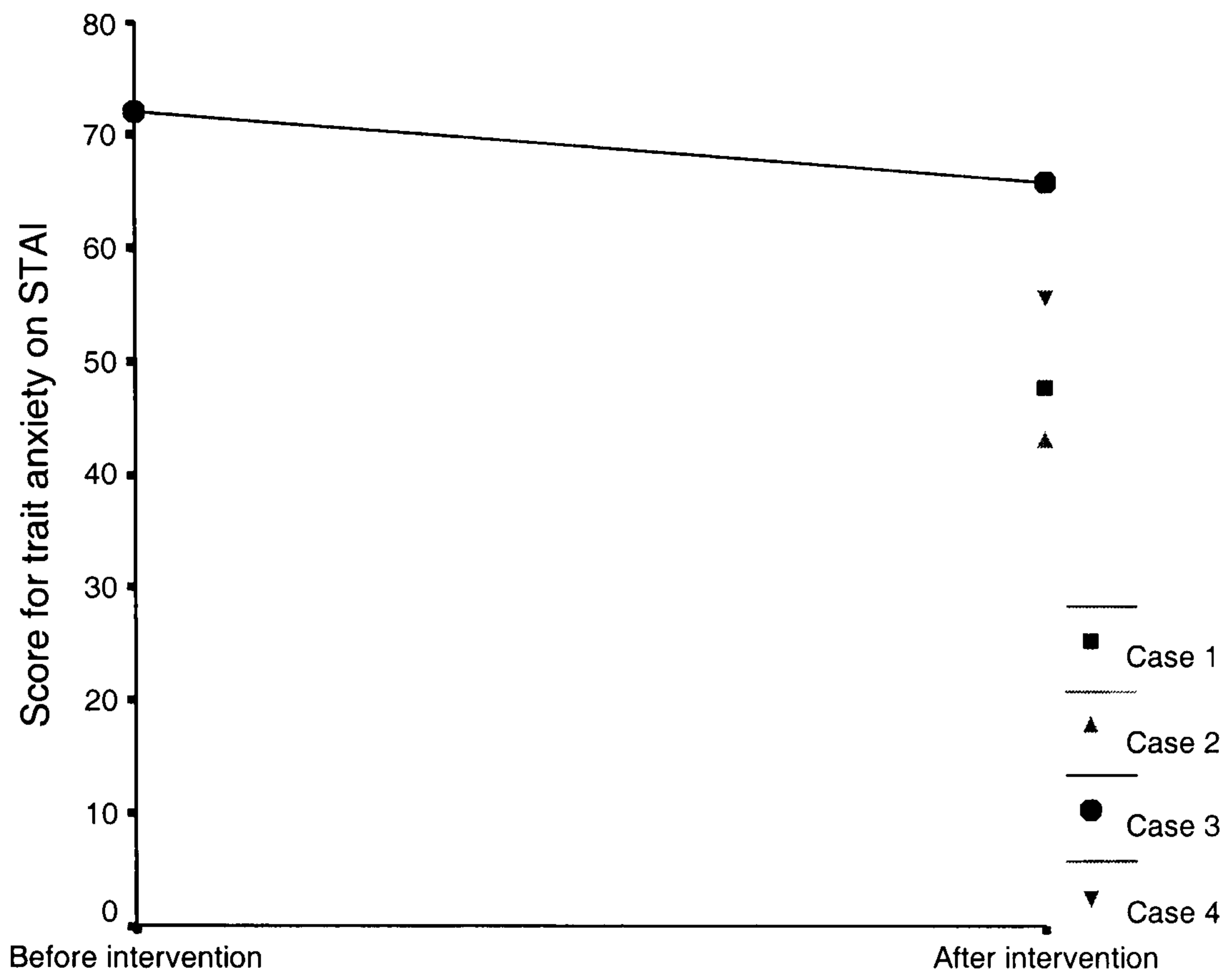


Percentage of assessments that each case reported different life situations to be causing anxiety



APPENDIX 10

Scores for trait anxiety as measured by the STAI at baseline and follow-up



LITERATURE REVIEW

Name: Joanna Mary

Date: January 2003

Year: 2

Title: Foster care, the experiences of foster carers and the psychological and emotional needs of children in their care.

Introduction

There is evidence throughout history of children being looked after or “fostered” by people/families other than their natural parents who were unable to bring them up themselves (see Triseliotis, Sellick and Short, 1995). However, foster care did not become a formal legally-sanctioned process in the UK until the implementation of the Children Act in 1948. At that time, foster care was predominantly long-term in nature, reflecting the idea that children who had experienced adverse family conditions should be removed from their situations permanently to “substitute” parents. Since that time, in keeping with the changing ideologies surrounding child care policy and practice, the nature of foster care and foster carers’ roles in the UK have changed. Recent government initiatives, such as the 1989 Children Act (Department of Health, 1989), have reflected the prevailing ideology that children are best off with their biological parents, except in extreme adverse circumstances. Therefore, foster carers are now expected to provide a family for a child, but at the same time encourage contact with their biological parents with the aim of returning them back to their biological parents if this is appropriate. Furthermore, it is widely recognised that children under local authority care (“looked after” children) remain one of the most vulnerable groups in society to developing emotional and psychological difficulties (e.g. Minnis and Del Priore, 2001). The role of foster carers may, therefore, include helping the child cope with these difficulties.

Currently, there are several different forms of foster care placements in the UK, including short term care (intended to be less than three months in duration with the aim of re-unifying the child with their natural family), long term/permanent care (for children who are not able to return to their natural family and who, therefore, require a permanent alternative family home) and relative care (in which a relative of the child/children takes on the role of foster carer). In addition, some foster carers are contracted to provide specialist care to children with specific special needs (e.g. learning difficulties, severe emotional and behavioural problems) and others still have the role of “teen carer”, providing care for adolescents.

In November 1998, the Department of Health introduced a major programme, “Quality Protects” (Department of Health, 1998b) which was designed to improve the quality and management of social services for children in England. Among its plans, to be carried out over a period of six years, were specific aims and objectives for improving the well-being and development of looked after children. As a result of this initiative, more funding is currently being given to agencies working with looked after children than ever before with an emphasis on promoting and meeting the needs of this group. Foster carers, therefore, play a central role in the implementation of these policies.

The current review focuses on the emotional and psychological needs of looked after children and on the role that foster carers play in relation to this. The review, therefore, aims to firstly evaluate what is known about the emotional and psychological difficulties that looked after children experience. This is followed by a discussion of the areas of foster care that research has traditionally focused on. Finally, the review aims to assess what is known about the experiences of foster carers and the types of support they require, with the aim of identifying any current gaps in this area.

Emotional and psychological difficulties in looked after children

It is widely known that many children who enter local authority care will have experienced a number of adversities, which could make them vulnerable to developing emotional and behavioural problems.

For example, a study by Bebbington and Miles (1989), on examining the backgrounds of their sample of children in care, found that a high proportion came from families with low incomes, and had lived in disadvantaged areas. In addition, they also found that many of the children had experienced marital distress within their families, and had lived within large families in overcrowded conditions. Each of these factors have been shown generally to make children vulnerable to psychiatric disturbance (e.g. Rutter, 1989).

Several studies have also shown that, prior to their entering care, many looked after children experience neglect and abuse (e.g. Benedict et al, 1996; Lawder et al, 1986; Rowe et al, 1984). A study by Ball et al (1991) found that two thirds of their sample of looked after children had been either physically or sexually abused. More recent studies have found higher rates of abusive experiences in their samples of looked after children prior to entering care (e.g. Minnis and Devine, 2001). The detrimental effects that abuse and neglect can have on different aspects of a child's emotional well-being and development have been well documented (e.g. Garborino, Guttman and Seeley, 1986; Brassard, Hart and Hardy, 1993; Claussen and Crittenden, 1991). Work from attachment theorists (e.g. Cicchetti and Toth, 1995) has been particularly useful in this area as it highlights how abusive and neglectful parenting can hinder a child's ability to develop secure attachments in early life. This then effects their emotional and cognitive development, and their ability to make and sustain relationships with others in later life.

In addition to children's experiences before entering care, some researchers have focused on the effect of entering foster care on a child's emotional well-being. In their study of foster children who were unable to return to their biological families, Dance, Rushton and Quinton (2002) highlighted how feelings of rejection from their biological parents could be invoked in children who enter care. Studies into the effects of parental rejection have shown this type of experience to be associated with emotional unresponsiveness, hostility or aggression, poor self-esteem and emotional instability in the child (e.g. Rohner, 1986). Furthermore, a child's experiences of rejection may be repeated if their foster care placement breaks down.

To date, there are a number of major, systematic studies that have examined the emotional and psychological difficulties that looked after children show. McCann et al (1996) investigated the prevalence and type of psychiatric disorder in adolescents (aged 13-17 years) being looked after by one local authority in England. In comparison to a control group, the looked after adolescents showed a significantly higher prevalence of psychiatric disorders.

Within the looked after sample, 57% of those who were in foster care were shown to have psychiatric disorders, the most common being conduct disorder. The rates of psychiatric disorder for children in residential care in this study were higher (96%). Furthermore, a high proportion of the looked after sample were reported to show co-morbidity and some were found to have been suffering from severe disorders, such as major depression, that had been undetected.

Dimigen et al (1999) carried out a study in Scotland aimed at gaining information about the frequency and severity of mental health problems in children (aged 0-18) entering local authority care. In this study, about half the children showed considerable emotional and behavioural problems. Adolescents were reported to show more problems than younger children and boys showed more problems than girls. Similar to McCann et al's study, children in residential care showed more problems than those in foster care; in general, high rates of conduct disorder were found and a high proportion of those with difficulties had not received psychological help.

Another Scottish study by Minnis et al (2001) assessed the emotional and behavioural problems of children in foster care as part of a randomised controlled trial of a training programme for foster carers. Children were also assessed for the presence of attachment disorder symptoms in this study. 60% of children from this study were found to show emotional and behavioural problems, a high proportion of which were with conduct and hyperactivity. They were also shown to have significantly more attachment disorder symptoms and significantly lower self-esteem than a control sample of children.

Finally, a recent study investigating the mental health needs of all looked after children over the age of 11 in a London borough (Beck, 2002, personal communication) found 30% of their sample to have a "probable" psychiatric diagnosis, and there was a high prevalence of conduct disorder within this. Furthermore, children who had moved placement three/more times within the preceding year were found to be three times more likely to have a conduct disorder than the other looked after children.

In general, despite the fact that each of the above four studies used different assessment measures and questionnaires, they provide consistent evidence of a higher prevalence of emotional and behavioural difficulties in looked after children than that of the general population. Future directions for research in this area are cited as being further investigation of the types of emotional and behavioural difficulties experienced by looked after children, and how these are related to previous experiences prior to and during care. Furthermore, the studies recognise the need for more detailed investigation of how child and adolescent mental health services are utilised by looked after children and the effects of this (Minnis and Del Priore, 2001).

Given that many looked after children experience difficult histories and complex problems, the expectations on foster carers, particularly those looking after children for whom attempts to reunify them back to their biological parents have failed, are high. The remainder of this review, therefore, focuses on research into the nature of foster care, beginning with an overview of the history of this research.

History of research into foster care in the UK

The first major collation of research studies into foster care in the UK was by Prosser (1978). Foster care at that time was mostly focused on providing a substitute family for children under the care of the local authority and the research that had been done up to that time reflected that ideology. Berridge (1997) highlights a number of gaps in the research at the time of Prosser's review, for example, a lack of studies focusing on the children's biological family and background, very limited official statistics on children in foster care and foster care placements, a lack of information about the recruitment, support and retention of foster carers, and very little qualitative research into the experiences of either the foster carers or the children being fostered.

The next major review of research into foster care in the UK was by Berridge (1997) who evaluated studies that had been conducted in the twenty years since Prosser's review. In his review, Berridge identified thirteen major studies on foster care over that time, amongst other smaller scale studies. A large proportion of these studies were focused on outcomes of foster care and factors leading to successful/failed placements, reflecting the ideologies in the 1980s around accountability and demonstrating effectiveness. Research on outcomes in foster care have also been reviewed by Triseliotis (1989) and more recently by Minty (1999) who focused specifically on long-term foster care.

Research on outcomes in foster care

Reviews into the research on outcomes in foster care have highlighted how studies have progressed over the years in terms of the level of sophistication in their methodology and sampling techniques (see Minty, 1999). For example, earlier outcome studies used measures such as social workers estimations of how much their objectives for placements had been met. In a study by Rowe, Hundleby and Garnett (1989), social workers were asked to rate the placements investigated as either "very helpful", "fairly helpful" or "unhelpful". They found that over half the placements were rated as "very helpful" and only 3% of the placements were rated as "unhelpful". Similarly, a study by Berridge and Cleaver (1987) found social workers to rate 63% of the placements investigated as satisfactory. However, the measures used in these studies could be questioned for their validity, meaning that the findings should be viewed with some caution.

Other studies have focused on whether placements have succeeded or failed by measuring failure in terms of the length of time the placement lasted. For example, early studies of long-term foster care, that viewed placements that had ended earlier than five years to have failed, reported breakdown rates of between 40% and 50% (George, 1970; Parker, 1966; Trasler, 1960).

More recently, studies have found differences in breakdown rates between authorities in the UK. For example, Berridge and Cleaver (1987) found the breakdown rate in a county authority to be 46% as compared to a rate of 20% in a London borough. However, these differences were reported to be due to the variations in the two samples of children (i.e. the children in the London borough sample were of a younger age as compared to the county authority sample) as opposed to differences in the organisational structures between the two authorities. Furthermore, the use of placement breakdown as a key criterion for outcome fails to acknowledge that even placements that have broken down may still have helped the child whereas placements that have continued may not necessarily be enriching for the child (Minty, 1999).

Despite the lack of clarity provided in these studies, research evidence about the factors related to outcome in foster care has revealed a number of patterns.

In terms of factors related to foster children's characteristics, research reviews indicate that there is no difference in outcomes for girls and boys (e.g. Berridge, 1997). However, there is consistent evidence that foster care is more successful for younger children as opposed to adolescents (e.g. Baxter, 1989; Rowe, Hundleby and Garnett, 1989; Scottish Office, 1991, 1988). Furthermore, behavioural problems shown by foster children have been related to a greater likelihood of placement breakdown. For example, Rowe, Hundleby and Garnett (1989) found an association between unmanageability and stealing in children and placement breakdown, and Fratter et al (1991) reported conduct problems to be associated with placement instability. Prior experience of sexual abuse in the child is also thought to possibly be associated with a greater likelihood of placement breakdown (Triseliotis, Sellick and Short, 1995). Finally, some research evidence has shown greater placement success to be associated with the child being placed with their siblings (e.g. Staff and Fein, 1992; Triseliotis, 1989).

A number of factors related to characteristics of foster carers have also been found to predict more successful placement outcomes (see Triseliotis, 1989). These have been if foster carers are relatives of the children in their care, if foster carers are over the age of 40, if they are childless or have no children of their own of the same sex and age or younger than the foster child, if foster carers welcome continuing contact with the foster child's biological parents and social worker, and if foster carers have received adequate training, preparation and support. Experienced foster carers have also been found to achieve more successful outcomes than inexperienced ones.

There are also a few studies that have focused on the skills and attributes of foster carers that predict successful placement outcomes. For example, Triseliotis et al (1995) interviewed social workers about the skills and qualities of successful foster carers with adolescents. These were defined as “being good with adolescents”, being tolerant but firm, having an understanding personality, and holding appropriate expectations about young people's contributions within the household. Another study by Hazel (1981) highlighted the following attributes as being positive for specialist foster carers – being able to communicate openly and honestly, showing a willingness to learn and possessing emotional resilience. Finally, Thoburn, Murdoch and O'Brien (1986) describe the foster carer skills needed to work with children with special needs as including enjoying being with children, having previous experience of children with special needs, being relaxed about achievement, talking about worries and problems instead of internalising them and being family-centred and having a strong marriage.

In addition to studies focusing on outcome factors, the research on foster carers has covered a number of other areas. These will now be explored.

Characteristics and motivation of foster carers.

The investigation of the characteristics of foster carers can be seen as important for helping to improve the procedures involved in their initial assessment. However, there has been relatively little research carried out on the circumstances and personal motivations of foster carers.

A comprehensive study by Bebbington and Miles (1990) examined the circumstances of foster carers from thirteen local authorities. They found foster carers to differ from other families in four different respects. Firstly, nine out of ten carers in their sample lived in homes with three or more bedrooms. Secondly, four-fifths of the foster mothers were aged between 31 and 55. Thirdly, two-thirds of the foster carers were made up of one of the partners working full-time and the other not at all, and lastly, only one in eight of the foster carers had a child under five years. In general, the study concluded that foster carers had a very conventional social profile.

In terms of their motivations, Rowe (1984) found that foster carers had a wish to help underprivileged children and to have one or more additional children in their family. Kay (1966) suggested that foster carers needed to have one or both of the following motivations in order to successfully cope with a long-term placement. Firstly, the foster carers needed to have a desire to parent a child, and, secondly, it was important that they were able to identify with deprived or unhappy children because of their own experiences in childhood. With regard to the latter motivation, it was seen as important that the foster carers were able to demonstrate a resilience and insight into their personal experiences. In keeping with these ideas, Ray and Horner (1990) found self-discipline, sensitivity, creativity, emotional stability, maturity and rationality to be related to foster carer effectiveness.

A more systematic study by Dando and Minty (1987) investigated the circumstances, personal characteristics and motivations of eighty foster mothers living within one county authority in England. Very few mothers were found to be working, in contrast to most of their partners who were in full-time employment, and 95% of the sample were in stable marital relationships. Among the motivations reported by the foster mothers were wanting to offer a home to children in care (“altruistic motive”), wanting a child because of inability to conceive, wanting to replace children who had grown up, and identification with deprived children because of personal experience. The authors concluded that motivation to foster appeared to arise from strong personal needs of the carers, although it was not suggested that these were necessary for good fostering.

The subjective experiences of foster carers

Research investigating the subjective experiences of foster carers is fairly recent. For example, in Berridge’s 1997 review, research in this area was identified as being relatively limited. Some studies have included an enquiry into foster carers’ experiences as part of a more general investigation into foster care, whereas other studies have focused on particular aspects of foster carers’ experiences, such as their relationships with the children in their care and their experiences of placement breakdown and stress. The majority of these studies have used interview or survey methods to obtain their data. Qualitative data analysis has been applied in a few cases.

One major study in this area was conducted in Ireland by Gilligan (1996), which involved a postal survey with a sample of 73 foster carers. This included questions about their experiences of coping with the children in their care’s behaviour and needs, their morale and their commitment to their roles. The results of this study revealed that one in five of the foster carers thought that the foster child’s behaviour made “life unpleasant” in the household and that one in five of the carers were also worried that their own children might suffer as a result of their fostering a child.

Furthermore, more than one in four of the foster carers admitted to having difficulty in knowing how to respond to what they saw as the foster child's difficult behaviour and almost half of the carers found it difficult to deal with the child talking about their difficult past experiences. However, in terms of their satisfaction with their role, most of the foster carers (93%) gave positive reports about this, and 96% of the carers viewed the foster child as having made "real progress" since coming to live with them.

Similarly, as part of a larger study by Golding (2002) looking at consultation to foster carers, a sample of 104 foster carers were asked to give five words to describe their experience of fostering. The foster carers in this study were found to use words such as "rewarding, fulfilling and satisfying", but at the same time, they described their role as "hard work, demanding, exhausting and time-consuming".

A number of studies have focused on stress that foster carers experience. For example, a study by Quinton et al (1998) investigating a sample of 61 foster carers and adoptive parents, revealed that they had found several different aspects of their role stressful. The carers reported experiencing stress as a result of learning about the child in their care's history and witnessing their current distress, as well as having to manage the child's difficult behaviour and develop a relationship with them. Furthermore, the carers also reported experiencing practical stresses in relation to the increased demands on their time.

Wilson, Sinclair and Gibbs (2000) examined comments on questionnaires from foster carers about their reactions to six potentially stressful events – placement breakdown, allegations of abuse, relationships with the foster child's biological parents, family tensions, "tug of love" cases and other disagreements with social services. Although most foster carers in the study reported satisfaction with their role, they also reported experiencing invalidations of their sense of self, reduced self-efficacy, tensions with social services, problems with neighbours and feelings of having to make a choice between damaging their own families and failing their foster children.

Other experiences of foster carers that have been focused on include their understanding of their attachment relationship with the children in their care. For example, as part of a study examining the attachment relationships of foster mothers and biological mothers with foster children, Tyrrell and Dozier (1999) interviewed twenty five foster mothers about the type of difficulties they experienced in relation to this and their knowledge of foster care issues. The findings revealed that foster mothers experienced difficulties with their children around avoidance and rejection of physical contact. However, they did not report sufficient knowledge of the therapeutic techniques that might help them deal with these difficulties.

Finally, a study investigating foster carers' and foster children's experiences of placement breakdown (Butler and Charles, 1999) used an in-depth semi-structured interview and then carried out a thematic analysis on their data. Some of the main themes that emerged from the study involved foster carers having viewed their role as being akin to that of a normal parent with little recognition that it may require any different skills, and that there had been a lack of open discussion between the foster carers and foster children about their expectations of the placement which were different.

In summary, therefore, as the above studies illustrate, research investigating the experiences of foster carers can provide a dearth of information about the challenges they face, and their feelings and beliefs about their role, as well as a greater understanding of their needs. However, there are a number of studies that have specifically focused on the needs of foster carers and the types of support they require.

Support for foster carers

As highlighted in the foster care outcome research, the absence of support and training for foster carers can increase the risk of placement breakdown. Moreover, it has been shown to be a major reason for high drop-out rates among foster carers (Bradley and Aldgate, 1994; Rowe et al, 1989).

Nixon (1997) identified a number of different types of support that foster carers need. These are: financial and practical support from child-care agencies; emotional/psychological support from family, friends, other foster carers and social workers; social support from extended family, friends, neighbours and social workers; agency-based training; task-focused problem solving through social workers or child and adolescent mental health services; respite care; and community support involving acceptance by the community of the importance of foster care.

However, research indicates that provision of support for foster carers is unsystematic and haphazard (e.g. Sellick, 1992). Furthermore, a number of previous studies have investigated the types of support foster carers require. For example, Triseliotis (1998) carried out a postal survey to foster carers to find out what foster carers expect in the way of support. The findings showed that foster carers wanted to be paid on time, to have regular contact with social workers, to have a specialist stand-by service, opportunities for respite, and support through false allegations. Another study by Nixon (1997) who carried out a survey to 67 foster carers who had experienced allegations of abuse, found that for most of the respondents, choice and source of support was an extremely personal one, being dependent upon a series of factors, such as the nature of the relationships established within services. There was also found to be a lack of congruence between the type of support the foster carers needed and the support provided by child-care agencies.

In addition to studies focusing on support for foster carers from social services, since the implementation of Quality Protects (Department of Health, 1998b), there is currently also a need for research into the types of support foster carers require from child and adolescent mental health services. To date, there are a number of studies that have focused on this issue. For example, Golding (2002) presented findings from her evaluation of a newly set up child and adolescent mental health service for looked after children, using both questionnaires and interviews with foster carers.

The foster carers involved in the study were found to be highly satisfied with the support and advice provided by specialist consultation interventions because they had the opportunity to feel listened to and understood, as well as further develop their understanding of the complex difficulties of the children in their care from a psychological perspective.

As part of a recent study by Beck (2002, personal communication) on the mental health needs of looked after children in a London borough, foster carers were also asked a number of questions about their experiences of child and adolescent mental health services. However, their feelings about these services were found to be more mixed, with some foster carers reporting difficulties in accessing the services in the first place.

It is clear, therefore, that more detailed research into the support needs of foster carers is required, both in terms of social services and child and adolescent mental health services, particularly with the recent increase in funding to services for looked after children in the UK.

Conclusion

Under the current child-care policies, reflecting the idea that children should remain with their biological families except in adverse circumstances, those children who remain in foster care are likely to have experienced a number of adversities, for example, abusive or neglectful parenting, and/or rejection. They are, therefore, likely to have emotional and behavioural problems that might have previously been untreated or undetected. The expectations of foster carers in coping with the well-being and needs of the children in their care are, therefore, high and complex.

Research into the emotional and behavioural difficulties of looked after children is relatively recent and still in its early stages, although a number of major, systematic studies have been carried out.

Furthermore, traditional research into foster care has focused on outcomes and the extent to which a placement succeeds or fails. However, more recent research into the experiences of foster carers has helped illuminate the complex nature of their role and needs. A review of the research already done in this area indicates there is still a gap in relation to studies using more in-depth interview methods to examine the experiences of foster carers, and very few studies to date have been analysed using qualitative methods. It appears that using these types of methodological techniques have the advantage of tapping in to the complexity of experiences of individual foster carers that other types of techniques would not be able to encompass.

Research into the support needs of foster carers is also still relatively limited and has become particularly pertinent given recent government initiatives. Once again, interviewing foster carers may be the most useful way of assessing their individual needs.

On the basis of this review of the research into foster care and related topics, further research is needed in the following areas: Firstly, more longitudinal studies need to be conducted on the emotional and behavioural problems of looked after children and their relation to past experiences the child may have had. Secondly, different types of research into foster care are needed, for example, qualitative studies and/or audits of need are required to improve understanding of the experiences and support needs of this group of people.

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Learning from foster carers: their experience of fostering and mental
health service provision

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ABSTRACT

The current study used a grounded theory approach to better understand the experiences of foster carers with regards to how they understood and coped with the emotional and behavioural problems of children in their care and what types of support they required from Child and Adolescent Mental Health Services (CAMHS).

Background: In recent years, there has been an increasing research interest in the qualitative experiences of foster carers, given the demands they face in the current context of child-care policy. Previous studies have focused on narrative accounts and specific aspects of experience, such as dealing with difficulties and support. There is, however, a lack of research using grounded theory to explore their experiences in detail. Over the last two years, following the government's "Quality Protects" initiative, new specialist mental health services for looked after children and their carers have been set up around the country. Given these recent service developments and limited research into their role with foster carers as yet, foster carers' views and experiences of CAMHS are valuable in informing future service provision for this client group.

Method: In-depth, subjective accounts of eight foster carers from six foster families employed in one local authority were obtained through interviews.

Results: Four major and inter-linking categories emerged from the interviews relating to ambivalent relationships with the children in their care, the children's parents and wider services, including CAMHS. However, one core category subsumed all of these categories and was referred to as the inherent contradiction in the foster carers' role - that of being a parent, but at the same time being a professional.

Discussion: The themes that emerged from the interviews with the foster carers related to previous literature on their experiences and issues of support. The findings had implications in terms of specialist psychological support and consultation to foster carers.

CHAPTER 1: INTRODUCTION

1.1: Introduction

Children who have been placed in the care of the local authority or who are “looked after” have been consistently found to have a higher rate of emotional, social, behavioural and educational problems in comparison to the general population (Rutter, 2000). High rates of psychiatric disorder and under-diagnosis of serious mental health difficulties have been found in looked after children (Richardson & Joughin, 2000; Mental Health Foundation, 1999). Research evidence also indicates that the majority of looked after children come from families where there are difficulties in parenting (e.g. Roy, Rutter & Pickles, 2000; Wolkind & Rutter, 1973) and experiences of neglect and abuse are common precipitants for entry into care (Benedict et al, 1996; Lawder et al, 1986; Minnis & Devine, 2001). As a consequence, a large number of looked after children may have experienced insecure attachments early in life, which has then had an impact on their ability to form secure attachments with others. Furthermore, looked after children may experience deep feelings of rejection and other emotional difficulties from having to leave their families of origin, enter the care system and, in some cases, not ever be able to return to their families (Dance, Rushton & Quinton, 2002). As such, therefore, children in the looked after system may present with complex difficulties and they remain one of the most vulnerable and socially excluded groups in today’s society.

National statistics indicate that the number of children in local authority care is growing steadily. The number of looked after children in England at the end of March 2002 was one percent higher than the number in the previous year and twenty two percent higher than ten years ago (1993/94) (Department of Health, 2003). Out of all the children who were looked after at the end of March 2002, sixty six percent were in foster care. This percentage has remained fairly constant since 1996 before which time there was a steady growth in the proportion of looked after children who were in foster care reflecting changing policies and philosophies about these children’s needs.

As such, there was a move away from placing looked after children in residential care to trying to place them in foster care due to the increasing emphasis being placed on the importance of family life for children in care. It is likely, therefore, that foster carers now have more challenging and vulnerable children placed with them than they did in the past when these children would have not been considered suitable for foster family care (Pallett et al, 2002). Furthermore, changes in policy over the last twenty years have moved towards the idea that all children are better off with their own families where possible meaning that those children who would have been in foster care around twenty years ago are now looked after in their own families.

One of the most recent government initiatives to be introduced that concerns the lives of looked after children and their carers is the Department of Health's "Quality Protects" programme. This was launched in November 1998 to span over a six-year period and was designed to improve the quality and management of health, social and educational services by developing an inter-agency strategy to meet a number of objectives for disadvantaged children (Department of Health, 1998). Given the poor outcome rates found in looked after children, one of the strategy's objectives was to improve their health, well-being and development. As part of this, local Child and Adolescent Mental Health Services (CAMHS) were identified as having a role in supporting the mental health needs of looked after children. They were, therefore, given funding to enable rapid access to mental health assessment and intervention for looked after children and to provide support, consultation and training to foster carers and other professionals involved in their care (see Department of Health, 2002). Given the substantial number of children in foster care today, the complexity of their needs and changing policies that place carers at the frontier of service provision, gaining knowledge and understanding about the experiences of foster carers and the types of support they need remains important. Yet systematic research into the experiences of foster carers is a relatively new enterprise (see Berridge, 1997). Furthermore, given that specialist CAMHS provision for looked after children and their carers is still very new, there is little research into this area as yet.

For clinical psychologists working in this field, the evidence base from which to draw from, therefore, remains small. As part of developing this evidence base, knowledge about the support needs of foster carers and the efficacy of psychological interventions with them is required.

This research project was borne out of an interest in further understanding the experiences of foster carers in light of recent policy changes and an identified need to investigate the types of support they required from a specialist CAMHS that served foster carers employed by one local authority.

The researcher's theoretical background and experience was grounded in the knowledge she had developed of psychological theories of child development and family systems, as an undergraduate student, in her work as an assistant psychologist and during her clinical psychology training course. It was from this background that the researcher became interested in investigating the experiences of foster carers and their support needs from CAMHS and it was this theoretical position that she held with regards to the data collection and analysis during this project.

In particular, the researcher was interested in theories of attachment, which are based on the idea that an individual's experience of care-giving relationships very early in their life can influence their beliefs about self and others and their subsequent relationships with other people. The concept of attachment was first developed by Bowlby (1969) to describe how an infant, in their first relationship with their caregiver, develops a particular set of mental representations, beliefs and ideas about self and others (an "internal working model"). If the infant develops a secure attachment, their internal working model is positive about self and others and relationships. However, if they experience an insecure attachment with their caregiver (e.g. through experiencing poor parenting, maltreatment or neglect), they are likely to become negative or anxious about self, others and the safety of relationships.

Their internal working model of relationships then adversely affects their ability to develop relationships with others as they grow older (e.g. Carlson et al, 1989). The fact that children in foster care are likely to have had difficult or adverse early experiences and disrupted attachments with their original care-givers suggests that they may find it difficult to develop relationships with other people and secure attachments to other care-givers. From this perspective, as well as wanting to understand the experiences of foster carers within the current political climate, it was also the researcher's intention to explore how foster carers experienced caring for and building relationships with the children in their care and their support needs with regards to this, in view of the possible attachment difficulties of the children.

1.2: Foster care in the UK

1.2.1: Changing policies.

One of the main beliefs behind foster care is:

to offer the experience of family life to children whose parents cannot do so, until the parents are able to have their child back (Triseliotis, Sellick & Short, 1995a, p.1)

However, as already highlighted, in the context of changing ideologies and political agendas, foster care is a changing rather than a static entity. In the past, long-term foster care was traditionally the main model which fostering services offered. Foster carers were viewed as substitute parents for children whose own parents were not able to care for them. The 1948 Children Act then introduced the idea that local authorities should consider the possibility of foster children returning to their family of origin. However, by the 1970s, it became clear that many children in foster care were just moving from one placement to another without any plans for the future. This phenomenon became known as "drift" in care (Rowe and Lambert, 1973) and prompted the beginning of permanence planning; i.e. providing more stability for foster children and firm plans for their futures.

This then fuelled the ethos present in the 1980s, which favoured rehabilitating foster children either to their family of origin or to an adoptive placement.

Foster care placements, therefore, came to be seen predominantly as short-term and task-centred and, reflecting this change in the nature of foster placements, the previously used term “foster parent” was changed to “foster carer”. Schofield, Beck, Sargent and Thoburn (2000) highlight the possible feelings of failure that long-term foster carers could have felt as a result of the changes in policy at that time in so much as they had cultivated a parental relationship with the children in their care. Furthermore, Berridge and Cleaver (1987) draw attention to the ambiguous role that foster carers were now expected to undertake; that of temporarily being in a broadly parental role with the children in their care.

At the end of the 1980s, the 1989 Children Act (Department of Health, 1989) heralded increased rights for the parents of foster children and the requirement that foster carers worked in partnership with the parents. This then formalised and made compulsory the foster carers’ role of working with the parents of children in their care to achieve rehabilitation where possible, as in the past this had not been part of the work for some foster carers. Today, in the light of previous policy changes, fostering services offer a variety of placements.

The majority of placements offered are short-term in nature (although the length of time that constitutes “short-term” varies considerably due to, for example, factors related to the shortage of suitable placements and unforeseen difficulties that arise in the rehabilitation process). However, long-term foster care placements still exist for those children for whom permanence best represents staying with the foster families that they had always been with as opposed to being able to move back to their families or to adoptive placements.

1.2.2: Current expectations of foster carers.

Given that there is currently a substantial demand for foster care placements, fostering services are in need of a constant supply of foster carers so that they can provide good carer/child matches and placement choice. However, studies have shown that foster carers with the necessary skills and expertise to take on specific tasks are in short supply, meaning that the possibilities of matching are often low (e.g. Triseliotis et al, 1995b; Sinclair et al, 1995). This also then increases the dangers of “stretching” where foster carers are persuaded to accept children outside the categories they have committed themselves to (Minty, 1999). A recent study by Waterhouse and Brocklesby (2001) revealed that three-quarters of the placements in their sample were made in a crisis led, unplanned way. Foster carers, may well, therefore, find themselves unequipped to deal with the particular needs of the child in their care.

Moreover, in the light of the initiatives set out by “Quality Protects” (Department of Health, 1999a) to raise standards in local authority child care, objectives have focused partly on placement stability and permanence, stemming from the idea that children should be enabled to develop secure attachments with their carers. As described earlier, given the high degree of poor parenting experiences in children who are looked after, they have often, therefore, developed insecure attachments and behavioural patterns which enabled them to survive in the adverse circumstances they were first subjected to (for example, showing anger, being avoidant, putting on a false self, or expressing their distress in indirect ways such as stealing). However, attachment theory suggests that they may also persist in these behaviours in the foster family environment, and find embracing the task of developing a new attachment/relationship with their carers extremely difficult.

Likewise, foster carers may find developing an attachment with the children in their care very difficult in the face of having to deal with and overcome these behaviours (see Howe and Fearnley, 1999).

Furthermore, an important aspect of the task of foster carers providing emergency or short term placements is to encourage the child's eventual move onto a more permanent placement or back to their family and thus to work through placement endings where possible. This has the risk of further complicating the attachment relationship between the carer and the child and, if the placement breaks down, endings may be premature or unresolved.

In the context of changing policies and the demands being placed on them, foster carers today are, therefore, expected to provide family homes and care for children with complex difficulties, often on a temporary basis and to work in partnership with their parents where possible. However, as stated earlier, despite the challenging tasks that foster carers face, foster care has, in general, received comparatively little research attention.

1.3: The subjective experiences of foster carers

Research into foster care has traditionally centred around measuring outcomes so as to identify the factors associated with a successful placement (please refer to Mary, 2003 for a review of the literature on outcomes). In recent years, however, there has been an increase in interest in the subjective experiences of foster carers. Foster carers' narrative accounts of their experiences can often be found in foster care journals and self-help manuals, and occasionally in the popular media. These accounts often highlight the difficulties foster carers are faced with in terms of dealing with chronic and severe emotional and behavioural problems of the children in their care and the sudden change to their lives that becoming a foster carer involves. They provide valuable information for foster carers and professionals working with them and the children in their care in terms of highlighting the individual differences and complexity of the challenges they face.

In addition to these personal accounts, however, there are a number of recent research studies that have systematically investigated foster carers' experiences using both quantitative and qualitative methods of inquiry.

Triseliotis et al (2000) carried out a major study in Scotland investigating the nature of fostering from the perspectives of foster carers over eight local authorities. The study used both questionnaires and interviews to examine the characteristics, motives and social circumstances of active and former foster carers in their sample, to seek explanations concerning carer retention and loss, to describe the experience of fostering and to evaluate post placement support and carers' general experiences of the fostering service. The qualitative data collected from interviews and written accounts were used to expand on the statistical information obtained from the questionnaires.

Many of the carers in the study reported to feel overloaded by difficult behaviours that the children showed and increased demands. They also reported that they did not always obtain the kind of support they would like to help them manage difficulties. However, most of the foster carers described their experience as rewarding despite the demands they faced. These rewards involved feeling a sense of achievement and that they had done something worthwhile. Nine in ten foster carers stated that their expectations of fostering were either fully or partly met. Statistical analysis of the data collected from the foster carers in the study indicated that finding the children in their care more difficult than expected was associated with having a poor relationship with the fostering services, feeling unprepared, perceiving support as being low and finding social workers unavailable.

Gilligan (1996), in a region of Ireland, also conducted a large scale investigation into the experience of foster carers. A postal survey was used to evaluate foster carers' experience of coping with the children in their care, levels of support, their role with the children's family and morale. Results from seventy three respondents yielded varying responses as to the level of difficulty they experienced in their role.

Difficulties with coping with, understanding and responding to the behaviours of the children in their care and separating from the children if they were to return to their parents were, however, reported in some cases. Furthermore, half the carers in the study reported to find it difficult when the children talked about their past experiences. Similar to the findings in Triseliotis et al's study, however, a large proportion (93%) of the carers in Gilligan's study reported frustration with a lack of support from services but at the same time, a sense of achievement and commitment with regards to their role.

Finally, in England, Schofield et al (2000) carried out the first phase of an in-depth longitudinal study focused on the progress of a group of children under twelve who had recently been placed in long-term foster care. As part of a larger investigation encompassing the children and birth families in eight local authorities, forty three foster carers were interviewed about the rewards and frustrations of long-term fostering. The interview data was subject to qualitative analysis that enabled definition of several themes pertaining to the foster carers' experiences of caring for the children on placement, the demands they faced and their motivations for fostering.

Firstly, with regards to the children in their care, the difficult behaviours and ways of relating that the foster carers identified were grouped into four different categories. For example, the foster carers built rewarding relationships with some of the children and these children were successful across a range of situations. Another group of children identified were those that were needy and emotional at times but coercive and uncontrollable at others, leaving the carers feeling drained. Yet another group were those that were well-behaved and compliant but untrusting and dismissive of relationships. Finally, the carers also identified children who switched unpredictably from being manipulative and angry to compliant and care-giving. The carers found these children very difficult to parent. In identifying these groups of children, the authors of the study related them to the different types of attachment patterns described and researched in attachment theory, these being secure, ambivalent insecure and avoidant insecure (described by Ainsworth et al, 1978) and disorganised insecure (described by Main and Solomon, 1986).

In order to deal with the difficult behaviours that the children presented with, the carers reported using strategies such as thinking through behaviours and their own responses to these; accepting both the positive and negative behaviours of the children; helping the children to manage their anger and distress and modelling their own emotional regulation to the children; and being emotionally and psychologically available to the children.

Finally, three types of foster carers were defined within the sample, in terms of their differing motivations to do long-term fostering. There were those carers who were seeking to establish or increase their families; those carers who had grown-up children who were wanting to rear a second family; and those carers who viewed fostering as a form of skilled employment but still regarded the children in their care as being part of their family. This last group of carers were paid higher salaries with the expectation that they would care for children with complex needs. Like the Scottish and Irish studies already described, the majority of carers in this study in England showed a strong commitment to the children in their care.

Common to the experiences of foster carers in all three of these studies appeared to be having to deal with difficult situations related to, for example, the carer/child relationship. However, despite the challenges they faced, respondents in all of the studies demonstrated high levels of commitment and reported finding their role rewarding.

In addition to research encompassing foster carers' general experiences, a number of studies have focused in on particular aspects of their experience with the aim of examining in more detail the specific situations that foster carers have difficulty with and the factors that are related to satisfaction with their role.

1.4: Rewards and difficulties associated with fostering

1.4.1: The difficulties faced by foster carers.

In order to investigate in more detail what type of experiences foster carers find difficult, Jones and Morrissette (1999) developed and then analysed a questionnaire with foster carers in Canada, which asked about the types of experiences they found stressful.

Themes that emerged from their analysis were related to stress in the carer/child relationship, relationships with the children's birth family, and dealing with the emotional difficulties that the foster children presented with. However, it was found that the most stressful situation for the carers in this study was in experiencing difficulties in communicating with fostering services and the administrative issues that this raised. This, therefore, had implications in terms of the support and training the foster carers received from services.

Quinton et al (1998), in England, investigated type and severity of problems in children (aged five to nine years) and their carers' responses to these at the start, middle and end of the first year of placement in a sample of sixty one foster carers and adoptive parents. A standardised parent interview and semi-structured interview using predefined codes were conducted with each of the carers/adoptive parents in the study. The study findings indicated that many of the participants experienced high anticipatory stress prior to the placements and continuing stress over the first year. One third of the mothers interviewed reported experiencing stress related to difficulties in coping with the behaviour of the children and the failure of a rewarding carer/child relationship developing.

Edelstein et al (2001), from the perspective of their clinical experience, focused on the feelings of loss and grief involved in fostering. Loss and grief in both the carers and the children was described as being experienced under different guises, thus being expressed in different ways, for example through guilt or anger.

In caring for the foster children, carers found themselves having to contain the loss and grief that the children were experiencing as a result of leaving their family. The carers, however, also had to deal with their own sense of loss if the foster child returned to their parents.

In their study, Butler and Charles (1999) focused on the development of and possible reasons behind difficulties experienced in the carer/child relationship by interviewing both carers and the children in their care on their experience of placement disruption. Thematic analysis of the interviews revealed that the carers and children had had conflicting expectations of the placement, which had not been fulfilled or discussed openly. When the foster children's expectations did not fit with their carers' image of themselves as offering a good model of family life, then disappointment and conflict arose.

In so much as stress and difficulties have been found to be experienced by foster carers with regards to dealing with the children in their care and other situations, a study by Wilson et al (2000) focused on a number of definitive stressful events that foster carers might be expected to come across in their experience in order to examine these in more depth. These events were: allegations, placement breakdown, relationship with the birth parents, family tensions, "tug of love" cases, and other disagreements with social services. By postal survey, they asked foster carers about their experiences of these events, the meaning that it held for them and the impact of the events on their self-esteem and views about fostering. The findings indicated that these experiences often intruded on their family life and caused great distress and low self-worth. The stressful events were also seen as detrimentally affecting the relationships that the carers had with their family, the children in their care and fostering services.

Finally, in describing the issues and themes raised in a series of workshops with carers around image and identity, Molin (1994) outlined the difficulties foster carers experienced in relation to the larger systems in which they lived, such as extended families, schools, neighbourhoods, the birth family and fostering services. These relationships were seen as being influenced by the cultural images and stereotypes that have developed with regards to foster care. Foster carers described feeling concerned that they were seen as incompetent because of the behavioural difficulties of the children in their care, or that they were dismissed as “paid babysitters” by the fostering services.

Furthermore, due to the stereotype of foster carers as dedicated, altruistic parental figures, they felt as if they were expected to take on burdens without complaint and manage issues on their own that other parents would not be capable of dealing with. This, therefore, had the effect of isolating them in so much as they were seen as not needing assistance or support from the wider system.

1.4.2: Factors relating to satisfaction in foster carers.

A number of studies have been concerned with the types of circumstances that predict satisfaction in the foster carers’ experience as opposed to difficulty. One such study conducted in the United States by Denby et al (1999) involved a postal survey with 539 foster carers over eight counties aimed at addressing this question. The results of this study indicated that some of the factors exerting the strongest influence on satisfaction were: feeling competent to handle the children who were placed; wanting to take in children who needed loving parents; and social workers giving information and showing approval to the carers.

Similarly, a study by Fees et al (1998), evaluating the predictors of satisfaction in foster carers one year after training found that pre-service training was a key component in this. Finally, Sanchirico et al (1998) found that quality of foster carer involvement in service planning and decision-making also had a positive effect on job satisfaction.

What all these studies seemed to imply was the need for more training and support for foster carers.

1.5: Support for foster carers

1.5.1: Types of support needed.

Although research into levels of satisfaction in foster carers highlights the importance of support and recognition from services, studies investigating whether the presence of support can make the defining difference in placement failure and attrition rates are equivocal. For example, Bebbington and Miles (1990) emphasised that in the absence of any research evidence, it was not possible to conclude that increased support could reduce attrition. Conversely, Bradley and Aldgate (1994) and Rowe et al (1989) viewed lack of support as a major reason for high drop-out rates among foster carers.

In general, studies have found that foster carers often receive a lack of training and low recognition from services (e.g. Berridge, 1997; Caesar et al, 1994; Sellick and Thoburn, 1996). However, the amount of research specifically focused on the support needs of foster carers is small.

In a study in Canada, Brown and Calder (2000) asked forty nine foster carers to describe their needs in response to the question “What do you need to be a good foster parent?”. The carers’ responses were then analysed using the technique of concept mapping and the following themes were found: good working relationships with professionals; professionals being sensitive to the different cultures of the carers; harmonious and stable family relationships; adequate payment; and a range of personality and parenting skills. This then had implications for both support and recognition, and training for foster carers.

Nixon (1997) identified the different elements of support that foster carers need for everyday problems as being: financial and practical support from child-care agencies; emotional/psychological support; social support; professional development; task-focused problem-solving; respite care and community support. He then went on to investigate the adequacy of these support systems during a crisis.

In the study, the crisis investigated was that of carers receiving an allegation. Interestingly, seventy six percent of the carers in the study sample did not use the formal support offered by the child-care agencies. Instead, for most of the respondents, choice and source of support was extremely personal, depending on the nature of the relationships they had established within the services. What also became apparent from the study was that there was a lack of congruence between the type of support the carers needed and the type of support offered by the child-care agencies.

Sellick (1992) investigated the support of short-term foster carers in four local authorities and two independent fostering agencies in England. Foster carers in the study identified a number of different qualities that they sought from social workers i.e. energetic, purposeful, reliable and flexible, as well as being friendly but knowledgeable. However, in examining the implications of this, the study drew attention to the circumstances of foster carers with regards to ongoing support. As such, foster carers were described as not having the benefit of day to day colleagues to off-load to, paid holidays or sickness leave. In this context, it could be seen why the support, recognition and respect of social workers was valued so much by the foster carers in the study.

In terms of the levels of support that foster carers perceived from social services, foster carers' reports of the relative contributions of link-workers and child social workers range over different studies from finding link-workers much more supportive than social workers to describing social workers in a more favourable light and more akin to their reports of link-workers (see Sellick, 1999).

However, Sellick (1992) pointed out the importance of the fact that for any type of support to be most effective, time is needed to develop a trusting relationship with the carer and, similar to Nixon's findings, that there were individual differences in levels and types of support that each foster carer needs.

Finally, in their research study following the progress of foster carers/adoptive parents and the children in their care over the first year of placement, Quinton et al (1998) found that although foster carers could get emotional support from social workers, they also required more specific support in managing behaviours of the children that they found difficult to deal with. Furthermore, in a study by Minnis and Devine (2001), which will be described in more detail below, foster carers undergoing training also reported needing support and advice in understanding and making sense of the emotional and behaviour problems the children presented with. Although they looked for help from a range of sources (e.g. friends, family, social services, GP), they sometimes required additional help from psychologists or psychiatrists. This type of specific advice falls under the remit of the types of support that new specialist CAMHS teams for looked after children and their carers can offer.

1.5.2: Research on CAMHS support for foster carers.

Given the relatively new development of specialist CAMHS for looked after children and therefore CAMHS training and support for foster carers, there is as yet a lack of research into this area. However, to date, there are a small number of research studies that have looked into the efficacy of CAMHS interventions with foster carers.

Golding (2002) describes the development and delivery of a local primary care and support project that was set up for carers of looked after children. In developing the project, which involved providing consultation to carers, it had become apparent that there was a great need for specialist support which complemented the other supports available.

As a result of the consultations the carers in the project reported to feel listened to, re-assured and understood. Furthermore, they also reported to have gained more understanding into the reasons for the difficult behaviours the children in their care showed which had made them easier to deal with (increased understanding appeared to reduce their feelings that the behaviours were directed personally at them). Golding's project, therefore, illustrates the value of exploring the views of foster carers so as to aid the development of future service provision.

The work of another specialist CAMHS team in England was described and evaluated by Pallett et al (2002) with particular reference to a training programme that was set up for foster carers there. The training programme, involving two courses – one for carers of the under-12s and one for carers of teenagers – was run in the community for groups of carers over a period of ten weekly sessions. In setting up the programme, the trainers drew upon currently available parenting programmes (e.g. Webster-Stratton, 1992; Neville et al, 1998) and based the training on cognitive-behavioural and social learning theory. They also used ideas from attachment theory around providing a “secure base” for children with the aim of developing these skills in the carers. The study authors highlighted the benefits of conducting a number of focus groups for foster carers while setting up the programme in order to evaluate their training needs. Prior to training, foster carers voiced concerns about the practical difficulties of attending training sessions on a regular basis and about being part of a group that was focused on learning. This highlighted the need for promotion of the training and of making it more community based.

In evaluating the programme, qualitative and quantitative measures (consisting of a number of questionnaires assessing satisfaction, parental stress and the behavioural problems of the children) indicated improvements in the emotions and behaviour of the children in the care of the participants and better care/child relationships. The carers also reported that the training had had a beneficial effect on their own confidence and self-efficacy.

Despite the encouraging results from this project, a need for a randomised controlled study was identified. One such study was conducted by Minnis and Devine (2001) in Scotland with a large sample of foster carers and their children. Foster carers in the treatment sample received three full days of training over and above the standard support and training they received, while the control group just had the standard services. The training was based on a programme by Richman (1993), which was developed for carers of children affected by war and disasters. The training was consultative in style and its focus was to help carers understand and cope with the behaviour and emotions of the children in their care and to develop skills in communication. Measures were conducted with the carers before and after training and at a nine month follow-up.

Findings indicated that foster carers were very positive about the training and felt that they had learnt a lot. However, a lack of significant changes in the foster children's behaviour suggested that the training was insufficient to address their complex needs and it was concluded that a longer training programme was needed.

In general, these research studies highlight the need to evaluate the support and training needs of foster carers from local specialist CAMHS in order to better develop and tailor interventions for them. Moreover, as these studies show, more research is also needed into the efficacy of specialist CAMHS interventions with foster carers. Altogether, this type of research could then inform psychologists and other mental health professionals working in this area.

1.6: The need for qualitative research into foster care

In reviewing the literature on the experiences of foster carers, their support needs and the research into specialist CAMHS provision, a number of conclusions can be drawn. Firstly, systematic research into the experiences of foster carers has been recent in its development. A number of recent large scale studies have investigated foster carers' experiences in general, highlighting the demands and difficulties they face as well as the rewards of their work.

In addition, a larger number of studies have focused on specific aspects of the foster carers' experience, for example, exploring the stressful parts of their work and factors related to satisfaction in their role.

Secondly, although most studies highlight the importance of ongoing support and training for foster carers, less is known about their specific support needs. Research investigating the types of support provided by social services is most developed, although somewhat inconsistent in its findings.

Thirdly, given the relatively new development of specialist CAMHS provision for foster carers, there is as yet, limited evidence from which to draw, regarding both the efficacy of CAMHS interventions with foster carers and the types of support they require from these services. However, the literature is consistent in the finding that foster carers do at times require specialist advice and support with regards to dealing with difficult behaviours that the children in their care might show. Furthermore, evaluations of specialist CAMHS provision for foster carers have yielded encouraging results in terms of the role they could develop in helping foster carers and thus indirectly helping the children in their care.

Finally, although a small number of research studies have utilised qualitative methods to analyse the accounts of foster carers, there remains a need for further studies of this kind in order to generate an in-depth understanding of their experiences. The advantage that qualitative techniques hold over quantitative techniques in this area is their emphasis on research in the naturalistic setting and on interpreting the meaning that people bring to their experiences. Qualitative research methods therefore make in-depth evaluation of people's experiences and accounts possible while at the same time locating these within their particular time and setting. The relevance of using this type of method with foster carers is evident in their ever changing roles and the complexity and range of experiences they might come across. For example, the qualitative analysis of interviews with long-term foster carers undertaken by Schofield et al (2000) illuminated the variations in and complexity of experiences they had in relating with the children in their care.

In the absence of any previous studies using a grounded theory methodology to investigate the experiences of foster carers, however, this study aimed to add to the existing literature by utilising this approach. Grounded theory methodology was first developed in the 1960s by Glaser and Strauss (1967) and it emphasises building a theory that is grounded in the accounts people give of their experiences. As such, it has the advantage of offering a way of dealing with complex, unstructured accounts of experience that is systematic and in which theoretical concepts and linkages can be generated from concrete descriptions.

Furthermore, through gaining a deeper understanding of the subjective experiences of foster carers in one local authority, in relation to key factors such as their work with the children in their care and the types of support they needed, this project also aimed to explicate the role of the local specialist CAMHS team for foster carers. The specific aims of the study are described below.

1.7: Aims of the current study

To explore in depth the individual experiences and needs of foster carers in one local authority with respect to answering the following questions:

1. How did foster carers understand and deal with the emotional and behavioural difficulties that the children in their care presented with?
2. What were foster carers' experiences of local child and adolescent mental health services?
3. What kinds of support did foster carers require from child and adolescent mental health services?

CHAPTER 2: METHODOLOGY

2.1: Introduction.

The major aim of the current study was to understand more fully the experiences of foster carers in one local authority by focusing on questions about how they understood and coped with the emotional and behavioural difficulties of the children in their care. In addition, the study aimed to investigate these foster carers' experiences of CAMHS and what they required from such a service. The study used a qualitative approach to research in order to obtain in-depth or "rich" accounts from the foster carers by interviewing them and to, therefore, generate a new understanding of the foster carers' experiences by exploring their multiple perspectives and interpreting the relationships between the themes that emerged.

Unlike quantitative approaches to research, which emphasise measuring causal relationships between observed variables from a value-free perspective, qualitative approaches consider the view that reality is socially constructed and study individual and interpersonal processes and meanings (Denzin and Lincoln, 1998). Qualitative approaches study phenomena within their natural setting and therefore take into account the constraints of the social world. They may also be focused on how individuals create and give meaning to social experiences. Some qualitative approaches are, therefore, concerned with how researchers themselves construct versions of reality through their involvement in social and cultural meaning systems and thus address the idea that fixing preconceived systems of meaning to participants' experiences in research is problematic (as in quantitative approaches which use, for example, standard surveys or make hypotheses). As such, this study was concerned with the meanings that foster carers brought to their experiences of fostering; what kinds of behaviours (if any) of the children in their care did they find difficult to deal with, what they understood to be the reasons behind the children's behaviour, how this impacted on their relationships with the children and other people, what supports and experiences they drew on to deal with these behaviours and how they viewed support from CAMHS.

2.2: Research Design

In the last twenty years, there has been an increasing interest in qualitative research in psychology, reflecting its increased use in a variety of different disciplines (Potter, 1998). Qualitative research draws from and uses a variety of approaches, methods and techniques and is informed by a range of intellectual traditions (see Nelson et al, 1992). Depending on the epistemological position taken within the qualitative paradigm, different research methodologies and techniques are adopted. On the basis of the connection between epistemologies and the use of methodologies and techniques, Henwood (1996) (based on an earlier model by Henwood and Pidgeon, 1994) identified three different strands in qualitative research approaches. Strand I includes approaches that are based on the idea that, by using induction, representations of social relationships that are valid and reliable can be found through qualitative observation/interviewing (e.g. using the methods of content analysis and protocol analysis). Strand II is made up of approaches that emphasise the generation of a new theory that is grounded in participants' accounts (e.g. grounded theory and ethogenics). Finally, strand III comprises approaches that focus on the reflexive functions of language, which construct realities in the social world (e.g. discourse analysis and narrative analysis). This study adopted a grounded theory approach and thus a focus on building a theoretical understanding of foster carers' experiences.

2.2.1: Grounded theory.

Grounded theory as a methodology was developed in the 1960s by two sociologists, Glaser and Strauss (1967), in the context of ongoing debates about qualitative versus quantitative research approaches (Hammersley, 1989).

Glaser and Strauss aimed for grounded theory methodology to be a way of making theorising within the social sciences, which they saw as being highly abstract, more contextual and thus more relevant to the particular individuals that were being studied. Grounded theory was, therefore, developed as a way of generating inductive theories, i.e. building levels of abstraction, directly from qualitative data. As such, it consists of a set of guidelines for collecting, analysing and conceptualising qualitative data in order to build a theory. These guidelines emphasise a continuous process of data collection and analysis from which theoretical concepts gradually emerge. This blending of the data collection and analysis phases of the research process is based on two methodological commitments (“constant comparison” and “theoretical sampling”) within the grounded theory approach that distinguish it from other types of qualitative analysis. These commitments are to conducting an in-depth analysis in order for themes embedded within rich/complex data to emerge. Constant comparison involves a process of continuously comparing different data, different cases, different emerging themes and different theoretical concepts throughout the whole time that the research is being carried out. This then alerts the researcher to the depth, range and complexity of similarities and differences between emerging concepts. Theoretical sampling refers to the idea that after initial data has been gathered and analysed, further cases are selected on the basis of how the emerging theory can be extended, deepened or made more explicit.

When it was first developed, grounded theory was rooted in two intellectual traditions. Firstly, it drew from the idea that social sciences research should place importance on the search for meaning (“Verstehen”) and understanding as well as on finding causal explanations for phenomena (as in quantitative approaches) (Dilthey, 1894, 1977). Secondly, it was rooted in the symbolic interactionist perspective (Blumer, 1969) which views an individual’s social world as “enacted and hence as involving the interplay of significant gestures, symbols and systems of meanings embedded within a significant social context” (Pidgeon, 1996, pp. 77).

With regards to grounded theory methodology, the interest, therefore, was in building a theory which illustrated multiple participants' thoughts, feelings, intentions and actions as well as context, structure and changing processes (Strauss and Corbin, 1998).

Since it was first developed, however, the practice of grounded theory has been influenced by different emerging intellectual philosophies and conflicting views about what grounded theory is actually grounded in are now evident (Pidgeon, 1996). This stems from what has been described as the "dilemma of qualitative method" (Hammersley, 1989) in so much as grounded theory method comprises both positivist and constructivist elements. On the one hand, it strives to objectively reflect participants' accounts, while on the other, it embraces the ideas of constructivism, acknowledging multiple perspectives and subjectivities (as in symbolic interactionism). From a constructivist point of view, the researcher is seen to bring their own prior understandings and theories to the process of interpretation and analysis, which throws into question the idea that grounded theory is grounded only within participants' accounts. In recent years, a number of grounded theory researchers have criticised Glaser and Strauss' original view that theoretical concepts can come out purely from participants' accounts and reflect their experience objectively (e.g. Henwood and Pidgeon, 1994). In light of these issues, the current study utilised the approach described by Charmaz (2003) who takes a constructivist position with regards to the practice of grounded theory. In Charmaz' view, throughout the research process, the researcher actively constructs their data with the research participants. The themes that emerge therefore reflect interactions between the researcher and the participants and thus the theory that is generated is grounded in this interaction.

2.2.2: Interviewing.

An important aim of grounded theory methodology is to collect data that is rich and detailed in order for in-depth analysis to become possible. In line with the aims of the current study, detailed narratives of foster carers' experiences were sought by conducting interviews with them. In order for complex theoretical issues to develop and come about during an interview with a participant, it is seen as important within a grounded theory framework to cultivate to a certain extent an open-ended conversation with them. On the one hand, close attention needs to be paid to not directing the interview too much as this might have the effect of curtailing the development of important issues and over-riding the participants' responses by the researcher's own assumptions. However, on the other hand, there is also a need within grounded theory to, at times, use more direct questions to facilitate the elaboration of particular issues. As such, interviews from a grounded theory point of view have been described as "directed conversations" (Pidgeon, 1996). Using this interview style was seen as relevant and appropriate in terms of facilitating the discussion of potentially sensitive and complex issues for foster carers. The strength of using this type of interviewing lies in the potential for the researcher to clarify and further elaborate on ambiguous responses from participants. In the grounded theory approach advocated by Charmaz (2003), importance is placed on looking for and exploring taken-for-granted meanings and un-stated intentions, which might, for example, be reflected in non-verbal behaviour or pauses in conversation. Attendance to the process of the interview is, therefore, important for obtaining rich data. However, the importance of using skills such as developing trust and rapport with the participants and of counteracting "researcher effects" (for example, unwittingly introducing biases into the interview which are relevant to the research topic) highlighted by Breakwell (2000), was also taken into account when conducting the interviews in this study.

In summary, the research design for the current study involved conducting interviews with foster carers in one local authority about their experiences of fostering and CAMHS provision. The grounded theory approach outlined by Charmaz (2003) was used in terms of collecting and analysing the data in the study with the aim of generating a theoretical understanding of the foster carers' experiences.

2.3: Context of the study and recruitment of participants

2.3.1: Site of the study.

The research was carried out with foster carers employed by and living in the catchment area of one local authority in England. Foster placements within the authority were organised by a family placements team in social services made up of link-workers who provided support for foster carers and social workers who provided support for each of the children in foster care. The team also included two family outreach workers who took referrals and provided family interventions for foster families in crisis.

Two and a half years prior to the start of data collection in the current study, a specialist CAMHS team was set up as a result of joint funding from health and social services to provide a service to looked after children and their carers living in the catchment area of the local authority. This particular catchment area was chosen as a site for the research because of an identified need of the specialist CAMHS team to evaluate and thus develop their service to foster carers. At the time that the study was being conducted, the specialist CAMHS team was made up of a Consultant Psychiatrist, Clinical Psychologist, Art Therapist, Family Therapist and two Clinic Social Workers who worked collaboratively with other services and provided consultations to carers and individual therapy for children who were in care.

2.3.2: Study sample and recruitment of participants.

A sample of foster carers who had had children in their care for longer than six months was sought. It was felt that if the foster carers had cared for a child for more than six months, they would have a sufficient amount of experience to talk about. Relative foster carers and foster carers who were planning to adopt the children in their care were, however, not included in the sample as the experiences of these two groups of carers were considered to be qualitatively different from other types of foster carers and beyond the scope of the study.

Furthermore, although the specialist CAMHS team provided a service to foster carers who were living within the catchment area but were employed by a different authority, these types of carers were also excluded from the sample as their needs might have also been qualitatively different from the carers living within the catchment area who were employed by the local authority.

In order to encompass a wider range of views and accounts from the foster carers, in line with a grounded theory approach, sampling was initially carried out with the aim of recruiting carers who varied in terms of the length of time they had been fostering, the ages of the children in their care, the types of placements they offered, their marital status and their experiences of CAMHS (including those who had had no prior experience of this type of service). It was thought that this initial sampling procedure could then be followed by “theoretical sampling” (Charmaz, 2003), that is, sampling participants who might help the development of a theoretical understanding of foster carers’ experiences following a grounded theory analysis of the data collected during the initial sampling phase. However, following the initial sampling phase, it was not possible to continue sampling using a theoretical sampling procedure due to time and resource constraints in the current study. This had the effect of limiting the extent to which themes that emerged from the analysis could be fully examined (see section 2.5).

Access to the sample was negotiated first of all through the managers of both the family placement and CAMHS teams. Visits were then made to family placement and CAMHS team meetings in order to gain a fuller understanding of the structure and organisation of the teams and the types of services they offered. Also, during these visits, presentations and information about the research project were given to the team members so that, in the first instance, they could make foster carers with whom they were working aware that the project would be taking place.

Before carrying out the interviews with the foster carers, it was initially planned to conduct a focus group with between four and ten carers as a pilot in order to develop the schedule for the interviews. However, two attempts to recruit foster carers by letter for this yielded very low response rates and it was, therefore, not possible to run a group. Feedback from the foster carers who did reply, which was also corroborated by the views of the family placements team, suggested a number of reasons why setting up a focus group was problematic. Firstly, given their busy time schedules and the demands of their job, some of the foster carers found it difficult to commit to an event at a pre-set time and venue.

Secondly, the feedback from the foster carers indicated that whereas they felt reluctant to talk about their experiences within a group, they were interested in talking to the researcher in a one to one interview preferably conducted with them at their home because of commitments to child care. Thirdly, it was also fed back that recruiting by letter was problematic in that some of the carers, because of having to deal with practical demands and other paperwork, tended to leave unimportant letters unopened until they had some time to deal with them at a future date. In this way, it is possible that a proportion of the carers remained unaware that the focus group was being run in the first place. In light of this feedback, it was decided to pilot the interviews in a different way. This will be described in section 2.4.

When recruiting participants for the interviews, the following plan was carried out. Firstly, more visits were made to the family placements and CAMHS teams to inform the team members of the next stage of the project and plans for recruitment so that they could pass this on to the foster carers they worked with. Secondly, it was decided to recruit participants for the interviews by telephone and to offer them the option of conducting the interviews in their home at a mutually convenient time. This method yielded a much higher response and carers who agreed to participate were sent an information sheet about the interviews (see appendix 1). The interviews, therefore, took place in the participants' homes, which had the advantage of giving the researcher a fuller understanding of the setting in which they lived and worked.

2.3.3: Ethical considerations.

Permission to carry out the research was gained from the local NHS Trust Ethical Committee (see appendix 2).

Participation in the study was dependent on informed consent (see appendix 1 and 3). Participants were informed that anonymity and confidentiality would be maintained when transcribing the interviews and writing up the study and that all recordings of the interviews would be destroyed once transcription was completed. Participants were also told that they could terminate the interviews at any time if they wished and time to debrief with the researcher after the interviews was offered.

2.4: Development of the interview schedule and data collection

2.4.1: Developing the interview schedule.

In drawing up an interview schedule for the study, the following steps were taken. Firstly, a review of the relevant literature was used to consider what important issues to include in the interviews with the foster carers.

Information was then sought about how to best word the interview questions so as to make them meaningful to the carers and to facilitate open discussion of the issues of interest. This was done by liaising with two experienced clinical psychologists working with foster carers as part of specialist CAMHS teams in other parts of the country.

Secondly, a visit was made to a Foster Carers' Support Group meeting to develop a preliminary understanding of the issues of current concern to the foster carers in the local authority and to gain experience of using an open-ended interview technique with this client group. The Foster Carers' Support Group was a peer support group available to all foster carers employed by the local authority, the meetings for which were held monthly and were facilitated by two link-workers.

During the meeting, at which seven carers were present, when asked about their experiences of fostering, open discussion highlighted a number of concerns common to the majority of individuals within the group. These were: reflections on the advantages and disadvantages of having more professional roles for foster carers than in the past; the importance of communication between services; and difficulties experienced with regards to dealing with behaviours of the foster children and with developing relationships with them. It was also clear that interview questions should be kept as open as possible so that issues could emerge, but at the same time, it became apparent that care should be taken to balance the open-ended nature of the interview with focusing questions so as not to stray from the general research topic.

Finally, a mock interview was conducted with a family outreach worker in the family placements team in order to pilot the interview questions. A description of the main issues discussed during that interview included: how foster carers' experiences were often variable, unpredictable and difficult to prepare for and how the level of the carers' understanding about the reasons behind the children's behaviour affected how their relationship with the children developed, what behaviour problems the children showed and how the carer dealt with this themselves.

Furthermore, the importance of supporting the carers in understanding and helping the children was seen as paramount. However, foster carers were seen to differ in terms of their willingness to confront the deeper issues involved in understanding the children in their care.

The development of the interview schedule that was used with foster carers in the study was, therefore, influenced by all of the above processes.

2.4.2: Data collection.

Data was collected through interviewing. Each interview that was conducted lasted for around one hour and was audio-tape recorded. When arranging the times at which the interviews were conducted, time was allowed between each interview to allow for transcription and some early analysis of the data to take place. The process of analysis will be described in detail in section 2.5. Please refer to appendix 4 for details of the interview schedule. At the start of each interview, participants were asked to provide demographic details about themselves and the children currently in their care in order to gain more understanding of their individual situations. The interview schedule then comprised of the following areas:

1. Behaviours of the foster children that presented a challenge to the carers. In order to avoid overwhelming respondents when asking about this area, the carers were initially asked to think about one of the current children in their care who was providing the most challenge for them. It was planned that this would better enable the carers to think and talk about their views.
2. Understanding the reasons behind the behaviours of the foster children.
3. Dealing with difficulties and types of support.
4. Experiences of/involvement with CAMHS.
5. Types of support required from CAMHS.

Although open-ended questioning, related to each area, was utilised in order to allow participants to express their views more fully and for the possibility of unforeseen themes to arise, focusing questions were also used to facilitate elaboration of issues where this was needed. Although the areas outlined above were covered in each interview, additional focusing questions were used in some of the later interviews with the aim of exploring issues that were emerging as a result of early analysis of the data (see section 2.5).

During each interview, observations of relevant non-verbal behaviours of the respondents, the interview process and points of interest were noted. Initial thoughts about the key themes and areas that required further inquiry were also noted immediately after each interview using a summary sheet devised by Miles and Huberman (1994) (see appendix 5 for the summary sheet written for the first interview conducted). Field notes were made at other times throughout the research process.

2.4.3: The interviewer's experience.

In so much as the development of the interviews and data collection phase has already been described, a number of additional points about the researcher's experience of conducting the interviews are noteworthy. A common experience when conducting the interviews was the need to make questions meaningful for the respondents and keep the interviewing style open to allow issues to develop. However, this was tempered by the need to be directive with regards to tendencies within some of the respondents to introduce topics far removed from and irrelevant to the research topic or to lose their train of thought. In these circumstances, focusing techniques were used but, at the same time, care was taken not to affect the dialogue with researcher bias. Furthermore, the emotional content of the interviews was, at times, high when respondents conveyed emotionally intense experiences or unresolved issues. Care was, therefore, taken at these times to be responsive but to also preserve researcher neutrality.

Finally, conducting the interviews within the foster carers' own homes was advantageous in terms of being able to better understand the context in which they lived and worked. However, some of the interviews (and thus the flow of conversation) were interrupted momentarily due to respondents having to attend to children in other rooms of their house and then coming back to continue the interview.

2.5: Data analysis

Grounded theory approaches require that the researcher scrutinises their data closely and is simultaneously involved in data collection and analysis. Analysis in grounded theory involves developing an "open-ended indexing system" (Pidgeon, 1996) by starting at the data and working systematically through it, making low-level and more abstract conceptualisations (or "codes"). The analytic process is akin to moving from the data towards more progressively abstract categories and themes. However, in using the method of constant comparison, analysis also involves moving backwards and forwards between the data, codes and emerging themes, refining and extending abstract categories and the relationships between them in order to develop a theory. While simultaneously collecting and analysing data, therefore, the researcher also adapts questions in their interviews to explicate emerging themes in the analysis more fully.

Grounded theory approaches differ not only in the epistemological view they assume with regards to the issues of grounding as described earlier, but also, therefore, in their methods of analysis. This study used the guidelines for analysis outlined by Charmaz (2003). Conceptualising the data in Charmaz' approach is called coding which is described as being the link between collecting data and developing emerging theory. Coding is taken to mean the process of defining what data are about or what is seen in the data. As such, the researcher "acts upon" rather than passively observes the data. Coding has two phases, which were adhered to in the current study.

In the study, the researcher transcribed each interview shortly after it had been carried out. The first phase of coding, “initial coding”, was started after each individual interview had been transcribed and involved examining each line of data in the transcriptions. This line-by-line coding involved the researcher defining, in short sentences, what was happening in each line of data, paying attention to the actions, events and processes that were occurring in or represented by it and examining how the context influenced these actions and statements as well.

As such, in defining these codes, the researcher explored how the interview participant viewed and understood their situation and experience. Through this type of coding, the researcher aimed to keep “close” to the data but at the same time take an analytic stance towards it and use terms that explicated it. The researcher also paid attention at this stage to similarities and differences between the data within and between each interview.

During the time in between each interview, the researcher began the process of initial coding of the interviews and reflecting on possible emerging categories, although this was not completed during the data collection phase. Through this early analysis, however, the researcher was able to follow leads about themes that were emerging in the data. For example, after the first three interviews with foster carers, the researcher found it necessary to follow-up the concept of “being a professional” more fully by asking carers in subsequent interviews “What does being a professional mean for you?” when this subject arose, therefore allowing further elaboration of that concept.

After initial coding of the data was completed, the researcher utilised the next phase of coding, “focused coding”. Focused coding involved synthesising and explaining larger amounts of data, sometimes using the initial codes if these made analytic sense, in order to more accurately and completely conceptualise the data. During focused coding, the researcher sometimes moved back to initial coding of data where previously unseen concepts had become explicit.

In order to facilitate the whole process of coding, therefore, the researcher entered the initial and focused codes next to their corresponding data in the transcriptions, giving each focused code a number to enable identification of which bit of transcript they referred to later in the analysis. The process of constant comparison (making comparisons within and between data and codes) was also carried out in this phase. Please refer to appendix 6 for the transcript and coding of the first interview to show how initial and focused codes were generated from the data and how this was presented to better facilitate the explication of the codes and the method of constant comparison.

In order to explicate the main themes or “categories” that were emerging from the data, the researcher systematically examined each focused code to assess which ones best reflected what was happening in the data.

Some of these individual codes were then raised to conceptual categories, while others were linked together in a logical way and then raised to categories. In this way, therefore, some of the categories embraced common themes and patterns in several of the codes. As the codes were raised to categories, narrative statements about them were written in “memos”. Each category had a corresponding memo in which its properties and, where present, subcategories were explicated. Categories were also described in terms of the conditions in which they arose and how they were maintained and changed. Categories were compared with codes and data to expand and refine them. As the categories developed through writing and re-writing the memos, links between the categories were clarified and described. Furthermore, each category was also defined in terms of whether it subsumed substantive processes or whether these processes were more generic in that they were more fundamental to social life and illustrated themes that ran through other processes. Categories that involved generic processes were named core categories.

Please refer to appendix 7 for a memo that was written about a category called “Working Together” that was included in the study, and appendix 8 which shows how focused codes from the first interview (as shown in appendix 6) were raised to that particular category and compared with focused codes from other interviews to facilitate expansion of the category. Please also refer to appendix 9 for an example of a category that was eventually discarded from the study to illustrate in more detail how categories were refined and developed.

In grounded theory approaches, theoretical sampling is used to extend and explicate categories further. This is where further data is collected and cases are chosen on the basis of their potential to shed more light on emergent categories.

“Theoretical saturation” occurs when data collection no longer brings forth any new insights and it can therefore be concluded that the categories have been fully examined (Charmaz, 2003). As outlined in section 2.3.2, the aim of the initial sampling procedure in the current study, in line with a grounded theory approach, was to obtain a broad perspective of foster carers’ experiences and views by including foster carers in the sample who differed in terms of the length and type of their experiences. The aim was then, in light of the categories that had emerged from the initial set of interviews, to carry out a theoretical sampling procedure, the purpose of carrying out further interviews being to illuminate aspects of the categories that might still be implicit or unexplained in order for theoretical development to take place. The data collected from the interviews in the current study, using the initial sampling procedure, proved to be rich and a number of salient themes emerged from the analysis. During the initial sampling phase, some theoretical leads were followed through as the interviews were conducted and themes were emerging. However, due to the limited time and resources available in the study, it was not possible to conduct any interviews using a theoretical sampling procedure more explicitly to fully examine the categories that had emerged.

Although this meant, therefore, that the sample size remained relatively small and that theoretical saturation was not achieved, due to the richness of the data collected, a number of significant and explanatory categories emerged from the analysis that subsumed many incidents and issues discussed in the interviews and it was also possible to begin to make conceptual links between these categories.

Finally, Charmaz (2003) advocates that throughout the research process, researchers need to become aware of their own way of verbalising concepts and asking questions as researchers are very much part of the meanings they observe and define. In this study, therefore, the researcher paid attention to becoming and remaining self-aware during the whole life of the research project for the purposes of the collection and analysis of data. This was facilitated by keeping personal notes about the research process throughout the project (see appendix 10 for an example of some personal notes that were made while carrying out the project).

The researcher utilised a number of checks of validity and reliability in the study to ensure greater research rigour. These will be described in the next section.

2.6: Establishing rigour in the study

2.6.1: Issues of validity and reliability in qualitative research.

Rigour in qualitative research refers to the degree to which a qualitative study's findings are authentic and its interpretation credible (Lincoln and Guba, 1985). However, issues of validity and reliability, which are used mainly in quantitative research approaches, are viewed by some qualitative paradigms, such as the constructivist approaches, as inappropriate. For example, study replication and reliability in this form is not an aim for qualitative researchers because studies are conducted within uncontrolled field settings as opposed to in controlled environments.

For qualitative researchers, their main aim is to achieve “trustworthiness” in their findings. Trustworthiness in a study is taken to mean that it was carried out fairly and ethically and that its findings reflect as closely as possible the experiences of the participants (Padgett, 1998). As such, there are three areas of threat to the trustworthiness of qualitative studies. Firstly, given that qualitative researchers study phenomena within the natural setting, their presence within it may potentially interfere with the incidents that they are hoping to understand.

Secondly, bias on the part of the researcher may occur with respect to asking leading questions during interviews or not choosing participants and ignoring data that do not support the researcher’s world view. Furthermore, researchers may become biased by “going native”, i.e. becoming too involved in the participants’ point of view and situation. Conversely, they may also become too alienated from the participants and field situation to be an effective researcher. Thirdly, bias on the part of the participant may also happen. For example, during interviews, participants may withhold information or lie to protect their privacy or they might try to be overly helpful by giving answers they think the researcher wants to hear.

In order to overcome the issue of irrelevance of using measures of validity and reliability in qualitative research but also acknowledge the need for establishing its soundness, Lincoln and Guba (1985), using a constructivist approach, provided a framework for thinking about rigour in qualitative studies.

In outlining this framework, they used terminology that was analogous, but not the same as, terms used in quantitative research. These were credibility (internal validity), transferability (external validity, generalisability), auditability (reliability) and confirmability (objectivity). Credibility, like internal validity, refers to assessing the truth of accounts, for example by checking with participants if they recognise their experiences in the research account and also being reflexive about the research process. Transferability, similar to generalisability, involves assessing whether research findings are applicable to settings other than the context of inquiry.

Auditability is analogous to looking at the reliability of a study and involves making each stage of a research project explicit by documenting and externalising processes such as choices made in the analysis and how interpretations were made. This is referred to as creating an “audit trail”. Finally, confirmability (objectivity) is about being able, as a researcher, to show that findings (categories and theoretical concepts in the case of grounded theory) are grounded in the raw data. In light of these issues, it was seen as important to establish rigour in the current study.

2.6.2: Strategies for enhancing rigour in the study.

In order to counteract possible threats to trustworthiness in the study and to, therefore, enhance rigour, the researcher applied the following strategies. Firstly, with regards to credibility of the findings in the study, the researcher engaged in a process of personal reflection about the role of their own values and interests at all stages of the research project (e.g. when selecting the sample, during the interviews and when analysing the data). Writing these reflections down as part of field notes during the study facilitated this process. The researcher also discussed codes and ideas in peer supervision to evaluate whether the codes made sense and to check that a suitable distance from the data and participants’ experiences was being maintained.

During and at the end of each interview with the study participants, the researcher made efforts to clarify that they had understood the issues that had arisen from the participants’ point of view. A further credibility check was also carried out with the study participants after the analysis had been completed, by asking them whether they thought that the themes that had emerged from the analysis of all the interviews were, in their opinion, a valid representation of their accounts. This was done by making another visit to a Foster Carers’ Support Group meeting after the analysis had been completed in order to present the themes that had emerged and to obtain feedback about their validity.

During the presentation of the themes at the meeting, three of the six sets of foster carers who participated in the study were present and five foster carers who did not participate in the study were also present (see appendix 11 for the summary of the project and themes that was presented to the foster carers). Confidentiality about the participants' identity was maintained throughout the presentation and all carers present at the meeting were invited to offer feedback.

Feedback from the group of foster carers (including both participants and non-participants in the study) was that they could relate to the themes and that they found them an accurate reflection of the main issues and conflicts that they had talked about during the interviews. During their feedback, the foster carers reported that they did not think that any important issues had been overlooked and that the themes encompassed the main aspects of their experiences.

The participants also reported feeling that the themes just "popped out" and that the themes encompassed a balanced perspective on the experiences of foster carers (i.e. including both positive and difficult aspects). The foster carers present also voiced opinions about the importance of receiving acknowledgement and support from CAMHS if they have been referred to them and about how they felt a lack of clarity about the roles of the different professionals within the system they were in. Overall, the feedback from both the study participants and foster carers who did not participate in the study but who lived within the local authority being studied, supported the credibility of the themes that had been generated out of the analysis of the interview data, thus enhancing the rigour of the current study.

When considering transferability of the findings in the study, it was thought that some of the issues raised might be applicable to the experiences of foster carers working in other authorities. This was thought to be the case with respect to the fact that the context of the local authority under study was not totally different from the contexts of other local authorities.

In general, however, caution was taken when considering transferability of any of the findings given that the study was carried out with foster carers in one particular local authority only.

Thirdly, issues of auditability in the study were addressed by documenting the decisions made throughout the research process. For example, initial and focused codes were presented next to the data to which they referred. Each focused code was then given a number, which was referred to when developing categories and writing field notes about interpretations in the analysis. In this way, evidence of an audit trail from the data to the categories was provided. Please refer to appendices 5 to 9, which illustrate the development of codes from the first interview and show, by providing an example of one category and its corresponding memo notes, how these codes were compared with codes from other interviews and raised to categories.

Finally, confirmability was addressed by moving backwards and forwards between abstract concepts and the raw data when developing the categories to check that the findings were grounded in the data that was collected.

CHAPTER 3: RESULTS

3.1: Introduction

In selecting the sample in the study, the main aim was to interview foster carers living and working within one local authority and who had experience of having at least one child in their care for a minimum of six months. In order to get a broad perspective of foster carers' experiences and views, it was seen as important to interview carers who varied in terms of the length of time they had worked in fostering, the types of placement they offered, the ages of the children they had in their care and whether they were married or single. It was also seen as necessary to interview both carers who had received or were receiving support from CAMHS and those who had not. Foster carers who were related to the children in their care and those who fell under the category of prospective adopters were not included in the sample as it was felt that the experiences of these types of carers might be qualitatively different and beyond the scope of the current study.

Six different sets of carers, comprising of two married couples, three single female carers and one married male carer took part in the study. Please refer to tables 1 and 2 for the age, gender and ethnic status of the eight individual carers who participated in the study.

Table 1: Age and gender of the individual participants.

Age Group	Number of Males	Number of Females
40-49 years	0	2
50-59 years	3	2
60-69 years	1	0

Table 2: Ethnic status of the individual participants.

Ethnicity	Number
White/UK	4
White/European	3
Afro-Caribbean	1

The six sets of carers varied in terms of the types of placement they offered (see table 3) and the length of time they had been fostering (see table 4).

Table 3: Types of placement offered by the carers.

Type of Placement Offered	Number of sets of carers
Short-term – teenagers.	4
Short-term – younger children.	1
Long-term.	2
Specialist – teenagers.	1
Permanent respite.	1

Table 4: Length of time each set of carers had been fostering children.

Length of time fostering	Number of sets of carers
0-10 years	3
11-20 years	2
21-30 years	1

All the sets of carers were fostering children at the time of the current study. The total number of children being fostered over the whole sample was twelve. The number of children being fostered by each set of carers ranged from one to three.

The length of time that these children had been in the participants' care ranged from two months to four years. Each set of carers, however, had at least one child who had been in their care for longer than six months. It should also be noted that the total number of children that each set of carers had fostered over their whole career ranged from two to over one hundred.

Please refer to tables 5 and 6 for details of the age, gender and ethnic status of the children currently in the care of the study participants and to table 7 for the lengths of time that these children had been in the care of the participants.

Table 5: Age and gender of children currently being fostered by the study participants.

Age group of children	Number of males	Number of females
0-5 years	1	0
6-10 years	0	0
11-16 years	4	7

Table 6: Ethnic status of children currently being fostered by the study participants.

Ethnicity	Number of children
White/UK	5
White/European	2
Mixed race (UK/African)	3
Mixed race (UK/origin unknown as yet)	1
Afghanistan	1

Table 7: Length of time the current children had been in the care of the participants.

Length of time	Number of children
0 -11 months	5
1-2 years	2
3-4 years	5

Four out of the six sets of carers did not have any other people living with them apart from the foster children. However, in the case of the other two sets, in addition to the foster children, one set had their own child living with them, and the other set had two adopted children living with them.

In terms of their experiences of CAMHS, two sets of carers had attended consultations with CAMHS, one set of carers fostered a child who had attended CAMHS, one set of carers had not attended CAMHS but they had attended consultations with a psychologist working in the community many years ago and one set of carers had no experience of CAMHS at all.

Through interviewing the foster carers, the study aimed to understand their experiences more fully with regards to how they understood and coped with the emotional and behavioural difficulties of the children in their care and what types of support they valued from CAMHS.

All the carers in the sample were interviewed about the following areas of experience: issues related to the children in their care that currently presented a challenge for them; their understanding of how these issues came about; how they coped with the difficult aspects of fostering; their experiences of outside support and CAMHS provision; and what support they required from CAMHS.

The data from these interviews were then analysed using the grounded theory approach outlined by Charmaz (2003), which is described in detail in the methodology section of this study (chapter two). As such, codes were defined from the interview data, from which, through a process of abstraction and constant comparison, the following categories and subcategories emerged:

1. Building relationships – dealing with ambivalent feelings.
 - Connecting with “damaged” children
 - Negotiating relationships with the children’s parents.

2. “It’s a secret society out there” – being on the system interface.
 - Being under the spotlight
 - Feeling misunderstood.

3. Needing training and support
 - Working together.
 - Learning on the job versus formal training.

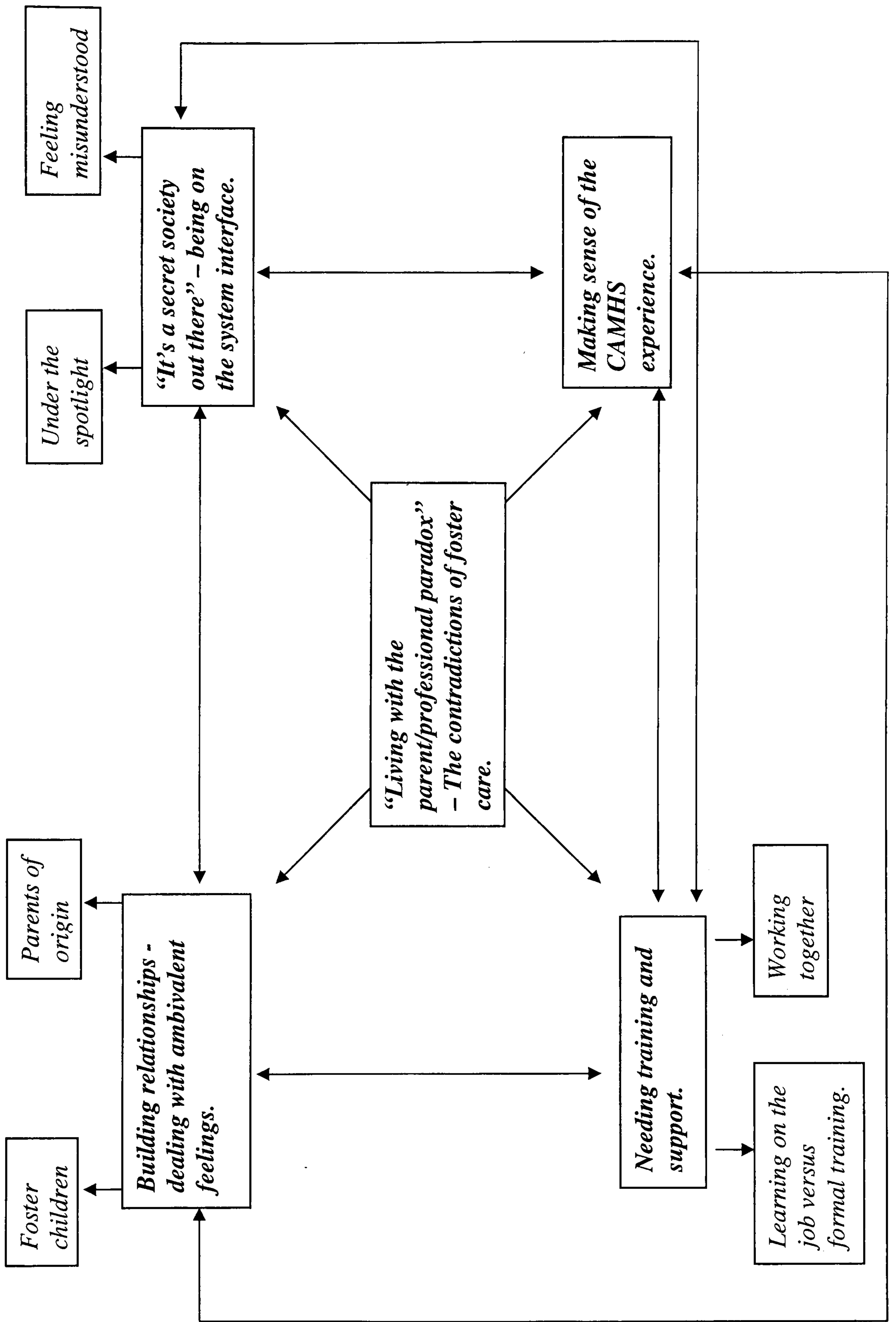
4. Making sense of the CAMHS experience.

Running through and linking all these categories was one core category, which was referred to as:

“Living with the parent/professional paradox” - the contradictions of foster care.

The links between all of the categories that emerged in the study are diagrammatically represented in Figure 1.

Figure 1:



As the foster carers described their experiences of fostering and their understanding of the children in their care, it became increasingly apparent that they faced many conflicting ideas and contradictory situations. These were present in their relationships with the children, with the children's parents and with the wider system including mental health services. The carers valued the role of both developing a relationship with the children in their care and helping them overcome difficult situations. Yet they often felt misunderstood, under-supported and untrained for the challenges they faced. It emerged from their interviews that at the heart of their role lay a paradox, that of being a parent/nurturer but at the same time being a paid professional. This pervaded all their work and relationships and was dealt with in different ways by the carers.

The order in which the categories are presented reflects how the carers' story developed. Starting with the often conflicting feelings that their relationships with the children and the children's parents threw up, the category "Building relationships – dealing with ambivalent feelings" will be discussed. The story then moves on to how these central relationships in the foster carers' experience were seen to be viewed within the wider system, which encompasses the categories "It's a secret society out there – being on the system interface" and "Needing training and support". This is followed by discussion of the category "Making sense of the CAMHS experience", which focuses specifically on the foster carers' experiences of mental health service provision. Finally, the core category "Living with the parent/professional paradox – the contradictions of foster care" will be presented and the links between this and the other categories will be considered.

3.2: Building relationships – dealing with ambivalent feelings.

3.2.1: Connecting with “damaged” children:

In describing the contradictions inherent in the foster carers’ experience, the story begins with the carer/child relationship and the feelings that the foster carers experienced with regard to the children in their care. These, often ambivalent, feelings were fuelled by the behaviours and/or backgrounds of the children, which appeared to challenge, in different ways, the carers’ ideas about parenting, normal family practices, relationships and helping.

Despite not being a universal experience in the sample studied, the majority of carers identified and viewed at least one ongoing behaviour that a child in their care showed as difficult to manage. Carers described having to cope with chronic, severe and sometimes unusual behaviours that stirred uncomfortable feelings within them, prompting them to, at times, respond in unexpected ways. This then made them question their own ability to sustain appropriate relationships with the children. The following is an example of a male carer dealing with a foster child’s illicit drug use. All the names used in the extracts are fictional representations of each carer/child to protect the identities of the participants in the study:

Fred: Whatever, you wanna be a saint, or you wanna be a god or something, there are minutes when you can urm [pause] lose it for a second, might say something that you don’t wanna say, er, it’s not easy when you have a child, sitting down for, say, five hours saying “I want pocket money”, “I want pocket money” a week early, you know “I want next week’s pocket money”, and then you say “no” and he says “yes I want it” and then you can’t give it to him because it’s like you’re encouraging him to have drugs.

Behaviours that carers found difficult in the foster children were, for example, those behaviours that they had not seen before, that for their own reasons they found unacceptable and/or that they did not expect children in general to show.

When reflecting on these behaviours, the carers described feelings of fear and confusion as shown in the following examples.

Janet: *She self-harmed, so that was scary for me. I wasn't used to dealing with people with self-harm.*

Sharon: *I find the fact that she swore at me is kind of up the anti now, because that's kind of a taboo that was, you know, no-one ever has sworn at me, even my worst placements never swore at me, so I just think, you know, that she's overstepped the mark now, and now anything could happen.*

David: *Well, er, well I mean obviously because the three year old had been abused, he was very timid, urm, he was very afraid that we might hit him or something, I mean we wouldn't hit him obviously, er, er, he used the wrong words for things, that were grown-up words for things, like going to the toilet sort of thing, urm, but, er, er, he would stand close to you and start rubbing your thigh sort of thing, and you've got to say "Well, you don't do that".*

Finding behaviours of the children difficult to manage and the feelings that these evoked were an intrinsic part of the types of relationships the carers experienced with the children. All the carers spoke of choosing to make an emotional investment with the children in their care (albeit of differing intensities) and how they saw building an emotional bond with the children, being like a parent or nurturer, as part of their role.

David: *You would not be doing your job right if you didn't have some urm, eternal attachment to the child, because if they, they need that, they need that, that, love, that sort of affection that you give them and attention, you just can't do that as if you were an office worker or someone.*

Building relationships with the children was seen as a two-way process with both carer and child bringing their own needs and ideals to the partnership. The importance of a “match” between the carer and child appeared to be central to this view as well as there being individual differences in the connections they built with the children. Thus, when analysing their own feelings with regards to the children, the carers described wanting to show parental love and affection, which was often cultivated in terms of what they felt the children needed from them and the type of placement being offered as illustrated in the following extracts.

Fred: *The young man is more, he leans more to my wife, and the young lady leans more to me cos that's what they need, they need er, one needs a mother, the other one needs a father, so, you know, depending on what the needs of the children that come here, they move to either my wife or to me.*

Mary: *It's the children's choice, and very often they'll put that on you.*

David: *There are some children that you, that have some, for no apparent reason, you think I can't give this child my whole er, hundred percent love and affection like I would my own, for some reason, it doesn't work and that can happen (carer talking about caring for younger children – 0-5 years).*

Fred: *It doesn't matter how you try and motivate that child, if that child takes a dislike to you, for any reason, it could be something very silly and something very simple, and you don't know what it is, you know, it won't work.*

Despite feeling and wanting to show affection towards the children in their care, many of the carers described how building this relationship could often be a complex task. Circumstances such as the child's background were seen as affecting the carer/child relationship in terms of developing trust and reciprocity. The carers spoke of having to deal with feelings of frustration and a lack of achievement when faced with unusual relationships with the children as in the following examples.

Fred: *With anybody that moves to you, you get a honeymoon period which can last from three to four weeks, where the child is best behaviour because they wanna impress you, that they're good, they're not bad and then, but after that, they start going back to their routine which is acceptable, because they can't keep this urm, this cloak over them, the good cloak over them. Then they say "well these people are going to reject us again" you know "they're not gonna care for us, why should we do it" and they start testing you. And they keep testing you and they keep testing you to see how far they can push, right. Then you reach a point when you have to say "Well, this is not working" [pause] or you reach the point where they say "well, we've tested you enough" you know "let him take a brick off" of the invisible wall, you know, so you take a brick off, they don't put it back.*

Janet: *Well it's just, it's just the way it goes, you've just got to keep going backwards and forwards all the time. Sometimes you take a step forwards and then two steps back, but, urm [pause], you've just got to put up with these things sometimes.*

Sharon: *Sonya has not made any emotional investment in the placement so I kind of feel that I've given a lot and nothing has come back, although foster care, that is actually that's foster care in a sentence – giving a lot and getting nothing back.*

Most of the carers reflected on the different ways that they communicated and showed affection towards the children, comparing their experiences as carers to that of a parent. As such, carers felt limited in the amount of parental affection they could show even if the children seemed to need that. The following is an extract from a male carer talking about the differences between being a parent and a carer.

Fred: *Your focus now has to change, because the smallest action you can do will cause an offence to the child. You know I could put my daughter on my lap, but I can't do this to another child, that's not my, which is a shame, but you have to be, or when you cuddle, I cuddle my daughter, a full cuddle, but when you cuddle a foster child, you have to do a side cuddle.*

In dealing with their relationships with the children, all of the carers expressed ideas and views as to the reasons behind the children's difficult behaviour and ways of interacting. It seemed that the way that the carers understood the foster children's behaviours and circumstances was very much connected with their emotional experience of caring for them. Most of the carers expressed strong feelings about the children's histories and backgrounds, such as anger and sadness at the way that they had been treated. Despite the frustration, fear and confusion they might feel with the children's behaviours, it seemed as if the carers also felt a high degree of empathy with the children's circumstances and firm ideas about the causes of the difficult behaviours. Some examples of this are illustrated below.

Fred: *There are times when I am very angry with him, there are times when I am really angry with him but then there's other times when I hear him say things like that "Where are you going to be?" and I know deep down that he's petrified about losing us or not knowing where we are.*

Sharon: *I kind of looked back on it and both of the times that she pooed in the room was when she had a big row with her mum on the phone. She had a very, very difficult relationship with her mum, her mum was urm, not really playing the adult, she was playing the child and making the child feel responsible for things that were not her fault, making her feel guilty, all kinds of er, her mum played a lot of urm tricks, you know, psychological manipulation of the child and then this is how she reacted, you know, by pooing in her room.*

Sharon: *It isn't her fault, she's been groomed to behave inappropriately to males because, you know, this man has been, had her in his bed since she was a child so it's not surprising, you know, that she shows inappropriate behaviour towards men.*

In so much as the carers had formed an understanding of the reasons behind the behaviours that the foster children showed, they also appeared in differing ways to link these reasons to the damaging effects of past experience. The damage was seen as needing a lot of work to repair. The environments in which the children had been brought up were seen as having had a lasting effect on the way that the children behaved and interacted. However, the carers also distinguished between causes they believed to be related to adverse experience and those that were more akin to general phases that all children go through.

David: *If kids come to us, if they've been taught bad habits, some of them come to us, they're dirty, they've been sick all over their clothes, they've just been left like that, you know, or they've been beaten or er, various kinds of abuse and it's effected them greatly, I mean it's, it's a challenge, a hell of a challenge to try and show that that's not the way people treat children, and the way people treat children is like this, you know, not like that, and urm, and that takes a while because that's all the experience they've had.*

Janet: *She could've been learning good stuff cos she's quite receptive, you know, but she's got to be in that environment and she hasn't been in it since she left home, she's been in worse environments. Sometimes I think she was better off at home, and that was bad enough, do you know what I mean?.*

Sharon: *Some of them have got real psychological problems from, you know, emotional problems, or, they've been abused when, you know, sexually, emotionally, they've been neglected, you know, earlier in their life, a lot of them have problems with attachment, they're the kind of problems and, and teenagers, I always say teenagers, all teenagers, no matter what culture they're in, they have wooden ears, they don't hear. They hear selectively, they hear the bits they want to hear and they will swear blind we didn't say it, or we didn't ask them or we didn't tell them or whatever it is you didn't.*

When reflecting on the children's situations and circumstances, most of the carers also spoke of how the children must be feeling as a result as illustrated in the following examples.

David: *The feeling that the child must have is one of constant rejection, low esteem.*

Fred: *It's not easy, you know, when you go to your family, and then you've got to say right you've got to go home now [pause] and, they're telling you, you've got to go home now when that is home to him, that's his home over there, this is not his home here.*

Fred: *Well, no child in foster care feels happy.*

Janet: *Social services, when they got the whole picture, they saw that the whole, the whole household was neglected, the younger siblings too, and then they were eventually taken away as well, they put her into care when they realised it was three of them that were in danger and they've taken those into care too, so, in a way, she sort of feels guilty about the whole thing that her family have been broken up.*

Kate: *She's so fired up to achieve and, you know, doing really well at school, there was concern and anger though, not guilt, but anger and concern for her mum and how her mum wasn't being cared for and her anger is directed at the authorities.*

Linked to the empathy that the carers had for the children were fears within themselves of “damaging” or hurting the children even further. This was particularly difficult to deal with when they were faced with a placement move as shown in the following extracts.

Fred: *We're working , ur, we're trying to find a way of working around this so [pause] not to have the placement break is [pause] you know, what do we do? We, do we break the placement and reject him? He's been rejected by everybody. Or do we carry on and hope that this [pause] cos he doesn't go to school either (dealing with foster child's difficult behaviour and school refusal).*

David: *We waved goodbye to them, and urm, from the child's point of view, is that they'd been rejected if you like by their parents to come to us and we'd rejected them, I mean it is a form of rejection when you're handing them over to other parents.*

What seemed to be important to all of the carers in the study was being able to help or “reach” the child and to change the difficult behaviours that they showed, thus representing the more professional side to their role. However, most of the carers described this as being a challenging task when the children did not want to accept help because they had “closed down” and no longer trusted care-givers.

Janet: *If you've been dragged from place to place, urm [pause]. They've just been thrown out wherever they go in, they would be kicked, a lot of this, a lot of this they create themselves, they jeopardise their own placements, they push boundaries to the limit and they just sort of see how much they can get away with before you chuck them out.*

Janet: *I mean I can understand that now, urm, I can understand that feeling, moving from one place to another, one area to another, moving schools, it must be, it must be really difficult. They must close down, they can't be open, they can't be, they can't develop properly if they keep moving all the time.*

Anne: *He doesn't admit help, he doesn't let anybody come in to help him, nobody, he doesn't talk to anybody.*

Fred: *It's a pattern that everybody needs help and he's not prepared to accept help from anybody, and he can't do it on his own.*

Finally, feeling that they were not able to help a foster child prompted various feelings and levels of personal reflection within the carers. This ranged from feelings of guilt and failure to acceptance and increased self-awareness to viewing the causes as external and beyond their control.

Sharon: *She's got a myriad of problems and I haven't made any difference to any of them, so if she was to leave, my point would be perhaps the next person will have a chance to make a difference because I don't feel that I have. So, you know, in terms of investing time and all that sort of thing, it won't be a sad ending because I'm very frustrated with the sys, with the relationship that we have. I mean as far as I can see I am investing a lot and there's nothing happening [laughs].*

Sharon: *You do come to a point where you are not having any effect and it's just causing frustration on either side and you have to, you have to know when you reach that point, you have to know.*

David: *I think you just suffer really, urm, if you, I think the only way you deal with it is to say to yourself well look, you know, and I don't think anyone could have succeeded with that case because it was an, an impossible situation, and that's the kind of compensation for saying to yourself well I'm, you know, not worthy to have, you know.*

David: *Every situation's different [pause] but er that, I think as a foster parent is the hardest part of all, is the actual sort of letting go when you've been looking after a child for so long, you've, you, you tend to sort of feel very protective like a normal natural parent would be, and er, releasing that, urm, sort of hold that you have on them is the hardest part, you know you feel, to a certain extent, that you're doing them a dis-service, I think, deep down, I, you know, I'm sorry but I'm not, I'm not gonna warm to you quite as much as I, as I did, kind of thing, because that's, that's where you're going, this kind of thing, urm, and I think they, urm, pick up on it (talking about short-term placements with younger children).*

Fred: *It's not because it's his fault or her fault or their fault that the placement is breaking or it's not working, because it's, every child is different and we can't do miracles.*

In summary, the carers in the study described experiencing many different, sometimes contradictory, feelings with regards to the children in their care. Investing emotion and building an attachment with the children was seen as an important part of their role. However, connecting with the children was sometimes a difficult task in the face of, for example, the effects that their past experience had on their ability to build relationships. Despite showing empathy and genuine affection for the children, the carers also sometimes felt frustrated and saddened by their inability to change the children's behaviours, which they also so as an intrinsic part of their role. As such, the carers experienced the duality of having the feelings associated with being a parent as well as feeling the responsibility of the carer's role.

3.2.2: Negotiating relationships with the children's parents.

All of the carers in the study described strong and often conflicting feelings about the parents of the children in their care. These stemmed from their views about the reasons for the distress that they witnessed in the children.

In addition, some of the carers interviewed were, as part of their role, required to forge relationships with the children's parents, which often entailed the task of having to then define the boundaries within this.

When reflecting on the foster children's difficulties, most of the carers disapproved of their parents' treatment of them before they entered care. The children's parents were, for example, seen as incompetent or as teaching their children "bad ways", which prompted feelings of anger and sadness in the foster carers, which are illustrated in the following extracts.

David: *The hideous level of abuse that was levelled at her, er, by a boyfriend of her mother, she just let it go on, urm, and I feel angry about that, there's noth, it's nobody's fault, other than her parents - her mother and this bloke.*

David: *The natural parents, you know, maybe they had, you know, sometimes they have to go to a special unit to, to learn because they're just not capable of looking after a child, for one reason or another, urm, maybe if they're alcoholics, they've gotta, you know, get out of the habit first, and, they'll, they'll love their child, but because of this habit they can't do it, or drug, drug addicts is the other common thing.*

Sharon: *The reason Sonya's life is in a state is cos she's still sorting your life out, yeah? So, if she wasn't sorting, if you're the adult here, you wouldn't be in this situation you are in (making hypothetical dialogue with foster child's parent).*

Janet: *She wants to be grown up and she's been subjected to that in her, at home with her parents, sort of that sort of talk, so she's sort of grown up very quickly, she's had to sort out the younger children cos her parents were out to lunch all day and were never really there, and was like doing errands for her parents, bringing drugs in and stealing things and stuff like that, so, you know, that's the sort of upbringing she's been with.*

The carers also described feeling as though the children's parents were the ones with the problems, not the foster children. This is shown in the following examples.

Kate: Our issues are more to do with the parents' mental health issues and the problems that you as a foster carer have in accessing that.

David: Some of the parents are a bit mental, it's true actually, some of them are, the only mental cases we come across really are the parents. The children are amazing sometimes, they've had alcoholic parents and the children have looked after their parents and come into care when they're children and there's nothing wrong with them, they were just, had to support their parents, amazing really, some of the things you see.

Despite having strong feelings in the face of the foster children's distress, in the cases where the carers were required to or did have relationships with the children's parents, feeling responsible for dealing with the parents' feelings and difficulties in the absence of any other support for the parents was a common experience as seen in these examples.

David: Some of the biggest problems of foster carers are, urm, dealing with the natural parents. Sometimes they are er, they can be, they're usually fairly anti, they can be quite abusive because obviously we're looking after their children and they can't do it, so there's a feeling of animosity often. One of the major problems I think is dealing with the er, with the parents because of their animosity and their, putting them at ease and trying to make them feel not inadequate which is dead easy because they do feel inadequate.

Mary: There's nobody listening, you know, it feels like there's nobody, and this poor woman is going through this on her own and nobody is helping, and it's very frustrating (talking about foster child's mother).

Tom: *I think mum's feelings are that nobody really seems to have achieved much other than these foster carers have come in and helped me through a bad patch and have kept it going for two years and I'm grateful for that.*

Kate: *They said that we should be knowing our, knowing where the line's drawn in the sand here and where our burden of care lies, you know, and I just, that we might be over-involved with mum and it's like well, we'd only love too much to be able to disengage, only, she lives around the corner and she's got no food, she's got no gas, she's got no electricity and she hasn't paid her rent, you know, so if we can sort those things out then we can just be firm and shut the door, you know, it's a bit difficult in between, 'til finally; it took four years, it's only in the last six months that we've actually finally got the last bit of gas and electricity sorted out.*

Some of the carers also described a more direct role of supporting the rehabilitation of foster children to their parents as shown below.

Tom: *The feeling is that well at the end of the day, it's not gonna be me, it's poor mum that's gonna have to deal with this, so you do tend to, to hold off that little bit and try and give the power to mum, so you, you talk to Chris about not what I want from him, but what his mum would want from him.*

In summary, therefore, the carers in the study described feeling anger and disapproval of the foster children's parents at times, yet they sometimes found themselves having to deal with the parents' animosity, support the parents in the absence of any other support and thus deal with possibly undefined boundaries in their relationships with them. In the case of placements in which rehabilitation to the child's parents was a possibility, the carers were required to achieve a balance between being a temporary parental figure but at the same time encouraging the child's parents to assume a more active role.

3.3: “It’s a secret society out there” – being on the system interface.

3.3.1: Being under the spotlight.

In addition to challenges within the carer/child relationship and with the children’s parents, the carers in the study spoke of having to deal with the pressure stemming from the expectations of their role by the wider system. This pressure involved feeling that the placement and carer/child relationship was under constant scrutiny, in terms of being accountable to and reporting the placement’s progress to the local authority. This is illustrated in the following extracts.

David: *I think while you’re with them you have a tremendous level of responsibility, maybe even more so than your own personal child cos you, you have to answer if anything happened, you know, you’d have to answer to so many people, as well as social services and everything, so you, you’ve gotta do a good job, you’ve gotta be a professional.*

Tom: *You feel restricted and you’re always conscious of the fact that urm these aren’t your children, and so you, you know, you’re limited anyway, as to what approach you can adopt and what you can and can’t do and, I mean, there’s not only written rules, but there’s psychological rules that are always in your head as to what you can and cannot do, and the extent that you, you turn to and expect the so-called multi-disciplinary team to pull in their resources.*

Fred: *He knows what he is doing that he’s putting himself in danger, and he knows that the placement is in danger and the more he feels that everything is getting on top of him, the more the pressure’s on, you know, it’s a vicious circle (talking about foster child).*

The carers also described how it was important to pay attention to their interactions with the foster children, for example, what language they used and how they showed physical affection as this could be misinterpreted by children from a different culture or background. It appeared, therefore, that the carers felt a need to be constantly vigilant and careful about their actions, as shown in the following examples.

Fred: At the beginning, when I once said, erm, to somebody "It's a half-cast child" and the outreach worker said "No, you can't say that, you've got to say they're mixed race", so, in a sense that's a criticism, that's their role to criticise us to make sure that we, we learn by our mistakes, not to, and learn to re-phrase certain things. It's very important how you say, you can say to your own child "I love you" but you can't say that to a fifteen year old female foster child and you're a male carer. It can be seen, especially if they live in a world which is unfortunately misunderstood, so as a male, these are the little things that you learn to avoid.

Mary: You start thinking my god, urm, I've never smacked anyone but supposing they [referring to previous foster children] say I have, so there's that worry, you know.

Finally, the feeling of being under scrutiny had the effect of some carers feeling that their privacy was intruded upon and that the foster family unit was stigmatised and singled out by the system. As such, the professional aspect of their role (being under the spotlight) came into conflict with being in a parental role. The following example involves a female carer describing her experience of sending a child in her care to an overnight party with friends.

Janet: I mean if you think about your own child, you'd find out who the parents are, you'd find out who the child is and let them go to a pyjama party, it's so normal, but these children can never go without, you've got to ask for police checks, so you don't wanna be police checked for a party do you.

3.3.2: Feeling misunderstood.

As well as feeling under pressure from the wider system, all the carers described feeling as if their role was misunderstood and sometimes disrespected by other professionals. This was related to their understanding of their being in quite an objective position in the multi-disciplinary team within social services (i.e. not as integrated as other members) but at the same time having a unique insight into the foster children given that they had most contact with them. For the carers, it seemed as if other professionals in the system did not recognise or acknowledge the complexity or full-time nature of their work, as shown in the following extracts.

Fred: *You know, it's very hard for somebody who's not in this kind of position that we are to understand what the pressure is on us.*

Fred: *Social workers and other professionals, they can walk away, whereas we're here twenty four hours, seven days a week, fifty two weeks a year.*

David: *At one time, I think it was believed that we should, we just look after them, you know, feed them, put them to bed, you know and I don't know, but, and then, then, we give them away and that's it like some kind of robot or something but it's not like that, it doesn't happen, it never will, it never really has.*

Furthermore, most carers spoke of not having their views listened to, wanting to but not being involved in decision-making within the multi-disciplinary team and not being informed enough about the children in their care. This is illustrated in the following examples.

Fred: *You feel that [pause], you're the one that's looking after the child, and you feel like somebody else is, they've brought the child and dropped them and never made a connection with you, you know it feels like there's a secret society out there, and you're left out.*

Tom: *I suppose, when, after a year that you start to, to question a bit more deeply exactly what are the plans for Chris, then all of a sudden, things could come at a rush and then they're, they sort of conflict against what you feel you've been achieving and you get quite hard and fast reports that seem to be at the complete other end, like, that say he shouldn't even be in foster care, that he's too damaged for that.*

Mary: *How you're treated by some people in the local authority, at the end of the day, you do end up with the feeling, that the term would be "Well just hold on a minute, you are only the carer", you know, there is a, you're, you're only allowed so much into this, you know, you might feel as though you're part of this group but, in actual fact, you do sit, your chair's just that little bit back, you know and so you think okay, right then, so what are you gonna do then? And then a lot of talking goes on, but then nothing actually, you know, materialises, nothing happens, and then because your chair's a little bit back, you tend to get more of an overall picture of what's going on.*

Janet: *I just think that maybe foster carers or long-term foster carers should be more involved in deciding with the child, cos quite a lot of the time, you're not quite sure what's going on, and I think there should be more er, more conferring with foster carers, something that I didn't get.*

Kate: *How do we ever get to a point where I can sit down with someone who's not going to, who's just going to say "Okay, I'm gonna listen to you for however long it takes to get through this and we'll just take that away and we might choose to agree or disagree with stuff but then at least you're getting heard.*

Kate: *You see my perspective is more on the interface and I know I'm not alone in that this is where we have our problems.*

In summary, when describing their relationships with the wider system, two sub-categories emerged from the interviews with the carers. Firstly, it seemed as if being constantly scrutinised by the local authority often put pressure on the placement and carer/child relationship which fuelled anxieties and feelings of being intruded upon. In addition to this, the carers felt misunderstood and under-valued by other professionals as well as uninformed and excluded from decision-making to the point where they felt somewhat alienated by the system instead of acknowledged and respected as fellow professionals. This had the effect of limiting their role and work with the children.

3.4: Needing training and support.

3.4.1: Working together.

Linked to their experiences of organisations and professionals within the system, the carers in the study spoke about their views on support and training. All the carers held strong beliefs in the importance of working together (e.g. as a family or as a community), and in communicating and working with other professionals. Furthermore, communication between organisations was also seen as vital in helping them in their role. However, in the absence of available or regular support, some carers felt that they had to “go it alone” or that they had to “fight” in order to receive communication and support.

When reflecting on their own support systems, all the carers valued connections with friends and family members. The presence of this type of support was, however, not universal to all the carers in the study, as shown below.

Sharon: I've got lots of friends. You have to have a good support system otherwise you will go under, and I must say when I do re-tell these things to my friends, I do end up laughing, but at the time, I'm really upset, but when I say it, I always manage to put, cos it's, I've kind of got a sense of humour, and it's, sometimes the only thing that enables you to survive.

Fred: *I think the strength is, if you want to be a foster carer, I think the strength is that you have to be a team [pause] you know, you've gotta work together with your wife or your husband.*

Kate: *I do have a very, very extensive support network of, of friends who are interested, you know. We have a community network, you know, and I help the neighbours here and I'm, of course, I'm the sort that will talk to anyone, you know, so you get to know your neighbours very quickly.*

Janet: *I've found out that when you have a very difficult child, you lose some of your friends. If they're the type of friends that don't understand the children, they take it very personally, you know, so you don't see them again for a long time. "Is she still with you?" [laughs]. They've gotta make sure they're not there before they come round.*

Working together with the professionals in the wider system was seen as affecting the foster children in a positive way in the sense that it could better facilitate change. However, some carers felt frustrated that the idea of working together was not achieved, as illustrated in the examples below.

Fred: *I found out in my bitter experience that unless everybody's working together from one direction, it's against the child.*

Tom: *We were hoping to rehabilitate him but we seem to be working on our own, because we're not getting any help from anywhere else and we work with mum quite a bit (talking about work with foster child).*

Tom: *I think in both cases I just mentioned, urm, I've really got to say there was very little support from the local authority. The ideas were there, but there was no action taken.*

In the following example, the carer reflected on how being viewed as competent resulted in their being left to work with the children on their own more. As such, being more professional in this case seemed to result in decreased rather than increased support.

Mary: *People know that they're okay with us, so you can understand, well yes, they've got to deal with the emergency of the time, and the kids that are doing, not okay, but are, you know, we're not screaming, they get left behind and even our, our link-worker is, is, because we do say everything to her, she is realising that, she feels frustrated because the social workers are not getting round to dealing with these children, cos I say "When are our kids going to be a priority?", but we deal with an awf, we do deal with a lot, which maybe another carer, other people wouldn't be able to deal with it, so that would become an emergency.*

In addition to working with professionals, all the carers held the idea of having an outlet or a professional to off-load to about their work in high regard.

Fred: *I speak now of our link-worker and outreach worker, it's like, they come here, whenever they come here, and, you know, you've got sort of a pressure cooker and they just turn the stat and let the steam out [laughs] and everything comes down, you know, and I think that's a role that they play very well and, you know, as soon as I, the boiler is boiling, I ring up and say "Look, I wanna speak to you".*

This type of support, however, was not always available. In the cases where there was lack of support, the carers found themselves having to deal with situations on their own and for some, this was accepted as an expected part of their role. This is illustrated in the following extracts.

Sharon: *I rang duty, duty social services, and er there was, as usual, there's nobody there, it goes onto an answer phone and they didn't actually ring me back (describing an incident when she felt at risk of harm from a child in her care).*

Janet: *I get asked for support, but the thing is they do ask me if I want support but what sort of support could anybody give me, that would be of any use to me?.*

Sharon: *I have these very difficult placements where none of the endings are brought to a close, and I have to, where do I put my anger? Where do I put my emotional investment that's now had the chop? Where do? You know if you want me to be a good carer, you have to look at the holistic picture, you must, yeah? And you have to help me to do that (talking hypothetically as if to other professionals).*

3.4.2: Learning on the job versus formal training.

The carers in the study felt very strongly that the most influential learning process that they went through was actually learning from the practical experience they gained from being a carer. They described feeling under-prepared and under-resourced as first-time carers. However, they also saw each foster child as coming with a different set of issues and needs, as shown in the following examples.

Anne: *It's like every job, you do have to learn on the job, there's only so much that people can tell you. You do have to learn on the job.*

David: *I think, you know, it's, you have to, I don't know if you can train for it, in how to deal with people.*

Fred: *The first placement we had, we were right in the deep end, with no paddle.*

Although on the job experience was felt to be important, most of the carers also highlighted the need for more training. They described their role as involving a high level of responsibility and professionalism. Linked with this was their belief that they needed to become professional through more training. The following examples illustrate this.

Janet: *Well people think it's a nice little lady that looks after children and all this sort of stuff, and it's not that at all, it's a job, it's actually a very difficult job and I think that more training should be provided, I really do, because the more experience you've got, it makes it easier.*

David: *Well, it's a high level of responsibility, I think it's a profession, yeah, it's not a job urm, and that's the thing you do because you like the kids.*

In terms of the types of training the carers valued, understanding psychological issues, the reasons behind behaviour and how the mind worked were seen as helping to prevent placement breakdown. Access to literature was also seen as beneficial.

Kate: *I'd love to see the Support Group far more in the way of nurses coming along and books and stuff and, you know, helping carers to understand that when a young person comes in and is really like this that perhaps space is a better way rather than confrontation, and understanding what has been going on in the family too.*

Fred: *Our outreach worker has brought me quite a few books to read, which I've enjoyed reading, and [pause] whether, as a normal family man, a father, or, looking after children, your own children, there's certain things that you don't read in the background, you don't read in your mind, er, so, when somebody does something, you know, what's the reason behind them doing what they did.*

Fred: *I think that social services should provide a library with books, where they were circulated to all foster carers, you know, I think that would be a tremendous amount of help to them, because you need to understand.*

In summary, a strong theme that emerged from the interviews with the carers was the ethos of working together with family and friends, but also within the system of professionals. However, support from the system was not always available; this was compounded by a lack of working together. In some cases, therefore, carers felt as though they were on their own. With regards to training, carers similarly placed importance on the availability of this, viewing their role as involving a need to be responsible and professional when caring for the foster children. However, the value of actual practical experience was held in high regard and there was the view that training could not prepare foster carers for some of the aspects of their role.

3.5: Making sense of the CAMHS experience.

Although the carers' experience of CAMHS differed, they had clear ideas about what they would like from such a service. For example, they wanted to learn about strategies and the reasons behind behaviour, help with the carer/child relationship, consistency and goals. The carers also felt that both the foster child and their parents should get support from mental health services, as shown below.

Sharon: It's about being creative [pause], and about what CAMHS should produce, you know, if they were like round the corner and available and nice people, you know, it's about supporting the young person, supporting the foster carer, and then supporting them joint, supporting them individually and jointly to, for the placement to work and coming up with strategies, I think that's part of their job. Come up with strategies, that's gonna help us cope, the young person and the foster carer cope with the issues that are coming up. Come up with stuff because they're trained professionals.

Kate: Well it's getting the services to communicate, because the mental health team are over here, [pause], CAMHS are over there, when the parents have got mental health issues.

Despite the carers viewing CAMHS as a potential support for the carer/child relationship, it seemed, in general, as if there was a mystery surrounding what CAMHS was and who it was for. Connected with this ambivalence were general views about mental illness being an extreme experience that most people did not understand or have to deal with. CAMHS seemed to be associated only with the most extreme, chronic difficulties that the foster children presented with and the problems of the children's parents, both of which threw up conflicting and unmanageable issues for the carers. As such, it seemed as if CAMHS was viewed as being for the most extreme of circumstances and that it was there predominantly for the children and not for the carers. Views about mental illness are illustrated in the following example where a female carer was talking about a friend who attended counselling.

Sharon: I know my friend quite well, and she, she didn't tell me, she only told me now because she's been going for a year, she didn't tell me she was going, but it is, you know, mental health is, people don't talk about it.

Ideas about CAMHS are shown in the following example where there was also an acceptance that carers dealt with most of the children's behaviour without needing external support.

David: I think that they are, yeah, they are a service that's there should we need them, I don't think we've ever had any need of them really, er, I think if we did have a child that was behaving very, very strangely, then I think we would. We've always dealt with whatever we've had.

Those carers who had had experience of CAMHS expressed the strong feelings that going to CAMHS brought up for them. These feelings seemed to be connected with earlier themes about the need to work together, feeling misunderstood by other professionals and feeling under the spotlight.

The core theme, encompassing the tension between being a professional and being a parent, was also part of this and pervaded the relationships the carers had with CAMHS professionals, their experience of not being part of the referral process and their wish for more mental health links in the community. This is illustrated in the following example.

Sharon: *They're not at ground level at all, they're not and I don't know what their perception of foster carers are cos a lot of them think that we're just mums, you know, and I've got a degree and I've got post-graduate qualifications, do you know what I mean?, so, I, and if they don't know where you're coming from, they haven't had any information about you, they've probably been given some information about the child, but if they haven't been given any information about you, and they start off on the wrong footing, these things are very critical issues and if the first one goes wrong, you're not gonna go back, you know.*

The following extracts illustrate some of the feelings that going to CAMHS consultations threw up for foster carers, ranging from guilt, anger or fears that they were mad themselves.

Sharon: *Their idea, their perception of what the sessions were about was I was sitting there with the young person, the young person would criticise everything that's happened in my household cos it's the last appointment, and then I, and then I felt that I had to defend all of this, I was kind of put on the defensive, and it was a very negative feeling for me, I got very angry, but of course I couldn't show any of my anger.*

Fred: *If it's not explained to you, or it's not finished in that session, in the right way, you understand, so you might, if you're not strong enough or you're not professional enough, you might feel that [pause] am I the one that's mad? Am I the one that's mental? You know, [laughs] and I felt that a couple of times. Some people might not have the confidence that I have and I think that's when you need to make sure they understand what the goal is right from the beginning, so they're not meant, not to feel guilty for doing fostering, now I've got to go and see a mental psychiatrist as well you know?*

The carers did, however, also highlight the types of support they had found helpful from CAMHS and what they had learnt from attending sessions with them. This included being part of three-way consultations as well as seeing benefits for the foster children who had attended, as shown in the following extracts.

Fred: *It's a funny triangle really, it's, it's like me and the child talk and the psychiatrist is listening and I'm saying things, and she's saying "no, it's not this way" and we're going round in circles and that's, that's helped me tremendously to understand.*

Janet: *I think she was very good [pause]. I think sometimes it would be a bit, oh I don't know, maybe not, she did see her about once every three weeks, and it sometimes wasn't enough really but that's, I'm sure it's better than what other kids have, so maybe it wasn't ideal, maybe she could've done with a little bit more at the time, but it did help a bit (reflecting on foster child's therapy at CAMHS).*

Finally, some of the carers also brought up the practical implications of attending CAMHS centres. This seemed to mirror the feeling that CAMHS were difficult to access in terms of not being in the community and being there only for the most extreme difficulties.

Sharon: *You've got to drive for an hour and a half, have a counselling session for an hour, drive for another hour and a half, you're not actually, it's not actually helping you either.*

In summary, making sense of the position that CAMHS held for foster carers in the wider system brought up conflicting views for the carers in the study. On the one hand, CAMHS was associated with stigmas about mental illness and the view that it was there to provide a service to foster children with extreme behaviours rather than the carers. On the other hand, some of the carers identified specific types of support that they saw CAMHS as being able to provide, for example, support to deal with the children's behaviour and learning about psychological issues in more depth. However, attending CAMHS sessions (an experience of a small proportion of the carers) had thrown up difficult feelings (such as guilt and defensiveness), which were, to some extent connected to feelings about professionals in the wider system, for example, feeling under scrutiny and not being understood or valued as professionals.

3.6: "Living with the parent/professional paradox" – the contradictions of foster care.

The core category that emerged, pervading across all the other categories, was that of the parent/professional paradox, which was felt to be at the heart of the foster carers' role and thus inherent in their experiences. The parent/professional paradox referred to the conflicting expectations of foster carers. That is, to develop an emotional attachment with the children in their care and take on a broadly parental role but to also be skilled and equipped to deal with and change difficult behaviours and in some cases encourage rehabilitation or a move onto a more permanent placement.

All the carers in the study reflected on the multi-faceted task that they faced in fostering, expressing a strong desire to build a relationship with the children, which involved aspects of being a parent. However, the carers also experienced their role with the children as requiring skills over and above those of a parent in order to be able to understand and deal with the behaviours of the children in their care. They, therefore, also placed great importance on being a professional when considering their work and relationships with the children, as shown in the following example.

David: *You've gotta do it properly, you know, because you're dealing with personal, people's lives, urm, I mean if you made a mistake at, at the office, you know, I don't know, it would cause a lot of problems maybe, but if you made a mistake with someone's life, I think that's more important, you know, so I mean it's, it's vital that you have to do the job as professionally as possible, but it is an emotional job as well, so it's kind of different to working at the office or something like that cos you're, you know, it's someone's life that you're partly in control of.*

Fred: *You have to be really, it's double for these children because they're very wise, you know, they've been through, some of these kids have been, what I say is that they've been tortured by experts, they've been starved by professionals, they've been mistreated by professionals, so when they come to us, we have to be professionals too, to find out how we're gonna help these children, and it's not always easy, you don't always succeed.*

Similarly, when defining their relationships with the children's parents, the carers sometimes found themselves faced with the conflicting feelings about the parents' incompetence and occasional animosity, but at the same time the task of empowering and supporting them in a professional role.

Tom: *With Chris, because there is a parent, you know, I feel they should be a stronger tie than we should be.*

Underlying the categories of being under the spotlight and feeling misunderstood, was the ambivalent role the carers assumed within the wider system. The carers' attempts to create a normal family environment and build a parental attachment with the children felt thwarted by the pressure and scrutiny placed on them by the local authority. At the same time, the carers felt misunderstood and under-valued by the other professionals in the system. It seemed as if the inherent contradiction in their role (parent or professional) was mirrored in their position within the multi-disciplinary team. As such, they did not feel acknowledged as "one of the professionals" by the team, yet they held an important and valuable perspective on the needs and difficulties of the foster children, which is shown in the following examples.

Mary: *I mean we knew what went on there [referring to house that foster child spent time at], so, it's a crack house anyway, because we do our research, we go out, you know, we, we don't just sit in here and you know, wait for them to come in and give them their tea and see 'em to bed..*

David: *We've been accused in the past of loving the child too much, you know, which, I mean they now know that if you stop short of loving a child, then, er, they're not getting what they need, you know, that love and trust.*

The carers valued the idea of working together with other professionals and receiving support to maintain their work. As such, these were the types of qualities associated with having a professional role. Furthermore, given the duality of their role with the children (as involving both emotional and professional aspects), great importance was placed on receiving support. However, working together and support were often in short supply, which the carers saw as detrimentally affecting their work and relationships with the children.

Although only a small proportion of the carers had had experience with CAMHS, it seemed as if these carers' relationships with CAMHS were affected by the way that they dealt with their conflicting roles and position within the wider system. For example, feelings about CAMHS were seen to also connect with feeling under scrutiny and feeling misunderstood in their role (as encompassing both parental and professional aspects). CAMHS was, however, also seen as a potential source of training, support and professionalisation for foster carers.

Having described each of the categories that emerged from a grounded theory analysis of the interviews in this study, the relationships between the categories, their connections with the existing research literature and the implications this then has on future research will be considered in the discussion section that follows (chapter 4).

CHAPTER 4: DISCUSSION

4.1: Overview of the study's findings

By utilising a grounded theory approach to analysing foster carers' accounts in one local authority, this study enabled further understanding of how foster carers understood the emotions and behaviours of the children in their care, how foster carers used these understandings in their relationships with the children, how foster carers experienced and utilised outside support and what types of support they valued from CAMHS.

The principle finding in this study was that foster carers have a wide range of complex experiences that can be conceptualised as being subsumed under an overall contradiction that is inherent in their role; that of being both a parent and a professional. This core theme pervaded other themes found, ranging from ambivalent feelings within relationships with the foster children and the foster children's parents to being on the interface of services and needing training and support.

This study reported how foster carers often experienced complex and conflicting feelings with regards to the relationships with the children in their care. Building an emotional attachment with the children was seen as very much part of their role. However, the process of building a relationship could be a difficult task in light of the emotional reactions carers might experience in relation to particular behaviours that foster children showed and the difficulties foster children were perceived to have in embracing a new relationship with a carer. Having empathy for what the children must be feeling as a result of the "damaging" effects of their past experiences fuelled a pressure within some foster carers to behave in such a way with the children so as not to contribute further to their distress. However, contradictory expectations of the foster carers made this difficult to achieve.

For example, some foster carers felt that the children would perceive them as “rejecting parents” when a placement came to an end, carers were sometimes not able to show physical affection to a child who was perceived as needing that, and some carers felt torn between the placement expectations to bring about change in the children’s behaviour and the realities of needing to build trust gradually with the children.

In terms of understanding the difficulties of the children in their care and the relationships they built with them, the foster carers experienced strong feelings towards the children’s parents. Parents were often seen as the perpetrators of abuse or incompetent nurturers who had detrimentally affected the lives of the foster children. Yet the foster carers were also sometimes in the position of having to work with and forge relationships with the parents in the absence of clear boundaries with regards to the extent of their involvement with them. In some cases, the foster carers felt an empathy with the parents in terms of their isolation from support and resources.

In general, the foster carers felt a strong sense of responsibility in their role to build a relationship with and provide a good experience for the children in their care, to help them overcome difficulties and to support and sometimes empower the children’s parents. Being a foster carer therefore involved professional skills and expertise in addition to being a parent.

The relationships that the foster carers experienced with the children in their care and the children’s parents were strongly linked to their relationships with professionals in the wider system, how they understood their role to be perceived by organisations and their views about training and support. Being in the position they were in, many of the foster carers felt that their experiences were under the spotlight of the wider system, which, in turn, brought pressure to the carer/child relationship. For example, being accountable to the authority and recording placement progress was an intrinsic part of their role.

This feeling of being under scrutiny was also seen to impede the natural processes of family life with the foster children, which were valued highly. Furthermore, all the foster carers experienced a lack of acceptance within the team of professionals with whom they worked. This was apparent in the lack of recognition professionals showed with regards to the amount of time the carers spent with and, therefore, the unique knowledge they held about the children. The foster carers felt that, on the one hand, there was an expectation of professionalism within their role, but on the other, a lack of awareness and acceptance from other professionals about their work. This was evident in, for example, not being involved in decision-making within the multi-disciplinary forum.

The foster carers' views about training and support were also bound up with these experiences. The concept of working together with other people, in terms of working together with the children, with other carers, with families, with friends and with other professionals was seen as important in facilitating their relationships with and their ability to help the children in their care. However, most of the foster carers found support and communication within professional organisations to be sporadic and limited. Moreover, given the complex nature of their work, most of the foster carers saw aspects of their experience as impossible to train for and that, therefore, the only way to learn was through the actual experience of fostering. However, there were other aspects, such as the acquisition of professional skills to help the children, which the foster carers valued training in.

Finally, for the few carers in the study sample who had attended CAMHS sessions, their experiences had fuelled a range of feelings such as guilt, defensiveness and fears that they were mad as well as empowerment and further knowledge. Negative feelings were connected with general views about the stigma of mental illness but also with fears of being scrutinised, devalued and misunderstood by professionals within CAMHS, as with the other organisations within the system.

Despite these feelings, the foster carers viewed CAMHS as having a clear-cut and valuable role in helping them to understand the psychological aspects of the children's behaviours and backgrounds, in developing strategies in dealing with difficult behaviours and in helping to enhance the carer/child relationship.

4.2: Relevance of the study's findings with other research

In so much as the current study was different from previous studies investigating the experiences of foster carers because it utilised a grounded theory approach, the findings in the current study relate to a number of aspects in the foster carers' experience that are known within the literature. Firstly, the contradictory role of foster carers highlighted in this study is similar to the ambiguities and lack of clarity about the expectations of foster carers referred to by Berridge and Cleaver (1987) when temporary foster placements were becoming more common-place. These ambiguities were seen as relating to the expectation that foster carers assume a parental role with the children in their care but only for the time-limited period of the foster placement. Since that time, however, expectations of foster carers have become even more complex in the advent of encouraging more active involvement of foster children's parents and the increase in the number of children with emotional and behavioural difficulties being placed in foster care. As such, the call for foster carers with professional expertise and therapeutic skills has greatly increased. However, recent research indicates a high incidence of emotional and behavioural difficulties in foster children in general (e.g. Dimigen et al, 1999; McCann et al, 1996; Minnis et al, 2001) suggesting that having to deal with these types of difficulty is a fairly common experience for foster carers today.

Recent studies that have focused on the subjective experiences of foster carers commonly highlight difficulties in terms of coping with the behaviours that the children in their care show (e.g. Gilligan, 1996; Jones and Morrissette, 1999; Quinton et al, 1998; Triseliotis et al, 2000).

However, in a qualitative study by Schofield et al (2000), types of relationship that the carers experienced with the children were grouped in terms of the patterns of secure and insecure attachment outlined in attachment theory. In so much as the current study sought to explore the ways that foster carers understood the behaviours of the children, it's findings in relation to the difficulties experienced in building relationships and connecting with the children are broadly consistent with the types of behaviours shown by the children in Schofield et al's study. However, themes related to how the carers thought about and reacted to the children's past experiences and behaviour, how this influenced their relationships with them and how this connected to paradoxes within their role and the wider system enhance the findings in earlier studies and have a number of clinical implications which will be outlined in section 4.3.

Themes that emerged in the current study concerning foster carers' conflicting feelings towards the parents of the children in their care are partially supported by previous studies that highlight the carer/parent relationship as being one of the strongest tests of carers' professionalism (Millham et al, 1986; Berridge and Cleaver, 1987). A more recent study that focused on the outcomes of a group of children, their families and carers in short-term placements (Aldgate and Bradley, 1999) found that a third of the carers experienced difficulties in setting boundaries with the children's parents who were often isolated and in need of support and care-giving themselves. This finding is consistent with the carers' accounts in the current study of their relationships with the children's parents.

The findings in the current study that foster carers felt misunderstood, undervalued, untrained and unsupported by organisations in the wider system are well supported by the existing literature on support for foster carers (e.g. Berridge, 1997; Caesar et al, 1994; Sellick and Thoburn, 1996). Furthermore, the findings that the carers valued a need for specific advice on coping with the emotional and behavioural problems of the children in their care is consistent with recent studies by Quinton et al (1998) and Minnis and Devine (2001).

In general, the findings in the current study with regards to the foster carers' relationships with the children in their care, the children's parents and the wider system are fairly consistent with the general picture portrayed in previous research. However, they also offer new ways of understanding the experiences of foster carers and the expectations and pressures that are placed on them in the current political climate. They also suggest that foster carers continue to experience difficulties with coping and a lack of support and that this experience is not necessarily specific to particular localities, although caution in generalising the findings of the current study should be taken into account.

In terms of the current study's findings on experiences of CAMHS for the foster carers, it should firstly be noted that these comprised a small sample of carers in the study as a larger proportion of the carers had not attended CAMHS themselves. Themes arising that concerned the stigma of mental health and attending CAMHS are well-known in and consistent with the literature about families who attend generic CAMHS teams.

Carers in the current study who had not attended CAMHS before, showed a lack of knowledge about the types of support it offered and to whom. This is an interesting finding in itself, but it may be context specific given the larger scale study carried out by Golding (2002) who evaluated the views of foster carers attending a consultation service at a CAMHS in another authority. In Golding's study, the foster carers reported positive benefits in terms of feeling heard and understood and starting to think more positively about the children in their care. As such, in addition to the fact that the current study did not access a larger sample of carers who had had experience of CAMHS, it was evident from the study's outset that the specialist CAMHS that was being researched was a less well-developed service than some of the more established ones described in the research literature (e.g. Pallett et al, 2002).

4.3: Clinical implications

The clinical implications of the current study can be viewed in a number of different ways. Firstly, an often key role for clinical psychologists working in specialist CAMHS for looked after children involves supporting and facilitating foster carers to develop skills that meet the complex needs of the children in their care. In better understanding the experiences of foster carers, professionals who consult with them in this way, are, therefore, more able to tailor interventions to suit their needs. Furthermore, gaining an understanding of the conflicts intrinsic to the foster carers' role, provides a framework from which to explore their difficulties with them. It is thought that acknowledging and validating foster carers' conflicts and experiences would facilitate awareness in and a good working relationship with this client group, thus making goals such as developing self-efficacy and problem-solving about difficult issues more attainable.

Secondly, the findings in this study have more over-arching implications in terms of highlighting a need for more consistency and team-work between professionals in the care system, increased support in general, and training about psychological issues and behavioural strategies for foster carers.

Finally, although conclusions about the study's findings with regards to the types of support foster carers require from the local CAMHS team are very tentative, they do shed light on issues of accessibility and lack of clarity about services. As such, it might be interesting to explore knowledge within the system of professionals in the local authority as well as with more foster carers about the types of support CAMHS offer.

4.4: Limitations of the study

Time and resource factors placed a number of constraints on the current study. These involved conducting the research as a single researcher within the time-limited framework of a doctorate degree.

In light of these constraints, the following limitations were present in the study. Firstly, in terms of analysing the interview data from foster carers in the current study, although constant comparison methods were utilised throughout the analytic process and adaptation of interview questions to explore issues of interest was carried out in the last few interviews that were conducted, it was not possible to carry out theoretical sampling after the initial sampling phase, which aimed to obtain a broad perspective of foster carers' experiences and views by including foster carers in the sample who differed in terms of the length and type of their experiences. As such, therefore, a shortcoming of the study was its small sample size, which meant that theoretical saturation was not met and thus the categories that emerged in the foster carers' accounts may not have been fully explicated. One direction for future theoretical sampling from the current study could have been, for example, to interview more foster carers living and working in the local authority who had had experience of CAMHS in order to examine the category "Making sense of the CAMHS experience" in more detail.

Secondly, and somewhat related to the first point, triangulation within qualitative research refers to the reliance on multiple sources of information to yield clearer and deeper observation of a phenomenon. In the current study, triangulation was evident in the consistencies observed between data within and between the interview accounts obtained. However, other types of triangulation that would have enhanced the trustworthiness of the study further could have included gaining the perspectives of other people involved in the care system, such as social workers or link-workers. Triangulation using different data sources, for example, observation or archival materials, was not appropriate in the study given the nature of the experiences being explored. Furthermore, triangulation using multiple coders of the interviews was not possible due to resource constraints.

Thirdly, a number of checks against researcher bias were carried out in the study, for example, peer supervision, researcher reflection and clarification with respondents during the interviews as well as member validation of the themes that emerged from the analysis after the analysis had been completed.

Feedback from a group that included some of the study participants and some other foster carers who did not participate in the study but who lived within the same local authority, indicated that the categories reflected and fitted with their experience. This, therefore, enhanced the credibility of the current study. It may have been interesting to conduct a second interview with each of the study participants, which would have enabled further examination of the emerging categories as part of a theoretical sampling procedure. However, this would have conflicted with ethical considerations about over-loading the carers with in-depth interviews and taking up their time.

Fourthly, although the credibility check of the themes indicated that some foster carers who did not participate in the study found them to accurately reflection their experiences as well, there was, in general, limited opportunity to gain understanding of the carers who did not participate in the study, for example, exploring the reasons why they did not take part or their characteristics. Finally, an assessment of the applicability of these findings to other settings was also not possible. To do this, it would have been necessary to interview foster carers living and working in different local authorities. However, given that the findings of this study echoed findings in earlier studies, it is possible that interviews with foster carers in other local authorities in the country would yield similar findings.

4.5: Directions for future research

In light of the issues raised with regards to the limitations of the study as outlined above, the following directions for future research in order to extend the study and thus develop a more complete theoretical framework about the experiences of foster carers would be useful.

1. Collection and analysis of further interview data with foster carers living and working within the local authority under study.
2. Collection and analysis of interview data with other professionals working within the local authority system who come into contact with foster carers regularly, for example, social workers, link workers and family outreach workers.
3. Collection and analysis of interview data with foster carers living and working in another local authority.

Given the interesting themes that emerged from the data surrounding foster carers' experiences of CAMHS in the study, future research might evaluate this service in more detail. For example, this could be done by conducting an audit of need with a larger sample of foster carers living and working within the local authority.

In this instance, it could be seen as appropriate, once qualitative analysis of a small number of foster carers' accounts was complete, to develop a quantitative survey based on the qualitative findings, in order to then access a larger sample of foster carers by asking them more specifically about the types of support they required from CAMHS.

Finally, on a larger scale, once a basis for which a clearer understanding of how foster carers understand and cope with the emotional and behavioural difficulties of the children in their care has been developed, a training package for foster carers could be developed and evaluated to better meet their need for advice in this area.

4.6: Conclusions

The findings in the current study, with regards to the contradictions in the experiences of foster carers and their relationships with the children in their care, the children's parents and wider services, were related to previous research with foster carers. In utilising a grounded theory approach to research, the study provided a new understanding of the in-depth processes inherent in the foster carers' experiences and the meanings they brought to them. The study had a number of implications regarding the development of a theoretical framework for understanding the experiences of foster carers, which could be used within a clinical setting to facilitate consultation and training with them. Furthermore, the study highlighted the need to audit a newly developed specialist CAMHS serving foster carers living in the catchment area of one local authority, thus to better understand the types of support they required from such a service. Finally, the findings in the current study were consistent with previous research that highlights the general need for increased support and training for foster carers as they embrace the challenging roles expected of them.

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APPENDICES

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APPENDIX 1

Version.....

PARTICIPANT INFORMATION SHEET (INTERVIEW)

- 1. Study Title:** *The Foster Carer's Experience – coping with the emotional and behavioural needs of children in their care and working with services.*

You are being invited to take part in a research study. Here is some information to help you decide whether or not to take part. Please take time to read the following information carefully and please ask if there is anything you do not understand or if you would like more information. Thank you for reading this.

2. What is the purpose of the study?

The current study was developed out of an interest in better understanding the experiences and needs of foster carers living in and around the Borough of ... when dealing with the emotional and behavioural problems of the children in their care. It is hoped that this study will determine what type of advice and support foster carers need from specialist child and adolescent mental health professionals to cope effectively with the needs of the children in their care.

3. Why have I been chosen?

You were chosen for this study in your capacity as a foster carer employed by and living within the Borough of You will be one of approximately based foster carers involved in this study.

4. Who is organising the study?

My name is Joanna Mary, and I am a trainee clinical psychologist at the University of Hertfordshire. I am carrying out the current study for my doctoral research project, which forms part of my training. The study will be completed in six month's time.

5. Participation

It is up to you to decide whether to take part in this study or not. If you do decide to take part you will be given a consent form. If you decide not to take part, this will not affect your current or future care from any service or your role as a foster carer.

Even if you decide to take part, you are free to withdraw at any time and without giving a reason, and this will also not affect your current or future care from services or your role as a foster carer in any way.

6. What will happen to me if I take part?

You are being invited to take part in an interview with me about your experiences of being a foster carer. I am interested in understanding your views about the emotional and behavioural needs of the children in your care, your experiences of dealing with these issues and your relationships, if any, with child and adolescent mental health services. You may choose not to answer particular questions and you are free to stop the interview at any time.

The interview will last for approximately one hour and will be audio tape-recorded. I am happy to visit you at your home in order to carry out the interview at a time that is convenient for you. However, if you prefer, we can meet to carry out the interview in a clinic room at ... Hospital.

7. Confidentiality

All the information you give during the interview will be treated with confidentiality and your decision to take part in the interview will not be released to any of the services you are involved with. However, in the event that you disclose to me that you wish to harm yourself or another person, I am required to inform your social worker about these disclosures.

The tape-recording of the interview will be transcribed onto a secure database using no identifying information about you whatsoever and it will not be used for any other purpose than for research analysis. Once transcribed, the tape recording of the interview will be destroyed. Should you decide to withdraw your consent at any point, all records of your interview will be deleted.

8. What are the risks in taking part?

It is possible that during the interview, you may be faced with issues that you find distressing. Should this happen I am happy to discuss this with you during the interview or give you time to 'debrief' at the end of the interview. Alternatively, you could talk in more detail about the issues discussed with your link worker who will respect your confidentiality with regards to these.

9. What are the possible benefits of taking part?

The information gathered from the interview will be used (together with information from other interviews) to inform specialist child and adolescent mental health professionals of the viewpoint of foster carers and of the types of support they may require.

10. LREC Approval

The current study has been approved by ... NHS Trust Local Research Ethics Committee.

11. Contact for further information

Miss Joanna Mary

(Address)

Tel. No:

Fax No:

E-mail:

Thank you for taking time to participate in this study.

APPENDIX 2

Dear Miss Mary

– The foster carer's experience – coping with the mental health needs of children in their care and working with services (Ms Joanna Mary, Trainee Psychologist)

Acting under delegated authority I write to acknowledge receipt of your letter dated 2002 (received 2002) and the enclosed clarification requested by the LREC in our letter to you dated 2002. There is now no objection on ethical grounds to the proposed study. I am therefore happy to give you the favourable opinion of the LREC on the understanding that you will follow the conditions set out below:

Conditions

- You do not undertake this research in a NHS organisation until the relevant NHS management approval has been gained as set out in the Framework for Research Governance in Health and Social Care.
- You do not deviate from, or make changes to, the protocol without prior written approval of the LREC except where this is necessary to eliminate immediate hazards to research participants, or when the change involves only logistical or administrative aspects of the research.
- You send an interim report to this LREC in one year's time or when you have completed your research or if you decide to terminate it prematurely.
- You advise this LREC of any unusual or unexpected results that raise questions about the safety of patients taking part in the research.

I confirm that LRECs are fully compliant with the International Committee on Harmonisation/Good Clinical Practice (ICH) guidelines as they relate to the responsibilities, composition, function operations and records of an Independent Ethics Committee/Independent Review Board.

Please quote LREC number on any future correspondence.

Yours sincerely

LREC Co-ordinator

APPENDIX 3

CONSENT FORM

(Interview)

Title of Project: The Foster Carer's Experience – Coping with the Mental Health Needs of Children in their Care and Working with Services.

Name of Researcher: Miss Joanna Mary, Trainee Clinical Psychologist.

1.	I confirm that I have read and understand the information sheet dated.....	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without my medical care, legal rights or role as a foster carer being affected in any way.	
3.	I agree to my interview being audio tape recorded for analysis and understand that recordings will be destroyed once transcribed. Names will not appear on the transcripts but rather they will be numbered and stored safely. No individual names or identifying material will appear in the final report.	
4.	I agree to take part in the above study	

Name of Participant Date
(block capitals)

Signature

I have explained the nature, demands and foreseeable risks of the above research to the participant.

Name of Person Date
(block capitals) taking
consent if different from
researcher (status/relationship)

Signature

Name of Researcher Date
(block capitals)

Signature

1 for participant;

1 for researcher

APPENDIX 4

INTERVIEW SCHEDULE

Introduction

1. Introduction by researcher - name, status and explanation of role as objective, non-judgemental interviewer.
2. Inform participant of aim of interview:
“I am interested in understanding your views about the emotional and behavioural needs of the child/children in your care, your experiences of dealing with these issues and your relationships, if any, with mental health services”.
3. Inform participant about the structure of the interview session: Will last for approximately one hour, start by asking several short questions about current circumstances, then will ask a number of questions about participant’s views and experiences.
4. Inform participant that they do not have to answer any questions that they do not wish to and that they are free to stop the interview at any time.
5. Inform participant about confidentiality and procedures surrounding audio tape-recording the session.
6. What will be done with the information gathered:
Participants will be informed that the study is a doctoral research project, which will be submitted to the University of Hertfordshire in November 2003. They will also be informed that the main themes and issues that come out of the interview will be summarised and then compared with other interviews to inform specialist child and adolescent mental health professionals of the viewpoint of foster carers and of the types of support they require.
7. Ask participant if they have any questions.

Questions

1. Participant details:- (10 minutes)

- (i) Age, gender, ethnic status of foster carer.
- (ii) Age, gender, ethnic status of child/children in care.
- (iii) What is the current situation with regards to the child/children in your care? (e.g. temporary placement, long-term, specialist etc.) and how long have they been in your care?
- (iv) For how long have you been a foster carer?
- (v) Who currently lives at home?

2. Subject Areas/Questions:-

- (i) I want to ask you first to think about one of the children in your care. It might be easiest to think about the child who is currently providing the most challenge for you. Can you describe to me a particular behaviour that this child shows, which you are currently finding difficult.
Possible focusing questions = Does your child/children show difficulties in, for example, the following areas: social situations/relationships; school; anxiety; feeling unhappy; aggression/anger. (10 minutes)
- (ii) What do you believe is going on for the child when they are behaving in this way? Why do you think they are behaving in this way? What are the main issues for you? (10 minutes)
- (iii) Tell me about your experience of dealing with these difficulties.
Possible focusing questions =
 - How do they impact on you and your family's life?
 - Did you expect these difficulties?
 - Have you managed to overcome dealing with these difficulties, and, if so, how?

What barriers have you experienced in being able to deal with these difficulties?

What advice would you give to other foster carers in similar situations?

What kinds of support do you draw on to deal with these difficulties?

Who's around to deal with the behaviour? *(10 minutes)*

(iv) What experience if any have you had of specialist child and adolescent mental health services? What kind of support have you received? Was it helpful? Did it meet up to your expectations?

(v) What support, if any, would you like from specialist child and adolescent mental health services? *(15 minutes)*

End of interview

(5 minutes)

1. Clarify main points of interview with participant.
2. Inform participant that an opportunity to “debrief” with the researcher after the interview is available, or alternatively, they can discuss any issues of concern with their link-worker.

APPENDIX 5

INTERVIEW SUMMARY FORM

Interview number: 1

Date: ...

1. What were the main issues that struck you in this interview?

Rejection

Pressure gets too much to keep the placement going – both child and carer have vested interest.

People “outside” don’t see the children in the way that the carers do.

Role of male carer – have to change way of doing things – not like being a father.

Being careful about what you say and do – carers and children both feel this (linked to pressure to keep placement going).

Notion of working together.

Children having a lack of trust of people.

CAMHS seen as being for “mental” people

2. Summarize the information you got (or failed to get) on each of the target questions.

(i) Nature of behavioural difficulties of child.

Drug use.

Damage to property.

Self harm.

Pushing boundaries.

Splitting.

Unable to open up.

(ii) Understanding of underlying issues to difficulties.

Fear of rejection.

Not able to ask for/accept help from others.

Given up on themselves.

Distrust of people.

Learnt bad coping strategies (e.g. drugs) from birth families.

(iii) Ways of coping with the difficulties.

Managing confrontation levels within the house, giving pressures an outlet.

?Tension between keeping or loosening boundaries.

Communication between professionals and working together.

(iv) Types of support.

Link-worker, outreach worker = listen, facilitate release of pressure, offer different perspective.

Each other (husband and wife).

Daughter – practical help.

(v) Past experiences of CAMHS

Felt mad/guilty for being bad foster carers when asked to go to CAMHS.

(vi) What needed from CAMHS.

“Weapons”/strategies.

Greater understanding of psychological issues.

3. Anything else that struck you as salient, interesting, illuminating or important in this contact?

The carers were friendly and willing to talk openly about a range of topics. I thought that they could have talked for longer than an hour. However, I also thought that they might have feared saying “too much”/”the wrong thing” during the interview (e.g. paying attention to be “politically correct” in the way they used language) perhaps because they felt they were being judged or that their work with the children in their care was being evaluated. It could be that these fears partly stem from experiences of being accused of misconduct from social workers in the past or that they are connected to feelings of guilt and of being seen to be “mad” that were felt when they attended some CAMHS consultations. Maybe the carers felt that their actions were very much under scrutiny and that other professionals were quick to judge.

Complexity of relationships between carer and child – As the interview progressed, the carers seemed to oscillate between feelings of frustration and feelings of empathy for the child that they were talking about – a reflection of the mixed experience of fostering?

4. What new (or remaining) target questions do you have in considering the next interview?

Asking more open questions – points for improvement on interview technique.

What does being a professional/expert mean to you?

How do you see the role of foster carers? Is your role limited in any way?

APPENDIX 6

Interview 1

Focused Coding	Initial Coding	Interview Transcript
		<p><i>Interview with male and female carer (husband and wife).</i></p> <p><i>Researcher: I'm really interested in your experiences and there must be lots of stuff that you could tell me that you would go way beyond an hour, but because we've only got an hour, I thought about the best way to do this was probably to ask you to think about one of the children who are currently in your care. It might be easiest to think about the child who's providing most</i></p>

		<p>challenge for you at the moment. I wanted to ask you whether you could describe to me a particular behaviour that this child shows that you are currently finding difficult. Some examples could be if the child shows some difficulties with relationships or something like that, or whether they're feeling unhappy or anxious.</p>
<p>Foster children being unhappy.</p>	<p>Foster children being unhappy.</p>	<p><i>Male carer:</i> Well, no child in foster care feels happy.</p>
<p>(1)</p>		<p><i>Interviewer:</i> No.</p>
<p>Children requiring specialist care.</p>	<p>Children in the special care system being difficult to care for.</p>	<p><i>Male carer:</i> Okay, so umm the two children that we've got that are under the special care system, which, they are very difficult children to look after.</p>
<p>(2)</p>		

	<p>Foster child fearing placement breakdown.</p>	<p><i>Researcher:</i> Yes.</p> <p><i>Male carer:</i> Okay, [name of child] has been with us</p> <p><i>Female carer:</i> [don't say the name</p> <p><i>Male carer:</i> [alright, well anyway, the young man's been with us for about four and a half years, he's developed into a urm, he's very petrified of losing the placement here.</p> <p><i>Researcher:</i> Mmm.</p>
--	--	--

Foster child fearing placement breakdown.	Foster child predicting placement breakdown.	<i>Male Carer:</i> Urm, and that brings pressure to everything because he's continuous feels threatened with the smallest urm thing. He has a slight problem in that he smokes a bit.
(3)	Foster child smoking.	<i>Female Carer:</i> More than
Smoking being a problem.	Foster child smoking heavily.	<i>Male Carer:</i> [well, quite heavy smoker now, and again
(4)	Foster child needing re-assurance.	that's a problem. We're trying to work around reassuring
Learning how to deal with behaviour.	Psychiatrists teaching behaviour management skills.	him and urm, [pause] social services has spoke to ur us to go and have lessons from a psychiatrist, how to deal with his behaviour.
(5)		<i>Researcher:</i> Right

		<p><i>Male Carer:</i> So, we're starting a course in lessons [smiles]</p> <p><i>Female Carer:</i> He doesn't want to go, so we have to go [laughs]</p>
<p>Learning how to understand the mind. (6)</p> <p>Being under pressure. (7)</p>	<p>Foster child refusing to see a psychiatrist.</p> <p>Psychiatrists knowing how foster children think.</p> <p>Placements being under constant pressure.</p>	<p><i>Male Carer:</i> [you know [pause] so to, to begin to understand how his mind works and how everything else works so that we try and stabilize the placement which is under a tremendous amount of pressure.</p> <p><i>Researcher:</i> Yes. So the main problem at the moment seems to be that because he's so nervous about losing this placement, that somehow, in a sense, he's jeopardising it.</p>

Male carer: Yeah.

Researcher: Urm, one of the things you mentioned was about him being a heavy smoker. Is that something that you find difficult to manage in the house?

Male carer: It's difficult to manage because he's not only a heavy smoker, he smokes weed as well

Researcher: Right

Male carer: Ur cannabis, ur and that, again,

Foster child smoking cannabis.

<p>Finding drug use difficult to manage. (8)</p>	<p>Foster child restricting smoking to his bedroom.</p> <p>Foster child spending their money on cannabis.</p> <p>Foster child not having enough money for cannabis.</p> <p>Foster child feeling anxious when they are not using cannabis.</p> <p>Foster child wanting money for cannabis.</p>	<p><i>Female carer:</i> He smokes in the bedroom</p> <p><i>Male carer:</i> [he, he spends all his money getting the stuff that he needs, and urm</p> <p><i>Female carer:</i> He hasn't got the money</p> <p><i>Male carer:</i> [when he's run out and he feels nervous, that's when the problem starts and until he gets his next ten pounds so he can buy stuff, it's a problem</p> <p><i>Researcher:</i> Yeah</p>
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<p>Not wanting to reject a foster child. (9)</p>	<p>Trying to prevent placement breakdown. Foster children preferring familiarity of current placement. Wanting to avoid further rejection for the child. Foster child having been rejected by other people in his life. Not knowing whether to continue the placement. Foster child not attending school.</p>	<p><i>Male carer:</i> But, we're working, ur, we're trying to find a way of working around this so [pause] not to have the placement break is [pause] you know, the devil you know is better than the devil you don't know, [laughs] you know, what do we do? We, do we break the placement and reject him? He's been rejected by everybody. Or do we carry on and hope that this [pause] cos he doesn't go to school either. He goes to a special unit</p> <p><i>Researcher:</i> Right.</p> <p><i>Male carer:</i> So that brings pressure.</p>
<p>Being under pressure. (10)</p>	<p>School refusal putting placement in jeopardy. School refusal causing pressure.</p>	<p><i>Researcher:</i> Urm, the reason that he goes to a special unit, is that to do with his</p>

	<p>Foster child being excluded from school.</p> <p>Foster child attending special unit.</p> <p>Increasing foster child's attendance at special unit.</p>	<p><i>Male carer:</i> [he's been [pause] ur</p> <p><i>Female carer:</i> [expelled</p> <p><i>Male carer:</i> [expelled now, so we're down to five, well, we started with one day a week at the special unit</p> <p><i>Female carer:</i> [half a day</p> <p><i>Male carer:</i> [half a day, and now we're five half days, so it's an improvement, but we're still having a few bits and pieces that we need and he's [pause] the clock's ticking, he's becoming sixteen soon and er, you know, he knows</p>
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Pressures increasing with foster child's

age.

(11)

Foster child feeling worried about

becoming sixteen years old.

Age causing pressure for the foster child.

the clock is ticking and that's what is putting a lot of pressure on him

Researcher: Yes. Yeah, so not only is he um scared of losing the placement, but it's also that he's getting to that age where [pause] do you think it's more responsibility at that age?

Male carer: Well, no because [pause] they know,

Foster child knowing the pressure that their age creates.

Female carer: [that they're growing up

Foster child knowing how the care system works.

Male carer: [they know that because his sister's in care as well, so he knows what the procedure is when you

<p>Foster children being aware of the pressures. (12)</p>	<p>Foster child not wanting to face the truth of their situation.</p> <p>Foster children knowing how the system works.</p> <p>People thinking that foster children don't understand their situation.</p>	<p>reach a certain age and you don't do this and you don't do that. Although he doesn't want to believe it, he knows.</p> <p><i>Researcher:</i> Mmm.</p> <p><i>Male carer:</i> Foster children know what the pattern is.</p> <p><i>Researcher:</i> Yes.</p> <p><i>Male carer:</i> I mean whatever they, people think that they don't know</p>
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	<p>Foster children not wanting to be in residential care.</p>	<p><i>Female carer:</i> [he's not in education, they could move him on into residential now isn't he, and then um, he doesn't want to do that does he?</p>
<p>Carer and child being under pressure. (13)</p>	<p>Foster placements being under a lot of pressure.</p>	<p><i>Male carer:</i> So, there's so many pressures, and that's just brings pressures high</p> <p><i>Researcher:</i> Yes.</p>
<p>Being misunderstood. (14)</p>	<p>Other people not knowing the extent of pressure for foster carers. Being unable to understand the pressure if not experiencing it.</p>	<p><i>Male carer:</i> You know, but that is um, and, of course [pause], it's very hard for somebody who's not in this kind of position that we are to understand what the pressure is on us.</p>

<p>Not wanting to break under the pressure.</p> <p>(15)</p>	<p>Foster carers being under pressure.</p> <p>Not wanting to break under the pressure.</p> <p>Having to be careful what you say to a foster child.</p> <p>Finding it difficult to deal with foster child's demanding behaviour.</p> <p>Foster child demanding money from carers.</p> <p>Foster child using pocket money for drugs.</p> <p>Not wanting to give pocket money for drugs.</p>	<p><i>Researcher:</i> Yes.</p>
		<p><i>Male carer:</i> Because it's a tremendous amount of pressure. Whatever, you wanna be a saint, or you wanna be a god or something, there are minutes when you can urm [pause] lose it for a second, might say something that you don't wanna say, ur it's not easy when you have a child, a young man of sixteen, sitting down for, say, five hours saying "I want pocket money", "I want pocket money" a week early, you know "I want next week's pocket money", and then you say "no" and he says "yes I want it" and then you can't give it to him because it's like you're encouraging him to have drugs.</p>

		<p><i>Researcher:</i> So, it's difficult, in a sense, because he's demanding money from you and you know what you are going to give it to</p> <p><i>Female carer:</i> [yes</p> <p><i>Male carer:</i> [I mean it's not like he wants money to go and have an activity, it's not like he wants something and we can see if he can have this.</p> <p><i>Female carer:</i> We know what he wants the money for and he's telling us.</p> <p><i>Male carer:</i> And he's very honest with us, he says "I want to go and buy drugs"</p>
<p>Feeling under pressure from the foster child.</p> <p>(16)</p>	<p>Knowing that pocket money won't go towards an activity.</p> <p>Being unable to decide the usefulness of giving pocket money.</p> <p>Knowing the child uses pocket money for drugs.</p>	

	<p>Foster child being honest with their carers.</p> <p>Not knowing what to do.</p> <p>Foster child damaging their property.</p> <p>Foster child protesting if they are denied money.</p> <p>Foster child having damaged a lot of property in the home.</p>	<p><i>Researcher:</i> Mmm.</p> <p><i>Male carer:</i> So, you know, what do you do? [laughs]</p> <p><i>Female carer:</i> Yeah, you say “no” and he goes, he goes off and he’s damaged his room</p> <p><i>Male carer:</i> [you know the damage he’s done in the house is tremendous</p> <p><i>Researcher:</i> Mmm. If he doesn’t get his own way as such, what kind of things would he do?</p>
<p>Foster child not accepting boundaries.</p> <p>(17)</p>		

<p>Foster child showing anger. (18)</p>	<p>Foster child showing anger if they don't get what they want. Foster child not being violent to others.</p>	<p><i>Female carer:</i> He gets very angry, really, really <i>Male carer:</i> [he gets very angry. He's not a violent young man, he won't hit anybody. This is one of the good things, you see</p>
<p>Foster child hurting himself. (19)</p>	<p>Foster child hurting himself. Foster child showing violence towards property instead of people.</p>	<p><i>Female carer:</i> [he's hurting himself <i>Male carer:</i> [but he would punch the wall, he punched the wardrobe, ur in the other spare room where he, where it's the TV room, <i>Female carer:</i> [he threw the chair, once or twice [laughs]</p>

<p>Foster child damaging property. (20)</p>	<p>Foster children damaging property on a regular basis. Replacing damaged property being futile. Foster carers providing belongings for the children. Foster carers building up foster child's belongings. Foster child not having their belongings anymore.</p>	<p><i>Male carer:</i> [he threw the chair against the wall [laughs] so he's damaged the wall, you know, and we don't prepare it now until we get over it because there's no point. He's damaged his wardrobe, ur he he had urm, a year and a half ago, he had over two thousand pounds worth of private equipment that we built up, you know, tapes and cassettes and <i>Female carer:</i> [Play Station <i>Male carer:</i> [Play Station, he hasn't got anything now <i>Researcher:</i> Cos he's destroyed them all?</p>
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Male carer: No, no,

Female carer: [no

Male carer: [he's sold them all

Female carer: [he's sold them all

Researcher: Oh

Male carer: And now he's beginning to sell his clothes

Female carer: [sell his clothes

Foster children selling their property.

Foster child selling their clothes.

<p>Waiting for the foster child to admit help. (21)</p>	<p>???Foster children selling their property for drugs??</p> <p>Re-habilitation being voluntary.</p> <p>Waiting for the foster child to admit help.</p>	<p><i>Researcher:</i> Right [pause] just to get the money for the drugs?</p>
<p>Waiting for the foster child to admit help.</p>	<p>Re-habilitation being voluntary.</p>	<p><i>Male carer:</i> And, unfortunately, unless a young person wants to go voluntary to re-hab or whatever it's called, to get help, there's not much anybody can do, we have to ride it until he's ready for help.</p> <p><i>Researcher:</i> Right</p>
<p>Forcing help for foster child being futile.</p> <p>Foster child admitting he has a problem.</p>	<p>Forcing help for foster child being futile.</p> <p>Foster child admitting he has a problem.</p>	<p><i>Male carer:</i> You can't drag him [pause] cos it would be a waste of time. Ur, and ur, he's just started to admit that he has a problem.</p>

<p>Foster child not accepting help from others. (22)</p> <p>Foster child thinking that he doesn't need any help. (23)</p>	<p>Foster child not accepting help from others.</p> <p>Foster child thinking he doesn't need help.</p>	<p><i>Researcher:</i> Right</p> <p><i>Male carer:</i> So that in one sense, he has admitted that he has a problem, but he thinks that he can get rid of it by himself which is not gonna happen</p> <p><i>Female carer:</i> He thinks he can do it by himself</p> <p><i>Male carer:</i> So [pause]</p> <p><i>Researcher:</i> He thinks that he's in control of it at the moment in some ways</p>
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	<p>Foster child not realising that he is out of control.</p> <p>Foster child using cannabis every week.</p> <p>Foster carers not smoking.</p> <p>Being able to detect smoking in the house.</p>	<p><i>Male carer:</i> Yeah, he knows that he has a problem, but he feels that he's in control which is not true</p> <p><i>Researcher:</i> Right, okay. How frequently is he using cannabis at the moment?</p> <p><i>Male carer:</i> I think</p> <p><i>Female carer:</i> [every week</p> <p><i>Male carer:</i> [every week [pause] we can smell it anyway. We're not smokers you see so we can smell the smallest cigarette or anything, we can smell it</p>
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<p>Feeling pressure from foster child. (24)</p>	<p>Foster child getting money for working during half term. Feeling pressured for money from foster child. Foster child not demanding carers when he has enough money. Being unable to predict foster child's behaviour.</p>	<p><i>Female carer:</i> I mean this week is half term and his friends, they're with, they go and do some work for his granddad and that get extra money for delivering leaflets, they get extra money, so we haven't got any pressure this week, cos they get the extra money, so from next week though [pause] don't know what's going to happen</p> <p><i>Researcher:</i> Mimm. It sounds like there's a pressure from him that he needs the cannabis urn and then on the other hand, there's another pressure on you as well about his fears about the, losing the placement</p> <p><i>Male carer:</i> He knows what he is doing that he's putting himself in danger, and he knows that the placement is in danger and the more he feels that everything is getting on</p>
<p>Foster child sabotaging the placement. (25)</p>	<p>Foster child sabotaging the placement. Foster child using drugs to deal with the pressure.</p>	<p><i>Male carer:</i> He knows what he is doing that he's putting himself in danger, and he knows that the placement is in danger and the more he feels that everything is getting on</p>

<p>Feeling the foster child's pressure. (26)</p>	<p>Foster child trying to deal with the pressure. Using drugs creating more pressure. Foster child deflecting pressure to foster carers. Foster carers feeling the foster child's pressure.</p>	<p>top of him, the more the pressure's on, you know, it's a vicious circle, so one thing leads to another and another, and whatever he tries to deflect it, I know he does at times, but then he puts bigger pressure, and it makes it even more harder from him to deflect and then that's when he starts picking on us and then, you know, you sit here and wonder how long you gonna be picked on</p>
<p>Feeling the pressure of possible placement breakdown. (27)</p>	<p>Feeling the pressure of possible placement breakdown.</p>	<p><i>Researcher:</i> Mmm. <i>Male carer:</i> And that's the pressure that leads to us which</p>

	<p>Foster child witnessing placements ending for other children.</p> <p>Foster children not wanting to leave their placement.</p> <p>Foster children enjoying the placement.</p> <p>Foster child saying one thing and feeling another.</p> <p>Foster child having mixed feelings about a placement.</p> <p>Foster child telling mother that they are not happy.</p>	<p><i>Female carer:</i> [the pressure is on him because he's seen so many children coming and going, since he's been here a long time and seeing</p> <p><i>Male carer:</i> [about ten children come and go</p> <p><i>Female carer:</i> [and he's</p> <p><i>Male carer:</i> [for different reasons, not for any particular reason [pause] there were children that came here that didn't want to leave really urm, cos they enjoyed it here, we tend to, I mean, the young lady that we have, she's had several moves, and she's quite happy here now, although she tells everybody "I'm not happy here". Last night, her mum came and urm, and she said I was cruel,</p>
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<p>Foster children knowing where they are most secure.</p> <p>(29)</p> <p>Getting a different perspective from other professionals.</p> <p>(30)</p> <p>Foster care being a twenty four hour job.</p> <p>(31)</p>	<p>Foster child feeling most secure in care.</p> <p>Foster children knowing where they are most secure.</p> <p>Getting a different perspective from other professionals.</p> <p>Foster children telling lies for attention.</p> <p>Foster children wanting sympathy from others.</p> <p>Other professionals having limited contact with foster children.</p> <p>Knowing the foster children the best</p> <p>Being with foster children all the time.</p> <p>Foster care being a twenty four hour job.</p> <p>Most children reacting against boundaries.</p>	<p>so in a sense, there's, the front line is that they're not happy, but in the back, they're know where they are secure. If you reach that magic point, you know that for outside people listening to the young people that we have in care, they get different perspectives from what we get because that's, the kids will spin stories, because they want sympathy, or they want somebody to, even for a split second, to say "well oh poor you, I understand you" or, you know, and they can walk away though like social workers and other professionals, they can walk away, whereas we're here twenty four hours, seven days a week, fifty two weeks a year.</p>
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<p>Foster children complaining to other professionals about carers. (32)</p> <p>Foster children talking about foster carers to other professionals. (33)</p>	<p>Not being foster children's parents. Not being related to foster children. Foster children having more rights to complain about carers. Foster children saying different things to different people.</p>	<p><i>Researcher:</i> Yes</p> <p><i>Male carer:</i> So the difference is [pause] is not the same, it's, you know, most kids say "I hate my mum" or "I hate my dad" because they've been very strict. With foster children, we're not their mums, we're not their dads, we're not even any of their relatives so the point is they can say things about us to a third and fourth person, and then to us say a different story.</p> <p><i>Researcher:</i> Yes. You've alluded already to how, what you think is going on for the children and in terms of the boy that you mentioned about, you know, with his pressures, and the cannabis, from your perspective, and what you know about him, what is it that you feel is</p>
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		<p>going on for him and urm you know why does he act the way he does?</p> <p><i>Male carer:</i> Well,</p> <p><i>Female carer:</i> He's very hurt</p> <p><i>Male carer:</i> Emotionally, he's been rejected by everybody, urm, [pause] a year and a half ago, well just over a year and a half ago, we found his dad that he hasn't seen for twelve years. Now, urm, there was his dad saying "You come and live with me" and all this and there was a huge pull to bring him into their, what he thinks is a family there. Everybody's looking for a</p>
	<p>Foster child feeling hurt.</p> <p>Foster child experiencing multiple rejection.</p> <p>Foster child having had no contact with his father.</p> <p>Father putting pressure for foster child to live with him.</p>	
<p>Foster child's family rejecting him.</p> <p>(34)</p>		

	<p>Foster children wanting a family.</p> <p>A family being what everybody wants.</p> <p>Foster child's family giving him mixed messages.</p> <p>Foster child's family rejecting him.</p> <p>Foster child having to make an appointment to see his father.</p> <p>Father not wanting foster child to stay overnight.</p> <p>Foster child knowing who wants him.</p> <p>Foster child being aware of how others feel about him.</p> <p>Foster child feeling rejected.</p> <p>Empathising with the feelings of the foster child.</p>	<p>family. And then the granddad dies, whose the main person that was holding that particular family together, so soon as the granddad dies, grandma said "Well sorry, you can't come here anymore", dad hasn't even picked up the phone to ring and says "Well you need to make an appointment to come"</p> <p><i>Female carer:</i> [and "you can't stay over night if you come"</p> <p><i>Male carer:</i> [and "you can't stay over night if you come", you know, and he's not stupid boy, he knows when he's wanted and when he's not wanted, so how would you feel if all of a sudden [pause] you were told</p>
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		<p>“Sorry, we don’t want you anymore” , “Oh but you can come for tea” , you know</p> <p><i>Researcher:</i> Yes, so it was another rejection [pause] from his father</p> <p><i>Male carer:</i> Yes, which</p>
<p>Foster child’s family not contacting him. (36)</p>	<p>Father not phoning foster child. Foster child’s family not contacting him on his birthday.</p>	<p><i>Female carer:</i> [he never picks up the phone to ring him</p> <p><i>Male carer:</i> [and nobody rings him, nobody says, I mean on his birthday, he never got a single call from anybody from his family</p>

Remembering Christmas.

Female carer: [what about Christmas?

Male carer: [oh yeah Christmas, so how would you feel?

Researcher: Mmm. Birthdays and Christmas must be especially hard for him

Male carer: Yeah absolutely [pause] it's not easy [pause], and, you know, when you go to your family, and then you've got to say right you've got to go home now [pause] and, they're telling you, you've got to home now, this is home to him, that's his home over there, this is not his home here

Home not being with your family.

(37)

Home not being with your family.

Home being the foster child's placement.

<p>Foster child wanting a home.</p> <p>(38)</p>	<p>Foster child wanting to live on placement.</p> <p>Foster child viewing placement as home.</p> <p>Foster child really wanting a “proper home”.</p> <p>Foster child wanting a home.</p> <p>Foster child never staying long in one place.</p> <p>Foster child never having had a home.</p> <p>Foster child moving around a lot.</p>	<p><i>Female carer:</i> [he will say “This is my home, I don’t want to live there”</p> <p><i>Male carer:</i> [well, he says that but I think that deep down, he wants a proper home [pause] I mean this has been his home for the last four and a half years, the longest place he ever stayed in his life [pause] and he’s coming up to sixteen, so can you imagine four years of his life, he’s been here, four and a half years, that’s the longest place he ever stayed.</p> <p><i>Researcher:</i> Yeah. That’s, for somebody who is only sixteen, that’s um</p>
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<p>Foster child having a lot of placements break down. (39)</p>	<p>Foster child having a lot of placements. Foster child having to leave his mother's house. Foster child having to leave another home. Foster child being repeatedly rejected.</p>	<p><i>Female carer:</i> He has been through different placements before, it's not his first</p> <p><i>Male carer:</i> You know, he moved in with his mother's mother, and he was chucked out of there, then he moved somewhere and he was chucked out of there, then he moved somewhere else and that broke down, and then he came here, so there was quite a lot of rejection</p>
<p>Foster child not letting people get close to him. (40)</p>	<p>Foster child not letting people get close to him. Foster child not kissing male carer.</p>	<p><i>Researcher:</i> Mmm. How do you feel the rejection has impacted on his relationship with you?</p> <p><i>Male carer:</i> He's [pause] he doesn't let anybody get close to him. He puts up, very rarely, he will kiss [<i>name of female carer</i>], he will not kiss me</p>

<p>Foster child becoming less physically affectionate with age. (41)</p>	<p>Foster child rarely kissing female carer. Foster child kissing female carer regularly in the past. Foster child withdrawing physical affection after disagreement with carers. Foster child needing physical affection for re-assurance. Foster child needing to checking how carers feel about him. Foster child needing to know whereabouts of his carers. Foster child fearing rejection from his carers. (42)</p>	<p><i>Female carer:</i> He used to, every day, before he went to school, he used to kiss me, but after he started smoking, and ur we were telling him off, that's when he's, you know [pause] he doesn't do it any more, but sometimes when we tell him off and urm before he goes out, he has to make sure that we were not angry with him and he comes and gives me a kiss again</p> <p><i>Male carer:</i> He says "What time are you going to be home?" if we go out, but one of the things is we say we are going out, he goes "What time are you coming back?", "I need to know what time you are coming back" and that his biggest fear is that we will go and not come</p>
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		<p>back [pause]</p> <p><i>Researcher:</i> So, on the one hand, he gets quite angry about the fact that you tell him off and that makes you feel that somehow that you're not providing him with something that he needs but then when he has a need also to make sure that he's still okay with you, whenever you go out, just to see whether you're still going to be there</p>
	<p>Foster child not telling carers where he goes out.</p> <p>Carers having tell foster child where they go out.</p>	<p><i>Male carer:</i> The thing is that we go out and we won't let him, I mean it's okay for him not to tell us where he goes, but we have to tell him where we go, so he needs to know where we are. I don't know why but he, he feels</p>

<p>Foster child fearing rejection from carers. (43)</p>	<p>Foster child fearing rejection from carers.</p>	<p><i>Female carer:</i> [threatened, that he's gonna come back and that he won't find anybody here</p> <p><i>Male carer:</i> But I don't know if that makes sense to you</p> <p><i>Researcher:</i> It seems as if it's connected with his previous rejections and so many knocks that he's had in the past, that must be</p>
<p>Foster child needing re-assurance that his carers will not reject him. (44)</p>	<p>Foster child needing re-assurance that his carers will not reject him.</p>	<p><i>Female carer:</i> He wants to be sure that we're going to be home</p> <p><i>Researcher:</i> I mean how do you feel about that, how does that make you feel as carers?</p>

<p>Foster child having a fear of rejection behind his behaviour. (45)</p>	<p>Feeling angry with the foster child. Having mixed feelings towards the foster child. Knowing that the foster child fears losing you. Feeling that done something positive for the foster child. Hoping that the foster child will get through his difficulties.</p>	<p><i>Male carer:</i> There are times when I am very angry with him, there are times when I am really angry with him but then there's other times when I hear him say things like that "Where are you going to be?" and I know deep down that he's petrified about losing us or not knowing where we are, but I feel, you know, we've done something, at least we've taught him something, you know, and lets hope that [pause] in the next couple of years that he pulls himself through, and from what the research shows and from what I've read is that a lot of kids from the ages of thirteen to sixteen smoke, and then they sort of stop [pause]</p>
<p>Hoping that the foster child will get through his difficulties. (46)</p> <p>Teenagers either using drugs as a phase or continuing into adulthood. (47)</p>	<p>Not knowing whether the child will get through his difficulties. Reading literature about teenage drug use. Teenagers using drugs as an age-related phase.</p>	

	<p>Teenagers starting on cannabis and progressing onto harder drug use.</p> <p>Foster child attending school to please carers.</p>	<p><i>Female carer:</i> Yeah, they stop or they</p> <p><i>Male carer:</i> [go on to harder stuff, so lets hope that he does pull, he goes to school and he says "Well, I'm going to school just to please you"]</p> <p><i>Researcher:</i> Yes.</p>
<p>Foster child being eager to please his carers.</p> <p>(48)</p> <p>Trying to understand the foster child's refusal to attend school.</p> <p>Foster child lacking motivation not</p>	<p>Foster child being eager to please his carers.</p> <p>Foster child being clever.</p> <p>Trying to understand the foster child's refusal to attend school.</p> <p>Foster child lacking motivation not</p>	<p><i>Male carer:</i> You know, he, on the one hand, he's desperately trying to please us,</p> <p><i>Female carer:</i> Yeah, he's very clever, he's not stupid at all, he's [pause] he could try with the exams without even going to school [pause], he's just a bit lazy I think</p>

<p>Foster child lacking motivation not ability. (49)</p>	<p>ability. Foster child feeling de-motivated. Foster child feeling hopeless.</p>	<p><i>Male carer:</i> Well no, I think he's just, it's just one of those things that he doesn't see why he should do anything now, he's not [pause], he feels what's the point</p>
<p>Foster child feeling de-motivated and hopeless. (50)</p>	<p>Foster child giving up on himself.</p>	<p><i>Female carer:</i> He's given up on himself sometimes</p> <p><i>Researcher:</i> So, motivation to do anything is quite low with him</p> <p><i>Female carer:</i> Yeah very low</p>
	<p>Foster child's motivation being very low. Trying to increase foster child's</p>	<p><i>Male carer:</i> I mean, we've tried to, with an outreach worker, we tried to put him on a few programmes of urm</p>

<p>Feeling unable to motivate foster child. (51)</p> <p>Foster child wanting to attend boxing lessons. (52)</p>	<p>motivation/interests/activity levels.</p> <p>Foster child not wanting to engage in activities.</p> <p>Feeling unable to motivate foster child.</p> <p>Viewing boxing as a dangerous sport.</p> <p>Deciding to let foster child attend boxing lessons.</p> <p>Paying for foster child to attend boxing lessons.</p> <p>Deciding to buy boxing equipment after initial attendance.</p>	<p>boxing, swimming or anything like that but he just doesn't want to do it, anything that we suggest to him, then he says, right, for a year he said "I want to do boxing" and we were saying no because we thought it was a dangerous sport. Then we said yes, you can do boxing and we paid for the first couple of lessons [pause] which was about forty pounds, and then we said once you've done a couple of lessons we're going to buy you the equipment that you need, and then</p> <p><i>Female carer:</i> He had to join</p> <p><i>Male carer:</i> Yeah that was joining fees. And then he just didn't go, so he was taking money for the daily</p>
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<p>Foster child not attending boxing when given the opportunity.</p> <p>(53)</p>	<p>Foster child not attending boxing when given the opportunity.</p> <p>Foster child using money for purpose other than it was meant for.</p>	<p>lessons that he was going and just not going up to boxing, using the money for something else.</p> <p><i>Researcher:</i> Right. Somehow, he can't quite get himself together. On the one hand, you feel that he really wants to please you, but somehow he can't quite get it together to do that</p>
<p>Foster child not accepting the help he needs.</p> <p>(54)</p>	<p>Foster child not accepting help from anybody.</p> <p>Foster child needing help.</p>	<p><i>Male carer:</i> That's why it's a pattern that everybody needs help and he's not prepared to accept help from anybody, and he can't do it on his own.</p> <p><i>Researcher:</i> How do you feel the cannabis fits in with all of this?</p>

	<p>Being a non-smoking family.</p> <p>Having alcohol in the home.</p>	<p><i>Male carer:</i> I don't agree with smoking anyway completely. We're non-smokers, nobody in my family smokes ur, there's plenty to drink around, but I'm not a, I don't drink in a sense</p>
<p>Foster child learning drug and alcohol use from his family.</p> <p>(55)</p>	<p>Having to keep alcohol locked away.</p> <p>Foster child learning drug and alcohol use from his family.</p> <p>Looking for causes for drug and alcohol use.</p>	<p><i>Female carer:</i> We have to lock up the drinks [laughs]</p> <p><i>Male carer:</i> [pause] but, he picked up this drinking and smoking from his family, it's a normal pattern for his mother and his father, and that's, I think that's what he's following</p>

<p>Foster child using drug and alcohol with his friends at school.</p> <p>(56)</p>	<p>Foster child being influenced by friends who use drugs and alcohol.</p> <p>Children engaging in drug and alcohol use at school.</p> <p>Foster child having friends who are smokers.</p> <p>Peer pressure influencing smoking and cannabis use in school children.</p>	<p><i>Female carer:</i> And his friends, they all do it outside the school</p> <p><i>Researcher:</i> Yeah, so there's a lot of urm people around him who are doing these things</p> <p><i>Female carer:</i> Everybody at school is doing it, isn't it</p> <p><i>Male carer:</i> All his friends are smokers</p> <p><i>Researcher:</i> Yeah. Do you feel it's a way to fit in with his peers?</p> <p><i>Male carer:</i> I think it's peer pressure as well for smoking and smoking cannabis. This is why I said that most</p>
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<p>Children experimenting with drugs.</p> <p>Needing to learn that drugs are bad for health.</p> <p>Waiting for foster child to accept his need for help.</p> <p>(57)</p>	<p>Children experimenting with drugs.</p> <p>Needing to learn that drugs are bad for health.</p> <p>Waiting for foster child to accept his need for help.</p> <p>Needing to reach a limit before accepting the need for help.</p> <p>Not being able to help foster child until he acknowledges that he needs help.</p> <p>Foster child not letting people help him.</p> <p>Foster child not talking about his problems.</p>	<p>school children do that at one stage or the other, and then they either carry it off and as they get older, they learn that they're not doing themselves any favours, or they carry on to distraction, I mean, [pause] we're just waiting for [<i>child's name</i>] to reach rock bottom and then, I think we've reached bottom, and now we're trying to climb up, and it's a slippery slope, and he needs help to come out of it, and until he says "yes, I need help", there's not much we can do</p> <p><i>Female carer:</i> He doesn't admit to help, he doesn't let anybody come in to help him, nobody, he doesn't talk to anybody, and then the outreach worker, we have problems, we have to sit with him most of the time, and</p>
<p>Foster child not letting people help him.</p> <p>(58)</p>	<p>Foster child not letting people help him.</p> <p>Foster child not talking about his problems.</p>	<p><i>Female carer:</i> He doesn't admit to help, he doesn't let anybody come in to help him, nobody, he doesn't talk to anybody, and then the outreach worker, we have problems, we have to sit with him most of the time, and</p>

	<p>Having to talk on foster child's behalf with outreach worker.</p> <p>Expecting friends to accept foster children as part of the family.</p> <p>(59)</p>	<p>we do the talking and it's just</p> <p><i>Researcher:</i> Yes, you were saying earlier, he seems to be very closed down. How does all of this impact on your lives and your feelings?</p> <p><i>Male carer:</i> It's not, it doesn't in a sense impact in our life cos we, all my friends that come here, you know, either they have to accept my foster kids or I don't accept my friends, so it's not</p> <p><i>Female carer:</i> They know</p>
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	<p>Family friends knowing that foster children are part of the family.</p> <p>Needing a babysitter sometimes.</p> <p>Inviting foster child on the family holiday.</p> <p>Needing to show foster child that they're part of the family.</p> <p>Foster child coming on family holiday every year.</p>	<p><i>Male carer:</i> They know, if they come here, that they are my kids. If they invite me, they invite them as well. If they don't invite them, I just don't go, I get a babysitter to be here.</p> <p><i>Female carer:</i> They've been on holidays everywhere with us. He's been to [<i>foreign country</i>], he's slept in the same room with us, when he was younger of course when we had to stay in a hotel, and, you know how expensive these, to stay in a hotel</p> <p><i>Male carer:</i> He's seen most of [<i>foreign country</i>]. He's been five years on holiday with us, five times, because it's four and a half years, so it's five times, ur and he's going again this summer, for a month.</p>
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<p>Predicting problems with foster child on holiday.</p> <p>(61)</p>	<p>Having problems with foster child on last family holiday.</p> <p>Not wanting foster child to come for the whole holiday.</p> <p>Foster child not wanting to be left behind during carers' holiday.</p> <p>Feeling apprehensive about taking foster child on holiday.</p> <p>Predicting behaviour problems on holiday.</p> <p>Feeling pressured by the foster child not to leave him behind.</p>	<p><i>Female carer:</i> Cos we had some problems last year and I said to him "You are not coming the whole month" and he said "No, I'm coming, I'm coming, I'm not staying behind" and he insisted that he wanted to come, I know he's got the smoking problem but</p> <p><i>Male carer:</i> We're dreading it but we're going to stick it out and see what happens</p> <p><i>Researcher:</i> He might not be able to</p> <p><i>Male carer:</i> [buy the stuff</p>
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	<p>Predicting problems with smoking while on holiday.</p> <p>Knowing what to expect.</p> <p>Having first worked for a different borough.</p>	<p><i>Researcher:</i> Yeah, over in [<i>foreign country</i>]</p> <p><i>Male carer:</i> But he'll buy cigarettes, so and cigarettes are very cheap in [<i>foreign country</i>] [laughs]</p> <p><i>Researcher:</i> Did you expect any of this when you</p> <p><i>Female carer:</i> We did, we knew, yeah</p> <p><i>Male carer:</i> [because the first placement we had from [<i>different borough</i>], when we worked for [<i>repeats name of borough</i>] urm it was</p>
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<p>Feeling unprepared and under-resourced as a first-time carer. (62)</p> <p>Having difficulties caring for a sexually abused child. (63)</p>	<p>Learning the hard way with the first placement.</p> <p>Having a difficult placement the first time around.</p> <p>Not expecting what it would be like the first time around.</p> <p>Feeling unprepared and under-resourced as a first-time carer.</p> <p>Being respite carers for a teenager who had been sexually abused.</p> <p>Child being sexually abused for a long time before discovery by authorities.</p> <p>Sexually abused child having mental health problems.</p> <p>Learning what the issues were.</p>	<p><i>Female carer:</i> [we were thrown into the deep end [laughs]</p> <p><i>Male carer:</i> [we were right in the deep end, with no paddle, and we had a girl that was placed with us only part-time, and er</p> <p><i>Female carer:</i> [on the weekends, respite on the weekends</p> <p><i>Male carer:</i> [we were respite carers for this young lady who was er sixteen and sexually molested by her father for about ten years, from the age of five I think she was sexually molested until the authorities found out. She was way out of her mind and er lived with her for three</p>
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	<p>Being careful how to act with sexually abused child.</p> <p>Having to do things differently from how a father would.</p> <p>Having to change your attitude as a male carer.</p> <p>Becoming aware that your actions can offend a sexually abused child.</p> <p>Being unable to cuddle a female foster</p>	<p>months. I think it made us really aware of what the problems are</p> <p><i>Researcher:</i> Mmm.</p> <p><i>Male carer:</i> I mean I had to be very careful not to sit next to her, not to do this, not to do that, you know, it's, things that a normal family man or a male carer does, you don't realise these things until you've got a young lady come into the house that's not your child, and er, that is a huge amount of change in a male carer. Your focus now has to change, because the smallest action you can do will cause an offence to the child. You know I could put my daughter on my lap, but I can't do this to another</p>
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	<p>child.</p> <p>Cuddling foster children differently to own children.</p> <p>Having to be careful with foster children.</p> <p>Being careful how to show physical affection to foster children.</p> <p>Being careful what to say to foster children.</p>	<p>child, that's not my, which is a shame, but you have to be, or when you cuddle, I cuddle my daughter, a full cuddle, but you when you cuddle a foster child, you have to do a side cuddle</p> <p><i>Female carer:</i> You have to be very careful</p> <p><i>Male carer:</i> You have to, you know like, you have to do it, this is the cuddle [<i>demonstrates cuddle that would do with foster child with female carer</i>], you know, so you are careful where your hands are, you are careful er</p> <p><i>Female carer:</i> [how you speak to them, you say</p>
<p>Being careful how to show physical affection to foster children. (65)</p> <p>Being careful what to say to foster children. (66)</p>	<p>child.</p> <p>Cuddling foster children differently to own children.</p> <p>Having to be careful with foster children.</p> <p>Being careful how to show physical affection to foster children.</p> <p>Being careful how to speak to foster children.</p>	<p><i>Female carer:</i> You have to be very careful</p> <p><i>Male carer:</i> You have to, you know like, you have to do it, this is the cuddle [<i>demonstrates cuddle that would do with foster child with female carer</i>], you know, so you are careful where your hands are, you are careful er</p> <p><i>Female carer:</i> [how you speak to them, you say</p>

<p>Foster children not trusting affection. (67)</p> <p>Foster children having received a lack of affection. (68)</p> <p>Male carers having to be constantly vigilant. (69)</p>	<p>Being careful about expressing affection verbally to foster children.</p> <p>Being careful what to say to a foster child.</p> <p>Foster children not trusting motives of male carer.</p> <p>Foster children not being used to compliments.</p> <p>Foster children not understanding affection.</p> <p>Foster children having received a lack of affection.</p> <p>Having to be constantly vigilant about your behaviour.</p> <p>Foster children wanting physical affection.</p>	<p><i>Male carer:</i> [because if I say “Oh I love you” or “You look beautiful today”, it is “You sexy old man what are you trying to do?”. This is their reaction. They’re not, they’re not used to it, having these compliments.</p> <p><i>Researcher:</i> They’re not used to compliments at all then in some ways.</p> <p><i>Male carer:</i> You know, so, as a male carer, you really have to be on your guard all the time. [pause]. And it’s a shame because these kids want a cuddle, they want, they want, when they’re angry, want you to cuddle them and say “Right, calm down” but you have to be really careful how you do it.</p>
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<p>Being unable to predict the experience of foster caring. (70)</p> <p>Learning from experience. (71)</p> <p>Every foster child being different. (72)</p>	<p>Wanting to cuddle an angry foster child. Being careful about how you show physical affection to foster children.</p> <p>Being unable to predict the experience of foster caring. Knowing the children when you live with them. Learning from experience. Having a lot of fostering experience. Every foster child being different. Experiences being different with every foster child. Some foster children not wanting to stay with you.</p>	<p><i>Researcher:</i> Mmm. And this is something that you really couldn't have foreseen</p> <p><i>Male carer:</i> You don't, you couldn't foresee because you never, you never know</p> <p><i>Female carer:</i> Unless you live with them</p> <p><i>Male carer:</i> Unless you live with these children, and experience. We've fostered, I think over eighty children. Urm, every child is different, you know, we've had children for, for one hour only [laughs], he walked in and walked out, you know, and we had mother and baby just</p>
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	<p>Having experience of fostering new-born babies.</p> <p>Having fostered children of all ages.</p> <p>Not being prepared for fostering a baby.</p> <p>Having to find your own resources.</p> <p>Social services bringing a baby straight from the hospital.</p> <p>Having to ask friends for help with baby equipment.</p> <p>Not being prepared in emergency placements.</p> <p>Having to act quickly in emergency placements.</p> <p>(73)</p>	<p>baby straight out of hospital</p> <p><i>Female carer:</i> We've had all ages [laughs]</p> <p><i>Male carer:</i> So, in the middle of the night, running to find, they brought the baby at eight o'clock and we were running around trying to find a bottle and things like that for it</p> <p><i>Female carer:</i> They brought the baby straight from the hospital here</p> <p><i>Male carer:</i> She had to go round looking for friends to see who's got spare bottles and spare baby food</p>
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<p>Feeling job satisfaction from coping with difficult experiences.</p> <p>(74)</p>	<p>Working through the night to care for babies.</p> <p>Having varied experience as a foster carer.</p> <p>Getting job satisfaction from achievements.</p>	<p><i>Female carer:</i> [and nappies and</p> <p><i>Male carer:</i> You know [laughs] but we did it and</p> <p><i>Female carer:</i> [we stayed up all night to feed the baby, change the baby every three hours [laughs]</p> <p><i>Male carer:</i> So the experience you get [pause] is quite varied, what we have</p> <p><i>Female carer:</i> But, generally, we feel so satisfied and happy and, when we get, when we have achieved something, you know, when we feel good.</p>
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<p>Coping with each day as it comes. (75)</p> <p>Getting strength from working together with your spouse. (76)</p>	<p>Coping with each day as it comes.</p> <p>Getting strength from working together with your spouse. Working as a team.</p> <p>Finding it difficult to be a single carer.</p>	<p><i>Researcher:</i> Yes. I'm just wondering how you cope with all of it</p> <p><i>Female carer:</i> We go day by day, we take it a day at a time</p> <p><i>Male carer:</i> I think the strength is, if you want to be a foster carer, I think the strength is that you have to be a team [pause] you know, you've gotta work together with your wife or your husband so</p> <p><i>Female carer:</i> By yourself, I think is very difficult</p>
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	<p>Some foster children needing a single carer.</p> <p>Single carers being needed.</p> <p>Some foster children needing homosexual carers.</p> <p>Foster children having identity problems.</p> <p>Foster children needing to be matched with the right carer.</p>	<p><i>Male carer:</i> A single carer, those single carers of either sex are very important, because there are children who need a single carer, you know, it's not that I'm saying that single carers shouldn't be, I think they are needed and male carers are needed for special kids and even um, er, [pause] the other side of the coin, gay people. We need them to be foster carers as well because we have children who don't know who they are and, you know, you need to place the child with the right carer so if it's a male carer and he looks after a young lad, you know, again, we need these kind of people, because maybe that's what that young man needs, you know, so you can't just say "Right this group of people are not needed" or "this group of people"</p>
<p>Foster children needing to be matched with the right carer.</p> <p>(77)</p>	<p>Not showing sexual discrimination towards foster carers.</p>	

<p>Foster care being easier with a partner. (78)</p>	<p>Foster care being easier with a partner.</p>	<p><i>Female carer:</i> [yeah but it makes it easier for us because it's two of us</p>
<p>Foster children having needs for a particular figure. (79)</p>	<p>Helping each other deal with the pressure. Foster children having needs for a particular parental figure.</p>	<p><i>Male carer:</i> [cos we can relieve, take the pressure off one another, I mean in this household, the young man is more, he leans more to my wife, and the young lady leans more to me cos that's what they need, they need er, one needs a mother, the other one needs a father, so, you know, depending on what the needs of the children that come here, they move either to my wife or to me and</p>
<p>Children trying to divide parents on discipline issues. (80)</p>	<p>Foster children trying to divide carers on discipline issues.</p>	<p>then, of course, they use the old trick of trying to split us up or they say "well, [<i>male carer's name</i>] said that I could do this" but I never said anything [laughs] so, and</p>

	<p>Splitting being a behaviour that every child shows.</p> <p>Foster children being wise from experience.</p> <p>Foster children having been through a lot.</p> <p>Foster children having been mistreated by other people.</p> <p>Having to be a professional to help foster children.</p> <p>Having to learn how to help foster</p>	<p>then they'll come back and say "[female carer's name] said I can do it" you know, and these are the splitting games that they can play, which, I mean even your own siblings, your own children would do that.</p> <p><i>Researcher:</i> Yes.</p> <p><i>Male carer:</i> Okay, and you have to be really, it's double for these children because they're very wise, you know, they've been through, some of these kids have been, what I say is that they've been tortured by experts, they've been starved by professionals, they've been mistreated by professionals, so when they come to us, we have to be professionals too, to find out how we're gonna help these</p>
<p>Foster children being wise from experience.</p> <p>(81)</p> <p>Having to be a professional to help foster children.</p> <p>(82)</p>		

<p>children. Being unable to help all foster children. Being aware that you can't help all foster children. Not seeing placement breakdown as a personal failure. Foster children needing to be matched with the right foster carer.</p>	<p>children. Being unable to help all foster children. Being aware that you can't help all foster children. Not seeing placement breakdown as a personal failure. Foster children needing to be matched with the right foster carer.</p>	<p>children, and it's not always easy, you don't always succeed. But, as a foster carer, that doesn't mean that [pause] if a child comes to us and it's a failure, in a sense that we can't reach that child, it's maybe that we're not the right people for that child. You know, each child is individual, so you have to match the child with the right foster carer.</p> <p><i>Researcher:</i> It sounds like there's kind of two issues there, on the one hand, you feel that you need to be professional about your role, but there's also something about a match, that, if the match doesn't work out right, if you're not right for the child and the child's not right for you, then it's not gonna work</p>
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<p>Placement success depending on child's willingness to be helped.</p> <p>(84)</p>	<p>Placement success requiring more than expertise and experience.</p> <p>Placement success depending on child's willingness to be helped.</p>	<p><i>Male carer:</i> It's not gonna work, no, because it doesn't matter how professional you are or how experienced you are, you can only, there's the saying that you can lead a horse to water, but you can't make it drink</p> <p><i>Researcher:</i> Yes.</p>
	<p>Foster children deciding that they don't like their carers.</p> <p>Not understanding how you have offended a child.</p>	<p><i>Male carer:</i> Right, so, it doesn't matter how you try and motivate that child, if that child takes a dislike to you, for any reason, it could be something very silly and something very simple, and you don't know what it is, you know</p>

Child/carer relationship not always working.	Child/carer relationship not always working.	
<p>(85)</p>	<p>Foster child lasting in a placement longer than ever before.</p> <p>Placement ending because child refusing school.</p> <p>Foster child crying when moved to a special unit.</p> <p>Disagreeing with decision to end placement.</p> <p>Foster carers not being part of placement decision-making.</p> <p>Feeling that you are starting to reach the foster child.</p> <p>Foster child becoming less defended.</p>	<p><i>Female carer:</i> It won't work</p> <p><i>Male carer:</i> It won't work [pause] and, you know, we had a child about three years ago, um, she was moved, the longest place she ever stayed was a couple of weeks in a foster home, and she stayed here a year, and she was crying when she moved to a special unit cos she wouldn't go to school. Now, at the end of the year, I was against the move for this particular child, because me and my wife felt that we'd reached that point where</p> <p><i>Female carer:</i> [we were just breaking the wall</p>
<p>(86)</p>		

<p>Foster children taking time to let carers close to them. (87)</p> <p>Foster children taking time to let carers close to them.</p> <p>Not expecting foster children to let their defences down straight away.</p> <p>Foster children initially trying to impress carers.</p> <p>Foster children pretending to be "good" children.</p> <p>Accepting that foster children will be defended. (88)</p>	<p>Foster children taking time to let carers close to them.</p> <p>Not expecting foster children to let their defences down straight away.</p> <p>Foster children initially trying to impress carers.</p> <p>Foster children pretending to be "good" children.</p> <p>Accepting that foster children have defences.</p>	<p><i>Male carer:</i> [you know we were taking two bricks down and she was putting one back</p> <p><i>Researcher:</i> So, you'd just started to get somewhere</p> <p><i>Male carer:</i> Yeah, after a year, and, with any foster child that comes here, it takes normally six months to a year before you see that they're not defending, they're starting to drop their guard [pause] you can't expect, with anybody that moves, you get a honeymoon period which can last from three to four weeks, where the child is best behaviour because they wanna impress you, that they're good, they're not bad and then, but after that, they start going back to their routine which is acceptable, because</p>
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<p>Foster children predicting rejection from carers.</p> <p>Foster children thinking that carers don't care.</p> <p>Foster children testing how much you care.</p> <p>Foster children pushing carers' boundaries to get proof of rejection.</p> <p>(89)</p>	<p>Foster children predicting rejection from carers.</p> <p>Foster children thinking that carers don't care.</p> <p>Foster children testing how much you care.</p> <p>Foster children pushing carers' boundaries to get proof of rejection.</p> <p>Not being rigid when children push boundaries.</p> <p>Being prepared to be flexible with foster children.</p> <p>Foster care being a learning experience.</p> <p>(90)</p>	<p>they can't keep this arm, this cloak over them, the good cloak over them for more than a month. Then, they say "well these people are going to reject us again" you know "they're not gonna care for us, why should we do it", and they start testing you. And they keep testing you and they keep testing you to see how far they can push, right, and then, if you're experienced, you still move the goal posts, every time you set up a goal post here [puts hand out], they come and they knock it, you know they're gonna knock it, so you've gotta be prepared to move it again two feet back, and then they come up to that one, and then, you know, it's a, it's a learning experience. Then you reach a point, when you have to say "well, this is not working" [pause] or you reach the point where they</p>
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<p>Foster children pushing until they are ready to start trusting.</p> <p>(91)</p>	<p>ready to start trusting.</p> <p>Encouraging foster children to open up/get close.</p> <p>Gradually building up trust with foster children.</p> <p>Foster children allowing carers to get close to them.</p>	<p>say “well, we’ve tested you enough” you know “let him take a brick off’ off the invisible wall, you know, so you take a brick off, they don’t put it back [pause] or you might take five or six bricks and then they say “Oh he’s taking bricks off” you know and they put two back but you can see that it’s beginning, the wall is beginning to become lower [pause]</p> <p><i>Researcher:</i> Yes. That must be a tremendous urn tremendously stressful to keep on moving your goal posts back</p> <p><i>Male carer:</i> You have to, you can’t [pause] what we try and say, with my wife, is that never corner a child. When you’re telling a foster child off, it’s not like your telling</p>
<p>Giving foster children a get-out-clause.</p> <p>(92)</p>	<p>Never pushing a child into a corner.</p> <p>Discipline with foster children being</p>	

	<p>different than with your own children.</p> <p>Giving foster children a get-out-clause.</p> <p>Always dealing with unacceptable behaviour.</p> <p>Dealing with unacceptable behaviour when the child is ready.</p> <p>Foster children not having experience of discipline.</p> <p>Foster children reacting angrily to discipline.</p> <p>Not letting anger escalate.</p> <p>Not confronting foster children.</p> <p>Returning to discipline issues at another time.</p>	<p>your own child off. You've gotta give them an escape route, a window, or a door to escape. And then you come back to it at a later date [pause] that's what I call it. You know, I don't know if it makes sense to you</p> <p><i>Researcher:</i> Is it that you're not setting them up to fail?</p> <p><i>Male carer:</i> No, you're telling them off, they've never been told off before, so it's no point in, you tell them off until you come to that point where something's gonna happen, you know it's gonna escalate, so you just back off a bit, let them escape, and then you catch them the next day and come back to that subject the next day.</p>
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		<p><i>Researcher:</i> Yes. Does that keep confrontations at a minimum?</p> <p><i>Male carer:</i> Yeah. [pause]</p>
		<p><i>Researcher:</i> What kind of advice would you give to foster carers who were just starting out?</p> <p><i>Female carer:</i> Good luck [laughs]</p>
	<p>First-time carers needing good luck.</p> <p>Foster care being rewarding.</p> <p>Foster carers needing to prepare before their first placement.</p>	<p><i>Male carer:</i> I think this is tremendously rewarding for anybody who's starting in foster care. Urm, [pause] there needs to be a lot of work done beforehand to make sure that the first placement, it's preferably that they have</p>

<p>First-time carers needing to start off with younger children.</p> <p>(94)</p>	<p>First-time carers needing to start off with younger children.</p>	<p>somebody who's under ten.</p>
<p>Younger foster children not being so damaged.</p> <p>(95)</p>	<p>Younger foster children not being so damaged.</p> <p>Younger foster children being easier to control.</p>	<p><i>Researcher: Right</i></p> <p><i>Female carer: Cos they're not so damaged.</i></p>
<p>Needing experience and patience to foster older children.</p> <p>(96)</p>	<p>Older foster children being influenced by peer pressure.</p> <p>Needing experience and patience to foster older children.</p>	<p><i>Male carer: So, well, they are damaged under ten, but they're easier to control in a sense that once they reach a certain age, they have outside pressure with friends, and they wanna go out and stay out late, then it's more difficult for a new carer to control this, you know, you need to have a lot of experience and a lot of patience</i></p>

<p>Being unable to control children when they're out. (97)</p>	<p>Being unable to control children when they're out on their own. First-time carers needing to start with babies. First-time carers needing to start with younger children. Carers needing to progress onto older children the more experience they get. Needing experience of other ages to foster teenagers. Needing a match between social workers and foster children. (98)</p>	<p><i>Female carer:</i> Once they go out, there's no control over them is there</p> <p><i>Male carer:</i> Any new foster carer who starts in this profession, they should start with babies</p> <p><i>Female carer:</i> Or younger children</p> <p><i>Male carer:</i> [or younger children, and then, within a year, move onto the more progressed age, and after two or three years, then they should go for teenagers. I mean this is er [pause] and another thing which I'm always saying is that social services try to match the children with foster carers, but they do not match the social workers with the children, 'cos it's very important. We</p>
<p>Needing experience to foster teenagers. (98)</p> <p>Needing a match between social workers and foster children. (99)</p>	<p>Needing a match between social workers and foster children. Social services not matching social</p>	<p>workers with the children, 'cos it's very important. We</p>

<p>workers and foster children.</p> <p>Being supported by a link-worker.</p> <p>Foster children being supported by a social worker.</p> <p>Link-worker calling in to help with problems.</p> <p>Social workers protecting foster children.</p> <p>Placements being inspected by social workers.</p> <p>A good match meaning greater understanding of foster children.</p> <p>Feeling lucky to have a social worker.</p> <p>Social workers causing placement breakdown.</p> <p>Social workers not having enough experience.</p>	<p>workers and foster children.</p> <p>Being supported by a link-worker.</p> <p>Foster children being supported by a social worker.</p> <p>Link-worker calling in to help with problems.</p> <p>Social workers protecting foster children.</p> <p>Placements being inspected by social workers.</p> <p>A good match meaning greater understanding of foster children.</p> <p>Feeling lucky to have a social worker.</p> <p>Social workers causing placement breakdown.</p> <p>Social workers not having enough experience.</p>	<p>have a link-worker, and the children have a social worker, you know, so, we are adults and we have someone who is calling in, that helps us</p> <p><i>Female carer:</i> [with our problems</p> <p><i>Male carer:</i> [with our problems, and the child has a social worker that comes in and inspects the child and makes sure the child is in a safe environment. Now, [pause] it's very important that the social worker of the child is matched to the child to understand the child</p> <p><i>Female carer:</i> We're very lucky to have a social worker</p>
<p>Link-worker helping with carers' problems. (100)</p> <p>Placements being inspected by social workers. (101)</p> <p>Needing social workers to understand the children. (102)</p>		

	<p>Lack of understanding causing problems for the placement.</p> <p>Foster children being influenced by social workers' feelings.</p>	<p><i>Male carer:</i> Yes, but even so, the social worker that has no experience can cause the placement to break [pause] can cause more problems [pause] than the child itself, because the child is picking up from the social worker and they, you know, their role is to protect the child, I understand this, their role is to</p>
<p>Carers knowing the foster children the best.</p> <p>(103)</p>	<p>Social workers not knowing the foster children.</p> <p>Foster carers having the most contact with foster children.</p>	<p><i>Female carer:</i> They don't really know the children do they. We know them because they're living with us twenty four hours a day</p>
<p>Social workers not having enough contact with foster children.</p> <p>(104)</p>	<p>Social workers having monthly contact with foster children.</p>	<p><i>Male carer:</i> They only come and see the child once a month for an hour</p>

<p>Social workers only hearing foster children's version of events. (105)</p> <p>Social workers not knowing foster children.</p> <p>Social workers hearing foster children's version of events.</p> <p>Foster child splitting adults involved in their care.</p> <p>Foster child criticising their carers in front of others.</p> <p>Foster child convincing others that carers are bad.</p> <p>Foster children saying what others want to hear from them. (106)</p>	<p>Social workers not knowing foster children.</p> <p>Social workers hearing foster children's version of events.</p> <p>Foster child splitting adults involved in their care.</p> <p>Foster child criticising their carers in front of others.</p> <p>Foster child convincing others that carers are bad.</p> <p>Foster child saying what people want to hear.</p>	<p><i>Female carer:</i> [so how can they know them? They just know what they tell them</p> <p><i>Male carer:</i> And some of the foster children, one particularly, that we've got here at the moment, she can sit on this table, alright, and within half an hour, have us all divided and fighting. Right, all, I've seen it, I sent for the police to pick her up once and by the time the police brought her here, the police were thinking that me and my wife were the bad people. Right, because she's that kind of child or she goes up against, she starts something at school, and she goes up against the head-teacher there or the governing body, she will lower her head and say "I'm sorry, and da, da, da, it was me, I'm guilty", you</p>
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Foster child being expert at pretending.

Foster children knowing what social workers want to hear.

Foster children learning from experience what to say to social workers.

Foster child saying what others want to hear.

know, "I surrender, I won't do it again" and she tells you exactly what you want to hear, and she's a professional, I've never seen a child say things that people wanna hear, she's such an expert, and she's not the only one that will sit and talk to a social worker or anybody and tell them exactly what they wanna hear because they've done this so many times, they know what you wanna hear. [pause]

Female carer: She's just telling them what they want to hear and she's still, but the children don't do it like that do they

Male carer: So, that's why it's very important that the social worker understands and connects with the foster

<p>Needing social workers to connect with carers.</p> <p>(107)</p> <p>Helping foster children by working together.</p> <p>(108)</p>	<p>Needing social workers to connect with carers.</p> <p>Some social workers not connecting with carers.</p> <p>Learning from bitter experience.</p> <p>Needing everyone to work towards the same goals.</p> <p>Inconsistencies in workers being detrimental to foster child.</p> <p>Needing everyone to work together.</p>	<p>carers, cos some social workers do not connect with the foster carers.</p> <p><i>Researcher:</i> So there's not a communication between the link-workers and the social workers and the foster carers</p> <p><i>Male carer:</i> And there needs to be, I found that out in my bitter experience, our bitter experience, that, unless everybody's working from one direction, it's against the child.</p> <p><i>Female carer:</i> They should be working together.</p>
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<p>Usually having a high turnover of link-workers. (109)</p> <p>Getting practical support from family and friends. (110)</p>	<p>Link-workers supporting foster carers. Usually having a high turnover of link-workers.</p> <p>Foster carers getting practical support from their daughter. Being trained to work with foster children.</p>	<p><i>Researcher:</i> Who's around for you?</p> <p><i>Male carer:</i> There's [name of link-worker], she's our link-worker and she's been our link-worker for four and a half years, which is very unusual for anybody to stand the job for that long.</p> <p><i>Researcher:</i> So, there's social services, what about other supports for you, I mean do you get support from friends or other organisations?</p> <p><i>Male carer:</i> No, we get mainly support from our daughter who is a support carer, she's done the training and she's lived with foster children for quite a long time, and she has an understanding. And we have one or two</p>
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	<p>Daughter living with foster children. Foster carers' friends babysitting. Foster children babysitting foster children. Ex-foster children babysitting foster children. Keeping in contact with previous foster children.</p>	<p>friends who baby sit for us [pause]</p> <p><i>Researcher:</i> Do they understand what it's like?</p> <p><i>Male carer:</i> Well, one of the people that baby sit for us, she's a foster child herself</p> <p><i>Female carer:</i> She was a foster child</p> <p><i>Male carer:</i> She was a foster child, yeah and, another person who used to be our foster child, she comes and baby sits for us, so we've kept contact</p>
<p>Ex-foster children offering practical support. (111)</p>		

<p>Getting support from training and peer group meetings. (112)</p>	<p>Using training as a support. Getting support from peer group meetings. Booking three training sessions this year.</p>	<p><i>Researcher:</i> Is there any other ways that you, I mean you've told me a few ways that you cope personally. It seems that communication is a big thing for you between yourselves and also with people around you</p> <p><i>Female carer:</i> We have training, and we go to the support group meetings</p> <p><i>Male carer:</i> [and we're booked for um three training sessions this year</p> <p><i>Researcher:</i> Right. [pause]. You mentioned um at the beginning of the interview that one of the current children in your care was meant to have gone to a psychiatrist, but he didn't want to go so you were asked to see them. I</p>
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	<p>Carer and child both involved in consultation with a psychiatrist.</p> <p>Not knowing the difference between psychologists and psychiatrists.</p> <p>Disagreeing with each other in sessions with psychiatrist.</p> <p>Both carer and child voicing their opinions in sessions with psychiatrist.</p> <p>Gaining understanding from a psychiatrist.</p>	<p>was wondering whether you have had any previous experience of child and adolescent mental health services and what that has been like?</p> <p><i>Male carer:</i> Yeah, I've been going for the last year with one of the young ladies living here, to a psychiatrist, [gives psychiatrist's name, who is actually a psychologist] and er, I sit in for a quarter of the time, and er, it's a funny triangle really, it's, it's like me and the child talk and the psychiatrist is listening and I'm saying things, and she's saying "no, it's not this way" and we're going round in circles and that's, that has helped me tremendously to understand, and then we've got [name of outreach worker], who is an outreach worker that comes</p>
<p>Benefiting from three-way consultation with psychiatrist.</p> <p>(113)</p>		

<p>Having most regular contact with outreach worker.</p> <p>(114)</p>	<p>Getting regular visits from an outreach worker.</p> <p>Having most contact with outreach worker.</p> <p>Outreach worker visiting placement for two and a half years.</p> <p>Having weekly contact with outreach worker.</p> <p>Contact with outreach worker sometimes being more than weekly.</p>	<p>ur, she's a regular here [laughs]</p> <p><i>Female carer:</i> She's come to this house more than anybody else</p> <p><i>Male carer:</i> I think she's been coming for the last two and a half years</p> <p><i>Female carer:</i> [every week]</p> <p><i>Male carer:</i> [every week, or every two weeks]</p> <p><i>Female carer:</i> [she's almost here every week, sometimes twice a week]</p>
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<p>Outreach worker helping foster carers deal with the children.</p> <p>(115)</p>	<p>Outreach worker helping foster carers deal with the children.</p>	<p><i>Male carer:</i> [you know, to help us with our, the children in our care</p>
<p>Outreach worker listening and relieving the pressure.</p> <p>(116)</p>	<p>Outreach worker relieving the pressure.</p> <p>Outreach worker listening to foster carers.</p> <p>Outreach worker having psychological background.</p> <p>Gaining understanding of the children</p>	<p><i>Researcher:</i> It seems that you have had quite a lot of contact with them, in terms of the outreach worker, it sounds as if she is there a lot</p> <p><i>Female carer:</i> She takes the pressure off of us, by listening</p> <p><i>Male carer:</i> [because [name of outreach worker] has a background in psychology and she's brought me quite a few books to read, which I've enjoyed reading, and</p>

<p>Learning about foster children from books.</p> <p>(117)</p> <p>Having to understand more than a father would.</p> <p>(118)</p> <p>Learning to look at the reasons behind foster children's behaviour.</p> <p>(119)</p>	<p>from books.</p> <p>Fathers not needing to think a lot about reasons behind behaviours.</p> <p>Having to gain a different perspective to understand foster children.</p> <p>Looking at the reasons behind foster children's behaviour.</p> <p>Not taking the perspective of a father.</p>	<p>[pause] whether, as a normal family man, a father, or, looking after children, your own children, there's certain things that you don't read in the background, you don't read in your mind, er, so, when somebody does something, you know, what's the reason behind them doing what they did, if you understand what I'm trying to say, so we discuss the reasons and we find out that x meant y and y meant this and, you know, so forth, so</p> <p><i>Researcher:</i> Yes, so discussion's good for that, looking at reasons</p> <p><i>Male carer:</i> Yes, and then trying to explain that, with different actions that are happening and why this thing is</p>
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<p>Outreach worker and link-worker taking the pressure off foster carers. (120)</p> <p>Asking for help when the pressure gets too much. (121)</p>	<p>Talking about the reasons behind situations.</p> <p>Finding it helpful to discuss what is happening in the placement.</p> <p>Outreach worker and link-worker taking the pressure off foster carers.</p> <p>Feeling the pressure building up.</p> <p>Letting off steam with outreach worker and link-worker.</p> <p>Asking for help when the pressure gets too much.</p> <p>Knowing that you have an outside support.</p>	<p>happening and why is that thing happening, and I think that helps you tremendously, and in a sense takes a lot of the pressure away from you cos it, er, [pause] I speak now of [<i>name of link-worker and outreach worker</i>], it's like, they come here, whenever they come here, and, you know, you've got sort of a pressure cooker and they just turn the stat and let the steam out [laughs] and everything comes down, you know, and I think that's a role that they play very well and, you know, as soon as I, the boiler is boiling, I ring up and say "Look, I wanna speak to you", you know, and I</p> <p><i>Female carer:</i> We know that somebody's there for us to help us</p>
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<p>Needing to let off steam to an outside support. (122)</p> <p>Having support available when you need it. (123)</p> <p>Needing someone to off-load to. (124)</p>	<p>Needing the support of outreach workers and link-workers.</p> <p>Needing to let off steam to someone.</p> <p>Having support as available when needed.</p> <p>Other professionals not being there all the time.</p> <p>Letting off steam to professional supports over the telephone.</p> <p>Unloading.</p> <p>Having support when feeling desperate.</p>	<p><i>Male carer:</i> And there is, and if they weren't there, I think the pressure cooker would have blown, so you need, really need to have these people around, whether it's [<i>name of link-worker</i>] or anybody else, but you need to be able to get hold of them very quick. [pause] because though they're not here twenty four hours, seven days a week, ur, just having somebody on the end of the line, to be able to shout at and scream at,</p> <p><i>Female carer:</i> [to unload</p> <p><i>Male carer:</i> [and to say "I'm really desperate" and then they sort of say "Well calm down, lets see what" you</p>
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	<p>Being able to calm down and talk through a difficult situation with someone.</p> <p>Everyone needing someone to off-load to.</p> <p>Psychiatrists being a new type of support.</p> <p>Other professionals deciding that foster carers need to see a psychiatrist.</p> <p>Specialist carers needing to understand foster children from a psychological perspective.</p>	<p>know and, it's a calming effect, you need that, everybody needs that, and it's something that I feel that they've helped me tremendously.</p> <p><i>Researcher:</i> Yes. As for the psychiatrist, what is their role?</p> <p><i>Male carer:</i> Well, this is a new thing, okay, that they, we've had a professional meeting and they've decided that if we're they're going to help the children that we have here, because we're specialist carers now, that we needed to understand a bit more about the psychology that happens to a young person or a young child, um, to begin to understand, because I think me and my wife are</p>
<p>Other professionals deciding that foster carers need to see a psychiatrist.</p> <p>(125)</p> <p>Specialist carers needing to understand psychology.</p> <p>(126)</p>		

	<p>Feeling relaxed with each other.</p> <p>Having a long marriage.</p> <p>Having a solid family base.</p> <p>Not needing help with family relationships.</p> <p>Not having psychological training.</p> <p>Needing psychological training to understand the children better.</p> <p>Gaining new ways/strategies/"weapons"</p>	<p>quite relaxed, I mean we've been married what, how many years now? Thirty two?</p> <p><i>Female carer:</i> Thirty three</p> <p><i>Researcher:</i> That's a long time</p> <p><i>Male carer:</i> So, it's not, there's no danger in a sense of our family falling apart or anything like that, but we need to understand now, we haven't got a background in psychology, but we need to understand certain things, and the only way that we can understand it, and this is how, for them to give us weapons to be able to look after the young people.</p>
<p>Needing additional understanding to a solid family base.</p> <p>(127)</p> <p>Psychiatrists providing new ways of helping foster children.</p> <p>(128)</p>		

	<p>of helping foster children.</p> <p>Needing to evaluate how you care for foster children.</p> <p>Needing to gain further understanding.</p> <p>Outreach worker helping foster carers to understand causes of behaviour.</p> <p>Reading books about making emotional connections.</p>	<p><i>Researcher:</i> Yes. Somehow, like weapons or armour or strategies</p> <p><i>Male carer:</i> Strategies, yeah, [pause] cos I think it's very important that we begin to understand what we're doing, you know, because, for example, you know, [<i>name of outreach worker</i>] was explaining to us how one thing led to another and why some people do these things, and then she gave me a book the other day and [pause] er, what is it called?, it's something to do with building er, building emotions and building er</p>
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Getting help to understand the reasons behind behaviour.
(129)

		<p><i>Female carer:</i> [it's about connecting</p> <p><i>Male carer:</i> [connecting with people, um, and that, it was a story about this particular young lady, who, you saw the story from her birth to very, sixteen or seventeen and how she went from foster carer to foster carer, and how she did all these things, and you had a bit of the story, and then you had the discussion with the psychiatrist, talking about the child, and that really opened my eyes to a lot of things that before I wasn't quite sure what was, what was happening, and then, we were told that, you know, sometimes, it's good to put your boundaries and stick to them, whether you get screaming and shouting and stuff thrown at you, you've still got to stick to your rules, and they are little things</p>
<p>Gaining understanding from learning about foster children's backgrounds. (130)</p>	<p>Gaining understanding from books about psychiatric cases of foster children.</p> <p>Reading about foster children's backgrounds.</p> <p>Gaining understanding from learning about foster children's past.</p>	
<p>Learning about behaviour strategies from psychological literature. (131)</p>	<p>Psychological literature giving foster carers answers/insight.</p> <p>Learning to maintain boundaries with foster children.</p>	
<p>Finding the right strategy for each individual child. (132)</p>	<p>Learning about behaviour strategies from psychological literature.</p> <p>Needing to find the right strategy for each child.</p>	

	<p>Finding it important to learn about strategies.</p>	<p>that you need to, it's not that one strategy might not work with all the kids,</p> <p><i>Researcher:</i> Yes, but at least then, you can pick and choose perhaps</p> <p><i>Male carer:</i> Yes, and it's important to go down that road.</p> <p><i>Researcher:</i> It sounds to me that what you would like from people within the child and adolescent mental health services is, as you say, advice about strategies to use, erm, and also a greater knowledge about psychological techniques</p>
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<p>Wanting social services to create a library for foster carers. (133)</p> <p>Foster carers finding psychological literature helpful. (134)</p>	<p>Social services not providing literature for foster carers.</p> <p>Wanting social services to create a library for foster carers.</p> <p>Being given/made aware of useful literature.</p> <p>Books being expensive.</p> <p>Foster carers being unable to afford psychological literature.</p> <p>Libraries for foster carers being helpful.</p>	<p><i>Male carer:</i> And I think that the social services, I think they should provide a library with books cos this particular book that [<i>name of outreach worker</i>] gave me to read, I mean she's given us about four books, and if you were to buy these four books,</p> <p><i>Female carer:</i> [they're very expensive</p> <p><i>Male carer:</i> [you would need a hundred pounds, I don't think a normal foster carer would go and spend that kind of money and have the books at home, so if they had a library where we, they were circulated to all foster carers, a month at a time, you know, I think that would be a</p>
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<p>Needing to understand other people's perspectives.</p> <p>(135)</p>	<p>Needing to understand other people's perspectives.</p> <p>Foster child putting her feet up across the settee.</p> <p>Foster child taking up inappropriate space in a social situation.</p> <p>Acting towards a foster child like a father would.</p> <p>Touching a foster child's feet without sexual motive.</p> <p>Touching a foster child without thinking.</p> <p>(136)</p>	<p>tremendous amount of help to them, because you need to understand, er [pause] how everybody feels, I mean, an example was that I was sitting on the settee when the young lady was putting her feet right across the settee</p> <p><i>Female carer:</i> [we had guests and there wasn't enough room for everybody to sit, and then she was just laying on the whole of the settee</p> <p><i>Male carer:</i> [the whole seat, so, without thinking, I just went and I went [<i>makes action as if moving someone's feet from a lying position to the floor</i>] and put the feet down, and I touched the feet and I put them down, and immediately she rang and said that I molested her [pause]</p>
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<p>Being accused of sexually molesting foster child. (137)</p>	<p>Foster child reporting physical contact by a male carer as sexual abuse. Being accused by child social worker of sexual abuse. Being unaware of actions being misinterpreted by foster children.</p>	<p>and I said that, you know, when the social worker comes, she said “You molested her, you touched her legs” and, you know, I didn’t even remember, it didn’t even click in my mind that I’d touched her legs, you understand what I mean, so I said “When did I touch her legs?”, she said “You know that night when everybody was in that room”, but she never told the social worker that everybody was in the room.</p> <p><i>Researcher:</i> She only said the bit about the</p> <p><i>Male carer:</i> [touching of the leg, so these are little things, that’s why I said it’s very important for everybody</p>
<p>Needing everybody to understand why a foster child makes an allegation.</p>	<p></p>	<p></p>

<p>Needing allegation cases to be handled with understanding/sensitivity.</p> <p>(138)</p> <p>Getting accused very quickly in allegation cases.</p> <p>(139)</p>	<p>Needing everybody to know how to handle allegations.</p> <p>Needing to have everyone involved informed in allegation cases.</p> <p>Getting accused very quickly in allegation cases.</p> <p>Social worker acting quickly in allegation case.</p> <p>Social worker reprimanding carer for touching foster child.</p> <p>Social worker investigating allegation from foster child.</p> <p>Being unable to remember when touching occurred.</p>	<p>to understand and realise how you question the child, when the child makes an allegation, it's [pause] everybody around understands what's happening</p> <p><i>Female carer:</i> They're very quick to hang you when this has happened.</p> <p><i>Male carer:</i> I mean the social worker was so quick to ring up and pick up the phone, and really had a go at me about touching her legs, and she said "We have to investigate this" and when she was saying to me, you know, "You touched the leg", and I went, I couldn't remember, I just couldn't remember when I did it, because it wasn't done in a sense, you know, you just "move your legs, I'm gonna sit there" you know? And I</p>
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	<p>Foster child reminding carer of touching incident.</p> <p>A lot of people being around when incident occurred.</p> <p>Social worker becoming aware of the circumstances of the incident.</p> <p>Allegation leading to damage in carer/child relationship.</p> <p>Foster child complaining about lack of pocket money from carers.</p> <p>Social worker investigating pocket</p>	<p>couldn't place it, and then when, when I said "Right, when was it that I touched your legs, cos I can't remember?" and she said "yes you do, that day that was" you know</p> <p><i>Female carer:</i> [so many people around</p> <p><i>Male carer:</i> [there were no seats, and then when she said that, of course the social worker clicked, but the damage was done [pause] or another thing that happened as an example, one of the children complained about their pocket money [pause] to a social worker, so the social worker came here and says "How much pocket money do you give your child?", I said "Well, six pounds", and she</p>
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	<p>money allegation.</p> <p>Social worker accusing foster carer in front of child.</p> <p>Social worker believing foster child's version of events.</p> <p>Social worker questioning carer's authenticity.</p> <p>Social worker undermining foster carers' authority in front of child.</p> <p>Foster child using allegations to split professionals.</p>	<p>says "Oh, I'll have to check that", she</p> <p><i>Female carer:</i> [in front of her</p> <p><i>Male carer:</i> [in front of the foster child, and then she said "How much clothing money do you give her?" I said "Well, sixteen pounds" or whatever and she said "Oh well I have to check that because the child is saying", so she was questioning me, us actually, we were both there, questioning us in a sense in front of the child, and not believing us and believing the child, so if I take six pounds, if I were to take a couple of pounds off the pocket money off the child, which is silly, but that damage is done, you see, because once they divide you,</p>
<p>Social worker undermining carer's authority in front of foster child.</p> <p>(141)</p> <p>Foster child using allegations to split professionals.</p> <p>(142)</p>		

	<p>Splitting professionals leading to damage in carer/child relationship.</p> <p>Splitting leading to damage of trust between carer and child.</p> <p>Social workers not having experience of splitting.</p> <p>Social workers causing damage because of lack of experience.</p> <p>Wanting allegations to be investigated privately.</p> <p>Wanting allegations to be investigated with respect.</p>	<p>[pause]</p> <p><i>Researcher:</i> You've had it?</p> <p><i>Male carer:</i> [you've had it, it's very difficult to pull that child back into your trust, because she's already done the damage, and the social worker, not being experienced, has fallen into the trap. [pause]. Now, what the social worker should have done, yes, they should have listened to the child, said to the child "Yes, I will investigate this", and then say "[name of male carer], I want to talk to you privately", and "could you please tell me what the rules are?" [pause] and I would have said "Well, here's the list, it says here, pocket money, so much, clothing</p>
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<p>Feeling disrespected by social workers in allegation cases. (144)</p> <p>Being careful to maintain authority in front of the foster child. (145)</p>	<p>Providing evidence to social worker of rationale for pocket money.</p> <p>Showing social worker how they could have avoided damage.</p> <p>Showing social worker how foster child split them.</p> <p>Social worker becoming aggressive.</p> <p>Confronting social worker's aggression with aggression.</p> <p>Maintaining authority with social worker because foster child present.</p> <p>Being careful to maintain authority in front of the foster child.</p>	<p>money", I mean the pocket money actually was less than six pounds but she was wanting to get ten pounds a week from me, so it was five eighty, the pocket money, for that particular age group, so I said "Look, it's all here in black and white" I said, if you had questioned me privately, I would have said to you, you would have gone to the child and said "Right, [name of foster carer] is giving you the right money, you're lucky you're getting it.", but, what you've done now is divided us. In the end, the social worker was very aggressive, so I got aggressive and I said "Right, I'm ending this, piss off out of my house", which I did say that, but that's, you know, it's something that you have to, you have to put that rule, because if you let, because the child was present, if you reacted any</p>
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	<p>Not showing vulnerability with foster children.</p> <p>Predicting blackmail from foster children.</p> <p>Foster children using blackmail to affect the placement.</p> <p>Needing to convey strength to foster children.</p> <p>Social workers listening and protecting foster children.</p> <p>Wanting social workers to investigate</p>	<p>other way, that gives the signal to the child that you are doing something wrong,</p> <p><i>Female carer:</i> [that you are weak and that you are</p> <p><i>Male carer:</i> [you are weak and you are afraid and they can, so, because they will blackmail you on anything, they'll say well, you know, they will use any weapon they can, and I would use the same weapons there as well, to affect the placement or to have one over you, so there's certain times and points that you really have to be strong and that's what I thought was one of them, you know, so this is why it's very important sometimes that yes, the social worker should listen to the child, should</p>
<p>Foster children using blackmail to affect the placement.</p> <p>(146)</p>		

<p>Wanting social workers to respect foster carers in allegations.</p> <p>(147)</p>	<p>allegations.</p> <p>Wanting social workers to respect foster carers in allegations.</p> <p>Being allowed to explain your side to social worker.</p> <p>Wanting to have rights in allegation cases.</p> <p>Foster children not tolerating sexual abuse on placement.</p> <p>Foster children knowing where they want to be.</p> <p>Using placement breakdown as a threat towards foster child.</p>	<p>protect the child, anything the child says to them, they should investigate. I have no problems with that, but if this is an allegation made against the foster carer, then that should be done in a more friendly, friendlier atmosphere, urm, you know, get the foster carer, and say “Well, this is what, this x, y, this person is saying about you, can you explain to me what this is all about?” Then you can explain to them, now, if the social worker is not happy with your explanation, because if you’re a molester, or anything like that, you can’t hide these things for too long, the children will not, will not tolerate it because when the argument was happening, I said “Right, if you feel this way, you can break the placement” and immediately the child says “No, I don’t</p>
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<p>Foster child making allegations to get more pocket money.</p> <p>(148)</p>	<p>Foster child making allegations to get more pocket money.</p>	<p>want to leave here”, that was the immediate reaction from the child, because she was trying to get more money, and she thought that if she put pressure this way, she would get it</p> <p><i>Researcher:</i> I suppose the frustrating thing about it, was that if the social worker had worked together with you more, then it would have been much easier to deal with</p> <p><i>Male carer:</i> Yeah, we would have dealt with it in two seconds, no aggravation, no nothing, because there’s, I can count, in the twenty, thirty times that [<i>name of outreach worker</i>] from outreach has come in and said to me “[<i>name of male carer</i>] you are doing this wrong”, you</p>
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<p>Outreach worker giving feedback constructively to foster carers. (149)</p> <p>Wanting feedback from knowledgeable professionals. (150)</p>	<p>Outreach worker giving foster carers feedback on their behaviour.</p> <p>Outreach worker recommending new strategies to foster carers.</p> <p>Not feeling offended by feedback.</p> <p>Being open to feedback/help.</p> <p>Not knowing anything.</p> <p>Learning to use politically correct language in foster care.</p> <p>Link-worker and outreach worker giving feedback on incorrect use of language.</p> <p>Foster carers being open to criticism.</p>	<p>know, "You should have tried this route", you know, "Why don't you go down this road?".</p> <p><i>Female carer:</i> [we don't get offended because we don't know anything</p> <p><i>Male carer:</i> [at the beginning, when I said once, erm, to somebody "Oh you're from mixed race" ur, you know, or if you say "black" or, you know, you've got to learn not to say these words, so, [pause] oh no, the word was "half cast", I remember, I said "It's a half cast child" and she said "No, you can't say that, you've got say they're mixed race", so, [pause] I've been told off by [<i>name of link-worker</i>] and by [<i>name of outreach worker</i>] in the</p>
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<p>Needing to learn how language can be mis-interpreted by foster children. (151)</p>	<p>Acknowledging the critical aspect of link-worker and outreach worker's roles. Needing to learn how language can be mis-interpreted by foster children. Male carers being cautious about expressing affection to female foster children. Not understanding the foster children's backgrounds. Learning to avoid comments that could be misinterpreted by foster child.</p>	<p>sense that it's a criticism, that's their role to criticise us to make sure that we, we learn by our mistakes, not to, and learn to re-phrase certain things because this is why I said to you in the beginning, it's very important how you say, you can say to my daughter "I love you" but you can't say that to a fifteen year old foster child, especially when they're a well developed fifteen year old, and you're a male carer. It can be seen, especially if they live in a world, which is unfortunately misunderstood, so as a male, these are the little things that you learn to avoid.</p> <p><i>Researcher:</i> We're coming to the end of the hour now, and erm, we've talked about a lot of things during the hour, about some of the difficulties that your, well, one</p>
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particular child in your care is currently showing, some stuff about how you cope and your experiences of working with professionals. One theme that comes through about working with professionals is the need for communication and erm that somehow people like the link-workers and the outreach workers who are more on the front line, they're good for letting off steam with and also from learning from mistakes as you're going along with it, but there needs to be a lot of working together with them, whereas people like psychiatrists and psychologists, and the people out in the child and adolescent mental health teams, you feel are more helpful, in terms of teaching you about all the different psychological techniques and helping you to get a deeper

		<p>understanding of how psychologists or whatever think about problems. Is there anything else from the child and adolescent people that would make your life easier or was there something when you went to see them in the past where you felt that it wasn't, that it didn't quite come up to what you wanted or needed?</p> <p><i>Male carer:</i> Not really, I mean, again you need to, the last session we had is [pause] in the beginning of the sessions, it made me feel like a little bit guilty in the sense that what am I doing wrong?, why am I, but as the sessions progressed, you know, and then, at the end of the day when the whole sessions finished and you've got a clearer picture, it's, you understood what they were</p>
	<p>Feeling guilty in the first sessions with a psychiatrist.</p> <p>Having to confront your own behaviour in the sessions.</p> <p>Clarifying the motives of psychiatrist at the end of the consultation.</p>	

<p>Misinterpreting psychiatrists' feedback as judgements on your professionalism/sanity. (152)</p> <p>Learning what you need to learn from psychiatrists. (153)</p>	<p>Seeing the help psychiatrists give in a positive light.</p> <p>Not understanding feedback at first.</p> <p>Having to be professional about receiving feedback.</p> <p>Thinking that psychiatrists judge you as mad.</p> <p>Using psychiatric consultations in a constructive way.</p> <p>Listening to what psychiatrists have to say.</p> <p>Learning from psychiatrists.</p> <p>Learning what you need to learn.</p> <p>Thinking that some carers might misinterpret psychiatrist's feedback</p> <p>Wanting clarity about reasons for seeing</p>	<p>trying to do, so erm, [pause] this is why I think they can't be seen as a negative [pause] if it's not explained to you, or it's not finished in that session, in the right way, you understand, so you might, if you're not strong enough or you're not professional enough, you might feel that [pause] am I the one that's mad? Am I the one that's mental?, you know? [laughs] and I felt that a couple of times, so, you know, but, because of the character I am, and I don't normally walk away from an argument, I sit and listen, and er, I talk a lot, is that, I learned what I needed to learn, but some people might not have the confidence that I have and I think that's when you need to make sure they understand what the goal is right from the beginning, so they're not meant, not to feel guilty for</p>
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Wanting clarity about reasons for seeing

a psychiatrist from the start.

(154)

a psychiatrist from the start.

Misinterpreting psychiatrists as judging
of foster carers.

Misinterpreting psychiatrists as judging
you insane.

doing fostering, now I've got to go and see a mental
psychiatrist as well you know? So that might be a bit off-
putting unless it's put, I mean, depending on who you
deal with, of course, you know

Researcher: One thing that you mentioned towards the
beginning of the interview was that erm, because your,
because the child currently with the cannabis issues,
doesn't want to go to the mental health professionals,
then you're having to go, I mean how does that work for
you, how do you feel about that?

Male carer: Well, this is just what I said a minute ago,
unless it's explained to you right at the beginning what

<p>Lack of communication from professionals leading to guilt and misunderstanding. (155)</p> <p>Needing to clarity reasons behind decisions with other professionals. (156)</p>	<p>Not being informed of the reasons behind going to see a Psychiatrist.</p> <p>Lack of communication leading to misunderstanding.</p> <p>Feeling guilty and judged by other professionals.</p> <p>Needing to clarify reasons behind decisions with other professionals.</p>	<p>the goals are, and what [pause] why you're doing it, you're not made to feel guilty, cos when the conversation started and this was put on the table that me and my wife should go, erm, for a flash second, I thought, my god what are we doing wrong, what are we, are we the ones that are needing the help, was it our fault?, so, in a sense that, you need to connect, that's why I said it's very important to make sure that everybody understands and if somebody doesn't really understand at the beginning, it's important that they understand</p> <p><i>Researcher:</i> Are mental health professionals sometimes, they're the people that people go to when they need [pause] help?</p>
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<p>Needing mental health professionals to explain that they can help carers to understand the children. (157)</p>	<p>Finding that mental health professionals try to make you talk. Not needing any help to talk. Needing mental health professionals to be open/clear about their role. Needing mental health professionals to explain that they can help carers to understand the children.</p>	<p><i>Male carer:</i> Yeah help, and I've sat through quite a few of the people, urm [pause] and they go "mmm, mmm", [laughs] and you end up, you know, you end up saying, I suppose it's a thing to make you talk, but I don't need any help with that [laughs] but it's something that I think they should open up and explain to the foster carers, what the whole idea is beforehand, and that they're not a judgement on their character, but it's to help them understand the child.</p> <p><i>Researcher:</i> Yes, so, to show right from the start that they're not being judgemental, that they're there to help, and what the goals are that will come over time.</p>
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<p>Feeling the blame for placement breakdown. (158)</p> <p>Needing to learn that you can't perform miracles. (159)</p>	<p>Needing mental health professionals to be clear about their goals from the start.</p> <p>Blaming yourself for placement breakdown.</p> <p>Learning that you cannot do miracles with foster children.</p>	<p><i>Male carer:</i> It's like when you started the interview, you said, you know, "If wanna stop, stop, or if you don't understand something, say", so, it's better to clear the air right from the beginning of the interview, so that when a foster carer goes to these places, he understands what the goals are and it's not because it's his fault or her fault or their fault, that the placement is breaking or it's not working, because, like I said, it's, every child is different and we can't do miracles.</p> <p><i>Researcher:</i> No. [pause] Okay, urm, we've come to the end of the interview now, before we finish, is there anything that you first of all would like to say more about</p>
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	<p>Wanting a match between social workers and foster children.</p> <p>Feeling strongly about the importance of social workers understanding foster children.</p> <p>Needing social workers to communicate</p>	<p>any of the issues that we've discussed today or is there anything that you want to ask me?</p> <p><i>Male carer:</i> Well, the only one thing I wanna say, is that I think you should report this down. Where possible, I know it's not easy, in every case, is that they should match the children with their social worker</p> <p><i>Female carer:</i> You've already mentioned that</p> <p><i>Male carer:</i> Well, I think it's very important, that's why I'm re-stating it, that the social worker of the child should understand the child, you know, and that they should spend, I know it's for the child's benefit, but they should</p>
<p>Wanting social workers to understand the foster children. (160)</p>		

<p>Needing social workers to communicate with foster carers. (161)</p>	<p>with foster carers.</p>	<p>spend a good fifteen or twenty minutes each visit with the foster carers alone. [pause] You know, I mean, that's what my recommendation would be [pause].</p> <p><i>Researcher:</i> Yes, just to have more communication with the foster carers and somehow that might show</p> <p><i>Male carer:</i> [yeah, we have enough communication with the, our link-worker because they come here and spend an hour with us and with [<i>name of outreach worker</i>], the outreach worker, but the child social worker, sometimes, they just bring them to the door and drop them and go away and they don't even come in and say hello.</p>
<p>Feeling disrespected by social workers. (162)</p>	<p>Having enough communication with link-worker and outreach worker.</p> <p>Not having enough communication with social workers.</p> <p>Feeling disrespected by social workers.</p>	

<p>Feeling left out and uninformed by other professionals. (163)</p> <p>Feeling it's a "secret society" out there. (164)</p>	<p>Feeling work with foster children undermined /disrespected by other professionals.</p> <p>Feeling left out by other professionals.</p> <p>Feeling that other professionals keep secrets from/don't inform foster carers.</p>	<p><i>Researcher:</i> Doesn't seem right really</p> <p><i>Male carer:</i> No, so, we need to [pause], that needs to be, cos you feel that [pause], you're the one that's looking after the child, and you feel like somebody else is, they've brought the child and dropped them and never made a connection with you, you know it feels like there's a secret society out there, and you're left out</p> <p><i>Researcher:</i> [and it fuels splitting</p> <p><i>Male carer:</i> [yeah, the splitting, and that's what's very important for me, not to split that. [pause] Do you want to say anything else?</p>
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Female carer: No.

Male carer: Shall we ask for more money for foster carers, or are we not allowed to? [laughs]

Researcher: [laughs]. Right, I'm going to turn off the tape recorder.

APPENDIX 7

Memo – “Working Together”

Working together means developing and maintaining links with other people, communicating with them, giving and receiving information, supporting each other, seeing different people’s perspectives on the situation and working as a team. When working together, the foster carers felt a sense that their work could be effective and that they could bring about change more readily (seen as part of their professional role). Working together gave them strength and the ability to face challenges more easily. They felt that it enabled consistency and inevitably helped the children in their care. It gave them the opportunity to off-load and share the pressure they were under with other people.

Working together was seen as important on several different levels for the foster carers: working together as a family on the foster placement; working together with the children (keeping the communication open, reducing barriers and supporting them); working together in partnerships (e.g. married couples); getting support from wider family and friends; keeping connections strong within their community; working with other professionals; carers supporting each other; working together with birth parents and adoptive parents; organisations working together (e.g. child and adult, health and social services).

Without working together, foster carers felt unsupported, isolated and dis-respected in their role – a feeling of “going it alone”, having to rely only on inner strength in the absence of external resources. Having “bitter experience” of not working together – brought up strong feelings for carers. There was also a recognition that without working together, the foster children might end up receiving mixed messages from different people, which led them to feel confused and engage in splitting behaviours.

This then reinforced their lack of trust in the carers and other professionals as adequate care-givers (gives way to possible re-enactment of previous experience of inadequate care-giving).

Barriers to communication and working together: high turnover of staff in local authority; other professionals not getting the support to be able to give support to foster carers; professionals having “personal agendas” – got in the way of how they worked with other people; confidentiality; “cultural defensiveness” – each profession being defensive about their role. Concept of “having to fight” the barriers to get support/communication.

Beliefs underlying the concept of working together: a strong sense of community/family spirit; viewing support as important and crucial; an aspect of being both a successful parent and a professional.

Links with other categories:

Parent/professional paradox = working together an important part of both roles – but does being a professional mean that you might have to be more independent or will be viewed in that way because you have had more training or if you have dealt with difficult situations on your own in the past (e.g. experienced foster carers)?

Being on the system interface = wanting more respect and understanding from professionals through working together, having to communicate with other professionals (being under scrutiny) and wanting communication back.

Making sense of the CAMHS experience = wanting CAMHS to enable working together, wanting to work together with CAMHS.

Building relationships with foster children and birth parents = needing the support and communication to deal with the difficult feelings these relationships bring up.

APPENDIX 8

Codes from interview 1 that were raised to the “working together” category.

(The codes in italics are some examples of codes from other interviews that were raised to this category to show how the codes between interviews were compared).

Helping foster children by working together:

- (1) 61. Helping foster children by working together.
- (4) 4. *Feeling that foster children lose out from system inconsistencies.*
- (3) 108. *Carer and child working through problem together.*
- (3) 45. *Foster children being in the middle of service disputes.*

Working together with family and friends:

- (1) 76. Getting strength from working together with your spouse.
- (1) 78. Foster care being easier with a partner.
- (1) 110. Getting practical support from family and friends.
- (1) 59. Expecting friends to accept foster children as part of the family.
- (4) 31. *Receiving support from family members.*
- (5) 57. *Partners supporting each other.*
- (2) 111. *Having friends who understand what type of support you need.*
- (3) 156. *Feeling that friends don't understand foster children.*

Peer support:

- (1) 112. Getting support from training and peer group meetings.
- (3) 54. *Wanting more information sources at peer group meetings.*

Support from other professionals:

- (1) 100. Link-worker helping with carers' problems.
- (1) 114. Having most regular contact with outreach worker.
- (1) 115. Outreach worker helping foster carers deal with the children.
- (1) 116. Outreach worker listening and relieving the pressure.

- (1) 120. Outreach worker and link-worker taking the pressure off foster carers.
- (1) 121. Asking for help when the pressure gets too much.
- (1) 122. Needing to let off steam to an outside support.
- (1) 123. Having support available when you need it.
- (1) 124. Needing someone to off-load to.
- (1) 149. Outreach worker giving feedback constructively to foster carers.
- (6) 143. *Having to suffer alone.*
- (4) 31. *Needing support from the local authority.*
- (3) 75. *Personal agendas causing barriers to support.*
- (4) 86. *Not getting help because of image as copers.*

Communicating with other professionals:

- (1) 30. Getting a different perspective from other professionals.
- (1) 32. Foster children complaining to other professionals about carers.
- (1) 33. Foster children talking about foster carers to other professionals.
- (1) 105. Social workers only hearing foster children's version of events.
- (1) 107. Needing social workers to connect with carers.
- (1) 142. Foster child using allegations to split professionals.
- (1) 143. Social worker allowing foster child to split professionals.
- (1) 155. Lack of communication from professionals leading to guilt and misunderstanding.
- (1) 161. Needing social workers to communicate with foster carers.
- (3) 8. *Fighting to get adult and child services to communicate.*
- (4) 94. *Professionals not working together.*
- (6) 105. *Social worker not working with carer and child.*
- (5) 163. *Needing social workers to listen and understand.*

APPENDIX 9

“Dealing with false allegations” – example of a category that was discarded from the analysis

“Dealing with false allegations” referred to fears that some of the foster carers expressed about current or previous foster children making allegations against them. Experiences of feeling ostracised and isolated by other professionals in these cases or seeing colleagues being treated in that way made these foster carers anxious about how they would deal with a false allegation. The experience of having a false allegation made against them was seen as having the potential to occur at any time and to threaten their “career and reputation” as well as further “damage” the foster child if not handled in the right way. Due to concerns that they would not receive adequate support if a false allegation were to occur or that other professionals would be “quick to judge” instead of listening to their point of view, the carers expressed a need to prevent such an event from happening by remaining particularly vigilant about this. In one case, the carer thought it important to look at the reasons why a foster child would make a false allegation, for example, if they felt particularly mistrustful of the way adults behaved towards them.

It was decided, however, not to include this category for a number of reasons.

Firstly, the frequency in which the codes that were raised to this category occurred both within and between interviews was relatively low, suggesting that, compared to other themes, this was not a major theme that ran through the experiences of the foster carers participating in the study.

Secondly, as the analysis developed, it was felt that the category “It’s a secret society out there - Being on the system interface” encompassed the category “Dealing with false allegations” in that it was related to the foster carers’ feelings of being excluded from the system but at the same time accountable to it. The way that the foster carers dealt with false allegations may also be related to the category “Connecting with damaged children” in that the feelings that are experienced when building a relationship with the children in their care might for some foster carers be influenced by their fears about having a false allegation made against them.

It was, therefore, concluded that “Dealing with false allegations” was not a central theme in the foster carers’ story, but that it was connected with more fundamental aspects of their experience as encompassed by other categories that were included.

APPENDIX 10

Personal notes following supervision with research tutor after second interview

Important issues that have come out of first two interviews and similarities and difference between emerging concepts:

Complex emotions = Strong feelings were expressed during both interviews when talking about a number of different experiences, for example, having to deal with feelings of failure and frustration when placements broke down and feelings of being unsupported and disrespected by other professionals. Particularly in the second interview, I felt a pressure at times to respond in a therapeutic way as the carer expressed their feelings of anger and lack of support and I had to be careful to remain neutral in my role as an interviewer – importance of keeping an appropriate distance to the data so as not to get too close to the foster carers' experiences as I do the analysis.

Interviewing in the carers' homes = advantageous – I got a strong sense of the environment in which carers' experiences occur and the communities in which they live. Differences between first and second interviews = who they have around them, who they value as support, what types of support they get where, how they are viewed within their community. Similarities = strong belief in keeping links with other people and maintaining a good support network (e.g. family, friends, wider community).

Difficulties of the children in their care = wide range, “every foster child is different”, carers drawing on different ways of thinking to explain reasons behind difficult behaviour e.g. attachment difficulties, fears of rejection and lack of trust, bad parenting, multiple placements and caregivers.

APPENDIX 11

“Living with the parent/professional paradox” – the contradictions of foster care.

Summary of research findings.

This research project was aimed at better understanding foster carers’ experiences of dealing with the emotional and behavioural difficulties of the young people in their care, their experiences of support from child and adolescent mental health services and/or what kinds of support they would like from child and adolescent mental health services, with the hope that the research findings would better inform mental health professionals in the ... Looked After Children CAMHS team about these issues.

As you will know, due to the government introducing their “Quality Protects” programme in 1998, which called for better integration of health, social and educational services for disadvantaged children in the UK, CAMHS services were given extra funding to set up local specialist teams for looked after children and their carers. This was because some children in the looked after system were not benefiting from the type of service offered by general CAMHS teams due to the sometimes temporary nature of their placements. The idea was that specialist CAMHS teams could provide interventions to looked after children who were experiencing difficulties, and support and consultation to foster carers. In (*name of local authority*), a specialist CAMHS team was created in (*three years ago*) and since that time, they have been expanding their service for both looked after children and foster carers. In developing this service, a need for research into the types of support foster carers would most benefit from was identified. By meeting that research need through carrying out my project, I hoped to gain a better understanding of the issues that foster carers face and their experiences of and views about support.

The project involved carrying out six in-depth interviews with foster carers, which I tape-recorded and then transcribed. The foster carers that I interviewed varied in terms of the length of their experience in fostering, their marital status and the types of placement they offered. Some of the foster carers I interviewed had attended CAMHS services in the past while others had not.

In each interview I asked the foster carers a basic set of questions related to the areas I was interested in finding out about, starting by asking them to think about one of the young people who was currently in their care, what they understood to be the issues surrounding this young person and how they were dealing with those issues. I also tried to allow time for the carers to talk and reflect about their experiences in detail during the interviews. As each interview progressed, the carers drew on experiences they had had with young people who had previously been in their care as well. In this way, I hoped to find out more about what fostering children and accessing relevant support meant to each of the carers.

As I carried out the interviews, what became apparent to me was the wealth of experience the foster carers could draw on. With each young person they had fostered, came a new set of experiences, which were sometimes very different from those they had encountered before. From that perspective, it seemed as if a one hour interview was too short a time to discuss the whole range of experiences and views that the foster carers had. Nevertheless, the interviews did give us enough time to talk in some depth about issues that the foster carers considered important to their overall experience.

My analysis of the interview transcripts involved exploring themes that arose from each interview and comparing them with the themes that emerged from the other interviews. Exploring and comparing these themes enabled me to develop a picture of those issues that were fundamental to the foster carers' experiences and how these issues might be connected with each other. Please refer to the diagram for an illustration of the themes I found and how I thought they were connected.

The principle finding of my analysis was that the foster carers faced many contradictory situations in fostering. One contradiction, however, seemed to pervade all of these situations because it was inherent to their role. I called this the “parent/professional paradox”. When reflecting on the multi-faceted task they faced in fostering, all of the carers referred to the emotional aspect of their role, to the importance of building a relationship with the young people in their care, which involved nurturance and aspects of being a parent. However, they also experienced their role with the young people as requiring skills over and above or different from those of a parent in order to be able to understand and/or meet the needs of the young people. Doing the job as professionally as possible in order to help the children was also, therefore, seen as an important part of their role. The roles of parent and professional were, however, sometimes experienced as being in conflict with one another.

There were four other salient themes that emerged from the interviews, which I thought were all underpinned by this conflict. They were as follows:

1. “Building relationships – dealing with ambivalent feelings”. This theme referred to the often contrasting feelings that the foster carers experienced with regards to developing relationships with the young people in their care and their parents.

The majority of the foster carers in the project identified at least one ongoing behaviour that a young person in their care showed, which they found difficult to manage, and they also talked about why they thought the young person behaved in that way, for example because of lack of trust, abusive experiences, feelings of anger and rejection and low self-esteem. These behaviours, which the foster carers were sometimes not used to dealing with, stirred up uncomfortable feelings for them and sometimes prompted them to respond in unexpected ways or ways in which they had not wanted to.

Moreover, although the foster carers wanted to make an emotional bond with the young people in their care, this was sometimes a complex task and not always possible if the young person resisted making an emotional connection to their carers due to their past experiences of abusive and/or uncaring relationships. For most of the foster carers, failure to reach or help a young person in their care had the potential to throw up feelings such as guilt or frustration for them.

Furthermore, due to the nature of their role, the foster carers experienced other conflicts such as taking the risk that the young person in their care might perceive them to be rejecting parents if the placement came to an end; not being able to show physical affection to young people who clearly needed that; and feeling torn between placement expectations to bring about change in the young person's behaviour and the realities of needing to build trust gradually and slowly with a young person before change could be effective.

Similarly, most of the foster carers also experienced ambivalent feelings with regards to the young people's parents. This was because, having witnessed the distress of the young people in their care, they felt disapproval and sadness at the way their parents had treated them. However, some of those foster carers also had the responsibility of forging links and working with the parents of the young people in their care and in some cases, this involved supporting the parents when there was an absence of any other support. Also, some carers were involved in encouraging the parents to assume a more active, functional parental role while the young person was still on placement with them.

2. "It's a secret society out there" – being on the system interface: This theme represents how the foster carers experienced their position in relation to the wider system of professionals. It encompasses two sub-themes.

(i) “Being under the spotlight” – This sub-theme refers to the pressure all the foster carers experienced from being on the frontier of fostering services. Being accountable and reporting placement progress to the local authority meant that the carer/child relationship was experienced as being under constant scrutiny or “under the spotlight”. Some of the carers found this an additional pressure and an intrusion on their ability to cultivate a normal emotional connection with the young people in their care.

(ii) “Feeling misunderstood” – This sub-theme represents how the foster carers experienced their role as unique because of the amount of time they spent with the young people in their care compared to other professionals. They felt that it was, therefore, difficult for other professionals to understand the extent of the work they carried out and what it was like to be a foster carer. Some of the carers also highlighted how they were in an objective position within the multi-disciplinary team, not feeling completely part of the team of professionals, despite the level of professionalism expected of them.

3. “Working together” – All the foster carers spoke about their experience of working together with other people as a necessity for enabling them to work with the young people in their care more effectively. Working together was seen as beneficial at all levels – for example, with family and friends, with the young people’s parents, with the community, with other professionals and with other services. Support from link-workers and outreach workers was seen as being particularly useful for the foster carers’ personal well-being and ability to help the young people as they helped the carers let off steam and deal with the pressures they were under more effectively.

4. “Learning on the job versus formal training” – This theme referred to the importance placed on the one hand on training and access to relevant literature but also on the values of practical experience which could only be gained through actually working as a foster carer.

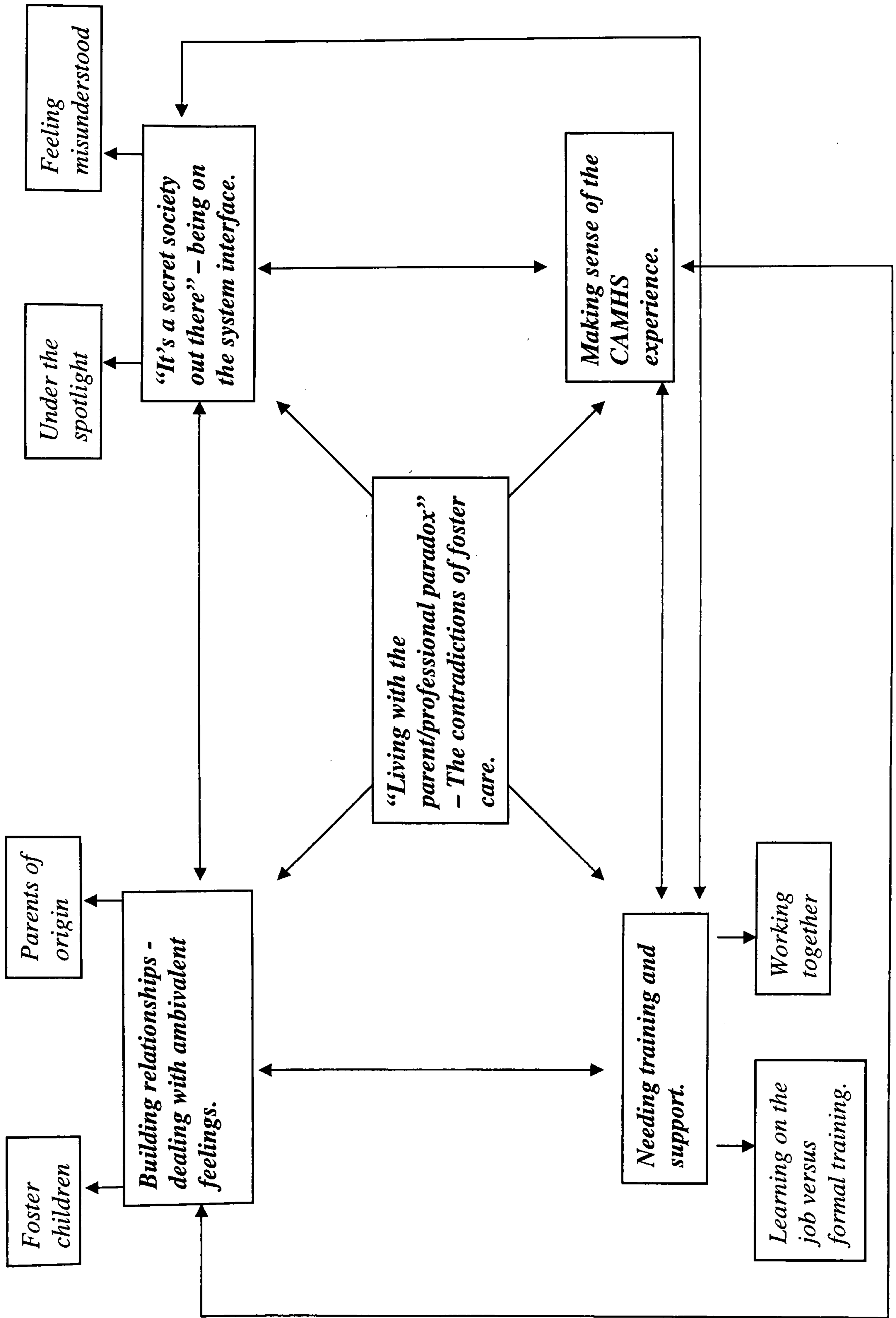
5. “Making sense of CAMHS” – Not all the foster carers who were interviewed had had contact with CAMHS in the past. However, when exploring their experiences or lack of experiences of CAMHS during the interviews, the following issues emerged.

Firstly, types of support the foster carers identified as wanting from CAMHS included: learning about strategies and the reasons behind behaviour, help with the carer/child relationship, consistency and goal-setting, support for the carer as well as the young person and more links with adult mental health services and the community.

Secondly, however, experiences of CAMHS included not feeling part of the referral process, not feeling informed enough about the CAMHS process, feeling that CAMHS were not informed enough about the foster carer’s work, and having difficulties with travel time to and from the CAMHS centre. There was also the view that not being properly informed about the goals of a CAMHS consultation made the carers more vulnerable to feelings of guilt that they had done badly by the young person in their care, anger because their expectations were not met and fear that they might be suffering from mental health problems. Positive feedback included gaining a better understanding of the young person’s background and psychological reasons for their behaviour and about factors involved in the relationship between the carer and young person.

As illustrated on the diagram, I thought that the four main themes that have been described, “Building relationships”, “Being on the system interface”, “Training and support” and “Making sense of the CAMHS experience” all inter-connect with each other in building up an understanding of the different aspects of foster carers’ experiences. At the heart of and running through all their experiences is the contradiction in their role – being both a parent and a professional, which each foster carer who I interviewed had had to deal with and face.

Diagram of themes



CRITICAL REVIEW

Name: Joanna Mary

Date: December 2003

Year: 3

Thesis title: Learning from foster carers: their experience of fostering and mental health service provision.

Summary of Research Study

This study aimed to understand more fully the experiences of foster carers with regards to how they understood the emotional and behaviour difficulties of the children in their care and the types of support they required from a specialist child and adolescent mental health service for looked after children and their carers.

Research Design

In-depth interviews were conducted with eight foster carers from six foster families employed by and living within one local authority. A grounded theory approach was utilised to collect and analyse the data in order to generate a theoretical understanding of foster carers' experiences that was grounded in their accounts.

Main Findings

The principle finding in the study was that foster carers had a wide range of complex experiences, which were conceptualised as being subsumed under an overall contradiction that was inherent in their role; that of being a parent and a professional. This core theme in the foster carers' experiences pervaded four other themes that emerged from the data and which were interlinked. These were defined as follows: 1. Building relationships – dealing with ambivalent feelings with regards to both the children in their care and the children's parents; 2. Being on the system interface – feeling under scrutiny from and misunderstood by other professionals working within the care system; 3. Needing training and support – placing importance on working together with other professionals, support networks and the need for further training; 4. Making sense of the CAMHS experience – defining a role for CAMHS within the wider system of professionals.

In general, the foster carers felt a strong sense of responsibility in their role to build a relationship with and provide a good experience for the children in their care, to help them overcome difficulties and to support and sometimes empower the children's parents. However, this often meant that foster carers had to face complex and contradictory feelings with regards to connecting to the children, dealing with their behaviours and negotiating the boundaries within their relationships with the children's parents. As such, being a foster carer involved professional skills and expertise in addition to being a parent.

Within the wider system, foster carers often saw their roles as undervalued by other professionals who were not totally accepting of them within the multi-disciplinary forum. The foster carers also found support and communication between professionals to be sporadic, which they saw as being detrimental to the children in their care. Furthermore, the foster carers distinguished between on the one hand, learning through gaining practical experience of fostering and on the other, the importance of receiving training to develop their professional skills. Finally, although a limited number of foster carers in the study sample had had experience of CAMHS, the carers saw a role for CAMHS in advising on psychological issues and training to help them build a relationship with the children in their care. However, their willingness to engage with CAMHS was thwarted by general views about the stigma of mental illness and their feelings of being under-valued and scrutinised by other professionals

Clinical implications of the study

In 1998, the Department of Health launched the "Quality Protects" programme (Department of Health, 1998), planned to run over six years in order to improve health, educational and social services to disadvantaged children by developing an inter-agency strategy. As part of this strategy, local CAMHS teams were given funding to develop specialist services for looked after children. This was in order to provide more rapid access to mental health services for this population and to provide advice and training to their carers.

Since that time, new specialist CAMHS teams for looked after children and their carers have been developed all over the country. Clinical psychologists can be seen to play a key role in the implementation of services for looked after children, for example, by conducting thorough assessments of their complex difficulties and providing psychological interventions informed by a variety of theoretical frameworks (e.g. cognitive therapy, attachment theory, family therapy). Furthermore, clinical psychologists also play an important role in supporting and consulting with foster carers to help them cope with the needs of the children in their care. Their work may involve individual consultative work with foster carers, group training, or direct work in facilitating an attachment between a foster carer and child.

The current study was borne out of an interest in understanding the experiences of foster carers given recent policy changes which place them in a central position with regards to service provision to looked after children. The study was carried out in one particular local authority, however, due to an identified need to evaluate the needs of foster carers living within the authority with regards to support from the local specialist CAMHS team. This CAMHS team was a relatively new service, having only been developed two and a half years before the data was collected in the current study. As a result of the aims of this study, therefore, it can be seen as having a number of clinical implications.

Firstly, with regards to the findings that highlighted the contradictory experiences of foster carers, the study has implications for clinical psychologists working in a supportive, training and consultative role with carers. The study represents the start of the development of a theoretical understanding of the experiences of foster carers in how they understand and cope with the children in their care. The usefulness of using a theoretical framework when working with foster carers in the clinical setting lies in it's potential to facilitate a supportive relationship with them. Through acknowledging and validating their experiences, clinical psychologists can build more meaningful relationships with foster carers and encourage awareness of the conflicts inherent within their role.

Through recognition and a mutually supportive relationship, foster carers may then be better able to develop self-efficacy and problem solve about difficult issues. The importance of feeling acknowledged and “heard” for foster carers has been documented in a study by Golding (2002) who, in a study evaluating the development of a service for looked after children found that the consultation process made carers feel re-assured and supported. This then had a positive effect on how they viewed and reacted to the difficult behaviours of the children in their care. However, there is, as yet, limited literature from which to draw in terms of working with looked after children and their carers. In terms of the approaches which can be utilised with this client group, Pallett et al (2002) based a training programme they developed for foster carers on ideas from cognitive-behavioural and social learning theory but also from attachment theory to highlight the importance of creating a “secure base” for the children in their care. Ideas from attachment theory are also used to highlight the difficulties that children with insecure attachment histories have in developing new relationships with care-givers. A recent study by Schofield et al (2000) highlighted these difficulties from the carers’ point of view in relation to the types of attachment pattern that children showed through their behaviour and interactions with others. Furthermore, attachment theory can also be applied by psychologists in a more directive way in the form of “attachment therapy” with foster carers and their children (e.g. Delaney, 1998; Hughes, 1997, 1998).

Secondly, when considering the findings in the current study regarding the foster carers’ experiences of the local specialist CAMHS, it was clear that there was a need to collect more data about this. However, the findings did suggest that there was a lack of clarity and knowledge about the types of services CAMHS offered. In general, the findings raised the issue of carrying out a more systematic evaluation of the CAMHS, and an audit of need with the foster carers. However, they also indicated that consideration of existing knowledge about the CAMHS team within the local care system would be useful.

Service implications

An over-arching implication of the findings in the current study was consistent with other studies in highlighting that, in general, foster carers need increased support and training (e.g. Berridge, 1997; Caesar et al, 1994; Sellick and Thoburn, 1996). This year, the Green Paper “Every Child Matters” was published (DFES, 2003), which sets out government proposals for reforming the delivery of services for children at risk. As part of the proposals, the paper sets out to tackle the recruitment and retention challenges in foster care and to ensure that foster carers have the skills and support they need to care for the children. This, therefore, holds promise for support and training for foster carers both before and during placements. However, it also highlights the need to better understand the support and training needs of foster carers.

Reflections on research process

The current study was limited by time and resource constraints in a number of different ways. However, it also raised a number of issues about conducting qualitative approaches and grounded theory research with foster carers.

A qualitative approach was chosen for the current study because of the strength that qualitative studies hold in terms of focusing on the subjective meanings and ideas about the world that individuals bring to their experiences and their study of phenomena within their natural setting. This approach was seen as paying attention to the way that foster carers understood their experiences and to understanding how this was influenced by changing policies and contexts. A grounded theory approach to research was chosen in order to generate a fuller and deeper understanding of foster carers’ experiences that was grounded in their accounts. Open-ended interviews in line with a grounded theory approach were conducted. These had the potential to allow the foster carers to explore complex and sensitive issues in detail.

As the research project was carried out, a number of issues came to light with regards to special considerations when using foster carers as research participants. Before conducting interviews with the foster carers, the researcher attempted to set up a focus group as a pilot to the interviews. This was seen as an opportunity to gain a preliminary understanding of themes for foster carers living and working within the local authority under study. In light of feedback from foster carers and the time limitations of the study, it was in the end not possible to conduct a focus group. However, the foster carers' feedback suggested that conducting focus groups with this population was problematic for a number of reasons. Firstly, the foster carers reported that, given the demands of their work and the fact that they worked at home, they found it relatively difficult to attend an event at a pre-set time and venue. Secondly, they also fed back that they would prefer to participate in research on a one-to-one basis rather than in a group. The exact reasons for this were not known, but it is possible that the foster carers felt that they would not be heard in a group setting due to the complexity, individuality and sensitive nature of their stories.

Furthermore, it became apparent while recruiting participants that recruiting by letter yielded little response from foster carers. This was also seen to be due to the busy lives of the carers. Promotion within the setting, such as attending team meetings, giving out information sheets and meeting with the different professionals involved in working with the carers helped facilitate recruitment of the participants. Telephoning as opposed to letter-writing was also necessary in recruiting carers for the study.

The experience of conducting interviews with the foster carers also yielded some interesting findings with regards to how best to collect in-depth accounts from them. Liaison with psychologists who were experienced in working with foster carers, visiting a Foster Carers' Support Group and conducting a mock interview were seen as essential to carry out before starting the interviews with the foster carers. This was because there was a need to make the questions in the interviews meaningful for foster carers and not so open-ended that they felt overwhelmed and unsure where to start.

It was also the researcher's experience that a number of the research participants had to go to attend to child-care issues during the interviews and that they also had a tendency to stray off the topic of the research interest. These experiences highlighted the need to be flexible, to build up a rapport and to be directive at times with the carers. This was particularly important given the high emotional content of the interviews at times as foster carers conveyed difficult experiences or unresolved issues. The researcher, therefore, needed to be sensitive and responsive during the interviews but at the same time remain self-aware and disciplined with regards to maintaining researcher neutrality. In addition, the tension between being open-ended and directive was also reflected in the researcher having to resist falling into a therapist role during the interviews, particularly when the foster carers quite often reflected on unsolvable problems and questions.

In terms of ensuring rigour in the study and controlling for researcher bias, the researcher engaged in personal reflection throughout the research process, discussed codes and interview data in peer supervision and used clarifying techniques during the interviews to check understanding of participants' accounts. The researcher also enhanced the credibility of the study by going back to check her interpretations of the foster carers' accounts with them. This was done by presenting the themes that had emerged in the analysis at a Foster Carers' Support Group meeting. Three of the six sets of foster carers who participated in the study and five other foster carers who had not participated in the study but who were employed by the same local authority were present at the meeting. Feedback from both the participants and the non-participants who were present at the meeting indicated that they found the study's findings to be an accurate representation of their experiences. Carers present at the meeting also reported that they felt validated through receiving feedback from the researcher about their experiences.

With regards to controlling for participant bias, it was thought that having the opportunity to interview each participant a second time might have further explicated themes and might have given the researcher the opportunity to build more trust and rapport with the participants. This might then have the effect of the participants feeling more able to talk openly with the researcher. However, disadvantages in getting to know interview participants better have been described (e.g. Padgett, 1998). As such, the researcher is at risk of becoming too enmeshed with the data they are collecting. Furthermore, in the current study, interviewing participants a second time would have conflicted with ethical considerations about over-loading the carers with in-depth interviews and taking up their time.

One shortcoming of the current study was not being able to carry out theoretical sampling and thus reach theoretical saturation due to time and resource constraints. The categories that were developed and described, therefore, might have been more fully explicated if more foster carers had been interviewed. Furthermore, more triangulation could have been achieved by interviewing other professionals who worked closely with foster carers in the care system. None-the-less, the researcher took great care, to use the method of constant comparison and to create an audit trail to ground emerging themes in the data. When considering the issue of grounding from a philosophical point of view, the researcher viewed the themes that were developed as being grounded in an interaction between the researcher and the interview participants. The themes that emerged were also significant and explanatory, and conceptual links were made between them due to the richness of the interview accounts that were obtained.

Conclusions

The current study highlighted a number of special considerations that needed to be taken into account when recruiting and obtaining narrative accounts from foster carers, such as their busy schedule and the emotionally sensitive content of their experience.

Using a grounded theory approach in the study was advantageous because in-depth, open-ended interviews allowed exploration and elaboration of the complex issues that foster carers are often faced with. Analysis also facilitated a new, more fuller understanding of the meanings they brought to their experiences. However, it was also disadvantageous in terms of firstly, the open-ended nature of the questions being over-whelming for foster carers who might become emotional as memories were triggered by talking about them, and secondly, the length of time taken to carry out the analysis. As well as being thought provoking, creative and generative, the process of grounded theory analysis was also labour intensive, lengthy and cumbersome. As such, if carried out within a clinical setting, the approach would yield interesting and meaningful findings, but it would be difficult carry out on a practical basis.

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