Understanding Looked After Children’s Experience with Peers: An Exploration of Young People’s Social Understanding of Children in Care

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Empirical Paper Abstract

Despite studies identifying the challenges looked after children (LAC\textsuperscript{1}) may experience in their peer relationships, there has been no research addressing school-aged children’s understandings of LAC. The current research aimed to increase our knowledge of children’s social understanding of LAC, and to recognise how this understanding informs children’s behaviour towards LAC. Forty participants, aged between eleven and twelve years of age, took part in focus groups exploring these two questions. The resulting data was analysed using the qualitative methodology of Inductive Thematic Analysis. The results identified one overarching superordinate theme, ‘looked after children are different’, reflecting participants’ overall understanding that LAC are different to themselves and that LAC are treated differently by their peers. This superordinate theme had two main sub-themes ‘why LAC are different’ and ‘LAC should be treated the same but...’. Participants’ understanding of why LAC are different fell into three further sub-themes; ‘there is something wrong with LAC’; ‘LAC have problematic behaviour’ and; ‘LAC have a hard, sad life’. These understandings seemed to inform how participants would treat LAC, as well as, how they thought others would treat them. The sub-theme ‘LAC should be treated the same but...’ demonstrated participants’ views that LAC should be treated the same, despite participants describing the ways in which they, and others, would treat them differently. This sub-theme was separated into three further sub-themes; ‘LAC need extra care, love and attention’; ‘walking on eggshells with LAC’ and; ‘LAC are treated badly by other children’. These results are discussed in detail, and in relation to current research around LAC children’s peer relationships.

\textsuperscript{1} As the empirical paper focuses on children in formal care only (e.g. residential care or foster care), whereas the literature review focuses on children in formal care as well as those living with kin, different terms will be used in each paper. The literature review will use the term children in care (CIC). This will encompass those living with kin, as well as those living in more formal care. The empirical paper will use the term looked after children (LAC) and will refer to children living in formal care only.
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Part 1: Research - MRP Empirical Paper

Abstract

Despite studies identifying the challenges looked after children (LAC) may experience in their peer relationships, there has been no research addressing school-aged children’s understandings of LAC. The current research aimed to increase our knowledge of children’s social understanding of LAC, and to recognise how this understanding informs children’s behaviour towards LAC. Forty participants, aged between eleven and twelve years of age, took part in focus groups exploring these two questions. The resulting data was analysed using the qualitative methodology of Inductive Thematic Analysis. The results identified one overarching superordinate theme, ‘looked after children are different’, reflecting participants’ overall understanding that LAC are different to themselves and that LAC are treated differently by their peers. This superordinate theme had two main sub-themes ‘why LAC are different’ and ‘LAC should be treated the same but...’. Participants’ understanding of why LAC are different fell into three further sub-themes; ‘there is something wrong with LAC’; ‘LAC have problematic behaviour’ and; ‘LAC have a hard, sad life’. These understandings seemed to inform how participants would treat LAC, as well as, how they thought others would treat them. The sub-theme ‘LAC should be treated the same but...’ demonstrated participants’ views that LAC should be treated the same, despite participants describing the ways in which they, and others, would treat them differently. This sub-theme was separated into three further sub-themes; ‘LAC need extra care, love and attention’; ‘walking on eggshells with LAC’ and; ‘LAC are treated badly by other children’. These results are discussed in detail, and in relation to current research around LAC children’s peer relationships.
Introduction

A looked after child (LAC) is a child who is looked after by their local authority (LA) and is living with foster parents, in a residential care home, or in another residential setting (NSPCC, 2018). They may have been placed in care voluntarily by their parents, or social services (SS) may have placed them in LA care, due to a significant risk of harm in their current living situation. Some definitions of LAC also include children living with their parents under the supervision of SS (NSPCC, 2018) or those in kinship care (when a family member or friend looks after a child who cannot be cared for by their birth parents, GOV.UK, 2018).

Several studies have discussed the importance of peer relationships for LAC (Hass & Graydon, 2009; Singer et al., 2013; Sugden, 2013). The reported potential benefits include; a sense of belonging (Ridge & Miller, 2000; Messing, 2006; Emond, 2014); positive self-image and identity (Burgess et al., 2010; Hedin et al., 2011; Madigan et al., 2013; Emond, 2014); increased self-confidence, (Bulleri, 2004; Farineau et al., 2013); school success (Hedin et al., 2011; Emond, 2014); protection from peers (Ridge & Miller, 2000; Emond, 2014); and social support (Ridge & Miller, 2000; Blower et al., 2004; Messing, 2006; Aldgate 2009; Burgess et al., 2010; Hedin et al., 2011; Madigan et al., 2013; Emond, 2014). However, research has also demonstrated the potential stigma and discrimination LAC experience in their peer interactions (Kools, 1997; 1999; Ridge & Miller, 2000; Messing, 2006; Aldgate, 2009; Hedin et al., 2011; Farmer et al., 2012; Luke & Banerjee, 2012; Madigan et al., 2013; McMahon & Curtin, 2013; Emond, 2014; Benbenishty et al., 2017). Given the importance of peer relationships for LAC, there is a need to understand more about what leads to these stigmatising interactions.

Several theories could help to understand the peer experiences of LAC. For example, attachment theory (Bowlby, 1969) would help to understand the impact LAC’s early
experiences have on their peer relationships, and developmental theories, such as Piaget’s developmental stages (1965), could help to understand children’s ability to make and maintain friendships. However, as the current research focusses on the views of children that are not looked after, and is interested in the social processes that may underpin the stigma LAC experience, a theory with a focus on how peoples’ understandings and behaviours can be informed by their social world was selected. Social Representations Theory (Moscovici, 1984) has been used to help understand stigma (Campbell et al., 2010). Social representations are a collective elaboration of a social object, by the community, for the purpose of behaving and communicating. These representations change over time and context, and are constantly re-negotiated between people, groups and institutions through every-day communication (Moscovici, 1963). However, it was decided that Social Identity Theory (SIT, Tajfel & Turner, 1986) would be most useful due to its focus on the impact of in-group and out-group membership (Turner et al., 1987). SIT appears a useful way of understanding the stigmatising interactions LAC experience with their peers. Stigma is thought to occur when a person’s social identity departs from the norm, causing others to feel discomfort (Goffman, 1963). Dovidio et al. (2000) suggest stigma has two components; the identification of difference, and the devaluation of one’s social identity by others. SIT suggests our social identity (how we define ourselves in terms of the dominant attributions of our in-group) impacts our group, and intergroup, behaviour (Tajfel & Turner, 1986). According to SIT, people represent social groups using prototypes (a set of “fuzzy” characteristics that all members of a social group have in common). These prototypes capture both in-group similarities, and out-group differences (Tajfel & Turner, 1986). They maximise the chance of a group being recognised as a distinct entity, with clearly defined attributes and boundaries, and result in people being placed in social categories (Tajfel & Turner, 1986). Therefore, according to SIT, LAC may be considered the out-group by their peers, and may be defined in terms of their differences,
rather than their similarities. In line with this, research seeking the views of LAC suggests LAC’s peers view them as “different” and believe their social identity departs from the “norm” (Kools, 1997; 1999; Messing, 2006; Aldgate, 2009; Hedin et al., 2011; Farmer et al., 2012; Madigan et al., 2013; Emond, 2014), a view that likely marks LAC as the out-group (Tajfel & Turner, 1986).

Turner et al. (1987) describe the process of depersonalisation that occurs as the result of the social categorisations described in SIT. Depersonalisation occurs when people view others, and themselves, in terms of their relevant group prototype, rather than as unique individuals, because their understanding is based on group membership, rather than personal attributes. The process of depersonalisation explains why we tend to see out-group members stereotypically (with fixed, overly simplified beliefs, Oakes et al., 1994), why we conform to in-group norms relating to feelings, attitudes and behaviours, and why we accentuate in-group similarities, and intergroup differences, in intergroup contexts. This process, named self-categorization theory (SCT), is the cognitive component of SIT (Turner et al., 1987).

Therefore, SIT suggests the peers of LAC will develop a collective understanding of LAC based on stereotypical views. In line with this, LAC have reported that their peers hold assumptions about them. For example, assumptions about their birth parents (Emond, 2014), their living situation and background (Kools, 1997; 1999; Messing, 2006; Aldgate, 2009; Hedin et al., 2011; Farmer et al., 2012; Madigan et al., 2013; Emond, 2014), their “in-care” status (Kools, 1997; Emond, 2014), their behaviour (Kools, 1997; Emond, 2014), and their emotional well-being (Kools, 1997; 1999), have all been identified. More specifically, peers have been reported to hold the view that LAC have a difficult life (Madigan et al., 2013), and are “delinquent” and “psychologically impaired” (Kools, 1997). This suggests LAC likely experience the first component of stigma, the recognition of difference (Goffman, 1963; Dovidio et al., 2000), as a result of being identified as an out-group. It appears that LAC are
viewed stereotypically, in terms of their group prototype, rather than individual attributes. However, as research has only sought the opinions of LAC (Kools, 1997; 1999; Messing, 2006; Aldgate, 2009; Hedin et al., 2011; Farmer et al., 2012; Madigan et al., 2013; Emond, 2014), rather than the opinions of those not in care, it is unclear what children’s social understandings of LAC are, and whether children do hold stereotypical views of LAC. Furthermore, from the current research it is unclear if children find LAC’s difference “uncomfortable” as would be predicted by stigma theory (Goffman, 1963).

SIT suggests that, as the groups we belong to define who we are, similarity between the in-group and out-group is perceived as threatening (Tajfel & Turner, 1986). As a result, our behaviour is informed by an attempt to seek positive distinctiveness for our in-group, relative to other out-groups (Tajfel & Turner, 1986). Lower-status groups try to improve their social identity by engaging in direct social competition or attempting to re-define in-group properties (looking to develop different, more positive characteristics), whereas higher-status groups seek to maintain their superior position (Tajfel & Turner, 1986). The process of trying to maintain group distinctiveness may also explain the occurrence of stigma by association. Stigma by association is a process by which an individual can be stigmatised themselves, if they are associated with a stigmatised individual (Goffman, 1963). SIT suggests that a member of the in-group being associated with a member of the out-group, may reduce group distinctiveness (Tajfel & Turner, 1986), which could explain why the in-group member is then defined in-terms of out-group properties, and stigmatised themselves as a result.

Research suggests that the stereotypical views children hold of LAC informs their behaviour towards LAC (Kools, 1997; 1999). Studies report how peers hold LAC’s “in-care” status against them (Madigan et al., 2013), question them intrusively about their living situation, family and past experiences (Kools, 1997; 1999) and isolate them socially (Kools, 1997; 1999; Ridge & Miller, 2000; Madigan et al., 2013). Research also suggests peers may
feel bad for LAC, resulting in over-protective and cautious behaviour towards them (Madigan et al., 2013). According to SIT, this behaviour may serve to maintain the superior position the peers of LAC hold (Tajfel & Turner, 1986), and may explain why LAC experience a devaluation of their identity (Kools, 1997; 1999), the second component of stigma (Dovidio et al., 2000). However, as studies have not explored the views of children that are not in care, it is unclear how children’s social understandings of LAC inform the development of their interpersonal communication towards LAC. The current reliance on LAC’s self-report on our understanding of the peer experiences of LAC, poses challenges. Research suggests that some LAC may hold a hostile attribution bias (a tendency to interpret the intent of others’ behaviour as hostile, Kay & Green, 2016). This attribution bias has the potential to shape the way LAC view peer relationships and may have impacted current research findings.

LAC also appear to experience self-stigmatisation. Self-stigmatisation is a process that occurs when a person becomes aware of the devaluation connected to their social identity (Bos et al., 2013). The stigmatising interactions LAC experience appear to impact their sense of self and result in an internalised stigmatised self-view (Kools, 1997; 1999; Edmond, 2014). LAC seem to be aware they are considered “weird” (Madigan et al., 2013) and recognise the weakened social identity associated with being in care (Ridge & Miller, 2000; Aldgate, 2009; Madigan et al., 2013; Emond, 2014). In terms of SIT, this self-stigma could be explained by LAC defining themselves in terms of their dominant in-group attributes and, identifying intergroup differences between themselves and their peers (Tajfel & Turner, 1986).

In turn, stigma, and self-stigma, appear to affect how LAC behave with peers. LAC are reported to keep peers at a distance and use aggressive behaviour to guard themselves from difficult peer experiences (Kools, 1997; 1999; Madigan et al., 2003; Aldgate, 2009; Emond, 2014). LAC often choose not to tell their peers they are looked after, or why they are
looked after (Kools, 1997; 1999; Messing, 2006; Aldgate, 2009; Burgess et al., 2010; Farmer et al., 2012; Madigan et al., 2013; Emond, 2014), perhaps due to concerns about being labelled the “in-care” child (Madigan et al., 2013). In terms of SIT this behaviour may reflect LAC’s attempt to improve their social identity. By hiding their “in-care” status, and guarding themselves from difficult peer experiences, LAC may be looking to develop different, more positive, characteristics associated with their identity (Tajfel & Turner, 1986). However, the behaviours LAC engage in can have adverse consequences, making it more difficult for them to maintain relationships, and can isolate them further (Kools, 1997; 1999; Emond, 2014). For example, hiding ones “in care” status can result in one-directional information sharing, which can negatively impact LAC’s peer relationships (Emond, 2014). The stigma LAC experience likely impacts aspects of their well-being; resulting in reduced self-confidence (Hedin et al., 2011; Madigan et al., 2013), anxiety (Emond, 2014) and feelings of isolation (Kools, 1997; 1999; Hedin et al., 2011), as would be predicted by other research focusing on stigmatised individuals (Meyer, 2003).

According to SIT, a group's desire to be distinctive means prototypes, and their resulting stereotypes, become more salient in intergroup communication (Turner et al., 1987). Therefore, stereotypes are flexible, dependent on the social context (Oakes et al., 1994) and are the product of communication between people (Wigboldus et al., 1999). However, current research appears to pay little attention to the theoretical underpinnings of the stigmatising interactions LAC experience (Messing, 2006; Aldgate, 2009; Burgess et al., 2010; Emond, 2014) and often focuses on the identity formation of LAC from a more individualistic perspective (Kools, 1997; 1999; Madigan et al., 2013). As stigma is considered to exist in the social context, within social interactions rather than within individuals (Hebl & Dovidio, 2005), and negative assumptions and stereotypes of LAC are thought to be communicated by peers through everyday communication (Kools, 1997; 1999),
the development of stereotypes, as explained by SIT, helps us to understand the stigma LAC experience in their peer relationships. The flexible element of stereotypes (Oakes et al., 1994) also highlights their potential for modification. This is relevant to research around stigma, as it suggests the potential for stigmatising stereotypes to change, which has the potential to improve LAC’s peer relationships.

**Summary of rationale and present study aims**

LAC’s experiences of stigmatising peer interactions appear widespread (Kools, 1997; 1999; Farmer et al., 2012; Madigan et al., 2013). Given the many benefits of peer relationship for LAC (Kools, 1997; 1999; Ridge & Miller, 2000; Aldgate, 2009; Burgess et al., 2010; Hedin et al., 2011; Madigan et al., 2013; Emond, 2014) and the adverse effects of stigmatising interactions (Kools, 1997; 1999; Hedin et al., 2011; Madigan et al., 2013; Emond, 2014), it is important to understand more about children’s social understandings of LAC. Given that the views of children who are not in care have been missed from current research, it is important to explore the understandings, assumptions and feelings that children have about LAC, to understand how these understandings and assumptions may impact their behaviour towards LAC, and to ascertain whether peers find LAC’s difference “uncomfortable” as would be predicted by stigma theory (Goffman, 1963). This may increase our understanding of what leads to supportive or stigmatising interactions with LAC and, therefore, may improve our understanding of how stigmatisation towards this group may be reduced. The present qualitative study therefore aimed to answer two questions:

1. What are young people’s social understandings of LAC?
2. How do these understandings inform young people’s interactions and what they say about their behaviour towards LAC?
Method

Design

The study employed a qualitative design, using semi-structured interviews in focus groups. It was thought focus groups may be a particularly useful way of exploring children’s social understandings of LAC, as interaction, and the social context, are important for creating and communicating stereotypes (Oakes et al., 1994; Wigboldus et al., 1999). Furthermore, focus groups allow us to explore how a phenomenon is articulated, censored, opposed and changed through social interactions and to understand how this relates to group norms (Kitzinger, 2005). They allow the study of different communication forms, such as joking and metaphors, which can help capture information that may be missed in direct questioning (Kitzinger, 2005). Data was analysed using the qualitative methodology of Inductive Thematic Analysis (Braun & Clarke, 2006).

Theoretical Underpinning:

Social constructionism (Burr, 2003) informed the study’s design, in keeping with the researcher’s epistemological position. Social constructionism sees knowledge as socially constructed, that is, created through interactions, and communication, between people. The theory assumes that although an individual’s knowledge is often presumed to be the “truth”, it does not represent reality, as all individuals have different knowledge and experiences that have shaped their understanding. The focus group design allowed the researcher to observe how participants’ social understanding of LAC developed through conversations, and to explore what ideas and assumptions impacted participants’ views.

Participants:

Recruitment strategy: fifteen mainstream schools, from the researcher’s professional and personal network, were contacted via email or telephone. Meetings to discuss the project further were arranged with three interested schools. Two schools agreed to assist with
recruitment. A member of staff within each school was identified to invite pupils who met the inclusion criteria to take part.

*Inclusion criteria:*

- Children aged between eleven and fourteen years of age
- Children not currently classified as a LAC
- Children able to understand and converse in English
- Children attending mainstream school

School staff invited 97 pupils (37 from School One, 60 from School Two), who met the inclusion criteria, to take part. Children were selected randomly from school registers (School One) or were invited as a form group (School Two). Children were given information about the study verbally and in written form. Information about the study was also sent to the identified children’s parents. Due to the low risk nature of this study, parental consent was not required, however parents were given the opportunity to opt out on their child’s behalf. This procedure is in keeping with guidance from the British Psychological Society, (2014). Five parents chose to opt out. Of the remaining 87 pupils, 44 pupils chose to take part. Four pupils did not attend the focus groups, resulting in a final sample of 40 participants (24 from School One, sixteen from School Two).

*Participant information*

The final sample consisted of participants aged between eleven to twelve years of age (eighteen females and 22 males), in their first year of secondary school (Year 7). This age group were targeted as the experience of transitioning to secondary school can have lasting effects on children, both academically and socially (Fenzel, 2000). It is also a time when young people become more dependent on their peers (Madge, 2000). All participants were recruited from the two-identified mainstream state secondary schools (non-fee paying schools funded and controlled by the state). Both schools were situated in the South-East of England.
Most participants were white British reflecting the demographic make-up of this area. According to the most recent Ofsted2 report, the proportion of children in School One eligible for pupil premium (additional government funding for students entitled to free school meals, those in care and those with a parent serving in the armed forces) was above the national average and over 80% of students were of white British heritage. The most recent Ofsted3 report for School Two reported the proportion of children eligible for pupil premium was below the national average. Most students were of white British heritage (no percentage was provided).

**Procedure:**

Pupils were invited to participate in March 2017 (School One) and May 2017 (School Two). Information sheets (Appendix B) and consent forms (Appendix C) were given to pupils when they were invited verbally. Information sheets, detailing the procedure for opting out, were also sent to parents via email (Appendix D). Pupils were invited to return the consent form to the identified member of staff, should they wish to participate. Both pupils and parents were also invited to contact the identified member of staff, or the researcher, if they had further questions. To preserve anonymity, pupils’ names were not shared with the researcher until consent was given.

Focus groups took part in March and April 2017 (School One) and June 2017 (School Two). Five focus groups were facilitated within school one, three were facilitated within school two. Each focus group was facilitated by the same researcher in a quiet room at the school. A co-facilitator was also in attendance to take notes. This role was shared between two research assistants. The groups consisted of between three and six participants. Groups of four to six have been found large enough to facilitate group discussion but small enough that

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2 Reference removed to avoid identification of recruited schools
3 Reference removed to avoid identification of recruited schools
children do not feel intimidated (Bloor et al., 2001). This size also reduces the possibility of children moving off task and talking over one another (Heary & Hennessy, 2002). Groups were homogenous in age, to encourage communication (Bloor et al., 2001).

At the beginning of each focus group the study was explained. It was made clear that participation was completely voluntary. Confidentiality and anonymity were discussed, and participants were given the opportunity to ask any questions they had. Participants were then invited to introduce themselves through an “icebreaker” task, to increase participants’ engagement in a group setting (Carrell, 1993). Participants were asked to throw a ball between one another and to say their name, and the first word that came to mind when they caught the ball. At this point it was made clear that there were no right or wrong answers or opinions.

Next, participants were asked to convey their understanding of a LAC, with conversation around this being encouraged. LAC living in a formal care setting (rather than those living in kinship care, or with their parents under the supervision of social services), were the focus of the study, as children in formal care may experience more stigma (Messing, 2006; Burgess et al., 2010). The researcher ensured participants were clear what a LAC was, before moving on.

Bagnoli & Clark (2010) emphasise the importance of using activities to facilitate conversation when carrying out research with children. A group task was used to facilitate conversation around LAC. The task, adapted from Carrell (1993), involved participants taking turns to select an unfinished sentence (see appendix E), out of a box in the centre of the group. Participants were asked to read the sentence aloud and to complete it. These sentences were developed based on the study’s questions and the literature around LAC’s peer experiences. For example, sentences around LAC’s biological parents (Emond, 2014), their behaviour (Kools, 1997; Emond, 2014), and their emotional well-being (Kools, 1997;
1899) were used. Sentences also addressed how LAC are treated at school, due to reports of intrusive questioning (Kools, 1997), bullying and ridicule (Kools, 1997; 1999; Hedin et al., 2011) towards LAC.

The researcher used summaries to facilitate further conversation, to allow participants to build on one another’s response and to encourage discussion around thoughts, feelings, intentions and behaviours towards LAC. Discussion around why LAC may be considered different was encouraged, as a sense of difference was identified by LAC in several studies (Ridge & Millar, 2000; Brewin, 2011; McMurray et al., 2011; Emond, 2014). Furthermore, the study explored how participants’ reported behaviour towards LAC may be impacted by opinions of them. Examples of follow-up questions can be found in Appendix F. The context of each focus group informed the use of follow-up questions, allowing the researcher to freely respond to participants.

To avoid the potential of inadvertently creating stigma within the recruited participants, for example through creating more of a focus on difference for LAC, at the end of the focus group, participants were encouraged to discuss how LAC may be similar to themselves (see Appendix F). They were also given the opportunity to ask questions about what was discussed during the focus group. Each focus group lasted around an hour. They were recorded using a digital recorder and the co-facilitator took verbatim notes, to aid later transcription.

The study was given favourable ethical opinion by the University of Surrey Faculty of Health and Medical Sciences Ethics Committee (Appendix G). See Appendix H for ethical considerations addressed during planning of the study.

Analytical strategy:

All focus groups were transcribed by a research assistant. A verbatim account was taken, to allow the researcher to explore more subtle cues in participants’ language, such as
pauses. Inductive thematic analysis (TA) was used to analysis the data (Braun & Clarke, 2006). TA was chosen as it allows themes to be identified across participants, and the entire data set (Braun & Clarke, 2006), a useful approach when each focus group has several participants. This approach is the most common method used for analysing focus group data (Wiggins, 2004) and involves identifying common themes emerging from the interplay between participants (Massey, 2011). An inductive approach to TA was taken, as possible themes could not be predicted prior to data collection (see Appendix I for a detailed description of the TA approach, Appendix J for coded extracts and a worked example, Appendix K for an example of an early thematic map. Appendix L provides examples of data extracts supporting each theme).

**Credibility:**

Quality was considered throughout the research process (Willig, 2006). Although a single researcher carried out the main analysis, credibility was supported through discussions in supervision. Attention was given to the process of line by line coding, identifying areas of interest and developing themes, all of which were checked against the data by the research supervisors. Findings were also discussed with colleagues completing similar research in the area. The researcher engaged with the data repeatedly to allow different understandings to emerge.

In addition, it was important for the researcher to reflect on how their own understanding, and prior experiences, impacted the research (Yardley, 2000). The researcher kept a reflective log to aid this process (Appendix M, for an example). This log, alongside discussions in supervision, allowed the researcher to engage in reflexive practice, and to seek alternative perspectives of the phenomenon under investigation. For example, the researcher’s prior experience of working therapeutically with LAC lead to an assumption that participants would hold negative views of LAC. Acknowledging this assumption allowed the
researcher to pay equal attention to both positive and negative opinions of LAC, during data collection and analysis. Further reflections on the role the researchers own position may have played, are included in a reflexive statement (Appendix N).

**Results**

The inductive thematic analysis identified one overarching superordinate theme; ‘LAC are different’. This theme reflected participants’ overall understanding that LAC are different to themselves and that they are treated differently by their peers. This superordinate theme had two main sub-themes ‘why LAC are different’ and ‘LAC should be treated the same but...’.

![Legend:](image)

**Figure 1:** Final thematic map of superordinate and subordinate themes

Participants’ understanding of why LAC are different fell into three further sub-themes. The sub-theme ‘there is something wrong with LAC’ reflected participants’ views that LAC may have been damaged by their past experiences, may have psychological disorders, or may have cognitive difficulties. The sub-theme ‘LAC have problematic behaviour’ reflected participants’ sense that LAC would likely be badly behaved, manipulative and socially withdrawn. The sub-theme ‘LAC have a hard, sad life’ demonstrates participants’ views that LAC’s past and current living situation would be
difficult. Participants assumed LAC likely lacked care, support and attention, and would have less material goods.

Participants’ understanding of LAC as different appeared to inform how they would treat LAC, as well as how they thought others would treat LAC. It is important to note that this study explored how children reported they would behave towards LAC, rather than how they behaved towards LAC in practice. Participants often reported they did not know a LAC and, therefore, were unable to draw on real life examples of how they had treated LAC previously. Participants’ reported behaviour towards LAC may not reflect how they would behave towards LAC outside of the research setting. The sub-theme ‘LAC should be treated the same but...’ reflected the idea that participants thought it was important to treat LAC the same but also discussed the ways in which they, and others, would treat LAC differently. This sub-theme was separated into three further sub-themes. Participants’ views that there is something wrong with LAC, that they have a hard, sad life and that they display problematic behaviour appeared to result in a concern about what to say and do with LAC (represented by the theme ‘walking on egg-shells with LAC’). Participants appeared to be worried about upsetting LAC and were concerned about how LAC may respond to their interactions.

Participants’ understanding that LAC have a hard, sad life, appeared to inform their view that ‘LAC need extra care, love and attention’. Participants described how they would want to provide LAC with extra support and care, as they believed LAC would not be receiving this elsewhere. In contrast, participants felt ‘LAC are treated badly by other children’. They felt LAC would be judged, bullied or avoided by peers and explained this negative treatment was likely the result of LAC being “an easy target” due to their perceived difference.

The identified themes are presented below, alongside data extracts that best illustrate each theme. Although participants built on each other’s ideas throughout the focus groups,
for brevity, data extracts do not include the interchange of dialogue between participants. Where material has been removed for brevity this symbol […] has been put in its place.

Figure 1 provides a thematic map of the identified themes.

**LAC are “different”**

This superordinate theme reflects how LAC were viewed as different by participants. Participants discussed how LAC are “different from like, normal children”. Although LAC were often described to be the same as other children and, when prompted, participants could think of similarities between themselves and LAC, this was frequently followed by a description of how LAC are different in many ways, “they’re exactly the same, they’re human, but they’ve just gone through different emotions”. This suggests a level of complexity and ambiguity in participants’ understanding of LAC. Participants were aware they shared similarities with LAC, but perceived differences appeared to be more salient during the focus groups.

LAC were sometimes referred to as “it” or “orphan”. This suggests LAC were objectified by participants, and highlights the sense of ‘otherness’ they felt towards LAC, “they can’t really look after it, and it’s like, put into like a home where like people look after it”. Participants also described how peers may be curious of LAC, reflecting their interest in the ‘other’, “they might want to, […] find out what’s really happening to them, cos they might not have any idea or experience of it”.

**Why LAC are different**

**There is something wrong with LAC:** One idea that seemed to inform participants’ views that LAC are different, was the idea that there may be something wrong with them. This related to psychological and cognitive difficulties, as well as LAC’s emotional well-being. For example, participants explained how LAC may have neuropsychological difficulties, “their child could have ADHD and they […] the LAC can’t control it properly”
or may not be as cognitively able, “a bit stupid [...] kind of weak in the head”. Some participants showed a complex understanding of why LAC may have these difficulties, describing how they were likely the result of environmental factors. For example, participants described how LAC may have been emotionally damaged by their past experiences, “they might have been like abused at home [...] damaged in a way, like emotionally”.

**LAC have problematic behaviour:** Participants thought it was likely LAC would display problematic behaviour, another view that seemed to mark them out as different. There was a sense that LAC may be more badly behaved, manipulative, reactive and sensitive to others’ comments. Participants had many ideas around why LAC may display these behaviours. For example, they felt LAC may behave badly to strengthen their position in peer relationships, “they might start swearing and try to be a bigger person”, to communicate how difficult their life is, “to prove a point that their life’s really hard” or to gain attention, “they might not get attention at home [...] they might want attention at school and that [...bad behaviour] was the easiest way to get it”.

Participants suggested LAC may be manipulative, “sneaky and stuff, like they might pretend to be like [...] disabled and stuff, but in reality they are fully aware of what they are doing, [...] so they could just ask for loads of things”. There was a sense that LAC may ‘use’ their peers, although participants appeared to find this hard to articulate “they, they, they are using you [...] they’re not like your friend, but then they like ask for your stuff,”. This suggests a sense of mistrust around LAC that participants were uncomfortable talking about. Participants also explained how LAC may be more sensitive and reactive to negative behaviour from peers, “say someone, like, was trying to wind them up, they would react to it, bigger”. One participant explained, “like a short temper [...] they get really angry, and like the worst thing would happen”.


LAC were often assumed to be more withdrawn and to have difficulty making friends, “they might want to sit on their own a lot […] it might be hard for them to make friends”. Participants felt LAC may be unwilling, or unable, to talk about the difficulties they may have experienced, or be experiencing, “they […] don’t really open up to people as much, cos they've never really had a parent to open up too”.

As the above quote suggests, there was a sense from participants that LAC’s problematic behaviours were likely to be the result of their past experiences. This mirrored participants’ views that LAC past experiences may have resulted in there being something wrong with them. Participants explained LAC may not have learnt appropriate behaviour from their parents, “if their parents hadn't treated them properly […] they might have different ideas on what, how to react in situations”. They described how LAC may not be nice to others as they have not had the experience of others being nice to them, “they don’t have any kindness to give, cos they weren’t given any in the first place”. LAC were also assumed to be more aggressive due to previous mistreatment, “if their parents were erm, not treating them well […] cos if they've been brought up that way then they don’t know any different”.

Regarding LAC struggling to make friends, participants described how LAC may have difficulty trusting others, due to previous bad experiences, “they might like, be afraid they’re gonna get hurt by someone, if they had a bad experience with their parents”. There was also a sense that LAC may be more autonomous, and may not want to talk about the past, which could impede their ability to make friends, “if you're looking after yourself a lot you'd be quite independent and rely only on yourself and if you've seen, seen quite shocking things then erm, you might be a bit more quiet and might not really want to tell people about it”. The sense that LAC may be more independent than their peers is interesting. It shows an
understanding that LAC’s previous experience may lead them to be more resourceful and self-reliant, a more positive view than other participants described.

**LAC have a hard, sad life:** LAC were assumed to have a hard, sad life, another view that marked them as different. Participants described the difficult past LAC likely experienced, and the challenges they may face in their current living situation, “they’ve probably had a hard time, [...] to be taken away from your parents isn’t a good thing [...] and it’s going to be hard for the adults to look after everyone [referring to a care home]”. Participants felt other children have a better life than LAC, “they might have parents and [...] more money than them”. They described feeling sorry for LAC because they appear isolated, “I would probably be sad because [...] there might be no one they can talk to”. Participants also assumed LAC lack care and attention, “they can’t exactly focus on one kid, and give all their attention to one kid, because they’re loads of them [referring to a care home]”, and may have less material goods than their peers, “some foster like parents [...] don’t really have like the money to just buy like, like iPhones for like every single child”. However, a lack of material goods was discussed less than a lack of care and attention. Participants assumed LAC may feel sad, due to their different circumstances, “they [LAC] feel sad, that they don’t have their parents with them”. They described how LAC may be jealous of their peers, “they like might wish that they had that life and [...] parents that could look after them”. Opinions around LAC’s ‘hard, sad life’ appeared, in part, to be informed by participants’ experiences of seeing LAC on television programmes. Participants explained how programmes can show care in a negative light, “make it as a negative thing, like they don’t enjoy being there [...] it’s like a prison” and suggest LAC’s life is bad, “life isn’t as good as it should be”.

Despite the dominant discussion around LAC’s ‘hard, sad life’, some participants recognised positive aspects of care, “they have like children to like play with”. Others
discussed how LAC’s situation may have improved since entering care, “they might enjoy life more, seeing as, if they’ve got like away from what’s going wrong”.

**LAC should be treated the same but…**

Participants often discussed how LAC should be treated the same as others, as treating them differently would have negative consequences, “[the LAC] would feel kind of different and maybe a bit isolated” and would make LAC stand out, “you don’t want to make them feel like they’re in a museum or something”. However, participants often described how they would give LAC extra care, love and attention. They reported concern around what to say and do with LAC (‘walking on eggshells’) and felt other children would treat LAC badly (these will be described further in the subthemes below).

Some participants showed a more sophisticated view around how to treat LAC, recognising the individual differences of LAC, “some children they might want people to talk about it to them, or want people to feel sorry for them, cos it makes them feel better about the situation they’re in, then some people might not, so I think it’s, you should treat them how they want to be treated”.

**LAC need extra care, love and attention:** The assumption that LAC had a ‘hard, sad life’, and the accompanying sense of feeling sorry for them, seemed to inform how participants reported they would treat LAC. Participants explained how they would be nicer to LAC, “a bit nicer [...] if they don’t have a good time at home, you might as well make the other times good”. They discussed how they may help LAC make friends and manage their emotions “maybe you need to help them at school [...] like emotionally and with friends”.

Despite demonstrating an awareness of the importance of treating LAC the same, participants often went on to describe this differential treatment, suggesting they were unsure what was best for LAC. For example, participants discussed the need to provide LAC with more care, “you should normally treat them the same as you, but [...] give them a teeny bit
more care cos they’ve gone through a bit more than normal” and love, “treat them normal but [...] they need to be like loved like maybe a bit more if they haven’t had that when they were little” due to their past experiences.

‘Walking on egg shells’ with LAC: Alongside the sense that LAC need extra care, love and attention, participants described a sense of ‘walking on eggshells’ with LAC. This appeared to be different to how participants would treat peers who were not LAC, and often followed a description of how LAC should be treated the same. Participants discussed the need to be careful with LAC, “you treat them exactly the same, but then always be cautious [...] what you say to them”. Participants described the fear that they may say the wrong thing to a LAC and make them uncomfortable, “I wouldn’t go too deeply into their like, their life, in case they didn’t feel comfortable” or may hurt them “you might just refrain from saying something that might accidentally hurt them”.

This sense of ‘walking on eggshells’ seemed to be informed by participants’ sense that LAC are different. Participants described how LAC’s difficult past experiences (their hard, sad life) may make interactions with them “awkward” and “intense”. They were worried they may make LAC’s situation worse, “cos like, if you try to help you might upset them by saying something wrong”. Participants’ assumptions that LAC may have ‘something wrong with them’, or may have ‘problematic behaviour’, also appeared to influence their concern about how to treat LAC, “if they like have an anger disorder or something I would probably just leave them alone, cause they might get angry”. Participants explained how they did not understand LAC’s experiences and this meant they did not know how to help them, “like a normal problem [...] you know how to comfort them, but [...] you've never been in that situation before, so like it’s harder, it’s so different to what you've been through”.

This sense of wariness also seemed to be present during the focus groups. Participants often appeared to feel uncomfortable talking about LAC, resulting in long pauses and
awkward dialogue. There was also a sense that participants were looking for the ‘right’ thing to say but often struggled to know what this was, with one saying, “it’s a hard subject to talk about”.

**LAC are treated badly by other children:** Participants described their views that LAC were likely to be treated differently by other children, describing how other children were likely to treat LAC badly. They reported LAC were likely to be judged, bullied or avoided by peers. Participants described how other children may use LAC’s background against them, “use what they’ve been through […] to bully them”. One participant gave the example of LAC being teased about their parents, “something like, […] your looked after because your parents work because they didn’t love you”. Participants felt that LAC would be treated as “equal” if they did not tell their peers they were in care, suggesting this negative differential treatment was assumed to be related to LAC’s difference, “if they keep quiet about their past and everything, there’s a chance […] they might not be picked on”.

When discussing why LAC are bullied, participants discussed how bullies may think that LAC are lower on the social hierarchy, “the bullies […] think they are on a higher scale than the orphans”. LAC were described as an “easy target” because they are more likely to respond to bullies, “people think that they can get, like, sad easily and they might try and make them sad”. However, in contradiction, some participants explained how LAC may be ‘hardened’ towards negative behaviour from peers, “they might, erm, be more like stronger against bad things happening, cos they’ve been through so much already”. There was also an idea that some peers would be jealous of LAC, due to the positive differential treatment they experience (for example, the increased attention described above), “it could make the bully feel better about themselves, if they make the person whose getting everything sad”.

Participants discussed how other children may want to avoid LAC, and their problematic behaviour, “cos you wouldn’t want to get into big dramas or arguments with them”. There
was a view that if a child was associated with a LAC, other children may make negative assumptions about them, “they might not want to be known as weird for talking to the other weird guy”.

In contrast to the differential treatment of providing extra care, love and attention, this negative differential treatment was rarely described from the ‘I’ position. Participants spoke about how likely it was that LAC would experience difficult peer encounters, but explained this would be from other children, rather than themselves. When discussing the increased chance of LAC being treated badly, participants again discussed how LAC should be treated the same. Participants explained how they may stand up for LAC, if they were being bullied, “I’d just like tell them to stop” and described how “you don’t really want to judge anyone […] cos you don’t actually know what they've been through”.

**Discussion**

**Summary of findings**

Despite the importance of peer relationships for LAC, there has been no research attempting to understand children’s social understandings of LAC. This study aimed to address this gap, using focus groups with school-aged children to explore; i) the social understandings of LAC, and ii), how these social understandings inform what they say about their behaviour towards LAC. With regards to the first research question, the current research gained good insight into the social understandings participants held of LAC. The second question was only partially answered. Participants often reported they did not know a LAC and, therefore, were unable to draw on real life examples of how they had treated LAC previously. This may reflect LAC’s choice to keep their “in-care” status a secret (as has been seen in research elsewhere, Kools, 1997; 1999; Messing, 2006; Aldgate, 2009; Burgess et al., 2010; Farmer et al., 2012; Madigan et al., 2013; Emond, 2014), as both recruited schools had LAC in attendance. Despite this, participants could talk hypothetically about how they, and others, would likely behave towards LAC. Participants articulated why they felt this
behaviour was probable but, due to the hypothetical nature of these discussions, it is unclear if the behaviours described accurately reflect what would happen if participants were to be in communication with a LAC. The findings of the current study will be summarised below and discussed in relation to current research and theory.

Although participants were aware of the similarities they may share with LAC, differences between themselves and LAC were discussed more regularly. A focus on difference may not be surprising, given that participants were asked about differences during the focus groups. However, discussions around difference were not confined to times when these had been prompted. According to SIT, a focus on difference could be expected in this situation (Tajfel & Turner, 1986). It is likely LAC were considered the out-group by participants in the focus group (in-group). According to the theory, similarities between LAC and participants would, therefore, be considered threatening and, as a result, participants would be expected to seek positive distinctiveness for themselves compared to LAC (Tajfel & Turner, 1986). Therefore, LAC being defined in terms of their difference, rather than their similarities, would be expected. The focus on difference is also in keeping with previous research. LAC regularly report how peers view them as “different” (Kools, 1997; 1999; Messing, 2006; Aldgate, 2009; Hedin et al., 2011; Farmer et al., 2012; Madigan et al., 2013; Emond, 2014).

Although prototypes, and the resulting stereotypes, become more salient in intergroup communication (Turner et al., 1987), it is possible that the introduction of LAC as a topic of conversation was enough to bring these stereotypes into focus. Just labelling someone as a member of a different group is usually enough to evoke discrimination (Turner et al., 1987). During the focus groups, participants appeared to develop a collective understanding of LAC, which was partly based on stereotypical views. In line with SIT (Turner, et al., 1987), viewing LAC in terms of their group prototype, rather than based on individual
characteristics, resulted in LAC being viewed as a distinct entity. LAC were described as “it” or “orphan”, highlighting the depersonalisation that resulted from this social categorisation (Turner et al., 1987). The stereotypical views described by participants in the current study have all been described by LAC (Kools, 1997; 1999; Messing, 2006; Aldgate, 2009; Hedin et al., 2011; Farmer et al., 2012; Madigan et al., 2013; Emond, 2014). LAC have described how peers hold assumptions around their living situation and background (e.g. LAC have a difficult life, Madigan et al., 2013), their behaviour (e.g. LAC are “delinquent”, Kools, 1997) and their emotional well-being (e.g. LAC are “psychologically impaired”, Kools, 1997). The identified themes suggest participants considered LAC’s social identity to depart from the norm and to be devalued compared to their own, in line with stigma theory (Goffman, 1963; Dovidio et al., 2000). The assumptions participants held marked LAC as “different” and ‘disadvantaged’, suggesting these stigmatising views enabled participants to achieve positive distinctiveness (Tajfel & Turner, 1986) compared to LAC.

It is interesting that participants’ descriptions of how they would treat LAC (cautious and careful), were informed by their assumptions of the problematic behaviour LAC would display. Research with LAC describes how LAC may isolate themselves, and use aggressive behaviour, to guard against difficult peer interactions (Kools, 1997; 1999; Madigan et al., 2003; Aldgate, 2009; Emond, 2014). This suggests that the negative behaviour some peers display towards LAC may impact LAC’s behaviour with peers, which, in turn, impacts peers’ behaviour towards LAC, creating a reciprocal interaction. Participants also felt LAC may want to strengthen their social status through their behaviour. Although other explanations for LAC’s behaviour were given (communicating how difficult their life was, or to gain attention), this is interesting as SIT would predict that lower-status groups strive to improve their social identity by re-defining their group attributes and engaging in direct social competition (Tajfel & Turner, 1986).
As SIT would predict (Tajfel & Turner, 1986), the stereotypes participants held of LAC appeared to impact the behaviour they reported they would demonstrate towards LAC. Participants talked about treating LAC differently, despite acknowledging the need to treat them the same. Differential treatment has been described in research examining the peer experiences of LAC (Kools, 1997; 1999; Ridge & Miller, 2000; Messing, 2006; Aldgate, 2009; Hedin et al., 2011; Farmer et al., 2012; Luke & Banerjee, 2012; Madigan et al., 2013; McMahon & Curtin, 2013; Emond, 2014; Benbenishty et al., 2017). Participants described the need to give LAC extra care, love and attention, due to assumptions of LAC’s hard, sad life. This highlights the possible social support LAC can receive from their peers, as mentioned elsewhere in the literature (Ridge & Miller, 2000; Blower et al., 2004; Aldgate 2009; Burgess et al., 2010; Hedin et al., 2011; Madigan et al., 2013; Emond, 2014).

However, despite this differential treatment being positive, it still has the potential to make LAC stand out and feel different (Madigan et al., 2013), suggesting this positive behaviour still facilitates positive distinctiveness between LAC and their peers (Tajfel & Turner, 1986).

Although participants in the current research reported that they would show LAC extra care, research with LAC more regularly describes how LAC receive negative differential treatment from their peers (Kools, 1997; 1999; Ridge & Miller, 2000; Messing, 2006; Aldgate, 2009; Hedin et al., 2011; Farmer et al., 2012; Luke & Banerjee, 2012; Madigan et al., 2013; McMahon & Curtin, 2013; Emond, 2014; Benbenishty et al., 2017). Participants’ descriptions of how other children would treat LAC more closely reflects the findings of studies carried out with LAC. These studies describe the stigmatising interactions LAC experience in their peer relationships. Peers of LAC are reported to; hold LAC’s “in-care status” against them, (Madigan et al., 2013); question them intrusively (Kools, 1997; 1999); and socially isolate them (Kools, 1997; 1999; Ridge & Miller, 2000; Madigan et al., 2013), all of which were described by participants in the current study, when discussing how other
children may behave towards LAC. Participants also describe how LAC would likely be treated the same as other children if they kept their “in-care” status a secret, suggesting that the collective view of LAC as an out-group informed the behavioural norms participants described. These findings add weight to previous research carried out with LAC and suggest a hostile attribution bias is not the sole explanation for LAC’s accounts of their difficult peer relationships (although this attribution bias may play a role in the peer difficulties of some LAC, Kay & Green, 2016).

Concerns relating to stigma by association (Goffman, 1963) were also described by participants. Participants explained how other children may want to avoid LAC, in case they were thought of as “weird”, for being with the “other weird guy”. It is possible that the desire for positive distinctiveness informed this view. Participants were mindful that, should a person be associated with a member of the out-group (a LAC), they would likely be attributed with the same stereotypical characteristics of that group (“weird”). This would prevent each group from being seen as a distinct entity and would threaten positive distinctiveness (Tajfel & Turner, 1986). Furthermore, participants felt peers would bully LAC because they were lower on the social hierarchy, or because they felt jealous of the positive differential treatment LAC may experience. This suggests children behave in a way that maintains their superior status (Tajfel & Turner, 1986).

It is possible that participants’ social identity impacted their reported behaviour towards LAC, as would be suggested by SIT (Turner et al., 1987). This may explain the discrepancy between how participants reported they would treat LAC, and how they felt others would treat LAC. For example, there may have been a group norm around the need to do what is best for those less fortunate, as participants described how they would support LAC because LAC do not receive support elsewhere. Furthermore, SCT suggests in-group norms can relate to feelings, attitudes and behaviours, (Turner et al., 1987). In line with this, participants’
Desire to give LAC extra care appeared to result, in part, from participants feeling sorry for LAC. Perhaps participants viewed “bullies” as the out-group, leading to positive differentiation between themselves, and those who may treat LAC badly. The researchers’ presence in the focus groups may also have impacted participants’ discussions. It is possible that participants did not feel they could talk about the negative treatment they may engage in. As a result, participants may have talked about this negative treatment in terms of others’ behaviour, rather than their own.

Participants’ reported positive treatment of LAC may be explained by the more complex understandings they showed of LAC. Participants often showed a sophisticated view of why LAC may be “different”. Important psychological concepts relevant to LAC were discussed. For example, in line with studies exploring the impact of attachment on children’s behaviour (Erickson et al., 1985) and friendships, (Zimmermann, 2004), participants discussed how LAC’s relationship with their parents may have impacted their behaviour, and ability to make friends. This understanding also informed some of the more positive assumptions participants held of LAC, for example the idea that LAC are more resourceful, strong and self-reliant, as they have had to learn these skills earlier than others. This indicates some participants held a multifarious understanding of LAC. It is possible that the prolonged time talking about LAC gave participants a chance to reflect on these different understandings, and to step away from the stereotypes that came to mind initially. SIT highlights how prototypes and stereotypes are flexible, dependent on social context (Oakes et al., 1994) and are the result of communication between people (Wigboldus et al., 1999). Perhaps participants’ prototypes adapted as the focus groups developed. This more complex understanding of LAC appeared to impact participants’ desire to treat LAC well, although participants were not always sure whether that meant treating LAC the same or differently.
Despite demonstrating this more complex understanding, participants also explained their concern that they did not understand LAC, as they had not been through the same experiences as them, and therefore did not know how to treat them. Participants’ uncertainty about how to treat LAC may have resulted in participants’ mixed views around whether to treat them the same, or differently. Participants were concerned they may say, and do, the wrong thing, and described the need to be “careful” with LAC. In line with this, LAC have described how their peers are often overprotective and cautious towards them, which they felt was the result of peers limited understanding of LAC (Madigan et al., 2013). At times, participants appeared uncomfortable talking about LAC, suggesting they experienced the discomfort Goffman (1963) described, when another’s social identity departs from the norm. As in-group norms relate to feelings, attitudes and behaviours (Turner et al., 1987) it is likely this feeling of discomfort, and the resulting cautious behaviour, was informed by group norms. Some opinions of how to treat LAC appeared to be informed by participants more stereotypical views of LAC. For example, participants described how it was important not to talk about LAC’s past, as LAC may become angry and aggressive. Perhaps feelings of discomfort, alongside feelings of uncertainty (owing to concerns of not understanding LAC) resulted in participants drawing on the more stereotypical views they held of LAC, to inform their reports of the behaviour they would demonstrate. In line with this, those who held more complex, less stereotypical views seemed to show a more complex understanding of how to treat LAC. For example, some participants described the need to treat LAC how they want to be treated, suggesting they were aware that all LAC are different.

**Limitations of the study and future research**

As stigma is considered a social phenomenon (Hebl & Dovidio, 2005), the focus group environment offered the opportunity to explore how stigmatising views may develop in the social environment. Focus groups allowed the researcher to explore discrepancies in
participants’ views, and the language participants used, to gain increased insight into the social understandings of participants. Furthermore, the sentence finishing task appeared to be a useful tool. The task enabled all participants to engage in discussion and facilitated conversation between participants. However, while findings of the current study link to previous research carried out with LAC, they can only cautiously contribute to our understanding of the peer interactions of LAC. It is possible the hypothetical approach to talking about participants’ behaviour towards LAC may not represent how children would behave in a real-life setting. It is also possible that the group environment resulted in a censored view of LAC, as participants’ difficulties talking in the focus group environment may have demonstrated. As such, future research could benefit from the use of repeat interviews. This approach has the potential to develop the relationships of those involved in the research, which could result in a less censored, more in depth view of the item under discussion (Cornwell, 1984). Furthermore, the use of a peer researcher may reduce the power imbalance between researcher and participants, which could enhance the quality of data collected (Lushey & Munro, 2015).

It appears that SIT (Turner et al., 1987) is a useful theory to help understand the peer relationship of LAC. SIT explains why LAC may be depersonalised, and viewed stereotypically, in terms of their difference. SIT also explains why LAC’s identity may be devalued by peers and goes some way to explaining the interactions LAC experience with their peers. However, SIT may explain the more complex views of participants, and the positive differential treatment they described, less well. It is possible that the prolonged time talking about LAC enabled participants to move away from stereotypical views. Furthermore, it is possible that in-group norms resulted in the need to treat LAC well, and that differential treatment, both positive or negative, is enough to maintain positive distinctiveness. However, as participants did not describe these as the underlying reasons for their reported behaviour,
this is only speculative. Again, gaining a less censored view of children’s social understandings, and behaviour, may help to better understand the positive differential treatment participants described.

As prototypes, stereotypes and stigma are socially and culturally defined (Oakes et al., 1994; Hebl & Dovidio, 2005) it is likely the assumptions and behaviours described in the current research would be different if the research had been carried out elsewhere. For example, if the research had taken place in a school with a higher percentage of LAC, it is possible less negative assumptions of LAC would have been present. Perhaps children with direct experience communicating with LAC would have a more informed understanding of LAC. As a result, the findings of this study need to be applied to other populations with caution.

Clinical implications and future research

The findings highlight the possibly limited understanding children have of LAC. Many stereotypical assumptions that lead to a description of differential treatment towards LAC were apparent. Given the many benefits of peer relationships for LAC (Ridge & Miller, 2000; Blower et al., 2004; Aldgate 2009; Burgess et al., 2010; Hedin et al., 2011; Madigan et al., 2013; Emond, 2014) the possibility of improving children’s understanding, and changing these stereotypical views of LAC, is an important avenue to explore further. As participants’ views appeared to change as the focus groups progressed, exploring whether group conversations have the possibility to change stereotypical views of LAC is an area of interest. These discussions could take place in classes within schools. Conversations could focus on the diverse living situations and family make up all children have, to challenge the view that LAC are “different”. Furthermore, LAC or care leavers could attend these classes to help children gain a broader understanding of LAC and to reduce the stereotypical views they may
hold. Involving LAC in these classes would need to be managed with care. For example, it may be necessary to invite LAC or care leavers who are not currently students at the school.

It will be important for future health and social care policies to discuss the impact of stigma and discrimination on LAC and to consider how to reduce the negative peer experiences of LAC. Current policies do not address these issues (Department of Health and Education guidelines, 2015, National Institute for Health and Clinical Excellence, 2015).
References


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MRP Empirical Paper Appendices

Appendix A: Guidelines for authors

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Participant Information Sheet

Young People’s Understanding of Looked After Children

Introduction

My name is and I am a Trainee Clinical Psychologist. I would like to invite you to take part in my research project. To help you decide if you would like to take part, please read this information sheet. Feel free to contact me using the telephone number or email address below if you have any questions. You are welcome to talk to others about the study if you wish, including your parents who have also been given information about the project.

What will I be asked to do?
I will ask you to spend some time talking with myself, and a group of around six other young people of your own age. This will take place during the school day. Your school will choose what time is best for us to meet. Another researcher will be present to take notes of what we talk about and our conversation will be recorded.

I am interested in your views of looked after children (or children in care). You will be asked to take part in a group where there will be some discussion and some activities. There will be a game to help you feel comfortable with others in the group and then you will be asked to finish the end of sentences about looked-after children. There are no right or wrong answers; I just want to hear your views. I hope this research will increase our understanding of how looked after children are perceived. Altogether we will meet for up to 60 minutes.

Young people that consent to take part in the study will be asked to keep the views and opinions of other participants to themselves and not discuss them outside the group. If during the focus group you say something that makes me worried for your safety or the safety of someone else then I would have to discuss this with your school.

It is okay if you want to leave the focus group at any time, just let me know. Some people enjoy group discussions but some can find them difficult or upsetting. If you do get upset or worried during the focus group, please let me know. If I think you are upset or worried, I will invite you to speak to . You will not have to go back into the group at this time if you do not want. Everyone will be given some information about who you can speak to if you feel upset or worried after the focus group.

This study has received a favourable opinion from the Ethics Committee of the University of Surrey’s Faculty of Health and Medical Sciences.

What happens after the group meets?
Once you have taken part in the focus group it will not be possible to remove the information you gave, regardless of how long you participated in the focus group for. This is because it
may not be possible to identify your voice from others in the audio recording. When the conversation has finished, we will type out everything the group has said and the audio recording will be deleted. I will use made up names in the typed version so that no one will be able to tell who took part in the group. Some of what you say maybe used in my report, but this will not include your name, so no one will be able to know you said it. Once the project is complete I will send a summary of the findings to the school, which you can ask to have a copy of.

**Do I have to take part?**
No, it is completely up to you and your parents whether you take part. Your decision will have no effect on your education at school. If you do want to take part, I will ask you to read and sign a consent form.

If you do decide to take part, it does not mean you cannot change your mind later. You will not need to say why you have changed your mind.

**What if there is a problem?**
If you have any concerns about the project you are encouraged to speak to or your parents who can call or email either myself or one of my supervisors. Their names are and at the University of Surrey. Our contact details are given below. You can also call us if you would like.

**What do I do next?**
If you have any questions about taking part please contact me on (this number will be monitored from Monday to Friday, 9-5) or via email, .

Thank you,

Supervised by (Email: Tel: ) and (Email: Tel: )
Appendix C: Consent Form – Participant

Consent Form (for participant)

Young People’s Understanding of Looked After Children

Please tick ✔ or cross ✗ each box

• I agree to take part in a group discussion to explore school children’s understanding of looked-after children (or children in care)

• I have read and understood the Information Sheet

• I understand that it is completely my decision to take part in the project

• I have been given enough information about this project

• I have been told about what may be difficult about taking part and that I will be offered support should this happen

• I will tell the researcher straight away should I find the group discussion difficult, or if I have any concerns after

• It has been explained to me how the information I give will be used

• I understand that if I say something that causes the researcher to worry for my safety, or the safety of another, they will have to speak to the ( ) at the school

• I am happy for the researcher to record what I say

• I understand that I should keep the views and opinions of other participants to myself and not discuss them outside the group.

• I give my permission for my words to be used in a report but understand that my name will not be mentioned

• I understand that I can leave at any time and do not have to answer all the questions if I do not want to.

• I understand that I will not be able to withdraw my data once I have taken part in the focus group, regardless of how long I participate in the focus group for. I understand that this is because it is not always possible to remove this information, as the researcher may not recognize my voice from others on the audio recording.

• I have read and understood everything written above and agree to follow the instructions of the project.
Name of participant (BLOCK CAPITALS) ......................................................

Signed ..............................................................................................

Date .................................................................................................

Name of researcher taking consent (BLOCK CAPITALS) ......................................................

Signed ..............................................................................................

Date .................................................................................................

, Trainee Clinical Psychologist, University of Surrey
Tel:  Email:
Appendix D: Participant Information Sheet – Parent

Participant Information Sheet
Parent/Guardian

Young People’s Understanding of Looked After Children

Introduction
My name is [Trainee Clinical Psychologist’s name] and I am a Trainee Clinical Psychologist at the University of Surrey. As part of my training to become a Clinical Psychologist, I am required to carry out some research. I have invited your child to take part in my research project into looked-after children (or children in care). To help you and your child decide if they would like to take part, please read this information sheet carefully, so that you know what your child will be asked to do and why the research is important. Feel free to contact me using the telephone number or email address below if you have any questions. Should you decide you do not want your child to take part, please contact [Trainee Clinical Psychologist’s name] or myself on the telephone number or email address below within a week of receiving this information sheet. You are welcome to talk to others about the study if you wish and I encourage you to talk through this information with your child.

The research
I am interested in school aged children’s views of looked-after children. I am also interested in how views of looked after children impact children’s behaviour towards them. I hope this research will help us understand why young people think the way they do about looked-after children. It is hoped that this could inform education and social care policies.

This study has received a favourable opinion from the Ethics Committee of the University of Surrey’s Faculty of Health and Medical Sciences.

Why has my child been invited to take part in the study?
I am hoping to talk with up to sixty young people who are aged between eleven and fourteen years of age and attend mainstream school. As children that are looked-after know much more about what it means to be in care, it will not be appropriate for them to take part in this study. However, I am keen to hear the views of looked-after children and will be inviting them to a meeting with myself to discuss this project.

Does my child have to take part?
No, it is completely up to you and your child whether they take part in the research or not and your decision will have no effect your child’s education at school. Your child will be asked to consent to taking part in the project. Should you decide you do not want your child to take part, please contact [Trainee Clinical Psychologist’s name], or myself on the telephone number or email address below within a week of receiving this information sheet.

What will my child be asked to do?
I will ask your child to spend some time talking with myself, and a group of around six other young people. This is called a focus group and will take place at school. Another researcher will be present to take notes of what the group talk about. The conversation will be recorded to ensure we have an accurate record of what is said. Altogether the focus group, including a group task will take up to an hour.
The group discussion may include conversations around why participants think looked-after children may enter care and the similarities and differences between looked-after children and themselves. Your child will also be asked to take part in a group task which will involve finishing the end of sentences about looked-after children. There are no right or wrong answers; I am just interested in hearing your child’s views.

Participants that consent to take part in the study will be asked to keep the views and opinions of other participants that attended the focus group confidential. If, during the focus group, your child says something that makes me worried for their safety, or the safety of someone else, then I would have to discuss this with your child’s school.

Participation will occur during the school day with the focus groups arranged at a time that effects participants’ education least. Your child can choose to leave the focus group at any time if they want to. Some people enjoy group discussions but for others they can be a difficult experience. For some the group discussion may be upsetting. If your child does experience discomfort during the focus group, they will be asked to let me know. I will also be aware of signs from your child that they are becoming distressed. If so, they will be invited to visit or at . Your child will then be given the option to end their participation at this time. I will give you and your child some information about who they can speak to if they feel upset or worried after the focus group.

If your child would like to take part in the study and you agree to their participation, I will ask your child to read and sign a consent form. Should you decide you do not want your child to take part, please contact or myself on the telephone number or email address below within a week of receiving this information sheet.

**What happens after my child takes part?**

When the focus group has finished we will type out everything the group has said and the audio recording will be destroyed. We will use made up names in the typed version so that no one will be able to tell who took part in the focus group. All information that is gathered as part of this project will remain anonymous, unless your child tells me something which causes me concern about their own safety or the safety of someone else. If this should happen I will follow the Schools safeguarding policy. Quotes from the focus group may be used when the project is written up, but these will be made anonymous, so that no one will be able to identify your child from anything they say. This anonymous data will be kept for at least 10 years in line with the University of Surrey policies.

Consent forms will be kept separate to data collected during focus groups, so that the information collected during the group cannot be traced back to your child. These will be kept for at least 6 years in line with the University of Surrey policies.

The research will take around five months to complete in total, although your child will only be asked to attend the focus group once during this time. Once complete, the school will be given the project report which you may request a copy of.

**Your rights**

If you and your child decide they would like to take part in this research it does not mean you cannot change your mind at a later date. You will not need to say why you or your child has changed their mind. However, once your child has taken part in the focus group it will not be possible to remove the information they gave, regardless of how long they participated in the
focus group for. This is because it may not be possible to identify their voice from others in the audio recording.

**What if there is a problem?**
If you have any concerns about any aspect of the research study you can contact either myself or one of my supervisors at the University of Surrey. Their names are and . Our contact details are given below. You can also contact the Head of School of Psychology, who is independent to the research team. His email address is .

**What do I do next?**
If you have any questions about your child taking part in this research please contact me on (this number will be monitored from Monday to Friday, 9-5) or via email, . If I am not able to answer the phone straight away then please leave a message with your contact details and I will get back to you as soon as possible.

Thank you for taking the time to read this Information Sheet,

Trainee Clinical Psychologist
Supervised by (Email: Tel: ) and (Email: Tel: )
Appendix E: Sentences for focus groups

Looked after children’s mum and dad are………………
If I were a looked after child I would think my mum and dad were………………
I feel happy for looked after children because………………
If I met someone that was looked after I would………………
The hardest thing about being a looked after child is………………
If I were a looked after child the hardest thing would be………………
Looked after children’s clothes are………………
Looked after children’s families would be better if………………
If I were a looked after child I would want my family to………………because………………
I would support a looked after child by………………
I do/don’t feel safe with looked after children because………………
If I did not agree with someone that was looked after they would………………
If I were a looked after child I would do………………because………………
When not at school looked after children enjoy………………
In school looked after children………………
If I were a looked after child I would think school was………………because………………
Looked after children need………………
If I were a looked after child I would need………………
Looked after children are different from me because………………
If I were a looked after child I would feel different because………………
Looked after children get into trouble when they………………
I would like to ask looked after children why………………
Looked after children seem happiest when………………
If I were a looked after child I would worry because………………
I feel sad for looked after children because………………
If I were a looked after child I’d feel sad because………………
Looked after children think ………
If I were a looked after child I would be most happy when………………
The best thing that could happen to a looked after child’s family is………………
Looked after children behave like………………
I would stand up for a looked after child because………………
What looked after children need most from people is………………
Looked after children feel………………about their mum and dad because………………
In class looked after children………………
At lunch looked after children………………
Looked after children need help because………………
Looked after children think school is……………… because………………
If I were a looked after child I would think school is………………because………………
Looked after children think other children are………………
If I were a looked after child I would think other children were………………
Looked after children’s brothers and sister are……
What looked after children need most from people is……
Looked after children wouldn’t want people to……
Looked after children are normal because……
Looked after children do/don’t fit in because……
When looked-after children move schools they worry…. 
When looked after children meet with their foster carers for the first time they think…..
Looked after children do not trust…….
Appendix F: Examples of questions used:

Examples of follow up questions:

“Is that different to your/others’ behaviour/clothes/worries”

“How do you think LAC’s behaviour/clothes/worries impact your/others’ behaviour towards them and why”

“Why do you think you/others behave this way towards LAC”

Example questions around similarities:

“What do you think other young people have in common with LAC?”

“Why do you think LAC are similar to you?”
Appendix G: Letter confirming favourable ethical opinion by the University of Surrey Faculty of Health and Medical Sciences Ethics Committee

Faculty of Health and Medical Sciences
Ethics Committee

Chair’s Action

Proposal Ref: 1257-PSY-17

Names of Student/Trainee:

Title of Project: Understanding Looked After Children’s experience with Peers: An Exploration of Children's social representations of Children in Care

Supervisors:

Date of submission: 17th January 2017

The above Research Project has been submitted to the Faculty of Health and Medical Sciences Ethics Committee and has received a favourable ethical opinion on the basis described in the protocol and supporting documentation.

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

Ethics Application Form
Detailed protocol for the project
Participant Information sheet
Consent Form
Risk Assessment (If appropriate)
Insurance Documentation (If appropriate)

All documentation from this project should be retained by the student/trainee in case they are notified and asked to submit their dissertation for an audit.

Signed and Dated: 23/02/2017
Professor Bertram Opitz
Chair, Ethics Committee

Please note:
If there are any significant changes to your proposal which require further scrutiny, please contact the Faculty of Health and Medical Sciences Ethics Committee before proceeding with your Project.
Appendix H: Ethical Considerations

Informed consent was gained from the school, participants and their parents. Participants were made aware that data would be anonymised and any names used would be pseudonyms. Confidentiality was explained. It was made clear confidentiality from other participants could not be guaranteed, despite this being requested. Participants were informed they did not have to answer any questions they did not want to and were informed of their right to withdraw. Debrief sheets included the names of members of school staff, and external organisations, children could access, should they find the process upsetting. The research assistant completing transcription signed the University’s confidentiality agreement. All researchers had an enhanced Disclosure and Baring Service (DBS) check in place and data was stored securely.

To avoid LAC within the school feeling excluded from the study, a clear rationale for why they were not asked to participate was given. To include LAC in the study, they were invited privately to a consultation meeting with the researcher. During these meetings, they were asked their opinion of the research protocol and what they thought was important for their peers to know about LAC. To avoid the potential of inadvertently creating stigma within the recruited participants, for example through creating more of a focus on difference for LAC, participants were encouraged to discuss how LAC may be similar to themselves. Participants were also given the opportunity to ask any questions they had, at the end of the focus groups. This allowed the researcher an opportunity to dispel any misunderstandings participants had of LAC, and to convey the information gained through consultation with LAC, around what they thought was important for their peers to know about being a LAC. A group of 6th formers, a foster carer, social worker and teacher, were also consulted about the research, to ensure the research was both appropriate and ethical.
Appendix I: Detailed description of TA approach

The following stages of analysis, based on Braun & Clarke (2006), were completed by the researcher:

- Stage one: Listening to recordings to ensure accuracy of transcriptions. Reading and re-reading transcriptions, to allow emersion in the data. Noting areas of interest.
- Stage two: Close, line by line coding to engage with the data set further.
- Stage three: Searching for emerging themes that explained meaningful and coherent patterns in the data. Codes that described similar aspects of the data were grouped together. Potential relationships between themes were represented on a thematic map, with an initial label given. Coded data supporting each theme was collated.
- Stage four: Each emerging theme was studied one at a time. When themes were too diverse, or did not have enough data to support them, they were split into two or more themes, collapsed together or discarded completely. Transcripts were re-read, to search for any further data supporting the identified themes, and to check the themes “worked” in relation to the full data set. This resulted in a final list of themes.
- Stage five: Giving each theme a final label, definition and descriptive account. Defining the relationships between themes. A final thematic map was produced (figure 1, see results section).
- Stage six: Choosing the data extracts that best illustrated each aspect of a theme. Data extracts from a range of participants, and focus groups, were selected for the final descriptive account

Data analysis was not a linear process, the researcher spent time moving back and forth between each step, as the analysis developed (Braun & Clarke, 2006). Themes not only
captured participants’ words, but also the researcher’s interpretations of the data (Braun & Clarke, 2006).

The decision was made not to use pseudonyms in the final analysis. With many participants, and several focus groups, it was not possible to follow participants’ dialogue throughout the analysis.
Appendix J: Coded extracts and worked example of thematic analysis process

<table>
<thead>
<tr>
<th>Transcript data</th>
<th>Line by line Code</th>
<th>Areas of interest</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Researcher:</strong> Do you think it’s more likely that looked after children would be bullied?</td>
<td>R quest/summary</td>
<td></td>
</tr>
<tr>
<td>Noah: Er,</td>
<td>P thinking</td>
<td></td>
</tr>
<tr>
<td>Ali: Yeah.</td>
<td>Yeah</td>
<td></td>
</tr>
<tr>
<td><strong>Researcher:</strong> Yeah.</td>
<td>R quest/summary</td>
<td></td>
</tr>
<tr>
<td>Noah: There’s a slight more chance but (pause)</td>
<td>Slightly more chance of bullying</td>
<td>Slightly more chance LAC will be bullied</td>
</tr>
<tr>
<td><strong>Researcher:</strong> Slightly more chance,</td>
<td>R quest/summary</td>
<td></td>
</tr>
<tr>
<td>Noah: But they should be treated exactly the same (pause)</td>
<td>Should be treated the same</td>
<td>LAC should be treated the same</td>
</tr>
<tr>
<td>Samantha: It’s because they’ve been through that so much, so they might erm, be more like stronger against bad things happening (pause)</td>
<td>Been through so much</td>
<td>LAC stronger as been through a lot</td>
</tr>
<tr>
<td>cos they’ve been through so much already.</td>
<td>Been through so much</td>
<td></td>
</tr>
<tr>
<td><strong>Researcher:</strong> Ok, so you think they might be a bit stronger (James: yeah) and you think that might mean that they get bullied more?</td>
<td>R quest/summary</td>
<td></td>
</tr>
<tr>
<td>Samantha: They like, if they were like to get bullied, it wouldn’t, it would, they would be like strong about it...</td>
<td>Bullying</td>
<td>LAC strong in response to bullying</td>
</tr>
<tr>
<td><strong>Researcher:</strong> Ok, so you think that they might be more likely to be bullied but they’d be stronger in reaction to that?</td>
<td>R quest/summary</td>
<td></td>
</tr>
<tr>
<td>Samantha: Yeah.</td>
<td>Yeah</td>
<td>LAC more emotional due to past</td>
</tr>
<tr>
<td>Noah: Yeah, I think it’s the complete opposite of that</td>
<td>Opposite of that</td>
<td></td>
</tr>
<tr>
<td>cos they’ve been through so much</td>
<td>Been through a lot</td>
<td>LAC can’t deal with bullying as much</td>
</tr>
<tr>
<td>they are really emotional (pause) so they (pause) (Researcher: Ok) can’t deal with it as much (pause).</td>
<td>Really emotional</td>
<td>LAC not as resilient against bullying</td>
</tr>
<tr>
<td>Ali: they would find it way harder</td>
<td>Can’t deal with bullying</td>
<td></td>
</tr>
<tr>
<td><strong>Researcher:</strong> So you think they would find it really hard. Ok. And James, you were kind of saying earlier that you don’t think they are more likely to be bullied, is that right?</td>
<td>R quest/summary</td>
<td></td>
</tr>
<tr>
<td>James: Erm, its sort of the same as anyone, like</td>
<td>Same as anyone</td>
<td>LAC more likely to be picked on if discuss past</td>
</tr>
<tr>
<td>if they keep quiet about their past and</td>
<td>If keep past secret chance</td>
<td></td>
</tr>
<tr>
<td>everything (pause) (Researcher: Yes) there’s a chance that the they might not be picked on, they might have just been</td>
<td>Really emotional</td>
<td></td>
</tr>
<tr>
<td>viewed as equal (pause) (Researcher: Ok) and no one will know their history.</td>
<td>Viewed as equal</td>
<td>Social hierarchy –</td>
</tr>
<tr>
<td></td>
<td>Don’t know history</td>
<td>LAC not viewed as equal</td>
</tr>
</tbody>
</table>

---

4 Names used are pseudonyms
Example of themes, and interesting aspects with in theme, alongside supporting data

<table>
<thead>
<tr>
<th>Transcript data</th>
<th>Line by line Code</th>
<th>Areas of interest</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme: LAC are treated badly by other children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Noah: There’s a slight more chance but (pause)</td>
<td>Slightly more chance bullying</td>
<td>Slightly more chance LAC will be bullied</td>
</tr>
<tr>
<td><strong>Interesting aspect to note within theme: LAC should be treated the same</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Noah: But they should be treated exactly the same (pause)</td>
<td>Should be treated the same</td>
<td>LAC should be treated the same</td>
</tr>
<tr>
<td><strong>Interesting aspect to note within theme: LAC stronger against bullying</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Samantha: It’s because they’ve been through that so much, so they might erm, be more like stronger against bad things happening (pause)</td>
<td>Been through so much LAC stronger</td>
<td>LAC stronger as been through a lot</td>
</tr>
<tr>
<td>They like, if they were like to get bullied, it wouldn’t, it would, they would be like strong about it...</td>
<td>Been through so much Bullying</td>
<td>LAC strong in response to bullying</td>
</tr>
<tr>
<td><strong>Interesting aspect to note within theme: LAC respond less well to bullying</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Noah: can’t deal with it as much (pause).</td>
<td>Can’t deal with bullying LAC find bullying harder</td>
<td>LAC can’t deal with bullying as much LAC not as resilient against bullying</td>
</tr>
<tr>
<td>Ali: they would find it way harder</td>
<td>LAC find bullying harder</td>
<td></td>
</tr>
<tr>
<td><strong>Interesting aspect to note within theme: Bullying happens as LAC are different/lower on social hierarchy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>James: Erm, its sort of the same as anyone, like if they keep quiet about their past and everything (pause) (Researcher: Yep) there’s a chance that the they might not be picked on, they might have just been looked upon as equal (pause) (Researcher: Ok) and no one will know their history.</td>
<td>Same as anyone If keep past secret chance might not be picked on Viewed as equal Don’t know history</td>
<td>LAC more likely to be picked on if discuss past Social hierarchy – LAC not viewed as equal</td>
</tr>
<tr>
<td><strong>Theme: There is something wrong with LAC</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Noah: Yeah, I think it’s the complete opposite of that cos they’ve been through so much they are really emotional (pause) so they (pause)</td>
<td>Opposite of that Been through a lot Really emotional LAC find bullying harder</td>
<td>LAC more emotional due to past</td>
</tr>
<tr>
<td>Ali: they would find it way harder</td>
<td>LAC find bullying harder</td>
<td>LAC not as resilient against bullying</td>
</tr>
</tbody>
</table>
Theme: LAC have problematic behaviour
Interesting aspect to note within theme: LAC don’t want to talk about past

| Noah: | Yeah some people don’t want to talk about it. LAC may not want to talk about past | LAC may not want to talk about past |

### Example of Coded Data Focus Group 8

<table>
<thead>
<tr>
<th>Transcript data</th>
<th>Line by line Code</th>
<th>Areas of interest</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Researcher:</strong> If teachers are giving more support to looked after children what, how do you think other children feel about that?</td>
<td>R quest/summary</td>
<td>Peers curious about LAC</td>
</tr>
<tr>
<td><strong>Simon:</strong> Curious</td>
<td>Peers curious about LAC</td>
<td></td>
</tr>
<tr>
<td><strong>Researcher:</strong> Curious. So, you think they might want to know why?</td>
<td>R quest/summary</td>
<td>Peers curious about LAC</td>
</tr>
<tr>
<td><strong>Bobby:</strong> Yeah. They might be a bit worried about them, if there like really good friends (Simon: Yeah) and might be worried about what’s happening, why are they being taken out all the time.</td>
<td>Worried about LAC if friend</td>
<td></td>
</tr>
<tr>
<td><strong>Researcher:</strong> Yeah, so they might worry about them. Any other things.</td>
<td>Worried about what’s happening to LAC</td>
<td></td>
</tr>
<tr>
<td><strong>Simon:</strong> The rest of the class may start asking him, the person, that erm, that is having trouble, asking or loads of questions.</td>
<td>Peers question LAC Asking LAC lots of questions</td>
<td></td>
</tr>
<tr>
<td><strong>Researcher:</strong> And how do you think, that would make them feel.</td>
<td>R quest/summary</td>
<td>Peers may intrusively question LAC if treated differently</td>
</tr>
<tr>
<td><strong>Simon:</strong> Not very good about, because they feel like their being interrogated.</td>
<td>LAC feel like being interrogated</td>
<td></td>
</tr>
<tr>
<td><strong>Researcher:</strong> Ok, so that might be quite difficult for them? Yeah. Why do you think they’d ask loads of questions?</td>
<td>R quest/summary</td>
<td></td>
</tr>
<tr>
<td><strong>Simon:</strong> Because they’d, they’d want to know.</td>
<td>Peers want to know about LAC Curious about LAC</td>
<td>Peers curious about LAC</td>
</tr>
<tr>
<td><strong>Guy:</strong> They, they just want to know, their curious.</td>
<td>Curious about LAC</td>
<td>Peers have no experience of LAC so want to find out more</td>
</tr>
<tr>
<td><strong>Bobby:</strong> Yeah, maybe like to children, even if they kind of know what’s going on, they might want to kind of, find out what’s really happening to them, cos they might not have any idea or experience of it.</td>
<td>Children may know what’s going on Curious about what’s really happening No experience of LAC</td>
<td></td>
</tr>
<tr>
<td><strong>Researcher:</strong> Ok, yeah. So even though, they know they know there’s something going on they want to know what, because they want to understand (Bobby: yeah.) (Pause) Ok, shall we do another sentence?</td>
<td>R quest/summary</td>
<td></td>
</tr>
<tr>
<td><strong>Guy:</strong> When looked after children meet with their foster carers for the first time, they think (pause) I'm not sure, I think they might be quite curious of what they would be like.</td>
<td>Reading sentence LAC curious about new foster parents</td>
<td></td>
</tr>
</tbody>
</table>
Appendix K: Example of early thematic map
# Appendix L: Summary table of super-ordinate and subthemes with example of supporting data

<table>
<thead>
<tr>
<th>Superordinate theme: LAC are “different”</th>
<th>Subtheme: Why LAC are different</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Erm, either like, they might have got like maybe hit on the head and like a bit of them, there brain kinda [researcher asked participant to expand] yeah, that might have affected them, their heads”</td>
<td>“There is something wrong with LAC”</td>
</tr>
<tr>
<td>“Maybe they would give them like, simpler stuff, then like, normal people”</td>
<td>“Some kind of like disability that makes them unable to live a normal life or something”</td>
</tr>
<tr>
<td>“Because erm, they might have like something wrong with them”</td>
<td>“LAC have problematic behaviour”</td>
</tr>
<tr>
<td>“They might be a bit badly behaved”</td>
<td>“If something’s wrong with them and they kind of like need it you give it to them, but if it’s like “oh I want this” just tell them I guess, see if they just want it to make them feel special or there just telling them to just play with them”</td>
</tr>
<tr>
<td>“And they, they might like, this isn’t like trying to look better but, they might react to things easily”</td>
<td>“Maybe like, keep themselves away from everybody else”</td>
</tr>
<tr>
<td>“Yeah cos they might not like feel too comfortable speaking to you cos they don’t really like, they can’t really like, some of them might not be able to express their feelings like others can”</td>
<td>“Sad, they wouldn’t really have like that happy of a life”</td>
</tr>
<tr>
<td>“They don’t have like, the proper environment that they need too, and they don’t like, have like food or anything”</td>
<td>“In class looked after children, they might be quite sad, cos like, maybe they had like a rough day or something at the care home or something”</td>
</tr>
<tr>
<td>“They might not have some of the advantages that other people [researcher asked participant to expand on advantages of others] erm, they have someone close to them, or closer to them, that they can talk about things”</td>
<td>“LAC have a hard, sad life”</td>
</tr>
</tbody>
</table>
### Subtheme: LAC should be treated the same but…

- “If you wouldn’t have gone through the same thing as them, you wouldn’t know how to react cos”
- “They might not want to like interrupt their situation and make it like, so, they don’t want to interfere with what their feeling at that point in time [researcher asked participant to expand] cos they don’t wanna like, they might feel like they don’t know that much about it so they don’t want to say like the wrong thing”
- “Cos if its private and personal then it might be difficult to bring it up cos if it’s their business then you don’t want to distress them”
- “You’ve got to be careful of what you’re saying”

### Subtheme: ‘Walking on eggshells’ with LAC

- “If I was, were a looked after child I would be most happy when I had people like helping me and being like kind”
- “I’d try and help them as much as I could to make them feel better”
- “Cos they, they know that their able, that they’ve then got somebody that’s worried about them, that’s, that’s trying to help them, and it’s not like, it’s not like an adult, its someone of their own age”
- “What looked after children need most from people is probably support”

### Subtheme: LAC need extra care, love and attention

- “Yeah and then some people might use what they’ve been through to be mean to them sometimes. Yeah”
- “Yeah, some people might, they kind of feel like, there’s a reason why they should bully them, so like, they’ve found a reason so then, they just do it”.
- “And they could like judge the child for being like they might be like sad at school and they might like judge them like, oh, kind of like oh get over it kind of thing”
- “I don’t think they would have as many because erm, of all the things we said before, about they could like act out, out of angry or they could be overreacting about things, and people just wouldn’t want too, be involved in that or be like, seen with someone who would do that kind of thing”
Appendix M: Example Reflective Log

(Removed due to personal nature of the information included)
Appendix N: Statement of researcher reflexivity

(Removed due to personal nature of the information included)
Part 2: Research - MRP Literature Review

Children in Care’s Experience of Stigma and Discrimination in Peer Relationships: A Review of the Literature

Abstract:

Research suggests that social support is especially important for children in care (CIC). Positive peer relationships have been linked to resilience, educational progress and protection from bullying for CIC. However, research has also demonstrated the stigmatising interactions CIC may experience in their peer relationships. Given the benefits of peer relationships for CIC, as well as the detrimental effects of stigma, the current literature review aimed to understand experiences of stigma and victimisation in the peer relationships of CIC. The review focussed on peer relationships between CIC and those that are not in care. Relevant studies were identified, critically appraised, and findings pertinent to the research question were extracted. Eleven articles were identified for inclusion in the review. Seven themes relating to stigma and the peer relationships of CIC were identified: 1) good peer relationships are considered crucial to CIC; 2) CIC experience negative behaviour from peers; 3) CIC discuss the importance of being the same as their peers; 4) CIC demonstrate a desire to guard the “in care” label and information associated with it; 5) the impact on children’s wellbeing and behaviour; 6) the impact of care and the care setting on CIC; and 7) the importance of context and sense making for CIC. Results are discussed in detail, discrepancies between studies are explored, and questions that have not yet been answered are identified.
Introduction

A child in care (CIC) is a child who is looked after by their local authority (LA), (NSPCC, 2018). They may be living with foster parents, or in a residential setting, such as a care home. A CIC may also be living with their parents, under the supervision of social services, or living in kinship care (KC). KC occurs when a family member or friend looks after a child who cannot be cared for by their birth parents (GOV.UK, 2018). The parents of a CIC may have placed them in care voluntarily, or social services may have placed them in LA care, as they were at significant risk of harm in their current living situation (NSPCC, 2018). As this review is interested in the stigmatising interactions CIC may experience, and living away from one’s birth family likely plays a role in these stigmatising interactions (Kools, 1999; Emond, 2014), in this review the term CIC will refer to children not currently living with their birth family. It will encompass those living in KC, and those in more formal care such as, foster care (FC) and residential care (RC).

Numerous studies have identified the unique challenges CIC face. CIC often experience difficult living situations (Holland & Crowley, 2013), move placement numerous times (Singer et al., 2013), have poor mental health outcomes (Mcauley & Davis, 2009), have poor academic functioning (Berridge, 2007) and have limited support networks (McMahon & Curtin, 2013). Previous research has identified the importance of peer support for CIC (Kools, 1999; Emond, 2003; Ridge & Millar, 2000; Hass & Graydon, 2009; Farineau et al., 2013; Singer et al., 2013; Sugden, 2013), whilst identifying the difficulties CIC can experience in their peer relationships (Luke & Banerjee, 2012; McMahon & Curtin, 2013). It also highlights the stigmatising interactions CIC experience (Kools, 1999; Emond, 2014).
The Importance of Social Support

Social support and peer relationships are important for wellbeing in children. They may buffer against the negative consequences of adversity (Criss et al., 2002; Salazar et al., 2011), can facilitate emotional regulation (Farley & Kim-Spoon, 2014), and are linked to academic achievement (Chu et al., 2010). For CIC, positive peer relationships are linked to resilience (Hass & Graydon, 2009), educational progress (Sugden, 2013), protection from bullying (Emond, 2014) and increased self-esteem (Farnieau et al., 2011). CIC reportedly value the support, advice and encouragement they receive from peers (Emond, 2003). This support can be both practical, and related to emotional needs (Blower et al., 2004).

Social Difficulties of CIC

Research has highlighted the role that CIC’s social understanding and behaviour may play in their peer relationships. Kay & Green (2016) found CIC showed a hostile attribution bias (a tendency to interpret the intent of others behaviour as hostile), and theory of mind deficits (TOM, the ability to attribute mental states to others) compared to a low risk comparison group. TOM was linked to social competence, suggesting social cognitive deficits and biases may play a role in the relationship difficulties CIC experience. Teachers and foster carers also describe how CIC exhibit behaviours that negatively impact their ability to make and maintain friendships (Canning, 1974; Luke & Banerjee, 2012;). They describe the; social withdrawal (Canning, 1974); aggression (Canning, 1974) and inappropriate behaviour (Luke & Banerjee, 2012) CIC display. Foster carers report how these behaviours result in peers rejecting CIC (Luke & Banerjee, 2012). Teachers also described how some CIC comply with peer custom (Canning, 1974), suggesting not all CIC demonstrate behaviour that negatively impacts their peer relationships. When discussing CIC’s peer
relationships, foster carers and teachers did not comment on the role stigma and discrimination play.

**Stigma and Discrimination**

Stigmatisation is a process that occurs when one’s social identity deviates from the norm, causing others to feel uncomfortable (Goffman, 1963). It is comprised of two components: the recognition of difference, and the devaluation of a person’s social identity by others (Dovidio et al., 2000). Stigma exists in a social context, rather than within individuals (Hebl & Dovidio, 2005). One form of stigma that may be particularly relevant to CIC is self-stigma. This occurs when people become aware of the social devaluation connected with their identity and internalise the negative value placed on them (Bos et al., 2013). Studies have demonstrated the negative consequences of stigmatisation on individuals’ wellbeing (Meyer, 2003). In particular, fear of being identified as belonging to a stigmatised group has been identified as a source of psychological distress (Pachankis, 2007).

Components of stigma have been identified in studies with CIC. Adults (both laypeople and those working with CIC) describe children in RC with negative attributes including; sadness, aggression, trouble-making behaviour and loneliness (Calheiros et al., 2015; Garrido et al., 2016). These perceptions are more negative than those held of children not in care (Garrido et al., 2016). Children in RC are less likely to be described as happy and nurtured than children not in care. Interestingly, adults working with CIC may be more likely to view CIC negatively, than laypeople (Garrido et al., 2016). These studies suggest CIC are recognised as different (stage one of stigmatisation, Dovidio et al., 2000).

CIC, and professionals who work with them, have reported the stigmatising nature of the care system (McMurray et al., 2010). CIC described how meeting with professionals,
such as health visitors, made them feel different to their peers. Similarly, Rauktis et al. (2011) discussed how children in RC perceived the restrictions placed upon them as stigmatising, especially if they were viewed as different to those placed on children not in care. These studies suggest CIC experience the second stage of stigmatisation (devaluation of a person’s social identity, Dovidio et al., 2000) as the recognition of difference results in differential treatment. CIC reject identities that can lead to stigma, particularly the “in care” identity (McMurray et al., 2010). CIC described how they are not like others in care, and rejected the involvement of professionals, as this set them apart from their peers. This suggests CIC experience self-stigma, as they are aware of the social devaluation connected with their identity (Bos et al., 2013).

It appears CIC also experience stigmatising interactions in their peer relationships and may experience self-stigma as a result. The peers of CIC have been reported to make assumptions regarding their; “in-care” status (Kools, 1997; Emond, 2014), birth parents (Emond, 2014), behaviour (Kools, 1997; Emond, 2014) and wellbeing (Kools, 1999). These assumptions are used to label CIC as ‘different’ (Kools, 1997; Emond, 2014), and lead to the diminished status of CIC (Kools, 1997). Children are also reported to display discriminatory behaviours towards CIC (Kools, 1997). CIC’s diminished status, and the discriminatory behaviour they experience lead to feelings of shame and difference, which can become internalised into their self-view (Kools, 1999). In turn, this self-view can impact CIC’s behaviour towards peers. CIC often choose not to disclose their “in-care” status (McMurray et al., 2011; Emond, 2014), owing to concerns about being “found out” (Emond, 2014). They were reported to “put up fronts” and to keep relationships superficial (Kools 1997; Ibrahim & Howe, 2011). These behaviours negatively impacted the relationships and wellbeing of
CIC (Kools, 1999), as would be expected from theory and research around stigma (Meyer, 2003; Pachankis, 2007).

Current Literature Review Aims

Given the importance of peer relationships for CIC, it is necessary to understand the role stigma may play. The negative impact of stigma on CIC’s peer relationships, as well as on their wellbeing, highlights the need to understand this phenomenon further. This is especially important given the potential to forget the influence others may play in CIC’s peer difficulties, and to focus solely on the impact of CIC’s social understanding and behaviour (Luke & Banerjee, 2012). Understanding the role of stigma in the peer relationships of CIC could inform interventions to facilitate more positive peer relationships for CIC.

The current literature review aims to examine the existing research around CIC’s peer relationships, with a view to exploring the role stigma may play. The research will be evaluated, common themes will be identified, discrepancies between studies will be discussed, and questions that have not yet been answered will be identified.

Method

The literature review followed four stages: identifying a research question; searching for relevant studies; critically appraising identified research papers; and extracting findings pertinent to the research question.

Identifying a research question

The research question was ‘what are the experiences of stigma and discrimination in CIC’s peer relationships’. Peer relationships were chosen as the review focus, as they have been identified as particularly important to CIC (Emond, 2003; Hass & Graydon, 2009; Sugden, 2013). To ensure a focussed review, CIC’s experiences of stigma and discrimination in other relationships and contexts were not included.
Searching for relevant studies

On the 5th of February 2018, a systematic search was undertaken to identify relevant research. Key words to include in the search terms were identified by scrutinising literature exploring the identified categories for common key words and synonyms. Using the search terms and Boolean Logic described in Table 1, EBSCO-HOST was used to search six electronic databases (Child Development & Adolescent Studies, Medline, PsychArticles, PsychBooks, Psychology & Behavioural Sciences collection, PsychInfo). Table 2 details the identified inclusion criteria. Articles were included and excluded in three stages using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher et al., 2009). Figure 1 describes the process used for identifying and selecting journal articles. This resulted in the identification of 270 articles, 244 following the removal of duplicates. Sixteen further articles were identified through communication with knowledgeable professionals. 28 articles were identified from screening the reference lists of articles identified in the original search.

Table 1: Search Terms Used

<table>
<thead>
<tr>
<th>No.</th>
<th>Search Category</th>
<th>Search terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Population</td>
<td>Title: child* looked after OR foster car* OR looked after child* OR out of home care OR child* in care OR former system youth OR care system OR residential care OR foster youth OR kinship care</td>
</tr>
<tr>
<td>2</td>
<td>Experience</td>
<td>All: stigma* OR discriminat* OR bias* OR prejudice* OR stereotyp* OR identity OR exclus* OR ineq*</td>
</tr>
<tr>
<td>3</td>
<td>Relationship</td>
<td>All: social OR peer* OR friend* OR psychosocial OR relations*</td>
</tr>
<tr>
<td>4</td>
<td>Excluders</td>
<td>Not: older OR elderly OR dementia OR aged OR geriatric OR disability OR medic*</td>
</tr>
</tbody>
</table>
**Figure 1: PRISMA diagram showing the decision-making process for article selection**

Exclusion Criteria:
Articles were excluded for the following reasons: they did not focus on the CIC (i.e. focussed on policy, professionals, assessment tools, or interventions); they focussed on a relationship other than peer relationships (i.e. relationships with birth parents or foster carers); they focussed on identity/mental health/school outcomes with no reference to the impact of peer relationships; they focussed on something other than peer experiences (i.e. pregnancy, race, sexuality); they focussed on physical health or health care provision; participants were not currently or previously in care; or they focussed on peer relationships in a residential care setting.

Articles were excluded if they took place in a non-westernised society. Reviews, books and dissertations were eliminated. Articles published before 1975 were excluded, as were articles not published in English.
Table 2: Inclusion criteria for journal articles

<table>
<thead>
<tr>
<th>No.</th>
<th>Inclusion criteria</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Participants were CIC, or had left care in the last five years.</td>
<td>This ensured participants remembered their time in care accurately.</td>
</tr>
<tr>
<td>2</td>
<td>Articles reported on CIC’s peer experiences, with discussion around the presence, or absence, of stigma and discrimination and its effects. Articles focusing solely on relationships within RC were excluded.</td>
<td>It was decided that, as stigma and discrimination associated with being a CIC was less likely in relationships with other CIC, articles had to include discussion of relationships with children not in care.</td>
</tr>
<tr>
<td>3</td>
<td>The search was restricted to research published after 1975.</td>
<td>As stigma is socially and culturally defined (Hebl &amp; Dovidio, 2005), it was decided that any articles published prior to 1975 would likely not be relevant to the current stigmatising interactions of CIC.</td>
</tr>
<tr>
<td>4</td>
<td>Research carried out in Westernized societies (including those in the USA, New Zealand, Australia and within the European Union) were eligible for inclusion.</td>
<td>It was decided that non-western societies may hold different beliefs about CIC, which may impact the stigma and discrimination children experience.</td>
</tr>
<tr>
<td>5</td>
<td>Articles were published in English, in either a peer reviewed journal or book.</td>
<td>This ensured the quality and relevance of included studies.</td>
</tr>
</tbody>
</table>

Critically appraising the research papers

Included studies were evaluated using either; the Consolidated Criteria for Reporting Qualitative Research (COREQ; Tong et al., 2007) for qualitative papers; or the Standard Quality Assessment Criteria for Evaluating Primary Research Papers (SQAC; Kmet et al., 2004) for quantitative papers. See Table 3 for a description of the evaluation tool used and Table 4 for details of the evaluation method.
### Table 3: Description of evaluation tool used

<table>
<thead>
<tr>
<th>Critical Evaluation Tool</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consolidated Criteria for Reporting Qualitative Research (COREQ; Tong et al., 2007)</td>
<td>The COREQ is a 32-item checklist focusing on research teams and reflexivity, study design and analysis and findings.</td>
</tr>
<tr>
<td>Standard Quality Assessment Criteria for Evaluating Primary Research Papers (SQAC; Kmet et al., 2004)</td>
<td>The quantitative SQAC is a fourteen item checklist focusing on aspects such as study design (sample size, controlling for confounds), reporting (sufficient detail) and findings (were the conclusions supported by the results).</td>
</tr>
</tbody>
</table>

### Table 4: Description of evaluation method used

#### Evaluation process

The COREQ and SQAC were used as a guide to inform the researcher’s thinking, and to establish areas of strength and weakness in the included studies.

Although the SQAC provides a numerical rating system, this was not used. The decision was made to categorise all studies using the same scale.

As the majority of studies were qualitative, and the COREQ does not use a numerical rating scale, the decision was made to evaluate each article against the appropriate checklist, and give it a quality rating of high, medium or low.

When an article was mixed methods, both sets of criteria were used and applied to the appropriate parts of the study to determine if the quality was high, medium or low overall.

Low quality articles (three identified) were included in the review, as researchers have concluded that low quality papers can still provide valuable information about a topic under investigation (Pawson, 2007), but the findings are treated with caution.

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**Extracting findings pertinent to the research question**

Any findings relating to stigma and discrimination in the peer relationships of CIC were extracted and grouped into themes using thematic analysis (Braun & Clarke, 2006).

Findings that contradicted each other were noted.
<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Participant details:</th>
<th>Care:</th>
<th>Recruitment method</th>
<th>Research questions/aims</th>
<th>Study design and data collection</th>
<th>Data analysis</th>
<th>Quality rating</th>
<th>Themes relevant to stigma and discrimination in peer relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aldgate (2009)</td>
<td>UK</td>
<td>30 8-16 17F 13M</td>
<td>30 White</td>
<td>Formal kinship care</td>
<td>Purposeful Sample</td>
<td>To find out from children what it was like to grow up as a child in kinship care. Interviews and ecomaps</td>
<td>No information regarding data analysis method (likely TA)</td>
<td>Low</td>
<td>Good peer relationships considered crucial to CIC. Experiences of bullying and negative behaviour from peers. The importance of being the same as their peers. The need to guard the &quot;in care&quot; label and information associated with it - some choose not to disclose, and for others telling people about their circumstance was not an issue. Some talked of having peers in similar circumstances which helped them cope.</td>
</tr>
<tr>
<td>Burgess et al (2010)</td>
<td>UK</td>
<td>12 11-17 7F 5M</td>
<td>Not reported</td>
<td>Kinship care (10 secured by statutory order, 2 informal)</td>
<td>Purposeful Sample</td>
<td>To develop understanding of children's experiences of living with kinship carers</td>
<td>Semi-structured interviews and mind mapping exercise</td>
<td>Unclear regarding data analysis method (likely TA)</td>
<td>Low</td>
</tr>
<tr>
<td>Emond (2014)</td>
<td>Ireland</td>
<td>16 8-18 1F 11M</td>
<td>Not reported</td>
<td>Residential care homes</td>
<td>Purposeful Sample</td>
<td>To gain an insight into the school experiences of children in residential care in Ireland. To examine the ways in which children negotiated and managed the two social arenas of school and children's home.</td>
<td>6 semi-structured interviews and a focus group with each participant</td>
<td>NA and TA</td>
<td>Medium</td>
</tr>
<tr>
<td>Farmer et al (2013)</td>
<td>UK</td>
<td>80 8-18 47F 33M</td>
<td>62 White British, 10 Mixed Ethnicity, 8 Black</td>
<td>Informal Kinship care</td>
<td>Purposeful Sample</td>
<td>To explore children and young people's views of being brought up by informal kinship carers.</td>
<td>Structured interviews using investigator-based approaches (Quinton &amp; Rutter, 1988), network maps and questionnaires.</td>
<td>Mixed methods approach, Bivariate analysis and TA.</td>
<td>Medium</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Participant details:</td>
<td>Care:</td>
<td>Recruitment method</td>
<td>Research questions/aims</td>
<td>Study design and data collection</td>
<td>Data analysis</td>
<td>Quality rating</td>
<td>Themes relevant to stigma and discrimination in peer relationships</td>
</tr>
<tr>
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<td>-------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hedin et al (2011)</td>
<td>Sweden</td>
<td>17</td>
<td>13-16</td>
<td>9F BM</td>
<td>Foster care</td>
<td>Purposive sample</td>
<td>States CA but reported process appears closer to TA</td>
<td>Medium</td>
<td>Good peer relationships considered crucial to CIC. Experiences of bullying and negative behaviour from peers. Responses to bullying seemed to change as a result of foster care placement. The importance of being the same as their peers. The need to guard the “in care” label and information associated with it.</td>
</tr>
<tr>
<td>Kools (1999), Kools (1997)</td>
<td>USA</td>
<td>17</td>
<td>15-19</td>
<td>9F BM</td>
<td>Group home</td>
<td>Purposive sample</td>
<td>Semi-structured interview, naturalistic observations and care records</td>
<td>Dimensional analysis</td>
<td>High</td>
</tr>
<tr>
<td>Malegan et al. (2013)</td>
<td>UK</td>
<td>9</td>
<td>12-18</td>
<td>4F SM</td>
<td>Foster care</td>
<td>Purposive sample</td>
<td>Semi-structured interviews</td>
<td>IPA</td>
<td>Medium</td>
</tr>
<tr>
<td>Messing (2006)</td>
<td>USA</td>
<td>40</td>
<td>10-14</td>
<td>22F 1SM 3 did not specify</td>
<td>Kinship care</td>
<td>Purposive sample</td>
<td>Focus group using semi-structured interview</td>
<td>No information regarding data analysis method (likely TA)</td>
<td>Low</td>
</tr>
<tr>
<td>Ridge and Millar (2000)</td>
<td>UK</td>
<td>16</td>
<td>11-19</td>
<td>9F 7M</td>
<td>Residential or foster care</td>
<td>Purposive sample</td>
<td>Semi-structured interviews</td>
<td>Thematic indexing (TA)</td>
<td>Medium</td>
</tr>
</tbody>
</table>

Key: CA= Content Analysis, TA= Thematic, NA= narrative analysis, IPA = Interpretative phenomenological analysis
Table 6: Summary of key methodological details and themes of included quantitative study

| Study                        | Country | N: | Age (years): | Gender | Ethnicity/Nationality | Type | Time in care | Recruitment method | Research questions/aims                                                                                                                                                                                                 | Study design and data collection | Measures | Data analysis | Quality rating | Findings relevant to stigma and discrimination in peer relationships                                                                                                                                                                                                 |
|------------------------------|---------|----|--------------|--------|-----------------------|------|--------------|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------|---------------|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------
<p>| Benbenishty et al. (2017)   | USA     | 393,792 non-foster youths, 1,576 foster care youths | 14-17  | Non-foster care sample 50.9% F / 49.1% M | Non-foster care sample 50.3% Hispanic origin, 3.7% African American, 1.0% Native American, 23.7% Caucasian, 10.4% Asian | Foster care sample 51.1% Hispanic origin, 10% African American, 2.6% Native American, 16.8% Caucasian, 4.4% Asian | Not reported | Not reported | Secondary data from California Healthy Kids Survey. Survey administered biannually to all public school students by the education department | To examine data collected from adolescents who are currently in foster care, alongside their same aged peers, with in the same schools in California. To examine whether differences in school experiences between foster students and their peers may actually explain the differences reported in their academic ability, specifically whether background variables and negative school experiences explain differences in academic performance. | ANCOVA and Hierarchical linear regression. | Medium                  | Significant differences in school-related perceptions and experiences between foster youth and non-foster youths. More victimisation ($F = 396.42$, $p &lt; .001$), more discrimination-based harassment ($F = 251.15$, $p &lt; .001$), less feeling safe in school ($F = 581.01$, $p &lt; .001$), lower levels of belongingness ($F = 862.36$, $p &lt; .001$), lower participation ($F = 663.481$, $p &lt; .001$) and lower self-reported grades ($F = 3,091.32$, $p &lt; .001$) in foster care youths compared to non-foster care youths. No significant difference in self-reported grades, after controlling for the students background, involvement with victimisation, climate perceptions and skipping class ($R^2 = 0.180$, $p &gt; .001$), (precise $p$ value not reported). |</p>
<table>
<thead>
<tr>
<th>Checklist domain (COREQ)</th>
<th>Domain 1: Research team and reflexivity</th>
<th>Domain 2: Study design</th>
<th>Domain 3: Analysis and findings</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aldgate (2009)</td>
<td>Lacking details regarding the researcher(s), their assumptions, and their relationship with participants</td>
<td>Lacking detail regarding the theoretical and methodological orientation, data analysis approach, number of non-participants, reasons for non-participation and data collection method (e.g. duration of interviews, example questions and prompts and whether interviews were recorded)</td>
<td>Lacking detail regarding how themes were derived and a description of the coding tree was not given. Results appeared to be presented as categories, rather than as themes, identified through analysis. Quotations were provided but participant numbers/names were not given alongside these. Little discussion of discrepancies in the data</td>
<td>Low</td>
</tr>
<tr>
<td>Burgess et al. (2010)</td>
<td>Lacking detail regarding the researcher(s), their assumptions, and their relationship with participants</td>
<td>Lacking detail regarding the theoretical and methodological orientation, data analysis approach, number of non-participants, reasons for non-participation and data collection method (e.g. duration of interviews, example questions and prompts and whether interviews were recorded). Gave good detail regarding participant characteristics</td>
<td>Multiple data coders were used, quotations were provided and participant numbers/names were given alongside these. However a description of the coding tree was not given. Results appeared to be presented as categories, rather than as themes. Identified through analysis</td>
<td>Low</td>
</tr>
<tr>
<td>Emond (2014)</td>
<td>Lacking detail regarding the researcher’s assumptions but did provide information about their relationship with participants</td>
<td>Gave good detail regarding the methodological orientation, data analysis approach and participant selection. Also utilised repeat interviews. However less information was given regarding the theoretical orientation, participant characteristics (e.g. ethnicity and time in care), number of non-participants, reasons for non-participation and data collection methods (e.g. duration of interview and example questions and prompts)</td>
<td>Results were presented clearly, quotations were provided that supported the findings, and participant numbers/names were given alongside these. Discrepancies were discussed. However, a description of the coding tree was not given</td>
<td>Medium</td>
</tr>
<tr>
<td>Farmer et al. (2013)</td>
<td>Lacking detail regarding the researcher(s), their assumptions, and their relationship with participants</td>
<td>Gave good detail regarding the methodological orientation, data analysis approach, participant characteristics and participant selection. Example questions and prompts were given. However less information regarding theoretical orientation, other data collection methods (e.g. duration of interview and whether interviews were recorded), number of non-participants and reasons for non-participation was given</td>
<td>Lacking some detail regarding data analysis (e.g. descriptions of coding tree), however these aspects are less relevant to the mixed method approach of the study. Findings reported were clear and quotations were provided that supported the findings.</td>
<td>Medium*</td>
</tr>
<tr>
<td>Hedin et al. (2011)</td>
<td>Lacking detail regarding the researcher(s), their assumptions, and their relationship with participants</td>
<td>Gave good detail regarding the theoretical and methodological orientation, data analysis approach, participant selection (including number of non-participants) and participant characteristics. However less information was given regarding reasons for non-participation and data collection methods (e.g. duration of interview and example questions and prompts)</td>
<td>Results were presented clearly, quotations were provided that supported the findings, and participant numbers/names were given alongside these. Discrepancies were discussed. However, a description of the coding tree was not given</td>
<td>Medium</td>
</tr>
<tr>
<td>Checklist domain (COREQ)</td>
<td>Domain 1: Research team and reflexivity</td>
<td>Domain 2: Study design</td>
<td>Domain 3: Analysis and findings</td>
<td>Rating</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------------------------</td>
<td>------------------------</td>
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<td>--------</td>
</tr>
<tr>
<td>Kools (1999), Kools (1997)</td>
<td>Lacking detail regarding the researcher's assumptions but did provide information about their relationship with participants</td>
<td>Gave good detail regarding the theoretical and methodological orientation, data analysis approach, participant selection (including number of non-participants, reasons for non-participation), participant characteristics and data collection methods (e.g. duration of interview and example questions and prompts)</td>
<td>Results were presented clearly, multiple coders were used, participants provided feedback on the findings, quotations were provided and participant numbers/names were given alongside these. Discrepancies were discussed and a description of the coding tree was given</td>
<td>High</td>
</tr>
<tr>
<td>Madigan et al. (2013)</td>
<td>Lacking detail regarding the researcher(s), their assumptions, and their relationship with participants</td>
<td>Gave good detail regarding the theoretical and methodological orientations, data analysis approach, participant selection (including number of non-participants) and duration of interviews. However less information was given regarding participant characteristics (e.g. ethnicity and time in care), reasons for non-participation and certain data collection methods (e.g. example questions and prompts)</td>
<td>Results were presented clearly, multiple coders were used, participants provided feedback on the findings, quotations were provided that supported the findings, and participant numbers/names were given alongside these. Discrepancies were discussed and a description of the coding tree was given</td>
<td>Medium</td>
</tr>
<tr>
<td>Messing (2006)</td>
<td>Lacking detail regarding the researcher's assumptions but did provide information about their relationship with participants</td>
<td>Lacking detail regarding the theoretical and methodological orientation, data analysis approach, number of non-participants, reasons for non-participation and certain data collection methods (e.g. whether interviews were recorded). Gave good details regarding other data collection methods (e.g. duration of interviews and example questions and prompts) and participant characteristics</td>
<td>Lacking detail regarding how themes were derived and a description of the coding tree was not given. Results appeared to be presented as categories, rather than as themes, identified through analysis. Quotations were provided but participant numbers/names were not given alongside these.</td>
<td>Low</td>
</tr>
<tr>
<td>Ridge and Millar (2000)</td>
<td>Lacking detail regarding the researcher's assumptions. Provided some information about their relationship with participants</td>
<td>Gave some detail regarding the theoretical and methodological framework and data analysis approach. However less information was given regarding participant characteristics (e.g. time in care), number of non-participants, reasons for non-participation and data collection methods (e.g. example questions and prompts, and duration of interviews)</td>
<td>Lacking some detail regarding how themes were derived and a description of the coding tree was not given. Results appeared to be presented as categories, rather than as themes, identified through analysis. Quotations were provided that supported the findings, and participant numbers/names were given alongside these. Discrepancies were discussed</td>
<td>Medium</td>
</tr>
</tbody>
</table>

* decided in combination with SQAC due to mixed methods approach to the study
Table 8: Summary of key factors relating to the quality ratings of quantitative and mixed-methods studies

| Checklist criteria (SQAC) | 1. Question/objective sufficiently described? | 2. Study design evident and appropriate? | 3. Method of subject/comparison group selection or source of information input variables described and appropriate? | 4. Subject (and comparison group, if applicable) characteristics sufficiently described? | 5. If interventional and random allocation was possible was it described? | 6. If interventional and random allocation was possible, was it reported? | 7. If interventional and binding of investigators was possible, was it reported? | 8. Outcome and (if applicable) exposure measure(s) well defined and robust to measurement/misclassification bias? | 9. Means of assessment reported? | 10. Analytic methods described/justified and appropriate? | 11. Some estimate of variance is reported for the main results? | 12. Controlled for confounding? | 13. Results reported in sufficient detail? | 14. Conclusion supported by the results? | Rating |
|--------------------------|---------------------------------------------|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| Benbenishty et al. (2017) | Yes                                         | Yes                                    | Partial                                                                                                                             | N/A                                                                             | N/A                                                                             | Partial                                                                       | Yes                                                                               | Partial                                                                       | Yes                                                                               | Yes                                                                               | Yes                                                                               | Yes                                                                               | Partial                                                                       | Medium                                                                         |
| Farmer et al. (2013)     | Partial                                     | Yes                                    | Yes                                                                                                                                | N/A                                                                             | N/A                                                                             | N/A                                                                           | Yes                                                                               | Yes                                                                            | Yes                                                                               | Yes                                                                               | N/A                                                                               | Yes                                                                               | Yes                                                                            | Medium*                                                            |

* decided in combination with COREQ due to mixed methods approach to the study
Results and Discussion

The following section will discuss the characteristics and quality of included studies and identified themes. Themes include: 1) good peer relationships are considered crucial to CIC; 2) CIC experience negative behaviour from peers; 3) CIC discuss the importance of being the same as their peers; 4) CIC demonstrate a desire to guard the “in care” label and information associated with it; 5) the impact on children’s wellbeing and behaviour; 6) the impact of care and the care setting on CIC; and 7) the importance of context and sense making for CIC. Of particular salience, and relevance to the research questions, were the themes; CIC experience negative behaviour from peers; CIC discuss the importance of being the same as their peers; and CIC demonstrate a desire to guard the “in care” label and information associated with it. The large majority of identified articles discussed these themes. Results will be considered in the context of current stigmatisation research and theory. Limitations of findings will be discussed, and considerations for further research will be presented. The results and discussion have been combined to prevent repetition.

Summary of Included Studies

Information about the studies’ location, participants, care setting, recruitment method, research aims, design, analysis, quality rating and identified themes were extracted. Where articles used psychological measures, these were reported if relevant to the extracted findings. Across the eleven identified articles, nine were qualitative (see Table 5), one was mixed methods (see Table 5) and one was quantitative (see Table 6). Two of the nine qualitative papers were from the same study (Kools, 1997; Kools, 1999) so these articles were analysed and evaluated as one. As the mixed methods study (Farmer et al., 2013) detailed a
predominantly qualitative data collection method, and did not use a comparison group, this article is presented with the qualitative articles. The quantitative paper (Benbenishty et al., 2017) used a comparison group, making it difficult to describe alongside the qualitative papers. Therefore, the characteristics of this study are described separately. Most studies were carried out in the UK (5), and the USA (3) with a minority from elsewhere; Ireland (1); and Sweden (1).

Qualitative and mixed-methods studies

Participant Characteristics

The views of 237 participants were captured in the qualitative and mixed methods studies. Just over half the participants were female (129 females/105 males), although the gender of three participants was not specified. Participants were between eight and nineteen years of age and were from a diverse range of cultural and ethnic backgrounds, however, not all studies reported participant’s ethnicity. 33 participants lived in RC, 26 were in FC and sixteen participants were in either RC or FC. 70 participants were in formal KC and 92 were in informal KC. Participants ranged from experiencing one to nine care placements. Time in care ranged from two weeks to fourteen years or more, however some studies did not report length of time in care. This suggests a large range of CIC’s voices have been captured, although the views of children under the age of eight have been missed.

Quality of Research

The quality of studies varied (see Table 7). The majority (5) were rated as medium quality, three were rated as low quality and one was rated as high quality. The mixed method study (Farmer et al., 2013) was rated medium quality (see Table 7 and 8). See Table 9 for a description of what each quality rating entailed, as described by the researcher. Most studies
did not provide enough detail about the researcher and their relationship with participants to allow evaluation of their reflexivity.

**Table 9:** Description of quality ratings of included studies

<table>
<thead>
<tr>
<th>Quality Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Quality</td>
<td>This study provided good detail in its description of data collection, design and analysis and provided convincing reasons for all aspects of the design. It had a clear theoretical underpinning, methodological orientation and analysis strategy and made attempts to improve reliability of analysis (for example, asking participants to review data). It provided clear findings, which were supported by the data (for example, quotations) and engaged in discussion around inconsistencies.</td>
</tr>
<tr>
<td>Medium Quality</td>
<td>These studies often had two to three weaknesses. They often missed details about data collection (for example, participant response rate, reasons for non-participation) and design and analysis (for example, theoretical underpinning, interview questions and participant characteristics, such as ethnicity and time in care). They provided clear findings, which were supported by the data (for example, quotations) and engaged in discussion around inconsistencies. Some made efforts to increase reliability (e.g. multiple coders). The mixed-method study provided good detail about data collection, design and analysis, although they missed some detail (for example, whether interviews were recorded, and reasons for non-participation). The study design was appropriate.</td>
</tr>
<tr>
<td>Low Quality</td>
<td>These studies had one or more major flaws. They provided no detail about theoretical and methodological orientation or the data analysis strategy used. Studies identified themes in the data prior to data analysis and/or did not discuss inconsistencies in the data. They missed key details about data collection and design, such as those discussed in medium rated studies.</td>
</tr>
</tbody>
</table>

**Design and Data Analysis**

All qualitative studies and mixed-methods research used purposive sampling techniques, recruiting through organisations in contact with CIC. It is therefore possible this could have resulted in recruitment bias. Those willing to engage with a social worker, or those attending support groups for CIC, may be in a more stable situation or may have had a better experience of care than others. If so, this may have resulted in the voices of CIC who have had a less stable, more difficult experience being missed. As time in care, number of placements,
participant attrition rates and reasons for non-participation were not always reported, this was hard to assess.

All but one of the studies used interviews as their main data collection method. Emond (2014) used multiple interviews to develop a trusting relationship between researcher and interviewee. This approach was likely to be particularly beneficial for research with CIC whose past experiences of discussing their opinions and feelings with professionals may have led to changes in their care. In addition to interviews, Hedin et al., (2011) used text messages, Emond (2014) used focus groups and Kools (1997; 1999) used naturalistic observations and care records. This additional data was combined with the interview data and examined using the same method of analysis (Kools, 1997; 1999; Hedin et al., 2011; Emond, 2014). These additional data collection approaches added depth to the data collected. For example, focus groups may have captured attitudes that could have been missed through direct questioning (Bagnoli & Clark, 2010). Messing (2006) used focus groups as their sole source of data collection.

Not all qualitative studies stated their data analysis approach. Those that did used Content Analysis (CA, N= 1), Thematic Analysis (TA, N= 2), Narrative Analysis (NA, N= 1), Dimensional Analysis (N= 1) and Interpretative Phenomenological Analysis (IPA, N= 1). The mixed methods design (Farmer et al., 2013) used Bivariate Analysis, alongside Thematic Analysis.

Quantitative study

Participant Characteristics

Benbenishty et al. (2017) included the data of 393,792 young people not in FC and 1,576 young people in FC. The proportion of participants in the FC sample reflected the prevalence of
CIC in the general population. Participants were fourteen to seventeen years of age and all from California, USA. All participants were in 9\textsuperscript{th} or 11\textsuperscript{th} grade, with a slightly lower percentage of the FC sample in 9\textsuperscript{th} grade. There was a slightly higher percentage of females in the FC sample. Participants were from a diverse range of ethnic backgrounds, with percentages from each ethnic background reflecting existing racial disparities in FC in the area. Demographic factors (gender, race and ethnicity) were controlled for by including them as covariates in the analysis. Findings cannot be applied to children younger than fourteen years of age, or from countries outside the USA, as the experiences of these children were not captured. Type of care, and time spent in care, was not reported. Therefore, it was not possible to identify any intra-group differences, for example, if time in care, or type of care, had an impact on self-reported grades.

\textit{Quality of Research}

Benbenishty \textit{et al.} (2017) was rated as medium quality (see Table 8). The study questions, design and results were well described and appropriate. More detail about the data analysis method would have been useful, to aid understanding of the methods used.

\textit{Design and Data Analysis}

Benbenishty \textit{et al.} (2017) used secondary data from a large survey administered bi-annually to all public-school students in California. The survey used non-standardised measures examining constructs including victimisation, discrimination-based harassment, school climate and academic achievements. Often these questions involved Likert Scales. Due to the challenges of self-report (Brener \textit{et al.}, 2003), especially self-report of academic achievement (Rosen \textit{et al.}, 2017), the findings of this study need to be considered with caution. The study used analysis of covariance to compare children in FC to those not in FC, and hierarchical linear
regression to explain which constructs were related to children’s self-reported academic achievement, which seemed appropriate given the studies aims.

**Findings and Major Themes**

The following incorporates the data of all included studies. Analysis of the findings resulted in the identification of seven themes related to stigma and the peer relationships of CIC. These are presented in Table 10. It appears that, although CIC often have good peer relationships, they also experience stigma and discrimination in their peer interactions, which can lead to a sense of difference surrounding their identity. CIC believe it is important to be the same as their peers and, as a result, they often hide their “in care” label, and information associated with it, to prevent others knowing they are “different”. The care setting also impacts on the peer experiences of CIC. It appears that the context a CIC is in, and the sense they make of this, impacts CIC’s peer relationships, and their feelings towards these experiences. These themes will be discussed in detail below.

**Table 10: Identified themes**

<table>
<thead>
<tr>
<th>No.</th>
<th>Identified Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Good peer relationships are considered crucial to CIC</td>
</tr>
<tr>
<td>2</td>
<td>CIC experience negative behaviour from peers</td>
</tr>
<tr>
<td>3</td>
<td>CIC discuss the importance of being the same as their peers</td>
</tr>
<tr>
<td>4</td>
<td>CIC demonstrate a desire to guard the “in care” label and information associated with it</td>
</tr>
<tr>
<td>5</td>
<td>The impact on children’s wellbeing and behaviour</td>
</tr>
<tr>
<td>6</td>
<td>The impact of care and the care setting on CIC</td>
</tr>
<tr>
<td>7</td>
<td>The importance of context and sense making for CIC</td>
</tr>
</tbody>
</table>

1. **Good peer relationships are considered crucial to CIC**

Eight articles discussed the importance of peer relationships for CIC (Kools, 1997; 1999; Ridge & Miller, 2000; Aldgate 2009; Burgess *et al.*, 2010; Hedin *et al.*, 2011; Madigan *et al.*,...
Researchers reported that the peer relationships of CIC are particularly important, as these provide a sense of belonging outside of the care system (Ridge & Miller, 2000) and are CIC’s only “chosen” and “free” relationships. Seven articles discussed participant’s positive experiences of peer relationships (Ridge & Miller, 2000; Messing, 2006; Aldgate, 2009; Burgess et al., 2010; Hedin et al., 2011; Madigan et al., 2013; Emond, 2014) suggesting not all peer interactions of CIC are stigmatising. Positive peer relationships were linked to positive self-image and identity (Burgess et al., 2010; Hedin et al., 2011; Madigan et al., 2013; Emond, 2014), a sense of belonging (Ridge & Miller, 2000; Messing, 2006; Emond, 2014), school success (Hedin et al., 2011; Emond, 2014), social support (Ridge & Miller, 2000; Messing, 2006; Aldgate 2009; Burgess et al., 2010; Hedin et al., 2011; Madigan et al., 2013; Emond, 2014) and protection from other peers (Ridge & Miller, 2000; Emond, 2014).

Peer interaction and peer approval were reported to make CIC feel proud and happy (Hedin et al., 2011). CIC often felt they had friends they could trust and from whom they could seek support (Ridge & Miller, 2000; Messing, 2006; Burgess et al., 2010; Hedin et al., 2011). Success in school (academic, social, behavioural) was reported to be shaped by CIC’s sense of connection to others (Emond, 2014). The significance of peer relationships has been suggested in other areas of research (Criss et al., 2002; Emond, 2003; Blower et al., 2004; Chu et al., 2010; Farineau et al., 2013; Farley & Kim-Spoon, 2014; Hass & Graydon, 2009; Salazar, et al., 2011; Singer et al., 2013; Sugden, 2013). In line with the findings detailed above, peer relationships and social support have been linked to wellbeing and self-esteem (Chu et al., 2010; Farineau et al., 2011), emotional regulation and resilience (Hass & Graydon, 2009; Farley & Kim-Spoon,
2014), and academic achievement (Chu et al., 2010; Sugden, 2013) for both CIC and those not in care, suggesting the benefits of peer relationships are apparent for all children.

However, not all participants included in the review reported positive experiences. Farmer et al. (2012) reported that one third of participants were very limited socially (describing four or fewer people as “part of their inner circle”), suggesting these participants did not have many peer relationships. Refugees and immigrants often reported not trusting peers (Hedin et al., 2011). Kools (1997; 1999) reported participants had few meaningful relationships, and a participant in Madigan et al. (2013) talked of having no friends. As Kools (1997; 1999) was the oldest study included in the review, it is possible this study’s emphasis on discrimination, when compared to other included studies, reflects a change in the peer relationships of CIC over time. Further possible reasons for this discrepancy between studies will be discussed below.

2. Stigma and discrimination: CIC experience negative behaviour from peers

Difficult peer experiences were described by CIC, in line with findings elsewhere in the literature (Luke & Banerjee, 2012; McMahon and Curtin, 2013). Ten of the identified articles discussed children’s experience of discrimination from peers (Kools, 1997; 1999; Ridge & Miller, 2000; Messing, 2006; Aldgate, 2009; Hedin et al., 2011; Farmer et al., 2012; Madigan et al., 2013; Emond, 2014; Benbenishty et al., 2017). These experiences were described as common place (Kools, 1997; 1999; Madigan et al., 2013). Farmer et al. (2012) reported a third of participants had experienced bullying. Benbenishty et al. (2017) found CIC reported more experiences of victimisation, discrimination-based harassment and reported feeling less safe in school, when compared to same age peers not in care.
The peer experiences CIC described were consistent with theory and research around stigmatisation. Stigma appeared to occur because children’s living situation, and background, deviated from those of their peers (Kools, 1997; 1999; Messing, 2006; Aldgate, 2009; Hedin et al., 2011; Farmer et al., 2012; Madigan et al., 2013; Emond, 2014). Assumptions and misconceptions about CIC marked them as different (Kools, 1997; 1999; Madigan et al., 2013; Emond, 2014). This supports Goffman’s (1963) description of stigma (a process occurring when one’s social identity deviates from the norm) and fits with the first stage of stigmatisation (the recognition of difference, Dovidio et al., 2000). Similar assumptions of CIC have been found in adults (Calheiros et al., 2015; Garrido et al., 2016). Goffman (1963) also discussed the discomfort that arises in response to a “stigmatised” individual. It is unclear if the peers of CIC feel uncomfortable because of CIC’s “difference”, as the voices of children not in care are not represented.

The second stage of stigmatisation; the devaluation of one’s social identity (Dovidio et al., 2000) was also apparent. Children reported being singled out and stigmatised (Ridge & Miller, 2000), being intrusively questioned about their “abnormal status”, their family and their background (Kools, 1997; 1999), being ostracised by peers (Kools, 1997; 1999; Madigan et al., 2013) and others “holding their looked after status against them” (Madigan et al., 2013). Kools (1997; 1999) reported the devaluation of children’s identity that occurred as a result.

In contrast, Messing (2006) found most children did not experience being ostracised from their peers and, when children did experience teasing, they “took it in their stride”. Furthermore, Burgess et al. (2010) reported participants did not describe any experiences of bullying from peers. Participants in these studies were in KC. However, other studies with
participants in KC (Aldgate, 2009; Farmer et al., 2012) did report experiences of bullying and isolation, suggesting some children within KC are exposed to bullying behaviours. It is possible that the context a child is in, and the sense they make of it, has an impact on their peer experiences and the impact these experiences have upon them. The quality of included KC studies may also have played a role in this discrepancy. These ideas will be discussed further below.

3. Self-stigma: CIC discuss the importance of being the same as their peers

Nine articles discussed issues relating to sameness and difference (Kools, 1997; 1999; Ridge & Miller, 2000; Messing, 2006; Aldgate, 2009; Hedin et al., 2011; Farmer et al., 2012; Madigan et al., 2013; Emond, 2014). Children reported a desire to be the same as peers (Kools, 1997; 1999; Hedin et al., 2011; Madigan et al., 2013; Emond, 2014;) but often felt different (Kools, 1997; 1999; Ridge & Miller, 2000; Messing, 2006; Aldgate, 2009; Farmer et al., 2012; Madigan et al., 2013; Emond, 2014). They reported feeling “weird” (Madigan et al., 2013), which was associated with their “in-care” status, living situation and background (Kools, 1997; 1999; Ridge & Miller, 2000; Messing, 2006; Aldgate, 2009; Farmer et al., 2012; Madigan et al., 2013; Emond, 2014). CIC recognised the diminished status associated with being in care (Ridge & Miller, 2000; Aldgate, 2009; Madigan et al., 2013; Emond, 2014), suggesting they experienced self-stigma (Bos et al., 2013).

Children’s experience with peers played a role in developing this sense of difference (Kools, 1997; 1999; Ridge & Miller, 2000; Aldgate, 2009; Madigan et al., 2013; Emond, 2014). Differential treatment by peers impacted CIC identities, and resulted in an internalised stigmatised self-view (Kools, 1997; 1999; Edmond, 2014). Alongside the negative treatment
described above, CIC described peers feeling sorry for them and being over-protective and cautious around them (Madigan et al., 2013). Madigan et al. (2013) discussed how peers limited understanding of LA care led to further feelings of difference for CIC. Misconceptions about CIC were used to mark them as different (Emond, 2014). Negative stereotypes and assumptions were communicated to children in everyday situations (Kools, 1997; 1999), in keeping with the view that stigma occurs within social interactions (Hebl & Dovidio, 2005). Assumptions around delinquency and psychological impairment (Kools, 1997; 1999) and of being different and having a bad life, (Madigan et al., 2013) were reported. These assumptions were similar to those held by adults (CIC are sad, trouble-making and less happy than peers, Calheiros et al., 2015; Garrido, et al., 2016). These assumptions could contradict children’s view of themselves. For example, one participant described how peers assumed her life was bad, although she did not believe it was (Madigan et al., 2013). CIC were expected to behave in line with the assumptions of others (Kools, 1997; 1999) and described how once they were viewed as different, they were different (Madigan et al., 2013).

However, some children discussed how their life was not that different to peers (Madigan et al., 2013) and others reported they felt no different to peers (Messing, 2006; Burgess et al., 2010). Again, this discrepancy may be related to the context a child is in, and the sense they make of it, or may be related to the methodological rigour of included studies. This will be discussed further below.

4. CIC demonstrate a desire to guard the “in care” label and information associated with it

CIC ‘feared’ being labelled the “in care” child (Ridge & Miller, 2000). They described their dislike for the label (Madigan et al., 2013), which was associated with diminished social
status (Kools, 1997; 1999). Children made attempts to hide their “in-care” status, or to keep the reasons why they were in care a secret, although they varied with regard to how much they told their peers (Kools, 1997; 1999; Messing, 2006; Aldgate, 2009; Burgess et al., 2010; Farmer et al., 2012; Madigan et al., 2013; Emond, 2014). Some chose to tell peers nothing about being in care; some chose to tell peers that they were in care, but not why; and some chose to tell peers they were in care and why. Farmer et al. (2012) found around a quarter of participants chose not to tell anyone about their living situation, just over half told a few close friends and a minority were completely open about it. Children often fabricated stories about where they were living and why (Kools, 1997; 1999; Aldgate, 2009; Madigan et al., 2013; Emond, 2014;) to avoid being “found out”. Even when children chose to tell peers they were in care they often gave caveats to this information sharing, making sure peers did not discuss it with others (Madigan et al., 2013; Emond, 2014).

Some children found it easier to be open with peers who also had a different living situation (Messing, 2006; Aldgate, 2009; Burgess et al., 2010; Madigan et al., 2013). They described how having friends in a similar situation was helpful, as they could talk about their living situation together (Messing, 2006). Madigan et al. (2013) suggested this could be because they have something in common to hide. Other children reported no problem talking with peers about being in care (Messing, 2006; Aldgate, 2009; Burgess et al., 2010). Possible reasons for this discrepancy will be discussed below.

5. The Impact on Children’s Wellbeing and Behaviour

The findings also showed the impact of stigma and self-stigma on CIC’s wellbeing, in line with the stigma research (Meyer, 2003). Stigma, and the resulting self-stigma, impacted
children’s self-confidence (Hedin et al., 2011; Madigan et al., 2013), resulted in feelings of anxiety (Emond, 2014), a sense of isolation (Kools, 1997; 1999; Hedin et al., 2011), and an internalised stigmatised self-identity (Kools, 1997; 1999; Emond, 2014). Feelings of shame, (Kools, 1997; 1999) and powerlessness were associated with these experiences (Madigan et al., 2013; Emond, 2014). CIC reported lower levels of belongingness and participation in school (Benbenishty et al., 2017). Although it is not possible to conclude what caused this difference, it is possible that experiences of discrimination impacted CIC sense of belonging and participation.

Farmer et al. (2012) found those with smaller support networks were less likely to talk about the reasons for being in care. Although causality cannot be inferred, it is possible that withholding personal information impacted participant’s ability to make friends. Keeping one’s “in-care” status a secret, and the resulting one-directional information sharing, has been reported to impact CIC’s ability to maintain friendships (Ridge & Miller, 2000; Emond, 2014).

CIC were reported to adopt the behavioural expectations of others (Kools, 1997; 1999). Some children used their “in-care” status to elicit stereotypical responses from others (Emond, 2014). For example, some children elicited the stereotype of violent and deviant to protect themselves from bullies, and girls sometimes elicited a vulnerable stereotype to get support from peers. CIC also distanced themselves from peers and used aggressive behaviour to avoid difficult discussions related to their “in-care” status, and to protect themselves from teasing and bullying (Kools, 1997; 1999; Madigan et al., 2003; Aldgate, 2009; Emond, 2014). However, these strategies could lead to further isolation (Kools, 1997; 1999; Emond, 2014).
Withdrawal and aggression have been reported in other research with CIC (Canning, 1974; Luke & Banerjee, 2012). This research suggests CIC’s behaviour can impact their peer relationships in keeping with the above findings, however, a different explanation of these behaviours was given. CIC’s behaviour was believed to result from deficits in their social understanding rather than from a desire to protect themselves from difficult peer experiences (Canning, 1974; Luke & Banerjee, 2012). The extent to which social understanding deficits, and stigmatising peer relationships impact the difficulties CIC face in peer relationships is not yet clear.

6. The Impact of Care and the Care Setting on CIC

Other factors, unrelated to peer interactions, were also perceived as stigmatising by CIC and likely impacted self-stigma. Aspects of the care system (Ridge & Miller, 2000), children’s backgrounds and school performance (Madigan et al., 2013) all lead to feelings of difference. Children reported not wanting to invite peers to their RC home, or to ask peer’s families to undertake the necessary police checks required for sleepovers (Ridge & Miller, 2000). This was described as embarrassing, intrusive and stigmatising, and influenced CIC’s ability to maintain friendships. The stigmatising nature of the care system has been described elsewhere (McMurray et al., 2010; Rauktis et al., 2011), with CIC describing a desire to be treated the same as their peers (Rauktis et al., 2011).

The uncertainty of placements, and continuous placement (and school) changes also played a role in the peer difficulties CIC experienced and, in turn, created a further sense of difference (Kools, 1997; 1999; Ridge & Miller, 2000; Aldgate, 2009; Hedin et al., 2011; Madigan et al., 2013; Emond, 2014). Multiple placement changes resulted in the need to adapt to new
social and cultural norms. CIC left friends behind and had to make new friends at a time when other children already had well established friendships (Emond, 2014). Ridge & Miller (2000) reported that uncertainty in placements lead some children to disengage from their new social situation, which impacted their sense of belonging. Kools (1997; 1999) explained that changing placements could impact CIC’s ability to maintain relationships, which could lead children to use self-protection strategies, such as distancing themselves from others, to prevent disappointment.

Other aspects of being a CIC impacted CIC’s ability to make friends. Farmer et al. (2012) found the size of children's networks correlated with their kinship carers’ age. As the age of carers increased the size of children's inner networks decreased, perhaps due to the limited social network of older carers, or because children took on a caring role (resulting in a lack of opportunity to develop a broad social network). Madigan et al. (2013) also described a participant whose previous experiences of being let down repeatedly in the past resulted in her choosing to socially exclude herself. Children associated their sense of difference with their pre-care experiences, for example they discussed how the need to grow up quicker impacted their ability to fit in with peers, as they were more mature and sensitive (Madigan et al., 2013). A sense that children were behind academically also lead them to feel different (Madigan et al., 2013).

However, it is likely that stigma in peer relationships also exacerbated these problems. For example, difficult peer interactions lead to an increased sense of difference related to CIC’s living situation (Madigan et al., 2013; Emond, 2014;). Benbenishty et al. (2017) found that lower self-reported grades of CIC, compared to same aged peers, were not explained by children’s
“in-care” status, when background, involvement with victimisation, climate perceptions of school, and skipping class, were taken into account. This suggests a child’s background, and peer victimisation, at least in part, impacts their self-reported grades, which, in turn, impacts their sense of difference (Madigan et al., 2013).

7. The Importance of Context and Sense Making for CIC

Stigma and self-stigma were not apparent for all CIC. Some children reported no experiences of bullying or feelings of difference (Messing, 2003; Burgess et al., 2010; Madigan et al., 2013). It is possible that children’s experience of peer relationships, and their feelings towards these experiences, were shaped by the sense they made of their situation and their context. This may explain individual differences in the size of CIC’s peer networks and their descriptions of; negative peer experiences, self-stigma, and the desire to guard their “in-care” status.

Studies that reported less bullying, less differential treatment and fewer feelings of difference for CIC, had participants in KC, who predominately took the view that their living situation was not that dissimilar from their peers. They viewed their situation as one of a range of different living situations (Messing, 2006; Burgess et al., 2010). Other children in KC described experiences of bullying and feelings of difference (Aldgate, 2009; Farmer et al., 2012). This difference may be explained by ethnicity. Most participants in Messing (2006) were African American, which may have impacted their interactions with peers, and their understanding of their living situation, as being looked after by extended family is more common place in this culture and is less likely to be viewed as “atypical” (Washington et al., 2013). Burgess et al.
(2010) did not report participant’s ethnicity so it was not possible to determine if this may be true for participants in their sample.

Participants in Messing (2003) and Burgess et al., (2006) had also experienced limited disruption when moving to KC. It is possible a sense of attachment already existed between these children and their carers, as many children described a good relationship with their carers prior to care. Children may have been more likely to understand, and identify with, the communication patterns, values and beliefs in their new social environment. This may have created a sense of belonging and reduced the sense of threat to one’s identity often experienced when entering care (Kools, 1997; 1999; Madigan et al., 2013; Emond, 2014;). In turn this may have resulted in a more positive attitude towards their situation, and more positive peer experiences as a result. The impact of a sense of belonging on one’s identity has been demonstrated in other areas of research (Kim et al., 2010). In line with this, Hedin et al. (2011) reported the positive impact FC had on children’s ability to respond appropriately to bullying and victimisation. The authors felt this may reflect an increase in confidence; as children became more settled in their care environment they became better at responding to bullying. However, although not discussed by Hedin et al. (2011) children may have become better at dealing with bullying as they developed and practiced better strategies to manage.

Farmer et al., (2012) found individual differences in CIC’s choices around disclosure. They found children above eleven years of age were three times more likely to be secretive about the reasons they were in care. Children's openness was also statistically associated with parental bereavement. The majority of those in KC because a parent had died were open with friends about it. Of those who did not share information about their background, the majority
had parents with drug misuse problems or a parent in prison. The authors concluded that the death of a parent was less likely to carry stigma compared to parental rejection and substance misuse. This suggests the views CIC hold of their situation are important to their disclosure choices. In line with this, Madigan et al. (2013) reported that the context a child is in, how happy, secure and confident they feel, impacts their sense making associated with their “in-care” status which, in turn, impacts their ability to discuss their living situation with peers. Perhaps not viewing ones living situation as a departure from the norm, and having confidence in one’s identity and sense of belonging, also facilitates one’s ability to discuss one’s living situation with peers. This may explain why all studies exploring the views of those in KC described participants who were happy to talk about their “in-care” status (Messing, 2006; Aldgate, 2009; Burgess et al., 2010; Farmer et al., 2012).

Interestingly, those with small inner networks were significantly more likely not to talk about the reasons why they were in care (Farmer et al., 2012). This mirrors findings from studies with those in FC, which found that disclosure choices impacted one’s ability to make friends (Emond, 2014). Children reported finding it easier to talk with peers in a similar situation about their living situation (Messing, 2006; Aldgate, 2009; Burgess et al., 2010; Madigan et al., 2013), suggesting they do not feel a sense of stigma in these relationships. Messing (2006), Aldgate (2009) and Burgess et al. (2010), all described participants who had peers with a similar living situation to them and, as a result, children did not feel as different. Children who appeared to lack clarity and struggled to make sense of why they were in care, found it harder to discuss their experiences with peers (Emond, 2014). Therefore, a coherent narrative about one’s experiences, likely supports the development of a sense of self (Emond, 2014). This
finding is in keeping with current narrative understandings of identity formation, which suggest that when one is unable to hold a coherent, unified story about one’s life, one’s sense of self is threatened (Mair, 2010). CIC’s worry around disclosure are also concerning, as research suggests that fears of being “discovered” are associated with psychological distress in stigmatised individuals (Pachankis, 2007).

Methodological Limitations and Gaps in the Literature

It is apparent from the above analysis that children in FC and RC settings experience both positive and negative peer experiences. Findings suggest negative peer interactions impact CIC’s wellbeing and result in concern about being considered different. Furthermore, the context a child is in, and the sense they make of it, appear to impact children’s experiences with their peers and their feelings towards these experiences.

However, studies exploring the experiences of those in KC (Messing, 2006; Aldgate, 2009; Burgess et al., 2010; Farmer et al., 2012) differed in the extent to which they described participants’ experience of discrimination in peer relationships. Although it is possible these differences are the result of the care context, and the sense participants made of this context (as discussed above), it is also possible these discrepancies are the result of the poor methodology these studies utilised. Three of the KC studies were considered low in quality and gave limited information about their data collection and analysis process (Messing, 2006; Aldgate, 2009; Burgess et al., 2010). It is possible that less rigorous data collection and analysis methods resulted in researcher’s biases impacting the study’s findings. As a result, more rigorous research into the peer experiences of children in KC is necessary. Furthermore,
research comparing the peer relationships of children in KC, to those of children in more formal care settings would help us to better understand the differences between their experiences.

In addition, only one study (Benbenishty et al., 2017) compared the peer relationships of CIC, with the peer relationships of children that are not in care. Although Benbenishty et al. (2017) showed differences in the amount of victimisation and discrimination-based harassment CIC report, without a qualitative comparison it is impossible to gain a sense of whether the experiences of discrimination CIC describe are unique, and different, to those experienced by children that are not in care. Moving forward it will be important to more thoroughly compare the peer relationships of CIC to those who are not in care, to understand more about how their experiences may differ, if at all.

The lack of important details about participants made it difficult to identify any intra-group differences. For example, studies rarely commented on the relationship between participant’s gender or ethnicity and their experiences of stigma and discrimination. Furthermore, studies rarely discussed the role of placement length on stigma and discrimination. Placement length is likely to have an impact on children’s experiences of discrimination with peers, as children may become more settled and feel a greater sense of belonging with time. Research into individual differences may improve our understanding of the impact of the care setting on the peer relationships of CIC.

Although the above studies give good insight into the views of CIC, they may not provide the full picture. Some CIC may hold a hostile attribution bias (Kay & Green, 2016), which may shape the way they view their peer relationships. Furthermore, teachers and foster carers stress the role of CIC’s social deficits when discussing their peer difficulties (Canning, 1974; Luke
& Banerjee, 2012). In the future, it will be important to make sense of these different positions to increase our understanding of how best to support children to make positive peer relationships.

The voices of children not in care have also been missed in this analysis. It would be interesting to understand more about the attitudes, assumptions and feelings that children who are not in care have about their peers in care. This would increase our understanding of whether CIC’s peers find their differences “uncomfortable” as would be predicted by stigma theory (Goffman, 1963). This could increase our understanding of how stigmatisation towards this group could be reduced. It would also provide another view of CICs peer difficulties.

**Conclusion**

It is apparent from the analysis above that children in more formal care settings experience stigmatising interactions in their peer relationships, as well as in other areas of their life. This discrimination appears to create a sense of difference and impacts CIC’s wellbeing and identity. It appears that these children want to be the same as their peers and, as a result, they make efforts to conceal their “in-care” status and information associated with it. Their sense of difference can also lead them to behave in ways that can negatively impact their relationships further, for example using aggression to avoid difficult peer interactions. Furthermore, it appears the context a child is in, and how they view this, can impact their peer experiences and their feelings towards these experiences.

Given the important benefits of friendships for CIC, and the damaging effects of stigma, the discrimination CIC experience in their peer relationships is an important area for further research. In particular, it would be interesting to explore the views of children who are not in
care, to help understand what leads to supportive or stigmatising reactions to CIC.

Furthermore, more rigorous research into the peer experiences of children in KC is necessary, as the extent to which children in KC experience discrimination in their peer relationships is less clear due to the poor methodology of studies in this area.

Foster carers, social workers, and other professionals working with CIC should be mindful of the stigma CIC may experience in their peer relationships. Allowing CIC space to discuss their peer experiences may be helpful for some. Talking with CIC about possible ways of responding to stigmatising interactions may also be useful. It appears that negative peer experiences impact the way CIC behave with peers, which negatively impacts their peer experiences further. Therefore, it may be helpful to talk with CIC about the consequences of responding to peers in certain ways, to help them make more informed choices about their behaviour. As the Department of Health and Education guidelines (2015) suggest CIC’s ability to make relationships and relate to peers should be assessed during health assessments; these assessments could provide a useful opportunity to discuss any difficulties in this area, and to plan actions to address any concerns.

Given that the context a child is in and the sense they make of it appears to impact children’s experiences with their peers, it may also be helpful for practitioners working with CIC to support them in making sense of their experiences (both past and present), and to include them in decision making wherever possible (in line with Department of Health and Education guidelines, 2015) to increase the positive experiences they have of care.

Furthermore, campaigns tackling stigma within schools and the wider community may be helpful. Psychologists and other professionals developing these campaigns should consider
involving CIC and care leavers in the planning and implementation of these schemes, to allow their voices to be heard and to reduce the sense of “difference” others feel towards CIC. In the future, it will be important for stigma and discrimination to be considered in health and social care policies, with regards to both the impact of stigma on CIC, and how to change their stigmatising peer experiences, as this is often missed (Department of Health and Education guidelines, 2015, National Institute for Health and Clinical Excellence, 2015).
References


Appendix A: Guidelines for authors

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Part 3: Clinical experience

The clinical psychology training programme requires the completion of five clinical placements. The details of these clinical placements are reported below.

In year one I worked in an Adult Community Recovery Service. This placement lasted a year. I carried out assessment, formulation and treatment with clients on an individual basis. I co-facilitated a group aimed at helping attendees learn coping skills for managing their mental health difficulties. This was a rolling group, meaning different clients attended each week. The main treatment model I drew from was Cognitive Behavioural Therapy (CBT), although I also utilised Acceptance Commitment Therapy (ACT) and Dialectical Behavioural Therapy (DBT). Clients presented with a wide range of difficulties from anxiety and low mood, through to more severe presentations such as psychosis and obsessive compulsive disorder (OCD). Some clients had a diagnosis of Emotionally Unstable Personality Disorder (EUPD) and presented with emotional instability and relational difficulties. I completed cognitive assessments, assessing client’s cognitive functioning and memory. I completed two presentations, one to the psychology team which involved discussion of a formulation based model of treating psychosis and one to a residential care team around the treatment of OCD. I also took part in child protection conferences and multi-disciplinary, multiagency team meetings.

In year two I completed two placements, a placement in a Child and Adolescent Mental Health Service (CAMHS) and a placement in a Community Learning Disability Team (CLDT). These placements were six months each. On the CAMHS placement I assessed, formulated and treated clients both individually and with their parents. I was part of the reflective team in a family therapy clinic. I drew on CBT and Systemic Therapy as my main models during this placement. Clients presented with anxiety, low mood, emotional instability, eating difficulties,
and gender identity concerns. Clients also had diagnoses of Autism Spectrum Condition (ASC) and Attention Deficit Hyperactivity Disorder (ADHD). I carried out school observations to assess for ASC and ADHD and completed a cognitive assessment to gain an understanding of a client’s cognitive functioning to inform their ASC assessment. This involved integrating information from schools, paediatric teams and families. I completed a presentation to families who were on the waiting list for CAMHS, discussing strategies they could use while waiting for an assessment. I also provided consultation to schools and social care systems and engaged in indirect work with families of children referred to the service. I supervised an assistant psychologist and a social worker who was using CBT.

On the CLDT placement I assessed, formulated and treated clients with mild to moderate learning disabilities who were struggling with low mood, anxiety, agoraphobia and emotion regulation difficulties. This often involved working with client’s families as well as directly with clients. The main models I drew on were Narrative Therapy and CBT. I also completed indirect work with residential care teams using positive behavioural support (PBS) for clients with more severe learning difficulties presenting with behaviours that challenge. I completed cognitive assessments to assess if clients met the criteria for a learning disability, or to assess if clients who already had a diagnosis of a learning disability had dementia when concerns had been raised. I completed a presentation to the psychology team around using a narrative approach with clients with a diagnosis of a learning disability.

In year 3 I completed a further two placements, a placement in an older adult community team and a specialist placement in a Mother and Baby Unit (MBU). These placements were 6 months each. On the older adult placement, I carried out psychological assessments, formulations and interventions with older people experiencing anxiety and low mood in a
community recovery service. This was mostly informed by a systemic approach and involved working with clients and their families. I completed cognitive assessments in the memory assessment team to determine if clients may have dementia. This involved collecting information from the client, their families, carers and other professionals involved in their care. I completed indirect work with residential care staff to help them understand and manage challenging behaviour in the care home liaison team. Finally, I worked in a rehabilitation service for older adults with physical health complaints such as Parkinson’s, Chronic Obstructive Pulmonary Disease (COPD) and mobility difficulties. In this role I assessed, formulated and treated clients using mostly an ACT approach. As a part of this role I co-facilitated a psycho-education group for clients with a diagnosis of COPD. On this placement, I also completed a presentation around sleep hygiene to attendees of a day care centre and carried out a teaching session for newly qualified nurses discussing the importance of professional boundaries.

On my final placement within the MBU I assessed, formulated and treated mothers who were pregnant or had given birth within the last year. Some of these women were on the MBU for parenting assessments. As part of this placement I also worked within the community perinatal team. I used several models in this work including Compassion Focused Therapy (CFT), CBT, and ACT. I also carried out couple’s therapy using a systemic approach. I carried out work with mothers and their babies to assess and aid the attachment process. This work was informed by Video Interaction Guidance (VIG). Within the community team I completed a psychology group for women experiencing postnatal depression. The group was informed by CBT principles but also included a session on attachment and bonding. I supervised the assistant psychologist who co-facilitated this group. At the MBU I regularly attended ward rounds and discharge planning meetings, contributing to multi-disciplinary and multi-agency care planning.
# Part 4: Assessments

**PSYCHD CLINICAL PROGRAMME**

**TABLE OF ASSESSMENTS COMPLETED DURING TRAINING**

### Year I Assessments

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<td>WAIS Interpretation (online assessment)</td>
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<tr>
<td>Practice Report of Clinical Activity</td>
<td>A psychological understanding of Rachel, a female in her forties, experiencing distress related to voice hearing, using a CBT approach</td>
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<td>Audio Recording of Clinical Activity with Critical Appraisal</td>
<td>Audio Recording of Clinical Activity with Critical Appraisal</td>
</tr>
<tr>
<td>Report of Clinical Activity N=1</td>
<td>A psychological understanding of Laura, a female in her thirties, experiencing anxiety, and her treatment using a CBT approach</td>
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<tr>
<td>Major Research Project Literature Survey</td>
<td>A literature survey reviewing Looked-After Children disclosure of personal information to their peers</td>
</tr>
<tr>
<td>Major Research Project Proposal</td>
<td>Understanding Looked After Children’s experience with Peers: An Exploration of Children’s social representations of Children in Care</td>
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<tr>
<td>Service-Related Project</td>
<td>An Evaluation of Health Care Professionals Experience of a Complex Case Consultation Group for clients with a diagnosis of Personality Disorder</td>
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### Year II Assessments

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<td>A neuropsychological assessment of Jo, a boy attending Junior School, who is experiencing difficulties both academically and socially</td>
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<td>When Talking is Tough: Working narratively with Lucy, a young woman diagnosed with a learning disability, and her mother, Jenny</td>
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5 Names used are pseudonyms
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<th>Major Research Project Literature Review</th>
<th>Children in Care’s Experience of Stigma and Discrimination in Peer Relationships: A Review of the Literature</th>
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