

FOSTERING CHILDREN WITH ATTACHMENT DIFFICULTIES:

Exploring the Experiences of New Zealand Carers

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Abstract

The objective of the present study was to explore the experiences of New Zealand non-relative foster carers fostering children with attachment difficulties (indicative of disorders of non-attachment). This objective was achieved using a detailed Interpretative Phenomenological Analysis (Smith et al., 2009). Analysis revealed five themes evident in carer accounts: expectations versus reality; satisfactions and strains of fostering children with attachment difficulties; attachment relationships and the benefits of information; the impact of others on the caring experience; and negative expectations and future concerns. Overall, these themes suggest that fostering children with attachment difficulties is a complex and challenging experience which significantly impacts carers and their families. While lack of public understanding and public judgement compound the difficulty of the experience, receiving information about fostering and attachment difficulties appears to alleviate it. The five identified themes and their relation to the existing literature are explored in detail in this thesis. Implications for social policy and practice are discussed, and potential future research directions are outlined.

CHAPTER ONE: INTRODUCTION

Who are Foster Carers/Caregivers?

The New Zealand Family and Foster Care Federation (2011) defines foster carers (also known as ‘caregivers’ or ‘carers’) as individuals over the age of 18 who “provide alternative care to meet the needs of a child or young person who is unable to live with their parents or usual caregiver, in an appropriate family-like setting.” Foster carers voluntarily assume care of children who are not their birth children because their parents have been unable to provide them with the necessary care and protection. The objectives of fostering children are to keep children safe and sponsor their developmental recovery by “placing them with new, protective and emotionally available carers” (Golding, Dent, Nissim & Stott, 2006a, p. xiii). Carers look after the children in their own homes, often raising them alongside their own birth children.

Foster carers (earlier termed “foster parents”) provide for their foster children’s basic practical and material needs, as well as supporting and facilitating their activities and providing them with an emotional relationship (Nutt, 2006). Their aim is to provide a “normal life” for foster children, who have often been exposed to early developmental adversity prior to placement (Nutt, 2006, p.7). The children remain in care until they can once again be appropriately cared for and protected by their original caregivers; they are adopted; or they reach adulthood. Carers are supported by other professionals who provide social services for the young people.

Changing a child’s carer can be considered “the most radical, and potentially most effective child care intervention” implemented in the world today (Stott, 2006, p. xiii). However, the potential for positive change through foster care is massive (Nutt, 2006). Foster care is currently considered the most effective strategy for supporting children who cannot safely stay in their own homes, and has been described as the “linchpin” of the child welfare system (Sinclair, Gibbs & Wilson, 2004, p. 7). Foster carers are “pivotal” elements in foster children’s recovery from traumatic experiences (Department of Child, Youth and Family [CYFS], 2007, p. 8). They have the opportunity to act as change agents who heavily influence their foster children’s developmental trajectories (CYFS, 2007; Nutt, 2006).

Despite the widely recognised importance of foster carers as a “vital resource in caring for children who have faced early adversity” (Golding, 2003, p. 64), foster carers have historically

been “largely undervalued” by societies and governments (Nutt, 2006, p. 96). The foster care system is frequently characterised by placement breakdowns and allegations of abuse. It receives frequent negative media attention because, as Graham has asserted, “care is only visible when it is not done” (1982, in Nutt, 2006, p. 22). Foster care is considered a low-status profession, and caregivers have historically been stigmatised, disrespected and viewed as lesser than birth parents (Golding, 2003; Lawrence, 2008; Nutt, 2006; Wilson, Sinclair & Gibbs, 2000). Research attention has only recently turned to the experiences of foster carers, despite fostering being the primary form of alternative care in many countries (Nutt, 2006; Golding, 2008; Sinclair et al., 2004).

History of Foster Care

Evidence suggests that dependent children have been cared for by unrelated adults since biblical times (Nutt, 2006). Approaches to child welfare have evolved greatly over time, as ideologies surrounding what constitutes appropriate care have changed (Dally, 1998; Schene, 1998). In the last three centuries, international child welfare goals have shifted from ‘rescuing’ children by removing them from their families to supporting and preserving families so that children can stay in their care (Schene, 1998). While residential care is still utilised today, foster care has become the primary method of care in Western countries (Hacsi, 1995).

Foster care grew out of eighteenth and nineteenth century schemes in which dependent children were sent to live with unrelated families, receiving accommodation and food in exchange for work (Hacsi, 1995; Schene, 1998). Hacsi states that these arrangements were originally primarily “economic rather than psychological in nature”, and were based on the ideology that children were ‘miniature adults’ who should grow up as soon as possible which was held by some at the time (1995, p. 185). Over time, childhood became considered a separate stage of life in which children should be nurtured and “allowed to be children” (Hacsi, 1995, p. 164). This ideology prompted the inception of “boarding out” in America, in which families were paid to care for young people (so they would not have to work for their accommodation). Boarding out was considered an effective method to provide care for children with special needs and children who were otherwise difficult to live with, and was later termed ‘foster care’. Foster care became acknowledged as a suitable care option for dependent British children in 1876, as it was considered an economically viable way to cut the cost of poor relief and instil the desired

values in children” (Nutt, 2006). In both America and Britain, foster care originally aimed to ‘save’ children by removing them from the negative influence of their families.

Until the mid-twentieth century, foster care was an ancillary welfare option which supplemented residential care. The twentieth century saw a shift towards foster care as the primary welfare option, as residential care drew heavy criticism and many argued that children should be cared for in families (Hacsi, 1995; Schene, 1998). This shift occurred at different rates in different countries. The American National Conference of Charities supported home placement as the preferred method of care for dependent children in 1899, and boarding out became more popular than institutions by 1920. In 1953, John Bowlby identified the importance of providing for children’s emotional development by allowing them to form exclusive bonds. His work provided psychological and developmental evidence which, combined with the aforementioned economic efficacy of fostering, rendered foster care the preferred form of child care in twentieth century Britain (Nutt, 2006). This preference was further strengthened by the British opinion that all children had a right to experience normal family life. By 1968, more than three times as many children were in foster care than in were in institutions (U.S. Department of Health, Education, and Welfare, 1968, in Hacsi, 1995). Fostering is now regarded as a more appropriate form of care which is cheaper, less institutional and less controversial than residential care (Sinclair et al., 2004, p. 8).

Like the United States and Britain, New Zealand experienced a shift away from residential care and towards foster care in the twentieth century. By the 1950s, children in care experienced a mixture of family care situations. The closure of many residential homes in the 1980s marked the elevation of foster care to New Zealand’s primary child welfare method. There are now only four Care and Protection Residences in New Zealand, which can house a combined total of 48 young people at any one point in time (CYFS, 2011). The shift towards foster care as primary care method was consolidated in the Child, Young People and their Families Act of 1989. This Act “lifted New Zealand to the forefront” of international policy and practice, and captured “a fundamental rethinking of the entire framework of child welfare” (Dalley, 1998, p. 46). It solidified prevention and reunification as primary welfare goals, placed families at the heart of the decision-making process surrounding their children, and emphasised the importance of cultural heritage (Dally, 1998). It also gave non-governmental organisations the potential to develop community-based responses to child care (Wells, 2004).

Modern Foster Care

Foster care is widely regarded as the primary option for children in need of care and protection in the Western world today (Lawrence, 2008; CYFS, 2007; Maclay, Bunce & Purves, 2006; Nutt, 2006; Sinclair et al., 2004). In 2006, nearly two-thirds of British children in care were fostered (Nutt, 2006). Foster care accounted for a more dominant proportion of children in care in Australasia, of whom 90 and 94 percent were fostered in New Zealand and Australia respectively (Ministry of Social Development [MSD], 2008; Sawyer, Crabone, Searle & Robinson, 2007). 500,000 young people are in foster care in the United States of America (Rubin et al., 2004). Residential care is still utilised in many countries to house children at the most extreme end of the complex needs spectrum, but residence numbers are steadily declining (Nutt, 2006).

Today, foster care is largely designed to be a temporary measure which provides for children while their families are rehabilitated (although some countries including New Zealand and England now also reserve permanent placement as an option). As Hasci states, “Whereas a century ago placing-out advocates sought to break up families, today's foster care system hopes to reunite families, so long as the home provides a safe environment for children” (1995, p. 177). This emphasis on supporting families, rather than replacing them, marks a dramatic departure from earlier models of foster care (Schene, 1998). It prompted by public concern about the fates of children who spent many years in foster care, drifting between foster homes without ever returning to their families or being adopted (Schene, 1998). Foster carers are now regarded as an “extension of family support” in the ecological model, rather than “parent substitutes” (Nutt, 2006, p. 7).

Kinship care (in which the children are cared for by members of the extended family), has recently become an extremely popular form of foster care. It was an important part of foster care services in America by 1990 (Hasci, 1995), and has dramatically increased in numbers since. 500,000 American children were in kinship care in the year 2000 (Kolomer, 2000). Kinship care can be viewed as an advantageous care option because it involves placing the children with members of their extended family in a culturally appropriate setting, and is potentially less restrictive than an unrelated placement (Kolomer, 2000).

In recent years, many have acknowledged that foster care is becoming an increasingly difficult vocation (Nutt, 2006; Sinclair et al., 2004; Wells, 2004). The reduction in residential

care has led to a “more difficult clientele”, as children with complex needs enter foster care rather than residences (Farmer, Moyers & Lipscombe, 2004; Sinclair et al., 2004, p.9). Carers must attempt to provide adequate care for these children, facing and managing challenges which would previously have been dealt with in a residential environment (Farmer et al., 2004; Hacsí, 1995; MacLay, Bunce & Purves, 2006; Wells, 2004;). The original nineteenth century view that removing children from their families was the “great panacea” has changed, and carers have become heavily involved in supporting children towards resuming positive developmental trajectories (Nutt, 2006, p. 7). The increasingly collaborative role of birth parents has also made the foster carer’s task “increasingly testing” (Nutt, 2006, p. 4), as carers are required to facilitate contact with birth parents and have less influence over decisions made about their foster children.

Many countries are considering professionalising foster care in response to the increasingly difficult nature of fostering. Countries such as Canada have adopted a mixture of voluntary and professional models, where payment amounts are determined by the children’s difficulties and the carers’ qualifications (Lawrence, 2008). Opinion about the advantages and disadvantages of professionalisation differ greatly amongst academics, services, governments and carers (CYFS, 2007; Nutt, 2006; Sinclair et al., 2004). New Zealand survey results suggest that some believe fostering is built on the altruistic motivations of carers, and fear professionalisation would encourage people to foster for the wrong reasons, while others believe the training, hours, and investment carers must provide for their children warrants professionalisation (CYFS, 2007). Treatment Foster Care has also been adopted in many countries to fill the “gap in arrangements aiming to provide therapy” which has been left by the shift away from residential care (Sinclair et al., 2004, p. 19). Sinclair and colleagues believe that the widespread adoption of treatment foster care would be a useful and effective way to negotiate dilemmas of who takes difficult children, and payment.

Fostering in the Current New Zealand Context

New Zealand foster carers provide one of six types of foster care: emergency care (in which the child is placed very briefly because of immediate risk); respite care (used to give the child’s full-time carers a break from caring for them); short term care; medium/long term care; permanent placement (“home for life”/adoption) or family/whanau/kinship care (when the child

is placed in the care of relatives). A recent CYFS survey found that 86 percent of primary carers in New Zealand are women, and men are 80 percent of secondary carers (CYFS, 2007, p. 1). Kinship care is extremely common in New Zealand, where relative placements are considered the ideal under the Children, Young People and their Families Act and between forty and fifty-five percent of foster children are placed with kinship carers (CYFS, 2007; Lawrence, 2008; Ministry of Social Development [MSD], 2009). However, non-relative foster care remains a key component of child welfare provision in New Zealand.

The majority of New Zealand foster children come into care through Child Youth and Family Services (CYFS), a department of the Ministry of Social Development. CYFS is responsible for approximately 5000 children at any one time, approximately 4500 of whom are in foster care (CYFS, 2007; MSD, 2009). Maori children are over-represented in this population, making up nearly fifty percent of children in care despite comprising only fourteen percent of New Zealand's population (Lawrence, 2008). Pasifika children are also over-represented (Dalley, 1998). While the number of children in care is relatively stable, the amount of foster carers in New Zealand is currently decreasing (Wells, 2004). This population decline has prompted discussion of professionalising foster care in New Zealand (Lawrence, 2008; MSD, 2009).

As in other parts of the world, New Zealand research and caregiver feedback indicates that fostering is becoming an increasingly difficult task (CYFS, 2007). New Zealand's pool of potential foster carers is shrinking, which increases the chance of child-caregiver combinations which are not necessarily of best fit. As Wells has asserted, New Zealand faces a crisis of care driven by numerous factors:

“The rising number of children with emotional and behavioural problems, the complexity of their behaviours and the impact of these on the lives of caregivers have been noted as contributing factors to the crisis in care” (2004, p. 104).

This shortage of foster carers makes it difficult to find placements for children with complex needs (Maclay, Bunce & Purves, 2006). Internationally, these shortages are causing many foster children to be placed with foster carers who are unable to meet their needs (Farmer et al., 2004).

New Zealand foster carers are not currently paid for their work. They receive allowances to assist them in covering some of the costs of raising the foster children, the amounts of which vary according to the child's needs and the region in which the carer lives. The allowances are often insufficient to cover the costs incurred: many foster carers receive up to sixty dollars too little per week (Lawrence, 2008). Some New Zealand carers argue for professionalisation because the "increased complexities" of children in care require more specialised skills and make fostering more challenging, while others fear people might foster for the "wrong reasons" if they were paid (CYFS, 2007, p. 4). Gayle Lawrence, president of the New Zealand Foster Care Association, has advocated for a tiered framework of professionalisation in which carers are paid according to the difficulties of the child (2008). This movement is yet to gain government support.

The Challenge to Foster Carers

Fostering is an extremely complex task in, which has been described as "the ultimate challenge" (Nutt, 2006, p. 103). Foster carers must juggle many responsibilities and aspects of their lives (Golding, 2006; Nutt, 2006). As well as dealing with the practical issues of having another child in their house, they must face the unique challenges each foster child brings. They must meet the child's emotional needs, providing a close, involved relationship to a child who they know will inevitably move on, and is likely to be very difficult in the interim (Lawrence, 2008; Nutt, 2006). Foster carers face the challenge of providing sensitive care to children who have experienced developmental adversity and disrupted attachments, and frequently present with complex needs (Stevenson & Hamilton-Giachritsis, 2006). They require "a high level of parenting skill" to provide these children with the special care they need (Golding, 2006, p. 196). Carers must also face challenges of non-collaborative practice with professionals; extensive bureaucracy; and lack of power regarding their foster child's situation (Nutt, 2006). In all these challenges, foster carers are normal people from "ordinary families" (Schofield & Beek, 2005, p.3) who may have received very little training (Sinclair et al., 2004) and often enter fostering with little knowledge of what the child, and the particular challenges they will bring, will be like (Stott, 2006). Particular difficulties of foster children will be explained in the following section.

The Burden of Care: Characteristics of Foster Children

While foster children are not a homogenous group, and their development depends on unique transactional interactions with their environments, they frequently present with “highly complex needs” (Stevenson & Hamilton-Giachritsis, 2006, p. 158). As Rutter has asserted, “there is consistent evidence that the rate of emotional, social, behavioural and educational problems found in children in such care is substantially higher than that in the general population” (2000, p. 685). Foster children face an increased risk of suffering various developmental difficulties, because their pre-placement care “is usually characterised by severe neglect, physical abuse, sexual abuse, rejection, emotional maltreatment or some combination of these” (Howe & Fearnley, 2003, p. 370). Exposure to these early adversities frequently results in difficult behaviours, as outlined in this passage:

“They might steal, break things, have tantrums, refuse to eat, smear walls, wet their beds, refuse to bath, continually defy their carers, set light to their bedding, take overdoses, make sexual advances to other children, expose themselves in public, make false allegations, attack others, truant, take drugs or get into trouble with the police” (Sinclair et al., 2004, p.4).

The development of children in foster care is frequently characterised by high levels of functional impairment across many other domains (Howe & Fearnley, 2003; Murray, Tarren-Sweeney & France, 2010). They present with higher prevalence and severity of emotional and behavioural difficulties, a higher prevalence of language and learning difficulties, and poorer physical health than other children (Tarren-Sweeney, 2008). They often develop confused, distorted understandings of how to express themselves and regulate their feelings, and have difficulty developing relationships because of their minimal opportunities to develop social skills in their early environments (Golding, 2008). They may also present with inappropriate sexual behaviour, which is extremely rare in the general child population (Nutt, 2006). Foster children often also underachieve at school (Golding, 2006). Meltezer and colleagues (2004) found that approximately 60 percent of children in care had marked difficulty with reading, spelling or mathematics (a percentage which shows they are nearly twice as likely to have these difficulties as other children). Finally, foster children frequently suffer from mental health issues and attachment problems, as outlined below.

Mental Health Issues

Children in care are grossly over-represented in mental health statistics. Their high prevalence of mental health issues is largely attributed to the risk factors they encounter prior to placement, which in their pre-placement histories of adversity, which may include abuse and neglect (Howe & Fearnley, 2003; Meltzer et al., 2006; Richardson & Lelliott, 2003). Children placed at older ages are far more likely to require mental health services than children placed as babies (Howe & Fearnley, 2003). Prevalence estimates, as well as the nature of specific mental health issues most commonly reported in foster children, vary between countries.

Studies indicate a high prevalence of mental health issues amongst American and British children in care (Burns et al., 2004; McMillen et al., 2005). One nationally representative study found that nearly fifty percent of all child welfare clients, and 63 percent of children in foster care, scored above the clinical cut-off on the Child Behaviour Checklist (Burns et al., 2004). The most common diagnoses of American foster children are Conduct Disorder, followed by Major Depressive Disorder and ADHD (McMillen et al., 2005). Over 60 percent of Scottish children in care have mental health issues (Minnis, Everett, Pelosi, Dunn & Knapp, 2006), while a national survey found that 45 percent of English children in care aged between 5 and 17 years had a mental disorder (Meltzer et al., 2003). These prevalence statistics were markedly higher than those of the general child population, and varied according to placement type (72 percent of children receiving residential care; 40 percent of those in non-relative foster care, and 32 percent of children in kinship foster care were identified as having mental disorders).

Australian prevalence estimates vary. An Adelaide study found the prevalence of mental health problems experienced by youths in foster care was two to five times higher than those experienced by youths in the general population (Sawyer et al., 2007). 61 percent of children in care in Adelaide scored above the clinical cut-off on the CBCL, and foster carers identified over 50 percent of them as being in need of mental health intervention. Externalising disorders were more common than internalising disorders, and young people in care also had higher rates of attention difficulties, social problems and suicide attempts than youths in the general population. A second study, from New South Wales, found children in care had “exceptionally poor mental health and social competence, relative to normative and in-care samples” (Tarren-Sweeney & Hazell, 2006, p. 92). The scope and severity of their issues resembled that of a clinical population, and their CBCL scores were the highest ever recorded in a study of this nature. This

study also reported that children had considerable difficulties with social behaviour, particularly with non-reciprocal and indiscriminate interpersonal behaviour. Most of the children surveyed had behaviours which suggested insecure relationships, and one third of them exhibited age-inappropriate sexual behaviour.

The only study to address issues of prevalence in New Zealand found that approximately one third of Child, Youth and Family clients had moderate or severe mental health disorders (Wells & Smith, 2000). Thirty percent of their primary diagnoses were alcohol and drug disorders, followed by conduct disorders (11%), ADHD (10%), severe behaviour disorders (8.6%), depression and suicide (7%) and post-traumatic stress disorder (6%). This study illustrated there was “a significant group of young people within the Department with serious mental health problems, accessing a limited range of treatment and support services” (Wells, 2004, p. 23). Evidence suggests that this is low estimate, due to under-recognition of mental health problems by social workers and low response rate (Wells, 2004; Wells & Smith, 2000). Given that age is an established predictor of mental health issues in foster children, and approximately fifty percent of New Zealand foster children were over the age of ten years between 2006 and 2008 (MSD, 2009), it is reasonable to assume that mental health issues are also common within the New Zealand foster care population.

Despite the high prevalence of mental health issues for children in foster care worldwide, studies suggest that they rarely receive interventions for their issues (Burns et al., 2004; Meltzer et al., 2003; Rubin et al., 2004). Only 27 percent of children with mental health needs in the Adelaide study had received professional help for their difficulties in the six months preceding the study (Burns et al., 2004; Sawyer et al., 2007). Children in foster care are less likely to access interventions than children in residential care (Burns et al., 2004). Wells (2000) has asserted that the use of mental health services by New Zealand children in care is minimal, due to a lack of services as well as the young people’s reluctance to become involved with mental health services (Wells & Smith, 2000). Limited access to mental health services, combined with low problem recognition by social workers, also often prevents foster children from receiving these interventions (Wells, 2004).

Despite a growing body of research on the prevalence of mental health problems in foster children, attachment disorders are frequently excluded from prevalence studies due to “uncertainties about the most appropriate definition of attachment disorder” (Meltzer et al.,

2003., p. 17) and the status of attachment disorders as often secondary rather than primary diagnoses (Wells, 2000). Despite this lack of research, foster carers report commonly encountering foster children with attachment difficulties. The exclusion of attachment disorders within prevalence studies is likely to be causing an under-representation of the prevalence of mental health issues in children in care.

Attachment Difficulties

In developmental psychology, attachment describes:

“... an emotional bond formed between an infant and one or more adults such that the infant will: (a) approach them, especially in periods of distress; (b) show no fear of them, particularly during the stage where strangers evoke anxiety; (c) be highly receptive to being cared for by them; and (d) display anxiety if separated from them.” (Reber & Reber, 2001, p.61).

Children in care are much more likely to develop attachment difficulties than children in the general population (Hudson, 2006; Golding, 2003). Their increased risk is largely attributed to their pre-fostering histories of adversity (including severe neglect; physical abuse; rejection; emotional maltreatment; histories of multiple placements and disrupted attachments), in which they have been prevented from experiencing the responsive and predictable caregiving which promotes secure attachment (Golding, 2006; Howe & Fearnley, 2003; Hudson, 2006; Stovall & Dozier, 1998). Instead of experiencing their parents as sources of security, love and protection, children with abusive and neglectful parents can experience them as sources of fear: “Their experience of being in caregiving relationships is that they are frightening and dangerous, hurtful and unpredictable, careless and confusing” (Howe & Fearnley, 2003).

Attachment theory (Bowlby, 1988) suggests that humans are evolutionarily predisposed to engage in behaviours which maximise the chances of being cared for by other humans. Because many foster children have grown up in adverse environments where standard attachment behaviour (for example, crying when hungry) has failed to elicit care from their parents, they develop behavioural strategies designed to increase their chances that their parents will respond to them. Children from neglectful backgrounds may not show pain, cry, or talk because they

grew up in environments where nothing they did caused their parents to respond (Hudson, 2006). Children who have experienced abusive parenting may seek to control all aspects of their relationships through tantrums, rage, being overly compliant or being overly self-reliant in order to stay safe. Those whose parents have been inconsistent may maximise attachment behaviour, clinging, crying and not letting the carers out of their sight, for fear of being abandoned. These attachment behaviours are transferred with the children into their new foster placements (Howe & Fearnley, 2003).

Reactive Attachment Disorder (RAD) is the only attachment disorder described in the DSM-IV-TR. RAD is characterised by “markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age 5 and is associated with grossly pathological care” (APA, 2000, p. 129). RAD is a disorder of non-attachment, in which children have failed to develop any significant attachment to their carer because of early adversities like major neglect or institutionalisation. It has two subtypes: inhibited (in which children are shy, hypervigilant and distrustful of relationships) and disinhibited (in which children have failed to develop a selective attachment to a carer, and therefore approach anyone). This disorder gained exposure following Conner Rutter’s studies of children who grew up in Romanian institutions. Rutter found that there was a close association between the duration of the child’s institutional deprivation, and the severity of their attachment disorder (O’Connor, Rutter & English and Romanian Study Team, 2000). While the DSM-IV-TR suggests that RAD is “very uncommon” (APA 2000, p. 129), carer reports suggest it is relatively common in foster children (Barth et al., 2005). Practitioners frequently attribute foster children’s difficulties to attachment problems.

Many other attachment-related difficulties are reported in the literature. Beyond disorders of non-attachment, children can form insecure or disorganised attachments. Insecure attachment is characterised by an inability to use the caregiver as a secure base from which to explore and fear of new situations. Children with insecure attachments have difficulty trusting their caregivers, and seek to control all aspects of their relationships through avoidant, controlling, disruptive or manipulative behaviour (Golding, 2003; Hudson, 2006; Schofield & Beek, 2005; Stovall & Dozier, 1998). This behaviour hides deep anxiety and fear about relationships (Golding, 2003).

Because attachment difficulties are frequently concealed beneath a veneer of naughtiness and disruption, they are often referred to as the “hidden disability” of foster children (Dent &

Brown, 2006). Evidence suggests that attachment difficulties are not easily treated through brief cognitive or behavioural treatments; rather, their issues require “long-term and multi-modal interventions” (Howe & Fearnley, 2003, p. 378). Children with attachment difficulties *can* form secure attachments given time and secure caregiving, but they are difficult to care for and their needs and behaviours present a unique challenge to foster carers (Dozier, Stovall, Albus & Bates, 2001).

Summary

Children in foster care as a group present with high and complex needs which are uncommon in the general population. Educational, physical and social domains can all be affected. Children in this population frequently present with mental health issues, with prevalence rates often twice or four times those evident in the general child population. Children in care frequently present with attachment difficulties, due to their histories of suboptimal care and relationship instability. These children engage in behaviours which are likely to present a particular challenge to foster carers.

The Impact of Fostering Children on Foster Carers

Foster care research has primarily focussed on the experiences of foster children (Nutt, 2006). The comparatively few studies which have focussed on carers suggest that fostering completely changes their lives, impacting personal, family, social and practical spheres (Nutt, 2006). Caring has both practical and psychological implications, which affect not only carers but also their families and wider social networks (Nutt, 2006). Most studies have suggested that carers experience a mixture of satisfactions and strains through fostering; some aspects can be “deeply satisfying” while others are “devastating” (Sinclair et al., 2004, p. 21). The impacts of fostering on foster carers will be outlined in this section.

Rewards and Satisfactions

Studies suggest that foster carers gain reward through seeing positive change in their foster children; gain fulfilment and satisfaction through fostering; and enjoy making a difference (Nutt, 2006; Wilson et al., 2000). Sinclair and colleagues’ (2004) study of 952 carers found that 97

percent gained a lot of satisfaction from fostering, and 88 percent felt fostering enriched their lives. Carers frequently stated they enjoyed fostering, and saw it as a way to contribute and do something worthwhile. Carers also described caring meeting their own personal needs, making them feel good about themselves and providing them with a challenge they relished. These satisfactions were cited as the reasons many carers continue fostering (Sinclair et al., 2004).

Studies suggest that carers experience as many joys of fostering as they do challenges (Nutt, 2006; Sinclair et al., 2004). Unfortunately, these positive experiences have been largely overshadowed by descriptions of negative experiences in the literature to date. This may be due to the research focus on supporting carers, which has prompted investigations of the negative impacts of fostering designed to determine how carers can best be supported. The lack of focus on the positive impacts of fostering may also be due to selective description in carer narratives, as negative impacts are “more noticeable and easier to describe” than positive impacts of fostering. (Sinclair et al., 2004, p. 58).

Negative Impacts

Many carers experience significant negative impacts of fostering. Fostering can produce “acute distress” which impacts all facets of the carer’s life (Sinclair et al., 2004, p. 207). As mentioned previously, foster children’s behavioural, emotional and physical issues developed in their pre-placement histories persist even after they are removed from negative pre-placement environments (Golding, 2006). The severity, complexity and frequency of their difficulties mean that foster carers encounter “a range of emotional, behaviour and educational difficulties from the children in care that are far outside normal parenting experiences” (Murray, 2007, p. 6). Murray’s 2007 study of Christchurch foster carers suggests that New Zealand foster carers are impacted by similar foster child difficulties as outlined in the international literature.

The difficult characteristics and behaviours of many foster children often cause carers to experience conflict with the child. These conflicts can impact the carer’s other relationships, including their marriages, and can sometimes result in the foster child making false allegations against the carer (Richardson & Lelliott, 2003). Children’s difficult behaviour can take a major toll on carers, causing them to feel overwhelmed (Golding, 2006, 2008; Nutt, 2006; Sinclair et al., 2004). It is often causally linked to placement breakdown, which has further negative impact on carers (Murray, 2007; Sinclair et al., 2004). Other negative impacts of fostering cited in the

literature include extreme stress, emotional unrest, and isolation (CYFS, 2007; Golding, 2003; Lawrence, 2008; Nutt, 2006; Schofield & Beek, 2005).

Carers describe being surprised at the level of involvement required in fostering, having their lives heavily impacted by fostering, and going through periods of believing they would not manage fostering (Nutt, 2006). As one caregiver wrote, “Nothing can prepare you for the impact fostering will have on your emotions, your family life, your attitudes and values” (Golding, Dent, Nissim & Scott, 2006b, p. 9). 31 percent of the 950 carers who participated in Sinclair and colleagues’ 2004 study felt fostering had impacted the level of strain they reported on the General Health Questionnaire. 65 percent had experienced at least one major fostering-related stressful event (either placement breakdown or disruption; allegations; difficult birth parent contact; family tensions; ‘tug-of-love’ cases; or disagreements with social services). Experiencing traumatic fostering-related experiences was associated with negative attitudes about fostering. The study acknowledged that these six events are not “the sole causes of stress in foster care” (p. 194), as they also encounter frequent daily hassles including public judgement, practical difficulties, and many others. Sinclair and colleagues also cautioned that their figures probably represented a falsely positive view of fostering, due to a strong likelihood that carers who experienced many stressful events would have ceased fostering and thus not participated in the study.

Difficulties with Balance

Foster carers often have difficulty balancing family life with fostering life; personal life with professional life; and allocating resources (Nutt, 2006; Sinclair et al., 2004). Fostering reduces the time carers have for other aspects of life. Evidence suggests that carers may be forced to prioritise the foster child’s needs “at the expense of... their own wishes...rights or desires”, as both personal and family time, routines, plan and outings are dictated by the needs of the foster child (Nutt, 2006, p. 77). Carers regularly adjust their own lifestyles, plans and routines to suit the needs of the foster child (Nutt, 2006). They can have difficulty balancing their desire to be responsive foster carers with their drives to further their careers (Nutt, 2006; Sinclair et al., 2004). Carers who wish to work as well as foster can find it impossible to fit fostering around work, and may feel forced to decrease their work hours (which in turn places financial pressure on their family). Findings from Sinclair and colleague’s study indicated that

those who wished to work found fostering more difficult, and were less positive about and more likely to leave fostering than those who did not desire to work.

Family Impacts

Fostering generally takes place in a family context – only 14 percent of the 944 carers in Sinclair and colleagues' 2004 study were fostering in isolation. The process of fostering is an intrusion into family life, and the decision to foster affects the entire family (Golding, 2006; Nutt, 2006; Sinclair et al., 2004). Caring for the foster child impacts the patterns of interactions and relationships which previously existed in the house, and life as a foster family is experienced as very different from previous family life (Nutt, 2006; Golding, 2006). Some carers have cited fostering as a key reason for their marriage breakdowns (Wilson et al., 2000). As with carer impacts, both positive and negative impacts on foster families are described in the existing literature.

Carers views on the effects of fostering on their families are largely mixed and dependent on the foster children (Sinclair et al., 2004). Some carers in Nutt's 2006 study felt their families had been drawn closer together, and that fostering had positively impacted their relationships with their spouses and their birth children. Others found fostering caused tension with family members and negatively impacted their time with their own family. Rivalry between foster siblings is common and can be intense, as birth children may struggle to accept the foster children and become jealous when the foster child dominates their parents' attention or is treated more leniently by the parents (Farmer et al., 2004; Golding, 2006; Nutt, 2006; Wilson et al., 2000). They can react badly to having their needs prioritised below the foster child's needs, and may copy the negative behaviours modelled by foster children (Sinclair et al., 2004). Sinclair and colleagues (2004) found that two thirds of foster carers reported experiencing an incident which had a significant negative impact on their family while fostering. Alongside this, however, they described ways their children benefited from fostering, as they learnt to share, be caring and value their privileged upbringing. They concluded that the fostering seemed to involve "more positives than negatives" for birth children (p. 56).

Fostering's impact on the family is a strong determinant of whether placements break down or continue (Farmer et al., 2004; Sinclair et al., 2004). Carers can sometimes be caught in a double bind, in which negative impact on the family forces them to decide between "damaging

their own families and failing their foster children” (Wilson et al., 2000, p. 207). Evidence suggests that negative family impact causes deterioration in the carer’s attitude towards fostering, and can also cause deterioration in the standard of parenting (Sinclair et al, 2004). Placements are particularly likely to break down if the carer feels fostering is negatively impacting their own family (Farmer et al., 2004).

Emotional Impact

Because fostering “involves both labour and love”, carers frequently find themselves being profoundly emotionally affected by fostering (Nutt, 2006, p. 27). The emotional impact of fostering is generally attributed to the personal nature of the task, and the emotional investment carers make in the children in their care (Nutt, 2006). This investment, while crucial if children are to be provided with secure, warm relationships, can cause major difficulties, especially following placement breakdown. Carers have described fostering as “emotionally draining”, and expressed their surprise at its emotional impact: “... you’re not prepared for that. You’re prepared for their difficult behaviour but not to handle being torn and having strong feelings...” (Nutt, 2006, p. 38).

Foster carers differ in the extent to which they commit to, and emotionally invest in, their foster children (Dozier, 2005). Carers must negotiate emotional boundaries and the dilemma of attachment versus nonattachment while fostering, as investing in foster children is a risk (Nutt, 2006). Because emotionally investing in the children leaves carers vulnerable to experiencing loss and pain, some carers deliberately distance themselves from the children for self-preservation (Murray, 2007; Nutt, 2006). Distancing for self-preservation can act as a buffer to experiencing loss, but can also compromise the carers’ abilities to provide the child with warm, responsive care which can impact the child’s development of trust and attachment (Golding, 2006).

Impact of Placement Breakdown and Identity Impact

Placement breakdowns are common and often unplanned (Nutt, 2006). Carers rarely control when the children are removed from them, and often face daily uncertainty about how long the children will remain in their care (Murray, 2007). Sinclair and colleagues found that 47

percent of carers had experienced placement breakdown (Sinclair et al., 2000). Placement breakdown can be extremely difficult and emotionally draining for carers, as they report making major emotional investments in their foster children, and becoming extremely attached to them. While carers are “expected to love and let go”, the joy they gain from their foster children can turn to grief and distress when those children have to move on, and losing the children can feel like bereavement (Nutt, 2006, p. 53; Sinclair et al., 2004). Evidence suggests that placement breakdown can cause carers to question whether fostering is worthwhile, and be a push factor which encourages carers to cease fostering (Sinclair et al., 2004). Fostering also affects the identities of foster carers and their view of self. Nutt has asserted that fostering becomes a central identity for carers, whose views of self become “crucially bound up with the children” once they begin fostering (2006, p. 100). Sinclair and colleagues found that the six negative fostering-related events they investigated, particularly placement breakdown, could “assault a carer’s picture of her- or himself as a caring and effective person” (2004, p. 103).

Social Impacts: Isolation, Misunderstanding, Blame

Carers can often feel misunderstood or criticised by the public, and isolated in their roles (Murray, 2007). Sinclair and colleague’s 2004 study found that while public perception of carers was generally positive, 25 percent of carers had experienced criticism and hostility from others who felt they were fostering for the money; being unfair on their birth children; or allowing their birth children to become subject to negative influence. Foster children’s difficult behaviour can heavily impact the daily interactions of carers, as carers are blamed for that behaviour: as Golding has written, “Getting on with the neighbours and socialisation at the school gate can take on very different meanings when the fostered or adopted child’s challenging behaviour has impacted upon these adults and their families” (2006, p. 198). Carers in Nutt’s 2006 study expressed feeling socially responsible and blamed for the behaviour of difficult children, as members of the public did not realise the children were fostered and judged the carers as bad parents. Carers have expressed feeling failure, guilt and embarrassment when children misbehave in public (Kolomer, 2000; Nutt, 2006).

Fostering can also impact carers’ friendships. Some carers have described being avoided and treated differently by friends, who did not understand why they were putting themselves in the position of fostering someone else’s difficult child (Sinclair et al., 2004). As one carer

stated, “The general feeling seems to be that we are strange people to live with difficult and aggressive children” (Sinclair et al., 2004, p. 107). Carers from Nutt’s 2006 study described impact on their social lives, when friends stopped inviting them over due to their foster children’s behaviour. Other carers described feeling hurt and misunderstood by people who did not foster:

“You try and stick with them, and help them but we’ve had a lot of comments like ‘You’re absolutely mad’ or ‘I wouldn’t have my home, no one would damage my home like that’ ... I find it very hurtful” (Kelly, 37, in Nutt, 2006, p. 42)

Carers have described finding it easier to be friends with other foster carers, because they understand what fostering is like and have been in the same position (Nutt, 2006; Wells, 2004). Some carers severed contact with friends who failed to support them (Nutt, 2006).

Bureaucracy, Lack of Power and Intrusion into the Private Sphere

Foster carers have reported struggling with the low status of foster caring as an occupation and with the constant supervision and interference of the state (Nutt, 2006; Wilson et al., 2000). Nutt asserts that foster carers are situated on the overlap of the private and public domains, and must act as though the children are a professional responsibility while also demonstrating the genuine concern any parent would show their child. Nutt has asserted that rules and regulations concerning foster children can interfere with the carers’ ability to provide genuine warmth and care to the children, as these rules “do not sit comfortably with informal, loving, private households” and interfere with carer agency (2006, p. 100). Foster carers can feel powerless towards their foster child’s situation, because they have neither legal power nor authority over the children or their circumstances (Nutt, 2006).

Conflict with Social Services and Exclusion from the Care Team

The considerable needs of most foster children bring foster carers into contact with a variety of professional and agencies. Many have described having difficulty working with these professionals, and feeling alienated by social care departments (Nutt, 2006). Foster carers are not always valued as equal members of the care team, and few are involved in the decisions

which affect their foster children (Maclay et al., 2006). As one carer described, “Sometimes I feel you are at the bottom of the pile. Everyone’s views – child/parents/social workers – seem to come first” (Sinclair et al., 2004, p. 71). Some carers have described feeling disempowered, helpless and undervalued by social services, and having to struggle with “noncollaborative practice” when their opinions were not taken into account by professionals (Golding et al., 2006, p. 8). In a study of foster carer motivation, support and retention, MacGregor and colleagues (2006) found that foster carers believed they should be more recognised as part of the foster care team, and wanted their opinions and abilities recognised by child welfare professionals. Carers find tensions between the child’s needs and the needs of the agency difficult to negotiate (Maclay et al., 2006). Because carers understand their children’s needs, they can feel powerless and angry when social services fail to consider their perspectives (Nutt, 2006). Conflict with social services is a major factor influencing foster carer retention rates: one third of Scottish carers who ceased fostering did so because of conflict with social services (Triseliotis et al., cited in Maclay et al., 2006).

Fostering without Information, and Need for Training

Existing literature suggests that carers frequently begin fostering with minimal information about what their foster children, and fostering itself, will be like. They “rarely have the luxury of a coherent and sustained narrative about the child” (Stott, 2006, p. 43). Gilbertson and Barber (2003) investigated the experiences of Australian foster carers who had recently experienced placement breakdown after fostering adolescents with behaviours problems. The carers described having their pre-placement questions ignored; being told minimal information about the child; being told lies and feeling information had been deliberately altered or withheld to ensure the child would be placed. This lack of accurate information caused frustration and compromised their standard of care, as most carers “were angry and felt that ignorance of the child’s background and circumstances compromised the care they could provide and their ability to be sensitive to particular needs or problems” (Gilbertson & Barber, 2003, p.333). Lack of information and preparation may contribute to carer feelings of dissatisfaction and isolation, as well as placement breakdown.

Carers’ levels of training varies across countries, services and agencies (Nutt, 2006; Wells, 2004). Many studies suggest that foster care training is insufficient, and both academics and

carers have argued that they should receive more (Nutt, 2006; Sinclair et al., 2004; Wilson et al., 2000). As Nutt has written "... it is as though social services departments expect their foster carers... to know instinctively what constitutes quality care" (2006, p. 22). Lack of training has been cited as a reason why carers are alienated in social care systems, and for the perceived low status of the fostering profession (Wilson et al., 2000). Carers have described feeling "thrown in at the deep end", being allocated foster children without adequate training (Nutt, 2006). This lack of training can place carers in situations where they feel overwhelmed and ill-equipped to foster.

Disappointment and Lack of Satisfaction with Fostering

In a New Zealand study, Murray (2007) found that carers' scores on Acceptability subscale of the Parenting Stress Index indicated that fostering and foster children did not meet the carers' expectations. Some carers have described feeling disappointed and unsatisfied with fostering, as the reality of fostering did not match their expectations of it (Nutt, 2006). Butler and Charles (1999, in Nutt, 2006) have reported that foster carers enter the experience expecting gratitude from the child, a mutually felt emotional attachment, and an effort from the child to fit in to the family. These researchers asserted that not gaining the expected rewards from fostering decreased carers satisfaction with fostering, and carers felt the strains of fostering outweighed the rewards they gained from it. This disappointment with fostering has also been described elsewhere (Nutt, 2006; Wilson et al., 2000).

Impact of Contact with Birth Families

The modern emphasis on family input with foster children has led to increased contact between foster families and birth families. Studies suggest that carers find these interactions stressful and have significant difficulties with birth parent contact (Farmer et al., 2004; Nutt, 2006; Sinclair et al., 2004; Wilson et al., 2000). Carers can feel both physically and emotionally threatened by birth parents, who may try to turn their foster children against them. They may also experience internal conflict if they feel that parent contact is not in the best interest of the child (Sinclair et al., 2004).

Unique Impacts on Male Foster Carers

Very little is known about male foster carers, but available evidence suggests that they are more marginalised than other foster carers. Parsons (2008) has asserted that male foster carers feel marginalised by welfare agencies and support groups, which they feel are female-oriented. Their marginalisation was evident when child welfare agencies only communicated with women, sometimes only addressing letters concerning foster care to their wives. One carer recalled winning a ‘couple carer of the year award’, and going home to find only his wife’s name was on the trophy. Concern about being accused of paedophilia were also evident in Parsons’ work, as men felt they would be labeled paedophile unless they could prove they were not. The minimal evidence available suggests male and female experiences of caring may differ (Parsons, 2008). Support groups for male carers are beginning to be established, such as “Men Who Care”, a support group for male carers in Wales.

New Zealand Perspectives – Kiwi Experiences of Foster Caring

Few researchers have explored the experiences of New Zealand foster carers in order to supplement the international literature described above. Two detailed studies of carer experiences have been carried out in New Zealand, and are outlined in this section.

“Caregivers Speak” Survey: the Overall Fostering Experience (Child, Youth and Family, 2007)

The largest investigation of New Zealand foster carers’ experiences was a national survey conducted by Child, Youth and Family in 2006 (published in 2007). The objective of the study was to help CYFS learn more about foster carers, “their perceptions and experiences, and their support and training needs” (p. 1). More than 720 carers (76% of whom were foster carers) participated in the survey. While findings suggested that the respondents were enthusiastic about and committed to fostering, believing they are making a positive difference for children, they were also frustrated and concerned about aspects of their experiences. As this survey is the largest and most detailed study of caregivers in New Zealand, its findings will be explored in detail here.

Survey respondents were generally positive about fostering. 97 percent believed they could “make a positive difference in the lives of their foster children”; 77 percent believed fostering positively impacted their own lives, and 68 percent felt fostering had a positive impact on their family (p. 2). 79 percent of carers enjoyed the challenges of fostering. At the same time, however, 46 percent of carers found their foster child’s behaviour “difficult to cope with”, and 33 percent “felt stressed by the responsibilities of fostering” (p.2). These challenges meant fostering “was not always a positive experience” for the carers and their families (p.2). Carers reported largely positive views of social workers, but many were frustrated with how long social workers took to communicate with them. Some carers also stated they felt pressured to foster children who did not fit with their families and skill levels (p.3). Carers expressed a desire for their views and opinions to be considered in the decision-making surrounding their foster child. Some stated they did not receive adequate information about their child, and sometimes felt “out of the loop” with the professionals working with their child (p.3).

This survey also provided useful insights about differences in experiences between foster carers and kinship carers in New Zealand. Because of the links between the carers’ families and the children’s families, the kinship carer’s extended family dynamics could change considerably during placement. The kinship carers in this survey were more likely than non-relative carers to have difficulty coping with their foster child’s behaviour; more likely to feel stressed by fostering; and less likely to receive support from their partners (p. 4). They were less positive about fostering than non-relative carers, and more likely to express need for respite and support in managing their children’s difficult behaviours (25% versus 17%). Kinship carer’s greater difficulties were attributed to the lack of financial support available to them, as well as evidence that kinship carers are less effectively dealt with by social services (p. 4). CYFS concluded that “The challenges of caregiving seem to significantly impact on many family/whanau caregivers” (p. 4).

In terms of service delivery, the respondents identified needing increased access to support services for their foster children, and more help with managing their challenging behaviour. These were ranked as the support the carers would value the most. They also identified needing more information and responsiveness from Child, Youth and Family, and requiring more “hands-on training” (p. 5). They identified training needs regarding kinship care, infant care and

parental access as being currently unmet. CYFS has been working to address these since the completion of the survey.

The Impact of Fostering Children with Mental Health Issues (Wells 2004)

The second relevant New Zealand study was conducted by Philippa Wells in 2004. Wells conducted a focus group to investigate the support needs of New Zealand caregivers fostering children with mental health issues (though the particular nature of these issues was not described). Wells' participants described the "in your face" nature of foster children with mental health difficulties, and explained that trying to meet their needs was "exhausting" (2004, p. 187). The caregivers commonly expressed being worn down by their children's complex needs. They also felt that fostering children with mental health issues was a unique experience which few people, other than caregivers, understood. Many caregivers described feeling unsupported by their families, who did not understand what they were going through, and in some cases felt the carers had brought their struggles upon themselves by choosing to foster the children. Carers preferred to gain support from carers rather than non-carers, because carers understood their position: Wells stated the common sentiment was "if you had to spend too much energy explaining why something was stressful in order to get support, you were worse off than if no approach had been made" (p. 189). Participants in Wells' focus group viewed other foster carers as "vital in the process of supporting their provision of enduring care" (p. 191).

Placement breakdown is particularly high in placements where foster children have mental health needs. In a study of over 1000 foster children with mental health diagnoses, Wells found there was "considerable instability" in their placements, with "nearly half of all placement changes being unplanned." Carers described feeling reluctant to terminate placements because they understood the negative effects transience could have on the young people with mental health problems. Wells' work was the only study that could be located which focussed on the experiences of New Zealand foster carers caring for children with mental health problems.

The Impact of Fostering Children with Attachment Difficulties

No studies which directly investigated the experience of fostering children with attachment difficulties could be found, despite extensive literature searches. Rather than studying the experience directly, some researchers have alluded to it within broader fostering publications, or

noted observations of carer experience while designing support programmes. Others have outlined the characteristics of children with attachment disorders, and speculated as to how carers may be affected by fostering them. Qualitative evidence on this topic is particularly scarce. No qualitative studies of the experience could be located. This section will outline the existing information regarding fostering children with attachment problems.

Evidence suggests that fostering children with attachment difficulties can be stressful, challenging, overwhelming and difficult (Golding, 2006, 2008; Howe & Fearnley, 2003). Attachment difficulties can compound the already demanding nature of fostering, as these children require more than ordinary sensitive parenting to learn to feel safe with the foster family (Golding, 2008). Children with attachment difficulties are widely acknowledged as “particularly difficult to manage”, and their placements are particularly likely to break down (Farmer et al., 2004, p. 11; Golding, 2006; Howe & Fearnley, 2003; Sinclair et al., 2004). A Romanian Adoptee study has asserted that carers who adopt these children experience high levels of parental stress (Mainemer, Gillman & Aimes, 1998).

Fostering children with attachment problems can take a high emotional toll on carers, who can feel incapable and demoralised by the children’s complex needs (Golding, 2006, 2008; Howe & Fearnley, 2003; Nutt, 2006). Carers may feel alienated when children meet their warm, genuine advances with hostility and fear (Golding, 2006; Schofield & Beek, 2005). Avoidant children who do not turn to their carers for comfort when they are distressed can make their carers feel inadequate, unneeded and rejected (Howe & Fearnley, 2003; O’Connor & Zeanah, 2003). Insecurely attached children may make their carers feel suffocated by their constant neediness (Farmer et al., 2004), while resistant children may make their carers extremely angry (Stovall and Dozier, 2004, 2000).

The children’s attachment-disordered behaviours can influence the quality of their foster relationships, eliciting responses from the foster carers which echo those of their birth parents (Stovall & Dozier, 2004, 2000). This is illustrated in the extract below:

“..an abused and rejected child might have survived by downplaying their negative affect, presuming that protective care is not available at times of need. He or she develops high levels of self-reliance and self-containment (an avoidant attachment pattern). In the new placement, such a child might continue to behave in an emotionally self-sufficient manner believing that caregivers are not available at times

of need and distress. Faced with such a child, an adoptive mother might feel not needed or wanted. She might therefore back off, deactivate her caregiving or ignore the child.” (Howe & Fearnley, 2003, p. 172).

Carers and children can become locked in a “vicious circle of mutual rejection” (Sinclair, Baker, Wilson & Gibbs, 2005, p. 146), in which neither party seeks the other out (Rushton, Mayes, Dance & Quinton, 2003).

Providing warm, sensitive caregiving to children who are distrustful and avoidant can be draining and upsetting for foster carers when the children do not respond positively (Farmer et al., 2004; Golding, 2006). Evidence suggests that foster carers display lower levels of warmth to children who have no attachment to them (Farmer et al., 2004). This may be due to lack of reinforcement for warm parenting (Farmer et al., 2004; Golding, 2006). In many cases, the needs and behaviours of foster children with attachment problems threatens the emotional availability of carers, who may choose to terminate placement or emotionally distance themselves from the child for self-preservation (Golding et al., 2006b; Howe & Fearnley, 2003). This pattern of rejection is concerning, given that an objective of foster care is to provide children with opportunities to form attachments, and their recovery depends on experiencing long-term, stable, sensitive caregiving (Golding, 2006, p. 337, 2008).

The difficulty of the task facing carers fostering children with attachment difficulties is widely acknowledged, and many have argued that carers fostering these children require specialised support and training in order to care for them effectively (Golding, 2006, 2008; Dozier, 2005). Kim Golding has written extensively about the support needs of these carers, asserting they should be trained to manage the difficult, abnormal and demanding behaviours of these children; to understand the child’s pre-placement experiences; and to interpret the child’s difficult behaviours as motivated by attachment issues, rather than deliberate malice (Golding, 2006, 2008). She asserts that this training has numerous beneficial effects on carers. Unfortunately, few receive training about attachment. Nearly 25 percent of the carers in Murray’s New Zealand study stated they would like information about how attachment impacted behaviour, and how children with attachment problems could be best supported (2007).

Summary

Recent focus on the experiences of foster carers suggests that fostering causes carers to experience both significant satisfactions and considerable strains. Satisfactions include reward from seeing the children progress; feeling one is doing something worthwhile; and believing one is making a difference, while strains include negative emotional impact; stress; family difficulties and public blame. Few studies have focussed on the experiences of New Zealand carers, however Wells' 2004 study suggests that New Zealand carers find fostering children with mental health problems is particularly stressful. To date, no studies have specifically focussed on the experiences of carers fostering children with attachment difficulties, despite the widely acknowledged difficulty of this task.

The Current Study

Rationale

Foster care is the preferred form of care for children who cannot be afforded the necessary care and protection by their own parents, both in New Zealand and beyond. A comparative paucity of literature about carer experiences exists, due to traditional research focus on the effects of fostering on the children. The increased complexity of fostering has recently led to an increased research focus on foster carers, their support needs, and the reasons they cite for ceasing fostering. Concern about the "high attrition rate" in foster carers and the shortage of people willing to foster have also encouraged researchers and social services to search for better strategies for meeting their needs (Maclay, Bunce & Purves, 2006; Wilson, Gibbs & Sinclair, 2000).

Research on New Zealand foster carers is particularly rare. Child, Youth and Family's Caregivers Speak survey is the only large-scale study has investigated the perspective of New Zealand foster carers (CYFS, 2007). While this study is a useful starting point, its survey-based nature is likely to have yielded understanding which was researcher-led rather than carer-led (that is, information that was confined by the questions CYFS decided to ask and what they wanted to discover, rather than reflective of what carers independently chose to share). Further, the nature of the organisation conducting the survey (New Zealand's major child welfare provider) may have resulted in biased data, as carer reports are likely to have been influenced by

their relationships with CYFS. Studies which allow carer perspectives to be presented with minimal constraint are needed to inform the research base surrounding the experiences of New Zealand carers.

Studies which have focussed on carer experiences generally focus on foster carers as a wide group, rather than specific subgroups of carers (for example, those caring for children with mental health issues, disabilities, or attachment difficulties). These broad studies provide useful information about the overarching experience of fostering, but do not present the unique experiences of particular carer subgroups. Wells' (2004) New Zealand study about fostering children with mental health needs is a useful starting point in examining the experiences of a subgroup of foster carers, and her focus group design is likely to have allowed greater carer autonomy in reporting than was apparent the Caregivers Speak survey. However, her failure to describe the nature of the mental health difficulties each child was experiencing may reflect greater generalisation of experience than truly exists. Children with mental health problems are not a homogenous group; caring for a teenager with depression is likely to be a very different experience than caring for a child with ADHD. Investigation of the experiences of caring for children with *specific* mental health issues is needed in order to do justice to their individual experiences and inform the development of effective supports designed to meet their needs. Attachment difficulties are one such specific mental health issue, which affects many foster children.

Carers fostering children with attachment difficulties are the least-investigated carer subgroup to date. While studies have alluded to and speculated about their experiences, no qualitative studies have explicitly focussed on this experience by collecting data from carers about their experiences. The paucity of literature surrounding this topic is concerning, given the high prevalence of attachment disorders in foster children, the high rate of placement breakdown that carers experience while caring for children with these issues, and the existing evidence that fostering these children is a unique and challenging experience (Howe & Fearnley, 2003; Golding, 2006; Sinclair et al., 2004). Studies which allow carers to describe their personal experiences in rich detail are needed to better inform understanding of these carers, and the development of supports designed to improve outcomes for them and the children they care for.

The present small-scale study was designed in the hopes of generating interest in this field and continuing the dialogue about particular issues facing carers fostering children with

attachment difficulties, both in New Zealand and globally. The study aimed to give these carers, a previously marginalised group, a voice in the literature. It was hoped that this study would help provide a more solid basis of understanding of this experience in the literature, from which support interventions for these carers can be designed. Further, it was hoped that the study would have implications of helping decrease the foster carer attrition rate; improving the quality of the fostering experience for those working with this specific population of children both in New Zealand and beyond; and contributing to the small body of foster care research which exists in New Zealand.

Research Objective

The objective of the current study was to explore the experiences of non-relative carers fostering children with attachment difficulties indicative of a disorder of non-attachment (rather than insecure attachment). Because this was an exploratory study using Interpretative Phenomenological Analysis, the research objective was designed to be deliberately broad. Understanding was to be gained through interviewing a small number of carers about their experiences, and looking for patterns and negative cases across their accounts. Their previously unexplored experiences were to be presented in rich detail, and used to inform the existing research base surrounding this issue. Data were collected via detailed, semi-structured interviews with New Zealand carers who had experienced the phenomena of interest. These interviews were designed to minimise the interviewer's impact on the data, so that carer understandings could be privileged and not constricted by researcher understanding. To the researcher's awareness, this was the first international study which aimed to directly explore these experiences of carers fostering children with attachment difficulties.

CHAPTER TWO: METHODOLOGY

Selecting a Qualitative Method

The aim of the present study was to explore the experiences of New Zealand foster carers fostering children with attachment difficulties suggesting a disorder of non-attachment. It was important to adopt a methodology which would facilitate this objective. Due to the paucity of literature on this topic, it was necessary to gather, analyse and present the understandings of the current experiential experts – the carers – in this study. This focus on personal, subjective experiences, combined with the study's exploratory nature, motivated the use of a qualitative method. Qualitative methods allow participants' subjective experiences to be presented as data, and provide tools for detailed, rich analysis of those accounts (Willig, 2001). Qualitative researchers act as “story-gatherers and story-tellers”, gathering and presenting participant accounts in their research (McLeod, 2003). This was appropriate for use in the present study. The qualitative capacities for examining previously unexplored experiences and giving voices to previously marginalised groups (McLeod, 2003, p. 159) were also consistent with the study aims.

The qualitative field comprises a complex set of different and competing traditions from which researchers must select specific methodologies. As suggested by McLeod (2003), I investigated various qualitative approaches in order to make an informed choice of methodology. These are outlined below.

Potential Methodology 1: Narrative Analysis

Narrative analysis's emphasis on hearing and exploring the stories of participants was consistent with the research aims. However, its focus on the constructivist role of language and *how* people tell their stories went beyond the scope of this thesis. Given the paucity of literature focussing on this topic, it was reasoned that primary focus needed to be placed on analysing participant experiences, rather than their expression of those experiences. With this in mind, a second possible methodology was explored: the abbreviated form of Grounded Theory.

Potential Methodology 2: Grounded Theory

Grounded Theory (Glaser & Strauss, 1968) is recognised as the “current market leader” in qualitative research, and is widely accepted as a valid method in academia (McLeod, 2003, p. 2003, p.70). It involves analysing data by coding it into categories, which build into superordinate themes that inform a theoretical understanding of the phenomenon. Rather than forcing the data to fit researcher-imposed categories and theories, the researcher derives the categories and theory from within the data (Willig, 2001). This emphasis on allowing data to inform the categories was consistent with the research aim to present data that closely reflected participant understanding. Grounded Theory’s aim to “help the reader to understand a previously unmet other” was consistent with the exploratory nature of the study, and its aim to give a previously marginalised group a voice in the literature (McLeod, 2003, p. 156).

Despite the aforementioned advantages of Grounded Theory, some of the method’s core elements rendered it unsuitable for use in the present study. Firstly, Grounded Theory’s focus on generating theory about experiences went beyond the objectives of present study. Because of the lack of literature on this topic, and the exploratory nature of the study, it was reasoned that generating theory about the carers’ experiences would be premature. Secondly, Grounded Theory does not provide sufficient guidelines for effective data collection (McLeod, 2003). Rich analysis is dependent on good data collection; therefore, the present study required a methodology that placed equal emphasis on effective data collection and data analysis, and provided guidelines for both aspects of research.

Practical concerns about sample size also made using Grounded Theory inappropriate in this case. Grounded Theory requires a large sample size of roughly 8 to 20 participants (McLeod, 2003). The specific nature of the target population in the present study made recruiting a large sample impractical. The limited timeframe of this thesis also made it unlikely that the researcher would have the opportunity to explore the experiences of a large group in sufficient richness and depth. Because of this study’s emphasis on honouring the experiences of the participants, it was important to select a method which would allow sufficiently rich analysis. Grounded Theory clearly was not the ideal method for this study.

With these objections to Grounded Theory in mind, a methodology which retained elements of Grounded Theory that were consistent with the research aims, but was holistically

more suitable for use in this study, was sought. The study required a method which would place explicit focus on exploring experience in rich detail; emphasise both data collection and data analysis procedures; and allow for smaller sample size. A third methodology, Interpretative Phenomenological Analysis (IPA), was subsequently considered.

Potential Methodology 3: Interpretative Phenomenological Analysis

IPA is a “recently developed and rapidly growing” psychological research method, which focuses on richly describing experience and gaining insight into other people’s worlds (Smith, Flowers & Larkin, 2009, p.1). It aims to capture the unique “quality and texture of individual experience” (Willig, 2001, p. 53), understanding phenomena from the perspectives of those experiencing them rather than from an objective perspective (Smith & Osborn, 2003). Participants are viewed as “experiential experts” in IPA, and given maximum opportunity to tell their stories in their own ways (Smith & Osborn, 2009, p. 56-57). IPA’s focus on experience, combined with its view of the participant as expert, was consistent with the study aims.

There is considerable overlap between the principles and procedures of Grounded Theory and IPA (Smith et al., 2009; Smith & Osborn, 2003; Willig, 2001). Similarities include systematic text analysis giving rise to themes, categories and superordinate themes; integration of cases to produce an overall picture of the experience; an attempt to capture the nature of the phenomenon; and adherence to a detailed set of analysis guidelines (Willig 2001, p. 68). Thus, IPA retained elements of Grounded Theory which were consistent with the aims of the present study. IPA also diverges from Grounded Theory in important ways which were consistent with the research objectives. IPA focuses exploring experience, rather than developing theory (Willig, 2001). Researchers using the method make no express attempts to derive theory from the data (Willig, 2001). IPA allows for a richer, more detailed analysis of the experience of a smaller sample than is used in Grounded Theory studies (Smith et al., 2009; Willig, 2001). It also places explicit focus on the importance of both data analysis and data collection; researchers are advised to create good rapport with participants, using semi-structured interviews to collect rich data and minimise their own impact on participant accounts (Smith et al., 2009).

IPA differs further from Grounded Theory because it acknowledges the researcher’s role in co-constructing the data alongside the participant. While researchers aim to present an insider’s perspective on the participants’ experiences (Smith et al., 2009), they recognise their analyses

will be influenced by their own viewpoints (Willig, 2001). Final analyses will ultimately be both phenomenological (aiming to represent the participant's view of the world) and interpretative (Willig, 2001). The founder of IPA encourages researchers to be reflexive and aware of their preconceptions and biases. He also advocates attempting to "bracket off" one's biases, prior knowledge and assumptions while collecting and analysing data, in order to be true to the participants' accounts (Smith et al., 2009). It was hoped that this acknowledgement of the researcher's role in constructing data would lead to the production of a more transparent, honest thesis.

Exploring numerous qualitative methods made it clear that Interpretative Phenomenological Analysis was the most appropriate methodology for facilitating the study objectives. Its experiential focus; emphasis on data collection; allowance for rich exploration of the experiences of a small sample and emphasis on researcher reflexivity were all compatible with the study objectives. IPA methodology has directly influenced the method and analysis procedures outlined below.

CHAPTER THREE: METHOD

Design

Interpretative Phenomenological Analysis was used to investigate the experiences of individuals fostering children with attachment difficulties. This qualitative approach informed both the procedure and the data analysis method. A brief quantitative measure, the Assessment Checklist for Children, was completed by the carers during the screening phase, but this was included purely to help determine eligibility for the study and did not affect the interpretation of the interview data.

Recruitment

Four recruitment strategies were used to reach the target population. One carer was recruited through advertisements in the New Zealand Foster Care Association (NZFCA) and Otautahi Foster Care Association (OFCA) newsletters. Two were recruited through receiving emails about the study following their attendance at an NZFCA conference. Finally, one participant was recruited through a personal contact. A fourth recruitment strategy, the researcher attending three meetings of the OFCA to explain the study and invite people to participate, yielded no participants because members of the association were predominantly kinship carers and thus ineligible for the study.

Measures

The Initial Screening Measure

The initial screening measure (see Appendix 1) consisted of two paragraphs which described the behaviours of fictitious children with attachment difficulties. The first paragraph described the behaviours of 'Joey', who displayed characteristics of inhibited subtype Reactive Attachment Disorder (RAD). The second described behaviours displayed by 'Samantha', who displayed characteristics of disinhibited subtype RAD. The descriptions were based on a combination of the DSM-IV-TR diagnostic criteria for RAD and Charles Zeanah's proposed revised criteria for RAD. They were written in the style of hypothetical carer accounts. Completing the screening measure involved carers reading the paragraphs, and indicating if they

had ever fostered a child who behaved like Joey, Samantha or a mixture of the two, or a child who had been identified as having attachment difficulties. If they had, the carer moved on to describe the child in a few sentences and complete the Assessment Checklist for Children (ACC) about the behaviour of that child.¹

Assessment Checklist for Children (Tarren-Sweeney, 2007)

The Assessment Checklist for Children is a carer-report measure of behaviours, emotions, and relationship styles exhibited by children in care. It includes four scales that measure interpersonal behaviour difficulties. The indiscriminate and non-reciprocal interpersonal behaviour scales contain items that approximate the disinhibited and inhibited sub-types of RAD respectively. The pseudomature and insecure interpersonal behaviour scales contain items which approximate other types of attachment difficulties. Beyond these attachment-related scales, the measure includes six clinical scales designed to measure other problem behaviours frequently exhibited by children in care, and two low self-esteem scales. While scores on the attachment-related scales were most relevant to this study, completion of the entire checklist gave the researcher a fuller understanding of the child difficulties being encountered by the foster carer.

This measure was selected for use in this study because it was specifically designed for use by people describing the behaviours of children in care. The measure was developed in collaboration with experienced foster carers and clinicians, who testified to the measure's readability, usability and item validity. Initial analyses suggest the instrument has good content and construct validity, high internal consistency, and adequately differentiates between children who are clinically referred and those are not (Tarren-Sweeney, 2007).

No identifying data about the children were collected throughout the screening and interview processes, as the children were not the subject of the study. Only their age at placement and their gender was recorded. This contributed to protecting the child's privacy, and also reflected the research focus on the foster carers, not the foster children.

¹ If the carer had fostered more than one child who fit criteria, they were asked to fill out the ACC for the child with the most severe attachment behaviours. Carers filled out the ACC which fit their caring relationship with the child (ie current or previous carer)

Participants

Consistent with the tradition of IPA, a relatively small and homogenous sample of between four and six participants who had experienced the phenomenon of interest (fostering children with attachment difficulties) was sought. Because evidence suggests that non-relative and kinship carers experience fostering differently, only non-relative carers were eligible to participate in the present study. The initial screening measure was distributed to 15 non-relative carers who had been recruited by the methods outlined above. Nine completed and returned the screening measure (a response rate of 60 percent). The screening scores of four carers indicated they had fostered children with insecure attachment, rather than attachment difficulties suggesting a disorder of non-attachment, and thus had not experienced the phenomenon of interest. This left five carers who were eligible for participation following the screening phase. Two of those were married, and fostering the same child. In order to make my sample reflective of different caring experiences, those carers were contacted and asked to decide on one of them to participate. Thus, the final sample consisted of four eligible participants.

Three females and one male participated in the study. All participants were married and fostering children with their spouses. They had been fostering for between one and eight years, and three were first-time permanent foster carers. All participants had cared for children with attachment difficulties; three for children diagnosed with Reactive Attachment Disorder, and the fourth for a child identified as having severe attachment problems. Rachel, Katrina and June were all New Zealand European, while Jim was English. Short profiles on the carers are given below (pseudonyms have been used to maintain confidentiality).

Carer Profiles

Rachel, aged 37, cares for Conner (aged 5) with her husband James. Conner has been identified as having severe attachment difficulties. Rachel and James also care for their four birth children, aged 5, 8, 11 and 13. They have been foster caring for eight years, and have cared for 20 foster children. Of those, Conner has been in their care the longest.

Katrina, aged 38, cared for Dylan (7) with her husband Mark. Dylan had been diagnosed with Reactive Attachment Disorder. The couple also care for their own two boys (aged 6 and 8). Dylan was Katrina and Mark's first permanent foster child, and had been with them for a year. They decided to cease fostering him one week after being interviewed for this study; however,

the understandings presented in this study were collected before this decision was made, when Katrina was currently fostering Dylan.

Jim, aged 53, cares for Meredith (14) with his wife Claire. They began fostering Mere (who is New Zealand Maori) one year after moving to New Zealand from the United Kingdom. Meredith has recently been diagnosed with Reactive Attachment Disorder. The couple also foster Mere's brother Evan (17), who they suspect also has attachment difficulties. Mere and Evan have been in Jim and Claire's care for four years, and are their first permanent foster children.

June, aged 53, cared for Aleisha (12) with her husband Brian for three and a half years. Aleisha had been diagnosed with Reactive Attachment Disorder, and was June and Brian's first foster child. There were no other children in the home which they were caring for Aleisha. June and Brian are strong, practising Christians. They decided to cease fostering Aleisha when a combination of their personal health problems and the difficult nature of caring for Aleisha became too much for them.

Procedure

Depending on the method of recruitment, participants were either handed out or posted an information sheet outlining the purpose and methods of the study; a consent form; and the initial screening questionnaire. They filled out the screening measure as outlined above and returned the documents to the researcher if they wished to participate.

Processing the Screening Measures

The screening data were processed to determine eligibility of carers for the study. Eligibility was contingent on screening scores which indicated the carer had fostered a child with attachment difficulties indicative of a disorder of non-attachment, rather than insecure attachment. For eligibility, the participant's response to the screening measure needed to show:

- Elevated ratings (above the sixtieth percentile) on either or both of the non-reciprocal and indiscriminate scales of the ACC, which were higher than the ratings on the insecure scale, AND/OR

- Identification that the carer had fostered a child who had been identified with attachment difficulties (for example, an attachment disorder)

Carers whose scores did not meet inclusion criteria were contacted, thanked for their involvement, and excluded from the study. Those who did meet criteria were contacted to confirm their participation, and to establish a time to interview them while their child was not in the home.

The Interview

In keeping with the IPA approach, a semi-structured interview lasting between 60 and 90 minutes was carried out at the participant's home. Permission was sought to record the entire interview for later transcription. The interviews were recorded on a digital voice recorder, and the researcher took notes when necessary to prompt her pursuit of points of interest raised by the participant. Because an IPA analysis "is only as good as the data it is derived from" (Smith et al., 2009, p. 180), the researcher paid close attention to the interview process; worked at maintaining good rapport with the participants and used sound counselling and psychological interviewing skills to guide her interview approach.

The semi-structured interview consisted of seven open-ended and non-directive topic areas, designed to explore the cognitive and emotional experience of fostering a child with attachment difficulties. In keeping with IPA, the topic areas were made deliberately broad, to minimise interviewer constraint or influence on the participant's answers. The topic areas were designed to facilitate broad description of experience, and included:

- What caring for a child with attachment difficulties is like
- What caring for a child with attachment difficulties feels like
- The strains and satisfactions of caring for the child
- Thoughts about the child, and caring for them, and how those changed over time
- How the experience of caring for this child compared to the experience of caring for other foster children without attachment difficulties
- How caring for the child affected the participant, personally and as a carer
- How fostering the child affected their family

The interview schedule guided but did not dictate the interview. Participants were able to direct the interview as they chose, and discuss any other topics they wished to. In accordance with IPA, they were viewed as experiential experts and given as much freedom to tell their story in their own way as possible. The interviewer followed the concerns and direction of participants, probing areas of interest but otherwise having minimal involvement in an attempt to avoid influencing the interview.

At the conclusion of the interview the participant was thanked and invited to contact the researcher with any questions or any further information they would like to give. They were informed they could receive a copy of the finished study if they wished. All four carers requested this. The researcher transcribed the interviews in full immediately after they were conducted, as is conventional in IPA. The data were analysed as outlined below.

Data Analysis Procedure

The data from the interviews were analysed according to the Interpretative Phenomenological Analysis (IPA) approach (Smith et al., 2009). According to its principles, the researcher engaged in a “sustained engagement with the text and a process of interpretations” (Smith & Osborn, 2003, p. 64) and was careful to take time to immerse herself in the data, poring over the texts and continuing the analysis “beyond the point of boredom” (McLeod, 2003, p. 165). The researcher was careful to consciously focus on slowing down in order to avoid superficial reading, immersing herself in the data and patiently dwelling on the topic (Willig, 2001, p. 41).

As recommended by Smith and colleagues (2009) and McLeod (2003), a series of analytical steps were applied to all of the transcripts in order to ensure all data were equally and thoroughly explored. These steps were based on those outlined in the works of Smith and colleagues (2009); Willig (2001) and Smith and Osborn (2003), which were combined to create the master series of steps outlined below.

Stage One: Reading, Re-reading and Initial Noting

As recommended by Smith and colleagues (2009), in the first stage the researcher aimed to produce “a comprehensive and detailed set of notes and comments on the data” (p. 83), recording

anything of interest (including descriptive, linguistic and conceptual comments) in the left margin of the printed transcript.

- a) The researcher listened to the recording of the interview, listing general points of interest in a notebook.
- b) The transcript was read for the first time, taking general notes.
- c) A detailed, line-by-line semantic reading was conducted. Further notes were recorded.
- d) A detailed, line-by-line linguistic reading was conducted. Further notes were recorded.

Stage Two: Developing emergent themes

During this stage the focus shifted from working with the transcript to working with the notes that had been taken. As recommended by Willig (2001), the researcher aimed to maintain the complexity of the data while reducing its volume by reorganising it into theme clusters. Throughout this stage the researcher continually moved back and forth between the list of themes being created and the actual transcript which had given rise to them. As recommended by Smith and Osborn (2003), themes which were not richly evident in the transcripts or which failed to fit well with the emerging structure were excluded from the analysis.

- a) Themes were derived from the notes which had been taken. The themes were noted in the right margin, opposite the notes which had given rise to them and alongside the text of the transcript.
- b) The theme titles were transferred into an electronic document, listed in chronological order.
- c) The researcher analysed the connections between themes evident in the electronic document, and clustered the theme titles according to these connections.
- d) The theme clusters were transferred into a summary table of themes. The researcher then returned to the original transcript and copied the quotes which had given rise to the themes into the summary table. This resulted in a summary table which had theme titles in one column, and the supporting quotes and line references in the other. The individual summaries were exhaustive and very detailed, because no themes were culled from the analysis prior to case integration.

Analysis was completed to the end of stage 2 for all transcripts before patterns across cases were formally explored. Any connections the researcher noticed before beginning the formal process of looking for them were recorded in a notebook.

Stage Three: Integrating the Cases and Creating a Summary Table of Themes

Smith (2009) and Willig (2001) each outline two possible ways to integrate cases; either by using the summary table from the first participant as a basis for coding the other transcripts, or by integrating the summary tables from all participants into a master summary table which reflects their combined experience. The latter method was chosen for use in this study, in order to retain individual differences in the data.

- a) The four theme and quote documents from stage 2d were combined to create a master document of themes and supporting quotes across cases.
- b) Convergences and divergences in the data were identified.
- c) The themes for inclusion in the final write-up were selected on the basis of their resonance within the data; their usefulness to other carers; and their potential clinical and practical interest.
- d) Individual participant similarities and differences in their descriptions of the themes were noted.

The outcome of the analysis is explored in the results section.

Ethical Considerations

Ethical clearance for this study was given by the Human Ethics Committee at the University of Canterbury, New Zealand. A number of important ethical issues were considered in relation to this research. All participation in the study was completely voluntary, and participants were free to withdraw from the study at any time. Participants were provided with detailed information sheets describing what participation in the study would involve, and informed consent was gained from all participants. Individual children were not participants in this study - caregivers did not reveal the identities of any children who had been, or was presently in their care. Measures were also taken to protect the carers' identities, including the use of pseudonyms in this thesis.

Before beginning the interview it was noted that participants may find describing their experiences of fostering children with attachment difficulties distressing at times. With this in mind, the interview topics were sensitively designed and all possible steps to minimise the risks of distress were taken. If participants did find the interviews distressing, they were offered referral to counselling.

CHAPTER FOUR: RESULTS

Five superordinate themes emerged from the data. They were:

- Expectations versus Reality
- Satisfactions and Strains of Fostering Children with Attachment Difficulties
- Attachment Relationships and the Benefits of Information
- The Impact of Others on the Caring Experience
- Negative Expectations and Future Concerns

These themes will be explored in this section. Multiple quotations from participant interviews are included, to allow the carers' voices to be presented. These quotations are referenced according to their line numbers in the original transcripts.

Theme 1: Expectations versus Reality

The theme of *expectations versus reality* was richly evident in all four participant accounts. The structure of this theme is presented in Figure 1. All four carers began fostering expecting the experience to be positive and manageable. They were largely unaware of their new foster children's difficulties, and expected them to develop normally. The extent of the children's difficulties became apparent over time, and the carers discovered the reality of fostering a child with attachment difficulties was very different to their expectations. Their journeys towards, and reactions to, this realisation are explored below.

Initial Positive Expectations about Fostering

All four carers began fostering with positive expectations. Rachel, Jim and June all believed fostering would give them the chance to positively impact a young person. Jim expected fostering to provide the chance to assist his foster daughter towards a brighter future, giving her the opportunity to succeed: "... *it's about giving them the opportunity*" (617-618). He looked forward to the challenge fostering would provide. Rachel and June also saw fostering as a chance to positively impact their foster children's lives. Katrina expected having a foster child in the house would positively impact her own family, while Rachel viewed fostering as a chance

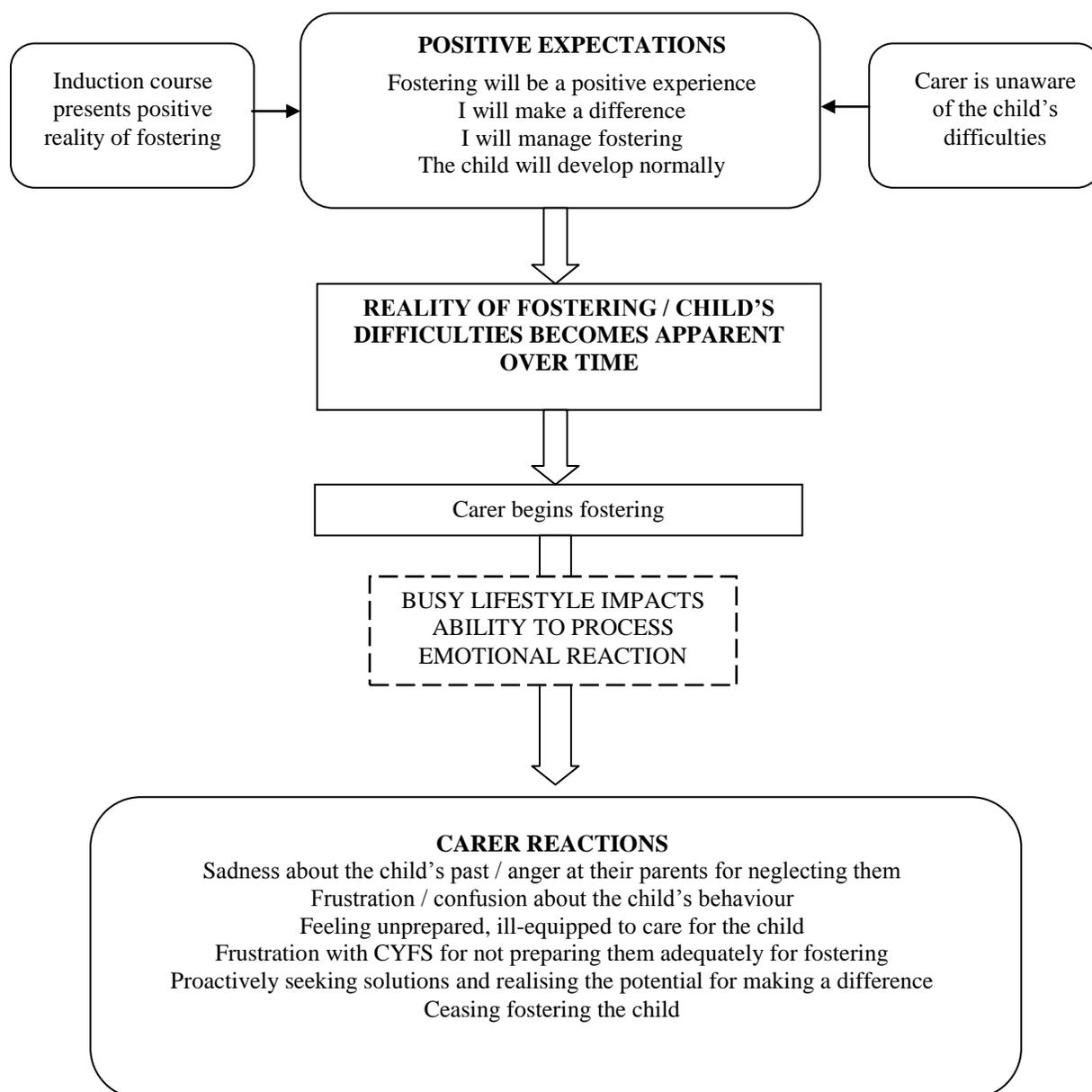


Figure 1: Expectations versus Reality theme

to do something worthwhile, which would positively impact her foster son. She described being very excited about fostering Conner:

“I love babies! So it was like ‘Yay! A baby!’ (laughs) {...} yeah, so I was really excited [...] it was it nice to be feeling like I was doing something worthwhile again” (425, 427-428).

June was also excited about the chance to have a child:

“I thought, ‘ooh! Here’s my chance! Haven’t had a child, I could... have this, y’know, have this child live with us and show her love...” (20-24)

None of the carers expected fostering to be unmanageable. Katrina explained she “didn’t expect anything like the Waltons” but expected the experience to be “manageable” rather than incredibly difficult (293). Katrina believed her expectations of fostering were heavily influenced by the positive experiences discussed at the foster care induction course she attended.

Expectations of Normal Development; Lack of Awareness of Difficulties

All four carers expected their foster children to develop normally. Rachel viewed Conner as a normal baby, and thought he would be fine:

“This stupid part of me, and, and I think ‘Well what was I thinking?’ ... the stupid part of me thought ‘It’s a baby, he’ll be fine because we’ve got him so young” (436-438).

None were aware of the child’s difficulties before they began fostering them:

“... we didn’t know back then that he was so high needs, we were just told he’s a difficult boy, he’s a bit violent, breaks a few stuff (mmm), smashes windows, and that was it!” (Katrina, 287-289)

None of the carers expected to be fostering children with severe attachment difficulties. They only discovered the extent of the child’s difficulties through experience, as outlined below.

Discovering the Difficult Reality of the Experience / the Child’s Difficulties

Over time, Katrina, Rachel, June and Jim all realised the children they were caring for were not developing normally. All four carers frequently described their children as “*abnormal*” throughout their interviews. Carers discovered their foster children’s abnormal development at differing points on their care journey. Jim discovered it on his first day with then 10-year-old Mere, while Rachel only realised Conner was not developing normally as he got older. She described an incident in which Conner badly burned his foot on a stove, but did not cry:

“... he had this huge burn on his foot that just bled and it was, it’s quite scarred today, and he cried a wee bit but y’know, not that much, y’know, and and yeah it was about a year old when we were starting to realise that actually there’s something not quite ... he’s not quite right...” (453-456)

The realisation that Conner was not developing normally came in stark contrast to Rachel’s expectations of what fostering him would be like:

“... it went from having this baby and thinking we were saving the world for this baby, that he was gonna grow up now and be normal, and having to come to this realisation that actually something’s not quite right here.” (457-459).

Reactions to Reality

The carers all reacted differently upon realising their foster children had major difficulties. These reactions were influenced by the busy lives of the carers. When asked what the shift from expecting to foster normal child to experiencing fostering a child with complex needs was like, Rachel explained she had been too busy to fully react and grieve at the time. She stated she had only recently been able to talk about her experiences her husband, and only realised the extent of the shift in retrospect while being interviewed:

“... today’s probably the first time I’m actually thinking about it, the first time I’ve verbalised, cos we really have had a really difficult um 4 years and, or 4.5 years... it’s only now that James and I actually get to say hello to each other and we’ve started to talk about some of the things that were happening. So it’s only now that I’ve got time to take a breath and think about it. Mmm. Up til then its just been... ‘do it.’” (472-478).

Despite this, Rachel shared many reactions with the other carers, which will be outlined below.

Sadness at the Child’s Past and Anger at their Parents for Mistreating Them

All four carers described feeling sad when they realised their foster children had major difficulties. June’s sadness was evident in the slow, sad and measured tone she used while

describing Aleisha's difficulties. She attributed Aleisha's difficulties to the early negative treatment her parents had subjected her to:

"I kind of... feels, it feels a bit like... the neglect and abuse that she's... kind of... experienced as a child or that adults who should have known better have done to her... it's just really implicated on her whole life." (618-621)

The carers were also angry at their foster children's birth parents, who they considered responsible for the children's difficulties. Their combined feeling is best represented in Katrina's description of Dylan as "*damaged*" by his birth parents (99).

Confusion and Frustration about the Child's Behaviour

Rachel, June, Katrina and Jim all described frequently being confused by their child's behaviour, and unable to understand why they behaved as they did. Jim and June were unable to understand why their adolescent foster children stole things for seemingly no reason. Rachel could not understand why Conner absconded whenever he had the opportunity, and Katrina could not understand why Dylan was emotionally needy and destructive. Not understanding Dylan's behaviour often caused Katrina to become frustrated with him:

"Why do they do it?! Y'know? Why? 'Are you ever gonna learn what's NORMAL for you?' [...] It's just the frustration, like, 'why are you, why are you doing this'? Like the other day, he was cross with me so he peed in his drawer full of clothes, and I was like, 'why? Why did you do that?!'" (92-93; 94-96)

Being unable to understand the reasons for negative behaviours caused the carers immense frustration, and made some carers feel unsure about how to parent their foster children.

Feeling Unprepared / Ill-Equipped to Care for the Child

Katrina and Jim both described feeling extremely unprepared and ill-equipped to foster the children once they realised the extent of their difficulties. When Jim realised Mere had very complex needs, he and his wife felt ill-equipped to raise her and were unsure how to help her. As normal parents, Jim felt that they did not have necessary skills to care for her effectively:

“... whilst this was all going on, we were (frustrated sigh), we’re neither of us teachers... uh, Claire’s a nurse, yes she’s used to, she’s a paediatrics nurse and works with kids at work (mmm) and what have you, uh... We’re parents, yes [...] Um... but we’d not come across a problem like this before.” (392-395)

Katrina was shocked that she, as a first-time foster parent, could be called upon to care for a child with Dylan’s major needs. She felt unprepared to care for Dylan, and believed he should have been placed with more experienced caregivers.

“... we got him and then we found out later on down the line that this was a very high needs child, y’know, somebody had showed us this score card and ... it was, like.... one of the highest in Christchurch apparently, and I’m like ‘Oh my God, they’re gave this to first-time foster parents? Are you kidding me?!’ (332-337)

Anger with Child, Youth and Family for Inadequately Preparing Them to Foster Children with Attachment Difficulties

As a first-time foster carer, Katrina strongly believed that the CYFS induction course failed to give her accurate expectations of what fostering would be like. The course encouraged her to expect fostering to be wonderful and rewarding, but did not prepare her adequately for the challenges it would bring:

“I, I don’t think, like, CYFS really prepare you properly for fostering? I mean they give you this light, fluffy thing and bring in, y’know, the role model foster parents, or caregivers, who sit and so y’know, say, y’know, how wonderful and rewarding it is and all this sort of rubbish, and well you sorta start to think ‘oh well!’, y’know, ‘it can’t be that bad!’ And then the reality is very, very different. So, I don’t think we were, y’know, properly equipped and prepared to take on the role as caregiving for CYFS.” (262-268)

Katrina felt CYFS had deliberately presented an overly positive reality of fostering in order to attract foster carers, and would never allow the actual reality to be presented to potential carers at the induction course:

“I thought, ‘Oh, my God, they’ll never get me up there to tell them what’s it’s really like!’” (laughs) (323-324).

She was frustrated that CYFS did not give her adequate information about Dylan’s difficulties:

“... we didn’t know back then that he was so high needs, we were just told he’s a difficult boy, he’s a bit violent, breaks a few stuff (mmm), smashes windows, and that was it!” (287-289).

Likewise, Jim was frustrated that CYFS did not provide information about Mere’s attachment difficulties when he began caring for her. He felt having the information would have equipped him to care for her more effectively, and felt his ability to provide appropriate care had been compromised.

Proactively Seeking Solutions and Realising the Potential for Making a Difference

Jim described immediately going into problem-solving mode as soon as he realised the extent of Mere’s difficulties, seeking to take action and find solutions to help her develop. After his initial feeling of inadequacy, Jim soon started to relish the challenge of caring for Mere. He realised he had the opportunity to positively impact her life, and help lead her towards normal development:

“I would love for her to stay with us, and let us sort her out. [...] she will learn, we will teach her how to live (mmm), and that will be fantastic.” (814; 817-818).

Jim quickly assumed a role of advocating for Mere against CYFS, her school and the Family Court. He began setting goals for Mere, and supporting her in achieving those goals. Jim found this rewarding and motivating.

Ceasing Fostering the Child

Over time, June realised that Aleisha’s difficulties were too much for her and her husband to handle. Aleisha’s difficulties, combined with June and her husband’s failing health, prompted them to cease fostering Aleisha after nearly four years. This was a very difficult decision for June.

Summary

All four carers described entering fostering with positive expectations. They were unaware of their foster child's attachment difficulties when they began fostering them. Over time, the carers realised the reality of fostering the children with attachment difficulties was very different to their positive expectations of the experience. They all reacted to the realisation in different ways. Reactions included sadness at the child's past, frustration with the child's behaviour, feeling unprepared to care for the child, being angry with CYFS for not preparing them for the experience, and realising their potential for making a difference.

Theme 2: Satisfactions and Strains of Fostering Children with Attachment Difficulties

All four carers described experiencing both strains and satisfactions while fostering children with attachment difficulties. Strains and satisfactions are presented together within a dual theme in order to reflect the way carers experienced both together, and felt they exacerbated each other. The dual nature of their experience is best reflected in the following extract from June's account:

"I really, I really enjoy Aleisha; I'm just trying to think of a percentage (both laugh). Probably, probably 65 percent of the time or 70 percent of the time. The other 30 percent... felt relentless..." (163-165)

Strains and satisfactions were frequently described alongside each other by all four carers. Juxtaposition of straining and satisfying aspects was most evident in June's account, in which she frequently followed up very sensitive and negative statements by discussing positive aspects of Aleisha:

"... you'd find knickers in her drawer that were quite heavily soiled, sometimes in her clean knickers drawer, or the bathroom cupboard, or wherever she chose to put them [...] I know, it, yeah, um, I... Oh, she's delightful! Y'know, resilient..." (194-200)

A strong, bidirectional relationship between strains and satisfactions was evident in all four carer accounts (see Figure 2). Satisfaction from watching the children progress could highlight their failures, making these seem more obvious and disappointing for the carers. For example, June

stated her distress at Aleisha sexually assaulting a child was exacerbated by the fact that “Aleisha seemed to be improving” prior to the incident (231), and Rachel found Conner’s misbehaviour on a holiday more difficult because of the recent “great satisfaction” she had been feeling through watching him improve and overcome obstacles (348). Likewise, the satisfactions gained through fostering could offset the strains. As Rachel described:

“... we structure our life to make it so Conner looks normal, but life’s not normal. So....and that,that’s a strain. But then he’ll do something amazing and, y’know, and yeah he’ll do so well at school, and he got a certificate this week at school, I’m sure it’s just for, cos all the kids at the start get a certificate a few weeks in. But y’know, then ya... ya get really happy about that.” (383-388)

The most commonly described strain/satisfaction bind concerned the slow nature of the children’s progress. Three of the four carers described being rewarded through their child’s progress (a satisfaction), but being incredibly frustrated by the slow nature of it (a strain).

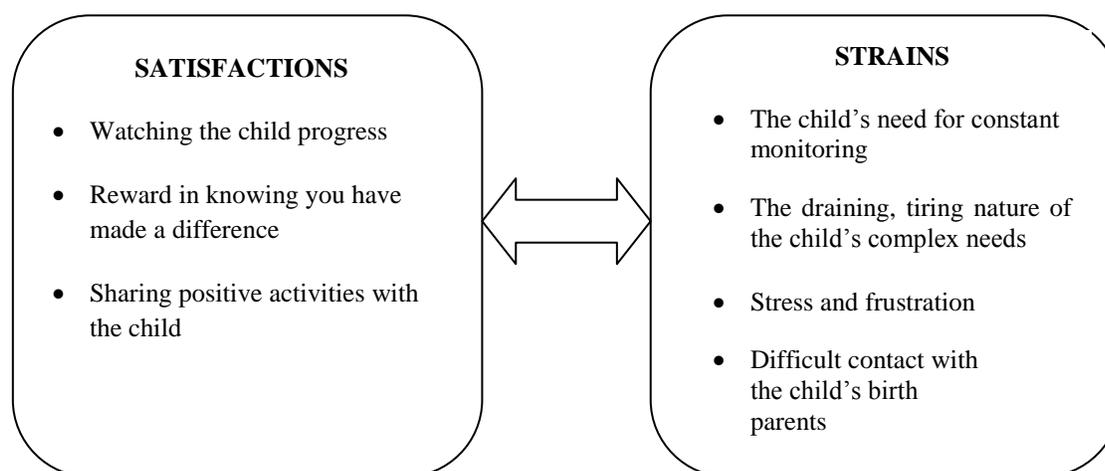


Figure 2: The Bidirectional Relationship between Satisfactions and Strains

The strains and satisfactions the carers described are outlined in this section.

A: Satisfactions of Caring for Children with Attachment Difficulties

All four carers described rewarding and satisfying aspects of their experiences caring for children with attachment difficulties. However, the carers considered these rewards

unconventional. Rachel explained that the rewards of fostering a child with attachment difficulties were different than the rewards of caring for other children:

“... ways of being rewarded for what you’re doing, they’re, y’know, if they’re, like, I suppose the child bonding with you a bit and that type of thing, you have to look for other ways to find reward in what you’re doing, because you’re not gonna get the normal, yeah, the things that y’know a normal child would come up and say ‘I love you Mummy’ and all that...” (158-162)

Jim echoed this theme in Rachel’s account, explaining that he did not experience conventional rewards through fostering Mere.

“It feels... at times like you’re being abused. Like you are... y’know, there is no reward for you.” (162-163).

Because of the unconventional nature of reward, Rachel described actively looking for positive aspects of Conner’s behaviour and progress in order to feel reward and satisfaction in a process referred to as *“taking the small things”* (814). For example:

“the fact that Conner has been at school a month, yeah no, 2 weeks, 2 weeks, yeah, and he HASN’T BASHED ANYONE! Y’know that’s... that, to other people that (is nothing)... but to me that’s HUGE! It sounds stupid but something like that I just feel this overwhelming sense of pride that, and love and, cos you know he’s doing so so well.” (813-815)

Rachel selectively attended to this satisfying aspect of Conner’s behaviour at school even though he misbehaved at after school care:

*“And yeah, at afterschool care he whacked someone over the head with a tennis racket and said ‘f**k’ and... (laughs), but at school! (Laughs). You know?” (285-286)*

Reward through Seeing the Child Progress, and Knowing You Have Made a Difference

All four carers stated their foster children had improved in many areas since they first began fostering them. These areas included confidence, behaviour, relationships and learning

(Jim); emotional development, empathy and self defence (Katrina); attention span and manners (June); and building relationships with others and complying with caregiver requests (Rachel). Jim, Rachel and Katrina all described experiencing immense satisfaction through watching their children progress and knowing they had made a difference to the children's lives, as shown in the following extracts:

“just seeing how he... when you think, I think back to what he was like when he first came to us to what he is now, he's a completely different child (mmm). So that's, like, really satisfying that oh yeah, I have changed him in some way.” (Katrina, 131-133)

“... when she first came here, she would hardly talk at all. Now, you can't shut her up. She's always got something to say and she's got confidence in what she's saying (mmm). And it's that build up in confidence, again, that makes you feel... 'I've helped with that!'" (Jim, 390-394).

“I feel like we've come so far. Like he used to smash his head against the wall and vomit at night when you put him to bed, and you know, we've got through all that...” (Rachel, 258-260)

Jim stated he believed that these were actually *more* rewarding with these children than with other foster children, because greater investment and work was required to help children with attachment difficulties progress. He also asserted that seeing the child progress was a major motivating factor which encouraged him to keep fostering:

“That (her progress) to me says it all... y'know, that's what we're in it for” (173).

While Katrina, Jim and Rachel described finding watching their children progress and knowing they had made a difference extremely rewarding, June did not. While June acknowledged Aleisha had improved in some areas, such as manners, she found the incomplete and slow nature of that progress difficult to cope with. June felt much of her teaching did not “sink in.” (178), and wished Aleisha had progressed faster, and put into action more of what June had taught her. Her account suggested she found Aleisha's lack of progress demoralising, as she felt it showed she had been unable to make a positive impact on Aleisha. Instead of gaining satisfaction

through watching her foster child progress and feeling she had made a difference, June gained primary satisfaction through sharing positive experiences with Aleisha, as outlined below.

Satisfaction through Shared Positive Experiences

June described sharing positive experiences with Aleisha as her primary source of satisfaction. She enjoyed baking, riding bikes, and sharing special lunches in the park with Aleisha:

“I would take the sauce and the dishcloth and a serviette and we’d go and buy hot chips and we’d go and share them at the park, and we’d sit at a table or on the grass or something, and that was most enjoyable. I really enjoyed that.” (401-404)

The other three carers also gained satisfaction through sharing positive experiences with their foster children. Katrina enjoyed watching Dylan get excited about the family getting a kitten; Jim enjoyed engaging in banter conversations with Mere; and Rachel enjoyed simple, day-to-day interactions with Conner, including hearing about his day. Rachel gained satisfaction from observing both Conner’s prosocial and renegade sides:

“... y’know I turn up to preschool and he would have done something good or something bad and just hearing about his day and I have the same sense of pride as with all my kids and yeah. And even the things that he does bad, I laugh about.” (299-301).

Experiencing these positive times helped carers develop attachments to their children, and brought them great satisfaction.

B: Strains of Caring for Children with Attachment Difficulties

As well as the satisfying elements, all four carers described experiencing significant strains while caring for children with attachment difficulties. These are outlined in this section.

The Child's Need for Constant Monitoring

June, Rachel and Katrina all stated that their foster children required constant monitoring because of their various disruptive behaviours, including stealing, absconding, violence and lack of social knowledge. Katrina explained the experience as follows:

"... you have to watch him all the time, (mmm) and nip things in the bud, and explain to him y'know 'don't do that', y'know, 'if you want to play a game or join in... y'know, don't just go whack someone over the head, or (mmm), annoy them, to join in, ask if you can play.' So you've always gotta be watchful like that." (460-464)

June found having to constantly monitor Aleisha very tiring:

"I had to kind of, be around all the time. I had to be able to see her, all the time. And ... that, oh, you asked me how it felt. It.. it felt ... wearying." (222-224)

Rachel also found having to constantly monitor Conner very stressful, as shown in this extract:

"...we couldn't relax camping cos the whole time it was "Where's Conner? Where's Conner? Where's Conner?" y'know, you'd turn your back and he'd be gone [...] it was really stressful and we, we haven't been camping since." (363-366)

As shown, Conner's need for constant monitoring impacted the outings Rachel had with her family, as Rachel actively avoided going places where it would be too difficult to monitor Conner. It also limited the time Rachel had for her birth children:

"James and I, y'know, the whole weekend either one of us or the other of us was having to be with him, parenting him the whole time (mmm) [...] and our kids wouldn't even get to see us." (354-356)

The child's need for constant monitoring was clearly a source of personal strain for some of the carers interviewed in this study.

The Draining, Tiring Nature of the Child's Complex Needs

Katrina and June both described moments of feeling extremely drained and tired while fostering

Katrina and June both described moments of feeling extremely drained and tired while fostering their children with attachment difficulties. Katrina found Dylan's need for constant emotional closeness very draining:

"It was horrible! Y'know, you'd go to the toilet and he'd be at the door listening to you, (mmm) and y'know, go hang out the washing and he's right there, or, yea, and it was just this constant neediness of him that... that I struggled with." (172-175)

Carers described being worn out and ground down by their foster children's behaviours. Katrina felt repetition of difficult behaviours was draining, describing them as a process whereby Dylan just "niggles away" at her (229). June explained that single behaviours in isolation were manageable, but that the build up of negative behaviour over time gradually depleted her and her husband's coping resources:

"I mean, it's probably not so much that she just did that one thing, it's kind of that kind of behaviour, just in your face, all the time." (379-381)

June was especially drained by Aleisha lying, which she found a "real energy-sapper" (166). The draining and tiring nature of caring for Aleisha, combined with complications in June's physical health, were cited as the reason June ceased fostering Aleisha.

Stress and Frustration

All four carers frequently described experiencing both stress and frustration while fostering children with attachment disorders. They were divided concerning which of the two were most intense. Rachel and June's narratives predominantly reflected experiencing stress. June recalled sometimes feeling like Aleisha's attachment behaviours, especially manipulation, were driving her mad:

"Occasionally I'd say [...] 'we just need to go on our bikes and get outta here,' cos it would drive me mad. I'd feel like I was getting driven mad, with... if you let your guard down a little bit [...] she just kinda managed to wheedle in" (447-452).

Rachel described experiencing both high general, day-to-day stress and particular stressful incidents while fostering Conner. These included Conner getting covered in bleach; throwing a

tantrum on a crowded bus; absconding in central Christchurch; and running away on his bike and falling into a sink hole after the September 4 Christchurch Earthquake. Rachel stated her stress levels had not decreased over the five years she has been fostering Conner.

Katrina and Jim's narratives predominantly reflected frustration. Unlike Rachel and June, Katrina frequently stated she did not feel she was particularly strained or stressed by Dylan, but did frequently experience acute frustration:

"I don't find, it's not like really, really hard, it's just more frustrating [...] and really sad that they're like that? And yeah, a little bit difficult, but I wouldn't say really, really difficult [...] I'd just say more frustrating." (86-90)

Jim also described getting more frustrated that stressed by his foster child's behaviour. He stated that he and his wife frequently had to take time out from Mere in order to release their frustrations: "We'll go and scream somewhere (laughs), and shout, and then come back" (533). Jim's frustrations generally centred on Mere's slow progress; tendency to take things literally; stealing and lying.

Difficult Contact with the Child's Birth Parents

All four carers described interacting with their foster child's birth parents as straining and difficult. Jim's account provided the richest account of difficulties with birth parents. Jim had extreme difficulty dealing with Mere's father, who repeatedly let her down through cancelling visits and lying to her. Jim described feeling "heartbroken" for Mere when her father let her down, and frequently got angry and frustrated with her father. Mere often irrationally blamed Jim for sabotaging her time with her father, which made Jim feel very hurt and frustrated: "*It's gutting. It really is, you feel rotten.*" (492-499). While he tried to be impartial about Mere's father around her, Jim really wanted to tell Mere what her father was like in order to protect her from further disappointment:

"You feel like you really wanna put her straight on what dad's about, but you've got to bite those words back every time." (588-590).

Like Jim, Rachel never put Conner's parents down in front of him, but stated she wanted nothing to do with them. While she had traditionally been very involved with her foster children's birth

parents, Rachel explained she had toughened in her approach to them because birth parent contact was sometimes detrimental for Conner:

“...we’ve always been very involved with all their parents and all their lives and all that, and I’ve, I suppose I’ve come to the point now where, actually this is about what’s good for Conner, and it’s not about what’s good for them. And, and it’s about what’s good for me because if I don’t... can’t get through this then, it’s not good for Conner.” (638-644).

Katrina also found birth parent contact disruptive, as Dylan’s behaviour deteriorated whenever he visited his mother:

“... whenever he saw his mum in jail his behaviour would just go extreme... he came to Australia with us and he saw mum when we got back, and he just stopped eating stopped drinking, just... stopped playing, stopped everything.” (105-107).

Finally, June sometimes found interacting with Aleisha’s family awkward, and was unsettled by what she saw as Aleisha’s family’s attempt to buy her love.

A Mixed Impact: Impact on Family

All four carers stated that fostering children with attachment difficulties significantly impacted their families, in both positive and negative ways. Both participants who were raising their foster children alongside their birth children explained the experience had some negative impacts on their own family, especially reducing the resources they had for their own family. Rachel stated that fostering Conner had severely reduced the time she had for her own children and her husband. She felt that family outings were negatively impacted by having Conner, as outings were dictated by what he could handle. She felt guilty about the impact fostering him had their activities and time:

“I feel guilt about the fact that the last few years we haven’t been able to do anything with our kids because one of us has been looking after Conner...” (624-626)

Finally, Rachel also described being concerned at the level of violence Conner showed against her birth children. As discussed earlier, she was concerned that this would escalate to the point that she had to choose between having Conner and keeping her own children safe.

Katrina explained further negative impacts fostering Dylan had had on her family. Dylan's jealousy, possessiveness and need for physical affection meant Katrina's opportunities to show affection to her other children were restricted. She felt this had negatively impacted her relationship with her youngest son:

“With Dylan in the house I can't... I kinda feel like I'm sneaking around with (her youngest birth son)? Like, to give him a cuddle when nobody's looking cos Dylan would just get insanely jealous that a) he didn't get one, and b) that, um, my son's with me? So y'know, like, oh, y'know when it's bed time y'know I have to sneak and just give him extra smushy cuddles...” (540-541)

Dylan also frequently manipulated and “wound up” Katrina's own children (285). Katrina stated she had to very aware of her actions towards her birth children, because how she interacted with them could impact Dylan. Despite the negative impacts described by these two carers, they also cited some positive impacts fostering had had on their families. Katrina and Rachel believed fostering had increased their birth children's senses of compassion and gratefulness. Katrina also felt having another child in the house had helped her introverted eldest son develop social skills.

Partners

The four carers described both positive and negative impacts that fostering a child with attachment difficulties had on their marriages. Jim and June both stated the experience had positively affected their marriage, as presenting a “united front” to the children to avoid manipulation had brought them closer together. June felt agreeing not to argue in front of Aleisha had helped settled her marriage. Jim had welcomed the chance to face a new challenge alongside his wife of many years, and had felt a “*much tighter bond*” with her since they had experienced success helping Mere (696). Rachel also stated that fostering helped her realise her husband's character strengths, and appreciate his gentle nature. The carers also described some negative impacts on their marriage. Katrina was sometimes frustrated when her husband

interacted with Dylan in ways which triggered his negative behaviour, and Rachel described being hurt when her husband had considered giving Conner up, while she was determined to keep him.

Summary

All four carers experienced both significant satisfactions and significant strains while fostering children with attachment difficulties. A strong, bidirectional relationship between strains and satisfactions was evident, whereby the child's successes could make their failures more disappointing, and their challenges could make their progress seem more significant. The satisfactions of the experience were often unconventional, but extremely important to the carers. They included watching foster children progress; knowing the carer had made a difference; and sharing positive experiences with the foster children. The strains of the experience ranged from feeling drained, tired, stressed and frustrated to negative impacts on relationships with others and finding birth parent contact difficult. They were experienced to different degrees by individual carers, but were significant enough to contribute to one carer ceasing fostering. The carer's families were heavily impacted by fostering in both positive and negative ways.

Theme 3: Attachment Relationships and the Benefits of Information

The third superordinate theme that was evident in the carer accounts was attachment relationships and the benefits of information. The structure of this theme is outlined in Figure 3 below. The carers all described feeling strong bonds to their foster children, even though the carer-child relationships were often unequal. Carers were generally more invested in the relationship than children. Investing the children left carers vulnerable to being hurt or strained by them. When this occurred, some carers made the conscious decision to emotionally distance themselves from their children for self-preservation while others remained emotionally invested and continued to experience strain. All four carer accounts reflected this theme to this point, and their experiences are shown above the black line in the figure.

The theme continued in the accounts of two carers, who described learning more about attachment difficulties after making the decision between distance and investment. Their experiences are represented in the continuation of the figure beyond the black line. One of these

carers had emotionally distanced themselves from their child, but reinvested in their child once they gained understanding of their issues. The other had remained invested but found his strain was eased by gaining knowledge of attachment. The two carers both found understanding the attachment difficulties reduced the strains they felt while caring for the children, and equipped them to love the children despite their difficulties. The elements of this theme will be explored here.

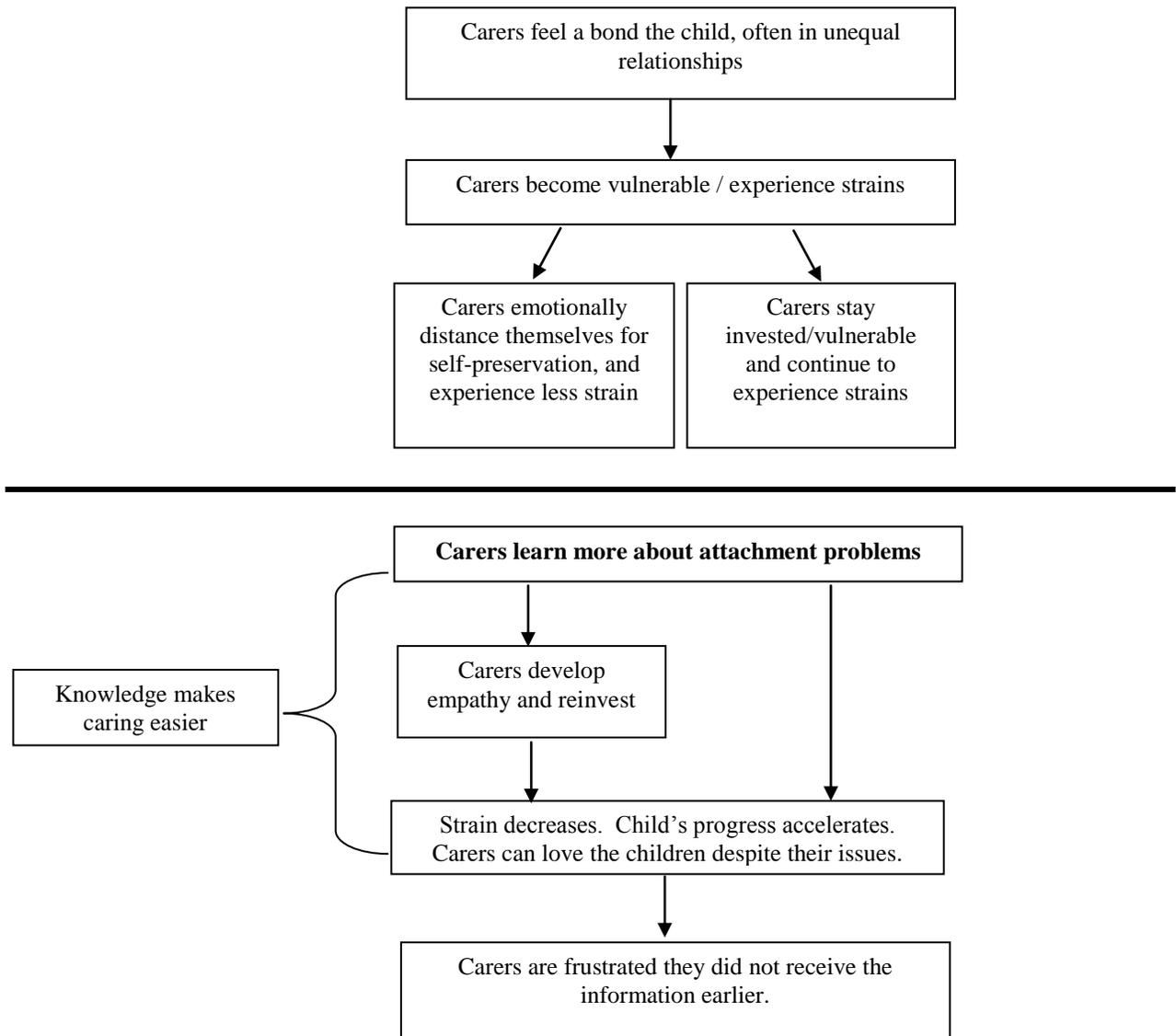


Figure 3: Attachment Relationships and the Benefits of Information

A: Attachment Relationships

Carers Bond with the Child in Unequal Relationships

June, Rachel, Katrina and Jim's accounts all illustrated they developed a strong bond to their foster children. Rachel, June and Jim had all placed major emotional investment in their foster children and spoke of loving them. Katrina stated she would "defend Dylan instantly" if needed, the same way she would defend her own children (421). Rachel was strongly attached to Conner within six months of caring for him, to the point that she knew she could not give Conner up:

"...at times James (her husband) would quite happily give Conner away. And, and I've said I can't do that, I'm too bonded." (686-687)

Rachel felt it was important to have strong attachment to the child:

"... there really has to be that deep bond, yeah, to get over sometimes the things the kids do." (696)

While some carers entered fostering expecting the chance to have relationships and give and receive love, in reality the relationships between carers and their foster children were often unequal. Rachel acknowledged she was probably more attached to Conner than he was to her (239). Jim described sometimes feeling like Mere saw him purely as a provider: "... at times it feels that you are just here to supply their physical needs and their wants (mmm), and that's *all* they see you as." (138-140). This inequality in relationships could be difficult for carers. Jim described feeling very hurt when Mere refused to acknowledge him and his wife as important people in her life for the first three years of their relationship:

"It feels... at times like you're being abused. Like you are... y'know, there is no reward for you... until about 3 months ago... she wouldn't acknowledge us as being parental figures, y'know, if we said, y'know, 'We've got parental responsibility for you', 'But you're not my parents! You are nothing to me!' (mmm) Um, and it's very hurtful at times. Y'know, at times it can be exceedingly hurtful." (136-142)

Emotionally investing in their foster children left carers vulnerable and caused them to experience being hurt and strained. Upon experiencing these strains, carers either emotionally distanced themselves from the child for self-preservation or remained invested in their children and continued to experience strain. The experiences of distancing themselves are outlined below.

Carers Emotionally Distance Themselves for Self-Preservation

Rachel and Katrina both described trying to distance themselves from their foster children in order to avoid being hurt. Rachel's distancing was extremely short-term, while Katrina's lasted longer. Rachel chose to distance herself from Conner because she thought he was only staying with her temporarily, and feared she would get hurt if she got attached to him and then he left. After six months she asked CYFS to take Conner away before she got even more invested in him:

"I rang them up and I said "I can't do this anymore, I'm getting too attached, and I don't wanna have to go through what I did last time (a child left), I just wanna, I want him to leave now before, you know, I can't cope..." (24-26)

Rachel was relieved when CYFS informed her Conner would be staying with her permanently, because she had bonded with Conner. She relished the opportunity to keep bonding with him now that he was staying long term, and stopped trying to hold back:

"I was like, 'Oh! Oh, OK then! cos yeah, in my mind, I'd been, you know, thinking I had to hold back my own emotions and it was like oh, oh OK well I can carry on bonding then!" (26-29)

Katrina's distancing was more long-term. She chose to emotionally distance herself from Dylan because his constant emotional neediness and disruptive behaviour were taking too much of a toll on her. Katrina made the decision to hold back after a "really horrible" day with Dylan on which she thought she was having a panic attack:

"... he was just taking too much of me I just, I didn't have that much to give, and, y'know, I was having panic attacks I remember just, we were cleaning out the toy

box, for something to do and I was sitting there and I'm shaking like this thinking 'Oh My God! What is wrong with me?' Um, and that's when I just, yeah, 'Get away from me, don't come near me' which is probably the worst thing you can do for a child with attachment disorder but I had to do that for my own sanity" (204-208).

Katrina consciously pushed Dylan away because she felt he drained her, and left her without emotional resources to invest in her own family:

"... it was just like he was just sucking me dry! Every kind of emotion, he was just, y'know he was like a leech once he's on he just (makes sucking noise) sucks everything out of you... [...] I was pushing him away, because ... I ... yeah, I just, I didn't have anything to give to my kids or my husband or even the cats because I had this child on me ... [...] He was just taking too much of me I just, I didn't have that much to give..." (167-170; 170-173; 203)

Katrina explained that she had experienced acute stress prior to distancing herself from Dylan, but had not felt nearly as drained, stressed or strained after she distanced herself. Carers who remained invested in their foster children experienced the numerous strains outlined in the previous strains section to a greater extent than Katrina.

B: The Benefits of Information

Jim and Katrina both described instances in which they learnt more about attachment disorders. They both found fostering their children much easier once this occurred and they understood attachment problems. They were given strategies to help them foster their children, which worked effectively and accelerated the foster children's progress. Jim and Katrina advised all carers to get information about attachment disorders, as they felt doing so was the only way carers could learn about the situation.

Learning about attachment difficulties helped Katrina, the carer who had emotionally distanced herself from her foster son, develop more empathy for and understanding of him. This prompted her to reinvest in the caring relationship

"I learnt, I got books out of the library and stuff and read it, like lots of Romanian orphans and all those kind of stuff, um, and I could understand it more, so I had a lot

more empathy for him and, it's not his fault, and I have to, it was, it was more like I have to um, it's not his fault so I should not be reacting to him, when he's not doing this on purpose? He's doing it cos he needs to? Yeah. And so yeah, once I got that more understanding, then, I let him get close." (215-221)

Katrina had found that being unable to understand why Dylan engaged in frustrating behaviours was the most difficult aspect of caring for him. Developing understanding of attachment removed this barrier to their relationship, and made caring for Dylan much easier: "I think once you *understand* it it's not *that* difficult" (82-83). Learning about attachment difficulties helped Katrina understand what triggered Dylan's behaviour, which allowed her to take control of the caring situation and feel confident with allowing him to get close to her:

"... because I understand him a bit more and what triggers a response out of him, I um, I'm modifying my behaviour, and how I feel towards him, so I'm starting to bring him a little bit closer? Like, get a wee bit more attached to him." (180-182)

Both Katrina and Jim explained that understanding attachment helped them better understand their children as individuals. As Katrina described:

"I think once you understand attachment disorders and how they work and how they evolve, I think then you get a better understanding of the child." (212-215)

Jim found that understanding Mere's attachment disorder allowed him to "divorce" the child from the disorder, and made it "very much easier" for him to see Mere herself. Jim suggested that carers in his position should seek to ignore the behaviours caused by the child's attachment difficulties, recognising the children rather than their difficulties:

"... ignore the fact that she's saying how, what a bastard you are and how you don't care for her...just got to walk away. Ignore that, that's the disorder saying it. And as long as you ignore the disorder, you're OK. The child will be OK" (726-729).

Doing this allowed Jim to experience less personal hurt, because he ignored hurtful things he felt reflected Mere's disorder rather than Mere herself: Jim found that separating the disorder from the child was a valuable coping strategy which helped him love Mere despite her negative behaviour:

“(viewing the disorder and the child separately) gives you a different focus. You can, you can hate the attachment disorder, but still love the child” (718-721)

Jim found this coping strategy significantly decreased the strain he experienced while caring for Mere.

Carers are Frustrated that they did not Receive the Information from the Outset

Having experienced the benefits of having information, both Jim and Katrina were extremely frustrated that they had not been provided with the information as soon as they began caring for their foster children:

“I just can’t believe that Child, Youth and Family cannot give you that information (mmm) when you first start taking these kids on. Because it would have made... all the progress so much faster, because we would have been starting right at the start, with the right information and the right way to deal with it...” (423-425).

They felt foster carers should be assisted in understanding attachment difficulties, so that they could provide better quality care and experience less personal strain.

Summary

All four carers described developing strong bonds to the children in their care, which were often unequal as carers were more deeply invested in the relationship than their foster children. These attachments often rendered them vulnerable to experiencing strain. Katrina decided to emotionally distance herself from the child in order to reduce this strain, which she stated was effective. The other carers remained invested in their children and continued to experience strain. Gaining information about and understanding of attachment difficulties made it easier for foster carers to understand their foster children, recognise their negative behaviours as disorder-motivated, and love them despite their difficulties. This prompted Katrina to reinvest in the caring relationship. Both carers who had received information about attachment problems were frustrated that they had not received it earlier.

Theme 4: The Impact of Others on the Caring Experience

Despite the personal focus of the interviews, all four participants described their experiences being heavily impacted by other people. This superordinate theme comprised two subthemes: lack of public understanding and public judgement (see Figure 4). These, and the themes which comprised them, are explored below.

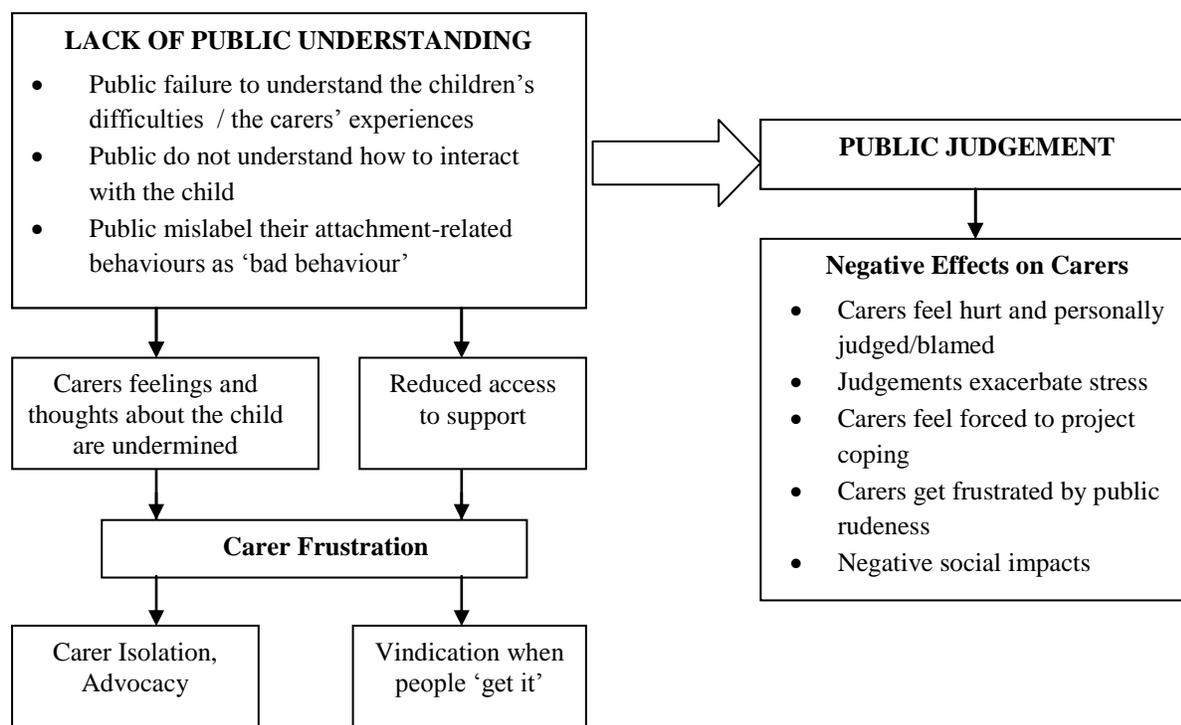


Figure 4: The Impact of Others on the Caring Experience

A: Lack of Public Understanding

The theme *lack of public understanding* was richly evident in the accounts of all four carers, who believed that members of the public did not understand their experiences caring for children with attachment difficulties. The most common misunderstanding described was failure to understand the children's difficulties.

Public Failure to Understand the Children's Difficulties

Three of the four carers stated they felt others did not understand their foster child's difficulties, as shown in Rachel's assertion "...everyone can't understand that he's not quite... a normal child" (135-136). Jim and Katrina attributed this lack of understanding to the normal appearance of their foster children:

"...the difficulty is, she looks normal. And anybody who looks at her says, 'Oh what a lovely child! What a beautiful child she is!' And they don't accept the fact that, because she looks normal, that there is something very much wrong with her. They expect her to be a normal, 14-year-old girl." (Jim, 791-795).

"...he initially seems really lovely and charming and people think 'Oh, he's a great kid!'" [...] Everybody says to me, like we were at the beach the other day and this woman goes 'Y'know, I look at him and I' she said 'I just don't see the problem!' "
(Katrina, 56-58; 184-186)

Carers described instances in which family members, friends, teachers and health professionals all failed to understand the foster child's difficulties. This public misunderstanding caused carers to frequently encounter resistance while explaining their child's difficulties to friends, professionals and family members. Jim described arguing with health professionals who did not recognise the difficulties his foster daughter had:

"... we've talked about it with colleagues from Claire's work (a hospital) and they say 'Oh, no no, she's just a normal girl.' Or 'she's just a bit slow.' Or this sort of thing, and you think 'No, it's more than that!'" (798-800).

Some of Katrina's friends failed to accept her opinion about her foster son's difficulties:

"... my really good friend, she was ... (sighs) Oh y'know I was saying something, she was like 'Really?! Is that what he's like?' I was like 'You don't see his behaviour! Y'know, you see him for half an hour at the park, you don't see the crap at home that he does!'" (578-581)

Rachel had frequent disagreements with teachers at Conner's preschool, who remained adamant there was nothing "wrong with" him even after taking extreme measures to control his behaviours:

"At preschool I kept saying to them, 'He's not normal' and they'd go 'Oh no, no he's fine, we've got other boys that are just like this' (mmm), and I'd be like 'No I've had a few kids now, I don't believe he is quite normal' [...] they put him in the cupboard and shut the door, with a small crack because he'd beaten up a teacher and he wouldn't say sorry (laughs) And, and it was, and still they were going 'Oh no, no he's normal, we've got lots of kids like this...' (305-308; 309-11)

Public do not Understand how to Interact with the Child (June, Rachel)

Carers also felt that public failure to understand the children frequently caused people to interact with the children in detrimental ways which caused them distress. Rachel explained that her father "still hasn't learnt" how to interact with her foster son (his grandson):

"... he'll go 'Oh, you'll have to come back and live with me.' Y'know, and, And I'm like 'Don't say that to him because then he gets upset that you're not taking him!'" (755-758)

June described an incident in which a friend allowed Aleisha to be alone with an infant, despite the fact that Aleisha was not allowed to be alone with children. This incident resulted in Aleisha engaging in inappropriate sexual behaviour towards the child, which placed Aleisha, June and the child in a dangerous and difficult position.

Mislabelling of Attachment-Related Behaviours / Reduced Access to Support (Jim and Rachel)

Public failure to understand and acknowledge the child's difficulties could also lead to misattribution of their attachment-related behaviours:

"They [...] expect her to behave in the way of a normal 14-year-old girl (mmm). And anything that is not normal that she does, they just see as bad behaviour (mmm). They don't see it as 'this is a disorder she's got.'" (Jim, 794-797).

It also reduced foster child's access to support. Jim explained that his child's school "just didn't get" his foster child's difficulties, and failed to implement any of the recommendations given in her psychological report (825). Rachel felt lack of support placed her child in a dangerous position, revealed when a preschool teacher took extreme measures to control his behaviour:

"...What had happened was this teacher had been pushed to her absolute limit and wasn't getting any support cos he was a normal child, they kept telling us, and... and y'know, you could see how it could happen." (321-324)

Lack of public understanding impacted the carers' experiences in many different ways, which are outlined below.

Carer Frustration

Katrina, Rachel and Jim described getting very frustrated when people refused to accept their views about their foster child's difficulties, and labelled the children as normal. Katrina felt others were unqualified to judge, and felt their refusal to believe her reflected questioning of her judgement and undermining of her opinion:

"It's horrible because everybody thinks I'm making it up [...] it's horrible when people say (that he is normal) cos they, it's like, 'You don't know my life, you don't know what he's like, you just see a one small snapshot of him'" (590-592)

Jim was vehement that the lack of public understanding was unacceptable, believing people ought to be aware of what attachment difficulties are and how children are impacted by them:

"I get annoyed because they don't understand. And I think that people should be aware, of what this is about, and the difficulties that that kid has got." (807-808)

Carers Feel Isolated and Become Advocates (Rachel and Jim)

Some carers felt like they were the only ones who understood their foster child's difficulties. This sense of isolation forced them to become advocates for the children. Rachel, isolated due to lack of public understanding, felt she had to advocate for Conner against an ignorant public:

“I feel like I have to stand up for Conner... I feel like it’s him and me against the world” (6911-692).

Jim also described advocating for Mere against CYFS, the Family Court, and her school, because he felt no one else would do so.

Sparkling Moments: Rare Incidents of Public Understanding

Carers described valuing friends of theirs who understood their foster children and were receptive to their descriptions of their experiences. Incidents of public understanding were very rare, and only described by Katrina and Rachel. Katrina described feeling vindicated she felt others really understood her foster son’s difficulties:

“... it’s always like, um, really vindicative, it’s like yeeeeess!’ when somebody gets it and they understand the behaviour.” (Katrina, 595-596).

Rachel described an occasion in which Conner’s behaviour drove a teacher to take extreme measures in an attempt to control his behaviour. Rachel was amused by the incident, as she felt it proved she was right about his difficulties:

“I thought it was hilarious!” [...] maybe the hilarity was in the fact it was like ‘ha ha, told you so!’” (292-296; 323-324)

Though rare, incidents of understanding were highly prized by the carers.

The Relationship between Lack of Public Understanding and Public Judgement

As shown in Figure 4, carers believed that lack of public understanding caused public judgement. As Rachel stated, *“...everyone can’t understand that he’s not quite... a normal child (mmm) and so you get all these huge judgements” (135-137).* Katrina implied the same relationship, explaining that people stopped judging her foster son so harshly once they understood his difficulties:

“... a lot of people who have been quite judgemental have then, ‘Ahh,’ they’ve seen Dylan, and ‘ooh, yes, OK’, and it’s ‘Oh! Thank you. You’ve been thinking it, you

haven't said anything but now you see the bigger picture, and, that's fine." (628-631)

This theme of public judgement and its effects is explored below.

Part B: Public Judgement

Katrina, Rachel and June all described experiencing public judgements about how they parented their foster children. Jim did not describe this. The female carers experienced both implicit, non-verbal judgements (looks, laughter) and explicit verbal judgements from others while in public. They described being acutely aware of this public scrutiny and judgement:

"... y'know on the bus when he's going completely mental and he'll be, y'know, trying to run round the bus and I'm holding him, and so because I'm holding him he's screaming and I've got everyone looking at me..." (Rachel, 133-137)

Rachel, June and Katrina were all affected differently by public judgement and scrutiny. Rachel and June viewed the judgements as personal and hurtful, while Katrina found them rude and irritating. The various effects of public judgement are outlined below, beginning with those experienced by Rachel and June.

Carers Feel Hurt and Personally Judged / Blamed

June and Rachel felt the public were personally judging and blaming them for their children's difficult behaviours. Rachel recounted incidents in which people she did not know invaded her personal space to blame her for her foster son's behaviour:

"I get this knock on my door with this woman, 'What have you done letting your child', you know, 'wander off'..." (110-111).

June's concern that people would blame and judge her for Aleisha's behaviour made public situations stressful for her. Her fear of public judgement made it difficult for her to "front up" at her foster daughter's school:

“...just facing people every day, it... felt difficult. And I, I think sometimes I kinda wondered what they thought of me, because we had this child that was, um, lying and stealing.” (556-559)

Rachel and June both described feeling hurt by public judgement. While Rachel has got used to public judgement, the hurt it causes her has not diminished over her eight years of fostering:

“I think you just get used... more used to it. It still hurts, because you can see, y’know, and you often get comments.” (137-138)

Public Judgement Exacerbates Stress

Rachel and June both explained that public judgement and scrutiny exacerbated stressful situations. Rachel described two incidents in which this occurred. The first involved finding her son playing with toxic cleaning products, having climbed up onto a laundry shelf:

“... I saw what had happened and I ran out there and I was screaming ‘get him in the shower’ rah rah, and it was all this huge hooah, and James was dragging him to the shower cos he didn’t want to go [...] and this lady came and knocked on the door and told us that she’d called the police and she could hear us abusing our child [...] and (mmm) and, and so I think that one, where and the the house was a bit of a mess, y’know, and it was a Saturday morning, you know, and I wasn’t... and, and I said to the kids ‘OK, we need to clean up the house, we need to make sure everything’s nice because the police are going to turn up and question us’. So um [...] that one was the one where I was worried.” (141-147).

The second occurred when her foster son had a tantrum on the bus. This incident left Rachel so stressed that she had a huge argument with her husband afterwards, and had limited resources to invest in her own children (762-763):

“... It was a horrendously stressful situation, all these people on the bus staring at us while I’m holding down one child and he’s screaming and he’s holding down another child who’s screaming and (mmm)... and y’know, and then something as simple as the 8year old wants to swap into the back seat so he can get a better view

and you're just like DON'T YOU DARE MOVE OUT OF THE SEAT YOU'RE IN!"
(765-770)

June's descriptions of stressful situations also suggested her stress and embarrassment was compounded by the presence of other people. June was particularly embarrassed by her foster child engaging in inappropriate sexual behaviour, which she found more difficult in the presence of others:

"I remember she kinda just came up and touched my breasts, and then, 'that's not really what you do, M' (laughs uncomfortably). I don't e... we might have had other people here as well..." (504-506)

Carers Feel Forced to Project Coping

Rachel felt forced to project coping in public, for fear that public judgement would be worse if she showed she was not coping.

"... you try to say it all with a smile on your face cos you know everyone's looking at you. [...] I'm still just as stressed, I'm still not coping, but I'm not gonna let other people see that cos they're already making a judgement, (mmm), y'know if I was to put one foot out of place while they were making their judgements (mmm), then it's gonna be even worse (776-779)

Public Judgement as Rude / Frustrating / Exasperating

While Rachel and June experienced public judgement as hurtful, Katrina found public judgement a source of irritation and frustration. Katrina did not consider herself bothered by public judgement. Instead of considering it hurtful, Katrina perceived it as rude, and was frequently frustrated by it:

"they're rude, cos it's like, as I tell Dylan, 'It's OK to think it (mmm), but you don't have to say it out loud.' And that what I think with other people, it's like 'Well why do you think it's OK to talk to me like that about this child who you've met once?' (mmm) Yeah." (619-622)

Negative Impact on Social Relationships

Rachel and June both stated that fostering their children had negatively impacted their relationships with friends. Rachel stated she no longer gets invited to dinner parties because her friends and neighbours all know Conner's reputation and are "wary of him" (149). She explained that she will only take her children to other foster carers' houses, because they understand what fostering is like. June lost friends through fostering Aleisha, and had other friendships complicated by Aleisha's difficult behaviour. Aleisha once brought a close friend of June's to tears by "chewing her up about not being married, and why wasn't she married? Why didn't she have children?" (455-457) On another occasion, Aleisha sexually assaulted a boy who was the son of June's friend. June described shift towards befriending foster carers, because they could relate to her experiences with Aleisha. Katrina was prepared for the possibility of losing friends through fostering, but had not lost any yet.

Summary

All four carer accounts indicated that their experiences fostering children with attachment difficulties were heavily influenced by other people. This could compound the difficult nature of the experience. Public failure to understand the difficulties of the children caused the carers to experience acute senses of frustrated and isolation. Lack of public understanding led to frequent judgements and scrutiny from members of the public. The three female carers interviewed for this study all had emotional reactions to being publicly judged, including feeling personally blamed and judged; feeling hurt; feeling they needed to project coping, and feeling irritated at the rudeness of people who judged them. Lack of public understanding and public judgment also influenced the social relationships of two carers in this study. Jim, the only male carer interviewed did not describe experiencing public judgement.

Theme 5: Negative Expectations and Future Concerns

The final theme evident in the current study was negative expectations and future concerns. Throughout the accounts, Rachel, Katrina and June frequently expressed negative expectations about their child's behaviour in daily situations. They also expressed significant concerns

regarding the future of the children, the placement, and themselves. Jim did not express these negative expectations, or concerns about the future. An overview of the structure of this theme is given below in Figure 5.

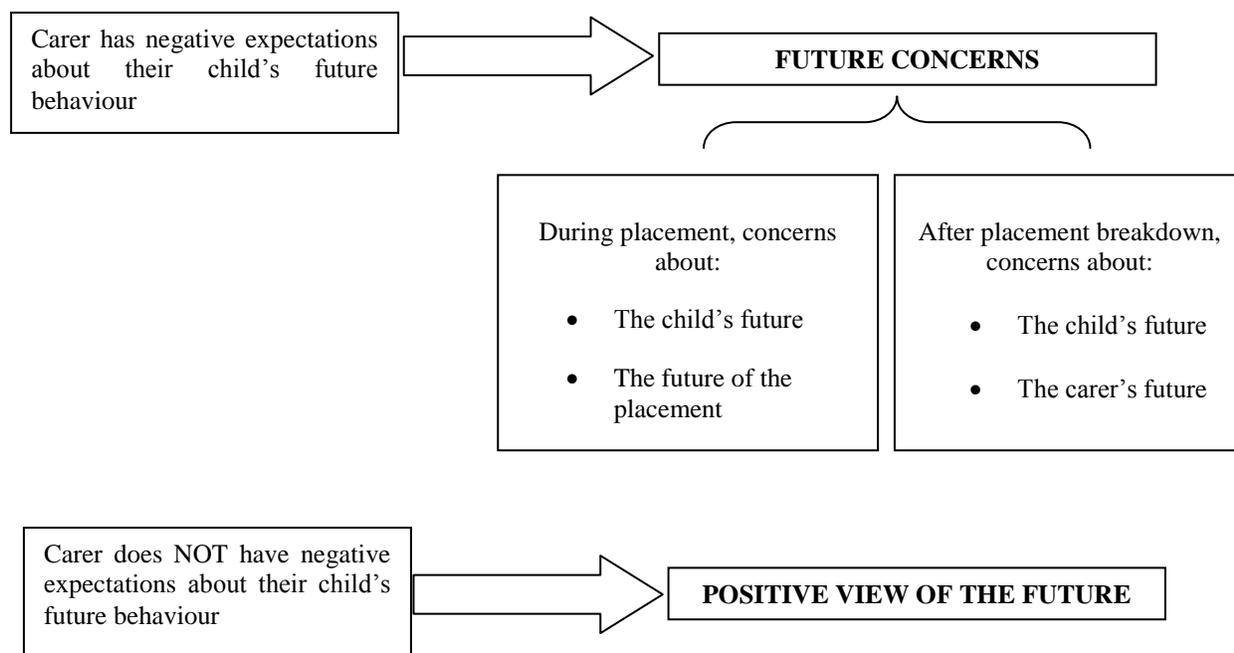


Figure 5: Negative Expectations and Future Concerns

A: Negative Expectations

Throughout the accounts, the carers' language showed they held negative expectations about their children's future behaviour. Phrases such as "*I know its coming*" (Rachel, 415) and "*We know he's gonna do these things*" (Rachel, 435) suggest the carers were certain of their negative expectations, believing they would inevitably be fulfilled. This "language of inevitability" was most apparent in Rachel and Katrina's accounts, and occasionally apparent in June's account. It appeared when discussing how they expected their child to behave in daily situations, as well as their expectations for the child's future.

Negative Expectations about the Child's Behaviour in Daily Situations (Katrina, Rachel, June)

Negative expectations about children's behaviour in hypothetical daily situations were frequently expressed in the accounts. This is illustrated in the following example from Rachel's account:

"... if he goes out onto the trampoline and he bounces unsupervised, he's gonna hurt someone, so we will be out there... We know when he goes to the park that he's liable to run away [...] it will always be that there's, that one of us is able to go..." (725-728; 730).

This extract illustrates Rachel's expectation that Conner will behave negatively in situations if given the opportunity. It also illustrates Rachel deliberately taking action to mitigate the negative behaviour she expects, rather than the actual behaviour which is occurring. Rachel stated this had become a lifestyle for her and her husband:

"I spose our whole life has been 'OK this is what he's gonna do, so how can we mitigate what's gonna happen'" (724)

Katrina, too, held negative expectations and acted to mitigate behaviours she saw as inevitable. This brought her into conflict with her mother, who did not understand why she was intervening when Dylan had not done anything wrong:

"I could see him, he was sidling up to Will and Finn who were playing, you could see him sidling up and I thought 'Oh here we go, he's gonna divide and conquer them', I just said 'Dylan', y'know, 'blablablabla' and my mother, honestly she just went so cross at me!" (464-467)

Katrina's negative expectations about Dylan's behaviour did not extend to her birth sons' behaviour. As shown in the extract below, Katrina intervened to prevent Dylan engaging in behaviours her foster sons were allowed to engage in for fear that he would take things too far:

"(her birth son) had Dylan down on the ground, was on top of him, going 'Aaaahh!' (laughs) And I was thinking 'Oh that's fine, they're fine' and then Dylan got up and was getting on top of him and I thought 'Oh, crap, they're right near the water, I can

just see Dylan going (makes strangling gesture) under the water so I'm running down the beach to pull apart these frantically screaming and slapping children..."
(507-512)

June occasionally spoke with language of inevitability about her foster daughter's behaviour in hypothetical daily situations. She considered stealing, Aleisha's most pervasive negative behaviour, to be Aleisha's 'default setting' brought on by her genetics:

"... stealing just seems to be... how it is [...] she's just, she's got this, I think there's lying and stealing running in the family, and I think she's picked it up. And it's, it's kinda the default setting" (245-246, 268-271).

June found this default setting very difficult to combat, and doubted Aleisha would ever change this behaviour.

B: Future Concerns

Rachel, Katrina and June all experienced concerns about the future in their accounts. These centred on the child's future, the future of the caring relationship and the carer's future.

Concern about the Child's Future (Rachel, Katrina, June)

Rachel, Katrina and June all described thinking about the future, and worrying about how their foster children would "turn out". Katrina viewed Dylan's future as inevitably negative, and spoke with certainty about negative things occurring as Dylan grows up. She stated she knew his teenage years would be "absolutely horrible" (114), and believed he would never have a happy life:

"I remember his therapist said a lot of children like him do end up really depressed later on because they don't know who they are because they're always putting on a front to people? (mmm) So that's really sad too, that y'know he's never gonna be a ... well I hope he's happy..." (108-111)

The above passage indicates Katrina interpreted information she was given about Dylan's *potential* future as inevitable. Katrina also reported wondering if Dylan would ever “learn what was normal” and “function as an adult” in the future, and was concerned he may become depressed and unhappy as he grew up (92-93; 100). She was certain her own boys would “be absolutely fine” in the future (99-100), but had reservations about Dylan:

“I think, y’know, I know my boys are gonna grow up to be wonderful strong men, because they’ve got, because I’ve made them that way and so’s James [...]and I hope Dylan will get there [...] Dylan’s the same, I can’t wait to see what he grows up like, half of me can half of me’s like ‘Oh, God...’ Hopefully genetics and nature don’t come much into it!” (429-431; 433-435)

Katrina's concern about genetics impacting her foster child's future was shared by June. June worried that the neglect and abuse Aleisha has suffered as a small child would continue to impact “her whole life” as she grew up (621). She hoped that eventually Aleisha would “wake up and think about behaviour” but felt that Aleisha developing normally would be “nothing short of a miracle” (624). She worried Aleisha might go to prison like her father, and was concerned that her inappropriate sexual behaviour would impact her job prospects:

“... she loves kids, she’d love to work with children but those kinds of things that she’s tended to do and be don’t lend her well for... looking after young children!” (624-627)

Finally, Rachel worried that Conner's lack of empathy and lack of caring when he hurts people would negatively impact his future development:

“it... worries me for what the future’s gonna be like (yeah). Cos [...] he’ll just whack people for the hell of it” (412, 415-416).

She also worried about her own children's future if Conner stayed in the house, and wondered whether she would be able to continue caring for Conner in the future. This will be explored below.

Concern about the Future of the Caring Relationship: Rachel

Rachel frequently expressed concerns about whether she would be able to continue caring for Conner in the future. She worried that he would become too violent to care for as he grew up:

“... he’ll come up behind me, and just smash me from behind. And so I’m trying to ignore him, and, but then I’m also trying to keep an eye out in the shop windows for when he’s gonna come up and lash into me (mmm), and y’know, in the back of the mind it’s ‘OK, I can handle this while he’s 5, (mmm), but what’s gonna happen further down the track?’ (208-212)

She was also concerned that Conner would hurt her birth children in the future, and feared the tension between her children’s wellbeing and her desire to continue caring for Conner may reach breaking point and cause placement breakdown. Rachel was concerned that she would not be able to handle giving Conner up:

“I love him a lot, and I [...]don’t know if I could give Conner away [...] I don’t want to be put in a situation where I have to choose between keeping Penny safe, and keeping Conner in our house. But I know that possibility is there. I mean, my daughter’s got scars on her from where he bit her, and when he bites he (takes flesh). And as a parent where your baby’s being hurt like that, it’s really difficult.” (237; 239-241)

Concern about the Carer’s Future After Placement Breakdown: June

June was the only participant in this study who had experienced placement breakdown after fostering a child with attachment difficulties. While sharing the concerns the other carers held about their children’s future, June also expressed a new concern: concern about her own future following placement breakdown. June repeatedly stated she was unsure what she would do now that Aleisha was gone, frequently stating “I’m not quite sure where to, from here, *for me* now” (545-546). June was unsure what form her relationship with Aleisha would take following

placement breakdown. While her sister assumed June would take Aleisha back, June was not convinced.

June also expressed uncertainty about the future of other aspects of her life which were tied up in fostering:

“we’ve made some other friends, I’ve been part of Fostering Associations and I’m not really sure what to do with that at the moment...” (560-562).

June’s account suggested placement breakdown prompted her to question her identity, which had been heavily tied up in fostering.

Jim’s Experience: Positive Expectations, No Future Worries

The theme of negative expectations and future worries was absent in Jim’s account. Jim did not speak with the same language of inevitability employed by the three other carers while talking of her behaviour. The only time inevitability was evident in his speech was during discussion of what he thought Mere’s life would have been like if she had stayed with her birth family:

“... if she’d carried on for another 20 years, in the environment she was in, she would never ever (have been able to live independently)... she would have been a teenage pregnancy and been in all sorts of trouble. No doubt about that.” (821-824)

At the time of the interview, Jim was the only carer who was not concerned about his foster child’s future. Jim acknowledged he had struggled to see how Mere would develop positively in the past:

“At the start of this year, I was really struggling to see how she was going to be able to live independently (mmm), when she’s older (mhmm), and see any sort of future for her...” (329-332).

However, as time went by and Mere progressed, Jim became less concerned about her future. At the time of the interview, Jim expressed positive expectations of Mere’s future: *“...gradually, I’m beginning to see more and more of a brighter future for her” (335-336).* While he

acknowledged the “difficult nature” of caring for Mere, he had a positive outlook about her future and was excited about assisting her towards independent living:

“If we can get her so that when she leaves us, she knows how to run a house, how to go about getting a job, and do all that, then I will feel ... I’ve achieved something really great, because when first came here she couldn’t.” (818-821)

Summary

Katrina, Rachel and June held negative expectations about their children’s future behaviour. These expectations did not extend to the behaviour or futures of their birth children. The carers often acted on these expectations, mitigating behaviours they thought would inevitably occur, rather than behaviours which were actually happening. These three carers also expressed multiple concerns about the future, including the futures of the children, the family and the carer, as well as the sustainability of the placement. Jim, the fourth carer, did not express negative expectations about his foster daughter’s behaviour or concerns about the future. While he acknowledged he had worried about Mere’s future early in the caring relationship, he had recently developed more positive about the future and stated he did not worry about it.

Discussion

The aim of the present study was to explore the experiences of New Zealand non-relative foster carers fostering children with attachment difficulties. This objective was achieved using semi-structured interviews with New Zealand carers who had experienced the phenomena of interest. The findings of this study were consistent with previous assertion in the international literature that fostering has acute impacts on carers (Golding, 2006, 2008; Nutt, 2006; Sinclair et al, 2004; Wells, 2004; Wilson et al., 2000). An Interpretative Phenomenological Analysis revealed six important themes that are detailed in the preceding chapter, and summarised below.

Summary of Findings

Carers in this study began fostering with positive expectations about the experience and their foster children, believing fostering would be manageable. They were given very little information about the foster children and their difficulties. As the extent of the children's difficulties became apparent over time, carers discovered the reality of fostering was extremely different to their expectations. They had various reactions to this realisation, including: sadness at the child's past; anger; feelings of inadequacy; and dedicating themselves to solving the child's "problems". Two carers believed that CFYS failed to prepare them adequately for fostering by giving them incomplete information about their foster children and encouraging them to develop unrealistic expectations about fostering. They felt frustrated and angry, and believed better preparation would have made their experiences easier and their caregiving more effective.

Carers in this study experienced both satisfactions and strains while caring for children with attachment difficulties. These strains and satisfactions could exacerbate each other, as the child's progress could make their failures seem more disappointing, while their successes could make their failures more bearable. Carers gained great reward through watching their foster children progress; feeling they were making a difference; and sharing positive activities with the children. They were strained by the children's complex difficulties, and their needs for constant monitoring, intervention and support. They were frequently frustrated by the children's emotional needs and behaviour, especially when they did not understand the reasons for these. They also had difficulty interacting with the children's birth parents. These gradual strains could build up

over time to leave carers feeling drained and worn down, to the extent that one carer chose to cease fostering when the strains, combined with ill health, became too much for her.

The carers in this study all felt strong attachments to their children, but felt their relationships with the children were unequal. These attachments left the carers vulnerable to experiencing hurt or strain. Upon experiencing this, carers either decided to emotionally withdraw from their children to minimise strain, or remain invested and continue to experience strain. Emotionally withdrawing was successful in reducing strain in Katrina's case. Receiving information about attachment difficulties made fostering children with attachment difficulties much easier for carers. The information helped them understand their foster children, and attribute disruptive and manipulative behaviours to their attachment difficulties rather than perceiving their children as being deliberately cruel. Receiving the information prompted Katrina to re-invest in her foster son, as she developed understanding and empathy towards him. Both carers who received the information felt they could have provided a better standard of care and been less strained if they had been given the information from the beginning of the placement, and were frustrated with CYFS for not providing the information earlier.

The carers' personal experiences were heavily impacted by other people. All four carers felt that others did not understand their experience of fostering these children, who they mistakenly labelled as 'normal'. Carers were frequently frustrated by this, and often had to fight to make others accept their perspectives about their children. Carers sometimes felt isolated and unsupported, so became advocates for their children and sought friendship with other foster carers who could understand their experiences. Lack of public understanding caused public judgement, of which all of the female carers were acutely aware. Two found such judgement exacerbated stressful situations; made them feel hurt, misunderstood and isolated; and made them feel blamed for their children's behaviour. A third was frustrated by the rudeness of public judgements, as she felt people had no right to judge her or her foster child. Jim, the only male carer in the study did not describe experiencing public judgement.

Over time, difficult experiences with their foster children made three female carers developed negative expectations about their foster child's future behaviour. These carers acted to mitigate negative behaviours they expected, rather than behaviours the child was actually exhibiting. Carers who formed these negative expectations also worried about the futures of the children, the placements, and themselves. Jim was the only carer who did not express this feeling

of negative inevitability or worry about his foster child's future. His more positive view of Mere's future meant he did not experience the anxiety expressed by other carers.

Comparing the Findings to the Existing Literature

The results of this study support many findings which have previously reported in the literature. The present study also makes several unique contributions to the literature. These will be outlined according to theme below. Overall, the findings of this study support previous suggestions that fostering children with attachment difficulties is a difficult and challenging task which impacts the carer's personal, family, social and practical spheres and has both practical and psychological implications for carers and their wider networks (Nutt, 2006; Sinclair et al., 2004). They also support assertions that these carers are normal people from "ordinary families" (Schofield & Beek, 2005, p. 3), tackling the unique complex challenge of caring for children with attachment difficulties.

Theme 1: Expectations versus Reality

The positive expectations of fostering, and altruistic motivations for entering fostering described by carers in this study are consistent with those commonly identified in previous literature (Nutt, 2006; Sinclair et al., 2004;). Their sadness about their children's past and anger with their birth parents are consistent with previous assertions that carers often grieve for what their children endured prior to placement, and blame the children's birth parents for their issues (Nutt, 2006). Their emotional reactions upon realising the extent of the children's difficulties, as well as their frustration and confusion about their children's behaviour, are also consistent with the results of previous studies (Nutt, 2006; Sinclair et al., 2004).

The findings of the present study are also consistent with previous assertions that carers often begin fostering with very little knowledge about what the experience or the child will be like, and may interpret the lack of information they are given as a deliberate recruitment technique (Nutt, 2006; Stott, 2006). Findings of this study are closely aligned with those of Gilbertson and Barber (2003), who found that Australian carers fostering children with severe behaviour problems were often given minimal information about the children before beginning fostering; had their pre-placement questions ignored; felt they had been lied to; and felt the

information they were given had been deliberately altered in order to increase the chances that the child would be fostered (Gilbertson & Barber, 2003). Jim and Katrina's anger and frustration at not being given adequate information to care effectively is also echoed in Gilbertson & Barber's study, in which carers were angry and believed that "ignorance of the child's background and circumstances compromised the care they could provide and their ability to be sensitive to particular needs or problems" (2003, p.333).

These foster carers reacted to discovering their foster children's difficulties in many different ways. Katrina and Jim's descriptions of feeling unprepared, ill-equipped and incapable of fostering children with attachment difficulties are consistent with accounts of carers fostering children with attachment difficulties and other complex needs, as well as carers fostering children for the first time (Golding, 2006, 2008; Howe & Fearnley, 2003; Wells, 2004). These findings are also consistent with accounts of carers being 'thrown in at the deep end' and allocated foster children in lieu of adequate training, which have been presented in Nutt's work (2006). Finally, the results of the present study suggest that the busy lives of carers may impact their ability to fully process their emotional reaction to discovering their foster children's needs when they begin fostering them. This may have important implications for service delivery, which will be outlined later.

Theme 2: Satisfactions and Strains of Fostering Children with Attachment Difficulties

Consistent with findings from previous international studies (CYFS, 2007; Nutt, 2006; Sinclair et al., 2004), carers in the present study experienced both strains and satisfactions while fostering. Experiencing a mixture of satisfactions and strains is also consistent with the findings of CYFS's *Caregivers Speak* survey, the only large-scale New Zealand investigation of fostering (CYFS, 2007). The bidirectional and enmeshed relationship between strains and satisfactions, as shown in the present study, provides greater insight into the complexity of fostering and may have implications for practice.

As found previously (Sinclair et al., 2004), carers in the present study described negative aspects of fostering more often, and in greater detail, than positive aspects of fostering. This was observed regardless of whether the carer was currently fostering the child. The present study findings support the assertion of other researchers that a seeming greater emphasis on negative aspects is at least partly due to the greater ease of remembering and describing negative events

(Sinclair et al., 2004). While June's decision to cease fostering is likely to have been partially based on the strains of fostering outweighing the satisfactions, this is likely to have been the case for the three carers who continued fostering. Studies suggest that, in reality, carers experience as many joys of fostering as they do challenges (Nutt, 2006; Sinclair et al., 2004). It is likely that this was also the case for carers in the present study, who were warm and genuine in their descriptions of the satisfying aspects of fostering.

Satisfactions

Carers in the present study stated they gained great satisfaction through some aspects of fostering. This is consistent with accounts from the literature, including Sinclair and colleagues' (2004) study in which 97 percent of 952 carers stated they gained a lot of satisfaction from fostering. The specific satisfactions outlined in this study, including seeing the child progress, sharing positive activities with the child and knowing they were making a difference, have frequently been described in the general foster care studies (CYFS, 2007; Nutt, 2006), as well as Wells' study of carers fostering children with mental health issues (2004). This consistency between findings suggests that caregivers can gain similar satisfactions through fostering children with attachment difficulties as through fostering children without them, despite the unique challenges children with attachment difficulties can present.

Despite the similarities in satisfactions, the nature of the rewards appeared to be different for carers fostering children with attachment difficulties. Carer accounts suggested that the children's attachment-disordered behaviours have forced them to seek rewards which are external to the child; for example, gaining satisfaction through watching the child interact successfully with peers, rather than through the child being openly affectionate towards the carer themselves. Despite extensive searching, no literature could be found on this phenomenon. This indirect approach towards satisfaction and the difference between the external nature of rewards for children with attachment difficulties and the intrinsic nature of rewards for other children require further exploration because they may have significant implications for carer training and support.

The most common source of satisfaction cited in the present study was watching their foster children progress. Rachel, Katrina and Jim gained great satisfaction through this, which Jim considered a major motivating factor which encouraged him to continue fostering. The importance of seeing positive change in children has been cited in other works (Nutt, 2006, p. 64;

Sinclair, et al., 2004; Wilson et al., 2000). Nutt has described it as the “ultimate” satisfaction for foster carers, suggesting it can be gratifying and compensate them for other areas of fostering which can be extremely difficult (2006, p. 64). Findings from Rachel, Katrina and Jim’s experiences support this assertion. Evidence from June’s account of *not* experiencing this satisfaction provides a useful contribution to the literature. Findings from her experience, combined with Jim’s experience of progress as motivating, supports Sinclair and colleagues’ (2004) assertion that observing foster child progress may be a crucial element in retaining the motivation to foster.

Strains

Evidence from the present study is consistent with previous assertions that fostering is a challenging and complex task (CYFS, 2007; Golding, 2006; Nutt, 2006; Sinclair et al., 2004; Stevenson & Hamilton-Giachritsis, 2006). The strains described in this study are largely consistent with those described in studies of carers fostering children without attachment difficulties (CYFS, 2007; Farmer et al., 2004; Golding, 2003; Lawrence, 2008; Nutt, 2006; Schofield & Beek, 2005; Sinclair et al., 2004; Wilson et al., 2000). They are also closely aligned with those reported from Wells’ 2004 study of New Zealand foster carers fostering children with mental health issues. Like participants in the present study, Wells’ participants described the “in your face” nature of foster children with mental health difficulties, and explained that trying to meet their needs was “exhausting” (2004, p. 187). They commonly expressed being worn down by their children’s complex needs, as indicated by one carer in this extract:

“It’s the intensity which is so demanding, you know she just wore down her caregiver, she was one of those kids who was just too close, too loud, too much.”
(Wells, 2004, p. 187).

This similarity in findings may indicate cross-over between the experiences of carers fostering children with other mental health issues and those fostering children with attachment difficulties.

Prior studies have suggested that fostering children with attachment difficulties can be particularly stressful, challenging, overwhelming and difficult (Golding, 2006, 2008; Howe & Fearnley, 2003). The accounts of the carers in the present study testify to the difficult and complex nature of the task. Findings from this study are consistent with the literature that

fostering children with attachment difficulties can take a particularly high emotional toll on carers (Golding, 2006, 2008; Howe & Fearnley, 2003; Nutt, 2006). As has been previously alluded to, (Golding, 2006, 2008; Howe & Fearnley, 2003), carers in this study described having felt helpless, hopeless, and incapable of fostering the children with attachment difficulties. As has been previously identified (Golding, 2006, 2008; Nutt, 2006; Sinclair et al., 2004), carers described feeling overwhelmed and emotionally drained by their children's difficult behaviour and need for constant monitoring. This could also negatively impact the time and resources they had available for their own families. These findings suggest that the emotional impact of fostering these children is great, and carers fostering these children may be at particular risk for experiencing emotional distress and burn-out.

Evidence from this study suggests that the strains of fostering are cumulative, steadily building up over time to wear caregivers down. This suggestion has also been made by other studies (Nutt, 2006; Sinclair et al., 2004; Wells, 2004). Sinclair and colleagues' large-scale study of British foster carers suggested that carers can frequently be strained by daily hassles as well as by major traumatic events (such as allegations):

“Daily ‘hassles’ – the unfriendly comments of neighbours, the problems of transporting different children to different places, the need to provide reports – and numerous other undramatic but wearing experiences may also place a strain on the foster carer” (Sinclair et al., 2004, p.194).

Carers in the present study frequently described daily hassles (such as children lying, stealing, and refusing to do what they were told). These difficult daily incidents, while manageable in isolation, built up over time and eventually caused foster carers significant strain. June cited this gradual build-up of strains as one of the key reasons she ceased fostering Aleisha. The carers rarely discussed being strained through the major fostering-related events described by Sinclair and colleagues. On this basis, the present study extends Sinclair and colleagues' assertion and suggests that cumulative stress from small difficulties, rather than major traumas, most heavily impacts carer stress levels on a daily basis. While traumatic events undoubtedly impact carers, the present study suggests that carers are more likely to be suffering stress stemming from daily niggles than from major traumatic fostering-related events. Carers are likely to benefit from

support and training efforts which focus on helping them manage daily practical and behavioural challenges, as well as traumatic events.

Family Impacts

Evidence from this study is consistent with previous assertions that fostering has a major impact on the whole family, including marriages and parent-child relationships (Nutt, 2006; Sinclair et al., 2004; Wilson et al., 2000). As described in previous studies, carers who were parenting their own children alongside their foster children had difficulty balancing the children's needs, and often prioritised the foster child's needs (Nutt, 2006; Sinclair et al., 2004). The foster children's complex needs and need for constant monitoring impacted the time and resources carers had available for their own children. Rachel expressed feeling guilty about the impact of fostering on her own children, and described fearing she may eventually need to give up her foster son in order to protect her own children. This is consistent with previous findings that carers may feel forced to choose between their foster child and their own children, and that the impact of fostering on the family can be a major determinant of placement breakdown or continuity (Farmer et al., 2004; Sinclair et al., 2004). Katrina's account of her foster child's jealous presence limiting her opportunity to show physical affection to her birth children also supports assertions that fostering impacts the interactions and relationships in the family (Golding, 2008; Nutt, 2006).

Theme 3: Attachment Relationships and the Benefits of Information

As has been found in previous studies, some carers in this study entered fostering expecting to be loved or appreciated by their foster children (Golding, 2008; Nutt, 2006). Because children with attachment difficulties often take a long time to show signs of forming meaningful relationships with their caregivers, carers in this study described feeling like they were in one-sided relationships which were only becoming mutual over time. Jim's foster daughter frequently behaved as if Jim and his wife were nothing to her, despite the deep investment they had made in her. Jim's pain and disappointment about this is consistent with assertions that carers can feel disappointed or demoralised when their foster children do not invest in the relationship (Nutt, 2006; Golding, 2008). Despite this unequal nature of

relationships, evidence from this study is consistent with previous assertions that carers can form very bond with, and become deeply invested in, their foster children (Nutt, 2006). The depth of feeling carers in this study showed towards their foster children provides promising evidence that foster carers can forge warm and caring relationships with children with attachment problems.

Findings from the present study support assertions that bonding with foster children can leave carers vulnerable to experiencing emotional strain (Nutt, 2006). Carers in the present study were aware of this potential risk, and exercised conscious control over how emotionally involved in their foster children they became. As in other studies, carers described choosing to push foster children away for self-preservation (Murray, 2007; Nutt, 2006). Rachel avoided investing in Conner until she knew he was staying, and Katrina decided to distance herself from Dylan. This is consistent with assertions that carers negotiate the dilemma of attachment versus nonattachment while fostering, deciding how attached to get (Nutt, 2006), and that rates of emotional investment can vary from carer to carer (Dozier, 2005).

Katrina's account supports previous claims that children with attachment difficulties may cause their foster carers to emotionally withdraw from them, in an attempt to avoid feeling drained and consumed (Golding et al., 2006a; Howe & Fearnley, 2003). Her experience also supports claims in the literature that children with attachment difficulties can push their new foster carers into parenting them in a way which echoes the responses of their original caregivers (Golding, 2006; Stovall & Dozier, 2000, 2004). Katrina's experience suggests that withdrawing from these children for self-preservation does reduce carer strain. Unfortunately, carer withdrawal compromises their abilities to care for the children in a warm, responsive manner. Given that experiencing warm, responsive care is crucial to the development of children with attachment disorders (Golding, 2006, p. 337, 2008), efforts to minimise carer withdrawal must be taken. These are outlined in the implications section.

The Impact of Information

Jim and Katrina both described positive impacts of receiving information about attachment difficulties, which significantly decreased their strain and accelerated their foster children's progress. Learning about attachment problems helped Katrina understand Dylan and attribute his behaviours to his difficulties rather than deliberate malice. This prompted her to reinvest in the caring relationship. It also helped Jim develop coping strategies for working with

Mere. The findings of this study are consistent with Golding's (2008) assertions that understanding attachment can reduce carer frustration and feelings of failure; increase their empathy for and understanding of the child; decrease emotional strain which stems from attributing the child's behaviour to deliberate malice; and provide hope for the future as they realise their potential for helping the children develop positively.

Both Katrina and Jim were angry with CYFS for not providing them with information about attachment when they commence fostering, as they felt the information would have made their journey far easier and accelerated their foster children's progress. While neither of their foster children were diagnosed with RAD when they began caring for them (and therefore their expectations of being prepared for this by CYFS may be considered extensive), their belief that all carers should receive this information has implications for social policy and practice.

Theme 4: Impact of Others on the Caring Experience

Findings from the present study support assertions that carers believe members of the public do not understand their experiences (Nutt, 2006; Wells, 2004). The findings are particularly similar to those of Wells (2004), who found New Zealand carers fostering children with mental health issues felt only other carers could understand their situations. The negative public judgement that all three female carers in the present study described experiencing has also been described in previous studies. Wilson and colleagues' 2004 study found that 25 percent of carers have experienced criticism and hostility from others while fostering. Carers' experiences of their children being mislabelled as either normal or naughty because there was nothing visibly wrong with them is also consistent with Dent and Brown's (2006) assertion that attachment difficulties are a "hidden disability" which can be "concealed beneath a veneer of naughtiness and disruption" (p. 64).

Rachel and June's descriptions of feeling personally judged and blamed for their children's difficult behaviour are consistent with previous findings that carers can feel blamed for, guilty about, and embarrassed by their foster children's behaviour (Kolomer, 2000; Nutt 2006; Wells, 2004). June's experience of finding situations in which she could be judged stressful and anxiety-provoking supports assertions that public judgement can heavily influence carers' daily interactions (Nutt, 2006; Wilson et al., 2004). However, evidence from this study did not support Golding's (2006) assertion that feelings of blame and responsibility can

undermine carer's abilities to effectively foster children with severe attachment difficulties, as carers did not describe their experiences of public judgement impacting their fostering abilities.

As has been shown in previous studies, lack of public understanding and public judgement influenced the social relationships of the carers in the present study (Murray, 2007; Nutt, 2006; Wells, 2004). Studies have suggested that carers find it easier to be friends with other foster carers, because they understand the fostering experience; have been in the same position; and do not judge (Nutt, 2006; Wells, 2004). This was evident in Rachel and June's cases, in which June described turning to other carers for friendship and support and Rachel described only taking her children to visit friends who were foster carers, to avoid being judged or misunderstood by her other friends. Carers in previous studies have also described severing ties with friends who failed to support them; being rejected by friends once they began fostering; feeling isolated by fostering and losing friends through fostering (Murray, 2007; Nutt, 2006; Wells, 2004). These themes were evident in Rachel and June's accounts, in which Rachel described no longer being invited to social events and June described losing friends through fostering Aleisha.

Jim, the only male carer in the present study, did not report experiencing public judgement (although he did experience lack of public understanding). The reason for this is unknown, but it may be linked to his gender. While it could also be linked to Mere's Māori ethnicity, this appears less likely as Jim did not mention Mere's cultural background influencing his experience or approach to fostering. While Jim may not have experienced public judgement, the pervasiveness of judgement in the experiences of other carers fostering children with attachment difficulties (both those in this study and described in the literature [Golding, 2006]) suggests this is unlikely. Future research ought to gather male perspectives surrounding this issue.

Theme 5: Negative Expectations and Future Concerns

Negative Expectations

Evidence from this study suggests carers can hold negative expectations about their foster children's future behaviour, which they perceive as inevitable and act to mitigate. Despite extensive searching, no other studies which explored this phenomenon could be located. The

findings of the present study may have implications for both the development of foster children with attachment difficulties and their relationships with their foster carers.

By acting to mitigate assumed future behaviours before they happen, carers may be limiting their foster children's opportunities to independently engage in positive behaviour. This may increase the likelihood of negative behaviour due to a lack of alternative behaviours in child's repertoire (see Figure 6 below). According to the proposed model, negative carer expectations and mitigating assumed future behaviours may actually function to *increase* the amount of negative behaviour the child exhibits when left to act independently. Carer expectations of negative independent behaviour will remain, as they are reinforced by experiences of negative behaviour and unchallenged due to a lack of independent positive behaviour. Thus, the present study tentatively suggests that negative expectations of foster children's future behaviour may form the basis of a self-fulfilling prophecy of negative child behaviour. Negative carer attitudes may also negatively impact the child's development, and decrease carer satisfaction with fostering.

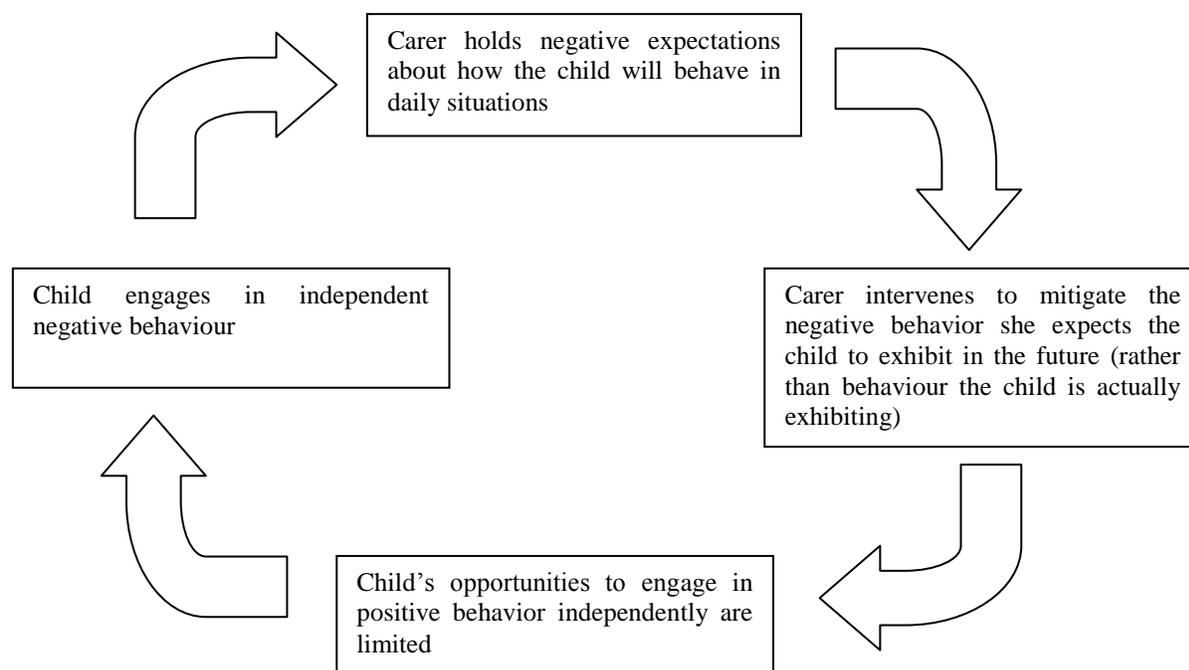


Figure 6: Proposed Relationship between Negative Expectations and Negative Behaviour

Mitigating children's expected behaviour, as outlined in the figure above, is not necessarily negative or unreasonable. Most parents learn to anticipate their children's behaviour

and intervene before they get into serious trouble (for example, asking children to be gentle while holding a baby), and this can be an effective parenting strategy. It is also possible that the complex needs and difficult behaviours of children with attachment difficulties children may render negative behaviours a reasonable expectation for carers. However, evidence from this study suggests that carers may be over-applying the principle, expecting their foster children with attachment difficulties to behave negatively in most situations (rather than just dangerous ones). If this is the case, carers' expectations and actions to mitigate future behaviours may be inadvertently increasing rather than decreasing the rate of negative behaviour their foster child engages in. Negative carer attitudes may decrease carer satisfaction with fostering, and also negatively impact the children's development. While the present study has provided useful initial evidence of negative inevitability, the phenomenon requires further investigation.

Future Concerns

The present study supports previous assertions that carers can have significant concerns about the future (Nutt, 2006; Sinclair et al., 2004). Three of the four carers in the present study expressed these, which included concerns about the child's future; the family's future; the sustainability of the placement and the future of the carer after placement breakdown. Specific concerns about balancing the needs foster children and birth children (described by Rachel and Katrina), and perhaps being forced to choose between the wellbeing of the family versus the foster child (described by Rachel), have been described in previous studies (Nutt, 2006; Wilson et al., 2000). June's concerns about her own future and lack of personal direction following placement breakdown are consistent with existing literature which suggests that carers derive a prominent part of their identity from fostering, which can become "crucially bound up with the children" (Nutt, 2006, p. 100; Sinclair et al., 2004). Her experience supports assertions that carers can feel confused and upset when this identity changes, and find themselves questioning their identities (Nutt, 2006; Sinclair et al., 2004). It also supports previous assertions that placement breakdown negatively impacts carers (CYFS, 2007; Howe & Fearnley, 2003; Nutt, 2006; Sinclair & Wilson, 2004)

As pertained to the inevitability theme, negative expectations about the future of foster children with attachment difficulties are not necessarily unfounded. Previous studies have shown that adults who were in care as children are over-represented in mental health, unemployment,

drug use and prison statistics, and are at major risk of having their own children placed in care (Nutt, 2006; Sinclair et al., 2004; Tarren-Sweeney & Hazell, 2006; Wilson et al, 2000). Despite this, the present study suggests that concerns about the future caused significant anxiety to three carers in the present study.

Evidence from the present study suggests that negative expectations of the children's behaviour and concerns about the future may be causally linked. While the three carers who held negative expectations about their children's behaviour also worried about the future, Jim, the fourth carer, did neither. Jim did not speak with the same tone of negative inevitability, except while discussing the negative things he believed would definitely have happened to Mere had she not come into his family. While he admitted he had worried about Mere's future early in her placement, Jim stated he was gradually beginning to see a brighter future for her as she progressed and met goals he had set for her. Jim's experience shows that negative carer expectations are not inevitable or permanent. It also suggests that monitoring and focussing on the child's successes may reduce carer strain, and increase carer hope about both fostering and the child's future. Future studies should address ways to help foster carers maintain positive expectations while fostering children with attachment difficulties, as this may contribute to minimising their concerns about the future.

Limitations of the Present Study

The present study exhibits a number of limitations which may be improved on in future studies. Firstly, the study is limited by current uncertainty regarding the conceptualisation of attachment disorders and attachment difficulties. Many have argued that attachment theory, attachment disorders and their subtypes are not clearly conceptualised or defined (Barth et al., 2005; Tarren-Sweeney, 2007). As O'Connor and Zeanah have stated, "Despite more than 20 years since the establishment of "disorders of attachment" there is still no consensual definition or assessment strategy; nor are there established guidelines for treatment or management' (2003, p. 241). This lack of clarity surrounding the definition and diagnostic criteria for attachment disorders or attachment difficulties may have influenced the validity of the screening measure, and made it possible that carers in the study may not have cared for children with attachment difficulties (and thus not experienced the phenomenon of interest).

Previous studies have avoided addressing attachment difficulties because of the lack of a clear, unified definition (Sawyer et al., 2007; Wells, 2004). However, the present study sought to address this possible limitation as much as possible by using a combination of the DSM-IV-TR criteria (2000), Zeanah's proposed revision to those criteria (2010), and the ACC. The screening measure also allowed for the possibility of there being two distinct RAD types, or one mixed type. The comprehensive nature of the screening measure is likely to have maximised the likelihood that only carers who had fostered children with severe attachment difficulties were included in this study. It also increases the ability of this study to remain current as conceptualisations of attachment evolve, particularly with the upcoming release of the DSM-V.

A second limitation concerns the fact that the limited timeframe of this thesis prevented the researcher from being able to take the identified themes back to the participants for feedback, extension and correction. "Taking-back" could have increased the robustness of the findings of this study. Further, larger-scale studies are likely to benefit from this approach. Finally, a further limitation concerns the validity of the data collection and analysis. The founder of Interpretative Phenomenological Analysis has asserted that "an IPA analysis is only as good as the data it is derived from" (Smith, Flowers & Larkin, 2009, p. 180). However, the sound interview skills and carer-led approach are likely to have maximised the possibility of collecting and recording data effectively. Carers were open with the researcher and shared many profoundly personal insights, which suggests the data collection methods were effective.

Strengths of the Present Study

The reflection of carer understanding is a strength of this study. This study appears to be the first which directly approached carers to ask about this experience, and this represents a useful starting point for understanding the experience of fostering children with attachment difficulties. The researcher took active steps to avoid constraining the data the participants gave, asking open questions and following participant cues regarding the direction of the interview. The researcher consciously attempted to present carer voices in this study as genuinely and accurately as possible, so that the findings of this study would be largely carer-driven rather than researcher-driven. This approach has resulted in a write-up which the researcher hopes honours the perspectives of participants.

The structured approach to data analysis is a further strength of the study. The data analysis procedure was rooted in IPA, and followed a system of discrete steps. Those steps were derived from the work of IPA's founder, as well as other leading qualitative researchers. This gave the qualitative procedure distinct guidelines, described in the method section, which can be re-used should other researchers desire to replicate the procedure. Applying the same steps to all four accounts ensured they all received the same depth of analysis. The data analysis in this study was carried out extremely carefully and in great detail, over a period of two months. This thorough analysis was an asset to this study.

Finally, the present study included the voice of a male carer. Given the lack of research focus on male carers, Jim's inclusion within this study gives unique insight into the world of a male carer fostering children with attachment difficulties. The fact that Jim was included in such a small sample is unusual, as the voices of male carers are largely unheard in the fostering literature. Further studies should also seek to include the voices of male carers, because of their unique insights and understandings.

Implications for Social Policy and Practice

Findings of the present study, combined with findings from the literature review, have implications for social policy and practice. The first of these concerns the provision of information to foster carers.

Need for Information before Beginning Fostering

Findings from the present study suggest that carers may enter fostering with unrealistically positive expectations about fostering and their foster children, which leave them vulnerable to experiencing shock, disappointment, grief, and feelings of inadequacy when they realise the reality of fostering. Evidence from this study suggests that carers' unrealistically positive expectations were largely founded upon information they received from child welfare agencies. As shown in the *Expectations versus Reality* theme, carers find fostering more difficult when they are not given comprehensive information about their foster children and the fostering experience. The present study suggests that carers would like to have been made more aware of the challenges they would face while fostering, and given accurate information about

their potential foster children's difficulties. Potential carers may benefit from receiving more information about the strains and satisfactions of fostering during induction training, which may help them develop realistic expectations of fostering and render them better prepared to begin fostering.

As the amount of potential foster carers in this country decreases, and the percentage of foster children with complex needs increases, child welfare agencies face a crisis in care (Wells, 2004). They face the dual challenge of recruiting high numbers of carers (to maximise the chances of placement best-fit), while also preparing them adequately and inspiring them to begin fostering. Providing carers with balanced information about both the positive *and* negative aspects of fostering could potentially prepare them for fostering's reality, while also drawing their attention to possible positives and encouraging them to foster. Providing accurate information about these challenges, alongside tools and supports the carers can utilise, may leave carers both informed of the challenges they face and aware of the supports they can access while facing them. It may also contribute to better relationships between foster carers and social service agencies, as the frustration and anger about being provided too little information described by participants in this study could be avoided.

Even when accurate information *is* provided, carers are still likely to experience shock and other emotions about the reality of fostering and the impact it will have on their lives (Nutt, 2006). While nothing can completely prepare caregivers for fostering, social workers and fostering agencies providing accurate information about the experience, the children and the supports would give caregivers the best possible chance at being prepared to foster, and leave them feeling better supported by social service agencies.

Need for Information and Training about Attachment Difficulties and How to Manage Them

This study asserts that carers fostering children with attachment difficulties benefit from receiving information about attachment difficulties and how to manage them. Receiving this information appears to make fostering these difficult children easier, reducing carer strain and increasing progress rates for the children. It also helped carers in this study understand and love their foster children, despite their attachment difficulties. Receiving information prompted one previously withdrawn carer to reinvest in the caring relationship, which has positive implications for child and carer outcomes. The positive impact of receiving information on carers in this

study, combined with their observations of how the information benefited both them and their foster children, provides support for Richardson and Lelliott's assertion that:

“There is a real need for foster carers to have training in understanding the mental health problems that may arise for these children and young people (with attachment difficulties).” (2003, p. 2254).

The findings of the present study support assertions that carers fostering children with attachment problems should receive specialised support and training to care for this population (Golding, 2006, 2008; Dozier, 2005). Murray's New Zealand study suggests that carers are eager to receive information about attachment. Nearly 25 percent of carers interviewed expressed wanting information about how attachment impacted behaviour, and how to best support children with attachment problems (2007). Evidence from this study suggests that most foster children with attachment difficulties enter their placements before being diagnosed. Providing all carers with this information, regardless of whether their foster child has been diagnosed with attachment difficulties, is potentially a simple and economically viable way to improve experiences and placement outcomes for carers and children, and ensure carers received the information they may need. The information may decrease carer strain, which may in turn reduce the rate of placement breakdown. Social workers and mental health clinicians are in excellent positions to provide this information.

Golding (2006, p. 10, 2008) has written about the support and training needs of carers fostering children with attachment disorders. She asserts carers should be trained to manage the difficult, abnormal and traumatised behaviours of these children; to understand the child's pre-placement experiences; to maintain empathy for the children in the face of their “nearly intolerable behaviour”, providing a secure emotional relationship and to interpret the child's difficult behaviour as motivated by attachment issues, rather than deliberate malice. Evidence from carer experiences in the present study suggests that training covering these areas would be warmly received by carers, and would enhance the caring experience.

Public Awareness Ramifications

Findings of the present study suggest that public judgement and lack of public understanding compound the difficulties of fostering children with attachment problems. Public judgement appears to stem from lack of understanding about attachment problems and fostering. The findings of this study suggest there is a need to increase public awareness about both attachment problems and the challenges of fostering. Increasing public awareness about attachment difficulties could potentially remove major stumbling blocks for both carers and children, as the children would they would become better understood (much like children with ADHD have recently become). Making this “hidden disability” visible could potentially increase public understanding of carers and children in this situation, and increase the likelihood of carers receiving understanding and support from people in their environment (rather than just from other carers). Increasing public awareness of the challenges of foster care may also contribute to improving public perception of foster care, which is currently perceived as a low-status profession in New Zealand (Lawrence, 2008).

Professionalism / Therapeutic Foster Care Debate

Findings from this study can also help inform the current debates about whether foster care should be professionalised in New Zealand (Lawrence, 2008; CYFS, 2007). While carers in this study did not specifically express views about that issue, the strains they described encountering while fostering children with attachment difficulties supports claims that fostering is a difficult undertaking (Nutt, 2006; Wilson et al, 2000). Fostering children with attachment difficulties appears to be a different and more complex experience from fostering those without attachment difficulties (Howe & Fearnley, 2003; Golding, 2006; Golding, 2008). Without incentives to begin fostering children with attachment difficulties, the crisis in care and difficulties finding appropriate placements for these children are likely to persist.

Findings from this study, combined with those from other studies, provide rationale for Lawrence’s proposed tiered model of foster care, in which carers are paid differently according to the difficulties of the child they are caring for and their own personal qualifications (2008). While some have argued that paying carers may cause some individuals to become involved in fostering purely for financial reasons (CYFS, 2007; Nutt, 2006), evidence of the strains carers

experience (as outlined in this study) suggest these people would be deterred from doing so. Because experiencing warm, stable caregiving is crucial in promoting the wellbeing of children with attachment difficulties, all possible steps to maximise the likelihood of them receiving this ought to be taken. Tiered professionalisation, as one of these steps, should perhaps be considered.

Support Implications

A final implication of this theme arises from Rachel's assertion that the busyness of her daily fostering life prevented her from fully processing her personal reaction to the reality of Conner's difficulties. This finding draws attention to the fact that carers may be too busy to process emotional events or realise their need for support. These supports should be offered to all carers, regardless of their expressed need. Social services must also work closely with carers to identify potential distress and signs of burn out.

Secondly, as has been asserted in previous studies (Murray, 2007; Nutt, 2006; Sinclair et al., 2004), carers often find solace and support through their interactions and friendships with other carers. Carers should be made aware of support groups and associations in their area, so they have easy access to other carers should they wish to meet them

Future Research Directions

The historic bias towards exploring child experiences of fostering has left us with a sound literature about the effects of fostering on children. However, impacts on carers remain less understood. Given that New Zealand and other countries currently face crises in care (Wells, 2004; Nutt, 2006), and that greater understanding can prompt more informed interventions, further research which explores and presents carer perspectives is needed. This research is likely to provide a more solid empirical base from which more effective carer supports can be designed. These may be effective in helping increase carer retention and recruitment rates, and decrease rates of placement breakdown.

Given the high prevalence of attachment difficulties within the foster care population; the complex needs of these children; the challenges they present to both foster carers and the care system; and the strains their carers experience, further research about the experiences of carers

fostering children with attachment difficulties is needed. Because experiencing stable, long-term, responsive caregiving is crucial to the development of children with attachment difficulties, it is important to maximise the likelihood that they will receive that care. Increased understanding of their carer experiences is likely to prompt development of better-informed, evidence-based interventions which can support carers in delivering that care. Effective supports are also needed to reduce personal strain on carers.

While this study sheds light upon the experiences of non-relative carers fostering children with attachment problems, the experiences of kinship carers fostering these children remain unexplored. Kinship carers were not included in the present study because IPA studies rely on interviewing groups who have experienced the same phenomenon of interest, and evidence suggests that kinship carers and non-relative carers experience fostering very differently (CYFS, 2007; Kolomer, 2001). Given that kinship carers comprise over 50 percent of carers in New Zealand (CYFS, 2007), and kinship is the most common form of foster care in many countries, future studies should explore their experiences of fostering children with attachment difficulties.

Evidence from one male foster carer, presented in this study, suggests that male experiences of caring may be quite different to female experiences. The voices of male foster carers have been largely marginalised in the literature (Maclay et al., 2004; Nutt, 2006). Future studies ought to seek to highlight the perspectives of these men, and explore how their experiences of fostering compare to female perspectives. Gathering perspectives of Maori and Pacific carers in future research will also be important.

Finally, the present study suggests that receiving information about attachment difficulties makes fostering these children easier for carers, and accelerates the children's rates of progress. Future research should respond to this expressed need, designing and trialling attachment resources given to this population. These resources should be evidence-based and accessible for carers with no prior knowledge of attachment, and need to outline both what attachment difficulties are, how children with them may behave, and how those children can best be managed and supported. Future studies should directly approach carers in this situation to find out what information has been most useful for them. These studies may benefit from liaising with a panel of carers for feedback about the resources as they are developed.

Conclusion

The present study provides a useful introduction to what the experience of fostering children with attachment difficulties is like for non-relative carers. It is hoped that this detailed exploration of the experience will help generate interest in this field; contribute to the foundation of a solid research base about this topic; and help inform practice-based responses towards carers engaged in the unique experience of fostering children with these highly complex needs.

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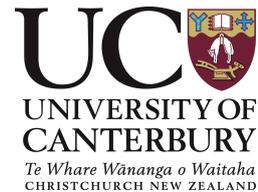
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Information Sheet



FOSTER CARING FOR A CHILD WITH ATTACHMENT PROBLEMS: INTERVIEW STUDY

What is the study trying to find out?

We are trying to learn what it is like to care for children with particular kinds of emotional problems that are called 'attachment problems'.

Am I eligible to contribute to the study?

We are looking to recruit foster carers who have previously cared for (or are currently caring for) a child with particular kinds of attachment problem, who was not related to them.

What would I do if I agreed to participate?

First, we would determine if you have cared for a child with an attachment problem by getting you to fill out a screening questionnaire. If we determine that you have cared for a child with these particular difficulties, you will participate in an interview that will be recorded on a digital voice recorder. The interview can be in your own home or at the University, whichever suits you, at whatever time you like.

How long will it take?

The screening questionnaire will take around 20 to 30 minutes to complete, and the interview will run for about an hour.

Can I refuse to answer certain questions, or withdraw from participating in the study?

Participation in the study is totally voluntary, so you are free to refuse to answer specific questions or to withdraw from the study at any time (without giving a reason). If you choose to withdraw from the study at any time, any information you had provided would also be withdrawn.

What will we talk about in the interview?

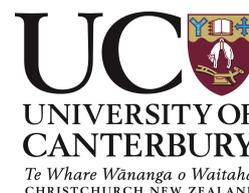
The researcher will ask about your experience caring for a specific child who had/has these particular relationship difficulties, including your feelings and thoughts about this child while you were caring for him/her. You will not be asked to identify the child. You will be able to tell the interviewer anything you feel was important about your experience. You may guide the interviewer away from discussing experiences if they are too distressing. Counselling support can be offered to you if you find that the interview has provoked unpleasant feelings or other distress.

This project has received ethical approval from the University of Canterbury Human Ethics Committee.

Complaints may be addressed to:

Dr Mike Grimshaw, Chair, Human Ethics Committee
University of Canterbury
Private Bag 4800, CHRISTCHURCH

Telephone: 364 2390



How will the researcher make sure the information I provide remains confidential?

The researcher, Nicola McDonald, is the only person who will know your identity. All information that you provide (including recording of the interview) will be kept in the strictest confidence, stored in a locked filing cabinet and a password-protected computer. No identifying details will be included in the final written thesis, and pseudonyms will be used to keep your identity confidential. At the end of the project all recorded information will be kept securely and then destroyed.

How will the study be written up?

The study will be written up as a Master's thesis, which will be a publicly accessible document through the University of Canterbury Library Database.

What can I do if I have questions?

If you want to know more about this study (either now or at a later date), please feel free to contact either the researcher or her supervisor.

Thank you for considering participation in this study!

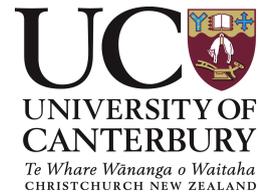
Researcher: Nicola McDonald (Master's of Child and Family Psychology student)
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 University of Canterbury

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Consent Form

FOSTER CARING FOR A CHILD WITH ATTACHMENT PROBLEMS: INTERVIEW STUDY

- I have read and understood the attached information sheet, and I have been given an opportunity to ask the researcher questions. I understand what is involved for the participants.
- I understand that the study will be written up as a Master's thesis, which will be publicly accessible via the University of Canterbury Library database.
- I understand that all information I give will be confidential, and that the final written thesis will not contain any identifying details. The information will only be available to the researcher, her supervisor and myself.
- I understand that I can withdraw from the study at any time, including the withdrawal of any information I have provided.
- I understand that the interview may bring up emotive content as I reflect on my caring experience. If this happens, I understand that researcher will do everything possible to handle the situation sensitively and refer me to support if I wish.
- I am willing to take part in the study as described in the attached information sheet.

I _____ (please print name) agree to participate in the foster carer interview study described in the attached information sheet.

Signature _____

Date _____

This project has received ethical approval from the University of Canterbury Human Ethics Committee.

Complaints may be addressed to:

Dr Mike Grimshaw, Chair, Human Ethics Committee
University of Canterbury
Private Bag 4800, CHRISTCHURCH

Telephone: 364 2390

**FOSTER CARING FOR CHILDREN WITH
ATTACHMENT PROBLEMS STUDY:
SCREENING MEASURE**



This questionnaire will help determine if you have cared for a child with specific types of attachment problems. The following two paragraphs are written about children with attachment problems, from the perspectives of their foster carers. Please read the paragraphs carefully and think about whether you have cared for any children who behaved similarly to Joey, similarly to Samantha, or showed a mixture of the behaviours presented by both children.

Example 1: Joey

Joey had difficulty starting or responding to social interactions. He never sought comfort from me or any other adult if he was upset. If I ever tried to comfort or support him, he would physically withdraw from me, push me away, or become more distressed. He seemed to be sad, irritable or scared much more often than he was happy. Joey was often withdrawn, and sometimes seemed really high strung and constantly on the alert. I could never tell how Joey would act towards me: sometimes he would approach me and want me but other times he would ignore me and totally avoid me. He acted like he didn't want me or anyone else to take care of him.

Example 2: Samantha

Samantha acted like her relationship with me was the same as her relationships with strangers; nothing different or special. She would wander away from me in public, and never think to come and check back with me. Sam never got scared if she was "lost" like other kids; she'd just find someone to talk to. She often went up to strangers and acted like she had known them for ages. She trusted them to look after her and would walk off with them if they let her. Sam would get really upset when the stranger left (like most normal kids do when their Mum leaves). If she was sad or hurt, Sam sought comfort from anyone near her; it didn't have to be me. I felt she didn't see me as a base for her; she lived as if she was attached to everyone, not just me.

PLEASE INDICATE IF YOU HAVE CARED FOR A CHILD WHO:

- | | |
|--|------------|
| 1) Behaved in similar ways to Joey | [] |
| 2) Behaved in similar ways to Samantha | [] |
| 3) Showed a mixture of Joey and Samantha's behaviours | [] |
| 4) Was identified as having attachment problems (eg an attachment disorder) | [] |

If you ticked one of the above boxes, please describe the child you cared for in a few sentences (if you have cared for more than one child who falls into the above categories, please describe the child whose attachment behaviours you considered the most severe).

Please move on to complete the Assessment Checklist for Children (on the next page) for the child you just described. Please ensure you pick the questionnaire appropriate for your caring relationship with that child (depending on whether or not the child is currently in your care). Please do not provide any identifying details for the child except their gender and how old they were when you cared for them.

Once you have finished, please place your responses in the provided postage paid envelope, and send it back to us. Thank you for completing these measures! We will be in touch with you soon.

Yours sincerely,

Nicola McDonald
Child and Family Psychology Master's Student

ACC

Assessment Checklist for Children

PART 1

Here are some statements that describe children's behaviour and feelings.

For each statement, please circle the number that best describes your foster child in the last 4 to 6 months.

- circle 0 if the statement is not true for your foster child in the last 4 to 6 months.
 → circle 1 if the statement is partly true for your foster child in the last 4 to 6 months.
 → circle 2 if the statement is mostly true for your foster child in the last 4 to 6 months.

Please do not check your answers with your child, as they may cause distress or embarrassment.

- | | | | |
|-------|---|-------|--|
| 0 1 2 | 1. Adjusts slowly to changes | 0 1 2 | 42. Lacks guilt or empathy |
| 0 1 2 | 2. Attention-seeking behaviour | 0 1 2 | 43. Laughs when injured or hurt |
| 0 1 2 | 3. Avoids eye contact, except if in 'trouble' | 0 1 2 | 44. Lives in a fantasy world |
| 0 1 2 | 4. Believes he/she is no good at anything | 0 1 2 | 45. Low self-esteem |
| 0 1 2 | 5. Can't concentrate, short attention span | 0 1 2 | 46. Manipulates or 'uses' friends |
| 0 1 2 | 6. Changes friends quickly | 0 1 2 | 47. Play includes violent or frightening themes |
| 0 1 2 | 7. Clingy | 0 1 2 | 48. Possessive, can't share friends |
| 0 1 2 | 8. Complains of not being likeable | 0 1 2 | 49. Precocious (talks or behaves like an adult) |
| 0 1 2 | 9. Craves affection | 0 1 2 | 50. Prefers to be with adults, rather than children |
| 0 1 2 | 10. Dislikes himself | 0 1 2 | 51. Prefers to mix with older children |
| 0 1 2 | 11. Distrusts adults | 0 1 2 | 52. Refuses to talk |
| 0 1 2 | 12. Does not cry | 0 1 2 | 53. Relates to strangers 'as if they were family' |
| 0 1 2 | 13. Does not share with friends | 0 1 2 | 54. Resists being comforted when hurt |
| 0 1 2 | 14. Does not show affection | 0 1 2 | 55. Risks physical safety, fearless |
| 0 1 2 | 15. Does not speak up for him/herself | 0 1 2 | 56. Says friends are against him/her |
| 0 1 2 | 16. Easily discouraged at home | 0 1 2 | 57. Says he/she is "bad", or "no good" |
| 0 1 2 | 17. Easily discouraged at school | 0 1 2 | 58. Secretive |
| 0 1 2 | 18. Easily influenced by other children | 0 1 2 | 59. Seems insecure |
| 0 1 2 | 19. Eats from garbage | 0 1 2 | 60. Startles easily |
| 0 1 2 | 20. Eats things that are not food | 0 1 2 | 61. Steals food |
| 0 1 2 | 21. Eats too much | 0 1 2 | 62. Suspicious |
| 0 1 2 | 22. Fearful of men in general | 0 1 2 | 63. Thinks he/she is someone or something else |
| 0 1 2 | 23. Fearful or nervous at bedtime | 0 1 2 | 64. Thinks other children are better than him/her |
| 0 1 2 | 24. Fears he/she might be molested | 0 1 2 | 65. Too compliant (over-conforms) |
| 0 1 2 | 25. Fears he/she might do something bad | 0 1 2 | 66. Too dramatic (false emotions) |
| 0 1 2 | 26. Fears you will reject him/her | 0 1 2 | 67. Too friendly with strangers |
| 0 1 2 | 27. Feels ashamed | 0 1 2 | 68. Too independent |
| 0 1 2 | 28. Feels worthless or inferior | 0 1 2 | 69. Too jealous |
| 0 1 2 | 29. Finds it hard to make decisions | 0 1 2 | 70. Treats you as though you were the child, and he/she was the parent |
| 0 1 2 | 30. Gets hurt a lot, "accident prone" | 0 1 2 | 71. Tries too hard to please other children |
| 0 1 2 | 31. Gives up too easily | 0 1 2 | 72. Tries too hard to please you |
| 0 1 2 | 32. Gorges food | 0 1 2 | 73. Turns friends against each other |
| 0 1 2 | 33. Has a low opinion of him/herself | 0 1 2 | 74. Uncaring (shows little concern for others) |
| 0 1 2 | 34. Has an imaginary friend | 0 1 2 | 75. Very forgetful |
| 0 1 2 | 35. Has nightmares | 0 1 2 | 76. Wants to be treated like a baby, or a toddler |
| 0 1 2 | 36. Hides feelings | 0 1 2 | 77. Wary or vigilant |
| 0 1 2 | 37. Hides or stores food | 0 1 2 | 78. Withdrawn |
| 0 1 2 | 38. Hugs men, other than relative or male carer | 0 1 2 | 79. Won't attempt new activities |
| 0 1 2 | 39. Is convinced that friends will reject him/her | 0 1 2 | 80. Won't communicate with other children |
| 0 1 2 | 40. Is fearful of being harmed | 0 1 2 | 81. Worries that something bad will happen to <u>yc</u> |
| 0 1 2 | 41. Lacks confidence | | |

Assessment Checklist for Children

PART 2

Please note that the instructions are different on this page.

On this page only

- circle 0 if the behaviour did not occur in the last 4 to 6 months.
- circle 1 if the behaviour occurred once in the last 4 to 6 months.
- circle 2 if the behaviour occurred more than once in the last 4 to 6 months.

- | | |
|--|--|
| <p>0 1 2 82. Asks to be physically punished</p> <p>0 1 2 83. Attempts suicide</p> <p>0 1 2 84. Bites him/herself</p> <p>0 1 2 85. Causes him/herself to vomit</p> <p>0 1 2 86. Causes injury to him/herself
(describe): _____
_____</p> <p>0 1 2 87. Cuts or pulls out his/her hair
(describe): _____</p> <p>0 1 2 88. Cuts or rips his/her clothes
(describe): _____
_____</p> <p>0 1 2 89. Describes how he/she would kill him/herself</p> <p>0 1 2 90. Describes or imitates sexual behaviour</p> <p>0 1 2 91. Distressed by traumatic memories</p> <p>0 1 2 92. Does not show pain if physically hurt</p> <p>0 1 2 93. Extreme reaction to losing a friend, or being excluded by other children
(describe): _____
_____</p> <p>0 1 2 94. 'Flirts' with strangers</p> <p>0 1 2 95. Forces or pressures children into sexual acts</p> <p>0 1 2 96. Has blackouts or periods of amnesia</p> <p>0 1 2 97. Has panic attacks
(when?) _____</p> <p>0 1 2 98. Hits head, head-banging</p> <p>0 1 2 99. Intentionally harms himself with knives or implements (describe): _____
_____</p> <p>0 1 2 100. Intentionally swallows dangerous substance to harm him/herself (e.g. medication, poison)
(describe): _____</p> | <p>0 1 2 101. Kisses with open mouth</p> <p>0 1 2 102. Masturbates at home in view of others</p> <p>0 1 2 103. Masturbates at school, or in public</p> <p>0 1 2 104. Picks at sores or injuries</p> <p>0 1 2 105. Requests to be harmed</p> <p>0 1 2 106. Rocks back and forth
(describe): _____</p> <p>0 1 2 107. Says his/her life is not worth living</p> <p>0 1 2 108. Sexual behaviour not appropriate for his/her age
(describe): _____
_____</p> <p>0 1 2 109. Sexual intercourse with another young person</p> <p>0 1 2 110. Sexual relations with an adult
(describe): _____
_____</p> <p>0 1 2 111. Shows sex parts to children (other than siblings)</p> <p>0 1 2 112. Starts rude conversations, tells jokes about sex</p> <p>0 1 2 113. Talks about suicide</p> <p>0 1 2 114. Threatens to injure him/herself</p> <p>0 1 2 115. Threatens to kill him/herself</p> <p>0 1 2 116. Throws him/herself against walls, onto floors, etc
(describe): _____
_____</p> <p>0 1 2 117. Touches or puts mouth on other person's sex parts</p> <p>0 1 2 118. Tries to involve others in sexual behaviour
(describe): _____
_____</p> <p>0 1 2 119. Unhealthy drinking (e.g. from discarded drink bottle, from toilet bowl)
(describe): _____</p> <p>0 1 2 120. Won't say when physically hurt</p> |
|--|--|

Please make sure you have answered each question on both sides of the page

Child's age when you last cared for him/her:

Child's gender:

Diagnoses/recognised issues of the child:

Your name:

Your address:

Your phone number:

PLEASE FILL IN THIS CHECKLIST IF YOU CARED FOR THE CHILD IN THE PAST BUT ARE NOT CURRENTLY CARING FOR THEM

ACC

Assessment Checklist for Children

PART 1

Here are some statements that describe children's behaviour and feelings.

Try to remember what your foster child's behaviour might have been like during a typical four month period.

For each statement, please circle the number that would best describe your foster child in that period.

- circle 0 if the statement would be not true for your foster child in a typical 4-month period.
- circle 1 if the statement would be partly true for your foster child in a typical 4-month period
- circle 2 if the statement would be mostly true for your foster child in a typical 4-month period.

- | | | | | | | | |
|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 1. Adjusted slowly to changes | 0 | 1 | 2 | 43. Laughed when injured or hurt |
| 0 | 1 | 2 | 2. Attention-seeking behaviour | 0 | 1 | 2 | 44. Lived in a fantasy world |
| 0 | 1 | 2 | 3. Avoided eye contact, except if in 'trouble' | 0 | 1 | 2 | 45. Low self-esteem |
| 0 | 1 | 2 | 4. Believed he/she was no good at anything | 0 | 1 | 2 | 46. Manipulated or 'used' friends |
| 0 | 1 | 2 | 5. Couldn't concentrate, short attention span | 0 | 1 | 2 | 47. Play included violent or frightening themes |
| 0 | 1 | 2 | 6. Changed friends quickly | 0 | 1 | 2 | 48. Possessive, couldn't share friends |
| 0 | 1 | 2 | 7. Clingy | 0 | 1 | 2 | 49. Precocious (talked or behaved like an adult) |
| 0 | 1 | 2 | 8. Complained of not being likeable | 0 | 1 | 2 | 50. Preferred to be with adults, rather than children |
| 0 | 1 | 2 | 9. Craved affection | 0 | 1 | 2 | 51. Preferred to mix with older children |
| 0 | 1 | 2 | 10. Disliked himself | 0 | 1 | 2 | 52. Refused to talk |
| 0 | 1 | 2 | 11. Distrusted adults | 0 | 1 | 2 | 53. Related to strangers 'as if they were family' |
| 0 | 1 | 2 | 12. Did not cry | 0 | 1 | 2 | 54. Resisted being comforted when hurt |
| 0 | 1 | 2 | 13. Did not share with friends | 0 | 1 | 2 | 55. Risked physical safety, fearless |
| 0 | 1 | 2 | 14. Did not show affection | 0 | 1 | 2 | 56. Said friends were against him/her |
| 0 | 1 | 2 | 15. Did not speak up for him/herself | 0 | 1 | 2 | 57. Said he/she is "bad", or "no good" |
| 0 | 1 | 2 | 16. Easily discouraged at home | 0 | 1 | 2 | 58. Secretive |
| 0 | 1 | 2 | 17. Easily discouraged at school | 0 | 1 | 2 | 59. Seemed insecure |
| 0 | 1 | 2 | 18. Easily influenced by other children | 0 | 1 | 2 | 60. Startled easily |
| 0 | 1 | 2 | 19. Ate from garbage | 0 | 1 | 2 | 61. Stole food |
| 0 | 1 | 2 | 20. Ate things that were not food | 0 | 1 | 2 | 62. Suspicious |
| 0 | 1 | 2 | 21. Ate too much | 0 | 1 | 2 | 63. Thought he/she was someone or something else |
| 0 | 1 | 2 | 22. Fearful of men in general | 0 | 1 | 2 | 64. Thought other children were better than him/her |
| 0 | 1 | 2 | 23. Fearful or nervous at bedtime | 0 | 1 | 2 | 65. Too compliant (over-conformed) |
| 0 | 1 | 2 | 24. Feared he/she might be molested | 0 | 1 | 2 | 66. Too dramatic (false emotions) |
| 0 | 1 | 2 | 25. Feared he/she might do something bad | 0 | 1 | 2 | 67. Too friendly with strangers |
| 0 | 1 | 2 | 26. Feared you would reject him/her | 0 | 1 | 2 | 68. Too independent |
| 0 | 1 | 2 | 27. Felt ashamed | 0 | 1 | 2 | 69. Too jealous |
| 0 | 1 | 2 | 28. Felt worthless or inferior | 0 | 1 | 2 | 70. Treated you as though you were the child, and he/she was the parent |
| 0 | 1 | 2 | 29. Found it hard to make decisions | 0 | 1 | 2 | 71. Tried too hard to please other children |
| 0 | 1 | 2 | 30. Got hurt a lot, "accident prone" | 0 | 1 | 2 | 72. Tried too hard to please you |
| 0 | 1 | 2 | 31. Gave up too easily | 0 | 1 | 2 | 73. Turned friends against each other |
| 0 | 1 | 2 | 32. Gorged food | 0 | 1 | 2 | 74. Uncaring (showed little concern for others) |
| 0 | 1 | 2 | 33. Had a low opinion of him/herself | 0 | 1 | 2 | 75. Very forgetful |
| 0 | 1 | 2 | 34. Had an imaginary friend | 0 | 1 | 2 | 76. Wanted to be treated like a baby, or a toddler |
| 0 | 1 | 2 | 35. Had nightmares | 0 | 1 | 2 | 77. Wary or vigilant |
| 0 | 1 | 2 | 36. Hid feelings | 0 | 1 | 2 | 78. Withdrawn |
| 0 | 1 | 2 | 37. Hid or stored food | 0 | 1 | 2 | 79. Wouldn't attempt new activities |
| 0 | 1 | 2 | 38. Hugged men, other than relative or male carer | 0 | 1 | 2 | 80. Wouldn't communicate with other children |
| 0 | 1 | 2 | 39. Was convinced friends would reject him/her | 0 | 1 | 2 | 81. Worried that something bad would happen |
| 0 | 1 | 2 | 40. Was fearful of being harmed | | | | <u>you</u> |
| 0 | 1 | 2 | 41. Lacked confidence | | | | |
| 0 | 1 | 2 | 42. Lacked guilt or empathy | | | | |

Please turn over to complete part 2



Assessment Checklist for Children

PART 2

Please note that the instructions are different on this page.

On this page only

- circle 0 if the behaviour did not occur in a typical 4-month period.
- circle 1 if the behaviour occurred once in a typical 4-month period.
- circle 2 if the behaviour occurred more than once in a typical 4-month period.

- | | | | |
|-------|--|-------|--|
| 0 1 2 | 82. Asked to be physically punished | 0 1 2 | 101. Kissed with open mouth |
| 0 1 2 | 83. Attempted suicide | 0 1 2 | 102. Masturbated at home in view of others |
| 0 1 2 | 84. Bit him/herself | 0 1 2 | 103. Masturbated at school, or in public |
| 0 1 2 | 85. Caused him/herself to vomit | 0 1 2 | 104. Picked at sores or injuries |
| 0 1 2 | 86. Caused injury to him/herself
(describe): _____ | 0 1 2 | 105. Requested to be harmed |
| | _____ | 0 1 2 | 106. Rocked back and forth
(describe): _____ |
| 0 1 2 | 87. Cut or pulled out his/her hair
(describe): _____ | 0 1 2 | 107. Said his/her life was not worth living |
| | _____ | 0 1 2 | 108. Sexual behaviour not appropriate for his/her age
(describe): _____ |
| 0 1 2 | 88. Cut or ripped his/her clothes
(describe): _____ | | _____ |
| | _____ | 0 1 2 | 109. Sexual intercourse with another young person |
| 0 1 2 | 89. Described how he/she would kill him/herself | 0 1 2 | 110. Sexual relations with an adult
(describe): _____ |
| 0 1 2 | 90. Described or imitated sexual behaviour | | _____ |
| 0 1 2 | 91. Distressed by traumatic memories | 0 1 2 | 111. Showed sex parts to children (other than siblings) |
| 0 1 2 | 92. Did not show pain if physically hurt | 0 1 2 | 112. Started rude conversations, told jokes about sex |
| 0 1 2 | 93. Extreme reaction to losing a friend, or being
excluded by other children
(describe): _____ | 0 1 2 | 113. Talked about suicide |
| | _____ | 0 1 2 | 114. Threatened to injure him/herself |
| 0 1 2 | 94. 'Flirted' with strangers | 0 1 2 | 115. Threatened to kill him/herself |
| 0 1 2 | 95. Forced or pressured children into sexual acts | 0 1 2 | 116. Threw him/herself against walls, onto floors, etc
(describe): _____ |
| 0 1 2 | 96. Had blackouts or periods of amnesia | | _____ |
| 0 1 2 | 97. Had panic attacks
(when?) _____ | 0 1 2 | 117. Touched or put mouth on other person's
sex parts |
| | _____ | 0 1 2 | 118. Tried to involve others in sexual behaviour
(describe): _____ |
| 0 1 2 | 98. Hit head, head-banging | | _____ |
| 0 1 2 | 99. Intentionally harmed himself with knives
or implements (describe): _____ | 0 1 2 | 119. Unhealthy drinking (e.g. from discarded drink
bottle, from toilet bowl)
(describe): _____ |
| | _____ | | _____ |
| 0 1 2 | 100. Intentionally swallowed dangerous substance
to harm him/herself (e.g. medication, poison)
(describe): _____ | 0 1 2 | 120. Wouldn't say when physically hurt |
| | _____ | | |

Please make sure you have answered each question on both sides of the page

Child's age when you last cared for him/her:

Child's gender:

Your name:

Your phone number: