Residential Care Workers’ Understanding and Experiences of Their Relationship-Building with the Children in Their Care

By

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Abstract

The purpose of this thesis was to gain insight into caregivers' lived experiences of the relationship building process with the children in their care; and to offer new insight into what works for the treatment of trauma in children who are in care from carers' perspectives in view of supporting good practice and better therapeutic outcomes for both children and caregivers. The first chapter contains a brief introduction describing the wider context of the research and each chapter of the thesis.

In Chapter two, a systematic literature review was conducted to analyse existing studies with variables focused on caregivers' experiences and characteristics. Conclusions from this chapter highlighted that there is scarce literature focusing on caregivers' experiences. In this review, caregivers highlighted a series of barriers and facilitators related to the perceptions and meaning-making of the relationship-building process. Meaning making is a concept widely used in IPA (interpretative phenomenological analysis for qualitative data) and refers to understanding how caregivers in this case, experience, perceive and make sense of their world and lived experiences in their own ways. In general, although it is acknowledged that this is important when working with children, oftentimes its function is not fully understood.

Chapter three consists of the empirical study conducted with six caregivers who agreed to participate in this research. Their experiences and meaning-making of the relationship-building process with the children in their care were analysed. Three superordinate themes were identified: *Relationship-building; The emotional impact on caregivers;* and *Caregiver similar lived experiences: Insight and motivation.* There was a narrative around meeting the practical needs of children and around the challenges that they

experience in building relationships. Participants also spoke of boundaries and their own limitations in terms of knowledge and expertise. In addition, they spoke of how hard they find the role at times but also noted that it could be enjoyable and rewarding. Lastly, there was a narrative around how their own life experiences had impacted on their desire to be a caregiver and there was a perception that past experiences enabled them to be more effective in their roles.

Chapter four focuses on the critique of a psychometric tool used to assess and identify trauma symptomatology in children, the Trauma Symptoms Checklist for Children (TSCC, 2001 Briere). The tool has been widely utilised (1882 citations to date), within academia and practice and has been translated into multiple languages such as Chinese, German, Swedish, Spanish, Korean. This indicates a high level of acceptance of the robustness and rigour of the instrument to assess for childhood trauma within academia, triage, and the professional community despite the limitations generally associated with self-report assessments. The critique revealed important factors related to the relationship-building process. That is, how understanding developmental trauma, attachment, and a child centred relational approach to treating traumatised children will positively benefit the assessment, diagnostic process, and treatment of children.

Chapter five of this thesis combines the overall findings of all the chapters and synthesises these in implications for future research and clinical practice, a general conclusion as well as strengths and limitations.

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Chapter 1

Introduction

“Children need relationships to thrive, traumatised children need relationships to heal…” (Golding, 2010, p. 56).

Children living in care represent one of the most vulnerable populations whose needs have become increasingly complex, misunderstood, and difficult to meet with traditional therapeutic approaches (Butterworth et al., 2017; de Voursney & Huang, 2016; Golding, 2010; Kalluri et al., 2021; Sankaran et al., 2018; Vig et al., 2005). Children who live in care are separated from their families of origin due to having suffered neglect and abuse whilst in the care of their parents and were therefore placed into the care of local authorities. In addition to pre-existing traumas, most of the children are traumatised by the separation from their primary caregiver, regardless of whether they were the source of abuse(Heine et al., 2021) . As a result, when children fail to successfully stabilise and engage meaningfully in an alternative placement (residential or foster), they are at risk of developing cognitive and intellectual problems, neuropsychological and developmental difficulties, severe psychopathology, addictions, and delinquency (Achenbach & Edelbrock, 1981; Baidawi & Piquero, 2021; Mota et al., 2016; Pardini, 2011; Quigley, 2005).

Prior to providing an overview of care provisions and caregivers, this chapter will provide an overview of the needs of children in care with a focus on relational and emotional needs. It will then provide a short overview of trauma informed support.

Children's Needs

According to research, internationally, children in care present with higher levels of needs regarding developmental, behavioural, emotional, social, and educational issues (Steenbakkers et al., 2018) Tarren-Sweeney; 2008;(Townsend et al., 2020; Trout et al., 2008). Furthermore, childhood maltreatment may have an adverse influence on neurological development which may predispose the children biologically and render them more vulnerable to abuse and re-traumatisation (Anda et al., 2006; Chartier et al., 2010). A review conducted with children in residential care suggests that children in care are typically school-aged males with lower-than-average IQ (Harmke Leloux-Opmeer et al., 2016). Many of the children appear to suffer from chronic health problems and many of them are prescribed medication. Difficulties of children in residential care include peer relationships, cognitive difficulties, emotional and behavioural difficulties (Leloux-Opmeer et al., 2016). Whilst it is not possible to determine the exact extent to which social-emotional problems may lead to attachment problems, it is evident that many children in care come from dysfunctional backgrounds (i.e., have experienced issues such as poverty, stress, parental mental illness, delinquency, and addiction) (Hong et al., 2021; Huefner et al., 2007; Reznikovsky-Kuras & Gerasimenko, 2020).

Attachment Needs

It has been established that early experiences of being cared for in the context of the relationship with the primary caregiver provides a template for future intrapersonal and interpersonal relationships patterns (Ainsworth, 1979; Atwool, 2006; Bailey, 2017; Becker-

Weidman, 2006). When safety and security are experienced during early stages of life, and where care is provided without the child having to develop survival strategies, children are more likely to develop a good sense of self-worth (Bowlby, 2008). In the context of security, they are more likely to develop and grow. Conversely, when the relationship is not secure, or in cases of abuse and neglect, where the caregivers are the source of threat, children are at significant risk for developmental trauma, attachment difficulties, and diverse psychopathology (Ainsworth, 1979; Whittaker et al., 2016). Experiencing inconsistent care and neglectful and abusive relationship with the people who are expected to protect and love the children leads to betrayal trauma (Alisic et al., 2014; Armsworth & Holaday, 1993; Bailey et al., 2019; Cook et al., 2005). As a result, children develop paradoxical maladaptive coping mechanisms (to avoid rejection and abandonment) sabotaging the relationship process, which in turn reaffirms their core beliefs about themselves "I am unlovable", "I am not worthy". Whilst attachment difficulties may or may not be the result of exposure to developmental trauma and adverse childhood experiences, it is likely that they contribute to interpersonal insecurity, lack of trust in others, and social ineffectiveness in relationships (Green & Myrick, 2014). There is a high level of comorbidity between attachment difficulties and other mental health problems, emotional difficulties, conduct problems, hyperactivity, and interpersonal problems (Moran et al., 2018).

Attachment theory emphasises the importance of the connection between the child and the caregiver which can affect a child's cognitive and social development (Ainsworth, 1969). Furthermore, the research suggests that the development of the social brain is crucial in the formation of attachment, empathy, social engagement, emotional regulation, and sense of self (Çak et al., 2015; Bassett & Gazzaniga, 2011; Schore,2008, 2017). Caring and supportive relationships exert a significant influence as they are formed, built, and regulated by social interactions. Positive warm relationships promote and contribute substantially to a child's healthy psychological and social development and empathy; while abusive and neglectful experiences have a detrimental impact on child's neuropsychological, behavioural, and emotional development (Etkin et al., 2015; Porges, 2011; Wessells, 2015).

Garcia Quiroga (2017) found that one of the main factors determining children's stabilisation in the care homes and their engagement and acceptance of care was the quality of the relationship between the caregiver and the child. In addition, engagement, sensitivity, affection, and discipline are correlated with positive relationship-building in residential care (Garcia Quiroga & Hamilton-Giachritsis, 2017a). These findings suggest that the relationship with the child is fundamental and that a good environment makes it easier for secure attachment to occur. Caregivers' capacity to relate in a meaningful and positive way with the children in their care is considered extremely important for children's therapeutic processes (Barbosa et al., 2020; Bastiaanssen et al., 2014; Ereky-Stevens et al., 2018). The emotional availability, interconnectedness, and intersubjectivity (shared meanings, subjective states and perceptions of a situation by two or more individuals), as well as caregivers' capacity to mentalise (thinking about one's own thinking to understand others' thinking) is fundamental to the development of a good sense of self, feelings of self-worth and emotional regulation in the child (Ereky-Stevens et al., 2018; Messer et al., 2018).

According to research over 80% of maltreated children develop insecure attachment (Cyr et al., 2010; Finzi et al., 2000; Silva et al., 2024). Children in residential care that have developed insecure attachment often mistrust those around them. They may view the world as unsafe and unpredictable. They may also present with poor emotional, physical, and sexual boundaries and have difficulties with forming meaningful relationships (Toth &

Cicchetti, 2013). Thus, attachment difficulties can present as behavioural dysregulation, challenging behaviours which leads then to be seen as not capable of living in a family environment. These difficulties can affect their engagement with caregivers and the support they receive due to struggles with forming meaningful relationships (Bohnenkamp et al., 2021; Davidson et al., 2011).

Research in the area of attachment difficulties and disorders have highlighted that developmental trauma and emotional dysregulation were common and prevalent in populations with high offending behaviour with 86% of this population having experienced at least one form of abuse and maltreatment and with another 10% suspected of having also suffered one form of maltreatment (Moran et al., 2018; Baidawi & Piquero, 2021; Becker-Weidman, 2006; Cook et al., 2005; Hanson & Lang, 2016). Findings from these studies also revealed that childhood abuse and trauma may not directly determine whether an individual commits an offence and is then involved in the criminal justice system. Whilst it can be stated that not all children who suffer abuse will grow up to commit such offences, unresolved trauma and other factors such as precarious life circumstances and lack of personal resource and poor resilience may constitute a significant push factor to committing offences. Therefore, early interventions aimed at mitigating these negative factors and building resilience, via relational therapy (see below) and therapeutically enabling environments are critical (Carlo, 1988; Ereky-Stevens et al., 2018; Melhuish et al., 2015; Thompson, 2014).

Relational therapy provides a framework to address the relational needs of children in care; promoting healthier relationships, emotional and practical support, can significantly impact children's emotional well-being. There is an emphasis on the importance of relationships in psychological health, making it particularly beneficial for children in care who, as mentioned above, often face complex relational histories, including trauma and attachment disruptions. The therapy involves attempts to repair and develop secure attachments, build relationships in which children feel safe, support self-development of the child, and helping children manage their emotions. It can involve techniques such as reflective listening, play therapy and attachment-based interventions (Golding, 2007; Hughes, 2004).

Trauma Informed Support

Many children in residential care are known to have been exposed to adverse childhood experiences, several types of abuse, chronic toxic stress, and trauma, usually caused by their caregivers, during their critical developmental period. Experiences of abuse, neglect, and violence can lead to the development of complex post-traumatic symptomatology and severe emotional dysregulation (Briggs et al., 2012). According to Colborn et.al, (2021), the integrated four streams of trauma theory (in development) include a set of treatment recommendations, one of which is therapy for post-traumatic stress symptoms and unhealthy accommodations to trauma (Colburn et al., 2021; Rivard et al., 2014). This includes strategies for healthy relationships, prosocial connection with peers, using cognitive behavioural techniques and psychoeducation for both caregivers and children about: empathy, problem solving, management of low mood and anxiety, and emotional regulation (Collier & Bryce, 2023).

The creation of and implementation of trauma informed support and guidance within residential care homes are essential to support the children in their trauma healing and recovery journeys addressing the impact of trauma(Zelechoski et al., 2013). It is suggested that trauma assessments and treatment in isolation are insufficient. The support for children needs to encompass a series of organisational and clinical factors in order to ensure that suitable caregivers are hired, trained, and monitor to establish a solid social system around the child (Heine et al., 2021). There have been several models of trauma informed care that have emerged in recent years and have been implemented in residential care for children successfully. Some of the most popular include Attachment, Self-Regulation, and Competency(Blaustein & Kinniburgh, 2010; Cook et al., 2005; Melhuish et al., 2015), Trauma-Focused Cognitive Behaviour Therapy (TF-CBT; (Cohen et al., 2018); and Structured Psychotherapy for Children Responding to Chronic Stress (SPARCS) (DeRosa & Pelcovitz, 2009). They all share similar components, ensuring physical and emotional safety for children and caregivers, allowing openness and clear communication, building a sense of trust, teaching self-control and emotional regulation skills. In addition, they support children in planning for their future and for staff to work collaboratively regarding daily activities and care of the children (Briggs et al., 2012; Collier & Bryce, 2023).

Nonetheless, little is mentioned about the practical means to achieve these goals and ensure that children’s emotional needs are effectively met. This is not surprising since reviews in this field have revealed that the caregivers’ interventions are mainly reactive to children’s presentation and mainly focused on managing and reducing the challenging behaviour. However, it is likely that the challenging behaviour only represents a means to express and resolve the emotional struggle caused by their past and present traumas. As such, the behavioural approaches can be unhelpful and sometimes counterproductive for the relationship-building process, as it can exacerbate the cycle of rejection and abandonment found within their original traumas. In this sense knowing more about how the relationship-building process is implemented in practice from caregivers' perspective and how to maximise and prioritise this as a vector for change might enhance children's capacity to open up and engage in both direct and indirect therapy.

Provision for Children and the Caregiver Role

There are a series of alternative placements that provide care for children who are removed from their parents; a first choice is usually a foster placement, where a child can benefit from a family home environment, with consistent care and carers. Residential care placements are an alternative to foster care, where children are looked after in a long-term individual or multi-bedded home. Caregivers are paid staff recruited to work 16-to-24-hour shift patterns within residential settings. These shifts involve sleeping in and night patterns to ensure that the children have someone to look after them constantly. The start of children's therapeutic readiness and healing process is preceded by a successful stabilisation process within their placement characterised by social and educational engagement, as well as positive relationship building with the caregivers. It is suggested that when children are considered stable and have a sense of purpose and achievement within a therapeutic enabling environment, children will be protected from further traumatisation and exacerbation of pre-existing traumas caused by abusive and neglectful parenting (Davidson et al., 2011; Ferguson et al., 2022).

A major protective factor, and crucial in the process of a trauma intervention, is that children receive "good enough care" (p. 89 Winnicott, 1987) in their residential placement, and that they are placed within predictable, safe, and therapeutically enabling environments

(Bailey et al., 2019; Hawkins-Rodgers, 2007; Koch & Franzsen, 2017; Kub et al., 2022). In addition to a therapeutically enabling environment, the caregivers' dyadic interactions with the children in their care are crucial for the therapeutic process to be effective. The caregivers' role is to initiate and lead the relationship building process forming a healthy relationship, which then will help the children to be more stable and prepared to undertake direct therapy if their symptoms persist (Fraley et al., 2020; Huscroft-D'Angelo et al., 2017; Mabille et al., 2022; Messer et al., 2018; Sochos & Najla, 2020; Withington et al., 2017).

Therefore, understanding caregivers' perspectives of the relationship-building process and capturing their meaning-making of the function of the relationship are key elements in supporting children in care and for their trauma treatment to be effective. Elucidating factors that may hinder or facilitate the formation of healthy and meaningful relationships will determine how to better support the caregivers to maximise and prioritise these relationships. Caregivers' understanding of the importance of fostering healthy relationships is key to supporting children with severe complex needs, such as emotional dysregulation, mental health difficulties, drug abuse, sexualised/offending behaviours, self-harm, sexual exploitation, delinquency and even suicide (Bailey, 2017; Bettmann et al., 2015; Golding, 2010; Staines et al., 2019).

Whilst there is extensive literature regarding children's experiences with the care system, not enough research has been undertaken with caregivers and their experiences of the care system and the deeper aspects of their role and motivations (Baidawi & Piquero, 2021; Brown et al., 2018; Cameron & Maginn, 2008; Hanson & Lang, 2016; Huscroft-D'Angelo et al., 2017; Steels & Simpson, 2017). Caregivers' involvement and capacity to care and support children who are placed in care is fundamental as their responses to children's complex presentations (emotional and behavioural) can amplify, exacerbate, or neutralise their symptomatology. As such, caregivers become a fundamental basis for the stabilisation process and psychosocial adjustment to the new environment and to the future unknowns. Whilst several different factors will influence stabilisation (e.g., the quality of the carer-child relationship, length of stay, staff ratios), caregivers are an important source of containment, emotional regulation and support for the children. Children would benefit from a responsive, sensitive, understanding, and emotionally available adult to support, contain and regulate their complex emotional presentations (e.g., unexpected anger outbursts, social anxiety, depression) and challenging behaviours (e.g., aggression, violence, sexualised behaviours and exploitation, delinquency) as part of their day to day care (Çak et al., 2015; Geller & Porges, 2014; Molano et al., 2021; Porges, 2009, 2011; Porges et al., 1994; Schore, 2000; Schore, 2017; van der Kolk et al., 2009; Wright & Edginton, 2016).

The quality of the relationship is an essential aspect of the children's therapeutic process (e.g., stabilisation in the placement, emotional regulation, trust, and a sense of safety and security) in preparation for more conventional individual therapy. Therefore, gaining access to caregivers' understanding and implementation in practice of the relational aspects of their support for traumatised children, is crucial in understanding and improving children's emotional well-being and future life outcomes (Kerr & Cossar, 2014; Schore & Schore, 2008; Sochos & Najla, 2020; Tarren-Sweeney, 2008b). Since children (in general) need relationships to thrive, and traumatised children need relationships to heal (Golding, 2007), enhancing the practical implementation of the relationship-building approach when caring for this vulnerable population, as well as focusing on caregivers' understanding of the impact of developmental trauma on children's emotions and behaviours, must become a priority.

Schore and Schore (2008) suggested that there is a *psychobiological core* to the relationship-building process, whereby the caregivers become an attuned nervous system regulator for a child. Within the dyadic parent/caregiver interaction, a series of biological and behavioural factors intertwine to engender the concept of co-regulation. This concept is particularly relevant in asymmetric relationships (e.g., parent/caregiver/therapist and child) whereby a child, who is dysregulated and traumatised, can mirror and attune to an emotionally stable adult, who will serve as a source of calmness and connectedness, so the child can experience a sense of safety. In this sense, support for traumatised children based on relationship-building so that the children can regain trust and safety with caring adults, is paramount. Nonetheless, for relationship-based therapeutic approaches to be effective and for an environment to be therapeutically enabling, the nervous system of a child must detect features of safety in the home environment and the caregiver, parent, or the therapist (Porges, 2007; 2009; 2017; Porges et al., 1994). Porges (2015; 2017) further noted that feeling safe not only requires the absence of threat, but also the presence of safety cues discernible to the nervous system. When these safety cues are detected, a down-regulation of involuntary defences (i.e., fight, flight, or freeze) are vagally stimulated[1] and the social engagement system is activated to support health, restoration, and calm social interactions (Porges, 2009; 2011).

The biopsychosocial framework is fundamental in supporting children's rehabilitation, emotional regulation and recovery; their implementation in practice when training caregivers to use these approaches in their daily interactions with the children through relationship-based approaches can be very effective (Tessitore et al., 2023). The

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[1] This relates to the polyvagal theory. In this context, the term "vagally stimulated" can be defined as the stimulation of the vagus nerve. The vagus nerve is the principal nerve of the parasympathetic nervous system (autonomous involuntary), involved in calm and connect functions of the body (Porges, 2020).

therapeutic approaches based on neuropsychological co-regulation and attunement postulate that caregivers should be equipped and trained to be able to manage and master their own emotional regulation and stability in order to mirror, attune, and synchronise with the child by means of solid self-regulatory and mentalisation based skills (Fonagy, 2011; Fonagy & Allison, 2013). NICE guidelines have emphasised the need to focus on effective interventions based on positive relationships to support looked after children and young people (Becker-Weidman, 2006; Becker-Weidman & Hughes, 2008; Briggs et al., 2012; Davidson et al., 2011; Ranjbar & Erb, 2019). However, the formation of a positive and meaningful relationship between caregivers and children, that can support and enhance children's therapeutic experiences in care, may be hindered by intrapersonal barriers. Sometimes caregivers' personal experiences of unresolved trauma or vicariously acquired trauma (described below) when exposed directly and indirectly to children's traumas may block their capacity to meaningfully relate to the children, in order to emotionally protect themselves (Bailey et al., 2019; Ireland et al., 2022; Zerach, 2013b). Intrapersonal variables such as unresolved traumas and losses of their own, or negative experiences whilst on shift of being targeted and assaulted by the children in their care, may lead caregivers to distance themselves emotionally from the children. This can be a normal response that caregivers implement as a way to self-preserve and manage the demands of the shift whilst keeping themselves and the children safe (see Chapter 3 for further detail).

Vicarious Trauma

Providing care for vulnerable populations, especially those at risk of being traumatised and having been traumatised, entails risk for the caregiver, especially when they may have a history of trauma themselves(McCann & Pearlman, 1990). According to DSM-V (2013) and CIE-11, PTSD (post-traumatic stress disorder) as well as C-PTSD (complex post-traumatic stress disorder) can occur even when a person has not been a direct victim of an accident and other life-threatening circumstances; they can experience trauma from seeing or hearing of others' past traumas. Prior to their removal from their families, many children may have suffered significant abuse (e.g., physical, psychological, sexual) and/or neglect. Given the relational and interactional nature of the caregiving role it is possible that caregivers may be impacted negatively or triggered by children's past traumas when reading or hearing about them. This phenomenon is known to lead to self-defence (withdrawal or freeze) mechanisms being used which may impact on their capacity to build relationships with the children.

Organisational Level Factors and Relationship Building

Several organisational factors appear to hinder the development of positive and supportive relationships between caregivers and the children in their care. These include discouragement of emotional expression and physical contact with the children, shift work patterns, inadequate remuneration, lack of recognition and professionalisation of caregiving roles, prioritisation of record-keeping over quality time with children, over-prescriptive practices, and limited opportunities for natural human interactions (Admon et al., 2013; Tarren-Sweeney, 2008a; van der Kolk et al., 2009).

Aims of the Thesis

The focus of this thesis was to explore caregivers' lived experiences of relationship-building in their work looking after children and young people. It contains three main chapters: Chapter two, a systematic literature review; Chapter three, an empirical qualitative research study; and Chapter four, a critique of a psychometric measure widely used to assess trauma symptomatology in children. The final chapter integrates the findings from the main chapters to help generate understanding and learning for effective childcare practices from the experiences of the caregivers who participated in this research and the findings of the literature review. Below are brief summaries of is covered in the four chapters that follow.

Chapter two contains a systematic review of existing literature based on caregivers' perceptions and experiences of the relationship-building process with the children in their care and the impact of this on children's well-being and emotional regulation. Since the relationship is a key protective factor to support traumatised children in their recovery, it is fundamental to understand caregivers' perceptions and views of the strategies they implement to build relationships, and their perceptions on the function and purpose of the relationship.

The third chapter is a qualitative study that explores the views, meaning-making and lived experiences of six caregivers (three men and three women) providing care for children with complex emotional and behavioural difficulties, following early exposure to childhood trauma and adverse childhood experiences. More specifically, it explored caregivers' personal experiences and meaning-making of their relationship-building with the children in their care and their understanding of the purpose and function of the relationship in children's stabilisation, emotional regulation, psychological well-being, and trauma recovery. Data were analysed using Interpretative Phenomenological Analysis (IPA) methodology(Gilmartin et al., 2022b; J. A. Smith et al., 2009).

The fourth chapter contains the critique of a psychometric tool widely used in assessing traumatised children: the Trauma Symptoms Checklist for Children TSCC(John

Briere et al., 2001). The TSCC is one of the most researched and used tools across the world to measure trauma related symptomatology in children who have been exposed to adverse childhood experiences (Briere, 1996; Nilsson et al., 2008; Wherry & Dunlop, 2018; Wherry & Herrington, 2018). The TSCC is not a diagnostic tool; however, this chapter offers an exhaustive description of its use, applicability, utility, and limitations when assessing children's difficulties and needs, as part of the diagnostic process and intervention planning. The aims of the critique were to analyse the properties of the TSCC (Briere, 1996) to comment on the suitability of this when assessing children in care and the understanding caregivers have when observing and reporting trauma symptomatology. Through this critique, results from previous studies using the TSCC were evaluated to draw conclusions on this psychometric’s reliability and validity as a screening method for acute trauma symptomatology (e.g., one single traumatic event) and chronic posttraumatic symptomatology (e.g., continuous and repetitive exposure to abuse and neglect) in children.

The fifth chapter summarises the aforementioned chapters and integrates the conclusions from each chapter, as well as outlining recommendations for future research and practical implications for clinicians. The strengths and limitations of the research are also addressed.

Chapter 2

Residential Child Caregivers' Perceptions and Perspectives of Relationship Building with Children in Their Care: A Literature Review Following a Systematic Approach

Abstract

In 2022, 12% of looked after children were living in residential care placements in England (Bennett et al., 2022; Chambers & Tzavella, 2022; MacAlister, 2022). As described in chapter 1, children and young people who live in care present with a series of complex emotional and behavioural needs (Bailey et al., 2019; Becker-Weidman & Hughes, 2008; Cook et al., 2005; Tarren-Sweeney, 2008a). Training that supports child caregivers' perceptions, understanding of their role and self-reflection, has been suggested to be important in improving the provision of care for children in residential settings (Steels & Simpson, 2017). Little is known regarding how child caregivers make sense of the relationship-building process and the factors that support it, as well as how these factors enhance their caregiving skills and intentions to help the children in their care. The main objective of this study was to explore these underlying factors.

The current paper conducted a systematic review whereby search terms relating to the above objectives were inputted into scientific databases using Boolean operators to identify 853 studies. A PEO framework and quality assessment were used to screen studies against defined inclusion and exclusion criteria. A total of six studies remained: five qualitative studies and one mixed-method study. Results found that although caregivers understood the benefit of relationship building, many did not have a good understanding of how attachment theory can be implemented in practice. This was often found to inform an intuitive, caregiver-led approach over a child-centred approach to care. Also, interpersonal factors of the caregiver along with organisational factors were found to affect the caregiver's relationship-building with the child. Limitations and implications for future research were discussed.

Introduction

Children in Care

The increasing number of ‘looked after’ children is a concern for the professionals who are involved in their care and management. In 2022 more than 12% of ‘looked after’ children were living in residential care with more than 151 local authorities responsible for ensuring and monitoring the effective delivery of social care to children (Bennett et al., 2022; Gilmartin et al., 2022; Mabile et al., 2022; MacAlister, 2022). Children and young people are often placed into the care of the local authority (LA) when exposed to a series of adverse childhood experiences such as abuse, neglect, and subsequent disruptions to the attachment with their caregivers (Becker-Weidman & Hughes, 2008; Briere et al., 2008; Chambers & Tzavella, 2022).

When a child is removed from the care of their family, depending on the complexity of their needs, they may be adopted, placed in foster care, placed in residential care, or are admitted to a secure unit. Foster care placement is a temporary residence immediately after a child is removed from their birth family due to safeguarding concerns. This tends to end relatively soon, or as soon as it is safe for the child to return to their primary caregivers. However, if LAs and sometimes courts decide that it is not safe for a child to return to their parents, a residential placement is then considered. These placements tend to be long term residences (between six months and several years) and are ongoing depending on the child’s age, emotional regulation, and psychosocial adjustment. When a child displays more severe and high-risk challenging behaviours and emotions, however, these complex needs may require different approaches, such as a secure or 1:1 placement (a child being with one caregiver 24/7), as they are deemed a risk to themselves and/or others.

It is widely acknowledged that children and young people who live in care present with a series of complex emotional and behavioural needs, the origins of which can lie in child maltreatment /abuse from their parents or caregivers (Beck, 2006; Kools & Spiers, 2002; Simkiss, 2019; Steels & Simpson, 2017; Tordön et al., 2019; Wigley et al., 2012). These complex needs are often exacerbated by the separation from their parents itself regardless of the maltreatment endured whilst in their care (del Valle et al., 2007; Tarren-Sweeney, 2008a, 2008b; Zerach, 2013a). Consequently, many children will present with multiple cumulative traumas: perceived rejection and abandonment from their caregivers, whilst also being forced to live with people whom they do not know in an unfamiliar environment. As a result of these experiences, children may display anxiety, depression, and potential attachment disorders (Bettmann et al., 2015; Hawkins-Rodgers, 2007; Steels & Simpson, 2017). When these difficulties persist, a child's capacity to bond with their new caregivers may be significantly hindered, and the relationship building with them compromised (Beck, 2006; Bettmann et al., 2015; Hong et al., 2021).

Foster placements are preferable to the other forms of placements as they involve a semi-permanent family-like environment. The child is placed with a family to recreate the atmosphere of a home environment where the child can feel safe and cared for by a consistent caregiver(s). This may provide the child with a sense of continuity, stability, and predictability and it has been shown to impact positively on their emotional regulation and attachment difficulties (Brannen et al., 2009; Cameron & Maginn, 2008; Delgado & Pinto, 2011; Messer et al., 2018; Molano et al., 2021; Tarren-Sweeney, 2008b). Whilst, many children who are placed in residential care fail to adjust and stabilise, some children can remain in residential care for many years and benefit from good relationships with their caregivers, which then significantly improves children's emotional well-being and future life outcomes (Cameron & Maginn, 2008; Garcia Quiroga & Hamilton-Giachritsis, 2017a; Messer et al., 2018).

Residential Care and Child Residential Caregivers

Residential care institutions accommodate children and young people who have experienced developmental trauma and abuse in their families of origin. Whilst there is evidence to suggest that the experiences of children residing in these homes can be both positive and negative, when considering alternative care for children, residential care is normally considered as the last resort(Bailey et al., 2019; Cyr et al., 2010; Shaw & Kendrick, 2016).

Residential placements can vary in type; they can be solo, dual, or multiple bedded depending on the presenting needs of the children and their psychological profile. There are specialised homes, for example, for girls at risk of sexual abuse and exploitation and for boys at risk of gang affiliation, criminal exploitation, and victimisation. Residential homes are staffed 24 hours a day, seven days a week. Staff members' shift lengths vary between 16 to 24 hours per day and may involve sleeping over or waking night shifts. As such, the consistent turnover of staff between the various shift patterns can make it difficult for children to experience predictability and a sense of stability in their placement. It has been argued that when in these types of residential placements, children may be re-traumatised due to high staff turnovers, in addition to other residents' emotionally dysregulated behaviours, and lack of sufficient and adequate psychological and therapeutic support (Abdulla & Kasese-Hara, 2020; Baidawi & Piquero, 2021; Steels & Simpson, 2017).

Given the trauma related factors that children in residential care have experienced, it is warranted that staff should be skilled and knowledgeable about these children's complex needs. Children may display difficulties in trusting others, and consequently, may not engage with new caregivers and resist attempts from them to build relationships, attachments, and a safe place to explore their difficulties (Becker-Weidman & Hughes, 2008; Davidson et al., 2011; Powell et al., 2020). Therefore, caregivers' knowledge, understanding, and meaning-making of the complex needs of children in care is crucial to allow children to stabilise in a placement. Adequate training and knowledge will provide caregivers with sufficient resources to understand a child's underlying needs, attachment difficulties, and the function of a child's rejection and resistance during caregiving experiences (Bailey, 2017; Bastiaanssen et al., 2014; Boel-Studt et al., 2018; Cameron & Maginn, 2008; Durka & Hacker, 2015).

Therapeutic Approaches in Residential Care

The main function of forming healthy and meaningful relationships in residential care is to support the children to rebuild their trust and repair any attachment disruptions suffered with their primary caregivers (Boel-Studt et al., 2018; Cahill et al., 2016; Davidson et al., 2011; Evans et al., 2011; Hodgkins et al., 2013; Kendrick, 2013). Several studies have concluded that child caregivers are crucial in the recovery process and responsible for assuring that the environment is therapeutically enabling (Cahill et al., 2016; Evans, 2003; Evans et al., 2011; Garcia Quiroga & Hamilton-Giachritsis, 2017a, 2017b; Muhamedrahimov et al., 2004; Shaw & Kendrick, 2016).

Relationship-based approaches and interpersonal therapies have been documented in literature and clinical practice as good treatment for children living in residential care who have experienced attachment disruptions (Davidson et al., 2011; Moses, 2000b; Tarren-Sweeney, M 2008).

Bowlby and Ainsworth (1960, 1970) described attachment as the secure base from which a child moves out into the world, and the guarantee of a safe, caring environment (Ainsworth, 1979; Mota et al., 2016). The secure basis plays a key role in promoting self-reliance and fostering a sense of self-trust, and trusting others, sympathy and helpfulness in children. This mental representation, also known as the Internal Working Model, is formed by the child based on their experiences being looked after by their primary caregivers (Bowlby, 1960); it also represents a template for future relationships where children display and learn basic concepts such as mutuality, reciprocity, empathy, and trust that their needs can be met by others. The experiential learning is vital for children as they learn to predict, control and influence their environment and construct their identities (Bretherton & Munholland, 2008). Central to relationship-based approaches is the idea that sensitive, warm, nurturing, caring, meaningful, and attuned relationships lead to better outcomes for children and their wellbeing (Kerr & Cossar, 2014; Messer et al., 2018). Restoring a child's attachment difficulties by means of creating a new and nurturing relationship, providing a secure basis, and positive role models constitute the basis of children support whilst in residential care (Kerr & Cossar, 2014; Molano et al., 2021; Tarabulsy et al., 2008; Wright & Edginton, 2016).

Many models of care in residential placements have used this approach as the basis for their interventions with children. Residential care facilities are expected to provide the children with a good level of care and create family like environments. This is determined by caregivers creating an environment that is safe, nurturing, warm and predictable (Collings et al., 2021; Conley, 2003). The caregivers’ own sense of internal security and emotional availability, mainly based on their own lived experiences, can be a source of positive attunement and mirroring, which can be fundamental for a child’s wellbeing and trauma recovery (Heine et al., 2021; Porges, 2011; Proeschold-Bell et al., 2019; Tessitore et al., 2023). The mirroring process is widely acknowledged in child development and parent-child interactions. This process involves parents recognising and reflecting their child’s mental and emotional states back to them, modelling understanding, acceptance, and empathy. It is grounded in mirroring, and helps parents regulate their responses to restore synchrony when the parent-child dyad falls out of alignment because of distorted mirroring and emotional dysregulation of the child and/or the parent (Heine et al., 2021; McMillan, 2020). It is therefore important to emphasise that, as residential care workers become a child’s main source of support and a “secure basis” for the child—since the child spends most of their time with them—awareness of these psychological processes is fundamental (Porges, 2011; Proeschold-Bell et al., 2019; Schore, 2017).

As previously mentioned, there is an expectation that caregivers are knowledgeable about children’s developmental needs, social care systems, attachment theories, developmental trauma, and the impact of trauma on children’s presentation in order to contain, support and help them regulate their emotions and challenging behaviours (Wright & Edginton, 2016). However, evidence from research and clinical practice in general has suggested that many caregivers who provide care for children living in care do not possess the relevant core training needed to meet children’s complex needs and attachment difficulties (Analía Soria & Bandeira, 2015; Atwool, 2006; Hurley et al., 2006; Kools & Spiers, 2002; Simkiss, 2019). This is particularly problematic given that research findings have suggested that when children are placed in residential care their behaviours and capacity to self-regulate worsen, which then can contribute to a significant deterioration in their mental health (Heine et al., 2021; Hong et al., 2021; Huscroft-D'Angelo et al., 2017). Furthermore, since children in care struggle to form meaningful relationships and a sense of belonging, there is an increased probability that they will affiliate with gangs in order to fulfil these emotional needs via adherence to delinquent groups and engagement in self-destructive behaviours (e.g., grooming, sexual abuse and exploitation) (Collings et al., 2021; Powell et al., 2020; Tarren-Sweeney, 2008a, 2008b).

It is fundamental that caregivers receive support to understand the underlying needs of the children who display intense challenging behaviours (physical and verbal aggression, self-harm, poor self-hygiene, drug and alcohol) because of their traumatic experiences inflicted by their caregivers and exacerbated by the removal from their homes. Without a good understanding of these factors, a sensitive approach to implementing a good response to the sever challenges that caregivers are faced with in their daily roles, the relationship-building process, as a healing factor is unlikely to occur, and re-traumatisation of the children becomes imminent (Gistau et al., 2017; Hong et al., 2021; Moreland & Ressler, 2021; Strijbosch et al., 2015). An appropriate therapeutically enabling approach will emphasises the importance of low arousal; well-equipped carers that are emotionally available, robust, and resilient in managing their own distress arising from working with traumatised children, as well as an understanding of children’s pre-existing and ongoing emotional difficulties. Within this approach to supporting the children, the caregivers’ roles are paramount since they become children’s source of emotional support and regulation, as well as role-models. For this to be accomplished, the work environment and caregivers need to promote and implement a sense of safety, trust, and empowerment within themselves and the work that they do, with a reasonable level of self-efficacy and competency. These factors taken together can effectively contribute to the quality of care and support that children receive, as well as better guide the policies and regulations of children’s home (Brannen et al., 2009; Cahill et al., 2016).

To provide good quality care, there is a need for residential organisations to clearly state, articulate, define, and implement fit-for-purpose treatment for the children they look after (NICE guidelines, 2020). However, little is known about how exactly care, therapy and support are implemented in practice within residential care homes. Instead, treatment and interventions have focused on children’s challenging behaviours, and the risk they pose to themselves and others (Becker-Weidman & Hughes, 2008; Davidson et al., 2011; Hanson & Lang, 2016). Consequently, the nature and potential cause of their difficulties remain largely misunderstood and mis-conceptualised, leading to miscommunication and poor guidance in the care plans that are created to meet children’s real needs. It is essential, therefore, to understand the purpose of children’s challenging behaviours to meet their needs and build a positive relationship, which is an important aspect of trauma recovery. To support this process children should also undergo a comprehensive psychological assessment of their needs and backgrounds to inform and guide caregivers on how to approach the children and respond to these behaviours in a more playful, accepting, non-judgemental, curious and empathic way.

The promotion of this philosophy of work and relationship-based support may dissuade caregivers from using an overly behaviouralist approach in their daily interactions with the children, which in turn may result in a much more positive and meaningful relationship-building process. As part of a trauma informed approach, there is emphasis that the *therapy* constitutes the support caregivers give to the children for all their daily routines and emotional regulation, as well as the quality of the relationship between children and caregivers. The implementation of this approach is centred on restorative parenting practices, which the caregivers are expected to use in their daily interactions with the children. The effectiveness of these implicit and non-directive support is measured through a child’s emotional regulation(reduction and/or desistance from displaying challenging behaviours), engagement with daily life/leisure activities, and ultimately their stabilisation in their placement (Bailey, 2017; Bastiaanssen et al., 2014; Cahill et al., 2016; Molano et al., 2021).

In a recent review of the Adverse Childhood Experience (ACEs) policy, the Welsh government recommended considering both the traumatic events and the impact these have on the victims (Review of Adverse Childhood Experiences Report, March 2021). The policy explores different ways to protect all those affected by ACEs and to prevent further risk of being impacted by adversities in early childhood by focusing on and developing resilience and solid protective factors. The main pillars of the policy are to develop trauma informed services, provide support to parents who have experienced ACEs themselves, and to raise awareness about these factors (NIHR, 2020). Within this document it is argued that ACEs are more prevalent in vulnerable populations, such as children in care who present with a series of pre-existing conditions and vulnerabilities as well as new complex emotional and behavioural difficulties developed following the separation from their parents (Review of Adverse Childhood Experiences Report, March 2021). In this context, the policy emphasises that it is important to consider and create programmes that are comprehensive, person-centred, and trauma informed. Whilst not everyone with ACEs develops post-traumatic stress disorders or other acute stress reactions, the interventions in care should follow a trauma informed and person centred approach (Gregorowski & Seedat, 2013; Le Page, 2005).

In addition, care provided should have a family-based approach in connection with the wider community to mitigate and deter social isolation, further deterioration, and intergenerational transmission of trauma (Chambers et al., 2021; Collings et al., 2021). Taking this approach has the potential to be validating for a child, by focusing on strengths and protective factors when addressing an attachment difficulty (Bailey et al., 2019). Golding (2015) stated that building relationships and supporting the children to trust again becomes key in supporting children and young people to overcome their difficulties. Similarly, the biopsychosocial approach to understanding human behaviour—particularly its functions and motivations for seeking safety, comfort, proximity, and predictability—emphasises that positive and meaningful relationships are essential for healthy neuropsychological and psychosocial development (Girelli et al., 2019; Siegel, 2015; Tessitore et al., 2023).

In summary, incorporating positive and meaningful relationship-building within the basis of therapeutic approaches for children in care, as well as creating therapeutically enabling environments within the different systems (schools, health, community) a child interacts with, must become a priority for residential care providers.

Issues with Residential Care Homes

The local authority's role in meeting the needs of children in care remains largely unclear, given the privatisation of this sector attracting leaders who are mostly business orientated and not always aware and sensitive to the children's needs and difficulties (Molano et al., 2021; Simkiss, 2019; Steels & Simpson, 2017). As privatisation of this sector of care continues to grow, there has been a prioritisation of business and administrative imperative over clinical and person-centred approaches (Garcia Quiroga &

Hamilton-Giachritsis, 2017b; Moses, 2000b; Shaw & Kendrick, 2016)**.** There have been increasing concerns worldwide about residential care placements and their adequacy to meet and support children’s complex needs (Cameron & Maginn, 2008; Castillo et al., 2012; Davidson et al., 2011; del Valle et al., 2007; McMillan, 2020). The lack of a clear definition and delineation of the child’s needs and difficulties, paired with very little understanding of the child's background and exposure to adversities and subsequent traumatisation when removed from their parents, can create a generalised sense of confusion and ineffective implementation of care (Heine et al., 2021; Morison et al., 2020). Furthermore, clinically specialised external inspections and monitoring are not well established to monitor children's treatment outcomes and follow-up (Davidson et al., 2011; Kerr & Cossar, 2014). Evidence within the literature suggests that many of children's needs are not understood and therefore remain largely unmet, which exacerbates their problems (Steels & Simpson, 2017).

Steele and Simpson (2017) suggested that strongly desired outcomes, when talking about children’s emotional needs, are the development of a therapeutically enabling environment and trusting relationships. In supporting these recommendations, The Trauma Recovery Model (TRM) developed by Skuse and Matthew (2019), emphasises the capacity of caregivers to meet children’s basic needs by acknowledging and understanding the nature of each individual child’s difficulties and the impact of ACEs prior to living in residential care and immediately after the removal from their families. Concomitantly, a child needs structure and routine in their everyday life as a base from which to develop readiness to form trusting relationships with appropriate adults (Evans et al., 2011; Hanson & Lang, 2016; Powell et al., 2020).

Whilst the TRM is helpful and supports the fulfilment of basic needs and the de-pathologising of children in care, it is not openly embraced by stakeholders (Atwool, 2006; Bailey, 2017; Beck, 2006). As with any other organisation, residential care homes need to comply with a series of administrative imperatives to be lawful, registered and recognised as a service provider. Complying with these operational requirements may interfere with caregivers' capacity and resources to invest quality time in relationship building with the children. These external factors, which are discussed in more detail in Chapter 3 of this thesis, can have a negative impact on the children and their recovery. Whilst the main function of residential homes is aimed at meeting children's basic needs (e.g., food, shelter, personal hygiene), little is known about how they perceive and meet children's emotional needs, that are oftentimes misunderstood and seen as behavioural issues (Rivard et al., 2004; Strijbosch et al., 2015). Numerous UK studies conducted with young people in care and young adults who left the care system support this view, highlighting that care workers could not discriminate between children's needs and children's behavioural problems(Bifulco et al., 2016; Brannen et al., 2009; Cameron & Maginn, 2008; Davidson et al., 2011; Evans et al., 2011; Hurley et al., 2006; Kerr & Cossar, 2014; Roberts, 2020; Steels & Simpson, 2017).

It becomes apparent that, while the mission and vision of residential system business models include providing therapy for the children in their care, the implementation of this service is not fully understood. In addition, it often lacks adequate clinical quality monitoring and supervision to ensure that therapeutic care is person-centred and recommended based on psychological assessments by qualified mental health professionals(Cahill et al., 2016; Cameron & Maginn, 2008; Eastwood & Ecklund, 2008; Harder et al., 2013; Morison et al., 2020; Roberts, 2020; Steckley & Kendrick, 2008). These circumstances and the lack of homogeneity and a well consolidated implementation of therapeutic care in practice may lead to care homes applying their own understanding of *therapeutic care* which may not be evidence based and might not align with children's needs and clinical guideline recommendations. Such "play it by ear" practices risk being ineffective and may even harm children's psychological health.

Importance of Child Residential Caregivers' Perspectives and Perceptions

Although child residential caregivers have not received much attention in research, some studies have highlighted a series of factors that may impact caregivers' capacity and availability to relate to the children in their care (Garcia Quiroga & Hamilton-Giachritsis, 2016). These factors can be personal and/or structural and may lead to staff burnout and poor performance, which is likely to result in disengagement and uninterest when caring for the children. When this happens, the relationship is compromised, and this can further exacerbate a child's already pre-existing difficulties and can potentially trigger caregivers' own potential unresolved trauma, difficulties and relationship issues. However, it has been argued that through mentalisation(the ability to think about the thinking i.e. reflective capacity and introspection) these difficulties can be significantly reduced if the caregivers are open to explore and reflect on their practice (Fonagy, 2011; Fonagy & Allison, 2013; Jacob et al., 2015). It has also been suggested that if caregivers do not fully understand the concept of attachment when caring for children they may adopt a more intuitive, exploratory, and spontaneous interaction (Atwool, 2006; Bailey, 2017; Bifulco et al., 2016; Brumariu et al., 2020; Cameron & Maginn, 2008; Cortina & Liotti, 2010; Ereky-Stevens et al., 2018).

Positive and meaningful relationships between caregivers and children promote healthy and secure attachments, and may significantly contribute to children’s therapeutic outcomes, psychosocial adjustment, emotional regulation, and educational attainment and positive future life outcomes. Children’s placement stability and positive engagement within their placement has been found to produce higher levels of job satisfaction for caregivers which will likely reduce the rates of turnover, burnout, vicarious trauma, and child re-traumatisation (Garcia Quiroga & Hamilton-Giachritsis, 2016). In this sense, enhancing caregivers’ skills, raising their payment rates, and acknowledging their fundamental contribution to children’s therapeutic outcomes are crucial.

Therefore, training that supports caregivers’ perceptions, understanding of their role and self-reflection, has been suggested to be important in improving the provision of good quality care for children in residential settings (Steels & Simpson, 2017). In a review of the literature on the perceptions of children in residential care, similar recommendations highlighted the importance of relationship-building between caregivers and the children in their care emulating a family like environment (Cahill et al., 2016; Carver, 2019; Kerr & Cossar, 2014; Kerr, 1981; Steels & Simpson, 2017). This focused on the procedural understanding from caregivers' perspectives and their awareness of the impact of the quality, function, and purpose of the relationship on both children's and caregivers' wellbeing and mental health (Steels & Simpson, 2017). Therefore, it is fundamental to explore caregivers’ understanding, perspectives, meaning making of their role and their relationship-building with the children in their care.

Aims of the Review

Therapeutic relationships are fundamental to a child's recovery, overall wellbeing, and positive life outcomes. Caregivers become very important care providers who look after children daily; as such, they are key in the process of co-regulation and attunement that children need to emotionally regulate and stabilise successfully in their placements. Gaining insight into their understanding—allowing caregivers to share their perceptions of children's experiences, how they interpret what has happened to the children, and listening to their views, opinions, and reflections on their motivations, challenges, and relationship-building is paramount. The focus of this review was to explore the existing literature on relationship-building between residential caregivers and the children in care, from the caregivers' perspective. When exploring these themes no existing systematic literature reviews were identified, therefore, the current review of the literature aimed to address this gap. Whilst several studies have been conducted by analysing children's views and perceptions of their experiences in residential care, some of which explored caregivers' understanding, meaning-making, and motivations when working as caregivers, none have been undertaken exclusively from caregivers' perspectives.(Davidson et al., 2011; Harder et al., 2013; McMillan, 2020; Steels & Simpson, 2017). These studies were not included as they did not meet the inclusion criteria and their focus was either on children's experiences and/or the interventions and treatment implemented to support the children, as opposed to the relationship building process, as per the aims of this review.

Specifically, this review sought out to address the following objectives:

- To review the literature concerning residential child caregivers' perspectives and meaning-making of the relationship-building with the children in their care.

- To explore the child caregivers' understanding and perceptions of the relationship with the children in their care and how they implement them in their practice.
- To identify key factors that promote, and potential barriers that hinder, the relationship-building process.

Method

Procedure

Scoping

An initial scoping search aimed to identify existing reviews relating to child caregivers’ experiences and meaning-making of the relationship-building process with children in their care. The scoping exercise was conducted in January and February 2022 by searching the Cochrane database, the Campbell Collaboration, Birmingham Library, and Google Scholar for previously published systematic literature reviews and other reviews. The purpose was to map effectively fundamental key terms and concepts related to the area of research being analysed, as well as the suitability of conducting a SLR. No systematic literature reviews were found solely relating to child caregivers' perspectives on their relationship-building with children in their care.

The initial scoping search also aimed to identify previously published research relating to caregiver’s views on therapeutic attachments with children in their care. As the scoping searches produced a limited number of papers in this area, the inclusion criteria were expanded to include studies that used mixed samples of children and caregivers, evaluating their care perspectives, and lived experiences. The broader search criteria yielded a systematic literature review, which analysed children's perceptions of their experience in care (Steels & Simpson, 2017). Although it was not included in this review, it was considered valuable and relevant from a conceptual and practical viewpoint. Based on the preliminary searches, the exclusion and inclusion criteria used to inform the selection of studies to be included in this review, was refined (see Table 1 and 2).

Although this study analysed both the perceptions of children and caregivers, it was considered for inclusion as it included concepts relevant to the current review, containing valuable analysis of caregivers' views in depth. Whilst it was mentioned before that the focus was mainly on caregivers' perceptions, this study was exceptionally added, as only a few studies were found to concentrate mainly on caregivers' experiences of looking after children in care. When conducting the scoping exercise and the initial searches, the terms and their order were altered to enable more comprehensive studies to be included in this review.

Inclusion and Exclusion Criteria

The relevant studies to the research question were identified within the PEO framework (population, exposure, outcome)(Butler et al., 2016). When compared to the PICO framework (population, intervention, comparator, outcome), the PEO framework does not take into consideration an intervention(Gough & Richardson, 2018). Therefore, the PEO framework was deemed suitable for identifying research to be included in this review since the papers identified during the searches did not implement experimental designs. This rationale guided the development of inclusion and exclusion criteria and is described in detail in Table 1 and 2.

Since this review concentrated on identifying child caregivers' experiences of the relationship-building with the children in their care, the "population" was defined as the childcare workers who provide care for institutionalised children who live in residential care (within local authorities' remit excluding foster carers) or similar. The review captured only those caregivers working in a residential care home and excluded child caregivers that were providing care for children in other care facilities, such as schools, foster care, or hospitals. Furthermore, the search strategy limited the studies to those published in the last twenty years (from 2000 onwards) as research in the field of residential care and out-of-home care provision significantly increased in this period due to more children living in care due to parental mistreatment, and subsequent psychological trauma as a result of being separated from their parents in first place (Tarren-Sweeney et al., 2018). The language of included publications was restricted to English and only peer reviewed papers were included. The restriction on language was to allow for a peer review process during the quality assessment stage of this review by another researcher who speaks only English. Grey literature was excluded because it was considered insufficiently rigorous. Given the limited number of relevant UK studies found for this review, studies from other countries, such as Chile, US, and Scotland were included.

In this review, "the exposure" criteria (from the PEO framework) refer to the relationship-building process that the caregivers experience as a fundamental part of their role. Thus, the reviews included both quantitative and qualitative papers focusing on caregivers' experiences of working with looked after children living in residential care. These papers contained mainly qualitative studies, in which caregivers were interviewed about their experiences of working with children in care, most of whom had experienced attachment disruptions and presented with severe emotional and behavioural difficulties. Only a small number of publications focusing only on caregivers' experiences, understanding of their roles and the relationship-building process with the children in their care were identified. Thus, studies including the experiences of both children in care and caregivers were included rather than just those of caregivers.

The "outcome" criterion (using the PEO framework) identified studies where caregivers' attitudes, insights, and awareness of the importance of the relationship they develop with the children in their care were captured.

Table 1

Inclusion and Exclusion Criteria using the PEO Framework

	Inclusion	**Exclusion**
Population	English Language Only 2000–2022 Publications should explore child caregivers who provide care for out-of-home looked after children	Publications related to foster care workers, secure/ forensic facilities, adoption studies and families Publications related to elderly, physical and palliative care settings Publications which explore the children's perceptions and experiences
Exposure	Caregivers' experience and attitudes towards working	Exclude studies with care workers not working with

	with children in care with complex trauma	children. This criterion was applied to guarantee sufficient experience to reflect upon different aspects of care and a wider range of experiences with this population.
Outcome	The perceptions, meaning-making, understanding of the relationship-building from the child caregivers' experience	Exclude editorials, books chapters, commentary, dissertation theses, and other non-primary studies. These exclusion criteria were used to avoid studies that were not meeting the standards for publication lacking sufficient scientific rigour. This criterion was applied for scientific robustness and adequate peer reviewed and published literature.

Sources of Literature

Several databases were used to identify relevant research papers meeting the inclusion criteria. PsycINFO, ProQuest, Web of Science, Social Sciences Premium Collection, PubMed, EBSCO Host, and Scopus were used as they produced the largest number of papers from July 2000 to July 2023 relevant to this review's aims. These are also widely recognised databases amongst social sciences and psychology researchers. The rationale behind the use of a temporal frame from 2000 to 2023 was to access contemporaneous data suited to the subject being more researched and observed over the last 20 years. Reference lists of retrieved papers were further analysed to cross reference and check for any relevant studies that may have been missed in the original searches. A further, four publications were identified, however, as they were dissertations or unpublished articles, they did not meet the inclusion criteria and were eliminated. Unpublished papers and dissertations were not included as these may introduce a bias within literature reviews as they are not normally peer reviewed, can lack scientific rigour and are vulnerable to confirmatory biases given researchers typically write such papers in isolation.

In addition, two experts within the field were identified, as they both had over 20 years of experience in research and clinical practice of working with children who have been removed from their parents' care following a court order (this is further detailed in Appendix A). The experts were emailed and explained the aims of this review. One expert advised that they were not aware of recent/new research, the other expert, however, provided a copy of the journal containing their latest publication about children and young people living in care. This paper was reviewed and as the research was undertaken solely with children and young people, it did not meet the inclusion criteria for this review.

The papers included in this review were analysed between January 2022 and July 2024, followed by an updated search to identify any other potential studies that may have been published from July to September 2023. Papers were identified from the following electronic databases:

- PsycInfo (2000–2022 on 31st January 2022)
- ProQuest (from 2000–2022, on 1st February 2022)
- Web of Science (from 2000–February week 2 2022 on 1st February 2022)
- Social Sciences Premium Collection (from 2000–February week 1 2022, on 2nd February 2022)
- PubMed from 2000–2022 to February week one on 2nd February 2022.
- EBSCO Host from 2000–February week 1 2022 on 3rd February 2022.
- Scopus (from 2000–February week 2 2022 on 1st February 2022)

A search was conducted from February 2022 to July 2024 to retrieve any new publications in these areas that may have been conducted. No noteworthy papers were found.

Search Terms

Terms relevant to the review question were identified and the following key words were used following an exhaustive terminology search of synonyms and words related to the main research question and relevant existing research. Synonyms were found using the Thesaurus database found on the University of Birmingham website (University of Birmingham, 2022). These were used to capture the highest possible number of studies relevant to the research question of this systematic review.

Once basic searches were conducted, a more sophisticated search strategy was created. The Boolean operators AND/OR were used as conjunctions to combine or exclude words in the search. The Boolean operators first combined "care workers" terminology as a priority and then “children in care”. This strategy was used to capture as many relevant studies as possible. “Care assistant” was excluded as it would mainly capture studies with caregivers working in hospital environments and care for physically ill people. The search syntax used were:

1. "child residential care work*" (Topic) AND/OR "Residential care" near/2 (caregiver* or worker* or staff) (Topic) AND/OR “Support care work*” or “support caregiver*” (Topic) AND/OR residential or institution* near/2 (caregiver* or worker* or staff*) (Topic) AND/OR (Residential or institution*) near/2 (caregiver* or worker* or staff*) (Topic)
2. “child in care” or “looked after child” or “looked after young” or “child in out of home care” (Topic) AND/OR child* or adolescent* or teen* or youth* or young* (Topic)
3.” relational therapy” or “emotional regulation” or “attachment therapy*” or “relationship building” (Topic) AND/OR “Relationship building” (Topic) AND/OR child* near/2 (connect* or bond* or nurture* or attach*) (Topic)

Summary of Search Strategy

Following the search, the following process (see Figure 1) was applied to the 853 studies initially identified:

- Stage 1 – remove duplicates
- Stage 2 – screen title
- Stage 3 – screen abstract
- Stage 4 – full text review using exclusion and inclusion criteria
- Stage 5 – quality assessment

Six hundred and forty-six studies were excluded due to duplication and not meeting the inclusion criteria based on titles. From the remaining 207 studies, 136 were removed as they did not meet the inclusion criteria based on abstracts. The remaining 71 studies were read in full, and 65 studies were excluded after checking against the inclusion/exclusion criteria. Due to time constraints, it was not possible to conduct an inter-rater reliability examination for all 71 studies, however, a sub-sample of nearly 10% of the papers were checked by a second reviewer against the inclusion and exclusion criteria. The second reviewer was in full agreement with the author of the review regarding whether the papers met the criteria for inclusion. Six studies remained to be included in the review.

Quality Assessment

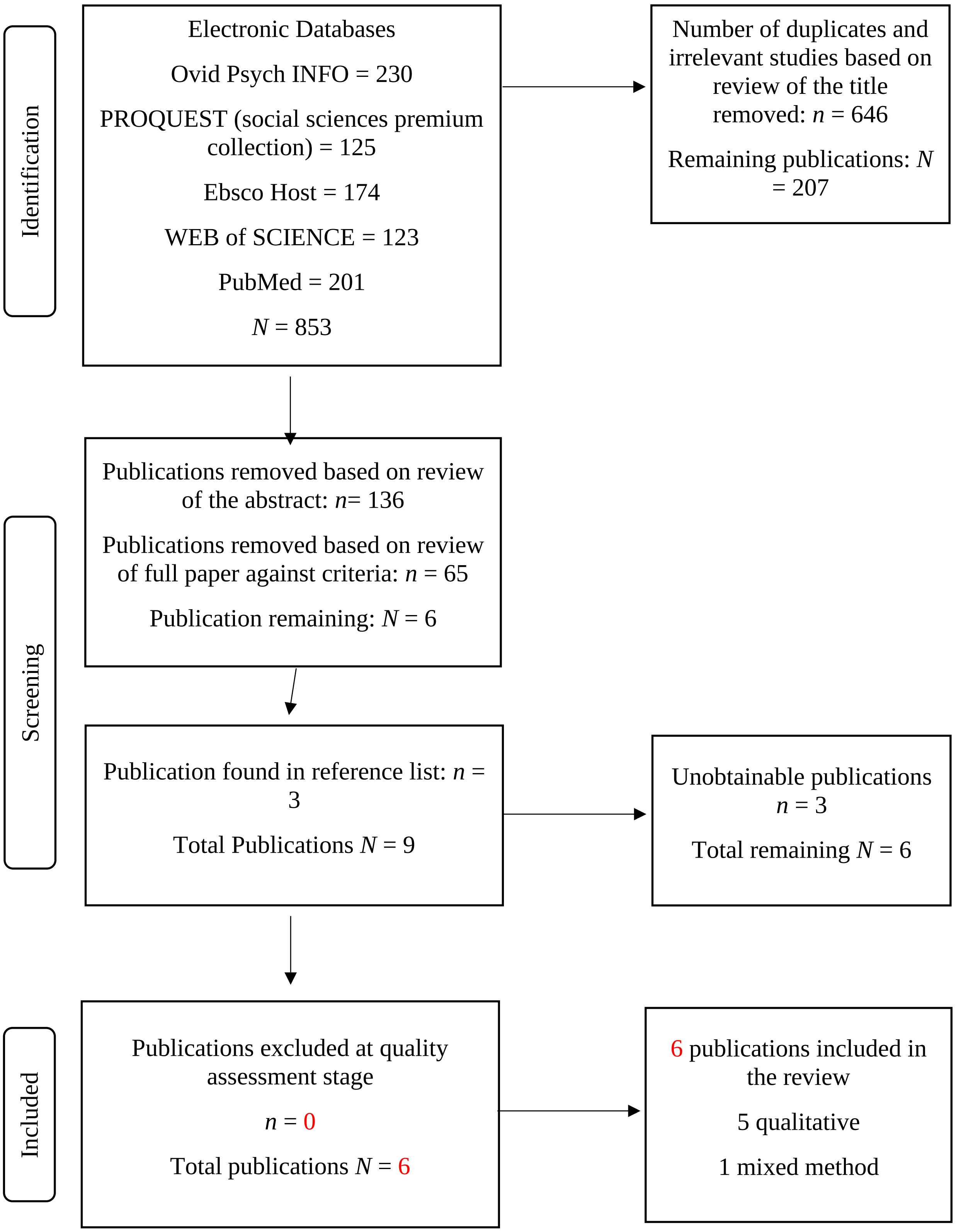
A comprehensive and exhaustive assessment tool, suitable for both quantitative and qualitative studies, was used to appraise systematically the trustworthiness and relevance of the chosen six papers used for the present review, the Critical Appraisal Skills Programme (CASP, 2018). It has proven useful to provide sufficient rigor and credibility and to ensure they met the scientific criteria to be included in this review. This specific tool is one of the most common implemented for quality appraisal in health-related qualitative research, according to Cochrane Qualitative and Implementation Methods Group. This assessment tool contains ten questions; however, some additional questions were considered necessary when scoring the articles. Given the reduced number of publications in this area, further aspects were considered to provide a more in-depth analysis of the studies being assessed, thus increasing the initial number of questions from 10 to 16 (see Appendix C). The original questions refer to areas such as measurement, the role of the researchers in the research process, and the additional six questions cover the clarity of the findings and conclusions, acknowledgement of strengths and limitation as well as recommendations for both research and clinical practice (see Appendix C).

All the initial papers met the criteria from the adapted CASP questionnaire, and each question was scored as follows: a score of 2 if the full criteria were met, a score of 1 if the criteria were partially met, and a score of 0 if none of the criteria were met. Unclear was marked when there was not sufficient information to assess the criterion. The total quality score for each paper (32 points) was then converted into percentages. A second reviewer quality assessed the six papers selected for inclusion in the review. The reviewer's scores fell within approximately 10% of my own scores, there was agreement that all studies should be included in the SLR (i.e. scored over 50%). The quality 'threshold' was

50%. This score was obtained by assessing the trustworthiness, credibility and reliability of the six papers against the following criteria: credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). The six papers were all scored from 0 to 5 then the results were transformed in percentages.

Figure 1

Flow Diagram of the Search Results



Descriptive Data Synthesis

From the six publications included in the review, five were qualitative and one used a mixed method design. The quality scores assigned to the papers during the quality assessment stage ranged from 53% to 78%. The overall sample size across the six included studies was *N* = 176, the vast majority being represented by females (*n* = 146 females; *n* = 30 males). Four studies were conducted with females only. Two of the included studies did not mention the gender of the participants (Cahill et al., 2016; Shaw & Kendrick, 2016). One study also used child participants; however, these were not included in the total sample of *N* = 176.

The five qualitative studies that were included used varying methodology. All six studies incorporated an in-depth semi-structured interview as their data collection method and an additional method for analysis of the data. Two of them were focus groups (Cahill et al., 2016; Garcia Quiroga & Hamilton-Giachritsis, 2016), one used the method of thematic analysis (Shaw & Kendrick, 2016), one used the constructivist grounded theory (Morison et al., 2020), and one used observations and generalisations from open-ended questions with minimal intervention from the researcher (Moses, 2000b). The mixed-method study used a series of measures, to include the Attachment Story Completion Task (ASCT; Bretherton, Ridgeway & Cassidy, 1990)(Bretherton, 1990), Motivations to Foster Inventory (MFPI;Yates et.al., 1997)(Yates et al., 2010), Revised Adults Attachment Scale (Collins, 1996)(Collins, 2008); Close Relationships Version, Observation for Measurement of the Environment (HOME) Inventory, Child Care- Early Childhood version(Bradley & Caldwell, 1984) and Caregiver-Child Social/Emotional and Relationship Rating Scale(McCall et al., 2010) (CCSERRS; McCall, Groark, & Fish, 2010) and observations (Garcia Quiroga & Hamilton-Giachritsis, 2017a).

Sample

The ages of the participants were very diverse, ranging from 21 to 86 years, with a mean age of 53 years old. The same was found regarding their years of experience as child caregivers, which ranged from three to 35 years of experience. The ages of the children that the caregiver sample worked with ranged from three to 18 years old. Most of the included participants were females.

The studies included in this review were conducted in Scotland (Cahill et al., 2016; Morison et al., 2020; Shaw & Kendrick, 2016), Chile (Garcia Quiroga & Hamilton-Giachritsis, 2016; Garcia Quiroga & Hamilton-Giachritsis, 2017a), and the USA (Moses, 2000a).

Table 3

Summaries of the Included Studies

Author/Date	**Study Type**	**Recruitment and Participant Characteristics**	**Measures and Data Collection**	**CASP score (%)”**	**Findings**
(Garcia Quiroga & Hamilton-Giachritsis, 2016)	Qualitative	Forty-three caregivers working in eight different residential children’s homes in Chile. Participants voluntarily took part in this study.	1.5 hr focus groups and thematic analysis in Spanish semi-structured format with three open ended questions	78%	Four principal overarching themes: negative first impressions, emotional involvement, positive experiences, and difficulties

		They were from Chile.			
(Cahill et al., 2016)	Qualitative	Twenty key work staff working in three targeted units and three aftercare workers who participated in individual interviews. Participants voluntarily took part	Three focus group interviews and individual interviews	53%	Unanimous understanding and awareness of the importance of formation of constructive and supportive relationships between caregivers

		in this study, and they participated in two different Irish studies.			and children in their care.
(Moses, 2000a)	Qualitative	Twenty-five Childcare Workers, 10 males and 15 females (three of the women were childcare assistant supervisors having direct contact with the residents.	In depth semi-structured interviews conducted and taped with 25 Child Care Workers Anonymity could not be secured; privacy and confidentiality of verbal accounts were secured.	60%	The care workers provided both individualised and standardised care descriptions; these depended mostly on the levels of familiarity and feelings toward the

	Average mean age of participants: 33.3 years (range 23–45). Caucasians (11), African American (10), and two Hispanic and Asian. Their experience varied from 8 months to 18 years. Participants voluntarily took part in the study. They were from 10 care	To maximise the representativeness of the sample two or more residential care workers were from all the 10 care units followed by purposeful random sampling.		child. It was found that the quality of the relationship determined if the treatment received by the children was individualised or standardised.

		units in a mountain region in Southern California, USA.			
(Morison et al., 2020)	Qualitative	Twenty participants working across eight residential care settings pertaining to the local authority by means of purposive sampling. The sample consisted of 14 females and six males from Scotland	Semi structured interviews that were recorded and a socio-demographic questionnaire. Grounded theory and a constructivist approach to capture a rich in depth understanding of caregivers’ perspectives.	69%	The results highlight that “doing it naturally with the theory in the background” followed by four theoretical concepts: ongoing temporal process of building relationships through working in a live

	with ages comprised between 24–62 years (*M* = 48.5, *SD* = 11.7). Their experience varied from 1–32 years with 95% having received training in attachment theory.		space; most staff described their relationships as a natural process as opposed to theory driven. There is clear reference to building relationships, and parenting as a natural, automatic and “common sense”. However, findings also emphasise that they

					struggle to articulate the attachment theory using the term interchangeably with relationships.
(Shaw & Kendrick, 2016)	Qualitative	Twenty-three participants (mid-fifties to mid-eighties) who worked as residential care workers in Scotland between 1960–1975.	In depth recorded semi-structured interviews.	69%	Findings highlighted both positive and negative experiences with many of the issues still resonating nowadays. Some of these are lack of

	They were recruited via purposive and snowball sampling from existing networks 18 females and 5 males. Participants voluntarily took part in the study, they were Scottish.		training, knowledge and experience, institutional imperatives, and an inability to raise concerns, whilst positive experiences have a strong basis on relationship, affect and attachment between staff and child.

(Garcia Quiroga & Hamilton-Giachritsis, 2017a)	Mixed method quantitative and qualitative.	Fifty-seven children (36 living in residential care, and 21 in foster care, with ages between 3–7 years old, 32 girls and 25 boys) and 45 caregivers (16 were foster carers and 29 worked in residential care, average age 51; range 30–75 years old).	The following measures were used: Attachment Story Completion Task, questionnaires for Caregivers (Barone et al., 2009), Motivation to Foster Inventory (Barone et al., 2009; Delgado & Pinto, 2011), Revised Adult Attachment Scale (Molano et al., 2021), Observation for Measurement of Environment Inventory	69%	An attempt to identify factors that impact the attachment was performed by means of this study. Findings discriminated Children's Factors and Caregivers' factors. In this study the age of the children was linked with the

	The study was conducted in Chile with a Chilean sample. Participants voluntarily took part; consent from parents and caregivers was sought for underage children participating in this study; child's welfare was considered.	(Cox & Bentovim 2000), Child Care Early Childhood version(Bruce,2001), Caregiver-Child Social/Emotional and Relationship Rating Scale (Barone et.al., 2009).		secure attachment with their caregiver; Caregivers' most prominent variable was the quality of the relationship (based on engagement, affection, and responsivity) they establish with the child translating into the security of the attachment.

Results

Overall Findings of Residential Child Caregivers' Understanding of the Relationship-Building with the Children in Their Care and its Implementation

Some studies concentrated on how the attachment theory is implemented and understood in practice(Morison et al., 2020; Moses, 2000b), whilst other studies were more focused on structural and personality factors and variables that may facilitate or hinder the relationship with the children in care(Garcia Quiroga & Hamilton-Giachritsis, 2017b; Shaw & Kendrick, 2016). In general, there was an agreement between the studies that the relationships that residential care workers establish with the children in their care are a key factor in children's recovery from traumatic experiences(Cahill et al., 2016; Garcia Quiroga & Hamilton-Giachritsis, 2016; Morison et al., 2020). However, there was little clarity on the process participants implemented in practice to build, maintain, and use the relationship as part of the therapeutic process.

In most of the included publications, the participants referred to the attachment theory framework to set the parameters, delineate, and define the relationships they establish within their role as child caregivers (Garcia Quiroga & Hamilton-Giachritsis, 2017a, 2017b; Moses, 2000b). There was a general assumption that the caregivers understood and implemented attachment theory in their practice (Morison et al., 2020). However, the findings suggested that caregivers use the word attachment indistinctively from relationships and have difficulties understanding the attachment theory in practice(Cahill et al., 2016; Garcia Quiroga & Hamilton-Giachritsis, 2017b). It was evident that even after receiving training on the attachment theory, the caregivers were unable to articulate key aspects of the theoretical underpinnings and how to apply this in practice(Morison et al., 2020; Moses, 2000b; Shaw & Kendrick, 2016). In addition, the caregivers also seemed to have difficulties in articulating and demonstrating the foundations of attachment theory and its implication in practice related to children's future outcomes and wellbeing (Garcia Quiroga & Hamilton-Giachritsis, 2017a; Moses, 2000b) The authors concluded that this could increase the probability of these children being further re-traumatised and neglected (Morison et al., 2020; Moses, 2000a; Shaw & Kendrick, 2016).

Another qualitative study using the attachment theory as a framework to conceptualise residential careworkers' understanding and perception of their relationship building with the children in their care was conducted in Chile with a Chilean sample (Garcia Quiroga & Hamilton-Giachritsis, 2016, 2017a, 2017b). The findings highlighted a great commitment to the job and emotional investment from the caregivers' perspective. They expressed high levels of emotional involvement, affectional display, and love bonds characterised by empathy, happiness, sadness, and mutual reward (Garcia Quiroga & Hamilton-Giachritsis, 2016). Their concepts of attachment were characterised by demonstrations of affection such as giving kisses, hugs, and telling the children, “I love you!”. This strategy may not be welcomed in other countries, where a culture of fear of showing affection and touching children appropriately, and of raising concerns and bad practice may result in a more emotionally inhibited and sterile environment (Shaw & Kendrick, 2016; Morisson 2020). In addition, the creation of a second home, and high levels of emotional involvement, according to Garcia Quiroga study 2017, determined a strong sense of team working, which constituted a strength and promoted a sense of belonging for the child. This cohesion facilitates the relationship with the children and adherence and continuous commitment to offering children the best quality of care.

Three qualitative studies investigated how residential care workers understand, make sense, and implement the attachment theory in their practice, more specifically in their relationships with the children in their care (Garcia Quiroga & Hamilton-Giachritsis, 2016; Morison et al., 2020; Moses, 2000a). Overall their findings suggested that caregivers perceive and implement the attachment theory spontaneously and intuitively in their daily interactions with the children (Morison et al., 2020). However, when further exploring their understanding and the implementation in practice, the concept of attachment appeared to be largely misunderstood within their relationships with the child and the connections established, as such overstated in their language. In contrast, within the support and care implemented within their daily practice, duties and responsibilities, other types of needs seemed to be prioritised as opposed to emotional connectedness. For example, caregivers seemed to perceive and fulfil their main role as providing practical care and support with children’s basic physiological needs, such as feeding, cleaning, and administrative work.

In general, findings suggested that child caregivers tend to use a more reactive rather than a proactive, interactional method in their daily practice (Moses 2000a; Shaw-Kendrick 2016; Morison et al., 2020; Garcia Quiroga 2017a). The implication of reactive practice is highly detrimental for the children, as it can interfere with their emotional regulation, exacerbating their psychological distress and can negatively impact the relationship formation and a child’s feelings of safety and stability. Furthermore, residential caregivers appeared to become more aware of attachment-based practices when the children are in crisis; for example when their emotions and challenging behaviours cannot be managed safely in the home and the children are discharged and sent to secure units or more restrictive environments (Morison et al., 2020; Shaw & Kendrick, 2016).

Whilst some studies emphasised the importance of the caregivers' initiative and perseverance in their relationship with children (Garcia Quiroga & Hamilton-Giachritsis, 2016; Morison et al., 2020; Moses, 2000b; Shaw & Kendrick, 2016), two studies held a different stance. These authors considered the relationship as a mutual and reciprocal process - the relationship is determined by a series of factors, some of which pertained to the child (Cahill et al., 2016; Moses, 2000a). Specifically, they suggested that variables such as a child's previous experiences (of being looked after at home and/ or in care), number of placements, and behavioural presentation, significantly impact the relationship-building process. In addition, intrinsic qualities of the child, such as an easy-going personality or non-challenging/non-problematic behaviours seemed to predict the quality of the rapport, a child's stabilisation in the placement and future outcomes (Cahill et al., 2016). Although the principle of reciprocity and mutuality in interpersonal relationships may be universally valid in the symmetrical relationship, it is inappropriate and even detrimental when applied in non-symmetrical interactions. This is even more the case in care system environments, where the adult is responsible for providing good quality care, which given children’s complex needs, can only be provided if a stable and consistent rapport is established between the child and the caregivers (Garcia Quiroga & Hamilton-Giachritsis, 2017a, 2017b).

Overall, caregivers' perceptions and conceptualisation of their relationship-building with the children in their care appeared to follow a common-sense and intuitive approach. In their views, relationships were more reciprocal rather than adult-led, and there seemed to be an expectation that the children should engage naturally as part of a normal social interaction, and not as part of the therapeutic process led and encouraged by the caregivers (Cahill et al., 2016; Garcia Quiroga & Hamilton-Giachritsis, 2017a; Kendrick, 2013; Morison et al., 2020; Moses, 2000a; Shaw & Kendrick, 2016).

There was evidence in some studies(Morison et al., 2020; Moses, 2000b) that an intuitive and common sense approach resulted in caregiver-led rather than child-centred relationship-building, thus based on caregivers' own personal characteristics, needs, and understanding of children's needs. In such instances, children's needs may be overlooked, trivialised, and not fully understood. In addition, the therapeutic quality of the relationship-building process may lead to further rejection, and trauma when there is not a professional quality to it or is reduced to merely having similar personalities, likes, clothes, and hobbies (Morison et al., 2020). This may leave the children who are more withdrawn and presenting with more internalised patterns of symptoms at risk of being neglected and re-traumatised (Garcia Quiroga & Hamilton-Giachritsis, 2016; Shaw & Kendrick, 2016).

The child residential caregivers also conceptualised relationship-building through both positive and negative experiences. The positive experiences were those characterised by expression of physical affection (Shaw & Kendrick, 2016). Caregivers reported that their job was to love, care and respect the children (Garcia Quiroga & Hamilton-Giachritsis, 2016, 2017a, 2017b; Shaw & Kendrick, 2016). In their views, caregivers affirmed that children need affection, and this should be safely offered without fear of negative consequences (allegations of abuse) and in a natural and spontaneous way(Garcia Quiroga & Hamilton-Giachritsis, 2017b). Their perspective of a healthy and secure relationship with children was that it should emulate as much as possible the family-like environment to normalise children's experiences and promote future psycho-social adjustment (Garcia Quiroga & Hamilton-Giachritsis, 2016, 2017b; Kendrick, 2013).

General recommendations regarding clinical practice and best outcomes for children emphasise the importance of relationship-building and the creation of therapeutically enabling environments. For example, Garcia Quiroga and Hamilton-Giachritsis concluded in their 2017a studies that creating and incorporating family-like dynamics in children's homes is crucial given children's needs for relating and repairing their attachment wounds. ANOVA analysis revealed significant differences between the quality of the interaction and a child’s attachment style (F (2,53) =8.72, p =.001) with a large effect size of .247 (Garcia Quiroga & Hamilton-Giachritsis, 2016, 2017a, 2017b). One study concluded that although the caregivers' knowledge and skills are important, the relationship they build with the children in their care is reciprocal, based on caregivers’ and children's characteristics and dynamics (Cahill et al., 2016).

Key Factors That Promote Relationship-Building and Potential Barriers That Hinder the Relationship-Building

The residential care workers in the SLR sample highlighted both positive and negative experiences of working in residential care. These views were based on structural factors, as well as relationship-building and person specific factors (e.g., child’s and caregivers’ personality, training, attitudes, motivations, and sensitivity to children's physical and emotional needs) (Garcia Quiroga & Hamilton-Giachritsis, 2016). Given the nature of this review, whilst some structural aspects were considered, the focus was on the perceptions of caregivers in relation to the therapeutic relationship.

Acknowledging the function of the relationship is an important factor of relationship-building, as this will achieve positive outcomes and good levels of engagement from children. Relating to the children means that caregivers learn about a child’s background, which allows the caregiver to effectively identify a child’s needs. By doing so, caregivers have reported that it was easier to teach the children new skills, emotional regulation, provide safety, nurture, structure, and boundaries (Morison et al., 2020). Residential caregivers' views of their relationship building with the children was mainly influenced by the way in which they perceived the children and their characteristics (Morison et al., 2020). There was a tendency for caregivers to build a good relationship and offer more child-centred care rather than standardised care to children who were more obedient, easier to work with and engage, had less behavioural and emotional issues, and showed respect to the staff (Morison et al., 2020; Moses, 2000b).

Other positive enabling factors highlighted within the studies were the use of individualised person-centred approaches. These approaches stipulate that each child must be treated as an individual with unique and specific needs. This will enable and facilitate an equal opportunity for the children to access healthy and secure relationship-building regardless of their characteristics and emotional and behavioural presentations (Moses, 2000a). The desirable relationship-building process, initiated by the caregivers should contain genuine interest, trust, negotiation, encouragement, engagement, structure, consistency, self-esteem enhancement, and a constant search for positive qualities within the children (Garcia Quiroga & Hamilton-Giachritsis, 2017a). These core aspects can positively influence children’s sense of worthiness and thus will make them feel that they deserve good care and may promote a sense of positive identity and belonging. In addition, caregivers’ self-awareness, reflective skills and practice, and parental sensitivity are crucial to establishing a secure basis and promoting positive and meaningful relationship-building (Morison et al., 2020).

Aspects regarding caregivers' understanding and implementation of relationships and attachment theory gravitated around the concept of connectedness. Some of the techniques highlighted were offering children a secure basis, sympathy, guidance, using trial and error, small talk, intuition, showing genuine interest, engaging, motivating, enhancing a child’s self-esteem, and encouraging the children to talk about themselves (Moses, 2000a). Another important enabling factor in the relationship-building process was the atmosphere at work and the role modelling of the relationship between the caregivers. This is particularly relevant since the caregiver emulates a family environment with long working hours, closeness and sharing of space and environment. Interestingly, although most of the studies discussed the creation of a family-like environment, only one study mentioned how important positive relationships between colleagues are when mirroring pro-social behaviours and interpersonal effectiveness for the children (Garcia Quiroga & Hamilton-Giachritsis, 2016).

Moses (2000) highlighted the detrimental effect of caregivers' perception of themselves as incompetent. This occurred when caregivers were repeatedly rejected and targeted by the children and young people in their care, which had a negative impact on their practice. The implications were that caregivers felt they lacked sufficient confidence, self-esteem, and self-efficacy, which hindered their capacity to build a rapport and form relationships (Morison et al., 2020; Moses, 2000b; Shaw & Kendrick, 2016). This issue requires more investigation, as this may suggest the existence of caregivers' factors that may be conducive to vicarious trauma, a high turnover rates, and burnout.

The study by Garcia Quiroga and Hamilton-Giachritsis (2017a) investigated factors that influenced the quality of attachment between children and their caregivers, identifying caregiver-led factors such as, caregivers' capacity to engage, be sensitive, exert disciplinary control and show warmth and affection towards the children (Garcia Quiroga & Hamilton-Giachritsis 2017a). These specific factors and the quality of the relationship between caregivers and the children in their care were found to have a positive impact directly on the quality of attachment to the children. As such, the better the quality of the interaction the healthier and more secure the attachment. There were also significant differences between the “secure”, “insecure”, “disorganised” attachment style and caregivers' factors associated with caregiving within the home. In other words, the poorer the relationship and the interaction, the more insecure and disorganised the child’s attachment. Another factor, found by Garcia Quiroga and Hamilton-Giachritsis (2017a), that seems to influence positive relationship-building is the beliefs held about the relationships with the children and how this should unfold. Beliefs consistent with a more distant approach and non-affectional involvement were linked with insecure and disorganised attachment in children. Consequently, caregivers’ perspective and understanding of their role and meaning making were that of a practical nature based on meeting their basic practical needs rather than becoming involved emotionally with the children (Garcia Quiroga & Hamilton-Giachritsis, 2017a; Morison et al., 2020).

Although challenges were acknowledged (as expected within in any relationship), most of the participants were ambivalent to forming close relationships for several different reasons (Garcia Quiroga & Hamilton-Giachritsis, 2017a; Morison et al., 2020; Moses, 2000b). Whilst recognising the need to look beyond behaviours, they also reported not being able to do so, as sometimes there were no overt triggers to a child's challenging behaviours. In this sense, self-awareness of one's own feelings, being human but not taking it personally, was a factor that facilitated and allowed the relationship formation (Cahill et al., 2016; Morison et al., 2020; Shaw & Kendrick, 2016). Building self-awareness, introspection and mentalisation skills were key factors when facilitating the relationship building process as emphasised within some of the studies included in this review (Cahill et al., 2016; Moses, 2000b; Shaw & Kendrick, 2016). The main consequence of this fundamental process is that caregivers, who were able to reflect and manage their own emotions and reactions to children's challenging behaviours, were more able to understand, accept, and empathise when faced with children's challenging behaviours (Garcia Quiroga & Hamilton-Giachritsis, 2017a). Thus, they were responding rather than reacting to children's trauma-led reactions, instilling a sense of containment, safety, security, and trust.

Some of the main factors associated with unstable and inconsistent relationships between caregivers and children are of a structural nature; staff turnover, staff ratios, low pay, poor working conditions, working very long hours, and undertaking multiple tasks around the house were perceived as barriers by 90% of the participants from the studies contained within this review. Not surprisingly, these factors were also responsible for burn-out, high rates of turn-over, vicarious traumatisation, disconnection from the children and lack of time and resources to invest in the relationship (Garcia Quiroga & Hamilton-Giachritsis, 2017a; Morison et al., 2020; Moses, 2000b).

The same studies have highlighted a series of structural, environmental, and operational factors that interfered with caregivers' potential and opportunities to build a healthy and secure relationship with the children (Garcia Quiroga & Hamilton-Giachritsis, 2017a; Morison et al., 2020). Prioritisation of tasks within this industry has meant that there was little time dedicated to building the actual attachment and connection with the children. It was reported that these administrative demands and the operationalisation of the job left the caregivers with little or no time to play, talk, engage, and attempt to build a positive and meaningful relationship with the children they looked after. Consequently, a series of both caregiver-related factors and institutional factors appear to guide the implementation of child-centred therapeutic approaches in residential care (Garcia Quiroga & Hamilton-Giachritsis, 2017a; Morison et al., 2020; Shaw & Kendrick, 2016).

Factors found to facilitate the relationship between caregivers and children were the emotional investment in the relationship (providing affection and nurturance), caregivers' personal emotional stability and emotional availability, as well as their responses to children's complex presentations (Garcia Quiroga & Hamilton-Giachritsis, 2016, 2017a, 2017b). These studies highlighted that the caregivers' characteristics, and their capacity to form a relationship can be facilitated by the quality of care, good organisational factors, stability in caregiving, emphasising that caregivers' ratios are also important (Garcia Quiroga & Hamilton-Giachritsis, 2017a; Morison et al., 2020).

Shaw and Kendrick (2016) found a large proportion of caregivers had low levels of qualifications (high school or lower) and no specific qualification in childcare. In addition, amongst the factors with a negative impact, there was also a lack of knowledge and experience; the caregivers were simply recruited because they had children of their own or were enthusiastic about working with children.

Within some included studies caregivers reported that they lacked information about children’s backgrounds pertaining to why they were placed in care (Moses, 2000b; Shaw & Kendrick, 2016). They identified a pronounced lack of awareness regarding children’s needs and psychosocial development upon coming into care. Thus, in retrospect, it was difficult to be empathic and compassionate and fully understand the children’s needs and identify signs of abuse (Shaw & Kendrick, 2016). A further challenge noted was the use of restraints. It was reported to have the potential to hinder the relationship-building and trust between caregivers and children, leading to more challenging and dysregulated states in the children who then failed to feel safe and stable within their placements. Lack of understanding of the underlying function of children’s presentation may lead to further exacerbation of the cycle of rejection and abandonment that children experience when the relationship-building process fails (Shaw & Kendrick, 2016).

An important aspect highlighted by all the studies was that a balance needs to be achieved between risk aversion and the fear of taking on a more clinical role (e.g., a therapist) and over compliance with operational and structural demands. Many children appear to benefit from residential care, especially when a positive rapport is built, and attunement to the child’s needs is established through kindness, compassion, empathy, acceptance, and curiosity (Moses 2000a, Garcia Quiroga 2017a, Cahill et al., 2016). In line with this, one study highlighted the importance of spontaneity in engaging in activities and the normalisation of a child’s experience of being in care to allow the formation of a trusting and secure relationship (Morison et al., 2020).

Table 4

Included Studies' Strengths and Weaknesses

Author /date	Strengths and Weaknesses
(Garcia Quiroga & Hamilton-Giachritsis, 2016)	*Strengths:* A strong rationale for having used qualitative method. The focus groups were very suitable enabling fruitful themes. *Weaknesses:* Chilean sample was small and not representative of the wider Chilean population and results were not generalisable to other countries.
(Cahill et al., 2016)	*Strengths*: The study used both staff and care graduates providing a broader view; the authors recognised more research is needed in this area.

	Weaknesses: The researcher did not consider their own role in the process. There was a lack of contradictory information and no self-acknowledgment of limitations of the study.
(Moses, 2000a)	*Strengths:* There was a clear statement of the aims of the research, and the design was appropriate to address the aims of the research. Purposeful randomised sampling was used; there was a clear explanation of the relationship between researcher and participants. *Weaknesses*: No mention of ethical considerations and there was no paragraph strictly designated to the discussion and limitations of the study except for mentioning that the sample was small and that further research, mainly longitudinal, is needed to identify specific practices and a particular environment that promotes attachment.

(Morison et al., 2020)	*Strengths:* In considering the methodology, rigour was achieved by using a crystallisation process, constant comparison between and within the data, theoretical sampling, involvement of three authors during analysis, and participants’ reflections. The implications for both theory and practice were highlighted. *Weaknesses:* There was a rapid uptake of participants, and it may be that the methodology and analysis used were not best suited. There was also a risk that the findings may be deduced from existing theory/ findings and may not generalise to other similar settings and residential caregiver groups.
(Shaw & Kendrick, 2016)	*Strengths*: A retrospective view enabled the analysis of temporal aspects of the evolution of the care industry in Scotland.

	Weaknesses: Relied on the accounts of caregivers whose experience in childcare was from 1960 to 1975; potential for memory decay and lack of generalisability due to different socio-political and historical backgrounds.
(Garcia Quiroga & Hamilton-Giachritsis, 2017a)	*Strengths*: The measures were clearly described as well as the method; there was a clear and transparent mention of the ethics approval both in the UK and in Chile. The reliability coefficients were included; independent variables were explained and relevant to this study. *Weaknesses*: Not all the analyses were presented, measures were prone to overinclusion, and the role of the researcher was not explored.

Discussion

The purpose of this review was to explore existing literature of residential childcare workers' perspectives and meaning-making of the relationship-building with children in their care. More specifically, this review analysed the extent of caregivers' understanding, perception, and implementation of relationship-based practice, and its implication for children's wellbeing. Better understanding caregivers' decision and meaning-making processes will enable policymakers to understand what caregivers need to connect with and meet children's emotional needs so that they can thrive.

This review comprised six studies; five of them were qualitative (Cahill et al., 2016; Garcia Quiroga & Hamilton-Giachritsis, 2016; Morison et al., 2020; Moses, 2000b; Shaw & Kendrick, 2016) and one used a mixed-method research design (Garcia Quiroga & Hamilton-Giachritsis, 2017a). The review findings indicate that a series of structural and person-specific factors determine the way in which childcare workers perceive, make sense, and implement relationship-based practice with the children in their care. These were shown to affect both components of the caregiver-child dyad.

The person-specific factors relating to the relationship-building process included both children's and caregivers' characteristics, such as personality, gender, common interests, similarities, personal qualities, skills, and knowledge. Indisputably, the dynamics of the dyad and constellations of different intrapersonal and interpersonal factors are important; however, when understanding a child's challenging behaviours, there appears to be almost an automatic tendency by caregivers to blame the child's past history and the presenting behaviours, rather than the function of the behaviour (Morison et al., 2020; Moses, 2000b). Thus, the emphasis is placed on children's previous experiences and history of abuse and neglect, and how these impair their capacity to develop and maintain future relationships.

Four studies used the attachment theory framework to conceptualise the relationship-building and its use in practice from the caregivers' perspective. There was agreement that the attachment theory is a quintessential component of human existence, nonetheless, its understanding and application by caregivers was largely misunderstood and mistaken with primarily meeting children's physiological needs (Garcia Quiroga & Hamilton-Giachritsis, 2016; Garcia Quiroga 2017a; Morison et al., 2020; Moses, 2000a). As such, the authors signalled that the applicability of the attachment theory in practice, especially by laypersons, has been extremely simplified and trivialised (Morison et al., 2020;(Moses, 2000a). However, these studies did not explore caregiver's own personal circumstances and experiences which is at least equally important, given caregivers' accountability and role in the relationship with the children. Except for the mixed-method study, the other studies made no references to caregivers' own attachment style and their own potential difficulties with relationship building.

It becomes paramount to balance the contribution of both parts of the dyad to avoid demonisation of children with difficult behaviours, as well as staff turnover, burnout, and vicarious trauma. In supporting this statement, the findings of one study concluded that the quality of the attachment was inversely correlated with the years of caring experience the staff had as well as their beliefs about the role (Garcia Quiroga & Hamilton-Giachritsis, 2017a); in other words, the more experience caregivers had the poorer the quality of the attachment and their attitudes about the role. These findings slightly contradict what would be expected from someone who has worked in the care industry for many years: the more experience one gains, the more skills and knowledge one must provide good quality care. This finding is very significant, and whilst there is evidence to suggest further exploration is required, this finding suggests that working as a child caregiver has a cumulative negative effect on the caregiver. A plausible contributing factor could be the interactions between the very nature of the job, the intrapersonal characteristics of the workers, and the systemic factors around the care setting.

For example, caregivers' emotional investment in the relationship with the child, caregivers' own insecure attachment, and a non-person-centred care environment may easily lead to difficulties in providing high quality care. That is, the caregivers may withdraw and become detached because of repetitive losses (real or perceived), a lack of control regarding the children's care pathway, and a sense of inadequacy and lack of self-efficacy. These aspects and perceptions of oneself can be extremely detrimental for both care workers and the children they look after. Making sure caregivers have access to clinical supervision and support is crucial to mitigate the impact of this, as it can impede connectedness with the children.

Cultural and socio-political factors need to be considered as well as the macro system in which the residential care environment is embedded. The studies analysed in this review present a much more humane conceptualisation of institutionalised care as compared to research carried out in the care system in Eastern Europe (Muhamedrahimov et al., 2004). An interesting aspect highlighted throughout the studies were factors such as socio-cultural and historical background, ability, knowledge, experience, personal attitude, and motivation to work with children. As such, most of the participants in this study had low levels of educational achievement, with 88% of the participants having achieved minimum standard qualifications and 98% not having had any specific training in human behaviour, child development, psychology, or trauma and attachment. As supported in similar literature, the lack of specialised training may imply low levels of introspection, insight, self-awareness, and reflection, which are key for parenting, mentalising, and implementing an attachment-based practice (Ensink et al., 2021; Steels & Simpson, 2017; (van Agteren et al., 2021).

All six studies scored above 50% in the quality assessment stage. The scores obtained after quality assessment ranged between 53% and 78%, (medium to high quality) with a mean average of 66% and mode of 69%. Garcia Quiroga and Hamilton-Giachritsis (2017) obtained 78% with no unknowns. Overall, there is a strong justification for, and suitability of the qualitative method approaches for exploring this topic area, and data collection was very explicit and transparent. The focus groups are considered suitable for exploring themes related to the underlying factors determining the relationship-building and the attachment between caregivers and the children in their care. The study by Garcia Quiroga and Hamilton-Giachritsis (2017a) demonstrated rigor by using a crystallisation process, constant comparison between and within the data, theoretical sampling, involvement of three authors during analysis, and participants’ reflections. The study was conducted with a Chilean sample, hence there is potential for cultural differences when interpreting these findings alongside the other included studies. It is also noted that the researcher did not consider their own role in the process.

The retrospective study by Shaw and Kendrick (2016) implemented appropriate measures and recruitment of the participants; however, there was insufficient clarity regarding the role of the researchers. A potential disadvantage is that it relied on the accounts of caregivers whose experience in childcare was from 1960 to1975, thus relying on participants’ long-term and semantic memory, assuming this is intact.

The mixed-method study (Garcia Quiroga & Hamilton-Giachritsis, 2017a) clearly described both the measures used and methodology, with a clear and transparent mention of the ethics approval obtained in the UK and in Chile. The reliability coefficients of the measures were included; the study used appropriate statistical analysis, and effect sizes were included and explained. The steps taken to analyse the data were clear, and there was sufficient data to support the themes. Independent variables were explained and relevant to their study. The results were clear with all the findings stated. However, the role of the researcher was not explored, and some measures were not fully discussed in terms of reliability. Also, the sample was small, and only large effect sizes were detected. Thus, it is likely that other factors contributed to determining the attachment quality but were not identified. Also, as the study was conducted in Chile findings may not be generalisable to care institutions in Europe.

The lowest scoring studies in quality were conducted by Moses (2000), and Cahill (2016). With the former, there was a clear statement of the aims of the research, and the design was appropriate to address the aims of the research. A specific strength was the representative sample and randomised assignment, and there was also a clear explanation of the relationship between researcher and participants. Nonetheless, there was no mention of ethical considerations, and minimal consideration was given to the limitations of the study. The study by Cahill (2016) highlighted strengths by using both staff and care graduates as participants in the study, which confers a more comprehensive view and a wider range of experiences. The main limitation was the lack of reflexivity in relation to the researcher's role in the process. There was also no self-acknowledgment of limitations of the study, and a lack of data to support the themes.

There was a tendency to register more positive experiences and meaningful relationship-building by those childcare workers who had less experience, were more secure in their attachment style, and worked in a well-established and optimal care setting (Garcia Quiroga & Hamilton-Giachritsis, 2016). The care setting environment, namely the structure of the systems around the child, seems to be a predictive variable of children's sense of safety, security, and stabilisation within the placement (Garcia Quiroga & Hamilton-Giachritsis, 2016, 2017a, 2017b; Morison et al., 2020). Amongst the structural factors, found within this review and wider research, the most noteworthy are: the caregiver to child ratio, work conditions, training, support, supervision, ability to raise concerns, and staffing (Garcia Quiroga & Hamilton-Giachritsis, 2017a, 2017b; Moses, 2000b; Shaw & Kendrick, 2016). The aforementioned studies were conducted internationally and with younger and older children. As such, the type of care system highlights the relevance of certain socio-economic and cultural determinant factors. Thus, the system around the conceptualisation and implementation of care and fulfilment of children’s needs in care is still largely understudied, unknown, underdeveloped, and misunderstood.

In addition, when looking into participants’ motivations and attitudes, most of the studies involved interviewing caregivers at their workplace (Garcia Quiroga & Hamilton-Giachritsis, 2017a; Morison et al., 2020; Moses, 2000b). This lends itself to issues such as sampling bias and respondent bias. Hence, the findings of this study may not be truly representative of what participants really feel, think, and have experienced. However, one of the studies adds robustness and scientific rigor in that they incorporated randomisation within their methodology (Garcia Quiroga & Hamilton-Giachritsis, 2017a). This was achieved by two or more residential caregivers from each of the ten living units being randomly selected to maximise the representativeness of the sample. This was followed by purposeful random sampling, and the caregivers were chosen from all units to capture the central themes across care providers (Morison et al., 2020; Moses, 2000a).

Furthermore, some of the findings within this review are not unanimous across all six of the included studies. Two of them were conducted with both children and caregivers (Cahill et al., 2016; Moses, 2000b). This may indicate that there is a potential sample and research bias due to including care graduates, caregivers, and managers from the same setting, who are in active employment within the same company. As such, it could have interfered with caregivers’ degree of openness, their motivations, and attitudes towards their roles, and they may have responded in a socially desirable manner. Further, caregivers’ bias could also be present due to the self-reported nature of data collection. Although it is highly beneficial to use open questions to allow the caregivers to express their experiences, this could be counteracted by having no way to verify caregivers’ accounts as representative of what they actually do in their day-to-day practice and interactions with the children.

Whilst the focus of this review was mainly on the attachment and its theoretical understanding, it is not clear what caregivers' pre-existing understanding (based on personal and professional experiences) of the relationship-building practical skills and their implementation were. Thus, key factors such as understanding and knowledge of child care, child psychology and development, developmental trauma, child's needs, awareness of child's circumstances prior to their admission in care, and their own attitudes and motivations in undertaking this role, were not fully explored (Cahill et al., 2016; Shaw & Kendrick, 2016).

The mixed-method study was adequate to the topic under scrutiny. However, the reliability of the measures used was not always reported. This creates doubt about the reliability of the surveys when measuring concepts such as attachment, motivations, social-emotional relationship, and the quality of the attachment between caregivers and children (Garcia Quiroga & Hamilton-Giachritsis, 2017a). Furthermore, this creates difficulties in understanding how participants' scores fit with those obtained by the normal population and whether this falls within clinical or non-clinical ranges.

Within the retrospective study (Shaw & Kendrick, 2016), reliability biases were identified in relation to relying on distant memories when attempting to recall accurate information regarding their experiences many years ago. As such, the interviews were assessed for internal consistency and related to the wider context of policy in practice at the time. For further transparency and robustness, the data considered both relevant themes and idiosyncrasies of each narrative. Whilst many socio-cultural and political aspects have changed, some themes such as lack of resources and training, staff ratios, low payment rates, and non-professionalisation of the role, still resonate nowadays. The testimonies contained in the Shaw and Kendrick (2016) study can be used to enable both caregivers and stakeholders to reflect and work together to detect and minimise rates of institutional abuse (Shaw & Kendrick, 2016).

In regard to the four studies which used attachment theory, whilst their findings are valuable, assuming and using an aprioristic theoretical framework may bias both the researcher and the participants. The researcher may interpret participants' responses through the framework of attachment theory and assume that the caregivers are experts in attachment, even though this may not be the case. On the other hand, the participants may be primed to believe that they must give the right answers and prove their knowledge of the theory, rather than reflecting upon their own experiences of the relationship-building process. A disadvantage of this conceptualisation is that the themes may have been already predetermined, potentially incurring selection and allocation biases as well as measurement bias.

Limitations of this Review

The outcomes of this review are based on published studies only, and this may constitute a publication bias. In addition, the inclusion of studies that have not yet been peer-reviewed may provide further insight and their exclusion is, as such, a limitation of the current review. In scrutinising the titles of dissertations and other unfinished papers during the search strategy for this systematic literature review, some of them appeared relevant and may have met inclusion criteria although the author decided to not include grey literature in this review to include only high-quality scientific studies that have been published and/or peer reviewed. Most studies in this review were undertaken by researchers who have worked, were working, or are involved professionally within the care system, which can be considered both a strength and a weakness.

A potential weakness of the data synthesised for this review is the difficulty in making generalisations to different contexts and populations, as well as the inclusion of English papers only. This is mainly the case, given that the verbal account of caregivers is subjective, hence not applicable to other staff working within the same centre and across other facilities and countries.

The advantages of the review were the search strategy and the intertwining of the search terms to identify as many relevant studies as possible. The search was performed across a wide range of databases comprising both psychosocial and social science domains to increase the diversity of the studies. A scoping search with Scopus was also conducted prior to the database searches. The scoping exercise as indicated in the section method, was used to identify an extensive range of already existing literature (relevant to the area of this study) to identify potential gaps and opportunities for innovative ways to research a specific area of knowledge. In terms of assessing the quality of the studies, the quality assessment tools that were used considered sampling bias, measurement bias, participant selection, the role of the researcher, ethics, confidentiality, and clarity of the studies. Another assessor conducted the quality assessment to increment the reliability of the same via inter-rater reliability.

In summary, the results extracted from the included studies seem to coincide in that the quality of the relationship-building process and perception of it is heavily influenced by caregivers' understanding, knowledge, own personal characteristics, and structural factors of the care settings. Although children's characteristics are also considered, since the relationship is asymmetrical in nature, more emphasis is put on caregivers' responsibility and accountability to initiate, persevere, and nurture the relationship. Future research will need to consider the methodological limitations of this review to further explore these findings, to provide a more in-depth understanding of caregivers' characteristics, attitudes, motivations, and own attachment style and interpersonal effectiveness. The findings from this review highlight the need to better understand caregivers' own attachment styles, attitudes towards their role, motivations to choose the caregiver role, knowledge, and understanding of their role when caring for children. This process can be facilitated by a more sensitive and well-informed recruitment process where greater emphasis is put on the caregivers and what they bring to the relationship with the children in their care, as well as provision of appropriate qualifications, training and supervision, and a good organisational work environment.

Conclusion

From the findings of this review, despite its limitations, there is an identified need to gain access to childcare workers' perspectives and reasons behind choosing their role, mainly those aspects related to relationship-building and the impact of the relationship on the well-being of a child. Developing an understanding of how childcare workers understand, perceive, and make sense of their relationship with children in their care is key to understanding what they need to perform their role optimally and how their practice should be conceptualised. A better understanding of these factors means that children's needs will be better understood and more effectively met.

Since many studies have emphasised the importance of attachment-based practices, very little research and attention has been given to caregivers who, in fact, constitute the secure basis for the children. The caregivers are an important component in children's therapeutic journey in the care system, and without including them in this process, there is a risk that children's emotional needs remain largely unmet. This review takes a step closer to bridging the gap between theory and practice and accurately informing the needs of residential care workers for them to be fully equipped and prepared to meet the needs of the children in their care. Based on the findings from this review, the relationship-building process and its quality are fundamental aspects of a children's therapeutic progress and caregivers play a very important and key role in trauma recovery.

Chapter 3

Empirical Paper

Caregivers’ Experiences of Relationship-Building as a Main Therapeutic Approach to Meet Children’s Needs in Care

Abstract

Children in residential care are known to be more vulnerable than children who live in foster care and kinship care. They are at high risk of being criminally exploited, victimised, and criminalised; many of them experience severe emotional, behavioural, cognitive, and psychosocial difficulties. The quality of the care they receive and the relationships they build with their caregivers are key for children's psychological well-being and healthy development. Whilst some research has focused on children's lived experiences, needs, and difficulties, very little research has focused on caregivers' experiences of the relationship building process with the children (Sims et al., 1997; Steels & Simpson, 2017 which is crucial to meeting children's emotional needs for attachment, connectedness, and belonging (Bailey, 2017; Casonato et al., 2017; (Goddard, 2021)Goddard, 2021; Molano et al., 2021). Implementing a qualitative methodology, Interpretative Phenomenological Analysis (IPA) was used to explore the perceptions of six caregivers' lived experiences of the relationship building process and its impact on children's general well-being. Following individual interviews with the six participants, three superordinate themes were identified: *Relationship building; the emotional impact on caregivers;* and *caregiver similar lived experiences: Insight and motivation.*

This research explored the challenges that the caregivers are facing in their daily interactions and their attempts to build a meaningful and positive relationship, that can be therapeutic, with the children in their care. The findings offer guidance for clinical practice and

policies regarding optimal ways to implement attachment and relational therapy in the care system. This is paramount given the risks of criminalisation and victimisation of children in care when meaningful and functional attachments and feelings of belonging are not established (Anderson et al., 2006; Beck, 2006; Casonato et al., 2017; Cook et al., 2005; Jo-Hanna et al., 2021; Sochos & Najla, 2020).

Introduction

One in 10 children in care in the UK live in a residential children's home (Bradbury, 2018). Children are placed in care if they are experiencing abuse, neglect, or other maltreatment (Department for Education, 2015). However, children can also be placed in care voluntarily if their parents are struggling with their parenting responsibilities (NSPCC, 2022). These children can be placed in foster care, residential care, secure units, and residential schools (NSPCC, 2022). Research in this area has suggested that children are placed in residential care as a last resort because they are seen as not capable of living in a family environment due to their high-risk behaviours (Briggs et al., 2012). Placing children with their next of kin or other family members or foster care are typically considered first(Jacob et al., 2015). When these options fail, residential homes can be viewed as being beneficial for children with complex needs if they require specialist care and support(Bath, 2008; Molano et al., 2021). For a more detailed discussion of the needs for children in care please see Chapter 1. The role of care workers in such settings is therefore crucial in understanding children's needs and development (Department of Education, 2015).

Furthermore, research on residential care has found that placement in the care system is associated with a higher risk of involvement in the criminal justice system; these findings have been replicated internationally (Gerard et al., 2019; H. Leloux-Opmeer et al., 2016; Malvaso & Delfabbro, 2015; Ryan & Testa, 2005; Sellers, 2015) Data from 2014 to 2016 in

Australia show that children in residential care were 19 times more likely to be under juvenile justice supervision compared to youth from the general population (Australian Institute of Health and Welfare [AIHW], 2017). Young people's association with criminal activity has been linked to family breakdown, conflict, harsh and/or weak boundaries, exposure to violence and victimisation, living in poverty and low school engagement (Pardini, 2011). These adverse experiences are common amongst children removed from their families of origin because of abuse and/or neglect. As is clear, the risk factors for youth violence and criminality bear close resemblance to those for entering residential care(Kor, 2024; Kor et al., 2021, 2022; Zeanah et al., 2002).

Caregivers' Role

Caregivers are crucial figures in the lives of children in care (Bloom, 2010; Costa et al., 2020; Proeschold-Bell et al., 2019) Research has suggested that caregivers can achieve significant outcomes in terms of meeting children's needs in general when they are committed, working within an agreed model of intervention, and believe and understand that children are capable of adapting to their trauma (Davidson et al., 2011). It has been suggested that models of intervention should be trauma-sensitive and based on the principle of *relational therapy* (i.e., building positive and meaningful relationships with children) (Geller & Porges, 2014; Perry, 2009; Porges, 2011; Powell et al., 2020; Roche, 2019)(See Chapter 1 for further detail). The implementation in practice of these fundamental aspects of childcare emphasise the importance of a mutual mission and vision of the crucial role of relationship-based care to construct better futures for the most vulnerable children. Understanding and implementing this concept in day-to-day practice is paramount. If caregivers do not consider a child's traumatic history, they may view their challenging behaviour as purely disruptive and focus solely on the challenging behaviour rather than seeing it as a trauma response; thus, the context of human relationships becomes even more critical since the trauma exposure can translate into a significant interpersonal deficit (Davidson et al., 2011; Porges, 2006; Van der Kolk 2005). Instead, caregivers should be aware of a child’s past experiences and respond appropriately. The environment created by caregivers should be non-judgmental, predictable, and congruent with children’s preparedness for change and relationship building, which will allow them to gain trust, and feel understood and accepted (Davidson et al., 2011).

The environment that caregivers create should be a safe space where children can express their feelings, needs and opinions without judgement or punishment (Davidson et al., 2011). This process and incorporating an awareness of insecure attachment styles can promote an attuned and responsive environment(Brown & Sen, 2014; Brown et al., 2018; Davidson et al., 2011; Gilmartin et al., 2022a; Ireland et al., 2022).

Within recent literature reviews, meeting children’s emotional needs has been found to be a missing aspect of the approaches used to assess and support children in residential care, especially when they present with trauma symptomatology (Steenbakkers et al., 2018). When mental health problems are present, children should receive individualised interventions to meet the aforementioned needs. The individualised treatment is important, as better adaptation to trauma has been identified as a strong predictor for a reduction in different psychopathologies (Stoner et al., 2015). Government guidelines have lacked references to specific and effective mental health interventions for children in residential care and instead have focused on the social care model and access to mental health services (Tarren-Sweeney, 2021). Overall, there is no coherent approach advocated by statutory services which enhances the level of psychological interventions within homes, rather the implication is that trauma related mental health difficulties should be treated by external services.

Challenges

It is critical for effective care-based therapeutic support, that caregivers can understand and reflect upon the underlying function of children's challenging behaviours, and emotional difficulties following early exposure to adverse childhood experiences and trauma (Abdulla & Kasese-Hara, 2020; Becker-Weidman, 2006; Cahill et al., 2016; Carlo, 1988; Sims et al., 1997; Wright & Edginton, 2016). In addition, children with this presentation very often have attachment difficulties; thus, trusting an adult and permitting implementation of good adult-led care is for the most part, resisted, rejected, or sabotaged. These types of responses from children become a significant barrier to the relationship building process(Padykula & Conklin, 2010). By not getting this connection with appropriate, sensitive, and emotionally available adults, children are likely to seek out this connection elsewhere, making them more vulnerable to criminal exploitation (Anda et al., 2006; Baidawi et al., 2020; Stone, 2018)

Research has shown the role of residential care workers to be highly demanding, with the need to be constantly available, potentially blurring the boundaries between professional and private life and creating an emotional burden(Barford & Whelton, 2010; Reznikovsky-Kuras & Gerasimenko, 2020). Some caregivers have reported receiving little support from management and a lack of involvement in decision-making about children (del Valle et al., 2007; Eastwood & Ecklund, 2008; Kanios & Bocheńska-brandt, 2021). There have been reports of experienced caregivers becoming less or not involved with children in their care due to previous experiences of separation and/or a breakdown in placement (Garcia Quiroga & Hamilton-Giachritsis, 2016). In addition, caregivers can experience vicarious trauma because of their interactions with children in their care (see Chapter 1 for further detail). Due to the complexity of the role, examination of the recruitment process found that identifying quality caregivers with the right skills through a screening process is critical, and once they have been successfully appointed, training and supervision should be provided (Reznikovski-Kuras & Gerasimenko, 2020).

Requirements for the Role

The Children's Act (1989) and Children's Home Regulations (2015) state that caregivers should use positive behaviour strategies and individual plans to encourage socially acceptable behaviour, and children should be loved, happy, healthy, and safe from harm and able to develop.

Despite this, there are no minimum requirements in terms of qualifications or training required to work as a child caregiver in the UK (National Careers Service, 2017), and with children's homes having no specific criteria to meet regarding the delivery of therapeutic care, support from caregivers is often the only intervention present (Tarren-Sweeney, 2021).

Further research has suggested that caregivers should create a stimulating environment and attend to children's emotional, mental, and physical health needs, including repairing early damages to self-esteem (Casonato et al., 2017; Hong et al., 2021; Kerr & Cossar, 2014; Molano et al., 2021; Woodier, 2011). Caregivers should also engage in ongoing learning about their role and the children they are working with (Berlin, 2001; Briggs et al., 2012; de Voursney & Huang, 2016). Due to the nature of maltreatment children have often experienced, their caregivers should know how to best meet the needs of such children to reduce the negative effect of early life trauma (Briere et al., 2001;(Herring, 2021); Zeanah et al., 2002), highlighting the importance of knowing and understanding children’s needs (Steels & Simpson, 2017). Please see Chapter 1 for an overview of the needs of children in care with an emphasis on relationships and attachment.

Adventure Therapy

The present study involved interviews with caregivers who use the Adventure Therapy approach; an approach which is not commonly used in the UK and something which has not been explored in previous studies exploring relationship building between children and caregivers in residential settings in the UK. As such, an overview of Adventure Therapy is provided here and referred to when discussing the findings of the study.

Adventure Therapy is an experiential based approach to supporting people who are resistant to more traditional cognitive based approaches(Bellegarde et al.; Bowen et al., 2016; Dobud, 2016; Dobud & Harper, 2018; Mohan et al., 2022; Neill, 2003; Schuele, 1996). It has been said to be particularly helpful with both children, adolescents and adults who have chronic and severe psychological difficulties (e.g., developmental trauma and attachment disorders, personality disorders, severe depression and anxiety, and drug addictions). It has been found that more traditional types of interventions are sometimes ineffective and can even be harmful for children with these types of issues (Williams et al., 2018). Whilst there is no well-established, evidenced based grounding for this approach, a series of studies have found this type of intervention to be particularly effective with at-risk young people with complex challenging and emotional difficulties (Russell & Gillis, 2017; Walsh & Russell, 2010).

Within the approach, caregivers engage and build trust with the children through direct experiences of mainly outdoor activities to build skills, knowledge and experiences. These experiences enable relationships to be built through teamworking which will ultimately, it is hoped, create a sense of connectedness, belonging, self-esteem, and self-worth. It represents a more natural and spontaneous way of building relationships in an ecologically valid environment, using more sensorial/emotional skill building and a less cognitive therapeutic approach, thus offering an alternative to talking therapy (Alisic et al., 2014; Bailey et al., 2019; Davidson et al., 2011). This type of care is most often used where a child has been found to struggle with conventional, longer-term care. Types of activities include (but are not limited to) building a tent, cooking in a forest, learning survival skills; children and caregivers interact whilst doing these activities.

Adventure Therapy has been shown to be effective even for children who have difficulties with stabilising in longer residential placements, (i.e., children who are more resistant to conventional ways of building trust and relationships) (Bettmann et al., 2015; Parry et al., 2022; Russell & Gillis, 2017). Adventure Therapy allows children to develop new healthy habits (BOWEN & NEILL, 2013a; Neill, 2003). Adventure Therapy helps to establish positive relationship with peers, staff and themselves and has been found to improve overall functioning of children(Bellegarde et al.; Bowen et al., 2016; Dobud, 2016; Dobud & Harper, 2018; Mohan et al., 2022; Neill, 2003; Schuele, 1996). The present study was undertaken with caregivers working in an Adventure Therapy provision with children and young people who had difficulties with settling in more traditional placement settings. This type of placement differs from more long term residential or foster placements as children reside there on average 28 days (as compared to six months for residential and foster care), although in some exceptional cases the length of time spent at the Adventure Therapy placement may be prolonged to up to six months.

Concomitantly, more recent studies emphasising the importance of group and community belonging have concluded that people, and especially children, learn intuitively by watching others and by doing. As such, experiencing real-life challenges in ecologically valid environments is essential for children to comprehend the impact of their actions/behaviours and natural consequences following actions and behaviours (Christian & Brown, 2021; Gass et al., 2020). When this intervention is done in a natural context, it has been said to have the ability to bring humans closer to their primal origins. This idea is reinforced within Theordore Roszak's (1992) concept of ecopsychology, archetypal rites of passages, and the folklores around the world, that as individuals we are lost if not connected with nature(Christian & Brown, 2021; Harper, 2017; Moore et al., 2018; Redfern et al., 2018). Adventure Therapy seeks to educate – to teach values and social, emotional and lifelong skills in a non-directive way and where the child is not just a passive subject. In line with the concept of constructivism, in which it is suggested that children must be active participants in their own learning for this to be effective; Adventure Therapy is an experiential process characterised by action and reflection. It involves the acquisition of prosocial behaviours in a relevant natural and relational context where the caregiver is a facilitator rather than an authoritarian(Miller et al., 2017; Ritchie et al., 2016).

Rationale for the Current Study

As demonstrated in the systematic literature review presented in Chapter 2, some research has been conducted on the topic of relationships between children and caregivers in residential settings. However, to date, no studies have used an Interpretative Phenomenological Approach to gain insight into the lived experiences of caregivers. In addition, it is evident that differences exist between and within countries regarding the type of residential care being provided (see Chapter 2 for more details). As such, it was felt that it would be beneficial to gain insight into the specific type of residential care provided by the participants in this study, i.e., where the care is generally short term and where there is a focus on giving the children opportunities for experiences using Adventure Therapy. It is of note that whilst the questions in the interview schedule did not directly ask about Adventure Therapy, it was felt that participants may refer to this when speaking of their relationship-building experiences.

Furthermore, speaking more broadly, this research was considered necessary due to several organisational and clinical difficulties identified regarding the system around children living in the care system in the UK (Kendrick, 2013; Shaw & Kendrick, 2016, 2017; Steckley & Kendrick, 2008). Researchers and clinicians have suggested that children's wellbeing and psychological health tend to deteriorate when children are placed in residential care (Steels & Simpson, 2017; Vorria et al., 2003). For many children, being placed in care is a traumatic experience, as the therapeutic support plans put in place may not fully understand their needs, thus the caregivers may not be best equipped to respond appropriately. One of the most significant issues identified within the research has been the lack of meaningful relationships between caregivers and the children in their care. In addition, caregivers are not trained to offer therapeutic support, but rather a more intuitive spontaneous approach is used to relate to the children and to support them with their emotional problems. These factors seem to negatively impact children's adaptation, stabilisation, and emotional regulation leading to an exacerbation of their difficulties, further traumatisation, and vicarious trauma in the caregivers (Brown et al., 2018; Ireland et al., 2022; Jo-Hanna et al., 2021).

Background Context of the Setting in Which This Research was Carried out

The present research was carried out in an organisation providing interventions for children and young people in crisis, with ages ranging between 12 and 18 years old, who could not live with their parents due to court and /or child protection orders. In addition, the children could not be accommodated in foster care due to emotional dysregulation, high risk challenging behaviours (to themselves and others), and concerns of them absconding to their families of origin. In most cases, a brief admission usually lasting up to 28 days (sometimes up to six months) would deter children's admission into secure or more seclusive and isolating environments, such as psychiatric hospitals. The available interventions to support the children are more experiential and relaxed, non-directive and playful in nature, focusing on engaging the child in outdoor activities and team building skills to establish mutual relationships and a sense of trust (see above for details of Adventure Therapy). The aim is to support the children to regulate their emotions and help them build a sense of mastery and safety. Children are assigned a key worker who will attempt to form a relationship with the child. The key worker may receive training in attachment principles; however, they are not clinicians and as such do not provide therapy for the children in their care. There is an emphasis on the relationship, part of which is trust building.

Rationale for the Research Design

An Interpretative Phenomenological Analysis (IPA) approach - both to the design of the study and the analysis – was used to explore caregivers' perspectives and experiences of the relationship-building process (J. A. Smith et al., 2009; Smith & Osborn, 2015). The study design involved interviewing participants using a semi-structured interview schedule to gather in-depth qualitative data (see below for further detail of the study design). This qualitative methodology was considered the most suitable to capture participants' *meaning making* of a certain psychological and experiential phenomenon (Smith & Osborn, 2015; Tindall, 2009), particularly caregivers' perspectives on their role, as well as their understanding of and approach to the relationship-building process with the children in their care. Meaning making within IPA refers to the process by which individuals interpret and find significance in their personal experiences. IPA focuses on how people perceive and make sense of their lived experiences, emphasising the subjective and interpretative nature of human understanding. By exploring and making sense of their experiences naturally, caregivers can identify important aspects of their work environment, their needs, and perceptions of relationship-building.

Alternative qualitative methods such as Thematic (Braun & Clarke, 2006) and Narrative Analysis (McLeod, 2024) were considered, however, it was felt they would not allow for a full experiential analysis of the participants and their lived experiences.

Research Questions

This qualitive research explored the experiences of caregivers in relation to building relationships with the children in their care, in an adventure therapy setting. The research aimed to answer the following questions:

1) What is the caregivers' understanding of their role in relationship building with traumatised children in their care?
2) What is the caregivers' understanding of the emotional impact on them, and their motivation and capacity to build meaningful relationships with the children?

Method

Interpretative Phenomenological Analysis (IPA) is a qualitative approach and method of analysis focused on understanding and making sense of personal lived experience (Smith et al., 2009). IPA's function is to examine a topic, as far as is possible, in its own terms. Semi-structured interviews were conducted with six participants and then analysed using this method. The analysis entailed the process of interpretation being undertaken by the researcher, the participants, and another expert. The interviews contained topics of interest which the participants could talk about and explore at length with minimal to no disruptions. IPA concentrates on the detailed examination of participants, by analysing first each interview alone then capturing a constellation of consonant and dissonant themes found in all the interviews given participants' different experiences of potentially similar phenomena (Smith et al., 2009).

IPA's aim is to use a purposive homogenous sample rather than a representative sample to ensure that the topic being researched can be explored in depth. Small sample sizes are best suited for this type of analysis, from one to 15 participants having previously been recommended in research(Bramley & Eatough, 2005; Gilmartin et al., 2022b; Larkin et al., 2019; J. A. Smith et al., 2009; Smith & Shaw, 2017)

For this study, six participants with experience of working as caregivers were interviewed, three men and three women.

Study Design

Six participants took part in a semi-structured interview between April and May 2022, following an interview schedule which focused on experiences within the role of a caregiver, concentrating on the relationship-building process.

Interview schedule *(see Appendix I)*

An interview schedule was developed and piloted in collaboration with two individuals, one ex-caregiver and one manager of two different children's homes, who both had seven years of experience of working with children in care. The questions were designed based on reflective practice with home managers and drawing on the need for further research identified within existing literature in this area (Bailey, 2017; Banerjee et al., 2015; Barbosa et al., 2020; Cameron & Maginn, 2008; Castillo et al., 2012; del Valle et al., 2007). The piloted interview schedule, done by the researcher, initially contained fourteen questions which were then narrowed down to seven questions due to concerns about the length of time the questions would take to answer and collect feedback on the topics to be explored. Two additional questions were added to the initial pilot study as it was considered relevant after the pilot interview.

A semi-structured interview with seven open-ended questions was used to comply with the IPA requirements and to encourage participants to share their inner experiences and meaning making (Smith, 2003). The interview contained open-ended questions, and the process was flexible enough to adapt to the narratives presented. It provided contextual information but was ambiguous enough to be open to interpretation based on the participants' perceptions and experience (Alase, 2017; Smith, 2011; Tuffour, 2017).

Participants were encouraged to think of the questions (see Appendix I) based on their own experiences and perceptions of their role and answer them accordingly. The first questions focused on their interest and experiences of working with children, their role and expectations about the role, the challenges of the role, their relationship-building strategies with the children in their care, and their own perceptions and lived experiences of the impact of the relationship on children's emotional regulation, well-being in general, and future outcomes.

The remaining questions explored their experiences of the potential impact that the role had on them and what they had learnt about themselves since doing the job. In addition, they were invited to add any additional comments to ensure their experience had been sufficiently covered. At the end of the interview, the participants were asked about their well-being, offered the opportunity for a verbal debrief by the researcher after the interview which included signposting to available services, and given a debrief sheet (see Appendix H). The interviews were audiotaped and transcribed verbatim.

Participants and Sample

The sample identification was purposive, consisting of establishing contact with the regional manager of a private residential care service acting as a gatekeeper to invite participants to take part on a voluntary basis.

Following ethical approval from the University of Birmingham (ERN_21-0230, dated 4.12.2022) a variety of caregivers were purposively recruited with the support of one of the supervisors of the lead researcher from a residential care setting within the supervisor's professional network.

To be eligible for inclusion, participants had to possess at least three years of experience of working with children with complex emotional and behavioural difficulties.

Written consent was obtained prior to the interview, and verbal consent was also audio recorded at the beginning of the interview. Six caregivers volunteered to take part in the study, having spent and average duration of 3.5 years in their profession. The sample consisted of three males and three females between ranging from 27 and 45 years of age (see Table 5). This sample size aligns with other IPA studies involving health care professionals, to provide a manageable number of detailed individual accounts(Bramley & Eatough, 2005; Eatough & Smith, 2017; Handley & Hutchinson, 2013; Kor et al., 2021; Redfern et al., 2018).

Table 5

Participants' Demographics

Age range	Number of years of professional experience	Gender	Participant number
25-35	3.5	Male	P1
35-45	3	Male	P4
25-35	5	Female	P3
35-45	10	Female	P2
35-45	12	Female	P5
35-45	6	Male	P6

Procedure

The interviews were conducted remotely via the videoconferencing application Zoom. Confidentiality was emphasised by asking participants to be alone in the room for the duration of the interview. The participants were given information about the study via a participant information leaflet given to them by the manager of the residential care setting (see Appendix F). Prior to the interview commencing, participants were asked for their informed written consent (see Appendix G). Recording of the interview, using the built-in recording function of Zoom, began when interviewees felt ready, and participants were reminded they could ask for breaks, if required. Interview length ranged between 40 minutes to one hour and 45 minutes followed by a debrief (see Appendix H).

Data Analysis

The IPA method was used to analyse the transcripts (J. A. Smith et al., 2009; Willig, 2003). The six transcripts were read several times to gain a degree of insight of each interview. Reflections, notes, and codes were noted in the margins of each transcript. On the right margin of the transcript, emerging initial themes were noted. The themes were then categorised into groups of themes when common patterns were identified regarding meaning. Quotes from the transcripts were then extracted to enable adequate representation and grounding of the data. The themes that were not robustly grounded were removed and the same criteria was applied for each transcript. The themes identified from the six transcripts were compiled and grouped into superordinate and subordinate themes to illustrate the components of participants' experiences.

Elliott et al.'s (1999) criteria, rooted within the phenomenological hermeneutic model, were applied for this study (Eatough & Smith, 2017; Oerther, 2020; Willig & Billin, 2011). The phenomenological hermeneutic method has traditionally pursued the interpretation of a phenomenon as a single unitary meaning of something. However, more recent approaches have highlighted that the purpose of interpretation also includes the plurality of meanings, experiences, and interpretations in a text or of any phenomenon. In this study, hermeneutic phenomenology was used to explore and freely express participants' experiences, along with reflective activities from both the participants and the researcher. These experiences and reflections were then analysed to understand their meanings. Extracts of the data have been used to support each theme, to create a coherent narrative approach. A personal reflexive journal was completed before, during and after the research (Guba & Lincoln, 1994). The journal helped the researcher remain aware of the potential biases, given their role as a practitioner clinical psychologist, which was necessary to avoid misinterpretations and inferential, experiential, or judgemental conclusions.

In Interpretative Phenomenological Analysis (IPA), it is generally uncommon to employ a second coder or independent researcher to review coding, as IPA emphasises the researcher's interpretative engagement with the data, which is central to the subjective analysis process (Larkin et al., 2019; Larkin et al., 2006). Introducing a second coder could complicate this interpretative approach by imposing additional perspectives that may detract from the researcher's direct engagement with participants' experiences. However, as a form of quality check, the researcher met with an academic supervisor and an IPA expert to discuss their interpretations and to ensure that selected quotes accurately reflected the theme descriptions. This practice is acceptable within IPA and serves to enhance the trustworthiness of the analysis while staying true to the method's principles.

Reflexivity

Qualitative analysis is a subjective method and IPA highlights that a researcher's perspective can influence the analysis(J. Smith et al., 2009). The researcher's interpretative framework would have been influenced by previous and present work in the residential care system, as a care worker and a practitioner clinical psychologist, which includes: knowledge about different psychotherapeutic models of care and interventions for children in care, familiarity providing clinical supervision and training for the caregivers looking after the children, personal experiences with changes in the culture and philosophy of care from a person centred model to a more business led model of care; all of which contributed to rapport building with the participants and effective analysis of the data. Preconceptions were documented to encourage awareness and interview questions were removed during analysis to focus purely on the data.

Results

Following data analysis, three superordinate themes emerged: *Relationship-building; The emotional impact on caregivers;* and *Caregivers' similar lived experiences: Motivation and insight.* The first two superordinate themes were further divided into subordinate themes (see Table 6).

Table 6

Superordinate Themes	Subordinate Themes
1. Relationship-building	1.1 Meeting practical needs
	1.2 Challenges to relationship forming
	1.2.1 Children's past trauma
	1.2.2 Time constraints
	1.2.3 Frustration and self-preservation
	1.2.4 Lack of trust
	1.3 Boundaries
	1.4 We have our limits: The need for professional help
2. The emotional impact on caregivers	2.1 It can be hard
	2.2 When it's all going well…
3. Caregivers' similar lived experiences: Insight and Motivation	

Superordinate Theme 1

1. Relationship-Building

This theme encompassed participants speaking about their thoughts on issues related to forming relationships with the children in their care. It is of note that in some instances the term *attachment* was used by participants instead of the term *relationship.* The term relationship has been used for the purpose of defining this theme, however, as participants used the term *attachment* in a broader sense than commonly understood as in research/literature. For example, some participants appeared to use the term *attachment* to denote any form of relationship/closeness with a child. In addition, again in reference to the broader use of the term *attachment*, participants referred to attachments that children had with them but also to attachments they had with the child.

1.1 Meeting Practical Needs. Participants spoke of the importance of meeting the practical needs of children in terms of this being intertwined with forming a relationship. They focused on day-to-day routine and on finding activities which the children would enjoy and engage in. For example, P3 noted that having a relationship with themselves (and potentially others in the house) was intertwined with the practicalities of giving them activities and making sure they felt included:

> I think it all comes down to having that, that relationship is the first thing you've got to have. They've got to have a reason they want to get up and engage with the day. Erm, yeah, and they've got to feel a part of what's going on; it all comes with that relationship, cause ultimately, you know, the home that they're in is just a house, it's just a building with wall, it's the people that are in that house. (P3)

In addition, providing them with a routine and finding things that the children enjoyed doing, that perhaps they had never experienced before, were considered important:

> Get them to experience a bit of everything they can. Erm, and then, we can kind of gauge what, what, interests they do really have and what, yeah, if there’s anything that they really didn’t like as well; just trying to get into that, sort of, a good routine basically, so that they’re not becoming so dysregulated. (P1)

Similarly, P5’s narrative was around providing a routine and helping them find opportunities they enjoyed which they had not been able to experience before. They also spoke of meeting the basic needs of the children. This aligns with a trauma informed approach (i.e., meeting practical needs is related to trust building and safety) and contributes to establishing trust (see 1.2.4 for a focus on trust) within the relationship building process.

> We can, you know, we can get them sort of, get them up in a morning, we can get them going to bed in a certain period of time, having three meals a day, hopefully eating a bit more nutritious, erm. And trynna to just find some positive parts of the day, you know making some good and happy memories and stuff, when, I mean, part of the reason we do, sort of activities is to try and make sure these young people have the same sort of, opportunities, and the same experiences that a lot of, everyone else sort of gets to experience. (P5)

In emphasising this more practical approach to the interaction with the children, P5 is perhaps implying that some distance was needed with them. However, P5 also spoke of the type of relationship they had with the children and what they felt was of key importance:

> Essentially for me, it's about them feeling safe, you know, you, you are not their friend. You are there to, you know, to be that person to care for them, to talk to 'em about these things. You are in charge. (P5)

In saying that they wanted the children to know that they were in charge but that they were also someone that the children could speak to (which would perhaps involve an element of the children trusting them), and someone who would care for them, they are perhaps still implying that this type of relationship dynamic (i.e., parent/child) is important in their interactions.

Although perhaps not explicitly recognised by P5, meeting the practical needs of the children, providing them with enjoyable experiences and being someone, they could trust was described as important for them to build a relationship. There appeared to be a prioritisation of activity-based interventions in their account that may be an organisational requirement, which then potentially results in less time for forming a relationship with the children. However, being involved with the children doing enjoyable activities may lead to relationships forming.

1.2 Challenges to Relationship Forming. Participants spoke of a range of challenges they faced when trying to form relationships with the children. As such, this sub-theme was divided into further sub-themes regarding difficulties as a result of: children finding it hard to understand or control their emotions (potentially as a result of their past trauma) which can result in challenging behaviour; time constraints (i.e., short placements and a lack of time in their day-to-day role); a lack of trust by the children; and the emotional impact on staff which can lead to a need for staff to protect themselves from distress by remaining detached.

These challenges/difficulties were largely spoken of in terms of being barriers to relationship forming, i.e., if it were possible to address these barriers then it would increase the likelihood that healthy relationships could be formed which could benefit the child and reduce emotional fatigue and distress for staff. In some instances, staff shared how they would go about addressing said barriers.

1.2.1 Children's Past Trauma. Participants spoke of an awareness that children had often experienced past traumas which they felt led to them finding it hard to regulate/control their emotions which, in turn, led to challenging behaviour. In addition, they spoke of how they responded to this type of challenging behaviour. They expressed empathy and understanding towards the children. Although the caregivers did not explicitly speak about taking a trauma informed approach, it is apparent that they recognised that past trauma experiences of children need to be considered:

> … some of these kids have seen things that they should never, ever anybody should ever see in their lifetime. And so, you have to be open minded of, you know, the trauma and stuff that these kids have experienced. Um, but also if, if you're not sure on something that a kid has been through, sort of like trauma neglect, you have your, your training, to go the extra mile, Google it research, um, like little things to give you, you know, just a bit of a, an thinking of what actually it, you know, has gone off with this kid and how best you, you could help him and keeps smiling…These kids have been neglected, they've been abused, you know, they've got emotional sort of trauma that they've, they've had to deal with from, you know, some being really, really young…no kids should ever have to go through any of any of that. Um, so yeah, we are just, it it's quite sad to be honest. (P4)

Participant four indicated that they had received some training around trauma and that they would do their own research to find out how best to understand and support the child. They expressed empathy for the children which was perhaps a driver for them to spend additional time in trying to understand the child.

Participant two spoke of past traumas in relation to children copying behaviours they had witnessed in the past and spoke of how they would go about helping the child:

> They're just angry because of their trauma em and all the stuff that has happened to them. And they just sort of they because of these behaviours that they've had modelled in the past, they just yeah, that's what they do and the thing. They say they're going to

> stab someone because that's what they've seen other people doing. Yeah. Hmm. You just try and model appropriate different behaviour…We use the low arousal approach because of the behaviours and that kind of thing. So, it's just easy to, you know, if we just follow those kind of things and then just have a laugh with them, it's sort of treat them like, erm, a fellow human being. (P2)

In saying this, P2 was perhaps suggesting that they could best support the children by modelling positive behaviour that the children may not have previously observed. This approach aligns with offering support that targets challenging behaviour, even if its underlying function is not fully understood.

Participant 4 also went into more depth about how they supported the children who had experienced trauma. They reflected on the methods they used in terms of their approach and resources/tools (i.e. emotion cards) they used to meet the child at their level rather than expecting them to be able to, for example, articulate their emotions:

> Cause you know, a lot of them have come, you know, from trauma. Um, but I treat 'em, I treat 'em like I would my own children. So, if you know, I'm honest with them, I, I, I don't lie to them. Um, I come to their communication level of their understanding. um, sometimes we'll use sort of pictures, um, like, and, um, I forgot what we've got, like little cards for emotions and things like that. So, we teach 'em how to be able to use these cards to promote their, like their emotional wellbeing. Some kids can't talk, but they can show us a card to say, you know, I'm happy I'm hun I'm unhappy. (P4)

1.2.2 Time Constraints. Participants spoke of time constraints in terms of the short-term nature of the stay and in reference to the amount of time they had on a day-to-day basis to spend with a child. Participants spoke of the unpredictable pattern and brevity of the placement. These factors may have a negative effect on the potential of the caregivers to emotionally connect with the children and serve as a barrier to forming more meaningful relationships. For example, P1 emphasised the brevity of their stay, speaking of the process being rushed due to crisis situations.

> Yeah, erm, so usually, erm, we do 28 days, erm and then they come to us, when we introduce ourselves, we try not to push anything, like I said, we do sort of different deal with crisis care sometimes so sometimes it can be a bit more, erm, rushed unfortunately, well more rushed than we would like to. Erm, I mean, sometimes, in the ideal circumstances, they come for sort of rest bite care. (P1)

It is of note that P1 said "…more rushed than we would like to" as this potentially implies that they would like more time to get to know the children and perhaps form a closer relationship.

Participant six was quite explicit about their view that it is not in the best interest of the child to form a close relationship with them. They used the term "we" rather than "I", implying that they felt this is perhaps the *norm* for caregivers. They implied that the reason for not forming close relationships is that the young people may not be with them for a long period of time so it could be unsettling for the children to form a close relationship and then have the relationship break down: "we don't have any sort of long term, um, relationships, it's almost good for the young person, I think, to they've come to us, they've had a break they're settled and moved on rather than being totally attached to us". (P6)

There appeared to be an acknowledgement that getting children to open up and being a source of emotional support for them could be a time-consuming process. There was a clear narrative from all participants that they did invest what time they had in their relationship with the children on an emotional level. However, overall, the participants' experiences suggested perhaps that children’s emotional needs may be better met if caregivers have more time with the children.

1.2.3 Frustration and Self-preservation. There was a narrative around the frustration and distress sometimes caused by the challenges staff experienced with children; where, for example, they tried to build a relationship and help the child, but they did not feel they were able to help. Within this, some spoke of the need to therefore detach from the child or situation in order to protect themselves.

Participant four expressed frustration that they tried to help but sometimes there was nothing that they could say to help. On reflection, they felt that it was not their fault that the help they offered the child was ineffective – implying that there were times when a child was, in their opinion, beyond their help:

> It's like banging a head against a brick wall because you're trying to tell this kid, you carry on doing what you're doing and you go into a secure unit and you know, we didn't fail him. He kind of failed himself. (P4)

Participant three spoke about their experiences - reflecting on the emotional investment they made to meet some of children’s emotional needs and the frustrations felt when they did not see fast changes in the child:

> It is really challenging to continuously as a job, kind of hold the space for somebody it is very much a long, long, long process; it's frustrating because it's almost like I'm at the other side and they are kind of egh egh. I just want to rip out all this knowledge and experience that have and fit them in and get them to see but you know it’s the incremental changes. (P3)

Participant three went further to speak of the need to, at times, step back (in their wording, to *detach*) from the child:

> …don't take it personally at all because you're just like, you know I've had this before, like in the nicest way possible. I'm not going to see you again. And I just kind of detach like it is a lot easier there is still.

Emotionally detaching could be viewed as a self-protective strategy whereby P3 did not want to form close relationships or invest too much time as this could lead to them experiencing negative emotions.

Many participants expressed concerns about the potential negative impact that forming close relationships with the children might have on both themselves and the children, which they cited as reasons for hesitating to build close connections. Participant four explicitly stated that they did not get *attached* to the children. Using the word "these" perhaps depersonalises the children by grouping them together. However, they noted that there were some nice children but are perhaps implying that, due to the ones they deemed to be "horrible", they cut off their emotions so as to not feel attached and potentially get hurt: "I don't get attached to these children. Um, even though there's some really nice kids out there and then there's some horrible kids out there. Um, I, I kind of like cut off my emotions" (P4).

Similarly, Participant six's narrative regarding forming relationships with the children also highlighted the behaviour of the children in relation to the need to detach themselves. They went on to analyse why this may have been the case, concluding that this protected them from feeling like they had "failed" in supporting a child.

> So, we're kind of like detach ourselves and if we do get one of these unruly kids in, we're just there to keep 'em safe. Um, yeah, it, it is hard. Um, but yeah, I just detach all emotion from it and then I don't get sort of like think, ah, I failed, or you know, I could

> have, could I have done this or could I have done that? Because I probably would've worked my hardest to help this kid. (P6)

1.2.4 Lack of Trust. Participants referenced, both explicitly and implicitly, the lack of trust that children initially had in them. They discussed how they worked to address this lack of trust in order to build a foundation of trust, which they saw as essential for forming a relationship.

> Um whereas I can think of a boy that I worked with, um, what used to, um, he, he would make statements and actions almost in an attempt to put a barrier up and push you away, sort of like it was going to punch you. It was quite apparent those behaviours were an attempt to sort of figure out who you were, how you were gonna respond to him, whether he could trust you. And if you were consistent in your approach, if you showed him that you weren't affected by all these different things that he was doing, and you continued to treat him in a respectful manner, he, that barrier broke down and he was able to trust you. (P5)

Participant six expressed similar views based on their past experiences, conveying perhaps that trust and a feeling of safety from the child’s perspective can be built through hard situations whereby the child learns that the member of staff can be trusted not to hurt or “hold a grudge*”* against them. They highlighted that there needs to be consistency in this on the part of the staff member:

> Obviously being consistent, um, showing that you can keep 'em safe, um, is, is another way you'll find that the children will gravitate to those ones who, who they feel can keep them safe um, that, and that ultimately might come from a negative experience. So, i.e., when the child has, um, is heightened and let's say there's been a need to

> physically intervene…or having to get hold of them and how you deal with that, I found that can also help following that once the child's calmed down that certainly working with them after that, there's a little bit of a shift because it's like, right, okay. I've been through this. You've, you've still come back…Normally you're not holding a grudge. And when I [the child] did behave like this, you know, you [staff member] didn't hurt me. Um, and, you know, everything was fine. (P6)

Trust was also discussed in the context of boundaries, with participants having shared that clear boundaries are important in building trust. Trust in relation to boundaries is further discussed in sub-theme 1.3.

1.3 Boundaries. The issue of boundaries was raised by many participants in relation to the relationship building process. Boundaries were discussed in reference to how much personal information they shared with children and were also mentioned in terms of the boundaries that are put in place for the children (i.e., rules, discipline). Both types of boundaries are presented in this sub-theme. It is noted that there may be some overlap with the sub-theme of *challenges to relationship forming* (1.2) in terms of caregivers reporting the need to be consistent when dealing with challenging behaviour, and in terms of building trust. However, this sub-theme is concerned with where caregivers have made explicit reference to boundaries. Most of the participants agreed that both professional and personal boundaries with children are fundamental. Whilst professional boundaries can be established pre- and post-recruitment via mandatory safeguarding training, it was evident from the narratives that personal boundaries can at times be blurred.

The participants all indicated that there was a need to form a relationship with the children but that they needed to be very cautious about what they disclosed about themselves and how close and familiar they were with the children. Without exception, they spoke about this cautiousness being as a consequence of having had a past negative experience or experiences, especially at the beginning of their career in care, whereby they had opened up to a child and felt that information had then been used against them:

> Like I said I think, them getting to know me is quite important as well, and a big thing is trust, like we're trying to get to know them, so it is important that they get to know me, but at the same time like there's definitely parts that I'm not going to tell them cause you know, I don't wanna give them sort of something that they can, anything that I think might be hurtful to me in the long run, I'm not gonna tell them cause I don't want them to have something if they change their sort of tone to me that they can start trying to, you know, pass stuff and throw stuff towards me. (P1)

Within their experience, P1 appeared to feel that to bring trust into the relationship, it was necessary for them to share things about themselves. It could perhaps be inferred that the child also needs to share things about themselves to support the formation of trust. Participant one is perhaps inferring that children can be changeable so caution was needed; if the child decided in the future that they did not like them then they could use personal information to hurt the caregiver in some way.

In the caregivers' narratives they are showing that they are thinking ahead and using knowledge acquired through past experiences with children to inform what they do and do not share about themselves. There was a recognition that "opening up" is necessary to build a relationship. They are maybe alluding to an implicit requirement that the child is required to open up to them, so they, in turn, need to open up to the child. However, it is up to the staff member as to what they chose to share:

> We have boundaries um, but our staff are quite laid-back um, and chilled and we normally, it's sort of like, we I'll have laughs and jokes to break that barrier of that first

> sort of like meeting of them. And then it's just sort of getting to know the kid and, you know, they, they get to know us. (P4)

Participants also spoke of their experiences in setting and maintaining boundaries in the context of what could be viewed as rules or expectations for the children in their care. For example, P4 reported:

> We put those boundaries straight in place. So, if they expect us to make them their tea or do this and do that, and it's like, no, mate, this is not how we work. You know, you need to be doing this to benefit yourself and, and to learn about daily, you know, life skills. But we, we imprint that you are with us for four weeks. (P4)

They spoke of making it clear from the outset as to what their expectations were of the children and what they would and would not do for them. They framed this is a positive way, i.e., that this was going to be helpful for the children.

Participant six appears to not want the children to feel as if they do not have any say in their lives but that, at the same time, the children need to know where they stand, and suggests that this is an important aspect of helping the children feel secure:

> Really clear balance on your boundaries. Cause we've all got our own emotions; you can be firm, but fair when it comes to enforcing boundaries, I think, and they do need the clear, you know, it's not, it's not a dictatorship, but ultimately there is that thing. It is important that there's boundaries because you can live or die by them, because, um, the, the young people are very good at picking up on this; it's not about being oppressive, but it's about going, knowing where you are, what the space that you've got to move in. of these kids are confused about things anyway. (P6)

Saying "because you can live or die by them" may suggest that P6 had past experiences whereby they did not have firm but fair boundaries resulting in negative consequences. It is interesting that they felt it is important that the boundaries they set for the children are considered "fair". It could be that they feel if children do not think boundaries are fair then this would have a negative impact on their relationship and the child's behaviour.

Participant two spoke about boundaries both in terms of giving the child some stability and in reference to how much they shared with a child. They experienced resistance from children about the boundaries they had put in place but, ultimately, they felt that fair boundaries were a necessity in reference to sharing and rules.

> They'll go, right. I know where I am now. Uh, and you will find, you'll get that initial resistance. Essentially for me, it's about them feeling safe, having boundaries to be able to build trust and have stability in their lives…providing care for this young person is quite a key thing for sort of that balance of knowing exactly how much you do share with them about your sort of, personal life. really clear balance on your boundaries. (P2)

Participant two mentioned the same issue of emotions that P6 mentioned; both suggesting that their emotions may impact on boundaries. There is perhaps a sense that they need to put their emotions to one side and focus on setting and/or enforcing boundaries for the sake of the child.

Participant six spoke of difficulties occurring when children viewed caregivers as friends rather than being in a parental role whereby, they needed to enforce rules; noting that it was a difficult balance:

> Um, I, I do find with staff that are kind of take the more friendly approach on everything. They can struggle a bit to draw it back, you know, when when's needed.

> Um, and it is a difficult skill to have that balance of maintaining safety, keeping the boundaries, but also relating to the young person and you know, them feeling comfortable with you. (P6)

Overall, most participants highlighted their experiences of building relationships with the children in their care and emphasised the importance of setting firm but fair boundaries. It appears they implement these boundaries not only in day-to-day routines and rules within the home but also regarding the disclosure of personal information.

There was a narrative from participants that boundaries are key to facilitating children's capacity to trust the caregivers and are necessary for them to protect the children and give the children the sense of being cared for.

Interestingly, P1 also referred to avoiding having a "friend" type of relationship with the children. Perhaps from past experiences, they believed that sharing personal information with the children would cross a line and make the children view them as a friend rather than a caregiver. It is evident that they would prefer to be viewed as a caregiver; it could be inferred that this is because this puts them in the position of responsibility/power over the children rather than the children seeing them as an equal, which could perhaps cause difficulties or lead to a lack of respect from the children. However, later in the narrative they appear to concede that it would be acceptable for the children to see them as a friend if they also recognised that they were also their caregiver:

> Like I wouldn't share anything, really from like my childhood that was like a real negative or anything like that kind of thing, erm, yeah, I think it's, it's, just important to be professional still all the way through, erm like the relationship, I think if you overshare with the young person too much, you, they're not gonna see you as a carer, they're gonna see you as a mate and you don't wanna be into that position where, they think you're, I say they think they're your mate, it's like they can get on with you and

> they can think you're friends and stuff but they must still know that you're their carer, you're not one of their mates… . (P1)

1.4 We have our Limits: The Need for Professional Help. Despite their efforts, caregivers presented a recurring theme that some of the children's needs, particularly the emotional aspects, could be challenging to manage. In this sense, most participants agreed that addressing these needs was not solely their responsibility and, at times, exceeded their level of expertise.

Although caregivers discussed their understanding of trauma and the various ways they support the children, some narratives suggested that they did not always feel prepared to manage children with more complex presentations. Some participants indicated that, at times, it was better not to push a child to disclose emotions, as they were not trained to handle more complex needs and, therefore, might not respond appropriately.

Some participants felt that dealing with this type of presentation fell outside of the remit of their roles, and that "clinical" issues must be treated by specialised mental health professionals.

> But, yeah, I mean when they move on past us that's when they really open up to these professionals and can get the support that they really need cause we have sort of had, I think, in the past where, they've really trusted the staff and they really have opened up but the staff haven't quite been able to manage or sort of deal with everything, sort of closing back up really. (P1)

Due to past negative experiences in encouraging children to open up, P1 may have become cautious about trying to support children with deeper issues, preferring intervention from specialised professionals:

> Some are presenting with things that we can't meet then we can, have to sort of speak to the social team and then you know say look we need you to find somewhere else for this young person cause we're not appropriate... we don't need them to open up about their whole life or anything like that cause again I don't think we can always sort of manage that, we're not the best people to sort of, for them, to sort of speak to us about everything really. (P1)

Participants suggested that additional psychological support can be beneficial, especially when children's emotional needs are complex and not adequately addressed by behavioural management techniques. Their narratives indicated a belief that support from mental health professionals would benefit some of the children in their care. They expressed a positive view of professionals, such as psychologists, believing these experts would be better equipped to help the children rather than feeling there was nothing more to offer

Participant one and P5 spoke of the fact that there are some children who need more support than others – with some needing input from other services in addition to psychologists:

> See, the greater the child's need, the larger that sort of multi-agency team tends to be and the more meetings and the more sort of people input on it, and the less needs they have, probably the less they'll do it. (P1)

Superordinate Theme 2

2. The Emotional Impact on Caregivers

This theme reflects participants' perspectives on how their work with vulnerable children may have affected them emotionally. They primarily discussed the challenges and negative emotional impact of the work. However, some also mentioned positive experiences, suggesting that, despite the difficulties, the work could be enjoyable and have a positive impact on their emotions as well.

2.1 It can be hard. Within this sub-theme, participants discussed the challenges of working with children who have complex emotional and behavioural needs, noting the negative emotional impact this work has had on them. In addition, they spoke of how they went about addressing the emotional impact, and how they felt they could have been better supported in order to lessen/address the emotional impact. There is a small amount of overlap with sub-theme 1.2.3, however, in this sub-theme there is more of an emphasis on the impact on the caregivers rather than an impact on their relationship with children.

Participant three spoke of the need to withstand the negative emotional impact:

> [the work is] …incredibly challenging from from all my different experiences. It is really challenging to continuously as a job, kind of hold the space for somebody; it is your job to kind of be the adult and just kind of sit and accept it and not let it kind of affect you emotionally. (P3)

It is interesting that P3 felt part of their job was to prevent the challenging behaviour of children from affecting them emotionally. In saying this, they acknowledged that it would be natural for the role to have a negative emotional impact, but felt they needed to withstand this, perhaps for the sake of the children. Participant four and P5 also indicated similar views regarding how challenging the role was and that they felt it was necessary to try and not to let the work impact their emotions.

Participants reflected on core aspects of their role, such as the direct and indirect exposure to children’s experiences and behaviours, and how it felt to witness their emotional turmoil. Some participants felt that the vicarious exposure to children’s trauma and intense emotional distress had an impact on their own emotional regulation, and their capacity to effectively support the children in their care. This narrative is perhaps indicative of the level of empathy and compassion they had for the children in their care; without which they may not have been as affected emotionally.

Participant three spoke more specifically about how their role in supporting children was particularly challenging, as it reminded them of their own experiences and associated emotions:

> It can be very triggering, especially when you meet young people that have a very, let's say for example have very similar upbringing to me and have been through the same thing as me. You know, tell me how they feel about it. That's what I find it hardest to, to kind of hold the space because it triggers me, and it brings up mine my my thoughts and feelings from my childhood. So that's hard too. (P3)

All participants acknowledged, in various ways, the impact of their work on their own mental health and, in turn, their capacity to effectively meet the children's emotional needs. Many of the participants experiences contained references to some very stressful experiences which perhaps suggests that at some point in their career they may have suffered burnout and/or vicarious trauma. It can be hypothesised that, through these past experiences, they may have developed coping mechanisms, such as emotional detachment (i.e., stepping back from emotional investment in the relationship (see sub-theme 1.2.3)) to keep themselves safe.

Participant three also spoke of experiencing compassion fatigue. They attributed this to their own emotions at the time. There is an implication that in order to cope with the challenging nature of the role whilst still feeling compassion for the children, they needed to feel happy and positive themselves.

> I experience compassion fatigue because I'm a heart machine, I'm a very, very loving and open, you know, high energy person. But when I am tired in myself or in my life

> experiences aren’t going well or when I’m not really myself, when I experience compassion fatigue for the kids. (P3)

Participant three highlights that their nature was to express love and care for the children. However, the implication is that this was, at times, emotionally taxing for them.

Some participants described the impact of the role on their level of patience. As P1 noted, “I mean, I know sometimes coming off, off shift and stuff like that, like it’s definitely shortened my patience, that I’ve got a lot shorter fuse then when I get home myself.” This may suggest that working with children who display challenging behaviour leaves them feeling emotionally drained; they may need to exercise patience with the children during their shifts, only to find they have little left by the time they go home.

Participant one went further to speak of how they coped with negative emotions:

> I think everyone does need someone to talk to, talk things through with sometimes, whether they want to admit it or not, like I know I said I shut myself away, but like my sister’s my one and I’ll normally talk to her quite a lot at some point. (P1)

Four participants mentioned that clinical supervision sessions had been removed from their support structure (P1, P2, P3, P6). Participant one spoke of a sense of regret that these were not embraced openly by staff despite their view that staff found them to be helpful:

> …clinical supervisions and stuff which the company no longer does, we still do sort of managerial ones but not the clinical ones and I think that that, I think a lot of staff, a lot of staff won’t want to admit that they actually found that beneficial. (P1)

In short, most participants affirmed that caregivers need help and support to effectively fulfil their multiple roles and meet the children’s emotional needs.

In the participants' narratives there was mention of the term "blame" in terms of attribution of blame to themselves for the behaviour or emotions of the children. It is clearly a very powerful aspect of their experience in their roles. Caregivers explained that to cope emotionally, it was "…important people don't blame themselves" (P3) – perhaps as this would lead to feelings of failure or inadequacy in their role that would have a negative emotional impact and make it difficult to form relationships with the children:

> Cause I think as well, cause sometimes if it's a case of blame as well and I think it's important not to blame cause it doesn't always go to plan, like you might try something and it doesn't go well and then, I don't think people should always blame themselves for trying something because no one knows, you don't know what's gonna get this young person to engage well. (P1)

It was perhaps evident that caregivers occasionally blamed themselves or felt that others had blamed them in the past when things did not go well. This type of self-attribution may negatively impact caregivers' motivation and confidence in their ability to positively influence the children in their care.

2.2 When it's all Going well…. This sub-theme captured participants' reflections on the positive aspects of their role such as experiences that kept them optimistic (despite the emotionally demanding nature of the work) and motivated. They expressed a recognition that each day would be different – some good, some challenging in nature. For example:

> I think when you know you've had good days cause there's days where you go to work and you're like I can't actually believe I've been paid to go in to do what I've done today, like, yeah it can feel quite surprising that you can actually make sort of a living off, like say doing what we do sometimes. Like some days are really good, erm, it doesn't feel like you're two carers, you know, in charge of a young person with

> challenging behaviours at all, it just feels like you're just taking a young person out for the day and having a good time. So, I think they're, they're really good days, erm, yeah. (P1)

Most participants expressed surprise that a job could be enjoyable (e.g., "I didn't realise I would enjoy a much as I do" (P5)); perhaps particularly as the job was also, at times, so challenging. There was an emphasis on the joy and shared passion for certain activities:

> So, all the activities that we do with the young people are things that I enjoy doing. So, when it, when it's all going really, really well, it's almost not like work…So, it's just very easy to do it because these are things I, I would do anyway. (P1)

Superordinate Theme 3

3. Caregivers' Similar Lived Experiences: Insight and Motivation

The third superordinate theme captured participants' past experiences and the insights these experiences provided, which helped them in their roles. These insights were closely tied to narratives about motivation, as participants felt that their understanding motivated them to support the children in their care and enhanced their effectiveness. Therefore, insight and motivation were combined within this theme.

Most of the participants expressed that their parental nature, and inherent compassionate and empathic attributes determined their choice to work with vulnerable children. These attributes and feelings were expressed with reference to their past experiences:

> I just want to be the adult I never had because if I had an adult like me when I was my age, it would have changed my whole entire life. So, I guess I just wanted to do that for as many people as possible. (P3)

This participant’s experience and sense of meaning appeared profound and emotive; they were deeply passionate about their role and viewed it as extremely important. Their recognition of its significance may have stemmed from understanding the impact on a child of not having someone like them in their life. For them it was perhaps the case that doing this role has meaning for them – in doing this role they view themselves in a different light, i.e., as a responsible adult: “I feel like me being in the job role that I am is almost communicating to my inner child that I'm the adult now, I'm in charge and you know, I'm not my child anymore” (P3).

As the interview questions moved from general aspects of the role to more personal attitudes and motivations, the participants appeared to incrementally acknowledge the children’s extremely difficult experiences through the prism of their own experiences. When given the time to reflect upon their motivation to do the role, caregivers displayed a tendency to explore the underlying potential causes of children’s behaviours and, in doing this, also reflected on their own experiences. As mentioned, some participants went further to explain that their past experiences were a motivator to do their role; implying perhaps that their past experiences made them well-placed (i.e., perhaps more effective) in their role:

> Thing that like drives me into doing the work that I do is sort of lived experience myself as well; I’ve got experiences of trauma and various difficulties, which have impacted on my wellbeing. So, I guess that understanding what that feels like. (P5)

Similarly, P3 spoke of their past experiences in relation to the motivation to do their role. Again, their narrative strongly emphasises the importance of their role in terms of the impact they can have on the life of a child:

> I had a really traumatic upbringing, as an expert by experience, to go and share my experience with these kids and to kind of support them because, you know, children in

> care is a big deal; would love to be able to support children that’ve been through something similar to me. So, it was really close to my heart. (P3)

Many participants expressed that having had difficulties of their own was a key aspect of being able to understand the children and have compassion for them; also, they reported that having had life experiences and difficulties of their own had significantly contributed to building empathy and compassion for the children. Participant six did not speak of childhood traumas but it is still evident in their narrative that they used their life experiences, in general (e.g., struggles) and broader life understanding, to be able to be effective in their role:

> I'm not gonna pretend that I've been through the same experience as them cuz I haven't, but I do know what it was like to be a kid. And I do know what it's like to feel to, to struggle with, with certain things. So, you know, being, being relatable to them, their experiences, um, I think having a good understanding of kind of modern society and culture, or certainly their perceived view of what is normal that helps. (P6)

Participant six also went further in their narrative of how they used their life experiences in their role:

> Um, probably that I've got um, I don't know maybe, my knowledge are transferable between adults and children and also elements of my personal life. Um, I've got my own child with his own difficulties, and I think that kind of experience or, um, is, is transferable. (P6)

Whilst not all participants had similar past experiences as some of the children in their care, it is perhaps clear that, for those that did, they felt that this made them more effective in their role (in terms of being able to understand the children) and was a driving force behind them doing their job. For those without traumatic experiences, there was still an acknowledgement that their past experiences and knowledge could be used to better understand the children.

Participant three provided more depth in their account of the specific aspects of a child’s behaviour and feelings that they understood through their own lens:

> But when dealing with these young people, most of the problems are self-worth you know it's, it's almost categorical that every single child that we say things like, nobody loves them and they don’t think they are good enough. Now I personally have had my own mental health issues. I’ve been there I’ve been in that place. And I understand that, I understand now looking back on it. But you need a place and you can get yourself out of it, but it is very much a long, long, long process. (P3)

They also described the connection between their past experience of lacking a supportive adult, their desire to be that supportive figure for the children in their care, and their belief that God had placed them in this role to help children who were like them. In having this belief, it perhaps informed their sense making of their own negative experiences (i.e., the negative experience was used by God for the greater good). This belief appears to impact their enjoyment of their role and how fulfilling they find it to be:

> It doesn’t feel like work. I feel like if everybody was given a gift, if everybody, let’s say God exists and gave us a path to go down, this would be mine. Like, I just, I just know that I just need to work with these kids. And I need to show them that there’s an adult that exist that is like them, had similar experiences to them but function and can have a kind of happy, happy life. So, I think it’s all my mission. (P3)

Discussion

The superordinate and subordinate themes discussed represent a progressive accumulation of organisational, operational, interpersonal, and intrapersonal factors involving both the children and caregivers, which collectively influence the relationship-building process. For the purposes of this discussion section, the findings of this study are considered with reference to the main research questions:

1. What is the caregivers' understanding of their role in relationship-building with traumatised children in their care?
2. What is the caregivers' understanding of the emotional impact on them, and their motivation and capacity to build meaningful relationships with the children?

In reference to the first research question noted above, the first superordinate theme *Relationship-Building*, contained four subordinate themes which encompassed a range of narratives around the caregivers' understanding of their role, with caregivers describing experiences they had with children in their care. As expected, due to the experiences that children in their care had gone through, caregiver narratives emphasised the difficulties that they experienced in building relationships. Each subordinate theme is discussed in reference to relevant literature.

Overarching the narratives within the identified themes was a recognition by caregivers that the key part of their role is to build relationships with children in their care and that this role is of utmost importance for the children. More specifically, participants spoke of meeting the basic needs of children in their care. In doing so, there appears to be a clear recognition that providing a routine and structure for a child provides a sense of safety, which is necessary for a relationship to build. This finding supports that of other studies in the field (e.g., Cahill et al., 2016; Cortina & Liotti 2010; Garcia Quiroga & Hamilton Giachristis, 2017a; Morison et al., 2020; Shaw & Kendrick, 2016). Although caregivers are not trained therapists, comments around ensuring children feel a sense of safety and helping them manage their emotions align with aspects of Relational Therapy (Bailey et al., 2019; Banks, 2006; Becker-Weidman & Hughes, 2008; Farnfield & Onions, 2021; Golding, 2007). In addition, there was an emphasis on ensuring that children are provided with opportunities to enjoy themselves and try new experiences – this is perhaps as a result of the emphasis placed on Adventure Therapy by the organisation. It could be inferred from the narratives of caregivers in this study that they are in support of the use of Adventure Therapy for children with complex needs and past traumas. This provides support for literature around the benefits of Adventure Therapy (Bellegarde et al.; Bowen & Neill, 2013b; Bowen et al., 2016; Gass et al., 2020; Mohan et al., 2022; Russell & Farnum, 2004).

The caregivers reflected on the importance of doing things that children *want* to do and doing these *with* them rather than enforcing activities. This is also in line with literature reported in Chapter 2 of this thesis whereby taking a child-centred approach was found to be beneficial to relationship building with children with complex needs (Morison et al., 2020; Moses, 2000b) and that caregivers should encourage children and give them consistency and structure (Garcia Quiroga & Hamilton-Giachritsis, 2017a).

Furthermore, all participants spoke of the challenges they faced in terms of forming a relationship with children. The fact that children had often experienced past trauma was referred to by all participants in relation to the resultant complex needs and challenging behaviours of the children. Whilst in an ideal situation children would openly and spontaneously engage, most children in care are known to display a series of complex emotional and behavioural needs mainly in the context of interpersonal relationships and attachment disruptions (Garcia Quiroga & Hamilton Giachristis, 2016, 2017a, 2017b). There appear to be shared experiences of frustration and helplessness when faced with children who display challenging and, sometimes, threatening behaviours towards caregivers; something that has been reported in previous studies (Bradbury, 2018; Davidson et al., 2011; Moore et al., 2018). Caregivers from this sample and from other studies, could be seen to be taking a trauma-informed approach to their relationships with children, i.e., helping them feel safe, have connections with others, and manage their emotions (Bath, 2008).

Time constraints were referred to by the caregivers. As mentioned in the introduction section, the particular type of care offered in this study's setting is shorter-term in nature and as such there was perhaps less time for caregivers to build a close relationship with the children as compared to other care settings. There was concern that building close relationships may be detrimental to children due to the short-term nature of the placement, i.e., the child may be negatively impacted by having a close relationship and then losing this relationship. This finding is in line with literature emphasising that ideally a child should have continuous, secure relationships with caregivers (Dozier et al., 2012). There is perhaps a dissonance between recognising the importance of building a relationship with a child, whilst being mindful that the relationship will come to an end, and that this could have a negative impact on the child.

Another experience which was spoken of by participants was the frustration that they felt when trying to support very challenging children in their care, investing their time and effort but not seeing any improvements in the child's behaviour or any relationship form. The frustration led them to emotionally detach from the child thus making it less likely that a positive relationship could form. This detachment perhaps creates a vicious cycle where the lack of a stable, supportive relationship further exacerbates the child's challenging behaviour, making it even harder for caregivers to connect with and positively influence the child (Dozier et al., 2001). Relatedly, the issue of trust was the final point raised in this subordinate theme. Caregivers spoke of children having a lack of trust in them to begin with and the need for consistency on their part in response to challenging behaviour to build trust, which was felt to be integral to relationship building.

The issue of boundaries was raised by participants in relation to how much participants shared about themselves and in terms of setting boundaries for children to provide them with structure. It is evident that many of the participants had learnt from experience that sharing too much with the children can blur boundaries and have a negative impact on the relationship dynamic. However, there was also a recognition that forming a relationship with a child, part of which involves building of trust, can be helped by sharing some personal level details. This mirrors literature around the delicate and complex balance which needs to be maintained in order to maintain professional boundaries whilst sharing enough to build relationships (Ruch, 2012). Maintaining this balance may be emotionally taxing for caregivers and it is evident that the caregivers in the current study were aware of the importance of getting the balance right for the sake of the children in their care and themselves.

Finally, within the first superordinate theme, was the subordinate theme of *We have our limits: The need for professional help*. It is perhaps unsurprising that, given the narrative around there being some children which participants did not feel they were able to help, participants referred to the need for some children to have support from professionals such as psychologists and, in some cases, a multi-disciplinary team. As mentioned in the results, caregivers in this study appeared to hold positive opinions regarding the expertise and capabilities of professionals in the field. This positive opinion may make it more likely that caregivers raise concerns with psychologists and other members of a multidisciplinary team. Such collaborations have been found to be crucial for providing effective support for children in care (Green et al., 2014).

The second research question posed was: *What are the caregivers' understanding of the emotional impact on them, and their motivation and capacity to build meaningful relationships with the children?* The second superordinate theme, *The emotional impact on caregivers*, highlights the impact of the challenges they experience in their roles (as discussed in the first superordinate theme) on their emotions and well-being. It is of interest that some caregivers feel that a key part of their role is to "…not kind of let it affect you emotionally" (P3). The impact on the emotions of caregivers in care home contexts is well documented in the literature (Barford & Whelton, 2010) and is reflective of the findings of Chapter 2 of this thesis. Compassion fatigue was mentioned directly by one participant. Compassion fatigue, according to Figley (2002), is the emotional and physical exhaustion that can occur in caregivers and helping professionals due to prolonged exposure to others' suffering, gradually reducing their capacity for empathy and compassion. In their study of residential care workers, Ireland et al. (2022) found that exposure to distressing and traumatic experiences within their day-to-day work, negatively impacted staff emotional wellbeing, coping techniques and sleep patterns.

Hughes and Baylin (2012) described the concept of "blocked care*"* as a state where caregivers, after prolonged exposure to the intense stress of trying to support and connect with a very disengaged child, may find their ability to provide, for example, affection, empathy, and care, to be depleted. The authors stated that the emotional exhaustion of continuously attempting to create a safe and reassuring environment for a child who remains unresponsive can have a negative impact on the caregiver's capacity to sustain effective caregiving. Narratives from participants in the current study perhaps imply that there is an element of emotional exhaustion in their roles if they found a particular child to be very challenging.

As mentioned in Chapter 1, caregivers may experience vicarious trauma particularly if they have suffered trauma in their past (Jackson & Rosser, 1992; McCann & Pearlman, 1990). This was potentially the case for some participants who referred to having similar past experiences as the children in their care. Interestingly, participant three found it harder to cope with their role when they experienced difficulties outside of work. This emphasises the need for those who work with challenging populations to practice self-care and receive support in order to be more effective in their roles (Collins, 2008; Figley, 2002). It is evident from the caregivers' narratives that they adopted their own coping strategies to cope with the emotional demands of the role, such as talking to those close to them. However, concerningly, mention is made to a lack of clinical supervision which participants felt would be beneficial for them, a belief that is supported by literature in the field (as discussed in Chapter 2). Participants expressed regretting not utilising the option for supervision when it was made available to them.

Participants spoke of trying not to attribute blame to themselves in their role where they were unable to help a child with complex needs. This seemingly conscious decision to not feel blame perhaps implies that feeling a sense of responsibility when they were unable to help a child was their first instinct and something they therefore had to challenge in themselves on a regular basis. This reflection is perhaps, in part, similar to previous findings around caregivers needing to be aware of their own feelings and not take things personally (Cahill et al., 2016; Morison et al., 2020; Shaw & Kendrick, 2016). Furthermore, this issue is important to consider in light of research having suggested that self-esteem and confidence in one's abilities is related to a caregiver's ability to be effective in their role (Morison et al., 2020; Moses, 2000b; Shaw & Kendrick, 2016). With this in mind, it is perhaps important that caregivers do not attribute blame to themselves as this would impact upon their belief in themselves.

This type of reflection on the issue of blame is likely to be beneficial to caregivers where they do work with challenging children. Such reflections could take place in clinical supervision and may help caregivers to cope with issues such as compassion fatigue, vicarious trauma and their feelings of responsibility. The need to provide emotional support for caregivers is suggested to be of the utmost importance given that emotional stability and availability of caregivers has been linked to the facilitation of good relationships between children and caregivers (Garcia Quiroga & Hamilton-Giachritsis, 2016, 2017a, 2017b).

Encouragingly, participants also spoke explicitly of their enjoyment of the role when they had positive experiences with the children in their care, and how this helped maintain motivation for their job. Such experiences could also lead to them feeling more competent in their role which has been associated with the ability to form relationships with children (Morison et al., 2020; Moses, 2000b; Shaw & Kendrick, 2016).

In the final superordinate theme, there were narratives from all caregivers around their past experiences in relation to their motivation to be a caregiver and their perceived effectiveness in their role. This perception of being effective in their role is likely to lead to confidence which, as mentioned above, is beneficial to relationship forming. Furthermore, these narratives are important from the perspective of highlighting that caregivers may have had traumatic experiences, experiences which could impact on their ability to cope with their emotions; thus, further highlighting the need for support for these individuals. The narratives expressed in this superordinate theme are indicative of individuals who see their role as being very important and one that they take very seriously. Strong terms used by participant 3 such as the work being “close to my heart” and “it’s all my mission”, are examples of the strength of the feeling about the importance of the role.

This superordinate theme (*Caregivers’ similar lived and experiences: Insight and Motivation*) can be seen to relate to literature on the topic of the Wounded Healer (Jackson, 2001) whereby personal experiences of trauma can enhance therapeutic practice. However, it is of note that whilst caregivers typically have some training in relationship-building and attachment, providing therapy is not part of their role. Having similar personal experiences to the children in their care was felt by the individuals in this study to enhance their own skills, increase their capacity to empathise, and provide children with hope that they could move forward from their past trauma. In short, the similar experiences afforded them some insight into what the children may be experiencing and was perceived to be a motivating factor in their work.

Strengths and Limitations of This Study

In terms of the sample size, although the number of participants met the criteria recommended for IPA projects conducted by students, it was felt that having more participants (e.g., eight) would have given a greater breadth of experiences, providing additional insights. Initially the intention was to use eight to ten participants, however the recruitment of the participants was more difficult than expected with fewer people showing an interest in sharing their experiences of working with children in care than expected by the researcher. Furthermore, as the study was conducted with residential care workers in a small, very specific provision of care using a therapeutic model of Adventure Therapy, access to a more traditional residential care environment with a larger pool of potential participants was not possible. Another important factor to consider when recognising limitations of this study, is that unlike the majority of other care facilities in the UK, participants in this study worked in a placement where children reside an average of 28 days. As such the findings of this study may not be representative of other care providers.

Concurrently, an important strength of the study is its uniqueness in analyzing UK caregivers’ lived experiences, and perceptions of their role with children in terms of relationship building, within a niche service which uses Adventure Therapy.

Overall, further research is needed to explore further variables related to caregivers who undertake a career in care. Knowing and understanding their motivations and experiences will enhance the quality of care that vulnerable children receive.

Implications for Practice

Understanding the needs and support required by caregivers when looking after children in care is crucial, due to them being on the front line with vulnerable children. Ensuring caregivers can cope positively, self-regulate, seek help, and manage disruptive and distressing experiences will, in turn, positively impact the experiences of the children they care for.

More specifically, findings from this study highlight the need for caregivers to receive clinical supervision and for more mental health professionals' involvement when looking after children with more acute and/or severe presentations. Evidence suggests that better training for caregivers in understanding the complexities of children in care, along with increased support in managing difficult situations, would benefit both caregivers and children (see Chapter 2 for further detail). Reflective practice, clinical supervision, enhanced emotional support, and the promotion of self-care practices for caregivers are techniques which can be used to better support caregivers at work. Such support may help caregivers become more aware of their own needs and understand their mental processes in working with challenging children (Barbosa et al., 2020; Bettmann et al., 2015; Castillo et al., 2012; Fonagy & Allison, 2013; Heyman et al., 2020; Porges, 2011; Silva et al., 2024).

This study underscores conclusions and recommendations found in other research, suggesting that children in care are more likely to feel secure and open up to caregivers if caregivers feel supported and confident in their abilities (Beck et al., 2016). Furthermore, although not directly mentioned by participants in the current study, enhancing caregivers' skills and providing good employment conditions and remuneration may significantly facilitate their capacity to build healthy relationships with the children in their care (Kerr & Cossar, 2014).

The findings highlight the importance of the relationship-building process in care provisions for vulnerable children with complex needs, including those with developmental trauma and attachment difficulties. Participants agreed that establishing these relationships is fundamental for positive engagement and meeting children’s needs. Furthermore, there is a need to extend understanding and knowledge among staff through training with an emphasis on the positive impact of relational practices, how to cope with challenging behaviour, and how to manage their own emotions. In addition, as highlighted by participants in the current study, it may benefit caregivers in this study to receive further training on the topic of boundaries as this may be helpful in achieving the correct balance between sharing information and remaining professional.

Such support and training require change/improvement at an organisational level whereby resources (i.e., supervision, reflective practice, training) can be developed and provided for caregivers to support them in the essential work that they do. It would be beneficial if organisations seek input from caregivers in the development of such support, and if areas of good practice and any associated policies and procedures are shared widely to ensure that relational practices are consistently and effectively implemented across the UK, and internationally, ultimately enhancing the quality of care for children.

Finally, it is suggested that organisations promote a culture of appreciation and recognition of the important work that caregivers do and the skills that they have. Recognising the strengths of caregivers may serve to enhance their confidence and wellbeing which may serve as a protective factor in their work (i.e., making them more resilient to the demands of their work).

Implications for Service Development

Alongside the necessary requirements for risk management and regulatory compliance, this research highlights the need within residential services to do more to enable caregivers to engage in relational practices and build therapeutic relationships with children in their care. Doing more means providing a solid supportive structure that, as well as training, offers concrete actions in response to caregivers' concerns to demonstrate that the essential nature of their role is valued. Such support can be developed by creating caregiver feedback forums or by identifying dedicated and ongoing reflective practices such as staff experiential groups and clinical supervision.

Furthermore, and perhaps an area for further research, to operate effectively, a relational practice model needs to be embedded across national curricula concerning policies and regulations in residential care businesses.

Conclusions

Participants in this study emphasise the importance of building relationships with children in their care. However, they also highlight the challenges they face such as limited time with the children, the necessity of maintaining professional boundaries, and the difficulties posed by children's lack of trust and behavioural issues stemming from past trauma. Caregivers recognise their limitations in terms of not being able to address the complex needs of some children and highlight the supplemental need for professional intervention from psychologists or other professionals as part of a multi-disciplinary team.

The study reveals that caregivers may have lived experiences similar to those of the children they care for, which can serve as a motivating factor in their roles. This finding aligns with the Wounded Healer literature, suggesting that personal trauma experiences can enhance caregivers' empathy and effectiveness in their professional duties (Jackson, 2001).

The findings of this study emphasise the need to consider the wellbeing of caregivers. Ensuring that caregivers receive the necessary support and resources is vital for enabling them to perform their roles effectively and for promoting the best possible outcomes for the children in their care.

Chapter 4

Assessing Trauma and the Emotional Distress in Children Who Have Experienced Adverse Childhood Experiences (ACEs): A Critique of The Trauma Symptoms Checklist for Children (TSCC)

Introduction

The aim of this chapter is to provide a critique of The Trauma Symptoms Checklist for Children (TSCC; Briere, 1996) with reference to its reliability and validity and how it is used in practice. Measuring psychological concepts has always been a challenge within psychology and allied professions (Jacob et al., 2015). The most viable means to do so has been through the creation of psychometric tests, and use of behavioural observations and physiological measures, aimed at statistically measuring psychological phenomena (Bassett & Gazzaniga, 2011). Although the TSCC is described in the title as a checklist as opposed to a psychometric measure, it can be seen to assess psychological issues and, as such, it is possible to investigate its psychometric properties.

The overall focus of this thesis explores child caregivers in relation to their involvement in the assessment and treatment of children in care; as such, it was considered relevant to provide a critique of the TSCC - a widely used tool for the assessment of trauma in children. Childhood trauma and its symptomatology requires thorough understanding and assessment to provide a child with appropriate care. After exposure to adversities and trauma it is necessary to use valid and reliable psychometric tools to support the assessment process and gather information about their feelings and emotions in order to assess the impact of their lived traumatic experiences (Gremigni, 2020).

One of the most researched and used tools across the world to measure trauma related symptomatology is the Trauma Symptoms Checklist (Briere, 1996; Nilsson et al., 2008; Wherry & Dunlop, 2018; Wherry & Herrington, 2018). The aim of this critique is to review the properties of the TSCC (Briere, 1996) and to comment on the suitability of this when assessing children living in a care environment. Throughout this critique, results from previous studies using the TSCC will be reviewed in order to draw conclusions as to whether the tool is a reliable and valid screening method for acute trauma symptomatology (e.g., one single traumatic event) and chronic posttraumatic symptomatology (e.g., continuous and repetitive exposure to abuse and neglect) in children (Brown et al., 2018; Sweeney et al., 2016; Tarren-Sweeney, 2008b).

The Prevalence and Impact of Trauma

According to the World Health Organisation (WHO, 2020), one in four people will suffer from a mental or neurological disorder across the lifespan. Severe mental health problems have been associated with complex trauma and adverse childhood experiences (ACEs) (Briere, 1996; Simkiss, 2019). Many commonly known psychological diagnoses appear to develop into long and enduring psychopathologies with a significant negative and disabling impact on the sufferer’s general levels of functioning and psychosocial well-being (Admon et al., 2013; Anderson et al., 2006; Goh & Agius, 2010; Hruska & Delahanty, 2012). Researchers and clinicians widely agree that ACEs and/or acute traumatic experiences (e.g., unexpected death of loved ones, natural disasters, and accidents) are strong precursors and antecedents for ill mental health (Briere et al., 2008; Cloitre et al., 2009; Collin-Vézina et al., 2011; Evans et al., 1987).

Empirical research with children showed statistically significant differences for gender and socioeconomic status, with females and children from lower socio-economic backgrounds having registered more abuse and subsequently more trauma and stress related symptoms (John Briere et al., 2001; Briere et al., 2008; Cloitre et al., 2009).

Measuring Trauma and PTSD in Children

Etymologically speaking, the word trauma comes from the Greek language and means *wound* or *hurt* (Spanic et al., 2014). In the DSM-V (the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, 2013), trauma is defined as emotionally overwhelming, highly upsetting events that may involve actual or threatened death, serious injury, or sexual violence (Collin-Vézina et al., 2011). Although this definition applies mainly to adults, evidence suggests that children can become traumatised at a very early stage in their life (Kaminer et al., 2005). Within the revised guidelines following the revision of DSM IV, one of the big changes to the DSM V guidelines for PTSD was that diagnostic criteria have been identified in respect of PTSD in children below the age of six years (APA, 2013). Child abuse and maltreatment has been one of the most socially and ethically condemned forms of human suffering that some children may endure through their lifetime and in their caregiving experiences (Boney-McCoy & Finkelhor, 1995; Briere et al., 2008; Briggs et al., 2012).

In recent years, scientific communities have agreed that children can develop PTSD because of childhood trauma, prenatal stress, neglect, abuse, and subsequent attachment difficulties. It has become of paramount importance to develop specific tools to measure the impact of exposure to acute and chronic experiences, and the presence of trauma following ACEs (Alisic et al., 2014; Briere et al., 2008; Chambers & Tzavella, 2021; Cloitre et al., 2009; Foa et al., 2018).

One important characteristic of any psychometric tool is to include items that are easily understood by the population of reference. Given the fact that children possess different cognitive models and levels of maturation (Briere et al., 2008; Cloitre et al., 2009; Collin-Vézina et al., 2011; van der Kolk et al., 2009) as well different motivations, attributional styles, and psycho-social and emotional needs (e.g., self-esteem, worthiness, acceptance, approval, love, affection, self-confidence) (Reynolds et al., 2021; Reynolds & Suzuki, 2012), it is very important to consider and reduce potential [2]common method biases when administering a psychometric tool (Podsakoff et al., 2012; Suzuki et al., 2012). For example, children may be

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[2] Common Method biases happen when variations in responses are caused by the instrument rather than the actual predispositions of the respondents that the instrument attempts to uncover.

motivated to please the interviewer and believe that the interviewer already knows the answer, what happened to them, or how they feel. One of the main implications of this mind set and societal norms in children is that they may usually present with inherent tendencies to give what they assume to be the right answer, or to agree excessively (acquiescence), to try and please adults or to avoid and deny access to their inner experiences. The latter is particularly common with children who have been exposed to early childhood adversities, developmental trauma (Briere et al., 2008), attachment difficulties, and severe relational deficits (Berlin, 2001; Bettmann et al., 2015; Ereky-Stevens et al., 2018; Kerr & Cossar, 2014). Thus it is important to design and produce measurement tools, specifically adapted for children and young people, that are sensitive enough to discriminate PTSD and trauma symptomatology as separate pathologies from other forms of mental health difficulties such as anxiety and depression (Yule, 2001). The specificity and sensibility of the tool is crucial to avoid misdiagnosis and inappropriate treatment and interventions(Alisic et al., 2014; Armsworth & Holaday, 1993; Cloitre et al., 2009; Kaminer et al., 2005; Santiago et al., 2016; Santiago et al., 2013; Sar, 2011; van der Kolk et al., 2009).

Aims of this Critique

The tool most widely used in clinical practice and research to measure and detect specific PTSD symptoms in children and young people is the Trauma Symptoms Checklist for Children (TSCC) developed by John Briere and colleagues in 1996. This critique examines the Trauma Symptoms Checklist for Children (TSCC) regarding its scientific properties, and its applicability to children who have been exposed to a series of ACEs and other forms of negative experiences, such as neglect, different types of abuse, caregiver attachment disruptions, parental ill mental health, and parental substance abuse.

Firstly, an overview of the TSCC will be provided. This will be followed by a review of existing research on the topic of the reliability and validity of the TSCC. There will be discussion regarding the strengths and limitations of the tool with reference to clinical practice. Finally, reference will be made regarding the utilisation of the TSCC in assessing trauma in children, and more specifically, children in care.

The Trauma Symptoms Checklist for Children (TSCC)

The TSCC is a self-report measure of posttraumatic distress and other related psychopathology, such as anxiety, depression, emotional dysregulation, defiant and oppositional behaviours, sexualised behaviours and sexual concerns, and dissociation (Briere, 1996; Briere, 2001). Please consult appendix K for a full description of each subscale. The TSCC was designed for children and young people between 8-16 years who have experienced traumatic events, such as physical or sexual abuse, major loss, or natural disasters, or who have witnessed violence.

It begins with a 20-item TSCC Screening Form, which allows screening for posttraumatic symptomatology in a very brief period (5 minutes). This screening form consists of two subscales: General Trauma (12 items) and Sexual Concerns (8 items). The TSCC is available in two versions: the full 54-item test that includes 10 items capturing sexual symptoms and preoccupation; and a 44-item alternate version (TSCC-A) that does not refer to sexual issues. The authors and experienced clinicians recommend the use of the 54-item version for a more complete evaluation unless there are factors that preclude its use. The TSCC is administered in 15 to 20 minutes where the responses are inserted on the top page of a carbonless test booklet, automatically transferring to the scoring page underneath.

TSCC Development and Objectives

Although there has been a clear acknowledgement and worldwide recognition of how early exposure to trauma and other traumatic circumstances may negatively impact children and young people’s wellbeing(Boney-McCoy & Finkelhor, 1995; Briere, 1996; J. Briere et al., 2001; Crouch et al., 1999; Finnerty, 2001)there are very few multiscale tests both in research and clinical practice that effectively measure this. Before the creation of The Trauma Symptoms Checklist for Children (TSCC), separate assessment tools were used to assess different trauma related experiences and symptoms. For instance:

- the Anxiety and Depression Tool explores anxiety and depression (Briere, 1996; Briere, 2001);
- the Child Sexualised Behaviours and Concerns Tool assesses victimisation related sexual problems (Kenny & Wurtele, 2013);
- the Post-traumatic Stress Tool measures symptoms/severity of Post-Traumatic Stress Disorders (Saigh et al., 2015);
- the Dissociation Scale tool measured symptoms of dissociation (Putnam et al., 1993);
- the Impact of Traumatic Events Scale to assess the impact of sexual abuse from the child’s perspective (Crouch et al., 1999).

The TSCC was developed to have a more comprehensive measurement tool for childhood post-traumatic symptomatology as opposed to other tools measuring isolated aspects related to trauma. The rationale of the self-report design of the tool is built on the idea that children have a short attention span, especially if they have experienced trauma (Briere, 2001; Finnerty, 2001; Sadowski, 2000).

As mentioned above, the TSCC is a self-reported questionnaire made up of 54 intervals questions that describe things that children sometimes think, feel, or do. Example statements are: “Thinking about having sex”; “Feeling stupid or bad”; “Feeling like things are not real”; “Wanting to hurt myself”. The child is asked to complete this independently with or without the presence of an adult, answering each statement on a Likert scale of 0 (never) to 3 (almost all of the time) to indicate how frequently they have thought, felt, or acted in this way over the last 6 months/years/lifetime. The scale does not indicate the time span to consider but rather has a more general approach to the child’s presentation (Lanktree & Briere, 1995; Nilsson et al., 2008; Sadowski & Friedrich, 2000; Wherry & Dunlop, 2018). The administrative approach is designed to reduce potential feelings of guilt (Wherry & Dunlop, 2018), blame and shame sometimes associated with different forms of abuse, particularly sexual abuse. Self-administration may also reduce the risks associated with acquiescence bias (Briere et al., 2008; Podsakoff et al., 2012).

TSCC Normative Data

The TSCC was originally developed with normative data (Briere, 1996). This measurement tool has been standardised on large sample including a range of key sociodemographic, with norms for age and sex applied accordingly and following rigorous scientific rules (Briere, 1996). The standardisation process determines the norms for a test. It ensures that all the participants undertake the same test under the same conditions, which are then scored with the same criteria. This is extremely important as it is the only way to ensure that results can be compared with each other (Briere, 1996; Nilsson et al., 2008; Sadowski & Friedrich, 2000; Wherry & Herrington, 2018).

Psychometric Qualities of the TSCC

Since the publication of the TSSC the tool has been widely utilised (1882 citations to date), within both academia and practice, and has been translated into multiple languages such as Chinese, German, Swedish, Spanish, and Korean (Chung, 2014; Kretschmar et al., 2016; William Martinez et al., 2014; Mohammadkhani et al., 2005; Nilsson et al., 2008; Wherry & Herrington, 2018). This indicates a high level of acceptance of the robustness and rigour of the instrument to assess for childhood trauma within the professional community despite the limitations generally associated with self-report assessments.

Broadly speaking, validity refers to whether a test measures what it is supposed to measure, whilst reliability is related to the consistency of the findings. Different types of reliability and validity of the TSCC will be discussed below.

Reliability

Internal Reliability

Internal consistency is an important measure of reliability and refers to the degree of homogeneity among the items on a test, i.e., that they are consistent with one another regarding what they are measuring (Briere, 1996; Butcher et al., 2013; Chung, 2014; Nilsson et al., 2012; Wherry & Herrington, 2018). Considering the TSCC, initial studies conducted by Briere et al. (1998) have found satisfactory internal consistency in most of the scales, except for the scale SC (sexual concerns) which was deemed as moderately reliable with Cronbach alpha .75, which indicates moderate-high levels of reliability. All the other clinical scales obtained high Cronbach alpha from .82 to .89 (Chung, 2014; William Martinez et al., 2014; Mohammadkhani et al., 2005; Morelli et al., 2020; Nilsson et al., 2008; Wherry & Dunlop, 2018; Wherry & Herrington, 2018). These studies suggest very good to excellent internal consistency.

In addition, Sadowski and Friedrich (2000) examined the psychometric properties of the TSCC using a sample of 119 adolescents, including 32 sexually abused children, who had been admitted at a psychiatric hospital. They calculated inter-correlations between the sub-scales of the measure. The overall reliability score for the tool ranged from Cronbach Alpha of .71 to .97, and .69 to .80 for inter-correlations for the individual subscales, which are considered high and acceptable, suggesting good levels of reliability for the total TSCC scale (Sadowski & Friedrich, 2000). The authors concluded that, "each scale is typically measuring a closely related aspect of a larger construct" (p. 370).

Test-retest reliability

Test-retest reliability refers to the ability of a measure to have consistent results over time. If the same results are not obtained when completed at a different time then a measure could be considered unreliable (Kline et al., 2000). A correlation between two sets of scores on the same measure of above .80 would denote a good test (Kline et al., 2000).

Nilsson et al. (2008), looking at the psychometric properties of the TSCC in Sweden, found the test-retest score for the whole scale was 0.81. For the scales within the tool the following was found, "Anxiety r = .75, Depression r = .81, Anger r = .75, Posttraumatic stress r = .75, Dissociation r = .67 (Dissociation-overt r = .61 and Dissociation-fantasy r = .67) and Sexual Concerns r = .81 (Sexual concerns-preoccupation r = .86 and Sexual concerns-distress r = .51)" (p. 631). This indicates that some sub-scales have better test-retest reliability than others, with the lowest being the sub-scale of dissociation.

Validity

Concurrent Validity

Concurrent validity refers to the degree to which a test scores correlates with another validated measure whose underlying construct is conceptually similar (Butcher et al., 2013; Kretschmar et al., 2016). A study conducted by Nilsson et al. (2008) aimed to investigate symptoms of trauma in a group of Swedish adolescents and children. This study screened children (*n* = 91) known to have experienced trauma in the form of sexual abuse as well as a group of Swedish children who did not have experiences of sexual abuse (*n* = 728). The study used [3]Confirmatory Factor Analysis and loadings consistent with other studies outside Sweden that utilised the TSCC. They used the Dissociation Questionnaire (Swedish Version) to test concurrent validity. TSCC scores were compared to 341 student scores on the Dissociation Questionnaire and a correlation of .75 was found.

Concurrent validity has also been looked at in terms of whether children who score highly on the TSCC are known to have had a history of trauma or not (Matulis, 2015). Butcher and Kretschmar (2016) looked at whether scores on sub-scales of the TSCC related to a DSM-V diagnosis in a sample of 2,544 young people who took part in a juvenile justice programme for children and young people with behavioural issues. These young people had received a full diagnostic assessment and completed a TSCC. By means of variance analysis examining the relationship between TSCC subscale scores and other scales measuring behavioural problems, the anxiety subscale contained within the TSCC was able to differentiate between young people with and without the DSM- V diagnosis (Butcher et al., 2013; Kretschmar et al., 2016). The studies by Matulis et al. (2015) and Wherry and Dunlop (2018) corroborated these findings,

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[3] Confirmatory Factor Analysis is a statistical technique used to verify the factor of a set of observed variables; it allows the researcher to test the hypothesis between observed variables and their underlying latent construct exists.

demonstrating a correlation between an already existing DSM-V diagnoses whose symptomatology was also found within TSCC subscales.

Despite these promising findings, in order to achieve specificity and sensitivity in detecting children's attitudes and motivations, underlying thought processes, emotions, and behaviours, the use of complementary tools, such the Beck Youth Inventory, Depression Scale for Children, Paediatric Symptoms Checklist, Spence Children's Anxiety Scale, Strengths and Difficulties Questionnaire, or Clinician-Administered PTSD Scale for DSM-5 Child/Adolescent, is highly recommended in line with recent NICE guidelines (NICE, 2020).

Furthermore, it is suggested that the TSCC needs to be used in combination with clinical interviews (i.e., to explore the history and background of the symptoms) and, where possible, additional information from a child's caregiver and other professionals who know the child, to tailor interventions for the child.

Construct Validity

Construct validity is concerned with whether the items of the test can be seen to measure the concept that it claims to measure (Butcher et al., 2013; Conijn et al., 2019; Putnam et al., 1993). The initial validation studies and subsequent translations have confirmed good construct validity for the TSCC; reporting that the subscale scores and the overall scores were found to be significantly higher in traumatised children than in non-traumatised children. In examining further, the researchers have also found that when children were exposed to ongoing trauma in the household, both TSCC total scores and the individual subscale scores would be increased. Furthermore, subscale and total scores were observed to decrease in those who were receiving trauma-focused treatment (Alisic et al., 2014; Armsworth & Holaday, 1993; Briere et al., 2008; Briggs et al., 2012; Butcher et al., 2013; Cloitre et al., 2009). In this regard, the TSCC not only should correlate in meaningful ways with similar psychometrics, but scale scores also should be higher in samples of children with histories of stressful/ traumatic events, increase in the presence of more severe trauma, and decrease as a consequence of treatment aimed at addressing trauma related symptomatology. Several studies have been undertaken and demonstrated that the TSCC possesses good construct validity when assessing the impact of trauma. For example, Singer et al. (1994) confirmed that abused children scored higher total TSCC scores scales and individual subscale scores when their scores were compared and analysed with the scores of non-abused children. Multivariant analysis found that child sexual abuse was associated with all scales except sexual concerns and neglect. Similar results were obtained when measuring different types of abuse within the abused and non-abused (normative) groups (Briere, 1996; Elliott & Briere, 1995; Evans et al., 1987; Singer et al., 1995).

In addition, Lanktree and Briere (1996) conducted studies on children undertaking treatment for sexual abuse and noted there was a significant reduction in the scores for the anxiety, depression, sexual concerns, and dissociation subscales when the TSSC was re-administered at a three–month interval over a one-year period (Lanktree & Briere, 1995). This suggests that the TSCC has solid construct validity.

Content Validity

Content validity refers to a measure being able to capture all aspects of the phenomenon under investigation (Butcher et al., 2013). As such, low content validity would indicate that some parts of a measure were not related to the phenomenon or that there were some aspects of phenomenon that were not captured by the measure. Content validity was considered when the tool was being developed; the authors sought to capture all aspects of trauma symptoms. In this case is it very important that researchers and clinicians agree to the underpinning theoretical model and different facets that compose the construct. This should include, for example, affective components (e.g., feeling mad, feeling bad, afraid, disgusted, feeling dirty inside); physiological features (e.g., agitation, feeling like vomiting, feeling shaky inside, sweaty), motor features (e.g., shaking the legs, rocking the body, pulling hair/ clothes); cognitive factors (e.g., thoughts of self-destruction, or that the world is a bad unsafe place); as well as behavioural features (e.g., acting on the negative thoughts and emotions-self harms, assaulting others, delinquency, substance abuse, suicidality).

In order to develop the items contained within the TSCC, 75 items were initially written to cover six domains: anxiety, depression, anger, posttraumatic stress, dissociation, and sexual concerns and worries. Consultation with several child psychologists specialised in the treatment of traumatised children, led to discarding 21 items as these were considered redundant and not representative of the domain of interest (Briere, 1996). The 54 items were then included in several studies of child abuse impacts (e.g., (Elliott & Briere, 1995; Friedrich et al., 1991; Lanktree & Briere, 1995; Putnam et al., 1993). The TSCC has been updated since and its psychometric properties have been re-affirmed by the author (Briere et al., 2000) and other national and international studies.

Convergent and Discriminant Validity

Convergent and discriminant validity are types of construct validity. Convergent validity looks at the degree to which the scores from the test correlates with similar measures, whilst discriminant validity is concerned with whether the test results correlates with measures of different constructs (i.e., if there is some correlation then this would be cause for concern) (Campbell & Fiske, 1959).

Preliminary studies were conducted in the process of validating the TSCC by their main authors. The validation studies were conducted with measures assessing and screening similar concerns and post-traumatic stress related traumas. Significant correlations and inter-correlations with the Youth and Parent report from CBCL (Child Behavioural Checklist) and CDI (Child Depression Inventory) were found. Significant convergent validity regarding the presence of trauma symptomatology were reported when compared to other measures measuring the same construct, high correlations were found between their results (Crouch et al., 1999). Similarly, Evans et al. (1995), found there to be excellent convergent validity in their findings using the social concerns and dissociation scales from the TSCC and other tests such as CSBI (Child Sexual Behaviour Inventory, 1991) and CDC (Child Dissociative Checklist) (Crouch et al., 1999; Friedrich et al., 1991).

Additional studies conducted to determine the validity of the TSCC tool have demonstrated that the TSCC scales vary in expected ways with other similar measures; strong correlations have been found with scales sharing similar content (convergent validity), and least with more different scales (discriminant validity). For example, the Child Depression Inventory (CDI) correlated most with the DEP (depression) subscale of the TSCC and least with the SC (sexual concerns) subscale. As expected with a self-report instrument, TSCC scales appear to correlate more with CBCL Youth-report scores as compared to CBCL Parent-report scores. CBCL youth report internalisation correlated most with the ANX (anxiety), DEP (depression) and PTS (post-traumatic stress) subscales, whereas the Youth Report CBCL (child behavioural checklist) subscale of externalisation was most associated with SC (sexual concerns), DIS (dissociation) and ANG (anger) subscales (Briere, 1996; Butcher et al., 2014).

To determine the discriminant validity of the TSCC, Sadowski and Friedrich (2000) compared abused and non-abused children on the TSCC and conducted a MANCOVA using socioeconomic status and sex as covariates; however, the differences were not significant indicating low discriminant validity. The authors suggest a range of potential reasons for this finding. Firstly, as mentioned before, children and adolescents may lack the necessary introspective capacities, and they may be accompanied by their caregivers who may be the perpetrators (53% of the abused group experienced incestuous abuse). Therefore, they may be confused and dissociative, hence unable to report accurately on their symptoms, or they may be under duress and constraints of loyalty and secrecy as common characteristics of abuse.

Secondly, children may present with a series of comorbidities; the authors note that a PTSD diagnosis may be correlated with ADHD and other anxiety disorders. In addition, children may not always disclose that the abuse has occurred; it is problematic for measures and assessments to be utilised while a child may under-report/over-report past trauma, rather than answer accurately and openly (Cloitre et al., 2009; Mannarino et al., 1994; Podsakoff et al., 2012; van der Kolk et al., 2009).

In addition, Wherry and Herrington (2018) have also compared the screening versions of both TSCC-SF AND TSCC -Y-SF (Trauma Symptoms checklist for younger children screening form) in a sample of sexually abused children (*N* = 200). Their findings support satisfactory reliability and validity levels which render both screening questionnaires as an effective tool in assessing and detecting children who may have been victims of sexual abuse, both alone or in conjunction with other tools in order to plan successfully for treatment, intervention and early detection of sexual abuse and other forms of abuse (Wherry & Dunlop, 2018; Wherry & Herrington, 2018). Because anxiety, depression and posttraumatic stress are more internalised symptoms, and sexual and angry behaviours are more externalised, these data suggest good convergent validity for the TSCC (Briere, 1996; Briere et al., 2001; Crouch et al., 1999; Elliott & Briere, 1995; Evans et al., 1987; Lanktree & Briere, 1995; Morelli et al., 2020). Appendix J illustrates these correlations.

Predictive Validity

Several studies have confirmed that TSCC predicts posttraumatic symptomatology and high scores obtained on all the six clinical scales appeared to be present in both acute and chronic post-traumatic symptomatology (Admon et al., 2013; Alisic et al., 2014; Briggs et al., 2012; Cloitre et al., 2009; Foa et al., 2018; Singer et al., 1995; Yule, 2001). A study conducted by Lanktree and Briere (1995) highlighted that sexual abuse was best predicted by scores on the following subscales: post-traumatic, dissociative, and sexual concerns subscale. Diaz (1994) used as sample of 232 girls (control *n* =151, sexually abused *n* = 81) to examine the potential for the TSCC to discriminate between the two groups. They found scores on the posttraumatic and depression scales to be highly predictive of trauma in children. In addition, in the study by Sadowski and Friedrich (2000), multiple regression was used to determine the predictive validity of the TSCC, showing that the PTS subscale (post-traumatic scale) was the only predictor of the diagnostic group, therefore, this suggests specific sensitivity of the TSCC to detect sexual maltreatment. More research is needed to further investigate the predictive validity of the TSCC.

Findings Relating to the Translation of the TSCC, the Shortened TSCC, and the Screening Versions

The findings of Nilsson et al. (2008, 2012) indicate that the TSCC is a robust and rigorous tool even when translated to different languages and used in different cultures. In addition, in more recent years, Wherry et al. (2018) demonstrated that the shorter versions of TSCC and TSCC Y (comprising of 20 items) are as robust as the original 54 item version. This finding has implications for clinical practice and research – using a shortened version has been found to increase the likelihood of a child being able to maintain concentration while completing the tool, i.e., using a shortened version reduces factors such as fatigue, distraction, and reduced attention span (Conijn et al., 2019).

(Wherry & Dunlop, 2018; Wherry & Herrington, 2018) have also compared the screening versions of both TSCC-SF AND TSCC -Y-SF (Trauma Symptoms checklist for younger children screening form) in a sample of sexually abused children (*N*=200). Their findings support satisfactory reliability and validity levels which indicate that both screening questionnaires can be used as effective tools in assessing and detecting children who may have been victims of sexual abuse. It is suggested that screening questionnaires be used in conjunction with other tools to plan successfully for treatment, intervention and early detection of sexual abuse and other forms of abuse.

Discussion

The TSCC is one of the most widely used tools to detect and effectively assess children's psychopathology related to exposure to trauma and other adverse childhood experiences. As outlined above, studies have found the TSCC to have good reliability and validity. However, there is room for improvement and there are issues which will now be outlined that need to be considered by clinicians who choose to use this tool. Firstly, although the TSCC has demonstrated a high level of validity across countries, the material can be problematic and there are limitations associated with the self-report method and response biases. Such response biases can affect the reliability/accuracy of the results (Paulhus, 2002; Tourangeau & Yan, 2007). It has been noted that an underreporting of symptoms may be as a result of shame, guilt, and/or fear (Butcher et al., 2013). Thus, it is crucial to consider a child's circumstances and other contextual factors like their attachment history, and social support (Arvidson, 2011; Boney-McCoy, 1995; Becker-Weidman, 2008) when considering administering the TSCC and when interpreting the results. In addition, it has been suggested that children in general possess a reduced ability for self-reflection, self-introspection, and emotional expression (Conijn et al., 2019; Tourangeau & Yan, 2007); these additional factors also need be considered when using the measure in clinical practice.

Due to factors such as these, it is suggested that the TSCC be used in conjunction with a thorough clinical assessment and additional psychometric measures. This would help to ascertain the psychological damage because of prolonged exposure to early adversities and potential attachment disorders they may have acquired, as previously suggested by Ward et al. (2006). Nonetheless, the TSCC measure can still yield valuable information to inform a psychological formulation and treatment approach, when corroborated with information from others (e.g., caregivers, teachers). Findings must be considered in the context of ACEs and developmental trauma (Briggs et al., 2012; Cloitre et al., 2009; Foa et al., 2018; Simkiss, 2019).

The TSCC is not a diagnostic tool, nonetheless, due to the overall high levels of reliability and validity outlined above, it can assist clinicians in evaluating PTSD criteria in younger children, and when used in combination with clinical interviews and other assessment tools, provides a possible PTSD diagnosis in children five years of age or older (Wherry & Herrington, 2018). As noted by Kretschmar et al. (2016), "According to the professional manual, the TSCC is not intended to establish a definitive mental health diagnosis but rather highlight areas in which the child may be experiencing elevated symptomatology and assist in the diagnostic process and the development of a treatment plan" (p. 883).

Regarding the clinical utility of the TSCC, as mentioned above, within the TSCC, the child records the frequency with which the statement describes her/him on a 4-point scale ranging from 0 (never) to 3 (almost all the time). Raw scale scores are calculated by summing all items comprising the scale and then dividing by the number of items in the scale; a higher score suggests greater symptomatology. [4]*T* scores at or above 65 for any clinical scale are considered clinically significant. A limitation of the TSCC is that it does not produce one single, interpretable score for the level of trauma present (Morelli et al., 2020). Instead, raw

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[4] T scores is a type of standardised score based on a score distribution that has a mean of 50 and a standard deviation of 10; for example, a raw score of 1 standard deviation above its mean would be converted to a T score of 60

scores and T scores are calculated for the individual subscales. Having no overall scores increases the importance of clinicians being trained in interpreting the individual scores from subscales as well as the overall scores, in order for them to effectively interpret and report on these. Ineffective training of clinicians (or others who may administer the tool) or the tool being used as a stand-alone measure without additional information, may place children at higher risk of incorrect diagnosis and therefore, incorrect treatment. In addition, it is of note that consideration needs to be given to the utilisation of the TSCC with children and young people with learning difficulties and/or other neurodevelopmental difficulties. There is a need for the tool to be tailored to those with specific needs. This is particularly important since children with learning disabilities, Autism Spectrum Disorders (ASD), Attention Deficit and Hyperactive Disorder (ADHD) or children who experience dissociation may not have sufficient introspection regarding the traumatic event, or may make deliberate and unconscious efforts to avoid and disconnect from the trauma in an attempt to reduce associated negative feelings (Alisic et al., 2014; Briggs et al., 2012; Cloitre et al., 2009; van der Kolk et al., 2009). In such cases it becomes of paramount importance to consider other sources of information and gather a detailed history of the child's systems (including [5]micro, meso, and macrosystem) in order to avoid misdiagnosis (Stavropoulos et al., 2018).

Given the nature of self-reported instruments, the TSCC scales tended to correlate best with other self-report tools as opposed to parent/care-giver information (Conijn et al., 2019; Foa et al., 2018). As such, it may be useful to corroborate both versions (self-reported and caregiver reported) with collateral information from other trustworthy sources of information. In addition, a good understanding of their background could effectively contextualise the nature

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[5] Micro, meso, macro system: Bronfenbrenner (1977) suggested that the environment of the child is a nested arrangement of structures, each contained within the next. He organised these structures in the microsystem, mesosystem, exosystem, macrosystem, and the chronosystem. These all impact on children's growth and development.

of their trauma; information which could be used to decide upon a treatment plan (Boney-McCoy, 1995; Cloitre, 2009).

Recommendations Regarding Utilisation of the TSCC with Children in Care

Regarding the use of the TSCC with children in a care setting, to date, no studies have been conducted which consider how effective it is to assess and contribute to the accurate identification of a child's traumatic experiences prior to being placed in a home care or whilst in a care home setting. Nonetheless, it is well accepted by clinicians and researchers that many of the children in care have developed trauma symptomatology as a result of early exposure to abuse (e.g., physical, psychological, emotional, sexual), neglect, poverty, and breaches in their attachments with their main caregivers (Cloitre et al., 2009; Simkiss, 2019; Zeanah et al., 2002). In addition, removal from their caregivers may have been traumatic as it implies the loss of their main attachment figure regardless of any abuse, rejection, and abandonment they may have suffered whilst in their care (Achenbach & Edelbrock, 1981; Briggs et al., 2012; Ereky-Stevens et al., 2018). Given the evidence base of the TSSC in research and clinical practice, it is suggested that it may be a valuable tool for children and young people in care and alternative living conditions after being removed from abusive parents and high-risk environments to identify trauma related issues and to identify treatment needs. However, studies would be needed to explore the use of the TSCC with this population.

Final Conclusions

Despite the limitations of the Trauma Symptom Checklist for Children, there appears to be a consensus that the TSCC can be utilised to assess a variety of problems which have arisen from childhood trauma (Sadowski & Friedrich, 2000). Overall, the TSCC is deemed a valid and reliable method of screening children and young people who have experienced both acute and chronic traumas, adverse childhood experiences, abuse, neglect, and subsequent attachment and relational breaches.

Despite good reliability and validity being found, it is suggested that improvements could be made and that there are additional issues which need to be considered when using the TSCC (as outlined in the above discussion). As such, where relevant, the TSCC can be used to help guide decisions for diagnoses made by clinicians, but it must be used in combination with other forms of information regarding the child’s history and presentation in order to increase the likelihood of an accurate diagnosis and a subsequent effective treatment plan (John Briere et al., 2001).

CHAPTER 5

General Discussion

The principal aims of this thesis were to explore the understanding of child caregivers, who look after traumatised children in care with complex emotional and behavioural difficulties. The research focused on exploring their personal lived experiences regarding the relationship building process with children in their care. The aim was to capture caregivers' own experiences and meaning making of the relationship building process with the children in their care based on their perceptions and understanding of their role in interaction with the children. Important contributing factors to the formation of positive and meaningful relationships were explored and reflected upon by the caregivers. The caregivers expressed intrinsic motivation and good knowledge about the needs of the children in their care and how their abilities can meet these needs. A series of variables negatively affecting the relationship building process were highlighted and mostly related to the motivation to do the work and the support received from the employing organisation.

Chapter 1 contains a general introduction to the main topic of the thesis as well as other themes related to caregivers' roles, experiences, motivations, and the socio-cultural context in which the organisational policies around the care of the children are developed.

The second chapter presents a systematic literature review gathering relevant studies, which focused on child caregivers' experiences and perceptions of their roles and their relationship building process with the children in their care.

Chapter 3 presents an empirical study using IPA to explore in detail the lived experiences of six residential child caregivers when forming relationships with the children they were looking after in their day-to-day work.

Chapter 4 details a critique of the TSCC (Briere, 1996), a psychometric tool relevant to the psychological difficulties often experienced by children who have been placed into residential care. The aim of this critique was to explore a contextual understanding of how children with adverse childhood experiences who are displaying trauma symptomology are understood in a clinical setting. The rationale behind choosing this tool was to analyse its utilisation both in clinical practice and research for both clinical and non-clinical populations and its applicability for children with a history of trauma, abuse, and neglect.

To understand the relevance of the use of this psychometric tool and its application and purpose to assess children, the main findings of the preceding chapters are summarised and discussed. Thus, this fifth and final chapter emphasises the importance of recommendations made based on the findings from this research and already existing previously published literature in view of improving both children's and child caregivers' quality of care and work in the care industry. The chapter concludes with insights and an acknowledgement of the strengths and weaknesses of the thesis, implication for clinical practice and needs for future research.

The systematic literature review in Chapter 2 explored previously published literature related to the relationship building process between child caregivers and the children in their care from the caregivers' perspectives and their experiences related to it. This review was undertaken to explore the factors that contribute to the formation of an adult led, healthy, meaningful, and positive relationship between child caregivers and the children in their care. The importance of analysing this topic stems from robust recommendations from research and clinical practice regarding the importance of healthy attachments and attuned caregivers for children's healthy psycho-social and emotional development (Becker-Weidman, 2006; Cameron & Maginn, 2008; Le Page, 2005; Siegel, 2015). The existing evidence shows that healthy attachments are even more important when vulnerable and traumatised children are removed from their families of origin and placed in residential care settings (Alisic et al., 2014; Bailey et al., 2019; Banks, 2006).

One of the pioneer studies in this area was conducted in 2000 (Moses, 2000b) indicating that there is very limited focus both in research and clinical practice on child caregivers' views and experiences regarding their role and its function. Most interestingly this study demonstrated that the relationship building process follows a rather intuitive approach based on the levels of familiarity and mutual sympathy with the child.

Most staff described their relationships as a natural process as opposed to theory driven. Whilst there is clear reference to building relationships, and parenting the children in a natural, automatic and "common sense" way, clear difficulties have been highlighted regarding the implementation of building healthy therapeutic attachments in practice. The most recent study published in 2020 indicated that staff are "doing it naturally with the theory in the background" (Morison et al., 2020). Similar results have emphasised that caregivers' perceptions of children's difficulties, their own attachment, motivations, attitudes and personality are crucial factors determining the quality of the relationship with the children in their care. Taken together these findings suggest that the relationship building process is not necessarily planned and led in a way that is psychologically informed and therapeutically led.

Morison et al. (2020) recommended a series of practical suggestions in response to the needs identified in residential care and specifically the needs of the caregivers to fulfil their roles adequately. One of the main issues was the lack of professionalisation of the role as childcare workers, with caregiver roles being significantly underrated and undervalued; in addition, care workers undertaking such challenging and demanding roles are only required to have a clear criminal record and minimal literacy skills, which are not verified upon recruitment. In addition, the need for more training, support, and individualised clinical supervision was highlighted with rates of vicarious trauma and burnout rising between care workers shortly after starting their role. Thus, findings from the present research support the series of practical suggestions transferrable to the reality of this specific type of work that aligns with caregivers' experiences and expectations, as well as opinion regarding the maximation of their potential to represent solid attachment figures for the children. Findings from this and similar studies strongly recommend that policymakers regulating children's homes prioritise caregivers' personality, emotional stability, and motivations. Likewise, they need to refine their recruitment process and be psychologically aware of these issues when creating alternative care for children and building this into regulations from business development point of view. This facilitates stakeholders and businesses to become more sensitised and knowledgeable about the needs of children, to channel the resources related to training and recruitment, accordingly. It would also potentially improve the work structure and organisational conditions to enhance childcare workers' motivation, good will and intentions to provide care for such a vulnerable population.

Conducting further robust studies focused on gathering information from front line childcare workers is crucial to elucidate the areas of strengths and where the training and support should be concentrated to maximising caregivers' abilities to build a healthy and therapeutic relationship with the children in their care. Despite evidence in this area being limited, the review emphasised that care workers have good intentions and actively choose their roles to help children. Nonetheless, they find themselves conflicted by operational imperatives, poor staffing ratios, lack of training and resources, and multiple roles that they must fulfil in the children's lives. These factors, paired with the lack of understanding of their role, lack of support when issues and concerns arise, and potential personal difficulties, were deemed to impact negatively care workers' capacity and emotional availability to invest in the relationship with the children in their care.

Based on of the identified need in Chapter 2, the empirical study focused on addressing the lack of research conducted with child caregivers, their experiences, and their meaning making of the relationship building process with the children in their care. One of the core aspects of this study was to explore care workers' understanding of their role in the relationship building process. By means of introspection and self-analysis they were enabled to express freely their perceptions and their own conclusions regarding their motivation for the roles, their strengths, limitations, challenges, and achievements when working and relating to the children.

Following thorough analysis of the data, three superordinate themes were identified: Relationship-Building; The Emotional Impact on Caregivers, and Caregivers' Lived Experiences: Insight and Motivation.

The findings from this research show that caregivers, whilst facing a series of challenges in their roles looking after traumatised children with complex emotional and behavioural challenges, still manage to enjoy their jobs and see the purpose of it. The caregivers unanimously reported that whilst organisational imperatives envisage and prioritise clearly how to promote the practical/ physical needs of the children, less clarity was portrayed in their experiences regarding how to meet children's emotional needs. The participants in this study faced a specific set back in their caregiver role regarding the short residential stay of the children (as dictated by the care setting) and the transitory nature of the relationship with the children. Caregivers appeared to face a dilemma of balancing how close the relationship they build with the children should be to maintain good professional and personal boundaries whilst also needing to sufficiently relate and connect with the children in order to meet their emotional needs. The difficult decision making, as well as the moral implications and psychological and emotional investment from the caregivers to "hold the space" and support the children with past and present traumas, whilst navigating children's lack of trust in caregivers and lack of time to form good quality relationships, were considered by most participants as highly frustrating. In such a context and when lacking sufficient personal and professional resources, caregivers found themselves overwhelmed with having to deal with very challenging situations which they considered outside of their level of expertise and commented that professional support was necessary. In such situations, where the support was not readily available and there were other organisational constraints, caregivers' level of frustration and self-preservation were common experiences.

Most of the participants found themselves more vulnerable, less patient and more defensive when their personal resources and emotional robustness were depleted, as it was more likely that they would be triggered. Caregivers appeared at higher risk of developing vicarious trauma and blocked care, when they were known to have unresolved childhood traumas themselves that were triggered by children's own traumas or their challenging behaviours against caregivers (see beginning of Chapter 3 for more details regarding vicarious trauma and blocked care concepts). Unsurprisingly, these dynamics, most of the time, exert a highly negative impact on the relationship-building process, however, paradoxically when sublimated (channelled correctly) caregiver's similar lived experiences can have a healing power, and when the energy from it is channelled positively, it serves a higher purpose. Some of the participants reported that being an expert by experience who has overcome totally or partially their own traumas is a unique strength and a superpower. In their views and lived experiences, they believe that helping as many children as possible with their skills, knowledge and similar life experiences is like a mission or power from God, a higher purpose. Without a doubt, this represents a very profound insight and motivation that allows many caregivers to undertake such difficult roles and believe in the children and their capacities to overcome their difficulties regardless how complex these seem to be.

Participants also acknowledged that more training before recruitment, in house clinical support and supervision would be very helpful to allow caregivers to debrief and discuss any work related or personal challenges. This was possible for them in the past; however, the clinical supervision was no longer held, and a feeling of regret was expressed as caregivers found themselves taking work home and ruminating over frustrations experienced at work. The lack of clinical supervision and emotional support for caregivers appeared to continue to impact them over several days as they reported feeling less patient, more hypervigilant, and not keen to go back to work. As such, caregivers all believed that having support for them at work and guidance on how to conceptualise children's difficulties could significantly improve their insight and motivations, as well as reduce the emotional impact that looking after children with complex difficulties may have on them.

Based on caregivers' own experiences, whilst *it can be hard* doing this job, (as it requires enormous energy, emotional investment, acceptance, patience and tolerance) sometimes when children stabilise in their placement and a good relationship is established, it does not feel like work. Concurrently when children are too unsettled, resist and sabotage caregivers' effort to build a relationship this most likely will negatively impact caregivers' motivation and willingness to remain in their roles**.** Low levels of motivation in caregivers may lead to high levels of burnout and staff turnover with a staggering negative impact on children who may experience rejection and abandonment because of this, leading to an exacerbation of trauma symptomatology (Ireland et al., 2022). In this context a combined effect is observed. Firstly, the children feel rejected and secondly, caregivers may feel unable to help the children which can impact the caregivers' confidence, and perceptions of their capacity to build future relationship with children. These interactions can lead to the formation of negative attitudes towards relating to the children, withdrawal, disconnection, lack of empathy and a distorted conceptualisation of their emotional needs (Bettmann et al., 2015; Bohnenkamp et al., 2021; Castillo et al., 2012; Garcia Quiroga & Hamilton-Giachritsis, 2017b; Steels & Simpson, 2017).

Concomitantly, caregivers reported that the work can be surprisingly enjoyable and fun when *it's all going well.* It becomes obvious that better working conditions, staff ratios, number of children per staff, time, remuneration, training, clinical supervision, represent important organisational factors that contribute to caregivers' motivation and capacity to invest in building positive and meaningful relationship with the children in their care. Therefore, awareness of the barriers and facilitators to the relationship-building process will improve policies, recruitment, and training to enhance caregivers’ capacities and skills to develop and form good relationships with the children in their care.

In conclusion, careful consideration of caregivers’ lived experiences and perceptions of their roles (including their own motivations, needs and views on how and what they need to complete their roles) may represent a key aspect to understand how to better implement and create robust policies and therapeutic approaches to adequately support the children and young people in their care.

A critique of the psychometric characteristics of the Trauma Symptoms Checklist for Children (TSCC; Briere, 1996) concluded that the TSCC is one of the most reliable and valid measurements for the assessment of trauma symptomatology in children. Whilst it is not a diagnostic assessment per se, it can be highly valuable and used in conjunction with other psychometrics and clinical interviews with children and their caregivers to diagnose and guide trauma interventions. Findings from the present research strongly suggest that caregivers’ awareness of children’s background, understanding of trauma and attachment, and insight into their own capacity to relate and regulate their emotions and respond to children’s challenging behaviours will most definitely support the assessment, diagnosis, and intervention of children’s needs and difficulties. In addition, the translation of this widely used tool into different languages led to many international studies corroborating its utility and robustness (W. Martinez et al., 2014; Matulis et al., 2015; Nilsson et al., 2012; Nilsson et al., 2008; Tordön et al., 2019).

Despite its suitability for the screening and assessment of trauma symptomatology in children from clinical and non-clinical populations there are a series of limitations. One of the main limitations has been related to its lack of a single overall interpretable score and the transformation of raw scores to scaled scores. This implies that the clinician interpreting the scales must be experienced and familiar with the TSCC and other complementary scales. Another limitation refers to the questionnaire being based on self-reported information and self-awareness of the symptoms. In this regard, given that children lack cognitive maturity, there is a risk to underreport or dissociate during completion of the tool, and thus, children may be afraid to disclose their experiences. Indeed, findings from the empirical study (Chapter 3) highlighted that often children will avoid talking about their experiences as they may perceive this as being vulnerable and weak. Nonetheless, most of the participants from the study reported that once a good relationship is built, children commence trusting the carers and talk more freely about their past and present experiences and emotions. Not surprisingly, these children stabilise and engage sooner in their placement, learn to emotionally auto-regulate, achieve better in school, and adjust better psychosocially. Similar to these findings, longitudinal studies conducted with children in care have concluded that the creation of a therapeutic system around the child with highly motivated and trained, emotionally stable caregivers is a priority over individual therapy for children’s complex challenging behaviours and emotions (Alisic et al., 2014; Anderson et al., 2006; Farnfield & Onions, 2021; Roberts, 2020).

Strengths and Limitations of the Thesis

This thesis as a whole has contributed to the wider literature by analysing existing research undertaken to explore childcare workers' experiences of their relationship-building process with the children in their care, and its implication for traumatised children's treatment and emotional well-being. Nonetheless, since only one researcher analysed and gathered the data for the systematic review, certain bias arising from the role and experience of the researcher may have been present. In addition, due to the scarcity of studies conducted with this population only a small number of relevant literatures was identified and reviewed. In spite of the small number of studies, this review has identified homogenous common themes across the papers, emphasised guidance and recommendations for future research and clinical practice and addressed a gap in the existing knowledge base.

Consequently, the empirical study carried out in chapter 3 adds to the limited knowledge base in this area and can be considered one of the first unique studies in the UK exploring childcare workers' experiences and understanding of their relationship-building with the children in their care within a residential care setting. A potential limitation of the empirical study (Chapter 3) is that it was conducted with a relatively small sample, and using a qualitative methodology, as such the results may not be generalisable. However, findings produced a high level of specificity leading to tangible recommendations regarding: the improvement of the quality of care for the children, caregivers' awareness and understanding of children's challenging behaviours and emotional needs, as well as caregivers' role definition, requirements and professionalisation, suitable and relevant training and clinical supervision.

In conclusion, understanding the intervention for children in care from the prism of their needs, from a systemic and developmental perspective, becomes paramount. De-pathologizing their presentation and normalising their experiences in the context of trauma will prioritise attachment-based interventions, at the heart of which is the figure of the caregiver. Acknowledging their importance by giving them a voice, listening to their experiences, offering them good and satisfactory work conditions will positively influence their commitment, motivation, emotional availability, and investment in the relationship building and attachment with the children. This is key in supporting traumatised children's recovery and their future life outcomes.

Final Conclusions and Implications for Clinical Practice

Overall, the need for the formation of healthy attachments/relationships within services for children with a history of early trauma is clearly articulated in the views of the caregivers participating in this study. The findings from this research highlight the difficulties from a caregiver's perspective in establishing close relationships with the children in their care. Establishing positive relationships can help protect children from engaging in criminality, substance misuse or abusive relationships. For this purpose, caregiver's understanding of the underlying reasons for presenting behaviours needs to shift the focus of their interactions with children in their care from behaviour management to emotional connection.

Overall, the research emphasises the importance of recognising at a higher hierarchical level that caregivers' wellbeing is intrinsically connected to the wellbeing and therapeutic outcomes of the children they care for. In addition, caregivers primarily need to feel safe and competent in their role. The lack of support, validation, recognition, and caregivers not having a voice has been a predominant theme within the data analysis (Parry et al., 2022). In addition, the need for increased levels of reflective practice was identified, in which those situations which trigger emotional distancing can be explored to enhance caregivers' capacity to build self-awareness, maintain a trauma informed mentalisation of presenting behaviours, and continue to be emotionally connected at times when the system as a whole is under stress (Davidson et al., 2011; Heine et al., 2021; Messer et al., 2018).

Future Research

Whilst some very valuable insights and important general conclusions are emphasised in the qualitative study (Chapter 3) based on the experiences and meaning making of six caregivers, further research is needed. Both quantitative and qualitative research should be undertaken to understand the needs and difficulties caregivers may encounter in such difficult roles. Only by comprehending what these are and valuing caregivers financially and professionally, will allow them to be passionate, motivated, and prepared to commit and offer the best quality of care to the children they look after.

Despite the limitations in terms of generalisability based on the small sample size of the empirical study, it is hoped that these results will influence policy makers and clinical practice, and stimulate further research in this area, looking more specifically at caregiver factors to enhance and maximise the quality of care for the children, and life/work satisfaction for the caregivers.

References

Abdulla, F., & Kasese-Hara, M. (2020). Care worker perspectives on the socio-emotional adjustment of orphans in residential homes. *Vulnerable children and youth studies*, *15*(1), 77-84. https://doi.org/10.1080/17450128.2020.1719250

Achenbach, T. M., & Edelbrock, C. S. (1981). Behavioral problems and competencies reported by parents of normal and disturbed children aged four through sixteen. *Monogr Soc Res Child Dev*, *46*(1), 1-82.

Admon, R., Milad, M. R., & Hendler, T. (2013). A causal model of post-traumatic stress disorder: disentangling predisposed from acquired neural abnormalities. *Trends in cognitive sciences*, *17*(7), 337-347.

Ainsworth, M. S. (1979). Infant–mother attachment. *American Psychologist*, *34*(10), 932-937. https://doi.org/10.1037/0003-066X.34.10.932

Alase, A. (2017). The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. *International journal of education and literacy studies*, *5*(2), 9-19.

Alisic, E., Zalta, A. K., Van Wesel, F., Larsen, S. E., Hafstad, G. S., Hassanpour, K., & Smid, G. E. (2014). Rates of post-traumatic stress disorder in trauma-exposed children and adolescents: meta-analysis. *The British Journal of Psychiatry*, *204*(5), 335-340.

Analía Soria, B., & Bandeira, L. M. (2015). Care work: a situational and multidimensional concept. *Revista Brasileira de Ciência Política*, *18*. https://doi.org/http://dx.doi.org/10.1590/0103-335220151803

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., Dube, S. R., & Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *Eur Arch Psychiatry Clin Neurosci*, *256*(3), 174-186. https://doi.org/10.1007/s00406-005-0624-4

Anderson, K. G., Ramo, D. E., & Brown, S. A. (2006). Life stress, coping and comorbid youth: An examination of the stress-vulnerability model for substance relapse. *Journal of Psychoactive Drugs*, *38*(3), 255-262.

Armsworth, M. W., & Holaday, M. (1993). The effects of psychological trauma on children and adolescents. *Journal of Counseling & Development*, *72*(1), 49-56.

Atwool, N. (2006). Attachment and Resilience: Implications for Children in Care. *Child Care in Practice*, *12*(4), 315-330. https://doi.org/10.1080/13575270600863226

Baidawi, S., & Piquero, A. R. (2021). Neurodisability among Children at the Nexus of the Child Welfare and Youth Justice System. *Journal of Youth and Adolescence*, *50*(4), 803-819. https://doi.org/http://dx.doi.org/10.1007/s10964-020-01234-w

Baidawi, S., Sheehan, R., & Flynn, C. (2020). Criminal exploitation of child protection-involved youth. *Children and Youth Services Review*, *118*, 105396.

Bailey, C., Klas, A., Cox, R., Bergmeier, H., Avery, J., & Skouteris, H. (2019). Systematic review of organisation-wide, trauma-informed care models in out-of-home care (OoHC) settings. *Health Soc Care Community*, *27*(3), e10-e22. https://doi.org/10.1111/hsc.12621

Bailey, E. K. (2017). Attachment focused caregiving training in residential children's homes: A pilot study. *Clinical Psychology Forum*(292), 47. https://www.proquest.com/scholarly-journals/attachment-focused-caregiving-training/docview/1885041647/se-2?accountid=8630

https://birmingham-primo.hosted.exlibrisgroup.com/openurl/44BIR/44BIR_Services?genre=unknown&issn=17475732&title=Attachment+focused+caregiving+training+in+residential+children%27s+homes%3A+A+pilot+study&volume=&issue=292&date=2017&atitle=Attach

ment+focused+caregiving+training+in+residential+children%27s+homes%3A+A+pilot+study&spage=47&sid=ProQ%3Aassia&author=Bailey

Banerjee, A., Armstrong, P., Daly, T., Armstrong, H., & Braedley, S. (2015). "Careworkers don't have a voice:" epistemological violence in residential care for older people. *Journal of aging studies*, *33*, 28-36. https://doi.org/http://dx.doi.org/10.1016/j.jaging.2015.02.005

Banks, A. (2006). Relational Therapy for Trauma. *Journal of Trauma Practice*, *5*(1), 25-47. https://doi.org/10.1300/J189v05n01_03

Barbosa, F., Voss, G., & Alice Delerue, M. (2020). Health impact of providing informal care in Portugal. *BMC Geriatrics*, *20*, 1-9. https://doi.org/http://dx.doi.org/10.1186/s12877-020-01841-z

Barford, S., & Whelton, W. (2010). Understanding Burnout in Child and Youth Care Workers. *Child & Youth Care Forum*, *39*, 271-287. https://doi.org/10.1007/s10566-010-9104-8

Barone, L., Del Giudice, M., Fossati, A., Manaresi, F., Actis Perinetti, B., Colle, L., & Veglia, F. (2009). METHODS & MEASURES: Psychometric properties of the Manchester Child Attachment Story Task: An Italian multicentre study. *International Journal of Behavioral Development*, *33*(2), 185-190. https://doi.org/10.1177/0165025409103134

Bassett, D. S., & Gazzaniga, M. S. (2011). Understanding complexity in the human brain. *Trends in cognitive sciences*, *15*(5), 200-209. https://doi.org/10.1016/j.tics.2011.03.006

Bastiaanssen, I. L. W., Delsing, M. J. M. H., Geijsen, L., Kroes, G., Veerman, J. W., & Engels, R. C. M. E. (2014). Observations of Group Care Worker-Child Interaction in Residential Youth Care: Pedagogical Interventions and Child Behavior. *Child & Youth Care Forum*, *43*(2), 227-241. https://doi.org/http://dx.doi.org/10.1007/s10566-013-9231-0

Bath, H. I. (2008). The Three Pillars of Trauma-Informed Care. *Reclaiming Children and Youth*, *17*, 17-21.

Beck, A. (2006). Addressing the Mental Health Needs of Looked after Children Who Move Placement Frequently. *Adoption & Fostering*, *30*(3), 60-65. https://doi.org/10.1177/030857590603000308

Becker-Weidman, A. (2006). Treatment for Children with Trauma-Attachment Disorders: Dyadic Developmental Psychotherapy. *Child and Adolescent Social Work Journal*, *23*(2), 147-171. https://doi.org/10.1007/s10560-005-0039-0

Becker-Weidman, A., & Hughes, D. (2008). Dyadic Developmental Psychotherapy: an evidence-based treatment for children with complex trauma and disorders of attachment. *Child & Family Social Work*, *13*(3), 329-337. https://doi.org/https://doi.org/10.1111/j.1365-2206.2008.00557.x

Bellegarde, N., Chintakunta, S. V., Christian, D. D., & Pemu, M.-M. Adventure Therapy to Mitigate the Harmful Effects of ACEs with Lower-SES Adolescents. *Journal of Creativity in Mental Health*, 1-17. https://doi.org/10.1080/15401383.2024.2415939

Bennett, D. L., Schlüter, D. K., Melis, G., Bywaters, P., Alexiou, A., Barr, B., ... & Taylor-Robinson, D. (2022). Child poverty and children entering care in England, 2015–20: a longitudinal ecological study at the local area level. *The Lancet Public Health*, *7*(6), e496-e503.

Berlin, I. N. (2001). Critical Collaboration in the Treatment of Attachment Disturbed Children and Adolescents in Residential Care. *Residential Treatment for Children & Youth*, *19*(2), 1-12. https://doi.org/10.1300/J007v19n02_01

Bettmann, J. E., Mortensen, J. M., & Akuoko, K. O. (2015). Orphanage caregivers' perceptions of children's emotional needs. *Children and Youth Services Review*, *49*, 71-79. https://doi.org/http://dx.doi.org/10.1016/j.childyouth.2015.01.003

Bifulco, A., Jacobs, C., Ilan-Clarke, Y., Spence, R., & Oskis, A. (2016). Adolescent Attachment Style in Residential Care: The Attachment Style Interview and Vulnerable Attachment Style Questionnaire. *The British Journal of Social Work*, *47*(7), 1870-1883. https://doi.org/10.1093/bjsw/bcw117

Blaustein, M. E., & Kinniburgh, K. M. (2010). *Treating traumatic stress in children and adolescents: How to foster resilience through attachment, self-regulation, and competency*. Guilford Press.

Bloom, S. L. (2010). Organizational stress and trauma-informed services. *A public health perspective of women's mental health*, 295-311.

Boel-Studt, S., Schelbe, L., Deichen Hansen, M., & Tobia, L. (2018). Increasing Youth Engagement in Residential Group Care: A Mixed Methods Pilot Study of a Youth-Guided Incentive Program. *Child & Youth Care Forum*, *47*(6), 863-880. https://doi.org/10.1007/s10566-018-9465-y

Bohnenkamp, J. H., Schaeffer, C. M., Siegal, R., Beason, T., Smith-Millman, M., & Hoover, S. (2021). Impact of a School-Based, Multi-Tiered Emotional and Behavioral Health Crisis Intervention on School Safety and Discipline. *Prevention science : the official journal of the Society for Prevention Research*, *22*(4), 492-503. https://doi.org/http://dx.doi.org/10.1007/s11121-020-01195-3

Boney-McCoy, S., & Finkelhor, D. (1995). Prior victimization: a risk factor for child sexual abuse and for PTSD-related symptomatology among sexually abused youth. *Child Abuse Negl*, *19*(12), 1401-1421. https://doi.org/10.1016/0145-2134(95)00104-9

BOWEN, D., & NEILL, J. (2013a). A meta-analysis of adventure therapy outcomes and moderators. *The Open Psychology Journal*, *6*(1), 28-53.

Bowen, D., & Neill, J. (2013b). A Meta-Analysis of Adventure Therapy Outcomes and Moderators. *The Open Psychology Journal*, *6*. https://doi.org/10.2174/1874350120130802001

Bowen, D. J., Neill, J. T., & Crisp, S. J. R. (2016). Wilderness adventure therapy effects on the mental health of youth participants. *Evaluation and Program Planning*, *58*, 49-59. https://doi.org/https://doi.org/10.1016/j.evalprogplan.2016.05.005

Bowlby, J. (2008). *Attachment*. Basic Books. https://books.google.ch/books?id=WA7JejeXYd4C

Bradley, R. H., & Caldwell, B. M. (1984). The HOME Inventory and family demographics. *Developmental psychology*, *20*(2), 315.

Bramley, N., & Eatough, V. (2005). The experience of living with Parkinson's disease: An interpretative phenomenological analysis case study. *Psychology & Health*, *20*(2), 223-235.

Brannen, J., Mooney, A., & Statham, J. (2009). Childhood Experiences: A Commitment to Caring and Care Work with Vulnerable Children. *Childhood: A Global Journal of Child Research*, *16*(3), 377-393. https://doi.org/http://dx.doi.org/10.1177/0907568209335317

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Bretherton, I. (1990). Assessing internal working models of the attachment relationship: An attachment story completion task for 3-year-olds. *Attachment in the presch*.

Briere, J. (1996). Trauma Symptom Checklist for Children (TSCC). *Journal of Abnormal PsychologyAssessment of family violence: A handbook for researchers and practitioners*. https://doi.org/10.1037/t06631-000

Briere, J., Johnson, K., Bissada, A., Damon, L., Crouch, J., Gil, E., Hanson, R., & Ernst, V. (2001). The Trauma Symptom Checklist for Young Children (TSCYC): reliability and association with abuse exposure in a multi-site study. *Child Abuse & Neglect*, *25*(8), 1001-1014. https://doi.org/https://doi.org/10.1016/S0145-2134(01)00253-8

Briere, J., Johnson, K., Bissada, A., Damon, L., Crouch, J., Gil, E., Hanson, R., & Ernst, V. (2001). The Trauma Symptom Checklist for Young Children (TSCYC): reliability and association with abuse exposure in a multi-site study. *Child Abuse Negl*, *25*(8), 1001-1014. https://doi.org/10.1016/s0145-2134(01)00253-8

Briere, J., Kaltman, S., & Green, B. (2008). Accumulated childhood trauma and symptom complexity. *Journal of traumatic stress*, *21*, 223-226. https://doi.org/10.1002/jts.20317

Briggs, E. C., Greeson, J. K. P., Layne, C. M., Fairbank, J. A., Knoverek, A. M., & Pynoos, R. S. (2012). Trauma Exposure, Psychosocial Functioning, and Treatment Needs of Youth in Residential Care: Preliminary Findings from the NCTSN Core Data Set. *Journal of Child & Adolescent Trauma*, *5*(1), 1-15. https://doi.org/10.1080/19361521.2012.646413

Brown, L., & Sen, R. (2014). Improving outcomes for looked after children: A critical analysis of kinship care. *Practice*, *26*(3), 161-180.

Brown, T., Winter, K., & Carr, N. (2018). Residential child care workers: Relationship based practice in a culture of fear. *Child & Family Social Work*, *23*(4), 657-665. https://doi.org/10.1111/cfs.12461

Brumariu, L. E., Diaconu-Gherasim, L. R., Kerns, K. A., & C. Lewis, N. (2020). Attachment figures in a middle childhood Romanian sample: Does parental migration for employment matter? *Attachment & Human Development*, *22*(3), 290-309. https://doi.org/10.1080/14616734.2018.1557716

Butcher, F., Kretschmar, J., Lin, Y., Flannery, D., & Singer, M. (2013). Analysis of the Validity Scales in the Trauma Symptom Checklist for Children. *Research on Social Work Practice*, *24*, 695-704. https://doi.org/10.1177/1049731513516803

Butcher, F., Kretschmar, J. M., Lin, Y., Flannery, D. J., & Singer, M. I. (2014). Analysis of the Validity Scales in the Trauma Symptom Checklist for Children. *Research on Social Work Practice*, *24*(6), 695-704. https://doi.org/10.1177/1049731513516803

Butler, A., Hall, H., & Copnell, B. (2016). A guide to writing a qualitative systematic review protocol to enhance evidence-based practice in nursing and health care. *Worldviews on Evidence-Based Nursing*, *13*(3), 241-249.

Butterworth, S., Singh, S. P., Birchwood, M., Islam, Z., Munro, E. R., Vostanis, P., Paul, M., Khan, A., & Simkiss, D. (2017). Transitioning care-leavers with mental health needs:'they set you up to fail!'. *Child and Adolescent Mental Health*, *22*(3), 138-147.

Cahill, O., Holt, S., & Kirwan, G. (2016). Keyworking in residential child care: Lessons from research. *Children and Youth Services Review*, *65*, 216-223. https://doi.org/https://doi.org/10.1016/j.childyouth.2016.04.014

Cameron, R. J. S., & Maginn, C. (2008). The authentic warmth dimension of professional childcare. *British Journal of Social Work*, *38*(6), 1151-1172. https://doi.org/http://dx.doi.org/10.1093/bjsw/bcm044

Campbell, D. T., & Fiske, D. W. (1959). Convergent and discriminant validation by the multitrait-multimethod matrix. *Psychological bulletin*, *56*(2), 81.

Carlo, P. (1988). Implementing a Parent Involvement/Parent Education Program in a Children's Residential Treatment Center. *Child and Youth Care Quarterly*, *17*(3), 195-206. https://www.proquest.com/scholarly-journals/implementing-parent-involvement-education-program/docview/9698275/se-2?accountid=8630

https://birmingham-primo.hosted.exlibrisgroup.com/openurl/44BIR/44BIR_Services?genre=unknown&issn=&title=Implementing+a+Parent+Involvement%2FParent+Education+Program+in

+a+Children%27s+Residential+Treatment+Center&volume=17&issue=3&date=1988&atitle=Implementing+a+Parent+Involvement%2FParent+Education+Program+in+a+Children%27s+Residential+Treatment+Center&spage=195&sid=ProQ%3Ancjrs&author=Carlo

Carver, H. (2019). The experiences of carers in using shared activities to communicate with looked-after young people about alcohol, tobacco, and drug use. *Child & Family Social Work*, *24*(1), 131-138. https://doi.org/10.1111/cfs.12590

Casonato, M., Nazzari, S., & Frigerio, A. (2017). Feasibility and efficacy of an attachment-based intervention in a maltreatment sample in residential care: A pilot study. *Clin Child Psychol Psychiatry*, *22*(4), 561-571. https://doi.org/10.1177/1359104517719115

Castillo, J. T., Sarver, C. M., Bettmann, J. E., Mortensen, J., & Akuoko, K. (2012). Orphanage caregivers' perceptions: The impact of organizational factors on the provision of services to orphans in the Ashanti Region of Ghana. *Journal of Children & Poverty*, *18*(2), 141-160. https://doi.org/http://dx.doi.org/10.1080/10796126.2012.710484

Chambers, C. D., & Tzavella, L. (2021). The past, present and future of Registered Reports. *Nature human behaviour*. https://doi.org/http://dx.doi.org/10.1038/s41562-021-01193-7

Chartier, M. J., Walker, J. R., & Naimark, B. (2010). Separate and cumulative effects of adverse childhood experiences in predicting adult health and health care utilization. *Child Abuse & Neglect*, *34*(6), 454-464. https://doi.org/https://doi.org/10.1016/j.chiabu.2009.09.020

Christian, D., & Brown, C. (2021). Using Adventure Therapy to Improve Self-Efficacy of Middle School Students. *19*, 1-44.

Chung, U. S. (2014). The Korean version of the trauma symptom checklist for children: psychometric properties and the connection to trauma among Korean children and adolescents. *J Korean Med Sci*, *29*(6), 837-845. https://doi.org/10.3346/jkms.2014.29.6.837

Cloitre, M., Stolbach, B. C., Herman, J. L., van der Kolk, B., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: childhood and adult cumulative trauma as predictors of symptom complexity. *J Trauma Stress*, *22*(5), 399-408. https://doi.org/10.1002/jts.20444

Cohen, J. A., Deblinger, E., & Mannarino, A. P. (2018). Trauma-focused cognitive behavioral therapy for children and families. *Psychotherapy Research*, *28*(1), 47-57. https://doi.org/10.1080/10503307.2016.1208375

Colburn, A., Kremer, K., & Jackson, D. (2021). Early trauma and psychosocial outcomes among college students. *Children and Youth Services Review*, *126*, 106052. https://doi.org/10.1016/j.childyouth.2021.106052

Collier, S., & Bryce, I. (2023). A Systematic Literature Review of the Teaching Considerations and Practices Provided to Children in an Education Setting with Comorbid Disability and Developmental Trauma. *Children*, *10*(8), 1289.

Collin-Vézina, D., Coleman, K., Milne, L., Sell, J., & Daigneault, I. (2011). Trauma experiences, maltreatment-related impairments, and resilience among child welfare youth in residential care. *International Journal of Mental Health and Addiction*, *9*(5), 577-589.

Collings, S., Wright, A. C., McLean, L., & Buratti, S. (2021). Trauma-informed Family Contact Practice for Children in Out-of-home Care. *The British Journal of Social Work*. https://doi.org/10.1093/bjsw/bcab147

Collins, S. (2008). Statutory Social Workers: Stress, Job Satisfaction, Coping, Social Support and Individual Differences. *British Journal of Social Work - BRIT J SOC WORK*, *38*, 1173-1193. https://doi.org/10.1093/bjsw/bcm047

Conijn, J. M., Smits, N., & Hartman, E. E. (2019). Determining at What Age Children Provide Sound Self-Reports: An Illustration of the Validity-Index Approach. *Assessment*, *27*(7), 1604-1618. https://doi.org/10.1177/1073191119832655

Conley, C. (2003). Conley, C. (2004). A Review of Parenting Capacity Assessment Reports. Journal of the Ontario Association of Children's Aid Societies, 47(3), 16-23. http://www.oacas.org/pubs/oacas/journal/2003_2004winter/2003_2004winter.pdf. *47*, 16-23.

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E., & van der Kolk, B. (2005). Complex Trauma in Children and Adolescents. *Psychiatric Annals*, *35*(5), 390-398.

Cortina, M., & Liotti, G. (2010). Attachment is about safety and protection, intersubjectivity is about sharing and social understanding: The relationships between attachment and intersubjectivity. *Psychoanalytic Psychology*, *27*(4), 410.

Costa, M., Melim, B., Tagliabue, S., Mota, C. P., & Matos, P. M. (2020). Predictors of the quality of the relationship with caregivers in residential care. *Children and Youth Services Review*, *108*, 104579.

Crouch, J. L., Smith, D. W., Ezzell, C. E., & Saunders, B. E. (1999). Measuring Reactions to Sexual Trauma among Children: Comparing the Children's Impact of Traumatic Events Scale and the Trauma Symptom Checklist for Children. *Child Maltreatment*, *4*(3), 255-263. https://doi.org/10.1177/1077559599004003006

Cyr, C., Euser, E. M., Bakermans-Kranenburg, M. J., & Van Ijzendoorn, M. H. (2010). Attachment security and disorganization in maltreating and high-risk families: a series of meta-analyses. *Dev Psychopathol*, *22*(1), 87-108. https://doi.org/10.1017/s0954579409990289

Davidson, C., Dumigan, L., Ferguson, C., & Nugent, P. (2011). Effective Therapeutic Approaches within Specialist Residential Childcare Settings. *Child Care in Practice*, *17*(1), 17-35. https://doi.org/http://dx.doi.org/10.1080/13575279.2011.528968

de Voursney, D., & Huang, L. N. (2016). Meeting the mental health needs of children and youth through integrated care: A systems and policy perspective. *Psychological Services*, *13*(1), 77.

del Valle, J. F., López, M., & Bravo, A. (2007). Job stress and burnout in residential child care workers in Spain. *Psicothema*, *19*(4), 610-615. https://www.proquest.com/scholarly-journals/job-stress-burnout-residential-child-care-workers/docview/68432251/se-2

https://birmingham-primo.hosted.exlibrisgroup.com/openurl/44BIR/44BIR_Services?genre=unknown&issn=02149915&title=Job+stress+and+burnout+in+residential+child+care+workers+in+Spain.&volume=19&issue=4&date=2007&atitle=Job+stress+and+burnout+in+residential+child+care+workers+in+Spain&spage=610&sid=ProQ%3Atoxline&author=del+Valle

Delgado, P., & Pinto, V. S. (2011). Criteria for the selection of foster families and monitoring of placements.: Comparative study of the application of the Casey Foster Applicant Inventory-Applicant Version (CFAI-A). *Children and Youth Services Review*, *33*(6), 1031-1038.

DeRosa, R., & Pelcovitz, D. (2009). Group treatment for chronically traumatized adolescents: Igniting SPARCS of change. *Treating traumatized children: Risk, resilience and recovery*, 225-239.

Dobud, W. (2016). Exploring adventure therapy as an early intervention for struggling adolescents. *Journal of Outdoor and Environmental Education*, *19*, 33. https://doi.org/10.1007/BF03400985

Dobud, W. W., & Harper, N. J. (2018). Of Dodo birds and common factors: A scoping review of direct comparison trials in adventure therapy. *Complementary therapies in clinical practice*, *31*, 16-24.

Dozier, M., Stoval, K. C., Albus, K. E., & Bates, B. (2001). Attachment for infants in foster care: The role of caregiver state of mind. *Child development*, *72*(5), 1467-1477.

Dozier, M., Zeanah, C. H., Wallin, A. R., & Shauffer, C. (2012). Institutional care for young children: Review of literature and policy implications. *Social issues and policy review*, *6*(1), 1-25.

Durka, K., & Hacker, T. (2015). The Experience of Receiving and Delivering Consultation in a Residential Childcare Setting for Looked-after and Accommodated Children: A Sequential Exploratory Design. *Child Care in Practice*, *21*(4), 392-407. https://doi.org/10.1080/13575279.2015.1008401

Eastwood, C. D., & Ecklund, K. (2008). Compassion Fatigue Risk and Self-Care Practices among Residential Treatment Center Childcare Workers. *Residential Treatment for Children & Youth*, *25*(2), 103-122. https://doi.org/http://dx.doi.org/10.1080/08865710802309972

Eatough, V., & Smith, J. A. (2017). Interpretative phenomenological analysis. *The Sage handbook of qualitative research in psychology*, 193-209.

Elliott, D. M., & Briere, J. (1995). Posttraumatic stress associated with delayed recall of sexual abuse: A general population study. *Journal of traumatic stress*, *8*(4), 629-647. https://doi.org/10.1007/BF02102892

Ereky-Stevens, K., Funder, A., Katschnig, T., Malmberg, L.-E., & Datler, W. (2018). Relationship building between toddlers and new caregivers in out-of-home childcare: Attachment security and caregiver sensitivity. *Early Childhood Research Quarterly*, *42*, 270-279. https://doi.org/10.1016/j.ecresq.2017.10.007

Etkin, A., Büchel, C., & Gross, J. J. (2015). The neural bases of emotion regulation. *Nat Rev Neurosci*, *16*(11), 693-700. https://doi.org/10.1038/nrn4044

Evans, G. W. (2003). The built environment and mental health. *Journal of Urban Health*, *80*(4), 536-555. https://doi.org/http://dx.doi.org/10.1093/jurban/jtg063

Evans, G. W., Jacobs, S. V., Dooley, D., & Catalano, R. (1987). The interaction of stressful life events and chronic strains on community mental health. *Am J Community Psychol*, *15*(1), 23-34. https://doi.org/10.1007/bf00919755

Evans, K., Law, H., Turner, R. E., Rogers, A., & Cohen, K. (2011). A Pilot Study Evaluating Care Staffs' Perceptions of Their Experience of Psychological Consultation within a Mental Health Setting. *Child Care in Practice*, *17*(2), 205-219. https://www.proquest.com/scholarly-journals/pilot-study-evaluating-care-staffs-perceptions/docview/870284325/se-2?accountid=8630

https://birmingham-primo.hosted.exlibrisgroup.com/openurl/44BIR/44BIR_Services?genre=unknown&issn=13575279&title=A+Pilot+Study+Evaluating+Care+Staffs%27+Perceptions+of+Their+Experience+of+Psychological+Consultation+within+a+Mental+Health+Setting&volume=17&issue=2&date=2011&atitle=A+Pilot+Study+Evaluating+Care+Staffs%27+Perceptions+of+Their+Experience+of+Psychological+Consultation+within+a+Mental+Health+Setting&spage=205&sid=ProQ%3Aeric&author=Evans

Farnfield, S., & Onions, C. (2021). The role of affect regulation in developmental trauma: an empirical study of children in residential care. *Journal of Child Psychotherapy*, *47*(3), 470-490.

Ferguson, E. F., Jimenez-Muñoz, M., Feerst, H., & Vernon, T. W. (2022). Predictors of satisfaction with autism treatment services during COVID-19. *Journal of autism and developmental disorders*, *52*(8), 3686-3697.

Figley, C. R. (2002). Compassion fatigue: psychotherapists' chronic lack of self care. *J Clin Psychol*, *58*(11), 1433-1441. https://doi.org/10.1002/jclp.10090

Finnerty, B. M. (2001). *Utility of the Trauma Symptom Checklist for Children: Distinguishing between PTSD and non-PTSD youth in residential treatment*. The Chicago School of Professional Psychology.

Finzi, R., Cohen, O., Sapir, Y., & Weizman, A. (2000). Attachment styles in maltreated children: a comparative study. *Child Psychiatry Hum Dev*, *31*(2), 113-128. https://doi.org/10.1023/a:1001944509409

Foa, E. B., Asnaani, A., Zang, Y., Capaldi, S., & Yeh, R. (2018). Psychometrics of the Child PTSD Symptom Scale for DSM-5 for trauma-exposed children and adolescents. *Journal of Clinical Child & Adolescent Psychology*, *47*(1), 38-46.

Fonagy, P. (2011). The mentalization-focused approach to social development. In *Mentalization* (pp. 3-56). Routledge.

Fonagy, P., & Allison, E. (2013). What is mentalization?: The concept and its foundations in developmental research. In *Minding the child* (pp. 11-34). Routledge.

Fraley, H. E., Capp, G., & Aronowitz, T. (2020). School Discipline Experiences Among Youth With Disabilities From the Perspective of School Nurses. *ANS. Advances in nursing science*, *43*(4), E148-E167. https://doi.org/10.1515/mlt-2013-0022.

http://dx.doi.org/10.1097/ANS.0000000000000320

Friedrich, W. N., Grambsch, P., Broughton, D., Kuiper, J., & Beilke, R. L. (1991). Normative sexual behavior in children. *Pediatrics*, *88*(3), 456-464.

Garcia Quiroga, M., & Hamilton-Giachritsis, C. (2016). “Getting involved”: A thematic analysis of caregivers’ perspectives in Chilean residential children’s homes. *Journal of Social and Personal Relationships*, *34*(3), 356-375. https://doi.org/10.1177/0265407516637838

Garcia Quiroga, M., & Hamilton-Giachritsis, C. (2017a). The crucial role of the micro caregiving environment: Factors associated with attachment styles in alternative care in Chile. *Child Abuse & Neglect*, *70*, 169-179. https://doi.org/https://doi.org/10.1016/j.chiabu.2017.05.019

Garcia Quiroga, M., & Hamilton-Giachritsis, C. (2017b). "Getting involved": A thematic analysis of caregivers' perspectives in Chilean residential children's homes: A thematic analysis of caregivers' perspectives in Chilean residential children's homes. *Journal of Social and Personal Relationships*, *34*(3), 356-375. https://doi.org/http://dx.doi.org/10.1177/0265407516637838

Gass, M. A., Hallows, G., & Russell, K. C. (2020). *Adventure therapy: Theory, research, and practice*. Routledge.

Geller, S. M., & Porges, S. W. (2014). Therapeutic presence: neurophysiological mechanisms mediating feeling safe in therapeutic relationships. *Journal of Psychotherapy Integration*, *24*(3), 178.

Gerard, A., McGrath, A., Colvin, E., & McFarlane, K. (2019). ‘I’m not getting out of bed!’The criminalisation of young people in residential care. *Australian & New Zealand Journal of Criminology*, *52*(1), 76-93.

Gilmartin, D., McElvaney, R., & Corbally, M. (2022a). “Talk to me like I’m a human” An interpretative phenomenological analysis of the psychotherapy experiences of young people in foster care in Ireland. *Counselling Psychology Quarterly,* 1-23. https://doi.org/10.1080/09515070.2022.2062702

Gilmartin, D., McElvaney, R., & Corbally, M. (2022b). “Talk to me like I’m a human” An interpretative phenomenological analysis of the psychotherapy experiences of young people in foster care in Ireland. *Counselling Psychology Quarterly, 36*, 1-23. https://doi.org/10.1080/09515070.2022.2062702

Gistau, J., Casas, F., & Montserrat, C. (2017). What Matters in for the Subjective Well-Being of Children in Care? *Child Indicators Research*, *10*. https://doi.org/10.1007/s12187-016-9405-z

Goddard, A. (2021). Adverse Childhood Experiences and Trauma-Informed Care. *J Pediatr Health Care*, *35*(2), 145-155. https://doi.org/10.1016/j.pedhc.2020.09.001

Goh, C., & Agius, M. (2010). The stress-vulnerability model how does stress impact on metal illness at the level of the brain and what are the consequences? *Psychiatria Danubina*, *22*(2), 198-202.

Golding, K. S. (2007). *Nurturing attachments: Supporting children who are fostered or adopted*. Jessica Kingsley Publishers.

Golding, K. S. (2010). Multi-agency and specialist working to meet the mental health needs of children in care and adopted. *Clinical Child Psychology and Psychiatry*, *15*(4), 573-587.

Gough, D., & Richardson, M. (2018). Systematic reviews. In *Advanced research methods for applied psychology* (pp. 63-75). Routledge.

Green, J. M., Biehal, N., Roberts, C., Dixon, J., Kay, C., Parry, E., Rothwell, J., Roby, A., Kapadia, D., Scott, S., & Sinclair, I. (2014). Multidimensional Treatment Foster Care for Adolescents in English care: randomised trial and observational cohort evaluation. *Br J Psychiatry*, *204*(3), 214-221. https://doi.org/10.1192/bjp.bp.113.131466

Gregorowski, C., & Seedat, S. (2013). Addressing childhood trauma in a developmental context. *Journal of Child & Adolescent Mental Health*, *25*(2), 105-118. https://doi.org/10.2989/17280583.2013.795154

Gremigni, P. (2020). The Importance of Using Valid and Reliable Measures in Psychology and Psychiatry. *9*, 24-25.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of qualitative research*, *2*(163-194), 105.

Handley, E., & Hutchinson, N. (2013). The Experience of Carers in Supporting People with Intellectual Disabilities through the Process of Bereavement: An Interpretative Phenomenological Analysis. *Journal of Applied Research in Intellectual Disabilities*, *26*(3), 186-194. https://doi.org/http://dx.doi.org/10.1111/jar.12025

Hanson, R. F., & Lang, J. (2016). A Critical Look At Trauma-Informed Care Among Agencies and Systems Serving Maltreated Youth and Their Families. *Child Maltreatment*, *21*(2), 95-100. https://doi.org/10.1177/1077559516635274

Harder, A. T., Knorth, E. J., & Kalverboer, M. E. (2013). A secure base? The adolescent-staff relationship in secure residential youth care. *Child & Family Social Work*, *18*(3), 305-317. https://doi.org/10.1111/j.1365-2206.2012.00846.x

Harper, N. J. (2017). Wilderness therapy, therapeutic camping and adventure education in child and youth care literature: A scoping review. *Children and Youth Services Review*, *83*, 68-79.

Hawkins-Rodgers, Y. (2007). Adolescents adjusting to a group home environment: A residential care model of re-organizing attachment behavior and building resiliency.

Children and Youth Services Review, *29*(9), 1131-1141. https://doi.org/http://dx.doi.org/10.1016/j.childyouth.2007.04.007

Heine, S., Nordanger, D., Halvorsen, A., Stige, B., & Milde, A. M. (2021). Prerequisites for Maintaining Emotion Self-regulation in Social Work with Traumatized Adolescents: A Qualitative Study among Social Workers in A Norwegian Residential Care Unit. *Residential Treatment for Children & Youth*, *38*(4), 346-361. https://doi.org/http://dx.doi.org/10.1080/0886571X.2020.1814937

Herring, N. (2021). Young people, living in care and adopted, talk about their experiences of receiving an NHS therapeutic intervention. Qualitative research analysed using Interpretative Phenomenological Analysis [https://doi.org/10.1111/1467-6427.12364]. *Journal of Family Therapy*, *43*(3), 426-444. https://doi.org/https://doi.org/10.1111/1467-6427.12364

Heyman, J. C., White-Ryan, L., Kelly, P., Farmer, G. L., Leaman, T. L., & Davis, H. J. (2020). Voices about foster care: The value of trust. *Children and Youth Services Review*, *113*, 104991.

Hong, S., Walton, B., Kim, H.-W., Lee, S., & Rhee, T. G. (2021). Longitudinal Patterns of Strengths Among Youth with Psychiatric Disorders: A Latent Profile Transition Analysis. *Child psychiatry and human development*. https://doi.org/http://dx.doi.org/10.1007/s10578-021-01217-3

Hruska, B., & Delahanty, D. L. (2012). Application of the stressor vulnerability model to understanding posttraumatic stress disorder (PTSD) and alcohol-related problems in an undergraduate population. *Psychology of addictive behaviors*, *26*(4), 734.

Huefner, J. C., Ringle, J. L., Chmelka, M. B., & Ingram, S. D. (2007). Breaking the Cycle of Intergenerational Abuse: The Long-Term Impact of a Residential Care Program. *Child Abuse & Neglect: The International Journal*, *31*(2), 187-199. https://www.proquest.com/scholarly-journals/breaking-cycle-intergenerational-abuse-long-term/docview/9741103/se-2?accountid=8630

https://birmingham-primo.hosted.exlibrisgroup.com/openurl/44BIR/44BIR_Services?genre=unknown&issn=&title=Breaking+the+Cycle+of+Intergenerational+Abuse%3A+The+Long-Term+Impact+of+a+Residential+Care+Program&volume=31&issue=2&date=2007&atitle=Breaking+the+Cycle+of+Intergenerational+Abuse%3A+The+Long-Term+Impact+of+a+Residential+Care+Program&spage=187&sid=ProQ%3Ancjrs&author=Huefner

Hughes, D. (2004). An attachment-based treatment of maltreated children and young people. *Attachment & Human Development*, *6*, 263-278. https://doi.org/10.1080/14616730412331281539

Hurley, K. D., Shaw, T., Thompson, R., Griffith, A., Farmer, E. M., & Tierney, J. (2006). Assessing Staff Competence at Implementing a Multifaceted Residential Program for Youth: Development and Initial Psychometrics of a Staff Observation Form. *Residential Treatment for Children & Youth*, *23*(3-4), 83-104. https://www.proquest.com/scholarly-journals/assessing-staff-competence-at-implementing/docview/742862395/se-2?accountid=8630

https://birmingham-primo.hosted.exlibrisgroup.com/openurl/44BIR/44BIR_Services?genre=unknown&issn=0886571X&title=Assessing+Staff+Competence+at+Implementing+a+Multifaceted+Residential+Program+for+Youth%3A+Development+and+Initial+Psychometrics+of+a+Staff+Observation+Form&volume=23&issue=3-4&date=2006&atitle=Assessing+Staff+Competence+at+Implementing+a+Multifacete

d+Residential+Program+for+Youth%3A+Development+and+Initial+Psychometrics+of+a+Staff+Observation+Form&spage=83&sid=ProQ%3Aeric&author=Hurley

Huscroft-D'Angelo, J., Trout, A. L., Lambert, M. C., & Thompson, R. (2017). Caregiver perceptions of empowerment and self-efficacy following youths' discharge from residential care. *Journal of Family Social Work, 20*(5), 433-456. https://doi.org/http://dx.doi.org/10.1080/10522158.2017.1350893

Ireland, C. A., Keeley, S., Lewis, M., & Bowden, S. (2022). Vicarious trauma and compassion fatigue in residential care workers of traumatized children. *Abuse: An International Impact Journal*, *3*(1), 43-54.

Jackson, G., & Rosser, R. (1992). Psychological Trauma and the Adult Survivor: Theory, Therapy and Transformation. By I. Lisa McCann and Laurie Anne Pearlman. New York: Brunner/Mazel. 1990. 376 pp. $39.95. *The British Journal of Psychiatry*, *161*(5), 726-727.

Jackson, S. W. (2001). The wounded healer. *Bull Hist Med*, *75*(1), 1-36. https://doi.org/10.1353/bhm.2001.0025

Jacob, J., Edbrooke-Childs, J., Law, D., & Wolpert, M. (2015). Measuring what matters to patients: Using goal content to inform measure choice and development. *Clinical Child Psychology and Psychiatry*, *22*(2), 170-186. https://doi.org/10.1177/1359104515615642

Jo-Hanna, I., Harris, A., McKeown, P., & Barry, J. (2021). Mothers experiences of the Parenting Under Pressure Program (PuP) in a Residential Therapeutic Community: A qualitative study. *Journal of Psychoactive Drugs*, *53*(3), 230-237. https://doi.org/http://dx.doi.org/10.1080/02791072.2020.1856455

Kalluri, N., Kelly, C., & Garg, A. (2021). Child care during the COVID-19 pandemic: A bad situation made worse. *Pediatrics*, *147*(3).

Kaminer, D., Seedat, S., & Stein, D. J. (2005). Post-traumatic stress disorder in children. *World psychiatry : official journal of the World Psychiatric Association (WPA)*, *4*(2), 121-125. https://pubmed.ncbi.nlm.nih.gov/16633528

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414752/

Kanios, A., & Bocheńska-brandt, A. (2021). OCCUPATIONAL BURNOUT AMONG WORKERS IN THE LONG-TERM CARE SECTOR IN RELATION TO THEIR PERSONALITY TRAITS. *International Journal of Occupational Medicine and Environmental Health*, *34*(4), 491-504. https://doi.org/http://dx.doi.org/10.13075/ijomeh.1896.01636

Kendrick, A. (2013). Relations, relationships and relatedness: residential child care and the family metaphor. *Child & Family Social Work*, *18*(1), 77-86. https://doi.org/https://doi.org/10.1111/cfs.12040

Kenny, M. C., & Wurtele, S. K. (2013). Child Sexual Behavior Inventory: A Comparison Between Latino and Normative Samples of Preschoolers. *The Journal of Sex Research*, *50*(5), 449-457. http://www.jstor.org/stable/42002073

Kerr, L., & Cossar, J. (2014). Attachment Interventions with Foster and Adoptive Parents: A Systematic Review. *Child Abuse Review, 23*(6), 426-439. https://doi.org/https://doi.org/10.1002/car.2313

Kerr, M. E. (1981). Family systems theory and therapy. *Handbook of family therapy*, *1*, 226-264.

Kline, T. J., Sulsky, L. M., & Rever-Moriyama, S. D. (2000). Common method variance and specification errors: A practical approach to detection. *The Journal of psychology*, *134*(4), 401-421.

Koch, L., & Franzsen, D. (2017). The effect of caregiver training in increasing social interaction and contact time with children living in residential care facilities. *South African Journal of Occupational Therapy*, *47*(3). https://doi.org/http://dx.doi.org/10.17159/2310-3833/2017/v47n3a8

Kools, S., & Spiers, J. (2002). Caregiver understanding of adolescent development in residential treatment. *Journal of Child and Adolescent Psychiatric Nursing*, *15*(4), 151-162. https://www.proquest.com/scholarly-journals/caregiver-understanding-adolescent-development/docview/230489422/se-2?accountid=8630

https://birmingham-primo.hosted.exlibrisgroup.com/openurl/44BIR/44BIR_Services?genre=unknown&issn=10736077&title=Caregiver+understanding+of+adolescent+development+in+residential+treatment&volume=15&issue=4&date=2002&atitle=Caregiver+understanding+of+adolescent+development+in+residential+treatment&spage=151&sid=ProQ%3Aeducation&author=Kools

Kor, K. (2024). Therapeutic Residential Care: Practice Components and Barriers. In *The Routledge Handbook of Child and Family Social Work Research* (pp. 412-426). Routledge.

Kor, K., Fernandez, E., & Spangaro, J. (2021). Interpretative phenomenological analysis of young people's lived experiences of therapeutic residential care [https://doi.org/10.1111/cfs.12792]. *Child & Family Social Work*, *26*(1), 89-99. https://doi.org/https://doi.org/10.1111/cfs.12792

Kor, K., Fernandez, E., & Spangaro, J. (2022). Relationship-Based Practice in Therapeutic Residential Care: A Double-Edged Sword. *The British Journal of Social Work*, *52*(2), 663-681.

Kretschmar, J. M., Butcher, F., Tossone, K., & Beale, B. L. (2016). Examining the Concurrent Validity of the Trauma Symptoms Checklist for Children. *Research on Social Work Practice*, *28*(7), 882-890. https://doi.org/10.1177/1049731516677065

Kub, J. E., DePriest, K. N., Bellin, M. H., Butz, A., Lewis-Land, C., & Morphew, T. (2022). Predictors of Depressive Symptoms in Caregivers of Children With Poorly Controlled Asthma: Is the Neighborhood Context Important? *Family & community health*, *45*(1), 10-22. https://doi.org/10.1016/j.jaip.2018.07.050. Hughes HK, Matsui EC, Tschudy MM, Pollack CE, Keet CA. Pediatric asthma health disparities: race, hardship, housing, and asthma in a national survey. Acad Pediatr. 2017;17(2):127–134. doi:10.1016/j.acap.2016.11.011. https://www.cdc.gov/violenceprevention/pdf/efc-building-community-commitment.pdf. Published 2014. Accessed May 29, 2021.

http://dx.doi.org/10.1097/FCH.0000000000000313

Lanktree, C. B., & Briere, J. (1995). Outcome of therapy for sexually abused children: A repeated measures study. *Child Abuse & Neglect*, *19*(9), 1145-1155. https://doi.org/https://doi.org/10.1016/0145-2134(95)00075-J

Larkin, M., Shaw, R., & Flowers, P. (2019). Multiperspectival designs and processes in interpretative phenomenological analysis research. *Qualitative Research in Psychology*, *16*(2), 182-198. https://doi.org/10.1080/14780887.2018.1540655

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, *3*(2), 102-120. https://doi.org/10.1191/1478088706qp062oa

Le Page, H. (2005). Healing Trauma: Attachment, Mind, Body, And Brain. In *Can Child Adolesc Psychiatr Rev* (Vol. 14, pp. 120-121). Copyright © 2005 Canadian Academy of Child and Adolescent Psychiatry.

Leloux-Opmeer, H., Kuiper, C., Swaab, H., & Scholte, E. (2016). Characteristics of children in foster care, family-style group care, and residential care: A scoping review. *Journal of child and family studies*, *25*(8), 2357-2371.

Leloux-Opmeer, H., Kuiper, C., Swaab, H., & Scholte, E. (2016). Characteristics of Children in Foster Care, Family-Style Group Care, and Residential Care: A Scoping Review. *J Child Fam Stud*, *25*, 2357-2371. https://doi.org/10.1007/s10826-016-0418-5

Lincoln Y. S., & Guba, E.G.(1985). Naturalistic inquiry .sage

Mabille, G., Skoglund, J., Thørnblad, R., & Holtan, A. (2022). Placement stability and satisfaction with foster home as predictors of life satisfaction for young adults raised in foster care. *Child & Family Social Work*, *27*(2), 267-277.

MacAlister, J. (2022). The independent review of children’s social care. *UK: UK Government*.

Malvaso, C. G., & Delfabbro, P. (2015). Offending behaviour among young people with complex needs in the Australian out-of-home care system. *Journal of child and family studies*, *24*, 3561-3569.

Mannarino, A. P., Cohen, J. A., & Berman, S. R. (1994). The children's attributions and perceptions scale: A new measure of sexual abuse-related factors. *Journal of Clinical Child Psychology*, *23*(2), 204-211. https://doi.org/10.1207/s15374424jccp2302_9

Martinez, W., Polo, A., & Zelic, K. (2014). Symptom Variation on the Trauma Symptom Checklist for Children: A Within-Scale Meta-Analytic Review. *Journal of Traumatic Stress*, *27*. https://doi.org/10.1002/jts.21967

Martinez, W., Polo, A. J., & Zelic, K. J. (2014). Symptom variation on the trauma symptom checklist for children: a within-scale meta-analytic review. *J Trauma Stress*, *27*(6), 655-663. https://doi.org/10.1002/jts.21967

Matulis, S., Loos, L., Langguth, N., Schreiber, F., Gutermann, J., Gawrilow, C., & Steil, R. (2015). Reliability, factor structure, and validity of the German version of the Trauma Symptom Checklist for Children in a sample of adolescents. *Eur J Psychotraumatol*, *6*, 27966. https://doi.org/10.3402/ejpt.v6.27966

McCall, R. B., Groark, C. J., & Fish, L. (2010). A caregiver–child socioemotional and relationship rating scale. *Infant Mental Health Journal: Official Publication of The World Association for Infant Mental Health*, *31*(2), 201-219.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, *3*(1), 131-149. https://doi.org/10.1007/BF00975140

McLeod, S. (2024). *Narrative Analysis In Qualitative Research*. https://doi.org/10.13140/RG.2.2.30491.07200

McMillan, N. (2020). Moral Distress in Residential Child Care. *Ethics & Social Welfare*, *14*(1), 52-64. https://doi.org/http://dx.doi.org/10.1080/17496535.2019.1709878

Melhuish, E., Ereky-Stevens, K., Petrogiannis, K., Ariescu, Penderi, E., Rentzou, K., Tawell, A., Slot, Broekhuizen, M., & Leseman, P. (2015). A review of research on the effects of early childhood Education and Care (ECEC) upon child development. CARE project. *Curriculum Quality Analysis and Impact Review of European Early Childhood Education and Care (ECEC)*.

Messer, E. P., Greiner, M. V., Beal, S. J., Eismann, E. A., Cassedy, A., Gurwitch, R. H., Boat, B. W., Bensman, H., Bemerer, J., Hennigan, M., Greenwell, S., & Eiler-Sims, P. (2018). Child Adult Relationship Enhancement (CARE): A brief, skills-building training for foster caregivers to increase positive parenting practices. *Children and Youth Services Review*, *90*, 74-82. https://doi.org/10.1016/j.childyouth.2018.05.017

Miller, J. G., Kahle, S., & Hastings, P. D. (2017). Moderate baseline vagal tone predicts greater prosociality in children. *Developmental psychology*, *53*(2), 274.

Mohammadkhani, P., Mohammadi, M.-R., Nazari, M. A., Dogaheh, E., Nikfarjam, M., & Azadmehr, H. (2005). Standardization of a trauma symptoms checklist for children. *Medical Journal of the Islamic Republic of Iran*, *19*, 41-48.

Mohan, A., Malhotra, S., Narayanan, M., White, H., & Gaffney, H. (2022). PROTOCOL: The effectiveness of wilderness therapy and adventure learning in reducing anti-social and offending behaviour in children and young people at risk of offending. *Campbell Syst Rev*, *18*(3), e1270. https://doi.org/10.1002/cl2.1270

Molano, N., León, E., Román, M., Jiménez-Morago, J. M., & Moreno, C. (2021). Building up secure relationships: Analysis of adult-child interactions in foster and adoptive families. *Children and Youth Services Review*, *126*. https://doi.org/10.1016/j.childyouth.2021.106026

Moore, C. C., Hubbard, J., Morrow, M. T., Barhight, L. R., Lines, M. M., Sallee, M., & Hyde, C. T. (2018). The simultaneous assessment of and relations between children's sympathetic and parasympathetic psychophysiology and their reactive and proactive aggression. *Aggressive Behavior*, *44*(6), 614-623.

Moran, K. M., Turiano, N. A., & Gentzler, A. L. (2018). Parental warmth during childhood predicts coping and well-being in adulthood. *J Fam Psychol*, *32*(5), 610-621. https://doi.org/10.1037/fam0000401

Moreland, A., & Ressler, K. (2021). A Perspective for Understanding Trauma and the Criminal Juvenile Justice System: Using a Trauma-Informed Lens for Meaningful and Sustained Change. *Harvard Review of Psychiatry*, *Publish Ahead of Print*. https://doi.org/10.1097/HRP.0000000000000290

Morelli, N., Elson, D., Duong, J., Evans, M., & Villodas, M. (2020). Examining the Factor Structure and Measurement Invariance of the Trauma Symptom Checklist for Children in a Diverse Sample of Trauma-Exposed Adolescents. *Assessment*, *28*, 107319112093915. https://doi.org/10.1177/1073191120939158

Morison, A., Taylor, E., & Gervais, M. (2020). How a Sample of Residential Childcare Staff Conceptualize and Use Attachment Theory in Practice. *Child & Youth Services*, *41*(1), 3-27. https://doi.org/10.1080/0145935X.2019.1583100

Moses, T. (2000a). Attachment theory and residential treatment: A study of staff-client relationships. *American Journal of Orthopsychiatry*, *70*(4), 474-490. https://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=psyc3&AN=2000-16475-006

https://birmingham-primo.hosted.exlibrisgroup.com/openurl/44BIR/44BIR_Services?sid=OVID:psycdb&id=pmid:&id=doi:10.1037%2Fh0087681&issn=0002-9432&isbn=&volume=70&issue=4&spage=474&pages=474-490&date=2000&title=American+Journal+of+Orthopsychiatry&atitle=Attachment+theory+and+residential+treatment%3A+A+study+of+staff-client+relationships.&aulast=Moses&pid=%3Cauthor%3EMoses%2C+Tally%3C%2Fauthor%3E%3CAN%3E2000-16475-006%3C%2FAN%3E%3CDT%3EJournal+Article%3C%2FDT%3E

Moses, T. (2000b). Attachment theory and residential treatment: A study of staff–client relationships. *American Journal of Orthopsychiatry*, *70*(4), 474-490. https://doi.org/10.1037/h0087681

Mota, C. P., Costa, M., & Matos, P. M. (2016). Resilience and Deviant Behavior Among Institutionalized Adolescents: The Relationship with Significant Adults: C & A: C &

A. *Child & Adolescent Social Work Journal*, *33*(4), 313-325. https://doi.org/http://dx.doi.org/10.1007/s10560-015-0429-x

Muhamedrahimov, R., Palmov, O., Nikiforova, N., Groark, C., & McCall, R. (2004). Institution-based early intervention program. *Infant Mental Health Journal*, *25*, 488-501. https://doi.org/10.1002/imhj.20021

Neill, J. T. (2003). Reviewing and benchmarking adventure therapy outcomes: Applications of meta-analysis. *Journal of Experiential Education*, *25*(3), 316-321.

Nilsson, D., Gustafsson, P. E., & Svedin, C.-G. (2012). The psychometric properties of the Trauma Symptom Checklist for Young Children in a sample of Swedish children. *European Journal of Psychotraumatology*, *3*. https://doi.org/10.3402/ejpt.v3i0.18505

Nilsson, D., Wadsby, M., & Svedin, C. G. (2008). The psychometric properties of the Trauma Symptom Checklist For Children (TSCC) in a sample of Swedish children. *Child Abuse & Neglect*, *32*(6), 627-636. https://doi.org/https://doi.org/10.1016/j.chiabu.2007.09.009

Oerther, S. (2020). Analysis methods in hermeneutic phenomenological research: Interpretive profiles. *Frontiers of Nursing*, *7*(4), 293-298.

Padykula, N. L., & Conklin, P. (2010). The self regulation model of attachment trauma and addiction. *Clinical social work journal*, *38*, 351-360.

Pardini, D. (2011). Perceptions of Social Conflicts among Incarcerated Adolescents with Callous-Unemotional Traits: "You're Going to Pay. It's Going to Hurt, but I Don't Care.". *Journal of Child Psychology and Psychiatry*, *52*(3), 248-255. https://doi.org/http://dx.doi.org/10.1111/j.1469-7610.2010.02336.x

Parry, S., Williams, T., & Oldfield, J. (2022). Reflections from the forgotten frontline:‘The reality for children and staff in residential care’during COVID-19. *Health & social care in the community*, *30*(1), 212-224.

Paulhus, D. (2002). Social desirable responding: The evolution of a construct. *The role of constructs in psychological and education measurement*.

Perry, B. D. (2009). Examining child maltreatment through a neurodevelopmental lens: Clinical applications of the neurosequential model of therapeutics. *Journal of loss and trauma*, *14*(4), 240-255.

Podsakoff, P. M., MacKenzie, S. B., & Podsakoff, N. P. (2012). Sources of method bias in social science research and recommendations on how to control it. *Annu Rev Psychol*, *63*, 539-569. https://doi.org/10.1146/annurev-psych-120710-100452

Porges, S. W. (2011). *The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation (Norton Series on Interpersonal Neurobiology)*. WW Norton & Company.

Powell, B. J., Patel, S. V., Haley, A. D., Haines, E. R., Knocke, K. E., Chandler, S., Katz, C. C., Seifert, H. P., Ake, G., Amaya-Jackson, L., & Aarons, G. A. (2020). Determinants of Implementing Evidence-Based Trauma-Focused Interventions for Children and Youth: A Systematic Review. *Administration and policy in mental health*, *47*(5), 705-719. https://doi.org/http://dx.doi.org/10.1007/s10488-019-01003-3

Proeschold-Bell, R. J., Molokwu, N. J., Keyes, C. L. M., Sohail, M. M., Eagle, D. E., Parnell, H. E., Kinghorn, W. A., Amanya, C., Vann, V., Madan, I., Biru, B. M., Lewis, D., Dubie, M. E., & Whetten, K. (2019). Caring and thriving: An international qualitative study of caregivers of orphaned and vulnerable children and strategies to sustain positive mental health. *Children and Youth Services Review*, *98*, 143. https://doi.org/http://dx.doi.org/10.1016/j.childyouth.2018.12.024

Putnam, F. W., Helmers, K., & Trickett, P. K. (1993). Development, reliability, and validity of a child dissociation scale. *Child Abuse Negl*, *17*(6), 731-741. https://doi.org/10.1016/s0145-2134(08)80004-x

Quigley, R. (2005). Building Strengths in the Neighborhood. *Reclaiming Children and Youth: The Journal of Strength-based Interventions*, *14*(2), 3-104. https://www.proquest.com/scholarly-journals/building-strengths-neighborhood/docview/62075077/se-2?accountid=8630

https://birmingham-primo.hosted.exlibrisgroup.com/openurl/44BIR/44BIR_Services?genre=unknown&issn=10895701&title=Building+Strengths+in+the+Neighborhood&volume=14&issue=2&date=2005&atitle=Building+Strengths+in+the+Neighborhood&spage=v14+n2+p104+Sum+2005&sid=ProQ%3Aeric&author=Quigley

Ranjbar, N., & Erb, M. (2019). Adverse Childhood Experiences and Trauma-Informed Care in Rehabilitation Clinical Practice. *Arch Rehabil Res Clin Transl*, *1*(1-2), 100003. https://doi.org/10.1016/j.arrct.2019.100003

Redfern, S., Wood, S., Lassri, D., Cirasola, A., West, G., Austerberry, C., Luyten, P., Fonagy, P., & Midgley, N. (2018). The Reflective Fostering Programme: background and development of a new approach. *Adoption & Fostering*, *42*(3), 234-248.

Reynolds, C. R., Altmann, R. A., & Allen, D. N. (2021). The problem of bias in psychological assessment. In *Mastering modern psychological testing* (pp. 573-613). Springer.

Reynolds, C. R., & Suzuki, L. A. (2012). Bias in psychological assessment: An empirical review and recommendations. *Handbook of Psychology, Second Edition*, *10*.

Reznikovsky-Kuras, A., & Gerasimenko, A. (2020). IDENTIFYING BEST-PRACTICE STRATEGIES FOR MANAGING RESIDENTIAL CAREGIVERS WORKING WITH CHILDREN AT RISK. *International Journal of Child, Youth and Family Studies*, *11*(4.2), 96-114. https://doi.org/10.18357/ijcyfs114.2202019990

Ritchie, S. D., Patrick, K., Corbould, G. M., Harper, N. J., & Oddson, B. E. (2016). An environmental scan of adventure therapy in Canada. *Journal of Experiential Education*, *39*(3), 303-320.

Rivard, M., Terroux, A., & Mercier, C. (2014). Effectiveness of early behavioral intervention in public and mainstream settings: The case of preschool-age children with autism spectrum disorders. *Research in Autism Spectrum Disorders*, *8*(9), 1031-1043. https://doi.org/https://doi.org/10.1016/j.rasd.2014.05.010

Roberts, D. (2020). *'The paradox of living with the unknown'The Mulberry Bush School: an exploration of how a therapeutic approach to looking after emotionally traumatised children affects their capacity to develop relationships, and to understand and regulate their feelings and behaviour* UCL (University College London)].

Roche, S. (2019). A scoping review of children's experiences of residential care settings in the global South. *Children and Youth Services Review*, *105*, 104448.

Ruch, G. (2012). Where have all the feelings gone? Developing reflective and relationship-based management in child-care social work. *British Journal of Social Work*, *42*(7), 1315-1332.

Russell, K., & Gillis, H. L. (2017). The adventure therapy experience scale: The psychometric properties of a scale to measure the unique factors moderating an adventure therapy experience. *Journal of Experiential Education*, *40*(2), 135-152.

Russell, K. C., & Farnum, J. (2004). A concurrent model of the wilderness therapy process. *Journal of Adventure Education & Outdoor Learning*, *4*(1), 39-55.

Ryan, J. P., & Testa, M. F. (2005). Child maltreatment and juvenile delinquency: Investigating the role of placement and placement instability. *Children and Youth Services Review*, *27*(3), 227-249.

Sadowski, C. M., & Friedrich, W. N. (2000). Psychometric Properties of the Trauma Symptom Checklist for Children (TSCC) with Psychiatrically Hospitalized Adolescents. *Child Maltreatment*, *5*(4), 364-372. https://doi.org/10.1177/1077559500005004008

Saigh, P. A., Yasik, A. E., Halamandaris, P. V., Bremner, J. D., & Oberfield, R. A. (2015). The parent ratings of traumatized children with or without PTSD. *Psychological trauma : theory, research, practice and policy*, *7*(1), 85-92. https://doi.org/10.1037/a0037433

Sankaran, V., Church, C., & Mitchell, M. (2018). A cure worse than the disease: The impact of removal on children and their families. *Marq. L. Rev.*, *102*, 1161.

Santiago, J. L., Hanley, G. P., Moore, K., & Jin, C. S. (2016). The generality of interview-informed functional analyses: Systematic replications in school and home. *Journal of Autism and Developmental Disorders*, *46*, 797-811.

Santiago, P. N., Ursano, R. J., Gray, C. L., Pynoos, R. S., Spiegel, D., Lewis-Fernandez, R., Friedman, M. J., & Fullerton, C. S. (2013). A systematic review of PTSD prevalence and trajectories in DSM-5 defined trauma exposed populations: intentional and non-intentional traumatic events. *PloS one*, *8*(4), e59236.

Sar, V. (2011). Developmental trauma, complex PTSD, and the current proposal of DSM-5. *European Journal of Psychotraumatology*, *2*(1), 5622.

Schore, J. R., & Schore, A. N. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical social work journal*, *36*(1), 9-20.

Schuele, M. (1996). Therapy in the Great “Outdoors”. *Psychology of Women Quarterly*, *20*(4), 619-620. https://doi.org/10.1111/j.1471-6402.1996.tb00329.x

Sellers, B. G. (2015). Community-based recovery and youth justice. *Criminal justice and behavior*, *42*(1), 58-69.

Shaw, J., & Kendrick, A. (2016). Reflecting on the past: children's services workers' experiences of residential care in Scotland from 1960-1975. *British Journal of Social Work*, *47*, 375-391.

Shaw, J., & Kendrick, A. (2017). Reflecting on the past: Children’s Services Workers’ experiences of residential care in Scotland from 1960 to 1975. *British Journal of Social Work*, *47*(2), 375-391.

Siegel, D. J. (2015). Interpersonal Neurobiology as a Lens into the Development of Wellbeing and Reslience. *Children Australia*, *40*(2), 160-164. https://doi.org/10.1017/cha.2015.7

Silva, A., Ferreira, S., Silva Pinto, É., Rocha, S. A., & Barbosa-Rocha, N. (2024). The Relationship Between Childhood Abuse and Adult Attachment Styles: The Mediator Role of Sensory Over-Responsivity. *Journal of Aggression, Maltreatment & Trauma*, *33*(2), 236-254. https://doi.org/10.1080/10926771.2023.2186298

Simkiss, D. (2019). The needs of looked after children from an adverse childhood experience perspective. *Paediatrics and Child Health*, *29*(1), 25-33. https://doi.org/https://doi.org/10.1016/j.paed.2018.11.005

Sims, M., Hutchins, T., & Taylor, M. (1997). Conflict as social interaction: Building relationship skills in child care settings. *Child & Youth Care Forum*, *26*(4), 247-260. https://doi.org/10.1007/BF02589418

Singer, M. I., Anglin, T. M., Song, L. Y., & Lunghofer, L. (1995). Adolescents' exposure to violence and associated symptoms of psychological trauma. *Jama*, *273*(6), 477-482.

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research* (Vol. 6).

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, *5*(1), 9-27.

Smith, J. A., Flowers, P., & Larkin, M. (2009). Interpretative Phenomenological Analysis: Theory, Method and Research.

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *Br J Pain, 9*(1), 41-42. https://doi.org/10.1177/2049463714541642

Smith, L. J., & Shaw, R. L. (2017). Learning to live with Parkinson's disease in the family unit: an interpretative phenomenological analysis of well-being. *Medicine, Health Care and Philosophy, 20*(1), 13-21. https://doi.org/10.1007/s11019-016-9716-3

Sochos, A., & Najla, A. J. (2020). Attachment provision in the Saudi orphanages: Exploring the narratives of residential staff. *International Journal of Social Welfare, 29*(3), 244-254. https://doi.org/http://dx.doi.org/10.1111/ijsw.12415

Spanic, A. M., Brezinscak, T., & Flander, G. B. (2014). TRAUMA RELATED SYMPTOMS AMONG CHILDREN EXPOSED TO DIFFERENT TYPES OF ABUSE AND NEGLECT. *Stress and Anxiety: Applications to Social and Environmental Threats, Psychological Well-Being, Occupational Challenges, and Developmental Psychology*, 231.

Staines, J., Golding, K., & Selwyn, J. (2019). Nurturing attachments parenting program: The relationship between adopters' parental reflective functioning and perception of their children's difficulties. *Developmental Child Welfare, 1*(2), 143-158.

Stavropoulos, K. K.-M., Bolourian, Y., & Blacher, J. (2018). Differential Diagnosis of Autism Spectrum Disorder and Post Traumatic Stress Disorder: Two Clinical Cases. *Journal of clinical medicine, 7*(4), 71. https://doi.org/10.3390/jcm7040071

Steckley, L., & Kendrick, A. (2008). Physical Restraint in Residential Childcare: The Experiences of Young People and Residential Workers. *Childhood: A Global Journal of Child Research, 15*(4), 552-569. https://doi.org/http://dx.doi.org/10.1177/0907568208097207

Steels, S., & Simpson, H. (2017). Perceptions of Children in Residential Care Homes: A Critical Review of the Literature. *The British Journal of Social Work, 47*(6), 1704-1722. https://doi.org/10.1093/bjsw/bcx107

Steenbakkers, A., Ellingsen, I. T., van der Steen, S., & Grietens, H. (2018). Psychosocial Needs of Children in Foster Care and the Impact of Sexual Abuse. *J Child Fam Stud, 27*(4), 1324-1335. https://doi.org/10.1007/s10826-017-0970-7

Stone, N. (2018). Child criminal exploitation:'county lines', trafficking and cuckooing. *Youth Justice, 18*(3), 285-293.

Strijbosch, E. L. L., Huijs, J. A. M., Stams, G. J. J. M., Wissink, I. B., van der Helm, G. H. P., de Swart, J. J. W., & van der Veen, Z. (2015). The outcome of institutional youth care compared to non-institutional youth care for children of primary school age and early adolescence: A multi-level meta-analysis. *Children and Youth Services Review, 58*, 208-218. https://doi.org/https://doi.org/10.1016/j.childyouth.2015.09.018

Suzuki, S., Harasawa, N., Ueno, K., Gardner, J. L., Ichinohe, N., Haruno, M., Cheng, K., & Nakahara, H. (2012). Learning to simulate others' decisions. *Neuron, 74*(6), 1125-1137.

Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: what is it and how can we further its development? *Mental Health Review Journal, 21*, 174-192. https://doi.org/10.1108/MHRJ-01-2015-0006

Tarabulsy, G. M., St-Laurent, D., Cyr, C., Pascuzzo, K., Moss, E., Bernier, A., & Dubois-Comtois, K. (2008). Attachment-Based Intervention for Maltreating Families. *American Journal of Orthopsychiatry, 78*(3), 322-332. https://doi.org/https://doi.org/10.1037/a0014070

Tarren-Sweeney, M. (2008a). The mental health of children in out-of-home care. *Current Opinion in Psychiatry, 21*(4), 345-349. https://doi.org/10.1097/YCO.0b013e32830321fa

Tarren-Sweeney, M. (2008b). Retrospective and concurrent predictors of the mental health of children in care. *Children and Youth Services Review*, *30*(1), 1-25. https://doi.org/https://doi.org/10.1016/j.childyouth.2007.05.014

Tessitore, F., Caffieri, A., Parola, A., Cozzolino, M., & Margherita, G. (2023). The Role of Emotion Regulation as a Potential Mediator between Secondary Traumatic Stress, Burnout, and Compassion Satisfaction in Professionals Working in the Forced Migration Field. *International Journal of Environmental Research and Public Health*, *20*(3), 2266.

Thompson, R. (2014). Stress and Child Development. *The Future of children / Center for the Future of Children, the David and Lucile Packard Foundation*, *24*, 41-59. https://doi.org/10.1353/foc.2014.0004

Tindall, L. (2009). J.A. Smith, P. Flower and M. Larkin (2009), Interpretative Phenomenological Analysis: Theory, Method and Research. *Qualitative Research in Psychology*, *6*(4), 346-347. https://doi.org/10.1080/14780880903340091

Tordön, R., Svedin, C. G., Fredlund, C., Jonsson, L., Priebe, G., & Sydsjö, G. (2019). Background, experience of abuse, and mental health among adolescents in out-of-home care: a cross-sectional study of a Swedish high school national sample. *Nordic Journal of Psychiatry*, *73*(1), 16-23. https://doi.org/10.1080/08039488.2018.1527397

Toth, S. L., & Cicchetti, D. (2013). A developmental psychopathology perspective on child maltreatment. Introduction. *Child Maltreat*, *18*(3), 135-139. https://doi.org/10.1177/1077559513500380

Tourangeau, R., & Yan, T. (2007). Sensitive questions in surveys. *Psychological bulletin*, *133 5*, 859-883.

Townsend, I. M., Berger, E. P., & Reupert, A. E. (2020). Systematic review of the educational experiences of children in care: Children’s perspectives. *Children and Youth Services Review*, *111*, 104835. https://doi.org/https://doi.org/10.1016/j.childyouth.2020.104835

Trout, A., Hagaman, J., Casey, K., Reid, R., & Epstein, M. (2008). The academic status of children and youth in out-of-home care: A review of the literature. *Children and Youth Services Review*, *30*, 979-994. https://doi.org/10.1016/j.childyouth.2007.11.019

Tuffour, I. (2017). A critical overview of interpretative phenomenological analysis: A contemporary qualitative research approach. *Journal of healthcare communications*, *2*(4), 52.

van Agteren, J., Iasiello, M., Lo, L., Bartholomaeus, J., Kopsaftis, Z., Carey, M., & Kyrios, M. (2021). A systematic review and meta-analysis of psychological interventions to improve mental wellbeing. *Nature human behaviour*, *5*(5), 631-652.

van der Kolk, B. A., Pynoos, R. S., Cicchetti, D., Cloitre, M., D’Andrea, W., Ford, J. D., & Teicher, M. (2009). Proposal to include a developmental trauma disorder diagnosis for children and adolescents in DSM-V. *Unpublished manuscript. Verfügbar unter: http://www. cathymalchiodi. com/dtd_nctsn. pdf (Zugriff: 20.5. 2011)*.

Vig, S., Chinitz, S., & Shulman, L. (2005). Young children in foster care: Multiple vulnerabilities and complex service needs. *Infants & Young Children*, *18*(2), 147-160.

Vorria, P., Papaligoura, Z., Dunn, J., van Ijzendoorn, M. H., Steele, H., Kontopoulou, A., & Sarafidou, Y. (2003). Early experiences and attachment relationships of Greek infants raised in residential group care. *Journal of child psychology and psychiatry, and allied disciplines*, *44*(8), 1208-1220. https://www.proquest.com/scholarly-journals/early-experiences-attachment-relationships-greek/docview/71368888/se-2?accountid=8630

https://birmingham-primo.hosted.exlibrisgroup.com/openurl/44BIR/44BIR_Services?genre=unknown&issn=00219630&title=Early+experiences+and+attachment+relationships+of+Greek+inf

ants+raised+in+residential+group+care.&volume=44&issue=8&date=2003&atitle=Early+experiences+and+attachment+relationships+of+Greek+infants+raised+in+residential+group+care&spage=1208&sid=ProQ%3Amedline&author=Vorria

Walsh, M. A., & Russell, K. C. (2010). An exploratory study of a wilderness adventure program for young offenders. *Ecopsychology, 2*(4), 221-229.

Wessells, M. G. (2015). Bottom-up approaches to strengthening child protection systems: Placing children, families, and communities at the center. *Child Abuse Negl*, *43*, 8-21. https://doi.org/10.1016/j.chiabu.2015.04.006

Wherry, J. N., & Dunlop, C. E. (2018). TSCC and TSCYC Screening Forms in a Clinical Sample: Reliability, Validity, and Creating Local Clinical Norms. *Child Maltreat*, *23*(1), 74-84. https://doi.org/10.1177/1077559517725207

Wherry, J. N., & Herrington, S. C. (2018). Reliability and Validity of the Trauma Symptom Checklist for Children and Trauma Symptom Checklist for Young Children Screeners in a Clinical Sample. *J Child Sex Abus*, *27*(8), 998-1010. https://doi.org/10.1080/10538712.2018.1517109

Whittaker, J. K., Holmes, L., del Valle, J. F., Ainsworth, F., Andreassen, T., Anglin, J., Bellonci, C., Berridge, D., Bravo, A., Canali, C., Courtney, M., Currey, L., Daly, D., Gilligan, R., Grietens, H., Harder, A., Holden, M., James, S., Kendrick, A., . . . Zeira, A. (2016). Therapeutic Residential Care for Children and Youth: A Consensus Statement of the International Work Group on Therapeutic Residential Care*. *Residential Treatment for Children & Youth*, *33*(2), 89-106. https://doi.org/10.1080/0886571X.2016.1215755

Wigley, V., Preston-Shoot, M., McMurray, I., & Connolly, H. (2012). Researching young people's outcomes in children's services: Findings from a longitudinal study. *Journal of Social Work*, *12*(6), 573-594. https://doi.org/http://dx.doi.org/10.1177/1468017310394036

Williams, I. R., Rose, L. M., Raniti, M. B., Waloszek, J., Dudgeon, P., Olsson, C. A., Patton, G. C., & Allen, N. B. (2018). The impact of an outdoor adventure program on positive adolescent development: A controlled crossover trial. *Journal of Outdoor and Environmental Education*, *21*, 207-236.

Willig, C. (2003). Discourse analysis. *Qualitative psychology*, 159-183.

Willig, C., & Billin, A. (2011). Existentialist-informed hermeneutic phenomenology. *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*, 117-130.

Withington, T., Duplock, R., Burton, J., Eivers, A., & Lonne, B. (2017). Exploring children’s perspectives of engagement with their carers using factor analysis. *Child Abuse & Neglect*, *63*, 41-50. https://doi.org/10.1016/j.chiabu.2016.11.022

Woodier, D. (2011). Building Resilience in Looked after Young People: A Moral Values Approach. *British Journal of Guidance & Counselling*, *39*(3), 259-282. https://www.proquest.com/scholarly-journals/building-resilience-looked-after-young-people/docview/881468897/se-2?accountid=8630

https://birmingham-primo.hosted.exlibrisgroup.com/openurl/44BIR/44BIR_Services?genre=unknown&issn=03069885&title=Building+Resilience+in+Looked+after+Young+People%3A+A+Moral+Values+Approach&volume=39&issue=3&date=2011&atitle=Building+Resilience+in+Looked+after+Young+People%3A+A+Moral+Values+Approach&spage=259&sid=ProQ%3Aeric&author=Woodier

Wright, B., & Edginton, E. (2016). Evidence-Based Parenting Interventions to Promote Secure Attachment: Findings From a Systematic Review and Meta-Analysis. *Glob Pediatr Health*, *3*, 2333794x16661888. https://doi.org/10.1177/2333794x16661888

Yates, T. M., Obradović, J., & Egeland, B. (2010). Transactional relations across contextual strain, parenting quality, and early childhood regulation and adaptation in a high-risk sample. *Development and psychopathology*, *22*(3), 539-555.

Yule, W. (2001). Post-traumatic stress disorder in children and adolescents. *International Review of Psychiatry*, *13*(3), 194-200. https://doi.org/10.1080/09540260120074064

Zeanah, C. H., Smyke, A. T., & Dumitrescu, A. (2002). Attachment disturbances in young children. II: Indiscriminate behavior and institutional care. *J Am Acad Child Adolesc Psychiatry, 41*(8), 983-989. https://doi.org/10.1097/00004583-200208000-00017

Zelechoski, A. D., Sharma, R., Beserra, K., Miguel, J. L., DeMarco, M., & Spinazzola, J. (2013). Traumatized youth in residential treatment settings: Prevalence, clinical presentation, treatment, and policy implications. *Journal of family violence, 28*(7), 639-652. https://doi.org/10.1007/s10896-013-9534-9

Zerach, G. (2013a). Compassion fatigue and compassion satisfaction among residential child care workers: The role of personality resources. *Residential Treatment for Children & Youth, 30*(1), 72-91.

Zerach, G. (2013b). Compassion fatigue and compassion satisfaction among residential child care workers: the role of personality resources. *Residential Treatment For Children and Youth, 30*(1), 72-91. https://doi.org/http://dx.doi.org/10.1080/0886571x.2012.761515

Zelechoski, A. D., Sharma, R., Beserra, K., Miguel, J. L., DeMarco, M., & Spinazzola, J. (2013). Traumatized youth in residential treatment settings: Prevalence, clinical presentation, treatment, and policy implications. *Journal of Family Violence, 28*(7), 639-652.

Appendices

Appendix A: ProQuest Searches Data Basis PSYCHINFO

January 31

Searched for:

((((((((((ab ("child* residential care work*") OR ab (children's caregivers) OR ab (health care support workers) OR ab (childcare staff) AND ab (children in childcare) OR ab (Looked After Children) OR ab (Children AND Young People Looked After?) AND ab(relationship building) OR ab(attachment therapy) OR ab(attachment AND emotional regulation)) AND steeplejack("Scholarly Journals")) AND at. Exact("Literature Review" OR "Article")) AND la.exact("English") AND pd(20100103-20220111)) AND stype.exact("Scholarly Journals")) AND at.exact("Literature Review" OR "Article")) AND la.exact("English")) AND stype.exact("Scholarly Journals")) AND at.exact("Literature Review" OR "Article")) AND la.exact("English")) AND (at.exact("Article") AND subt.exact(("caregivers" OR "children & youth" OR "qualitative research" OR "health knowledge, attitudes, practice" OR "health personnel" OR "focus groups" OR "workers" OR "child care") NOT ("index medicus" OR "adult" OR "infant" OR "parents" OR "middle aged" OR "surveys and questionnaires" OR "cross-sectional studies" OR "pediatrics" OR "young adult" OR "quality of life" OR "parents & parenting" OR "mothers" OR "mental health" OR "families & family life" OR "risk factors" OR "nursing" OR "health care" OR "patients" OR "public health" OR "questionnaires" OR "age" OR "child development" OR "infant, newborn" OR "aged" OR "mental disorders" OR "hospitals" OR "pregnancy" OR "health services" OR "medical personnel" OR "socioeconomic factors" OR "studies" OR "dentistry" OR "covid-19" OR "family" OR "autism" OR "parent-child relations" OR "abridged index medicus" OR "anxiety" OR "hiv infections" OR "poverty" OR "prospective studies" OR "education" OR "data collection" OR "pandemics" OR "infants"

OR "stress, psychological" OR "longitudinal studies" OR "human immunodeficiency virus--hiv" OR "nurses" OR "preschool children" OR "parenting" OR "asthma" OR "regression analysis" OR "child abuse" OR "interviews as topic" OR "follow-up studies" OR "behavior" OR "animals" OR "childrens health" OR "teenagers" OR "prevalence" OR "adaptation, psychological" OR "depression" OR "retrospective studies" OR "households" OR "interviews" OR "health promotion" OR "decision making" OR "clinical trials" OR "mortality" OR "low income groups" OR "obesity" OR "health services accessibility" OR "primary care" OR "health education" OR "rural areas" OR "rural population")) AND la.exact("ENG")) AND pd(20100103-20220111)

Limited by:

Date: From January 03 2010 to January 11 2022

Databases: PSYCHINFO

Advanced More	Display Results	
24 and 25 and 26	230	Advanced
20 or 21 or 22 or 23	56069	Advanced
16 or 17 or 18	45240	Advanced
(child or adolescen* or teen8 or youth* or young*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	1053936	Advanced
(child* adj4 (connect* or nurtur* or bond* or attach*)).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	12117	Advanced
(relational therap* or emotional regulation or attachment therap* or relationship building).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	17601	Advanced
exp Attachment Behavior/	31969	Advanced
relationship building.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	1877	Advanced
(child in care or looked after child* or looked after young or child*in out of home care).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	490	Advanced
support care worker*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	4	Advanced
exp Residential Care Institutions/	45186	Advanced
(residential care adj2 (caregiver* or worker* or staff or key worker*)).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	172	Advanced
1 and 3 and 6	306	Advanced
limit 13 to (english language and abstracts and yr="2005 - 2021")	766439	Advanced
6 or 7 or 8 or 9 or 10	1298585	Advanced
3 or 4 or 5	137008	Advanced
1 or 2	88283	Advanced
exp Attachment Behavior/ or exp Attachment Disorders/ or exp Treatment/ or exp Childhood Development/	1231532	Advanced
exp Emotional Regulation/	12783	Advanced
exp Childhood Development/ or exp Behavior Problems/ or exp Attachment Behavior/	166742	Advanced
exp Childhood Development/	110493	Advanced
exp Adolescent Development/	60469	Advanced
exp Child Care/ or exp Child Welfare/ or exp Residential Care Institutions/	65268	Advanced
exp Caregivers/ or exp Child Care Workers/ or exp Child Care/ or exp Child Welfare/ or exp Attachment Behavior/ or exp "Quality of Care"/	95965	Advanced
exp Caregivers/ or exp Child Welfare/ or exp Child Care/	52177	Advanced
exp Child Welfare/ or exp Child Care Workers/ or exp Child Care/	20760	Advanced
exp Child Care/ or exp Residential Care Institutions/ or exp Occupational Stress/ or exp Child Care Workers/ or exp Child Welfare/		

34 Data Bases were selected

View list

Saved:

January 11 2022

Appendix B: Expert who provided a research list

Professor Taren Sweeney is a professor and researcher in the School of Educational Studies and Human Development, University of Canterbury, New Zealand.

Appendix C: Quality Assessment Form for Qualitative Research

Author(s):

Title:

Journal:

Year:

Screening Questions	Outcome		Maybe (m)= 1	Comments
	Yes (Y)	NO(N)		
Was there a clear statement of the aims of the research?				
Is the qualitative methodology appropriate?				
Is it worth				

Detailed Questions	Scores YES = 2 Partial = 1 NO = 0	Unclear (U)	Comments
Was the research design appropriate to address the aims of the research? (Have the authors discussed why the methods were used?)			
Was the recruitment strategy appropriate to the aims of the research? (The way in which the participants were selected and why is going to be considered).			
Were the data collected in a way that addressed the issue? (Is the process of			

how data collected was collected and where from explained clearly).

Is there discussion about why the methods were chosen?

Is the form of data clear? (i.e., tape recorded interviews, focus groups, in depth interviews).

Has the relationship between the researcher and participants been appropriately considered? Has the researcher considered his own role and bias during the research process?)

Have the ethical issues been taken into consideration? (To consider if there was appropriate information about how the participants were informed about the research, if issues like confidentiality were discussed and how they were dealt with, and how approval was sought?

Was the data analysis sufficiently rigorous? (In here it is important to consider if there is a description of the analysis process and if thematic analysis was used, is it clear how themes were categorised?

Is there enough data from participants to support themes?

Is contradictory data taken into account?

Is there a clear statement of findings? - are the findings clear and do they relate to original research aims?

Is there evidence for both for /against researchers’ arguments?

Is the credibility of the findings discussed?

How valuable is the research? Has the research contributed to knowledge and practice?

Is there a discussion of the findings being transferred to other populations?

Has future research been considered?

Appendix D: MMAT mixed method tool

1. Is there an adequate rationale for using a mixed methods design to address the research question?
2. Are the different components of the study effectively integrated to answer the research question?
3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?
4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?
5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?

Appendix E: Data extraction form

Authors:

Title:

Journal:

Year:

Method:

Type of study:

Recruitment process:

Samples size:

Characteristics of participants (socio-demographic information):

Quantitative:

Measures used (DV, IV)

Validity of measures:

Independent variables:

Qualitative:

Data collection method:

Analysis method:

Results/analysis

Quantitative, statistical analysis, findings

Qualitative

Main themes: Overall findings:

Appendix F : Participant Leaflet information sheet

PARTICIPANT INFORMATION SHEET

You are invited to take part in research exploring residential care workers' experiences of their relationship building with the children and young people they look after.

What is the purpose of the study?

The purpose of the study is to give residential workers the opportunity to talk about their lived experiences in their relationship building with the children.

Why have I been chosen to take part?

You have been chosen to be part of this study because you are aged 25 to 55 years old, you have been working with children and young people with emotional and behavioural difficulties for at least 3 years, and you have never been subjected to any disciplinary acts due to misconduct or malpractice involving children or other vulnerable people.

What are the benefits of taking part?

By sharing your experiences with us, you will be helping myself and the University of Birmingham to better understand your own lived experiences when building relationships with the children and young people in your care. Your valued opinions, perspectives, and insight are very important and can help others doing the same job. This is the main reason why an exclusive and personalised conversation is needed to access your unique experience of your role as a residential care worker. If you take part in the study, you will be rewarded with a 20 pounds voucher for Amazon.

Are there any risks associated with taking part?

There are no significant risks associated with the participation. No risk assessment will be needed. The study will be conducted via secure link, zoom. Ideally during the conversation, you will have to be in a quiet and comfortable place with no distractions or interruptions.

Do I have to take part? And What will happen if I decide to take part?

No, the participation is completely voluntary. If you would like to take part, you can withdraw within 2 weeks of taking part in the conversation. Once the data has been transcribed withdrawal will not be possible as the data will have been transcribed by then. If you decide to withdraw you will need to inform me as soon as possible via email. No repercussion is associated with the withdrawal.
If you decide to take part, you will be contacted via email and a time and day convenient for both will be arranged. Once we decide the date and time, I will send you a zoom link and we will have our conversation.
The conversation will be recorded with an encrypted Dictaphone. It will be handled confidentially, and your personal data anonymised. For clarity and retrieval, pseudonyms will be used. Once the conversation is transcribed and uploaded to RDS (University secure basis), it will be deleted from the Dictaphone.

Data Protection and Confidentiality

Your data will be processed in accordance with the General Data Protection and Data Protection Act 2018.
All the information that you provide me with is confidential unless something that implies you or another person is at risk of harm or that a crime or misconduct has taken place (e.g. disclosure of abuse against a child or other carers or witnessed abuse).
You are required to refrain from giving any identifiable information about yourself, a child, or other carers). If that happens anyway, it will be erased and not transcribed. No identifiable information of any kind will appear on the transcribed conversation; therefore, it will not be analysed either.
The raw data will be stored on RDS (research data store), and only the anonymised transcriptions and analysis will be kept on a password protected personal laptop, which will only be accessible to myself and my supervisors. The data will be destroyed by my supervisor after 10 years in line with UoB policy.

The consent forms and, demographic data and any notes taken during the conversations will be stored in a locked cabinet when not being used, and any notes which are uploaded onto a computer for university use will be held on an encrypted USB. Once the data are stored with RDS, all paper notes will be destroyed.

The consent form will be sent via email, and it will be returned to me via email.

The results of this study may be summarised in reports and presentations. The findings will always be made anonymous. You will be able to access feedback by ticking this option on the consent form. I will then send the project write-up. Your email address will be stored on a word document on a password protected laptop and deleted after you have received the results.

Making a complaint

If you are dissatisfied with any aspect of the research, please contact me at LXD023@student.bham.ac.uk in first instance. If the query is not resolved, please contact the project's supervisor Dr Shola Apena Rogers at S.ApenaRogers@bham.ac.uk.

Lorena Dumitrache
Lead Researcher
University of Birmingham
Birmingham, B15 2TT

Appendix G: Consent Form

Date:

CONSENT FORM

The aim of this study is to gain access into residential care workers' experiences of their relationship building with the children in their care. The study is being conducted by Lorena Dumitrache, a trainee Forensic Psychologist at the University of Birmingham.
The information which you supply and that which may be collected as part of this research will be entered into a database and will only be accessed by authorised personnel involved in the project. The information will be retained by the University of Birmingham and will only be used for the purpose of research, and statistical and audit purposes.
You have been selected to participate in this study because you are a care worker looking after children for more than 3 years. Your participation will consist of an informal conversation regarding your lived experiences and perceptions of your relationships built with the children and young people in your care. Your participation is completely voluntary, and you can withdraw within two weeks from the conversation. If you agree to take part, your collaboration will be mainly constituted by 45 to 60 minutes conversation over zoom. This conversation will be recorded with a Dictaphone. Your details will be treated confidentially and anonymised when transcribing the conversation for analysis purposes and within any research outputs.

By supplying this information, you are consenting to the University of Birmingham storing your information for the purposes stated above. The information will be processed by the University of Birmingham in accordance with the provision of the Data Protection Act 1998. No identifiable personal data will be published.

For further information or if you have any queries, please contact the Lead Researcher, Lorena Dumitrache (LXD023@student.bham.ac.uk). If you have any concerns that cannot be resolved by the Lead Researcher, please contact Dr Shola Apena Rogers, study supervisor (S.ApenaRogers@bham.ac.uk).

I, therefore, confirm that I have read and understood the details provided within the participant leaflet for the study. I have had the opportunity to ask questions if necessary and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw up to two weeks from the participation

I understand that my personal data will be processed for the purpose detailed above, in accordance with the Data Protection Act 1998.

Based on the above, I agree to take part in the study.

I would like to be sent a copy of the project write-up once it is finalised:
YES

NO

NAME, SIGANTURE AND DATE

Name of participant…………………………………………Date…………………………..
Signature……………………

Name of the researcher Lorena Dumitrache…………..	Date…………………………..
Signature………………….

Appendix H: Debrief Sheet

PARTICPANT DEBRIEF

Thank you for participating in the study.

The findings of the study can have important implication in the most vulnerable children wellbeing, prospects and outcomes.

If you wish to receive a summary of the write-up, be email, please tick this box

Please provide your email address:

Your email address will be stored on a password protected laptop of the lead research who will email a summary of the study to you and then delete your email details.

If you experience any distress or concerns after participating in thus research and would like further support and advice, please refer to the below list of relevant organisations:

Mental Health Helpline

Wellbeing Helpline and Texting Service is a Freephone out of hours, person centred listening environment for people requiring emotional support in relation to their own mental health or that of someone they know. The Helpline aims to empower callers through active listening and information to make their own choices about how their health care needs may be met. Fully trained volunteers operate the helpline, they offer their time to listen and support callers.

0800 9154640

Samaritans
Helpline: 116123
Website: www.samaritans.org

Thank you

Appendix I: Interview schedule

1. **Can you start by telling me how you have arrived at doing the job you are doing?**
2. **Can you tell me about how you became interested/involved in working with children?**
3. **Can you tell me a bit about your role, and what it is like?**
4. **What is it like working with the children you are working with? (when they mention challenges, really prompt to uncover what is difficult)**
5. **Can you tell me more about what it is like to look after the children and young people you are working with, and develop relationships with them?**
6. **Looking back, can you tell me more about whether the job/role is what you expected it to be, and why?**
7. **I would be interested to hear from you also about what you feel you have learnt about yourself since taking up this role/doing this job?**

General prompting questions, applicable to all of the above.
Can you tell me more about that, what do you mean, in which way, tell me more about it, how does that make you feel, can you elaborate that? What /why do you think that is the case? What makes you feel like that? Do you think/feel this all the time? What happened? Have you always thought/ felt that?

Appendix J: Correlations between TSCC Scales and CDI Scores

Correlation of TSCC Clinical Scales with CBCL and CDI Scores in a Child Abuse

	ANX	**DEP**	**PTS**	**SC**	**DI**	**ANG**
CBCL-P-1	.16	.22*	.23*	.08	.09	.08

CBCL-P-E	.31**	.26*	.22*	.21*	.13	.27*
CBCL-Y-1	.78**	.82**	.75**	.51**	.68**	.55*
CBCL-Y-E	.47**	.48**	.53**	.62**	.65**	.68**
CDI	.54**	.73**	.64**	.45**	.60**	.59**

*p=<.05, **p<.01 Source: (Briere, 1996, p.30)

Note: Centre Sample[a.] (N is range from 51 – 66 because of missing data)

Appendix K: TSCC (Trauma Symptoms Checklist for Children) Subscales Descriptions

Description of component of the TSCC

ANXIETY: this construct refers to generalised anxiety, hyperarousal, and worry; specific fears (of men and women, of the dark; of being killed); episodes of free-floating anxiety; and a sense of impeding danger.

DEPRESSION: refers to feelings of sadness, unhappiness, and loneliness; episodes of tearfulness, depressive cognitions such as guilt and self-denigration; and self-injurious behaviour, and suicidality.

POST-TRAUMATIC STRESS: the post-traumatic symptoms include intrusive thoughts, sensations, and memories of painful past events; nightmare; fears; and cognitive avoidance of painful feelings.

DISSOCIATION: the main dissociative symptomatology includes derealisation; one’s mind going blank; emotional numbing; pretending to be someone else or something else; daydreaming; memory problems; and dissociative avoidance. Has two subscales: DIS-O (Overt Dissociation) and DIS-F (Fantasy).

ANGER: this psychological set of symptoms include angry thoughts, feelings, and behaviours, including feeling mad, feeling mean, and hating others; having difficulties de-escalating anger; waiting to yell at or hurt people; and arguing and fighting.

SEXUAL CONCERNS: these series of symptoms include sexual thoughts or feelings that are typical when they occur earlier than expected or with greater than normal frequency; sexual conflicts; negative responses to sexual stimuli; and fear of being sexually exploited. It has two subscales: SC-P (Sexual Preoccupation) and SC-D (Sexual Distress).