**A Review of Factors Associated with Placement Breakdown in Foster Care and an Interpretative Phenomenological Analysis of Foster Carers Lived Experience of Blocked Care**

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Finally, I would like to dedicate this thesis in loving memory of my grandad.

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**Thesis Abstract**

Paper one presents a systematic literature review of nine studies, which investigated factors associated with or predictive of foster care placement breakdown (PB). These studies were critically appraised and a narrative synthesis of the findings was then completed. Percentage quality appraisal scores ranged from 33% to 73%, which has implications for confidence in the conclusions drawn. Factors associated with or predictive of PB were older child age, previous experience of PB or placement movement and contact or conflict with the biological family. There is a need for future research to be more transparent in the reporting of methods and results. Contact with the biological family should be appropriately scaffolded by social care to reduce conflict. Care planning and placement matching implications are discussed.

Paper two presents an empirical paper which investigated foster carers lived experience of blocked care (BC) using Interpretative Phenomenological Analysis (IPA). BC describes instances in which caregivers find it difficult to provide the care that the child needs (Hughes, 2015). Foster carers are understood to be at increased risk of experiencing BC. There is no current research regarding foster carers experience of BC, which the present study aims to redress. Five themes were identified: “We didn’t understand”, ‘something took over me’, ‘neglected and “left to get on with it”’, ‘having a break’ and ‘now I get it’. Practice implications include further consideration of foster carer’s past experiences in the matching process and additional support early on in placement. Future research is required regarding foster children’s experience of BC and the development of reflective functioning, mentalisation and attunement over time.

Paper three presents an executive summary of the empirical paper. The executive summary was created to communicate key information about the study in a succinct and accessible manner.

**Paper 1: Literature review**

**“What are the factors associated with or predictive of placement breakdown in foster care?” A literature review**

**Word count: 7972**

**Target Journal:** Child & Family Social Work

Note. Author guidelines are in appendix P. Please note that additional formatting in line with author guidelines will take place following thesis submission.

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**Abstract**

Placement breakdown (PB) in foster care is relatively common and associated with adverse outcomes for the child, carer and system. Understanding factors associated with placement breakdown is therefore important. The current review provides an up-to-date synthesis of factors associated with foster care placement breakdown between 2017-2022. A systematic literature search was conducted which identified nine papers. These were critically appraised using the CCAT and a narrative synthesis of the findings was then completed. Percentage quality appraisal scores ranged from 33% to 73%, which has implications for confidence in the conclusions drawn. Factors associated with or predictive of PB were older child age, previous experience of PB or placement movement and contact or conflict with the biological family. There is a need for future research to be more transparent in the reporting of methods and results to enable future replication. Older children and children who previously experienced PB are likely to have experienced more maltreatment, traumatic experiences and negative caregiving relationships which needs to be accounted for in care planning and placement matching. Contact with the biological family should be appropriately scaffolded by social care to reduce conflict.

Key words: foster care, placement breakdown, placement disruption, placement instability, placement failure, placement dissolution

**Introduction**

Foster care placements are proposed to have the highest prevalence of placement breakdown (PB) (Holloway, 1997) with around one in five UK placements breaking down (Children & Young People Now, 2015). PB is an issue in foster care settings internationally (Vinnerljung et al., 2017) and is thought to contribute to multiple negative outcomes for the child, carer, and system. It is important to keep abreast of factors that are associated with PB due to changes in cultural contexts and social care policy and provision over time, which could impact upon the factors that contribute to PB. Further awareness of factors influencing PB could aid care planning to improve outcomes for young people. The present review aimed to provide an up-to-date synthesis of studies investigating factors that are associated with or predictive of foster care PB.

The Children’s Act (1989) defines looked after children (LAC) as children and young people whose care is provided for 24 hours plus by the local authority. In the UK, the majority (71%) of LAC are placed within family foster care settings (Gov.uk, 2021) and this is also the case internationally (Munro & Gilligan, 2013).

Across countries, social care systems differ substantially in terms of policies and provision (Price-Robertson et al., 2014). For example, in the UK, Australia, and America a ‘child protection’ approach is taken and is thought to be a reactive approach to child maltreatment to protect children from further harm (Price-Robertson et al., 2014; Sheehan, 2019). Alternatively, Belgium, Norway and the Netherlands take a ‘family service approach’ focused on providing support or intervention to children and their biological families (Price-Robertson et al., 2014). Care entry reasons also differ across countries. For example, in Belgium the most common reason for care entry is ‘parenting problems’ whereas in the UK ‘abuse and neglect’, ‘family dysfunction’ and ‘family in acute stress’ are the most common reasons for care entry (Gov.uk, 2021). These substantial differences between social care systems and reason for care entry across cultures makes it challenging to generalise findings from studies investigating PB across cultures, particularly since certain reasons for care entry have been found to be associated with PB (Konijn et al., 2019; Oosterman et al., 2006, Rock et al., 2015).

In the UK ‘abuse and neglect’, ‘family dysfunction’ and ‘family in acute stress’ are the most common reasons for care entry (Gov.uk, 2021). Therefore, a high proportion of LAC experience trauma and attachment disruptions prior to care entry (Browning, 2020). LAC may develop attachment difficulties (Hillman et al., 2020) and negative internal working models (cognitive representations that we hold of our early life experiences with caregivers which shape our self-view and view of others) in response to adverse early life experiences with primary caregivers (Kelly & Salmon, 2014). In combination, these experiences could contribute to LAC struggling to trust others, being hypervigilant to threats and finding it difficult to receive care.

**Placement Stability (PS)**

Due to these experiences, stability is particularly important for children in care. In line with attachment theory, PS with appropriate, consistent, nurturing, and responsive foster parents who can engage in mentalisation, and parental reflective functioning (Cooper & Redfern, 2015) is important to help LAC to develop secure attachments, positive internal working models, healthy relationship models and for child development (Ainsworth & Bowlby, 1991; Joseph et al., 2014; Kelly & Salmon, 2014). It has also been proposed that PS can reduce the likelihood of further traumatic experiences (including re-traumatisation) and can help children to recover from previous traumatic experiences (Browning, 2020). LAC who experience PS are also less likely to experience prolonged behavioural difficulties (Rubin et al., 2007), mental health difficulties (Jones et al., 2011) and may be more likely to achieve in education and have a successful career (Goyette, 2021). In line with this, Department for Education (DFE) (2013) supports the importance of PS and states that early placement permanence and stability (including both physical and emotional permanence) should be a goal for all LAC placements. This is also recognised as a goal of LAC placements internationally (Konijn et al., 2019).

**Placement Breakdown (PB)**

Terms such as PB, placement instability and placement disruption have been used interchangeably and defined in numerous ways in the literature (Konijn et al., 2019). For consistency, the term PB will be used throughout this review to refer to any placement that ended due to a negative reason (e.g., abuse, relational issues). A broad approach to PB definition was taken due to the varied definitions in the literature.

PB is thought to contribute to multiple negative outcomes for the child, carer, and system. Research has identified that PB may increase the likelihood of a child engaging in criminal activity, experiencing homelessness, imprisonment, behavioural and mental health issues, further traumatic experiences and developing substance misuse difficulties (Long et al., 2017; McAuley & Young, 2006; Mishra et al., 2020; Ryan & Testa, 2005; Shah et al., 2017). Carers who experience PB may experience grief in relation to the loss of the foster child: this could make it more difficult for carers to develop adaptive relationships with other foster children in the future, which may have a negative effect on foster carer’s mental wellbeing and could ultimately impact on foster carer retention (Valentine et al., 2019). In terms of systemic issues caused by PB, Patton et al. (2018) found that PB predicted higher health care costs in adolescents aged 12-17. One PB is estimated to result in an additional £11,415 in health care costs (Bazalgette et al., 2015).

**Factors that contribute to PB**

Three previous literature reviews synthesised findings from studies investigating factors that are associated with or predictive of foster care PB. Oosterman et al. (2006) and Konijn et al. (2019) conducted meta-analyses of studies conducted between 1960-2005 and 1990-2017. Rock et al. (2015) completed a narrative review of studies conducted between 1960-2009. All three reviews included international studies.

All reviews identified that older children were more at risk for experiencing PB. Konijn et al. (2019) and Rock et al. (2015) investigated gender and ethnicity and found no significant effect of these factors on PB. Reasons for foster care entry (e.g., abuse, maltreatment, behavioural difficulties) were associated with a higher risk of PB across studies. However, reviews did not consistently find the same reasons for care entry to be associated with PB. Oosterman et al. (2006) and Rock et al. (2015) found that biological parent or family factors were not related to PB (Konijn et al., 2019 did not study this). All reviews found that behavioural problems (particularly externalising behaviours) increased the risk of PB. Oosterman et al. (2006) and Rock et al. (2015) found that placements were more likely to breakdown when foster parents also had biological children living in the home (Konijn et al., 2019 did not study this). All reviews found that foster children placed without their siblings were more likely to experience PB than children placed with their siblings.

Rock et al. (2015) and Konijn et al. (2019) found that non-kinship care placements were more likely to breakdown than kinship placements. Oosterman et al. (2006) found no significant effect. Biological parent contact and relationship factors were inconsistent across Oosterman et al. (2006) and Rock et al.’s (2015) reviews (Konijn et al., 2019 did not investigate this). Oosterman et al. (2006) and Rock et al. (2015) found that a higher number of previous placements or previous PB experiences contributed to higher risk of PB. Konijn et al. (2019) found no significant effect of the number of previous out-of-home placements.

**Aims**

The most recent review of foster carer PB by Konijn et al. (2019) reviewed studies up to 2017. Therefore, the current review aimed to provide an up-to-date review of studies conducted between 2017 and 2022 to identify factors that are associated with or predictive of PB in foster care. By bringing the literature up-to-date, it also aimed to clarify inconsistencies in the findings of the three previous reviews. It is also important to keep PB on the agenda due to the adverse impact of PB on LAC outcomes, carers, and the system. Identification of current risk factors for PB could contribute to the development of more effective quality standards, practice, policy, and intervention to mitigate against PB.

**Literature review question:**

What are the factors that are associated with or predictive of PB in foster care?

**Methodology**

An initial scoping search of Google Scholar identified three previous reviews regarding this topic. Since 2017, there have been no literature reviews regarding factors that contribute to PB in foster care placements. A Cochrane Library and PROSPERO search also revealed no previous systematic reviews registered between 2017-2022. Online databases used for searching included: EBSCO (ERIC, Education Research Complete, SPORTDiscus with Full Text, eBook Collection (EBSCOhost), MEDLINE, CINAHL Plus with Full Text, APA PsycInfo, APA PsycArticles, APA PsycBooks) and Scopus. Due to the publication bias inherent in published research, grey literature was reviewed via ETHOS and Open Grey, which revealed no literature reviews between 2017-2022 on the topic.

**Search strategy**

Search terms were developed by reviewing search terms used in previous reviews. Search terms included: PB terms: "placement instability" OR "placement breakdown\*" OR "placement failure\*" OR "placement move\*" OR "placement transition\*" OR "placement disrupt\*" OR "placement drift\*" OR "placement dissolution" OR "failed placement\*" OR "placement change\*” AND factor terms: predict\* or "risk factor\*" or determin\* or factor\* or caus\*.

Searches were conducted in June 2022. The author took a two-step approach to searching. PB terms were searched initially. Following this, PB and factor search terms were searched together with AND. A two-step approach was necessary because the original one-step approach (searching PB and factors terms together) appeared to be missing pertinent papers when paper reference lists were cross checked by the author. Limiters were set to remove exact duplicates and date limiters were set (2017-2022). All articles generated by the searches were screened by title and abstract. The eligibility criteria (see table one) was used to determine whether the article was eligible for inclusion in the review. The author reviewed the full article if the title and abstract did not provide sufficient information to enable the author to establish whether the study met eligibility criteria. All searches were saved in EBSCO and Scopus initially and then exported to RefWorks. Figure one outlines the search strategy and screening process.

**Study Selection**

**Eligibility criteria**

See table one for eligibility criteria.

**Table 1**

*Eligibility Criteria*

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Inclusion** | **Exclusion** |
| Population | At least 90% of the study sample needed to be in kin and non-kin home foster care placements | Other LAC placements  Non-family based foster care settings (e.g., residential, and secure placements).  Children with significant learning disabilities or serious medical illness and ‘unaccompanied migrant children’. Factors influencing PB may differ across placement settings or where young people have additional presenting issues. Inclusion of these placements / groups may impact on the precision of findings. |
| Study Aim | Investigating a factor / factors associated with or predictive of foster carePB | PB as a result of reunification |
| Study Type | Peer reviewed to increase rigour of findings  Quantitative / mixed method studies to identify factors predictive of / associated with PB | Non peer reviewed, qualitative only |
| Study Date | Studies published between 2017-2022 | Studies published prior to 2017 |
| Language | English | Non–English due to no translation budget |
| Geographical Location | International studies |  |

**Quality appraisal**

The Crowe Critical Appraisal Tool (CCAT) (Crowe, 2013) was used to critically appraise the quality of the studies in this review (see appendix A). The CCAT can be used to evaluate studies with multiple research designs and has been demonstrated to have a good (.83) intra class correlation coefficient (Crowe et al, 2011). The CCAT was used in line with guidelines: the CCAT has eight different categories (preliminaries, introduction, design, sampling, data collection, ethics, results, and discussion) containing 22 items. Items within a category are appraised as ‘not applicable’, absent’ or ‘present’. Following this, categories are scored out of 5 (0-5 possible range), scores in each category are totalled to provide the total score (out of 40) for the study. The total score can be converted into a percentage to enable comparison across studies.

**Process**

The author extracted aims, design, method, sample, factors, measures, analysis, findings, limitations, and practical implications from each study and then appraised each study using the CCAT. Following this, the author generated a study table (see table two) which includes the key characteristics of the studies and their overall appraisal scores.

**Synthesis**

A narrative synthesis was used in line with guidance provided by Popay et al. (2006) to synthesize studies. Individual factors were only reported in the synthesis section if three or more studies investigated and reported the results of the same factors, in line with synthesis guidance provided by Sallis et al. (2000). A meta-analysis was considered however, the studies included disparate samples, methodology, and findings. Due to the level of heterogeneity, a meta-analysis would have been unsuitable (in line with Deeks et al., 2022).

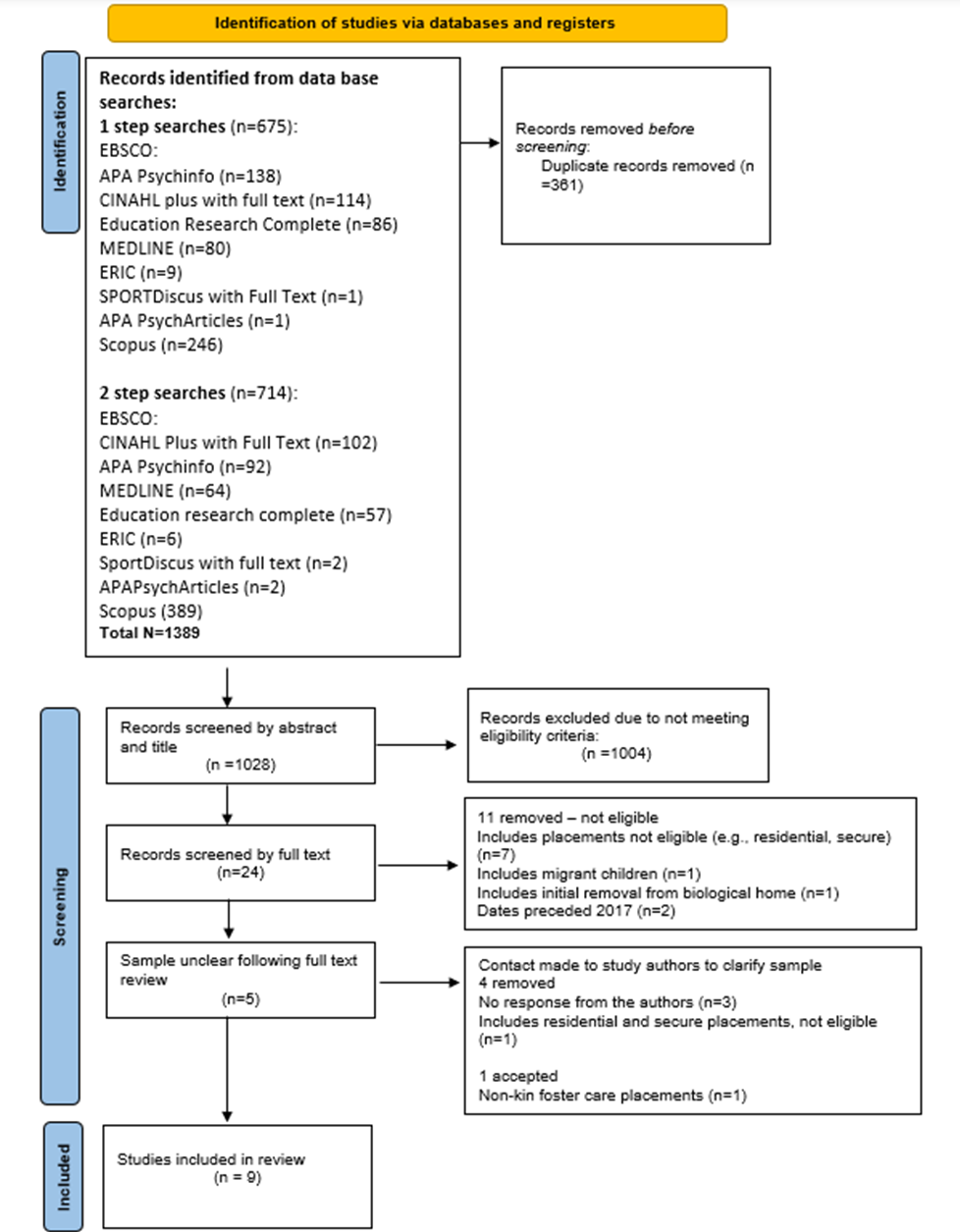
**Results**

**Study characteristics**

Nine studies met inclusion criteria. Four studies (Font & Kim, 2021; LaBrenz et al., 2022; Leathers et al., 2019; Osborne et al., 2021) were conducted in America, the remaining studies were conducted in Australia (Miller et al., 2019), Spain (Montserrat et al., 2020), Norway (Tonheim & Iversen., 2018), Belgium (Vanderfaeillie et al., 2018b) and Netherlands and Belgium (Vanderfaeillie et al., 2018a). Two studies used some of the same data (Vanerfaeillie et al., 2018a; Vanderfaeillie et al., 2018b) however this is not made explicit in either article. The remaining seven studies appeared to be independent of each other. See table two for a summary of study characteristics.

**Figure 1**

*Search strategy and screening process PRISMA diagram (Page et al., 2020)*



|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Study**  **Table 2**  *Study Characteristics* | **Aims** | **Method** | **Sample** | **Main**  **Findings** | **Practical Implications / Future Research** | **Quality Appraisal**  **(CCAT)** |
| **1.**  **Font & Kim (2021)** | Assess impact of sibling separation on PB. | Retrospective  Longitudinal  Case file analysis | 2,297, children (60% aged 7 or below) 90%+ of sample in kin / non-kin foster care. | Separation from all siblings increased risk of PB (for children with one sibling, multiple siblings not significant).  Aged 4+, black & Hispanic children, non-relative foster care, having an older sibling & parent child conflict increases the risk of PB. | Children in care should be placed with at least one sibling where possible. | 60% |
| **2.**  **LaBrenz et al.**  **(2022)** | Assess Relationship between racially matched placements & PB. | Prospective Longitudinal  Case file analysis | 36,191 children (mean age 5.2 years) non-kin placement. | Non-racially matched placements increased the risk of PB.  White children had a lower risk of PB, ‘emotionally disturbed’ and older children at higher risk of PB. | Racial matching should be used in placements. | 53% |
| **3.**  **Leathers et al.**  **(2019)** | Assess the relationship between PB, child characteristics, & foster parent factors. | Prospective Longitudinal  Interview  Case file analysis | 139 foster parents. | Child risk to others, older age of entry & placement with African American foster parents increased risk of PB.  Negative foster parenting experiences were associated with PB. | Additional studies are required to further investigate exploratory findings. | 60% |
| **4.**  **Miller et al. (2019)** | To investigate the association between foster carer characteristics & PB. | Prospective Longitudinal  Survey | 212 foster parents. | Foster carers with reduced cognitive empathy, social support, levels of care giving satisfaction & less role demand satisfaction experienced more PB.  Foster carers who felt the placement was not a good match, who had a more distant relationship with the child & more relational conflict experienced more PB. | Further studies are required to confirm exploratory findings. | 38% |
| **5.**  **Montserrat et al.**  **(2020)** | Identify child, family & system factors associated with PB. | Retrospective Case file analysis  Questionnaire | 1255 child cases (aged 0-17) non-kin foster care placement. | Previously in care, only one caregiver, having a sibling placed apart, age (4-11 particularly vulnerable), experience of neglect, psychological/ emotional/ sexual abuse, gender violence, more than one foster child in the home & biological children in the home associated with PB. | Breakdown occurs for multiple interconnected reasons across child, family, and system level. | 68% |
| **6.**  **Osborne et al.**  **(2021)** | Investigate the impact of kin or non-kin placement on PB. | Retrospective Longitudinal Case file analysis | 450 child cases (mean age: 9.94). | Non-kin placements contributed to increased PB across the first three placements.    In placement 3 risk increased as age increased. | LAC should be placed in kin placements where possible.  Further studies required to confirm this finding as parts of the analysis were underpowered. | 53% |
| **7.**  **Tonheim & Iversen (2018)** | Identify factors that contribute to PB. | Retrospective semi-structured survey | 132 foster parents. | The most highly rated (+40%) factors for PB were: child behaviour, child’s need for care, concern regarding biological children’s well-being and lack of support from child welfare services. | Further studies required to confirm exploratory findings. | 33% |
| **8.**  **Vanderfaeillie et al (2018a)** | Identify child, foster family and placement factors associated with PB. | Retrospective Longitudinal Case file analysis | 580 foster children’s case files (Mean age: 6.) kin or non-kin placement. | Increased age of child at the beginning of placement, difficult behaviour at admission to care, increased previous number of moves &, removal reason sexual abuse was associated with PB.  Less contact with birth family and foster child not receiving treatment associated with PB. | Behavioural difficulties should be assessed throughout the placement so appropriate support can be provided.  Contact between biological and foster family should be scaffolded by social care.  Foster children should have opportunity for treatment. | 63% |
| **9.**  **Vanderfaeillie et al**  **(2018b)** | Assess foster child, family and case characteristics associated with PB. | Retrospective Longitudinal Case file analysis | 309 foster children (mean age 8) kin or non-kin placement. | Neglect, child gender (male), age of foster parents(older), age of foster child at admission (older), problem behaviour of child at admission and during placement, foster child not receiving treatment, and conflict between birth and foster family increased the risk of PB. | See Vanderfaeillie (2018a) practical implications - the same implications apply. | 73% |

*Note.* All findings in this table are significant (p < 0.05). The remainder of the factors studied were non-significant or too disparate to synthesise. See appendix C and D for further information on measures and study characteristics.

**Aims**

All studies aimed to investigate a factor or factors that are associated with or predictive of PB.

**Sample / recruitment**

Sample sizes ranged from 75 (Miller et al., 2019) to 37,330 (LaBrenz et al., 2022).

Leathers et al. (2019) utilised a random sampling technique and Miller et al. (2019) used a volunteer sample to recruit foster parents. Leathers et al. (2019) provided only brief information on recruitment which causes issues with replication. Seven studies used case file data or historical survey data.

Sampling limitations were identified across studies. Only Montserrat et al. (2020) provided justification for their sampling method. Leathers et al. (2019) was the only study that justified their sample size selection. Most of the studies (n=8) were quantitative and sample size calculations are important in quantitative research to ensure that the sample is large enough to enable analysis to be powered. There were issues with sample suitability across six studies: LaBrenz (2022) included only those who had been in the same placement for the entirety of 2015, meaning that PB prevalence is underestimated, and the factors identified may only be applicable to foster children who maintained a placement for a year. Leathers et al. (2019) state that older children are more at risk of PB. However, their inclusion criteria only included foster parents with relatively young children. Miller et al.’s (2019) sample appears small for a quantitative study; although 212 participants originally took part only 75 participants were included in the analysis. This limited sample makes it difficult to generalise the results. Vanderfaeillie et al., (2018a) included case files from only two out of 28 foster care agencies in the Netherlands, this makes it difficult to generalise the results. Tonhiem and Iversen (2019) included foster parents who experienced PB as well as those who nearly experienced PB; factors identified may have been disparate across these groups. Vanderfaeillie et al. (2018b) notes that in the Flanders children with behavioural difficulties are largely in residential care therefore the impact of behavioural difficulties may be underestimated. Overall, studies provided clear inclusion criteria with the exception of Miller et al. (2019), Osborne et al. (2021) and Tonheim and Iversen (2019). Only Miller et al. (2019) documented exclusion criteria.

**Design / procedure**

Four studies conducted case file reviews using a retrospective longitudinal design (Font & Kim, 2021; Osborne et al., 2021; Vanderfaeillie et al., 2018a; Vanderfaeillie et al., 2018b). Three studies (LaBrenz et al., 2022; Leathers et al., 2019; Miller et al., 2019) used prospective longitudinal designs utilising casefile analysis, quantitative interview, and quantitative survey respectively. One study conducted a retrospective questionnaire from case file data collected at one point in time (Montserrat et al., 2020). The above studies were quantitative in nature and most utilising casefiles used child welfare system case files. Due to the self-report nature of case file data, it is limited by bias and inconsistency. Tonheim and Iversen (2019) used a mixed methods design in the form of retrospective survey analysis. See appendices 3 and 4 for further information on study methods.

LaBrenz et al. (2022) was the only study to justify their design and only Leathers et al. (2019) fully and explicitly stated the design. Lack of clarity regarding the design can make it difficult to ascertain the type of design used, causing issues for replication. Most designs appeared congruent with study aims (n=6). Osborne et al.’s (2021) design lacked transparency, Miller et al. (2019) followed up on multiple occasions without justification, Leathers et al. (2019) followed up at two years to assess PB (with no re-measurement of factors, factors viewed as important at initial interview may have changed significantly at two years) and Tonheim and Iversen (2019)’s retrospective survey only included limited questions.

**Measures**

Studies used various definitions of PB (see table 3) and a wide range of factors were investigated across studies (see appendix C). The most common factors studied were age, ethnicity, gender, kin or non-kin care, previous experience of PB, child behaviour, removal reason and biological family factors. Most studies (n=5) clearly defined measures and variables, Leathers et al. (2019), LaBrenz et al. (2022), Osborne et al. (2021) and Miller et al.’s (2019) definitions of PB lacked clarity. Consideration of validity and reliability of measures was generally poor across studies. Most studies underreported how bias may have affected the design.

**Table 3**

*Definitions of PB*

|  |  |
| --- | --- |
| **Study** | **PB Definition** |
| Font & Kim (2021) | change in placement due to a difficulty with the placement (e.g., parenting difficulties) |
| LaBrenz et al. (2022) | at least one placement move |
| Leathers et al. (2019) | unplanned change in placement |
| Miller et al. (2019) | placement that ended and was ‘unsuccessful’ |
| Montserrat et al. (2020), Tonheim & Iversen (2019) | unplanned placement ending |
| Osborne et al. (2021) | No clear definition but PB can be inferred from the information in the introduction and multiple placements are investigated |
| Vanderfaeillie et al. (2018a; 2018b) | unplanned placement ending for negative reasons (e.g., conflict) |

**Analysis**

Most studies (n=8) included descriptive analysis. Tonheim and Iversen (2018) did not analyse the quantitative data and used thematic analysis for qualitative data. Font and Kim (2021) used survival analysis. Miller et al. (2019) used multiple t-tests and Mann-Whitney-U tests. The remaining studies used various regression analyses. All studies were explicit about data analysis methods. Most studies justified choice of data analysis method (Miller et al., 2019 and Tonheim & Iversen, 2019 did not).

Five studies used suitable analysis methods; other studies analysis appeared unsuitable due to use of descriptive analysis only (Tonheim & Iversen, 2019), power issues (Leathers et al., 2019) and type one error issues (Miller et al., 2019). Lack of clarity in Osborne et al. (2021) made it difficult to ascertain whether the analysis was appropriate. Most studies (n=7) summarised results appropriately (Tonheim & Iversen, 2019; Vanderfaeille et al., 2018b did not). Precision of effects (e.g. confidence intervals, standard deviation) were fully reported in only four studies (Font & Kim, 2021; LaBrenz et al., 2022;Miller et al., 2019; Vanderfaeille et al 2018b): this is disappointing as precision is important to understand the magnitude and precision of results.

***Quality Appraisal***

The author developed loose descriptive categories based on CCAT percentages (0-20% very low, 20%-40% low, 40%-60% fair, 60%-80% high and 80% to 100% very high) to support interpretation. Quality appraisal scores ranged from low (33%) to high (73%). Two studies were appraised as low quality (Miller et al., 2019; Tonheim & Iversen, 2019). Most quality appraisal scores are within fair quality (n=4). OnlyVanderfaeillie et al. (2018a; 2018b) and Montserrat et al. (2020) scored high quality.

All studies had transparency issues particularly regarding data collection, design, and sampling. This limits the possibility for accurate replication. Data collection method was identified by all studies. However, only Montserrat et al. (2020) provided justification for the method chosen. Data collection method appeared suitable in four studies (LaBrenz et al., 2022; Osborne et al., 2021; Vanderfaeillie et al., 2018a; Vanderfaeillie et al., 2018b); the remaining five studies data collection methods were deemed unsuitable due to lack of transparency, risk of bias, limited questions and due to issues with data collected at follow up. All collection protocols were missing key details on either: dates, locations, settings, personnel, materials, and processes which is important for replication. Studies scored particularly poorly on transparency regarding personnel, which is important to enable the reader to assess possible bias.

Overall studies scored poorly on ethical matters: confidentiality and anonymity were only considered explicitly by four studies (Montserrat et al., 2020; Tonheim & Iversen, 2019; Vanderfaeillie et al., 2018a; Vanderfaeillie et al., 2018b). Only Miller et al. (2019), Leathers et al. (2019) and Tonheim and Iversen (2019) reported that consent was sought. Participant ethics should be thoroughly considered and explicitly reported in line with the Declaration of Helsinki principles (World Medical Association, 2013). Ethical approval was explicitly sought in four studies (Font & Kim, 2021; Leathers et al., 2019; Miller et al., 2019; Osborne et al., 2021). Funding information was reported in most studies (Font & Kim, 2021; LaBrenz et al., 2022; Miller et al., 2019; Montserrat et al 2020; Osborne et al 2021). Most studies (n=6) provided information on conflicts of interest (Leathers et al., 2019; Tonheim & Iversen, 2019; Vanderfaeillie et al., 2018a did not). No studies reported on subjectivity, or relationships with participants or cases, therefore it is difficult to assess potential bias.

**Synthesis**

A narrative synthesis approach was used to synthesise the main findings from reviewed papers. Although the focus of the papers included varied significantly, eight common themes were identified of conceptually alike factors: demographic factors, placement factors, carer factors, child factors, removal reason, lack of support, relational factors, and household composition factors. Individual factors were reported in the synthesis section if three or more studies investigated and reported the results of the same factors.

**Demographic Factors**

Seven of the eight studies that investigated child age as a risk factor for PB found that foster child age was associated with PB. Increased age predicted a higher risk of PB in six studies (Font and Kim, 2021; LaBrenz et al., 2022; Leathers et al., 2019; Osborne et al., 2021; Vanderfaeillie et al., 2018a; Vanderfaeillie et al., 2018b). Montserrat et al. (2020) found that children aged four to 11 were at increased risk of PB. Miller et al. (2019) found no significant association between child age and PB. However, significant limitations of Miller et al.’s (2019) study undermine the validity of findings. Three studies investigated the relationship between foster parent age and PB: findings were mixed with two finding no association (Miller et al., 2019; Vanderfaeillie et al., 2018a) and Vanderfaeillie et al. (2018b) finding a positive association.

Seven studies investigated ethnicity and PB: factors measured, and findings were mixed. Font and Kim (2021) and LaBrenz et al. (2022) found that ethnic minority children were more likely to experience PB than ethnic majority children. Leathers et al. (2019) found that placements with ‘African American’ foster parents were more likely to breakdown than ‘White’ or ‘other’ ethnicity foster parent placements. Four studies found no significant effect of ethnicity on PB (Miller et al., 2019; Osborne et al., 2021; Vanderfaeillie et al., 2018a; Vanderfaeillie et al., 2018b).

Eight studies investigated child gender and PB: five studies reported no significant relationship (Font & Kim, 2021; LaBrenz et al., 2022; Miller et al., 2019; Osborne et al., 2021; Vanderfaeillie et al., 2018a). Leathers et al. (2019) did not report the outcome of gender. Montserrat et al. (2020) and Vanderfaeillie et al. (2018b) found that males were at increased risk of PB.

**Placement factors**

Four studies investigated the effect of kin and non-kin placements on PB: Font and Kim (2021) and Osborne et al. (2021) found that non-kin placements experienced more PB; Vanderfaeillie et al. (2018a) and Vanderfaeillie et al. (2018b) found no effect.

Four studies investigated previous experience of PB or moves on PB. Three studies found that previous experience of PB or placement moves predicted a higher chance of PB (Leathers et al., 2019; Montserrat et al., 2020; Vanderfaeillie et al., 2018a). Vanderfaeillie et al. (2018a) found no effect.

**Carer factors**

Five studies (Leathers et al., 2019; Miller et al., 2019; Tonheim & Iversen, 2019; Vanderfaeillie et al., 2018a; Vanderfaeillie et al., 2018b) investigated the impact of carer factors on PB. Disparate carer factors studied (e.g., foster parent stress, parenting expectations, empathy, health problems) made it difficult to compare findings (see appendix C for a summary of carer factors). Rock et al. (2015) also noted this observation.

**Child factors**

Seven studies investigated child behaviour as a factor for PB. LaBrenz et al. (2022), Miller et al. (2019), Osborne et al. (2021) and Leathers et al. (2019) found no effect of child behaviour on PB. Vanderfaeillie et al. (2018a), Vanderfaeillie et al. (2018b) and Tonheim and Iversen (2019) found that children’s behaviour problems increased the risk of PB. However, significant limitations of Tonheim and Iversen’s (2019) study call into question the validity of the results.

**Removal reason**

Four studies investigated reason for removal as a risk factor for PB. Disparate factors were considered across studies; only three factors were investigated in at least three studies. Montserrat et al. (2020) and Vanderfaeillie et al. (2018b) found that neglect was associated with increased risk of PB (although both findings should be interpreted with caution as they violated assumptions of the data analysis) whereas Font and Kim (2021) and Vanderfaeillie et al. (2018a) found no significant association. All four studies found no significant relationship between physical abuse and PB. Montserrat et al. (2020) and Vanderfaeillie et al. (2018a) found that sexual abuse was associated with an increased risk of PB. Font and Kim (2021) and Vanderfaeillie et al. (2018b) found no significant association between sexual abuse and PB.

**Lack of support**

Three studies investigated foster parent support. Factors studied and findings were disparate across studies making it difficult to compare findings. For example, Miller et al. (201) found that social service support had no effect on PB, Tonheim and Iversen (2019) found that lack of social service support was one of the most highly rated causes of PB; and Leathers et al. (2019) found no effect of ‘general support’.

**Relational factors**

Four studies investigated biological family factors and PB. Vanderfaeillie et al. (2018a) and Vanderfaeillie et al. (2018b) found conflict between biological family and foster parents leads to an increased risk of PB. Tonheim and Iversen (2019) found that 33 foster parents (out of 132) identified that such conflict contributed to PB. Vanderfaeillie et al. (2018a) and Vanderfaeillie et al. (2018b) found that less contact with the birth family lead to an increased risk of PB whereas Montserrat et al. (2020) found no significant relationship.

**Household composition**

There were inconsistences with findings, Tonheim and Iversen (2019) and Montserrat et al. (2020) identified that having biological children in the foster home increased the risk of PB; Vanderfaeillie et al. (2018a) and Vanderfaeillie et al. (2018b) found no effect. Findings were mixed for the effect of additional foster children living in the home and PB: Montserrat et al. (2020) identified an increased risk of PB if more than one foster child resided in the home; Tonheim and Iversen’s (2019) qualitative question identified that foster parents concern for other foster children living in the home was a risk factor. Vanderfaeillie et al. (2018a) and Vanderfaeillie et al. (2018b) found no effect.

**Discussion**

This review aimed to appraise and synthesise studies which investigated factors associated with or predictive of PB in foster care. A systematic review of the literature identified nine studies which met inclusion criteria. Studies ranged from low to high quality on the appraisal with most studies falling within the fair range. Studies lacked transparency or clarity regarding data collection, design, sampling or recruitment, definitions of PB and potential bias. Studies also scored poorly on justification of sample size, design and data collection methods, inclusion of precision of effects in results, suitability of data collection methods, suitability of methods of analysis (n=4), consideration of validity and reliability of measures and consideration of ethical issues. The varying quality of the studies should be taken into account when considering confidence in the main findings.

Factors such as older age of the child, previous experience of PB or placement movement and lack of contact with or foster parents experiencing conflict with the biological family, were found to be associated with or predictive of PB. Mixed results were noted for the following factors: foster parent age, ethnicity, gender, kin or non-kin placements, behaviour, foster parents’ biological children or other foster children living in the home and removal reason (sexual abuse or neglect). Some studies found an association or difference in PB based on these factors’ others found no effect. No association or difference was found regarding removal reason (physical abuse).

Older children may have remained in potentially harmful living environments for longer than younger children. Similarly, children who experienced PB or placement movement may have more experience of relationships that have broken down. These children may have experienced more negative experiences with caregivers, more maltreatment, and more traumatic experiences (Mitchell, 2018). The link between these factors and PB could be understood through attachment theory and trauma informed approaches. These children may have had little experience of secure relationships or a stable base, which might make it more difficult to develop and maintain secure attachments and develop positive internal working models of self and other (Greeson et al., 2011). In addition, children may exhibit re-enactment behaviours of past abuse (Wubs, 2018) and could experience other mental health and behavioural difficulties that foster parents may find challenging (Mishra et al., 2020) which could ultimately contribute to PB. Similarly, foster parent conflict with the biological family could make it more difficult for the foster child and carer to develop a secure relationship.

The mixed picture identified for ethnicity factors could partially be explained by diversity of factors investigated in the studies in this review. Unstudied cultural factors could also contribute to this mixed picture. Previous studies have identified that it is important that foster children are placed with foster parents who are able to understand and meet their cultural needs and this does not necessarily mean that they need to be from the same ethnic background (Ni Raghallaigh & Sirriyeh, 2014). This should be studied in future reviews.

**Previous reviews**

The finding that older age of the child is associated with or predictive of PB was also identified in the three previous reviews. Similarly, to the current review, Oosterman et al. (2006) and Rock et al. (2015) found that previous experience of PB or movement was a factor associated with or predictive of PB. However, Konijn et al. (2019) found no effect. In line with the current review’s findings, Konijn et al. (2019) and Rock et al. (2015) found no effect of gender on PB (Oosterman et al. (2006) did not investigate this independently). In contrast to the current review, Konijn et al. (2019) and Rock et al. (2015) found no effect of ethnicity on PB (Oosterman et al. (2006) did not investigate this independently). Similarly, to the current review mixed findings were noted in all previous reviews with regards to removal reason. All previous studies found that behavioural problems increased the risk of PB. This contrasts with the current review which found mixed findings. Having other biological children in the home was identified to contribute to PB in Rock et al. (2015) and Oosterman et al. (2006) (Konijn et al., 2019 did not investigate this), the current study found mixed findings. It is somewhat surprising that the current reviews findings were so mixed because it seems plausible that the presence of additional children in the foster home could contribute to PB. For example, via foster parents being concerned about potential risk of harm to their biological children (e.g., Tonhiem & Iversen, 2019). Additionally, foster parents with more than one child in the home may have increased caregiving demands: foster parents could experience stress or exhaustion (e.g., Tonheim & Iversen, 2019) which could contribute to PB.

Rock et al. (2015) was the only study to investigate other foster children in the home as a factor and found that having other children reduced the risk of PB. The current review found mixed findings. The current review found mixed findings regarding kin or non-kin care and PB. Konijn et al. (2019) and Rock et al. (2015) found that being in a non-kin placement increased the risk of PB; Oosterman et al. (2006) found no effect. Where there is no risk attached to placing siblings together or placing a child with kin it could be hypothesised (in line with attachment theory) that placement with siblings or kin might help to provide continuity and stability which could enable children to settle more quickly into new placements and to develop stable attachments. The current review identified an association between contact and conflict with the biological family and PB. This association was inconsistent in Oosterman et al. (2006) and Rock et al. (2015) (Konijn et al., 2019 did not investigate this).

**Limitations of the review**

Although the author followed the guidelines of the CCAT to ensure that scoring was as reliable and valid as possible (Crowe, 2013), a limitation of this review is that only one author synthesised and critically appraised the papers. Therefore, no inter-rater reliability was established. This leads to limitations in terms of reliability, validity, and generalisability of findings.

Another limitation is the CCAT does not give descriptive categories to interpret the overall quality percentage, which makes it difficult to describe differences between papers in terms of quality. Therefore, the current author developed loose descriptive categories based on percentages (0-20% very low, 20%-40% low, 40%-60% fair, 60%-80% high and 80% to 100% very high) to support interpretation. These categories have not been tested for reliability or validity, which is a limitation of the current review.

**Limitations of the studies**

One considerable limitation is that all studies were conducted outside the UK and in Western cultures. Due to cultural differences and differences in terms of foster care systems and guidelines the results of these studies cannot be generalised to explain factors that contribute to PB in the UK particularly since children in the UK are usually taken into care due to risk of abuse or neglect and this contrasts with reason for removal in other countries. Neither can findings be generalised to non-Westernised cultures. Previous reviews also only included studies from Westernised cultures. Further research in the UK and non-Western cultures is required, especially due to the research bias favouring research in Western cultures (Tindle, 2021).

Studies lacked transparency or clarity regarding data collection, design, sampling or recruitment, definitions of PB, potential bias, and exclusion criteria. Studies also scored poorly on justification of sample size, design and data collection methods, inclusion of precision of effects in results, suitability of data collection methods and methods of analysis (n=4), consideration of validity and reliability of measures and consideration of ethical issues. This limits the validity, reliability and generalisability of findings identified and conclusions drawn. Also due to issues with transparency, it would be difficult to replicate these studies, which is a key issue because capability of replication is what makes research scientific (Lamal, 1990).

Most studies relied on data from child welfare case files, this relies on the data being accurate which is not always the case. Furthermore, it could be assumed that most case files are filled in by social workers, this introduces the possibility of further validity, reliability, and bias issues because social workers may interpret the factors that contribute to PB differently to foster carers and foster children. Social care workers may have an implicit bias in their perception of factors: due to working within the social care system, they might feel compelled to underestimate the influence of system factors in PB. Again, this limits the conclusions that can be drawn from the findings of these studies. The remainder of the studies used self-report data, this data is also limited by bias issues.

Studies used different definitions of PB, studied different factors and measured factors differently. This makes it difficult to draw direct comparisons and conclusions regarding factors that are associated with or predictive of PB (Oosterman et al., 2006). The different definitions of PB are a particular issue because some studies definitions were so broad it was difficult to ascertain whether or not PB would also include ‘any move’ and ‘unexpected positive moves’. This limits the overall conclusions that can be drawn about factors studied in this review.

Most studies investigated the association between factors and PB. Although some included hazard models to determine the percentage of hazard of PB depending on certain factors, another unknown or unmeasured third factor (not accounted for as a covariate or control variable) could be influencing the results.

**Research implications**

It is important for further studies to investigate how identified risk factors for PB contribute toward PB (Rock et al., 2015). For example, it is a common finding that older age at time of entry to care increases the risk of PB, however the mechanisms behind this remain unstudied. Further studies need to be conducted on factors that are inconsistently associated with PB to clarify if factors are associated with or predictive of PB.

To the author’s knowledge, no previous literature has investigated foster children’s perception of factors contributing to PB. Foster children may have different perspectives regarding factors that contribute to PB. It has been consistently acknowledged that foster children’s perspective is often neglected in research and care planning decisions (MacAlister, 2022). Future research should investigate foster children’s perception.

Future research should aim to develop consistency in terms of definitions of PB, factors measured and measurement methods. This is to enable direct comparison between findings of studies, which would help to develop a better understanding of factors which contribute to PB.

Future research is required to address the limitations of studies in this review. Studies should be transparent in their reporting of methods and results to enable future replication. For example, studies should explicitly state research design, report exclusion criteria, data collection protocol and report precision of effects. Studies should justify the sample size used. Use of design and collection methods should also be justified for transparency. It is important that bias is considered in terms of methods, data analysis and reporting so that the reader can evaluate bias. Similarly, future studies should consider and report validity and reliability of measures. Ethical issues should also be considered further by future studies. These suggestions might help to increase the validity and reliability of the current evidence base regarding factors associated with or predictive of PB. It would also increase the possibility of accurate study replication.

The impact of carer attachment, experience of trauma, reflective functioning and mentalisation on PB does not appear to have been studied in the literature. This is surprising given that a large proportion of foster carers experience attachment difficulties and have trauma histories (Choi, 2009) and foster parents’ experience of trauma can predict insecure attachment in their foster children (Cole, 2005). Foster parents who have previously experienced trauma may be re-traumatised by trauma re-enactments which could make it difficult to care for (or develop an attachment to) the child. Mentalisation and reflective functioning helps parents to understand the meaning behind children’s behaviour (Bammens et al., 2015) without this capacity foster parents may misinterpret their child’s behaviour. It could be hypothesised that these factors could impact on PB. Future studies should investigate these factors.

**Practice implications**

As discussed, children who enter care later and children who experience PB may have experienced more negative experiences with caregivers, more maltreatment, and traumatic experiences. These experiences must be considered by the social care system when care planning and selecting placements to ensure that placements have the best possible chance of stability. A multidisciplinary approach would be useful. For example, therapeutic attachment parenting training may promote secure attachments. It is important that psychological intervention is considered with regards to past experiences of trauma and maltreatment. Further training should be available to foster parents regarding how previous experiences might affect a child’s presentation to increase understanding of the child’s internal world and reduce misinterpretation of behaviour. These suggestions are in line with actions proposed in the 2022 independent review of social care (MacAlister, 2022) and National Institute of Health and Care Excellence (NICE) guidance (2021).

The Children’s Act (1989) states that wherever possible contact with the biological family should be maintained. Contact and relationships between the biological family, foster parents and foster children should therefore be scaffolded by social care to reduce the level of conflict across these systems particularly since conflict between these systems was identified as a factor associated with PB in this review. In line with this, it has been suggested that social workers should directly work with children and families to improve relationships between these systems because it can help facilitate secure relationships and help foster children to overcome previous adversity (MacAlister, 2022; NICE, 2021).

**Conclusion**

The current literature review found that the following factors were associated with or predictive of PB: older age of the child, previous experience of PB or placement movement and a lack of contact with or foster parents experiencing conflict with the biological family. However, confidence in these findings is impacted by study limitations such as a lack of transparency regarding data collection, design, sampling, definitions of PB, potential bias, a lack of explicit consideration of validity and reliability of measures and ethical issues. Future studies are required to address the limitations outlined above, to demonstrate consistent findings across studies and to address gaps in the current literature.

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**Appendices**

**Appendix A**

**Crowe Critical Appraisal Tool (CCAT) Form**

**Crowe Critical Appraisal Tool (CCAT) Form (v1.4)** Reference

This form must be used in conjunction with the CCAT User Guide (v1.4); otherwise validity and reliability may be severely compromised.

|  |  |
| --- | --- |
| Citation |  |
|  | Year |
|  |

|  |
| --- |
| Research design (add if not listed) |
| ❏ Not research Article | Editorial | Report | Opinion | Guideline | Pamphlet | … |
| ❏ Historical … |
| ❏ Qualitative Narrative | Phenomenology | Ethnography | Grounded theory | Narrative case study | … |
| ❏ Descriptive, A. Cross-sectional | Longitudinal | Retrospective | Prospective | Correlational | Predictive | … |
| Exploratory,  Observational B. Cohort | Case-control | Survey | Developmental | Normative | Case study | … |
| ❏ True Pre-test/post-test control group | Solomon four-group | Post-test only control group | Randomised two-factor | experiment Placebo controlled trial | … |
| ❏ Quasi- Post-test only | Non-equivalent control group | Counter balanced *(cross-over)* | Multiple time series |  Experimental  experiment Separate sample pre-test post-test [no Control] [Control] | … |
| ❏ Single One-shot experimental *(case study)* | Simple time series | One group pre-test/post-test | Interactive | Multiple baseline | system Within subjects *(Equivalent time, repeated measures, multiple treatment)* | … |
| ❏ Mixed Methods Action research | Sequential | Concurrent | Transformative | … |
| ❏ Synthesis Systematic review | Critical review | Thematic synthesis | Meta-ethnography | Narrative synthesis | … |
| ❏ Other … |

|  |  |  |
| --- | --- | --- |
| Variables and analysis |  |  |
| Intervention(s), Treatment(s), Exposure(s) | Outcome(s), Output(s), Predictor(s), Measure(s) | Data analysis method(s) |
|  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Sampling |  | |  | |  | |  | |  | | |
| Total size |  | Group 1 |  | Group 2 |  | Group 3 |  | Group 4 |  | Control |  |
| Population, sample, setting |  | |  | |  | |  | |  | | |

|  |  |
| --- | --- |
| Data collection (add if not listed) |  |
| a) Primary | Secondary | …  Audit/Review b) Authoritative | Partisan | Antagonist | …  c) Literature | Systematic | … | a) Formal | Informal | …  Interview b) Structured | Semi-structured | Unstructured | …  c) One-on-one | Group | Multiple | Self-administered | … |
| a) Participant | Non-participant | …  Observation b) Structured | Semi-structured | Unstructured | …  c) Covert | Candid | … | a) Standardised | Norm-ref | Criterion-ref | Ipsative | …  Testing b) Objective | Subjective | …  c) One-on-one | Group | Self-administered | … |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Scores |  | |  | |  | |  | | |
| Preliminaries |  | Design |  | Data Collection |  | Results |  | Total [/40] |  |
| Introduction |  | Sampling |  | Ethical Matters |  | Discussion |  | Total [%] |  |

|  |
| --- |
| General notes |
|  |

Logo

Description automatically generated with low confidence Crowe Critical Appraisal Tool (CCAT) :: Version 1.4 (19 November 2013) :: Michael Crowe (michael.crowe@my.jcu.edu.au) Page 1 of 2

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Appraise research on the merits of the research design used, not against other research designs.

|  |  |  |  |
| --- | --- | --- | --- |
| Category Item | Item descriptors  [ Present; Absent; ■ Not applicable] | Description  [Important information for each item] | Score  [0–5] |
| 1. Preliminaries |  |  |  |
| Title | 1. Includes study aims ❏ and design ❏ |  |  |
| Abstract  (assess last) | 1. Key information ❏ 2. Balanced ❏ and informative ❏ |  |  |
| Text  (assess last) | 1. Sufficient detail others could reproduce ❏ 2. Clear/concise writing ❏, table(s) ❏, diagram(s) ❏, figure(s) ❏ |  |  |
|  |  | Preliminaries [/5] |  |
| 2. Introduction |  |  |  |
| Background | 1. Summary of current knowledge ❏ 2. Specific problem(s) addressed ❏ and reason(s) for addressing ❏ |  |  |
| Objective | 1. Primary objective(s), hypothesis(es), or aim(s) ❏ 2. Secondary question(s) ❏ |  |  |
|  | Is it worth continuing? | Introduction [/5] |  |
| 3. Design |  |  |  |
| Research design | 1. Research design(s) chosen ❏ and why ❏ 2. Suitability of research design(s) ❏ |  |  |
| Intervention,  Treatment, Exposure | 1. Intervention(s)/treatment(s)/exposure(s) chosen ❏ and why ❏ 2. Precise details of the intervention(s)/treatment(s)/exposure(s) ❏ for each group ❏ 3. Intervention(s)/treatment(s)/exposure(s) valid ❏ and reliable ❏ |  |  |
| Outcome, Output,  Predictor, Measure | 1. Outcome(s)/output(s)/predictor(s)/measure(s) chosen ❏ and why ❏ 2. Clearly define outcome(s)/output(s)/predictor(s)/measure(s) ❏ 3. Outcome(s)/output(s)/predictor(s)/measure(s) valid ❏ and reliable ❏ |  |  |
| Bias, etc | 1. Potential bias ❏, confounding variables ❏, effect modifiers ❏, interactions ❏ 2. Sequence generation ❏, group allocation ❏, group balance ❏, and by whom ❏ 3. Equivalent treatment of participants/cases/groups ❏ |  |  |
|  | Is it worth continuing? | Design [/5] |  |
| 4. Sampling |  |  |  |
| Sampling method | 1. Sampling method(s) chosen ❏ and why ❏ 2. Suitability of sampling method ❏ |  |  |
| Sample size | 1. Sample size ❏, how chosen ❏, and why ❏ 2. Suitability of sample size ❏ |  |  |
| Sampling protocol | 1. Target/actual/sample population(s): description ❏ and suitability ❏ 2. Participants/cases/groups: inclusion ❏ and exclusion ❏ criteria 3. Recruitment of participants/cases/groups ❏ |  |  |
|  | Is it worth continuing? | Sampling [/5] |  |
| 5. Data collection |  |  |  |
| Collection method | 1. Collection method(s) chosen ❏ and why ❏ 2. Suitability of collection method(s) ❏ |  |  |
| Collection protocol | 1. Include date(s) ❏, location(s) ❏, setting(s) ❏, personnel ❏, materials ❏, processes ❏ 2. Method(s) to ensure/enhance quality of measurement/instrumentation ❏ 3. Manage non-participation ❏, withdrawal ❏, incomplete/lost data ❏ |  |  |
|  | Is it worth continuing? | Data collection [/5] |  |
| 6. Ethical matters |  |  |  |
| Participant ethics | 1. Informed consent ❏, equity ❏ 2. Privacy ❏, confidentiality/anonymity ❏ |  |  |
| Researcher ethics | 1. Ethical approval ❏, funding ❏, conflict(s) of interest ❏ 2. Subjectivities ❏, relationship(s) with participants/cases ❏ |  |  |
|  | Is it worth continuing? | Ethical matters [/5] |  |
| 7. Results |  |  |  |
| Analysis, Integration,  Interpretation method | 1. A.I.I. method(s) for primary outcome(s)/output(s)/predictor(s) chosen ❏ and why ❏ 2. Additional A.I.I. methods (e.g. subgroup analysis) chosen ❏ and why ❏ 3. Suitability of analysis/integration/interpretation method(s) ❏ |  |  |
| Essential analysis | 1. Flow of participants/cases/groups through each stage of research ❏ 2. Demographic and other characteristics of participants/cases/groups ❏ 3. Analyse raw data ❏, response rate ❏, non-participation/withdrawal/incomplete/lost data ❏ |  |  |
| Outcome, Output, Predictor analysis | 1. Summary of results ❏ and precision ❏ for each outcome/output/predictor/measure 2. Consideration of benefits/harms ❏, unexpected results ❏, problems/failures ❏ 3. Description of outlying data (e.g. diverse cases, adverse effects, minor themes) ❏ |  |  |
|  |  | Results [/5] |  |
| 8. Discussion |  |  |  |
| Interpretation | 1. Interpretation of results in the context of current evidence ❏ and objectives ❏ 2. Draw inferences consistent with the strength of the data ❏ 3. Consideration of alternative explanations for observed results ❏ 4. Account for bias ❏, confounding/effect modifiers/interactions/imprecision ❏ |  |  |
| Generalisation | 1. Consideration of overall practical usefulness of the study ❏ 2. Description of generalisability (external validity) of the study ❏ |  |  |
| Concluding remarks | 1. Highlight study’s particular strengths ❏ 2. Suggest steps that may improve future results (e.g. limitations) ❏ 3. Suggest further studies ❏ |  |  |
|  |  | Discussion [/5] |  |
| 9. Total |  |  |  |
| Total score | 1. Add all scores for categories 1–8 |  |  |
|  |  | Total [/40] |  |

Crowe Critical Appraisal Tool (CCAT) :: Version 1.4 (19 November 2013) :: Michael Crowe (michael.crowe@my.jcu.edu.au) Page 2 of 2

**Appendix B**

**Results of appraisal using Crowe Critical Appraisal Tool (CCAT, 2013)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CCAT**  **Item** | **Font & Kim (2021)** | **LaBrenz et al. (2022)** | **Leathers et al. (2019)** | **Miller et al. (2019)** | **Montserrat et al. (2020)** | **Osborne et al. (2021)** | **Tonheim**  **& Iversen (2019)** | **Vanderfaeillie et al. (2018a)** | **Vanderfaeillie et al. (2018b)** |
| **Preliminaries** | 4 | 4 | 5 | 2 | 4 | 3 | 3 | 4 | 4 |
| **Introduction** | 4 | 4 | 5 | 2 | 4 | 4 | 2 | 5 | 5 |
| **Design** | 2 | 3 | 2 | 2 | 3 | 1 | 1 | 3 | 3 |
| **Sampling** | 3 | 2 | 3 | 2 | 4 | 3 | 3 | 3 | 3 |
| **Data Collection** | 1 | 2 | 2 | 2 | 3 | 3 | 1 | 3 | 3 |
| **Ethical Matters** | 2 | 1 | 1 | 2 | 2 | 2 | 1 | 1 | 2 |
| **Results** | 4 | 3 | 3 | 1 | 3 | 3 | 1 | 2 | 4 |
| **Discussion** | 4 | 2 | 3 | 2 | 4 | 2 | 1 | 4 | 5 |
| **Total score (out of 40)** | 24 | 21 | 24 | 15 | 27 | 21 | 13 | 25 | 29 |
| **Total percentage** | 60% | 53% | 60% | 38% | 68% | 53% | 33% | 63% | 73% |

Note. Each CCAT item is scored out of 5.

**Appendix C**

**Factors & Measurement table**

|  |  |  |
| --- | --- | --- |
| **Study** | **Factors & Measures** | **Data Collection** |
| Font & Kim (2021) | ***Primary factor:***  Sibling groups / sibling separation  *Variables:*   1. only sibling in foster care 2. one or more siblings in foster care but not in the same placement 3. with some siblings in foster care placement 4. With all siblings   ***Covariates:***  Child  *Variables:* age, sex, race/ethnicity  Sibling  *Variables:* number of siblings, age of oldest sibling, having only same sex siblings  Removal episode characteristics  *Variables:* Removal year and whether removal was child-related (behaviour problems or disability), due to neglect (supervision, physical and medical needs), abandonment or relinquishment or abuse (physical, sexual, emotional), parent-child conflict, parent drug or alcohol abuse  Placement characteristics  *Variables:* number of previous placements, setting (non kin, kin or congregate), level of placement (not assigned, mild, moderate, severe) | Case file analysis |
| LaBrenz et al. (2022) | ***Primary factor:***  ‘Racial matching’  *Variables:*   1. One foster parent from the same racial or ethnic group as the foster child (‘racial matching’) 2. foster parents from different racial or ethnic group to foster child   ***Covariates:*** child sex, child age, child race/ethnicity, child behaviour problems (removed due to behaviour), child emotional disturbance (any emotional disturbance reported) foster family structure (married / unmarried in a relationship / single), foster parent race/ethnicity, child identified as having a disability / not, number of removals (number of foster care entries) | Case file analysis |
| Leathers et al. (2019) | ***Primary factors:***   1. Behaviour problems 2. Risk to others 3. Foster parent expectations 4. Need for support 5. Foster parent stress 6. Parenting experiences   *Measures of primary factors:*   1. Ohio Youth Problem Scale 2. One narrative question: “how much do you feel that your child poses a risk to someone in your home or community at this time?” 3. Two narrative questions: expectation to provide just a temporary placement or emergency placement until another placement could be found. How long they expected the child to be in their home 4. Short Support Functions Scale 5. Ohio scale item (“how much stress or pressure is in your life right now?”) 6. Measure of 20 items related to perception of parenting experiences   ***Control variables:***  household composition (marital status, number of adults in home, number of foster parents adoptive, biological and foster children at home), child age at time of interview, age placed in foster home, foster parent demographic variables (age, race, income and education), child gender | Case file analysis  Telephone Interview |
| Miller et al. (2019) | ***Primary factors:***  Carer characteristics  *Variables:*  age, sex, ethnicity, relationship status and level of education (1 = no secondary school qualifications – 8 =postgraduate qualifications)  Parenting competence  *Measure:*  Parenting Sense of Competence Scale  Carer empathy  *Measure:*  Basic Empathy Scale  Carer support  *Measure:*  Multidimensional Scale of Perceived Social Support  Carer-partner relationship  *Measures:*  5 items about relationship satisfaction, severity of problems, how much they love their partner, level of happiness  Quality of placement match  *Measures:*  Asked to rate quality of placement match  ***Control variables:***  Child demographics  *Variables:*  Age, sex  Child progress  *Measures:*  Rated on a 5 point scale  Child behaviour  *Measures:*  Strengths & Difficulties questionnaire | Online / paper survey |
| Montserrat et al. (2020) | ***Primary factors:***   1. Child characteristics 2. Placement type and number 3. Previous foster family characteristics 4. Protection measure characteristics 5. Relationship with biological family 6. Case ending 7. Agency responsible for case   *Measure:*  30-item questionnaire regarding the above seven factors developed by the researchers | Case file data  Online questionnaire |
| Osborne et al. (2021) | ***Primary Factor***  Placement type  *Variables:*  kin or non kin placement  ***Control variables:***  Age, gender, race  Treatment group  *Variables:*  Intervention (more kin / fictive kin (‘family friends, religious leaders, coaches’) involvement) or control  Fictive kin and kin involvement  *Measure:*  Kin Identification and Level of Engagement Form  Externalising behaviour  *Measure:*  Child and Adolescent Needs and Strengths | Case file analysis |
| Tonheim & Iversen (2019) | ***Primary Factors***  Child factors (child’s behaviour, need for care, problems at school)  Insufficient support / input (from child welfare system, other agencies, counselling/ supervision, insufficient financial / practical arrangements)  Foster home factors (problems in the foster home)    Relationship with biological parents/ family  *Measures:*  Quantitative questions:  list of ten factors rate on 5-point scale how relevant these factors were to them  Qualitative questions:  Foster parents were asked which factor caused PB.  Foster parents who rated ‘other’ on the list of ten factors could provide additional comments | Semi-structured survey |
| Vanderfaeillie et al. (2018a; 2018b) | ***Primary Factors***  Child factors  *Variables:* gender, age at start of current placement, ethnicity and reasons for removal (child mental health, parenting or parental problems, families living circumstances, abuse, neglect), number of movements from entering care, behaviour (*Measure:* Behavioural Problems Questionnaire)  Case characteristics  *Variables:*  Duration of foster care placement, referring authority (voluntarily or court ordered),contact with birth family (yes/no), treatment for foster parents, foster children, and parents (yes/no)  Foster family's characteristics  *Variables:* household composition (*Measures:* single‐parent, two‐parent), type of foster family (*Measures:* kinship vs. non kinship foster care), foster mother's and foster father's age at start of the current placement, number of biological children of the foster parents, number of other foster children in the foster family | Case file analysis |

*Note.* Only primary measures are included in this table.

**Appendix D**

**Extended study characteristics table**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Author, Date, Country**  **Font & Kim (2021)**  **Pennsylvania** | **Design/ Method**  Retrospective  Longitudinal  Case file analysis - child welfare case files | **Sample**  N= 2,297, children’s (age 0-17, with one plus siblings) who had first removal from home between 2015-2019, 90% in kin / non kin foster care 10% congregate care | **Analysis**  .  Descriptive statistics  Survival Analysis | **Limitations**  Definition of siblings could have over/ underrepresented number of siblings  Case file data bias/inconsistencies | **Quality Appraisal Score**  60% |
| **La Brenz et al. (2022)**  **U.S** | Prospective  Longitudinal  Case file analysis | N= 36,191 children (0-17) who entered care in 2015, placed with the same nonrelative foster family for 2015-2019 Sample actually adds up to 37330? | Descriptive statistics  Inverse probability weighted regression adjustment. | Definition of PB is very broad. Could include those who moved for positive reasons.  Sample unclear reports 36,191 but appears to be 37,330  case file data bias /inconsistencies  only included children who remained in one placement for whole of 2015 (PB may be underestimated) | 53**%** |
| **Leathers et al 2019**  **U.S** | Prospective longitudinal study  Initial interview (via telephone) & follow up at 2 years to track placement moves  Case file analysis. | Random sample  139 foster parents (kin,traditional) providing care to a child (8-14) with a history of PB | Descriptive statistics  Least squares regression & logistic regression | Exploratory only  Measures taken at baseline only 2 years before follow up. Factors could have changed significantly.  Sample age 8-14 limited particularly given that older children tend to experience more PB  Study underpowered due to sample size  Conclusions drawn are not in line with the strength of data  self-report measures, bias | 60% |
| **Miller et al (2019)**  **Australia** | Prospective Longitudinal study 20months Paper/ online survey.  Followed up on four occasions at four-month intervals. | 212 Volunteer sample of foster carers (non-relative, in-home foster carers). From foster care agencies (only 75 participants data used in analysis). Those with children aged below 2 / respite care were excluded. Age 0-17 | Descriptive statistics  Multiple T tests / Man- Whitney-U | No detailed reason why only 75 participants included in analysis (? Bias)- small number for quantitative  Does not include information on how measures were modified – replication issues / bias    Self-report information could be affected by social desirability  PB definition is not clear enough in terms of what is ’unsuccessful’  Multiple t test increased risk of type 1 error and limits conclusions that can be drawn  Conclusions and implications noted do not appear to fit with the strength of the data  Volunteer sampling | 38% |
| **Montserrat et al (2020)**  **Spain** | Retrospective study  Case file data & social workers completion of structured questionnaire (7 topics) based on this | 1255 child (0-17) cases (2008-2018) from 13 different foster care organisations nonrelative foster care placements case closed between 2008-2018. | Descriptive data analysis  Logistic regression model | Case file data and self-report data bias /inconsistencies | 68% |
| **Osborne et al (2021)**  **U.S** | Retrospective  Longitudinal  Case file analysis - all foster children in Illinois who entered care between 2011-2014 | 450 foster children’s (kin/non kin foster care) records (all ages eligible) | Descriptive analysis  Cox regression analysis  Cox proportional hazards regression models | PB definition unclear  Information taken from secondary data as part of a wider study bias /inconsistencies in case worker reports  Forth placement analysis was underpowered and they did not report the control outcomes.  Case worker completed kin involvement and externalised behaviour information – carer perspective more useful  Data collected from a study conducted at the same university as the researchers  No information about the researchers for data extraction? bias? | 53% |
| **Tonheim & Iversen (2018)**  **Norway** | Retrospective  data from semi structured online survey sent out by child welfare in 2015-2016 | 132 foster parents (home foster carers) who experienced PB as well as those who nearly experienced PB between 2013-2015 (all ages of foster children were eligible) | No data analysis method for quantitative data  Qualitative data analysed thematically | Small sample size for quantitative part  no data analysis-not even descriptive analysis    Only 96 answered qualitative questions (only eligible to take part if put other reasons in response to quantitative)  Only two questions  Self-report data bias / inconsistencies in interpretation  No control variables | 33% |
| **Vanderfaeillie et al (2018a)**  **Netherlands & Flanders** | Retrospective  Longitudinal  case file analysis of 6 years’ case records. Trained researchers analysed using coding scheme related to placement ending / foster child and placement factors. | 580 foster children (kin/non kin placements) placed between 2004-2007. Case files from 2/5 (Flemish) / 2/28 (Dutch) foster care agencies. (all ages of foster children were eligible) | Descriptive analysis  Cox regression – association of risk factors with duration of placement before breakdown | Case file data and self-report data bias /inconsistencies  p-values reporting unclear, lacking precision values  Only put information on significant outcomes in table for the cox regression. Did not report statistics for those that were non-significant.  Does not report significance levels which led to exclusion of variables in the regression doesn’t refer to non-significant results in the text  Reports on data same data as below study and does not acknowledge this  Only a small number of foster care agencies in the Netherlands took part (2/28)  Only moderate interrater reliability for measures e.g., conflicts with parents, problems with foster parents | 63% |
| **Vanderfaeillie et al (2018b)**  **Flanders** | Retrospective  Longitudinal  Over 6 years  Case file analysis-2 trained researchers filling in coding scheme questionnaire related to foster child, foster family and case characteristic | 309 foster children (any age) case files placed in long term foster care (kin/non kin) between 2005-2007. Two out of five provincial foster care services. | Descriptive analysis differences analysed using T-test and Chi Square  Cox regression | Case file data and self-report data bias /inconsistencies  Notes that in foster care in the Flanders children with behavioural difficulties are largely in residential care – may have underestimated the impact of behavioural difficulties  Does not explicitly state where t / chi used all their p-values are brought together  Interrater reliability for conflict with parents, and problems with parents quite low only fair agreement | 73% |

**Paper 2: Empirical Paper**

**“I was still providing everything for their basic needs, but not necessarily meeting their emotional needs.” An Interpretative Phenomenological Analysis of Foster Carers Lived Experience of Blocked Care.**

**Alice Keenan**

**Word count: 7991**

**Thesis submitted in partial fulfilment of the requirements of Staffordshire University for the degree of Doctorate in Clinical Psychology**

**Target Journal:** Child & Family Social Work

Note. Author guidelines are in appendix P. Please note that additional formatting in line with author guidelines will take place following thesis submission.

**April 2023**

**Abstract**

Blocked Care (BC) describes instances in which caregivers find it difficult to provide the care that the child needs (Hughes, 2015). Foster carers are understood to be at increased risk of experiencing BC. There is no current research regarding foster carers experience of BC, which the present study aims to redress. Five non-kinship foster carers participated in a semi-structured interview regarding their experiences of BC. Interpretative Phenomenological Analysis (IPA) identified five Group Experiential Themes (GETs) and two subthemes. GETs included: “We didn’t understand”, ‘something took over me’, ‘neglected and “left to get on with it”’, ‘having a break’ and ‘now I get it’. Participants described difficulties in understanding the child, occasions where their emotions or past experiences took over and feeling neglected by services. These experiences made it difficult to provide the care that the child needed. Participant’s responses appeared to indicate that mentalisation, reflective functioning and attunement developed over time. Practice implications include further consideration of foster carer’s past experiences in the matching process and additional support early on in placement to further understand the child. Future research is required regarding foster children’s experience of BC and regarding the development of reflective functioning, mentalisation and attunement over time.

*Keywords:*foster care, foster children, blocked care, attachment, trauma, looked after children

**Introduction**

The term Blocked Care (BC) was developed by Baylin et al. (2012) to define instances in which caregivers find it difficult to provide the care that a child needs (Hughes, 2015). The phenomenology of BC is based on clinician’s conceptualisation of it rather than those who may have lived experience of BC. Foster carers are understood to be at increased risk of experiencing BC. There is no current research regarding foster carers experience of BC, which this study aims to redress.

The majority of looked after children (LAC) in England are placed in foster care, 79 percent of children in care are placed in care due to risk of ‘abuse’, ‘neglect’ or ‘family dysfunction’ (Gov.uk, 2021). Due to these experiences, many children in care experience repeated loss and trauma in their early years, particularly in relationships with primary caregivers (Hughes et al., 2019; Lyons et al., 2020). These experiences can affect child development (Van der Kolk, 2005) and attachment representations (Kelly & Salmon, 2014). In response to perceiving primary caregivers as threatening, children may develop strategies to keep themselves safe in close relationships (Baylin, 2017). These strategies may include not trusting or developing close relationships with primary caregivers and supressing needs for nurture (Akerman et al., 2022; Donachy, 2017). This presentation has been defined as ‘blocked trust’ where children cannot trust others, may be defensive and are hypervigilant to threats (Baylin, 2017). As foster carers are in the primary caregiver role, this presentation may become activated in the foster carer-child relationship. This can make it difficult for children to receive care (Emanuel, 2006; Henry, 1974).

Mentalisation describes the capacity to understand our own and others mental states (e.g., thoughts, feelings) and their influence on behaviour (Bammens et al., 2015). Parents’ ability to reflect on their and their child’s mental states and understand how they might affect behaviour and interactions is known as Parental Reflective Functioning (PRF) (Slade, 2005). PRF is important when caring for children who have experienced trauma and attachment disruptions (Hughes et al., 2019) as these experiences may lead to children’s needs being presented in confusing or fragmented ways (e.g., they may miscue primary caregivers) (Hughes et al., 2019). PRF is vital to develop an understanding of the child (Browning, 2020), the meaning behind their behaviour, their level of development (Cooper & Redfern, 2015; Rocco-Briggs, 2008) and the acting out or re-experiencing of previous trauma and relational experiences (re-enactment) in the parent-child relationship (Browning, 2020; Levy, 1998). PRF also increases the likelihood of remaining engaged in the parent-child relationship and of understanding and responding sensitively and empathically to the child’s needs (attunement) (Baylin & Hughes, 2016; Siegel, 2007).

During BC, parents and carers may feel unsafe being close to the child, they may find it difficult to attune to and empathise with the child, and mentalisation and PRF may become impaired (Redfern et al., 2018). Parents might find it difficult to understand the child, the influence of the child’s thoughts and feelings on their behaviour and they may find it difficult to identify and provide the care that the child needs (Adkins et al, 2018; Emanuel, 2006). Parents may find it difficult to tolerate the child’s behaviour and may respond to the child based on high expressed emotions. Negative parenting narratives may develop and parents may lack joy or pleasure in interactions with their children (Baylin & Hughes, 2016). BC is also proposed to be associated with negative outcomes for foster carers and children including poor emotional and behavioural outcomes and placement instability (Golding, 2017; Baylin & Hughes, 2016).

Baylin et al. (2012) defined four forms of BC: stage specific, child specific, acute and chronic. Stage specific BC may occur during the teenage and toddler years; the child’s need for independence from their carer over a prolonged period may be a risk factor for BC. Child specific BC occurs when children have experienced trauma or attachment disruptions; the child’s reluctance to allow carer-child closeness overtime could contribute to a defensive response in the carer. Acute BC may develop when negative or stressful life events make it difficult to remain engaged in parenting. Chronic BC may develop following the carer experiencing traumatic, stressful or difficult life events during their early years; this could make it difficult to provide particular qualities of caregiving (Baylin et al., 2012) such as mentalising and being sensitive and emotionally available in the parent-child relationship (Golding, 2017).

Since foster carers care for children who may have experienced trauma and attachment disruptions, they may be at increased risk of developing child specific BC (Baylin & Hughes, 2016). In line with this, research has identified that foster carers with high mentalising abilities developed impaired mentalisation and PRF when caring for children with a disorganised attachment pattern who were distrusting and rejecting (Akerman et al., 2022; Redfern et al., 2018). Difficulties in mentalising and PRF could place foster carers at risk of developing BC. Research has also highlighted that a large proportion of foster carers experienced trauma and attachment disruptions in their early years (Choi, 2009); this may place foster carers at increased risk of developing chronic BC.

The current understanding in the literature regarding foster carers experience of BC appears to be theoretically based or speculative. It appears to have developed through reflection on clinical practice and neuroscience research or application of psychological theories to the construct of BC (e.g., Baylin et al., 2012; Hughes, 2015) rather than specific research with foster carers. One study (Ottaway & Selwyn, 2016) investigated ‘compassion fatigue’ in foster carers. The researchers perceived BC and ‘compassion fatigue’ to be synonymous, however, this has been disputed (Hughes, 2015; Stamm, 2010). It is particularly important to gain the perspective of those with lived experience of BC to provide further insight into the phenomenology of BC, in line with the aim of the current study.

**Aims and rationale**

IPA is a qualitative research method, used to develop an idiographic, and phenomenological understanding of participants lived experiences of phenomena. The current study aimed to use IPA to investigate non-kinship foster carer’s lived experience of BC. Non-kinship placements tend to break down more often than kinship placements (Konijn et al., 2019; Rock et al., 2015); therefore, it seems particularly important to explore BC in this population. The current study hoped to provide insight into the lived experience and phenomenology of BC amongst foster carers. Furthermore, Wilson (2020) found limited evidence for the efficacy of PRF and mentalisation interventions for foster carers. BC may be associated with reduced PRF and mentalisation. A better understanding of the phenomenology of BC could inform appropriate support and intervention and could improve outcomes and permanence for children in care.

**Research question**

What are foster carers lived experiences of BC?

**Methods**

**Ethics**

Ethical approval was received from Staffordshire University (Appendix A), Health and Care Research Wales (Appendix B), the Health Research Authority (Appendix C) and the NHS trust in which the research took place (Appendix D). All participants provided informed consent. Measures were implemented to mitigate for distress: participants were informed that they did not need to answer questions that they preferred not to and they could have a break or stop the interview at any point. If participants became distressed, interview questioning was paused and time was taken to explore what had distressed them to ascertain if they needed additional support. All participants were debriefed and signposted to relevant support (Appendix E and J).

**Design**

Participants took part in an in-depth, one to one, semi-structured interview in line with an IPA approach (Pietkiewicz & Smith, 2014). The interview schedule (Appendix I) was developed following a thorough literature review and discussions with the research supervisors. Questions were open-ended following recommendations provided by Pietkiewicz and Smith (2014). IPA can be used to explore potentially emotive or ambiguous phenomena (e.g., BC) (Pietkiewicz & Smith, 2014; Smith et al., 2022) and it enables a rich, detailed and in-depth exploration of participants lived experience of phenomena and the sense that they make of it (Pietkiewicz & Smith, 2014). This study aimed to develop an in depth and meaningful understanding of participants lived experience of BC. A qualitative IPA approach was selected, as it is the most appropriate methodology for collecting this data. IPA has three key elements: hermeneutics (interpretation of the meaning of experiences), idiography (understanding of individual experience) and phenomenology (the study of participants lived experience of a phenomenon) (Smith et al., 2022).

**Service user involvement**

Clinicians in a specialist LAC team invited kinship carers to provide feedback on the usability, accessibility and language of the participant information sheet (PIS), demographic questionnaire and interview schedule. Two kinship carers provided feedback. Feedback was positive overall. All recommendations were considered (e.g., regarding the phraseology of blocked trust and BC) and implemented where appropriate.

**Recruitment**

Participants were recruited through a specialist LAC service in England. Clinicians used caseload screening and eligibility criteria to identify eligible foster carers. Clinicians informed potential participants of the nature of the study and provided them with the PIS (Appendix E). Interested participants were asked to provide verbal consent for their contact information to be shared with the researcher. The researcher then contacted participants via email or telephone. The researcher emailed participants a cover letter (Appendix F), consent form (Appendix G) and demographic questionnaire (Appendix H). Participants were encouraged to ask questions. Participants returned the completed consent form and demographic questionnaire by email. The researcher then signed and returned a copy of the consent form to participants via email. Following this, the interview was arranged.

**Sampling**

In line with IPA principles, purposive sampling was used to identify a homogeneous sample (Smith et al., 2009) (see table 1). Homogeneous samples are important in IPA; participants with some shared experience of the phenomenon are selected. This enables analysis of patterns of convergence and divergence within participants lived experiences (Smith et al., 2022). Between 4-10 participants has been identified as an appropriate sample size for qualitative doctoral research projects employing IPA (Smith et al., 2009). IPA aims to develop an in-depth and rich interpretive understanding of participants lived experience of a phenomenon. In analysis with larger samples, this depth of understanding can become lost (Smith et al., 2009). Therefore, smaller samples with participants lived experiences explored in depth is preferable to larger samples with a descriptive level of analysis.

**Table 1**

*Eligibility Criteria*

|  |  |
| --- | --- |
| Inclusion Criteria | Exclusion Criteria |
| * Non-kinship foster carers under the care of the Specialist LAC team * Experience of at least one placement * Cared for a foster child for at least six months * Able to provide informed consent * English speaking | * Kinship foster carers |

*Note.* Experience of BC was not an inclusion criterion. The ethical reviewers stipulated that recruiting clinicians should not identify participants as experiencing BC.

11 participants were interested in participating, 5 participated. Of those providing a reason for not taking part, most explained that due to recently arising difficulties regarding their foster child, they lacked the resource to take part. All participants were female. Four participants were White British, one participant was Black British. Participants mean age was 51.6 years (range: 43-58 years). The mean number of foster placements experienced was 5.6 (Range: 1-10+ placements). Participants mean number of foster children currently in care was two (range: 1-3). Participants range for length of time as a foster carer was between 2 to 25.8 years. Participants longest placement ranged between 2 years to 10+ years. Participants experienced between nought to four placement breakdowns. Two participants were single carers.

**Procedure**

Participants completed a demographic questionnaire (Appendix H) and consent form (Appendix G) prior to the interview. Participants took part in one semi-structured interview regarding their lived experience of BC. Interview duration was between 93-124 minutes (mean 110 minutes). Interviews were conducted on Microsoft Teams and were audio and video recorded. The Teams transcription function was used to transcribe videos. Transcripts were checked and amended to ensure accuracy. Participants were signposted to relevant support and were emailed a debrief form following the interview. Where concerns regarding risk were identified, concerns were discussed anonymously with the research supervisors and participants were contacted where necessary. Participants who requested a copy of the executive summary were informed that they would be provided with this following completion of the research.

**Analysis**

The researcher followed the identified steps for IPA (Smith et al., 2022). Interviews were transcribed. Following this, transcripts were read several times and recordings were listened to a few times to enable immersion in the data. Transcripts were read line-by-line. On the transcripts left-hand margin exploratory notes were documented regarding language use, descriptive and semantic content. Important exploratory notes were summarised to develop experiential statements, which were noted on the right-hand margin of the transcript (Appendix K). All experiential statements were transferred to a separate word document and randomly distributed on the document (Appendix L). Connections between experiential statements were identified to develop Personal Experiential Statements (PETs) and subthemes (Appendix M). This process was repeated for each participant. Following analysis of each individual data set, all PETs were placed into one word document and patterns of convergence and divergence were identified across participants PETs. This led to the development of Group Experiential Statements (GETs) and subthemes. For clarity, a table was developed with the GET’s, subthemes and supporting quotes (Appendix N).

**Epistemology and Reflexivity**

Reflexivity is the examination of the researcher’s beliefs, interests, values and experiences and how they could influence the research process (Smith et al., 2022). Reflexivity is important in IPA as analysis involves a ‘double hermeneutic’, whereby the researcher attempts to make sense of the participant’s sense making of a phenomenon (Smith & Osbourn, 2003).

The researcher kept a reflexive diary to reflect on her thoughts, feelings, and interpretations throughout the research process (Appendix O). The researcher also engaged in an IPA discussion group and research supervision. These reflexive processes provided further insight into the researcher’s preconceptions and experiences. Due to her experience of working with children in care and foster carers, the researcher had some awareness of factors that might influence BC. For example, the researcher had observed that difficulties in understanding the meaning behind the child’s behaviour and foster carers attachment and early life history could influence BC. The researcher also had theoretical knowledge of BC from conducting a literature review. The researcher was mindful of her preconceptions and experiences during interpretation; this enabled the researcher to be aware of how they might influence interpretation.

The researcher took an interpretivist epistemological approach to the research. Interpretivism acknowledges that meaning making of reality is situated in the time and culture in which it takes place (Moon & Blackman, 2014). An interpretivist approach is in line with IPA principles (Smith et al., 2009) and is consistent with relativist ontology, which acknowledges that there are multiple realities (Moon & Blackman, 2014) mediated by individuals lived experiences of reality and phenomena. Therefore, a relativist ontological approach was taken. These approaches enable an in-depth, idiographic and interpretative understanding of participants lived experience of BC, in line with the aims of the research.

**Credibility / Rigor**

The researcher followed the steps of analysis outlined by Smith et al. (2022) and often returned to the original transcripts to ensure that the developing PET’s and GET’s were reflective of participants experience of BC. The researcher used direct quotes from the transcripts to ground interpretation. This was in order to promote validity, rigor and reduce the influence of researcher bias. In line with IPA principles (Smith et al., 2022), the researcher also kept an audit trail of each process of the analysis to increase transparency. Analysis and interpretation was discussed with the research supervisors to assess the logic, consistency, and plausibility of the researcher’s interpretations and to minimise bias (Smith et al., 2009).

**Results**

IPA was used to explore foster carers lived experience of BC. Analysis identified five GETs and two subthemes (See Table 2). GETs included: “We didn’t understand”, ‘something took over me’, ‘neglected and “left to get on with it”’, ‘having a break’ and ‘now I get it’. Each GET was present for at least three participants.

**Table 2**

*GETs and Subthemes*

|  |  |
| --- | --- |
| GET | Subthemes |
| 1. “We didn’t understand” |  |
| 1. ‘Something took over me’ | 1. ‘The emotion took over’ 2. “They reminded me of…” |
| 1. ‘Neglected and “left to get on with it”’ |  |
| 1. ‘Having a break’ |  |
| 1. ‘Now I get it’ |  |

**GET 1: “We didn’t understand”**

Four participants appeared to find the child confusing (“I think…why are you doing that”; Ava) and they had trouble understanding the child, their needs, their thoughts, communication style, behaviour and triggers to behaviour. This appeared to contribute to BC.

“He will go into a meltdown situation and scream and yell and and it was like it's come from nowhere there's no trigger and all of a sudden it happens and not knowing what to do with them” (Betty)

“…she's not communicating, so it's quite difficult to know exactly what she thinking… I can't help if I don't know what the issue is” (Eva)

Betty and Eva illustrate that it was difficult to understand and identify triggers to the behaviour and to understand the child’s communication style, behaviour and thoughts. This contributed to difficulties in identifying and providing the care that the child needed.

Participants expressed that the caregiving qualities that they would usually provide, or the strategies that they would usually use to manage behaviour or situations did not work. They appeared to try multiple strategies with limited effect; this meant that the child’s behaviour continued.

“Whether I held him close, he carried on and he hit me and was throwing things, if I sent him away, he would then throw things around his room…it was ridiculous because I just did not know what to do” (Betty)

Due to difficulties in understanding the child, it is possible that the care provided was not the care that the child needed, perhaps explaining why strategies did not work. Participants appeared to feel unable to get through to the child and felt that the child was unable to respond to the care that they provided.

“It was very hard to get through to her…you’re trying to build her up…you feel helpless like you can't do anything…you should be able to stop this happening and you can't” (Daisy)

Cumulatively and over time, these processes appeared to make some participants feel “hopeless” and “helpless”. Ava, Betty and Daisy appeared to question if they could provide the care that the child needed (“Sometimes I think to myself oh gosh am I actually helping…”; Ava) or if they could “cope” with the behaviour. Some participant’s withdrew on varying levels from the child. This included physical and emotional withdrawal. For example, feeling unable to be close to the child or spend time with the child and removing themselves from situations in which the child demonstrated behaviours returning following the child self-regulating.

“I just have to walk away and leave it because I'm getting nowhere… leave until she comes around” (Eva)

“I would want to spend time with a little one and not him and that will make him even worse… I pushed him away…” (Betty)

The processes outlined above describe how difficulties in understanding the child contributed to participant’s experience of BC.

**GET 2:** **‘Something took over me’**

Participants described occasions where their emotions or past experiences took over. This made it difficult for participants to provide the care that the child needed. It appeared that this particularly occurred when the child displayed behaviour that was interpreted as difficult, concerning or challenging.

1. **‘The emotion took over’**

Four participants appeared to describe situations where rational thought escaped them and emotions took over. In these moments, they appeared to respond to the child’s behaviour or presentation based on their high expressed emotions rather than providing the care that the child needed.

“I find it quite frustrating because I know what's best for her I know her…originally I'm thinking It was winding me up so I'm, you know, I'm not gonna give her that care because I'm so frustrated about it...” (Eva)

Eva appeared to feel frustrated because the child was not acting in their best interests and was not responding to Eva’s attempts to provide care. Eva appeared to respond to this based on her own high expressed emotions. Daisy describes responding to the child based on an immediate response to the situation. It appeared that the child’s behaviours felt difficult and potentially dangerous. Daisy appeared to withdraw at the times in which these behaviours were displayed subsequently returning following the child self-regulating.

“You’re caught off guard, if you're doing something else and suddenly something kicks off… your just reacting… If you then get the this [gestures her hand into her face] at ya that's when you'd say, OK, I'm done… then walk away, walk away…I'm done until you calm down.” (Daisy)

1. **“They reminded me of…”**

Two participants noted that the child’s behaviour reminded them of their experiences of domestic violence. This appeared to contribute to BC.

“He reminded me of [previous partner]…he was very physical, very violent… it was just the way that mannerism.” (Betty)

There was a sense that the participant’s previous experiences became re-enacted in their relationship with the child. Interactions and the child’s behaviour appeared to “take” participants’ “back to” (Betty) the time of their previous experiences. It appeared difficult to separate past experiences from experiences in the current relationship: “it was different, but it wasn't because [foster child] still sat there hitting me still screaming at me he's still saying… which was very, very similar to…” (Betty).

Participant's emotional responses to the child’s behaviour were “heightened” due to their experiences: “… it would. Umm straight away, heighten me… I and almost just feel that overwhelming like, oh my, I'm like the fight and flight?”(Charlotte). Due to participants past experiences, the child’s behaviour appeared to activate their threat systems. There appeared to be little space to think before responding to the child: “that triggered me and I went straight from nought to five…because of my lived experiences, it just went straight down.” (Betty). In these moments, participant’s responses to the child appeared to be influenced by their past experiences, rather than the care that the child may have needed.

“So I find a barrier for me…is when I get upset and and I get angry and I’ve done all the [training] and I can understand…I'm thinking I should be doing this I should say this but that comes out that's what I say because I'm so frustrated…I can't, cope with you screaming…and shouting at me” (Betty)

Betty’s high expressed emotions appeared to take over, blocking her ability to see the child in the ‘here and now’, as separate to her experiences and to meet the child’s individual needs in these moments.

Charlotte identified that it was difficult to compartmentalise her thoughts and feelings and maintain connection with the child following the child displaying aggression.

“When he wanted that physical touch, like in a in a positive way, I just found it really difficult to do that I was like, you know, you're literally trying to kick the hell out of me, like ten minutes previous but now you want me to hug you…?”

Charlotte was left with difficult feelings following the aggression, which appeared to make it challenging to offer the nurture that the child was seeking. This may have been particularly challenging due to Charlotte’s previous experiences.

Over time, participants appeared to withdraw from the child to protect themselves and the child.

“I was almost withdrawing myself away… you get to the point where actually I can't I need to kind of protect myself as well…giving notice was the best thing all around…I was failing him as well by not being able to be emotionally attached and emotionally there.” (Charlotte)

It appeared difficult to develop or maintain an emotional connection with the child, to meet the child’s emotional needs, to spend time with the child and to provide or receive physical affection (“I had to really find some reason to want to sit him on my knee and hug him”; Betty). There appeared to be an understanding that withdrawing was not the care that the child needed.

“I just didn’t want to be with him… so if I could send him to… all day that's what I was gonna do but again, that's that rejection for him”. (Charlotte)

The reason for withdrawal appeared to relate to participants past experiences. Charlotte appeared to want to correct the child’s perception of aggression. This appeared particularly important due to Charlotte’s past experiences.

“It is difficult when they're presenting in the same way as what you've dealt with previously…you're desperately trying to show them… that's not ok… hitting people isn't ok… it was just the norm for him because that's what he’d grown up with… trying to change…that mind-set…was really difficult… I just didn't understand why he never got it.” (Charlotte)

Charlotte’s experience of being able to understand that physical aggression is “not ok” appeared to make it difficult to understand why the child could not take this on-board. Over time the child’s “constant” “verbal” and “physical” aggression and feeling unable to get through to the child about the aggression made Charlotte feel hopeless (e.g., “you had ground me down with those behaviours”) and contributed to withdrawal and BC.

Betty identified that she wanted to keep her previous experiences in the past. The re-enactment appeared to pull Betty into a “place” or past role that she did not want to be in (“I didn’t want to be that person”). Over time, re-enactment contributed to Betty withdrawing from the child possibly in an attempt to resist the place or role that this experience was pulling Betty into.

“I could close my eyes and I could move myself back…[X] years. So it was like, no, I don't. I don't want this. I don't need this.” (Betty)

**GET 3: ‘Neglected and “left to get on with it”’**

Four participants discussed feeling dismissed; invalidated and unheard when they shared concerns with social care and other professionals about the child or placement, (“I remember saying to social workers…my concerns. They won't listen…”; Ava). Participants also appeared to feel that their needs and the needs of the child were not met by services. This had a knock-on effect on participants’ ability to provide the caregiving qualities that the child needed. The lack of necessary support (“there was no support from social services”; Daisy) meant that participants had to rely on their own resources for a prolonged period; this appeared to contribute to BC.

“Every time you try and seek some support or you know something for the child from the services that you don't get each time that's just that knocks you down that little bit more then a little bit more… to the point where it's like I can't do it I can't provide the care that I need to provide…” (Charlotte)

Over time feeling undermined or neglected by services and repeatedly using their own resources in an attempt to provide the care that the child needed depleted some participants resources to the point that it eventually contributed to BC where they withdrew from social care and the child. For example, Charlotte noted, “you just start to become more and more resentful and more and more, you know, you're back off more and more urm because… you're giving them you're all you know”.

Betty identified that she needed support with understanding and responding to the child and she did not receive this in a timely manner (e.g., “I hadn't seen a supporting social worker for like [X] weeks”). This appeared to make Betty feel hopeless and she questioned whether she could provide the care the child needed. For example, Betty noted, “I need to give my notice because I can't do it I don't know what to do because no matter what I try, it's not giving me that response that I that I should have”.

**GET 4: ‘Having a break’**

Four participants discussed the importance of having a break from the children and from their role as foster carers in order to promote self-care. “I always take time for me… because I think that's vitally important urm for any foster carer” (Charlotte).

Participants discussed the importance of respite care for facilitating a break. Three participants had trouble accessing respite care (“when we've needed [respite care] you waiting and waiting”; Daisy). It appeared that Charlotte thought respite care would have enabled her to recharge and re-engage in the relationship with the child.

“I was saying to them I need this, I need some respite I need you know, sometime away… and I need some time out… you could never recharge… you know, have have a weekend away and do nice things to then come back”. (Charlotte)

Participants appeared to view having a break as serving a protective function against BC by enabling them to look after and do something for themselves, recover from the demands of their role and rejuvenate so that they could remain engaged in the relationship. Ava noted, “He's been on [respite]… and I explained to him that sometimes… I I need to recharge my batteries” and Eva noted “If we go back to respite, I need that every couple of months, otherwise I'll just burn out”.

**GET 5: ‘Now I get it’**

Four participants identified that their understanding of the child, their presentation, and their needs developed over time throughout placement and through their development as a foster carer.

“I now pre-empt and anticipate the situation I'm putting him into before doing it…I know to prepare him if he knows what's happening generally speaking, he is a lot better. He can't cope with the unknown…” (Betty)

“When they first came…I probably reacted in the way I shouldn't… now I know that's not the best thing to do is to just stop it and come back to it.” (Eva)

This level of understanding appeared to help participants to identify and provide the care that the child needed (“the understanding obviously helps with how you deal with things”; Daisy) and it appeared to develop through experience and reflection. For example, Daisy noted “more situations you're in the more you look back and think ah well that work then, but that didn't work... so you've got, like, more things to draw on”.

External support also appeared to contribute to this level of understanding by developing PRF and participants understanding of the influence of trauma and attachment experiences on children’s presentation and behaviour.

“There have been times when…I've put him in his bedroom…and that's not what he's needed…my frustration gets me and and I did it a lot more at the beginning… because I didn't know how else to deal with it but once I…reflected on it, I thought, well, he's doing the same thing he doesn't know what to do with it… he's doing what he knows how to do …When we did the [trauma and attachment] training… it was like that's where it comes from… he’s gonna be totally different because he's had that love, that nurture that he cries I pick him up where as [foster child] hadn't, and it didn't occur to me that that made a difference to the child” (Betty)

Betty describes how training and reflection enabled her to understand the influence of the child’s previous attachment experiences on their presentation and responses to Betty’s attempts to provide care. Betty reflected on her and the child’s mental states and thought about how this affected their behaviour and interactions.

Mentalisation also appeared to develop through support and time. Ava describes how support enabled her to understand the child’s emotional and behavioural responses in the context of prolonged childhood experiences of trauma.

“It’s trauma… what they said… it gave me a better insight, because what the therapist said because he was in care later… because he went in there quite late…there's so many things going on, he's sort of like fighting fight flight all the time.” (Ava)

Support also appeared to develop participants understanding of how to provide the care that the child needed. For example, Betty noted “I then had reached out to social services… she said… let's find you some strategies to learn which has helped me understand how he is that I need those strategies to help him”.

Understanding more about the child, their presentation and provision of the care that the child needed appeared to contribute to the participants connecting with the child or re-engaging in the relationship. For example, Betty noted, “that gave me that breathing space to think, actually, let's nurture this little light let's bring it back”.

Although GET 1 and GET 5 are both about understanding of the child, they are two distinct themes; GET 1 refers to difficulties in understanding the child whereas GET 5 refers to the development of participants understanding of the child.

**Discussion**

This study explored foster carers lived experience of BC. Five GETs were identified: “we didn’t understand”, ‘something took over me’, ‘neglected and “left to get on with it”’, ‘having a break’ and ‘now I get it’ which describe participants lived experience of BC. Participants experienced difficulties in understanding the child, occasions where their emotions or past experiences took over and insufficient support from services. Over time, these experiences contributed to BC and some participants withdrew from the child. In contrast, self-care in the form of ‘having a break’ appeared to serve a protective function against BC. Participants understanding of the child (including mentalisation, PRF and attunement) appeared to develop over time, through support, reflection and experience. This appeared to enable participants to provide the care that the child needed. The discussion will link the findings to the literature and outline practice implications, strengths, weaknesses, and recommendations for further research.

Difficulties in understanding the child’s behaviour and presentation contributed to BC (GET 1). In line with this, Bunday et al. (2015) found that foster carers implemented caregiving qualities or strategies that did not meet the child’s needs due to difficulties in understanding the child’s behaviour and presentation. Marrero (2020) also found that foster carers experienced difficulties in interpreting and responding to the child’s behaviour and emotional responses. Difficulties in attunement, mentalising and PRF might explain why participants experienced difficulties in understanding the child and BC (Baylin & Hughes, 2016; Bunday et al., 2015). In line with GET 1 (“we didn’t understand”), it has been proposed that difficulties in understanding the child’s behaviour and presentation may lead to misattributions regarding the meaning behind the behaviour (Marrero, 2020) and could contribute to foster carers feeling hopeless and helpless regarding their ability to provide the care that the child needs (Baylin et al., 2012; Donachy, 2017; Marreo, 2020). These processes could make it difficult for foster carers to remain connected with the child over time (Baylin et al., 2012). In line with this, three review studies (Konijn et al., 2019; Oosterman et al., 2006; Rock et al., 2015) identified that perceived ‘behavioural difficulties’ contributed to increased risk of placement breakdown and the current study found that some participants withdrew from the child.

Participants described responding to the child’s behaviour or presentation based on their own high expressed emotions rather than the care they needed (GET 2a). This finding is congruent with the literature, which suggests that when experiencing BC, parents may respond to the child based on their own high emotions (Baylin & Hughes, 2016). Difficulties in attunement, mentalisation and PRF could explain why participants appeared focused on the child’s behaviours and why they found it difficult not to respond to the child based on high emotions (Baylin & Hughes, 2016).

Participants past experiences appeared to become re-enacted in the carer-child relationship. This appeared to make it difficult for participants to provide the care that the child needed (GET 2b). A trauma response may have been activated in response to participant’s previous experiences becoming re-enacted in the relationship. In line with this, Bunday et al. (2015) identified that if carers own adverse life experiences are ‘unresolved’ children can activate these memories resulting in carers experiencing high emotional arousal in response to the child’s behaviours or presentation, this is in line with the current study’s findings (GET 2b: “they reminded me of…”). Golding (2017) identified that when carers have experienced trauma or difficult early life experiences in significant relationships, the child’s behaviour or presentation can remind foster carers of these painful experiences. Due to this, carers may respond to the child based on the emotions associated with their previous experiences rather than by providing the care that the child needs during those moments. This is in line with the current study’s findings.

Participants appeared to feel dismissed; invalidated and unheard by services and they expressed that services did not meet their needs or the needs of the child, this eventually contributed to BC as participants resources became depleted (GET 3). In line with the findings of this study, repeated experience of feeling unsupported and neglected by services has been proposed to lead to feelings of rejection and subsequent withdrawal from services placing carers at further risk of developing BC (Baylin & Hughes, 2016). ‘Triple deprivation’ appears to encapsulate this experience; children experience difficult early life experiences, which activates their defences. These defences are re-enacted by services who due to competing demands and high caseloads may struggle to provide the support that the child and carer need (Emanuel, 2006). This could reinforce the child’s defences and could activate the carer’s defences, which could make it difficult for them to provide the qualities of caregiving that the child might need as they may be in a state of survival (Baylin & Hughes, 2016).

The importance of supportive relationships with ‘skilled practitioners’ in enabling carers to remain open and engaged in the carer-child relationship, to enable empathy and reflection, to understand the child and their behaviour and to be able to provide the qualities of caregiving that the child needs has been consistently acknowledged in the literature (Baylin, 2017; Golding, 2017). The current findings (GET 3: ‘neglected and “left to get on with it”’) suggest that these qualities of caregiving may become suppressed following repeated experience of being invalidated and unsupported. These caregiving qualities are particularly important when caring for children who have experienced attachment disruptions and traumatic early life experiences (Golding, 2017), without these qualities, children could maintain a position of blocked trust placing foster carers at further risk of BC. In line with this, Developmental Dyadic Psychotherapy (DDP) highlights the importance of professionals providing a ‘secure base’ for foster carers based on attachment and Playfulness, Acceptance, Curiosity and Empathy (PACE) principles. This may support foster carers to understand their emotional responses to the child, to feel safe, open and engaged in the carer-child relationship and support them to provide the care that the child needs (Hughes et al., 2019).

Over time, in response to the processes outlined in the first three GETs, some participants appeared to withdraw from the child. This finding is consistent with the literature which suggests that when experiencing BC, parents or carers may feel unsafe near the child or may not know how to respond to the child, so they may withdraw over time to protect themselves from the painful feelings associated with remaining close to the child (Baylin & Hughes, 2016; Redfern 2013).

Participants identified that self-care in the form of ‘having a break’ served a protective function against BC (GET 4). Research has identified that ‘having a break’ helps to prevent burn out, supports the maintenance of mental wellbeing (Bridger et al., 2020) and helps foster carers to cope with the demands of their role (Redfern, 2013), in line with the current findings (GET 4: ‘having a break’). Department for Education (DFE) (2017) identified that foster carers value respite care and the independent social care review (MacAlister, 2022) supports the importance of ‘having a break’, by suggesting that additional funding is required for respite care.

Mentalisation, PRF and attunement appeared to develop over time, through support, reflection and experience (GET 5). This is a particularly important finding as it could suggest that foster carers may be more at risk of BC early on in the placement as a capacity to reflect, mentalise and attune to the child is particularly important in order to be able to provide the qualities of caregiving that the child needs (Baylin & Hughes, 2016). In line with this study’s findings, Baylin and Hughes (2016) suggested that support can help carers to remain open and engaged in carer-child relationships and help to understand the child, their behaviour and the care they need. Onions et al. (2018) found that reflective practice increased foster carers level of understanding of the child, in line with the current findings. The DFE (2017) and the independent social care review (MacAlister, 2022) also highlight the importance of appropriate support.

Overall, the phenomenology of BC for participants appeared to fit with the current understanding in the literature. Participant’s experiences appeared congruent with ‘child specific’ and ‘chronic’ BC. This study provides further insight into ‘chronic’ BC. The literature proposes that ‘chronic’ BC may develop following experiencing traumatic, stressful or difficult life events early in life. This study suggests that these events at any stage in life may contribute to BC (e.g., in a relationship with a partner). Participants did not describe experiencing BC with children of a particular age (e.g. teenage and toddler years) or in response to negative or stressful live events in contrast with ‘stage specific’ and ‘acute’ BC proposed by Baylin et al. (2012).

Participant’s perception of the term BC varied. Some participants found the term unhelpful. Others felt that the term provided meaning to their experiences. Despite this, there was sufficient shared understanding of the term to ensure that the participants were referring to BC.

**Practice implications**

The impact of foster carers past experiences and attachment history on their subsequent aptitude to care for children with particular histories (e.g. domestic violence) should be considered more thoroughly in the matching process. This is particularly important as successful matching promotes placement stability (DFE, 2017) and could reduce the likelihood of BC. Golding (2017) suggests that it is not the content of the previous experience that is important to consider in the matching process but the processing of this experience that is important. For example, if it is still so painful that the person has to ‘cut off’ from the experience they may be more likely to respond to the child based on their past experiences when their relationship with the child or the child’s behaviour reminds them of previous experiences.

In addition, the identified impact of foster carers’ previous experiences suggests a need for time and space for foster carers to have the opportunity to reflect on or process past experiences. This could include therapy provision, consultation, reflective practice and peer support groups (Hughes et al., 2019). It would be helpful if this was provided by psychological professionals rather than social workers as foster carers are often evaluated by these professionals and this could prevent them from sharing information due to fear of the impact of disclosing.

PRF, mentalisation and attunement appeared to develop over time; this could indicate that foster carers are particularly at risk for experiencing BC early in placement. This suggests a need for additional support early in placement. Such support could include further supervision or training regarding attachment and trauma informed care, therapeutic parenting and a space to reflect on their experience of caring for the child. This could promote the development of PRF, mentalisation and attunement which could enable foster carers to understand the child, their needs and to provide care in line with this (Hughes et al., 2019; Onions, 2018).

This study highlighted the importance of self-care in the form of ‘having a break’ to mitigate against BC. Therefore, it is important that this is available and accessible. This is in line with recommendations detailed in the independent social care review (MacAlister, 2022) and National Institute of Health and Care Excellence (NICE) guidance (2021) which highlights the importance of self-care to prevent ‘burn out’.

**Strengths and limitations**

To the researchers knowledge this is the first study exploring foster carers lived experience of BC and the first empirical piece of research regarding BC and foster carers. This study adds to the available research literature.

Although IPA values depth of analysis over a large sample, a limitation of this study is that the sample was small (n=5), all participants were female and recruited from the same service. Participants may have only been exposed to one LAC services or social care systems approaches to thinking about BC. These factors may have influenced participant’s experiences of BC. This study only describes this particular samples experience of BC.

**Future Research**

To the author’s knowledge, no previous literature has investigated foster children’s perception of BC. Children may have a different experience of BC. Also, it has been consistently acknowledged that foster children’s perspective is often neglected in research and care planning decisions (MacAlister, 2022). Future research should investigate foster children’s experience of BC.

This study identified that mentalisation, PRF and attunement seem to develop over time. To the researcher’s knowledge, there is no direct literature regarding the development of mentalisation, PRF, attachment and attunement over time in the foster carer-child relationship. Future research is required regarding how these phenomena develop. This could help to inform appropriate support and training for foster carers and other substitute carers (e.g., adoptive parents).

This study explored individual participant’s experience of BC. Discussion of findings largely focused on attachment and trauma informed perspectives, in line with the literature regarding BC. These approaches have been critiqued for overlooking the influence of societal factors and oppressive systems (Buchanan, 2013). Systemic and contextual factors may influence BC. Future research should consider the influence of these factors when researching BC.

**Conclusion**

This study aimed to explore foster carers lived experience of BC. Participants appeared to find it difficult to understand the child’s behaviour and presentation. Participants described occasions where their emotions or past experiences took over and described feeling neglected by services. Over time, these experiences contributed to BC and some participants withdrew from the child. Participants expressed that ‘having a break’ served a protective function against BC. Mentalisation, PRF and attunement appeared to develop over time.

Foster carer’s previous experiences should be considered more thoroughly in the matching process and they need to be offered a space to reflect on or process their previous experiences. Additional support for foster carers may be beneficial early on in placement. It is important that foster carers are supported to ‘have a break’. Future research should investigate foster children’s experience of BC and the development of PRF, mentalisation and attunement over time.

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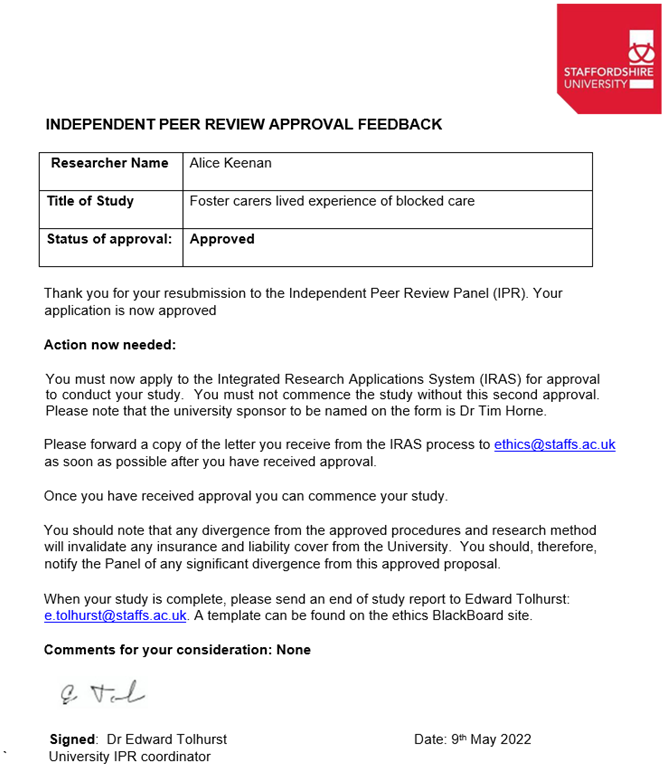
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**Appendices**

**Appendix A**

** Independent Peer Review Approval**

**Appendix B**

**Health and Care Research Wales Approval**

**Gwasanaeth Moeseg Ymchwil**

**Research Ethics Service**

**Wales REC 7**

**Carmarthen**

**E-mail : Wales.REC7@wales.nhs.uk**

**Website : www.hra.nhs.uk**

**Please note: This is the**  **favourable opinion of the**  **REC only and does not allow**  **you to start your study at NHS**  **sites in England until you**  **receive HRA Approval.**

15 November 2022

Miss Alice Keenan

Trainee Clinical Psychologist

XXXXXXXX

Dear Miss Keenan

|  |  |
| --- | --- |
| **Study title:** | **Foster carers lived experience of blocked care** |
| **REC reference:** | **XXXXXX** |
| **IRAS project ID:** | **XXXXXX** |

Thank you for your letter responding to the Research Ethics Committee’s (REC) request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair & ViceChair.

Confirmation of ethical opinion

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

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

registering research studies

reporting results

informing participants

sharing study data and tissue

Conditions of the favourable opinion

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

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

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

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

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

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that all clinical trials are registered on a publicly accessible database within six weeks of recruiting the first research participant. For this purpose, ‘clinical trials’ are defined as:

clinical trial of an investigational medicinal product

clinical investigation or other study of a medical device

combined trial of an investigational medicinal product and an investigational medical device

other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: Research registration and research project identifiers).

If you have not already included registration details in your IRAS application form you should notify the REC of the registration details as soon as possible.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: https://www.hra.nhs.uk/planning-and-improving-research/applicationsummaries/research-summaries/

N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven’t already done so, please register your study on a public registry as soon as possible and provide the REC with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at:

https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/

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

After ethical review: Reporting requirements

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

Notifying substantial amendments

Adding new sites and investigators

Notification of serious breaches of the protocol

Progress and safety reports

Notifying the end of the study, including early termination of the study

Final report

Reporting results

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvalsamendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

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

|  |  |  |
| --- | --- | --- |
| *Document* | *Version* | *Date* |
| Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional Indemnity] | 1.0 | 01 August 2022 |
| Interview schedules or topic guides for participants [Interview Schedule] | 3.0 | 20 October 2022 |
| IRAS Application Form [IRAS\_Form\_XXXXXXXX] |  | 19 August 2022 |
| Letter from sponsor [Sponsor Letter ] | 1.0 | 09 May 2022 |
| Letters of invitation to participant [Invitation Letter] | 3.0 | 05 October 2022 |
| Non-validated questionnaire [Demographic/ Contextual Questionnaire] | 2.0 | 15 April 2022 |
| Other [Additional Sponsor Letter Confirming Indemnity/Insurance Arrangements] | 1.0 | 05 August 2022 |
| Other [Additional Indemnity / Insurance Information] | 1.0 | 01 August 2022 |
| Other [GCP certificate ] | 1.0 | 17 October 2022 |
| Other [Debrief Form] | 4.0 | 20 October 2022 |
| Other [Response to Ethical Review] | 1.0 | 02 November 2022 |
| Other [PPI involvement information] |  |  |
| Participant consent form [Consent Form] | 3.0 | 05 October 2022 |
| Participant information sheet (PIS) [Participant Information Sheet ] | 4.0 | 20 October 2022 |
| Referee's report or other scientific critique report [University Approval Letter] | 1.0 | 09 May 2022 |
| Research protocol or project proposal [Peer review form with proposal] | 2.0 | 15 April 2022 |
| Summary CV for Chief Investigator (CI) [CV for Chief Investigator] | 1.0 | 04 August 2022 |
| Summary CV for student [CV Student ] | 1.0 | 04 August 2022 |
| Summary CV for supervisor (student research) [CV supervisor] | 1.0 | 02 August 2022 |

Statement of compliance

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

User Feedback

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

HRA Learning

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

IRAS project ID: XXXXXX Please quote this number on all correspondence

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

Yours sincerely



PP: Katie Horley

Dr John Buchan

Chair

E-mail: Wales.REC7@wales.nhs.uk

|  |  |  |
| --- | --- | --- |
|  |  |  |
| *Enclosures:* |  | “After ethical review – guidance for |
|  |  | researchers” |
|  |  | After ethical review guidance for sponsors and investigators – |
|  |  | Non CTIMP Standard Conditions of Approval] |
| *Copy to:* |  | Professor Nachiappan Chockalingam |

**Appendix C**

**Health Research Authority Approval**

Miss Alice Keenan

Trainee Clinical Psychologist Email: HCRW.approvals@wales.nhs.uk

XXXXXXXXXXXX

15 November 2022

Dear Miss Keenan

**HRA and Health and Care**

**Research Wales (HCRW)**  **Approval Letter**

|  |  |
| --- | --- |
| **Study title:** | **Foster carers lived experience of blocked care** |
| **IRAS project ID:** | **XXXXXX** |
| **REC reference:** | **XXXXXXXX** |
| **Sponsor** | **Staffordshire University** |

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the “Information to support study set up” section towards the end of this letter.

**How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?**

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

**How should I work with participating non-NHS organisations?**

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

**What are my notification responsibilities during the study?**

The standard conditions document “*After Ethical Review – guidance for sponsors and investigators*”, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

* Registration of research
* Notifying amendments
* Notifying the end of the study

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

**Who should I contact for further information?**

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **XXXXXX**.Please quote this on all correspondence.

Yours sincerely,

Sue Byng

Approvals Specialist

Email: HCRW.approvals@wales.nhs.uk

*Copy to: Professor Nachiappan Chockalingam*

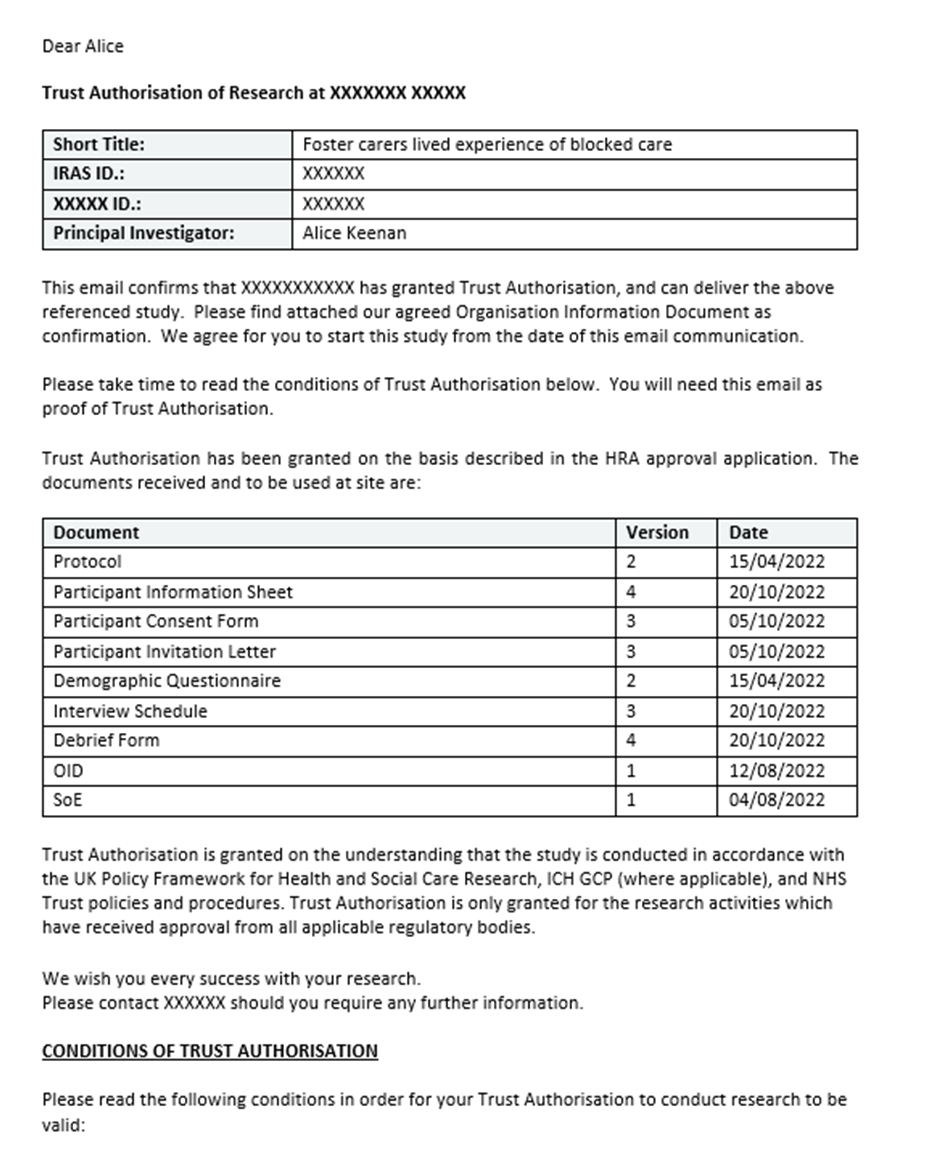
**List of Documents**

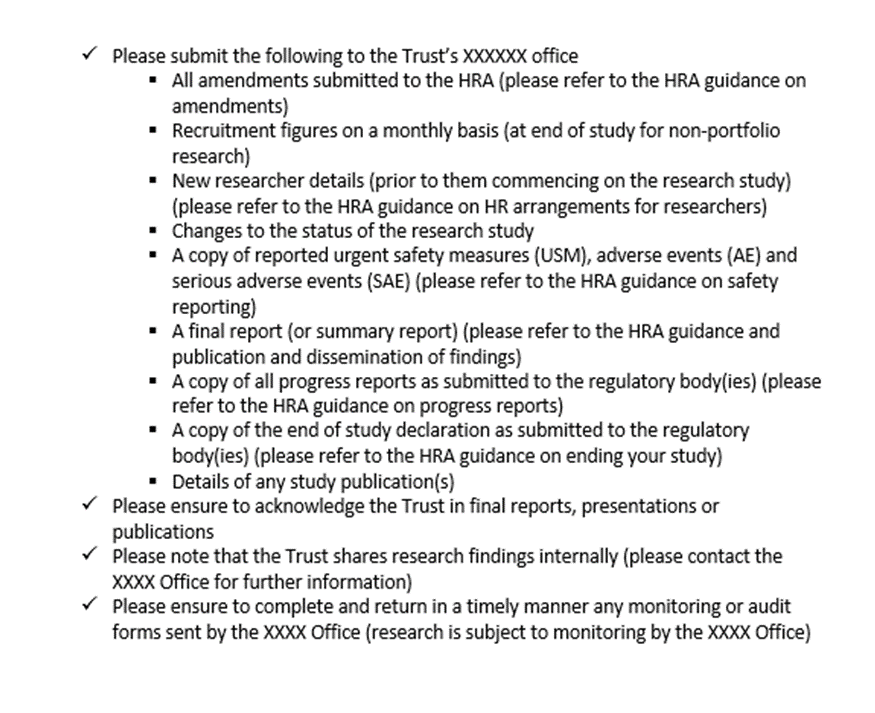
The final document set assessed and approved by HRA and HCRW Approval is listed below.

|  |  |  |
| --- | --- | --- |
| *Document* | *Version* | *Date* |
| Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional Indemnity] | 1.0 | 01 August 2022 |
| Interview schedules or topic guides for participants [Interview Schedule] | 3.0 | 20 October 2022 |
| IRAS Application Form [IRAS\_Form\_XXXXXXXX] |  | 19 August 2022 |
| Letter from sponsor [Sponsor Letter ] | 1.0 | 09 May 2022 |
| Letters of invitation to participant [Invitation Letter] | 3.0 | 05 October 2022 |
| Non-validated questionnaire [Demographic/ Contextual Questionnaire] | 2.0 | 15 April 2022 |
| Organisation Information Document [Organisation Information Document] | 1.0 | 12 August 2022 |
| Other [Additional Sponsor Letter Confirming Indemnity/Insurance Arrangements] | 1.0 | 05 August 2022 |
| Other [Additional Indemnity / Insurance Information] | 1.0 | 01 August 2022 |
| Other [GCP certificate ] | 1.0 | 17 October 2022 |
| Other [Debrief Form] | 4.0 | 20 October 2022 |
| Other [Response to Ethical Review] | 1.0 | 02 November 2022 |
| Participant consent form [Consent Form] | 3.0 | 05 October 2022 |
| Participant information sheet (PIS) [Participant Information Sheet ] | 4.0 | 20 October 2022 |
| Referee's report or other scientific critique report [University Approval Letter] | 1.0 | 09 May 2022 |
| Research protocol or project proposal [Peer review form with proposal] | 2.0 | 15 April 2022 |
| Schedule of Events or SoECAT [Schedule of Events] | 1.0 | 04 August 2022 |
| Summary CV for Chief Investigator (CI) [CV for Chief Investigator] | 1.0 | 04 August 2022 |
| Summary CV for student [CV Student ] | 1.0 | 04 August 2022 |
| Summary CV for supervisor (student research) [CV supervisor] | 1.0 | 02 August 2022 |

**Appendix D**

**Trust Capacity & Capability Approval**





**Appendix E**

**Information Sheet**

**PARTICIPANT INFORMATION SHEET**

**Study Title**

Foster carers lived experience of blocked care

**Researcher:**

Alice Keenan

**Invitation Paragraph**

The researcher would like to invite you to participate in this research project, which forms part of their Professional Doctorate in Clinical Psychology research. Before you decide whether you want to take part, it is important for you to understand why the research is taking place and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask the researcher if anything is unclear or if you would like more information.

**Background Information**

We are aware that many children in care experience difficult events and/or trauma in their early development particularly in their relationships with their primary caregivers. These experiences may influence how children behave and how they think and feel about themselves and important others such as their carers. These early experiences may contribute to the development of strategies to keep themselves safe in their close relationships. Some of these strategies may include pushing away people who are trying to care for them and not trusting others. It is understandably very difficult for foster carers when their genuine attempts to care are met with rejection, anger, avoidance or a lack of trust (Hughes, 2015).

The term blocked care was developed by Hughes and Baylin in 2012. Blocked care has been defined by Hughes (2015) as instances in which a parent or carer might find it particularly challenging to provide the care that their child needs. For example, parents may struggle to empathise with or remain engaged in a relationship with the child.

**What is the purpose of the study?**

To understand foster carers perception of the term blocked care. For example, is it a helpful term?

To understand foster carers experience of instances in which it has been particularly challenging to provide the care that their foster child (/children) needs (to understand their experience of blocked care). Also, it has been suggested that many different things contribute to blocked care developing and to parents or carers experience of blocked care.

The researcher would like to understand foster carers perception of and experience of blocked care because (as far as the researcher is aware) no previous research has attempted to understand this by directly asking foster carers about their experience of it.

Please note that we are aware that most parents and carers experience instances in which it is particularly challenging to provide the care that their child needs. This may be particularly the case however for foster carers parenting children in care whose experiences have led to the development of strategies to block trust and closeness in caregiving relationships. We hope learning about your experiences will enable greater understanding of blocked care.

**Why have I been invited to take part?**

You have been invited to take part because you are a non-kinship foster carer currently under the care of the XXXXX Looked After Children (LAC) XXXXX team, you have experience of at least one placement, have cared for a foster child (could be a child who is currently placed with you or a child who was previously placed with you for) for at least six months, are able to speak English and able to provide informed consent.

If you consider yourself to be distressed regarding a recent placement breakdown you are advised to consider whether it would be appropriate for you to take part at this time.

**What will happen if I take part?**

If you agree to take part, you will be asked to sign a consent form.

You will be asked to complete a brief questionnaire before the interview. This questionnaire includes demographic questions (e.g. ‘what gender do you identify as?’) and contextual questions (e.g. ‘how long have you been a foster carer?’).

After this, you will be invited to take part in one interview, which should last around an hour, in some cases it might be shorter or longer depending on how much you have to say about the issue. In this interview, you will be asked about what blocked care means to you and your experiences of this. Examples of questions and question themes are provided below to give you an understanding of the type of questions that you could be asked in the interview:

**Sample questions:**

* “Is the term blocked care a helpful one?”
* “Can you bring to mind times when it has been more challenging to provide care for a foster child?”

**Question themes:**

* Perception of the term blocked care
* Occasions in which it is more challenging to provide care
* Situations in which barriers to providing care arose
* How you made sense of things and the meanings you gave to these experiences
* How your understanding changed overtime
* Any factors that made providing care more challenging

Interviews will be conducted online via Microsoft Teams. However, if you prefer to attend the interview in person or if there are issues with finding a confidential space in your home the interview may take place face to face on XXXX trust or university premises. Please note that should your interview take place in person unfortunately there is no funding available for reimbursement of travel expenses.

It would be inappropriate for the interview to take place in an environment where children or young people could overhear the interview. Therefore, if there are interview times that would be inappropriate for you due to this please contact the researcher so that she is able to arrange the interview for a more appropriate time (e.g. when the children or young people are at school).

The interview will be recorded so that the researcher can type up the interview before analysing the data. You will be asked for your informed consent for this and you will be informed when the recording will start. You will also be informed when it has ended. You can turn your camera off for the recording if you would prefer this. This recording will be destroyed as soon as the interview has been typed up.

**Do I have to take part?**

Participation is completely voluntary. You should only take part if you want to. Choosing not to take part will not disadvantage you in anyway. Once you have read this information sheet, please contact the researcher if you have any questions that will help you to make a decision about taking part. If you decide to take part, you will be asked to sign a consent form and you will have a copy of this consent form to keep.

**What are the possible risks of taking part?**

There is a risk that individuals may experience emotional distress in response to the interview questions or material. For online interviews, there is a risk that others living within the household might overhear the interview, including your responses to interview questions. Some individuals may disclose information (e.g. regarding poor practice or risk). Disclosing this information could distress the individual and they may worry about whom the information might be shared with.

**How is the researcher minimising these risks?**

You will be provided with information about how to seek support in case you become distressed by the interview questions or material. You can take the interview at your own pace and breaks will be offered if required. The interview can be stopped or suspended if you do not wish to continue. If you find any questions particularly distressing, you do not need to answer them. If you disclose something, the researcher will aim to discuss what will happen next with you before taking any action. Before starting the interview, the researcher will ask how confidential your space is to assess the risk of others within your household overhearing the interview. If your household environment is not considered a confidential space, it may be suggested that you complete the interview in person.

**What are the possible benefits of taking part?**

There are no direct benefits of taking part. Some people do find it beneficial talking about their experiences. By taking part, you will also help to improve our understanding of blocked care. By increasing the knowledge base on this topic, it might contribute to a better understanding of foster carers perception of and experience of blocked care. This could contribute to the development of recommendations for further support, training and interventions for foster carers and other professionals in the future.

**Data handling, confidentiality and protection**

**How will we use information about you?**

If you agree to take part in the study, you will need to sign the consent form provided. Information collected from you prior to and during at the interview, will be kept strictly confidential at all times, only accessible by the research team at Staffordshire University, and only identifiable to the main researcher. All published data will be anonymised. All electronic data (e.g. consent forms and demographic forms completed electronically) will be stored on an access controlled and password protected university OneDrive account for at least three months after study completion, then deleted. All hardcopy data (e.g. paper consent forms and demographic forms) will be stored securely at Staffordshire University for 10 years following study completion, then confidentially destroyed in accordance with Staffordshire University policy.

The only exception to confidentiality is if you mention something during the interview indicating that you or someone else might be at risk of harm. On these occasions, this will be discussed with the research supervisory team at Staffordshire University. Following this, appropriate action will be taken relevant to the concern identified. We will always try (where possible), to discuss this with you first, prior to taking any action. You will be informed during or shortly after the interview if any concerns were identified.

Upon study completion, the anonymised data will be analysed by the researcher (and at times discussed with the researcher supervisory team at Staffordshire University and XXXXXXXX Trust) and a study report will be produced. The report will include anonymised quotes from your interview and your name will be changed to uphold confidentiality. The report will be shared with key personnel from XXXXXXXX Trust, Staffordshire University, and the research regulatory agencies for monitoring purposes. An executive summary of the report will be made available to participants. You will be asked if you would like to receive a copy of this at the consent form stage.

The data controller for this project will be Staffordshire University. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the data protection law is a ‘public task’ and ‘consent’.

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation (2016). You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the Staffordshire University Data Protection Officer, please visit https://www.staffs.ac.uk/legal/data-protection.

If you wish to lodge a complaint with the Information Commissioner’s Office, please visit www.ico.org.uk.

For further information about how researchers use participant information, please visit https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/data-protection-and-information-governance/gdpr-guidance/templates/template-wording-for-generic-information-document/

**What if I change my mind about taking part?**

You are free to withdraw at any point of the study, without having to give a reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up until **TWO WEEKS** after completion of the interview,after which withdrawal of your data will no longer be possible, as the data analysis would have commenced.

If you choose to withdraw from the study, we will not retain any information that you have provided us as a part of this study.

**What will happen to the results of the study?**

The results will be written up into a study report to form part of the researchers Professional Doctorate in Clinical Psychology thesis. The anonymised report may be submitted for publication in a peer reviewed scientific journal and it will also be shared with XXXXXXXX Trust and Staffordshire University. The anonymised report may be presented in scientific forums (conferences, seminars, workshops) or could be used for teaching purposes. Anonymised quotes may be used in teaching and training. There will be an executive summary report which will be shared with participants should they wish to view it.

**Who should I contact for further information?**

If you have any questions or require further information about the study, please contact the researcher as follows:

Email: alice.keenan@student.staffs.ac.uk

Work Mobile: XXXXXXXX

It is important to note that I only have access to my work mobile from 9am to 5pm Monday to Friday. Please only use this number for correspondence regarding the study.

Alternatively, you can contact the academic supervisor of the project- Dr Yvonne Melia:

Yvonne.Melia@staffs.ac.uk

**What if I have further questions, or if something goes wrong?**

If you feel this study has harmed you or you wish to make a complaint about the study, please contact the research supervisor or Chair of the University Ethics Committee as follows:

**Research Supervisor**

Dr Yvonne Melia

Email: Yvonne.melia@staffs.ac.uk

**Chair University Ethics Committee**

Professor Nachiappan Chockalingam

Email: ethics@staffs.ac.uk

Address: School of Health, Science and Wellbeing, Science Centre Building,

Leek Road, Stoke-on-Trent, ST4 2DF

**Who is organising this study?**

The study is being conducted as part of the researcher’s professional doctorate programme, sponsored by Staffordshire University.

**Who has reviewed this study?**

The study has been reviewed and approved by Staffordshire University Research Ethics Committee; Wales 7 NHS Research Ethics Committee and the Health Research Authority.

**Thank you for reading this information sheet and for considering taking part in this research.**

Version 4.0, 20/10/2022

IRAS ID.: XXXXXX

**Appendix F**

**Invitation Letter**

Dear (Participant name)

**Study Title: Foster carers experience of blocked care**

My name is Alice Keenan and I am a Trainee Clinical Psychologist XXXXX XXXXX Trust and currently studying at Staffordshire University.

I would like to invite you to participate in this research project, which forms part of my Professional Doctorate in Clinical Psychology.

You have been invited to take part because you:

* Are a non-kinship foster carer under the care of the XXXXX Looked After Children (LAC) XXXXX team
* Have experience of at least one placement
* Have cared for a foster child for at least six months
* Have provided your verbal consent to be contacted about the study

Blocked care has been defined by Hughes (2015) as instances in which a parent or carer might find it particularly challenging to provide the care that their child needs.

The purpose of this study is to understand foster carers perception of the term blocked care and to understand their experience of blocked care in relation to their foster child (/children).

Taking part is voluntary and if you chose not to it will not affect the care you receive presently or in the future from the LAC XXXXX team and/or any other services within XXXXXX Trust.

Please contact me via email: XXXXXX or on my work mobile: XXXXXX if you have any questions about the study or if you would like to have a conversation about the study. Please be aware that I only have access to my work mobile from 9am to 5pm Monday to Friday.

Thank you in advance,

Kind Regards,

Alice Keenan

Principal Investigator

Version 3.0, 05/10/2022

IRAS ID.: XXXXXX

**Appendix G**

**Consent Form**

**PARTICIPANT CONSENT FORM**

**StudyTitle:** Foster carers experience of blocked care **Researcher:** Alice Keenan

**Participant ID.:**

|  |  |
| --- | --- |
| Statement | Initials |
| I confirm that I have read and understood the information sheet dated………... (Version….) for the above study, been given the opportunity to ask questions, and have had satisfactory answers. |  |
| I understand that my participation in this study is voluntary, and that I am free to withdraw at any time (up to two weeks after the interview is completed) without giving any reason, without my medical care or legal rights being affected. |  |
| I understand that anonymised data collected from myself during the study, may be looked at by individuals from the XXXX Trust, Staffordshire University and regulatory authorities. I give permission for these individuals to have access to my anonymised data. |  |
| I understand that the interview will be audio and video recorded. I understand that I can turn my camera off for the recording if I would prefer this. I give permission for these recordings to be made then destroyed after transcription. |  |
| I understand that my confidentiality may be breached if I disclose information that indicates that I or someone else is at risk of harm. |  |
| I understand that anonymised quotes from the interview will be included in the study reports. I give permission for anonymised quotes to be used in the reports. |  |
| I understand that data collected from me will be anonymised and used in the study report (and executive summary report) which, will be shared with participants, the XXXX Trust, Staffordshire University, and could be published in peer reviewed scientific journals, presented in scientific forums (conferences, seminars, workshops) and used for teaching purposes. I give permission for my anonymised data to be used in study publications. |  |
| I would like to receive a copy of the executive summary of findings once the study report has been published. |  |
| I agree to take part in the above study. |  |

*Please insert your initials after each statement so we know that you have read, understood, and agree to it.*

*Please return consent form to alice.keenan@student.staffs.ac.uk or send via post ([pre-paid envelope provided)[omit email or postal address depending on participants’ preference for contact]*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Participant (print) Date Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Researcher (print) Date Signature

1 copy for the participant, 1 copy for the study file

**Appendix H**

**Demographic Questionnaire**

**PARTICIPANT DEMOGRAPHIC / CONTEXTUAL QUESTIONNAIRE**

**Study Title:** Foster carers experience of blocked care

**Researcher:** Alice Keenan

**Participant ID.:**

*Please complete this questionnaire prior to attending your interview on………..….. Please circle or highlight your answer. Please return completed questionnaire to alice.keenan@student.staffs.ac.uk or send via post (pre-paid stamped addressed envelope)[omit email or postal address depending on participants’ preference for contact] or if you are attending the interview in person and would prefer to bring this with you please do so.*

1. How old are you? *(Please state in years)*

1. What is your ethnicity?

Asian / Asian British

Black / African / Caribbean / Black British

Mixed / Multiple Ethnic Group

White

Other ethnic group (please state) …………………………………

1. What gender do you identify as?
2. How long have you been a foster carer? *(Please state in months and years)*
3. What is the longest placement that you have had? *(Please state in months and years)*
4. How many foster children have had placements with you? *(Please circle one option)*

1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10+

1. How many placement breakdowns have you experienced? *(Please circle one option)*

None, 1, 2, 3, 4, 4+ (please state amount)………....

1. How many foster children are currently in your care?
2. Are you a single carer? *(Please circle one option)*

Yes / No

1. On the scale below, please circle the response that best describes how much support you feel you receive from family, friends, professionals (etc.) in your role as a foster carer?

No support / Little support / Adequate support / Good support / Great support

1. Have you previously had training about blocked trust and blocked care, parental reflective functioning or mentalisation? If so, please state what training:

**Thank you for taking the time to complete this questionnaire**

Version 2.0, 15/04/2022

IRAS ID.: XXXXXX

**Appendix I**

**Interview Schedule**

**INTERVIEW SCHEDULE**

**Study Title:** Foster carers experience of blocked care

**Researcher:** Alice Keenan

**Introduction**

Hi, its lovely to see you. Thank you for taking the time to read the study information and for completing the consent form and demographic questionnaire ahead of the interview appointment. As you are already aware, in the following interview I will ask you questions about your experience of times in which it has been challenging to provide the care that your foster child (/children) might need. By asking you about this, I hope to get a better understanding of foster carer’s perception of and lived experience of blocked care in relation to their foster child (/children). It feels important to develop a better understanding of this because as far as I am aware no previous research has attempted to explore or understand this by directly asking foster carers about their experience of it.

The interview will should last around an hour in some cases it might be shorter or longer depending on how much you have to say. Please let me know if you need a break at any point, or if you would like to stop the interview.

Are you still happy to take part in the research? Do you have any questions?

Are you in a confidential space where you feel safe to talk, where you will not be disturbed or overheard (particularly by any children)?

**Please note**

For ease and to avoid jargon we will be asking you about times in which it has been challenging to provide the care that your foster child might need, when we are referring to this, we are asking you about your experience of blocked care.

**Interview Questions**

1. ***Do you recall the definition of blocked care that was provided in the information sheet?*** If no repeat this information. Then ask all participants “does this concept make sense to you?” “Is the term blocked care a helpful one?”
2. ***Can you bring to mind times when it has been more challenging to provide care for a foster child?***

For example, this could include occasions where you might have felt that you were struggling to connect with the child, coped by distancing yourself from the child, struggled to think about the kind of care that the child might require, when you have acted upon strong emotions / high emotional arousal (e.g., anger or sadness), when it has been difficult to understand your child and their behaviour or your own responses to the child.

***Whilst holding a particular child that you have cared for in mind, can you describe an example of a situation (or situations) when you experienced barriers to providing the care that this child might have needed? Please explain what these barriers were and how they contributed to it being more challenging to provide the care that this child might have needed.***

*Follow up questions for question 2:*

*Child centred*

* What was the child doing?
* What sense did you make of the child’s behaviour and their reactions to you at the time? What were their intentions? How were they feeling? What were they thinking?
* If not already covered ask: in your opinion, did their past experiences, affect how they were thinking, feeling and behaving?

*Carer centred*

* What were you doing?
* What sense did you make of your thoughts, feelings and behaviour at the time?
* What affect did this have on how you cared for and reacted to the child?
* Did this instance remind you of any experiences you have had in the past? (E.g. your own early life experiences or experiences in your adult life)?
* If so, how does this impact on your experience of situations where it has been more challenging to provide the care that this child might have needed?
* If not already covered ask: how does it affect your thoughts, feelings and behaviours in response to these situations?
* Was there something about how you experienced this child that made it particularly challenging to provide care for them?
* Did they remind you of anyone (this could include yourself)?
* Did their pattern of behaviour / your pattern of behaviour in response to them remind you of anything/ anyone?
* Did this situation (/situations) reoccur?
* Were you aware at the time that it was becoming challenging to provide the care that this child might have needed?
* Was there a turning point when you noticed this?
* Can you provide an early example of when you first noticed it was becoming challenging?

*Other*

* What were others doing (e.g., household members, other professionals, others in the child’s and your life)? Did this contribute in any way to it being more challenging to provide care for the child?

1. ***Has your experience or understanding of those instances in which it was challenging to provide the care that the child might have needed changed or developed overtime?***

*Follow up questions for question 3*

* Did your thoughts or feelings about it, how you responded to it or how you made sense of it change overtime?
* When you think about the times when you found it more difficult to provide care for the child (/children) do you notice any patterns?
* Did any of these patterns reoccur when caring for other foster children?
* Alternatively, was there something about your experience of caring for this child (or the dynamic with this child) that was different to your experience of caring for other foster children?
* When you think of those situations in which it was challenging to provide care for the child do you think that you ever acted in a way that seemed out of character for you?

1. ***Was anything else happening in your life at that the time that might have made it more challenging to provide care? (e.g., any stressors or traumatic/ negative life events e.g. bereavement)?***
2. ***Is there anything else that you would like to tell us about*** ***your experience of instances in which it has been more challenging to provide the care that the foster child (/children) might have needed?***

If they focus on a specific child throughout the interview, ask how long they cared for this child and age of the child at the time.

**Do you have any further questions about the study?**

**Explain and then give debrief form to participant.**

Version 3.0, 20/10/2022

IRAS ID.: XXXXXX

**Appendix J**

**Debrief Form**

**PARTICIPANT DEBRIEF FORM**

**Study Title:** Foster carers experience of blocked care

**Researcher:** Alice Keenan

*Thank you for taking part in this study, your time and contribution are valued greatly.*

This research aimed to understand foster carers perception and experience of occasions in which it has been more challenging to provide the care that your foster child (or children) might need (your experience of blocked care). The researcher will now transcribe the interview recording. Following this, the researcher will make notes of important themes in your interview responses. The researcher will complete this process for every participant and then your interview responses will be compared with other participants to see if there are any common themes throughout the interviews. Following this, the researcher will write up a research report and an executive summary.

We hope that by increasing the understanding of this topic, we will learn more about occasions in which it is challenging for foster carers to provide the care that a foster child (or children) might need. We would hope that this understanding will contribute to the development of further support or training about blocked care for foster carers and other professionals in the future. Also, we hope that you may have found it useful to discuss and reflect on your experiences.

**Confidentiality**

As already explained all data will be anonymised and unidentifiable for the purpose of the report and the executive summary. The researcher will not share any of your confidential data unless there is a concern about psychological or physical harm to yourself or others. In this instance, the researcher would aim to discuss this with you first.

**Right to Withdraw**

Please remember that you have until up to **TWO WEEKS** after the interview to withdraw your data from this study should you choose to. After this time, you will be unable to withdraw your data, as the data analysis will have commenced.

If you do wish to withdraw, please contact the researcher via her email address or work mobile number.

**Further Information**

If you require any further information about the study or wish to discuss something regarding the study, please contact:

The researcher

Alice Keenan

Email: alice.keenan@student.staffs.ac.uk

Work mobile: XXXXXXXXX

It is important to note that I only have access to my work mobile from 9am to 5pm Monday to Friday. Please only use this number for correspondence regarding the study.

OR

The academic research supervisor

Dr Yvonne Melia

Email: Yvonne.Melia@staffs.ac.uk

**Seeking Support**

During this study, we have asked you to discuss and reflect on sensitive topics. Due to this, some individuals may feel distressed following the interview. If you are feeling this way, it is important that you inform the researcher and seek support.

If you are experiencing difficulties with your mental health of a non-urgent nature, please contact your GP as they will be able to signpost you to appropriate support services and they may also be able to support you themselves.

If you are particularly concerned about something which might impact on your foster child, relates to your foster child or your relationship with your foster child, it might be useful to discuss this with your foster child’s social worker, your supervising social worker or your key worker XXXXXX at the XXXXX Looked After Children’s Team.

**Other Sources of Support Include**

***Mind***

This service provides support to individuals who are experiencing mental health difficulties

https://www.mind.org.uk/

Mind also has a helpline (called infoline) for non-urgent mental health support queries

0300 123 3393

***XXXXXXXXX XXXXXXX Team***

Contact this service if you are concerned about your own or others mental health

This number is available 24 hours a day 7 days a week. XXXXXXXXX

XXXXXXXXX

***Samaritans***

This service aims to support people when they need support with their mental health, they also aim to prevent suicide.

https://www.samaritans.org/

Their helpline operates24 hours a day 7 days a week.

116 123

***The fostering network***

Leading fostering charity who aim to bring together those involved in the lives of foster children to develop foster care

https://www.thefosteringnetwork.org.uk/

***Coram***

Provides support and advice related to fostering and adoption.

https://www.coram.org.uk/adoption-and-fostering

***Fosterline***

Offers information and support on anything related to fostering.

https://www.fosterline.info/

Their helpline is open 9-5 Monday to Friday apart from bank holidays

0800 0407 675

enquiries@fosterline.info

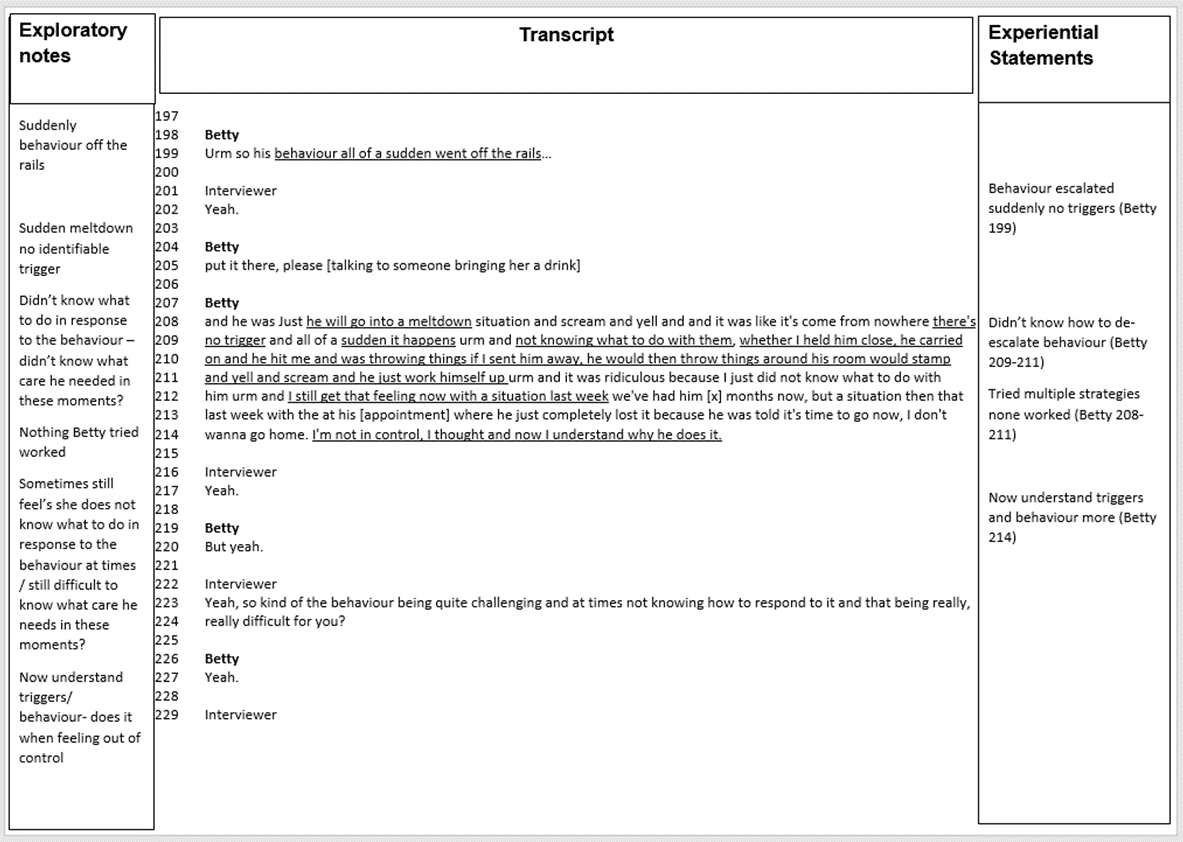
***In an emergency, please contact 999 or attend A&E***

Version 4.0, 20/10/2022

IRAS ID.: XXXXXX

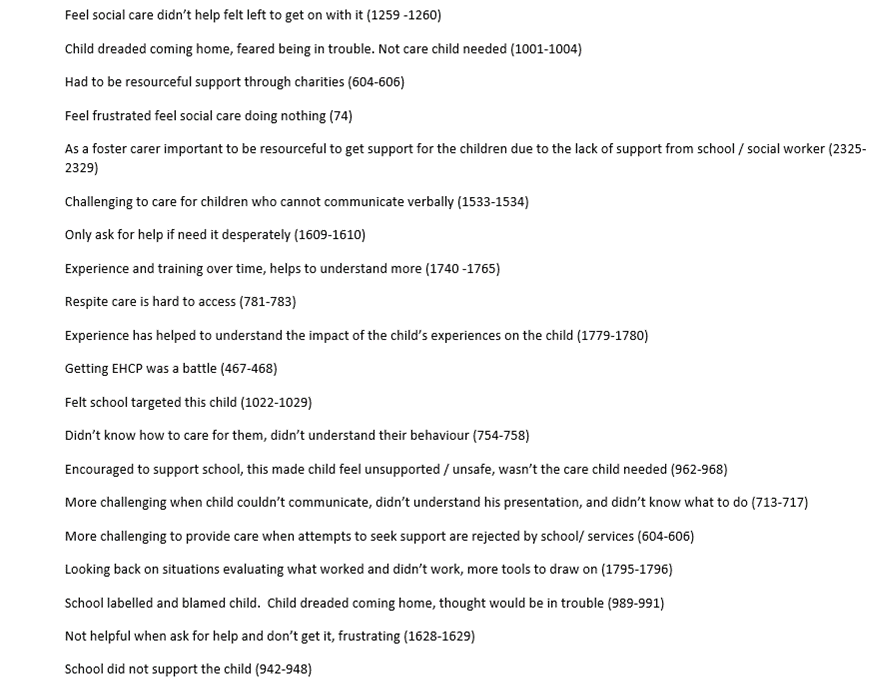
**Appendix K**

**Transcript Excerpt with Exploratory Notes and Experiential Statements**

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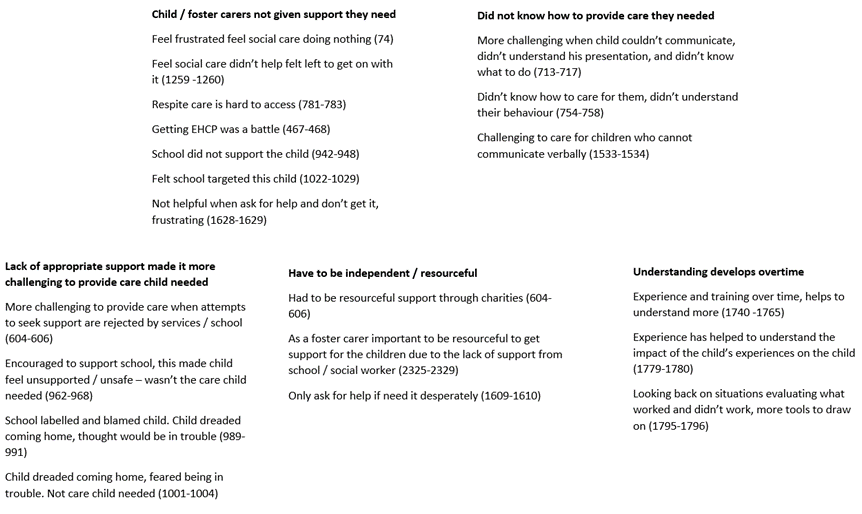
**Appendix L**

**Random Distribution of a Sample of Experiential Statements**

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**Appendix M**

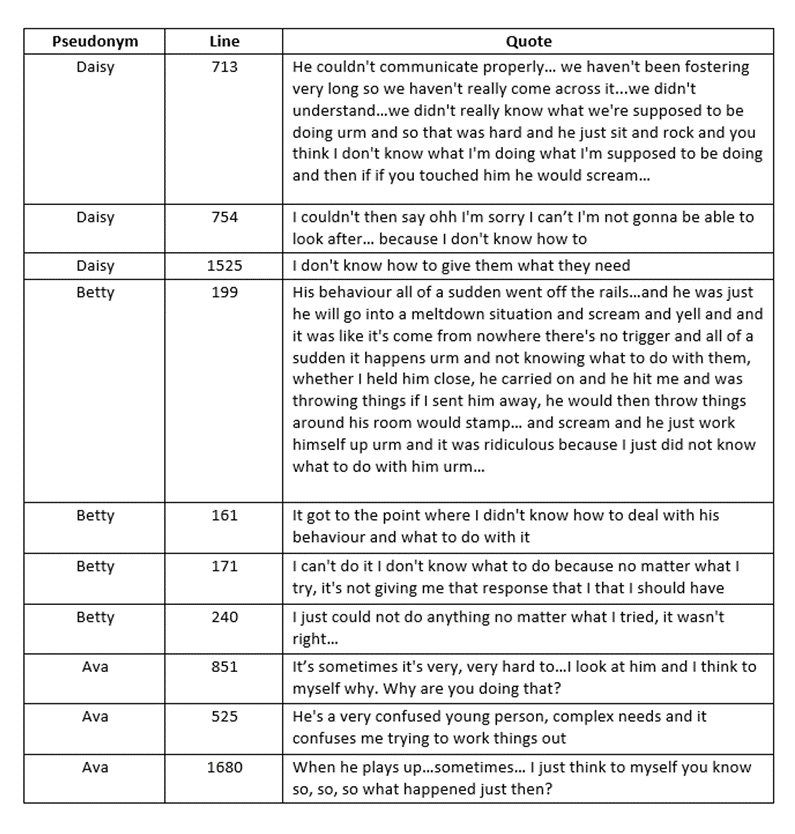
**Sample of Possible PETs**

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**Appendix N**

**Sample Table of GETs**

**GET 1: “We didn’t understand”**

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Note. Only one page of the GETs table is included in the appendix, as the risk to anonymity was deemed too high to include more than this since participants were recruited by clinicians in a particular service. Some of the clinicians may know the participants well. There is a potential risk that clinicians could identify participants if more quotes were included in the appendix.

**Appendix O**

**Sample Excerpt from Researchers Reflexive Diary**

**Date: 6.12.2022**

**‘Very conscious of being in a researcher / interviewer role rather than a clinician role–wonder if participants were aware of this, trying to resist my pull to a therapeutic position. Very aware of not overly sharing my perspective, awareness of my non-verbal and verbal communication particularly of the use of nodding. Aware of needing to ask questions in the interview schedule not wanting to come across as dismissive by bringing things back to the question particularly when the participant is saying something that appears particularly important to them.’**

**Appendix P**

**Journal Guidelines for Child and Family Social Work**

The below link is for the ‘Author Guidelines’ for Child and Family Social work

**https://onlinelibrary.wiley.com/page/journal/13652206/homepage/forauthors.html#manuscript**

Child and family social work guidelines state: ‘Original Articles should normally be a maximum of 7000 words, including the abstract and any appendices, although shorter papers will be welcomed. References are not included in the 7000 word limit. The abstract should not exceed 200 words and it should be followed by six keywords…References may be submitted in any style or format, as long as it is consistent throughout the manuscript’

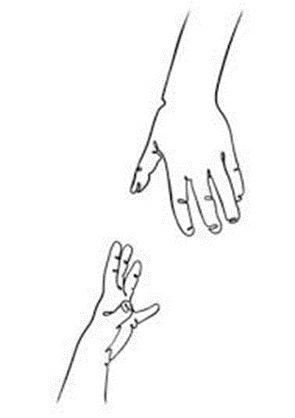
Please visit the above link for any further information.

**Paper 3: Executive Summary**

**“I was still providing everything for their basic needs, but not necessarily meeting their emotional needs.” An Interpretative Phenomenological Analysis of Foster Carers Lived Experience of Blocked Care.**

**Alice Keenan**

Word count: 2394

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**2023**

**CONTENTS**

**INTRODUCTION**

**HOW WAS THIS INVESTIGATED**

**WHAT WERE THE KEY FINDINGS?**

**WHAT ARE THE IMPLICATIONS OF THESE FINDINGS?**

**MAIN STRENGTHS AND LIMITATIONS**

**KEY IMPLICATIONS FOR FUTURE RESEARCH**

**DISTRABUTION OF THE FINGINGS**

**REFERENCES**

**With special thanks to the foster carers who took part in the research.**

**Introduction**

This executive summary has been created to communicate key information about the study in a succinct and accessible manner. The target audience of this executive summary is foster carers and professionals who might support them such as social workers. Clinicians who work with foster carers and children in care provided feedback on the readability and sensitivity of this paper.

The majority of children in care in England are placed in foster care placements (Gov.uk, 2021) and 79 percent of children in care are placed in care due to risk of ‘abuse’, ‘neglect’ or ‘family dysfunction’, (Gov.uk, 2021). Due to these experiences, many children in care experience difficult events and or trauma in their early development particularly in their relationships with primary caregivers (Hughes et al., 2019). These experiences may influence how children behave and how they think and feel about themselves and important others such as their foster carers. These early experiences may contribute to the development of strategies to keep themselves safe in their close relationships. Some of these strategies may include pushing away people who are trying to care for them and not trusting others. It is understandably very difficult for foster carers when their genuine attempts to care are met with rejection, anger, avoidance or a lack of trust (Hughes, 2015).

**What is blocked care?**

The term blocked care was developed by Baylin et al. in 2012. Blocked care has been defined by Hughes (2015) as instances in which a parent or carer might find it particularly challenging to provide the care that their child needs. When experiencing blocked care parents may:

* Struggle to empathise with or remain engaged in a relationship with the child
* Feel unsafe being around the child
* Find it difficult to understand the meaning behind the child’s presentation or behaviour
* Respond to the child’s behaviour based on their own highly charged emotions
* Find it difficult to understand how the child’s thoughts and feelings influence their behaviour
* Find it difficult to reflect on their own and the child’s mental states (e.g. thoughts and feelings) and think about how this might affect interactions in the parent-child relationship
* Find it difficult to identify the child’s needs (Baylin et al., 2012; Baylin & Hughes, 2016; Hughes, 2015; Redfern et al., 2018).

**How is blocked care relevant to children in care?**

Blocked care is proposed to be associated with negative outcomes for foster carers and foster children including poor emotional and behavioural outcomes and placement instability (Baylin & Hughes, 2016; Golding, 2017). Since foster carers care for children who may have experienced trauma and disruptions in their primary attachments, they may be at increased risk of developing blocked care. This is because foster carers look after children whose previous experiences may have led to the development of strategies by the child to attempt to block trust and closeness in caregiving relationships (Baylin & Hughes, 2016).

**Why is there a need for this research?**

Past research regarding blocked care is based on reflection on clinical practice, neuroscience research and the application of psychological theories to blocked care. No previous research has attempted to understand foster carers perception of and experience of blocked care by directly asking foster carers about their experience of it. It is important that foster carers lived experience is understood because this could provide further insight into blocked care.

**What were the aims of this research?**

To understand foster carer’s perception and experience of blocked care.

**How was this investigated?**

Full ethical approval was received for the research. Following this, participants were invited to take part.

**Who could be a participant?**

In order to take part, participants needed to meet the below criteria:

* Non-kinship foster carers under the care of the Specialist Looked after children (LAC) team
* Experience of at least one placement
* Cared for a foster child for at least six months
* Able to provide informed consent
* Able to speak English

**How were participants approached?**

Participants that met the above criteria were approached by clinicians in the specialist LAC team. The clinicians discussed the research with participants, shared an information sheet about the research and asked for participant’s consent for their personal information to be shared with the researcher. Following this, the researcher contacted the participants.

**Who took part?**

Five participants took part.

* Four participants were White British one participant was Black British
* Participants mean age was 51.6 years old (range: 43-58 years)
* The mean number of foster placements experienced was 5.6 (Range: 1-10+ placements)
* Participants mean number of foster children currently in care was two (range: 1-3)
* Participants range for length of time as a foster carer was between two to 25.8 years
* Participants longest placement was between two years to 10 plus years
* Participants experienced between nought to four placement breakdowns
* Two participants were single carers

**What did participants do?**

Participants who agreed to take part were asked to complete a consent form and a demographic questionnaire. After this, participants’ took part in one interview about their experience of blocked care, which took place on Microsoft Teams. Interviews were recorded. Interviews took between 92-124 minutes. Participants were debriefed after the study.

**How did the researcher analyse the data?**

After the interview, the researcher typed up the interview word-for-word so that she could analyse the data using Interpretative Phenomenological Analysis (IPA). This method of analysis enabled the researcher to identify and understand similarities and differences in participants’ experiences of blocked care and identify data themes.

**What were the key findings?**

Five themes and two subthemes were identified. The themes included: “We didn’t understand”, ‘something took over me’, ‘neglected and “left to get on with it”’, ‘having a break’ and ‘now I get it’. Each theme will be outlined below. Each theme was present for at least three participants. Quotes will be used to provide evidence of the themes. The participants’ names have been changed in order to uphold confidentiality.

**Theme 1: “We didn’t understand”**

Participants’ appeared to find it difficult to understand the child and their behaviour. Participants noted that due to difficulties in understanding the child’s behaviour and presentation, it was difficult to know what care was needed. These factors appeared to make it challenging to provide the care that the child needed.

*“She’s not communicating, so it's quite difficult to know exactly what she thinking… I can't help if I don't know what the issue is”* -Eva

Participants expressed that the caregiving qualities that they would usually provide, or the strategies that they would usually use to manage behaviour or situations did not work. Participants also described a sense of feeling unable to get through to the child and feeling that the child was unable to respond to the care that they were trying to provide.

*“Whether I held him close, he carried on and he hit me and was throwing things, if I sent him away, he would then throw things around his room…it was ridiculous because I just did not know what to do*” - Betty

Cumulatively and over time, these experiences appeared to make some participants feel hopeless and helpless. Some participants withdrew on varying levels from the child. For example, some participants felt unable to be close to the child or to spend time with the child. In combination and over time, these processes appeared to contribute to participant’s experience of blocked care.

**Theme 2: ‘Something took over me’**

Participants described occasions where their emotions or past experiences took over. This made it difficult for participants to provide the care that the child needed in these moments. Participants appeared to find it particularly challenging to identify and provide the care that the child needed when the child displayed behaviour that was interpreted as difficult, concerning or challenging.

**Subtheme A. ‘The emotion took over’**

Some participants appeared to react to the child’s behaviour based on their high emotions (such as sadness and anger) regarding the child’s behaviour rather than what the child needed in those moments.

*“I find it quite frustrating because I know what's best for her I know her…originally I'm thinking It was winding me up so I'm, you know, I'm not gonna give her that care because I'm so frustrated about it...”* - Eva

**Subtheme B. “They reminded me of…”**

Some participants identified that the child’s behaviour reminded them of their experiences of domestic violence. When the child behaved in certain ways or when the relationship that they had with the child reminded them of their past experiences they appeared to feel as though they were taken back to the time of their previous experiences. Their emotional responses to the child’s behaviour appeared heightened during these times. This appeared to make it difficult to provide the care that the child may have needed in these moments.

*“He reminded me of [previous partner]… he was very physical, very violent… it was just the way that mannerism.”* – Betty

*“…it would. Umm straight away, heighten me… I and almost just feel that overwhelming like, oh my, I'm like the fight and flight?”* - Charlotte

Over time, the experience of previous experiences being repeatedly brought up by the child’s behaviour or interactions with the child appeared to contribute to blocked care and withdrawal from the child. This appeared to make it difficult for participants to develop or maintain an emotional connection with the child, to spend time with the child and to provide or receive physical affection. On reflection, participants identified that they withdrew to protect themselves and the child and that withdrawing may not have been the care that the child needed.

*“I just didn’t want to be with him…so if I could send him to… all day that's what I was gonna do but again, that's that rejection for him”* - Charlotte

**Theme 3: ‘Neglected and “left to get on with it”’**

Participants discussed feeling dismissed; invalidated and unheard when they shared concerns with social care and other professionals about the child or placement. Participants also appeared to feel that their needs and the needs of the child were not met by services. This meant that appropriate support was not in place, which lead to participants relying on their own resources for prolonged periods. Over time, this meant that participants’ could not provide the qualities of caregiving that the child needed, which contributed to blocked care. Eventually, some participants withdrew from social care and the child.

*“Every time you try and seek some support or you know something for the child from the services that you don't get each time that's just that knocks you down that little bit more then a little bit more… to the point where it's like I can't do it I can't provide the care that I need to provide...”* – Charlotte

**Theme 4: ‘Having a break’**

Participants identified that self-care in the form of ‘having a break’ served a protective function against blocked care by enabling them to look after and care for themselves, recover from the demands of their role and rejuvenate so that they could remain engaged in the relationship with the child. Participants discussed the importance of respite care for facilitating a break, most participants noted that it was difficult to access respite care.

*“He's been on [respite] and I explained to him that sometimes…I I need to recharge my batteries”* – Ava

**Theme 5: ‘Now I get it’**

Participants identified that their understanding of the child, their presentation and their needs developed over time through support, experience and reflection. This level of understanding helped participants to identify and provide the care that the child needed.

*“When they first came...I probably reacted in the way I shouldn't have…now I know that's not the best thing to do is to just stop it and come back to it.”-* Eva

*“more situations you're in the more you look back and think ah well that work then, but that didn't work... so you've got, like, more things to draw on”* - Daisy

**What are the implications of these findings?**

* Foster carer’s previous experiences should be more thoroughly considered in the placement matching process.
* Foster carers should be provided with the opportunity to further understand the potential influence of their previous experiences and should be provided with the opportunity to process these experiences. This could include therapy provision, consultation, reflective practice and peer support groups. It would be helpful if this was provided by psychological professionals rather than social workers as foster carers are often evaluated by these professionals and this could prevent them from sharing information due to fear of the impact of disclosing.
* Additional support may be helpful early on in placement and early on in foster carer’s careers; this could help foster carers to develop a further understanding of the child and their relationship with the child. This support could include further supervision or training regarding trauma informed care, therapeutic parenting and a space to reflect on their experience of caring for the child.
* ‘Having a break’ should be available and accessible to foster carers in order to promote self-care.

**Main strengths and limitations of the research**

**+** This is the first study to explore foster carers lived experience of blocked care.

* There was a small number of participants, who were all female and all attended the same specialist LAC service. This study only describes this sample’s experience of blocked care.

**Key implications for future research**

* Research is needed with larger and more diverse samples
* Research is needed to understand foster children’s experience of blocked care
* Research is needed to understand how foster carers understanding of the child and their relationship with the child developed over time

**Distribution of the research**

* This research will be shared with the research participants
* The academic research supervisor
* The clinical research supervisor
* The clinicians in the specialist LAC service in which the research took place
* The head of research and development at the service in which the research took place
* It will be submitted to a peer reviewed scientific journal
* It will be submitted as part of the researchers Professional Doctorate in Clinical Psychology thesis
* It may be presented in scientific forums (conferences, seminars, workshops)
* It could be used for teaching purposes

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