A PORTFOLIO OF ACADEMIC, THERAPEUTIC PRACTICE
AND RESEARCH WORK

Including foster carers' experiences of developing a relationship
with young children who have experienced multiple placements:

An interpretative phenomenological analysis

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Statement of anonymity

The confidentiality of clients and participants has been protected throughout this portfolio. Names have been replaced with pseudonyms and identifying information has been changed or omitted to preserve the anonymity and confidentiality of those referred to.
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## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to the portfolio</td>
<td>1</td>
</tr>
<tr>
<td>Academic Dossier</td>
<td>9</td>
</tr>
<tr>
<td><strong>Essay</strong></td>
<td></td>
</tr>
<tr>
<td>The early emotional development of young children</td>
<td>11</td>
</tr>
<tr>
<td>up to the age of five years, and the influence of early</td>
<td></td>
</tr>
<tr>
<td>relationships on this development: The usefulness of this</td>
<td></td>
</tr>
<tr>
<td>knowledge to the Counselling Psychologist</td>
<td></td>
</tr>
<tr>
<td><strong>Essay</strong></td>
<td></td>
</tr>
<tr>
<td>Historical and contemporary perspectives of countertransference; 24</td>
<td></td>
</tr>
<tr>
<td>its helpfulness, or hindrance, in the therapeutic relation</td>
<td></td>
</tr>
<tr>
<td><strong>Essay</strong></td>
<td></td>
</tr>
<tr>
<td>The development of cognitive behavioural therapy, the</td>
<td>37</td>
</tr>
<tr>
<td>cognitive-behavioural perspective of the therapeutic</td>
<td></td>
</tr>
<tr>
<td>relationship and the concept of resistance</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Practice Dossier</td>
<td>54</td>
</tr>
<tr>
<td>Introduction to the Therapeutic Practice Dossier</td>
<td>55</td>
</tr>
<tr>
<td>Description of Clinical Placements</td>
<td>56</td>
</tr>
<tr>
<td>Year 1: Psychology Department</td>
<td></td>
</tr>
<tr>
<td>Year 2: Psychotherapy Department</td>
<td></td>
</tr>
<tr>
<td>Year 3: Community Mental health Team</td>
<td></td>
</tr>
<tr>
<td>Specialist Psychological Therapies Service</td>
<td></td>
</tr>
<tr>
<td>Final Clinical Paper</td>
<td>63</td>
</tr>
<tr>
<td>My professional and personal development in becoming a</td>
<td></td>
</tr>
<tr>
<td>Counselling Psychologist</td>
<td></td>
</tr>
</tbody>
</table>
Introduction to the portfolio

This portfolio aims to provide an overview of my journey through doctoral training to become a Counselling Psychologist. The portfolio consists of three dossiers reflecting my academic, therapeutic practice and research work and I present an account of my personal and professional growth during this process. I have included aspects of my training that have been particularly influential for my professional and personal development. I hope that these dossiers illustrate a range of competencies and the skills that I have developed and integrated into my clinical practice.

I came to study psychology after undertaking a parent-infant facilitator training, involving an infant observation study, in order to promote the parent-infant relationship between mothers and babies with whom I worked in my previous role as a health visitor working with families. My learning at that time integrated my interest in early relationship development, my work with mothers who had post natal depression and my work with child behavioural management and parenting difficulties. I became more interested in the development of relationships within the family context, working with child behavioural difficulties, parent-child relationship problems and the parental-couple relationship. Further, I had a strong interest in self-development and personal growth and sought to combine these values with continuing professional development. As I was so interested and curious regarding psychological processes, human behaviour and interpersonal relationships, it seemed natural to me to proceed to study further psychology. In this way, psychology would underpin my future professional development as a competent practitioner: one in which the relationship is central to the therapeutic work and remains informed by psychological theory, research and practice.

Following my psychology studies, I took time out to travel to New Zealand for 12 months, where I became interested in differing beliefs systems, including the New Zealand Maori and Polynesian family values of cohesive family systems and the mythological beliefs surrounding their lifespan development. I returned to take up counselling psychology training and continue my personal and professional growth. I was attracted to counselling psychology because of its humanistic roots as well as the
opportunity to train in multiple therapeutic models. I was drawn to the philosophical underpinnings of counselling psychology based in humanistic psychology (Strawbridge & Woolfe, 2003) and its emphasis on the therapeutic relationship. I further valued its recognition of phenomenological experience as a valid method of research enquiry, and its focus on both professional and personal development of the practitioner, including its requirement and valuing of personal therapy as part of the training. My understanding of the therapeutic relationship has been at the core of my training and development within the three approaches that I have been introduced to, that is, humanistic, psychodynamic and cognitive behavioural. I present here an introduction to each of the three dossiers in this portfolio.

The academic dossier

The academic dossier begins by reflecting on how my interest in child development and the parent-infant relationship evolved out of my earlier interest in this from my roots in health visiting, and prior to that in nursing. As a trainee Counselling Psychologist, my interest has developed in exploring the therapist-client relationship and interpersonal interactions, particularly through conscious and unconscious processes and this is shown through my three essays provided in this dossier.

The first essay is concerned with ‘Lifespan Development’ which specifically focuses on early emotional development. This essay shows the influence of a wider perspective in my thinking regarding other psychological theories that have interested me in the study of young children and their emotional development, apart from attachment theory (Ainsworth, 1969; Bowlby, 1969, 1979). These theories have contributed to and influenced my thinking and understanding underpinning my therapeutic work as a Counselling Psychologist. Exploring this area in depth provided me with the opportunity to begin to link more fully the similarities and differences in early relationship development with my current learning regarding the therapeutic relationship. In relation to this aspect, this essay also considers the importance of understanding early emotional development for the Counselling Psychologist in their therapeutic work with clients.
The following two essays specifically consider theoretical aspects of the therapeutic relationship related to two of the three models that I have worked with in my own clinical practice as a trainee, i.e. psychodynamic and cognitive behavioural therapy (CBT). The second essay explores the historical background to the psychodynamic concept of countertransference, its development and contemporary views of countertransference with consideration of its therapeutic use as helpful, or as a hindrance, within the therapeutic relationship. The Counselling Psychologist’s use of countertransference in the therapeutic relationship is considered, supported by a clinical illustration from my own clinical practice whilst working with the psychodynamic approach in the context of a psychotherapy department. The complexity of investigating countertransference as a construct in research of this phenomenon is also considered.

In examining the history and development of countertransference theory, I came to understand how my own countertransference and the processes involved could be understood and worked with in light of my clients’ presenting difficulties and interpersonal relating patterns. My interest in undertaking this essay on countertransference emerged from my therapeutic work and psychodynamic supervision. This model of supervision had a strong focus on the unconscious processes occurring between me and my clients: hence, this linked psychodynamic theory with my own practice on an experiential level. In this way, I came to understand how unconscious processes were enacted in the transference-countertransference (Clarkson, 2003) therapeutic relationship. In supervision, through self-monitoring and exploring my own responses too, the formation of my own ‘internal supervisor’ (Casement, 1985; 1990) developed. I recognised that learning about countertransference phenomenon also held a fascination because it integrated with my previous learning, observations of and working with the parent-infant relationship (Brazelton & Cramer, 1991; Miller, Rustin, Rustin & Shuttleworth, 1989) and early psychic development (Stern, 1985, 1995).

Finally, the third essay in the academic dossier considers the development of CBT as well as more contemporary developments in the cognitive behavioural approach (Leahy, 2004; Safran, 1993; Safran & Segal 1990; Young, Klosko & Weishaar, 1993).
The attention given to the more interpersonal aspects of working with the therapeutic relationship have increasingly attracted me to integrate these ways of working into my overarching relational/intersubjective conceptualisation of working with the therapeutic relationship. The concept of resistance in CBT, as it has been understood within this model (Leahy, 2003; Padesky & Greenberger, 1995) is considered in this essay and this is illustrated with a clinical example from my own practice as a trainee Counselling Psychologist. Working with difficulties such as resistance or non-compliance in the therapeutic relationship in my final year guided me to exploring the literature, as I met increasing challenges arising from the context of my clinical placement.

The therapeutic dossier

The therapeutic dossier includes my final clinical paper which describes the experience of each year of my training and my own developmental journey to becoming a Counselling Psychologist. The essay provides a snapshot of my learning in working with three main therapeutic approaches in the therapeutic work I undertook with my clients in each of my placements. Clinical illustrations have been used to show aspects of my therapeutic work, including themes of attachment, separation and loss and working with countertransference in the therapeutic context. Further clinical accounts of my work, i.e. one client study and one process report, are enclosed in the confidential attachment to this portfolio (due to the confidential nature of therapeutic work, these are available to the examiner for examination purposes only).

In this dossier, I provide a separate description of each of my clinical placements for the three years of my training. These placement overviews include: brief descriptions of the wide range of clients which each service serves and with whom I have worked in a therapeutic capacity; the varied disciplines with whom I have worked with in multi-disciplinary teams, psychology teams and psychotherapy teams and from whom I have learnt more about team dynamics in differing therapeutic contexts; the differing referral processes and therapeutic approaches in each placement, various models of supervision and ‘in-house’ continuing professional development in the work base, and the care programme approach and discharge processes. The fact that each placement is
within an NHS service reflects also my conscious choice to have continued my professional development and progression in working within this service.

The research dossier
This dossier highlights an area of interest for me as clinician and researcher. The research dossier contains my first year literature review and two empirical studies: one qualitative report undertaken in the second year, and one quantitative report undertaken in the third year. Together these three reports present my engagement with exploring the development of attachment in young foster children and foster carers’ perspectives on developing and maintaining new relationships with young children, factors influencing the foster-carer/foster-child relationship with children who have had multiple foster placements, and hence experienced repeated separation and loss from their carers.

The literature review builds on my exploration of early emotional development in my lifespan development essay in my first year of training. I chose this topic because of my prior interest in parent-infant relationship formation and child development. In reviewing the relevant literature, I present a focused literature review that explores Bowlby’s (1969) early ideas on attachment and the effects of unstable care. Revisions to Bowlby’s original theory and its impact on childcare practice are discussed. Individual differences in attachment, such as secure-insecure, multiple attachments, and differing contexts, for example, kibbutz, day-care and fostering, are discussed. Finally, attachment measures, recent developments, such as infant attachment in foster care, recent advances from Neuropsychology (Perry, Pollard, Blakely, Baker, Vigilante, 1995; Schore, 2001) and disorganised attachment, are explored. In reading the literature, I was struck by the breadth of attachment related literature available and how my readings applied to my therapeutic practice and, further, to my own personal experiences of attachment, separation and loss.

In the following year, I undertook a study using interpretative phenomenological analysis (IPA) that explored foster carers’ experiences of developing relationships with young foster children who had experienced multiple placements, thereby having repeated experiences of separation and loss of carers. This was an engaging and
particularly emotive undertaking given the range of emotions that can be evoked in
the fostering context. The research process involved listening to carers’ experiences of
relating with young children who had experienced repeated separation and loss. In
using an IPA process, I felt engaged with the research process because of its
interpersonal nature, which seemed to fit with my training as a Counselling
Psychologist. I also became more aware, and more mindful, of my own feelings
aroused in the research and therapeutic process. Hence, this year, attachment related
themes connected across research, professional clinical practice and personal domains.

In the final year, I sought to quantitatively investigate factors that could influence the
quality of the foster-carer/foster-child relationship. Factors included foster children’s
number of previous placements, foster carers’ empathy, parenting stress, foster carers’
own childhood parental bonds, and foster carers’ childhood experience of separation
or loss. In using a different methodology involving questionnaires for data collection
and SPSS for statistical analysis, I felt more challenged by the less personal nature of
the research than that of the previous year. However, over these three years I have
learnt to use a range of methodologies, such that I feel more competent in my ability
as a researcher.

Conclusion
In reflecting on my training as a Counselling Psychologist, as documented in this
portfolio, I provide a picture of my professional and personal development along my
journey. I also show how my abilities as researcher and clinician have grown and the
value I give to my continuing professional development and personal growth.
References


Introduction to the academic dossier

The academic dossier consists of a selection of essays submitted over the three years of my psychotherapeutic and counselling psychology training. The first essay is concerned with 'Lifespan Development' and focuses on early emotional development. This essay considers the importance of understanding early emotional development for the Counselling Psychologist in working with clients and was undertaken in the early part of the first year of this course. Hence, my continuing development is seen in the two subsequent essays. These two essays, undertaken during year two and three respectively, consider more of the theoretical aspects of the therapeutic relationship related to two of the three main models that I have worked with in my therapeutic clinical practice as a trainee, i.e. psychodynamic therapy and cognitive behavioural therapy, with the use of clinical illustrations. The first essay explores the historical background and development of the psychodynamic concept of countertransference and contemporary views of countertransference with consideration of its use as helpful or as a hindrance within the therapeutic relationship. The third essay considers the development of cognitive behavioural therapy and recent contemporary developments. The concept of resistance, as it has been understood within cognitive behavioural therapy, is considered and is illustrated with a clinical example from my own practice.
The early emotional development of young children, and the influence of early relationships on this development: the usefulness of this knowledge to the Counselling Psychologist.

A wealth of literature on child development exists which integrates emotional development of the child with its social and cognitive development. However, the aim of this essay is to focus on the normal emotional development of the child, up to the age of five years and specifically during the first year, and to consider factors of early relationships that facilitate healthy emotional development. Finally, relevance of this knowledge for the therapeutic work of the Counselling Psychologist with clients is discussed.

Emotions involve physiological changes of the nervous and endocrine systems, e.g. increased heart rate, subjective experiences, e.g. happiness, behavioural components, e.g. smiling, plus cognitive appraisal of the emotions themselves within the situational context from which they derive. Whilst acknowledging the influence of cognitive development on emotions, emotions develop and are enacted within social relationships, the main focus of this essay. Important tasks for normal emotional development of the young child, under five years of age, include: the ability to express one’s own emotions and to recognize emotions in others, the development of empathy, making sense of others’ expressive behaviour, and learning to regulate one’s own emotions according to the display rules of culture, gender and situation.

Babies’ and infants’ abilities to express their own emotions, and to recognize emotions in others, have been extensively investigated. The innateness, or not, of emotions remains a controversial issue that will only be briefly mentioned here. Certain facial expressions are considered to be innate (Darwin, 1872; Ekman & Davidson, 1994), i.e. instinctively and biologically derived, evolving for their adaptive survival function to aid humans to deal with essential life tasks, and are universal regardless of culture. Six ‘basic’ (primary) emotional states, i.e. anger, sadness (sorrow), joy (happiness), fear, disgust and surprise have been identified (Ekman & Davidson, 1994; Plutchik, 1986) and are similarly expressed across cultures (Ekman, 1973). Studies (Ganchrow, Steiner & Daher, 1983; Izard, Heubner, Riser, McGinner
& Dougherty, 1980; Mesquita & Frijda, 1992) showed that babies react to stimuli to display appropriate facial expressions that are recognisably interpreted by others. Eibl-Eibesfeldt's (1975) studies (including cross-cultural) of other primate species and blind/deaf babies deprived of observational learning, reported babies are born with innate emotional responses and proposed a direct unlearned instinctive connection between an inner emotional state and outer facial expression enabling infants to recognise others' emotional states. ‘Basic’ emotional expressions appear from birth and during the first year, whereas the appearance of more ‘complex’ emotions, such as jealousy, guilt and shame, appear some time from eight months of age into the second year of life, and are considered to be influenced by the unfolding of cognitive processes (Izard & Malatesta, 1987; Stern, 1985; Strongman, 1987) regarding infants’ lack of representational skills and interpersonal awareness (see Draghi-Lorenz, Reddy & Costall, 2001, for an in-depth review).

Infants’ emotional development appears to be influenced by the unfolding of cognitive processes, and by learning and socialization processes. Meltzoff and Moore’s (1983; 1997) term ‘inter-modal mapping’ describes infants as having an innate representation that connects visual stimuli of their caregiver’s face to the infant’s own muscular movements to respond with the same expression. Newborns show that they learn to imitate facial gestures, e.g. tongue protrusion, early. By four to six weeks of age, they show responsive ‘social smiles’ that have developed in response to their carer, in comparison to the ‘reflex smiles’ before this age. Early socialization of expression, via the learning of social display rules, through baby imitation and mother reinforcement, was reported by Malatesta and Haviland’s (1982) observations of babies at three months of age, and again later at six months, in mother-infant dyads. These dyads showed increasing similarity and convergence in matching of emotional expressions that alleviated or dampened expressive behaviour, e.g. anger; any gender differences observed in this study will be discussed later. Interestingly, Haviland and Lelwica, (1987) reported ten week old babies accurately reflected their mother’s ‘happy’ expressions. However, in response to their mother’s ‘angry’ and ‘sad’ expressions they did not appear to produce accurate reflections but their own inner emotional state instead, so, rather than employing complex ‘cross-modal’ skills to imitate, as the older
infant/child does, this might be more of a ‘sympathetic’ or ‘sensitive attunement’ to the emotional signals of the caregiver.

Infants appear ‘sensitively attuned’ to caregivers’ emotional signals observed in the intricate reciprocal ‘dance’ communications of mother-infant interactions that Trevarthen (1977, 1979) terms ‘primary intersubjectivity’, involving: ‘maternal attunement’ (Stem, 1985) to the baby’s emotional behaviours and states, ‘co-regulation’ (Trevarthan, 1993), turn-taking and mutual synchronizing connected with emotional expressiveness (Brazelton & Cramer, 1991; Miller, Rustin, Rustin & Shuttleworth, 1989). These factors facilitate normal emotional development, particularly early control of inner emotional states developing the infant’s abilities for self-regulation of its own emotions. Although focus tends to predominantly be on the mother-infant dyad, others may also take this role, e.g. father, grandparent, who also exert significant influence on emotional development of the child, particularly if they provide high levels of day-care (Belsky, 1988).

Studies (Cohn & Tronick, 1983; Hains & Muir, 1996; Stein, Gath & Butcher, 1991) have shown the effects of disruptions in the above process. For example, Murray (1992) found that mothers showing depressed facial expressions to their three month old babies resulted in the infants becoming negative and showing protest and wariness. Hobson (1993) suggested emotional consequences of disruptions in mother-infant relating are not based on co-ordination of behaviours but on some form of psychological linkage where the infant expects appropriate forms of expressive response from the other. As only one example from many potentially disruptive parent-infant communication factors, babies of mothers suffering severe post-natal depression experience more negative affect and on-going disruptions as a feature of their communication system, with adverse influences (Milgrom, Martin & Negri, 1999). Mothers are also more likely to have a negative view of their baby’s emotional state (Murray, Fiori-Cowley & Cooper, 1996), contributing further to disruptions in the early development of affective communication. Emotional expression and recognition are important processes for inter-relating and influencing others, particularly for developing secure attachment relationships. An awareness of the ways in which early emotional development and interpersonal communication develops, such as the concepts of ‘emotional attunement’, ‘mirroring’, empathy, etc. is
important for the Counselling Psychologist in their therapeutic work with clients. Aspects of a clients' particular emotional communication patterns learnt in early childhood, and the interpersonal experiences in which their emotions developed, such as avoidance of emotional awareness or expression of emotions, emotionally incongruent behaviours, or disturbances in emotional self-regulation are likely to be displayed in the therapeutic relationship too. Hence, these are likely to be an important aspect of client communication to the therapist and for the therapeutic work.

The foundation of normal emotional development is the child’s emotional tie to its main carer (often the child’s mother but this might equally be father or foster/adoptive carer). The quality of the early attachment relationship is important for healthy emotional development (Ainsworth, 1985; Belsky & Nezworski, 1988; Bowlby, 1979; Goldberg, 2000; Steele & Steele, 1994) and this can, though not inevitably, have long term consequences for subsequent healthy emotional relationships (Steele & Steele, 1994). Due to the breadth of information on implications of insecure attachment on a child’s emotional development, emphasis will be restricted to a few pertinent points.

According to attachment theory (Bowlby, 1979), ‘internal working models’ (IWMs) are cognitive structures, or representations, of repeated and daily interactions with attachment figures, often the primary caregiver in babies and young children, and these IWMs incorporate emotions associated with these interactions into schemas that guide the child’s behaviours. Goldberg (2000) emphasised that children classified as ‘securely attached’, indicated by proximity seeking behaviours to the main carer provoked by a perceived threat, tend to be more spontaneously emotionally expressive and more accurate in their abilities to read the emotions of others than those children in other categories of attachment. Further, children classified as ‘insecure-avoidant’ were found to be minimally expressive, observed to restrain expression of negative emotions, and appear to underestimate the intensity of negative emotions in others. Insecure attachment has negative repercussions on the emotional and behavioural functioning of the child, and often has implications later as an adult (Howe, Brandon, Hinings & Schofield, 1999). However, cultural difference must be born in mind. The early studies that identified infants’ attachment styles through the ‘strange situation’ (Ainsworth, 1985), were not only small in sample size and based on observational studies, but may not be so universal for generalisation across cultures as first claimed.
For example, in the Japanese culture physical proximity is actively encouraged when raising infants and hence, any separation experience as used in the strange situation experiments would not be sensitive and comparable in this culture (Takahashi, 1990). Hence, the Counselling Psychologist needs to be aware of cultural differences in attachment styles and emotional expression.

For one to five years olds, emotional development is facilitated by social referencing to the responses of others in the child’s social environment and their reactions to the child’s behaviours, in specific contexts, and is influenced by language and play. Social referencing is used by infants and young children to check out the facial expressions of carers to guide and regulate their own emotional reactions (Feinman & Lewis, 1983; Feiring, Lewis & Starr, 1984; Sorce, Emde, Campos & Klinnert, 2000) and behaviour in specific situations. Sensitivity to and recognition of others’ emotions in social relationships are the first signs towards more advanced empathic development.

Between ten months and two years of age, increasing patterns of empathy (Yarrow & Waxler, 1975) develop from an early reactive ‘personal distress’ to another’s distress, ‘emotional contagion’, a sympathetic emotional display to the others emotion; to an ‘egocentric empathy’, the offering of comfort that the child itself finds comforting. Between two to four years, more mature empathic skills emerge in developing the ability to take the perspective of the other, necessary for normal adult emotional and interpersonal functioning. Dunn’s studies (1988) of emotional development revealed the central role of emotion in social understanding, driven by interactions between siblings that include teasing, conflict, jokes, humour, comforting, within emotionally charged family relationships. Dunn’s studies can be commended for being naturalistic, longitudinal ones, however, they were observational, highly subjective accounts in minimally controlled environments. For Harris (1989), children’s understanding of emotion is one aspect of their cognitive development, notably ‘theory of mind’ (Harris 1989; Frith 1989) i.e. when the child is able ‘to take the perspective of the other’, an aspect of development that is so essential for understanding what others think and feel, and pretend play being central to this process. Further, children’s emotional and social
understanding is assisted by the development of early language used in the everyday talk of both their own feelings and feelings of others, cognitive appraisal commences and learning to recognise links between behaviours, situations and emotions.

Dunn (1988) argues, that young children are interested in and affected by their parents' and siblings' feelings and that it is the quality and emotional power of these close relationships that motivates the child to develop its early affective understanding of their own socio-emotional role and position within the family group. Emotional states of children at age two to three years become increasingly labelled, even when the child is not experiencing the emotional state, depending on the amount of ‘feeling type’ talk the family normally uses and most talk about feelings occurred in pretend play. Dunn, Bretherton and Munn (1987) found a gender difference in the amount of feeling talk provided by mothers: girls experienced more feeling talk from their mothers than boys did and, when older, these girls were also found to be talking more about feelings. The influences of ‘child-child’ relationships also increase in terms of their emotional significance and also in terms of their emotional understanding (Dunn, Brown & Beardsall, 1991; Dunn & Kendrick, 1982;).

The abilities to use display rules for regulating emotional expression, according to gender and cultural differences, in order to appropriately reveal or hide one’s feelings, develops as a product of maturation and socialization: socialization both inhibits expression and also directs expression in socially approved ways. Powerful rules of appropriate displays of emotional expression are learnt by children from an early age and regulated according to gender and culture, initially within the realms of family life. Three-month-old babies were found to have developed gender differences displayed by six months in response to imitation and maternal reinforcement (Malatesta & Haviland, 1982). Cultural groups will vary in tolerance and encouragement of emotional expression and the coping strategies implemented for strong feelings that are considered acceptable and appropriate. For instance, the Kaluli of Papua of New Guinea encourage anger to be expressed by stomping up and down furiously outside their log houses, whereas the Utku Eskimos were traditionally discouraged from expressing anger, except towards their dogs! (Mesquía & Frijda, 1992). An awareness of cultural differences in emotional development is important
for the Counselling Psychologist to be aware, for example, in promoting attunement to and understanding of clients’ emotional expressions in the therapeutic context.

Further, clients tend to present with varying issues in therapy regarding some aspect that relates to their emotional life. Whether this presents as current distress or past issues, knowledge of individual client’s emotional development and possible influences of their early relationships may be important predictive and maintaining factors that influence the effectiveness and outcome of therapy. As part of assessment and an early formulation of the client’s issues, obtaining a history of early emotional and social development can provide useful information as to how the client perceives emotions were expressed and regulated in their family of origin, or subsequent environment if fostered/adopted.

How clients describe their early emotional attachment relationships, and the emotional quality of these relationships, is an important indicator for current emotional functioning in close relationships (Steele & Steele, 1994), and this is likely to be mirrored similarly within the therapeutic relationship. Adverse experiences have shown negative effects on the course of children’s’ normal emotional development. For example, Camras, Grow & Ribordy, (1983) found that for five year olds who had suffered earlier physical abuse, their abilities to match appropriate expressions to stories were compromised compared to a control group. The effect of early adverse emotional relationships on child development and later psychological health and emotional functioning has been well documented (Howe et al., 1999). However, evidence (Thompson, 1986) suggests that negative early emotional experiences might be compensated for by later high quality emotional experiences, provided by others outside the family. For a Counselling Psychologist, awareness that early emotional development affects later functioning is important, as is also remaining aware that other factors in an individual’s history can later influence this earlier development constructively or adversely.

Events in infancy and childhood have an impact on later emotional functioning (Hetherington, Parke & Locke, 1999) and, under stress, early emotional patterns and management can resurface for clients, particularly in the area of parenting. Clients
may raise parenting issues regarding their own young children. Knowledge of early emotional development can help the Counselling Psychologist in planning therapeutic interventions according to the child’s age and emotional development, and parent’s emotional history, emotional functioning and ways of relating.

Early emotional experiences and emotional relating patterns may be mirrored in adult relationships both outside and inside of therapy. Feelings are central to whatever therapeutic approaches are used by the Counselling Psychologist. For example, in person-centered therapy, the therapeutic relationship is based on Rogers’ (1951) core principles, including therapists’ unconditional positive regard, congruence, empathy and emotional warmth. Cognitive-behavioural therapy links clients’ behaviour, feelings and cognitive appraisals, whereas, some psychodynamic models include Freud’s psychoanalytic view of personality rooted in an individual’s early emotional conflicts held in the unconscious.

In conclusion, although emotional development is not distinct and separate from social or cognitive development, early emotional development is strongly influenced by the quality and experiences within early relationships, particularly within the family. Innate capacities for expression and recognition of emotion that become the foundation of learning of emotional regulation within social relationships are facilitated by the quality of ‘interactional synchrony’ in the parent-infant dyad. Emotions develop, are enacted and communicated, within social relationships influenced by social referencing and social display rules of appropriate gender and culture norms. Early attachment relationships are considered to influence subsequent relationships and later emotional functioning. Apart from parent/s, other family members, such as siblings, become increasingly important for driving emotional development, particularly in children’s emotionally charged play. In the course of their everyday work, the Counselling Psychologist works with clients who bring a wide range of emotional issues to therapy. Knowledge of early emotional development aids the Counselling Psychologist in understanding what factors from clients’ early developmental and early life history might be relevant and influential in the development of therapeutic relationship and the therapeutic approach used.
References


Historical and contemporary psychodynamic perspectives of countertransference; its helpfulness, or hindrance, in the therapeutic relationship

Countertransference has been referred to as an aspect of one of five potential relationships between therapist\(^1\) and client\(^2\) (Clarkson, 2003), that of the transference-countertransference relationship. Although this essay will focus on the ‘countertransference’ aspect of the transference and counter-transference relationship, it is acknowledged that both aspects are complementary and interactional. The aim of this essay is to explore the historical and contemporary perspectives of countertransference, to consider both the helpfulness and hindrance of countertransference in the therapeutic relationship, and the importance of countertransference for the therapeutic work with the client. From a trainee Counselling Psychologist perspective, my own interest in focusing on the therapeutic use of countertransference emerged during my psychodynamic placement where I was immersed within a strong psychoanalytic ethos. I aimed to develop my understanding of this concept and the use of countertransference processes within my clinical practice in order to integrate this into my clinical work with my clients, to develop my reflective abilities in supervision, and, where needed, in personal therapy.

First, however, the protracted dilemma of the differing definitions of countertransference will be considered that accounts for a schism in countertransference theory between ‘classical’ and ‘totalist’ views (Kernberg, 1965). In order to gain a relevant background perspective, countertransference will be explored from its historical origins within the psychoanalytic world to contemporary perspectives. Consideration of the helpfulness and hindrance of countertransference in psychodynamic therapy will be discussed, along with the processes involved, such as projective identification; an illustration from my own clinical practice will be used to enhance understanding of this concept.

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1 The term ‘therapist’ is used for simplicity to refer to: psychoanalyst, psychotherapist, psychologist or counsellor, although in some instances the term analyst may be used in referring to early psychoanalytic literature

2 The term ‘client’ used in this essay refers to both client and patient referred to in the literature.
Historical origins of countertransference: the classical perspective

Freud (1910/1959) developed the original concept of countertransference during his pre ‘ego-psychology’ era, before he had developed his structural theory of the psyche. He initially considered countertransference as the therapist’s unconscious reactions to his client, and these were strictly seen as a source of disturbance in the therapist himself through “the analyst’s transference on to the patient, causing a disturbing, distorting element in treatment” (Rycroft, 1995, p. 28). Freud saw countertransference as unhelpful and as a resistance to the therapeutic encounter. He advised that “no psychoanalyst goes further than his own complexes and internal resistances permit” (Freud, 1910, p.145). Essentially then, countertransference was a resistance arising from unresolved intra-psychic conflicts within the analyst and, as such, was viewed as an obstacle to the analytic work. Countertransference was a resistance to be overcome and eradicated via the therapist’s own analysis of his ‘blind spots’. Hence, early psychoanalytic training institutions required trainees to undertake one full analysis in an attempt to obtain “purification”, if not a second later, in order not to ‘contaminate’ and thereby hinder their analytic work. However, the ‘classical’ perspective has been heavily criticised (Abend, 1989; Heimann, 1950; Kernberg, 1965) for adopting a cold, detached stance and a lack of ‘humanity’ through analysts inhibiting, avoiding and denying emotional reactions to their clients in attempts to comply with Freud’s demand for a ‘neutral’ analytic stance. However, Freud’s intention appeared to have been interpreted more radically than he originally intended for he had not meant an indifference and loss of spontaneity or warmth. Further, an almost fearful attitude of therapists to their own emotional responses had been promoted that risked limiting understanding of the analytic situation to a more intellectual activity (Abend, 1989).

The totalist perspective

The totalist view of countertransference developed from the late 1930s onwards as theoretical challenges (Gitelson, 1952; Heimann, 1950; Little 1951; Racker, 1968) to the original classical concept, and Freud’s prohibition of countertransference, increased. Also, later psychodynamic theories, for example, from the ‘object relational’ school (Heimann, 1950; Little, 1951; Racker, 1957; Winnicott, 1965) and the interpersonal school (Sullivan, 1953) supported ‘interactional’ aspects between therapist and client as pivotal to their analytic work. This was in contrast to the
centrality given to intra-psychic dynamics by 'ego-psychology' analysts. So, the totalist view developed in parallel to divergences emerging out of Freud's original psychoanalytic theories, i.e. through ego-psychology, object-relations, self-psychology and the interpersonal schools of thought. Countertransference expanded substantially to include the totality of conscious and unconscious responses to the therapeutic interaction (Tansey & Burke, 1989), whether considered as real or neurotic. Also, included in this definition is the more 'objective countertransference', described as the same responses as other therapists would experience with the same client (Kiesler, 2001; Winnicott, 1975), and also the therapist's idiosyncratic reactions from personal (infantile, or archaic) unresolved conflicts. In sum, this means "all those reactions of the analyst to the patient that may help or hinder treatment" (Slakter, 1987, p. 3).

However, the literature of the 40s and 50s reveals confusions within the way the two differing perspectives of countertransference were defined. The early concept of countertransference had been described as the analyst's 'transference' of a figure in their own past onto the client, i.e. their own unresolved conflicts and neurosis, thereby 'analyst-centred countertransference'. However, the use of the term countertransference in the literature varied depending on the preceding view of the concept of 'transference' already held by differing analysts. Freud had originally viewed 'transference' as neurotic, unresolved, past conflicts from the client's early relationships transferred onto the analyst (Bateman & Holmes, 1995). Although he initially avoided working directly with the transference in his early analytic work, Freud later adopted this part of the analytic process as the crucial focus of the analysis, as distinguished from the 'reality' aspects of the therapeutic relationship. The development of the transference was considered to be the 'resistance' as well as intrapsychic conflict within the client. Later, the concept of 'transference' was then broadened to encompass 'all' aspects of the relationship with the analyst, past and present, unconscious and conscious, distorted and reality later: notably this development similarly occurred in later (post Freudian era) definitions of 'countertransference'.
Similar to transference, ‘countertransference’ became all encompassing by those supporting the totalist perspective (Gitelson, 1952; Little 1951; Racker, 1968; Winnicott, 1975). One landmark publication (Heimann, 1950) argued for countertransference to refer to all of the feelings the therapist has for the client because clear differences between the analyst’s ‘realistic’ and ‘distorted’ responses to the client are too difficult to make. Heimann suggested that a strong rapport surfaces through the analyst’s responses to being acted upon by the client. The analyst’s responses can be compared to the client’s associations and behaviours to verify, or to challenge, the analyst’s understanding of the client’s unconscious communications. Hence, countertransference can be used as a route to understanding the client’s unconscious and, hence, a helpful therapeutic tool to be used for the benefit of the client. The client for their part was now seen as creating the countertransference, the countertransference was no longer seen as only part of the transference-countertransference dynamic, but it was related also to the client’s present experiences and subjective reality. Heimann then recognised the importance of the therapeutic relationship between client and analyst, rather than either analyst or client as the focus for consideration. Her view was also supported by, and the central tenet of, interpersonal psychoanalysis (Sullivan, 1953), where treatment was seen as a two-person interaction with the therapist as a ‘participant observer’. In this role, the therapist both influences and forms what is being observed (Sullivan, 1953), hence treatment progressed away from the detached un-involvement of earlier analysts. However, this totalist view was heavily criticised by those supporting (Fleiss, 1953; Reich, 1951) the classical view of countertransference. In expanding the term to include all the emotional responses in the therapist, it also risked becoming too encompassing and meaningless. Also, by increasing the importance of the analyst’s emotional reactions in the therapeutic encounter it increased their subjectivity and promoted an undue influence of the analyst’s personality, so losing their ‘neutral’ stance. Although the totalist view of countertransference saw the concept develop as a useful analytic tool for helping the client, and this was seen by its supporters (Heimann, 1950; Money-Kyrle, 1955) as progress, Money-Kyrle warned of the risk of it being a hindrance too. Also, countertransference processes have more recently been considered as major influences that can impair the ‘alliance’ aspect of the therapeutic relationship (Clarkson, 2003).
Countertransference processes – projective identification

So, by the 1970s, therapists’ attitudes, feelings and behaviour had been increasingly taken into account in attempting to understand their clients through use of their own countertransference, and dynamic processes had been considered in attempting to explain countertransference. Tansey and Burke (1989) suggested countertransference be used as “an umbrella term including introjective and projective identification, and empathy” (p. 41), thus referring to all the feelings and attitudes towards the client, whether or not these are the result of projective identification from the client, or include empathic processing. Use of the term ‘projective identification’ (within an intra-psychic framework) was extended (Bollas, 1983; Cashden, 1988; Ogden, 1982) into the ‘interpersonal’ arena following Klein’s (1946) original introduction of the term to the analytic world through her work with children. In projective identification, the client unconsciously expels (projects) unwanted, disowned (and often bad) aspects of the self into the therapist to rid the self of unwanted, aggressive parts and thereby control the therapist from within. The therapist unconsciously identifies with those parts and may feel or behave accordingly. In this way, the therapist’s countertransference feelings can reflect aspects of the client’s inner world and are considered as an unconscious meta-communication from the client: as such it is viewed as a valuable and important part of the treatment process. An example from my own clinical practice will be used as an illustration of my countertransference response:

*Ms A, presented with features of an obsessive and compulsive nature, and issues around separation-individuation. In one session, Ms A had talked, non-stop, and in a ‘matter-of-fact’ way, of being a recipient of teenage bullying at school. Apart from experiencing flitting feelings of anger, I became aware towards the end of the session of my increasing sense of powerlessness and silence in this session. As I attempted to observe what was happening between myself and my client and to monitor my own responses, as opposed to solely listening and processing content, I became more aware of my responses during the session, on self-reflection, and later in supervision.*

My countertransference feelings of anger may have arisen from a projective identification, and my feelings of powerlessness may also have been a response of this type of process. Following self-reflection, and during supervision, I considered my
countertransference responses to Ms A. My responses may have been one of a ‘concordant countertransference’ in which Ms A may have communicated to me not only her sense of powerlessness that she felt from the bullying but was unable to consciously communicate, but she may also have been projecting her anger. Others have described this aspect of countertransference as ‘patient-derived countertransference’ (Money-Kyrle, 1955) or ‘reactive concordant countertransference’ (Clarkson & Nuttall, 2000).

Racker (1957; 1968) suggested that the analyst moves ‘back and forth’ between ‘complementary’ and ‘concordant’ identifications with the client that are shown in the analyst’s reactions that provide clues to understanding the client’s inner emotions. He suggested empathy comes from ‘concordant identification’ where the analyst experiences within himself the corresponding part of the client, as in: ego-ego, superego-superego. Whereas, in a ‘complementary identification’, also known as ‘role responsiveness’ (Sandler, 1976), the analyst has the emotion that the client projects into his analyst, who is now representing the transference object, whilst the client himself experiences the emotion he had in the past with that object (parental image).

In practice, early response by the therapist to attribute countertransference responses (via identification) to being induced by the client before examining these as hypothetical cues, or by investigating one’s own contributions first, can have a negative impact on the therapeutic relationship (Tansey & Burke, 1989). The therapist’s emotional experience is often a bit of both types of processes and therapists should check for alternative factors before relying on their first hunch (Sandler, 1976). Different therapists might respond in varying ways to the same client and need to be aware of their own tendencies and biases (Racker, 1968). Racker emphasised the importance for the therapist of developing their ability to monitor their own countertransference responses within themselves: an aspect of the therapist’s self-development described as the ‘internal supervisor’ (Casement, 1985). However, distinguishing between influencing factors can be problematic, and is no easy feat for the trainee. Developing my own ‘internal supervisor’ was a skill that I began to develop in a reflective space both during and following client sessions, and further in supervision sessions with my ‘external supervisors’.
Cashden (1988) and Casement (1985) discuss the complexity in distinguishing between therapist or patient factors, or even both, in leading to the therapist’s emotional countertransference responses. Cashden also viewed countertransference as including those influences outside of the therapeutic interaction influencing the therapist that are not necessarily unresolved conflicts from the therapist’s past, but may be more contemporary in nature and are the influence of factors in the therapist’s everyday life, including relationships outside the therapy. Further, therapist responses appropriate to the ‘real’ relationship between therapist and client (working alliance and person-to-person) can risk being over-looked (Sandler, Dare & Holder, 1992) and not taken into account. However, Tansey and Burke (1989) suggest that countertransference reactions are more easily analysed between sessions, or over several sessions, when the interactional pressure ‘in the moment’ is less: certainly from my own experience this was where supervision was particularly helpful. As Ogden (1982) also acknowledged, the importance of supervision cannot be underestimated, as well as personal therapy, particularly for the trainee therapist whilst learning about and experiencing countertransference, its complexity, its helpfulness, or its potential hindrance as an adverse influence on the therapeutic work with the client.

The recent ‘moderate’ perspective: recent research on countertransference

Much of the research on countertransference has lacked clarity and robustness owing to a lack of a comprehensive theory and testing of unrelated hypotheses. In the recent research literature (Gelso & Carter, 1985; Gelso & Hayes, 1998; Hayes & Gelso, 1991; Hayes et al, 1998; Rosenberger & Hayes, 2002a, Rosenberger & Hayes, 2002b), countertransference has been defined in terms of a more ‘moderate’ perspective. This definition is similar to the classical concept of countertransference in that it refers to the therapist’s responses as arising from the therapist’s own unresolved conflicts. However, it is not similar to the classical tradition but more similar to the totalist perspective, in that the therapist’s responses are not seen as only in response to the client’s transference and, importantly, countertransference is not viewed as negative. Research regarding therapeutic use of countertransference found therapists’ countertransference reactions influenced their therapeutic work by therapists’ use of
avoidance and approach behaviours (Hayes & Gelso, 1991). Further, conscious management by therapists of their countertransference responses influenced therapeutic outcome to some extent and was considered by them as an important aspect of their therapeutic work (Gelso, Latts, Gomez, & Fassinger, 2002). However, research on countertransference has been limited by methodological constraints, such as: the lack of a unified theoretical framework; validity and reliability limitations; laboratory as opposed to field conditions; single-case designs; participants’ recruited were predominantly trainee therapists (who may be less experienced in managing therapeutic induced countertransference compared to experienced therapists), and use of the restricted ‘moderate’ definition to operationalise the concept in the research context. Gelso et al (2002) acknowledged conceptual difficulties that have plagued research designs and stress that countertransference reactions of the therapist require more attention in both research and training and need to be more clearly understood, because failure to manage countertransference responses can adversely influence therapeutic work.

Conclusion
Although countertransference as a concept originated from within the analytic world, an understanding of its use has been increasingly valued by non-analytic therapists for enhancing their therapeutic work; this is also true of other disciplines working therapeutically with clients (Jones, 2004), particularly those using psychodynamic principles and this includes Counselling Psychologists. As a Counselling Psychologist, it seems important to understand the development of the countertransference concept, for the original classical concept of countertransference may still be favoured in some clinical establishments. Alternatively, the classical view may be held in parallel with the totalist view, which might become confusing for trainees when attempting to develop an understanding of and the use of countertransference in their clinical practice.

The analytic and psychotherapeutic literature provides conflicting definitions of the concept and phenomenon of countertransference. Countertransference has been conceptualised from its classical and contemporary perspectives. However, difficulties exist in reaching a consensus of definition, as reflected in the relatively limited
research that has investigated it. Countertransference, as a construct, has attempted to be operationalised in research by use of the recent moderate definition. Overall, countertransference definitions have ranged from being viewed from a negative position, in which countertransference was considered by analysts as a dangerous and undesirable phenomenon, to that of a more positive position, where it has been viewed as a potentially useful and desirable therapeutic phenomenon to be harnessed for the benefit of the client, when managed appropriately. One final agreement in the literature appears to be that the use of countertransference in the therapeutic relationship is important in developing understanding of unconscious and conscious processes in interactions between therapist and client.
References


The development of cognitive behavioural therapy, the cognitive behavioural perspective of the therapeutic relationship and the concept of resistance

Cognitive behavioural therapy (CBT) has become the main therapeutic approach and the focus of widespread research in the western world, particularly in the context of the NHS in the UK. In order to explore the relevance of CBT to the Counselling Psychologist, first this essay will contextualise the development of CBT, including its theoretical and therapeutic development, prior to focusing on the cognitive-behavioural perspective of the therapeutic relationship. Finally, in the context of the therapeutic relationship, how a specific difficulty such as the concept of resistance is perceived and understood by CBT therapists is explored. Reference to my own clinical practice as a trainee Counselling Psychologist, working with clients who have chronic and enduring mental health needs in the context of a Community Mental Health Team, will be used to illustrate relevant factors of this aspect.

Cognitive behavioural therapy – theory and evolution.
CBT’s roots dates back to the 1950s in behavioural therapy (BT) applying the two main principles extrapolated from learning theory: classical conditioning (Pavlov, 1927) and operant conditioning (Thorndike, 1898). In BT, dysfunctional behaviour patterns were considered to result from unhelpful learning (Eysenck, 1960) and therefore could be unlearnt through applying behavioural techniques based on learning theory. For example, behaviour modification based on the principle of positive reinforcement was frequently used with children, and also with adults who had learning disabilities, and token economies (Ayllon & Azrin, 1968) became used in psychiatric hospitals for patients with schizophrenia (Liberman, 1972). BT’s focus on therapeutic efficacy and its stringent empirical standards of measurement, evaluation, and outcome research was its greatest asset for its acceptance as a science. However, its increasing focus on application of technique, rather than further theoretical development, brought about its decline and interest turned to other influences on behaviour. The value of social learning theory (Bandura, 1965) was brought into BT to accommodate the influence of observation and modelling on behaviour, followed
by the motivational aspects of reinforcement, and the social influence of behavioural techniques was increasingly recognised.

Although reluctantly, interest in the role of cognitive factors, such as attribution and self-instruction, developed in BT and were taken up by behaviour theorists whose backgrounds were grounded in the principles of behaviour modification (Goldfried, 1982; Mahoney, 1974; Meichenbaum, 1977). The 1960s and 1970s heralded a cognitive revolution in psychology. Cognitive processes, such as thinking, memory and perception in information processing (occurring between stimulus and response processes considered to influence behaviour) became increasingly recognised for their therapeutic potential for influencing behaviour change for clients suffering depression and/or anxiety disorders (Beck, 1970, 1976; Beck, Emery & Greenberg, 1985; Beck, Rush, Shaw & Emery, 1979; Meichenbaum, 1977).

The development of early cognitive therapy
The central role now being given to the influence of cognitions on behaviour and emotions challenged the earlier domination of technique orientated behaviour therapy. Cognitive therapy (CT) was strongly influenced by Ellis (1962) and Beck (1970) who, coming from psychoanalytic backgrounds were disillusioned with the psychoanalytic focus on insight as the mediator of effective change and the lack of empirical standards now demanded in determining psychology as an acceptable science. For Beck, “an individual’s affect and behaviour are largely determined by the way in which he structures his world” (Beck, Rush, Shaw & Emery, 1979, p. 3). Through investigating the types of thoughts held by depressed people, Beck (1976) asserted that depressed people are subject to a ‘cognitive triad’, involving pessimistic views of themselves, the world and the future. Beck’s early cognitive therapy of depression (Beck et al, 1979) was based on the influence of an individual’s negative thinking (arising from assumptions gained in childhood), which he asserted also had a central role in the maintenance of their depression. For example, Beck suggested that negative automatic thoughts (NATs) reduced affect, and reduced affect increases the likelihood that further NATs will occur; this produces the cycle that maintains depression. However, by altering clients’ idiosyncratic, dysfunctional thoughts and beliefs during CBT, behavioural and affective change could follow.
CBT essentially evolved from the merging of behavioural and cognitive approaches. The theoretical rationale underpinning the cognitive-behavioural approach taken from a CT perspective is that people’s thought processes mediate the way people feel and behave (Mahoney, 1974; Rachman, 1997). Psychological problems, such as depression and anxiety, are conceptualised as arising from unhelpful thinking, the making of inaccurate inferences and failure to test out these inferences for accuracy. Behavioural and cognitive techniques and the strict empirical basis from behaviour therapy underpin behaviourist and cognitive theories in CBT. Although it is predominantly the person’s interpretations, inferences and evaluations that are targeted for change (Dobson, Backs-Dermott & Dozios, 2000; Hollon & Beck, 1994), cognitive techniques, such as systematic discussion (Hawton, Salkovskis, Kirk & Clark, 1989) and monitoring of and challenging of NATs (Beck, 1995), as well as carefully structured behavioural experiments (Bennet-Levy et al, 2004) are carried out. Homework and/or in-vivo assignments and testing with the CBT therapist are aimed to help the client evaluate and modify unhelpful thoughts and dysfunctional behaviour. Hence, a diversity of principles and procedures were incorporated into CBT that made it a hybrid of behavioural strategies and cognitive processes with the goal of achieving behavioural and cognitive change.

**Strengths and limitations of CBT**

Although CBT is a relatively recent development in psychological treatment, it has nevertheless developed widespread applicability across a range of psychological disorders. The merging of BT and CT particularly flourished further with the development of CBT theories and treatment for panic disorder (Salkovskis & Clark, 1991; Salkovskis, Clark & Gelder, 1996; Clark, 1986) and obsessive compulsive disorder (Salkovskis, 1985). CBT’s application has since advanced into treatments for: obsessions and health anxiety (Salvkovskis & Warwick, 1986); social phobia (Wells, 1997); personality disorders (Young, 1999); anorexia, bulimia and binge eating (Fairburn, Cooper & Safran, 2003; Fairburn, Marcus & Wilson, 1993). Furthermore, CBT has maintained its strict empirical roots from the behaviourist tradition. Therefore, it is open to evaluation through systematic investigation in clinical trials, so promoting its scientific credibility. Hence, it has come to dominate both research and
practice (Orlinsky, Grawe & Parks, 1994), unlike other therapeutic approaches. Hence, CBT's empirical underpinnings have revealed therapeutic efficacy and has been recommended by the National Institute of Clinical Excellence (NICE) as the therapeutic treatment of choice for many of the above disorders. CBT can also be delivered briefly (Curwin, Palmer & Ruddell, 2000; Padesky & Greenberger, 1995) and effectively, especially in comparison to most psychodynamic therapies. Further, psycho-education is a strong component of CBT that helps clients to develop 'self-therapy'. Self-therapy is an aspect promoted in the emerging self-help literature that increases wider accessibility and promotes economic appeal. Economic appeal is an important factor also for healthcare purchasers and providers, such as the NHS and private healthcare insurers. Further, CBT’s brevity and usability by a wide range of professionals, such as nurses and educators, has also contributed to its appeal and in making it the most widely accepted form of therapy today.

However, CBT may be criticised for being mechanistic in focusing on techniques and testing of hypotheses about dysfunctional beliefs and in over-estimating the role of cognition in therapeutic change. A further limitation can be attributed to the lack of recognition by BT in particular, but also by CT, of the importance of the therapeutic relationship in terms of recognising its potency as an agent of change, particularly in comparison to psychoanalytic and humanistic approaches. Hence, it is to the exploration of the therapeutic relationship in CBT that attention is directed for the remaining section of this essay.

The therapeutic relationship

In traditional BT, the therapeutic relationship has been given less attention in both research and theory in preference of concentrating on empirical measurement, evaluation and on the technical aspects of the therapy, i.e. promoting behavioural change by objectively applying behavioural principles and intervening with goal-directed techniques. A rather negative view of the therapeutic relationship can be concluded from the lack of relative importance attributed to it in the BT literature. Similarly, during the early phase of the CT literature, attribution to the role of the therapeutic relationship is noticeable by its relative absence in comparison to the
emphasis on identifying and evaluating thoughts maintaining dysfunctional mood, and on behavioural change.

In CBT, the development of the therapeutic relationship is characterised by a collaborative empiricism (Beck et al, 1985) that encourages active participation on the part of the client and the therapist, who instructs the client in monitoring, recording, testing the reality of their own appraisals, perceptions and beliefs, and implementing behavioural experiments specifically designed to assist the client in achieving preset therapeutic goals. The ‘collaborative’ nature of the therapeutic relationship holds more of a psycho-educative stance that might be equated with that of teacher-student, however, collaboration also aims to facilitate self-empowerment in the client and, further, implies an equality of responsibility by the client for the endeavour (Herbert, 2002). The collaborative nature of the relationship also encourages transparency through information sharing between client and therapist and empirical testing that demands a joint effort in working with the client’s presenting problems: these aspects can contribute to a climate of trust within the therapeutic relationship (Padesky & Greenberger, 1995; Wills & Sanders, 1997).

However, the role of the therapeutic relationship has more recently come under scrutiny and emphasis has been given to examining the credibility of the influence of relationship variables as acting both on the change process and as a force in its own right as the agent of change. “The therapeutic relationship can have a positive or negative impact on the effectiveness of the diverse activities directed towards change” (Schaap, Bennun, Schindler & Hoogduin, 1993, p. 17). Although, this still suggests that the relationship is construed as a help or a hindrance that impacts on the stronger influence of behavioural activities as the factors for change. This is in comparison to a more central role given to the therapeutic relationship, as in psychoanalysis and person-centred therapy.

A positive view of the impact of the relationship, for its role in facilitating effective CBT activities, has been emphasised by some therapists in the CBT community (Dryden & Feltham, 1994; Jacobson, 1989; Safran, 1984). The importance of securing relationship factors, such as trust and safety, has more recently been seen as important
in maintaining on-going therapy and in contributing to the overall collaborative
deadvantage (Leahy, 2003; Padesky & Greenberger, 1995). Keijsers, Schaap &
Hoogduin (1990) identified two groups of interpersonal behaviour associated with
positive CBT outcome. The first, the working alliance has been acknowledged
(Horvath & Greenberg, 1994) for its part in securing the early engagement of the
client and in encouraging client responsibility for the collaborative role of enquiry and
testing. The second, involves the Rogerian (1951) core principles of empathy,
unconditional positive regard and congruence; these aspects can harness hope in the
client and a degree of relief that also helps to engage the client during early stages of
therapy (Beck, Rush, Shaw & Emery, 1979); although in CBT these core conditions
may be considered necessary, they are not factors considered sufficient for change on
their own. Therefore, a theory that integrates both relationship and technical factors
has been lacking in CBT, however, attention to the interpersonal aspects of the
relationship has more recently been considered, as will now be discussed.

**Developments in CBT**

Safran (1990a, 1990b) and Safran and Segal (1990) were interested in the centrality of
the therapeutic relationship, the experiential aspects of the therapy process and the
underlying mechanisms of change, and subsequently raised the profile of the
therapeutic relationship; this has stimulated interest by CBT therapists regarding the
interactional aspects of techniques and the therapeutic relationship, not just in the
application of technique. Hence, a wave of fresh interest was recently breathed into
CBT by cognitive therapists. Attention is now being given to incorporating concepts,
such as ‘self-perpetuating interpersonal schemas’ (Safran & Segal, 1990) based on
self-other relationships which link in ideas from interpersonal theory (Sullivan, 1953)
and attachment theory (Bowlby, 1988). Interpersonal schemas are interactional and
evoke a ‘cognitive-interpersonal cycle’ (Safran, 1990), or ‘schema maintenance’
(Young, Klosko & Weishaar, 2003). For example, persons who see themselves as
‘vulnerable’ are likely to perceive others as ‘care-takers’. The therapeutic relationship
is seen as an opportunity for addressing ‘maladaptive interpersonal schemas’ through
experiencing new ways of relating that Young et al (2003) have called ‘limited re-
parenting’ in providing corrective emotional experiences. Further, these ideas also
have similarities to the concept of ‘transference’ in the psychodynamic approach, in
which the client relates to the therapist as if he or she were a significant figure from the client’s past. Although the concept of ‘transference’ had not been related to CBT ideas before, it is no longer so abhorred, for some CBT therapists have been considering concepts associated with psychodynamic models in their clinical work, such as transference and their own countertransference responses (Leahy, 2004; Safran & Segal, 1990). However, due to the subjective nature of transference and countertransference and inference of unconscious processes, these concepts may challenge CBT’s theoretical basis and empirical underpinning, for example, CBT’s focus on objective evidence, measurable behaviours and conscious cognitive processes. However, the movement in CBT towards integrating relational concepts from other therapeutic modalities is an optimistic development for the Counselling Psychologist, as it places an increasing importance on the role of the therapeutic relationship in the change process and may help progress, across the therapeutic arena, towards consensus regarding the importance of the therapeutic relationship. Furthermore, difficulties in the therapeutic endeavour across theories can be attributed to relationship factors and the concept of resistance in CBT is one aspect of this.

The concept of resistance

Resistance occurs in all forms of therapeutic treatments and in CBT it has been given various definitions, for example, non-adherence or non-compliance. However, the roots of the term ‘resistance’ originated in classical psychoanalytic therapy, where resistance is a central aspect of the therapeutic work and was considered to be more of an intra-psychic force reflecting an internal conflict. According to this understanding, resistance was welcomed as the focus of change within the transference-countertransference relationship (Beach & Power, 1996; Jones, 2004; Ogden, 1982; Racker, 1968).

In CBT, the range of behaviours that can be attributed to resistance is endless and depends on the therapist’s interpretation and definition of resistance. Turkat and Meyer (1982) suggested resistance was any client behaviour defined by the therapist as anti-therapeutic. Resistance has been conceptualised in terms of “behavioural non-compliance” (Newman, 2002, p.166) both to the therapist’s instructions and to the ‘extent’ that a client opposes change that is encouraged by the therapist: as such it has
been considered to be a ‘disruption’ to the therapeutic endeavour (Schapp et al, 1993). Resistance tends to maintain the status quo and acts against change. Strong and Matross (1973) have suggested that it is the form of resistance that propels clients to seek therapy. Further, if resistance did not exist, at least to some degree, then clients might resolve their difficulties independently. Hence, as such “resistance walks through the door with the client” (Miller & Rollnick, 2002, p. 98).

In the CBT literature, one of the main forms of ‘non-compliance’ is failure to carry out homework assignments (Lazurus & Fay, 1982; Leahy, 2003; Padesky & Greenberger, 1995). A clinical illustration will be discussed here of how this difficulty presented and was attended to in my own clinical practice whilst I was working with Miss A with whom a CBT approach was used:

Miss A, a 19 year old single woman with anxiety and mild depression, was referred by her psychiatrist. Miss A attended weekly sessions in the context of a CMHT setting. Having established the preliminary requirements for an effective therapeutic alliance with Miss A, I focused on collaboratively working with Miss A and guiding her in the use of homework assignments between sessions to supplement the in-session work. However, each week Miss A returned to provide differing, and ingenious explanations, as to why homework tasks had not been undertaken. Therapeutic progress was significantly disrupted. My initial supportive responses developed into more enthusiastic attempts on my part in directing Miss A’s actions and to ‘overcome’ non-compliance in order to progress. Struggling with my own responses to Miss A’s ‘resistance’, including my own eagerness and then frustration, I took this difficulty to supervision. I was able to understand how, through enthusiastically applying my developing skills and budding knowledge of CBT techniques (for this was my first CBT client) I may have paid insufficient attention to providing a relevant rationale for homework activities. Further, I may have become less empathic towards my client in my enthusiasm to ‘do’ CBT.

How CBT therapists tend to work with this procedural difficulty is by providing an adequate rationale for the tasks, in step-by-step chunks, and by developing homework
activities in ‘collaboration’ with the client, relevant to the client’s needs (Padesky & Greenberger, 1995). Credibility is thus gained for the therapeutic endeavour and for homework activities, and prevents misunderstandings and non-compliance (Beck et al, 1979; Beck et al, 1985; Schaap et al, 1993). Also, Rees, McEvoy & Nathan (2005) found that this has been shown to positively correlate with successful treatment outcome. Further, behaviour therapists (Schaap et al, 1993) have suggested: “resistance is a sign that the therapist is not handling that particular client in the right way (and by the same token as a sign that the therapist should search for an alternative way of handling the client).” (p. 41). Attending to therapeutic resistance with Miss A helped to rectify this aspect. Most importantly, through attending further to the therapeutic alliance in terms of modifying my empathic responses, helped strengthen and reduce risks of threat of rupture to the alliance.

A further consideration in respect of the above clinical illustration is a threat of rupture to the therapeutic alliance in terms of ‘interpersonal theory’ (Sullivan, 1953). Safran (1990a, 1990b) and Safran and Segal (1990) have been integrating interpersonal theory into their framework involving ‘interpersonal schemas’ and ‘cognitive-interpersonal cycles’. Miss A’s tendency towards passivity and my response in becoming increasingly directive, provided a rich source of therapeutic information regarding my client’s dysfunctional interpersonal relating schema, i.e. possible passivity in response to an ‘over-smothering mother’: this helped me develop an understanding, experientially, of Miss A’s difficulties. Therefore, in this instance, through attending to Miss A’s resistance this also enabled me to gain a deeper understanding of her relating difficulties. I was then able to unhook from my over-enthusiastic and dominant responses accordingly. Hence, this provided Miss A with an alternative ‘self-other’ interpersonal experience to help disconfirm her perception of herself as helpless and in need of my caretaking. Following the point that Miss A was able to tell me emphatically that she would make decisions for herself, rather than let others do this for her (including me), engagement increased and self-directed testing of her unhelpful beliefs proceeded within a more collaborative relationship. Awareness of subtle interpersonal factors, such as those discussed above, can help the CBT therapist in planning appropriate treatment for the unique interpersonal needs of
the individual client along with the CBT model of treatment. As Safran (1990) emphasises, the so called ‘non-specific’ factors of the therapeutic relationship are, in practice, inextricable from technical factors used in the consulting room.

**Conclusion**

In conclusion, CBT evolved from behavioural and empiricist roots to incorporate ideas from cognitive psychology in understanding psychological disorders. CBT psychological treatments have been designed using a hybrid of behavioural experiments and cognitive techniques. However, the role of the therapeutic relationship in CBT, regarding interpersonal factors and their therapeutic properties, is increasingly being viewed as an opportunity in terms of working with interpersonal schemas and cognitive-interpersonal cycles. In a CBT approach, resistance, or non-compliance, has been associated with the quality of the therapeutic bond and is particularly important in engagement of clients and in gaining understanding of and working with maladaptive interpersonal schemas, or dysfunctional cognitive-interpersonal cycles. Therefore, Counselling Psychologists can use resistance and its impact on the therapeutic relationship when working within CBT, to increase awareness of relating difficulties and how these can be associated with clients’ presenting problems and concerns.
References


THERAPEUTIC PRACTICE DOSSIER
Introduction to the therapeutic practice dossier

The Therapeutic Practice Dossier provides an overview of aspects of my clinical work throughout the three years of my clinical practice whilst undertaking my psychotherapeutic and counselling psychology training. This dossier comprises descriptions of each of my clinical placements during these three years, the client populations, multi-disciplinary working and also my professional activities. These descriptions are followed by my Final Clinical Paper which provides a reflective account of my professional practice and my personal journey during my three years of training to become a Counselling Psychologist. My final clinical paper shows how I understand and use learning from academic theory, research and clinical practice in my clinical work. This paper also reflects on what I have brought with me into my training from my past clinical, professional and personal life experience, my use of self and my development as applied in my therapeutic work with clients and in my development as a Counselling Psychologist.
First year clinical placement: A NHS Psychology Department
October 2003 – August 2004

This placement was set in the Department of Psychology in a Health and Social Care NHS Trust. The service provided primary care psychology services to GP practices of four Primary Healthcare NHS Trusts and a secondary care psychology service to an in-patient unit located on the same hospital site. The Department of Psychology is based in a Community Hospital located in a large busy town and serves both rural and urban communities.

The psychology team consisted of: three consultant clinical psychologists (B grades), of which one had a combined role as Head of this Psychology Department; five A grade Clinical Psychologists, of which one has a split role across primary and secondary care; six A grade Counselling Psychologists; one assistant psychologist; two secretaries and an Art Psychotherapist. The psychology team also provide group therapy for anxiety, depression, obsessive-compulsive disorder and self-esteem facilitated with professional staff from the Community Mental Health Team (CMHT), also based in the hospital.

The clients I saw were referrals from Psychiatrists’ and GPs’ for adults, age 18 years and over, who did not require an ‘enhanced care’ care programme approach, i.e. clients with complex needs involving care management. All referrals were triaged by a senior Clinical Psychologist and my clients were allocated in consultation with my supervisor, a Counselling Psychologist. Although short-term therapy of six sessions was advocated for many clients, in order to meet the increasing pressures of a lengthy waiting list, longer-term psychological therapy of 12 – 18 weeks, and more, could be offered according to individual client assessment and individual therapist therapeutic orientation. A range of therapeutic modalities were offered by psychologists ranging from psychodynamic, cognitive behavioural, integrative and systemic/narrative therapy. My supervisor was a Counselling Psychologist and the therapeutic model in which I worked during this placement was person-centred, plus behavioural focused work towards the end of placement. I worked with a range of presenting issues
including: general anxiety, depression, loss, life-stage events and transitions, social anxiety and interpersonal-relating difficulties.

In this placement, I also attended the monthly departmental meetings, primary care staff meetings and fortnightly in-service training sessions for trainees provided by individual psychologists in the psychology team. Topics of these sessions included: risk assessment, CBT formulation, Eating Disorders, sexual abuse, personality disorders and self-harm, Post Traumatic Stress Disorder, cultural considerations, mindfulness and relaxation. Towards the end of this placement, I joined narrative supervision sessions recently started for psychologists and provided by the team family therapist and attended a Trust psychology service study day on clinical supervision and supervision research.
Second year clinical placement: A NHS Psychotherapy Department
September 2004 – August 2005

The context of this placement was based in a Psychotherapy Department of a large Mental Health NHS Trust providing psychotherapy services to outpatients referred by GPs, Psychiatrists and CMHT, and to in-patients on wards in the Psychiatric Hospital, in which the department was based. The psychiatric hospital was on the acute general hospital site and both served nearby rural and urban communities.

The psychotherapy team consisted of: two Consultant Psychiatrists in Psychotherapy, one of which was also the Head of the Department; one Senior Registrar in Psychiatry undertaking Specialist Training in Psychoanalysis in this placement, six Adult Psychotherapists, including one who was a Couples Psychotherapist and one who was a Group Analyst who also worked in a Child and Adolescent Mental Health Service; and one secretary. The team worked closely with the five psychiatric teams whose offices were also in the psychotherapy department.

The psychotherapy service accepted referrals for older adolescents and adults up to 65 years of age from Psychiatrists, Community Psychiatric Nurses, GPs, and Psychologists in the primary and secondary care sectors. All therapy assessments were undertaken by the Adult Psychotherapists and then allocated during client allocation meetings to team members for therapy: trainees did not attend these or undertake any assessments. Psychotherapy was offered once per week, for 50-minute sessions, of longer-term duration (one to two years) though brief therapy of 40 sessions was also offered. Couple therapy was based on the Tavistock’s twelve-session brief therapy model. The theoretical orientation of the department was psychoanalytic psychotherapy; some clients attended for psychoanalysis of three sessions weekly for three years. The department also provided group therapy for outpatient clients.

I received supervision from three supervisors for psychodynamic therapy. Two individually supervised me weekly for two clients each. My third supervisor supervised me weekly for couple’s therapy jointly with the Psychiatric Registrar, also seeing couples. Supervision was predominantly process orientated and focused on
unconscious communications between myself and my clients within the therapeutic relationship. I saw clients referred with obsessive-compulsive disorder, depression; post-natal depression; borderline personality disorder; sexual difficulties; interpersonal relating difficulties.

Other activities included regularly attending a Consultant Psychiatrist's weekly ward round on the in-patient unit, attending the psychiatric teams' weekly teaching seminars, which included case study presentations including: bi-polar disorder, schizophrenia, generalised anxiety disorder, personality disorder, post traumatic stress, Aspergers syndrome and an external enquiry into an in-patient suicide. I also attended the psychotherapy team's weekly case presentations where I presented two of my own clients: one client with borderline personality disorder and the other with recurrent post-natal depression. Other team meetings that I attended debated topical issues including: a trial utilising 'Clinical Outcome in Routine Evaluation' (CORE) in a psychodynamic psychotherapy audit, the Care Programme Approach (CPA), risk assessment, recent attachment research publications and psychoanalytic readings of sexual perversions in males and females.
Third year clinical placement: A Community Mental Health Team
September 2005 – August 2006

This placement was based within a Community Mental Health Team (CMHT) that served a large urban town with a multi-cultural population. The CMHT consisted of three Consultant Psychiatrists, three Registrar Psychiatrists, three Senior House Officer Psychiatrists, three Mental Health Social Workers, one Consultant Clinical Psychologist, two Counselling Psychologists and one trainee Counselling Psychologist, one Clinical Psychologist and one trainee Clinical Psychologist, six Community Psychiatric Nurses, three administrators, three secretaries and one receptionist. The Forensic Psychology Team, the Crises Resolution Service and the Assertive Outreach Team were also based in the same building.

The CMHT provided a working age mental health service (WAMHS) to adults of between 18 and 65 years who had chronic and enduring mental health needs, clients referred following an acute crisis and some clients referred for psychological therapy from primary care. The team was split into three sectors. Referrals for psychological assessments and/or psychological therapy were accepted from other members of the CMHT via the three sectors’ weekly clinical allocation meetings attended by the members of the relevant sector.

In this placement, I was supervised by two supervisors: a chartered Counselling Psychologist and a chartered Clinical Psychologist. The Counselling Psychologist supervisor’s time was split between working in the CMHT as well as a Specialist Psychological Therapies service and worked using an integrative approach, combining narrative and cognitive-behavioural therapies. The Clinical Psychologist from another sector of the CMHT worked using a cognitive-behavioural approach. I predominantly worked using Cognitive Behavioural Therapy with clients. I also participated in narrative supervision groups as time permitted. I undertook all of my own assessments for clients I worked with and I participated in further assessments undertaken with my supervisor. I saw clients that presented with general anxiety, phobia, obsessive-compulsive disorders, panic disorder with agoraphobia and social anxiety, health anxiety disorder, post-traumatic stress, depression, post natal depression,
interpersonal-relating difficulties, eating disorders, i.e. anorexia nervosa, bulimia nervosa, binge eating.

During my time in this placement, I established a local Eating Disorders Self-help Support Group in the local day hospital in response to a local identified need. I chaired a planning group and provided consultation and support to two new co-facilitators prior to transferring responsibility and affiliation to the Eating Disorders Association. I also co-presented a talk on Eating Disorders to a service user group at a local community rehabilitation support centre. During this placement, I also attended the CMHT’s monthly business meetings and continuing professional development (CPD) monthly in-house training sessions for staff provided during lunchtimes.

A ‘Specialist Psychological Therapies’ Service
During this placement, I also undertook work with clients in a Specialist Psychological Therapies (SPT) service attached to an NHS Hospital. The SPT service took referrals from local CMHTs and other specialist services inside and outside of this Trust. However, this service was newly formed and in the process of a further reorganisation included upheaval and its referral criteria being modified. The SPT consisted of a psychology team managed by a consultant Clinical Psychologist and included Clinical Psychologists, Counselling Psychologists, trainee Clinical Psychologists, trainee Counselling Psychologists and assistant psychologists. Although individual practitioners worked according to a variety of psychotherapeutic models (e.g. psychodynamic, cognitive behavioural and humanistic), there was a strong interest in narrative and systemic approaches within this department. Clients receiving psychological therapies were of adult age across socio-economic groups and generally had complex difficulties of moderate severity. In most instances, clients were required to have a care co-ordinator from one of the CMHTs.

My two supervisors in this placement also supervised my work based within my CMHT placement. The therapeutic approach I worked with was Cognitive Behaviour Therapy on an individual and group basis. Group therapy was promoted in this service and I co-facilitated an Obsessive-Compulsive Disorders Group and an Eating Disorders Group with each of my supervisors. I also participated in optional narrative
therapy supervision for trainees, as time permitted. I also took up the opportunity offered to support a Counselling Psychologist presenting a credited training course in the placement for multi-disciplinary professional staff working with adults who had been abused as children: a course that also incorporated cognitive behaviour therapy and an attachment theory perspective. I also attended monthly business meetings at the psychology teams and attended monthly training sessions for trainees provided by the psychologists from both teams on topics that included: ‘Mind over Mood’ group work; personality disorders; post-traumatic stress disorder; schizophrenia and psychosis; depression and mindfulness; working alongside interpreters in therapeutic work; service users perspectives.

At this placement, I also took up opportunities for further CPD. I attended a two-day continuing professional development training, provided from the University College London (UCL) training team for team psychologists and psychotherapists working with clients with Borderline Personality Disorder (BPD) and establishing a new personality disorder service. I was able to learn more about personality disorders when working with this client group, particularly as service users and their family’s perspectives were represented also. I also had the opportunity to attend a two day conference at UCL for clients with BPD and a study day at the Cassell Hospital, a ‘Therapeutic Community’, on psychodynamic work with mothers who have Borderline Personality Disorder and their families. Whilst in this placement, and related to my research, I attended a study day at the Tavistock Marital Institute regarding ‘Working with couples from an attachment perspective’, which presented current on-going research. This interested me because of the implications of combined interactions of the parent-child and marital attachment systems on child development and emotional-social development. In line with my research interest, I had the opportunity to attend the Association for Child and Adolescent Mental Health’s Emanuel Lecture on ‘Fostering, Adoption and Alternative Care’: here, eminent attachment researchers presented recent research on fostering and adoption and from a research perspective raised stimulating debates between policy, research and practice.
Final clinical paper

My professional and personal journey to becoming a counselling psychologist

"we shall not cease from exploration
and the end of all our exploring
will be to arrive where we started
and know the place for the first time"

(T. S. Elliot, 'Little Gidding', 1942)

Introduction
This paper describes the learning experiences on my journey towards 'becoming a Counselling Psychologist' that have facilitated and challenged my professional and personal growth. First, I briefly discuss aspects from my professional life brought with me into training that had influenced my early therapeutic perspectives and expectations, for these undoubtedly influenced my clinical practice as well as my research topic. I particularly emphasise that my core values and my professional identity as a trainee Counselling Psychologist are based on the priority I give to the therapeutic relationship in my clinical practice, irrespective of which theoretical model I may work within. I will reflect on the theories and therapeutic models I have been exposed to that have most informed my therapeutic practice, notably humanistic, psychodynamic and cognitive-behaviour therapy (CBT), and the way that I work with the therapeutic relationship that connects with each of these. Further, learning from research and 'evidence-based practice' that contributes to my clinical practice and professional development is emphasised. I also use clinical illustrations for my clinical practice where it is helpful to do so.

In this paper, I also reflect on some of the opportunities taken up and challenges presented to me on my journey, without denying those aspects that I have struggled with in the process. It is from my struggles and through learning to tolerate uncertainty that my professional and personal 'way-of-being' as a Counselling Psychologist has developed in my work with clients. Although limits are set on the extent I am able to offer a full account of my professional and personal growth, I hope
to provide the reader with a flavour of my journey and development to becoming a Counselling Psychologist.

What I brought with me into Counselling Psychology training

My journey to becoming a Counselling Psychologist began before the start of the course. I entered my training as a mature student and brought with me not only my personal history and experiences, but alongside that my professional experience as a health visitor. Working as a health visitor with child development and parent-infant/child relationships invited my curiosity to undertake further study of the psychological and emotional aspects of relationships. As part of undertaking parent-infant relationship facilitator training, I completed a parent-infant observation study based on the Tavistock’s model (see Miller, Rustin, Rustin & Shuttleworth, 1989) and from this I gained invaluable learning about ‘inter-relatedness in the early development of relationships’ (Belsky & Kelly, 1994; Bowlby, 1979, 1988; Brazelton & Cramer, 1991; Stern, 1985, 1995; Trevarthan & Hubley, 1978; Winnicott, 1965, 1979), as well as in my day-to-day work with mothers and their infants. My learning from this training enhanced my psychological understanding within my work with parents and children in primary health care and also directed my interests towards this area, i.e. my research topic. In my role as health visitor, I also sat as a member of the health team on an adoption panel in a local authority. This position broadened my experience regarding the subsequent care of ‘Looked After Children’ who had experienced disrupted relationships, and this interested me regarding the development of new relationships, child care provision and social policy.

In undertaking further psychology study, I became more interested in the wider application of psychology and therapeutic practice. However, it was in counselling psychology that my interest in psychology developed, where the therapeutic relationship is foremost and therapeutic practice with differing theoretical approaches and skills are combined. I entered counselling psychology from the perspective of believing that humans are born biologically programmed to seek to relate with others (Gerhardt, 2004) and develop in the context of interpersonal relationships with others; this is evident in my research interests, the psychological theories I am drawn to, and in my therapeutic practice.
The therapeutic relationship

The therapeutic relationship is the central overarching theme linking together my training with three theoretical approaches and my clinical experience in my placements. Strawbridge and Woolfe (2003) emphasised that the priority given to the therapeutic relationship is an important factor in the recent growth of counselling psychology in Britain and it is at the core of the counselling psychologist’s practice. Woolfe (1990) noted that there is:

"An increasing awareness among many psychologists of the importance of the helping relationship as a significant variable in facilitating the therapeutic endeavour"

(Woolfe, 1990, p. 4)

O’Brien and Houston (2000) have suggested that “the (therapeutic) relationship is the therapy” (p.133) and this is the perspective I work from in my therapeutic work with clients. My journey as a trainee counselling psychologist actually began within the humanistic approach and focusing on the therapeutic relationship.

The Humanistic approach and the therapeutic relationship

‘And this above all: to thine own self, be true
And it must follow, as the night the day,
Thou canst not then be false to any man’

(Shakespeare: ‘Hamlet the play’, Act 1)

Counselling psychology’s roots lie in the humanistic-existential paradigm where ‘being with’ takes priority over ‘doing to’ (Woolfe, 1990). As a trainee counselling psychologist, my therapeutic practice developed during my placement in a psychology department and was underpinned by the principles of person-centred therapy. In person-centred therapy (Rogers, 1951, 1961; Mearns & Thorne, 1990), ‘being with’ is central to the therapeutic relationship. I was also attracted to the humanistic approach for its holistic view of the person as a ‘unitary being’, in contrast to a ‘dualistic mind-body’ split, and the more medicalised view. Further, Maslow’s conceptual hierarchy of basic human needs (Maslow, 1968) was familiar from my nursing past. As Baron
(1978) and Szalita (1985) have suggested, therapists tend to be drawn to therapeutic practice in those approaches that best fit their own value system.

In person-centred therapy, I was attracted to the priority given to the client’s subjective and perceptual experiencing and ‘what it is to be human’, as I also value these aspects. My own understanding of Roger’s (1961) theory of personality development is that the person naturally strives for growth, to reach their potential, to be true to their self and seek meaning to their life. Thorne (1996) emphasised that person-centred therapy aims to facilitate the client’s connection with their true, authentic self and to promote the development of an internal ‘locus of evaluation’. This change corresponds with the dissolution of the person’s need for facades and an inauthentic self. Hence, the need for external evaluation and to meet ‘conditions of worth’ set by significant others in childhood that had originally led to their thwarted development, is significantly reduced.

The person-centred model provided me with a framework within which to develop the therapeutic relationship which was in keeping with my own value system. Firstly, I learnt how to develop the working alliance aspect of the therapeutic relationship and to value the ‘real’ (person to person) relationship (Clarkson, 2003). Working with clients within the person-centred model, I valued its core therapeutic qualities of non-judgemental acceptance and respect (unconditional positive regard) for the client, genuineness (congruence) and empathic understanding. These core conditions have also been shown to be a strong predictive factor in outcome studies, though notably irrespective of specific therapeutic modality (Orlinsky, Grawe & Parks, 1994). I value these qualities, not least because they provide me with a link to what was most familiar and central to me from my professional and personal identity, but in valuing ‘the other’, in respecting and embracing difference, as well as similarity. These therapist qualities were felt to be integral to my natural way of being, hence a ‘goodness-of-fit’ for which to base my early learning in therapeutic practice. Also, I felt that person-centred therapy offered that which I value in human relatedness: an appreciation of clients’ uniqueness and their own views of themselves and their external world; and, most importantly, to be and to feel understood by another, for this can validate a client’s self-worth. As Martin Buber (1951) emphasised:
Buber’s quote highlights the importance of affirming the other in relatedness in order to value one’s own inner self. I found that by facilitating client’s feeling of being understood they were able to explore previously denied aspects of themselves which then promoted emotional growth and new behaviour. As is particularly emphasised by person-centred therapists (Mearns & Thorne, 1990; Rogers, 1951; 1961), it is the therapist’s ‘way of being with’ a client that facilitates the therapeutic relationship; this includes establishing the working alliance aspect early in therapy. I refer to a therapeutic illustration to demonstrate the above points:

**Clinical illustration: an example of developing the therapeutic relationship**

Mr E was a 34 year old divorced man who presented with depression, generalised anxiety, low self-esteem and low self-worth compounded by feelings of loss following the betrayal by his ex-wife and ex-best-friend together. He subsequently followed his career but had become socially isolated and depressed. Having recently returned home to temporarily reside with his mother, he reported a submissive relating pattern towards her and his elder brother; this way of relating was certainly apparent in the therapy room with me also. Mr E reported feeling misunderstood by his family and his narrative provided examples of him acting according to ‘conditions of worth’ so that he might gain approval and acceptance. His anxiety in relating had continued following two anxiety management groups and he felt little had changed in how he felt about himself in relating with others. Mr E avoided reflection where possible regarding his feelings. Initial therapeutic engagement had been difficult, because he tended to portray an illusive emotional quality that required close tracking by me to prevent me from losing connection with him. I think I could understand this as I had previously recognised this at times in myself too when avoiding emotional connection. In therapy, I offered empathy, congruence and acceptance regarding Mr E’s view of his world and his past and current experiencing of himself within it. Slowly, but
surely, he began to show more aspects of his self, including feelings previously denied, followed by movement towards changes in his life. He chose changes in accordance with his own beliefs and wishes and directed these changes for himself. In this way, he showed an increasing development of an internal `locus of evaluation’, acceptance of his own needs and less need to accept others conditions of worth, whilst able to remain respectful of difference. He then felt more able to reflect on how he contributed towards his work and personal relationships and felt more able to choose those aspects of himself that he wanted to retain and those to shed.

I am unable to claim that the therapeutic process went smoothly, as I also grappled with the ethics of whether the person-centred therapy conflicted with Mr E’s wish to be directed by me early in the therapy. I had considered whether a cognitive-behavioural approach might be more suitable. Reflecting on this dilemma in supervision enabled me to consider his wish for me to be directive, with his expectations stemming from an external `locus of evaluation’. Remaining with person-centred therapy enabled Mr E to explore his subjective experience, feelings and needs and develop his internal locus of evaluation. In negotiating endings in therapy with clients, I am informed by attachment theory (Bowlby, 1979, 1988; Holmes, 2001) and clients’ previous experiences of endings. I gave Mr E opportunity to discuss the ending and control of the timing, within the time constraint of my own departure from placement. In this way he could have a differing and reparative experience compared to previous relationship endings. I was also aware of how my own sadness and hope was evoked and the potential impact of my own feelings influencing the ending of therapy.

**Cultural awareness and sensitivity**

An early aspect of training that stayed with me and has impacted on my practice was the focus given to learning about and valuing individual difference and diversity, whether regarding gender, race, culture, sexual orientation, disability or age. I found my own belief system and values further challenged in learning from suspending my judgements and my own pre-conceived values and ideas of ‘the other’, as well as judgements I observed made by others. Challenges have arisen at times when I had assumed an understanding of ‘the other’s’ value and belief system. However, I
became increasingly reflective, curious and questioning in monitoring my own internal reactions and this developed in my work with Mrs A:

Clinical illustration: cultural awareness in therapy

Mrs A was a 38 year old married Turkish woman of Muslim faith who escaped to Britain from her abusive father. She was referred following a depression precipitated by her becoming the sole supporter for her mother now residing with Mrs A, Mrs A’s husband and their young daughter. Mrs A’s elderly father lived in a nursing home in Turkey. In one early session, due to my own pre-conceived assumptions about her cultural background, I had mistaken Mrs A’s caring for her mother as part of traditional cultural values that she embraced. However, it was in checking out directly with her what her cultural values and beliefs were that I began to understand the situation in which she felt guilty and trapped by her mother in order to meet her mother’s expectations of her. Mrs A wanted to resolve the discrepancy between what was expected of her versus being true to her own needs in her new life, which was part of the acculturation process (Berry, 1997). She may have experienced a clash of two cultures where traditional values conflicted with the new values that she adopted in her host culture. Subsequently, I now endeavour not to assume my awareness of the values and beliefs held by ‘the other’. I gain understanding of difference from background reading, experiences with colleagues and friends, and from clients of how they subjectively experience themselves, according to their culture, gender, etc, in order that I can understand and that they may feel more understood and accepted by me.

The person-centred approach does not preclude the influence of early experience as a contributory factor to a hindered self-growth. This appealed to me as it corresponded both with my research interest on the influence of early emotional development and attachment relationships and was expressed in many of the narratives expressed by clients that I worked with. However, the therapeutic model allows flexibility for the client to be the one to choose whether to work on here-and-now or past issues, or both, depending on the client’s needs to make meaning of their subjective experiences, to develop an internal ‘locus of evaluation’ and for self-growth.
The Counselling Psychologist as Reflective Practitioner: integrating supervision and personal therapy

'An unreflecting mind is like a poor roof,
Passion, like the rain, floods the house,
But if the roof is strong, there is shelter'

('The Buddha (c.500-200 BS): The Dhammapada',
In Byron & Weiber, 1976, p. 76)

The importance of personal awareness and self-reflection has been emphasised for the therapists’ therapeutic capacity and personal development (O’Brien and Houston, 2000). Working as a reflective practitioner is fundamental to the counselling psychologist’s practice and is emphasised in the professional body’s code of practice for continuing professional development (CPD) (BPS, 2006). I valued my past experience of CPD in health visiting (Gibbs, 1988; Johns, 2000; Palmer, Burns & Bulman, 1994) and hence valued this is an integrated aspect of my professional identity and brought this value with me into my counselling psychology training. I found that from early in my training using my ‘reflective journal’ became a useful resource for containing my thoughts and feelings regarding my therapeutic practice, my research, my academic study and my personal development. The use of my journal helped to facilitate a space for self-reflection on my learning and practice, and also to bring specific issues to supervision to ‘reflect-on-practice’ (Schön, 1991).

Through reflecting in supervision, I came to see alternative perspectives, differing realities and learnt more of my own values and perceptions as a therapist that might be helpful or can hinder the therapeutic relationship. I also became more able to disentangle more of ‘what was mine, and what was not mine’ in my clinical practice. This has also been part of my personal growth in my personal therapy during the course and had particularly developed through psychodynamic practice and supervision. Developing my reflective abilities in supervision and personal therapy was central to my stumbling at times through what Schön called ‘the messy, swampy lowlands’(Street, 1990). I felt I really grasped this concept whilst working in a more ‘psychoanalytic-psychodynamic’ NHS department in my second year clinical placement.
I began my psychodynamic placement experience enthusiastically, despite my roots in humanistic philosophy. Although I considered myself less deterministic in my therapeutic approach, I was aware that I felt passionate regarding particular psychodynamic concepts from my reading about concepts that included Bowlby’s (1979; 1988) ‘secure base’, Ainsworth’s (1969) ‘secure/insecure attachment styles’ and Winnicott’s (1965) ‘facilitating environment’, ‘good-enough’ mother and emotional ‘holding’. These concepts appealed to me probably because they linked directly with what I understood and had observed for myself in facilitating early parent-infant relationships and in parenting. I looked forward to learning about interrelational processes and how to work with these with adults in therapeutic work using a psychodynamic approach.

The psychotherapy department in which my placement was based shared a building with an in-patient psychiatric unit. The psychotherapists were psychoanalytic orientated and their theoretical configurations underpinned their therapeutic work and the team working ethos. As a trainee my learning was initially focused on giving priority to the processes emerging within the therapeutic relationship, as this was the aspect my supervisors particularly focused on in supervision, rather than focusing on one specific psychodynamic model. However, this approach caused me some anxiety regarding lack of one theoretical framework in which to locate and link my clinical work at the start. During this experience I felt extremely uncertain, de-skilled and anxious about my inadequacies as a therapist. However, it was here that I really learnt to grapple with myself as a therapist with tolerating ‘not knowing’ and ‘uncertainty’ in the therapeutic encounter itself.

In supervision (consisting of three sessions weekly with three supervisors, including a ‘couple’s psychoanalytic psychotherapist’), I learnt to reflect on the unconscious
processes between me and my client. Transcribing of moment-to-moment of each of my clients' sessions facilitated 'micro-reflection' in clinical supervision as well as motivating my therapeutic observations and recall abilities. Initially I was perplexed at seemingly abstract and hypothesised processes that were occurring in the room between me and my clients. I had some doubts regarding therapeutic application of the psychodynamic approach, particularly regarding subjective inferences of unconscious processes. At times I considered there to be a risk that its relative potential for lack of flexibility and the traditional psychoanalytic school's 'blank screen' approach used, could withhold the 'real' (person-to-person) aspect of the relationship. My humanistic values struggled with this aspect as I developed my own way of working with the therapeutic relationship within a psychoanalytic context. However, I was able to work on overcoming the 'resistance' that I had developed towards psychodynamic practice. Hence, I utilised my own psychodynamic personal therapy and supervision to enable me to work through my own unconscious and conscious processes involved in this.

I became increasingly familiar with psychodynamic unconscious processes, such as projection, introjection and projective identification and defence mechanisms (Cashden, 1988; Gomez, 1997; Klein, 1946; Lemma, 2003; Lemma-Wright, 1995; Sandler, Dare & Holder, 1992). I observed and worked with transference and countertransference processes within the developing transference-countertransference relationship (Bateman & Holmes, 1995; Tansey & Burke, 1989) and balanced this with maintaining the working alliance. I sought to gain more understanding of theoretical concepts from my learning on the course and psychoanalytic literature in this placement's psychoanalytic library. From a psychoanalytic perspective, my need to understand was not only to enhance my theoretical understanding but could be considered as an intellectual defence against my anxieties regarding 'not-knowing' and 'uncertainty'.

Undertaking an essay on the theoretical and practical complexity of the therapist's countertransference enabled me to develop a deeper understanding of this phenomenon. In practice I began to understand more of how to use this and the transference relationship in therapeutic work for the benefit of my client. It was the experience of monitoring my clients' unconscious processes through my observations,
their self-report, the transference-countertransference relationship, and reflecting on these in supervision that brought the greatest learning in the beginning. I became more aware of my own countertransference and learnt how to take note of this for reflection in supervision; it was then that my reading began to compliment my experiential learning. In this way, my early learning was ‘practice led’, rather than ‘theoretically led’. I developed my reflective abilities that helped me ‘reflect-in-practice’ on the unconscious processes through developing my own ‘internal supervisor’ (Casement, 1985, 1990), which is incorporated into my natural practice with clients.

Utilising supervision facilitated my learning and also limited any potential, as a therapist, for unconsciously hindering a client’s therapy (Lemma, 2003). In this respect, supervision and personal therapy is an important ethical responsibility of the counselling psychologist for protection of the clients, as well as for the counselling psychologist. My personal development was enhanced through my own therapy too, in helping me become more aware of my own ‘blind spots’, process my feelings and increase self-awareness: it also provided a form of modelling during this period. Personal development is an on-going process as part of my professional development as a Counselling Psychologist. I value my learning as a life-long process where continuing professional development remains integral to my professional identity.

On reflection, this experience of psychodynamic practice was one that I had struggled with, having previously worked with person-centred therapy and the value system I entered this placement with. However, I grappled with this differing paradigm presented to me and became able to tolerate the differences between the psychodynamic and humanistic philosophies in my clinical practice. I valued my own psychodynamic therapy from which I have been able to model empathic respect of ‘being with’ as well as psychodynamic working with transference and countertransference. Most importantly, the main similarity was the priority given to the therapeutic relationship, both theoretically and in my clinical practice working in both approaches. Two clinical illustrations describe how I work with the therapeutic relationship in the psychodynamic approach:
Clinical illustration: individual therapy

Mrs B was a 32 year old divorced mother of three girls who was referred following her third episode of antenatal and postnatal depression the previous year. Mrs B’s attachment history indicated an ‘avoidant attachment’ pattern (Main, Kaplan & Cassidy, 1985). She spoke of feeling emotionally detached in her relationships and expressing irritability in a dismissive manner which pushed others away, leaving her isolated and unsupported, and so repeating her childhood lack of a supportive environment. I held this hypothesis in mind as an indication for a potential transference to me in the therapeutic relationship too. Given her personal history, I understood her emotional detachment and dismissive manner in terms of her defence from an unconscious fear of abandonment, and that motherhood may have evoked unresolved feelings from childhood loss (Fraiberg, Adelson & Shapiro, 1980). Object relations therapy (Cashden, 1988; Lemma, 2003) and attachment theory (Bowlby, 1988) informed my therapeutic approach.

In the therapy, I concentrated on establishing the working alliance and building trust, maintaining clear, firm boundaries and holding the frame, so providing and protecting the therapeutic space for Mrs B to use. However, transference took the form of her expecting no emotional contact in the therapeutic relationship with me, as was her pattern with others. I noticed Mrs B use of defences, such as the use of intellectualising and denial. Often she engaged me at an intellectual level, which I initially colluded with. At the start this may have felt safer for me too as I worked with a new approach, but at times I felt ‘despair’ at the detached manner in which she spoke, for example, by her referring to me as “a professional – your just doing your job”. Although I understood this in terms of Mrs B maintaining a ‘safe’ distance, this also challenged the humanistic aspects of relating that I value. I reflected on my countertransference feelings and responses, including despair, irritation and feeling emotionally distanced. In supervision, I understood these as a form of ‘projective identification’ (Cashden, 1988; Klein, 1946; Ogden, 1982; Tansey & Burke, 1989). I worked for the year with Mrs B and in view of her dismissal of feelings and emotional contact, I offered a more supportive therapeutic approach, involving moment-by-moment tracking of her feelings and ‘mirroring’ (Kohut, 1984) of these, remaining empathically attuned to her, an experience she lacked in early childhood: slowly she
began to respond to this. As I became more able to use tentative transference interpretations that I presented with an overt curiosity, providing linking, and a held awareness of her denied emotional aspects, she became more reflective and began to allow in and reflect on interpretations I tentatively offered, gain insight and connect with her feelings.

Mrs B also began to reflect with me on emotional connection with her children’s feelings, showing her increased reflective function and capacity for ‘mind-mindedness’ (Fonagy, 2004; Lecours & Bouchard, 1997; Meins, 1999; Steele, Hodges, Kaniuk, Hillman, & Henderson, 2003) which I had learnt about in the research literature whilst undertaking my research study: it was this ‘mind-mindedness’, that would be important for facilitating secure parent-infant attachment with her baby due at the end of therapy. During early therapy, Mrs B became pregnant with her fourth child, to be born at the end of therapy. Tentatively, she began to enjoy her pregnancy, bringing her fantasies and dreams of her baby to be thought about and reflected on in the therapy. She became more accepting of herself and others; her emotional needs and her marital relationship felt emotionally closer to her.

Inevitably, attachment issues (Bowlby, 1969, 1979, 1988) regarding endings are evoked in therapy. Therapeutic space was made available for processing Mrs B’s feelings aroused, to be thought about, expressed and reflected on. I remained mindful that feelings about separation and loss may also touch on therapists’ personal experiences. The end of therapy with Mrs B also evoked my own feelings of sadness. For me, my use of supervision was helpful to identify and reflect on these feelings. Also, my personal therapy was an invaluable space for my personal development regarding insight into my own past experiences of separation and loss. In therapy, Mrs B was able to reflect on her relationship with me without denying or dismissing her sadness, acknowledging the ‘good’ as well as ‘bad’ aspects of her experience of therapy. She left therapy, with her baby due the following week, feeling she had had a different antenatal experience to her previous three, and more hopeful for her future. This was a valuable therapeutic encounter because it taught me further of the importance of processing feelings regarding endings in therapy.
Clinical illustration: Couple therapy

Mr M (aged 48 years) and Mrs M (aged 58 years), a married couple presented with marital difficulties. Mr M’s ‘avoidant’ attachment style and Mrs M’s ‘anxious/preoccupied’ attachment style, her depression and feelings of rejection, including anger at Mr M’s transvestism, created relationship tension following expulsion from their home country four years previously. Therapy utilised the Tavistock Brief Couple Psychotherapy twelve-session model (Daniell, 1985; Ruszczynski, 1992) underpinned by attachment and object relations theory (Clulow, 1999). The focus of therapy was the couple relationship as ‘the client’ and unconscious relating processes that underpinned their ‘intimacy-distance’ relating pattern. The ‘couple’s shared defence’ (Clulow, 1999) was revealed in Mr and Mrs M’s ‘avoidance-approach’ relating pattern; this may have protected both partners against unconscious fears of abandonment. From the beginning of therapy, Mr and Mrs M’s hostility towards each other frequently spilled into the room in verbally heated, aggressive and explosive outbursts, often resulting in stand-offs. In providing a containing, reflective space, the couple’s projective processes involving ‘good/bad’ splitting (Cashden, 1988; Ruszczynski, 1992; Segal, 1988), to cope with their anxieties, were observed, heard, held and thought about by me in the room (and in supervision), without me becoming overwhelmed in the process. In this way, as I re-presented these in a more digestible and manageable form through offering tentative interpretation, they created their relationship metaphor of ‘clearing out and re-organising their chaotic kitchen cupboard’, this resonated with their external and internal worlds. Mr and Mrs M became more able to tolerate both good and bad feelings, becoming reflective, showing compassion and reparative connections to each other, inside and outside of sessions. Hence, these signs indicated ‘couple relationship’ movements from the ‘paranoid-schizoid’ to the ‘depressive’ position and a healthier couple functioning (Ruszczynski, 1992).

A further learning from this therapy involved working with my own feelings of loss following my co-therapist’s unexpected departure mid-therapy, as well as the couple’s defensive denial of their feelings regarding this. Ruszczynski (1992) noted that this event in a couple’s therapy can be anxiety provoking for the remaining co-therapist as well as the couple. Oedipal issues become more immediate and maybe unconscious
fears of loss of their remaining therapist. I certainly became more aware of oedipal processes (Ruszczyński, 2005) emerging that required my attention, as well as maintaining the working alliance. Supervision and personal therapy provided me with a reflective and containing space to process my own feelings evoked and to hold a containing therapeutic space for the couple.

**The Cognitive Behavioural approach.**

> "There is nothing either good or bad, but thinking makes it so"

(Shakespeare: ‘Hamlet the play’, Act 1)

My third year was based in a Community Mental Health Team (CMHT) context, using a cognitive-behavioural approach. The main principle of CBT being that thoughts, emotions, behaviours and physiology are part of one system and influence each other, such that alteration in any one will result in change in the others (Greenberger & Padesky, 1995; Scott & Dryden, 2003). I learnt to work with conscious processes, such as thoughts, dysfunctional assumptions and core beliefs to reduce symptoms by facilitating clients to replace maladaptive thoughts, beliefs and behaviours with new adaptive ones (Beck, 1995; Beck, Emery, Greenberg, 1985; Beck, Rush, Shaw & Emery, 1979). Although I felt de-skilled, as I expected, I looked forward to learning a new approach in a different context. CBT also appealed to a part of me that yearned for structure and certainty. Initially, I noticed that I understood my clients in using psychodynamic terms. However, this was helpful as it contributed to my understanding of my clients in this context. Working in a context where consulting rooms were at a premium and seeing the same client in the same room each week was not guaranteed; this differed from the firmer boundaries of my previous placement. Working in a busy multi-disciplinary context, I realised how much I had developed in my last placement in terms of maintaining the therapeutic frame, and my evaluating the effect of context on the therapeutic relationship had become a natural aspect of therapy to me.

In supervision I reflected on my own resistance to using more ‘directive’ techniques of CBT which felt mechanistic and intrusive to the therapeutic relationship.
Conceptually it took some time for me to grasp cognitive-behavioural ways of working, and many CBT techniques I learnt often didn’t fit with the complexity of my clients’ problems in this context, for many were ‘atypical’ in how they presented. Further, I struggled at times with balancing the ‘collaborative’ therapeutic relationship and therapy as a joint endeavour, with feeling as if I was ‘doing (CBT) to’ rather than ‘being with’. As I relaxed more into the approach, without feeling as if I needed to know all the ‘manualised guidelines’, I learnt to become more comfortable and adaptive according to the client’s therapeutic needs. Clinical illustration 5 will provide an example of this:

**Clinical illustration: adapting therapy to the needs of the client in CBT**

Miss D is a 19 year old single female living at home with her mother, referred by her psychiatrist with ‘Panic disorder, with agoraphobia’. CBT was the indicated approach as this has been shown to be effective in the treatment of anxiety and agoraphobia (Salkovskis, 1996; Salkovskis, Clark & Gelder, 1996; Salkovskis & Hackman, 1997) and is recommended according to the National Institute of Clinical Excellence (NICE) guidelines. Miss D seemed to show an ‘ambivalent/pre-occupied’ attachment style (Bartholomew & Horowitz, 1991; Brennan, Clark, & Shaver, 1998) and had had difficulty negotiating the separation-individuation stage of development (Erikson, 1968). Although Miss D appeared quiet and timid, she showed some reflective ability to think about her problems and her motivation. I focused on promoting a safe and trusting environment given her history of bullying. The aim was to establish the working alliance and a collaborative relationship, focusing on here-and-now symptom reduction and working towards treatment goals.

Although Miss D appeared to engage, she found difficulty undertaking home-tasks. I attempted to explore the underlying reasons for this. When straightforward CBT failed to implement change, I reflected on this in supervision. I reviewed my assessment, formulation, goals and treatment plan. I considered my use of CBT ‘techniques’ and whether my over-enthusiasm, my ‘therapist qualities’ and ‘perfectionist’ tendency interfered with the relationship. I read CBT literature on non-compliance and resistance of how to best manage ‘stuckness’ and ‘impasse’. I concentrated on the therapeutic relationship, providing more empathic resonance and this seemed to instil
some enthusiasm in Miss D’s responses. A dependency ‘early maladaptive schema’ (Young, 1990), or ‘negative cognitive-interpersonal cycle’ (Safran & Segal, 1990), may have been triggered by my enthusiasm regarding homework tasks at the start of this placement, so Miss D may have responded as if I was her ‘smothering mother’.

Further, I referred to motivational interviewing (Miller and Rollnick, 2002) to consider change processes and adaptation of therapy to integrate more person-centred elements. I sought other cognitive perspectives, such as increasing validation of client’s subjective experience (Leahy, 2003) for clients with atypical presentation and more complex needs. Miss D responded to my incorporating changes in the therapeutic relationship and took increasing independance to lead changes in her life outside of therapy, as well as changes in interpersonal qualities. Where patients may present with atypical presentations, CBT model may not meet the needs of clients with more complex needs Adapting the therapeutic style in accordance with client’s specific schemas, e.g. to more ‘interpersonal’ or schema focused work (Safran & Segal, 1990; Young, 1990) may be helpful. Safran (1993) reported that “alliance ruptures are important therapeutic junctures, since the resolution of such ruptures would seem to be a critical factor in helping patients at risk for poor outcome” (p. 36).

I recognised that listening and learning from the client was more important than my own agenda to do CBT and the fine balance between using manualised guidelines and flexibility to meet the client’s needs. Hence, this was a valuable experience regarding the impact of the therapeutic relationship and application of this therapeutic model.

The Counselling Psychologist and the scientist-practitioner model

Working in the NHS throughout my psychology training, I have become more aware of the pull towards evidence-based practice and cost-effective treatments, based on randomised controlled trials, for clinical decisions (Department of Health, 2001; NICE, 2004), although this has been questioned within the psychological and psychotherapy realms (Aveline, 1997). Counselling psychology’s humanistic value-based practice may not fit with the more ‘objective reality’ that has been valued by the positive/empiricist perspective associated with the traditional scientist-practitioner model of applied practice (Strawbridge & Woolfe, 2003). However, psychology is increasingly incorporating other epistemological perspectives, involving the use of
qualitative research, for example, interpretative analysis and grounded theory, so emphasising the value of subjective, individualised experiences and multiple truths, which I value as a Counselling Psychologist. This brings a different knowledge and truth, which is equally as informative: however, I acknowledge that both perspectives also have value in my therapeutic practice.

**Professional accountability as a counselling psychologist**

Accountability involves being able to use research findings, and contribute to research, in clinical practice and ensure ethical principles are adhered to. My professional responsibility as Counselling Psychologist also involves me being accountable for my practice to a wide range of parties. In my practice, these interests include: to clients, for example, competency to practice; informed consent; providing copies of letters, etc; to the professional regulatory body, for example, adherence to the British Psychological Society (BPS) Code of Ethics and Conduct (BPS, 2006); to employer and colleagues, for example, work based policies, NICE guidelines, knowing when and why alternative provision is required; to society, via the legal and political systems, for example, data protection; as well as having personal integrity in my own therapeutic practice. Further, supervision, reflective practice and CPD remain an important aspect of my professional accountability in maintaining my competence to practice as a Counselling Psychologist.

**Conclusion**

I have attempted to show how I have developed my practice during my training utilising three approaches I have worked with. I was naturally drawn to person-centred therapy, however, I have developed further in the psychodynamic approach both personally and professionally, embracing many of its theoretical concepts, particularly object relations and attachment theory, and in working with unconscious processes in the transference-countertransference relationship. As I integrate cognitive-behavioural concepts into my knowledge base and clinical work, my practice as a Counselling Psychologist remains focused on the centrality of the therapeutic relationship. As I consolidate my learning, I remain open to new learning from continuing professional development and from my clinical practice. In this way, I “shall not cease from
exploration” (Eliot, 1942). Approaching the end of my training is to also realise the enormous significance of feeling that I am but approaching a new beginning: one of excitement and hope, laced with some trepidation and fear. The ending is but one more growth spurt in my continuing professional and personal development, where consolidation of my learning and the integration of new learning will evolve on my journey ‘to become’ a Counselling Psychologist:

‘Come to the edge, he said
They said: we are afraid
Come to the edge, he said
They came ..................
He pushed them ...........
................ and they flew’

Guillaume Apollinaire.
References


RESEARCH DOSSIER
Introduction to the research dossier

The research dossier is a presentation of my three research reports, one taken from each of the three years of the PsychD Psychotherapeutic and Counselling Psychology course. Each report is presented for a different journal as follows: a literature review undertaken in year one, for the *Child Development* journal; a qualitative study research report undertaken in year two, for the *Counselling Psychology Review journal*; a quantitative study research report completed during year three, for the *Adoption and Fostering* journal.
The influence of multiple foster placements on the pre-school child's development of attachment: A literature review

Sharon M Chambers

MATERIAL REDACTED AT REQUEST OF UNIVERSITY
The influence of multiple foster placements\(^1\) on
the pre-school child's development of attachment

Abstract

Literature regarding the development of attachment in the pre-school child experiencing multiple foster placements is considered. In these circumstances, children also experience repeated separations from a series of attachment figures. Most of these children have already experienced prior maltreatment and/or neglect from their attachment figures leading to the children's removal into care by a Local Authority. Limited research has been undertaken on this age group in foster care, particularly regarding their development of attachment in multiple foster placements; most studies have focused on the later age groups. Case studies stress difficulties in attachment experiences for young children. The wider attachment literature suggests further exploratory research is required to add further insight to this subject area.

\(^1\) Multiple foster placements = three or more foster family-home placements (not institutional home).
Introduction

In England, almost 20% of the 60,000 or so children who are living in local authority care have experienced multiple foster placements, i.e. three foster placements, in a single year (Department of Health/DH, 2000a; DH, 2000b). 15,000 children in foster care are under five years of age, and some of these have experienced many foster carers during their multiple foster placements (anecdotal evidence; Gill, personal communication, 2004; Hindle, 2000; Kenrick, 2000).

The Children’s Act of 1989 (DH, 1991) directed Local Authorities to increase attempts to rehabilitate children with their natural parents, or families. Courts have been given specific responsibilities to ensure rehabilitation is considered and ultimately attempted, prior to granting adoption placement orders. New standards (DH, 1999b) directed the local authorities to ensure that children have no more than three placements per year: yet no lower age limit was set. Further, rehabilitation to biological parents or release for adoption should occur within six months of entry into care. Rushton (2000) has emphasised the paucity of evidence on which government directives regarding children in care has been based. Further, the logistics of the implementation of these standards may prove a challenge to service providers (DH, 1999) often constrained by legal delays, parental deviations from involvement in the process, to professional assessment delays. A full discussion of this issue is outside the remit of this study, the focus of which will be restricted to the child under five years of age in multiple foster placements.

Various factors influence the ‘necessity’ of multiple foster placements including: delays in Court proceedings for adoption release and permanence planning, breakdown in foster placements, lengthier delays in rehabilitation attempts, etc. Many children have experienced up to nine placements by the age of ten years and some have had five or more placements before the age of five years (DH, 2000a; Kenrick, 2000; Hindle, 2000). Hence, these children experience cumulative separations and re-attachments to a series of new primary carers: this process may range from an initial attachment to their biological mother, followed by numerous foster mothers. Hence,
the development of attachment for the child under five in these circumstances is the subject of this review.

The development and maintenance of a child's attachments during the pre-school years is emphasised by Bowlby's (1969) attachment theory. During the early years, disrupted or broken attachments predispose the child to later mental and/or emotional disorder (Harris & Bifulco, 1991; Rubin, Allesandrini, Feudtner, Localio & Hadley, 2004). Much of the research on children in care has arisen from adoption studies and the effects of institutional care (Goldfarb, 1945, 1947; Rutter, 1979; Spitz, 1945; Tizard and Hodges, 1978), or focused on post-adoption placements (Howe, 1998; Quinton et al, 1998) and have tended to mention unstable and pre-permanent placement events retrospectively. Studies relating to foster children have been scant, particularly regarding children placed in the care of foster parents in the foster parents’ own home (Rushton & Dance, 2002). Since the 1970s, foster parents have increasingly provided short and long-term foster care as opposed to the pre-dominance in the previous era of ‘institutional type’ care homes. This trend has increased following raised awareness of adverse effects of institutional care on a child’s development and a rise in the number of young children being placed for adoption. Adoption studies reveal that children who have been in the care system longer than children who are adopted following a shorter time span in care are more likely to suffer social and educational disadvantage and develop significant emotional and psychological problems (Heath, Colton & Aldgate, 1994; McCann, James, Wilson & Dunn, 1996; Quinton et al, 1998; Rushton et al, 1995). Further, those who have a history of multiple placements are more likely to be high cost users of mental health services (Rubin et al, 2004). One important factor is the child's development of attachments to caregivers in pre and post foster care placements, particularly for those children who have experienced multiple foster placements.

In adopting an attachment perspective, this study aims to review the literature regarding the influence of multiple foster placements on the pre-school child's development of attachment. However, limited research on the specifics of multiple foster placements has been undertaken, and this has mainly focused on adolescence or older primary school age group, i.e. eight years and over (Quinton, Rushton, Dance &
Children in the middle childhood and adolescent age groups have a multitude of influencing factors, including their developmental stages and lengthier life histories that differ from the pre-school group. Also, ideas on children’s attachment relationships have been frequently revised since Bowlby’s (1969) original ideas and these ideas can provide further insight to the topic of this report. Hence, there is a need for a ‘focused’ literature review on the effects of multiple placements on the development of attachment in pre-school children, the findings of which might be informative not only to counselling psychologists, therapists, child-care workers, researchers, etc, but may add further information to political debates regarding children in foster care.

First though, consideration will be given to the relevance of this topic to counselling psychology. Many adults and children who are users of mental health services have also been in the care system at some time during their childhood and along with adoptive parents, foster parents, adolescents and children who have been in care, may present with issues relevant for therapeutic intervention. The psychological effect of early separations on a young child’s development of attachment, particularly for children in foster care, is likely to impact on later psychological functioning. For the counselling psychologist, awareness of how these experiences, and prior adversity, impact on attachment development and identity formation are important in planning, delivery and management of therapeutic interventions. Hence, investigating the influence of multiple foster placements on the development of attachment in the pre-school child is a viable area of study for the counselling psychologist.

[Personal Reflection: My previous work with young children and their families initially raised my interest in the field of attachment and in foster and adoption care. Prior to starting the counselling psychology course, my experience as a panel member on a Local Authority Adoption Panel provided me with new insights into fostering and adoption processes that I had previously been unaware of. Part of the process prior to the monthly panel meeting involved me familiarising myself with the histories of the children from their case notes before being placed for adoption. The experience gave me a new perspective on the experiences that children in care may have had. I was particularly surprised by the number of different foster placements young children
had experienced during their time in care, many not retaining contact with natural parents despite rehabilitation attempts. I became aware of the numbers of children who had entered care under the age of five. Some of these had experienced five and more moves before being released for an adoption placement and to live with a permanent carer. In my previous work with young children and foster mothers, I had seen only one aspect of children's lives, i.e. during the current foster placement. As a panel member, I had become more aware of a larger picture. For example, one nearly four year old child about to be placed for adoption had experienced three foster placements before the age of three years plus, two placements the following year: this meant five differing foster carers, and new primary relationships in new environments, in his first four years of life. Thus, I was curious about the influence of these experiences on children's attachments and, in searching for a research topic for my first year study, I focused my interest and attention on the child's development of attachment and separation in the fostering context.

Childhood separation

Although conditions have vastly improved in the UK, multiple foster family placements result in the child experiencing a series of carers as attachment figures. The child experiences cumulative separations and loss of attachment figures plus repeated moves and instability to his/her home environment. Separations can be sudden and unexpected and are followed by new carers to whom the child might be expected to make new attachments. Further, young children who are removed from their parents care by a Local Authority are most likely to have suffered maltreatment and/or neglect prior to the separation: these children are already vulnerable on arriving into a first foster home. The dilemma that long-term psychological risks for children remaining with maltreating and/or neglectful parent/s might be on a par to those of cumulative separations is outside the scope of this report. However, the cumulative effects of repeated separations on a child's long-term functioning might indicate a need for further investigation.

Research on children's separations has been carried out using case studies (Robertson, 1953) and observations, from film footage, of children in hospital separated from their mothers. Also, Robertson and Robertson (1989) observed individual children whom
they fostered short term whilst their mothers were in hospital. Film footage from observations of children’s responses to separation from their attachment figure showed the importance of the attachment relationship. Children’s responses typically showed responses in three stages following separation from their attachment figure: protest, despair and detachment (or re-organisation); younger children particularly display separation protest when access to their attachment figure is denied them. The separation or threat activates the child’s attachment system to attempt to ward off the separation. Bowlby (1973) writes that young children’s sense of security derives from experiences of the principal attachment figure as accessible and responsive. Separation threatens the child’s security and separation protest follows, the failure of the attachment figure to return leads to despair, and finally to detachment in the child.

Individual differences in the quality of the attachment relationship have been measured by standardised measures (Ainsworth & Wittig, 1969). Ainsworth identified three patterns: avoidant, secure and resistant, and a fourth category named disorganised was later added (Main & Solomon, 1990). These differences have since been used in numerous studies investigating children’s quality of attachments to their parent/carer and will be referred to later in this report regarding recent research. Reactions to short-term separations from an attachment figure were first identified from naturalistic observations of young children with their parents (Ainsworth, 1967).

[Personal reflection: Watching the experiences of ‘Laura’, filmed in hospital by the Robertsons, following a separation from her mother re-awakened my own experience of hospitalisation during my own childhood in the 60s. Although I understand that parental visitation practice was changing by this time, I can remember my own feelings of alarm at discovering I would not be allowed visitors, including my mom and sister, except on Sunday and then for 30 minutes. Having recently discussed this episode with my eldest sister, she confirmed this was acceptable practice at that time for children to be separated from their parents when going in hospital. As an adult, having worked on children’s wards in the past, it was common practice for a parent or carer to stay and sleep in too. I had also observed the routine care given by New Zealand Maori and Polynesian mothers, who always ensured many family members stayed permanently on the ward with their children to provide care and comfort. This
had reminded me of the impact the Robertsons’ film and Bowlby’s findings have had on changing practice in children’s wards regarding visitations.]

Recent evidence of the effects of multiple foster placements

Goldberg (2000) highlights the fact that systematic studies of children’s attachment relationships in multiple foster placements have not been undertaken. Further, there is limited research regarding children under five who have experienced multiple foster placements. Multiple foster placements refer to three or more placements in foster care, where the child experiences sequential carers acting as the child’s primary attachment figures. In these circumstances, the child experiences instability and a lack in continuity of a primary attachment figure. Children are removed from their parents only in extreme circumstances when not to do so would be more damaging for the child’s safety and health. Therefore, most have already experienced abuse and/or neglect from previous caregivers and are more likely to have developed an insecure attachment style before foster placement (Crittenden, 1985; Egeland & Sroufe, 1981; Erickson & Egeland, 1987; Radke-Yarrow, Cummings, Kuczynski, & Chapman, 1985). Even in ideal situations, children may have generalised difficulties due to the adverse conditions experienced prior to placement into care. Hence, any research enquiry needs to take into account antecedent experiences to entry into care. For the purpose of this report, the limited literature on pre-schoolers’ attachment development in multiple foster placements will be discussed.

The main trend of the studies found in the literature that was relevant to multiple foster placements have investigated factors leading to children entering care or factors contributing to the multiplicity of placements, social work management of these children’s care, or therapeutic treatment of children in care. The majority of studies relate to older children, i.e. over seven years, and adolescents (Brodzinsky & Schechter, 1990; Cooper & Peterson, 1987; Newton, Litrowick & Landsneck, 2000; Pardeck, 1983, 1984; Pardeck, Murphey & Fitzwater, 1985; Quinton et al, 1998). Pardeck and his colleagues analysed case records from the United States Children’s Bureau for children in foster care seeking reasons for entry into foster care, the number of multiple placements and length of time in care. However, the younger age group’s age details are not explicit and the discussion refers to school age children and
predictive factors increasing the risk of multiple placements. Most of the literature relevant to attachment and young children in care is found in the adoption and institutional care studies explored later in this report. However, some literature refers to case studies of children whose experience includes multiple foster placements.

In the analytic literature, retrospective case studies have provided a wealth of therapists’ accounts of therapy with young children who have been in foster care (Hindle, 2000; Hoxter, 1983; Kendrick, 2000). Accounts that describe children as young as five who have experienced multiple foster placements illustrate the difficulties and struggles these children have in establishing and developing trust in attachment relationships in their current placement: therapists relate this to the deprivation of constancy and stability of a caregiver (Hoxter, 1983). Hoxter states these children have not had adults who have been physically and emotionally available to them in order to be receptive to their feelings and to ‘think about them’. Individual case studies provided data revealing that some very young children who have experienced multiple foster placements appear to suffer later attachment related difficulties that require early therapeutic intervention. However, case studies could be considered limited due to therapists’ subjective reports and participants taken from a clinical population, therefore generalisation to the non-clinical population is questionable. Further limitations include: single case studies may not be representative; known histories of the children appear to be retrospectively obtained therefore accuracy of recall may have been suspect and sometimes incomplete; interpretations of the children’s behaviour is open to therapists’ subjectivity; the influence of earlier deprivation and/or maltreatment prior to foster care cannot be separated out from the multiple placements retrospectively. Further detailed information might be obtained from a longitudinal study, for instance following young children from entry into foster care in one Local Authority. Comparisons could be made between those in stable foster placement, multiple foster placements and a control group.

*Personal reflection: Reading some of the clinical case studies (Edwards, 2000; Hopkins, 2000; Hoxter, 1983; Kenrick, 2000) that I discovered in the literature, in preparation for this review report, was a particularly moving experience. Although*
these were subjective, reflective, therapists’ accounts, they enabled me to realise more about the struggles that some foster children may continue to have in developing later on-going attachments following intense earlier adversity. During this reading, I reflected on and found my own experiences of working with families where children had experienced adversity, was also illuminating evidence that I linked with these clinical findings and which helped me develop more understanding from a psychological perspective. Although my own experiences, such as these, contributed to developing my understanding of attachment, I became more aware that my own experiences of working with young children and families, that initially sparked my interest in this topic, also presented me with a researcher bias that I needed to remain mindful of in evaluating evidence. However, my developing awareness from the case studies, my own past experiences, and theoretical literature, and recent evidence, had challenged some of my prior assumptions enabling me to question my own perspectives. In my current placement, my recent client work with an adult who had been adopted was facilitated through the development of my awareness and increased insight, and a shift in my assumptions and perspectives.

The literature regarding multiple foster placements and pre-school children is limited. However, clinical case studies have documented and provided evidence of children’s attempts to cope with losing caregivers and repeated moves, and the difficulties these children have had in forming new attachments to subsequent caregivers. Bowlby (1988) had suggested a stable attachment figure for the emotional security of infants and children was required and next this review will look to Bowlby’s original ideas, modifications of these, and recent research from associated attachment literature. Therefore, literature relevant to the development of attachment for children will be further explored, plus, those studies that relate to non-parent caregivers will be discussed.

**Early attachment development and disruptions in care**

Over 50 years ago, Bowlby (1951) emphasised “an infant and young child should experience a warm, intimate and continuous relationship between child and mother (or permanent mother-substitute) in which both find satisfaction and enjoyment” (p. 11). Bowlby made two bold claims at the time: 1) if a child’s attachment bond was not
formed between a child and the child’s mother during a ‘critical phase’ of the child’s life, i.e. the first 12 months, and further, if delayed until after two and half to three years of age, then the child would suffer irreversible effects regarding emotional and social development; 2) the child’s bond with his or her mother was ‘monotropic’ in that it was a unique bond between mother and child that reduced the likelihood of other attachment relationships developing during this critical period. Bowlby’s work launched the ‘maternal deprivation’ debate and a wealth of subsequent attachment related research that has strongly influenced the care of children, particularly in the fields of fostering, adoption and hospitalisation.

Early institutional studies and maternal deprivation
Bowlby’s maternal deprivation hypothesis and the critical period arose from his own clinical observations and interviews from his work in a children’s clinic that he supported with evidence from early orphanage and hospitalisation studies (Goldfarb, 1945, 1947; Spitz, 1945). Goldfarb found that children reared in institutions from age 6 months to three years, prior to permanent fostering, compared to children fostered from 6 months, showed severe intellectual, social and emotional difficulties; these findings appeared to support the critical period. Bowlby’s claim that it was the absence of a continuous mother figure that caused these adverse effects was challenged by other factors that had not been considered. For example, variables such as the total number of caretakers and the quality of care were not accounted for, or that the institutions were un-stimulating environments. Separating out the effects of the un-stimulating environment and the lack of close, continuous caregivers (a form of privation prohibiting opportunity to form attachments, not maternal deprivation) is not possible from these findings. Further, though a comparative study design, Goldfarb’s subjects were not randomly assigned to groups and a control group was not included. Hence, the findings were open to the subsequent challenges from ethological and adoption studies that modified Bowlby’s original hypotheses.

Bowlby favoured evidence from ethological and animal studies to support the existence of a ‘critical’ period for establishment of the monotropic bond in humans. For example, goslings ‘imprint’ on the first moving object after birth, maintaining proximity to this object for survival and this imprinting is established during a
'critical' period of 9-24 hours, otherwise the effects appeared irreversible (Lorenz, 1966). Bowlby generalised this finding to the human infant for the first three years of life claiming the critical period for the development of human attachment relationships was six months to three years; otherwise irreparable adverse effects occurred. Harlow (1958) found rhesus monkey babies separated from their mothers and reared in isolation became disturbed, withdrawn or aggressive resulting in irreversible effects if separated longer than three months. As adults, the monkeys had difficulty socialising and mating; those that had offspring were unable to nurture their own young. Although the extent that findings from observations of animal behaviours of other species can be extrapolated to humans is questionable, they did provide a springboard for subsequent research. However, evidence from other studies disputed the maternal deprivation hypothesis. For example, Suomi and Harlow (1972) found improvement in the social behaviours of maternally deprived monkeys when they were later cared for with younger and peer age ones with whom they made attachments. Hence, monkeys showed recovery from the effects of 'maternal deprivation' and that adverse effects were reversible. Thus the crucial ingredient of 'maternal care', as identified by Bowlby (1969), did not appear to have been the key missing ingredient. Ethologists subsequently modified the 'critical' period to a 'sensitive' period for the learning of attachment related behaviour.

Longitudinal adoption studies and disrupted attachments

The modification of the critical period and the reversibility issue was further supported by Tizard and colleagues' adoption studies (Tizard & Hodges, 1978; Tizard & Rees, 1974, 1975). The use of longitudinal designs, as opposed to the retrospective design of previous research, had the advantage of following three groups of children raised in institutions from four months to at least two years of age and who were either adopted, returned to their natural mother, or they remained in institutional care respectively and these groups were compared to a control group of children not in care. No apparent difference was found at age 4.5 years in cognitive, social and emotional development between these groups. Further, the adopted children group showed that they did develop attachments after the age of four: hence these results challenged both the critical period and irreversibility issue. The institutions in these studies had stimulating environments that were assumed to account for the findings.
However, at eight years of age, the institutional group of children showed severe problems in their social and emotional development. Tizard argued that this was due to their experience of the large numbers of caregivers, sometimes as many as fifty, which disrupted the children's ability to form stable, close attachments and had adverse consequences for forming these later. Hence, the number of carers and lack of continuity of carers appear to be factors that hinder development, effects that may not appear until later in middle childhood. Although, disruptions in early attachment relationships from experiencing many carers can affect the child's capability to form future attachment relationships, if adopted into well-functioning families, the adverse effects can be reversed.

Rutter (1981) criticised Bowlby for not distinguishing between the effects of privation and deprivation. Privation refers to the lack of opportunity to develop an attachment bond to any person and deprivation refers to the breaking of the attachment relationship once formed. Rutter argued that privation is likely to prevent the ability to form later relationships, which the institutional studies have shown, whereas deprivation (where an attachment relationship has been formed in the first year) has less detrimental long-term effects. Rutter et al, (2001) found that children did experience separation without ill-effects, and that their anti-social behaviour was more associated with prior family discord or psychiatric illness than with separation itself. Rutter argued that it is not the separation itself but the support, or not, of other attachment figures that influence the child's development: separation can be compensated for by others who provide stimulation and interaction for that child. A direct causal link between earlier separation itself and later emotional development has not been proved. Bowlby (1969) claimed a stable attachment figure was needed for the emotional security of infants and children. Rutter concluded that children need an opportunity to make a relationship with an adult and a relatively stress free home with warm, friendly relationships. However, for children who experience multiple foster placements, repeated separations seem likely to have some influence on the development of their attachment relationships.

More recent longitudinal studies (Chisholm, 1998; Rutter et al, 2001) have extended Tizard's findings from studies of harsher institutional conditions of privation in
Romanian orphanages. Children adopted before 42 months of age were reviewed at four and six years and compared with a control group of within-UK adoptees of similar ages adopted in infancy and were also found to be able to form attachments. Substantial recovery of malfunctioning occurred, suggesting lasting damage is not inevitable, although emergence of late sequelae is as yet unknown. Yet, attachment problems were more common in the Romanian sample, particularly for older placed adoptee children. Problems of attachment that were described in parental interviews included: undiscriminating social approach, lack of social boundaries, difficulties in picking up social clues on socially appropriate behaviour. Unfortunately, no attachment measurements were used to assess attachment styles of children or adoptive parents to provide information on developmental progression of attachment patterns. Rutter et al concluded that profound privation prior to the age of three years is still compatible with normal psychological functioning at age six years, provided that several years of good adoptive family care follow. Unfortunately, clinical assessments had not been undertaken on all children and data remain uncompleted in this study, hence, Rutter et al’s results need to be evaluated in this light.

**Simultaneously formed relationships and multiple attachments**

Children have been shown to form multiple attachments. Further disputing the ‘monotropic bond’, young children have been found (Dunn, 1993; Schaffer & Emerson, 1964) to make other attachments and these attachments are being constructed from birth. Schaffer and Emerson’s observations of 60 babies revealed that multiple attachments, for example, to father, siblings, grandparents, were formed within weeks after developing an initial attachment relationship and, by 18 months of age, few of these children attached to only one person. Schaffer and Emerson argued that any person who provides a great deal of stimulation and interaction can become an attachment figure for the child; separation experiences can be compensated for by the presence of another attachment figure once a first attachment relationship has developed. One of the strengths of this study was its naturalistic, longitudinal design following the same children across a period of time in their natural environment. However, the use of an uncontrolled environment, parental self-reports, researcher interpretations, and subjectivity of observational data, as opposed to the more standardised measures available later e.g. the Strange Situation (Ainsworth, 1969)
limit the findings. However, animal studies (Suomi & Harlow, 1972) with monkeys have also revealed attachments with peers, and that these reversed the effects of earlier privation.

Investigations of disruptions to the continuity of attachment between the child and his/her mother in the context of ‘multiple carers’ have mostly concentrated on childcare providers in day care, such as nursery nurses, or teachers. Belsky and Steinberg’s (1978) review of studies in the USA found little support that day care caused disruption in continuity, for these children still formed preferential attachments to their mother: care does not have to be continually provided by the mother. Belsky (1988) modified his view in a later review, finding that children having 20 hours or more day care showed significantly more insecure attachment patterns with their mothers than those who had less. However, Clarke-Stewart (1988) challenged this, arguing that the rate of insecure attachments in Belsky’s later review was similar to the normal range in other US studies. Also, children might have developed strong attachments to other important carers, e.g. grandparents, and insecure patterns might be due to other factors affecting the relationship of working mothers rather than the separation itself and the amount of alternative care. Melhuish, Lloyd, Martin, & Mooney (1990) and Melhuish, Mooney, Martin, & Lloyd (1990) compared nursery care to childminder or relative care and revealed less affectionate interactions in nursery care where quality appeared influenced by factors such as staff ratios and limited experience of nursery carers. Findings suggest that the quality of the non-maternal day care influence attachment and high numbers of carers influence attachment development. However, Essa, Favre, Thuvett, & Waugh (1999) found that if the child kept the same nursery caregiver, this continuity promoted a more secure attachment relationship than one developed by the child who had experienced repeated change of carers. Also, in a recent national longitudinal study (NICHD Early Child Care Research Network, 1997), infants who received poor quality care for more than 10 hours per week, were in more than one child-care setting in the first 15 months of life, plus had mothers who were low in sensitivity, were more likely to be insecurely attached. The attachment figure’s sensitivity to and appropriate responsiveness to the child’s needs and emotional signals is a crucial contributing factor for the development of a child’s healthy and secure attachment that has been
extensively studied in mother-child attachments. It seems that continuity in caregiver, one who is sensitive and responsive and available to the infant, is more likely to facilitate a secure attachment.

Further evidence regarding the effect of continuity and quality of childcare has come from the kibbutzim studies. Sagi et al’s (1994, 2002) quasi-experimental studies investigated communal child-rearing in kibbutzim in Israel. Here young children are raised together in a home, known as a ‘metaplot’, by a team of carers. Parents visit and provide the day care but the ‘metaplot’ carers provide the sole night-time care. Higher rates of insecure attachment styles were found and attributed to the lack of continuity and inaccessibility to the child’s selected attachment figures (parents) during the night when the young children required responsive care. Subsequently, child-rearing practices in many of the kibbutzim are now reorganising to family based care to increase contact to primary carers. In addition, those children receiving day-centre care also showed more insecure attachment patterns argued to be from poor quality centre-care and high infant-caregiver ratio. If an alternative relationship is constructed simultaneously with the primary mother–child attachment, the adult (such as a child care provider) may have less emotional investment or spend less time with the child. In these instances, insecure attachments might be more likely to develop between the adult and child. For children in foster care this might be similar, particularly for those in multiple foster placements where comparatively shorter lengths of time might provide less opportunity to develop an attachment relationship and is compounded by the child managing sequential attachment relationships and repeated separations. The child may approach each new foster carer with increasing wariness and lack of trust. However, the lack of research in this specific area limits inferences that can be made.

**Patterns of attachment in foster children**

The recent attachment literature has tended to use differences in the quality of attachment relationship in investigating and evaluating attachment development in children. Foster children are more likely to have an insecure attachment style (Marcus, 1991) and these are likely to have originally developed from their prior adverse experiences of being parented that had led them into care. Evidence from recent
studies (Dozier, Higley, Albus & Nutter, 2002; Tyrell & Dozier, 1999) of foster-infants and foster-mother attachment patterns found that infants over 12 months of age who have a higher prevalence of insecure attachment are likely to display alienating behaviours in interactions with their new carers. These interactions deter nurturing responses from foster parents and negative cycles of interactions follow that influence attachment relationships, hence making these more difficult and foster placement breakdown more likely. The effect of multiple transactions, such as these, are emphasised by Sameroff and Chandler's (1975) transactional developmental model, where the reciprocal influences between environmental forces, caregiver characteristics and child characteristics are dynamic reciprocal contributions to the course of child development.

Recent evidence on the development of infants' attachments in foster care may provide some information on attachment development regarding subsequent development of attachment in later multiple foster placements. Stovall and Dozier (1998) stress that research has only recently begun to investigate the development of attachment with foster carers, and to date this has focused on infants. Given that an infant has an accessible and responsive caregiver, attachment related behaviours, showing an attachment relationship exists between infant and care-giver, are easily observed by others from 6 months of age, and by 12 months of age at the latest (Ainsworth, 1973; Bell, 1970). The timing of this development has implications regarding the age of the young child at an initial placement with a foster carer and appears to be a prognostic factor in the development of a first secure attachment for the child entering foster care, as shown in one recent study (Stover & Dozier, 2000).

Stover and Dozier (2000) investigated the evolution of ten foster infants' attachment before 12 months of age and after, using a single subject analysis. Findings revealed that infants placed in care before 12 months of age showed stable attachment behaviours towards their new carer within two weeks of placement, whereas, for a child after 12 months, stable attachment behaviours can take up to three months to develop. Bowlby suggested that, for an older infant and toddler who has developed a first attachment relationship, the immediate effects of the separation from their caregiver activate attachment related behaviours that cannot be terminated (due to
unavailability of the attachment figure), and these might inhibit formation of new attachments in the short term relative to the child’s age at separation.

Mothers with an autonomous (secure) attachment style are more likely to facilitate a secure attachment in their child (van IJzendoorn, 1995). Stover & Dozier (2000) also found this in 71% of cases for foster infants less than 12 months of age in their study. Findings in this study suggested that secure foster mothers similarly facilitated secure attachments in foster children: secure foster infants were cared for by autonomous (secure) foster mothers. Yet, infants over 12 months of age when placed in care are more likely than those placed earlier to develop insecure attachments to their new caregivers, even with an autonomous foster mother. Hence, over 12 months of age, these infants were more likely to develop one of the insecure attachment styles irrelevant of the foster mother’s own attachment style. The foster mother’s style does not appear to naturally facilitate change for foster children over 12 months of age: most foster children develop an insecure style due to experiencing prior maltreatment and/or neglect (Crittenden, 1985, 1988; Egeland & Sroufe, 1981; Radke-Yarrow et al, 1985). Therapeutic programmes (Dozier et al, 2002; Lieberman, 2003) are being established to enable foster parents to become facilitative in developing secure attachments with their foster infants. A longitudinal study is in progress by this team of researchers beginning a new phase of research in foster care and attachment of young children. The long-term effects of this work are not known to date.

One of the strengths of the above study was the use of the natural environment of the child and foster mother’s home to undertake assessments; this is more likely to reduce participant stress that can influence results. Also, it is more likely to reflect a true-to-life perspective than the false environment of a laboratory most commonly used for undertaking the Strange Situation (Ainsworth & Wittig, 1969), a procedure used for assessing attachment patterns in 12 to 18 month old infants. Further, standard attachment measures had been used, although the Strange Situation was originally validated for use with infants and their natural mothers. Hence its validity with foster carers is questionable although it has been used in studies of other carer-infant dyads, for example, in day-care centres. Despite the findings from this study, if the older infant is insecure before placement and then an insecure style continues, it is not clear
whether this is from the child’s initial attachment style developed in inappropriate care, or if it is reflecting the foster mother’s if her style is also insecure. Changes in concordance between foster-mother and foster-infant/toddler could be investigated in a longitudinal study comparing attachment styles at differing time periods which might reveal the extent to which the foster care influences the child’ development of attachment. Further studies need to be undertaken with the older ages of pre-school children and foster carers, such as the two – four year olds. Maybe a comparative study of children in multiple or stable foster placements could be undertaken to observe the trends in attachment with age and foster carers.

Ritchie (1995) conducted research on security of attachment of two groups of 4-year old children, all of whom had been exposed to alcohol and/or other drugs during the prenatal period, and were currently cared for either by foster carers, biological mothers, adoptive mothers or grandmothers. One group of children attended a community preschool group whilst the other group comprised children who had been excluded from pre-school and joined a therapeutic pre-school group. Children in the pre-school group were more likely to have higher attachment security, as assessed by the Attachment Q-sort (a standardised attachment measurement) (Goldberg, 2000), to have been adopted and lived with non-substance abusing care-givers, and therefore experienced a stable environment. Children in the therapeutic pre-school group were found to have lower attachment security and were more likely to have experienced multiple changes in caregivers, i.e. 4.2 changes, to have been in foster care, be currently living with their biological mothers and receiving care from a substance abusing care-giver. Although the Attachment Q-sort as a measure of attachment can be less reliable when parental reports are used, it is increasingly being found to be a reliable indicator of the strength of attachment in relationships. However, Ritchie suggested that children with a prior risk for developing insecure attachments are able to construct secure relationships when their care-giving environments are stable and consistent. From this evidence, it seems likely that children in multiple placements are more likely to develop less secure attachment relationships, the development of which is compounded by their prior difficult experiences. However, further research is required that takes into account the multitude of factors that influence this group of children to illuminate this conjecture further.
In summary, regarding the foster-mother/foster-infant studies' findings, studies on developing attachment patterns between foster mothers and their foster infants have shown that both infant age and foster mother attachment style can influence the developing attachment system. Foster infants entering care before 12 months and who have autonomous foster mothers are more likely to develop secure attachment styles. However, older infants are more likely to have already developed insecure attachment styles prior to foster care, which are likely to influence the progression of their attachment relationships. This may be particularly difficult for those experiencing multiple foster placements and instability in carers.

Children in multiple foster placements are more likely to have developed one initial model of an attachment relationship, which makes this group of children different from other children, such as those in the adoption studies who had experienced institutional care. For the toddler and older pre-school age group, their histories and stage of development are likely to influence the development of attachment relationships. However, how this develops for this particular group of children is an untapped area of research.

'D' classification of attachment

Further, interesting evidence from recent advances in brain imaging surveys and other studies (Perry, 2002; Perry, Pollard, Blakely, Baker & Vigilante, 1995; Schore, 2001; Teicher, 2002) in the field of Neuropsychobiology are emphasising the importance of environmental influence on brain development in young children, particularly in the first two years. Schore (2001) describes the direct connections that have been found between traumatic attachment, inefficient right brain regulatory function and maladaptive infant and adult mental health. Events in the environment, notably traumatic experiences of maltreatment and neglectful child-rearing, can cause damage to the neural structure and function of the developing brain during the first two years of life, with long term consequences. Although these findings are related by these authors to the effects of the environment on the developing brain and attachment system prior to foster placement, the consequences of cumulative separations early in life might add further trauma and are worthy of consideration. Hence, further studies in this field might illuminate this particular area of potential research.
According to Albus and Dozier (1999) and Zeanah (2000), children entering foster care with insecure attachments due to abusive child rearing experiences are more likely to display an indiscriminate friendliness or a terror of strangers as is found in children who have the ‘D’ disorganised attachment pattern (Main & Solomon, 1986). In this pattern of attachment, a disorganisation in the child’s strategies for managing stress impedes the child’s ability to make contact with their parent when distressed and will hinder further development of attachment relationships, whereas, for children who have either of the other two insecure patterns, i.e. avoidant and ambivalent, they have organised strategies to manage attachment related incidents, albeit insecure ones. The ‘D’ classification type behaviours were described by Bowlby in his studies and have been highlighted in the Romanian adoption studies too. Solomon and George (1999) suggest, on a par with Bowlby’s (1980) views, that all experiences that activate the attachment system without terminating it, will result in a disorganisation of the attachment system; these experiences include separation, loss, and neglect. These experiences challenge the child’s expectation of protection and security and threaten the child’s survival. Hence, it appears that for those young children who experience multiple foster placements, their development of attachment is likely to be further compromised by the repeated separations and experiences of different carers, who may also have differing attachment styles to their previous carers.

Conclusion

Limited research on multiple foster placements with preschool children has been undertaken. Clinical case studies have described the difficulties these young children have in developing subsequent attachment relationships once settled in a long-term placement. Other associated evidence regarding attachment development for children in alternative child-care has been explored. Bowlby’s original ideas on attachment have been modified following further evidence suggesting that the effects of early maternal deprivation are reversible given that there is subsequent opportunity for stable, caring relationships with caregivers. The ‘critical’ period has been modified to a ‘sensitive’ period for the optimal development and learning of attachment behaviour. During this sensitive period, it is important that a child has the opportunity to develop an attachment relationship. Hence, the availability and continuity of caregivers is important to enable these relationships to develop: young children can make later
attachments. However, six months to three years of age is the most sensitive period for this to occur in order to minimise later emotional and social difficulties.

Children can make multiple attachments to other attachment figures, within weeks of the initial attachment relationship, and not all children suffer long term adverse effects from early separations or loss providing other responsive attachment figures are available to them. Evidence suggests that where a child is exposed to a large number of caretakers the continuity of stable attachment figures is disrupted and this appears to inhibit the development of later attachment relationships in young children, and can result in severe socio-emotional developmental delay. Pre-school children in care who experience multiple foster carers in placements, appear to be more at risk and the development of their attachment is likely to be strongly compromised by the lack in continuity and stability of attachment figures, plus the compounded trauma and stress of repeated separations. Over 12 months of age, foster infants show attachment to a first foster parent within three months, and this is likely to be one of the insecure attachment styles given the foster children’s prior adverse child-rearing. Thereafter, repeated separations and sequential carers are likely to inhibit further attachments as trust is less likely to develop. Young children in the care system may have little opportunity to make sense of repeated separations and loss from a series of different carers and the lack of continuity in their early experiences.

Knowledge of attachment development is important for planning foster and adoptive placements and is the rationale behind providing children with a stable and continuous relationship with another caregiver if the child cannot return to the parent. Webster et al’s (2000) longitudinal study followed 5000 children’s placements and found that those that entered non-kinships care between birth and six years, and had more than one move during their year of entry, were more likely to experience instability in the long term. Remarkably limited research has been undertaken on young children in multiple foster placements, where children will have already suffered some form of maltreatment and/or neglect from their attachment figure, and are more likely to have an insecure attachment pattern if over the age of 12 months when entering care.
However, research has begun to investigate foster care attachments with young children; predominantly this has started with the infant age group. Although confounding factors influence individual circumstances, further research in this area is warranted. For example, longitudinal design studies tracking children from entry into foster care, across the various ages of the under fives age group, collating data on placement progress, e.g., regarding time in placement, comparing foster-parent and foster-child attachment measurements, obtaining prior histories of earlier experiences before foster care, etc, might provide illuminating data regarding these children’s attachment development.

[Personal reflection: My original interest in ‘attachment’ stemmed from both my previous work in health visiting and nursing with families, and from undertaking a six-month ‘parent-infant observation study’ during the 1990s that raised my awareness of the early development of attachment and complexity of the interpersonal interactions between mother and infant from birth to six months of age. In undertaking this current literature review and in the reading of the vast amount of associated literature, my own perspectives have been repeatedly challenged by the findings of different researchers and writers. In particular, I enjoyed reading a new body of literature (Boris & Zeanah, 1999; Lieberman & Pawl, 1990; Zeanah, 1996;) related to the disorganised classification, psychopathology, and attachment disorders in children. Although I personally struggle in accepting the discrete diagnostic classifications per se, it has raised my awareness and interested me further in an area of study that I might not have been presented with otherwise. Further, my reading has re-stimulated self-reflection on my own attachment relationships, particular my childhood ones with my own parents and sibling attachments with my brothers and sisters, and how the strengths in these relationships have changed across the life cycle as we have grown older. I have become increasingly aware of how my own experiences of these attachments have influenced my own process and thinking regarding the material I have read, and how, subsequently, I may have presented this review.]
References


Appendix 1

Child Development Notice to Contributors

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Types of Articles Child Development considers manuscripts in formats described below. Inquiries concerning alternative formats should be addressed to the Editor prior to submission. All submissions are expected to be no more than 40 manuscript pages, including tables, references, and figures (but excluding appendices). Authors should provide a justification if the submission is substantially longer. Unless the editor finds that justification compelling, the submission will be returned to the author for shortening prior to editorial review.

Empirical articles comprise the major portion of the journal. To be accepted, empirical articles must be judged as being high in scientific quality, contributing to the empirical base of child development, and having important theoretical, practical, or interdisciplinary implications. Reports of multiple studies, methods, or settings are encouraged, but single-study reports are also considered. Empirical articles will thus vary considerably in length (approximately 8 to 40 manuscript pages); text and graphics should be as concise as material permits. All modes of empirical research are welcome.

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Foster carers' experiences of developing a relationship with young children who have experienced multiple placements: An interpretative phenomenological analysis

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Note: This report is not under consideration elsewhere.
Abstract

This study explores foster carers’ experiences of developing relationships with foster children who have experienced multiple placements whilst in foster care. In-depth qualitative interviews with nine foster carers, who have cared for foster children in the two to six year age group, were undertaken. Information was gathered on the foster carers’ experiences in developing a relationship with their foster children and their reports of foster children’s responses to them. Interpretative phenomenological analysis was used to analyse the data in examining any associations, noting similarities and highlighting differing perspectives of the foster carers’ experiences. Emergent themes included: the initial establishment of a secure base relationship that was emphasised by many foster carers; aspects of separation and loss as factors influencing the developing relationship; the foster carers’ use of self and foster carer’s sense of agency also emerged as key aspects. Implications for Counselling Psychology practice and research are discussed.
Introduction

Multiple foster placements (that is, three or more foster placements) (Pardeck, 1983, 1984), in one year, were reported to be the experience of almost 20% of the 61,100 children living in local authority care in England (Department of Health/DH, 2000a; DH, 2000b), Quality Protects (DH, 1998, 1999a; 1999b). The government's recent standards for children in care (DH, 1999a) have since given local authorities a directive to ensure that no more than 16% of children have more than three placements in a year, yet have not set a lower age limit to this. Many children have experienced nine or more placements by the age of ten years, some have had as many as 25 – 30 and have been moved into institutionally run foster homes; some have had a total of five or more placements before the age of five years (DH, 2000a; Rushton & Dance, 2005). Webster, Barth and Needell (2000) found 52% of pre-school age foster children had experienced multiple placements in one USA state. Although in England 15,000 foster children are under five years of age, the official numbers of these with multiple placements do not appear to be recorded (DfES, 2003). Yet, evidence from case studies (for example, Hindle, 2000; Kenrick, 2000), and foster and adoption managers (Gill, 2004; Lewis, 2003), suggest multiple foster placement experiences by the younger age group of children occur frequently enough to be of concern within child welfare agencies.

Much of the early research on children following disruptions in care has focused on socio-emotional development. Bowlby (1969) emphasised the development and continuity of a child's attachment to their primary carer during the pre-school years as paramount for the child's development of psychological health and emotional security. An in-depth literature review of the development of attachment theory and associated supportive and challenging views from research are documented in the researcher's literature review (Chambers, 2004). However, the literature is limited on the influence of 'multiple' disruptions on the child's psychological development, including re-attachment and relationship building, regarding the child who has experienced multiple foster placements within foster-family care. Rushton (2000) emphasised the paucity of evidence on which past government policies regarding children in care have been based, including policies regarding foster care placements,
however, system failures regarding placements were acknowledged in the governments Quality Protects agenda (DH, 1999). To date, studies (Brodzinsky & Schechter, 1990; Cooper & Peterson, 1987; Newton, Litrowick & Landsneck, 2000; Pardeck, 1983; Pardeck, Murphy & Fitzwater, 1985; Quinton, Rushton, Dance & Mayes, 1998) have focused on the middle childhood or adolescent age groups and multiple foster placements, where more complex factors are likely to influence the development of new relationships with foster carers, for example, lengthier time living in the care system, developmental stage, the wider social influences of school and peers.

Only recently have studies begun to investigate the development of the relationship with new foster carers in the pre-school age group and, to date, this has focused on foster infants in a first foster placement (Stovall & Dozier, 1998). Again, attachment perspectives dominate investigations of parent-child relationships with foster carers. Studies (Dozier, Higley, Albus & Nutter, 2002; Marcus, 1991; Tyrell & Dozier, 1999) suggest that infants over twelve months of age on entry into foster care are more likely to have already developed insecure attachment styles, plus they are more likely to display alienating behaviours that can unfavourably influence the development of new relationships with foster carers. Hence, it seems reasonable to consider that subsequent experiences of disruptions, involving separation and loss of attachment figures via multiple foster placements, are likely to complicate the child’s psychological development and functioning in developing new relationships with foster, or adoptive, carers.

Little research exists from literature on exactly how caregivers might be expected to provide a secure base in the attachment relationship for young foster children who predominantly have insecure attachment styles. Maternal sensitivity, responsiveness and ‘attunement’ are qualities well documented (Stern, 1985) to promote birth mother–child relationships, and these have also been emphasised in the recent foster carer–foster infant literature (Dozier et al, 2002; Tyrell & Dozier, 1999). Most studies have been observational studies, recently including foster carers’ use of diary recordings of behavioural observations of newly placed foster infants. In the foster care services, it is expected that caregivers will provide a secure relationship, despite previous adverse
care received by the child and an increased risk of disorganised attachment strategies (Howe, Brandon, Hinings & Schofield, 1999; Main & Solomon, 1986) that make new attachment relationships difficult to develop. Tyrell and Dozier’s study (1999) found that children in care are more likely to display alienating behaviours that reject carers’ attempts at closeness, hence attachment related ‘polarised’ response patterns of either avoidance, or over-friendliness, may be observed (Lyons-Ruth, Brentwood & Attwood, 1999). Young children in the care system may have little opportunity to make sense of repeated separations and losses from a series of different carers and a lack of continuity in their early experiences, yet there is little evidence of research interest regarding the compounded emotional experiences for the younger age group of children.

Many adults and children who are users of mental health services have been in the care system at some time during their childhood and may present to the counselling psychologist with issues for therapeutic intervention. 60% of fostered children who have also had multiple placements receive mental health care at some point during their lives (Cantos, Gries & Slis, 1996). For the counselling psychologist, developing an awareness of the potential impact of childhood experiences that clients may have experienced in the fostering and adoption context are important in terms of assessment and formulation of clients’ presenting concerns and in the planning and implementing of appropriate and effective therapeutic interventions; for example, engagement, attachment, separation and loss are salient issues that are likely to arise in the therapeutic relationship. Further, foster parents or adoptive parents may also present themselves individually, or with their family, for therapy either for themselves or in response to parenting difficulties with their foster or adopted child. Also, the role of psychology has expanded within child-care teams responsible for children who are placed in care, i.e. ‘Looked After Children’¹, within local authorities’ Social Service Departments, and also within NHS Child and Adolescent Mental Health Teams, and the counselling psychologist is able to contribute to these developing areas.

¹Definition of ‘Looked After Children’: children for whom the ‘Local Authority (Social Services Department) has specific responsibilities under the regulations of the Children’s Act (1989).
The aim of this current study was to gain insights into how young foster children who have experienced multiple placements develop relationships. This may be helpful information for the counselling psychologist to consider the phenomenological experience of carers in the carer-child relationship, for similar interpersonal features may also arise in the therapeutic relationship with clients who were fostered as children. As foster carers are the 'other' in the foster child's dyadic relationship, an understanding from foster carers' 'insider' perspective and the meanings they attribute to their experiences, might be an informative and insightful source of information for studies on relationships with young children who have experienced multiple placements and separations and loss of primary carer. A qualitative approach facilitated this enquiry through the use of interpretative phenomenological analysis (IPA) (Smith, 1996). Most research in this area has been driven by attachment theory applied to parent-infant and carer-infant relationships and this theoretical body of knowledge and the researchers own 'lens' through which this has been viewed has undoubtedly influenced the researcher's prior ideas and expectations regarding this research. Hence, attachment theory informed the data collection phase and was informative during the analysis, however, the researcher was not constrained by this theory and remained open to new perspectives, so that data was related to other theories when these were more meaningful or when new potential areas of enquiry emerged.
Method

Participants
Nine foster carers were included in this study: seven women and two men whose ages ranged from 40 to 60 years (mean 50.11, SD 6.53). Two men were husbands of two of the women who took part and actively co-shared the primary foster carer role. Foster carers’ years of experience as a foster carer ranged from 3 to 37 years (mean 16.56, SD 12.67) (see table 1 - appendix 8).

Inclusion criteria: participants who were registered as a foster carer with their Local Authority’s Social Services Department, had at least three years foster carer experience, had experience of fostering young children in the under six age group, had fostered a young child who had had multiple placements, i.e. two or more previous and sequential placements following removal from birth parent; were currently fostering young children aged between two to six years at the time of the study, or had had recent experience of this (see table 1 – appendix 8 ). Foster carers must have been providing foster care in their own home and be the primary carer, as opposed to a part-time child-care worker. For details of the foster children’s ages, gender, ethnic origin, and length of stay with participant, see table 2 (appendix 9) and table 3 (appendix 10). Pardeck’s (1983, 1984) definition of multiple placements was used in this study, i.e. three or more foster care placements; and this included the current foster placement (hence the child must have had two previous placements, at least). An emergency placement would be accepted as a previous placement, as this constituted a move and a new carer (emergency placements can also be longer stays).

Exclusion criteria: Foster carers that were not currently fostering children, or have had recent experience of this, or whose experiences was restricted to children in the older age groups, i.e. middle age group (seven years of age and over) and the adolescence age group.

Recruitment of participants: Participants were recruited via managers of the Local Authority Fostering Teams: these managers became known to the researcher via professional contacts working within the Looked after Children team of two Local Authorities, and were contacted by telephone and email communication by the researcher. One locale was in the South East of England and the second locale was in
the South West of England. Participants were informed of the research by their link social worker and if participants were then interested in participating, their contact details were forwarded to the researcher. Due to a slow response in recruitment, wider attempts to recruit had included: an advert on the Fostering Network (the foster carer association) website for foster carers; email requests to the Foster Team managers of over forty Social Service Departments covering the South East of England, including London, whose contact details were obtained via the British Adoption and Fostering Agencies Directory (2005). Four foster team managers responded and offered to pass information on to foster carers; two managers replied reporting no foster carers fitted the inclusion criteria. An introductory letter (appendix 1) was posted out to each foster carer from the researcher providing further study information and asking whether they wished to take part in the study. The researcher then contacted each participant by telephone to ascertain their willingness to take part, and an interview date and time was arranged. At each stage of the process participants were given opportunity to decline involvement.

Procedure

In-depth interviews were undertaken by the researcher and used to collect data. Each interview lasted 55-75 minutes. Most interviews took place in the foster carer’s home to facilitate foster carers’ availability regarding child care commitments. One interview was undertaken in a private interview room at the Fostering Team’s office. An information letter (appendix 2) was given to each participant to read prior to the interview and opportunity was given to ask questions of the researcher. Prior to the interview the participant signed the consent form (appendix 3) and completed a demographic and background questionnaire (appendix 4) that clarified the participant’s experience as a foster carer.

A semi-structured interview schedule (appendix 5) acted as an interview guide, and included areas to be explored that had been taken from relevant associated literature should the participant not spontaneously raise these areas for discussion. The interview format allowed sufficient scope for the participant to influence the direction of the interview. Open-ended questions were used wherever possible and the researcher’s wording of questions attempted to maximise use of the individual
participant's own words. However, the opening question was standardised across the interviews. Each interview was recorded on audiocassette and transcribed verbatim by the researcher.

Following the interview, participants were given an opportunity for de-briefing with the researcher and provided with a de-brief letter (appendix 6).

A pilot study was undertaken using two participants to test and refine the interview schedule and procedure. The pilot data has been included, as minimal adjustment was required to the interview schedule.

**Analytic approach**

The researcher was interested in foster carers’ perceptions and their experiences of developing relationships with young, multiply placed, foster children, and the meanings that foster carers give to these; this formed the analytical focus of this study. Attachment theory led research has been so well researched that it might be difficult not to go into a research study influenced by this knowledge, and hence the influence of attachment theory on the researcher’s thinking during interviews and in the analysis is acknowledged.

Interpretative Phenomenological Analysis (Osborn & Smith, 1998; Smith, 1996; Smith, Flowers & Osborne, 1997; Smith, Osborne & Flowers, 1999) was chosen as the analytic method in order to understand the content and the complex nature of foster carers’ accounts by attempting to adopt an ‘insider’ perspective on the research topic. The use of Interpretative Phenomenological Analysis (IPA) is derived from a phenomenological and symbolic interactionist perspective. IPA creates meanings of an individual’s reality from their own perceptions, through interpreting selected aspects of their accounts in relation to their context rather than generating objective statements. IPA stands in contrast to the positivist hypothetical-deductive approach, which uses data to test theories about a reality. Hence, IPA gives importance to themes emerging from the data and to the selection process that involves the researcher’s own interpretative processes in capturing the meaning of participants’ perceptions and experiences from their transcripts.
The procedural steps of the analysis
The process involved each tape being transcribed and each transcript being read separately by the researcher. Initial notes were recorded in the left hand margin of the transcript of key phrases, interesting processes, and associations or connections made with other aspects of the transcript. Each transcript was re-read a number of times for the researcher to become familiar with each account and thus a detailed examination of each transcript was undertaken in turn. Initial emerging theme titles were noted in the right margin, however, these were not considered definitive at this stage. Similarities and differences in the meanings within each transcript were identified and considered. On a separate sheet, emerging themes were listed and connections sought between themes, and some clustered together into sub-ordinate or super-ordinate concepts. Shared themes and individual variations, providing insights into the complexity of the study topic and the processes operating within them, were grouped under theme headings. New clustering of themes emerged that were re-checked with the transcripts. Some themes were dropped that either did not fit into the structure or were not found to be rich in evidence. Identifying numbers as markers were given to each theme and instances where these were found in the transcript. The researcher repeated the above stages in a cyclical way, particularly at times of the researcher feeling uncertain about, or curious, regarding the relevance of emerging themes, hence, the analytic process was repeated. Connections between themes were made and meaningfully brought together different themes. Some themes followed the interview schedule questions, however, some were new. A table for each participant was produced. The themes from the tables were then consolidated into a master theme table. The themes were then compared to the most similar literature in this area to support the analysis. Most of the analytic process was undertaken manually, which enabled an almost complete immersion in the analytic process by the researcher.

Ethical considerations
The University of Surrey Ethical Committee’s approval was obtained (appendix 7), and the foster team managers accepted the University’s Ethical approval and confirmation of this was sent to the Ethics Committee. The British Psychological Society (BPS) ethical research guidelines (BPS, 2004) were ensured. Written information regarding confidentiality and anonymity was provided and a consent form
signed. Participants were given opportunity to ask questions before and after the interview. Participants were given written and verbal information that they could withdraw prior to, during, or following the interview. The use of the research data and findings was explained to each participant. Participants were advised in writing on the method of subsequent destruction of the audiotape.

The researcher anticipated that participants might ask advice regarding children in their care provoked by the research. In anticipating this, the researcher's intention was to acknowledge the request but refer the participant to their social worker, without the researcher offering advice/guidance that could be inappropriate given the 'Looked after Children' context. The researcher informed each participant at the time of arranging the interview date/time that interviews would not be undertaken with children present, and would be re-arranged if this seemed likely.

The researcher anticipated that should any participant suffer anxiety or distress during the interview then the researcher would use counselling skills at the time and follow-up support would be negotiated with the participant, such as their foster link social worker. Details of support contacts were provided on the de-brief letter for each participant.

**Evaluation**

Although various authors (Elliot, Fischer & Rennie, 1999, Yardley, 2000) have proposed evaluative criteria for qualitative research, the following have been drawn from Yardley's criteria that might be useful in evaluating this study: sensitivity to context; commitment and rigour; transparency and coherence; impact and importance. Further, the sample has been sufficiently described to enable readers to judge how widely results might apply. Credibility checks were undertaken and a full description of the analytic procedure has been described, so making it transparent to the reader. The researcher's own perspective informed by attachment theory has been described. Further, an internally coherent interpretation and persuasive interpretation of the data was undertaken.
Analysis

Four master themes emerged from the analysis of the transcript: Establishing a Secure Relationship; Separation and Loss; Use of Self; and Sense of Agency. Establishing a secure base relationship, Separation and Loss, and The Use of Self are presented here, with a selection of their associated sub-themes, to provide a rich expression of the most salient themes rather than provide a superficial view of every theme and risk losing a meaningful representation of the data. In order to facilitate the reader in conceptualising the sub-themes within the each domain, a diagram for each of the main domains is provided in the text (located at the beginning), as each main domain is presented along with each of sub-themes for that domain embedded in the diagram. Linked lines between themes are connections only and are not implying a causative or directional flow.

The term ‘carer’ is used to denote foster carer and ‘child’ or ‘children’ to denote foster child or foster children. Pseudonyms are used throughout in place of foster carers’ and foster children’s actual names. The examples that are included in the analysis presented are taken from participants’ transcripts to support the themes that emerged. Each theme is considered in turn and illustrated with verbatim excerpts from the transcripts. Minor hesitations and repeated words (e.g. ‘um’) have been deleted for readability. Ellipsis points ... show a pause in the participant’s speech. Words in square brackets [his] have been added for explanatory purpose. Empty square brackets [ ] indicate where data has been omitted. Double quotation marks “...” indicate quotations from the participants.

Many carers lacked a full knowledge regarding the child’s separation experiences from their birth mother and/or previous foster carers. However, carers were aware of aspects of the children’s histories; these differed greatly and hence the carers’ stories were diverse.
Establishing a secure base relationship

According to Bowlby (1979, 1981), for optimum psychological development, the concept of a secure base lies in a sufficiently trustworthy and responsive adult who is available to act as a safe haven for a young child to return to when feeling threatened and at times of stress, and from which it can wander to explore its environment. Carers spoke of developing ‘trust’ with the child and of providing ‘safety’, along with holding an awareness of the child’s ‘need to belong’ and these emerged as associated sub-themes of establishing a secure base (see diagram 1).

Diagram 1:

![Diagram showing the relationship between establishing a secure base, developing trust, safety, and need to belong.]

Developing trust
Most carers reported the importance of trust, for example: “I think it’s important that you build up that trust as quick as possible, and a relationship” (Tony) and this was a priority in establishing a relationship with the child from arrival into their care. Many carers reported that their children needed carer’s that were available to them to develop this trust in ways such as sharing more time in carer-child joint activities than their normal amount of time with a foster child. As Susan reported:
"(trust was built by) spending time taking them over the park, taking them out for the day, whereas normally I'd just let the kids stay out in the garden, with these it was different, I'd spend time out there with them"  
(Susan)

For Tony, caring for a child who had had multiple placements was felt as a "totally new ball game" that demanded the carer's motivation and investment in the child to develop trust:

"it's spending time with him and making it work, I wanted it to work, I wanted to see him happy ] its knowing that he can trust me"

(Tony)

Spending time with their child meant being attentive and available to them. Some carers talked of their child's low self-confidence and self-esteem, and saw building trust as associated with helping the child to improve self-efficacy too:

"You gotta gain their confidence by talking to them and listening to what they are saying ] he had no confidence in himself, now once we boosted his confidence up, then he started to talk to us"

(Harry)

Harry felt confidence building helped to facilitate the child's acceptance of him, and hence establish himself as a secure base for the child. However, some carers spoke of the precarious nature of developing trust for these children who have experienced repeated moves and hence carers:

"they keep saying that, they feel that, the fact they have been moved from one and then to another, it takes a long time for the child to start trusting you, and they think you are going to chuck them out and then they are going to go to another one"

(Julie)

Children who have had multiple placements are likely to mistrust relationships because of fear that such relationships may not last. The first psychological conflict for a child, that of trust versus mistrust (Erickson, 1968), has been compromised, not only because the first primary relationship has been broken, but his/her subsequent ones have too.
Safety

Bowlby (1988) claimed that before the child can engage safely in exploration of its environment (its outer world), a secure base must be established. Most carers spoke of helping the child to feel safe:

“it’s about trying to create a stability in their life, whereby they know at this time, this is gonna happen [ ] then that child knows where it’s at, it’s happy because it...cos this is gonna happen every day, and they feel quite safe, I think it’s a safety thing for them”

(Harry)

Establishing routines and boundaries to provide a safe structure in order to help the child to feel more secure, and consciously setting these from the beginning:

“ground rules go in, boundaries go in, and we start off with day one, firm, fair, getting to know the child, getting to know what they want, what they like, er, and just settling them down from the first night”

(Harry)

In this way, the use of routines and boundaries appeared to have a stabilising and safety function. At a practical level this strategy had been adopted by most carers and can be interpreted as one strategy used to contain the child’s feelings and anxieties arriving in a new, strange environment. However, one carer offered another function of setting boundaries and rules immediately as:

“(so) it doesn’t get to the point where you feel like everything is getting out of control”

(Beverly)

Hence, this may not only have been intended to promote safety and contain the child’s feelings but also to enable the carer to maintain a sense of control over a potentially chaotic start to the relationship; particularly relevant to Beverly when her child displayed aggressive behaviours, as discussed later. So, in these ways, carers felt they provided a new experience for these children, that of safety. As Alice said:

“it was something that they hadn’t had at home, so they didn’t know what was going to happen next when they was at home, but once here...they reacted very well to a routine”

(Alice)

The attachment literature (Perry, 2002; Perry, Pollard, Blakely, Baker & Vigilante, 1995) suggests that predictable routines provide security and structure, particularly for
children with a history of maltreatment. The child has a need to know that caring and safe adults are in control, and may become even more anxious if they are not informed ahead of changes to their routines.

Also included in this theme is helping the child to feel safe within the relationship between the child and the carer, which can be a new experience, as Tony commented on:

“I think it was just re-assuring them that they have nothing to fear from me, cos I think there was definite fear in their other relationship with their other parents”.

(Tony)

Whereas for Harry it was; “what you call cool, calm, and collected, basically...no need going in heavy handed, er, you need to be soft and gentle”. However, this was often not such a smooth process, understandably so considering these children’s previous mistreatment, as Alice remarked:

“it was hard to get through to Karl to make him understand that he was safe and that things weren’t going to go back as they were before he came to us [ ] so he know(s this is) different from earlier experiences”.

(Alice)

Further, promoting the child’s development of discriminating their foster carer as the ‘safe’ adult for the child to turn to for affection was tied in for three of the carer’s with their concerns that:

“anyone that came round, she didn’t know them but she’d want attention from them, and when they were walking out the door to go she’d be crying [ ] it seemed to be that she was grabbing onto every bit of attention that she could”

(Susan)

As such these carers appeared to be speaking of ‘indiscriminate friendliness’ (Albus & Dozier, 1999; Zeenah, 1996), found in children with a disorganised attachment pattern (Main and Solomon, 1986) and where the child seeks affection from anyone without discriminating towards a preferred attachment figure. Developing a relationship with these children involved a need to emphasise more their protective function as carers and a teaching aspect:

“I talk to her about the dangers of walking off with people she
doesn't know, ‘(you) must be with someone that we know you’re safe with!’” (Mary)

Need to belong

Three carers reported the child’s need to develop a sense of belonging in their relationship with the carer, such as making tokens for their carer and through family rituals:

“other children make mother’s day cards and father’s day cards, and what do they make, you see, so it’s sort of, you know, and they’d call us mom and dad, like we are theirs” (Harry)

As a form of ‘claiming’ behaviour, this also indicated to sensitive carers the child’s wish to be wanted by them as if they were their own children in taking on part of their identity. As part of the family identity this was closely bound up with a sense of security of the self as a wanted child, rather than as a discounted self (Goffman, 1964) often felt by the foster child. Feeling a sense of belonging and identifying with part of the family are necessary for children to gain a sense of psychosocial security within the family home that can then be translated into the outside world (Schofield, 2002, 2003).
Separation and loss

All of these children had been placed in care due to parental mistreatment, or neglect, and/or abandonment. However, what united the carers’ experiences is that their young child had also experienced repeated experiences of separation and/or loss. Diagram 2 shows this domain with the associated sub-themes.

Diagram 2:

Some carers made overt references to separation and loss, whilst many were implicitly embedded in their accounts. Separation and loss came into focus in the ways in which the new relationship was negotiated between the children and their new carers and the child’s feelings and behaviours regarding this. Diagram 2 shows the sub-themes in this domain.

*Influence from past attachment figures - on separation process*

Carers reported trying to develop the relationship whilst their child was in the process of separating from previous carers and referred to the immediate aftermath following
the child’s arrival into their care. Many felt that the child’s attachment to their previous carer, and pre-occupation with their previous attachment figure, complicated also by the child’s understanding of the separation process, caused initial difficulties in developing a new relationship because of the child’s wish for a reunion with them:

“They had nine months with the previous one to me, and twelve months with the one before, and that one was supposed to be permanent. So there were issues over that when they came, because they wanted to go back to that placement” (Mary)

Other carers echoed similar experiences of this hindering the development of the relationship:

“I think she didn’t have any room in her little heart for another foster mum [ ] I think she just couldn’t take to me because I wasn’t Marjorie (previous carer)” (Brenda)

Whilst other carers spoke of the child’s wish for reunion:

“their bonding was difficult because they had been in and out of care so many times that they didn’t really bond that well, because they knew (believed) that in the end they would go home” (Mary)

The child may have believed separation was temporary, and hence the hope of a reunion with the past attachment figure remains, and is not easily dropped, as this seems the most likely event from the child’s viewpoint: this might prevent the child’s wish to seek affection or closeness with the substitution of a foster carer. Psychologically it seemed that the child has not relinquished the relationship with the past carer/attachment figure. Hopkins (2000) explains how a child, following separation or loss, wishes for reunion with the ‘lost object’: a belief they will return to them. Hence, the child defends itself from the pain of grief when the reality of loss is denied.

However, some carers reported children were kept deceived regarding the realities of separations by social workers, and carers felt torn in their role resulting in frustration, anger and despair believing this was preventing their relationship with the child from developing:

“she didn’t want me at all! she just wanted to go home [ ] because
nobody told her she wasn’t going back there! if they’d have told her the truth, then she would have been alright I think”  (Brenda)

For carers then, it seemed that the child’s awareness of the reality of the loss would facilitate the child’s acceptance of the carer and facilitate development of the relationship. Others similarly spoke of this: “it wasn’t really until mom and dad were off the scene that he started to accept us more” and Mary reported:

“I thought it was important they should know exactly where they stand, because it might help them to basically separate that bit, a little bit, so that they knew that they were gonna stay here, and they would always be here”.  (Mary)

Hence, carers believed that informing the child of the facts of the separation would help the child accept their new foster carers easier.

Julie spoke of the children’s reactions to separations and changes of carers:

“They come here to another, and it does disturb the children”.  (Julie)

Susan’s account resonated with this as she spoke of the siblings’ distress following a sudden separation from a trial placement with a prospective adoptive mother:

“They came to us and hadn’t even been told that the placement had broken down [ as she was walking out the door the little girl was hanging onto her and screaming… and telling her that she didn’t want her to go”  (Susan)

Hence, carers spoke of the children’s painful feelings from another separation and loss expressed in the children’s behaviours:

“all the tears, every time she went to bed and… er…bed-wetting started up, where they were so distressed”  (Susan)

Carers reflections on the children’s behaviours seemed to also carry some of their own emotional responses to witnessing the child’s distress and in some way the child’s feelings may have resonated with them.

**Reciprocal rejection responses to separation and loss**

Carer’s spoke of feeling rejected by the child, including the care-taking aspect of their parenting role. Rejection was a particularly prominent theme emerging from Brenda’s account:
“she ran straight past me, she didn’t want me”. (Brenda)

Hence, avoidance and dismissal of Brenda by her child was felt as a personal rejection and it seemed that her subsequent reciprocal rejection of the child was imminent. As Brenda exclaimed:

“If (she) carried on like this (rejecting) I told them she must go by the summer!” (Brenda)

Brenda made sense of her child’s rejecting behaviours as the child’s hope for reunion with her previous foster carer, particularly as the child believed the separation was temporary as she had not been told otherwise. Hence, carers’ sensitivity to their child in some instances was tested out by rejecting behaviours and themselves sometimes feeling indignant:

“If didn’t quite work like I thought it would, so that was difficult, just because she wanted to be somewhere else!” (Brenda)

In psychodynamic terms, an understanding of this might be that through the processes of projective identification (Klein, 1946), the child splits off its painful feelings and projects these into the carer, the carer either contains the child’s intolerable feelings of anger and despair (Winnicott, 1986), as Brenda was struggling to do, or rejects the child, which may also be elicited unconsciously by the child in accordance with its history of abandonment. Interpersonal relationship strategies such as these can alienate or reject the foster carer and put the child at risk for failing to develop secure relationships with even the most available and responsive caregiver (Stovall & Dozier, 2000).

Other carers also experienced children as pushing them away. Mary described this aspect:

“I found it very difficult, because I wanted to be doing it (caring), and I felt like a spare part really”. (Mary)

However, many carers experienced this in more aggressive ways that prevented them getting close to the child. Carers spoke of a wide range of rejecting behaviours towards them, including physical attack, withdrawal and indifference. Although these can be considered in light of their adverse histories of maltreatment, here these can be understood as responses to separation and loss. From the child’s viewpoint, the risk of losing the person he/she gets attached too may be too high to risk closeness. Most
carers experienced overt aggression, such as biting, hitting, spitting, and kicking the carer:

“kick out at me, call me a cow, anything that’d turn you off that he could think of, Mark had a lot of aggression [ ] at times it was difficult, sometimes you just wanted to walk away from him and just let him get on with it [ ] but there were tears rolling down his face”  

(Susan)

Two carers noted this aggression in their children as distancing behaviours:

“he would suddenly realise someone is showing him affection and then the anger would start coming out, and he would just throw his toys”  

(Julie)

In these ways these behaviours disrupted the development of a secure relationship and can also be seen as a function for the child in rejecting the carer, before the child became rejected by the carer, and so maintaining some sense of internal control in an essentially uncontrollable situation for the child, as the child’s experiences of separation and loss has shown him/her: in this way it seems the child was able to prevent closeness to the new foster carer. In psychodynamic terms, this aggression can be understood as a defensive behaviour that the child uses to protect himself against allowing a trusting, attachment relationship and hence anxieties of further hurt from repeated abandonment (Fahlberg, 1981, 1988). The most common reasons for placement breakdown in the two older age groups is aggression, withdrawal and passive–aggressive behaviours; and these seemed to appear here in the younger age group too and can be understood as rejecting behaviours too. However, a few carers seemed to understand their child’s aggression as expression of their child’s underlying fear and pain:

“He just wanted cuddles, but he was too scared to get attached [ ] he goes into a big tantrum over it, but he would never come to us for attention, or anything”.  

(Susan)

Julie attempted to reduce the risk of rejecting her child and attain his trust:

“I think I put up with it (rejecting behaviour) for so long that you just end up just ignoring it, you have to ‘switch off your own feelings’ because you are so busy trying to think of different things to do to try and help him and to try and get his trust”.

(Julie)
Loss of foster child’s attachment figure

Some carers talked of sadness evoked relating to losses experienced by their foster child and six carers spoke of associations to separation in their own childhoods, an aspect presented later in theme on ‘the Use of Self’. Two carers spoke of their child experiencing additional loss through the death of siblings and the effect of this on the child and their relationship. Julie’s child had: “been to five or six foster carers before me” and she spoke of:

“he was a very angry child, very angry, to me he was really hurting inside, you know, he’d seen a lot, I think it really disturbed him the fact that his baby sister had died”

(Julie)

She went on to describe how difficult it was for her to cope with her own feelings about Andrew’s feelings of sadness:

“when he thinks no-one is looking at him he would cuddle the doll, but it was very sad, it was really emotional and that, but you couldn’t let him see that you was watching, but I’m very emotional anyway and things like that really get to me, you know, and then... I have to walk away (laugh)... I won’t talk to him...”

(Julie)

The pain of the children’s separation and loss can also provoke foster carers own unresolved childhood feelings (Fraiberg et al, 1980), and this link is discussed further in the theme ‘Use of Self’.

Separation Anxiety

Most of the carers talked of the child’s anxiety and the child seeking frequent re-assurances. Some found their child became clingy and displayed separation anxiety.

After a respite weekend Mary found:

“very clingy, very clingy, arms around me all the time, she really just wanted re-assurance that she was coming back here”.

(Mary)

Susan reported:

“He keeps asking me, ‘I’m staying aren’t I? You’re not sending me away are you?”

(Susan)
The child’s anxiety and uncertainty about further separations appeared as a sign of the lack of trust in the stability and continuity experienced with past carers, which is carried into the relationships with new carers. This issue was raised by a few of the foster carers:

“like when the social worker comes to tell them that they won’t be going back to mommy and daddy and they’ll be getting a new mommy and daddy, and then you can see in their minds ‘Oh what’s gonna happen now? Who is this new mommy and daddy gonna be? Where am I gonna go?’ all those sorts of questions”

(Alice)

Hence, signifying the complexity of emotional issues around separations these carers negotiated:

“we prepared them for their new family, and that was quite difficult for us cos how do you explain to a child that young that they are going to find a new family for them, yet again?”

(Tony)

Emotional responses to separation and loss

Apart from overt anger shown in aggressive behaviours, all carers spoke of a range of other emotional responses showed by children that can also be understood as emotional responses to experiences of separation and loss (Bowlby, 1979; 1981). Four carers spoke of abrupt mood changes:

“he would just sort of switch on and off” (Beverly), and “it’s just an explosive thing that he did [ ] it was like he was a ‘Jekyl and Hyde’, you know, literally he would click in and out”

(Harry)

Some carers experienced their child as emotionally withdrawn, including the child not seeking comfort from the carer even when physically or emotionally hurt:

“she keeps it all in, I don’t think I’ve ever seen her cry... which is strange”

(Brenda).

Alice said:

“he’d go into his shell” and he was ‘the type of little boy who liked to work in his own world”.

(Alice)

Other carers experienced the child as showing a lack of emotion:

“you’d give him a cuddle and he’d sort of freeze, you know, he’d sit on your lap...but there was no sort of emotion”

(Tony)
The Use of Self in promoting the relationship

Carers talked of their ‘use of ‘self’ in facilitating the relationship, including having: ‘empathy, sensitivity and responsiveness’ and many carers associated this with ‘foster carers’ own childhood experiences, see diagram 3.

Diagram 3:

Empathy, sensitivity and responsiveness

Some carers talked of their sensitivity and responsiveness to the child:

“we have never really had children like that before, I mean it was really like you had to re-assure her that you are there, give her lots of cuddles and that”

(Joan).

Whereas for others this theme was linked to ‘rejection’, in the ‘separation and loss’ main theme, when their own feelings of rejection from the child became paramount.

Many carer’s spoke of their empathic ability:
"I pick up on things more than most people [ ] whether its that I've got some sort of sixth sense or something, but I sort of get the feel for how they, um, ....[ ] I try and read them [ ] listen and try and feel how they are accepting me"  

(Tony) 

Alice spoke of needing to take the child’s perspective: 

“You’ve got to really put yourselves in their shoes and think ‘well what are they going through and what have they been through’”  

(Alice) 

Further, many carers commented on their empathic abilities and responsiveness to the children’s experiences which seemed to be resonating with their own childhood experiences: 

“I can create empathy with them, you see, cos my own upbringing wasn’t brilliant, so I had to change things”  

(Harry) 

Foster carers’ own childhood experiences resonating with their child’s experiences 

Six of the carers’ showed empathy and responsiveness towards their child which could be understood as the child having activated memories of the carers’ own childhood experiences of separation, loss or rejection, and their own feelings associated with these. For example, Harry, aged 60 years, emphasised how he experienced a separation from his own mother during his childhood, whilst he was in hospital for ten days, had continued to impact on his later life: 

"that [separation from mother] really done me for the rest of my life, so I developed a lot of sympathy, no it was empathy rather than sympathy, cos you can empathise with the child". 

Two carers also spoke of their own experiences of being fostered by carers themselves as children. Joan spoke of experiencing her own foster mother’s empathic support after her earlier childhood experience of paternal physical abuse, 

“cos I remember my dad used to beat me and my mom and I was so frightened...[ ] I remember what my foster mom was like with me [ ] and it [foster mom] really helped me a lot then”.  

(Joan) 

As such, she appeared to have experienced this as a ‘reparative’(Clarkson, 2003) experience, so that she may have been able to identify with and recognise her child’s fear and also to show empathic understanding of her child’s feelings.
For some carers, feelings associated with their childhood separation and loss seemed salient in resonating with experiences of childhood rejection and of them feeling unwanted. For Brenda:

"cos my mom left me when I was a child [ ] she never wanted me". (Brenda)

In Julie’s childhood, her grandmother, whom she spoke of as her main attachment figure, died and she spoke of how she had felt unwanted by her mother:

“my mom didn’t want me, cos I had three brothers and I was the girl, and she didn’t want the girl, and I think that is why I have always been so close to children [ ] I went to stay with me Nan...but then when me Nan died... I had to go back home again” (Julie)

Feeling rejected and unwanted in Julie’s own maternal relationship seemed to be associated with the loss of her own grandmother. Her own early experiences, with themes of rejection, separation and loss, may have enabled Julie to identify with, imagine and to empathically resonate with the feelings of her child’s experience.

Overall, carers expressed some awareness that their own childhood experience had in some way contributed to their empathic ability and therefore their ability to empathise and understand their children’s current feelings and behaviours. Carers seemed to identify with their child’s experiences and feelings, particularly regarding the children’s feelings of rejection. In object relation’s terms, this may be thought of as the carers’ use of their own countertransference processes (Cashdan, 1988), as well as their experience of projective identification (Klein, 1946) where powerful and unprocessed feelings associated with rejection, separation and loss are projected by the child into their foster carer, who unconsciously identifies with these feelings.

Finally, a fourth main theme emerged from the data encompassing the foster carers’ own ‘Sense of Agency’. In this theme, the foster carers expressed feelings regarding the ‘carer role’ in caring for young foster children who had experienced multiple placements. The salient sub-themes associated with this domain that emerged included: Helplessness; Disappointment and Sense of Failure and Threat to Carer/Parent Identity; Need for Reward and Recognition, see diagram 4 (appendix 14). Unfortunately, word limits further exploration at this point but this is an area of further development.
Discussion

The extent to which this study has met the evaluation criteria (Eliot, 1999; Yardley, 2000) will be included in discussing the methodological aspects of this study and the use of IPA. This study used a small sample, whose findings are not generalised to the wider population. There was no prior intent to generalise as the aim of this study was to ascertain foster carers’ phenomenological experiences of developing relationships with foster children who had had multiple placements. The use of IPA in this study facilitated meanings generated about foster carers’ experiences that has stimulated further understanding and potential for further enquiry.

In using IPA, four salient main themes emerged for all foster carers. However, ‘Establishing a Secure Base Relationship’, with its associated sub-themes of ‘trust’ and ‘safety’, and the ‘need to belong’, was a relatively unsurprising finding as these are basic aspects of developing any parent-child relationship, according to the literature (Bowlby, 1979; Schofield, 2002). However, the foster carers in this study confirmed and consciously prioritised trust and safety aspects for the foster children with multiple placement experiences. The theme of ‘Separation and Loss’ was a central and rather broad theme. However, the complexity of its associated sub-themes showed how these factors contributed together to present subsequent difficulties for foster carers in negotiating and developing the relationship. Difficulties included: the child’s wish for reunion with attachment figure, whether birth parent and / or foster carer and the child’s rejecting behaviours. The challenges and complexity of negotiating provision of a secure base relationship and carers continuing availability for children with specific needs, who anticipate rejection and emotional and behavioural difficulties, was tribute to the carers’ willingness to continue this endeavour.

One interesting main theme that emerged, although this had not been sufficiently explored in this study, was that of ‘The Use of Self’, and its associated sub-themes that emerged which had not been anticipated in advance. It is acknowledged that the researcher’s own bias and interpretative lens during the analytic process and in presenting the findings, lent towards presenting the attachment related thematic
content of the carer-child relationship. Further, due to time limitations in undertaking this study, a full exposition of theme four might be an interesting area of further development, particularly regarding the carers’ level of helplessness and need for support in caring for these children. In hindsight, it could be considered further that some carers might be motivated towards their foster caring roles by their own childhood experiences: an area only briefly referred to in other studies (Gilligan, 1996). Developing an understanding regarding carers’ motivations to foster care could be an area of further enquiry that might also provide insight into the processes in developing relationship with these foster children.

Context
This study was limited by the researcher’s lack of differentiation between types of foster care, such as emergency, long-term, pre-adoption, and resulting in disparate accounts between participants’ experiences that potentially minimised analytic cohesiveness. However, some themes had emerged across the transcripts and so provided credibility. Other credibility evaluation involved a colleague and supervisor undertaking a credibility check of the data and analysis. Recruiting participants via local authorities was the most productive method of access to the participants. However, this ‘gatekeeper’ role that foster team managers hold may have prohibited access to other potential and ‘data rich’ participants that may provide equally valuable experiences. The service demands of foster team managers’ adversely impacted on the timeframe. An advert, via the official ‘Fostering Network Organisation’ manager was placed onto its private membership website, with no response, and the research time schedule restricted further adverts in this instance. Other contacts within the field of fostering and adoption, or psychotherapy similarly brought no response.

Establishing a one-year restriction on carers’ last experience of caring for a foster child with multiple placements aimed to reduce memory distortion and recall abilities of retrospective accounts, but this also limited the number of participants available within the time schedule of this study. Hence, this criteria was relaxed to enable carers who had experience within the previous three years to participate, one had six years but was included because of a clear recall ability and provided rich and informative data. Recruitment difficulties need to be born in mind as a potential limitation in
future research in the fostering field, particularly if accessing thought busy local authority service providers.

Interviews were undertaken in carers’ own homes, as this was most convenient to carers with the demands of their fostering role. Despite early priming of participants regarding protection of the ‘interview space’, in reality less than ideal environmental control could be exerted over interruptions, including: phone calls, dogs barking, singing budgerigars, and neighbours entering. The flexible use of interviews facilitated collection of rich, in-depth data, not so obtainable through methods such as questionnaires. Semi-structured interviews enabled foster carers to bring their own experiences in a meaningful way, rather than responding to the imposition of a question/answer format. However, following the topics set on the interview schedule tended to be over-restrictive as the interviews progressed. A more flexible approach was adopted, allowing the researcher and participants more freedom of expression, and then an engagement in sharing the crucial aspects of carers’ experiences unfolded. However, this needed to be counterbalanced with diversions to other child-care experiences that some foster carers were very eager to share with the researcher, but were irrelevant to this study: hence the researcher’s discriminatory interview skills necessarily developed.

Evaluation of IPA: commitment, rigour, transparency. Comparative methods. Strengths of this study included its rigour, such as repeating analytic stages and making each theme explicit in the data. The researcher tackled the analysis with commitment through immersion in the process and repeatedly returning to the transcripts to ensure the interpretations were ‘grounded’ in the data. The analytic steps were made explicit and transparent in the methodology. Further, objectivity is not an issue in producing credible phenomenological studies such as this, for the analysis produced is the participants’ experience (from the researcher’s interpretative perspective).

IPA makes use of the analyst’s reflexivity and requires the analyst’s interpretative engagement with the data. Hence, interpretations emerged as ‘co-constructed’ (Denzin & Lincoln, 1998; Osborn & Smith, 1998). In this way, IPA enabled the abstraction of
themes that captured something of the meaning being expressed by foster carers. However, it is important to recognise that IPA is limited as to the extent that one can ever represent another’s experience, this could equally apply to other methods. The discovery of facts, or the use of assumptions from previous literature to ‘test’ pre-determined theories, via a hypothetico-deductive approach, was not intended in this study.

In evaluating the methodology used, a grounded theory method was excluded as the purpose of the study was not to generate new theory. A qualitative thematic content analysis may have been useful, particularly in managing large quantities of data, though it would lack the more meaningful and process oriented engagement with the data that is found in IPA.

**Future research**

For future research, differing samples of foster carers could establish differing themes or enlighten on processes. This could be combined with a more formal questionnaire on parents’ habitual parenting styles and differences. The emergence of unexpected data can open up new avenues of enquiry, for example in this study, the impact of ‘foster carers own childhood experiences’, where these foster carers linked their ‘own experiences’ to their motivation to foster, and exploration of the associated interpersonal processes involved for foster carers in developing relationships with foster children. It might be useful to discover if past experiences are more useful or a hindrance to foster carers in their role, particularly as the role of foster carers in providing specific therapeutic intervention work with foster children is an area of therapeutic potential area increasingly being explored.

**Counselling Psychology**

The findings from this study may help raise awareness and be informative to therapeutic practice of counselling psychologists, particularly when seeing clients who are foster carers or who have been fostered as children. This may also be helpful to other therapists, researchers, child-care and welfare workers, for example, in child care services or agencies, particularly those with responsibilities for planning foster placements. Further, awareness and understandings can be contributed to debates and
policies regarding young children in care. This study adds some understanding to the potential difficulties those who have experienced multiple foster carers may have in relationships and whose interpersonal strategies may lead them to seek therapeutic intervention. Further, limited research contributions have been made to the field of fostering and adoption by counselling psychologists. Yet, counselling psychologists are best placed to provide therapeutic intervention with their central focus remaining on the therapeutic relationship. Also, psychologists have much to offer in terms of contributing research to inform a field, such as this, where psychological research has been comparatively limited and marginal so far (Sass & Henderson, 2000; Zamostny, 2003).

Conclusion
This study contributes to psychological enquiry, and the field of fostering, by providing insights from four areas emerging from foster carers’ experiences of developing relationships with young foster children; children who have a history of multiple placements. IPA was found to be a useful method in developing rich and salient themes in the emotive context of repeated separation and loss. Although findings are necessarily limited to this particular study, aspects of these foster carers’ experiences can be taken into consideration in future research studies of this field.
References


Lewis, R. (2003). Personal communication with R. Lewis, Fostering Manager, Social Services Department, South West England.


Dear

Research Study: Foster carers’ experiences of developing relationships with children who have experienced multiple foster placements

My name is Sharon Chambers and I am undertaking a research study as part of my Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey. and have given me your contact details to write to you to see if you might be interested in taking part in my study.

Briefly, my research study aims to explore foster carers’ experiences of developing relationships with young children (in the two to six year age group) who have experienced multiple foster placements (two or more previous placements prior to your placement). I enclose an information sheet for you to read which will tell you more details of what the study involves and about your participation. I will contact you again within the next few days, by telephone, and if you wish to take part after reading the information sheet, I can then arrange with you a convenient time to meet.

Kind regards

Sharon Chambers
Researcher and Counselling Psychologist in training
Email: psm2sc@surrey.ac.uk
Study Information Sheet

Study title: Foster carers' experiences of developing relationships with children who have experienced multiple foster placements

You are invited to take part in this research study. Before you decide, it is important for you to understand why the research is being done and what it will involve.

What is the purpose of the study?
The aim of this research is to gain insight into foster carers’ own perspectives of developing a relationship with young foster children (in the two to six year age group) who have experienced multiple foster placements. Hence, it is an ‘inside’ view from your own experiences. It is anticipated that the findings will add to the knowledge and understanding of this topic and inform those working with carers and foster children.

Do I have to take part?
No. Your participation is voluntary. If you decide to take part I will give you a consent form to sign. If you decide to take part but find later on you that you change your mind, then you can stop taking part at any time, you don’t have to tell me why. Foster carers that will be asked to participate are: those that are registered as a foster carer with a Social Services Authority; have experience of fostering young children (ages two to six years) who have had two or more previous, and sequential, placements prior to the foster placement with you (your placement is counted as either the third, or above, foster placement) and following removal from parental care; be currently fostering young children aged between two to six years, or have recent experience of this. Foster carers must be providing foster care in their own home and be the primary carer, as opposed to a part-time child-care worker. Foster carers that will not be asked to participate are: those that are not currently caring for foster children in the capacity of primary foster parent; foster carers whose experiences as a foster carer have been only with children in the middle age group (seven years of age and over) or the adolescence age group.

What will happen to me if I take part?
I will ask you to meet with me for a 45-60 minute informal interview where I will invite you to discuss with me your own experiences of the topic explained above.
Only you and I will be present during the interview and I ask that any children you have are alternatively cared for during this time. I would like to undertake the interview in a convenient location: you may decide this is in your own home, or, if preferred, in one of the rooms at your fostering team’s offices. After typing up, I will offer you a copy of the transcript of your interview and ask for your comments, prior to my submission of it to the University.

Confidentiality
Any identifiable information will remain confidential to myself. In typing the transcript, your name and any others referred to during the interview will be substituted with replacement names so that they will not be identifiable by others. In any written reports of this research, or any submission for journal publication, these confidentiality precautions will be maintained. I will record our interview onto an audiotape, which I personally will keep secure in my own locked cupboard and the tape will not have your name on it, only an interview number (e.g. 1, 2, or 3) to identify the tape to me. I will erase the tape completely following submission of my study to the University at the end of July 2005.

What will happen to the results of the study?
The results of this study will be written up into a research report as part of my Practitioner Doctorate in Psychotherapeutic and Counselling Psychology (PsychD), University of Surrey. Further, it may also be submitted later to a journal for publication. Any identifying details, i.e. names, will remain anonymous.

Please discuss any questions that you might have with the researcher.

If you need any further information please contact me via:

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Consent Form

Research study title:
Foster carers' experiences of developing relationships with children who have experienced multiple foster placements

Please read the information points below. Should you agree to participate in this study, please sign this consent form to provide your consent to participate and to confirm that you have read this and the participant information sheet.

• I the undersigned voluntarily agree to take part in the study on foster carers’ experiences of developing relationships with foster children who have experienced multiple placements.

• I have read and understood the Information Sheet provided. I have been given a full explanation of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

• I understand that all personal information relating to volunteer research participants is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I consent to the interview being audio recorded, and to the recording being transcribed for the purposes of this research, and that anonymity will be maintained.

• I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice, and any details and/or information already gathered from me will be destroyed.

• I confirm that I have read and understood the above and freely consent to participate in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of this study.

Name of participant ...........................................
(BLOCK CAPITALS)

Signed: .......................................................... Date: ...............
Study title: Foster carers’ experiences of developing relationships with children who have experienced multiple foster placements

Background Information Questionnaire

1. How old are you? .......... years

2. What is your gender? male □ female □

3. How would you describe your ethnic origins? 1

Choose one section from (a) to (e) and then tick the appropriate box to indicate your ethnic origins.

(a) White
   British □ Irish □
   Any other White background (please specify)............................

(b) Black or Black British
   Caribbean □ African □
   Any other Black background (please specify)...........

(c) Mixed
   White and Black Caribbean □ White and Black African □
   White and Asian □
   Any other mixed background (please write in here) .................

(d) Asian or Asian British
   Indian □ Pakistan □ Bangladeshi □
   Any other Asian background (please specify)...........................

(e) Chinese or other ethnic group
   Chinese □ Any other background (please write in here)...........

---

1 The format of this question is taken from the 2001 UK census
Please answer the following questions with reference to your experience as a foster carer, your current fostering placement situation and brief details of the foster child/children you will be referring to in this interview:

4. How many years experience do you have working as a foster carer? ....... years

5. Are you currently fostering children? (please tick box) yes □ no □

If no to Q5, then ignore Q6 and Q7 below and move on to answer Q8 below

6. If yes to Q5, how many children are you currently fostering? ..........

7. Are you currently fostering a child who has had two or more previous placements? yes □ no □
   i. If yes, the current age of this foster child now is ....... years
   ii. Age of foster child at arrival into your care was ....... years
   iii. Gender of child (please tick box) male □ female □
   iv. Ethnic origins of child (use terms from Q3, page 1) ...........

8. If no to Q5, have you previously fostered a child who has had two or more previous placements? yes □ no □
   i. If yes, the age of this foster child at that time was ....... years
   ii. Age of foster child at arrival into your care was ....... years
   iii. Gender of child (please tick box) male □ female □
   iv. Ethnic origins of child (use terms from Q3, page 1) ...........

Thank you for completing this questionnaire

Sharon Chambers
INTERVIEW SCHEDULE

Opening phrase and question

“I would like to hear about your experiences of fostering young children, ages 2 to 6 years, who have experienced multiple placements.

What do you feel is important to tell me about your experience/s of developing a relationship with him/her?

Areas of enquiry to guide interview for use if areas not raised spontaneously by participant:

1. Initial development of your relationship with child:
   - Easy or difficult? in what ways
   - how managed? what helped? what didn’t help?
   - your felt importance to child? vice-versa, felt bonded?
   - how this experience compares to experiences of children with only one foster placement: similar or different – in what ways

2. Experiences of offering safety and protection:
   - how child sought this from you/strategies child used to gain access (proximity) to you or your attention
   - whether child discriminated you from others?/ considered usual/unusual? (may enquire if excessively bright greetings towards you or anyone, including strangers; or child sought to be held and excessively resisted being put down/)
     - your reaction to child seeking/not seeking you: what did/didn’t help
     - fear/wariness (terror) of strangers (e.g. hides self or face/screams/freezes/runs away)

3. Development of trust:
   - how/what ways you experienced child’s trust of you developing, or not?
   - child’s approach to you or avoidance of you in relationship?
   - separation experiences from you
   - reunion experiences with you
   - your reactions to the above, or how managed?

4. Physical/emotional comfort seeking of you by child
   e.g. when child has hurt knee
   - how/if child sought/accepted from you, able to be comforted by you? or self soothed?
   - your responses (behaviours/feelings)
   - what helped/didn’t help
5. Child’s exploration and playful interactions with you:
   a) how you experienced this, or didn’t experience?
   b) your presence needed whilst child playing, in can play on own (allow for age appropriate developmental stage of play)
   c) experiences of enjoyment? fun?
   d) Child able to explore environment – checks back to you, or not?

6. Care-giving experiences
   e.g. everyday routines such as, feeding/meal times, bathing, help with dressing, toileting, settling to sleep, etc,
   - how experienced and managed in the relationship

7. Discipline (& behavioural issues)
   - What behaviours displayed?
   - How managed?
   - Match expected age appropriate, or not

8. Teaching
   e.g. self care & social skills, concentration, cognitive tasks, problem solving,
   - help sought from you to accomplish a task, etc?

9. Companionship and socialising
   - child seeks you/ or not for company?
   - responses to you as companion?

Towards end of interview:

“So you have mentioned (summary of the participant’s points), is there anything else you think is important about your experiences that you would like to add?”

At close of interview:

- Thank participant for taking part.
- De- brief and ask participant if she/he has any questions at this point
- Leave de-brief letter with participant and ensure has researcher contact details.
Prompts: to be used as and when needed during the interview alongside reflecting back, summarizing and paraphrasing to encourage exploration and elaboration.

- What makes you say......?
- Could you give me an example of that/of what you mean?
- Could you say more/something else about that?
- What do you think about that?
- What are your thoughts/feelings about that?

Is there anything else/anything more that you would like to add/say
De-brief letter

Thank you for participating in this study. If you have any comments or questions on the interview and/or the research process please ask me. If you think of further information that you would like to tell me, please contact me via email or at the address below.

The tape of the interview you have given will now be transcribed and analysed along with interviews conducted with other foster carers. The information gathered will be anonymous and any quotes from the interviews used in the reports will be given pseudonyms (replacement names). I will contact you again, in approximately one month, with a copy of the transcript from your interview for you to read and comment on. I would be grateful for your feedback on the transcript.

I will also offer you a copy of my final research report for you to keep upon completion and approval of this study by the University.

If following this interview you feel you have suffered distress caused by the interview, details are included below of support people you might wish to contact:

- Your own named foster care link social worker
- British Adoption and Fostering Association, Skyline House, 200 Union street, London, SE1 OLX. Telephone:
- Supported Fostering Services, 29 High Street, Lewisham, London. SE13 5AF. Telephone:

Thank you again for your participation in my research. If you need any further information please contact me via:

MATERIAL REDACTED AT REQUEST OF UNIVERSITY
09 March 2005

Ms Sharon Chambers
Department of Psychology
School of Human Sciences

Dear Ms Chambers

Foster carers' experiences of developing relationships with foster children who have experienced multiple placements (EC/2004/130/PSYCH)

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: 09 March 2005

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

Document Type: Application
Dated: 15/12/04
Received: 21/12/04

Document Type: Insurance Proforma
Received: 21/12/04

Document Type: Summary of the Research
Received: 21/12/04

Document Type: Information Sheet
Received: 21/12/04

Document Type: Consent Form
Received: 21/12/04

Document Type: Interview Schedule
Received: 21/12/04

Document Type: De-brief Letter
Received: 21/12/04

Document Type: Research Proposal
Received: 21/12/04
This opinion is given on the understanding that you will comply with the University's Ethical Guidelines for Teaching and Research.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected, with reasons.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethic Committee
    Dr R Draghi-Lorenz, Supervisor, Dept of Psychology
Table 1: Participants details from demographic questionnaire

<table>
<thead>
<tr>
<th>Foster carer</th>
<th>Age/Gender</th>
<th>Ethnicity</th>
<th>Years as foster carer</th>
<th>No of current foster children</th>
<th>Q7: Currently has f/child with 2+ previous placements</th>
<th>Q8: Previously had f/child 2+ previous placements</th>
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<tr>
<td>Harry</td>
<td>60/M</td>
<td>White</td>
<td>37</td>
<td>2</td>
<td>No</td>
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<tr>
<td>Alice</td>
<td>58/F</td>
<td>White</td>
<td>37</td>
<td>2</td>
<td>No</td>
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</tr>
<tr>
<td>Susan</td>
<td>48/F</td>
<td>White</td>
<td>13</td>
<td>2</td>
<td>No (recently adopted own f/c with 2+)</td>
<td>Yes: see table 3</td>
</tr>
<tr>
<td>Tony</td>
<td>50/M</td>
<td>White</td>
<td>13</td>
<td>2</td>
<td>No (recently adopted own f/c with 2+)</td>
<td>Yes: see table 3</td>
</tr>
<tr>
<td>Beverly</td>
<td>42/F</td>
<td>Caribbean</td>
<td>13</td>
<td>4</td>
<td>Yes: see table 2</td>
<td>Yes: see table 3</td>
</tr>
<tr>
<td>Joan</td>
<td>52/F</td>
<td>White</td>
<td>4</td>
<td>1</td>
<td>No</td>
<td>Yes: see table 3</td>
</tr>
<tr>
<td>Julie</td>
<td>49/F</td>
<td>White</td>
<td>9</td>
<td>1</td>
<td>No</td>
<td>Yes: see table 3</td>
</tr>
<tr>
<td>Mary</td>
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<td>White</td>
<td>20</td>
<td>3</td>
<td>Yes: see table 2</td>
<td>No</td>
</tr>
<tr>
<td>Brenda</td>
<td>40/F</td>
<td>White</td>
<td>3</td>
<td>2</td>
<td>Yes: see table 2</td>
<td>No</td>
</tr>
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Table 2: Currently fostering child with 2+ previous placements

<table>
<thead>
<tr>
<th>Foster carer</th>
<th>Current age/gender of child</th>
<th>Age of child at arrival into current placement</th>
<th>Ethnicity</th>
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</thead>
<tbody>
<tr>
<td>Beverly</td>
<td>11 yrs./ M</td>
<td>Age 4mths / returned at age 3 yrs</td>
<td>White British</td>
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<tr>
<td>Mary</td>
<td>7 yrs./ F</td>
<td>5 yrs.</td>
<td>White British</td>
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<tr>
<td>Brenda</td>
<td>6 yrs./ F</td>
<td>5 yrs.</td>
<td>White British</td>
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Table 3: Details of children fostered in the past who have had 2+ previous placements

<table>
<thead>
<tr>
<th>Foster carer</th>
<th>Age of child at that time</th>
<th>Age at first arrival into placement</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harry</td>
<td>4yrs/M</td>
<td>4yrs</td>
<td>White British</td>
</tr>
<tr>
<td></td>
<td>3yrs/M</td>
<td>3yrs</td>
<td>White British</td>
</tr>
<tr>
<td></td>
<td>5yrs/M</td>
<td>5yrs</td>
<td>White British</td>
</tr>
<tr>
<td></td>
<td>3yrs/M</td>
<td>3yrs</td>
<td>White British</td>
</tr>
<tr>
<td>Alice</td>
<td>4yrs/M</td>
<td>4yrs</td>
<td>White British</td>
</tr>
<tr>
<td></td>
<td>3yrs/M</td>
<td>3yrs</td>
<td>White British</td>
</tr>
<tr>
<td></td>
<td>5yrs/M</td>
<td>5yrs</td>
<td>White British</td>
</tr>
<tr>
<td></td>
<td>3yrs/M</td>
<td>3yrs</td>
<td>White British</td>
</tr>
<tr>
<td>Susan</td>
<td>4 yrs/F</td>
<td>4 yrs</td>
<td>White British</td>
</tr>
<tr>
<td></td>
<td>2 yrs/M</td>
<td>2 yrs</td>
<td>White British</td>
</tr>
<tr>
<td>Tony</td>
<td>4 yrs/F</td>
<td>4 yrs</td>
<td>White British</td>
</tr>
<tr>
<td></td>
<td>2 yrs/M</td>
<td>2 yrs</td>
<td>White British</td>
</tr>
<tr>
<td>Beverly</td>
<td>5yrs/M (child focused on in interview)</td>
<td>5yrs</td>
<td>White British</td>
</tr>
<tr>
<td>Joan</td>
<td>3 yrs/F</td>
<td>3 yrs</td>
<td>White British</td>
</tr>
<tr>
<td>Julie</td>
<td>4.5 yrs/M</td>
<td>4 yrs</td>
<td>White British</td>
</tr>
</tbody>
</table>
Research Interview Transcript

R = researcher
P7 = participant 7

R what was it like for you, your experience, of trying to develop a relationship with Andrew?¹

P7 well, when he first came he was a very mixed up child, he had been neglected. The worst part of it was that he had seen his baby sister die. The mom apparently never wanted Andrew and he used to be chucked from one person to another, but I think as a child because he could have been helped he had been to five or six foster carers before me, he was five. He had such a bad upbringing I suppose he had no boundaries. He wouldn’t do as he was told, he would swear and he would kick you and he wouldn’t go to the toilet, he would just poo on the floor, up the walls, everything. He was very disturbed, but for some reason I just felt that if you could keep persevering with him. I got him into pre-school and the teachers were brilliant with him, but he started getting really spiteful to her children, but then he started to bite the teachers, you know, he bit through the teacher. She had her coat on and he bit right through her coat in to her arm and pierced her skin, but he just became more and more violent, and you know it don’t matter what you try and do for him. I thought he wanted the help, but he wouldn’t accept the help, he didn’t want anyone to help.

R you felt he wanted help

P7 I don’t know. There was something about him, he was a child that I felt you could help if you persevered with him, but I think I had him for at least six months, but I don’t know. But after he started to get really violent with the children at school they said ‘oh we just can’t cope with him’ and they persevered with him for a long while but he was too violent for the other children and that he would totally wreck the bedroom, and you know my children, he would just like spit at them and kick them and tell him to do something and oh would just say no and he would swear at you and everything.

R so he seemed to be showing some difficult behaviour for you to manage, how was that for you?

P7 oh it was a very emotional time because it was hard work. I don’t know why I felt he could have help in the end. I realised he didn’t want the help, I mean after he had been taken away from the school cos the school couldn’t cope with him.

¹ Pseudonyms have been used in the transcript to substitute all names in order to preserve anonymity
R  *sounds as if he was expelled from there?*

P7  yeh, he was expelled from school. It got worse cos he had contact with his mom once a month and when he come back he was even worse, you know, very disruptive when he come home. He was a very angry child, very angry, to me he was really hurting inside, you know, he’d seen a lot, I think it really disturbed him the fact that his baby sister had died.

R  *how old was he then?*

P7  he was four when the baby died.

R  *and the baby?*

P7  only a few weeks.

R  *was he at home then at that point ...mmm...cos he had been at a number of foster carers I understand before here*

P7  yeh he had had four of five foster carers before me but because they couldn’t cope with him he kept going back into care and that he had to keep going to other foster carers.

R  *so that was because other foster carers couldn’t cope with his behaviour?*

P7  yeh, like if you tell him something he would just lose his temper and just go and smash anything, eating habits he wouldn’t sit at the table really. I mean it is a horrible thing to say, but he ended up being just like an animal, you know, you just couldn’t teach him anything cos he was so disturbed and you just couldn’t teach him anything and I think it was all to do with his upbringing. The worst part of it must have been when his baby died cos you know he went to his Nan a couple of times but you know apparently he just been left and any food on the floor he would eat from the floor and everything, and he went to another foster carer after me, but then he was put into a residential unit.

R  *so how was that for you?*

P7  it was difficult for me, because I felt that I could have helped him. I felt that I had let myself down and I had let Andrew down.

R  *so was that a sense of disappointment for you?*

P7  yeh, I felt that I should have persevered with him more but I think I did realise that no matter how much I did try and help him he wouldn’t
accept the help, you know. As far as I know, he ended up being put on tablets to try and calm him down a little bit, you know

*R*  
*did he have any illnesses or conditions then?*

*P7*  
no illnesses or any conditions as such.

*R*  
*mmm ...so what support did you have through that experience?*

*P7*  
None. I just, I mean the social worker, I mean there wasn’t at lot of social workers at the time and I just got on with it you once the children come I just treat them as my own and I just get on with things I don’t phone them up and ask for help or nothing

*R*  
*What did you find that helped you with him?*

*P7*  
He did like school and that’s why I couldn’t understand why he got so spiteful at school, you know. I kept saying to him ‘they wont let you go to school, Andrew, you know, if you don’t behave yourself and stop being horrible to the other children.’ They wont let you go and then he would start being nice and saying “oh I’ll be a good boy but then when you put him up to bed he would totally wreck the bedroom he would wee on the floor up the wall, anything go up there and there would just be poo spread over the quilt and everything up the walls. Very disturbed child.

*R*  
*uhm...so he showed some disturbing behaviours that sounded like they might have been difficult to manage...*

*R*  
*I wonder… mmm… would he come to you for looking for affection at all?*

*P7*  
yeh, oh yeh. You could give him a cuddle and everything you know. I would take him to school and go give me a kiss as he went in, but you know, that was what made me feel there was a lot of emotion there that he was too scared to show it he was scared to take affection as well you know you go to give him a kiss and a cuddle but then he’d pull away as if it was wrong for you know to get a cuddle.

*R*  
*was that different or similar behaviour to other children?*

*P7*  
oh it was totally different, you know, you’d feel him at ease a bit when you give him a kiss and a cuddle, and then it was is if something was telling him “you are not allowed to have a cuddle” and he’d pull away from you and he would go out and do something naughty, you know. He would throw something on the floor like in temper.

*R*  
*so he’d pull away then from cuddling...how was that for you?*
it was cold, his emotion. It was really horrible to experience it. I felt angry that I hadn’t persevered longer, I keep thinking that if I had persevered longer then he wouldn’t have gone into that residential. I mean, it wasn’t so bad when he first went cos I thought he was going to another foster carer, but, er, they were taking him to special clubs for disturbed children. But even that didn’t work, and that, but then when I found that he had been moved from that foster carer after a few weeks and out in a residential place, you know, I was annoyed that I didn’t persevere a little longer.

so him moving on into a residential care home left you feeling as if you hadn’t gone on trying long enough?

and yeh, where there just wasn’t enough social workers you couldn’t get the help. I mean, I can get help now, get a lot more, and I say I need this and I need that. They do offer me more help now, but when I had Andrew you didn’t get the help that I get now, I mean you were just left to fend for yourself.

so it seems like it was quite an isolating, lonely, experience at times

oh yeh

and did you have other children in the home at the same time as Andrew?

yeh, my daughter. She’s 18 now.

so it was very difficult, right from the beginning, when he first came to you then... I’m wondering if there was anything that you had found that had been helpful with him?

no, the only thing was school. If he misbehaved then I said “well if you can’t behave yourself I’m not going to school tomorrow”, or “I’ll tell your teacher just how naughty you have been”, maybe he would calm down for a little while and then he would seem to forget what you had just told him and he would start again.

and how was that compared to other children that you’ve had?

I mean, when children have been here for a little while, I mean all children push their luck when they first come, but they learn their boundaries, you know. They know that there are rules and regulations and I normally put those in quite quick when they come here, and I have a naughty chair, you know, “if you don’t do as you are told then you will sit on the naughty chair”. It’s only like one of them chairs at the table but they can’t play with the other children until they done as they are told, its important to get their routine going too, cos Andrew, he was just to getting himself dressed and you ended up fighting with
him to get himself dressed in the morning and try and wash. It was a struggle, it was constantly battling against everything.

R  was that a way of getting closer to you then, or was it as if he was pulling away from you?

P7  yeh, there was fear of someone getting close to him, I feel.

R  mmm... what do you associate that with?

P7  I think it is neglect or sort of. I know he was abused and hit and that at home, but I think he felt that someone showing him affection wasn’t right in his mind. If someone was showing him affection then it might mean that something else was going to happen to him, you know, if he was getting hit and just pushed out of the way and that sort of thing he seemed scared of affection.

R  mmm... what are your thoughts about him having had carers before?

P7  it was as if he had never even been to other carers, he was just like blanked from everything. It was as if he had just blotted everything out, you know. He never ever mentioned any other carers. The only time like he did mention anything was about the baby, like I used to have a little teddy bear and there was another, I think it was probably my daughter, like she had this doll and there was another, I think it was probably my daughter, like she had this doll and he went “oh that looks like my baby”, and that was the first time he had ever said anything... it was very sad.

R  mmm... sounds like there was a lot of sadness... and how did you manage those feelings with him when he did that?

P7  I said to him “oh that’s nice isn’t it”, you know, “that doll’s hair looks like your baby, you can give it a cuddle”, you know, and then I said to him “where is your baby then?” you know, cos you have to be careful what you say, and he said “oh, she has gone to heaven” and I said “oh, well if your baby is in heaven then you could cuddle that little dolly”. I said, you know, “if you think like it’s a real baby, then the baby knows that you are cuddling her”, and a couple of times you see him like, cuddling her, when he thinks no-one is looking at him he would cuddle the doll, but it was very sad, it was really emotional and that, but you couldn’t let him see that you was watching, but I’m very emotional anyway, and things like that really get to me, you know, and then... I have to walk away (laugh)... I won’t talk to him...

R  mmm...it felt like it was too much

P7  yeh.
R what helped you to develop this sensitivity you have for him?

P7 I think in my eyes a child doesn’t ask to be born, and I mean I wasn’t wanted a as a child, and I was beaten up, and I think through my childhood it has made me want to look after children. You know, kids don’t ask to be born and they don’t ask to be beaten up. I mean in my day, I just took it for granted that that was how kids were treated, I mean there wasn’t all the help you can get now, you know. My mom didn’t want me cos I had three brothers and I was the girl and she didn’t want the girl, and I think that is why I have always been so close to children, I mean there is so much help for children.

R uhm...so was it then that there is something for you about being able to understand him because of your own experiences of not feeling wanted by your mom, and so you developed this empathy for children like Andrew.

P7 yeh... I went to stay with me Nan... but then when me Nan died... I had to go back home again. Even me own children I’ve never hit, but there are so many children you could help if only they could accept it, but some of them are so disturbed, feels severely (word unclear at 14.7) like a couple of the children I have had, they are really upset. They have already been taken from their parents and then they go to a foster carer and then they come here to another and it does disturb the children, you know.

R so it seems that it disturbs the children... in what way did you notice it disturbs them?

P7 well their emotional state, and they keep saying that, they feel that, the fact they have been moved from one and then to another, it takes a long time for the child to start trusting you, and they think you are going to chuck them out and then they are going to go to another one.

R can you tell me more about what they say, if anything, to you?

P7 yeh, a couple of them have said “oh, are we gonna have to move again, have we gotta go to another foster carer?” and I said “no”, I said “wait until you see what happens with the social workers,” you know I mean most of the kids do know that they can stay here as long as they can. There was another three that I had for three years, they came for two weeks and then they went to their dad and they came to see me here the other day which was nice.

R so you maintained that contact with them afterwards, how was that important?

P7 yeh it is nice to think that they can trust me to come back. It makes me feel that I have done something that is worthwhile as well, you know.
And for them too, they always know that they can ring me if they got a problem and I will always go and help them or whatever.

R so do you mean they’ve got you for like an extended family and support for them that they haven’t got otherwise then?

P7 yeh, it is like that, and I think that is why with Andrew I felt so negative about myself. I felt like I didn’t do enough to help him and I shouldn’t have just and I felt that I had given up on him and yet I didn’t really give up on him cos he didn’t want the help, he wouldn’t accept the help. I don’t think he got any different when he went to the residential unit, you know, I think that he was so disturbed, you know, that there wasn’t anything anyone could do to help him.

R so that seems to have felt quite painful for you to come to terms with that experience.

P7 yeh, he thought, you know, that I had let him down, you know, dear of him. I think it’s that I don’t like giving up on these children cos I think all kids can be helped, he is the only one that I have given up like that, he was a very unhappy little boy in the first place, you can see that.

R and did you pick up on some of that around him here at home?

P7 oh yeh, his anger sort of, anger in his mind and everything. I think he blames himself for what happened to his sister as well. I think he might have been going through all of it.

R so he was at home with her when she died?

P7 yeh, I think he definitely got the blame for it. There was just something about him that he thought it was his fault or someone had blamed and said it was his fault, cos he had been so naughty. I mean, you don’t know what is going through a child’s mind when they won’t talk, to that as such you don’t know what is going on.

R would he ever open up to you, let you close to him?

P7 no only the once ever, he has never opened up for anyone.

R would he come to you for a cuddle, or try to get close to you?

P7 oh I had to go to him, I would sort of try and play with him and then make it as a joke, and then give him a kiss and say “oh that’s a good boy, you done that well,” but you know, he would carry on playing with you and then he would suddenly realise someone is showing him affection and then the anger would start coming out, and he would just throw his toys.
so as soon as he started to feel closer to you

yeh, he just backed away.

and what if he hurt himself physically, like if he hurt his knee, what would he do?

he would cry, he’d start screaming and I’d think “oh god.” I’d go to him and say “what have you done, Andrew?” and I’d get a tissue with water on it and go to sort of touch it and he would say “no, I’ll do it”, and even like putting a patch on his knee or something, he would have to do that himself, there was hardly any sort of physical contact with him at all.

that was difficult for you, having that distance too.

yeh, when he went to school he did start mixing with other children and he learnt to share, cos he wouldn’t share nothing so he’d start learning to share and everything, but then all of a sudden he didn’t like, he felt that the other children had more stuff than him, and he would get angry with them and start pushing them. He started getting this thing about biting and he punched another little girl in the eye, so I had the parents complain about that and it did start getting really bad, but you know, the teachers, there was one teacher, they got a special teacher in for him, you know, for special needs, and they used to take him to the park, and then he would sit outside like the classroom cos they had a special desk and a chair and everything where they took children outside for special needs, and like Andrew used to go out there, cos he would point out, I don’t think he had been to school before or anything, and he would start pointing out and trying to say the words, but then all of a sudden he would throw it up in the air then there was like no sort of span where he was able to sit down and concentrate on anything. He would sit there for a little while and play with the other children and then he would become very angry and then he start getting very spiteful and bite someone or throw something at someone.

were these sudden, or expected, changes in the ways he behaved?

oh no, they, you just know, it’s one of those instant things like

so it sounds like with his behaviour it was difficult for you to develop trust or

no there’s no trust, he just didn’t trust anyone.

did that change at all during the time that you had him?

well, it wasn’t as bad. He did start trusting me a bit more and there was one teacher he would stay with, just the one teacher that is the teacher

188
that I was really surprised at he bit her arm and he bit through and she was so good with him. She really tired as I did but he just got too violent, she don’t know what started it off. She was walking in the playground and all of a sudden he just turned really violent and started kicking her, and then just bit through her coat. The fact that he pierced her skin that is what the school said “no we can’t have that children being violent to the teachers.”

R so how was that when he came home to you after that incident?

P7 I think I felt annoyed with Andrew, cos I know he enjoys school and he had been warned so many times, and I said to him “why did you do it, now you can’t go to school?” And then the next morning he sort of, like he was creating cos I couldn’t take him to school and I had to take the other children to school, so he had to come with me and he started creating like merry hell he was kicking me and pinching me and everything, and I said “well you can’t go,” I said “look what you done to your teacher.”

R what do you think was happening?

P7 I think he knew what he had done really and then because he couldn’t go to school it was everyone else’s fault you know he would blame everyone else

R that’s seems quite a difficult experience for both of you

P7 yeh, it was frustrating. I think he was blaming everyone else, and I tried to put across to him that it was your fault and you was told to behave yourself and if you want to go to school then you got to do as the teacher tell you he just thought he could do it, and get away with it, but the fact that he had done it too a teacher that was it

R apart from school, were there any other separation experiences from you that

(23.4)

[tape off house phone call/ tape on]

P7 well, I just think that he is never gonna trust anyone. He’s been so damaged, I suppose that you felt he was never going to be able to trust anyone.

R mmm...so, if you think of him wanting to comfort himself when you might have expected him to come to you, did it seem as if he was pushing you away, was that how it was for you with him?

P7 well, I think I put up with it for so long that you just end up just ignoring it. You have to sort of switch off your own feelings, because you are so busy trying to think of different things to do to try and help
him and to try and get his trust, tried all sorts of different things, use of star charts, buy him sweets if he was good, like taking him out up the park. If he was good at school then take him up the park

R as a type of reward like

P7 couple of times it worked, you know, threaten him he can’t go to school, you know, he would behave himself for a little. You know, it was like a switch on and off, so the switch on and off would be like for him he would switch on and off, like you would talk to him and say “if you can’t be nice at school then you can’t go to school,” you know, he seemed to know what I was saying but within ten minutes, he would go back to his usual self.

R so that might seem like the start of coming towards you like trying to start to make a relationship with you and then

P7 yeh, he would like “no I’m not allowed to do that, I have to go back to where I was, I mean the main thing when you get a child is for them to trust you, cos it must be so difficult, I mean with their mom and then the other foster carers and being taken away and coming to people they don’t know. You know, they need to get their trust. I mean, unless you got their trust or know they can trust you, then it is just so difficult cos you know they obviously don’t know what I am going to do next, its hard.

R sounds like the trust is important then, and quite difficult in that its left you with maybe some mixed feelings too.

You said that when he went to bed, he used to get distressed, I suppose he was five then...did he need as much physical care then as a younger one?

P7 well, we had to wash him and clean his teeth and that cos he wouldn’t wash himself or anything no matter how much you tried. Well, he did when he was about three, but then everything just stopped, all seemed to me, I got the impression that when the baby died that was when everything about Andrew changed and that is why either someone blamed him or he blames himself for it.

R so is it that you think then he...mmm...do you know when he originally went into care for the first time?

P7 it had only been about six months before me

R so in those six months he had had about five placements!

P7 yeh, nobody could cope with him cos he was very violent
R oh...that must have been difficult

[P7's adult daughter comes in to room ...tape paused...adult daughter leaves room]

R what would happen if you had other people come to the home to visit?

P7 he would just ignore them!

R so you say he wasn't a child then that would come up and

P7 oh no he wasn't like that, it was like he was a child that was in a shell that was wouldn't break out of it, it's the only way I can describe it really, by trying to break the shell but whoever broke that shell would have a hard job. I feel pleased that I'd sort of persevered so long as six months and I do feel disappointed that I couldn't cope with him any longer. I think I was disappointed cos I knew that with help cos I feel that with help he could have been a really lovely boy, but he just didn't want the help that's what I think, I mean it was such a waste I felt he could have been a lovely boy, but someone had reared him to be like that.

R how was he when he wanted to play?

P7 oh, he would play with a few toys for a little while and then he would jump up on the furniture. Like that's what I mean, it was like a switch on and off, you know, he would sit there for a little while, and then his concentration, and then he would just start being naughty and then just go, it was like he wanted attention, but for the wrong reasons. He wouldn't accept any emotional attention sort of thing or physical, he just wanted everyone to look at him for him to say look how naughty I am and no matter what you say I'm still going to do it.

R what did that leave you thinking about him?

P7 well it was a cry for help in my eyes, he needed something, but I couldn't give him what he needed, I don't know what he needed.

R and that was a struggle for you then, to understand how to help a child like that when it seemed he was pushing you away...maybe it also felt like a sense of rejecting contact

P7 and then he reject just everything.

R and you said there was little support around at the time, what would you have liked to help at the time?

P7 I think if there was someone who could take him just on a one to one basis, people that sort of experience with just one to one and someone
to try and talk to him just on his own, or do things with him or try and talk him, find out of what was wrong with him.

*R* what might have helped you as well if there was any help around at the time?

P7 even if he had just been taken for a couple of hours like, you know, maybe once he come home from school if he could be taken for a couple of hours, cos when he did come home from school, cos once he come home from school he would just go hyper, he like being at school, but then I felt he was blaming me that he was at school. It was just mixed all the time, it was just mixed messages all the time.

*R* so for you then there was a sense of feeling quite confused around what was

P7 yeh, I didn’t know what I could do to help him.

*R* sounds a real struggle... especially when there was no-one else around at the time... what about the GP helping with his behaviour?

P7 well, I take him for his medical, there was nothing medically wrong with him, it was just where he was disturbed from his family life.

*R* and there was no behavioural support available from there like?

P7 no he was just on and off all the time and you think “oh he’s going to start playing now,” but it didn’t last long enough to be able to sit there playing with, or doing drawing and painting with him, well he did start enjoying drawing pictures, but it was more of a like scribble, it was more of a two year old, then he done drawings like he drew picture at school but it wasn’t anything that should have been for a five year old, in my eyes he was mentally disturbed through no fault of his own

*R* when he came home would he come to you to show you his pictures?

P7 oh yeh, he would show me his pictures and say “look what I done,” he’d be really pleased, but then he would switch ‘off’, he’d shown that he was pleased with himself, it was just a constant ‘on and off’.

*R* mmm... interesting that, experiencing him as ‘switching on and off’ that you say

P7 yeh that was how it is seemed to be, that ‘on and off’.

*R* so any show of affection or show of pleasure or anything that feels good then immediately after that he would immediately
yeh, apparently this is what would happen at school, like his teacher said to him “oh, good boy”, cos they were doing sports day or something, and he’d been a good boy helping to put out things, but the minute he got praise that is when he changed.

so how did you work out when to praise him?

yeh, you are constantly thinking what to do, what do I do for the best here, you know. Sometimes it got to the point cos I can’t do nothing to help him, but then you still look at him the next day and you think “no, I can’t give him up”, you know, there will be help there, he will accept it soon, he just never did.

so you felt there was hope, he would change, and you just kept on trying like...

would he look at you in the face... in the eyes

no he’d never look you in the face, he would be quite distant

what about other family members how was he with them?

same with everyone. He wouldn’t develop a relationship with the social worker, he would just like scream and kick in the car and everything, I mean you couldn’t really take him out in the car, cos he would undo the straps and just jump about.

was he dangerous at times to himself as well?

only where he would throw things and things would bounce back off the wall, I found that he tended to attack me more than anyone else, cos I don’t know whether he felt he could do that with me or it was cos he was with me mostly or what. There was just so many mixed feelings with him, it was you know, cos you felt I could do something and perhaps he’d realise that I am not going to hurt him, I am not going to push him away, but then it was him, he didn’t want the help for some reason, you know. He had been so disturbed, whatever caused it was worse when I found out that he had gone into the residential really, I know they have got a lot of staff, but he won’t get the attention I felt, you know, that he needed.

so you felt he needed the attention, but it also felt as if he was pushing you away.

yeh, in my eyes I thought it was as if he wasn’t allowed to have it, as if someone had told him he wasn’t allowed to have cuddles and kisses and affection and then as soon as you start to give it to him he’s fine and then it’s all of a sudden like “no I’m not allowed to do that”, and he would just push you away.
mmm...was there a sense of him wanting to control what was happening around him?

I just felt he felt this was how it was supposed to be.

cos maybe trying to make it like he was used to?... you said he had quick changes in his moods, were there any times when he acted more babyish for his age?

yeh, he would just lay on the floor and start crawling and just things like that. He would just go and sit and sulk if you had said something to him and that's when he would start having his temper tantrums and he would throw things.

I think you have given me a clear picture of how it was, your experiences with Andrew and the struggles, like not only for him but for you as well, when it sounds like you were really wanting to help

yeh, I really thought he would, after being here. The fact he had been to all the foster carers before, I persevered with him, you know, so that he'd realise you know that he don't have to be chucked away all the time and even that didn't work.

so you had a lot of determination

it was more disappointment, then actually wore out, that it didn’t work out

have you had opportunity to talk with the social worker about the disappointment you have felt following Andrew?

(laugh) no! These are things that you have to keep to yourself.

that's sounds quite tough cos children do bring up all sort of emotions for adults as well, particularly ones that have had these experiences.

oh yeh, no, you are supposed to not get attached, you are supposed to just get on with it.

perhaps find it amazing that you can have so many children, and they have difficulties, maybe aggressive too, and you have to cope with all that, and all the separations.......what helps to keep you in it?

I suppose cos there are a lot of people there and you can help them, it's like the little one that just went when she first came, it was like only two hours sleep at night, cos she, it was just constant moaning and walking and everything, but that was only through being neglected, you know, through being left in her cot all day and having a bottle chucked
in her mouth, but she did start to become so good didn’t she, you know, she would start a cup to drink which she wouldn’t have before, I started giving her a cup and uhm she said “I don’t want it.” I said “well, don’t have it then, I leave it on the side,” but then she knew she wasn’t gonna get her bottle, and after a while she would go and pick her cup up and say “thank you,” you know she did start learning didn’t she.

R  uhm, ... are there any other children that you have had apart from Andrew, cos you have had one or two placements, are there any more that come to mind like, did you say?

P7 I had Luke.

R  had he had previous placements too?

P7 yeh.

R  how old was he when he came to you?

P7 Luke was just under two.

R  right, and he had already had a couple of placements?

P7 as far as I know, but I can’t remember about Luke really, I can’t.

R  when did he come to you, after Andrew?

P7 oh he used to do this scream and kick out, “uh-uh, uh-uh, uh-uh”, it was just constant “uh-uh, uh-uh, uh-uh” all the time (laugh) and then it would stop after a time and then Jess, she had Luke after me, a couple of times she has had a lot of mine after me.

R  how long did you have Luke for?

P7 I think it was about six months, and then he went back to, he went to another foster carer and then he went back to his mom, then I found he was back in care again, no it weren’t six months it was about three months weren’t it.

R  apart from the noises he made, what was it like to start to develop a relationship with him at the beginning?

P7 I think he could take your affection when you were showing him attention like, I think the main thing was that he just didn’t sleep and it was that constant noise and you’d play with him and everything and you could get close to him, you know, he would respond to you. He was totally different then Andrew.
R so do you think there was something about an age difference do you think at two he might have been a little more approachable?

P7 no, not really. I’ve had all different ages and I find that all children, once they have got your trust and know that you are not going to hurt them, no matter what age they are, it’s about getting that trust.

R and were you able to develop that with Luke?

P7 yeh I think I did.

R how were you able to develop that with him?

P7 it was just like playing with him mainly or not leaving him sat in that buggy all the time, you know, playing with him, going up the shops with him, just actually going and doing something with him, just actually going and doing things with him ..which is what a lot of children, you know, they don’t get people doing anything with them, they are just left there, just left to think to themselves really, they don’t get no, you know, like being taken over the park, parents don’t do nothing with the child, they’ve got the child but they don’t do nothing with them. They don’t even play out in the garden or anything, don’t play with the toys or talk to them.

R so it sound that you are offering them a different experience in that you offer them play and more time.

P7 yeh, I mean, I think taking them over the park helps them, you know, they seeing other children playing and putting them, you know Claire, even putting them on the swing, she used to laugh so much, she loved being in the swing and its silly little things like that, and I think it’s that day to day one to one attention, this is what I said to social about Claire, she needs one to one constantly, which you can’t do when you got four other children, you can’t give her all the attention.

R mmm that’s an interesting point you made there, are you thinking the same about Andrew too that if he had had one to one too that might have been helpful?

P7 I don’t know with Andrew. I don’t think that would have helped. Afterwards, when you think of everything we tried, I don’t think it would have helped. I think he had been too far disturbed, I mean there are a lot of children it does help when there are other children around, you know, they can play together, they are all mixing together.

R aha..mmm... so how did Andrew get on with other children here?
oh he was violent, he was spiteful to them. If they were playing with toys, he would snatch them off them and go “no, no”.

and Luke?

oh he didn’t pay much attention.

was he interested in what was happening around him?

oh yeh, he would look at what you were doing and everything.

mmm would he approach you for cuddles?

no not really. I think he was too young, he was, he was only two weren’t he, cant remember. Oh yeh. If he was hurt he would come to you, or if I heard him crying I would come in here and pick him up and say “Oh what you done now?”

mmm, how was he with strangers?

no he would take notice with everyone.

mmm would he come to you for cuddles?

he was more sort of a like normal little boy, I think, I mean the main problem was him not sleeping and that noise, you know, it sort of done my brain in the end cos you were so tired and I couldn’t just cope with the noise cos it was such an annoying noise.

what was the noise about?

oh, they said it was just habit to get his own way, to get his mom’s attention, it was more like it was attention seeking.

mmm so that had worked for him before?

so she used to give him everything just to shut him up.

mmm... did it drop off at all towards the end?

no (laugh), no, that’s why I asked the social to move him, couldn’t cope with it.

that sounds like it felt quite difficult.

yeh yeh.

and did he have any quick changes in his emotions and things?
oh he was a bit more placid.

mmm... is there anything else that you might want to tell me about your experiences?

no, not really, think that’s it.

well thank you very much for sharing these experiences with me...I guess it might feel quite daunting sitting here and having me asking all these questions about what it’s like.

no just bringing it back, it makes you think some of the things that some of the children have had, and how many I have been able to help.

yes, and I think it’s important for you to keep hold of that as well.

yeh, cos you can get very down and think what’s the point, and then I look at some of the children, I think at least I’ve done something to help them, I mean, and now it’s nice sort of. I’ve had a lot of contact with social services, it’s nice that they are actually praising me up and telling me that “it’s time you realised how much you are thought of instead of putting yourself down all the time,” you know that is actually nice to hear that from them because you never get any feedback normally about, you know, what you are doing, you know just recently I think they must sort of know that I’ve been feeling a bit down and what’s the point.

how many children have you looked after in total then?

about 20 or 30

whew, how many years have you been fostering?

oh, about 9 years now, before that I was a childminder, before then time wise I was a childminder for 20 years and then I gave that up a couple of years ago, cos they said I couldn’t do childminding and fostering, cos I was getting too many kids. I used to have a mini bus, I used to bung them all in for the day, and we used to go to go to the sea-side for the day, Drake Island, Rhodes park, we were never in, we were always out all the time.

so you must have lots of happy memories too then.

any child that comes here I just treat them as my own, they get balls, they get fizzy things, sweet things same as all mine did, you can’t treat any child different cos they are in care cos in my eyes it’s a child it don’t matter what.
you said your own experiences have helped you now as an adult to understand the children you foster

I think they have all been really helpful cos I mean when I was growing up I thought that was what the daughter was there for, you know, to get a good hiding, to do all the housework, if you don't do all the housework you get another good hiding, you know. In my eyes that was what the girl was for, but you know, I didn't know any different, I never went to school, I wasn't allowed to go to school cos I had to stay at home and do all the housework, and then my dad found out, I mean it's not my dad's fault, my dad was always at work he done three jobs so he never knew. I never been able to blame it on my dad, you know, when I did threaten to tell my dad that's when I got another good hiding (laughs). It's all in my head and I know what happened and that's why it annoys me when you know can't, you give up looking after kids but unless they have been through that experience, they never understand why I do it and how I feel about looking after the kids, people that have had a normal life they can't understand why I do it, and I'm constantly getting criticism, you know, "oh, don't you think it's time to live your own life?" and I say "no," it's something I've always, its me, just...I look after children, these children have been abused.

mmm... so sounds as if other people are not so supportive of you then, it sounds like.

well not now, because I'm like, I'm 49. They are saying well, I've looked after kids all my life, it's time I started looking after my own life. I was never allowed out when I was younger anyway, and I'm not the sort of person that likes going out to night clubs and things like that, it's just not me as a person. I'm quite happy going down to the sea-side, I love being by the sea.

sounds like you have a good understanding of the children that come to you, which seems to have been helpful when you were looking after them
The early phase of undertaking this research was based on my rather optimistic view, and maybe a naive enthusiasm, that my research would roll out as smoothly as I had initially planned, although this view supported me well into the research process. After negotiating the university’s ethical roundabout and struggling to obtain participants, my initial enthusiasm slowly waned. Yet, it was because of these struggles that I gained valuable insights both into the research process and about myself as a researcher. This reflective account presents a flavour of my engagement with the research process and its mutual influence on me as a researcher.

Interviews

Undertaking these interviews with carers raised dilemmas about obtaining the information required for the research as distinct from the broader stories foster carers wished to tell me about that were outside the remit of my study. Management of this aspect required a balance in deciding what to attend to and what not to. The interview process was influenced by undertaking the interviews in the context of foster carers’ homes, with less environmental control. Interruptions, such as barking dogs, cats chewing at my tape, whistling budgerigars and neighbourly visitors needed to be managed without impinging on the content of the interview. I was also mindful that I entered foster carers’ homes in a very different role in comparison to home visiting in my past work; this had a ‘deja-veux’ feel to it and maybe this enabled me to negotiate the experience with relative ease when interruptions from everyday family living arose. However, I was aware of being seen, and of seeing myself, in a different role, i.e. as researcher. My own anxiety around this role difference may have influenced my first few interviews with ‘overly polite’ carers in a way that indicated their perception of me as an ‘authoritative figure’. This might also have been related to my contacting
them via their social work manager. Attending to the ‘research alliance’ in the early part of subsequent interviews seemed to ameliorate this.

In undertaking these interviews, I felt humbled by the carers’ willingness to share in-depth, powerful stories with me as a researcher appearing for one brief episode. Some linked their stories to their own childhood experiences and some of these seemed to parallel their foster child’s distress. Hence, ethically there was a fine balance between maintaining my researcher role and a need to use counselling skills where appropriate. Some of the interviews touched me regarding some of the children’s experiences and powerful feelings of separation and loss that the foster carers needed to contain. At times, I left interviews with a sense of sadness that had resonated with me too.

**Personal process – themes of separation and loss**

I was surprised at how exploring this topic touched my own experiences of past separation and loss. On a conscious level I was aware my interest in exploring this topic may have associations to my own experiences, but I wasn’t prepared for how this research process influenced me on an experiential level. I became more mindful of this during the research and the impact on my personal development.

It feels important to acknowledge the influence of studying and working therapeutically with the psychodynamic approach this year too, for this undoubtedly permeated into the interview, analysis and writing up stages, and would have inevitably influenced those areas of interest to me and what I attended to; both on a conscious and unconscious level. My increasing self-awareness and personal development, my learning within my clinical placement, my use of supervision and my personal therapy, helped me to take care of myself as a researcher, clinician, and on a personal level too. My own experiences of supervision and personal therapy aided the development of my own understanding of where my own feelings, during and following the interviews, were evoked, associated with separation, loss, and sometimes a feeling of helplessness that at times were identified with. I engaged with my own processing alongside my research and my clinical work as part of my personal and professional development. Hence, I learnt more about my own countertransference processes and these resonated with my past learning about
mother-infant interpersonal processes, maternal containment and intersubjectivity. I found my learning about unconscious processes in my psychodynamic therapeutic work this year was influenced by themes of attachment, separation and loss, and hence paralleled the research process that I was engaged in too.

**Analysis**

In the analysis stage, time management and data organisation were challenges. I had chosen manual analysis in order to get a real ‘feel’ of the data, though I hadn’t anticipated over 200 pages: my skills at managing this were tested. However, the advantage of being immersed in the data on paper was that some aspects of the carers’ most meaningful experiences were not missed in the way that computer analysis might do. This immersion also raised doubts within me as to the extent I brought my pre-formed expectations into the research process. The risk of over interpreting the experience of others caused me some conflict resulting in me re-visiting the data yet again. I struggled with holding themes across the group without feeling as if I was losing the individual's unique experiences and perspective. Yet, it was through these experiences that I became acquainted with IPA process as a researcher.

**Writing up and personal influences on the research process**

During the writing up stage, external disruptions in my home impinged on my research in an uncanny, yet parallel, way to the research topic. These involved the departure of some of my housemates during this period, which resulted in physical disruptions within the house involving my move of room, in part to obtain larger space for study and analysing of my research papers. On reflection, I could see how these external influences of change impinged on me as researcher and the emotional links between my own inner and outer world. My experience whilst undertaking this research involved re-reading literature on separation and loss, re-visiting the content of my research, stress from re-locating personal possessions and study materials (amidst studying), and separations and environmental disruptions. However, these experiences enabled me to reflect further on the experience of separation and loss, and the disruption and the emotional/social impact of young children’s emotional and social development when separation, loss and environmental disruptions are experienced at an early stage in their development.
Appendix 13

Notes for Contributors

Counselling Psychology Review

Contributions on all aspects of Counselling Psychology are invited.

Academic Papers: Manuscripts of approximately 4000 words excluding references should be typewritten, double-spaced with 1" margins on one side of A4, and include a word count. An abstract of no more than 250 words should precede the main body of the paper. On a separate sheet give the author’s name, address and contact details, qualifications, current professional affiliation or activity, and a statement that the paper is not under consideration elsewhere. This category may also include full-length in-depth case discussions, as well as research and theoretical papers.

Issues from Practice: Shorter submissions, of between 1000 and 3000 words, are invited that discuss and debate practice issues and may include appropriately anonymised case material, and/or the client’s perspective. As with academic papers, on a separate sheet give the author’s name, address and contact details, qualifications, current professional affiliation or activity, and a statement that the paper is not under consideration elsewhere.

These two categories of submission are refereed and so the body of the paper should be free of information identifying the author.

Other Submissions: News items and reports, letters, details of conferences, courses and forthcoming events, and book reviews are all welcomed. These are not refereed but evaluated by the Editor, and should conform to the general guidelines given below.

- Authors of all submissions should follow the Society’s guidelines for the use of non-sexist language and all references must be presented in APA style (see the Code of Conduct, Ethical Principles and Guidelines, and the Style Guide, both available from the British Psychological Society).

- Graphs, diagrams, etc., should be in camera-ready form and must have titles. Written permission should be obtained by the author for the reproduction of tables, diagrams, etc., taken from other sources.

- Subject to prior agreement with the Editor, papers and other copy may be submitted as e-mail attachments. If you prefer to send hard copy, please include three copies of your paper, together with a large s.a.e. and a copy of the file on disk or CD-ROM.

- Proofs of papers will be sent to authors for correction of typesetting errors, and will need to be returned promptly.

Deadlines for notices of forthcoming events, letters and advertisements are listed below:

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All submissions should be sent to:
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E-mail: h.sequeira@sgul.ac.uk
All submissions and correspondence should include e-mail address, where available.

Book reviews should be sent to:
Kasia Seymanska, Book Reviews Editor,
Centre for Stress Management,
156 Westcombe Hill, London SE3 7DH.
Main theme 3: Sense of agency

Sense of Agency

- Need for reward & recognition
- Need for support
- Helplessness
- Disappointment & sense of failure
- Self efficacy & threat to 'carer' identity
Factors influencing the foster-carer/foster-child relationship

MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Abstract

A cross-sectional design study, using a postal survey, investigated factors influencing the quality of the foster-carer/foster-child relationship. Factors included: the number of previous foster placements a foster child had experienced; the foster carers' parenting stress, empathy, own childhood parental bond and the foster carers' childhood experience of separation, loss or foster care. 114 foster carers responded to a postal survey. No significant difference was found in the quality of the foster-carer/foster-child relationship according to the number of previous foster placements that the children had experienced. Parenting stress accounted for the largest variance (43%) in predicting the quality of the relationship. After controlling for parenting stress, foster carers' perceived childhood parental bond with their own mother accounted for a significant but small amount of the variance. Implications of these findings are discussed.
Introduction

“There are few greater intrusions into a child’s life than separation from parents” (Little, 2005, p. 20). Despite a ‘Quality Protects’ directive (Department of Health (DH), 1999a; 1999b) to local authorities recommending no more than 16% of foster children should have three or more foster placements in one year, multiple placements (three or more) are the experience of 20% of the 61,100 children living in local authority care in England (DH, 2000a; DH, 2000b). For the under 6s age group, this period is an important formative stage in their early social, emotional and cognitive development and, in the main, entry into foster care tends to follow histories of early abuse or neglect by primary caregivers (Berridge, 2005). Webster, Barth & Needle (2000) found in one USA state that 52% of pre-school age foster children had experienced multiple placements. In the UK, the official statistics of multiple placements by age group are not yet publicly recorded at a national level (Department for Education and Skills (DfES), 2003; British Association of Adoption and Fostering (BAAF), 2006). However, in England, 15,000 foster children are under five years old and some foster children under the age of five in the UK have been reported to have experienced five or more placements (DH, 2000a; Rushton & Dance, 2005) with many having experienced more than nine placements before ten years of age; some as many as 25 – 30 followed by their subsequent entry into foster institutions. A further point worthy of note is that 60% of children who have experienced multiple placements have also received mental health care (Cantos, Gries & Slis, 1996).

Much of the early research on children following disruptions in care has focused on socio-emotional development. Bowlby (1969) emphasised the development and continuity of a child’s attachment to their primary carer during the pre-school years as paramount for the child’s psychological health and emotional security (see Chambers, 2004, for a review of the literature on the development of attachment theory and research challenges). The literature has been limited to the degree it has specifically focused on the effects of ‘multiple’ disruptions, thereby serial separations and loss, on the child’s psychological development, including future relationship formation.

Elsewhere (Minnis, Pelosi, Knapp & Dunn, 2001), concerns have been voiced specifically regarding the lack of literature focusing on any specific effects on the
child of multiple foster placements; in situations where children have inevitably suffered repeated separations and loss of primary caretakers. Concerns regarding this issue have also been echoed by fostering and adoption managers (Fordham, 2005; Gill, 2004; Lewis, 2003) regarding these children’s emotional and social development, children who are more likely to have suffered psychological, emotional and social harm before entering the system.

For foster children who have experienced multiple foster placements, experiences of repeated separations and loss of their primary carers are likely to impact further on their social and emotional development (see Chambers, 2004, 2005). As Little’s scathing (2005) account of Sinclair’s (2005) recent, and restrictive, review of foster care literature has emphasised, no clear conclusion has been drawn on the effects of foster care on outcomes since Rutter’s Maternal Deprivation Reassessed was published (1981): and methodologies used have been limited, such as focusing on outcomes at the neglect of process factors.

Again, this point is concerning, given the high number of multiple placements some of these children experience, and subsequent repeated separations and loss of primary carers. Psychologists are increasingly being commissioned in social and health services to work therapeutically with this client group on specific mental health issues and parent-child interpersonal relationship difficulties. As the role of psychology has expanded within services responsible for children who are placed in care, i.e. ‘Looked After Children’ teams in local authorities’ Social Service Departments and in NHS Child and Adolescent Mental Health Teams, and more recently in innovative therapeutic fostering teams, the Counselling Psychologist is well placed to contribute to these developing areas.

In the older child age groups, Sinclair’s (2005) recent government review of key fostering studies noted that foster children display a wide range of difficult behaviours, for example, externalising behaviours, and their behavioural problems exacerbate other difficulties. Further, most have problems in forming subsequent

1 Definition of ‘Looked After Children’: children for whom the Local Authority (Social Services Department) has specific responsibilities under the regulations of the Children’s Act (1989).
trusting relationships because of prior abuse and/or neglect. Sinclair suggests that “in general foster carers who provide ‘authoritative’, ‘responsive’ and ‘encouraging’ parenting were less likely to experience placement breakdowns” (p. 80). Schofield and Beek (2005) acknowledged that for middle age and adolescent age groups, following prior history of abuse and neglect, multiple placements increase the likelihood of developmental difficulties and children need care-giving that is consistent with attachment research, hence care that promotes trust in carer availability, reflective function, self-esteem and autonomy and promotes family membership through identity and belonging.

Also, foster children are more likely to have suffered psychological, emotional and social harm before entering the care system, which is the major reason for them entering care (Quinton, Rushton, Dance & Mayes, 1998). These factors are likely to adversely impact on subsequent experiences of separation and loss that the foster child experiences. Awareness of this is important for Counselling Psychologists to consider in assessing and planning appropriate therapeutic work with clients involved, or who been involved, in fostering contexts, for example, regarding issues for therapeutic engagement, particularly, as higher than expected rates of mental health difficulties among foster children in the care system have been reported (Dimigen et al, 1999; McCann et al, Dunn, 1996; Minnis et al, 2001; Wolkind & Rushton, 1994).

Recent studies investigating formation of new foster-carer/foster-child relationships in the pre-school age group have focused on foster infants, in their first foster placement (Stovall & Dozier, 1998). After twelve months of age on entry into care, infants are likely to have already developed insecure attachment styles and display alienating behaviours, such as aggression towards carers or an aloof, emotional detachment, following from prior abusive or neglectful care (Albus & Doxier, 1999; Dozier, Higley, Albus & Nutter, 2002; Marcus 1991; Tyrell & Dozier, 1999). Lyons-Ruth (1999) also observed attachment related ‘polarised’ response patterns of either avoidance, or over-friendliness. These behaviours adversely challenge the formation of new relationships.
Foster children are also more likely to display alienating behaviours that reject carers' attempts at closeness with them (Stovall & Dozier, 2000; Tyrell & Dozier, 1999). Interpersonal strategies involving approach and/or avoidant behaviours, such as aloofness, aggression or over-friendliness, may make it more difficult for foster carers to negotiate providing secure base relationships (Albus & Dozier, 1999; Tyrel & Dozier, 1999). Foster carers are expected by foster agencies to provide a 'secure base' relationship despite the foster child's increased risk of insecure 'disorganised' attachment strategies and existing trauma from previous adverse care received by the child (Howe, Brandon, Hinings & Schofield, 1999; Main & Solomon, 1986); these factors can lead to displays of alienating behaviours making new relationships difficult. Also, the cumulative effect of separations and loss of primary carers through multiple placements is likely to have a further adverse effect on the child's psychological development and functioning in future relationships with carers, such as severe separation anxiety.

Research appears relatively limited in how foster carers might be expected to provide a secure base in the new attachment relationship for young foster children who predominantly have insecure attachment styles. To date, the majority of foster care trainings have focused on teaching specific behavioural management and problem solving skills sessions based on parent training programmes (for example, see Breston and Eyberg, 1998; Hutchinson, 1997; Webster-Stratton, 19984) and small foster parent supports groups; empirical outcome studies involving evaluations of behavioural change (Minnis & Devine, 2001; Hill-Tout, Pitthouse and Lowe, 2003) have shown disappointing results. However, the wider literature on early parent-infant/child relationship formation does emphasise the importance of interpersonal processes, such as birth mother maternal sensitivity (Belsky & Fearon, 2002), 'maternal empathic reciprocity', also known as 'attunement' (Stern, 1985), and responsiveness of the mother to her child's emotional displays, are qualities that have been found to facilitate optimum birth mother–child secure attachment relationships (Lyons-Ruth, Bronfman & Attwood, 1999; Stern, 1985): these qualities have recently been emphasised in foster infant studies and building therapeutic foster care in this age group (Dozier et al, 2002; Tyrell & Dozier, 1999). However, most of these studies have been short-term observational studies with small samples, although diary
recordings of behavioural observations of newly placed foster infants have recently been included, but they are on the infant age group and do not include infants with multiple placements. However, they do take into account the role of the foster carer in facilitating relationships with the foster infant.

Where there has been research focusing on multiple placements, generally the foster carer’s influence or perspectives on the carer-child relationship has received less attention. Chambers’ (2005) phenomenological study found foster carers emphasised their own empathic qualities in facilitating the foster parent-child relationship for multiply placed foster children, particularly for the building of trust and the child’s use of the foster carer as a ‘secure base’. Trust lies at the theoretical core of both Attachment Theory (Bowlby, 1988) as well as Erickson’s (1968) model of psychosocial and emotional development and healthy relationship functioning.

In the literature, Gilligan (1995) found that foster carers in a remote rural area in Ireland reported that their own childhood experiences influenced their motivation to care for foster children. The influence of childhood experience on current parent-child relating has also been reported (Fraiberg, Adelson & Shapiro, 1980) regarding the adverse effects of early parental loss that can impact on mothers’ parenting of their own children. However, Dando and Minty (1987) found that foster mothers who reported unhappy childhood experiences were viewed by social workers as ‘good foster carers’. This may be due to social workers believing this level of identification created a more cohesive/empathic relationship due to the experiences in their own childhood: a point also reported by foster carers in Chambers’ phenomenological study (2005). Interestingly, some foster carers spontaneously reported that their own childhood experiences of separation and loss had helped them to build relationships with foster children, they also linked this to their empathic ability towards foster children (Chambers, 2005). Further, foster carer empathy towards the foster child and the child’s circumstances has been suggested as a factor towards preventing placement breakdown (Minnis & Devine, 2001). Whether these factors can be seen to influence the foster-carer/foster-child relationship remains to be seen. Further, in the parent-child literature, several studies have found parents’ own childhood parental bonding experiences to be related to the quality of their parent-child attachment relationships
when they become parents (Belsky, Hertzog & Rovine, 1986; Cowan, Cohn, Cowan & Pearson, 1996; Main and Goldwyn, 1995; van IJendoom, 1995, Ward & Carlson, 1995).

Stress has been observed in foster carers whilst caring for foster children (Sinclair, 2005; Sinclair, Gibbs & Wilson, 2004; Wilson, Sinclair & Gibbs, 2000). Stress within the parenting role has been studied as a phenomenon different from stress arising from outside of the parent-child relationship, for example, life events or financial stress, (Abidin, 1990, 1995; Pianta & Egeland, 1990) and the impact this specific stress has on the parent-child relationship. Foster carers have reported requiring increased support to manage challenging behaviours (Maclay, Bunce & Purves, 2006; Triseliotis, Sellick & Short, 1995) and prevent placement breakdown. Hence, foster carer stress needs to be considered as the role of foster carers becomes more ‘professionalised’ (Testa & Rollock, 1999; Wilson & Evette, 2006) and as they are being considered to provide specific therapeutic intervention for foster children in their care.

Also, parenting stress within the foster-carer/foster-child relationship may arise as an important aspect of therapeutic assessment and subsequent therapy. Hence, regarding therapeutic practice, the counselling psychologist needs to be aware of issues that may be an important aspect of therapeutic intervention for clients. Either clients who have been fostered during childhood, foster carers, or adoptive parents may present themselves for individual or family work in response to personal issues or regarding specific interpersonal difficulties with their foster or adoptive child.

Further, factors relevant to influencing the foster-carer/foster-child relationship need to be held in mind for future therapeutic practice. Increased awareness of potential issues likely to be salient for foster carers, as substitute parents, and for adults who have been fostered, seems important for aspects of therapeutic work, for example, in negotiating engagement, developing the therapeutic alliance, and issues associated with separation, loss and ending of therapy. Also, adults who have been in foster care have been reported as higher users of mental health services compared to those who
have not (Dimigen, Del Priore, Butler, Ferguson & Swan, 1999; Mc Cann, James, Wilson, Dunn 1996; Minnis, Pelosi, Knapp, Dunn, 2001).

Awareness of fostering and adoption issues have relevance for continuing professional development. Counselling Psychologists need to be aware of the implications of current policy developments. Indeed, psychologists have only recently become aware (Society, 2006) of the new legislation in the Adoption Support Regulations 2005 (OPSI, 2006), a recent government statutory directive, which stipulates that any therapeutic work with adopted children, adoptive parents or adults adopted as children, now requires the therapist, or their organisation, to register themselves with the official Commission for Social Care Inspection (CSCI). This policy change highlights that an increased importance is finally being given to adoption and fostering field. One can only predict that this may equally apply, in the near future, to the fostering context and hence may have implications for Counselling Psychologists and for continuing professional development.

Most foster care studies have focused on the two older age groups, middle (7-12 years) and adolescent (13-18 years) (Brodzinsky & Schechter, 1990; Newton, Litrownick & Landsverk, 2000; Pardeck, 1983; Pardeck, Murphy & Fitzwater, 1985; Quinton et al, 1998). In children aged 6 and over, research that has mentioned multiple placements has tended to acknowledge it with other factors affecting placements, rather then the specific effects of serial separations and loss of primary carer-givers on the child and its future formation of foster-carer/foster-child. The length of time in foster care has been found to predict children who experienced replacements (Fanshel & Shinn, 1978; Pardeck, 1983, 1984, 1985). Rushton and Dance (2005) further found higher re-placement rates associated with emotional and behavioural problems at children’s entry into care: this supported professionals’ beliefs. Cooper, Peterson and Meir (1987) finding similar results, also found the younger the age of child at entry predicted later disruptions. However, the specific effect of separation and loss itself on children already displaying vulnerable behaviours has lacked specific focus. Further, literature lacks foster children’s or foster carers’ experiences of multiple placements where children have inevitably
suffered repeated experiences of separation and loss, as has been noted by others elsewhere (Minnis et al, 2001).

What is not clear from empirical research is whether or not the number of previous foster placements (with cumulative separations and loss of foster carers) has an influence on a subsequent foster parent–foster child relationship. Most difficulties, such as problem behaviours and high disruption rates, tend to be attributed to the foster child’s adverse history prior to foster care. However, according to attachment theory, if applied to the foster care of children, the number of previous foster placements, and thereby separations and loss of foster carers, are as likely to adversely influence the quality of subsequent fostering relationships, and this impact is likely to compound any impact. This remains a question for empirical research in the context of multiple foster placements to explore, before further investigating the underlying processes applicable to this group of foster carers and foster children by further in-depth studies.

The aim of this study was to investigate whether there was a relationship between the number of previous foster care placements (thereby the number of foster carers) that a foster child has experienced and its influence on the quality of the foster carer-foster child relationship. However, this study also aimed to investigate the potential influence of factors that include: the foster carers’ empathic ability; parental stress on the foster-carer/foster-child relationship; foster carers’ childhood experiences of separation and loss; foster carers’ childhood parental bond, as these have been highlighted as possible influences.

Research hypotheses:

1. A significant difference will be found between the number of previous foster placements the foster child has experienced and the quality of the foster-carer/foster-child relationship.
2. Foster carers' empathy, parenting stress, childhood parental bond, childhood experience of separation or loss, number of placements, significantly predict the quality of the foster-carer/foster-child relationship.
Method

Design
A cross-sectional design was used comprising of a postal survey questionnaire aiming to investigate relationships between the quality of the foster carer/foster-child relationship and number of previous foster placements that the foster child has experienced, foster carers’ parenting stress, foster carer’ empathy, foster carers’ own childhood parental bonds and the foster carer’s childhood experience of separation or loss.

Participants
A random opportunity sample drawn from the 25,000 foster carers currently registered as members of the Fostering Network Organisation (FNO) (previously known as ‘The National Foster Carer Association’). To be included in the study, the participant had to be aged over 18 years, employed as a foster carer either within their local authority or with a private fostering agency, be members of the FNO and currently have a foster child. Additionally, participants were excluded if they were involved in a ‘kinship’ relationship (i.e. if they were related to the foster child).

Sample size
‘A priori’ power calculation was undertaken, as suggested by Cohen (1988), which calculated that the number of participants required to obtain a level of power at .8, a medium size effect at .15, and alpha level at .05, was 91 for each group (total n = 273) with an expected return rate for a postal survey of 33% (Oppenheim, 1992). In order to obtain the minimum of participants required to be returned from this postal survey, 1000 participants were selected.

Measures
A booklet of questionnaires (appendix 1) was used. The first part of the booklet was comprised of demographic questions to obtain factual data relating to the participants and the foster children currently in the participant’s care. The demographic questions related to: participant’s age, gender, ethnic origin, how long they had been registered as a foster carer and if this is their first experience of being a foster carer.
Demographic details related to the foster child/ren currently living in the foster carer’s care: foster child’s age, gender, ethnic origin, age foster child entered care of foster carer and number of previous foster placements experienced by the foster child.

The following section of the booklet comprised of the Child-Parent Relationship Scale (CPRS), Parental Stress Index - Short Form (PSI-SF), Interpersonal Reactivity Index (IRI) and the Parental Bonding Instrument (PBI), plus factual questions devised to ascertain the foster carer’s experience of childhood separation or loss.

**Child-Parent Relationship Scale (CPRS)**

The CPRS (Pianta, 2006) is a standardised pre-validated self-report measure comprising four factors, i.e. conflict, warmth and closeness, overdependence and over-involvement, to form an overall measure of the quality of the child-parent relationship, A total of 30 questions are included, for example, item 25: “Despite my best efforts, I’m uncomfortable with how my child and I get along”. The order of the questions is presented on a 5 point Likert type scale ranging from 1 = Definitely does not apply to 5 = Definitely applies. Possible scores range from 30 - 180 with the higher the total score, the more positive the overall quality of the child-parent relationship. Internal reliability is good (Cronbach’s alpha = .83 for mother-child and .80 for father/parent/other) (Pianta, 2006). The questionnaire was adapted to the foster-carer/foster-child context in this study and the term ‘child’ was modified to the term ‘foster child’. Two questionnaire sets, 25 questions per set, were used and the participant was directed to answer the first set for one of the foster children currently in their care (foster child number 1) and the second set to complete only if they had a second foster child currently in their care also (foster child number 2). Items 2, 4, 9, 11, 12, 14, 15, 17, 18, 19, 21, 23, 24, 25, 27, 28 were reverse scored. Good internal consistency reliability was found in this current study (Cronbach’s alpha = 0.82).

**Parenting Stress Index – Short Form (PSI - SF)**

The PSI-SF (Abidin, 1995) is a standardised pre-validated self-report measure of parenting stress and parent-child relationship. The scale comprises 36 statements each scored on a five-point Likert type scale ranging from 1 = strongly disagree to 5 = strongly agree. Questions 1 – 11 pertained to the foster parent’s stress in a parenting
role: for example, item 2, "I feel trapped by my responsibilities as a parent". The higher the total score the higher the level of stress. The possible scores range from 11 – 55. The next 25 questions were related to the stress the parent felt in their relationship with the child, for example, item 12, "I find myself giving up more of my life to meet my child's needs than I ever expected" and was scored on a 5 point Likert scale ranging from 1 strongly disagree to 5 = strongly agree. The higher the total score the higher the total level of parental stress felt within the relationship with the child. Possible scores ranged between 25 – 125. Two sets of 25 questions per set were used. The first set related to one foster child currently in the participant’s care (known as foster child number. The participant was directed to complete a second set only if they currently had a second foster child in their care also (known as foster child number. The questionnaire comprised of 61 questions in total. The questionnaire was adapted to the ‘foster-parent/foster-child’ context specifically for this study, where the term ‘child’ was replaced with ‘foster-child’ and the term ‘parent’ was modified to ‘foster parent’. This scale has high reliability (Cronbach’s alpha 0.91).

Interpersonal Reactivity Index (IRI)
The IRI (Davis, 1983) is a standardised pre-validated self-report measure of trait empathy. The IRI contains 28 items, with seven items measuring each of four sub-scales, i.e. ‘perspective-taking scale’ (PT), an ‘empathic concern scale’; a ‘fantasy scale’ (FS) and a ‘personal distress scale’ (PD). An example is item 28: “When I'm upset at someone, I usually try to ‘put myself in their shoes’ for a while” (PT). Each statement uses a 5 point Likert type scale ranging from 0 = does not describe me well to 4 = describes me very well. A total score for overall empathy was derived with a range from 0 to 112: the higher the score, the higher the level of empathy. Items 3, 4, 7, 12, 13, 14, 15, and 19 were reverse scored. This scale had moderate internal consistency reliability (Cronbach’s alpha 0.72).

Parental Bonding Instrument (PBI)
Participants’ perceived relationship bond with their own parents was measured using the PBI (Parker, Tupling & Brown, 1979). The PBI is a standardised pre-validated measure (Parker, 1989) of an adult’s recollections of their relationship with their own mother and their own father during the first 16 years of their life. Wilhelm, Niven,,
Parker and Hadza-Pavlovic’s (2005) recent study also showed long term stability of the PBI. The PBI comprises two sets of 25 identical questions in each set. One set of 25 questions specifically related to the participants’ relationship with their mother, such as item 5: (my mother) “was affectionate to me”, and the second set specifically related to the participants’ relationship with their father, such as, item 5: (my father) “was affectionate to me”. A four point Likert scale was used for both sets of answers ranging from 0 = very like to 3 = very unlike. Items 1, 5, 6, 8, 9, 10, 11, 12, 13, 17, 19, 20 and 23 were reverse scored. Total possible scores range from 0 to 75: the higher the score the higher the carer’s perceived bonding with mother or father. This scale has high internal reliability (Cronbach’s alpha for PBIM = 0.92; for PBIF = 0.91).

Carer’s childhood experience of parental separation or loss
A final section asked questions related to participants’ experiences of childhood separation or loss. These questions were devised by the researcher for the purpose of this study to ascertain if the participant’s had had these experiences during childhood. For example, item 3 “as a child, did you experience the permanent loss of one of your parents?”. The response was a tick box, Yes or No. If the answer was yes, participants were directed to answer “how old were you?” by writing the age on the response line indicated, as well as indicating whether the separation or loss was of mother or father.

Procedure
A pilot study of the combined questionnaire booklet was undertaken by the researcher to specifically test the use of the questionnaire and the instructions given. Ten participants, representative of the general population, piloted the questionnaire. A minor adjustment was made subsequently to the structure of questions in the final section on separation and loss to clarify and obtain more details of factual questions, as well as increasing the clarity of the instructions to participants to complete the questionnaire itself.

The FNO were informed of the study details and agreement was secured from the FNO manager regarding the organisation’s participation to gain postal access to the sample. Participants were selected at random (n = 1000) from the members’ mailing
list by the FNO. An introductory information letter (appendix 2) was attached to the front of the questionnaire which explained background to the study and participant exclusion criteria. The FNO then distributed the questionnaires via their established mailing system to protect confidentiality and anonymity. On the questionnaire, participants were requested to answer the carer related questions pertaining to themselves and the child related questions pertaining only to the foster child or foster children currently living in their care. Participants were advised not to write any names, that was either their own or any of the foster children’s names, on the questionnaire, to ensure anonymity. Each participant was then asked to return the completed questionnaire in the freepost SAE envelope attached, to the researcher at the Department of Psychology, University of Surrey. Participants were advised that individual feedback would be offered upon request to the researcher following completion and submission of the research to the University, and that the findings may be submitted for publication. Hence, a brief, written synopsis of the study findings would be made available, via the psychology department’s administrative system or via the researcher’s email contact if the participant requested.

Statistical analysis
ANOVA and Multiple Regression were the statistical tests (Allison, 1999; Tabachnick & Fidell, 2001; Cohen, Cohen, West & Aiken, 2003) applied using the SPSS 13.0 package for Windows. ANOVA statistical analysis was undertaken first to investigate the relationship between the quality of the foster-carer/foster-child relationship and the number of previous foster placements experienced by the foster child. Multiple regression statistical analysis was then used to explore the relationship between the quality of the foster-carer/foster-child relationship, participant’s parenting stress, participant’s empathy, and participant’s own experience of childhood separation, loss or foster care.

Ethical issues
A favourable ethical opinion (appendix 3) was obtained from the University of Surrey’s Ethical Committee prior to the distribution of questionnaires to participants. Anonymity was assured to participants in the information letter attached to the
questionnaires as well as on the questionnaire itself. Return of questionnaires was taken as the individual participant’s consent.

The researcher gave consideration to the potential for distress to be caused by completion of the questionnaire due to the nature of the topic (childhood separation and loss). The FNO inserted telephone contact details of their telephone support line, called Foster-Line, in the same mail pack as the questionnaire was distributed. The researcher and the researcher’s supervisor’s contact telephone at the University department was enclosed on the study information sheet for the participants, should they wish to discuss specific details regarding completion of the questionnaire. Also, participants were advised to seek support via their usual support system of family, friends, or link social worker if they experienced distress evoked by answering questions from the questionnaire. Participants were also given the option of contacting the researcher, or the researcher’s supervisor, if they required specific details of organisations for support.

Data from the questionnaires were stored in accordance with the Data Protection Act (1998) in a secure and locked cupboard, within a locked room, in the Department of Psychology, until they were destroyed personally by the researcher on completion and submission of the research report to the University.
Results

A total of 114 (n = 114) completed questionnaires were returned, indicating a response rate of 11.4%. 101 (88.6%) female and 13 (11.4%) male participants responded.

Age and marital status of foster carers
The mean age of foster carers was 49.28 years (range 27 to 68 years, SD 7.92) and the mean length of time that the participants had been registered as foster carers was 118.08 months (range 1 to 444, SD 108.02). 79 (69.3%) of foster carers described themselves as married, 13 were divorced (11.4%), 11 (9.6%) were co-habitating, six were single (5.3%) and three (2.6%) were widowed.

Occupation of foster carers
Whilst 42 (36.8%) reported their occupation only as ‘foster carer’, 71 (76.3%) reported themselves as also currently employed in other types of work, such as administration, nursery nurses/manager, child-care roles, as well as being a foster carer. Only one (0.9%) was unemployed. 24 (21.1 %) foster carers reported that they were first time foster carers.

Ethnic origins of foster carers and foster children
104 (91.2%) foster carers were reported as White British, 7 (6.1%) as White British – Welsh; one (0.9%) foster carer was White background other – non specific; and two (1.8%) foster carers did not respond to this question. Foster carers reported that the ethnic origins of the foster children currently living in their care were: 135 (80.4%) White British, one (0.6%) White Irish; 13 (7.7%) White background other - Welsh; four (4.24%); six (3.6%) Mixed White and Black Caribbean; one (0.6%) Mixed White and Black African; two (1.2%) Mixed White and Asian; two (1.2%) Mixed White and Black other – not specified; four (2.4%) foster carers did not respond.

Numbers of foster children residing with foster carers, age of foster children and number of female and male foster children.
Although the foster children reported on in this study were not actual participants themselves, foster carers provided the following demographic details. Foster carers (n
reported that a total of 168 children were currently residing in their care (range 1-3; mean 1.47, SD 0.61). 74 (61.2%) of foster carers had one foster child living with them, 40 (33%) foster carers had two foster children living with them and seven (5.8%) had three foster children living with them. Table 1 describes the mean age of the foster children and the number of female and male foster children.

Table 1: Demographic information of participants’ current foster children

<table>
<thead>
<tr>
<th>Number of foster children</th>
<th>Mean age (months)</th>
<th>Female foster children</th>
<th>Male foster children</th>
</tr>
</thead>
<tbody>
<tr>
<td>168</td>
<td>136.21 (SD 56.2)</td>
<td>88 (52.4%)</td>
<td>80 (47.6%)</td>
</tr>
<tr>
<td>(range 24 to 228)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster child 1: 114</td>
<td>136.84 (SD 53.66)</td>
<td>63 (55.3%)</td>
<td>51 (44.7%)</td>
</tr>
<tr>
<td>(Range 24 to 228)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster child 2: 47</td>
<td>137.32 (SD 49.29)</td>
<td>24 (51.1%)</td>
<td>23 (48.9%)</td>
</tr>
<tr>
<td>(Range 65 to 141)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster child 3: 7</td>
<td>118.43 (SD 61.68)</td>
<td>1 (14.3%)</td>
<td>6 (85.7%)</td>
</tr>
<tr>
<td>(Range 7 to 192)</td>
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</tbody>
</table>

Number of previous placements experienced by foster children
56 (33%) foster children had experienced no previous placements, hence, this current placement was their first placement. 29 (17.3%) had experienced one previous placement and 83 (49.4%) had experienced two or more previous foster placements.

Quality of foster-carer/foster-child relationship and the number of previous foster placements.
The foster children’s mean age at arrival into foster care was 103.52 months (range 0.03–192 months, SD 53.45). The mean length of stay of the foster children in current foster placement was 32.32 months (range 1-224 months, SD 34.45). The mean scores for the quality of the foster-carer/foster-child relationship (as measured by the CPRS-SF scale) was 109.93 (SD 15.20) for children who had had no previous foster placement (n = 56); the mean score was 110.65 (SD 16.48) for children who had had one previous foster placements (n = 29); and for children who had had two or more
previous placements (n = 83) the mean score was 106.71 (SD 14.98). A one-way between groups analysis of variance was undertaken to ascertain whether any differences could be found in the quality of the foster-carer/foster-child relationship (as measured by the CPRS-SF) according to the number of foster placements the foster children had previously experienced. Hence, foster carers were placed into three groups according to their foster children’s number of previous placements, i.e. no previous placement; one previous foster placement; two or more previous foster placements. No statistically significant difference was found between these groups (F(2, 165) = 1.10; n.s. as p>0.05).

Foster carers’ empathy, parenting stress, foster carers’ parental bond with their mother and father, and foster carers’ separation or loss of their mother or father. Table 2 describes the means and range for foster carers’ level of empathy, as measured by the Interpersonal Reactivity Index (IRI), the foster carers’ level of parenting stress, as measured by the Parenting Stress Index – Short Form (PSI-SF), and the foster carers’ childhood parental bond with their own parents, as measured by the Parental Bonding Instrument (PBI).

Table 2: Mean scores of foster carers’ level of empathy, parenting stress and foster carers’ parental bond with each of their parents

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emptiy</td>
<td>62.98 (SD 10.72)</td>
<td>39.00</td>
<td>90.00</td>
</tr>
<tr>
<td>Parenting Stress</td>
<td>126.80 (SD 20.46)</td>
<td>66.00</td>
<td>170.00</td>
</tr>
<tr>
<td>Parental Bond with mother</td>
<td>49.82 (SD 14.16)</td>
<td>19.00</td>
<td>75.00</td>
</tr>
<tr>
<td>Parental Bond with father</td>
<td>49.88 (SD 14.18)</td>
<td>5.00</td>
<td>74.00</td>
</tr>
</tbody>
</table>
24 (21.1%) foster carers had experienced separation from their mother and six (5.3%) had experienced the loss of their mother. 84 (73.7%) foster carers had experienced no separation or loss from their mother.

31 (27.2%) of foster carers had experienced separation from their father and 6 (5.3%) had experienced loss of their father. 77 (67.5%) had had no experience of separation or loss from their father.

*Empathy, parenting stress, childhood parental bond; foster carer age as predictors of the quality of the foster-carer/foster-child relationship*

A standard multiple regression analysis was used to investigate factors predicting the quality of the foster-carer/foster-child relationship for foster child 1 \( (n = 114) \). The factors investigated included: empathy, parenting stress, foster carers' childhood parental bond and separation or loss of own mother or father, foster carers' age, occupation, education, marital status, ethnic origin, length of time registered, number of children born, plus age, gender, ethnic origin of foster child, gender of foster child, number of foster children currently fostering, own parental bond and childhood separation or loss of own mother or father. The model arising from the standard regression analysis had only one significant predictor variable \( (F(20, 68) = 4.27, p<0.0001) \): parenting stress (as measured by the Parenting Stress Instrument – Short Form) which accounted for 43% of the variance explaining the quality of the foster-carer/foster-child relationship (see table 3 over page).
### Table 3: Factors predicting the quality of foster-child/foster-carer relationship

<table>
<thead>
<tr>
<th>Standard Regression</th>
<th>R</th>
<th>R²</th>
<th>AR²</th>
<th>B</th>
<th>β</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Status</td>
<td>.75</td>
<td>.56</td>
<td>.43</td>
<td>.038</td>
<td>.67</td>
<td>4.27</td>
</tr>
<tr>
<td>Age of f/carer</td>
<td>.75</td>
<td>.56</td>
<td>.43</td>
<td>-.003</td>
<td>.97</td>
<td>4.27</td>
</tr>
<tr>
<td>Gender of f/carer</td>
<td>.75</td>
<td>.56</td>
<td>.43</td>
<td>-.044</td>
<td>.66</td>
<td>4.27</td>
</tr>
<tr>
<td>Education</td>
<td>.75</td>
<td>.56</td>
<td>.43</td>
<td>.004</td>
<td>.96</td>
<td>4.27</td>
</tr>
<tr>
<td>Number born</td>
<td>.75</td>
<td>.56</td>
<td>.43</td>
<td>.000</td>
<td>.10</td>
<td>4.27</td>
</tr>
<tr>
<td>Number adopted</td>
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<td>.56</td>
<td>.43</td>
<td>.075</td>
<td>.43</td>
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</tr>
<tr>
<td>Number fostered</td>
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<td>.56</td>
<td>.43</td>
<td>.068</td>
<td>.44</td>
<td>4.27</td>
</tr>
<tr>
<td>F/child 1 age</td>
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<td>.43</td>
<td>-.443</td>
<td>.33</td>
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</tr>
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<td>F/child 1 gender</td>
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<td>.56</td>
<td>.43</td>
<td>-.023</td>
<td>.81</td>
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<td>F/child 1 has learning disability</td>
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<td>.56</td>
<td>.43</td>
<td>.074</td>
<td>.42</td>
<td>4.27</td>
</tr>
<tr>
<td>Emergency Placement</td>
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<td>.56</td>
<td>.43</td>
<td>.032</td>
<td>.74</td>
<td>4.27</td>
</tr>
<tr>
<td>Length of stay</td>
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<td>.56</td>
<td>.43</td>
<td>.123</td>
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<td>.56</td>
<td>.43</td>
<td>.417</td>
<td>.33</td>
<td>4.27</td>
</tr>
<tr>
<td>F/child 1 number of previous placements</td>
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<td>.56</td>
<td>.43</td>
<td>-.066</td>
<td>.49</td>
<td>4.27</td>
</tr>
<tr>
<td>Parenting Stress</td>
<td>.75</td>
<td>.56</td>
<td>.43</td>
<td>.676</td>
<td>.000**</td>
<td>4.27</td>
</tr>
<tr>
<td>Carer empathy</td>
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<td>.43</td>
<td>.154</td>
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</tr>
<tr>
<td>Parental bond with mother</td>
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<td>.56</td>
<td>.43</td>
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</tr>
<tr>
<td>Parental bond with father</td>
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<td>.56</td>
<td>.43</td>
<td>-.007</td>
<td>.95</td>
<td>4.27</td>
</tr>
<tr>
<td>Separation/loss mother In childhood</td>
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<td>.56</td>
<td>.43</td>
<td>.011</td>
<td>.92</td>
<td>4.27</td>
</tr>
<tr>
<td>Separation/loss father In childhood</td>
<td>.75</td>
<td>.56</td>
<td>.43</td>
<td>.112</td>
<td>.20</td>
<td>4.27</td>
</tr>
</tbody>
</table>

**p<0.0001
Predictors of foster-carer/foster-child relationship quality

As parenting stress was found to be a significant predictor of the quality of the foster-carer/foster-child relationship, mediation regression analysis was not warranted. However, as carers' scores on the Child-Parent Relationship Scale and the Parenting Stress Index – Short Form showed high correlation ($r = .681$), it seems that they may be measuring similar underlying constructs.

Therefore, a further regression analysis was performed to ascertain predictors of foster-carer/foster-child relationship quality, whilst controlling for parenting stress. The foster carers' parental bond with their own mother was the only variable found to be have a statistically significant value to predict the foster-carer/foster-child relationship ($F(19, 69) = .84, p < 0.05$) (See table 4 on over page).
Table 4: Factors predicting quality of foster-carer/foster-child relationship, after controlling for stress

<table>
<thead>
<tr>
<th></th>
<th>R</th>
<th>R²</th>
<th>AR²</th>
<th>B</th>
<th>β</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>F/child 1 number of previous placements</td>
<td>.43</td>
<td>.19</td>
<td>-.04</td>
<td>-.14</td>
<td>.27</td>
<td>.84</td>
</tr>
<tr>
<td>Marital Status</td>
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<td>.19</td>
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<td>.03</td>
<td>.82</td>
<td>.84</td>
</tr>
<tr>
<td>Age of foster carer</td>
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<td>.19</td>
<td>-.04</td>
<td>-.10</td>
<td>.47</td>
<td>.84</td>
</tr>
<tr>
<td>Gender of foster carer</td>
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<td>.19</td>
<td>-.04</td>
<td>-.20</td>
<td>.19</td>
<td>.84</td>
</tr>
<tr>
<td>Education</td>
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<td>.19</td>
<td>-.04</td>
<td>-.01</td>
<td>.97</td>
<td>.84</td>
</tr>
<tr>
<td>Number born</td>
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<td>.19</td>
<td>-.04</td>
<td>.05</td>
<td>.69</td>
<td>.84</td>
</tr>
<tr>
<td>Number adopted</td>
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<td>.19</td>
<td>-.04</td>
<td>.10</td>
<td>.44</td>
<td>.84</td>
</tr>
<tr>
<td>Number fostered</td>
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<td>.19</td>
<td>-.04</td>
<td>.10</td>
<td>.40</td>
<td>.84</td>
</tr>
<tr>
<td>F/child 1 age</td>
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<td>-.04</td>
<td>-.41</td>
<td>.50</td>
<td>.84</td>
</tr>
<tr>
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<td>.19</td>
<td>-.04</td>
<td>-.07</td>
<td>.60</td>
<td>.84</td>
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<tr>
<td>F/child 1 learning disability</td>
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<td>.19</td>
<td>-.04</td>
<td>.04</td>
<td>.76</td>
<td>.84</td>
</tr>
<tr>
<td>F/child 1 age arrived</td>
<td>.43</td>
<td>.19</td>
<td>-.04</td>
<td>.33</td>
<td>.56</td>
<td>.84</td>
</tr>
<tr>
<td>F/child 1 length of stay</td>
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<td>.19</td>
<td>-.04</td>
<td>.15</td>
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<td>.84</td>
</tr>
<tr>
<td>Emergency placement</td>
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<td>.19</td>
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<td>-.05</td>
<td>.72</td>
<td>.84</td>
</tr>
<tr>
<td>Carer empathy</td>
<td>.43</td>
<td>.19</td>
<td>-.04</td>
<td>.14</td>
<td>.27</td>
<td>.84</td>
</tr>
<tr>
<td>Parental bond with mother</td>
<td>.43</td>
<td>.19</td>
<td>-.04</td>
<td>.33</td>
<td>.02*</td>
<td>.84</td>
</tr>
<tr>
<td>Parental bond with father</td>
<td>.43</td>
<td>.19</td>
<td>-.04</td>
<td>-.07</td>
<td>.61</td>
<td>.84</td>
</tr>
<tr>
<td>Carer separation/loss mother in childhood</td>
<td>.43</td>
<td>.19</td>
<td>-.04</td>
<td>-.17</td>
<td>.22</td>
<td>.84</td>
</tr>
<tr>
<td>Carer separation/loss father in childhood</td>
<td>.43</td>
<td>.19</td>
<td>-.04</td>
<td>.11</td>
<td>.35</td>
<td>.84</td>
</tr>
</tbody>
</table>

*p<.05
Discussion

The aim of this study was to investigate whether the number of previous foster placements was related to the quality of the foster carer/foster-child relationship. A further aim was to explore whether other factors influenced this relationship, i.e. parenting stress, empathy, foster carers’ childhood parental bond, foster carers’ childhood parental separation or loss. Results found no significant differences between the number of previous placements a foster child has experienced, i.e. none, one, two or more, and the quality of the foster-carer/foster-child relationship. However, the results did find that parenting stress accounted for a large and significant proportion of variance in the quality of the foster-carer/foster-child relationship. Foster carers’ childhood parental bond with their own mother made a significant and unique contribution, although this was small.

A significant difference was not found between the numbers of previous placement children had experienced and the quality of foster-carer/foster-child relationship (hypothesis 1) in this study. However, these results need to be interpreted tentatively, particularly in respect of the low response rate that did not meet the expected power. Research has associated higher foster placement disruption outcome rates and behavioural difficulties for children who have histories of multiple placements (Rushton & Dance, 2005; Pardeck, 1983, 1984; Pardeck, Murphy & Fitzwater, 1985) suggesting a potential influence on the quality of the carer-child relationship. Although this study did not seek to measure child behaviour, this is a factor that may be worthy of further investigation.

The association of parenting stress was found to account for a large proportion of variance in the quality of foster-carer/foster-child relationship (hypothesis 2). This finding may not be unexpected given the increasing demands on foster carers to care for children displaying more challenging interpersonal and emotional disturbance. Although no child behaviour assessment was undertaken in this current study, behavioural factors might account for the high parenting stress previously found (when institutional care was predominantly used. Behavioural difficulties are likely to be reflected to some extent within the carer-child relationship, and have been cited as
associated with placement disruption rates and (Pardeck, 1983; Rushton and Dance, 2005). However, as the PSI-SF scale was also found to highly correlate with the CPRS ($r = 0.681$), although this is still just below the 0.70 cut off point recommended as too highly correlated by Tabachnick and Fiddell (2001), this was kept within the multiple regression. The strength of its correlation with the CPRS should, however, be born in mind for future studies. A too high correlation (i.e. >.70) between scales results may mean it may be measuring the same construct, and hence the variance of the other factors in the regression may have been taken up by the stress measure.

Although the finding that foster carers’ own childhood parental bond showed a statistically significant result accounting for a small amount of variance in the quality of the relationship, it is unlikely in this study to provide support for the influence of early internalised relationships on current parent-child relating; this could be a factor worthy of exploring further regarding the foster-care/foster-child relationship context. Empathy failed to account for any significant variance, when this might be an expected factor that contributes to the foster-carer/foster-child relationship. Empathy has been emphasised as an important factor in other relationships, e.g. therapeutic and education contexts (Rogers, 1970) and has been reported to have a close alignment to sensitivity and responsiveness, which it has been equated with elsewhere (Davis, 1983). However, empathy has been reported as a difficult construct to define and investigate (Gladstein, 1983). It may be that this construct itself is not the most appropriate in the fostering context and the use of a more traditional parent-child measure may be more useful. Further, childhood separation or loss was not found to be a factor; this may be because of the low proportion of foster carers who had experienced childhood separation or loss compared to the high proportion that had not had this experience. This aspect might be improved by an independent study investigating this aspect and use of a control foster carer groups.

Despite a relatively high distribution, limitations of this study include an 11.4% response rate. Use of a postal survey may have contributed to this low response. Although postal questionnaire methods are reported to have lower response rates (Oppenheim, 1992), response was particularly low in this study. Hence, this is likely to be a biased sample and findings cannot therefore be generalised. Another
contributing factor may be the posting procedure used. One participant telephoned the researcher with concerns regarding the university’s freepost number on the return envelope supplied with the questionnaire and asked whether this could be a personally identifying number. Improvement in future postal research would be to explain the Freepost numbering system in the information letter provided. As anonymity and confidentiality are an aspect particularly emphasised within the system of foster care, this is likely to underpin participants’ concerns more for this group. Further, lower response rate and sample size also meant that further sub-group analyses, i.e. comparison of specific age groups of children could not be viably undertaken in this study: the under 6 age group of foster children were under-represented whilst the adolescent age-group were over-represented.

Other foster carer postal surveys have shown higher response rates accessing samples via local authorities, however, despite this Beck’s (2006) recent postal survey returned a relatively low response of 25% in one local authority. Perennial pressures on local authority departments combined with study schedule limitations, restricted this researcher’s access via this route, which may have resulted in improved response rates, but would have been much slower in terms of negotiating inherent difficulties of government department to access this participant group, as has been reported by more seasoned researchers (Minnis et al, 1999). As a group, foster carers have been reported as low responders to other methodologies too (Quinton, Rushton, Dance & Mayes, 1998).

Those who replied may have been motivated foster carers. Reasons for high non-response rate may include: foster carers who are struggling with particular foster care difficulties with current foster children may be less inclined to want to focus on these by completing questionnaires; foster carers time limitations due to the nature of the fostering role and its demands, for example, as one participant telephoned the researcher to report: “generally foster carers as a group are often too busy with demands from the fostering situation as well as further demands on their time from social services, such as attending meetings, and restrict them from responding”. Also, the sensitive nature of a study undertaken by an unknown researcher, compared to research undertaken through known research teams via foster carers social service
department or fostering agency may have limited responses: other studies have accessed this population via known links in social service gateways. Other factors may include a lengthy questionnaire and sensitive nature mentioned earlier of the subject matter.

The use of self-report data, instead of clinical interviews or observational methods, and retrospective accounts (e.g. of childhood parental bonds), which may not be indicative of actual experience have been criticised for unreliability (Brewin, Andrews & Gotlib, 1993). However, the CPRS, PSI-SF, IRI and PBI have indicated good reliability and validity in previous studies as indicated below. A further limitation may be that the adaptation of measures to the fostering context challenged validity. Further validity studies could demonstrate validity in this context.

The CPRS scale has high internal consistency reliability and its items were parent-child relationship focused, adapted by its author from his earlier student-teacher relationship scale (STRS) (Pianta, 1998, 1999; Pianta & Steinberg, 1992) and is valid regarding it deriving from a literature review on carer-child interactions, attachment theory and the attachment Q-set (Waters & Deane, 1985). However, the CPRS was derived from a non-foster sample/context; hence it may not be so easily extrapolated to the fostering context. Improvement could be the use of the ‘Expression of Feelings Questionnaire’ (EFQ) devised by Quinton, Rushton, Dance and Mayes (1998), used in studying long term placed foster children, although the reliability of this scale remains uncertain, or a valid questionnaire could be developed and tested for correlation with measurements used in observation studies.

The PSI-SF has been well used in published studies across a wide range of differing parent-child groups, e.g. learning disabilities; abusive parenting contexts, and has showed high internal consistency reliability (Abidin, 1995) as was found also in this current study (Cronbach’s alpha 0.92). However, the PSI-SF has been validated on children in age groups 2-14 years and its validity for the 14-18 years age group may not be so valid and may need to tested against a measure for adolescents to ascertain this aspect: adolescents developmental negotiation between independence and
dependence may have impacted on stress in the parent-child relationship which may be more difficult to negotiate in the fostering context.

Although adequate internal consistency was shown in this current study, this was relatively low. Empathy also has a range of definitions and conflicts regarding valid measures have been reported (Gladstein, 1983; Moore, 1990). The scale offers both cognitive and emotional aspects that Davis (1983) argues should be incorporated, and these seemed appropriate for this context. However, two of the IRI’s four underlying constructs, i.e. personal distress and fantasy, have been challenged as to their accuracy in reflecting interpersonal empathy. Also, the IRI may not be as valid a measure of carer empathy if this is equated to the concept of maternal sensitivity and responsiveness in the biological parent-child context: hence validity may be impaired in the fostering context. Improvement might be to use the ‘Sensitivity to Children Questionnaire’ (SCQ), or test the IRI’s validity against this measure.

The PBI was deliberately designed to obtain a ‘product moment of innumerable experiences’ (Parker, Tupling & Brown, 1979; Wilhelm & Parker, 1990) so that the instructions force a general assessment of the parent that limits variation in differing developmental stages. Validity studies of the PBI (Mackinnon, Henderson & Andrews, 1991; MacKinnon, Henderson, Scott & Ducan, 1989; Parker, 1986) showed that the PBI measured actual and observable, not just perceived, parenting, despite being a recalled and retrospective account (Gerlmsa, 1994): memory recall ability could not have been controlled for in this postal survey, but this may be worthy of further investigation in the fostering context. The use of the PBI showed high reliability in this current study and its advantages include: high test-re-test reliability; independent of participants’ gender (Parker, Tupling & Brown, 1979) and mood state (Parker, 1989; Wilhelm & Parker, 1990); long-term stability (Parker, 1986; Wilhelm, Niven, Parker & Hadzi-Pavlovic, 2005). However, the PBI has been criticised for its use of a two factor construct (Murphy, Brown & Silka, 1997) and it has been modified to three factors, i.e. care, overprotection and abuse, in adult psychiatric samples. However, the current study was assumed to be non-clinical, as required to meet foster carer registration.
A factor that could have influenced the response rate may be the sensitive nature of the questions on separation and loss, and this aspect should be considered in future studies. A statement clarifying separation and loss definition may have been helpful, as ambiguity resulted in some foster carers responding equally to separation as well as loss. Also, order effects could not be controlled as a postal survey was used and foster carers could complete these in any order in the researcher's absence. Further, socially desirable answers are highly likely to occur in this population, who may wish to be seen as 'good' and 'coping' foster carers, although in order to counteract this effect, foster carers were asked to answer as truthfully as possible. Also, foster carers prior knowledge of children's number of previous placements may have impacted on carers' willingness to accept certain foster children, such as high behaviour problem children, therefore contributing a bias. Improvement might be to direct research through local authority service gateways where this aspect could be controlled for. Similarly, in this way the type of foster placement could be controlled for, which was not possible in this study due to the use of a postal survey.

Although the findings from this study may be limited in the extent to which they contribute to advancing knowledge in this area, the importance of raising Counselling Psychologists' awareness regarding fostering context issues are relevant for continuing professional development. This is particularly relevant considering the high rates of children who have experienced multiple placements that have also received mental health care (Cantos et al, 1996), and the number of adults who have been in foster care who are high users of mental health services (Dimigen, et al, 1999; McCann, et al, 1996; Minnis, et al, 2001). Hence, Counselling Psychologists may provide therapeutic treatment to clients who have been fostered, to foster carers or adoptive parents who present for individual or family work, in response to their own difficulties or interpersonal difficulties with their foster child. Further, parenting stress also seems an important factor to consider when working with foster carers or fostered children.

Further, psychologists are increasingly being commissioned by social services and health services sectors to work therapeutically with foster carers, foster children and fostered adults. Hence, the role of psychology has expanded within these services, for
example with/in, 'Looked After Children'\(^2\) teams in local authorities and in NHS Child and Adolescent Mental Health Teams, and more recently in innovative therapeutic fostering teams; the counselling psychologist is well placed to contribute to development in these areas.

Counselling Psychologists may also have a consultative role regarding preventative services to foster carers, on an individual or group basis, to foster carer training programmes and social workers, to primary health care services for health visitors and support workers, or NHS Mental Health Services, e.g. Child and Adolescence Mental Health Service. Hence, this study is not only relevant to Counselling Psychologists working at the secondary or tertiary end of the fostering experience. As the new concept of 'Therapeutic Foster Parent' develops, Counselling Psychologists need to be aware of new developments in this area and the potential for expansion of the psychologist’s role into this field, in a therapeutic, consultation or training capacity. Further, Sinclair (2005) emphasised not only that further research is required in the fostering field, but that the difficult task facing foster carers needs to be recognised: this also needs to be held in mind by the counselling psychologist when seeing foster carers and/or foster children.

Counselling Psychologists are well placed to expand their psychological skills and competencies as researchers, theoreticians and practitioners to influence future policy development, i.e. regarding standards and best practice in meeting the needs of foster children. Findings from this current study may be informative for other therapists, researchers, child-care workers, e.g. in Sure Start initiatives; the British Association for Adoption and Fostering; those matching foster and adoptive placements; and add information to debates regarding young children in care.

_Conclusion and future directions_

In this study, an investigation exploring previous placements and quality of relationship was undertaken, as well as factors including empathy, parenting stress, carers’ own childhood parental bond, separation or loss. The main hypothesis was not

\(^2\) Definition of 'Looked After Children': children for whom the Local Authority (Social Services Department) has specific responsibilities under the regulations of the Children’s Act (1989).
supported in that the number of previous placements did not predict the quality of the foster-carer/foster-child relationship. However, parenting stress accounted for a large amount of variance in the quality of the foster-carer/foster-child relationship. Methodological limitations such as use of valid questionnaires and the relatively low response rate restrict findings to this study alone. Further studies could be undertaken to investigate the effects on a larger and potentially less biased sample and controlling for foster children’s age, length of stay, foster carer placement type and behavioural influences.

Key words: Foster-carer/child-relationship; Multiple placements; Separation; Loss.
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Appendix 1

Thank you for participating in this research study.

Please complete the following information questions about yourself on this page (page 1) and about the foster child/ren that are living with you now on the next page (page 2). Please do not enter any names on this questionnaire in order to maintain anonymity. The information that you do give in this questionnaire will not be used to identify you in any way. If you don’t wish to answer some of the questions, please do not feel pressurised to do so.

Please either circle your response, tick box, or write on the dotted lines next to the questions.

1. Marital status: Married Single Divorced Widowed Co-habiting


5. Education: CSE GCSE A level Degree Masters Doctorate

6. Number of children: (please do not put any names)
   a) Born to you ....... b) Adopted by you: ....
   c) Currently fostered by you.......  

7. How would you describe your ethnic origins?  
   Choose one section from (a) to (e) and then tick the appropriate box to indicate your ethnic origins.

   a/ White
   British □ Irish □
   Any other White background (please specify) ...........

   b/ Black or Black British
   Caribbean □ African □
   Any other Black background (please specify) ...............

   c/ Mixed
   White and Black Caribbean □ White and Black African □ White and Asian □
   Any other mixed background (please write in here) ...............

   d/ Asian or Asian British
   Indian □ Pakistan □ Bangladeshi □
   Any other Asian background (please specify) ...................

   e/ Chinese or other ethnic group
   Chinese □ Any other background (please write in here)........

1 The format of this question is taken from the 2001 UK census
8. How long have been registered as a foster carer? ...... years

9. Regarding the foster child/ren living with you now, is this the first time that you have fostered? 
   Yes □ No □ 

PLEAS ANSWER THE REST OF THE QUESTIONNAIRE BASED ONLY ON THE FOSTER CHILD, or FOSTER CHILDREN, LIVING WITH YOU NOW

10. FOSTER CHILD NO 1:

    Age: ........ Gender: Female Male

    Ethnic origin of child (write in words as in Q7) .............

    Age of child when arrived into your care: .............

    How long has child lived with you? Year/s ........ Months ........

    Is this an emergency placement? Yes □ No □

    Number of previous foster placements this foster child has had, including emergency placements: 
        0 1 2 or more

11. FOSTER CHILD NO 2:

    Age: ........ Gender: Female Male

    Ethnic origin of child (write in words as in Q7) .............

    Age of child when arrived into your care: .............

    How long has child lived with you? Year/s ........ Months ........

    Is this an emergency placement? Yes □ No □

    Number of previous foster placements this foster child has had, including emergency placements: 
        0 1 2 or more

***IF YOU HAVE MORE THAN 2 FOSTER CHILDREN LIVING WITH YOU NOW - then please continue by adding in on a separate sheet to provide the same information as above for each additional foster child and clearly label in the same way to identify child number as for foster child one and two as above, e.g. foster child 3.
The following questions relate to how you feel about your relationship with foster child no 1 (as in foster child no 1 on page 2 of this questionnaire). Please reflect on the degree to which each of the following statements currently applies to your relationship with your foster child.

**FOSTER CHILD NO 1 : age ........ (please do not write in any names)**

Using the scale below, circle the appropriate number for each item.

<table>
<thead>
<tr>
<th>Definitely does not apply</th>
<th>Not really</th>
<th>Neutral, not sure</th>
<th>Applies somewhat</th>
<th>Definitely applies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. I share an affectionate, warm relationship with my foster child.  
2. My foster child and I always seem to be struggling with each other.  
3. If upset, my foster child will seek comfort from me.  
4. My foster child is uncomfortable with physical affection or touch from me.  
5. My foster child values his/her relationship with me.  
6. My foster child appears hurt or embarrassed when I correct him/her.  
7. My foster child does not want to accept help when he/she needs it.  
8. When I praise my foster child, he/she beams with pride.  
9. My foster child reacts strongly to separation from me.  
10. My foster child spontaneously shares information about himself/herself.  
11. My foster child is overly dependent on me.  
12. My foster child easily becomes angry at me.  
13. My foster child tries to please me.  
14. My foster child feels that I treat him/her unfairly.  
15. My foster child asks for my help when he/she really does not need help.  
16. It is easy to be in tune with what my foster child is feeling.  
17. My foster child sees me as a source of punishment and criticism.  
18. My foster child expresses hurt or jealousy when I spend time with other foster children.  
19. My foster child remains angry or is resistant after being disciplined.  
20. When my foster child is misbehaving, he/she responds to my look or tone of voice.  
22. I've noticed my foster child copying my behaviour or ways of doing things.  
23. When my foster child is in a bad mood, I know we're in for a long and difficult day.  
24. My foster child's feelings toward me can be unpredictable or can change suddenly.  
25. Despite my best efforts, I'm uncomfortable with how my foster child and I get along.  
26. I often think about my foster child when at work.  
27. My foster child whines or cries when he/she wants something from me.  
28. My foster child is sneaky or manipulative with me.  
29. My foster child openly shares his/her feelings and experiences with me.  
30. My interactions with my foster child make me feel effective and confident as a parent.
The following questions relate to how you feel about your relationship with foster child no 2 (as in foster child no 2 on page 2 of this questionnaire). Please reflect on the degree to which each of the following statements currently applies to your relationship with your foster child.

**FOSTER CHILD NO 2: age .......** (please do not write in any names)

Using the scale below, circle the appropriate number for each item.

<table>
<thead>
<tr>
<th>Definitely does not apply</th>
<th>Not really</th>
<th>Neutral, not sure</th>
<th>Applies somewhat</th>
<th>Definitely applies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. I share an affectionate, warm relationship with my foster child. 1 2 3 4 5
2. My foster child and I always seem to be struggling with each other. 1 2 3 4 5
3. If upset, my foster child will seek comfort from me. 1 2 3 4 5
4. My foster child is uncomfortable with physical affection or touch from me. 1 2 3 4 5
5. My foster child values his/her relationship with me. 1 2 3 4 5
6. My foster child appears hurt or embarrassed when I correct him/her. 1 2 3 4 5
7. My foster child does not want to accept help when he/she needs it. 1 2 3 4 5
8. When I praise my foster child, he/she beams with pride. 1 2 3 4 5
9. My foster child reacts strongly to separation from me. 1 2 3 4 5
10. My foster child spontaneously shares information about himself/herself. 1 2 3 4 5
11. My foster child is overly dependent on me. 1 2 3 4 5
12. My foster child easily becomes angry at me. 1 2 3 4 5
13. My foster child tries to please me. 1 2 3 4 5
14. My foster child feels that I treat him/her unfairly. 1 2 3 4 5
15. My foster child asks for my help when he/she really does not need help. 1 2 3 4 5
16. It is easy to be in tune with what my foster child is feeling. 1 2 3 4 5
17. My foster child sees me as a source of punishment and criticism. 1 2 3 4 5
18. My foster child expresses hurt or jealousy when I spend time with other foster children. 1 2 3 4 5
19. My foster child remains angry or is resistant after being disciplined. 1 2 3 4 5
20. When my foster child is misbehaving, he/she responds to my look or tone of voice. 1 2 3 4 5
21. Dealing with my foster child drains my energy. 1 2 3 4 5
22. I've noticed my foster child copying my behaviour or ways of doing things. 1 2 3 4 5
23. When my foster child is in a bad mood, I know we're in for a long and difficult day. 1 2 3 4 5
24. My foster child's feelings toward me can be unpredictable or can change suddenly. 1 2 3 4 5
25. Despite my best efforts, I'm uncomfortable with how my foster child and I get along. 1 2 3 4 5
26. I often think about my foster child when at work. 1 2 3 4 5
27. My foster child whines or cries when he/she wants something from me. 1 2 3 4 5
28. My foster child is sneaky or manipulative with me. 1 2 3 4 5
29. My foster child openly shares his/her feelings and experiences with me. 1 2 3 4 5
30. My interactions with my foster child make me feel effective and confident as a parent. 1 2 3 4 5

If you have more than two foster children, you can write the details (i.e. the question number and answer number only) for foster child no 3 on a separate sheet and attach it to the questionnaire.
Please circle the response which best represents your opinion for the questions below, and note that the answers on this page are agree (A and SA) on the left side to disagree (D and SD) on the right side.

The next questions are related to yourself:

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I often have the feeling that I cannot handle things very well</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>2. I feel trapped by my responsibilities as a parent</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>3. Since having a child, I feel that I am almost never able to do the things that I most like to do</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>4. I am unhappy with the last purchase of clothing I made for myself</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>5. There are quite a few things that bother me about my life</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>6. Having a child has caused more problems than I expected in my relationship with my spouse (or male/female friend)</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>7. I feel alone and without friends</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>8. When I go to a party, I usually expect not to enjoy myself</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>9. I am not as interested in people as I used to be</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>10. I don’t enjoy things as I used to</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>11. I feel that I am: Please circle your response</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The next questions only refer to FOSTER CHILD NO 1:

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. I find myself giving up more of my life to meet my foster child’s needs than I ever expected</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>13. Since having my foster child, I have been unable to do new and different things</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>14. My foster child rarely does things for me that make me feel good</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>15. Most times I feel that my foster child likes me and wants to be close to me</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>16. My foster child smiles at me much less than I expected</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>17. When I do things for my foster child, I get the feeling that my efforts are not appreciated very much</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>18. When playing, my foster child doesn’t giggle or laugh</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>19. My foster child doesn’t seem to learn as quickly as most children</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>20. My foster child doesn’t seem to smile as much as most children</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
</tbody>
</table>
21. My foster child is not able to do as much as I expected

22. It takes a long time and it is very hard for my foster child to get used to new things

23. I expected to have closer and warmer feelings for my foster child than I do and this bothers me

24. Sometimes my foster child does things that bother me just to be mean

25. My foster child seems to cry or fuss more often than most children

26. My foster child generally wakes up in a bad mood

27. I feel that my foster child is very moody and easily upset

28. My foster child does a few things which bother me a great deal

29. My foster child reacts very strongly when something happens that this foster child doesn’t like

30. My foster child gets upset easily over the smallest thing

31. My foster child’s sleeping or eating schedule was much harder to establish than I expected

32. There are some things my foster child does that really bother me a lot

33. My foster child turned out to be more of a problem than I had expected

34. My foster child makes more demands on me than most children

35. I have found that getting my foster child to do something or stop doing something is: Please circle your response

   1) much harder than I expected
   2) somewhat harder than expected
   3) about as hard as I expected
   4) somewhat easier than I expected
   5) much easier than I expected.

36. Think carefully and count the number of things which your foster child does that bother you. For example: dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc. Please circle the number which includes the number of things you counted.

   1) 1-3  2) 4-5  3) 6-7  4) 8-9  5) 10+

*If you have another foster child (foster child 2) then please continue below, if not then please go to page 8

The next questions refer only to your FOSTER CHILD NO 2:

37. I find myself giving up more of my life to meet my foster child’s needs than I ever expected

38. Since having my foster child, I have been unable to do new and different things

39. My foster child rarely does things for me that make me feel good

40. Most times I feel that my foster child likes me and wants to be close to me
<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Not Sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>41. My foster child smiles at me much less than I expected</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>42. When I do things for my foster child, I get the feeling, that my efforts are not appreciated very much</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>43. When playing, my foster child doesn’t giggle or laugh</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>44. My foster child doesn’t seem to learn as quickly as most children</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>45. My foster child doesn’t seem to smile as much as most children</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>46. My foster child is not able to do as much as I expected</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>47. It takes a long time and it is very hard for my foster child to get used to new things</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>48. I expected to have closer and warmer feelings for my foster child than I do and this bothers me</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>49. Sometimes my foster child does things that bother me just to be mean</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>50. My foster child seems to cry or fuss more often than most children</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>51. My foster child generally wakes up in a bad mood</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>52. I feel that my foster child is very moody and easily upset</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>53. My foster child does a few things which bother me a great deal</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>54. My foster child reacts very strongly when something happens that this foster child doesn’t like</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>55. My foster child gets upset easily over the smallest thing</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>56. My foster child’s sleeping or eating schedule was much harder to establish than I expected</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>57. There are some things my foster child does that really bother me a lot</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>58. My foster child turned out to be more of a problem than I had expected</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>59. My foster child makes more demands on me than most children</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>60. I have found that getting my foster child to do something or stop doing something is: Please circle your response</td>
<td>1) much harder than I expected</td>
<td>2) somewhat harder than expected</td>
<td>3) about as hard as I expected</td>
<td>4) somewhat easier than I expected</td>
<td>5) much easier than I expected.</td>
</tr>
<tr>
<td>61. Think carefully and count the number of things which your foster child does that bother you. For example: dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc. Please circle the number which includes the number of things you counted.</td>
<td>1) 1-3</td>
<td>2) 4-5</td>
<td>3) 6-7</td>
<td>4) 8-9</td>
<td>5) 10+</td>
</tr>
</tbody>
</table>

*If you have another foster child, e.g. foster child 3, please complete questions 37 - 61 on an attached sheet by writing the question number and answer letter only (e.g. 57 = A).
The questions on this page relate to you only and inquire about your thoughts and feelings in a variety of situations. Please indicate how well each statement describes you by circling the number on the scale next to each statement running from 'does not describe me well' on the left-hand side of the scale to 'describes me very well' on the right-hand side.

1. I daydream and fantasize, with some regularity, about things that might happen to me.

2. I often have tender, concerned feelings for people less fortunate than me.

3. I sometimes find it difficult to see things from the "other guy's" point of view.

4. Sometimes I don't feel very sorry for other people when they are having problems.

5. I really get involved with the feelings of the characters in a novel.

6. In emergency situations, I feel apprehensive and ill-at-ease.

7. I am usually objective when I watch a movie or play, and I don't get completely caught up in it often.

8. I try to look at everybody's side of a disagreement before I make a decision.

9. When I see someone being treated unfairly, I sometimes don't feel much pity for them.

10. I sometimes feel helpless when I am in the middle of a very emotional situation.

11. I sometimes try to understand my friends better by imagining how things look from their perspective.

12. Becoming extremely involved in a good book or movie is somewhat rare for me.

13. When I see someone get hurt, I tend to remain calm.

14. Other people's misfortunes do not usually disturb me a great deal.

15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.

16. After seeing a play or movie, I have felt as though I were one of the characters.

17. Being in a tense emotional situation scares me.

18. When I see someone being treated unfairly, I sometimes don't feel much pity for them.

19. I am usually pretty effective in dealing with emergencies.

20. I am often quite touched by things that I see happen.

21. I believe that there are two sides to every question and try to look at them both.
22. I would describe myself as a pretty soft-hearted person.

23. When I watch a good movie, I can very easily put myself in the place of a leading character.

24. I tend to lose control during emergencies

25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while.

26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.

27. When I see someone who badly needs help in an emergency, I go to pieces

28. Before criticizing somebody, I try to imagine how I would feel
The following statements list various attitudes and behaviours of parents. As you remember your **MOTHER** in your first 16 years, would you place a tick in the most appropriate box.

<table>
<thead>
<tr>
<th>My mother</th>
<th>Very like</th>
<th>Moderately like</th>
<th>Moderately unlike</th>
<th>Very unlike</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Spoke to me in a warm friendly voice</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>16. Made me feel I wasn’t wanted</td>
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<td>18. Did not talk with me very much</td>
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<td>19. Tried to make me feel dependent on her</td>
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<td>25. Let me dress in any way I pleased</td>
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The following statements list various attitudes and behaviours of parents. As you remember your FATHER in your first 16 years, would you place a tick in the most appropriate box.

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<tr>
<th>My father</th>
<th>Very like</th>
<th>Moderately like</th>
<th>Moderately unlike</th>
<th>Very unlike</th>
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<td>1. Spoke to me in a warm friendly voice</td>
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The next three questions are of a sensitive nature. These questions ask whether you may have had any possible experience of parental separation or loss, or foster care experience during your own childhood.

1. As a child did you have any experience/s of what you felt was a prolonged separation/s from your own mother or father? Please tick box and write on dotted line which of the following apply to you:-

   a) Mother: Yes □ No □

   If yes, how long were you separated?
   1st time............. How old were you?.......
   2nd time............. How old were you?.......  
   3rd time............. How old were you?.......   

   b) Father:  Yes □ No □

   If yes, how long were you separated?
   1st time............. How old were you?.......  
   2nd time............. How old were you?.......   
   3rd time............. How old were you?.......   

2. As a child did you have any experience/s of the permanent loss of one of your parents? Please tick which of the following apply to you:-

   a) Mother: Yes □ How old were you? .......... No □

   b) Father: Yes □ How old were you? .......... No □

3. As a child, did you ever experience being in foster care? Please do not include experiences of living with your family members during your childhood. Please tick which apply to you:-

   Yes □ How old were you?......... No □

END OF QUESTIONNAIRE
If you have any comments about completing the questionnaire or regarding the questions asked, please write any comments here:

**THANK YOU FOR TAKING PART IN THIS STUDY**

**Please do not put your name anywhere on this questionnaire**
Please now return your completed questionnaire in the freepost addressed envelope enclosed.

Note
If you should feel you are worried or feel that you have become distressed by answering any of these questions, you may wish to contact someone to talk to such as a friend, a relative or your own named link social worker from your /storing organisation.
Appendix 2

Department of Psychology
Direct line:

6th March 2006

Research study:
An investigation exploring factors influencing
the foster-parent / foster-child relationship

Dear Foster Parent

I am a mature student and I am in my final year of doctoral training as a Counselling Psychologist at the University of Surrey. I am undertaking research that explores factors associated with the foster-parent / foster-child relationship. I am interested in foster parent’s own views from their experiences: these have been underrepresented in research in comparison to professionals’ views and I feel it is important that foster parent’s voices are heard; therefore I would appreciate your participation.

I am seeking foster parents who are registered with their local authority or a private fostering agency and who are currently fostering. If you are interested in taking part, please complete the enclosed questionnaire and return it to me in the enclosed freepost addressed envelope by 21st April 2006. Please do not write your name on the questionnaire, as I want your responses to remain anonymous. You are under no obligation to take part. The questionnaires will be kept secure, by me, until I destroy them on completion of the study. The findings from this study will be written up into a research report as part of my Doctorate Portfolio and contribute towards the research on fostering, they may also be helpful to other foster parents. On completion of the study I would be pleased to supply you with general feedback on my study upon request.

Please answer the questions as honestly as possible - there are no right or wrong answers. If you have any questions about completing this questionnaire, please contact me at the address/phone number below. If you should feel worried or upset about completing the questionnaire, do not feel you have to continue. In this event, you may wish to contact someone for support such as a friend, a relative, or your own named social worker at your fostering organisation. Alternatively, you can either contact myself, Sharon Chambers, or my supervisor, Dr Jason Ellis, (both contact details are below) if you would like contact details of support organisations.

Regards

MATERIAL REDACTED AT REQUEST OF UNIVERSITY
28 February 2006

Ms Sharon Chambers
Department of Psychology
School of Human Sciences

Dear Ms Chambers

**An investigation exploring factors influencing the foster parent – foster child relationship (EC/2005/145/Psych)**

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: **28 February 2006**

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

Document Type: Application
Dated: 12/12/05
Received: 21/12/05

Document Type: Research Proposal
Received: 21/12/05

Document Type: Appendix 1 - Questionnaire
Received: 21/12/05

Document Type: Appendix 2 – Information Letter
Received: 21/12/05

Document Type: Your Response to the Committee’s Comments
Dated: 07/02/06
Received: 14/02/06

Document Type: Amended Protocol
Received: 14/02/06
This opinion is given on the understanding that you will comply with the University's Ethical Guidelines for Teaching and Research.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected, with reasons.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethics Committee
    Dr R Draghi-Lorenz, Supervisor, Dept of Psychology
    Dr J Ellis, Supervisor, Dept of Psychology
Appendix 4

British Association for Adoption & Fostering

Adoption & Fostering – quarterly journal.

Contributors' guidelines

Content
Articles may cover any of the following: analyses of policies or the law; accounts of practice innovations and developments; findings of research and evaluations; discussions of issues relevant to fostering and adoption; critical reviews of relevant literature, theories or concepts; case studies. All research-based articles should include brief accounts of the design, sample characteristics and data-gathering methods. Any article should clearly identify its sources and refer to previous writings where relevant. Contributions should be both authoritative and readable. Please avoid excessive use of technical terms and explain any key words that may not be familiar to most readers.

Submission
In the first instance, three hard copies of the manuscript should be submitted to The Editor, Adoption & Fostering, BAAF, Skyline House, 200 Union Street, London SE1 0LX, UK. A covering letter must be included on behalf of the authors that the work has not been published and is not being considered for publication elsewhere.

An electronic copy of the final, revised article should be sent as an e-mail attachment (Word doc) to miranda.davies@baaf.org.uk or on IBM-compatible disc - preferably Word for Windows - clearly labelled with the completion date and author name(s). Please accompany by a hard copy ensuring that the electronic file and paper version are the same.

Peer review

Manuscripts are sent to two reviewers for comment and recommendations to the Editors regarding suitability for publication. Reviewers take account of the following:

- Appropriateness to the contents of the journal
- Current interest and importance of the contents
- Originality (e.g., adding to knowledge; dealing with a neglected area)
- Clarity of language, structure and presentation
- Use of non-discriminatory language
- Length of article
- Overall coherence
- Links between introduction, main text and conclusions
- Awareness shown of other relevant developments or previous relevant publications
- Appropriateness of title and headings
- Accuracy and clarity of references

The Editors reserve the right to refuse any manuscript and to make suggestions or modifications before publication. We aim to let you know within 6-8 weeks whether the article has been accepted, possibly on condition that certain amendments are made. Provided that revisions are done quickly, publication will then usually occur 3-6 months later.

Copyright
Once a paper has been accepted for publication the lead author(s) are asked to sign a 'licence to publish' agreement whereupon copyright of their article becomes the property of BAAF.
Manuscripts
Please abide by the following:

- Articles should normally be 3-6,000 words in length, but the extent of individual articles can be negotiated with the Commissioning Editor.
- Please ensure that the article is numbered and double-spaced, with wide margins at the sides, top and bottom of each sheet.
- At the beginning of the article, provide a summary of 150-200 words.
- Please indicate how you would like to be described, eg giving your name, job title and organisation.
- As far as possible, use one level of heading in bold with no capital letters except for the first word and proper names, eg Developing post-adoption services.
- If you require sub-headings use italics not bold, eg Foster children's relationships.
- Please avoid the use of footnotes.
- At the end of the article, suggest up to six key words (which can include phrases of 2-3 words each) to describe central themes, eg fostering, post-adoption support, child protection.

References
When you refer to a publication in the text, give the author's name and the year of publication in parentheses, eg (Fahlberg, 1994) or (Rowe et al, 1989). At the end of the article, please provide a list of all references in alphabetical order (by author), using the following style:


Shaw M and Hipgrave T, 'Young people and their carers in specialist fostering', *Adoption & Fostering* 13:4, pp 1-17, 1989


Tables
Tables must be typewritten on a separate sheet. No vertical rules should be used. All abbreviations should be defined in a Note.

Proofs
These must be returned to the Production Editor within five days of receipt. Only typographical corrections and other essential changes can be made at this stage. Major text alterations cannot be accepted. Free copies

Each contributor receives two free copies of the edition in which their article appeared.

Contact
For information please phone the Production Editor Miranda Davies (Tuesday to Thursday) on +44 020 7421 2608, fax her on +44 020 7421 2601 or email miranda.davies@baaf.org.uk
Appendix 5

Reflections on self as researcher: quantitative research.

I underestimated the impact this quantitative study would have on me regarding how, as a researcher, I engage with data collection, computer statistical analysis and report writing. I had initially experienced quantitative methods of design and analysis following immersion in IPA as a stimulating experience and I was hopeful, if somewhat unduly ambitious, regarding obtaining a large sample to provide data that might add to the ‘body of knowledge’ in this subject area. However, overall I found it to be a less engaging research process, in the sense that although I felt motivated and felt passionate about the topic itself, I found the limitations I met, such as accessing an adequate sample, frustrating to achieve within the time constraints if this project. This was compounded, for example, by bureaucracy in local authorities to gain access to a sample in this time frame.

Although self-funding my research placed limitations to what was possible for this study, it was through managing this aspect I have become more aware of costing involved, even for relatively small projects like mine. I have come to understand the advantages and necessity of research grants, particularly once printing and postage costs mounted. Hence, in planning future research projects, one of my early considerations will be funding. I had also underestimated the preparation time required for printing, labelling and preparing questionnaires for posting on a large scale. After so much time spent in the planning process, the final posting felt daunting with my anxieties heightened regarding ‘letting go’ of my questionnaires when I placed them in the hands of the FNO’s system for mailing on my behalf: then I realised the emotional investment I had developed in this study.

As questionnaires returned initially in mass, I felt rewarded and my separation anxiety from my questionnaires turned to hope, excitement and enthusiasm. I began a whole new learning experience in developing what became a rather intimate relationship with ‘SPSS 13.0’. Negotiating SPSS turned out to be one of the swiftest learning curves of the research process for me during this year, alongside learning new
statistical tests, and this risked submerging all else into oblivion, for the period of data entry. Statistics, not being one of my stronger virtues, took on a whole new meaning via SPSS, as did the quantitative research process. Distant memories of undergraduate research involving small scale data and manual calculations with a hand-held calculator! Although, I had grasped the underlying principles during that laborious process, in comparison to this SPSS data processing has the advantage of handling larger amounts of data using advanced statistical tests. However, I needed to get to grips with negotiating SPSS and this process was similar to learning a new language, under time pressure (alongside other study); and multi-tasking took on a new meaning for me: I found this process to be the most challenging. However, I was disappointed in that undertaking this immersion it felt as if it took my time away from a ‘real’ and ‘meaningful’ engagement with the data. Entering data felt ‘dry’ compared to last year’s immersion in use of language and underlying meanings as opposed to the manipulation of numbers: this may reflect my underlying philosophical stance that veers towards qualitative methodologies.

Further, the high level of concentration required whilst entering numbers into thousands of cells was an intense and monotonous experience, and I encountered a first experience of OCD type behaviours emerging for fear of losing the hours I had spent on data entry! In comparison to my interaction with IPA the previous year, I felt more distanced from the nuances of the meanings of the data and subject matter, but also less in control during the data processing stage and application of statistical tests due to my initial lack of knowledge and learnt more about my own self-management in these situations. Further, I had initially required more statistical support than I had anticipated and this in itself helped me to realise how I negotiate dependence and independence during the learning process and my fear of being and seeming less than competent in this area. I had even pondered whether an immersion on a statistics course might have enabled me to undertake this process feeling more competent.

However, despite my trials whilst immersed in this new research learning experience, this was not what I had expected to come away with. However, having stepped back from this, I feel I have learnt a vast array of new research skills, and feel far more confident with SPSS. Surprisingly, I recently ‘enjoyed’ a return to SPSS to review
tests and the outcome data, with increased confidence, and was able to question and challenge results myself. I was disappointed that I had received a low response rate, yet this was combined with relief regarding data entry once that stage was reached, considering the questionnaire length and time limitations; further learning in the planning and devising research studies. Comments on returned questionnaires left me wondering about who had commented and what else they may have been able to tell me, or have wanted to express about their fostering experience had I undertaken a qualitative approach. In a way it seemed as if I was taking a small and relatively superficial snippet of information and I wondered if I could possibly do this topic justice using the data in this way. It was this point that particularly resonated with me when I received the following comment from a research participant, written to me on a questionnaire:

"ticking boxes is no way to gain understanding of people's experiences. I consider this questionnaire both limited and of little use."

I realise now that my tendency is towards the qualitative aspects of research, where meanings of subjective experiences and understandings are more engaging to me.

My frustrations in this research included coming to terms with not being able to commit sufficient time and attention that I think this study deserved. Hence, I am subsequently left feeling it is yet but part completed, and wanting to proceed on to investigate aspects of this research further: I am aware this is unlikely to be a 'unique experience' for the researcher. However, much of the more positive learning that I have taken from this experience has included improving my time management skills in quantitative research, prioritising and planning of larger scale research, and being more realistic regarding ambitious research plans. Also, I have recognised how adaptable and resilient I am when learning under pressure, for example, use of a statistics programme. In writing this reflective account, I also remain aware of how the way I have written this account may reflect my experience and process of undertaking this type of research compared to last year, which had a richer and more engaging quality to it for me.