

**FAMILIES' EXPERIENCE OF SHORT-TERM  
RESIDENTIAL RESPITE CARE  
FOR CHILDREN  
IN THE CONTEXT  
OF PARENTING STRESS**

**A dissertation submitted in partial fulfillment  
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The road through a dissertation can be a solitary and winding one. For my colleagues who have completed theirs – congratulations - it is a road once traveled. To those yet to make this journey, keep a steady focus on the goal ahead. You will make it.

*Carpe diem*

## **ABSTRACT**

Four families participated in this exploratory study which aimed to understand their experience of short-term respite care in a community children's home and considered how this might relate to parental stress. Qualitative and quantitative data were collected concurrently over a 12-week period. Interviews allowed participants to voice their perspective of their experience while psychometric estimates of parental stress and parent and child psychological wellbeing were used to extend and validate (or refute) qualitative data. Discrepancies were found between parent report and children's experience of residential respite care. Younger children, especially, found residential care difficult. Overall, parent report of reduced stress and improved psychological wellbeing were not validated by psychometric measures. Limitations of the study are discussed and suggestions proposed for future research.



## **THE RESEARCHER'S POSITION**

My interest in the field of residential care has arisen from a brief period of casual employment in a statutory residential centre. During this time a number of young people entered, exited and re-entered the care system. This cycling through residential care has motivated my interest in understanding the experience of residential care from the perspective of the child and his or her family.

The opportunity to conduct a small research study with Cholmondeley Children's Home has facilitated rare insight and understanding of the experience of residential care from the perspective of children and their families. At the time of commencing this study I had no prior affiliation with Cholmondeley Children's Home or the staff thereof. As well, none of the families involved in the study were previously known to me.

The methodology in this study is shaped by my belief in allowing people to speak from the role of expert in their own experience and from learning about that experience by listening to their stories. Indeed, Clough (2000, p. 137, as cited in Clough, Bullock & Ward, 2006, p. 6) asserts that "To understand people ... you must take account of their perceptions of what has happened (and what it means to them)".

Throughout this research, I have played an active role in the lives of the families who participated in this study and in interpreting the data collected. At all times I have attempted to remain empathetic and supportive of both the families in the study and the children's home while retaining a neutral involvement and a focus on the research goal. It is therefore anticipated that the impact of personal bias is minimised in the planning, conducting and writing up of this dissertation.

## **CHAPTER 1**

### **Introduction**

Parenting can be a stressful and challenging undertaking. Although the majority of parents report the joys and rewards together with the hassles associated with caregiving for children; for families in distress, parenting may be a tiresome, unrewarding and relentless task (Olson et al, 1994 and Thompson & Ensminger, 1989, as cited in Crnic & Booth, 1991). Furthermore, parenting in a context of disadvantage, characterised by poor parental adjustment, single parenthood, low income, inadequate housing and few social networks (Kalil, 2003) increases the risk of ineffective parenting and places individuals and families at risk of poor outcomes (Webster-Stratton, 1990).

Social and economic disadvantage compounded by high levels of parenting stress exacerbates parenting problems (Carr, 2006). Furthermore, family disadvantage, stress, and dysfunctional parenting increases the risk of attachment difficulties in children (Carr, 2006), child and parent psychopathology (Abidin, 1990; Webster-Stratton, 1990), family breakdown, and the maltreatment of children (Garbarino, 1976). Greater stress is associated with poorer individual and parent-child relational outcomes (Crnic & Greenberg, 1990). Research suggests that social support ameliorates the detrimental impact of frequent parenting hassles (Crnic & Booth, 1991) and social and economic stress, and appears likely to reduce the potential for child maltreatment (Garbarino, 1976; O'Brien, 2001). However, parents that are distressed and at risk for the development of parenting problems seldom have strong social networks (Garbarino & Sherman, 1980). Overall, parental time and economic resources are found to predict family functioning and parenting stress (Smith, Oliver, & Innocenti, 2001).

Families that are isolated and have few social support networks have fewer resources for coping with problems and are vulnerable to the development of problematic parent-child relationships (Carr, 2006). Parent-child relationships serve to buffer or intensify a child's exposure to hostile or chaotic environments (Black, 2000) and are a salient source of stress in families where parents are unable to meet the needs of their children (Cowen & Reed, 2002). Furthermore, the accumulation of minor parenting hassles (quarrels, transport difficulties) and major stressful life events (illness, unemployment, marital separation) increases the vulnerability of parents and children toward behaviours that initiate and maintain dysfunctional parent-child interactions (Abidin, 1995; Carr, 2006). Moreover, frequent hassles and major stress are more common among families who are socially disadvantaged (Carr, 2006). Psychological distress that arises from dysfunctional parenting practices and problematic parent-child relationships may contribute to the development of child and parent psychopathology (Abidin, 1995; Carr, 2006).

Parents with personal adjustment problems and those who lack competent parenting skills or who experience harsh economic conditions are most likely to experience high levels of stress in parenting (Abidin, 1995; Webster-Stratton, 1988). The capacity of parents to manage intrinsic and external stressors depends on the frequency and intensity of stressful events, the degree of family cohesion, and the availability of informal and formal sources of support (Garbarino & Sherman, 1980). Where a mismatch occurs between personal capacity for coping, levels of stress and the availability of adequate and reliable social support, parents encounter significant

difficulty in managing stress (Garbarino & Sherman, 1980) and may turn to community support networks for relief.

Short-breaks from caregiving provide parents with time to recharge their energy systems (O'Brien, 2001). For many parents, this relief occurs naturally through informal networks of support – perhaps time-out while the child attends after-school activities or visits with friends. Extended family members, friends, neighbours and communities are common sources of support for families. However, families who encounter high levels of stress may find it more difficult to arrange breaks from constant caregiving (MacDonald & Callery, 2004; Thomson, 2002). Parents confronted by extreme, diverse or continuing challenges, and those with limited social networks, may need additional resources and support to achieve successful outcomes for their children. For these parents the availability of quality respite care services may provide the support needed to sustain good-enough parenting to promote healthy child development.

Although a number of studies report that parent's clearly desire and value respite care services for the positive effect they have on parental wellbeing and family functioning (Chan & Sigafos, 2001; Cowen & Reed, 2002; Thomson, 2002) others found little evidence that respite care does in fact reduce stress in the caregiving role (Bruns & Burchard, 2000). Moreover, few studies clearly differentiated the model of respite care used, rather, they incorporated a variety of models; or substantiated the impact of respite care on parental stress (Chan & Sigafos, 2001; FRIENDS National Resource Centre for Community-Based Child Abuse Prevention, 2007).

A small number of studies have reported the perceptions and experiences of parents who utilised respite care services for their children (Pollock, Law, King, &

Rosenbaum, 2001; Stalker & Robinson, 1994; Thomson, 2002). Even fewer studies have considered the child's experience: Gerard (1990) and Stalker and Robinson (1994) surveyed parents' of children with severe learning disabilities regarding their perspectives of their child's experience and Minkes, Robinson and Weston (1994) interviewed children with severe communication difficulties. However, research in this area has overlooked the experience of children who live in at-risk families.

Although out-of-home respite care most often occurs in foster family type placements, this may also be provided in statutory or community residential settings. Two studies of children's experience of residential respite care have been conducted, however they both pertain to children with moderate to severe learning and communication difficulties (MacDonald & Callery, 2004; Minkes et al., 1994). Additionally, studies of children's homes in England conducted by Berridge (1985) and Sinclair and Gibbs (1998) have provided much insight into the life of children in residential care.

There is a dearth of information regarding residential or respite care services for children in New Zealand. Most recently, Marjoram and Fouche (2006) explored the perceptions and experiences of children in a residential care and protection centre. They reported that "as far as we are aware, no studies of this nature have been carried out in New Zealand. This is a matter of concern..." (p. 26). Similarly, in his overview of statutory and non-statutory residential child care facilities McDonald (1977) identified only previous two studies which expressly reported residential care, the most recent being 34 years prior. No studies of respite care services in New Zealand were found.

Consequently, there is a paucity of research which evaluates the impact and effectiveness of respite care services in general (ARCH National Resource Center, 1994;

Pollock et al., 2001); out-of-home respite care (MacDonald & Callery, 2004); respite care for children with emotional and behavioural problems (Bruns & Burchard, 2000); and which considers the experience of the child (Gerard, 1990; Kendrick, 2008; Marjoram & Fouche, 2006). Additionally, much of the literature indicates methodological limitations which have reduced the quality and usefulness of research (Bruns & Burchard, 2000; Chan & Sigafoos, 2001; Pollock et al., 2001; Stalker & Robinson, 1994). These include a lack of controlled studies, small sample size, over-reliance on indirect measures (for example, stress, psychological wellbeing, quality of life), little direct observation with measures of inter-rater reliability, limited follow-up to studies, and overall, a small number of studies for comparative purposes.

The literature pertaining to these topic areas is now reviewed.

## **CHAPTER 2**

### **Literature Review**

#### ***Introduction***

Most families with children need a break from time to time but families with few social supports or whose children have emotional, behavioural and developmental difficulties may find this difficult to arrange. Pre-planned short-term respite care in a community residence is one means of obtaining a break from the routines and stress associated with continuous caregiving. This chapter will lay a foundation for the research by outlining current trends in New Zealand family demographics, thereby providing a local context for the families in the study, before reviewing the literature relating to the key concepts: parenting stress, respite care and residential care. First, the methodology for the literature search is discussed and definitions of key concepts are provided.

#### ***Literature Search Methodology***

The literature review was completed using a systematic search strategy. An initial search was conducted of the University of Canterbury library catalogue and relevant texts were studied. In addition, the following electronic databases were searched: Te Puna, PsycINFO, PsycARTICLES, ProQuest, ERIC, MEDLINE, Science Direct, Academic Expanded ASAP, Scopus and Factiva. Key search-words included: respite care, residential care, children, parent, parenting stress, and family stress. As well, the World Wide Web was searched using the Google search engine and national and international government and agency reports were sourced. Finally, hand searching followed, based on references from the books and articles retrieved through these media.

### *Definitions*

**Family** refers to a “kinship unit consisting of a group of individuals, united by blood or by marital, adoptive, or other intimate ties” (VandenBos, 2007, p. 366). For demographic purposes, Statistics New Zealand defines family “as a couple, with or without children, or one parent with children, usually living together in the same household. Couples can be same-sex or opposite sex. Children can include adult children” (Stevens, Dickson, Poland, & with Prasad, 2005).

Gonzales-Mena (2002) defines the role of family as one of guiding any children produced to become well-functioning citizens of the next generation and suggests its function is to provide financial and emotional support, teach children about relationships, parent with authority, provide care, intellectual stimulation, education, and housing as well as family traditions, and religious and spiritual teaching.

**Parent** is identified as the primary caregiver or caregivers in the home who assume responsibility for all actions associated with raising children. Parenting practices that promote healthy child psychosocial development include appropriate “affection, comfort, nurture, the provision of role models, exerting control, stimulation, protection and meeting the child’s need to be needed” (1980 Working Party, p. 67-8, as cited in Bullock, Courtney, Parker, Sinclair, & Thoburn, 2006, p. 8). In contrast, negative parenting is characterised by low sensitivity and high intrusiveness, few limits, little monitoring and punitive punishment. An individual’s capacity for parenting “depends on genetics, childhood experiences and current circumstances” (Quinton, 2004, as cited in Bullock et al., 2006, p. 9).



*Attachment*, derived from the seminal work of John Bowlby, refers to an enduring emotional tie between an infant and his or her primary caregiver/s which develops out of reciprocal interactions (Berk, 2006). Attachment seeking behaviours (crying, clinging, following, etc.) are activated when the infant perceives threat or danger with the aim to restore the proximity of an adult who will provide comfort and protection (Bowlby, 1979, as cited in Howe & Fearnley, 1999). From age six to seven months the infant's primary caregiver, usually the mother, becomes the preferred attachment figure (Howe & Fearnley, 1999). Broadly speaking, attachment styles are classified as secure or insecure (Howe & Fearnley, 1999). The nature and quality of the attachment is in direct relationship to the goodness-of-fit between caregiving and the characteristics of the child (Berk, 2006).

Caregiving that is characterised by sensitive, consistent and appropriate responses to the needs and cues of the infant promotes the development of a secure attachment. A child with a secure attachment has trust and confidence that mother will be emotionally available in times of need and therefore has a safe base from which to explore and learn about the world. In contrast, when caregiving is unpredictable, rejecting, or intrusive the infant learns that mother is unreliable or psychologically unavailable to soothe or protect and develops an insecure pattern of attachment (Berk, 2006).

Attachment underlies children's development and is foundational in the development of personality, identity, self-regulation of emotion, and internal working models (unconscious expectations) of the self (as worthy/unworthy; loved/unlovable) and others (reliable/unreliable) in social relationships (Berk, 2006; Howe & Fearnley, 1999).

**Stress** is “a state of physiological or psychological response to internal or external stressors. Stress involves changes affecting nearly every system of the body, influencing how people feel and behave ... stress contributes directly to psychological and physiological disorder and disease and affects mental and physical health, reducing the quality of life” (VandenBos, 2007, p. 898). Common symptoms of stress include frequent headaches, fatigue, constipation, diarrhoea, misuse of alcohol, drugs and food, social withdrawal, difficulty in concentrating, irritability, anxiety, and feelings of inadequacy.

**Social support** refers to “the availability of meaningful and enduring relationships that provide nurturance, security and a sense of interpersonal commitment” (Shonkoff, 1985, as cited in Webster-Stratton, 1990, p. 307).

**Respite Care** refers to “the shared care of a person with an illness or disability, either at home, in the community, or in a short-term residential setting, in order to give the family a break from the routine of caregiving” (Treneman, Corkery, Dowdney, & Hammond, 1997, p. 548). Middleton (1998, as cited in Thurgate, 2004, p. 20) however, argues this definition “reinforces the idea that the child is a problem for the family rather than an individual with his or her own needs”. Respite care is typically a placement of a few days, planned in advance and with the same carers each time (Bullock, Gooch, & Little, 1998).

**Residential Care** refers to an out-of-home placement, that is formally arranged, and where adults are generally employed to care for children. Residential facilities include mainstream children’s homes (substitute care for children with reasonably straightforward needs); residential treatment homes (professional support for children with complex needs, often with histories of abuse or neglect); high support need facilities

(intensive specialist care for children with severe psychological needs compounded by very challenging behaviour) (Clough, Bullock, & Ward, 2006) and secure facilities for children unable to be accommodated elsewhere. Clough and colleagues suggest the task of children's homes is "to provide good quality daily care and support for children who need to live away from home, perhaps for a short period during a family crisis or following an episode of difficult behaviour ..." (p. 105). This defines the task of the children's home in this study. Additionally, statutory children's homes provide care for children when family or foster home placements have broken down. Sinclair (2006, p. 205) proposes "The main reason for using residential care is that it is believed the residents cannot be managed in others ways".

***Mental Health*** refers to "a state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stressors of life" (VandenBos, 2007, p. 568). Mental health is influenced by complex interactions of biological, psychological, emotional, social and developmental factors (Barlow & Durand, 2005). Psychological disorders are "*behavioural, emotional, or cognitive dysfunctions that are unexpected in their cultural context and associated with personal distress or substantial impairment in functioning*" (italics original, Barlow & Durand, 2005, p. 4). Symptoms of disorders are categorised and classified according to the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (Text Revision) (DSM-IV-TR) (American Psychiatric Association, 2000) or the *International Classification of Diseases and Health Related Problems*, Tenth Edition (ICD-10), (World Health Organisation, 1993).

### *Trends in New Zealand Families*

New Zealand families are in a period of rapid change. As a consequence, families are becoming more diverse and more complex. Although the majority of children are raised in two-parent families the proportion of dependent children living in single-parent households is increasing and is projected to rise (Statistics New Zealand, 2008). Compared to two-parent families, adults in single-parent families are likely to be younger, female, unemployed, have low educational attainment and low family income (Poland, Cameron, Wong, & Fletcher, 2007). Additionally, children today are more likely than children in the past to experience a number of different family structures (Poland et al., 2007). These include living between family groups, in the legal guardianship of grandparents, and in statutory care (Pryor, 2006).

New Zealand families value a “strong and supportive family life ... highlight[ing] being able to cope with challenges, having positive parenting skills and strong communication between family members” (Stevens et al., 2005, p. 9). However, families with low income, dependent on social benefits, who live in private rental accommodation, and families with one non-European adult encounter more challenge to family functioning than other families (Stevens et al., 2005).

The increasing complexity of modern society together with demands placed on family functioning by individual, familial and environmental factors has left some families with fewer means of informal social support than others, thereby increasing the need for external services to promote successful family outcomes. A number of factors which impinge on parents' capacity to cope with the demands of parenting are described below.

### ***Parenting Stress***

Parenting provides the structure for the family environment in which children grow and develop. Parenting that is effective in promoting healthy child development is characterised by a secure child-caregiver attachment, age-appropriate intellectual stimulation, and an authoritative parenting style that combines warmth and nurturing with a moderate amount of control (Carr, 2006). Nevertheless, parenting is not an easy task. Abidin (1990, p. 298) empathises

The task of parenting is a highly complex one that often must be performed within very demanding situations, with limited personal and physical resources, and in relation to a child who by virtue of some mental or physical attribute may be exceedingly difficult to parent.

It is inevitable therefore, that some degree of stress is synonymous with parenting. The level of stress experienced by parents varies according to the number, frequency and intensity of stressors, and the coping strategies of the individual (Garbarino & Sherman, 1980). Moreover, stressors relating to parenting are associated with individual, familial and environmental factors (Abidin, 1995).

### ***Individual Factors***

“Parents are very likely to parent the way they were parented” (Couchenour & Chrisman, 2008, p. 107). Thus, parents who have grown up in unnurturing environments where their basic needs were not met, within disorganised or abusive families, or where parents had mental health problems have poor models of family and relational functioning and may encounter great difficulty in their adjustment to parenting (Carr, 2006). Despite their pivotal role in shaping children’s development, parents generally receive “little

preparation beyond the experience of having been parented themselves, with most learning on the job, through trial and error” (Sanders, Markie-Dadds, & Turner, 2003, p. 1). Indeed, Seth-Purdie, Cameron & Luketina (2006) found that many parents felt ill-prepared for the impact of parenthood and their changing roles. Low parenting competence and skills likely results in negative and harsh parenting that increases children’s vulnerability to maladaptive behaviours (Luthar, 2006). Parents who struggled in their role reported low parenting satisfaction, increased psychological

Parents’ psychological wellbeing underlies the quality of care provided to infants distress, abusive behaviour, and insecure child-caregiver attachments (Smith et al., 2001).and influences their attachment style (Simpson, 1999). Accordingly, parents who have unresolved attachment difficulties with their own parents may have an impaired capacity to interpret accurately and respond in a sensitive and appropriate manner to their child’s attachment seeking behaviours (Carr, 2006) or to independently reflect on their own and their child’s mental states (Slade et al., in press, as cited in Fonagy & Target, 2005). A moderate to strong concordance between maternal and infant patterns of attachment suggests that children of mothers with unresolved attachments are at considerable risk of insecure child-parent attachment and later relationship difficulties (Zeanah, Boris, & Larrieu, 1997).

Thus, parental psychopathology compromises the capacity of parents to provide a safe, secure, stimulating and effective parenting environment (Carr, 2006) and has pervasive and enduring effects on children’s emotional, behavioural and social development (Burstein, Stanger, Kamon, & Dumenci, 2006). Most commonly, adults experience mood, anxiety and substance use disorders with high rates of prevalence and

comorbidity among young adults (Oakley Browne, Wells, & Scott, 2006). Specifically, maternal depression is a risk mechanism for negative, low competent, and emotionally unavailable caregiving (Biringen, Robinson, & Emde, 2000; Burstein et al., 2006; Goodman & Gotlib, 1999; Steinhauer, 1991; Webster-Stratton, 1990); disharmonic intimate relationships (Goodman & Gotlib, 1999); stressful environments (Webster-Stratton, 1990); attachment and temperament difficulties and developmental delays in children (Goodman & Gotlib, 1999) and conduct problems in boys (Webster-Stratton, 1990).

Additionally, parental anxiety is associated with attachment difficulties and inhibited playful interactions with children. Specifically, obsessive-compulsive disorder is predictive of parenting that is intrusive (Biringen et al., 2000). Overall, “the severity and chronicity of a given disorder seem to be more important than the specific diagnosis” (Seifer and Dickstein, 1993, as cited in Zeanah et al., 1997).

Parents who use illicit substances may be consumed with their own needs to the exclusion of their children. Observations of mother-child interactions demonstrated poor quality and negative parenting behaviours, ambivalent feelings toward children, little understanding of basic child development (Suchman, Pajulo, DeCoste, & Mayes, 2006), chaotic caregiving environments and children’s exposure to multiple caregivers (Zeanah et al., 1997). Overall, maternal substance use was found to predict involvement with child protection services during children’s pre-school years (Street, Whitlingum, Gibson, Cairns, & Ellis, 2008) while substance abusing fathers were found to contribute little to the parenting environment (Couchenour & Chrisman, 2008).

Rooted in adverse childhood experiences, personality disorders are characterised by grossly disordered cognitions, affect and functioning, and a substantially reduced capacity to care for others (Parker et al., 2002). Antisocial and borderline personality disorders are the most common personality disorders among parents and may predispose parents toward authoritarian (low parental warmth, firm control and punitive discipline) or under-involved parenting styles. Furthermore, a father with antisocial and hostile personality traits, living in the home of a mother and infant, has a negative affect on the nurturing skills of the mother (Florsheim, Moore, Zollinger, MacDonald & Sumida, 1999, as cited in Couchenour & Chrisman, 2008).

Notwithstanding individual dysfunction, parenting is an interactive phenomenon; mutually determined by the caregiving environment and the child. Family environments are more likely to be harmonious when parental demands and expectations are compatible with a child's temperament and capabilities (Thomas & Chess, 1977, as cited in Berk, 2006). In contrast, where a parenting style is a poor fit with a child's attributes, the parent and child may enter into a coercive pattern of interacting which is highly predictive of behavioural and emotional difficulties in children (Paterson & Stouthamer-Loeber, 1984, as cited in Burstein et al., 2006).

Stress in the parent-child relationship is therefore, bidirectional, contributed to and maintained by children's innate and learned behaviours. Accordingly, children's attachment style may serve to buffer (in the case of secure attachment) or exacerbate their stress hormone (cortisol) levels in response to stressful situations (Gunnar, 2000, as cited in Luthar, 2006). Additionally, mental health difficulties have pervasive impacts on children's wellbeing and development and contribute to or maintain stressful family



environments. For example, families of children diagnosed with conduct disorder experienced twice the number of negative life stresses as families not seen by professionals (Webster-Stratton, 1990). Most commonly, boys are diagnosed with conduct, attention-hyperactivity and mood disorders and girls with mood and anxiety disorders (Ferguson, Horwood, & Lynskey, 1997). Although the prevalence of mental difficulties in children is increasing and increases with age (Ferguson et al., 1997), children's mental health difficulties remain largely undetected and under-served (McCann, James, Wilson, & Dunn, 1996).

### ***Family Factors***

“Strong family relationships ... [are] critical in maintaining good adjustment in the face of adversities” (Luthar, 2006, p. 755). Nevertheless, family circumstances can be a significant source of stress for parents. Whether stress is predictable (birth of a child, relocation, remarriage) or unexpected (perhaps separation, bereavement, single or young parenting, serious illness, violence, homelessness), families with adequate support and resources may find it easier to adapt and function than families with limited resources.

Central to family wellbeing, marital relationships that are harmonious and include spousal support are consistent with increased maternal sensitivity in parent-child interactions and attachment security (Simpson, 1999). In contrast, the impacts of marital difficulties are pervasive. They exacerbate the negative effects of maternal depression and are strongly associated with problematic outcomes for children (Fendrich, Warner & Weissman, 1990, as cited in Goodman & Gotlib, 1999). Family violence, in particular, is “strongly associated with attachment disturbances” (Zeanah et al., 1997, p. 175).

Parent-child relationships lay the foundation for patterns of children's attachment, behaviour and personality and are protective against hostile environments (Berk, 2006). Conversely, within this relationship poor quality parent-child interactions serve as a risk mechanism for the transmission of parental stress to children's problematic behaviours. For example, parents who experienced high rates of minor parenting hassles were more irritable and coercive in their interactions with their children, than parents in general, and reported higher levels of antisocial behaviour in children, especially for boys (see Webster-Stratton, 1990). Additionally, the quality of parent-child interactions was influenced by parents' interpretation and evaluation of an event and may determine the degree that stress impairs parenting (Mash & Johnston, 1990; Webster-Stratton, 1990). "Stress in the parent-child interaction is seen as having an impact on child characteristics (e.g. exacerbating child behaviour problems), environmental characteristics (e.g. increasing daily hassles and reducing social opportunities), and parental characteristics (e.g. development of negative expectations for the child)" (Mash & Johnston, 1990, p. 316).

Longitudinal studies suggest that family and social context have a stronger direct impact on child outcomes than family structure alone (Fergusson, Boden, & Horwood, 2007). For example, teenage and single parenting are associated with low quality parenting and high levels of distress (Kalil, 2003; Webster-Stratton, 1990) Specifically, teen mothers displayed less affection and physical contact than older mothers and reported a low level of parenting satisfaction, skill and commitment (Passino et al., 1993, as cited in Zeanah et al., 1997). Meanwhile, single parenting was associated with low socioeconomic status, frequent housing changes and social isolation; factors which

increase the risk of depression and vulnerability to stress and stressful life events (Webster-Stratton, 1990).

More and more, when family functioning breaks down, for reasons such as parental substance abuse, incarceration or death, children are raised by grandparents. As can be expected, due to their early environments, the mental health difficulties of children living in foster and kinship care greatly exceed those of children living in the community (Tarren-Sweeney & Hazell, 2005). Although grandparent-headed homes are at increased risk of financial and emotional stress they offer children strengths in terms of resilience and stability (Brodsky, 1999, as cited in Wenar & Kerig, 2006).

Family environments characterised by multiple difficulties place children at greatest risk for the development of psychological distress, problematic behaviours, poor academic outcomes and substance use (Ferguson et al., 1997; Kalil, 2003). Extended social support may buffer this risk and is associated with improved parent-child interactions and greater attachment security in children (Kalil, 2003; Simpson, 1999). Nevertheless, for some families shared parenting, intergenerational conflict, and difficulties in establishing family roles and identities may exacerbate parental stress (Kalil, 2003). Moreover, factors such as cultural values, geographic distance, family disputes, divorce, immigration, and changing social and economic circumstances may impede family's access to extended family support (Seth-Purdie et al., 2006).

### ***Environmental Factors***

Adverse life events, often outside the control of the family (chronic illness, job loss, poverty, death, homelessness, and infertility) are salient sources of stress and risk for individual adjustment and poor family outcomes (Abidin, 1992; Kalil, 2003). Major

stressors are associated with parenting behaviour that is controlling and harsh and with high levels of child deviance (Webster-Stratton, 1988). Furthermore, the probability of harsh discipline increases with the number of stressful events (Webster-Stratton, 1990). Moreover, the distribution of stressful life events in families is unequal. Single-parenthood, teenage non-marital childbearing and low socioeconomic status are major risk factors for family adversity and poor child outcomes (Kalil, 2003, p. 6).

Poverty is the greatest individual risk factor for single-parent families (Kalil, 2003). However, large families and those who relied on social benefits also reported economic distress and pervasive effects on family life, including inadequate housing, poor healthcare, and education and childcare difficulties (Kalil, 2003). Low family income predicted negative and uninvolved parenting, limited opportunities for children's learning (Kalil, 2003; Webster-Stratton, 1990), increased marital distress, insecure child attachments (Sroufe, 2005); low community cohesiveness, exposure to community violence (Wenar & Kerig, 2006), and heightened exposure to negative life events (Zeanah et al., 1997). Finally, consequences for children developing in impoverished environments include developmental delays, poor health, emotional and behavioural problems, and learning difficulties (Kalil, 2003); factors congruent with high levels of parenting stress.

Mechanisms which explain the link between economic conditions and children's development are offered by economic and social capital theories and developmental psychology. Economic theory proposes that deficits in the provision of quality learning materials and the home environment have greater impact on children's development than

reduced parental warmth and parent-child relationships (Miller, 1997). Kalil (2003, p. 40) explains:

Resources can include not only income, but also non-monetary resources such as education and information. A poor family may have a deficit in both material resources (such as housing, food and cognitively stimulating toys and books) and non-material resources (such as education, information and skills). Families with lower incomes have a lower capacity to invest in their children's human capital. Children from such families are likely to do less well in life.

Kalil refers to "human capital" as children's emotional health and wellbeing and proposes that an increased investment of parental time and resources in children's lives is effective in improving their wellbeing.

Alternatively, social capital theory considers that parental investment in social relationships with persons outside the family can be drawn on to provide children with a variety and diversity of opportunities that enhance and promote their development (Kalil, 2003). However, low income families have fewer social networks than wealthy families and their children therefore have less opportunity to benefit. Finally, developmental psychology offers the family process model. This model emphasises that parental stress, induced by poverty, adversely influences parental attitudes, behaviours and wellbeing, which directly affects the quality of parent-child interactions (Kalil, 2003).

Studies show that the availability of emotional and practical support, parents' satisfaction with this and their perception of their experience of poverty, mediated the effect of poverty on psychological wellbeing among single low-income mothers (Olson et

al, 1994 and Thompson & Ensminger, 1989, as cited in Kalil, 2003). Similarly, social support, positive parent-child relationships and an authoritative parenting style weakened the association between economic hardship and negative child outcomes (McLoyd, 1990, as cited in Kalil, 2003).

While evidence suggests that stress is additive, parental stress does not inevitably lead to family dysfunction (Webster-Stratton, 1990). Nonetheless, effective parenting requires considerable social support. Without this, stress may impact on individual wellbeing, parenting behaviour, the overall quality of family life and outcomes for children. One of the community supports provided for parents who struggle in caregiving for children with emotional and behavioural problems, developmental delays, disabilities or chronic illness, is preplanned respite care. This is considered next.

### *Respite Care*

Respite child care serves two primary purposes. Planned respite care was originally developed to provide parents of a child with a disability or chronic illness with a break from full-time caregiving in order to strengthen the family's ability to maintain the child in their own home (Cowen & Reed, 2002; Thurgate, 2004). More recently, the value of respite care has been recognised in a child welfare context. In this context, temporary relief from the demands of parenting "especially for those who experience the additional stress of poverty, isolation or coping alone" is intended to reduce the risk of child maltreatment and long-term out-of-home care (O'Brien, 2001, p. 52). One study found children in respite care "less conspicuous by the extent and severity of physical, behavioural and learning disabilities ... than by the difficulties faced by the parent" (Bullock et al., 1998, p. 176). Respite care is, therefore, an intervention strategy aimed at

enhancing family wellbeing (Cowen & Reed, 2002; FRIENDS National Resource Centre for Community-Based Child Abuse Prevention, 2007; O'Brien, 2001).

Many models of respite care exist with services varying according to purpose (relief for caregivers/from caregiving, meet specific needs of the individual), duration (few hours, a day, short-term residential), location (in-home, out-of-home) and provider (volunteer, friend, relative, public, private, specialist) (Pollock et al., 2001). Parents who utilise respite care services report attending to household chores, spending quality time with a partner or with a child's siblings, catching up with friends or taking time-out for themselves (MacDonald & Callery, 2004; Thomson, 2002).

### ***Impact of Respite Care on Parenting Stress***

A number of studies suggest that planned respite care does reduce stress caused by caregiving for a child with extraordinary needs; however, few papers disseminate models of care (Chan & Sigafos, 2001; Cowen & Reed, 2002; Kirk, 2004; MacDonald & Callery, 2004; Thomson, 2002). Furthermore, much of the research refers to parents of children with disabilities or severe mental health problems. These studies suggest that increased access to respite services is associated with greater reduction in stress and stress-related health problems, improved family functioning, better parental attitudes toward children, fewer out-of-home placements for children, improved marital satisfaction, and reduced social isolation (Bruns & Burchard, 2000; Chan & Sigafos, 2001; FRIENDS National Resource Centre for Community-Based Child Abuse Prevention, 2007; Kirk, 2004)).

Bruns and Burchard (2000) compared the outcomes of short-term respite care for 73 families of children with severe emotional and behavioural problems ( $m = 9.6$  years,

SD = 3.1) over a six-month period, compared to a wait list comparison group. Modest but significantly more positive outcomes were found for families who received services. However, no significant relationship was found between respite care and caregiver stress or respite care and improvement in children's behaviour. Nevertheless, Bruns and Burchard concluded that, in their study sample, increased access to respite care was associated with fewer out-of-home placements and greater parental optimism regarding their ability to care for their child. The respite care was pre-planned and included in-home, out-of-home and overnight foster care options.

Results of an American-wide study of 1014 respite care users, representative of the general population, concluded that "respite care has an overall therapeutic effect on caregivers and their families" (Kirk, 2004, p. 1). Families who utilised planned respite care reported statistically significant improvement on measures of parental stress, mental health, caregiver-child relationships, (fewer) marital separations, and (reduced) out-of-home placements. The Fact Sheet detailing this study states survey measures were field tested and revised on two occasions prior to data collection. However, the full report of the study was able to be accessed ([www.archrespite.org](http://www.archrespite.org)).

In a review of research studies which evaluated the impact of respite care for parents of children with developmental delays on parenting stress, Chan and Sigafos (2001) concluded that while short-term respite care was associated with reduced stress in families (particularly mothers), the benefits may be short-lived. These authors acknowledged there were few studies which objectively measured the effects of respite care on parental stress and those that did had significant limitations. They reviewed no studies which reported respite care in a residential setting.



However, since this review, Cowen and Reed (2002) have researched the impact of respite care for families of children with developmental difficulties (n = 148) on parenting stress. Results of pre- and post-respite measures using the Parenting Stress Index showed that respite care significantly reduced parental stress and improved parental wellbeing and parents' perceptions of their children's behaviour. Again though, the respite care intervention did not include residential care.

Although an anecdotal report, child welfare professionals advocated the benefits of planned respite care in reducing family breakdown and supporting disadvantaged parents to cope better with their difficulties (O'Brien, 2001). They proposed benefits particular to this context, including: relief of stress associated with continual poverty, relief for sick parents, reduced potential for physical abuse, allowance of time for parents to address their own difficulties, a break for children from stressful daily living, a support network for children, an alternative to full-time out-of-home care, and increased parental self-esteem and parenting competence (Aldgate, Bradley & Hawley, 1996, as cited in O'Brien, 2001). O'Brien concluded "the repeated experience of welfare professionals is that respite is a crucial means of preventing child abuse and neglect, by giving vulnerable families a break from the stress arising from adverse economic and social conditions" (p. 62). However, respite care in this context primarily occurs within an alternative family setting rather than in group residential care (O'Brien, 2001).

### ***Respite Care in a Residential Setting***

The literature suggests that respite care in residential settings occurs primarily for children with severe difficulties in families where parents have few alternative supports. Indeed, families who had exhausted the goodwill of extended family and friends or whose

aging grandparents were less able to manage children's caregiving needs, strongly advocated the use of residential respite care (MacDonald & Callery, 2004; Murphy, Christian, Caplin, & Young, 2006). Argent and Kerrane (1997) comment:

Parents whose children present very challenging behaviour found that residential respite care has proved the only reliable option. Some tried a series of family placements which failed and understandably they now prefer the reliability of residential provision. (p. 63)

MacDonald and Callery (2004) interviewed parents of children with disabilities and found that regular, scheduled, residential care for their children was essential to their wellbeing and the stability of their families. One parent was very specific: "I think that if we didn't have [residential] respite we'd be split up as a family" (p. 283). Another family, desperate for a break from caregiving but unable to access respite care, placed their child in foster care for one year. Others similarly considered foster care.

The perspective of nurses interviewed in this study supported that of parents. Furthermore, nurses suggested a change of carers, environment and routines may be beneficial for children. In contrast, social workers perceived residential placement as the "least desirable" option – one that should be reserved for crisis only (p. 285). Social workers felt that removing children from their homes was detrimental to children's wellbeing and that breaks of a few hours or over-night in-home care were preferable to residential care.

A large Australian study which surveyed parents of children with severe disruptive behaviours (n = 1412) found the majority of parents' preferred information-based outpatient services, such as counselling, rather than out-of-home respite care. The

parents in this study ranked residential respite care the lowest of five community service options (Hazell, Tarren-Sweeney, Vimpani, Keatinge, & Callan, 2002).

Whittaker (2006) offers some innovative ideas for optimising the use of residential care in the future. He proposes “a new service continuum that softens the differences and blurs the boundaries between in-home and out-of-home options” (p. 225). In relation to respite services he suggests: “expanding residential respite care options, short-term residential treatment options, increased family involvement, and whole family care combining “respite with holiday time and skill building” (p. 226). For a full discussion of Whittaker’s ideas see Whittaker and Maluccio (2002, as cited in Whittaker, 2006).

### ***Parents’ Experience of Respite Care***

For the most part, the literature illustrates parents’ satisfaction with respite care services (Pollock et al., 2001; Stalker & Robinson, 1994; Thomson, 2002). Parents valued services that were flexible, available and provided high quality care from which they could select the model that best fit the needs of their family at a particular time (Pollock et al., 2001; Thomson, 2002). Pollock and colleagues (2001) found that parents preferred respite care that was frequent and short in duration and chose home-based services as these were least disruptive to the child and family and parents were able to monitor service quality. Mothers interviewed by Thomson (2002) reported that respite care was essential to their own and their family’s wellbeing. Mothers were well satisfied with the care provided and felt supported by the agency. Of highest priority for parents was their need to trust that the service would provide a “positive, enriched and supportive environment” for their child (Pollock et al., 2001, no page).

Parents reported a demand for respite care that exceeded the availability of services (Murphy et al., 2006; Thomson, 2002). Additionally, a number of barriers impeded families' access to respite care. These included agency restrictions such as age, disability, and income eligibility (FRIENDS, 2007); long wait lists and shortages of services together with a lack of trustworthy and competent caregivers, especially for overnight and weekend care (Murphy et al., 2006; Stalker & Robinson, 1994). Researchers found that many parents' lacked knowledge of the services available or were reluctant to seek help (FRIENDS, 2007). Low income families, in particular, were reluctant to seek informal or formal help with parenting citing fear of criticism and judgment and expressed a low level of trust in professional organisations as well as concerns that extended family members lacked sufficient skill to help (Keller & McDade, 2000, as cited in Stevens et al., 2005).

Despite mounting research which supports the positive effects of respite care on parental functioning, an early study by Joyce, Singer and Isralowitz (1983, as cited in Stalker & Robinson, 1994) found no clear relationship between respite care and parental quality of life. Rather, they proposed that it was the "knowledge that relief was available if required [that] enabled parents to cope better". (p. 99)

### ***Children's Experience of Respite Care / Effects of Respite Care***

Increasingly, the importance of listening to children's voices is being recognised in research (Taylor, 2000); nonetheless, only one study was found which directly consulted with children regarding their experience of respite care. Two further studies were located which sought a parent/caregiver advocacy for the child's experience.

Minkes and colleagues (1994) used classroom teachers to interview 63 children and young people, aged ten to 19 years regarding their experience of residential respite care. Respondents had mild to severe communication disabilities which somewhat limited their ability to comprehend and respond to questions. Overall, it was concluded that while the vast majority of young people enjoyed their experience of residential care, others clearly “preferred being at home” (p. 54). Participants in this study were drawn from six residential settings as part of a larger study which evaluated the quality of services provided to children with disabilities. However, the focus of the report is more a reflection of the process of consulting with children with communication disabilities rather than reporting their lived experience.

Gerard (1990) used a postal questionnaire to determine the impact of respite care on children’s and caregivers’ quality of life. Caregivers advocated for children who had severe learning difficulties and received respite care in one of three residential settings. Not surprisingly, Gerard found that children’s past experience of respite care had an impact on their response to being told of an imminent stay as well as the quality of that stay. Overall, Gerard concluded that, according to respondent report, residential respite care had an “overwhelming majority of good effects on resident’s quality of life” (p. 186). While Gerard does not consider it relevant to her study, she identified that a potential problem may occur with parent advocacy in situations where parent’s views may conflict with, or override, those of children.

Stalker and Robinson (1994) interviewed mothers about their perceptions of children’s residential respite care experience. Although two-thirds of children experienced considerable difficulty in settling into respite care, overall, parent reports of

children's homesickness were fewer than expected. The children in this study had severe learning disabilities and were exposed to regular periods of respite care. They had an average age of 15 years. Stalker and Robinson (1994) concluded that:

Respite care does not always have a beneficial effect on the child nor, indeed, on the child's family. In a minority of cases, parents acknowledged that they were the only beneficiaries of the service. However for some parents the lack of an alternative service left them with the choice of coping without any break at all or else continuing to use the service offered. (p. 115)

Oswin (1984, as cited in Stalker and Robinson, 1994, p. 99) also encountered homesickness among children in residential care, reporting "severe, but largely undetected, homesickness was widespread among the children" he observed in residential respite care. Unfortunately this book was unable to be located.

No research was located which examined the experience of children who do not have developmental problems. This leaves a significant gap in the knowledge base regarding children's experience of respite care. Clearly though, from the literature that is available, the experience of respite care is not always a positive one for children.

### ***The Need for Respite Care Services***

Parents' felt-need for respite care services which support them in caregiving for children with extraordinary needs or within adverse caregiving environments is strongly emphasised in the literature (MacDonald & Callery, 2004; Murphy et al., 2006; Pollock et al., 2001; Thomson, 2002). Yet respite care is frequently identified as an unmet need (MacDonald & Callery, 2004; Sturtevant & Elliott, 1994; Thomson, 2002). Furthermore,

family's requirements for respite care change over time and in relation to the age of children (MacDonald & Callery, 2004; Pollock et al., 2001; Thomson, 2002).

Changes in child care practices have resulted in a shifting emphasis from residential to home-based care for children with severe disturbances or disabilities. Consequently, more and more parents are caring for children with complex needs in their own homes. These mothers reported high levels of emotional and physical stress and considered their mental and physical health were compromised by their caregiving role (Murphy et al, 2006; Thomson, 2002). As expected, mothers who spent the greatest number of hours in caregiving reported the poorest health, many feeling "overwhelming feelings of despair with no end in sight" (Murphy et al., 2006). Clearly, parents valued the relief from caregiving that respite care provided. Nevertheless, caregivers also reported positive impacts from caregiving for children with special needs, identifying personal growth, new skills and a new way of looking at life (Murphy et al., 2006; Thomson, 2002).

Many families of children with extraordinary caregiving needs require additional support to prevent a build up of stress which may ultimately impair their ability to care for their child. However, some studies and literature reviews question the service preferences of parents (Hazell et al., 2002; Pollock et al., 2001) and the real and lingering benefits of respite care (Chan & Sigafos, 2001; MacDonald & Callery, 2004; McNally, Ben-Shlomo, & Newman, 1999; Stalker & Robinson, 1994).

Social support is shown to reduce psychological distress (Olson et al, 1994, as cited in Kalil, 2003), improve children's social functioning (Sroufe, 2005); buffer the effects of contextual influences, increase maternal positive involvement with children,

and increase parenting competence (Hashima & Amato, 1994, as cited in Wenar & Kerig, 2006; Webster-Stratton, 1990). Carr (2006) suggests that without social support “parents and children have fewer personal resources for coping with problems and are more likely to drift into problem maintaining interaction patterns” (p. 68). There is much research which demonstrates that competent parenting is crucial in promoting competent child outcomes (Webster-Stratton, 1990; Werner & Smith, 1982, 1992, as cited in Luthar, 2006) and is therefore central in reducing stress associated with the parenting role.

In the current study formal social support occurred through the provision of respite care in a community-based children’s home – a residential setting. This literature review will now turn to residential care.

### *Residential Care*

Residential care as we know it today has evolved from the early institutional accommodation provided for homeless, abandoned and orphaned children, children of poor families, and those with intellectual, sensory or physical disabilities. Often administered by charitable or religious organisations, residential institutions thrived until the mid 1900s when research by John Bowlby precipitated change. Bowlby highlighted the negative effects of institutional care on children’s development and emphasised the importance of a family environment in promoting healthy child outcomes (Crosson-Tower, 2007). This knowledge, together with a desire for more cost-effective services, scandals of abuse, and poor outcomes led to the deinstitutionalisation movement and the rapid growth of foster and kinship care services for children and families in need (Crosson-Tower, 2007; Kendrick, 2008).



### ***Current Trends in Residential Care***

Changes in child care policy and practice have resulted in a dramatic decline in the use of residential care facilities and in the number of children admitted to these (Berridge & Brodie, 1998; Crosson-Tower, 2007). Additionally, the face of residential care has changed. Contemporary residences are likely to be smaller (six to eight children), to accommodate older children, and have a specific purpose, for example, therapeutic treatment (Clough et al., 2006). Facilities vary between a community-like setting with few restrictions and a locked setting with high staff monitoring. Increasingly, children with the most complex needs are being accommodated in single or two-children homes (Clough et al., 2006).

In New Zealand, a range of statutory care options including family homes, specialist family homes and single-child homes provide varying levels of care for children and young people where kinship or foster care placements have failed (Child, Youth & Family, 2004). Residential facilities are the “last resort” option, used when children and young people require 24 hour supervision and alternate placements are not viable. Four care and protection residences (58 beds) and three youth justice residences (108 beds) provide secure accommodation for children and young persons aged eight to 16 years (Child & Youth & Family, nd). Residential facilities have formerly operated from a control model; however, a commitment has been made toward an evidence-based therapeutic rehabilitation approach. This includes a better match between individual needs and services received and increased family/whanau involvement (Child Youth and Family, 2004).

Although the range of care options is increasing, research suggests the complexity of psychological, social and behavioural difficulties of children entering care is also increasing (R. Clough et al., 2006; Dimigen et al., 1999; Tarren-Sweeney, 2007). Many have significant attachment disruptions, exhibit self-harming or harmful behaviours and/or have severe physical disabilities (Crosson-Tower, 2007). A well-cited study by McCann and colleagues (1996) found that 96 percent of children in residential care had some level of psychiatric disorder with almost one-quarter of children diagnosed with major depression. Residential care establishments are, therefore, dealing with the most troubled and troublesome young people (Kendrick, 2008).

### ***Children's Homes***

In a classic study, Berridge (1985) resided for one week each in 20 children's homes throughout England and Wales. More than 200 children aged 18 months to 18 years (median age = 14 years) lived in the homes. Berridge determined five functions of children's homes: respite care, care for sibling groups, recovery from foster placement breakdown, preparation for permanent placement, and control. In terms of respite care, Berridge (1985, p. 124) suggests that children's homes "offer respite in a temporary but stable and less emotionally demanding environment" than foster care. Overall, Berridge noted a "lack of specialization in children's homes and the incongruence between residential styles and children's needs and problems" (p. 127) suggesting that children need careful placement in a residential setting appropriate to their needs.

In a follow-up study, Berridge and Brodie (1998) noted a substantial reduction in numbers of children (less than half), a shift toward the adolescent age-group and greater severity of children's difficulties than in their earlier study. Nevertheless, they concluded

that for comparable groups of young people “children’s homes are equally effective in meeting their objectives as their main alternatives, especially foster care” (p. 24).

In a further study of children’s homes, Sinclair and Gibbs (1998) explored the perceptions and experiences of over 200 children residing in 48 homes. Most commonly children stated they were in care because they were not getting along with others at home. Two-thirds of children were either unsure or thought that residential care was a “bad idea” and reported that bullying, homesickness, loneliness, peer relationships and lax discipline were the most problematic. Younger children liked residential care the least. Parents, on the other hand, saw the effects of residential care as positive but also reported sadness in relation to separation from their child. Sinclair and Gibbs (1998) concluded that a children’s home placement was “not ideal” but reasoned that for many parents it was a pragmatic choice. They found that smaller homes had better social environments, less individual misery and improved children’s social adjustment; however, the effects of size have not been substantiated in other research (Bullock, 2005).

### ***Violence in Residential Care***

Children’s mental health difficulties and early experience of trauma and abuse, together with close contact with children and adults in residential settings, renders them highly vulnerable to abuse and victimisation. Indeed, scandals of sexual harassment, bullying and abuse of children in residential care are rife (Barter, 2008; Crosson-Tower, 2007; Kendrick, 2008). Almost half of children interviewed by Sinclair and Gibbs (1998) reported they had been bullied and almost one quarter of girls and seven percent of boys reported attempted sexual abuse. Children were deemed at most risk from their peers with girls most likely the victim and boys the perpetrator.

In a study of peer violence in children's home, Barter and colleagues (2004) concluded that peer violence occurred on a continuum. High levels of physical and non-contact violence (bullying, threats) were reported by children. Verbal violence was the most common and sexual violence the least common. These authors concluded that "a great deal of the violence ... was hidden from staff" (Barter et al., 2004). Overall, younger children and those bullied in other environments were especially vulnerable to bullying (Barter et al., 2004; Sinclair & Gibbs, 1998).

The official inquiries, reports and research studies in response to allegations of violence have played an important role in reviewing and improving standards of care for children and staff (R. Clough et al., 2006; Mainey et al., 2006). Crosson-Tower (2007) asserts that scandal together with a historic culture of providing shelter, not care, has resulted in residential facilities being considered a "last resort" placement for children; to be used when all other options have failed.

However, recent literature indicates an international resurgence toward evidence-based practice to ensure high-quality standards of care and improved outcomes for children in residential care (and in care in general) and to promote a positive role for residential care (Argent & Kerrane, 1997; R. Clough et al., 2006). Accordingly, Sheryl Burton, Director of Social Inclusion at National Children's Bureau (UK) states "Residential child care is a critical component of the children's services provision for vulnerable children and young people" (National Centre for Excellence in Residential Child Care, 2006, p. 1). Others agree (R. Clough et al., 2006; Kendrick, 2008)

***Other Risks Associated with Residential Care***

There is overwhelming evidence that early institutional care has detrimental and enduring effects on children's development (Johnston, Browne, & Hamilton-Giachritsis, 2006). Specifically, the lack of a sensitive and consistent caregiver and child-caregiver interactions may result in disordered attachment and emotional vulnerability; impaired neurological, cognitive and language development; and predispose children to social and behavioural difficulties (Johnson et al., 2006). However, the quality of later parenting environments, life stress, peer relationships and social support also play an important role in altering patterns of adaptation, beyond attachment alone (Johnson et al., 2006; Sroufe, 2005).

Additionally, trauma associated with the separation of children from their family has been identified as a salient risk factor associated with residential care (Whittaker, 2006), and the development of psychopathology (Rutter, 1979; 1985, as cited in Keenan, 2002). Disrupted attachments in early childhood increase the risk of an insecure attachment style which exacerbates the risk of psychopathology (Sroufe, 2005). Rutter acknowledges that separation may be stressful, but asserts "the lack of an opportunity to form selective attachments is likely to be more damaging" (Rutter, 1995, p. 567).

Although rotation, shift-work and caring for large numbers of children reduce opportunities for residential staff to make emotional investments in children, residential placements offer children with attachment difficulties opportunities for "diluted emotional interactions" with a variety of parenting figures from which they may develop a selected attachment (Crosson-Tower, 2007, p. 389). Less intense relationships may allow children to work on learning to trust (Crosson-Tower, 2007). However, Bullock and

others (2006) caution that new attachments may conflict with earlier (biological or foster) attachments and create a further tension for the child.

Additionally, the predominant feeling of children placed in residential settings is that “they are bad” and that residential placement “is a form of punishment” (Crosson-Tower, 2007, p. 396). Accordingly, children may feel isolated and alone and take time to build peer and staff relationships.

A further risk and concern of parents of children in residential care is the negative influence of deviant and antisocial peers (Whittaker, 2006). This may be well-founded. Indeed, experimental and longitudinal research has shown that, for vulnerable children, deviant peer friendships and peer-group interventions increased problematic behaviours in adolescence and maladjustment in adulthood (Dishion, McCord, & Poulin, 1999).

### ***Children’s Experience of Residential Care***

Research suggests that residential facilities provide stable accommodation and continuous care for troubled children, many of whom report positive experiences and successful outcomes (Happer, McCreddie, & Aldgate, 2006; Sinclair & Gibbs, 1998). Reflecting on their experience, past residents reported “feeling accepted, secure and a sense of belonging”, “the home ... was just a giant family”, and “good parenting without making [me] feel different from the other children” were factors which made a positive difference (Happer et al., 2006, p. 17-18). Additionally, some young people who had lived in both residential and foster care placements preferred residential care (Happer et al., 2006; Kendrick, 2008; Sinclair & Gibbs, 1998).

Similarly, themes of security and attachment were evident in a New Zealand study which explored the perceptions and experiences of children living in a residential care

and protection unit. Marjoram and Fouche (2006) interviewed seven children, aged 11 – 13 years. Of greatest importance to children were a sense of security (safety, trust, belonging), having an attachment (most children wanted contact with family), friendships, relationships with caregivers and staff (secure relationship with one staff member increased children's wellbeing), a sense of identity (children expressed low self-esteem and self-worth), desire for normality (playing sport, joining clubs, hanging out with friends), and having autonomy (freedom, choice, space, residential care is "like a jail") (p. 26). Marjoram and Fouche (2006) reported that listening to children had "provided a highly valuable pool of information which adds meaning to the way children experience life in residential care" (p. 23).

In contrast, a South Australian study found that children living in residential care were less satisfied in their placement than a comparison group of children in foster care (Delfabbro, Barber, & Bentham, 2002). Although both groups reported they were "generally very happy" (mean rating = 8 out of 10) with their placement, those in residential care felt less secure, less understood, less satisfied with the way they were treated and felt their carers were less interested in them than did children in foster care (p. 530). In interpreting these results Dalfabbro and others caution that children in the residential care sample were generally older than children in foster care and had more severe behavioural difficulties. Moreover, the complaints of the residential care group pertained to rules and discipline (no smoking and curfews) rather than quality of care.

The rules and structure of residential settings were also identified as an unpopular feature of residential care by children in a British study (Ward, Skuse, & Munro, 2005). Other unpopular aspects included a culture of delinquent behaviour, bullying, and

homesickness. Some children identified relationships with staff members as the most positive aspect of care while others reported a lack of empathy among staff. Overall, children's experiences were diverse and unique leading the authors to conclude that "professionals will need to understand a range of needs and experiences if they are to help plan and support better outcomes" (Ward et al., 2005, p. 14).

### ***Outcomes of Residential Care***

Evaluation studies of residential care suggest that clear and coherent leadership, staff cohesion, congruent management and staff beliefs and goals, and strong positive staff and child cultures are central to successful outcomes for children (Clough et al., 2006). Additionally, Minkes and colleagues (1994) found that quality of care was associated with children's reporting of favourable experiences, and R. Clough and others (2006) found that the quality of relationships between care staff and children was highly important in determining children's outcomes following discharge from residential care.

Although residential environments may provide a framework for children with attachment difficulties to establish more emotionally secure relationships with residential staff; Clough et al, (2006) also outline less positive aspects – "difficulties of providing unconditional love, constraints on children's emotional development, poor staff continuity and marginalisation of children's families and other welfare services" (p.71). Furthermore, concerns about the impersonal nature of residential care are expressed by parents of children in this form of care (Stalker & Robinson, 1994).

Relative to contemporary residential care, Hill (2000) concluded that at least in the short-term "most [children] usually do show considerable progress during their stay" (p. 22). He cautioned though, that retention of gains beyond discharge depends on the



quality of support provided to the young person. Good quality support provided by birth parents was associated with better outcomes. Studies from the UK have shown that children in residential care performed as well as a comparative group of children in foster care across a number of outcome measures (Hill, 2000).

While some studies show strong support for residential care, others espouse strong criticism. Sinclair (2006) and Whittaker (2006) debated the pros and cons of residential care in the United Kingdom and the United States (respectively). Sinclair (2006) acknowledged that some children chose residential care, while for others it was a necessary form of control. He suggested that residences may have the potential to deliver effective interventions, although as yet, this is unproven. Sinclair further asserted there is no clear evidence that residential care is “more or less effective” than other models of care, stating that homes

... are unstable, and prone to scandal and disorder. They lack a coherent theoretical justification ... the existence of a resident group – is commonly seen as a threat rather than asset. Their outcomes are ... discouraging. They are very expensive ... mak[ing] it impossible to keep young people in them as long as they would often like. They divert resources from former residents and other needy young people alike. (p. 214-5).

Whittaker (2006) reinforced Sinclair’s assertion that the risks associated with group care and the lack of conclusive evidence that residential care is superior to the alternatives has resulted in a lack of belief in residential care. His citation of Bath (2002) reflects the British experience.

... it is not more safe, or better at promoting development, it is not more stable, it does not achieve better long term outcomes, and it is not more efficient as the cost is far in excess of other forms of care. (p. 31, as cited in Whittaker, 2006, p. 217).

### *A View to the Future*

Despite their criticisms, Sinclair and Whittaker appear to accept that residential care will survive into the future and proposed roles and characteristics which may enhance the effectiveness of services. As well, they reflected on the limitations of the current research and urged future evaluations which utilise rigorous methods to compare models of home-based and out-of-home support services provided to children and their families.

Nevertheless, the literature identifies that children are best cared for within their own families, or at least, within a family environment (Johnson et al, 2006; Kendrick, 2008). To this end, the British government has launched an intensive home-based family support programme aimed at reducing out-of-home placements for children at risk of being taken into care or custody (Department for Children Schools and Families, 2007). Trained professionals will deliver Multisystemic Therapy with an aim to retaining young people within their homes, school and communities, and reducing social exclusion.

### *Chapter Summary*

This chapter has sought to provide a background for families' experiences of respite care in a residential setting. As demonstrated, parental capacity for caregiving is shaped by early experience and later environmental context. Nevertheless, challenges to effective caregiving are many and varied and have roots in individual, familial and

environmental factors. Furthermore, individual and familial adjustment to stress is dependent on complex interactions between risk and protective factors. Informal and formal social support is highly valued by families and is fundamental to optimal individual and family functioning. However, stressors do not fall evenly on families and those with few personal, economic and social resources may have difficulty procuring external support. For a number of families, out-of-home respite care fills this void.

The literature, however, reports mixed findings regarding the efficacy of respite care in reducing parental stress. Parent reports favour respite care although studies suggest that real benefits may be small or limited in duration. Few studies have disseminated the model of respite care used and even fewer examined the impact of respite care in a residential setting. Seldom has the impact of respite or residential care on the child been considered. Indeed, the voice of the child is largely unheard. Examination of the literature reveals the experience of respite or residential care may not be a positive one for children. Younger children may be vulnerable to homesickness and peer violence. Furthermore, the literature suggests possible disparities between parent perception and child report regarding the experience of out-of-home care.

Previous studies of residential respite care at the level of the child pertain to children with pervasive developmental, learning or communication difficulties (MacDonald & Callery, 2004; Minkes et al., 1994). The experience of children who live in stressful family environments and whose parents utilise residential respite care to obtain a break from the stress of continuous caregiving has been overlooked. It is important to understand this experience from the perspective of disadvantaged families for the planning and provision of social support services for families in need. The current

study is exploratory in nature and will contribute the views and experiences of children and parents in high-risk families to the small body of research which seeks to understand residential respite care and how it may reflect on parental stress.

### ***The Current Research***

#### ***Aim of the Current Research***

The current research is an attempt to address some of the gaps identified in the research literature: few studies that have explored parents' or children's perceptions and experience of respite or residential care; few studies that have investigated the experience of respite or residential care by a community sample; few studies that have examined the experience of respite care in a residential setting (and measured its impact on parental stress) and; no New Zealand studies that have explored respite care services in a residential setting. The need for such research is therefore clearly evidenced and emphasised in the literature.

Foremost however, this study wishes to give a voice to the children and parents who utilise residential respite care services at Cholmondeley Children's Home in an endeavour to relieve parental stress.

#### ***The Purpose of the Research***

The intent of this concurrent mixed-methods study is to better understand the experience of parents and children who utilise respite care services at Cholmondeley Children's Home and to consider how residential respite care might relate to parental stress. Qualitative data, in the form of parent and child interviews, are used to provide

rich information and insight of participants' lived-experience. At the same time, quantitative instruments are used to provide psychometric estimates of the intensity of parenting stress and other contextual factors which, when converged with qualitative data, will provide a holistic, broad context from which to interpret and understand participants' experience of residential respite care.

Specifically, the research attempts to address the following questions:

- a) What is children's perception, expectation and experience of respite care in a community residential setting
- b) What is parents' perception, expectation and experience of respite care in a community residential setting
- c) How might the experience of respite care relate to parenting stress

### ***Audience of the Research***

It is expected this dissertation will have a limited audience consisting of the research supervisors and examiners, and management at Cholmondeley Children's Home.

### ***The Children's Home***

The location of residential respite care services accessed by families in the current study was Cholmondeley Children's Home in Governors Bay, Canterbury, New Zealand. Opened in 1925, Cholmondeley Children's Home was purpose built and bequeathed to the province by a private benefactor whose vision was to ensure a safe place for children in times of family crisis (Amodeo, 2005). Now a registered Child and Family Support Service, this non-denominational home provides long-term accommodation for around seven children and short-term emergency and respite care for up to 23 more, although the

average occupancy is around 23-24 children. Respite care is provided on a planned or as-needed basis with the average length of stay being seven to nine days. Cholmondeley caters for all children between the ages of three and 12 years, except where the child is known to be a danger to him or herself, other children, and/or staff.

Children come to Cholmondeley for respite care from families who are troubled, disadvantaged, or in crisis. Referrals are received from parents, health, welfare and education professionals, as well as statutory and social service agencies. The goal of Cholmondeley Children's Home is to restore children to their family or prepare them for foster placement. As well as residential care, the home offers an outreach service to families, including home visits and weekly parenting groups which provide a forum for sharing parenting experiences, support, and parenting skills (Cholmondeley Children's Home, 1998).

School-aged children attending Cholmondeley are educated in a two-classroom school located on-site by teachers trained in working with children with special needs. Teaching staff liaise with a child's home school to provide individualised programmes for children. Pre-school children attend a local kindergarten.

Cholmondeley Children's Home operates as a charitable trust and is administered by an honorary Board of Management. Day-to-day proceedings are overseen by a General Manager who works alongside a child psychologist, family social workers, care supervisors, child care workers, administration staff, kitchen staff, and an events and fundraising coordinator. The Home maintains a close partnership with the community and relies on volunteer and financial support from private, community and business

donations, fundraising, membership subscriptions, parent donations, and grants and sponsorship (Cholmondeley Children's Home, 1998).

The current study was conducted in real-time in a real-world situation. No expectations were placed on families, or on Cholmondeley, regarding the use or availability of respite care services. As this is the first outcome evaluation to be conducted with families of Cholmondeley Children's Home this study may become a pilot for further research. The methodology of the current study is now discussed.

## CHAPTER 3

### Method

#### *Introduction*

This chapter describes the design and procedures of the present study. First the decisions made in selecting the research design are discussed and then the selected research design, ethical considerations, participants and procedures, data collection measures, and data collection procedures are presented.

To address the research question it was determined that perceptions of respite care in a residential setting are best derived from the words and actions of participants and the meanings they assign to their experience. The research problem therefore was given the central focus of the study and methodological approaches which would enable the best understanding of the problem were systematically investigated. Thus, a pragmatic approach to knowledge has been adopted for this research. This theoretical perspective allows for “multiple methods, different worldviews, and different assumptions, as well as ... different forms of data collection and analysis” (Creswell, 2003, p. 12).

It was thought that a study of people’s perceptions and experiences would be best conducted using qualitative research methods. Qualitative research explores a little known phenomenon through the experience of participants (Creswell, 2008) and focuses on investigating “*naturally occurring, ordinary events in natural settings*” (italics original, Miles & Huberman, 1994, p. 10). Interested in “what people do, know, think, and feel” (Patton, 2002, p. 145), qualitative research “relies on the views of participants; asks broad, general questions [and] collects data consisting largely of words (or text)” (Creswell, 2008, p. 46). Raw data are gathered from open-ended interviews, observations



or analysing documents, processed (edited, typed up or transcribed) and systematically analysed for themes and patterns. The findings are interpreted and reported in text as well as represented in figures and tables in the written document. The inquiry is conducted in a “subjective, biased manner” (Creswell, 2008, p. 46) drawing conclusions which are tested and verified. Qualitative research is especially amenable to family research where both individuals and family groups may be represented in the research methodology and findings (Daly, 1992).

A pure qualitative approach to the research problem would have provided the “rich descriptions and explanations of processes” (Miles & Huberman, 1994, p. 1) sought to understand the experience of short-term respite care in a residential setting. However, the research question also asks how short breaks of respite care might reflect on parental stress and therefore quantitative methods of research were explored as a means to gauge severity and measure change in levels of parental stress.

Quantitative research methods develop knowledge through the collection, analysis and interpretation of data in numeric form. The quantitative researcher “asks specific, narrow questions, collects quantifiable data from participants, analyzes these numbers using statistics; and conducts the inquiry in an unbiased, objective manner” (Creswell, 2008, p. 46). Predetermined instruments are used to collect information pertaining to individual performance or attitudes and are commonly used for pre- and post-test measures (Creswell, 2003). It was determined therefore, that standardised questionnaire and rating scale instruments would provide useful pre-, during and post- study measures of parenting stress and individual wellbeing that would complement and extend the qualitative data.

After considering these methodologies, it was determined that a combination of both approaches would provide a deeper, broader understanding of the research problem than a single method. A relatively new approach, mixed methods research design provides “a procedure for collecting, analyzing, and “mixing” both quantitative and qualitative research and methods in a single study to understand a research problem” (Creswell, 2008, p. 552). This is a distinct methodology often used in education and social science research (Sieber , 1973, as cited in Creswell, 2008).

### ***Research Design***

An embedded mixed methods research design has been used in this exploratory study. Utilising this approach, qualitative and quantitative data are collected concurrently in one data collection phase, but one strand of data plays a supportive role to the other (Creswell, 2008). The embedded model was chosen because there are two parts to the research problem: the participants’ voice is primary in understanding the experience of short-term respite care in a residential setting but the research also investigates how respite care may impact on parental stress. Accordingly, qualitative strategies have been used to guide this study with quantitative data being nested within to enrich and extend the qualitative data.

Additionally, a collective case study approach has been utilised. The case study provides for the in depth study of a bounded system (individual, group, event or activity), using multiple data collection procedures, over an extended period of time (Creswell, 2008). Boundaries are usually in terms of time or place (Creswell, 2008). Using multiple cases allows for the findings of a single case to be compared in relation to others and for

common themes or differences to be identified and discussed. Caution should be used in generalising findings to larger populations. However, where findings are common across multiple cases it may be possible to generalise these to similar populations (Creswell, 2008).

Qualitative methods, in the form of face-to-face and semi-structured interviews were conducted with parents at four-week intervals over a 12-week study period and with children at the beginning and end of the study and during admissions to the children's home. The purpose of interviews was to ensure that participants were given a voice in their experience and to seek insight and understanding of the meanings that individuals gave to this experience. Interview questions were derived from the literature and focused on family functioning, social support, stability and challenges, peer relationships and participants' expectations, experience and reflections of respite care. Open-ended questions allowed participants to describe and explain their perceptions and experiences in their own terms and provided background information which elaborated their current experience. Participants were therefore treated as experiential experts in the research topic. Although interviews were guided by their focus on the research area, participants were able to give emphasis to matters of their own priority.

Interviews were held in natural settings, usually in the home of families or in the dining room at Cholmondeley Children's Home when participant children were accommodated there. Conducting face-to-face interviews allowed the non-verbal messages of participants and the interactions between parents and children to be observed thereby increasing the validity of the evidence gathered through interview and instrument

measures. All of the interviews were conducted by the author who recorded participant's responses in hand-written notes on the interview form.

Additionally, telephone contact was maintained with families during weeks when personal contact did not occur. This was a brief, informal call which enquired about the wellbeing of family members, day-to-day family matters, and anticipated use of respite care at Cholmondeley. The purpose of telephone contact was to maintain a high level of rapport with families and to monitor their use of respite care services at Cholmondeley Children's Home.

Quantitative data, the embedded form in this study, were collected to provide a holistic and comprehensive context for families' experiences of residential respite care and to validate, or refute, qualitative data. Brief questionnaire and rating scales were used to gather information about family functioning with the minimum burden of time to parents. Questionnaires enquired about parenting stress, minor parenting hassles and major life events as well as adult and child mental health, and were administered at regular intervals throughout the study period. All parents were given the option of having questionnaires presented orally and this was taken-up in one case. Where there were two parents in one family the forms were completed independently. The questionnaire and scale scores provided quantitative estimates that helped to characterise similarities and differences within the group of families and to describe patterns of family functioning across case studies. Additionally, quantitative data provided baseline measures of family functioning from which to measure change over time.

Data analysis in mixed methods research occurs both within, and often between, qualitative and quantitative approaches, relative to the research strategy chosen for the procedures (Creswell, 2003).

Accordingly, a qualitative interpretative phenomenological analysis (IPA) framework has been used to examine the shared experience of participants. Phenomenology “focuses on descriptions of what people experience and how it is that they experience what they experience” (Patton, 2002, p. 107) with the aim of “gaining a deeper understanding of the nature and meaning of our everyday experiences” (p. 104). Phenomenology assumes “that human experience makes sense to those who live it and that human experience can be consciously expressed” (Dukes, 1984, as cited in Creswell, 2007).

Data is collected from individuals who have lived-experience of the phenomenon being studied and “develops a composite description of the essence of the experience for all of the individuals” (Creswell, 2007, p. 58). The researcher is required to get as close as possible to the lived experience of participants while remaining an objective outsider in her interpretation of the meanings and experiences of participants. Lyons (2007) describes the researcher’s role as twofold:

First they strive to put themselves in the place of the participant and second they ask critical questions of the participants’ words, being aware that there is no straightforward and/or direct relationship between what people express and what they experience. (p.162)

In phenomenology the researcher is required to adopt both an empathic and a critical stance; at one time primarily concerned with understanding the point of view of

participants and then standing back to curiously evaluate their account of their experience (Smith & Eatough, 2007). Accordingly, it is necessary to remain open and nonjudgmental of the perceptions and voices of participants. However, the mere process of interviewing means the interviewer and interviewee co-construct their conversation. Furthermore, subjective interpretation of the data necessitates the active implication of the researcher's beliefs and background knowledge in order to understand and describe participant's experiences (Lyons, 2007). To this end, it is anticipated that the use of quantitative data will neutralise any personal bias inadvertently imposed on the qualitative data.

### ***Strengths and Limitations of the Mixed Methods Design***

The mixed methods research design has both strengths and limitations. Primarily, mixed methods incorporate multiple data sources utilising the strengths of both qualitative and quantitative methods, thereby providing “a very powerful mix” in a single study (Miles and Huberman, 1994, p. 42). Furthermore, the data may be collected concurrently resulting in a single data collection phase. Additionally, the findings of one method may complement the other, thereby granting broader perspectives than using a single method alone.

However, Creswell (2008) cautions that mixed methods research is labour-intensive, requiring considerable commitment to collect and analyse both qualitative and quantitative data. As well, both methods must be understood. Additionally, one style of data needs to be transformed to integrate with the other.

Mixed methods are a newly developing model of research and, as such, guidelines for data transformation, analysis, resolving discrepancies between the data, and determining the validity of studies are still evolving (Creswell, 2003).

### ***Data Analysis***

Data analysis is the process of data reduction (Grbich, 2007). In the current study, preliminary analysis occurred at each stage of data collection. By continuously asking “what is the experience of this parent/child of short-term respite care in this residential setting?”; “how is it impacting on parental stress?” and “how is this meaning changing over time?” an emerging picture of the meaning of respite care for each family was constructed.

Data were checked for completeness following each contact with families and were monitored to identify themes that were emerging. In a step identified as *horizontalisation* (Moustakas, 1994, as cited in Creswell, 2007), significant points or phrases in the qualitative data which provided insight and understanding of each participant’s experience were colour-coded with highlighter pens and noted on a summary sheet attached to the interview form. Also noted were contextual factors which may have influenced the contact, results of questionnaire and scale forms, and any factors which needed follow-up. In this way, understanding of the research area developed as data collection progressed.

On completion of data collection, the qualitative and quantitative data were closely examined for insight and understanding at the level of the individual and the family, and within and across questionnaire instruments. The main points were highlighted and reviewed. Meanings were formulated for salient points and clustered into themes common to all participant groups (parents, children, families). Themes were then used to write the description of participant and families’ experiences and factors which may have influenced this – identified as *textual* (what happened) and *structural*

*descriptions* (how was respite care was experienced) (Moustakas, 1994, as cited in Creswell, 2007). Finally, an “essence” summary was composed from these descriptions which described participants’ and families’ shared experiences of respite care. Polkinghorne (1989, p. 46, as cited in Creswell, 2007) suggests the reader should come away from phenomenology with the feeling, “I understand better what it is like for someone to experience that”.

In accordance with the embedded model, the qualitative and quantitative data are reported separately (Creswell, 2008). This is because the data sets reflect different parts of the research question. Patterns emerging from the quantitative data have been used to support the themes derived from qualitative data. The qualitative data are reported with the intent to let the data “speak for itself” with meanings assigned according to the meanings of participants.

Grbich (2007) asserts, the phenomenological researcher must provide a transparency of research process which brings the reader “as close as possible to the experiences and structures of the essences being displayed” (p. 92) suggesting that trustworthiness in phenomenology lies in whether a reader “adopting the same viewpoints articulated by the researcher, can also see what the researcher saw, whether or not he agrees with it” (Giorgi, 1975, p. 96 as cited in Grbich, 2007, p. 92).

In sum, a mixed methods research design employing a concurrent embedded research strategy and using a collection of case studies was chosen for this exploratory research. These methods have provided a holistic and comprehensive context from which to understand families’ experiences of residential respite care for their children and consider how this might relate to parental stress. The qualitative and quantitative data



have been examined in the data analysis phase of the study using a systematic IPA strategy. Themes have been identified and are reported. The use of multiple research methods has strengthened the research design, data collection and analysis thereby enhancing the overall validity of the study (Rand, 2004). This design is therefore appropriate to meet the goals of the current study.

### *Ethical Considerations*

Approval to conduct this study was granted from the Board of Management for Cholmondeley Children's Home (see Appendix A) and from the University of Canterbury Human Ethics Committee (see Appendix B). Approval from the latter pertains to the research design, recruitment of participants, data collection processes and handling of data.

Throughout the planning and implementation of this study awareness has been maintained that families who utilise respite care for their children are experiencing high levels of distress. Accordingly the study has been designed to gather the information necessary to address the research problem with minimal imposition to participants. Prior training in interviewing and counseling skills, together with an empathetic stance toward the emotional state of participants, has kept interviews and personal contact at a level that is supportive and sensitive. For example, data was not collected for one family when the parent was admitted to inpatient mental health care and, following discussion with the parent, the family was withdrawn when it was felt that completing the study may exacerbate the parent's acute mental state. Additionally, to reduce the invasion of family

time over the Christmas and New Year period, contact was not made with participants during this time.

All participants received written and verbal information about the study and gave consent to participate. Parental consent included permission to maintain weekly contact with the family, visit with child/ren while at Cholmondeley Children's Home, and review their child's daily records kept by the home. Child participants gave written or verbal assent to participate according to their level of understanding. Participation in the study was voluntary and participants were informed they may withdraw from the study at any time without consequences. (See Appendix C for the family information letter and Appendix D for consent and assent forms).

All participants were assured confidentiality and anonymity in the research. Accordingly, letter-codes have been used for identification on paper documents and no identifying information has been entered into a computer. Furthermore, the precise timing of the study is not reported, cases are not definitively profiled, and data is presented in aggregated form. Parents have been informed of the written report and where this will be located. Two families have viewed the report prior to submission for examination.

Parents and children were informed, both verbally and in writing, of ethical and professional responsibilities should abuse or neglect be disclosed during the research process. Children were reminded of this during each meeting. Decisions regarding action of such information would be made in consultation with supervisor/s. Prior to commencing data collection discussions were held with an evidential interviewer, appropriate literature was read (Aldridge & Wood, 1998; Bannister, Barrett, & Shearer,

1990; Bourg et al., 1999; Sattler, 1998), and guidelines for dealing with disclosure were prepared (see Appendix E).

At no time has intentional deceit been involved nor information purposefully withheld from participants. On completion of the study participants were sincerely thanked for their contribution and given family movie passes in acknowledgement.

### ***Participants and Procedures***

#### ***Recruitment Design***

The potential sample group for this study was all families who were new self-referrals to Cholmondeley Children's Home over a ten week period. New- and self-referrals were required as it was wished to explore parents and children's first experiences of respite care at the children's home in a community-based population.

Given the above inclusion criteria, some families have been excluded from the study. These include families whose children are in the custody of the Chief Executive of Child, Youth and Family as their participation would have required statutory consents which are not readily obtained. As well, families who utilised respite care in an emergency situation were excluded. This was because the research design states that information meetings will be held with families prior to children attending Cholmondeley in order to ascertain their perceptions and expectations of residential respite care. Moreover, families who made emergency admissions to Cholmondeley were likely to be in extreme crisis, a situation not conducive to participation in a 12-week research study.

Participation in the study was by way of purposeful selection. New families to Cholmondeley were intentionally selected into the study as their stories could provide the

rich and meaningful information needed to understanding the real-world experience of short-term respite care in a residential setting. Furthermore, the site of Cholmondeley Children's Home was chosen because it is unique in its provision of residential respite care for children living in the community. Notwithstanding purposeful selection, all parties participated in the study of their own free agency.

### ***Recruitment Procedures***

During the recruitment period, all families who met the above criteria and had received an admission date for their child/ren, (so they did not feel obliged to participate in order to be accepted at Cholmondeley) were contacted by telephone by the residential psychologist who informed them of the study. Families were advised their participation was completely voluntary and would not impact on their relationship with Cholmondeley.

Parents who agreed to receive further information about the study had their contact details forwarded by the psychologist, via email, to the researcher who telephoned them to introduce the study. Where they agreed to meet to discuss and receive written information and requirements of participation, a time was arranged. Parents were invited to have a support person attend this and future meetings. Parents who agreed to participate completed the family consent forms. Families were then deemed to be participants in the study.

### ***Participation Rate***

Eleven families new to the children's home referred their children for respite care during the recruitment period. One family was unable to be contacted by the residential psychologist; therefore, ten families were approached to inform them of the study. Of

these, nine families agreed to their contact and admission details being forwarded for inclusion in the research sample. On receiving preliminary information about the study two families declined further involvement. One family cited the additional stress participation would incur, such as in keeping appointments; the other gave no reason. Thus, parents in seven families agreed to receive further information regarding the study. Of these, the parent in one family was unable to be located at the arranged meeting time nor contacted thereafter. Upon receiving verbal and written information about the study a further parent declined the participation of his family. This parent was concerned that questions to be asked of his child would place undue strain on the child. The difficulties encountered in contacting and recruiting parents in research is reported by other studies (Sinclair & Gibbs, 1998).

Overall, recruitment was achieved in 50 percent of families who received some information about the study. The demographic information available makes it difficult to characterise the differences between families who did and did not participate in the study. Both groups comprised single, separated and coupled parents, and families where some of the children would be admitted for respite care and others would not. It is therefore suggested that the research sample reflects a more stable, somewhat organised group of families who experienced high, but not unmanageable levels of stress and therefore does not accurately represent all families who self-refer for respite care at Cholmondeley Children's Home.

As already reported, one family was withdrawn from the study. The child in this family experienced respite care at Cholmondeley Children's Home on one occasion with

planned second and third admissions thwarted by the parent's deteriorating mental health. Consequently, data collected for this family are not included in the report.

### *Participant Characteristics*

Participants were four families who were purposefully selected to the study because they utilised short-term residential respite care at Cholmondeley Children's Home. The families comprised five parents and 13 children, seven of whom attended the home. Five parents and seven children (four boys and three girls) thus made up the research group. The children's ages ranged from three to 11 years with a median age of seven years. Two families had one child in the study, one family had two children, and one family had three children who were study participants. Three families had children who were not admitted to respite care at the children's home. The children in one family lived in the legal custody of their maternal grandmother and another child lived in a stepfamily. One parent and five children identified as Maori, the remainder as European. Table 1 displays the family grouping of children who participated in the study. They are in random order and do not relate with the order of families presented in tables in the Findings section of this report.

Table 1

#### *Family grouping of children in the study and timing of respite care*

	<b>FAMILY</b>	<b>FAMILY</b>	<b>FAMILY</b>	<b>FAMILY</b>
<b>Age of Children</b>	5, 7, 11	8	3, 7	4
<b>Gender of Children</b>	Male, Female, Female	Female	Male, Male	Male
<b>Timing of Respite Care</b>	Week 1	Week 1	Wks 1, 12	Wks 1, 12

The median age of parents was 29 years. The range was 24 to 51 years. All parents attended secondary school, at least until their third year, and two parents had completed additional training upon leaving school. One parent had full-time employment, one casual employment, and the remainder received a welfare benefit. One family had married parents; all others were headed by single women, none of whom reported stable intimate relationships. One family owned their home; others lived in rented homes and reported extensive histories of unstable accommodations. All parents had private transport, except one who relied on walking, public transport or the good-will of friends.

Two parents reported respite care at Cholmondeley Children's Home in their own childhoods. Others families were recommended Cholmondeley by community support agencies and in one case, by an extended family professional.

### ***Data Collection Procedures***

Continuous measures of qualitative and quantitative data were collected for each family for a period of 12 weeks. Upon completion of the family consent form parents were invited to continue with the initial interview and questionnaire forms or to arrange a later time to meet and complete these. In every case parents chose to continue. After the initial data were collected another time was arranged to meet with those children identified as attending respite care at Cholmondeley Children's Home. This meeting occurred either at the family home prior to children's admission to Cholmondeley (50 percent of child participants) or while the child was at Cholmondeley, according to the circumstances of each family. Children were introduced to the study using developmentally appropriate language and assent attained for their participation. In every case, this occurred prior to data collection.

Qualitative data in the form of semi-structured interviews were collected at the beginning, during and end of the study. Face-to-face interviews were held with parents and children as families entered the study, or at the latest, during the first week of participation. In addition, weekly contact was made with each family during the study period, excluding the week of Christmas and New Year. Contact was in person or by telephone depending on the requirements of data collection and the perceived needs of the family. Telephone contact seemed less intrusive for some families, while other families appeared to welcome the social contact. Contact was informal with telephone calls generally five to ten minutes long and visits in person lasting 30 to 120 minutes, depending on how much information the parent wished to share. Face-to-face interviews were again conducted with parents and children on completion of the study period. These occurred in conjunction with collecting quantitative data and were held at the family home. The duration was approximately one hour.

In addition to qualitative data gathered by interview format, the children's home records pertaining to each child's experience of respite care at Cholmondeley Children's Home were reviewed. These records provided additional information about the day-to-day functioning and adaptability of the children in the home setting.

Quantitative measures of stress related to the parental role were taken using the *Parenting Stress Index – Short Form* and the *Parenting Daily Hassles* on commencement of the study and again during weeks 4, 8 and 12. In addition, information was gathered regarding the number and lingering impact of stressful life events experienced by parents. The *Recent Life Events* scale was used at the beginning of the study to record major events of the previous year and again at the end of the study recording events that had



occurred in the 12 week period of the study. Measures of adult wellbeing and children's emotional and behavioural difficulties were recorded at the beginning and end of the study using the *Adult Wellbeing Scale* and the *Strengths and Difficulties Questionnaire* respectively. The procedure for data collection is detailed in Table 2.

Table 2

*Timing and frequency of qualitative and quantitative data collection methods*

<b>WEEK</b>	<b>QUALITATIVE METHODS</b>	<b>QUANTITATIVE METHODS</b>
<b>1</b>	Parent semistructured interview Child semistructured interview Researcher met with child while in residential respite care at children's home – semistructured interview	Parenting Stress Index Parenting Daily Hassles Recent Life Events Adult Wellbeing Scale Strengths and Difficulties Questionnaire
<b>2</b>	Weekly contact with parent/s	
<b>3</b>	Weekly contact with parent/s	
<b>4</b>	Weekly contact with parent/s	Parenting Stress Index Parenting Daily Hassles
<b>5</b>	Weekly contact with parent/s	
<b>6</b>	Weekly contact with parent/s	
<b>7</b>	Weekly contact with parent/s	
<b>8</b>	Weekly contact with parent/s	Parenting Stress Index Parenting Daily Hassles
<b>9</b>	Weekly contact with parent/	
<b>10</b>	Weekly contact with parent/s	
<b>11</b>	Weekly contact with parent/s	
<b>12</b>	Parent semistructured interview Child semistructured interview Review of children's home records relating to each child's experience of respite care	Parenting Stress Index Parenting Daily Hassles Recent Life Events Adult Wellbeing Scale Strength and Difficulties Questionnaire

*Note:* Weekly contact with parents occurred either by telephone call or home visit according to the perceived needs of the parent. Personal visits were made with children each time they had respite care at the children's home.

### *Data Collection Measures*

#### *Interviews*

A series of semi-structured exploratory interviews comprising open-ended, neutrally worded, though focused questions were conducted with parents and children. Open-ended questions with probes allowed the participants to discuss their personal thoughts, experiences, feelings and opinions and to elaborate on matters they felt were important. The purpose of the interviews was to gain insight into and try to understand each participant's perceptions, expectations and experience of short-term residential respite care. As well, interviews yielded the direct quotations used in this report.

Interviews were conducted with parents and children at the beginning, during and end of the study (see Appendix F for parent interviews and Appendix G for child interviews). The initial interview with parents sought information about the composition of the family, family relationships, functioning and support systems. As well, parents were asked how they knew of the children's home, their plans and expectations of respite care for themselves and their child/ren, and how they perceived that residential respite care may make a difference to their family in the short and longer term. In the two-parent family the interviews were conducted as a couple, otherwise parents were met alone. The duration of the initial interview was one-and-a-half to two hours depending on how much information parents wished to share.

A meeting was also conducted with the child or children who would be attending Cholmondeley Children's Home. All children had been informed of their impending stay at Cholmondeley. Child/ren were told about the study, using developmentally appropriate language appropriate. It was explained that although their parent/s had agreed for their

family to participate, their individual agreement was also sought. Matters of confidentiality, freedom to withdraw from the study at any time, and the need to report the disclosure of abuse or neglect, were discussed with each child. Written assent or verbal assent to participate was obtained from children according to their ability to comprehend and sign the form.

The initial focus of the interview with children was on relationship building and covered their hobbies, pets, friends and school. Once a mutual rapport was established, the children were asked more specific information-gathering questions, such as words they would use to describe themselves, about their relationship with family members, their roles at home, why they thought they were going to Cholmondeley and what they thought this would be like. Generally, this discussion lasted around 30 minutes.

The research plan was for the initial interviews with parents and children to be conducted prior to the child/ren's first admission to Cholmondeley. However, due to parent and child sickness, unplanned or short-notice admissions to the home, and a parent changing telephone numbers, this occurred in 40 percent of cases. Where meetings with parents were not conducted prior to the child's admission to Cholmondeley, this meeting occurred at the earliest possible convenience to parents, but always before meeting with the child. In the instance where the parent had changed her contact details, this occurred after the child (aged four years) had returned home from two days of respite care. Prior commitments and the parent's unavailability during the evenings were compounding factors in this delay.

Throughout the study parents were contacted on a weekly basis, excluding the week of Christmas and New Year. Contact occurred in person during weeks 4, 8 and 12

when questionnaire forms were repeated, and in person or by telephone in interim weeks. Contact was informal with telephone calls generally lasting five to ten minutes and visits in person lasting 30 to 60 minutes, depending on how much information the parent wished to share. Personal visits usually occurred at the family home although one participant lived with a relative for a period of time and chose to meet at a shopping mall. Records of all participant contact were maintained (see Appendix H).

Participant children were visited at Cholmondeley during each period of respite care. In families where children were already at the home when information meetings were held with parents, additional time was taken to introduce and inform the child of the study, gain their assent to participate and build rapport. This followed a similar format to that used for children met in their family home. Very young children were supported during meetings held at Cholmondeley Children's Home by an older sibling or a staff member.

All children chose to participate in a kinetic family drawing activity during initial visits at the children's home. In this activity children are asked to draw every member of their family doing something and the drawing becomes the focus for discussion about a child's family and his or her model of the world. Trained clinicians gain information beyond that given by the child through observing the child's approach to the activity and interpretation of the content of the drawing (Beaver, 1996). In the current study the drawing was used a medium for talking with the child about his or her family and family roles. Additionally, children were asked about their current experience at the children's home. An informal semi-structured interview was used to guide this meeting with

children and to record children's responses. In general, the duration of these meetings was 30 to 45 minutes.

Semi-structured parent and child interviews were again conducted with each family on completion of the 12-week study period. Interviews with parents sought information about their experiences of residential respite care for their child/ren and of their perception of this experience for the child/ren. As well, parents were asked about perceived changes in themselves, the child/ren and in family functioning. Finally, parents were asked about their plans for continued use of respite care, whether they would recommend this to their friends, and a retrospective question pertaining to things they may do differently given the opportunity to begin the process over. Interviews held with children at completion of the study period focused on their experience of respite care at Cholmondeley Children's Home and their views regarding further periods of respite care.

Throughout the 12-week study period at least four face-to-face interviews and 11 telephone contacts were conducted with each family. Many more attempts at telephone contact went unanswered. Such close contact with families enabled a high level of rapport to be maintained with participants and facilitated in depth learning about the family and the stressors which impacted their day-to-day functioning. In addition to exploring participants' experiences of residential respite care, the research investigated how this may reflect on parental stress.

### ***Measures of Parenting Stress and Wellbeing***

The research asks whether short breaks of residential respite care may have an impact on parental stress. Quantitative instruments were used to provide baseline and continuing estimates of parental stress to support the qualitative data in exploring this

question. Self-report measures of stress relating to parent and child relationships and frequent parenting hassles (*Parenting Stress Index-Short Form* and *Parenting Daily Hassles*) were administered with parents at intake and during weeks 4, 8 and 12 of the study. Additionally, the *Recent Life Events* scale was administered at entry and exit points to the study. Furthermore, the literature indicated that parent and child mental health has a substantial impact on parenting stress and therefore measures of psychological wellbeing (*Adult Wellbeing; Strengths and Difficulties Questionnaire*) were made at entry and exit points to the study. The instruments selected to measure these constructs are now presented and discussed.

#### ***Parenting Stress Index-Short Form.***

The Parenting Stress Index-Short Form (PSI-SF) was used to identify stress in the parent-child relationship. Stress associated with parenting is related to psychological problems in parents and behavioural difficulties in children (Creasey & Reese, 1996). A derivative of the full-length Parenting Stress Index (PSI), the PSI-SF is a brief self-report measure designed to be administered in less than ten minutes and is suitable for parents of children aged one month to 12 years (Abidin, 1995). For reasons of copyright the PSI-SF is not included as an Appendix).

Parents indicate their level of agreement with statements reflecting parenting experiences on a five-point scale (*strongly agree, agree, not sure, disagree, strongly disagree*). The 36 items contribute evenly to three subscales: Difficult Child (stress results from behavioural characteristics of the child), Parent Distress (personal distress related directly to parenting), and Parent-Child Dysfunctional Interaction (parent views

interactions with child negatively). A score indicating the degree of Total Stress incurred in the role of parenting is obtained by summing the subscale scores ((Abidin, 1995)).

The PSI-SF was hand-scored following directions in the manual (Abidin, 1995). Subscale scores between the 15<sup>th</sup> and 80<sup>th</sup> percentile are deemed within the normal range, between the 81<sup>st</sup> and 84<sup>th</sup> percentile in the borderline range, and scores in the 85<sup>th</sup> percentile or greater indicate high levels of parenting stress. Total Stress scores at or above the 90<sup>th</sup> percentile indicate clinically significant levels of stress (Abidin, 1995). Additionally, the PSI-SF incorporates a Defensive Responding scale comprising seven items from the Parental Distress scale. Scores of ten or below indicate the parent has responded to items with a strong bias toward presenting a favourable impression of himself or herself or minimises signs of difficulties in the parent-child relationship. This score does not contribute to the Total Stress score (Abidin, 1995).

The PSI-SF is based on factor analysis of the full-length PSI and was developed in response to requests for a brief screening instrument to identify, assess and evaluate parenting stress. Although sound reliability, construct and predictive validity for the PSI is well documented across populations, and Abidin (1995) found high correlations between Total Stress scores on the two tests ( $r = .94$ ), few independent examinations of the PSF-SF have been conducted. Nevertheless, evidence for the psychometric properties of the PSI-SF is growing and support high internal consistency (alpha range across subscales = .80 to .87) and stability over time. Results are mixed regarding discriminant validity and the factor structure is the subject of ongoing debate (Haskett, Ahern, Ward, & Allaire, 2006; Reitman, Currier, & Stickle, 2002; Roggman, Moe, Hart, & Forthun,



1994; Whiteside-Mansell et al., 2006). The PSI-SF is a suitable instrument for use with low income and ethnic minority groups (Reitman et al., 2002).

***Parenting Daily Hassles.***

The Parenting Daily Hassles (PDH) scale was used to give estimates of the day-to-day frustrations and inconveniences that occur within the parenting context. Frequent and intense minor parenting hassles were related to detrimental effects on family functioning, including parents' psychological wellbeing, parenting satisfaction, parent-child relationships (Creasey, 1996; Crnic & Greenberg, 1990) and may exacerbate parenting stress (Patterson, 1983).

The PDH scale contains 20 brief statements that describe common parenting experiences associated with children's challenging behaviour or with parenting tasks and can be used to monitor change over time. Parents rated each statement on two Likert scales, first scoring the frequency an event occurs "*Rarely*", "*Sometimes*", "*A lot*", or "*Constantly*", and then recording how hassled they felt by the event on a 5-point scale labeled 1 (low hassle) through 5 (high hassle) (Crnic & Greenberg, 1990). The scale takes approximately ten minutes to complete. (See Appendix I).

Four subscales are derived from the PDH scale: Frequency, Intensity, Challenging Behaviour and Parenting Tasks. The Frequency scale is calculated by summing the frequency ratings (*rarely* = 1, *sometimes* = 2, *a lot* = 3 and *constantly* = 4) of all items. Individual scores of three or four indicate an above average frequency of this event. The range on the Frequency scale is 0 to 80; scores above 50 indicate a high frequency of minor parenting hassles. The Intensity scale is scored by summing parent ratings on the hassle items. Scores of four and five indicate this event causes some difficulty to the

parent. The range on the Intensity scale is 0 to 100 with scores above 70 indicating the parent is experiencing significant pressure in day-to-day parenting. Total scores on the Challenging Behaviour rating are calculated by summing scores on the Intensity scale for items 2, 4, 8, 9, 11, 12, and 16. The range for Challenging Behaviour score is 0 to 35 with high scores indicating the parent perceives parenting difficulties as lying in the troublesome behaviour of the child/ren. Finally a measure of parenting tasks is calculated by adding scores on the Intensity scale for items 1, 6, 7, 10, 13, 14, 17 and 20. The range for the Parenting Tasks score is 0 to 40. High scores in Parenting Tasks indicate the parent perceives parenting hassles as lying in the role of caregiving.

Crnic and Greenberg (1990) report the PDH scale has adequate internal consistency ( $\alpha = .81$  for frequency scale and  $.89$  for intensity scale) and high correlation between the two scales ( $r = .78$ ) as well as good predictive validity, suggesting the scale is a useful measure of parenting stress. Creasey and Reese (1996) further reported good re-test reliability ( $r = .77$  over six months) and found that mothers and fathers of children with average behavioural problems (measured on the Child Behaviour Checklist) reported consistent results across all scales for parenting hassles. The PDH scale has also been used in large population studies such as the *Framework for the Assessment of Children in Need and their Families* (Department of Health, Department for Education and Employment, & Home Office, 2000). This British study assessed families where children were accommodated in respite care and residential care as well as with their families.

***Recent Life Events.***

The Recent Life Events questionnaire was used to identify major events which have occurred for parents in the previous 12 months and then during the study period. Major life stressors, although occurring infrequently in most families, are negatively related to healthy child, parent and family systems. Furthermore, the literature shows that significant events occur unequally among families (Kalil, 2003; Webster-Stratton, 1990). Knowledge of the number of significant life events and their ongoing effect provided rich contextual information regarding stress experienced by families.

Comprising 21 statements related to significant events, parents ticked boxes if they have experienced the event and if the event has an ongoing influence. Some items pertained to the respondent individually and others included immediate family members. Each ticked item received a score of 1. A high number of significant life events indicate an increased likelihood of an enduring impact on parent, child and family systems. This is especially so if the impact of events is ongoing. (See Appendix J).

This scale, used in the *Framework for the Assessment of Children in Needs and their Families* (Department of Health, 2000), was developed from a scale by Brugha, Bebington, Tennant and Hurry (1985) with further items added.

***Adult Wellbeing Scale.***

Based on the Irritability, Depression, Anxiety (IDA) Scale (Snaith, Constantopoulos, Jardine, & McGuffin, 1978), the Adult Wellbeing Scale (AWS) was used to assess the mental health status of parents in the study. The cumulative impact of frequent parenting hassles, children with challenging behaviours and stressful life events are likely risk factors for the development of psychological symptoms in parents (Creasey

& Reese, 1996). Moreover, parent's psychological problems, such as depression or substance use, may influence their interpretation and management of children's behaviour and negatively impact on family functioning (Goodman & Gotlib, 1999).

The AWS contains 18 brief statements, expressing both a healthy and morbid mental state. Each statement has four possible response options and the scale takes approximately ten minutes to complete. Four subscales are derived from the test items: Depression (5 items), Anxiety (5 items), Outward Directed Irritability (4 items) and Inward Directed Irritability (4 items). Scoring varies across subscales and is detailed in the authors work. Scores of 4 to 6 on the Depression scale, 6 to 8 on the Anxiety scale, 5 to 7 on the Outward Directed Irritability scale, and 4 to 6 on the Inward Directed Irritability scale are considered borderline with higher scores indicating likely difficulties in this area. The AWS is located in Appendix K.

Derived from existing scales and inpatient and outpatient self-reported behaviours the authors report "reasonably satisfactory" reliability of this scale, however, no independent research was located. The scale has been utilised in recent studies such as a pre-and post-test intervention for panic disorder (Nutt & Glue, 2004) and was included in the *Framework for the Assessment of Children in Need and their Families*.

#### ***Strengths and Difficulties Questionnaire.***

The Strengths and Difficulties Questionnaire (SDQ) was used to assess parent perceptions of challenging behaviours among the child participants. Children's behavioural difficulties are found to be predictive of parenting stress (Crnic & Greenberg, 1990). A brief single page format, the SDQ contains 25 attribute statements, both positive and negative, which contribute to five clinical subscales of five items each: Conduct

Problems, Emotional Symptoms, Hyperactivity, Peer Problems and Pro-social Behaviour. Devised for children aged 4 to 16 years, a modified scale is available for younger children.

Parents recorded their level of agreement with items that described behaviour over the last six months, using a 3-point Likert scale (*not true, somewhat true, certainly true*). A Total Difficulties score is generated by summing the scores for all but the pro-social behaviour subscale. Additionally, an impact supplement enquires about the chronicity of difficulties, distress experienced by the child, impairment to the child's functioning and burden of care to the family. The SDQ and impact supplement takes five minutes to complete. It is downloadable free-of-charge from the World Wide Web and can be scored online ([www.sdqinfo.com](http://www.sdqinfo.com)). (See Appendix L).

The SDQ is shown to reliably distinguish psychiatric disorders among children and adolescents in community and clinic populations (Goodman, Ford, Simmons, R., & Meltzer, 2000; Mathai, Anderson, & Bourne, 2002). The data collected for children in the study were compared to a normative population of British children, aged 5–10 years ([www.sdqinfo.com/bba3.pdf](http://www.sdqinfo.com/bba3.pdf)). Cutoff scores are reported as normal, borderline or abnormal ranges. Total Difficulties scores in the borderline or abnormal range or on any of the conduct, emotional symptoms, hyperactivity and peer problems scales indicate the likelihood the child has a significant problem (Goodman, 1977).

The SDQ is a reliable and valid screening tool, used internationally in the assessment of children's behavioural, emotional and relationship difficulties, and in evaluating intervention (Goodman, 1977; Goodman et al., 2000). The SDQ correlates highly with the Rutter Scales (Elander, 1995; Goodman, 1977) and the Child Behaviour Checklist (Achenbach, 1991; Goodman & Scott, 1999), and moderately with the

HoNOSCA (Mathai et al., 2002). Of high relevance in this study, the SDQ has shown to be an appropriate and reliable instrument to assess behavioural difficulties among Māori children (TeWhata, 2006).

### ***Cholmondeley Children's Home records***

The daily records written by staff during each child's period of respite care were reviewed. These records provided information about children's emotive experience of respite care, such as how they adapted to routines at the home and their relationships with other children. The perspective of staff is not a focus of this research and these records are therefore not reported directly. Nevertheless, they contribute an additional source of information that is useful in understanding and validating the children's report of their respite care experience and are referred to, where appropriate.

### ***Chapter Summary***

The overall objective of this dissertation was to explore parents and children's experiences of respite care in a residential setting and to gain insight and understanding of the meanings they gave to their experience. Additionally, the research question explored how short-term residential respite care may reflect on parental stress. Participants in the study were four families comprising five parents and seven children, purposefully selected to provide rich information and insight into the research problem. An embedded mixed methods research design was used incorporating the simultaneous collection of qualitative and quantitative data. The primary approach to the research was qualitative. Qualitative data were collected from regular face-to-face interviews, telephone contacts and indirect observations of parent and child interactions, over a 12-week period. As

well, quantitative data in the form of self-report measures of parenting stress, major life events and parent and child wellbeing were collected across the study period. The data were systematically analysed using a phenomenological approach. The research design, selection of participants, and data triangulation provided a valid framework from which to explore the research problem. The findings are now reported.

## **CHAPTER 4**

### **Findings**

The intent of this research was to explore and understand parents and children's experience of respite care in a residential setting as well as to consider how respite care might relate to parental stress. This chapter explains the data analysis process and reports the data collected.

An embedded mixed methods research design has been used in this study. In this approach, qualitative and quantitative data have been collected concurrently in one data collection phase, with one strand of data playing a supportive role to the other (Creswell, 2003). Accordingly, the primary data has been collected using semi-structured interviews conducted with parents and children over a 12-week period. At the same time, questionnaire estimates of parenting stress, stressful life events and parent and child wellbeing were made. The intent of quantitative data is to provide a more holistic and comprehensive context for the voice of participants and to validate the qualitative data.

Thus, qualitative methods provide the framework for analysis of the data. Interviews conducted with participants have been carefully and thoroughly read and analysed using a systematic phenomenological approach. Phenomenology values the voice and lived experience of the participant and strives to gain a deeper understanding of the meaning that participants give to their experience (Patton, 2002). The qualitative data have been examined from both an individual and familial perspective. Main points were highlighted and meanings formulated. Themes common to individuals and families have been developed from the main points and are used to guide the report and interpretation



of the research findings. A phenomenological report describes the essence of the lived experience of participants. Accordingly, the voice of participants is used to tell their story.

The quantitative data have been analysed to give deeper insight and understanding of the qualitative data. The data have been examined at an individual and familial level both within and across instruments. Through the process of triangulation, the qualitative and quantitative data have been analysed for areas of convergence and divergence. Convergence between the data will increase the validity of the research. Divergence will indicate areas where future research may facilitate greater understanding. In accordance with a mixed methods design where qualitative approaches provide the framework for the research, the quantitative data are reported in text. However, the data are also displayed in tabulated format to visually assist the reader through the findings.

Five parents participated in the study and the data is reported in consistent order. That is, Parent 1 is the same parent in each table. Nevertheless, this does not correspond with the order of families as detailed in Table 1, nor the order that data pertaining to the children is listed in Table 7. The reporting of SDQ scores for children is in randomised, not familial order.

Furthermore, the questionnaire and rating scales used in this study are self-report measures and therefore should be interpreted with caution as parents may underestimate or exaggerate distress. Accordingly, *High*, *Moderate* or *Low* scores do not conclusively guarantee that significant levels of distress are present, or absent.

A case study approach has also been used in this study. This has played a minor role in the reporting of findings. The reason for this is to preserve the anonymity of participants. However, a brief précis of quantitative data for each family is reported to

provide the reader with a familial context for participants' commentary of their experience.

This chapter will first report the findings of the quantitative data followed by the qualitative data. This is because the quantitative data provide a background for the perceptions and reflections of participants.

### ***Parental Stress***

Six parents, five mothers and one father, completed the estimates of parental stress using the Parenting Stress Index-Short Form (PSI-SF) and the Parenting Daily Hassles (PDH) questionnaires. These were completed at four-week intervals throughout the study period. The questionnaires give estimates of the level of stress experienced by parents in their parenting role. In addition, the Recent Life Events (RLE) questionnaire recorded stressful life events and their ongoing impact as experienced by parents in the 12 months prior to the study and during the study period.

### ***Comparison of PSI-SF Scores***

The Total Stress score is assumed of primary importance in determining levels of stress in the parent-child system and for identifying families who may be at risk for the development of dysfunctional parenting behaviours or problematic behaviours in the child (Abidin, 1995). This score reflects the sum of the three subscales which estimate personal parental distress (PD), stress associated with parent-child interactions (P-CDI) and stress derived from the child's behavioural characteristics (DC). The Total Stress and subscale scores derived from parent report are displayed in Table 3.

Table 3

*Parent estimates of stress measured on the Parenting Stress Index-Short Form during weeks 1, 4, 8 and 12 of the study.*

Parent	Total Stress				Parental Distress				Parent-Child Interaction				Difficult Child			
	Wk 1	Wk 4	Wk 8	Wk 12	Wk 1	Wk 4	Wk 8	Wk 12	Wk 1	Wk 4	Wk 8	Wk 12	Wk 1	Wk 4	Wk 8	Wk 12
1	C	C	C	C	C	C	C	C	C	N	C	C	C	C	C	C
2	C	C	C	C	L	N	N	N	N	C	C	C	C	C	C	C
3	VH	C	C	C	N	VH	N	C	N	C	H	N	C	C	C	C
4	VH	C	C	C	L	N	N	N	C	C	C	C	C	C	C	C
5	C	C	C	H	C	C	C	C	C	C	C	N	C	C	C	L

*Note:* L = low range (scores below 14%); N = normal range (scores of 15%-80%); H = high range (scores of 81%-85%); VH = very high range (scores of 86%-89%); C = clinically significant levels of stress (scores of 90% and above)

The Total Stress scores suggest that all parents reported clinically significant levels of stress associated with the parenting role across the majority of the study period. At intake, two parents reported very high levels of stress which increased to within the clinical range from week two and beyond. The Total Stress score for one parent lowered from the clinical range to the high range at conclusion of the study period.

The Parental Distress subscale reflects general emotional distress and dissatisfaction within the parenting role. The results indicate varying degrees of parental distress. The scores for two parents were within the clinical range across the study period and a further two parents were within the low to normal ranges. The scores for the final parent fluctuated between the normal, very high and clinical ranges. Elevated scores on the PD scale suggest that stress in the parent-child system may relate to dimensions of

parent functioning, for example, low parenting competence, depression, lack of social support, inter-parent conflict and role restriction due to parenting (Abidin, 1995).

Scores on the Parent-Child Dysfunctional Interaction subscale indicate parents' level of dissatisfaction in their interactions with their child/ren. The data suggest that four parents experienced dysfunctional interactions with their child/ren within the clinical range for at least three of the four weeks measured. The scores for the final parent varied across the normal to clinical ranges. Overall, these scores suggest that some parents may have low levels of bonding with their children, and at least some of the time, may find their children unacceptable to them.

Parent scores on the Difficult Child subscale suggest that all parents found their children's behaviour extremely difficult to manage. With the exception of Parent 5 (week 12) the scores for parents were within the clinical range across the entire study period. This suggests that the behavioural characteristics of the children are a major contributing influence to overall stress in the parent-child relationship. These behaviours may be intrinsic to the child (temperament) or derived from learned patterns (defiant, demanding, noncompliance) (Abidin, 1995).

The PSI-SF also contains a Defensive Responding (DR) subscale. Low DR scores suggest a parent may have completed the questionnaire with a strong bias toward making a favourable impression or to minimising stress in the parent-child relationship (Abidin, 1995). Parent 2 recorded a low score on the DR scale for week one suggesting the corresponding low score on the PD scale may be an underestimate of parental distress. Additionally, three parents scored very high DR scores across the PSI-SF scales indicating low levels of defensive responding. Lafiosca and Lloyd (1986, as cited in

Abidin, 1995) suggest that low defensiveness is indicative of valid PSI scores. Scores on the DR scale do not contribute to the Total Stress score.

### ***Comparison of PDH Scores***

Parent ratings of the Frequency scale of the PDH suggest that two parents experienced a high frequency of minor parenting hassles and three parents experienced a normal frequency of minor hassles across the study period. The most common hassles reported by parents were cleaning up after children, children's interruptions of adult conversations and difficulty in securing babysitters.

With the exception of one parent rating for one week (Parent 5, week 1), all parents rated the Intensity of minor parenting hassles as within the normal range. Locating babysitters, being nagged, whined at or complained to, sorting out sibling arguments and managing children's behaviour in public places generated the greatest pressure for parents.

The Challenging Behaviour and Parenting Tasks subscales suggest that parents were more likely to attribute their minor parenting frustrations to the challenging behaviours of their children rather than to parenting tasks. This finding is consistent with findings of the PSI-SF which suggested that parents found the behavioural characteristics of their children difficult to manage. Table 4 displays the subscale findings for parents on the PDH.

Table 4

*Parent ratings of the frequency and intensity of parenting hassles and parents attribution of these using the Parenting Daily Hassles scale.*

Parent	Frequency				Intensity				Challenging Behaviours				Parenting Tasks			
	Wk 1	Wk 4	Wk 8	Wk 12	Wk 1	Wk 4	Wk 8	Wk 12	Wk 1	Wk 4	Wk 8	Wk 12	Wk 1	Wk 4	Wk 8	Wk 12
1	H	H	H	H	N	N	N	N	H	H	H	H	N	N	N	N
2	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
3	H	H	N	H	N	N	N	N	H	N	N	N	N	N	N	N
4	N	N	N	N	N	N	N	N	H	H	H	H	N	N	N	N
5	N	N	N	N	H	N	N	N	H	H	H	N	N	N	H	N

*Note: Frequency Scale (high score = 50 or >); Intensity Scale (high score = 70 or >); Challenging Behaviours (high score = 23 or >); Parenting Tasks (high score = 27 or >)*

### ***Pre- and Post-study measures of Recent Life Events***

At intake to the study parents reported they had experienced between three and eight major life events in the 12-months prior. The median number of events was six. Most commonly occurring events for parents (or immediate family members) were housing difficulties, unemployment or financial difficulties, contact with the Police or judicial system, burglary or assault, serious illness or injury, and relationship difficulties. One parent reported a continuing impact from two events.

Parents reported they had experienced between three and seven major life events during the 12-week period of the study. The median number of events was four. Most commonly occurring were housing difficulties and burglary or mugging of the self or a close family member. One parent reported an ongoing impact from four events; the

remainder of parents reported no lasting impact. The number of events experienced by parents and indication of lingering effects is displayed in Table 5.

Table 5

*Number of major life events experienced by parents and number of events with ongoing impact*

Parent	Intake to Study		Conclusion of Study	
	Number of Events Experienced	Events with Ongoing Impact	Number of Events Experienced	Events with Ongoing Impact
1	8	0	7	0
2	5	0	3	0
3	8	0	4	0
4	2	0	3	0
5	6	2	4	4

### *Mental Wellbeing of Participants*

#### *Parents*

Self-reported pre- and post-study estimates of parental mental health (Depression, Anxiety, Inward Directed Irritability, Outward Directed Irritability) were completed using the Adult Wellbeing Scale (AWS). The data indicates that at intake to the study all parents recorded high or borderline scores on two scales each. However, scores for two parents decreased over the study period and at conclusion of the study two parents recorded symptomology in the normal range on three of the four scales. Overall, the majority of parent scores remained the same across the data collection period.

The data suggests that depression is the greatest psychological risk for parents. All parents reported borderline or high levels of depressive symptoms during the study and four parents reported an increase in symptoms across the study period. Three out of five

parents also reported anxiety-related symptomology within the borderline or high range and four parents reported an increase in symptoms of outward directed irritability, although scores remained within the borderline range. Parents were least likely to report elevated scores of inward directed irritability. Table 6 displays parent-reported mental health difficulties at intake and conclusion of the study.

Table 6

*Estimates of parental mental health as per the Adult Wellbeing Scale*

Parent	Depression		Anxiety		Inward Directed Irritability		Outward Directed Irritability	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1	B	B	N	N	N	N	B	B
2	B	B	B	N	N	N	N	N
3	N	B	B	H	B	N	N	B
4	B	N	N	N	N	N	B	B
5	H	H	H	H	N	N	N	B

*Note:* H = High level of symptomology. B = Borderline level of symptomology, N = normal level of symptomology

Further analysis of the data suggests comorbid patterns of symptomology among parents. High levels of depression and anxiety were consistent for one parent; borderline levels of depression and anxiety were reported for another parent; two further parents reported borderline levels of depression and outward directed irritability, and the final parent reported borderline levels of anxiety and inward directed irritability.

### ***Children***

The severity of children's emotional and behaviour disturbance were reported by parents using the Strengths and Difficulties Questionnaire (SDQ). Pre- and post study



scores are summarised in Table 6. The same raters completed the SDQ on both occasions. On the Total Difficulties scale, parents reported that five children were in the abnormal or borderline ranges at intake to the study and/or conclusion of the study period. Overall, all children except one, had either an intake or end-of-study Total Difficulties score in the abnormal or borderline range.

At intake to the study, parents reported that six children had emotional, behavioural, hyperactivity/concentration *and* peer difficulties in either the abnormal or borderline ranges. However, parents reported that the severity of children's difficulties declined across the study period and at conclusion of the study four children had emotional, behavioural and hyperactivity/concentration difficulties in the abnormal or borderline range and five children had reported peer difficulties within these ranges. The data suggests that children experienced greater severity of emotional difficulties than behavioural difficulties although more children experienced behavioural difficulties in the abnormal or borderline ranges than emotional difficulties. One child had no scores in the abnormal range and a majority of scores within the normal range. Across the study period, children's scores were more likely to remain the same or to decrease, rather than increase.

Parents reported that five children had experienced emotional or behavioural difficulties for more than one year and that the difficulties of three children caused considerable stress to the child and the family. Overall, the data suggest that the emotional or behavioural difficulties experienced by children had an abnormal level of impact on family, school and peer relationship functioning for five children and a borderline level of impact for one child, at either the intake or conclusion of the study.

However, these scores were not consistent among children across the period of the study suggesting that at a given time almost half of the children experienced considerable impact from their difficulties.

Across the study period, all children except one were considered by parent-report to be at moderate or high risk of diagnosis with a psychiatric disorder. The highest risk was for a behavioural disorder followed by an emotional disorder. Overall, these scores suggest that children in the study experience greater severity of emotional and behavioural disturbance than children in general.

Table 7

*Pre- and post study estimates of children's emotional and behavioural difficulties as reported by parents using the Strengths and Difficulties Questionnaire*

Child	Total Difficulties		Emotional Difficulty		Behave Difficulty		Hyper/Concent		Peer Difficulty		Pro-social Behaviour		Impact Score	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1	A	B	A	A	B	B	A	N	A	B	N	N	A	N
2	A	A	A	A	A	B	B	A	A	A	N	B	A	N
3	N	N	B	N	N	N	N	N	B	B	N	N	N	N
4	B	B	B	N	A	A	B	A	N	N	N	N	N	B
5	A	N	A	A	B	N	B	N	B	N	N	N	N	A
6	A	A	B	A	A	A	A	A	A	A	N	N	A	N
7	N	A	N	N	B	A	N	A	N	A	N	N	N	A

*Note:* A = Abnormal range; B = Borderline range; N = Normal range. Data has been compared to a normative population of British children, aged 5–10 years ([www.sdqinfo.com/bba3.pdf](http://www.sdqinfo.com/bba3.pdf)).

### ***Interviews***

Face-to-face interviews were conducted with parents at intake and at four-week intervals throughout the study period. In addition, telephone or personal contact was maintained with parents during the interim weeks. Face to face meetings were also held, where possible, with children prior to their initial respite care stay at Cholmondeley. Additionally, all children were visited at Cholmondeley during each period of respite care. At the conclusion of the study period the researcher met with parents, and with children, to gather their reflections on their experience of respite care.

#### ***Interviews with Parents***

##### ***Perceptions and Experience of Residential Respite Care.***

Parents anticipated use of respite care for their children was discussed during the initial interview. Most parents had formed an idea of how respite care may work for their family. Their responses indicated that in two families, children would be consulted regarding subsequent respite care. Parents anticipated ...

*“Regular stays ... if the children like it”*

*“Its up to the children ... if they like it they can go again”*

*“Weekend stays”*

*“One weekend a month”*

With regard to their perceptions of respite care for their children, parents said ...

*“I know he’ll love it”*

*“(Oldest child)’s looking forward to it ... (youngest child) is a bit worried about it”*

In thinking about how children’s respite care may be for themselves, parents reported ...

*“I’ll miss him but it’ll be a good break”*

*“I’ll miss her but it will relieve the pressure”*

*“I’ll catch up with the housework and spend time with (other child)”*

*“Totally beneficial”*

*“Good ... there’ll be no arguing”*

During children’s respite care at Cholmondeley, two parents reported they *“felt lost”* and considered picking child/ren up early. In general, parents felt more relaxed during children’s second period of respite care and better able to take time for themselves. Overall, parents spent their time ...

*“Chilling”*

*“Catching up on sleep”*

*“Catching up at home”*

*“Spending time with ...”* (other children)

*“Taking care of myself ... eating healthy, exercising”*

Following children’s return from respite care, parents reported ...

*“Feeling rested”*

*“Felt more positive toward the children”*

*“It was a positive experience for us all”*

However, respite care came at a cost to parents who reported that children were *“loud”*, *“lost it”*, *“really disruptive”*, *“swearing”*, and *“really angry”* after they returned home. Disruptive behaviour tended to last two to three days until children settled into home routines. One parent reported the children *“are usually really tired when they come home”* and prepared for this by planning quiet activities and giving children time to wind-

down. Parents also reported “*tightening the boundaries*” at home. They considered that children’s disruptive behaviours occurred “*because s/he’s used to the wide open spaces at Cholmondeley*” or due to the negative influence of children at the home.

At the conclusion of the study, parents in three of the four families reflected positively on their experience of respite care. They reported ...

*“I’m glad I’m going to be more involved with Cholmondeley”*

*“There are ups and downs for the children ... it’s hard for them leaving mum but they end up enjoying it”*

*“Getting some space gives me an opportunity to miss the kids”*

*“Enjoyed the stay and the staff ... loved the teacher”*

*“I can enjoy time to myself ... getting better with each visit to Cholmondeley”*

*“I’m starting to get more time with the children ... we can talk now ... not all bottled up ... we have clear rules ... hardly any fighting anymore”*

*“Mum has more energy for them when they come home”*

#### ***Satisfaction with Residential Respite Care.***

Prior to their children’s respite care, most parents anticipated that in the short-term respite care would relieve pressure in the home and allow them time for other matters. Some parents perceived benefits for themselves and their child/ren ...

*“Give us a break from each other”*

*“Relieve stress”*

*“Less pressure and better organisation in the family”*

*“They will improve their manners”*

At the close of the study, the majority of parents felt their short-term aims were achieved ...

*“The (siblings) get on better ... not in each others face all the time”*

*“I’m a better parent ... the kids are realising that”*

*“Having space makes it easier for me to be consistent [with parenting] ... rules, routines, structure ... not so worn down”*

With regard to the long-term impact, most parents anticipated benefits for themselves and their child/ren, although some expected that respite care would encourage a child to change his/her behaviour becoming more acceptable to them ...

*“We’ll get along better”*

*“She might begin to realise the impact of her behaviour”*

*“She’ll miss out on things at home ... learn that if she keeps misbehaving she’ll spend more time away at Cholmondeley ... so she’ll change her behaviour”*

*“Space from each other”*

With continued use of residential respite care, parents anticipated ...

*“Me and [child] will get on better”*

*“Get the child/ren back on line”*

*“The kids have more appreciation for mum ... I’m taken for granted too much”*

*“I didn’t want to break down ... gives you time out to think ... time to relax”*

Parents in three families reported their satisfaction with residential respite care and proposed more regular use of Cholmondeley Children’s Home services ...

*“Yes ... he gets a break from his brother ... they’re best buds when he comes back”*

*“Yes ... I loved having time away from the kids”*

*“A holiday for the children ... we have no family for them to have a holiday with”*

The fourth family did not reflect positively on their experience. Their comments reflect lack of satisfaction with the agency rather than with residential respite care itself. It is unlikely this family will use respite care services at Cholmondeley again and have investigated alternative sources of residential respite care.

### ***Parents Perceptions of Children’s Experience***

Most parents considered children had enjoyed their experience of respite care ...

*“They had a ball”*

*“They didn’t want to leave”*

*“They absolutely loved it”*

*“Loved school and the swimming”*

*“Says s/he doesn’t like it but s/he can’t wait to get there”*

Some parents also reported their children were called names and were *“beat up”* by other children. All parents, except one, reported that, overall, the child/ren were very positive about their stay but that they tended to focus on the negative aspects when they were *“tired and grumpy”*. One parent reported that her child was *“excited”* when told of a return visit.

### ***Interviews with Children***

Overall, children whom the researcher met before they went to Cholmondeley had an optimistic and open-minded attitude toward their impending stay and anticipated getting along well with other children.

*“It’ll be fun ... seeing what the school is like”*

*“When we come back we’ll have better manners”*

*One child looked forward to “seeing the playground”*

*“It’ll be boring”*

*“I’m a bit nervous”*

Most children appeared to know little about Cholmondeley although one child knew of Cholmondeley from peers at school. When asked about why they were going to Cholmondeley, the understandings of three older children were concordant with those of their parents (improve their manners, better behaviour, give mum a break) whereas younger children were more likely to consider they were going on a holiday.

During the study, children had a total of 47 nights respite care at Cholmondeley. Although most children did not enjoy their experience, the older children adapted better than the younger children. The younger children reported they missed their mums and cried at night. They sought a lot of reassurance during research meetings at Cholmondeley that *“mum is coming to pick them me soon”*.

All children reported they made one or two friends and most children considered they had a good relationship with staff members, saying they were *“cool”* and *“pretty good”*. Children enjoyed the food at Cholmondeley. They reported that bedtime was the most difficult time of the day, saying that children were *“noisy”*, and *“others play up”*. Where there were sibling groups, it was observed that older children were very supportive and nurturing of younger children.

School was well-liked by children who said

*“Teachers are nicer”*

*“Classes are smaller”*

*“Works easier”*



*“School is more fun”.*

When asked about the good things about Cholmondeley, children responded:

*“It’s cool”*

*“I want to stay longer, not go home”*

*“Nothing”*

*“Being at Cholmondeley”*

*“School ... swimming ... playground”*

*“Getting certificates”*

When asked about the things they found the most difficult, children responded:

*“Going to bed ... I don’t like sharing with other children”*

*“Being called names”*

*“Everything”*

*“Kids screaming, yelling, swearing, lying ... setting a bad example for younger kids”*

*“Takes kids a long time to settle down (at night)”*

*“Kids swear”*

*“When people back-chat to teachers”*

*“I miss my mum”*

Daily notes maintained by care staff at Cholmondeley reported that most children appeared to settle well in the beginning, made friends with other children (eventually, for some), and had a successful stay. Staff records verified the children’s reports that they found night-times difficult (five children had at least one unsettled night), and that younger children, in particular, experienced significant homesickness.

When asked what children thought that Cholmondeley might be able to do to make their stay easier for them, they suggested ...

*“Put TVs in the bedrooms”*

*“Stop kids being mean and disrespectful to staff”*

*“Get kids to listen”*

*“Have rules around swearing”*

*“Have a merry-go-round thing in the playground”*

Children’s level of interest and participation in interviews conducted at the conclusion of the study depended largely on their age, the length of time since their experience of respite care and other things they might rather be doing.

In general, children reflected positively on their stay at Cholmondeley. They remembered ...

*“Getting lollies”*

*“Playing with my friends”*

*“School ... teachers ... incentives and rewards”*

*“Swimming”*

*“The playground”*

*“Having responsibility as a monitor”*

and did not enjoy ...

*“Bed-times ... can’t get to sleep”*

*“Going for the first time ... I felt really scared and sad”*

*“Mean kids”*

Overall, children reported they got on “good” or “pretty good” with the children at Cholmondeley and found it “easy to make friends”. Children also reported they got on well with staff.

Some children found it was “sometimes hard to settle at home again” after being at Cholmondeley, but others found it “good” or “easy to come home”. They “enjoy(ed) coming home to friends and school”.

Children exhibited mixed reactions when asked how they felt about a return visit to Cholmondeley. Children responded ...

*“Excited – cos it was fun”*

*“Good ... but a bit unsure”.*

Overall, younger children were less likely than older children to respond positively to discussion regarding future residential care.

However, subsequent visits appeared to ease the transition from home to Cholmondeley for some children. A child who had two experiences of residential respite care reported ...

*“It’s easier with more visits cos you know what you’re supposed to do”.*

Contrary to the meeting held with one of the older children during a respite care admission, at the conclusion of the study the child expressed that s/he did not have a positive experience at Cholmondeley and was adamant there would not be a return visit, “No, I don’t want to go back”. This child reported s/he had made friends at Cholmondeley and got along well with staff. However, s/he also recalled bullying in the form of name-calling and putdowns (by peers).

When asked for suggestions to help new children settle into Cholmondeley one child proposed a buddy system whereby an established child is matched with an incoming child and would support and play with that child during the first few days of their stay.

***Peer Violence.***

Three children reported peer violence during respite care. Predominantly this was of a verbal nature involving name-calling by older children and was usually focused on physical characteristics of the child. Younger children especially reported they were bullied or felt physically intimidated by older children. Specifically, children said ...

*“People called me \_\_\_\_\_”*

*“Kids be mean to me”*

*“Some people pick on me so I’m going home”*

The records kept by staff at Cholmondeley report that one of the younger children physically lashed out at another child.

***Discrepancy between Parent and Child Reports.***

The data suggests substantial differences between parent and children’s reporting of respite care. Parents in two families reported their child/ren enjoyed their stay at Cholmondeley although the children said otherwise. Conversely, a child/ren reported positively and enthusiastically of their experience during a research meeting at Cholmondeley while the parent/s report was much less positive. In a further example, a parent reported the child was *“very happy”* on admission to Cholmondeley whereas the child reported feeling *“really angry”*. Overall, the parent/s and child/ren in one family were consistent in reporting the child/ren’s experience.

### *Case Study Overview*

It is the writer's intention to provide the reader with enough information to grasp a feeling for the functionality of each family in the study while still protecting the identity of participants. Some factors were common among families. For example, all children had experienced considerable loss or separation from a significant person; absent parents had little involvement in children's lives; all children viewed their parent/s at home positively; high levels of sickness occurred among parents during the study; the majority of children experience asthma-related conditions which impair their quality of life; families currently, or historically, experienced significant housing difficulties including many relocations, overcrowding and damp conditions; parents' social relationships tended to be within extended family boundaries; few children participated in extracurricular activities; substance use did not appear to be a major risk to parenting; all parents reported they would recommend residential respite care for children to other families.

#### *Family 1*

Family 1 is headed by a single mother who relies on a welfare benefit for family income. Mother disclosed a history of depression and anxiety during the intake interview and this is supported by the AWS. This scale also indicated that mother experienced symptoms of outward and inward expressed irritability within the borderline range. This suggests that, at times, she is as likely to internalise her frustrations as to express them through her parenting actions.

Mother experienced a high frequency of minor parenting hassles across the study period and attributed these both to her child/ren's behaviour and the burden of parenting. However, she was more likely to attribute the behavioural characteristics of her child/ren

to parenting stress on the PSI-SF. Mother reported varying degrees of dissatisfaction in her role as parent on the PSI-SF and consistently reported a severe level of overall stress. A high number of stressful life events were reported in the year prior to the study and a moderate amount occurred during the study period.

The SDQ scores suggest that mother considers the behaviour problems of her child/ren generate more difficulties than emotional problems. Across the study, mothers reporting of an increase in behavioural difficulties in the child/ren corresponded with an increase in self-reported mental health difficulties for mother and an increased parental distress on the PSI-SF. This may be associated with poorer mental health or with a lower level of parenting competence. Of note, the satisfaction that mother derived from interactions with her child/ren increased at this time.

Mother has social and extended family support but has little support in the day-to-day parenting of her children. She has attended formal parenting skills training. Mother identified single-parenting and economic constraints as primary challenges to her family.

### ***Family 2***

Mother in Family 2 is also a single parent on a welfare benefit. Scores on the AWS suggest that she experienced symptoms of anxiety and outward directed irritability within the borderline range. Mother reported that her child/ren experienced emotional and behavioural difficulties at a level which greatly exceeded that of children in general and that she consistently finds her child/ren's behaviour highly stressful and extremely difficult to manage. She was equally likely to attribute minor parenting hassles to the behavioural characteristics of her child/ren as to tasks associated with parenting. Overall, it appears that mother derives little satisfaction from interactions with her child/ren and

attributes her parenting stress to the difficult qualities of her child/ren and to personal distress associated with parenting. Comparison of scores on the PSI-SF and the AWS together with informal observations made during home visits suggest this mother may have a low level of competence in parenting.

Additionally, mother reported the highest number of stressful life events both prior to and during the study period. Primarily these pertained to interpersonal, financial and housing difficulties. She has a broad social network but little extended family support. She receives little support in her parenting role. Mother reported that financial difficulties were the major challenge for this family.

### ***Family 3***

This family has parents who are married. One is employed full-time and the other has casual employment. One parent reported symptoms of depression and anxiety within the borderline range; the other reported symptoms of depression and outward expressed irritability within the borderline range. Parent report on the SDQ suggests the child/ren in this family experienced emotional, behavioural and peer difficulties that caused a substantial amount of distress for the child/ren and the family. Both parents were consistent in their reporting of the frequency and intensity of minor parenting hassles, which were within the normal range. Both parents attributed the hassles associated with parenting to the difficult behaviours of the child/ren. Parental distress was within the normal range for both parents. Overall, the results suggest that neither parent derives satisfaction from their interactions with their child/ren which appear to be related to the difficult behaviours of the child/ren. Total parenting stress scores were consistently at a

very elevated level throughout the study period. Both parents reported stressful life events below the median at intake and conclusion of the study.

These parents have sound agency and extended family support and have recently attended a parenting course. Their lower scores on the parental distress scale of the PSI-SF, compared to other parents in the study, may indicate that sharing the tasks and responsibilities of parenting relieves individual distress when coping with a child/ren who exhibit difficult behaviours. The parents identified economic constraints and psychopathology within extended family as the most salient risks to family functioning.

#### ***Family 4***

This family is headed by a single mother who receives a welfare benefit. The scores on the AWS suggest it is highly probable that mother experiences depression and anxiety. Borderline levels of outward directly irritability were also recorded. The Frequency and Intensity scores on the PDH were within the average range and mother appears likely to attribute parenting hassles to the difficult behaviours of her child/ren. Mother reported extremely high levels of parenting stress across all the scales on the PSI-SF, however, the scores on two scales decreased substantially at conclusion of the data collection period. This corresponded with a reduction in minor parenting hassles attributed to the challenging behaviour of children, and an overall reduction in the emotional and behavioural difficulties reported for the child/ren. The child/ren in this family were more likely to experience social and emotional difficulties than behavioural difficulties. A median number of stressful life events were reported by the mother in this family, but, relative to other parents, she reported a more lingering impact from events.



Financial difficulties, psychopathology and social isolation were identified as salient risk factors by mother.

### *Chapter Summary*

The findings suggest that the experience of respite care in a residential setting can be a difficult one for children. Younger children especially, reported peer violence and homesickness which they found difficult to manage, while older children found the attitudes and behaviours of some of the children quite dissimilar to their own. Some children would just rather be at home.

Although parents were aware of the difficulties reported by children, they were most likely to consider the experience was ultimately a positive one for their children. Alternatively, for one family, the positive experience reported by a child (or children) may have been influenced by the experience of the parent/s.

Most parents reported that, from their perspective, respite care had been a positive experience. Although some parents found the initial adjustment to their child/ren being away from home more difficult, this appeared to ease if subsequent periods of out-of-home care occurred. All parents reported positive effects in family functioning and/or mental wellbeing. While the psychometric measures support this for one family these effects cannot be attributed to respite care because of temporal and confounding factors. Overall, respite care was not found to relate to parenting stress.

With regard to particular family situations, the findings suggest that parents with few social supports are more likely to report higher levels of adult and child psychological disturbance, greater parenting stress and more major life events than parents with greater social and parenting support. Furthermore, in this study, parent/s who

reported a decrease in children's emotional and behavioural disturbance also reported lower parenting stress and daily hassles, and fewer major life events.

The findings of the study will now be discussed in relation to the literature.

## CHAPTER 5

### Discussion

#### *Interpretation of Findings*

Given small numbers, the study was limited to hypothesis generation, rather than hypothesis testing. The data identified a number of themes from which several hypotheses are generated. First, the experience of respite care in a residential setting was a difficult one for most children; second, the majority of parents reported their experience of residential respite care was a positive one; finally, a mismatch occurred between parents' perceptions of children's experience of respite care and reports made by children.

Within the context of parental stress, although the findings suggest that one parent experienced reduced levels of stress at the conclusion of the study period, this cannot be attributed to the use of respite care. Overall, the psychometric estimates of parental stress and parent and child psychological wellbeing remained consistent across the study. Therefore, for the families in this study, no trends were found between the use of residential respite care for children and parental stress.

This chapter will discuss how the themes derived from the findings of the current study relate to the literature reviewed. Firstly though, it is pertinent to consider how the families in the current study may be similar, or dissimilar, to families reported to have used respite care services in other studies.

#### *Characteristics of Families*

Although the present sample is too small to generalise these findings to a larger population, it is noted that a number of trends have emerged across families in the study

that are similar to those of families reported by previous studies. Specifically, these include: a high level of single parenthood, unemployment, reliance on social benefits, unstable relationships, social disadvantage, poor neighbourhoods, overcrowded and/or rented accommodation, and low levels of social support (Nissim, 2006; Stalker & Robinson, 1994). Furthermore, Bebbington and Miles (1989, as cited in Nissim, 2006) found that many parents of children in residential care had previous experience of residential care themselves. Similarly, in the current study two parents reported they had respite care at Cholmondeley Children's Home during their own childhoods.

In addition, studies of children's homes by Berridge (1985) and Sinclair and Gibb's (1998) have indicated that children's lives were characterised by inadequate parenting, unsatisfactory and disrupted childhoods, and complex difficulties in their relationships with parents. While the current study did not consider parenting practices, it is noted that, as reported by parents, all of the children had experienced some disruption within their families during their early childhood as well as separation from, or loss of a person important to them. Additionally, the findings suggest a trend for parents in the study to experience serious difficulties in their interactions with their child/ren.

On the other hand, although the numbers of children in the current study are small, the findings suggest they are less similar to children reported by other studies in terms of their age (typically adolescent in residential care) (Gerard, 1990; Berridge, 1985) and the type of difficulties experienced. While the emotional and behavioural difficulties of children in this study might arise from patterns of ineffective parenting together with social and economic disadvantage, most literature pertains to families where children have pervasive developmental, learning or language disabilities (Stalker & Robinson,

1994; Thomson, 2002) or severe psychological difficulties (Bruns & Burchard, 2000; Marjoram & Fouche, 2006).

### *Children: A Difficult Experience*

Within the current study, the findings suggest that all of the children encountered some difficulties in their adjustment to residential respite care. Although the sample of children is very small, the difficulties reported by the children appeared to be somewhat related to their age. For example, the four eldest children reported considerable discomfort with the attitudes and behaviours of children that were dissimilar to their own, while two youngest children experienced considerable overt distress associated with separation from their parents. As well, children with overt physical differences (obese body size) and younger children were especially vulnerable to peer violence. All of the children reported that bed times were the most difficult time of the day. That young children liked residential respite care the least has also been found in other studies (Sinclair & Gibbs, 1998).

Before discussing the main difficulties faced by children in the study it should be remembered that the children who come to stay at Cholmondeley Children's Home do so because there are vast difficulties within their family system. As identified in the literature these difficulties are complex and may predispose children to risk for the development of psychological difficulties. Increasingly, children in residential care have early experiences of trauma and exhibit extreme and complex emotional and behavioural disturbance (Crosson-Tower, 2007). As well, many have underlying attachment difficulties and experience problems in forming relationships (Crosson-Tower, 2007).

In addition to offering respite care, Cholmondeley Children's Home is the semi-permanent home of around seven children. These children are not identified as perpetrators of behaviours that are different from other children. They are acknowledged because their early experiences and care needs are most likely different from those of children in the study.

### *Adjustment to Residential Care*

It is not known how parents in the study prepared children for their respite care placement at Cholmondeley Children's Home but the research suggests that many children received little preparation (Kendrick, 2008; Stalker & Robinson, 1994) and that those who are consulted make a better adjustment to residential care (Minkes et al., 1994). Crosson-Tower (2007) cautions that "children have feelings about the transition" and for the majority of children separated from parents "the predominant feeling ... is that they are bad" or that residential placement is a "form of punishment" (p. 398). She further suggests that some children may feel they have been "too bad" for a family setting. A child who is framed as "bad" may develop a self-concept of him or herself as a failure and therefore unable to control events around himself or herself (Carr, 2006).

In the current study, some of the older children were aware that parents found their attitudes and behaviours difficult to manage and wished for these to change. The children, themselves, were unsure if residential care would effect these changes. Similarly, children interviewed by Berridge (1985) reported they were living in a children's home because of difficulties in their relationships with parents. Only a minority of children understood their placement was due to their parents' inability or unwillingness to manage (Berridge, 1985). Little is known about the relationship between a child's

understanding of the reason for care and his or her adjustment to residential or respite care. However, Stalker and Robinson (1994) reported that two-thirds of children experienced substantial difficulties in their adjustment to residential care.

However, one family in the study proposed that respite care at Cholmondeley will become a regular (three to four times a year) “holiday break” for the children. Although these children encountered some difficulties in their initial adjustment to residential respite care, they report looking forward to an impending visit with a sense of eagerness and positivity.

Three of the children in this study were clearly unhappy about their placement in residential respite care. While this finding is inconclusive, it reinforces the need for further research which considers children’s perceptions of respite care in a residential setting. Other studies also reported children’s unhappiness in residential care (Marjoram & Fouche, 2006; Minkes et al., 1994; Sinclair & Gibbs, 1998), while Stalker and Robinson (1994) proposed the need for alternate services which better meet the needs of children who report their dislike for residential care.

Although all children reported they had developed friendships among the children already at Cholmondeley Children’s Home, the staff records show that for some children this took longer than others. The study findings show that parents considered most children experienced greater than average difficulties in peer relationships and Crosson-Tower (2007, p. 398) suggests that “feelings of aloneness” in their adjustment to residential care may cause children to isolate themselves from their peers. It may therefore be possible that children who experienced feelings of loneliness also experienced greater difficulties in establishing peer relationships. The relationship

between children's self-esteem and their adjustment to residential care warrants future research.

The literature suggests that many children in residential care have a history of problematic relationships (Crosson-Tower, 2007; Sinclair & Gibbs, 1998). The aggressive, hyperactive, antisocial and impulsive behaviours that are characteristic of children in residential settings (Crosson-Tower, 2007) are scarcely conducive to positive social relationships. For the children in the study, the behaviours of children already in-care at Cholmondeley are most likely equal to, or more extreme, than their own. In this way, Cholmondeley brings together a group of children who exhibit very complex and challenging behaviours in a single setting. Some parents expressed concern that children returned home from Cholmondeley displaying behaviours that were more extreme than prior to respite care and there is ample evidence to suggest that children learn antisocial and aggressive behaviours through socialisation and reinforcement of negative behaviours by peers (Barter et al., 2004; Dishion et al., 1999). Some of the children, too, recognised they had some difficulty in making the adjustment back to family.

In concurrence with other studies, children reported they had developed good relationships with residential staff (Minkes et al., 1994; Sinclair & Gibbs, 1998). Additionally, studies have reported that children identified "having someone who cares" as a positive aspect of residential care (Shaw, 1998, p. 72, as cited in Ward et al., 2005, p. 14). Shaw suggests that children contrast their current experience of care with previous experience. Accordingly, it is suggested that children in the current study did not reflect on the quality of residential care either because they considered their care at home superior or they were consumed with managing aspects of daily living.



### ***Behaviours of Other Children***

The behaviour of other children was a concern to children in the study. In particular, older children found the attitudes and behaviours of some of the children at Cholmondeley especially difficult. Specifically, they reported that swearing, screaming, fighting and rudeness towards adults were unsettling. These findings lend support to previous studies which have indicated a culture of aggressive and antisocial behaviours among children in residential care. Similarly, children interviewed by Sinclair and Gibbs (1998) and Ward and colleagues (2005) reported that the negative and antisocial behaviours of others were among their least favoured aspects of residential care. Children in the current study felt there were few rules around the disruptive and antisocial behaviours of children and that staff should intervene more to encourage functional behaviour. Laxness of regime and discipline has also been reported by children in other studies (Sinclair & Gibbs, 1998). Crosson-Tower (2007) asserts that even though interactions with peers may be negative, residential care can provide children with valuable opportunities for developing social skills.

### ***Separation from Parent/s***

This study found that most children experienced some difficulties associated with separation from their parent/s and this is verified in the daily notes written by staff at Cholmondeley. Children reported that bed times were the most difficult and that children, in general, were unsettled at this time. Younger children were most likely to experience intense anxiety caused by separation from their parents and this occurred during the day time as well as in the evenings. During visits with children at Cholmondeley, two children in particular, sought constant reassurance that mother would collect them soon.

Similarly, other studies have identified widespread homesickness as a salient difficulty for children in residential care (Minkes et al., 1994; Sinclair & Gibbs, 1998; Ward et al., 2005). Oswin (1984, as cited in Stalker & Robinson, 1994) observed that severe and widespread homesickness among children in residential respite care was often undetected. However, Stalker (1990, as cited in Stalker & Robinson, 1994) found that homesickness among children was not isolated to residential care but was also reported among children placed in family-based respite care.

Separation from parents challenges children's attachment to their primary caregiver (Bowlby, 1973, as cited in Berk, 2006). Steinhauer (1991) proposed that the intensity of separation from parents is most keenly felt by children aged six months to four years. At this age their emotional and physical development renders them highly dependent on their primary attachment figure. Furthermore, their level of cognitive development is insufficient for them to understand the reason for separation or be reassured of its temporary nature (Steinhauer, 1991). Steinhauer further proposes that children who have multiple experiences of separation, those temperamentally vulnerable, or with an insecure attachment style "could be expected to respond more acutely to even a moderate separation than could a securely attached or a relatively invulnerable child" (p. 25). The reliance of younger children on older siblings was observed during meetings with children at Cholmondeley, and Steinhauer proposed the presence of siblings may reduce the "distress and long-term ill effects of separation" (p. 25). The detrimental effects of separation were also expressed by the social workers in MacDonald and Callery (2003).

As reported by parents, all children in the study have experienced the loss of a significant person in their lives. In addition, a child in the current study who had previously experienced prolonged separation from mother reported feeling “angry” about being left at Cholmondeley, and parents reported that two older children have previously displayed symptoms of separation anxiety beyond what is developmentally appropriate. In terms of attachment theory, these behaviours may “reflect a natural response to separation and loss” (Byrne, O'Connor, Marvin, & Whelan, 2005, p. 121). The true effects of separation of children from their parent/s to residential respite care cannot be established from this study; however, it is noted that for younger children especially, the short-term effects were intense.

### ***Peer Violence***

Peer violence is a long standing concern in residential care (Barter, 2008; Sinclair & Gibbs, 1998). Although this is largely an over-looked area in research, it is established that children in residential care “are most often at risk from *other young people* in the home” (italics original, Barter, 2008). Bullying (teasing, name calling, being picked on) is the most common form of violence, with young children especially vulnerable and assailants most likely to be male (Barter, 2008; Sinclair & Gibbs, 1998). Although questions relating to peer violence were not specifically asked in the current study, more than half of children reported having been bullied. This is comparable to findings by Sinclair and Gibbs (1998) who found that 44 percent of children they interviewed had experienced bullying. In both studies, younger children were most likely to be victims of bullying. Sinclair and Gibbs (1998) reported that bullying is a “particularly serious problem”, widespread and often undetected in children’s home (p. 181). They proposed

that some children were especially vulnerable to bullying and that most children who were bullied had also experienced bullying prior to residential care. However, this is not known for children in the current study. Moreover, it appears that verbal violence is most often unchallenged by staff (Barter et al., 2004). Although often dismissed as minor, verbal violence may cause long-lasting emotional harm, more damaging than physical attacks (Barter et al., 2004).

Physical violence was reported by the youngest children in the study and staff records indicate that one child was also an assailant. While previous studies suggest high levels of physical violence (Barter et al., 2004), this was not a finding of the current study. Research suggests that retaliation is the primary justification for violent acts by children (Barter, 2008); however, reasons for violence were not explored with children in the current study.

Barter (2008) and Sinclair and Gibbs (1998) proposed that resident group hierarchies are a primary context for peer violence in children's homes. They suggested that although peer hierarchies, associated with intimidation and violence, are common the power of these is often underestimated by staff. Barter further proposed that "peer group dynamics ... [are] most problematic when they [children's homes] were in a flux" (p. 144). Such situations occur with the arrival of new residents and the departure of those in "top dog" positions (Barter, 2008). Children in a study by Emond (2000, as cited in Emond, 2008) "were of the view that whilst they couldn't control who they lived with they could control how they lived with them in terms of their inclusion and belonging to the resident group". Additionally, the research suggests that boys are most commonly the perpetrator of violence, and that there appears to be a danger of accepting violence as a

characteristic of boys behaviour, rather than as acts of violence (Barter, 2008). Furthermore, much of the violence is minimised by or hidden from staff (Barter, 2008).

Howe and Fearnley (1999) suggest that restless and antisocial behaviours may be manifestations of attachment difficulties. They proposed that when a child who has attachment difficulties is confronted with a situation that is assessed as frightening, threatening or unpredictable they “begin to feel the only route to feeling remotely safe, physically and psychologically, is to take control of the self, other people and the environment” (p. 23).

### ***Parents: Perceived Benefits and Satisfaction***

The majority of parents’ in the study reported a positive experience of residential respite care and similar findings are abundant in the literature (Argent & Kerrane, 1997; MacDonald & Callery, 2004; Murphy et al., 2006; Stalker & Robinson, 1994). Nevertheless, one family was less than satisfied with particular aspects of the agency and have pursued respite care services elsewhere. Although, few studies reported parent dissatisfaction, Stalker and Robinson (1994) found that parents were less satisfied with residential services than with family-based care. Moreover, parents surveyed by Hazell and others (2002) ranked residential services the least popular of five community-based family support options.

Similar to the reported studies (Stalker & Robinson, 1994; Thomson, 2002) parents in the current study identified the need for a break from constant caregiving, the demands of their children and limited social support as reasons for utilising respite care services. During their children’s respite care parents attended to household tasks, self-

cares and spent time with other family members. These activities parallel those of parents in similar studies (MacDonald & Callery, 2004; Thomson, 2002).

Parents in the study anticipated benefits both for themselves and their children. These were associated with enhanced family wellbeing, separation – “absence makes the heart grow fonder” and enduring social benefits (children with good manners have more friends). At the conclusion of the study, parents of three families reported their expectations of respite care had been satisfied. In particular, two parents each reported improved family relationships and feeling more competent in their parenting. Similarly, others studies have found that parents expectations largely pertained to enhancement of family wellbeing and that respite care met these expectations (Stalker & Robinson, 1994), Thomson, 2001). Overall, the findings of the psychometric estimates in the current study do not lend support to parents’ report of improved wellbeing.

One parent in the study recognised that her child/ren experienced difficulties in their adjustment to residential care. Similarly, Stalker and Robinson (1994) found that a small number of parents reported that residential respite care had benefits for themselves but not for their child/ren. Predominantly, in studies where parents have proposed benefits of respite care for children, these have pertained to increased independence and broadening of social contact for children with disabilities (Stalker & Robinson, 1994). However, in concurrence with other parents, parents in the current study reported a lack of alternative means to procure a break from continuous parenting (Sinclair & Gibbs, 1998; Stalker & Robinson, 1994).

A number of studies have implied that access of respite care may in fact increase parental stress (Chan & Sigafos, 2001; Stalker & Robinson, 1994). Anxiety relating to

the effects of separation, organising transportation and instances where the placement of the child outside the family destabilised the family beyond their ability to adapt were found to exacerbate parental stress. Two parents in the current study reported feelings of increased anxiety with their children away from home although these passed with time. A further parent faced major transportation difficulties but resolved this by utilising Cholmondeley transport services for her child/ren's return home.

Prior to using respite care services at Cholmondeley Children's Home parents' anticipated regular and reasonably frequent use of respite care. However, two periods of respite were the maximum accessed and this was by two of the four families in the study. Although reasons for parents' less than anticipated usage are not known, two suggestions are offered. Firstly, there are a number of limitations regarding the timing of the study and these are discussed later in this chapter. Alternatively, Joyce and colleagues (1983, as cited in Stalker & Robinson, 1994) proposed that knowledge of being able to access respite care, if desired, improved parents' ability to cope. A longitudinal study will be needed to address this question.

### *Discrepancy between Parent Perception and Child Report*

An important finding of the study was that parent perception of children's experience of respite care often conflicted with children's own reports. It is not suggested that children did not convey their displeasure at residential care to parents, as this was observed during visits with parents and children, but rather than parents did not, or could not, acknowledge their child was unhappy. Indeed, Oswin (1984, as cited in Stalker and Robinson, 1994, p. 106) suggests "it would be very difficult for parents to acknowledge, even to themselves, that a child receiving regular respite care is unhappy".

This pattern of disparity pertained to three families in the study. In two families children reported their distinct lack of liking for residential care while parents seemed sincere in reporting that children's comments, in the absence of the author, were mostly positive. Conversely, a child in another family reported enthusiastically of his/her experience of residential care during a visit with the author at Cholmondeley while the parent/s' report was much less positive. It is suggested that, in this case, the perception of the child may have been influenced by the view of the parent/s.

The present study is the first to consider the perspective of parents and children regarding residential respite care. Although a small number of studies have listened to children's perspectives of care, the majority focus on parent perspectives. Gerard (1990) recognised the propensity for conflict to arise in situations where the views of parents may override those of children. She proposed that alternate advocates should be sought whose views would be used in conjunction with parents. However, the findings of the current study suggest that the views of *both* parents and their children should be ascertained.

### ***Residential Respite Care in the context of Parental Stress***

Given the small sample, the current study was unable to determine the relationship between residential respite care and parental stress. However, there was a clear trend for the psychometric estimates of parental stress to remain consistent throughout the study period.

Notwithstanding these inconclusive findings, the case study approach in this dissertation allows for the findings of individuals to be identified and reported.



Accordingly, one parent reported feeling more rested and less stress in the home, and the psychometric estimates support a substantial reduction in parenting stress. However, the child/ren in this family had a single period of respite care and this occurred during the initial week of the study. It is therefore suggested that while respite care may have allowed this parent time to rest and reflect on parental and family functioning, the reduction in parental stress cannot be attributed to respite care alone.

Other studies have suggested that more intensive use of respite care is associated with greater reduction in parenting stress (Bruns & Burchard, 2000; Chan & Sigafos, 2001; Thomson, 2002). Although it was hoped the timeframe of the current study may allow for more frequent use of respite care by families, this was not the case, and therefore the findings of this study can neither support nor refute this assertion. It is noted though, that one parent whose child/ren had two admissions to respite care reported increased benefits with more frequent use.

Previous studies have also suggested that the immediate benefits of respite care are not sustained over time (Sinclair & Gibbs, 1998). The methodology of the current study does not allow for this to be substantiated; however, the children in two families attended residential respite care during the final week of the study period and data collected in the week following respite care did not indicate a measurable reduction in parental stress.

Overall, the findings of this study suggest there is much more to learn with regard to the usefulness of residential respite care in ameliorating excessive parenting stress.

### *Value of the Research Design*

An embedded mixed methods research design has facilitated the capture of the real-world experience of participants who have utilised respite care in a community children's home. Qualitative methods have enabled participants to tell their experience in their own words and have been used to guide the interpretation and meaning making of this phenomenon. This method has made it possible to see beyond the surface of participants' experiences; to consider the impact of the experience. Quantitative methods yielded estimates of the severity and extent of parental stress and parent and child mental health disturbance, which has provided additional context for the qualitative findings. These data reduce researcher bias (Creswell, 2003) and have contributed to an enriched, holistic and comprehensive foundation for participants' voices. The comparison and convergence of data collected from multiple methods across multiple timeframes has allowed the development of broader perspectives and a more balanced understanding of the research phenomenon than a single research method.

Data analysis utilising an IPA approach "attempts to understand the hidden meanings and the essence of an experience together with how participants make sense of these" (Grbich, 2007, p. 84). This process has facilitated critical reflection from outside the phenomenon and is central to understanding people's emotional experience of phenomena (Grbich, 2007). Understanding has emerged through in depth exploration of the data and meanings assigned to the experience. In accordance with IPA, the current research has attempted to claim rigour by getting "as close as possible to the experience of the things" (Grbich, 2007, p. 86).

In addition, the case study approach has facilitated the reporting of individual cases which has provided valuable insight into the experience of individuals and families. Furthermore, this approach has enabled a relationship of trust and respect to be established and maintained with participants. From this relationship, and the information derived from the data, a rich and complex picture has emerged of the lived experience of residential respite care from the perspective of consumers.

Foremost, the design of the research has allowed the voices of children to be heard and this has added value to the findings. This is important as children's voices have seldom been heard in the sphere of residential or respite care (Kendrick, 2008). Although a small number of studies have sought the perspectives of children through survey methods or the advocacy of parents (Gerard, 1990; Stalker & Robinson, 1994), few have spoken directly with children (Marjoram & Fouche, 2006; Minkes et al., 1994; Ward et al., 2005). Although the perspective of parents has provided some insight into children's experiences, data collected directly from children allows greater insight into their lived experience (Marjoram & Fouche, 2005). Furthermore, this study has revealed the potential for disparities between parent and child perceptions of a child's experience. Observations made during visits to Cholmondeley Children's Home and review of the daily records maintained by staff has strengthened the validity of children's reports.

Given that mixed methods procedures are resource intensive (Bryman, 1988, as cited in Creswell, 2008) and that the research was conducted within limited timeframes, this study has gone some way toward capturing and representing a credible and authentic picture of the lived experience of participants. This is the first such study to consider residential respite care, from the perspectives of both children and their parents.

Additionally, it is one of few studies to focus on the experience of respite care for families in a position of disadvantage rather than disability. Previous research has focused primarily on parent perceptions and satisfaction with respite care services (Thomson, 2002). Studies that have included the voice of children have involved children with moderate to severe learning and communication disorders (Minkes et al., 1994) or those in statutory residential care (Happer et al., 2006; Marjoram & Fouche, 2006). Additionally, two large studies which have included the voice of children living in children's homes (Berridge, 1985; Sinclair & Gibbs, 1998) have focused more on the role and function of children's homes than the experience of children. The findings of this exploratory study offer some rich personal insight to the small body of research that seeks to understand the experience of residential respite care from the perspective of the consumer.

### *Limitations of the Study*

A number of limitations warrant comment. First, the timing of the research may have limited the scope of data collected. Although the data collection period for each family was staggered, this spanned the close of the academic year, Christmas, New Year, and part, or all of the summer school holiday period for each family. As well, Cholmondeley Children's Home was closed to respite care admissions for two weeks. This may have impacted on families to two ways: It is likely that parents faced atypical stressors at this time of year as members adjusted to the demands of the season and changes in schedules and routines. This may have impacted on estimates of stress and psychological wellbeing attained through quantitative instruments. Additionally, events such as a family holiday, extended time with grandparents, children's attendance at

community holiday programmes and out-of-home care for siblings which occurred across this time may have influenced families use of respite care services. The timing of the research is unfortunate but was determined by unforeseen circumstances and resource constraints.

Although phenomenological research is typically conducted with small samples, recruitment difficulties, timeframes and the withdrawal of one family from the study resulted in a smaller sample than desired. Furthermore, the use of purposeful sampling procedures reduces the generalisability of findings (Creswell, 2003). Moreover, it is expected that the sample reflects some bias. Participation in the study was voluntary and largely a matter of goodwill. Although parent scores on the PSI-SF suggest severe levels of parenting stress it is anticipated that parents in the study represent those who are quite well organised and better able to manage the intrusion of a stranger in the lives of their family over an extended period of time. This presumption is perhaps verified by the fact that families who formed the research sample were less than half of families who may have participated. Additionally, the research was conducted in a single geographic location.

The main findings of the study are derived from qualitative interviews. The very nature of interviews implies that information is indirect and filtered through the beliefs and values of both the interviewee and interviewer and may therefore represent bias (Creswell, 2003). Furthermore, people are not equally articulate and perceptive and may respond to questions in a manner that presents a biased view (Creswell, 2003). Moreover, the age of the children and their varying verbal abilities and capacity to understand the interview process and questions and articulate their views clearly has limited the extent of

data gathered. On some occasions parents were present when children were interviewed prior to or following respite care and this may have influenced children's responding. It is also proposed that, for younger children especially, their overwhelming desire to be reunited with their mother over-rode their capacity to reflect on their experience of respite care. While every effort has been made to fairly and accurately represent the experience of participants, it is recognised that the qualitative findings are the subjective interpretation of the researcher and therefore may be subject to other interpretations.

Additional limitations pertain to the psychometric measures used in this study. These are self- and parent-report measures and are therefore a function of the characteristics of the respondent (Keenan, 2002). The use of supplementary data from other informants would have increased the validity of these results however this was deemed not realistic for this study due to ethical considerations and resource limitations. Further, distressed parents are found to be accurate reporters of children's behavioural problems (Richters & Pellegrini, 1989 as cited in Creasey, 1996). Nevertheless, multimethod approaches involving multiple informants offer the best protection against bias and are necessary to determine the presence, or absence, of psychopathology (Barlow & Durand, 2005). However, the measures used are proven, thus, it is probable they provide an accurate indication of parental stress and adult and child mental health.

The results of the Defensive Responding subscale (DR) of the PSI-SF are somewhat ambiguous. In one instance a parent has attained a very low score suggesting a desire to "look good" on this test which may have been interpreted as a measure of parenting skill (subsequent scores were within the average range). Additionally, DR scores for three parents were consistently within the high range, perhaps suggesting a low

level of defensive responding or a desire for their child/ren to “look bad”. Little specific information was found with regard to the meaning of low DR scores; however, Lafiosca and Lloyd (1986, as cited in Abidin, 1995) suggested that low defensive responding is indicative of valid PSI scores. Other studies suggest that maternal psychopathology may lead to biased and over-reporting of children’s behavioural difficulties (Kroes, Veerman, & De Bruyn, 2003). Whether this may extend to all self-report data is not established.

Notwithstanding the use of multiple data sources, this was not a controlled study and therefore cannot account for the passage of time or changes within family relationships or family functioning. As stated, parents in two families have attended parenting training and may have implemented new learning during the course of the study.

### *Implications of the Study for Practice*

Although the present findings are not definitive they are consistent with the literature suggesting a need for Cholmondeley to re-examine models of care. It is hoped that the findings of the current study may be useful in this direction. It is further hoped that the opinions and experiences of these children and their parents may be considered in planning services or reviewing the match between service provision and consumer need.

Previous studies have suggested that families’ initial experience of respite care has a lasting impact on future care (Stalker & Robinson, 1994). In one case this has resulted in a family choosing to access respite care from an alternate source. Previous studies have found that children are often under-prepared for the transition from home to residential care (Stalker & Robinson, 1994) and the findings of the current study lend support to this assertion. It is proposed that increased communication between the family and

Cholmondeley together with increased support in preparation for the transition to residential care may improve this process and go some way towards alleviating additional anxiety for parents and children. At the suggestion of one of the children in the study, a buddy system which matches a child who is familiar with the routines at Cholmondeley with a child new to Cholmondeley may facilitate a smoother transition for children's first admission to respite care. Overall, effective communication between the family and agency is highly valued by parents (Stalker & Robinson, 1994; Thomson, 2002).

Of the children in the study, unequivocally, the adjustment was much more difficult for younger children than older children. For two children, their distress at separation from their parent/s was overt, for a third child this may have been more covert. It is important that caregiving staff remain attuned to the needs of individual children, are alert to the early signs of distress and are well trained in how to best support children. Notwithstanding this, Steinhauer (1991) alerts that young children do not have the cognitive development to "allow them to express easily or to work through successfully at a symbolic (i.e. verbal or play) level the acute distress generated by the disruption of their primary attachment" (p. 18).

A culture of disruptive and aggressive behaviour in children's homes has been reported in previous research and was identified by older children in the current study as the most difficult aspect of their respite care experience. Furthermore, the children suggested that much of this behaviour went unchallenged by staff. Barter and others (2004) noted that varying thresholds for violence occurred across children's homes suggesting that staff regularly exposure to disruptive and antisocial behaviours may become desensitised to the impact of violence. R. Clough and others (2006) described the



task of residential caregivers as a paradoxical one, “of trying to provide some short-stay stability and reliability for what is often a rapid turnover of children whose lives have been (temporarily at least) disrupted and unsettled” (p. 28-29). Nevertheless, a sense of belonging and feeling included are important to children in residential care (Happer et al., 2006; Marjoram & Fouche, 2006). Accordingly, a culture of respect and inclusiveness may go a long way toward supporting children in their adjustment to group living. Research suggests that congruent and appropriate staff and child cultures improve the quality of life for children in residential settings (R. Clough et al., 2006).

It is acknowledged that Cholmondeley Children’s Home care for a diverse group of children with varying high and complex needs. Communication with Mike Field, General Manager of Cholmondeley Children’s Home (personal communication, February 13, 2008) has indicated that the Board of Management have recognised the differing needs of children presently accommodated at Cholmondeley. It is understood that the lower age limit of children admitted to Cholmondeley may be reviewed and that respite care and children in transition to permanent foster care placements will be accommodated separately. Children for whom Cholmondeley is to become home on a semi-permanent basis while they are prepared for foster placement will be accommodated in an independent homelike setting with permanent houseparents, who will act as surrogate parents. This proposed change to Cholmondeley services is well supported in the research literature (R. Clough et al., 2006; Stalker & Robinson, 1994).

### ***Recommendations for Future Research***

Primarily, the current study indicates a critical need for further research which broadens empirical understandings of the experience of residential respite care for

families confronted with disadvantage. The findings of this study provide a basis for a larger study, with more rigorous methodological and analytical approaches which explores at a deeper level the respite care experience of children and their parents. Larger numbers of participants and a longitudinal approach would increase the validity and usefulness of subsequent research. Other key areas for research include the disparity between parents' perceptions of children's experience of residential respite care and children's reported experience of care. Deeper exploration of this important finding is needed to ascertain the assumptions which underlie these differences.

Further research is also warranted of children's understanding and meaning-making regarding their admission to respite care. Crosson-Tower (2007) found that children placed in residential care predominantly saw themselves as bad and viewed their placement as punishment. Understanding how children perceive their placement and their sense of control over what happens to them is important because children's evaluations of themselves and how they function in the world are central in their development of self-esteem (Berk, 2006). It is hypothesised that children who perceive their admission to respite care is the result of their own (mis)behaviour may encounter greater difficulty in their adjustment when compared to children who understand that it is the difficulties of their parent/s that has facilitated their out-of-home care.

The impact on children of separation from their primary parent is another important area for future research. The majority of children in the current study experienced some distress during respite care. Observational data would give valuable insight into the effects of separation on children's adjustment to out-of-home care. This could include some assessment of children's attachment to their primary parent. It should

be remembered also that separation may manifest in covert withdrawn/isolating behaviours as well as overt displays (Steinhauer, 1991).

Additionally, greater understanding is needed of the culture of disruptive and aggressive behaviour reported at Cholmondeley and in other children's homes (Sinclair & Gibbs, 1998). Talking with children and direct observational data may facilitate greater understanding of this phenomenon so that best practice intervention may be implemented. Research suggests that children value a culture of inclusiveness and belonging (Happer et al., 2006) and it is suggested that developing children's sense of ownership in Cholmondeley may help to develop a more appropriate culture.

The findings of this study suggest that increased and effective communication between the agency and families may facilitate a smoother transition from home to residential care for children. Most of the children in the current study had little insight into life at Cholmondeley prior to their respite admission. Photos or a brochure pitched at the level of the child, a brief orientation visit or a home visit by a staff member may help to ease the anxiety faced by children and parents confronted with this atypical experience.

Other studies have found that more intensive respite care is associated with greater reduction in parenting stress (Bruns & Burchard, 2000; Thomson, 2002). Although the current study cannot substantiate this, one parent whose child/ren experienced two periods of respite care reported an increased sense of wellbeing from the second period of respite. Longitudinal studies are needed to ascertain patterns of respite care usage and their impact on parenting stress. This may also allow investigation of the hypothesis by Joyce and others (1983, as cited in Stalker & Robinson, 1994) that "the knowledge that relief was available if required enabled parents to cope better" (p. 99). Longitudinal

studies would also allow researchers to ascertain if increased use of residential respite care was associated with ease of adjustment for children. Although one child in the study was not happy about a repeat admission to respite care, s/he reported that prior knowledge of routines and structures made adjustment during the subsequent admission less difficult.

## CHAPTER 6

### Summary

The key findings of this study have emerged from the voices of participants. Although the study sample was small and findings were inconclusive, it is noted there was a clear trend for families who encountered personal, social and/or economic disadvantage, and who have low levels of familial or social support, to report a much greater than average level of parenting stress. It is well known that a high level of stress impairs the capacity of a parent to provide effective caregiving (Webster-Stratton, 1990). Furthermore, a disorganised family environment and dysfunctional parent-child relationships increase a child's vulnerability to the development of attachment and psychological difficulties (Carr, 2006). Families characterised by high levels of parenting stress, poor family functioning and children with challenging behaviours are likely to need strong social networks to help them cope with problems (Carr, 2006).

Families with few social networks may turn to community agencies for support. Respite care in a community children's home is an available source of parenting support for families (in this location) who experience high levels of stress. Many studies attest the positive benefits of respite care for relieving parental stress and improving parental wellbeing (Cowen & Reed, 2002; Kendrick, 2008). However, very few studies have explored the impact of residential respite care on children's wellbeing. The current study has found that the experience of residential respite care can be a difficult one for children. Younger children, especially, felt the intense effects of separation from their mother, their primary attachment figure. Young children and those with overt physical differences were

especially vulnerable to acts of intimidation and bullying. Older children found the culture of disruptive and aggressive behaviour difficult to adjust to.

The most important finding to emerge from this study was the disparity between parent's perceptions of their child/ren's experience and the child/ren's own report of their experience. Differences between parent and children's reporting of respite care occurred in three out of four families in the study. Listening to the voices of individuals has allowed the differing and conflicting views of parents and children to emerge.

It is hoped the findings of this study offer some "food for thought" to the providers of residential respite care. Clough and others (2006) assert that "individual children can only be looked after properly if their needs have been understood and effective services developed in response to them" (p. 92). The challenge now is to take these messages and use them to provide services that meet the needs of parents' who seek respite from continuous caregiving in disadvantaged and stressful environments without increasing the risk of detrimental effects on the wellbeing of vulnerable children.

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APPENDIX A: Approval for research from Cholmondeley Children's Home



28<sup>th</sup> August 2007

Karen Read  
3/245 Montreal Street  
Central City  
CHRISTCHURCH

Dear Karen

Thank you for your correspondence regarding the research you would like to undertake on families who have utilized Cholmondeley's services.

I am pleased to inform you that the Board of Management and Mike Field, General Manager are happy that you undertake this research pending a satisfactory research agreement to be signed by Mike.

Please can you contact either Mike or myself ASAP to book a time to negotiate the research agreement. We look forward to hearing from you in due course.

Yours faithfully

A handwritten signature in blue ink, appearing to read 'Sally Lloyd', is written over a horizontal line.

Sally Lloyd  
P/A – Administrator  
**CHOLMONDELEY CHILDREN'S HOME**

APPENDIX B: Approval for research from Human Ethics Committee,  
University of Canterbury

Human Ethics Committee

Secretary

Tel: +64 3 364 2241, Fax: +64 3 364 2556, Email: human-ethics@canterbury.ac.nz



HEC Ref: 2007/137

17 October 2007

Ms Karen Read  
Educational Studies & Human Development  
UNIVERSITY OF CANTERBURY

Dear Karen

The Human Ethics Committee advises that your research proposal "Family experiences of short-term respite care for children and its impact on parental stress: A case study approach." has been considered and approved. However this approval is subject to the incorporation of the amendments you have provided in your email of 8 October 2007.

Yours sincerely

A handwritten signature in dark ink, appearing to read 'M Grimshaw'.

Dr Michael Grimshaw  
*Chair, Human Ethics Committee*

## APPENDIX C: Information letter for families

SCHOOL OF EDUCATIONAL STUDIES  
AND HUMAN DEVELOPMENT



**Research project with families  
of Cholmondeley Children's Home**

**INFORMATION FOR FAMILIES**

Dear

I am a student in a child and family psychology course at the University of Canterbury. I am doing a research project for my course and I would like to find out about families experiences of short-term care for their children at Cholmondeley Children's Home and how this affects the family.

I plan to recruit six families into the study and follow their experiences over a three month period. This will involve meeting with the family before the child/ren go to Cholmondeley and talking about what the parents and children think this will be like for them, and filling in some questionnaire forms. I am happy to read out the questions if this is helpful. During the study I will keep in touch with families each week by telephone or by visiting and we will redo two of the questionnaires during week four and week eight so that we have ongoing measures of what is happening for each family. With parents permission I would like to talk with the children while they are at Cholmondeley about how it is for them staying there. At the end of the study we will meet again to talk about the family's experiences and repeat the questionnaires.

The information that is gathered through meeting and talking with families and from the questionnaire forms will be combined and written into a report of the study. This report will help the managers and trustees at Cholmondeley to understand what happens for families whose children stay at Cholmondeley and how this affects the family. Having this information will help the managers to provide the best services they can for families.

I wish to invite your family to take part in the study. This is voluntary and you may withdraw at any time. Cholmondeley staff will not be told whether you agree to participate or not and there will be no negative consequences for yourselves or your children if you decide not to take part. All the information about your family will be kept confidential and will be reported in a way that your family or no member of your family

can be identified. Although the staff at Cholmondeley may see me talking with your child they are bound by their employment contract to keep this confidential. All the information about the study will be kept in a locked filing cabinet at the university and will be destroyed by shredding once the study is finished.

This is a private study and is not part of Cholmondeley Children's Home; however, the Board of Trustees have given their approval for the study. This study has also been read and approved by the Human Ethics Committee at the University of Canterbury.

All of the information that your family tells me will be kept confidential, though if your child/ren tell me about unsafe or harmful practices toward them, I will need to discuss this with my supervisor, Dr Michael Tarren-Sweeney, Psychologist and Senior Lecturer in the Child and Family Psychology programme.

Your family's story is important. Taking part in this study gives you and your child/ren an opportunity to share your experiences of short-term residential care and how this has been for your family, in an anonymous way. As well as being useful to Cholmondeley Children's Home this information may help other families who consider short-term residential care for their children.

Families who take part in the study will receive a family movie voucher to thank them for their time and efforts.

Thank you for reading this.

Karen Read  
Child and Family Psychology Trainee  
University of Canterbury  
Phone: 0274 360 932  
Email: [kdr22@student.canterbury.ac.nz](mailto:kdr22@student.canterbury.ac.nz)

Supervisor:  
Dr Michael Tarren-Sweeney  
Senior Lecturer in Child and Family Psychology  
School of Educational Studies and Human Development  
University of Canterbury

Date:

## APPENDIX D: Family participation consent form, written and verbal assent forms for children

SCHOOL OF EDUCATIONAL STUDIES  
AND HUMAN DEVELOPMENT



**FAMILY PARTICIPATION CONSENT FORM**

*Our family has been invited to take part in a study which looks at families experiences of short-term residential respite care for children at Cholmondeley Children's Home and its impact on family stress. We agree that*

- the study has been explained to us and we have read the information sheet
- we have been given time to ask questions about the study
- we are taking part in the study of our own free will
- our family's participation in the study will not be known to anyone outside of Cholmondeley Children's Home. Staff of Cholmondeley Children's Home are bound to confidentiality of my family's identity by their staff contract
- the information that identifies our family or family members will only be seen by the researcher. No one else will have access to this information
- our family, or members of our family, will not be identifiable in the written report of the study
- the researcher may talk with our child/ren about their experiences at Cholmondeley Children's Home while they are in residence

*Permission granted*    *yes / no*    *Signature* \_\_\_\_\_

- the researcher may read the daily notes written about our child/ren while they are staying at Cholmondeley Children's Home

*Permission granted*    *yes / no*    *Signature* \_\_\_\_\_

- we are free to withdraw our family from the study at any time without giving a reason, and without consequences. If we withdraw, the information about our family will be deleted from the study and paper records will be shredded

- all information about our family will be stored safely and destroyed by paper shredding once the written report of the study is complete
- the researcher may contact us each week during the study, either by telephone or by visiting us
- our family will receive a family movie pass for taking part in the study

*Please tick the box if you wish to read and comment on a draft report of the study*

This study has been approved by the Human Ethics Committee, University of Canterbury. If you have any questions or concerns please contact the researcher or her supervisor.

Karen Read  
Phone 0274 360 932  
Email: [kdr22@student.canterbury.ac.nz](mailto:kdr22@student.canterbury.ac.nz)

Supervisor:  
Dr Michael Tarren-Sweeney  
Senior Lecturer in Child and Family Psychology  
School of Educational Studies and Human Development  
University of Canterbury  
Private Bag 4800  
CHRISTCHURCH

Parent's Signature \_\_\_\_\_

Date \_\_\_\_\_

SCHOOL OF EDUCATIONAL STUDIES  
AND HUMAN DEVELOPMENT



## WRITTEN ASSENT TO PARTICIPATE IN RESEARCH

Hi

My name is Karen and I'm a student at the University of Canterbury. I'm doing a study about children who go to stay at Cholmondeley Children's Home and what they think about it and what its like for them. This study's going to help the staff at Cholmondeley to know what its like for kids and their families when kids stay there and they might be able to change some things to make it better for you if you stay here again or for the kids who stay here after you. Mum and dad have said its ok for you to take part in the study but I'd like to check with you as well. I'll be asking some other kids who are going to Cholmondeley to take part in the study too.

You can talk about this with mum and dad before you decide if you want to take part. Even though they've said "yes" you can still decide not to take part. Its totally is up to you and no one will be upset if you don't want to take part or if you change your mind and want to stop.

If you do agree to be in the study I'll visit with you before you go to stay at Cholmondeley and we can talk about things about you, like ... things you like doing in your spare time, your family, friends, pets, school, and what you think its going to be like at Cholmondeley. You don't have to answer any questions that you don't want to and it won't take very long.

I'll come and see you again while you're at Cholmondeley. We can do some drawing or play in the sandpit and chat about what you do there and how you get on with the other kids, see how things are going for you. I'll get a staff member to let you know when I'm coming.

My study lasts for three months and when this times up I'd like to talk with you about how things are for you then – about what it was like for you staying at Cholmondeley and about what things were good or bad for you. This will be just a short talk.

I don't think you will get hurt if you take part in the study and I will try not to upset you. If you do take part and you think that you have been hurt or upset then you may stop being in the study. You just have to tell me that you don't want to take part any more.



I won't tell anyone else the things you tell me about yourself or your family or about any other person. But if you tell me that someone at home or at Cholmondeley is hurting you, then I have to talk to my supervisor and decide the best thing to do about that.

What you tell me about yourself and your family and about being at Cholmondeley is going to be written into a report/story about the study. Your name will not be in the report and no-one who reads it will be able to tell that you or your family has taken part in the study. When the report is all finished and its been marked, all the information that you and your family have told me will be destroyed using a machine that gobbles up paper.

You can ask me any questions that you have about the study. If you have a question later that you didn't think of now, you can ask me next time.

Signing your name at the bottom of this page means that you agree to be in this study.

Signature of Child \_\_\_\_\_

Printed Name of Child \_\_\_\_\_

Signature of Researcher \_\_\_\_\_

Date \_\_\_\_\_

**SCHOOL OF EDUCATIONAL STUDIES  
AND HUMAN DEVELOPMENT**



## **VERBAL ASSENT TO PARTICIPATE IN RESEARCH**

Hi

My name is Karen and I go to a big school called a university. I'm learning about what its like for children who go to stay at Cholmondeley Children's Home. This is going to help the staff at Cholmondeley know what its like for kids and their families when kids stay there and they might be able to make some things better for you if you stay here again or for kids who stay here after you. Mum and dad have said its ok for you to take part in the study but I'd like to ask you as well. I'll be talking with other kids who stay at Cholmondeley too.

You can talk with mum and dad about this before you decide if you want to take part. Even though they've said "yes" you can still decide not to do it. Being in this study is up to you and no one will be upset if you don't want to participate or even if you change your mind later and want to stop.

If you say its ok for me to talk to you I'll visit you again soon and we'll talk about things like what you like doing in your spare time, your family, friends, pets, school, and what you think it's going to be like at Cholmondeley. You don't have to tell me anything that you don't want to and we won't talk for very long.

I'd like to come and see you while you are at Cholmondeley. We can do some drawing or play in the sandpit and chat about what you do there and how you get on with the other kids, see how things are going for you. I'd get someone to let you know when I'm coming.

My study lasts for three months and when this times up I'll come and talk with you about how things are for you then – about what it was like for you at Cholmondeley, about what things were good or bad for you. This will be just a short talk.

You won't get hurt if you take part in the study and I will try not to upset you. If you do take part and you think that you have been hurt or upset then you can stop being in the study. You just have to tell me that you don't want to take part any more.

I won't tell anyone else the things you tell me about yourself or your family or about any other person. But if you tell me that someone at home or at Cholmondeley is hurting you, then I have to talk to my supervisor and decide the best thing to do.

What you tell me about yourself and your family and about being at Cholmondeley is going to be written into a story about the study. Your name will not be in the report and no-one who reads it will be able to tell that you or your family has taken part in the study. When the report is all finished and marked, all the information that you and your family have told me will be destroyed using a machine that gobbles up paper. You can ask me any questions that you have about the study. If you have a question later that you didn't think of now, you can ask me next time.

Signing your name at the bottom means that you agree to be in this study.

Do you think you would like to take part in the study      Yes / No

Name of Child \_\_\_\_\_

Witnessed by \_\_\_\_\_

Signature \_\_\_\_\_

Signature of researcher \_\_\_\_\_

Date \_\_\_\_\_

## APPENDIX E: Guidelines for disclosure of abuse during interview

**PLAN FOR DISCLOSURE OF ABUSE DURING INTERVIEWS**

Get the information clear enough to say it is abuse?? Or does it fit within the realm of parenting??

Look for patterns

Ask who, what, when, where, how?

- Tell me more about that?
- What happened next?
- What was happening at this time?
- What have you been doing when this happens?
- Who else was there?
- Who else have you told?
- What did they say?

**CHECK –**

**Frequency** - how many times?  
- how often?  
- patterns?

**Intensity** - what with?  
- hand? open hand? closed fist?

**Severity** - how badly?  
- where on your body does this happen?  
- how does your body feel afterwards?  
- how long does this feeling last?  
- what does your body look like afterwards?  
- have Mum or Dad taken you to the doctor?

- Pass information to Supervisor or to Cholmondeley Manager/Psychologist and they will take over
- Follow up while the child is at Cholmondeley
- Talk to evidential interviewing unit

## FORENSIC INTERVIEWING OF CHILDREN

Explain my role - talking to kids and listening to kids

### **THREE PHASES**

***Beginning*** – acclimatise child to the setting and task

- Create atmosphere of acceptance and understanding
- It is helpful to tell the child that your job is to talk to kids and that you have talked with many kids in the past
- I'm going to take notes because what you tell me is important and I want to remember it correctly
- Tell the child what to expect – give the child control
- Child deciding whether can trust interviewer with sensitive information
- Goals – rapport building, developmental assessment, task definition
- Assess child's developmental level of concepts such as time and child's language abilities

***Middle*** – questioning

- Pose careful, non-leading questions
- Use neutral nonverbal behaviour
- Use open-ended questions that encourage the child to produce a free-running narrative
- Match your language to the child's language
- Questions flow from general to specific
- Cue the memory without tainting the memory
- Ask clarifying questions so long as not unduly stressful for the child
- Check exposure to risk factors, e.g. drug abuse, domestic violence, pornographic materials
- Remain sensitive to the child's emotional needs and digress from the task if necessary
- Can use drawings and simple figure drawings

***End*** – child seeks resolution

- Focus on the child's emotional needs
- Allow the child to achieve closure and emotional resolution
- Commend the child for his or her cooperation
- Time to ask the interviewer questions, express worries/fears re disclosure
- Engage the child in lighter topics to ease transition out of the room – finish the interview on a positive note

**At all times -**

- Communicate warmth and support through your voice
- Be careful of timing of affirmative nods, writing children's responses – may imply an expected response or disapproval to a child's response - provide these, and verbal praise noncontingently throughout the interview
- Acknowledge disclosure with neutral verbal and nonverbal responses “um hmm, head nods, I see”, paraphrase the child's statements, encourage them to continue “what happened next?”
- Avoid affective reactions to the child's statements – no pleasure, anger, disgust

**Cueing:** Ok to ask more specific questions to cue a child's memory and thereby elicit more information, e.g. child has disclosed ...

See: A Child Interviewer's Guidebook, pg 96

If you **suspect coaching**, ask child

- If there were conversations about abuse with ...? What did they say?

If you **suspect vengeance**, ask child

- About feelings towards the alleged perpetrator before and after touching happened – How do you feel about ... now? How did you feel when you first met him? What changed your mind? What do you want to happen to .....?

**Handling emotional responses during disclosure –**

“I can see this is hard for you, I wonder how you are feeling right now?”

“What were you afraid of?”

“Would it be easier if we hugged teddy bears while we talk?”

Use drawings etc.

**REFERENCES**

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A. Bannister, K. Barrett & E. Shearer (Eds.). (1997). *Listening to children. The professional response to hearing the abused child*. Chichester: John Wiley & Sons

Bourg, W., Broderick, R., Flager, R., Meeks Kelly, D., Lang Ervin, D., & Butler, J. (1999). *A child interviewer's guidebook*. Thousand Oaks: SAGE Publications

Sattler, J.M. (1998). *Clinical and forensic interviewing of children and families. Guidelines for the Mental Health, Education, Pediatric, and Child Maltreatment fields*. San Diego: Jerome M. Sattler Publisher

APPENDIX F: Parent interview – intake, interim and conclusion of study

SCHOOL OF EDUCATIONAL STUDIES  
AND HUMAN DEVELOPMENT



**Research project with families  
of Cholmondeley Children’s Home**

**PARENT INTERVIEW – INTAKE OF STUDY**

**Date:**

**Time:**

**Location:**

**Present:**

**FAMILY CODE - A B C D E F**

**Lets look at who’s in the family?**

Mum –

Age –

Ethnicity –

- Likes –
- Dislikes –
- Education –
- Job –

Dad –

Age –

Ethnicity –

- Likes –
- Dislikes –
- Education –
- Job –





Have there been any times of long separation from the children?

How long have you lived in this home?

- If a short while – number of other homes / locations?

**Lets talk about family things –**

What sort of things do you do together?

- Something you wish you could do together?

What sort of things cause difficulties for your family?

- What would you change if you could?

How does the family deal with stressful times?

Who makes the rules in the home?

- Who enforces the rules?
- What happens when rules are broken?

How does the family solve problems?

How happy are you with the way your family communicates?

Who is the most healthy person in the family?

Whose get sick the most often?

- Who looks after them?

Does anyone in the family have a disability?

What about alcohol and drug use in the home?

Does your family have enough money to manage to your satisfaction?

What community groups are you involved in?

Are there other families that you get together with?

Who supports your family?

- Mum's family?
- Dad's family?
- Agencies?

Has your family had involvement with agencies such as Child Youth & Family?

What do you think is the greatest risk for your family?

If you could start all over again, knowing what you know now, what would you do differently?

**Lets talk now about the children going to Cholmondeley ...**

How did you find out about Cholmondeley?

Have you experienced care similar to Cholmondeley in your own childhood?

How do you plan for your family to be involved with Cholmondeley?

What do you think this will be like for your family?

- Parents?
- Children?

How do you think being able to access respite care at Cholmondeley will make a difference to your family?

- In the short-term?
- In the longer term?

Are you aware that Cholmondeley offers courses for parents?

- Do you plan to attend these?

**Psychometrics –**

- Parenting Stress Index
- Parenting Daily Hassles
- Adult Wellbeing Scale
- Recent Life Events Questionnaire
- Strengths and Difficulties Questionnaire

**INTERVIEW ANALYSIS**  
**(Attached to each interview)**

**PRIMARY POINTS TO NOTE:**

**SECONDARY POINTS TO NOTE:**

**CONTEXTUAL INFORMATION:**

**MATTERS TO FOLLOW-UP:**

**OTHER NOTES:**

SCHOOL OF EDUCATIONAL STUDIES  
AND HUMAN DEVELOPMENT



**Research project with families  
of Cholmondeley Children's Home**

**PARENT CONTACT – INTERIM**

**Date:**

**Time:**

**Present:**

**Location:**

**FAMILY CODE -    A    B    C    D    E    F**

*Just checking in on how things are going for you and your family ...*

What's been happening over the past week?

- Most major thing?
- Good things?
- Difficult things?

What's been happening with the children?

Are things going as you would like?

What would you change if you could?

What would you like to happen?

Any plans for the coming week?

*Make arrangements for contact during the forthcoming week*

SCHOOL OF EDUCATIONAL STUDIES  
AND HUMAN DEVELOPMENT



**Research project with families  
of Cholmondeley Children’s Home**

**PARENT INTERVIEW – CONCLUSION OF STUDY**

**Date:**

**Time:**

**Location:**

**Present:**

**FAMILY CODE -    A    B    C    D    E    F**

Information about admissions to Cholmondeley –

	<b>Duration of Stay</b>	<b>Ages of Child/ren</b>	<b>Comments</b>
<b>Stay 1</b>			
<b>Stay 2</b>			
<b>Stay 3</b>			
<b>Stay 4</b>			
<b>Stay 5</b>			
<b>Stay 6</b>			

It’s now 12 weeks since your child/ren began respite care at Cholmondeley Children’s Home, how has this been for you?



How do you think it has been for the children?

- Why do you think that?

Have you noticed any changes in yourselves?

- Why do you think this is?

Have you noticed any changes in your children?

- Why do you think this is?

Have there been any changes at home?

- Tell me about these?
- Attended parenting course? Comments ...

Has accessing respite care for your children worked out as you expected?

- Please tell me more about this?

How do you think respite care has impacted on your family?

- In the short-term?
  
- In the longer-term?

How do you think you may use respite care in the future?

Would you recommend short-term respite care for children to your friends?

Why / why not?

Looking back over your experiences in the past 12 weeks what would you do differently another time?

Three wishes for your family for the future?

**Re-administer psychometrics –**

- Parenting Stress Index – Short Form
- Parenting Daily Hassles
- Recent Life Events Questionnaire
- Adult Wellbeing Scale
- Strengths and Difficulties Questionnaire

APPENDIX G: Child Interviews – Intake to study,  
while in respite care, and conclusion of study

SCHOOL OF EDUCATIONAL STUDIES  
AND HUMAN DEVELOPMENT



**Research project with families  
of Cholmondeley Children’s Home**

**CHILD INTERVIEW – INTAKE TO STUDY**

**Date:**

**Time:**

**Location:**

**Family Code:**    **A**    **B**    **C**    **D**    **E**    **F**

**Childs details:**    **M / F**                      **Age:**                      **DoB:**

Lets start with some things about you so that I can get to know you a little –

- Things you like
- Things you don’t like
- Pets
  
- Friends
  
- School
  
- Who helps you with your homework?

- Extra help at school?
  
- Things you do in your spare time - activities / hobbies / clubs / teams
  
  
  
  
  
  
  
  
  
  
- Things that make you happy
  
  
  
  
  
  
  
  
  
  
- Things that make you sad
  
  
  
  
  
  
  
  
  
  
- How you get on with Mum
  - Three words to describe Mum
  
  
  
  
  
  
  
  
  
  
- How you get on with Dad
  - Three words to describe Dad
  
  
  
  
  
  
  
  
  
  
- How you get along with sisters/brothers
  - Compared to your mates

- How do you describe your sisters/brothers
  
- Chores that you do at home
  
- Who makes the rules at home
  
- What happens if you break the rules
  - Who does this?
  
- What are the best things about you
  
  
- What are the not-so-good things about you
  
  
- What things do you find difficult
  
  
- Illness / disability / things that make your life difficult
  
  
- Who do you talk to when you are having difficulties

- If you had a magic wand ...

### **About Cholmondeley**

- I hear that you are going to stay at Cholmondeley - why do you think this is?
- Has mum or dad told you about Cholmondeley?
  - What have they told you?
- How long will you be there?
- What do you think it will be like staying there?
- Are there things that you think might be better than at home?
- What do you think might be more difficult?
- How do you think you will get along with the other children?
- Do you have anything special to you that you are going to take with you?

***Check with child that it is ok to visit with them during their stay at Cholmondeley***

SCHOOL OF EDUCATIONAL STUDIES  
AND HUMAN DEVELOPMENT

**Research project with families  
of Cholmondeley Children's Home**



**CHILD CONTACT – AT CHOLMONDELEY**

**Date:**

**Time:**

**Family Code:** A B C D E F

**Childs details:** M / F

**Age:**

**DoB:**

**Where held:**

**Activities used:**

*I just wanted to chat with you about how things are going for you at Cholmondeley ...*

- Good things?
- Difficult things?

What do you do in your free time?

- Who do you do this with?

What's the best part of the day? Why?

- Worst part of the day? Why?

How do you get along with the other children?

- Special friends?

How do you get along with the adults at Cholmondeley?

How well do you sleep here?

If you could change things at Cholmondeley how would you make it different?

Anything else?

*Is it ok for me to call and visit with you again if you are here?*



SCHOOL OF EDUCATIONAL STUDIES  
AND HUMAN DEVELOPMENT



**Research project with families  
of Cholmondeley Children's Home**

**CHILD INTERVIEW - CONCLUSION OF STUDY**

**Date:**

**Time:**

**Location:**

**Family Code:**    **A**    **B**    **C**    **D**    **E**    **F**

**Childs details:**    **M / F**                      **Age:**                      **DoB:**

*Its time for me now to close the study that I've been working on so I just wanted to check with you about how its been for you at Cholmondeley?*

- So tell me about your stay/s at Cholmondeley
  - How many?
  - Sleeping?
  - Meal times?
  
- What was it like for you there?
  
- How did you get along with the other kids?
  
- How did you get along with staff?
  
- Did you have a favourite place?
  - Time of day?
  
- What was the best thing about going to stay at Cholmondeley?





## APPENDIX I: Parenting Daily Hassles Scale



## Parenting Daily Hassles SCALE

The statements below describe a lot of events that routinely occur in families with young children. These events sometimes make life difficult. Please read each item and circle how often it happens to you (rarely, sometimes, a lot, or constantly) and then circle how much of a 'hassle' you feel that it has been for you **FOR THE PAST 6 MONTHS**. If you have more than one child, these events can include any or all of your children.

EVENT	How often it happens				Hassle (low to high)
	Rarely	Sometimes	A lot	Constantly	
1. Continually cleaning up messes of toys or food					1 2 3 4 5
2. Being nagged, whined at, complained to					1 2 3 4 5
3. Meal-time difficulties with picky eaters, complaining etc.					1 2 3 4 5
4. The kids won't listen or do what they are asked without being nagged					1 2 3 4 5
5. Baby-sitters are hard to find					1 2 3 4 5
6. The kids schedules (like pre-school or other activities) interfere with meeting your own household needs					1 2 3 4 5
7. Sibling arguments or fights require a 'referee'					1 2 3 4 5
8. The kids demand that you entertain them or play with them					1 2 3 4 5
9. The kids resist or struggle with you over bed-time					1 2 3 4 5
10. The kids are constantly underfoot, interfering with other chores					1 2 3 4 5
11. The need to keep a constant eye on where the kids are and what they are doing					1 2 3 4 5
12. The kids interrupt adult conversations or interactions					1 2 3 4 5
13. Having to change your plans because of unprecedented child needs					1 2 3 4 5
14. The kids get dirty several times a day requiring changes of clothing					1 2 3 4 5
15. Difficulties in getting privacy (eg. in the bathroom)					1 2 3 4 5
16. The kids are hard to manage in public (grocery store, shopping centre, restaurant)					1 2 3 4 5
17. Difficulties in getting kids ready for outings and leaving on time					1 2 3 4 5
18. Difficulties in leaving kids for a night out or at school or day care					1 2 3 4 5
19. The kids have difficulties with friends (eg. fighting, trouble, getting along, or no friends available)					1 2 3 4 5
20. Having to run extra errands to meet the kids needs					1 2 3 4 5

Questionnaire completed by *mother/father/adoptive parent/foster carer* (please specify)

APPENDIX J: Recent Life Events Scale



**Recent Life Events**  
QUESTIONNAIRE

Listed below are a number of events. Please read each item carefully and then indicate whether or not each event has happened to you in the past year.

Please tick the YES box if the event has occurred.  
Please tick the 'still affects me' box if the event is still having an effect on your life

EVENT	YES	Still affects me
Have you had a serious illness or been seriously injured?	<input type="checkbox"/>	<input type="checkbox"/>
Has one of your immediate family* been seriously ill or injured?	<input type="checkbox"/>	<input type="checkbox"/>
Have any of your close friends or other close relatives been seriously ill or injured?	<input type="checkbox"/>	<input type="checkbox"/>
Have any of your immediate family died?	<input type="checkbox"/>	<input type="checkbox"/>
Have any of your other close relatives or close friends died?	<input type="checkbox"/>	<input type="checkbox"/>
Have you separated from your partner (not including death)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any serious problem with a close friend, neighbour or relative?	<input type="checkbox"/>	<input type="checkbox"/>
Have you, or an immediate family member been subject to serious racial abuse, attack or threats?	<input type="checkbox"/>	<input type="checkbox"/>
Have you, or an immediate family member been subject to any abuse, attack, threat – perhaps due to you or someone close to you having a disability of any kind (i.e. a mental health problem, a learning disability or a physical problem)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you, or an immediate family member been subject to any other form of serious abuse, attack, or threat?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or your partner been unemployed or seeking work for more than one month?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or your partner been sacked from your job or made redundant?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any major financial difficulties (e.g. debts, difficulty paying bills)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you, or an immediate family member had any Police contact or been in a court appearance?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or an immediate member of your family been burgled or mugged?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or another individual who lives with you given birth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or another individual who lives with you suffered from a miscarriage or had a stillbirth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you moved house (through choice)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you moved house (not through choice)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any housing difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any other significant event (Please specify)?	<input type="checkbox"/>	<input type="checkbox"/>

\* immediate family includes: mother, father, sister, brother, partner, child

## APPENDIX K: Adult Wellbeing Scale

**ADULT WELLBEING SCALE**

This form has been designed so that you can show how you have been feeling in the past few days.

Read each item in turn and UNDERLINE the response which shows best how you are feeling or have been feeling in the last few days.

Please complete all of the questionnaire.

- |   |                     |                  |                      |  |
|---|---------------------|------------------|----------------------|--|
| <b>1. I feel cheerful</b>   | Yes, definitely     | Yes, sometimes   | No, not much         | No, not at all                                 |
| <b>2. I can sit down and relax quite easily</b>                           | Yes, definitely     | Yes, sometimes   | No, not much         | No, not at all                                 |
| <b>3. My appetite is</b>  | Very poor           | Fairly poor      | Quite good           | Very good                                      |
| <b>4. I lose my temper and shout and snap at others</b>                   | Yes, definitely     | Yes, sometimes   | No, not much         | No, not at all                                 |
| <b>5. I can laugh and feel amused</b>                                     | Yes, definitely     | Yes, sometimes   | No, not much         | No, not at all                                 |
| <hr/>   |                     |                  |                      |  |
| <b>6. I feel I might lose control and hit or hurt someone</b>             | Sometimes           | Occasionally     | Rarely               | Never  |
| <b>7. I have an uncomfortable feeling like butterflies in the stomach</b> | Yes, definitely     | Yes, sometimes   | Not very often       | Not at all                                     |
| <b>8. The thought of hurting myself occurs to me</b>                      | Sometimes           | Not very often   | Hardly ever          | Not at all                                     |
| <b>9. I'm awake before I need to get up</b>                               | For 2 hours or more | For about 1 hour | For less than 1 hour | Not at all. I sleep until it is time to get up |
| <b>10. I feel tense or 'wound up'</b>                                     | Yes, definitely     | Yes, sometimes   | No, not much         | No, not at all                                 |
-

<b>11. I feel like harming myself</b>	Yes, definitely	Yes, sometimes	No, not much	No, not at all
<b>12. I've kept up my old interests</b>	Yes, most of them	Yes, some of them	No, not many of them	No, none of them
<b>13. I am patient with other people</b>	All the time	Most of the time	Some of the time	Hardly ever
<b>14. I get scared or panicky for no very good reason</b>	Yes, definitely	Yes, sometimes	No, not much	No, not at all
<b>15. I get angry with myself or call myself names</b>	Yes, definitely	Yes, sometimes	Not often	No, not at all
<b>16. People upset me so that I feel like slamming doors or banging about</b>	Yes, often	Yes, sometimes	Only occasionally	Not at all
<b>17. I can go out on my own without feeling anxious</b>	Yes, always	Yes, sometimes	No, not often	No, I never can
<b>18. Lately I have been getting annoyed with myself</b>	Very much so	Rather a lot	Not much	Not at all

APPENDIX L: Strengths and Difficulties Questionnaire and Impact Supplement



# Strengths and Difficulties QUESTIONNAIRE

TO BE COMPLETED BY A MAIN CARER OF A CHILD AGED BETWEEN 4 AND 16

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain, or the items seem daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name \_\_\_\_\_ Male/Female \_\_\_\_\_ Date of Birth \_\_\_\_\_

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot sit still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries, often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, downhearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please complete questions on the next page...



Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No difficulties	Yes – minor difficulties	Yes – more serious difficulties	Yes – severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1–5 months	5–12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
Home life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friendships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Classroom Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leisure activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature \_\_\_\_\_

Date \_\_\_\_\_

Mother/Father/Other (please specify) \_\_\_\_\_

Thank you very much for your help