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Compassion fatigue and compassion satisfaction in foster carers: a mixed methods approach

Item Type	Thesis
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UNIVERSITY *of* LIMERICK

O L L S C O I L L U I M N I G H

*Compassion Fatigue and Compassion
Satisfaction in Foster Carers: A Mixed Methods
Approach*

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2016

Thesis submitted to the University of Limerick in fulfilment of the requirements for
the Doctoral Programme in Clinical Psychology (Ph.D.)

Declaration

I declare that this thesis is my own work and has not been submitted as part of another degree at the University of Limerick or any other academic institution.

Claire Reinhardt

Acknowledgements

Firstly, I'd like to thank Patrick Ryan for your support and guidance both in developing this research project, and throughout my three years of clinical training. Having such a supportive and mindful course director made a difficult endeavour enjoyable.

Secondly, I'd like to extend my sincerest gratitude to Stephen Gallagher for all your help and advice with this research project. I feel extremely privileged to have had a supervisor with such a wealth of knowledge about research and psychology.

Thank you to all the UL Clinical Psychology course team for your support over the past three years, and thank you to my classmates. I have made friends for life.

Thank you to my parents, Harry and Maura, for your unconditional love, support and encouragement. I couldn't have achieved this without you. Not forgetting to thank my sisters, Sarah and Rachel, and my niece and nephew, Amie and Conor. You provided much needed laughter and entertainment when I needed it most.

Last, by no means least, thank you to my wonderful fiancé, Nick, for your unfaltering love and support. You have been a constant source of reassurance and motivation, and I know you'll be relieved when I'm finally finished!

Abstract

Background: Research suggests that caregiving professionals are at risk for developing both compassion fatigue (including both burnout and secondary traumatic stress (STS)) and compassion satisfaction (CS) through caring for others. However, foster carers have received little research attention. **Aim:** The present study aimed to examine the prevalence of, and predictors of, STS, burnout and CS in foster carers. **Methods:** A mixed methods design was employed. In the quantitative phase, participants (n= 99) completed an online survey to assess levels of burnout, STS and CS and to gain information on foster child behaviour, perceived social support, and self-care behaviour. Subsequently, semi-structured telephone interviews were completed with two groups of foster carers; those experiencing high levels of CS (n =5), and those experiencing high levels of compassion fatigue (n=5). **Results:** Results showed that foster carers experienced significantly higher levels of burnout, STS and CS compared to normative data (Stamm, 2010). Self-care behaviour was shown to be the strongest predictor of all three outcome variables (STS, burnout and CS). Qualitative analysis generated six main themes: 'the foster child', 'being a foster parent', 'support', 'coping', 'the big brother effect', and 'outcomes'. **Conclusion:** This study provides both quantitative and qualitative evidence for the high risk of compassion fatigue (both STS and burnout) and the significant potential for CS in foster carers. It highlights the need for interventions to be developed and implemented to help foster carers who are already experiencing compassion fatigue, in addition to the need to implement preventative measures, particularly practical (e.g. training) and emotional supports.

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CHAPTER 1: INTRODUCTION

1.1 Overview of the study

Research suggests that there is a cost to caring, with formal caregivers being at risk for being both positively and negatively impacted through caring for vulnerable others (Beck, 2011). One group of formal caregivers who have been neglected in the research is foster carers. Due to the dearth of research examining the impact of fostering on foster carers, the present study aimed to explore burnout, secondary traumatic stress and compassion satisfaction in foster carers. To simultaneously establish both breadth and depth of this under-researched area, a mixed methods design, including both a quantitative followed by a sequential qualitative phase, was employed. The quantitative phase aimed to establish prevalence rates of burnout, secondary traumatic stress and compassion satisfaction in foster carers, in addition to determining which, if any, demographic and work-related variables were linked to the manifestation of these three constructs in foster carers. A final aim of the quantitative phase was to examine associations between child behaviour, social support and self-care and the three constructs of interest. Due to the impossibility of exploring every possible contributory variable using quantitative methods, the qualitative phase aimed to expand on the quantitative phase by exploring compassion fatigue (both burnout and secondary traumatic stress) and compassion satisfaction in more depth to gain a more thorough understanding of the phenomena in foster carers. The qualitative study compared a sample of foster carers who scored high on compassion fatigue (and low on compassion satisfaction) to a group of foster carers who scored low on compassion fatigue (and high on compassion satisfaction). The purpose of comparing the two

groups was to gain an insight into possible differences between the two groups to further understand influential factors in the development of compassion fatigue and compassion satisfaction.

1.2 Thesis structure

The thesis is structured into chapters. The literature review is presented in Chapter 2. Chapter 3 outlines the methodology. Chapter 4 presents the quantitative results, followed by the qualitative findings. Finally, chapter 5 discusses and integrates the findings of both the quantitative and qualitative studies, while also making suggestions for possible clinical and policy applications and directions for future research. Chapter outlines are presented in more detail below.

1.2.1 Chapter 2: Literature review

This chapter reviews the existing literature on burnout, secondary traumatic stress and compassion satisfaction in formal caregivers. An overview of children in care, their complex presentation, types of out of home care and the context of out of home care in Ireland is initially presented, to demonstrate the importance of the foster carer role and how foster carers may be impacted through their work. The potential contribution of demographic factors, child behaviour, social support and self-care to the development of burnout, secondary traumatic stress and compassion satisfaction is also considered, in reference to previous research and theory. The aims of the research are also presented.

1.2.2 Chapter 3: Methodology

This chapter provides a description of the thesis methodology. Justification for the use of a mixed methods approach is initially presented. Then, the methodology for the quantitative study is detailed, including the design, the participants and the procedures, the measures used and data analytic procedures employed. Finally, the methodology for the qualitative study is described, including the pilot phase, the participants and procedure, how the data was managed and the use of thematic analysis, according to the Braun and Clarke (2006) framework, for data analysis.

1.2.3 Chapter 4: Results

This chapter presents the results of the quantitative and the qualitative studies sequentially, starting with the quantitative results. Descriptive data is presented first, followed by t-test and correlational results. Then, results of each hypothesis are presented, followed by results of regression analyses. Next, the findings of the qualitative study are presented. Six themes were identified, each consisting of a number of subthemes. Each theme is presented in turn, supported by a selection of relevant quotes from the interviews.

1.2.4 Chapter 5: Discussion

The final chapter presents a discussion of the results. It is broadly divided into three sections. It begins by discussing the results of the quantitative study, in relation to previous research and theory, followed by a discussion of the qualitative findings, again in relation to existing literature. Finally, the implications of both the quantitative and qualitative results for policy and practice are

considered together, along with the relative strengths and limitations of the thesis, and directions for future research.

CHAPTER 2: LITERATURE REVIEW

2.1 Chapter Introduction

This chapter reviews the existing literature on burnout, secondary traumatic stress and compassion satisfaction in formal caregivers. An overview of children in care, their complex presentation, and the context of out of home care in Ireland is initially presented, to demonstrate the importance of the foster carer role and how foster carers may be impacted through their work. The contribution of demographic factors, child behaviour, social support and self-care in the experiences of burnout, secondary traumatic stress and compassion satisfaction are also considered.

2.2 Children in Care

'Children in care' are a subset of children who are under the care of the state, typically as a result of their biological parents' inability to provide a safe and nurturing caregiving environment. Unfortunately, many of these children have suffered abuse and neglect, precipitating their admission to the care system, and present with significant and complex care needs as a result (Vig, Chinitz, & Shulman, 2005). Children in care are also more likely to have intrauterine exposure to drugs and alcohol, leaving them at increased risk for the development of conditions related to toxic in utero conditions, such as foetal alcohol syndrome (Oswald, Heli, & Goldbeck, 2010). Compared to the general population, children in care also experience higher rates of physical, cognitive, developmental, emotional and behavioural difficulties (Carbone, Sawyer, Searle & Robinson, 2007; Oswald et al., 2010). Children in care have been shown to have higher medical needs (Ringeisen, Casanueva, Urato & Cross, 2008), with one UK-based study finding that

two thirds of children in care present with at least one physical health complaint (Meltzer, Corbin, Gatward, Goodman & Ford, 2003). Moreover, children in care are more likely to have delays across developmental domains, including speech and language delays (Leslie et al., 2005), cognitive delays (Leslie, Gordon, Ganger & Gist, 2002; McNichol & Tash, 2001; Pears, Kim & Fisher, 2008), and fine and gross motor delays (Pears & Fisher, 2005; Stahmer et al., 2005), in addition to being at increased risk for emotional and behavioural difficulties (Tarren-Sweeney, 2008). A UK-based national survey found that 45% of children in care had a diagnosable mental health disorder (Dimigen et al., 1999). More recent UK-based research found that 37% of children had a conduct disorder, 12% had an emotional disorder (either depression or anxiety) and 7% had clinically significant hyperactivity (Ford, Vostanis, Meltzer & Goodman, 2007). High rates of mental health difficulties have been substantiated by additional research (e.g. Greeson et al., 2011), with Sempik, Ward and Darker (2008) finding that 72% of children in care, between the ages of 5 to 15 years presented with a mental health or a behavioural problem. Research further highlights the risk of trauma-related symptoms for children in care as a result of their separation from their birth parents and the neglect and abuse that they have often experienced. In some studies, up to 64% of children in care have met diagnostic criteria for a diagnosis of post-traumatic stress disorder ([PTSD], Dubner & Motta, 1999; Greeson et al., 2011). Overall the research highlights that children in care present with more complex care needs than typical children living with their biological parents, including the presence of trauma-related symptoms.

Recent figures from the Republic of Ireland confirm that children in care in Ireland experience adversities prior to being taken into care. The primary reasons for admission to care in 2012 were; neglect (28.6%); physical abuse (8.4%); emotional abuse (7.4%); sexual abuse (1.7%); and child welfare concerns (53.9%), (Department of Child and Youth Affairs, 2012). These figures are in line with those of other countries, including the United Kingdom (Zayed & Harker, 2015) and the United States (Stukes, Chipungu & Bent-Goodley, 2004), confirming the applicability of research demonstrating the significant care needs of foster care children in other countries to those in Ireland.

2.2.1 Types of out-of home care

While in some incidences children under the care of the state are accommodated in residential homes or special units, the majority are placed with foster carers. Foster care is seen as the preferred form of care for children who can't remain with their biological parents, as it provides opportunities for children to develop attachments with a parental figure, which typically cannot be facilitated in residential settings due to care being shared by a number of staff members working shifts (Smyke, Zeanach, Fox, Nelson & Guthrie, 2010). There are two types of foster care, namely relative foster care and general foster care. Relative foster care, is out-of-home care provided by a relative of the child under state legislation, while general foster care is provided by foster carers who are not related to the child.

2.2.2 Context in Ireland

According to figures released in April 2015, there are 6420 children in care in Ireland, with 93% (5959 children) of children in care in Ireland placed in foster care (Department of Children and Youth Affairs, 2015). These figures demonstrate that the majority of children in care in Ireland are cared for by foster carers, which is appropriate based on research demonstrating enhanced outcomes for children placed in foster care compared to other forms of out of home care (Dozier, Kaufman et al., 2014; Dozier, Zeanah, Wallin & Shauffer, 2012; Kerman, Wildfire & Barth, 2002,).

2.3 The impact of caring on the caregiver: conceptualisations within the literature

Given the complex care needs of children in care, it is imperative to consider the impact of providing such care on the caregivers. Over the past three decades there has been an increased focus on the 'cost of caring', with a recognition that those in caring professions may suffer effects to their personal wellbeing as a result of their work (Beck, 2011). Aside from the typical indicators of health and wellbeing, a number of specific constructs have been developed to account for the negative impact of caring on people working in caregiving roles. It is hypothesised that the impact of providing empathic care to emotionally disturbed and traumatised individuals transcends beyond typical experiences of stress, resulting in more extreme consequences for the caregiver. However, there is some disagreement in the literature over the conceptual differences between constructs, which will be discussed further below.

2.3.1 Burnout

One of the first conceptualisations of the potential negative impact of caring was 'burnout'. The term 'burnout' was first coined by Freudenberger in 1974 to describe the physical and mental exhaustion observed in workers at free clinics in the United States, in response to unrealistic and excessive demands (Freudenberger, 1974). Since Freudenberger's (1974) original use of the term 'burnout', several varying definitions of burnout have appeared in the literature. Pines and Aronson (1983, p.263) define burnout as *"a state of physical, emotional, and mental exhaustion [that] typically occurs as a result of working with people over a long period of time in situations that are emotionally demanding"*. Etzion (1984) supplemented Pines and Aronson's (1983) definition by emphasising the contribution of additional life pressures, external to the workplace, to burnout. However, the most widely accepted and most commonly used definition of burnout was proposed by Maslach and Jackson (1986, p.1), who describe burnout as *"a syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind"*. The 'emotional exhaustion' component of burnout refers to the depletion of emotional resources. According to Maslach and Jackson (1981), individuals who are experiencing burnout feel lethargic and as though they have nothing left to give. Maslach and Jackson (1981) further suggest that a common symptom of emotional exhaustion is dread at the prospect of another day at work. The second component of burnout, depersonalisation, is characterised by treating service users as objects, or developing negative attitudes towards service users. The third component of burnout is reduced personal accomplishment, which is typified by diminished feelings of job competence and achievement (Maslach, 1982). Despite

some disagreement in the literature there appears to be agreement that burnout is a condition unique to human service providers, with the central theme of definitions being the developing sense of exhaustion (Seti, 2008).

Burnout has been found to be associated with a multitude of symptoms, which according to Kahill (1988) fall into five categories; physical, emotional, behavioural, interpersonal, and attitudinal, and manifest differently in different individuals. The most common physical symptoms of burnout identified in the literature include; fatigue (Burke & Richardsen, 1996; Kahill, 1988; Matthews, 1990); physical exhaustion (Burke & Richardsen, 1996; Freudenberger, 1974; Miller, 1995); sleep difficulties (Kahill, 1988; Maslach, Jackson, & Leiter, 1996); headaches (Burke & Richardsen, 1996; Pines & Maslach, 1978); colds and flu (Burke & Richardsen, 1996; Pines & Maslach, 1978); and gastrointestinal problems (Cherniss, 1980, Miller, 1995). Behavioural symptoms of burnout have been reported to comprise; chronic disorganisation (Cherniss, 1980); alcohol and drug use (Maslach & Jackson, 1981, 1984); opposition to change (Matthews, 1990); and rigidity with respect to following rules (Freudenberger, 1977; Pines & Maslach, 1978). Emotional symptoms commonly reported by individuals experiencing burnout include; irritability, anxiety, guilt, and depression (Jackson & Maslach, 1982; Seti, 2008). Pines and Maslach (1979) suggest that attitudinal symptoms are evident in such behaviours as arriving late to work or leaving early, taking extra breaks, or avoiding important tasks. Finally, according to burnout literature, interpersonal symptoms of burnout are displayed in both co-worker relationships and in relationships outside of work, with individuals experiencing burnout frequently withdrawing from friends and family and engaging in conflict with co-

workers (Jackson & Maslach, 1982; Seti, 2008). Therefore, burnout literature suggests that experiencing burnout can have a negative impact on an individual, with the symptoms transcending across domains of functioning and wellbeing.

In addition, research suggests that the consequences of burnout can go beyond the individual experiencing the condition. Research suggests that burnout can also significantly impact the recipients of care, when the caregiver is experiencing burnout. When caregivers experience the depersonalisation component of burnout they withdraw from the individuals in their care, and communicate in negative or impersonal ways (Maslach, 1976; Pines & Maslach, 1978). Consequently, in the case of children as the recipients of care, the results of depersonalisation can be detrimental to any relationship previously developed with the child, with researchers suggesting that the effects of burnout can ultimately undo any progress that children have made in the care relationship (Seti, 2008). Furthermore, burnout can have an impact on organisations, as staff who are experiencing burnout are likely to have more absenteeism and are significantly more likely to resign from their job (Lee & Ashforth, 1996; Razza, 1993). In the case of foster carers, burnout may make foster carers more likely to cease fostering, as this has been the case in other caring professional contexts (e.g. Leiter & Maslach, 2009).

2.3.2 Secondary Traumatic Stress

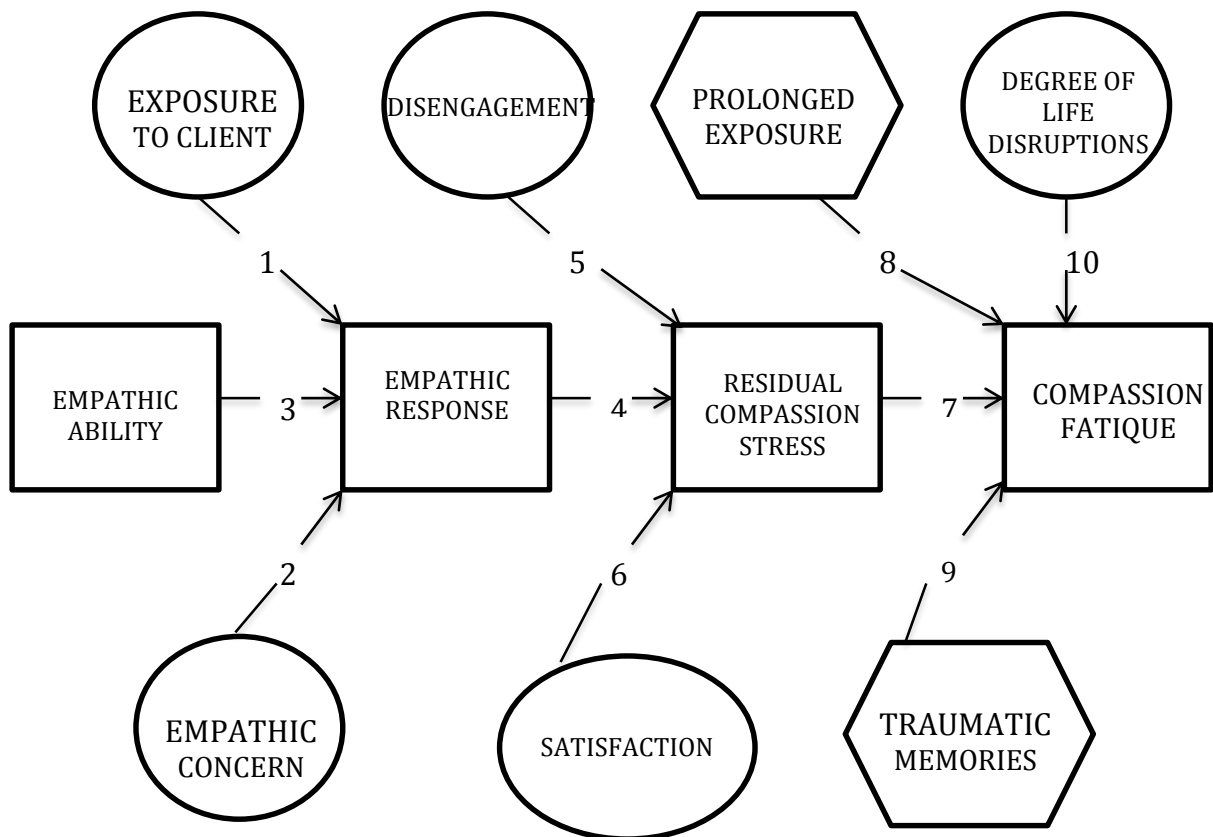
A second proposed negative impact of caring is secondary traumatic stress (STS). STS has been defined as *“the natural consequent behaviours and emotions resulting from knowing about a traumatising event experienced by a significant other - the stress resulting from helping or wanting to help a traumatized or suffering person.”* (Figley, 1995 p.10). STS is similar to burnout in that it also arises in the context of work and shares some common symptoms (Udipi, McCarthy Veach, Kao & LeRoy, 2008), however, their respective causes are theorised to differ. While burnout is typically related to stressful and demanding work conditions, STS results only in the context of exposure to another person’s trauma (Elwood, Mott, Lohr & Galovski, 2011). According to Udipi and colleagues (2008, p.461) *“professionals who experience secondary trauma feel overwhelmed whereas professionals who experience burnout feel overworked”*. The symptoms of STS are described as mimicking the traditional symptoms of PTSD as listed in the Diagnostic and Statistics Manual, 5th Edition ([DSM-V], American Psychological Association [APA], 2013) with the exception that in STS the traumatic event is experienced indirectly through caring for an individual who has experienced trauma. Research suggests that individual’s with STS can re-experience the client’s trauma events, can dream about the traumatic event, can experience intrusive thoughts or images, can engage in avoidance of reminders of the traumatic events and can experience persistent arousal (e.g. anxiety) associated with the traumatised individual (Cerney, 1995; Figley, 2002). Yassen (1995) suggests STS can affect physical, behavioural, emotional, cognitive, spiritual and interpersonal wellbeing. The range of symptoms of STS have been summarised by Yassen (1995, p.184) and can be seen in Figure 1 below.

Figure 1. The Personal Impact of Secondary Traumatic Stress (Yassen, 1995, p.184)

Cognitive	Emotional	Behavioural	Spiritual	Interpersonal	Physical
<ul style="list-style-type: none"> • Diminished concentration • Confusion • Spaciness • Loss of meaning • Decrease self-esteem • Preoccupation with trauma • Trauma imagery • Apathy • Rigidity • Disorientation • Whirling thoughts • Thoughts of self-harm or harm towards others • Self-doubt • Perfectionism • Minimization 	<ul style="list-style-type: none"> • Powerlessness • Anxiety • Guilt • Anger/ rage • Survivor guilt • Shutdown • Numbness • Fear • Helplessness • Sadness • Depression • Hypersensitivity • Emotional roller coaster • Overwhelmed • Depleted 	<ul style="list-style-type: none"> • Clingy • Impatient • Irritable • Withdrawn • Moody • Regression • Sleep disturbances • Appetite changes • Nightmares • Hyper vigilance • Elevated startle response • Use of negative coping (smoking, alcohol or other substance misuse) • Accident proneness • Losing things • Self-harm behaviours 	<ul style="list-style-type: none"> • Questioning the meaning of life • Loss of purpose • Lack of self-satisfaction • Pervasive hopelessness • Ennui • Anger at God • Questioning of prior religious beliefs 	<ul style="list-style-type: none"> • Withdrawn • Decreased interest in intimacy or sex • Mistrust • Isolation from friends • Impact of parenting (protectiveness, concern about aggression) • Projection of anger or blame • Intolerance • Loneliness 	<ul style="list-style-type: none"> • Shock • Sweating • Rapid heartbeat • Breathing difficulties • Somatic reactions • Aches and pains • Dizziness • Impaired immune system

The dominant theoretical model for the development of STS is the trauma transmission model (Figley, 2002, see Figure 2). The model attempts to explain the process of trauma transmission and to account for why some people develop STS (which Figley refers to as compassion fatigue in his model) while others do not. The model positions empathy as the key element and begins with exposure to a client's trauma. The model purports that the carer's empathic concern and empathic ability produces an empathic response, which can lead to residual compassion stress. The model suggests that effective disengagement strategies as well as deriving satisfaction from one's work can allay STS, while one's risk of experiencing STS can be increased by prolonged exposure to trauma or suffering, memories of previous trauma experiences, and life disruptions.

Figure 2. Trauma transmission model (Figley, 2002)



Several authors have critiqued Figley's model for being too narrowly focused (e.g. Sabo, 2011). Figley's model emphasises the role of empathy in the development of STS, but fails to consider other personal factors, for example resilience and coping strategies. Furthermore, although the model does take into account 'prolonged exposure' and 'degree of life disruption' it does not consider other potentially important environmental factors, for example social support or organisational support. Therefore, although the trauma transmission model provides a basic framework for understanding the development of STS, the literature suggests that it is not comprehensive enough and is unlikely to fully explain the phenomenon.

Despite the critique that Figley's (2002) trauma transmission model does not fully explain all of the factors involved in the development or mitigation of STS, there is widespread agreement in the literature that those individuals who assume a caregiving role for individuals who have experienced trauma, are at risk for developing STS. There is also a consensus that at the root of STS is indirect exposure to the traumatic event experienced by the care recipient. Research also suggests that those working with children who have experienced trauma may be more susceptible to experiencing STS than caregivers who work with adults because of the inherent vulnerability of children, the desire for retaliation and the stronger sense of disbelief in human cruelty, that can occur when a caregiver learns about any act of brutality against a child (Brady et al. 1999; Cunningham, 1999).

Like burnout, STS in a caregiver is thought to have a knock-on effect on the care recipient. STS can lead to a decreased ability to engage compassionately and

empathetically (Bride, Radey & Figley, 2007; Elwood et al., 2011; Figley, 2002) and can, therefore, lead to nontherapeutic and unhelpful interactions between the caregiver and the care recipient, and, in extreme situations, can be re-traumatizing or harmful to the care recipient (Figley, 2002). Therefore, in the case of foster carers experiencing secondary traumatic stress may further traumatise the children in care and hamper any progress they had made since admission to the care system.

2.3.3 Conceptual Clarification

A number of other terms are frequently used in the literature when describing the negative impact of caring, with some confusion over the conceptual differences between terms. 'Vicarious traumatisation' is a term often incorrectly used interchangeably with STS in the secondary trauma literature. While both terms refer to the consequences of empathic engagement with traumatised individuals, and therefore originate from exposure to another individual's trauma material, vicarious traumatisation focuses exclusively on the cognitive changes that can occur as a result of indirect trauma exposure. Vicarious traumatisation is defined as the "*permanent transformation in the inner experience of the therapist that comes about as the result of empathic engagement with clients' trauma material*" (Pearlman & Saakvitne, 1995, p.31) and involves disruptions to caregivers' schemas about safety, trust, esteem, intimacy, and control. In contrast, STS encompasses a range of cognitive, emotional, behavioural, physical, and interpersonal symptoms, paralleling those of PTSD (Figley, 1995). Another difference between the two terms is that the cognitive changes reported in

vicarious traumatisation are viewed as permanent (Pearlman & Saakvitne, 1995), while STS is hypothesised as a treatable phenomenon (Figley, 2002).

Another term often used interchangeably with both burnout and STS is 'compassion fatigue'. The term 'compassion fatigue' was first used in regard to discussions related to burnout in nurses exposed to traumatic work-related experiences (Joinson, 1992). Figley (1995) later proposed that compassion fatigue is merely a more acceptable term to describe STS and therefore employed the term compassion fatigue in his trauma transmission model when theorising how STS develops (discussed above). However, Stamm (2010) has more recently conceptualised compassion fatigue as an overarching term for the negative impact of caring comprising of both burnout and STS. The use of the term compassion fatigue in the current study is consistent with Stamm's (2010) interpretation.

2.4 Burnout and secondary traumatic stress in foster carers

Astonishingly, despite foster carers acting as the primary caregiver to the majority of children in care both nationally and internationally, scant research has examined the impact of providing this care to children with such complex and challenging care needs. In an extensive search of the literature no published peer-reviewed studies examining the specific constructs of burnout or secondary traumatic stress in foster carers could be found. However, a limited number of previous PhD theses were found. McLain (2008) utilised a quantitative methodology to examine levels of burnout and STS in foster carers in the United States. While 201 foster carers were included in the study, data was only available for 174 foster carers. Using the Professional Quality of Life, 4th edition (ProQOL-IV,

Stamm, 2005) to assess levels of burnout and STS, the author found that mean levels of burnout and STS were lower for foster carers compared to the available means for the measure, normed with a variety of other caregiving professionals (Stamm, 2005). In contrast to these findings, Parker (2009), using the same quantitative measure (ProQOL-IV) with 35 foster carers, found that foster carers mean scores on the secondary traumatic stress subscale were significantly higher than normative means for the measure (Stamm, 2005), suggesting markedly different findings between the two studies. Parker (2009) did not provide any data on the means achieved by foster carers, or the percentage of foster carers that scored in the 75th percentile for STS, making it difficult to sufficiently interpret the results and determine the extent of the differences between the two studies. Furthermore, the small sample size in Parker's (2009) study makes drawing conclusions from the findings problematic.

In her PhD study, Redfern (2013) explored the positive and negative impact of fostering on 13 foster carers using a qualitative methodology. Interpretative phenomenological analysis was used to analyse the data. Findings indicated both emotional and cognitive implications for foster carers, which the author interpreted as signifying the presence of STS in the foster carers. However, while the author drew comparisons between the emotional and cognitive impact described by foster carers and the concept of STS, the absence of quantitative measures within the study in the context of an under-researched population, makes it difficult to determine whether the experiences captured by the authors in this study are in fact reflective of STS, or whether burnout or another unexplored phenomenon could more accurately account for their experiences. Furthermore,

all foster carers in the study were engaged with child and adolescent mental health services, and therefore represent a small subset of foster carers who are receiving support from professional mental health services in the management of the children's complex needs, and may not be reflective of foster carers experiences more generally.

Overall, while previous theses suggest that foster carers are impacted negatively in their caregiving role, the available data has been limited and inconsistent. Moreover, because the available studies on burnout and secondary traumatic stress in foster carers, discussed above, have not been peer-reviewed or published, caution needs to be exercised when drawing any conclusions from the reported findings.

2.4.1 Other indicators of the negative impact of fostering on foster carers

Other studies examining the negative impact of caring on foster carers, not specific to burnout or secondary traumatic stress have also been limited. One UK-based study conducted by Farmer, Lipscombe and Moyers (2005) examined the health and wellbeing of foster carers at two time points following the placement of an adolescent with the foster carers. They found significant social functioning, somatic and anxiety difficulties for foster carers in the sample. Eighty-one to ninety-eight per cent of foster carers studied were experiencing clinical or subclinical social functioning difficulties, 48-50% were experiencing clinical or subclinical somatic symptoms and 38-48% were experiencing clinical or subclinical levels of anxiety. Rates of depression were low in the sample (2-5%), which has subsequently been replicated by other researchers (e.g. Bywater et al.,

2011; Cole & Eamon, 2007), suggesting that while providing care for foster children may lead to social functioning difficulties, somatic symptoms and higher levels of anxiety, depression is not a common outcome for foster carers.

Another negative outcome which has been explored in relation to foster carers is 'burden', though conceptualisations of the concept have been lacking, and results varied. For example, Murray, Tarren-Sweeney and France (2011) found high levels of burden in their sample of 17 foster carers, while Fuentes, Salas, Bernedo and Martin (2015) reported low levels of burden in their sample of 71 foster fathers and 86 foster mothers. However, neither study offered a clear definition of 'burden' and, on closer examination, they appeared to examine different outcomes. Murray and colleagues (2011) examined parenting stress, while Fuentes and colleagues (2015) utilised a measure of 'burden', originally designed for family carers of older adults with dementia (Zarit Burden Interview; Zarit, Orr, & Zarit, 1985), which essentially measures depression. Previous studies have indicated that depression is not a common outcome for foster carers (Cole & Eamon, 2007; Farmer et al., 2005), which explains why Murray and colleagues (2011) found high levels of 'burden' in foster carers, while Fuentes and colleagues (2015) did not.

Overall, the limited research does suggest that foster carers are at risk for negative outcomes in their caregiving role. The findings of higher levels of anxiety, somatic symptoms and social functioning difficulties are particularly relevant to the current study. Somatic symptoms and disturbances in social functioning are considered core diagnostic criteria for PTSD (APA, 2013), therefore suggesting that foster carers may experience symptoms synonymous with trauma as a

consequence of their work. This supports the hypothesis of the present study; that foster carers may be at risk for secondary traumatic stress.

2.5 Burnout and secondary traumatic stress in other caregiving professionals

Although there has been a lack of research examining burnout and secondary traumatic stress in foster carers, the wider literature in formal caregivers provides clues as to the implications of providing care to vulnerable groups as part of a care service. Research with other professionals caring for individuals who have experienced trauma has been more prominent. Empirical research has highlighted the risk of burnout and STS in a variety of professionals who provide care to individuals who have experienced trauma including; chaplains and clergy (e.g. Roberts, Flannelly, Weaver & Figley, 2013); mental health professionals (e.g. Devilly, Wright & Varker, 2009); nurses (e.g. Beck & Gable, 2012; Hinderer et al., 2014); and palliative care workers (e.g. Slocum-Gori, Hemsworth, Chan, Carson & Kazanjian, 2013), among others.

2.5.1 Burnout and secondary traumatic stress in professional caregivers working with children

Professional groups who offer the most insight into the experiences of burnout and secondary traumatic stress in foster carers are likely to be those who are also work with children in care. One such group is child welfare workers. Child welfare workers can include a variety of professionals working to protect children from abuse and neglect, though most studies involving child welfare workers have included social workers, case managers and supervisors of direct line staff under the overarching title of child welfare workers. Therefore, depending on their

specific role, child welfare workers can be exposed to child trauma stories through direct contact with children and their families as well as through the reading of files and hearing stories of abuse and neglect from colleagues. A number of studies have highlighted the risk of STS in child welfare workers (e.g. Hemsworth, Leslie, Howe & Chau, 2004; Horwitz, 2006; Pryce, Shackelford & Pryce, 2007). For example, in a sample of 187 child welfare workers, Bride, Jones and MacMaster (2007) found moderate levels of STS. Moreover, the study showed that 59% of child welfare workers reported experiencing one or more symptoms of STS often in the previous week. Further, 34% met the core criteria for a diagnosis of PTSD using the most up-to-date diagnostic and statistical manual of mental disorders available at the time (DSM-IV-TR, APA, 2000), as indicated by experiencing at least one intrusion, three avoidance and two arousal symptoms in the previous week, demonstrating that those caring for children in care can become traumatised themselves, as indicated by the high levels of PTSD symptoms. Similarly, Van Hook and Rothenberg (2009) found that child welfare workers reported moderate to high levels of STS, further highlighting the risk of STS in professionals exposed to the trauma material of children in care.

Conrad and Kellar-Guenther (2006) examined only frontline child welfare workers and found that 14.3% were at moderate risk, 15.7% were at high risk and 34.2% were at extremely high risk for the development of STS, further substantiating the risk of STS for professionals in direct contact with children in care. This suggests that secondary trauma is a major occupational hazard for the majority of child welfare workers who work directly with children in care. While these findings provide clues as to the likelihood of foster carers developing STS and burnout, a

number of study limitations are notable. In the case of Conrad and Kellar-Guenther's (2006) study, the sample was drawn from one state only in the United States, making generalizability of the findings to child welfare workers generally, and subsequently foster carers more difficult, as it is impossible to rule out other issues responsible for the development of the secondary traumatic stress, for example state-specific difficulties, such as systemic problems within the child welfare system.

Another group of formal carers who have been receiving increasing attention in the traumatology literature are residential childcare workers. Residential childcare workers provide care to children in care as an alternative option to foster care. They are involved in the direct care of traumatised children, providing for both their functional and emotional needs. Residential workers are frequently exposed to the trauma stories of the children in their care, talking to children about their experiences as well as witnessing the manifestations of their abuse and neglect in their behaviour, placing them as a group of caregivers potentially at risk for STS. Residential childcare workers arguably offer the greatest insight into foster carers experiences, since residential childcare workers perform many of the same tasks as foster carers with the same population of children, albeit in a different environment with shorter working hours and more shared responsibility.

Research with residential childcare workers has shown increased risk for both burnout and STS. For example, in their study of 57 residential childcare workers, Eastwood and Ecklund (2008) found that 45.6% and 42.1% of residential workers were at medium and high risk for secondary traumatic stress respectively. This

indicates that the risk of prolonged and direct work with traumatised children places caregivers at high risk for developing trauma symptoms themselves. Results further showed that 36.8% were at medium risk for burnout, while 14% were at high risk for burnout, suggesting that residential childcare workers are at risk for both burnout and STS in their caregiving role with children in care.

These findings of high levels of STS and burnout in residential childcare workers has been substantiated by more recent research, with Zerach (2013) finding 31% of residential childcare workers reported experiencing high levels of STS (above the 75th percentile), while 25.2% reported experiencing high levels of burnout. However, Zerach (2013) also employed a comparison group of boarding school workers and found that residential childcare workers reported levels of STS and burnout did not significantly differ from those reported by boarding school workers. However, it would be unfair to conclude that caring for traumatised children does not place caregivers at increased risk for STS and burnout based on Zerach's (2013) findings. The study was conducted in Israel and did not examine trauma histories of the children in either residential care or boarding school. Given the location of the study and the high occurrence of adverse events and war threats in the country (Ronen & Seeman, 2007), it is possible that the children in the boarding schools had also experienced trauma, and therefore both groups were caring for traumatised children. Nonetheless, regardless of whether residential childcare workers risk of STS or burnout is higher than or equal to that of other formal caregivers, the research clearly shows that working with children in care presents risks for caregivers.

2.6 Compassion satisfaction: The positive impact of caring

In parallel to the increased focus on the negative 'cost of caring', there has been increased interest in the positive impact of caring on professional caregivers. The term compassion satisfaction (CS) has been proposed to describe the positive effects of helping suffering individuals and has been defined as "*the sense of fulfilment or pleasure that therapists derive from doing their work well*" (Larsen & Stamm, 2008, p. 282). It is the positive benefit that one receives from helping a traumatised or suffering other (Stamm, 2002). CS is theorised to consist of three components: (1) the level of satisfaction that a person derives from their work; (2) a person's appraisal of how well they do their job, related to their perceived competency to deal with the traumatic material they are exposed to; and (3) the degree of positive organisational support that a person has (Stamm, 2002). Research has demonstrated that higher levels of compassion satisfaction are associated with reduced risk of STS and burnout (Conrad & Kellar-Guenther, 2006; Van Hook & Rothenberg, 2009), demonstrating the protective function for carers of achieving satisfaction from their work. Compassion satisfaction is further linked with caregivers' health, provision of care, and continuation in their job, suggesting that the experience of CS has impacts beyond the caregiver themselves and, in the case of foster carers, can equate to longer-term provision of placements for children and more empathic and compassionate care.

2.6.1 Compassion satisfaction in foster carers

Research examining the positive impact of caring of foster carers has also been limited. While some unpublished PhD theses have highlighted high levels of CS in foster carers in both quantitative (McLain, 2008) and qualitative studies (Redfern,

2013), the conclusions that can be drawn from these studies are restricted by the limitations of the studies and the lack of additional confirmatory research. Some research has highlighted more general positive outcomes for foster carers. For example, in a qualitative analysis Metcalfe and Sanders (2012) found that foster carers felt that they were contributing to the younger generation through fostering, which gave them a positive view of themselves, while in a quantitative study Whenan, Oxlad and Lushington, (2009) found that foster carers scored high on the Satisfaction with Foster Parenting Inventory (SFPI; Stockdale, Crase, Leksies, Yates, & Gillis-Arnold, 1997). While these studies suggest that foster carers are impacted positively in their caregiving role, the available research examining CS specifically is insufficient.

2.6.2 Compassion satisfaction in other professional caregivers of children in care

Research with other professional caregivers of children in care can provide an insight into the potential for CS in foster carers, given the identical care recipient population. In their study examining 363 child protection workers, Conrad and Kellar-Guenther (2006) found that potential for CS was high, with 50.7%, 22.6%, and 1.7% being at good, high and extremely high potential for CS respectively. Similarly, Eastwood and Ecklund (2008) found that 45.6% and 42.1% of their 57 residential childcare workers were at medium and high potential for CS. Finally, Zerach (2013) found that residential childcare workers were at significantly higher potential for developing CS than boarding school workers, further highlighting the potential for positive outcomes of working with traumatised children.

2.7 The influence of demographics and work-related factors

Because not everyone who cares for traumatised children are impacted identically by their work, research has looked to personal and role characteristics, in an attempt to find potential protective and ameliorating factors for the development of burnout, STS and CS. Because no peer-reviewed research examining potential correlates of burnout, STS or CS in foster carers could be found, research examining possible associated variables with other professional caregivers need to be considered instead. These may provide an insight into potential protective and risk factors in foster carers.

Research on protective and risk factors in the development of burnout, STS and CS has highlighted considerable overlap in influential factors between the three variables. Unfortunately, findings between studies have been somewhat inconsistent, making it difficult to draw clear conclusions on what factors do in fact contribute to or protect against burnout, STS and CS. For example, demographics have received considerable research attention, particularly age and gender. Some studies have found young age to be a risk factor for developing burnout and STS (Sprang, Craig & Clark, 2011; Nelson-Gardell & Harris, 2003), while others have found no significant association between age and burnout or STS (Von Rueden et al., 2010). Similarly, some researchers have demonstrated female gender as a risk factor for developing burnout and STS (Meyers & Cornille, 2002; Sprang, Clark & Whitt-Woosley, 2007), while others have shown males to be more likely to develop burnout and STS (Sprang, Craig & Clark, 2011; Zerach, 2013), and yet more have found gender to have no effect (Robins, Meltzer & Zelikovsky, 2009). Research examining factors associated with compassion satisfaction have been more limited,

however, some studies have found no association between gender and compassion satisfaction (e.g. Zerach, 2013).

With regard to work-related variables, research suggests that more experience is significantly associated with reduced levels of STS (Cunningham, 2003; Pearlman & Maclan, 1995), but higher levels of burnout (Kelly, Runge & Spencer, 2015), particularly increased emotional exhaustion (Baird & Kracen, 2006), and CS (Craig & Sprang, 2010), suggesting that some factors may be preventative against one negative outcome, but simultaneously contribute to another.

Another commonly explored factor is trauma exposure. A number of studies have shown that long working hours and a caseload with more traumatised clients, is associated with increased risk for STS (Devilly, Wright & Varker, 2009; Nelson-Gardell & Harris, 2003), suggesting that exposure to a greater number of trauma stories, and reduced time to process the trauma, leads to higher levels of STS. Moreover, the large number of inconsistencies between studies on the relative association between personal and role-related factors and burnout, STS and CS suggests that there may be other more influential factors involved in the development of burnout, STS and CS, such as characteristics of the care recipient (e.g. challenging behaviour or prosocial behaviour), social support, and self-care strategies.

2.8 Challenging behaviour

Challenging behaviour can encompass a range of behaviours that present management difficulties for carers, including; emotional symptoms, conduct problems, hyperactivity and inattention, and peer relationship problems, among

others. Challenging behaviour has the potential to cause considerable distress for caregivers, with numerous studies highlighting the relationship between challenging behaviour and caregiver stress (e.g. Duchovic, Gerkenmeyer & Wu, 2009; Gallagher & Hannigan, 2014). For example, Spratt, Saylor and Macias (2007) found that in parents of children with medical and behavioural problems including developmental delay, cognitive impairment, conduct disorders, and learning and attention difficulties, child behaviour difficulties were the strongest predictor of parenting stress. This relationship between child challenging behaviour and caregiver distress has also been demonstrated in studies with professional caregivers, including nurses and support workers (e.g. Hastings, 2002), highlighting the impact that a child's behaviour can have on their caregiver's wellbeing. The negative impact of challenging behaviour on caregiver wellbeing has also been explored in foster carers, though studies have been limited. Both Whenan et al. (2009) and Morgan and Baron (2011) found that foster carers' levels of parenting stress, anxiety and depression increased with increased levels of child challenging behaviour.

With regards to the constructs under investigation in the present study, some research attention has been given to the impact of challenging behaviour on burnout in professional caregivers, with findings typically showing a direct relationship between caregiver burnout and the recipients' levels of challenging behaviour (e.g. Freeman, 1994). Chung and Harding (2009) found higher levels of challenging behaviour to be positively associated with burnout, with caregivers' feelings of emotional exhaustion increasing and feelings of personal accomplishment decreasing in response to increased challenging behaviour. Other

studies have linked specific challenging behaviours with caregivers' experiences of burnout, for example Mills and Rose (2011) highlighted a link between aggressive behaviour and burnout, while Huang et al. (2014) found conduct problems to be significantly associated with caregiver distress, perhaps due to the potential management and safety risks posed by aggressive behaviour and conduct problems.

In a search of the literature, research examining the influence of challenging behaviour on the experience of STS and CS could not be found for any professional caregiver group. However, in considering Figley's (2002) model of STS, the potential influence of challenging behaviour is clear. Figley's (2002) model emphasises how 'degree of life disruptions' is an important contributing factor in the development of STS. According to Figley (2013), life disruptions can include changes in life style, marital status, social status, or professional or personal responsibilities. Challenging behaviour can be understood as an enormous stressor that amounts to huge personal and professional responsibilities for foster carers, in ensuring the safety and protection of the child displaying the challenging behaviour, themselves, their own family, and the general public. Additionally, challenging behaviour may function to eliminate feelings of success or achievement in their role as foster carers, thereby reducing the opportunities for feeling CS in the role. Furthermore, according to Figley's (2002) model, reduced CS in the caregiving role is another contributing factor for the development of STS. This inverse relationship between CS and STS has been substantiated by numerous empirical studies (e.g. Simon, Pryce, Roff & Klemmack, 2006), further supporting the notion that challenging behaviour may lead to reduced CS for foster carers as

well as increased STS. Therefore, the present study hypothesises that foster carers who report more child behaviour difficulties will experience higher levels of secondary traumatic stress, higher levels of burnout, and lower levels of compassion satisfaction.

2.9 Prosocial behaviour

Children can also display prosocial behaviour such as sharing their belongings, being kind and considerate of others, and volunteering to help others, including their caregiver (Renzaho, Mellor, McCabe & Powell, 2013). Research examining the impact of prosocial behaviour on caregiver stress and wellbeing has been more limited. However, available studies have demonstrated that prosocial behaviour can have a positive impact on caregivers' wellbeing. For example, Beck, Hastings, Daley and Stevenson (2004) examined parental stress in 74 mothers of children with disabilities and found that mothers who reported more child prosocial behaviour experienced significantly lower levels of stress, demonstrating the impact of positive child behaviour on caregiver stress and wellbeing.

As with challenging behaviour, explorations of prosocial behaviour in relation to burnout, STS and CS have been scarce across formal caregiving groups. However, it is anticipated that child prosocial behaviour would have the opposite effect to challenging behaviour on caregivers. In relation to burnout, a potential role for prosocial behaviour in the prevention of burnout can be easily seen. According to Maslach and Jackson's (1981) theory of burnout (described above) one component of burnout is emotional exhaustion. If a child is engaging in prosocial behaviour, it is likely that this will place less demands on foster carers emotional resources,

thereby reducing their chances for burnout. Furthermore, another key factor in the development of burnout is reduced personal accomplishment. Reduced personal accomplishment essentially means a diminished sense of achievement and accomplishment in an individual's role. If a child is displaying prosocial behaviour, it is likely that foster carers will interpret these positive behaviours as evidence of their success as foster carers, thereby increasing their sense of personal accomplishment, rather than reducing it, as is necessary for the development of burnout.

In a similar way, prosocial behaviour may contribute to the development of CS. If a child is engaging in prosocial behaviour, foster carers may again see this as proof of their success as foster carers. This success may then in turn function to authenticate their role as a foster carer and allow them to derive meaning and purpose through seeing the changes that they can bring about through their work.

The role of prosocial behaviour in the amelioration of STS can be predicted in relation to Figley's (2002) model. Firstly, prosocial behaviour may indirectly impact the development of STS through increasing CS, and thereby decreasing the risk of STS. Prosocial behaviour may further decrease the 'degree of life disruptions' by potentially reducing the physical and emotional demands placed on foster carers. For example, if the foster child is considerate of the foster carer's wellbeing and volunteers their help (e.g. by assisting with basic household chores) this may somewhat reduce the role demands of the foster carer. Thus, the present study hypothesises that foster carers who report more child prosocial behaviour

will experience lower levels of secondary traumatic stress, lower levels of burnout, and higher levels of compassion satisfaction.

2.10 Support

Another potential factor in the development of burnout, STS and CS is the availability of social support. Social support has been found to be protective for health and is associated with reduced mortality (see Lundstad, Smith & Layton, 2010 for review). For example, social relationships have been linked to improved outcomes for people with cancer (Kroenke et al., 2012; Waxler-Morrison, Hislop, Mears & Kan, 1991), cardiovascular disease (Knox et al., 2000; Kop et al., 2005), and HIV (Lauby et al., 2012). In a large meta-analytic study, Lundstad and colleagues (2010) found social relationships to have a significant impact on mortality, with those with stronger social relationships being shown to have a 50% increased likelihood of survival compared to those with weaker social relationships. Moreover, research has demonstrated associations between social support and reduced depression (Teo, Choi & Valenstein, 2013) and suicidal ideation (Cruwys et al., 2013; Vanderhorst & McLaren, 2005), further highlighting the significance of social support on health and wellbeing.

One of the pathways through which support impacts health and wellbeing is the 'buffering hypothesis' (Cohen, Gottlieb & Underwood, 2000; Cohen & Willis, 1985). This mechanism purports that social support moderates the effect of stressful life events by providing resources (including informational, emotional and practical resources) that promote adaptive responses to stressful events (Lunstad et al., 2010). An abundance of research supports this buffering effect of social support on

both physical health and mental health in stressful situations (e.g. Cohen, 2004; Cohen & Wills, 1985; Lundstad et al., 2010). In the context of caring, social support was found to buffer against stress in parents caring for children with complex needs (Cantwell, Muldoon, & Gallagher, 2015), implying that for carers support is a key resource when dealing with stressful situations.

Primarily, support can be categorised into two types; practical support and emotional support. Practical support involves acts of a functional nature, such as running errands, housework, collecting children from school and babysitting, and essentially increases the recipients' time for event-focused coping strategies and for engaging in self-care activities, such as rest and leisure (Wills & Shinar, 2000). Emotional support is distinct from practical support and involves providing a space to discuss emotionally-distressing material. According to Shrout, Herman and Bolger (2006) emotional support can increase an individual's sense of social connection and self-worth, in addition to allowing the recipient to express their emotions while helping them to process and cognitively reframe the situation to make it less distressing. Emotionally supportive actions can also function to distract the recipient from their worries, and reinforce other coping strategies including self-care practices (Heller & Rook, 1997).

While the influence of social support on burnout, STS and CS is yet to be explored in foster carers, previous research has highlighted a relationship between unsupportive relationships with professionals in the fostering system and discontinuing fostering (Cavazzi, Guilfoyle & Sims, 2010; Maclay, Brouwer & Samuelson, 2006; Rodger, Cummings & Leschied, 2006). Furthermore, in a

qualitative study, foster carers reported that their emotional difficulties were alleviated by social support, particularly from friends and family (Farmer, Lipscombe & Moyers, 2005). This suggests that social support can impact foster carer wellbeing.

Research with other formal caregivers has highlighted associations between social support and the three constructs under investigation in the present study. For example, studies have found social support from family and friends to be significantly negatively related to both burnout and STS, such that as social support increases, levels of burnout and STS decrease (Ariapooran, 2014; Galek, Flannelly, Greene & Kudler, 2011; Janssen, De Jonge & Bakker, 1999; Kassam-Adams, 1995; Ortlepp & Friedman, 2002). Greater availability of social support has also been shown to be significantly associated with increased CS (e.g. Killian, 2008; Murray et al., 2009), demonstrating that social support has a significant role in preventing burnout and STS and promoting CS. Given these strong associations, the present study hypothesises that foster carers who report greater availability of social support will experience lower levels of secondary traumatic stress, lower levels of burnout, and higher levels of compassion satisfaction.

2.11 Self-care

Another theorised way to reduce the risk of burnout and STS, and increase CS is through engaging in self-care. The term self-care encompasses a wide range of activities that an individual can engage in with the purpose of managing their physical and emotional health (Lee & Miller, 2013). Self-care is essentially a behavioural means of coping with stress. However, the behaviours employed to

manage stress can be either healthy (e.g. exercise, socialisation) or unhealthy (e.g. smoking, alcohol consumption). Numerous research studies provide examples of how health behaviours relate to stress. For example, studies show increased snacking and consumption of unhealthy foods (O'Connor, Jones, Conner, Mcillan & Ferguson, 2008) and lower consumption of fruit and vegetables are related to increased stress levels (Mikolajczyk, ElAnsari, & Maxwell, 2009). Importantly, health behaviours are not always motivated by a desire to reduce stress, but stress reduction may be a secondary outcome. For example, people may engage in exercise with the goal of improving fitness or attractiveness, socialising or having fun, with stress reduction being an ancillary outcome (Park & Iacocca, 2014).

The preventative roles of health behaviours and self-care practices have been demonstrated by empirical research, with different self-care behaviours being found to be associated with different psychological outcomes. In their study with residential childcare workers, Eastwood and Ecklund (2008) found reading for pleasure to reduce risk for STS, while socialising with family was found to significantly reduce burnout. Eastwood and Ecklund (2008) further found a healthy nutritional diet to be significantly positively related to CS. Zerach (2013) found spirituality to predict burnout and CS, but not STS. Results showed that spirituality was negatively related to burnout, such that as spirituality increased burnout decreased, and positively related to CS, such that as spirituality increased so too did CS. These findings regarding the protective effects of engaging in spiritual practices on burnout and the contribution of spirituality to the development of CS are consistent with other studies (e.g. Zerach & Levin, 2015), substantiating the role of engagement in spiritual rituals in the prevention of

burnout and the occurrence of CS. In a study with hospice workers, Alkema, Linton and Davies (2009) found a number of self-care dimensions to be significantly related to burnout and STS, including psychological, emotional, spiritual, work environment and personal balance. However, physical exercise was found not to be associated with either burnout or STS. On the other hand, exercise has been found to be related to CS (Hinderer et al., 2014), highlighting that self-care strategies do not have equal effect on the prevention of burnout and STS and the development of CS.

Overall, the research with other professional carers points to a role for self-care in the prevention of burnout and STS and the development of CS. To date however, there are no studies examining self-care behaviours in foster carers. Therefore, it would be expected that in the present study, self-care would have a similar relationship to burnout, STS and CS for foster carers. It is hypothesised that foster carers who report more self-care behaviours will experience lower levels of secondary traumatic stress, lower levels of burnout, and higher levels of compassion satisfaction.

2.12 Gap in existing knowledge

Although some research has explored the impact of caring on foster carers, no published peer-reviewed research examining the experience of burnout, STS or CS in foster carers could be found. Further, the unpublished studies do not provide precise levels of burnout, STS or CS in foster carers, making it difficult to determine whether the phenomena are in fact relevant to a foster carer population. However, research with other formal caregivers, providing care to children in care, have

highlighted the risk of burnout and STS, in addition to the potential for compassion satisfaction in caregivers working with children in care. While these studies provide clues as to how the constructs might occur in foster carers, it would be inappropriate to assume that their experiences of the phenomena are synonymous with those of other professionals, given the uniqueness of the foster carer role. Moreover, formal caregivers typically work a limited number of specified hours per week in a workplace-specific environment, which is separate from their home environment. In contrast, foster carers typically provide care 24 hours a day, 7 days a week, in their own home, integrating foster children into their home and family life. This essentially means that while other caregiving professionals naturally receive time to process and recover from the difficult and traumatic experiences of their work, by returning home at the end of their shift, foster carers do not have such opportunities. Foster carers assume the role of primary caregiver, opening their homes and their lives to children in care, and therefore, essentially do not have any time in their day or week where they are 'off-duty'. Foster carers are at risk for being adversely affected by their role, through hearing about the children's traumatic stories and directly witnessing and helping children to work through their symptoms of trauma. Foster carers have more prolonged exposure with the children and their trauma material, and very limited time to process the trauma material due to the constant nature of their 'parental' role. This prolonged exposure and reduced recovery time places foster carers at significant risk for burnout and STS, as well as for CS.

2.13 Research aims

Due to the lack of research examining burnout, STS and CS, this study aims to use quantitative methods to determine prevalence rates of burnout, secondary traumatic stress and compassion satisfaction in foster carers. It further aims to determine which demographic and work-related variables are linked to the manifestation of the three constructs in foster carers. Because demographic and work factors are unlikely to adequately account for levels of burnout, STS and CS in foster carers, this study will also examine associations between child challenging behaviour, child prosocial behaviour, social support and self-care and the three constructs of interest. It aims to determine which factors predict burnout, secondary traumatic stress and compassion satisfaction in foster carers.

Given the extremely limited knowledge of burnout, STS and CS in foster carers, this study will also seek to qualitatively explore the phenomena in foster carers. It would be impossible to examine all potential contributory variables using quantitative methods. Therefore, it is hoped that qualitative techniques will give a voice to foster carers to increase our understanding of burnout, STS and CS in foster carers, and ascertain other influential factors in developing burnout, STS and CS. Two groups of foster carers will be included, a group experiencing high compassion fatigue (and low compassion satisfaction) and a group experiencing high compassion satisfaction (and low compassion fatigue) to illuminate between-group differences and thus, potential influential factors in the development of compassion fatigue (burnout and secondary traumatic stress) and compassion satisfaction. Mixed method designs are gaining increased popularity because they

allow for compensation of uni-paradigmatic limitations, and allow for examination of research questions with both depth and breath (Lonner, 2009; Ponterotto, Mathew, & Raughley, 2013).

CHAPTER 3: METHODOLOGY

3.1 Chapter overview

This chapter provides a description of the methodology. It begins by providing a rationale for the use of a mixed methods approach and considering the ethical issues. Then, the methodology for the quantitative study is detailed, including the design, the participants and the procedures, the measures used and data analytic procedures employed. Finally, the methodology for the qualitative study is described, including the pilot phase, the participants and procedure, how the data was managed and the use of thematic analysis, according to the Braun and Clarke (2006) framework, for data analysis.

3.2 Rationale for mixed methods

Qualitative and quantitative research methods are underpinned by opposing paradigms, namely the constructivist approach and the post-positivist approach respectively. The literature demonstrates a longstanding paradigm debate among researchers who identify as adopting and appreciating a single approach only (either qualitative or quantitative) due to their differing philosophical beliefs. However, other researchers have suggested that the two approaches are in fact complementary and can be combined effectively to provide a more thorough account of a phenomenon than one approach could provide independently (Tashakkori & Creswell, 2007). This approach of combining both quantitative and qualitative methods has become known as mixed methods research, with some authors claiming mixed methods research as an emerging third methodological tradition (the other two traditions being qualitative and quantitative, Johnson,

Onwuegbuzie & Turner, 2007). Essentially mixed methods research involves the use of both qualitative and quantitative methods in a single study or in a series of linked studies. A number of benefits for using mixed methods have been suggested in the literature. Using a mixed methods approach is thought to offset the weaknesses that quantitative and qualitative methods present when used independently (Guevel, Pommier & Jourdan, 2015), to provide a more complete picture of the phenomena under investigation (Morse, 2003), and it may help to answer questions that cannot be answered by one approach alone (Creswell & Plano Clark, 2007). Quantitative research allows for the identification of variables and the assessment of relationships between variables (Creswell, Plano Clark, Gutmann & Hanson, 2003). It is deductive in nature and generates hard data, for example counts, ratings, and classifications (Wilson, Williams, & Hancock, 2000). Qualitative research is useful for exploring the nature of unknown phenomenon (Polit & Hungler, 1995). It allows researchers to gain insight and to explore peoples' individual experiences (Denzin & Lincoln, 2005).

In the present study quantitative methods were employed to; determine prevalence of secondary traumatic stress (STS), burnout and compassion satisfaction (CS) in foster carers; to assess for differences in levels of STS, burnout and CS across demographic and work-related variables; to examine relationships between demographic and work-related variables, child characteristics and the main independent variables (child behaviour, support and self-care) and STS, burnout and CS; and to determine predictors of STS, burnout and CS.

Qualitative methods were also utilised in the present study to expand on the quantitative data by providing an insight into foster carers experiences of STS,

burnout, and CS, in addition to allowing for the exploration of other variables that can act as protective or contributing factors to the experience of STS, burnout, and CS, beyond those examined in the quantitative phase.

3.3 Ethical issues

The University of Limerick ethics committee granted approval for this project. A number of potential ethical issues were considered, including issues of consent and confidentiality, which were dealt with according to guidelines set out by the University in both studies, as detailed below. An additional issue that warranted consideration in the qualitative study was the potential for foster carers to become distressed when discussing their experiences. This risk was minimised by the author being a 3rd year Psychologist in Clinical Training and remaining conscious of the risk whilst conducting the interviews. The author was prepared to halt interviews if participants became distressed. One foster carer became audibly upset during and was offered to halt the interview, which they declined. Time was given following this and all interviews to debrief participants and to thank them for their participation.

3.4 Quantitative Methods

3.4.1 Design, participants and procedure

The quantitative phase of the research utilised a cross-sectional design. Participants were foster carers recruited through the Irish Foster Care Association (IFCA). Permission for recruitment via the IFCA was granted from the CEO of the IFCA. An invitation email was distributed to all foster carers who had provided an email address to the IFCA and had agreed to receive electronic communication from the organisation. For data protection reasons the researcher did not have access to the email addresses of potential participants. Therefore, the invitation email (Appendix A) was drafted by the researcher and sent to potential participants via the IFCA. The email included a participant information sheet detailing the research in addition to a link to the online questionnaire (Appendix B), hosted by Unipark. Following completion of the measures, participants were given the option to express their interest in participating in the qualitative phase of the study by providing their telephone number. Participants were also given the option to enter a prize draw for an electronic tablet device on completion of the survey. The mean completion time for the questionnaire was 27 minutes and 26 seconds. The questionnaire was available for completion between 22/06/2015 and 31/08/2015. Inclusion criteria were being an approved foster carer and providing foster care to at least one child under the care of the state at the time of survey completion. In total, 99 foster carers completed the questionnaire (see results section for more carer details).

3.4.2 Measures

3.4.2.1 Demographic and work-related information and foster child characteristics

Respondents provided information on their age, gender, the type of care they provide (i.e. relative or general foster care), length of time as a foster carer, number of children currently fostered, number of children fostered in total, traumatic experiences faced by the children in their care prior to placement with them (i.e. experiences sexual abuse, physical abuse, emotional abuse/ neglect, or other traumatic events), hours of respite received and foster carer training attended.

3.4.2.2 Secondary traumatic stress, burnout and compassion satisfaction

The Professional Quality of Life Scale, version 5 (ProQOL-5, Stamm, 2009) was used to assess STS, burnout and CS. The 30-item measure yields scores on three subscales; secondary traumatic stress (e.g. *“As a result of my fostering I have intrusive, frightening thoughts”*), burnout (e.g. *“I feel bogged down by the system”*), and compassion satisfaction (e.g. *“I am happy that I chose to do this work”*). Each subscale includes 10 items. The measure allows for a limited number of specified words to be substituted in the questionnaire to make questions more relevant to the population under investigation, for example the word *“helper”* in the item *“I have thoughts that I am a ‘success’ as a [helper]”* was altered to *“foster carer”* to make the item more applicable to the participant group. Items are rated on a 5-point likert scale (which includes 1=*Never*, 2=*Rarely* 3= *Sometimes*, 4= *Often* and 5=*Very Often*). Scores on each subscale can range from 0 to 50, with higher scores indicating greater levels of STS, burnout and CS. Cut-off scores are provided for

categorisation of those at low (< 22), average (23-41) and high (≥ 42) risk for STS, burnout and CS. A total score is not derived from the measure. The ProQOL-5 has been used in similar research with formal caregivers and has been shown to be reliable with a high Cronbach alpha of .81 (e.g. Khan, Khan & Malik, 2015). Reliability for the subscales has also been shown to be high; compassion satisfaction $\alpha=0.88$; burnout $\alpha=0.75$; and secondary traumatic stress $\alpha=0.81$ (Stamm, 2010). In the present study a medium level of reliability was observed for the total scale ($\alpha = .59$) while a high level of reliability was seen for each of the three subscales (compassion satisfaction $\alpha = .87$; burnout $\alpha = .80$; secondary traumatic stress $\alpha = .70$); the subscales served as the main outcomes of the present study.

3.4.2.3 Foster child challenging and prosocial behaviours

The Strengths and Difficulties Questionnaire (SDQ, Goodman, 1997) was used to measure child challenging and prosocial behaviour. The SDQ consists of 25- items divided equally across 5 scales; emotional symptoms; conduct problems; hyperactivity/inattention; peer relationship problems; and prosocial behaviour. A total challenging behaviours score is derived from the addition of the 20-items pertaining to challenging behaviour. Participants are asked to rate the foster child's behaviour over the previous 6 months, on a 3-point likert scale, ranging from 0= *not true*, 1= *somewhat true*, and 2= *certainly true*. Some items are reverse scored (e.g. generally obedient - usually does what adults request). Challenging behaviour scores can range from 0 to 30, and prosocial behaviour scores can range from 0 to 10, with higher scores indicating more challenging behaviour and more prosocial behaviour respectively. The SDQ has good concurrent validity with

scores derived from the SDQ being highly correlated with scores on the Child Behaviour Checklist (CBCL, Achenbach, 1991) questionnaires (Goodman and Scott, 1999). The SDQ has also been shown to be reliable with a high Cronbach alpha of .76 (Goodman & Scott, 1999) and in the present study a medium level of reliability was observed for the total scale ($\alpha = .64$) and high levels of internal consistency were observed for the 6 subscales; prosocial behaviour $\alpha = .76$; hyperactivity $\alpha = .74$; emotional symptoms $\alpha = .77$; conduct problems $\alpha = .69$; and peer relationship problems $\alpha = .74$.

3.4.2.4 Social support

Social support was assessed using the 12-item Support Functions Scale (SFS, Dunst, Jenkins & Trivette, 1984). Foster carers were asked to rate the availability of support on a 5-point likert scale ranging from 1 (*“never”*) to 5 (*“quite often”*). The scale yields scores on availability of both practical support (e.g. *“someone to help take care of your child”*) and emotional support (e.g. *“someone to talk to about things that worry you”*), with a total support score derived from the summation of the practical and emotional support scores. Total support scores can range from 12 to 60, with higher scores indicating greater perceived availability of support. Scores from both subscales as well as total scores were used for analysis. The SFS has been used in previous research with caregivers, with high reliability reported (e.g. Gallagher & Whiteley, 2012). In the present study excellent internal consistency was found for the total scale ($\alpha = .89$), the emotional support scale ($\alpha = .83$) and the functional support scale ($\alpha = .84$).

3.4.2.5 Self-care

Self-care behaviour was assessed using the Health-Promoting Lifestyle Profile II (HPLP-II, Walker, Sechrist & Pender, 1995). The HPLP-II consists of 52-items, which asks participants to indicate how often they adopt particular health-promoting behaviour on a 4-point likert scale, ranging from 1=*never*, 2= *sometimes*, 3= *often*, 4= *routinely*. The scale comprises 6 subscales, including health responsibility; physical activity; nutrition; spiritual growth; interpersonal relations; and stress management. The mean of the 52 items can be calculated to yield a total self-care score, which can range from 1 to 4. Higher scores on the HPLP-II are indicative of greater engagement in self-care behaviours. The scale has previously been shown to have a highly reliability, with a Cronbach alpha of .93 (Sousa, Gaspar, Vaz, Gonzaga, & Dixe, 2015). In the present study a high level of reliability was observed for the total scale ($\alpha = .94$), health responsibility ($\alpha = .80$), physical activity ($\alpha = .87$), nutrition ($\alpha = .67$), spiritual growth ($\alpha = .87$), interpersonal relations ($\alpha = .79$), and stress management ($\alpha = .84$) scales.

3.4.3 Data analysis

Data were extracted to IBM SPSS Statistical Package version 22 and scored according to questionnaire guidelines using SPSS syntax. Missing data from the ProQOL-5, SDQ, SFS and HPLP-II were handled by calculating the mean of the remaining items and substituting that number for the missing item values.

3.4.4 Statistical analyses

Descriptive statistics were used to establish that data met assumptions for the use of parametric tests. Cut-off scores for the ProQOL-5 were used to determine

prevalence of STS, burnout and CS in the sample. Continuous scores of the ProQOL-5 were used for all other statistical analyses related to the outcome variables, as recommended in the ProQOL-5 manual (Stamm, 2010). Independent subjects t-tests and one-way analysis of variance (ANOVA) were used to examine differences between group means across demographic and work-related variables (gender, abuse, and relative versus non-relative relationship) for burnout, STS and CS. Pearson's product moment correlation coefficients were used to investigate the strength and direction of relationships between continuous independent variables (age, length of service, respite received, training attended, number of children fostered, and each dependent variable (burnout, STS, and CS). To test whether social support and self-care behaviours were predictive of the outcome variable independent of child behaviours a series of hierarchical linear regressions were performed. Here, in step 1, potential confounds were added, in step 2, child behaviours were added and in step 3, social support and self-care were added separately. This was followed by step 4, whereby both of these were added simultaneously to determine which was the strongest predictor of the outcome of interest. Occasional differences in degrees of freedom reflect incomplete questionnaires.

3.5 Qualitative Methods

3.5.1 Pilot

One participant was randomly selected for a pilot interview to check whether the interview schedule yielded the appropriate information. Following the pilot interview minor adjustments were made to the phrasing of some questions to

increase the clarity of the questions. For example, “How has fostering affected you as a foster carer?” was revised to “How have you been affected by your work as a foster carer?” to capture data pertaining to how fostering affected participants as people, rather than how fostering impacted them solely in their role as foster carers. An additional question probing the children’s past experiences to gain information about trauma exposure was also added following the pilot interview.

3.5.2 Participants and procedure

When completing the online survey in the quantitative phase of the research, participants were asked to indicate whether they would be willing to participate in an interview. Forty-three participants (43%) expressed a willingness to take part in the qualitative study. The 43 potential participants were categorised according to high, average, and low levels of STS, burnout and CS. Five participants were randomly selected from the high levels of STS and burnout group and five participants were randomly selected from the high levels of CS group as a means to explore foster carers experiences of both compassion fatigue (CF) and compassion satisfaction (CS), and any contributory or ameliorating factors related to their experiences of CF and CS. Purposive sampling has been used successfully in similar research previously (e.g. Lawrence et al., 2006). Descriptive information pertaining to participants can be seen in Figure 3 below. Foster carers were contacted by telephone to explain the nature of the interview and to enquire whether they remained interested in participating. A convenient time for the interview was arranged during the initial

telephone call. A participant information sheet (Appendix C) was emailed to all participants following the initial phone call and prior to their scheduled interview. Participants were not informed of their scores on the ProQOL-5.

Interviews were semi-structured in nature, broadly lead by an interview schedule (Appendix D) and were conducted telephonically. Telephonic interviews were deemed to be the most time-efficient method of data collection, and have been used successfully in previous studies (e.g. Mitchell & Chaboyer, 2010). Verbal consent, informing participants of their right to withdraw from the study at any time, that the interview would be audio-recorded, and that any information they provided would be kept strictly confidential, was obtained from participants and recorded using a verbal consent transcript (Appendix E). Interviews were audio recorded using a Dictaphone and were subsequently transcribed verbatim. Interviews ranged in length from 27 minutes and 3 seconds to 55minutes and 24 seconds (mean= 41 minutes and 8 seconds, standard deviation = 10 minutes and 31 seconds).

Figure 3. Descriptive information pertaining to participants of qualitative study

**Missing data*

Participant number	Participant pseudonym	Age	Gender	Length of service as a foster carer	Total number of children fostered
Compassion fatigue					
1.	Mary	50	Female	3 years 11 months	5
2.	Jack	61	Male	23 years	22
3.	Susan	55	Female	13 years	24
4.	Eric	*	Male	4 years 10 months	10
5.	Sarah	41	Female	12 years 2 months	26
Compassion satisfaction					
6.	Mark	53	Male	1 year 1 month	1
7.	Lucy	42	Female	1 year	3
8.	Jessica	50	Female	4 years 7 months	6
9.	Nicola	54	Female	4 years 3 months	17
10.	Sophie	55	Female	19 years 6 months	26

3.5.3 Data management

After transcription by the researcher, all potentially identifiable data were removed from the transcripts and audio files were destroyed. Following data analysis, transcripts were stored securely in the University of Limerick, in accordance with University ethics guidelines.

3.5.4 Data analysis

The analytic approach used was inductive thematic analysis, guided by the framework published by Braun and Clarke (2006). Interviews were transcribed verbatim and were read and reread to ensure familiarity with the content. Initial ideas about what was in the data were also noted to facilitate coding. Initial line by line coding was performed and cross-validated with the research supervisor, going back to the data again to ensure consistency before moving on to the next phase of

analysis. Equal attention was given to all data and Microsoft excel was used to record and collate codes (see Appendix F for example). The researcher examined the data for patterns, analysed and coded the data and sorted codes into potential subthemes and themes using hand-drawn brainstorming graphs (see Appendix G for example). This was an inductive process where codes and themes were predominantly data-driven (Maxwell, 2008). Coded data extracts, themes and subthemes were reviewed and discussed with the research supervisor to ensure that the data formed a coherent pattern and the validity of the themes in relation to the entire data set and to generate a thematic 'map' of the analysis (Braun & Clarke, 2006).

3.6 Positionality

In conducting research it is important for the researcher to be aware of their position in the research process. As someone without first-hand experience of fostering or parenting, I feel that I faced both challenges and opportunities as a result of my positionality in the current research. Not having experience of being a parent or a foster parent allowed me to take what participants said at face value, without making comparisons to, or judging participants against, personal experiences. This helped me to gain depth and breadth by allowing participants to detail their experiences, without having my own parenting or fostering experiences to influence the direction of questioning. Some researchers have suggested that being an 'outsider' in research (i.e. not being a member of the population under investigation) can create challenges for the researcher. Specifically, some authors have raised concerns that participants may not feel understood by researchers who have not experienced the phenomena under

investigation (e.g. Dwyer & Buckle, 2009). On reflection, I do not feel that me not having parenting or fostering experiences impeded the interviews in any way. All of the participants appeared to speak openly about their experiences, and none made reference to feelings that I may not understand their experiences. I think that this may, at least in part, be due to my professional role as a Psychologist in Clinical Training and my experience of working with children in care in a professional capacity in the past. Furthermore, a number of participants made reference to having had positive professional relationships with Psychologists in their role as foster carers, which likely influenced their perception of my ability to understand their experiences. Overall, I feel that if I had experience of being a parent or foster carer it is likely that there would have been some differences in the data collected, but I don't feel that this data would necessarily have been superior or inferior.

3.7 Feedback to participants

At the end of both the quantitative and qualitative phases, participants were asked whether they wanted to receive feedback on the overall results of the study. Following study completion, those who wanted to receive feedback were emailed a summary of the study findings.

CHAPTER 4: RESULTS

4.1 Chapter overview

This chapter presents the results of the quantitative and the qualitative studies sequentially, starting with the quantitative results. Descriptive data is presented first, followed by t-test and correlational results. Then, results of each hypothesis are presented, followed by results of regression analyses. Next, the findings of the qualitative study are presented. Six themes were identified, each consisting of a number of subthemes. Each theme is presented in turn, supported by a selection of relevant quotes from the interviews.

4.2 Quantitative Results

4.2.1 Prevalence of secondary traumatic stress, burnout and compassion satisfaction

Descriptive statistics for the ProQOL-5 scale, based on normative data and recommended cut-off scores can be seen in Figure 4. Relative to the normed ProQOL-5 scores, foster carers had a higher mean score on the secondary traumatic stress scale, $t(1284) = 17.01, p <.001$, a higher mean score on the burnout scale $t(1284) = 3.12, p <.05$, and a higher mean score on the compassion satisfaction scale $t(1284) = 5.87, p <.001$. The range of scores for STS, burnout, CS, challenging behaviour, prosocial behaviour, support and self-care can be seen in Figure 5. The means scores of the main independent and outcome variables can be seen in Figure 6.

Figure 4. ProQOL-5 results from the present sample (n=99) and comparison to the normed score

Scale	ProQOL-5 norm ^a M (SD)	Present sample M (SD)	t	Cohen's d	Participants at 'low' risk N (%)	Participants at 'moderate' risk N (%)	Participants at 'high' risk N (%)
Secondary Traumatic Stress	12.0 (6.5)	23.45 (5.57)	17.01**	1.78	20 (20%)	48 (49%)	31 (31%)
Burnout	20.0 (7.0)	22.27 (6.26)	3.12*	0.33	26 (26%)	45 (46%)	28 (28%)
Compassion Satisfaction	36.5 (7.5)	41.04 (5.57)	5.87**	0.61	24 (24%)	50 (51%)	25 (25%)

^a Stamm (2010) * significant at the p<.05 level ** significant at the p<.001 level

Figure 5. Range of scores for outcome and main independent variables.

	Range
Secondary traumatic stress	12-35
Burnout	10-39
Compassion satisfaction	25-50
Challenging behaviour	4-36
Prosocial behaviour	0-10
Support	12-60

Figure 6. Means and correlations between main independent variable and outcome variables

	Mean	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1. Secondary traumatic stress	23.45	-																		
2. Burnout	22.27	.648**	-																	
3. Compassion Satisfaction	41.04	-.460**	-.785**	-																
4. Emotional issues	5.04	.230*	.360**	-.206*	-															
5. SDQ Conduct subscale	4.95	.235*	.365**	-.235*	.476**	-														
6. Peer Problems	4.55	.182	.055	-.013	.293**	.018	-													
7. Prosocial behaviour	6.06	-.182	-.314**	.214*	-.280**	-.447**	-.161	-												
8. Hyperactive behaviour	6.35	.184	.279**	-.180	.447**	.514**	.157	-.442**	-											
9. Total challenging behaviour	20.97	.270**	.390**	-.246*	.812**	.767**	.378**	-.511**	.794**	-										
10. Total support	37.76	-.145	-.314**	.247*	-.143	-.158	-.033	.039	-.029	-.138	-									
11. Practical	22.74	-.111	-.306**	.238*	-.140	-.210*	-.029	.014	-.047	-.163	.971**	-								
12. Emotional Support	15.02	-.186	-.272**	.219*	-.122	-.022	-.037	.018	-.014	-.061	.875**	.733**	-							
13. Interpersonal relations	3.11	.277**	-.424**	.403**	-.161	-.045	-.033	.117	-.106	-.129	.549**	.472**	.604**	-						
14. stress management	2.51	-.347**	-.485**	.349**	-.283**	-.216*	-.115	.189	-.204*	-.291**	.380**	.354**	.361**	.578**	-					
15. Health responsibility	2.47	-.107	-.236*	.302**	.097	.112	.090	.006	.081	.131	.370**	.325**	.392**	.559**	.518**	-				
16. Physical activity	2.2	-.059	-.149	.093	.099	.042	.096	-.067	-.039	.063	.144	.141	.124	.379**	.552**	.478**	-			
17. Nutrition	2.82	-.234*	-.264**	.216*	.091	-.062	-.049	.124	-.163	-.064	.298**	.280**	.278**	.469**	.409**	.547**	.483**	-		
18. Spiritual growth	3.02	-.318**	-.570**	.552**	-.165	-.152	-.034	.167	-.111	-.176	.451**	.403**	.463**	.714**	.668**	.510**	.332**	.400**	-	
19. Total self-care	2.7	-.284**	-.454**	.409**	-.070	-.066	-.003	.111	-.114	-.094	.470**	.425**	.475**	.788**	.809**	.791**	.718**	.716**	.780**	-

4.2.2 Foster carer socio-demographic characteristics and secondary traumatic stress, burnout and compassion satisfaction

The response rate (i.e. the percentage of people who completed the survey out of all those who were invited to participate) was 26% and the completion rate (i.e. the percentage of people who completed the survey out of those who began filling out the survey) was 51%, of which 83% (n=82) were female and 17% (n=17) were male. Participants ranged in age from 34 years to 64 years, with a mean age of 50.5 years (SD = 7.14 years). Independent t-tests showed no significant gender differences for STS, burnout, or CS (all $p > .05$). Similarly, correlation analyses found no significant relationships between the age of foster carers and their levels of STS, burnout or CS (all $p > .05$). Therefore, neither gender nor age was controlled for in our main analyses.

4.2.3 Work-related variables and secondary traumatic stress, burnout and compassion satisfaction

Ninety-five participants (96%) were general foster carers, while 4 (4%) participants were relative foster carers. Reported length of service as a foster carer ranged from 1 to 384 months, with a mean of 126.2 months of service (SD= 93.23 months). Twenty-nine participants (29%) reported that they did not attend any foster carer training in the past 12 months, while 70% (n=70) reported that they attended some training in the past 12 months. The mean number of hours of foster carer training attended in the past 12 months was 10.3 hours (SD=12.56 hours). Eighty-seven participants (88%) reported that they did not receive any respite in the past month, while 12 (12%) participants reported that they received some

respite in the previous month. The reported number of hours respite received in the past month ranged from 0 to 168 hours, with a mean of 7.3 hours (SD=27.04 hours). Seventy-three participants (73%) reported receiving no respite in the past 12 months, while 26 participants (26%) reported receiving some days of respite in the previous 12 months. The number of days respite received in the previous 12 months ranged from 0 to 28 days, with a mean of 2.1 days (SD=4.90 days).

Independent t-tests showed no significant differences between relative and general foster carers for STS, burnout or CS (all $p > .05$). A significant positive relationship was found between the length of service as a foster carer and reported levels of STS. Participants who had longer service had higher levels of secondary traumatic stress on the ProQOL-5 ($r = .20$, $n = 99$, $p = .043$) than those who reported shorter durations as foster carers. No significant relationships were found between length of service as a foster carer and burnout or CS (all $p > .05$). Correlation analyses found no significant associations between respite received or training attended and STS, burnout or CS (all $p > .05$).

4.2.4 Child characteristics and secondary traumatic stress, burnout and compassion satisfaction

The number of children currently in the foster care of participants was reported to range from 1 to 4, with a mean of 1.7 children currently fostered (SD= .89 children). Participants reported that the total number of children that they had fostered since becoming a foster carer ranged from 1 to 50, with a mean of 10.6 children (SD=11.34 children). Thirty-nine participants (39.4%) reported that a child currently in their care experienced sexual abuse, 67 participants (68%)

reported that a child currently in their care previously experienced emotional abuse, 47 participants (48%) reported that a child currently in their care previously experienced physical abuse, 80 participants (81%) reported that a child currently in their care previously experienced neglect, and 16 participants (16%) reported that a child currently in their care previously experienced another form of abuse. Other forms of abuse reportedly previously experienced by children currently in the care of participants included; foetal alcohol abuse (n=6), being left unaccompanied (n=2), parental mental illness (n=1), and exposure to parental alcohol and drug abuse (n=2). Three participants (3%) reported that the children in their care did not experience any abuse prior to admission to care, while 73 participants (74%) reported that the children in their care experienced more than one type of abuse prior to entering the care system.

Significant relationships were found between the total number of children fostered and STS, burnout and CS. Participants who fostered more children had significantly higher levels of STS ($r = .310$, $n = 99$, $p = .001$), significantly higher levels of burnout ($r = .227$, $n = 99$, $p = .024$) and significantly lower levels of CS ($r = -.236$, $n = 99$, $p = .019$). This was included as a potential confound in regression analyses. No significant relationships were found for the number of children currently fostered and STS, burnout or CS (all $p > .05$).

Independent t-tests found no significant differences between foster carers caring for children who previously experienced physical abuse, sexual abuse, emotional abuse or neglect and foster carers caring for children who did not previously

experience physical abuse, sexual abuse, emotional abuse, or neglect on the STS, burnout or CS scales of the ProQOL-5 (all $p > .05$).

4.2.5 Hypothesis testing

4.2.5.1 Hypothesis 1) Foster carers who report more child behaviour difficulties will experience higher levels of secondary traumatic stress, higher levels of burnout, and lower levels of compassion satisfaction

As can be seen from Figure 6 above, child emotional issues, child conduct problems, and child total behaviour difficulties were all positively correlated with STS and burnout and negatively correlated with CS, such that, foster carers who reported the child/children in their care to have more emotional difficulties, more conduct problems and more total behaviour difficulties experienced significantly higher levels of STS, significantly higher levels of burnout and significantly lower levels of CS (all $p < .05$). Burnout was positively associated with child hyperactive behaviour, with foster carers who reported more child hyperactive behaviour experiencing significantly higher levels of burnout ($p < .001$). No significant associations were found between child hyperactive behaviour and STS or CS, or between child peer problems and foster carer's levels of STS, burnout or CS (all $p > .05$).

4.2.5.2 Hypothesis 2) Foster carers who report more child pro-social behaviour will experience lower levels of secondary traumatic stress, lower levels of burnout, and higher levels of compassion satisfaction

Child prosocial behaviour was significantly negatively correlated with burnout and significantly positively correlated with CS, such that foster carers who reported more child prosocial behaviour experienced significantly lower levels of burnout

($p < .001$) and significantly higher levels of CS ($p < .05$). No associations were found between child prosocial behaviour and STS ($p > .05$); see Figure 6.

4.2.5.3 Hypothesis 3) Foster carers who report greater availability of social support will experience lower levels of secondary traumatic stress, lower levels of burnout, and higher levels of compassion satisfaction

As predicted, for foster carers, perceived emotional support, perceived practical support and total social support was significantly negatively associated with burnout and significantly positively associated with CS, such that foster carers who reported more availability of emotional support, more availability of practical support and more total social support experienced significantly lower levels of burnout (all $p < .001$) and significantly higher levels of CS (all $p < .05$). However, as can be seen in Figure 6 there was no association between STS and emotional, practical or total social support (all $p > .05$).

4.2.5.4 Hypothesis 4) Foster carers who report more self-care behaviours will experience lower levels of secondary traumatic stress, lower levels of burnout, and higher levels of compassion satisfaction

Interpersonal relationships, stress management, nutrition, spiritual growth and total self-care behaviours were all negatively associated with STS and burnout and positively associated with CS; see Figure 6. Foster carers who scored higher on the interpersonal relationships, stress management, nutrition, spiritual growth and total self-care behaviours subscales experienced significantly lower levels of STS (all $p < .05$), significantly lower levels of burnout (all $p < .001$) and significantly higher levels of CS (all $p < .05$). Health responsibility was significantly correlated with burnout and CS, such that foster carers who scored higher on the health responsibility subscale reported significantly lower levels of burnout ($p < .05$) and

significantly higher levels of CS ($p < .001$). Health responsibility was not associated with STS ($p > .05$). Correlation analyses found that physical activity was not significantly associated with STS, burnout or CS (all $p > .05$).

4.2.6 Predictors of secondary traumatic stress, burnout and compassion satisfaction

A series of hierarchical linear multiple regression analyses, controlling for a number of confounds, were used to examine predictors of each of the outcome variables; burnout; STS; and CS in foster carers. During initial correlational analyses length of time as a foster carer was significantly associated with STS and total children fostered was significantly associated with STS, burnout and CS. Therefore, time as a foster carer and total children were entered in step 1 of the multiple regression equations, as appropriate. To identify how much of the variance in burnout, STS and CS was attributed to support and self-care, child challenging behaviour and child prosocial behaviour were controlled for by entering these variables at step 2, in separate regression analyses. Support and self-care were added independently at step 3 and together at step 4 when both were found to be significant. In the final step each self-care behaviour was entered to determine which self-care behaviour was the greatest predictor of burnout, STS and CS. Support was not examined as a potential predictor for STS because it was not found to be significantly associated with STS during initial correlational analyses. Similarly, when examining which self-care behaviour was the greatest predictor, health responsibility was not assessed for STS and physical activity was not examined for any of the three outcome variables. Results from the series of multiple regressions can be seen in Figure 7 through to Figure 11.

4.2.6.1 Predictors of secondary traumatic stress

Time as a foster carer and total children were shown to account for 10.4% of the variance in STS. However, time as a foster carer was found not to be a significant predictor of STS when entered simultaneously with total children (see Figure 7), and was therefore not included in subsequent steps. Total children remained a significant contributor throughout the equations. Challenging behaviour explained a further 7.5% and self-care accounted for an additional 7.5% of the variation in STS. When individual self-care behaviours were added to the regression model, stress management was shown to significantly negatively predict STS, such that those who scored higher on the stress management subscale reported significantly lower levels of STS.

4.2.6.2 Predictors of burnout

Total children accounted for 6.6% of the variation in burnout (Figure 8) and again remained significant at each step. At step 2, challenging behaviour explained an additional 15.7% of the variance. Support and self-care were entered separately into the regression model and were shown to account for 5.7% and 17.1% of the variation in burnout respectively. When both support and self-care were entered into the model simultaneously, support was found to no longer be a significant predictor of burnout ($p > .05$). When individual self-care behaviours were added to the regression model spiritual growth was found to be a significant predictor of burnout.

Child prosocial behaviour was controlled for in a separate multiple regression analysis by entering this variable at step 2 (see Figure 9). Prosocial behaviour accounted for an additional 10.1% of the variance, on top of total children. Support

explained an extra 7.6% and self-care explained an additional 17.4% of the variation in burnout when these variables were added separately. When support and self-care were added to the regression model simultaneously, support was shown not to be significant ($p > .05$). When the self-care behaviour subscales were added to the model, spiritual growth and stress management were found to be significant predictors of burnout, such that those who scored higher on the spiritual growth and stress management self-care subscales reported significantly lower levels of burnout. Total children and prosocial behaviour remained significant predictors of burnout at this step.

4.2.6.3 Predictors of compassion satisfaction

As found earlier, total children was shown to explain 7.4% of the variation in CS (Figure 10) and continued to explain compassion satisfaction in the regressions. Challenging behaviour explained an additional 6.3% of the variance. Support was added at step 3(a) and was found not to be a significant predictor of CS after controlling for total children and challenging behaviour. Self-care accounted for an additional 14.7% above that variance accounted for by total children and challenging behaviour. When the self-care behaviour subscales were added to the regression model, spiritual growth was found to be a significant predictor of CS, such that those who scored higher on spiritual growth, reported significantly higher levels of CS.

Child prosocial behaviour was controlled for in a separate multiple regression analysis (see Figure 11). Prosocial behaviour accounted for an additional 4.7% of the variance in CS, on top of the 7.4% explained by total children. Support and self-care were entered separately at step 3 and were shown to account for an

additional 4.4% and 14.6% of the variation in CS respectively. When support and self-care were added to the model simultaneously, support was found to no longer be a significant predictor of CS ($p > .05$). Self-care behaviour subscales were added at step 5, with spiritual growth being shown as a significant predictor of compassion satisfaction. Total children also remained a significant predictor at this step.

Figure 7. Secondary traumatic stress predicted by self-care, controlling for challenging behaviour

	β	t	β	t	β	t	β	t
<i>Step 1</i>								
Total children	.279	2.596*						
Time as a foster carer	.082	.764						
<i>Step 2</i>								
Total children			.318	3.372*				
Challenging behaviour			.274	2.905*				
<i>Step 3</i>								
Total children					.331	3.628**		
Challenging behaviour					.251	2.751*		
Self-care					-.240	-2.624*		
<i>Step 4</i>								
Total children							.356	3.888**
Challenging behaviour							.102	1.001
Nutrition							-.199	-1.765
Spiritual growth							-.037	-.256
Interpersonal relations							-.057	-.429
Stress management							-.384	-2.578*

*Significant at the $p < .05$ level **significant at the $p < .001$ level

Figure 8. Burnout predicted by support and self-care, controlling for challenging behaviour

	β	t	β	t	β	t	β	t	β	t	β	t
<i>Step 1</i>												
Total children	.256	2.567*										
<i>Step 2</i>												
Total children			.260	2.847*								
Challenging behaviour			.397	4.342**								
<i>Step 3 (a)</i>												
Total children					.244	2.755*						
Challenging behaviour					.363	4.068**						
Support					-.242	-2.702*						
<i>Step 3 (b)</i>												
Total children							.257	3.137*				
Challenging behaviour							.354	4.311**				
Self-care							-4.16	-5.059**				
<i>Step 4</i>												
Total children									.264	3.189*		
Challenging behaviour									.352	4.222**		
Support									-.077	-.824		
Self-care									-.357	-3.831**		
<i>Step 5</i>												
Total children											.228	2.831*
Challenging behaviour											.250	2.780*
Health responsibility											.045	.403
Nutrition											-.068	-.684
Spiritual growth											-.389	-4.035*
Interpersonal relations											-.010	-.088
Stress management											-.198	-1.515

*Significant at the p<.05 level **significant at the p<.001 level

Figure 9. Burnout predicted by support and self-care, controlling for prosocial behaviour

	β	t	β	t	β	t	β	t	β	t	β	t
<i>Step 1</i>												
Total children	.264	2.663*										
<i>Step 2</i>												
Total children			.257	2.737*								
Prosocial behaviour			-.318	-3.386*								
<i>Step 3 (a)</i>												
Total children					.241	2.661*						
Prosocial behaviour					-.308	-3.416*						
Support					-.276	-3.061*						
<i>Step 3 (b)</i>												
Total children							.253	2.975*				
Prosocial behaviour							-.260	-3.054*				
Self-care							-.421	-4.929**				
<i>Step 4</i>												
Total children									.258	3.025*		
Prosocial behaviour									-.272	-3.172*		
Support									-.121	-1.258		
Self-care									-.339	-3.508*		
<i>Step 4</i>												
Total children											.238	2.930*
Prosocial behaviour											-.171	-2.043*
Health responsibility											.123	1.160
Nutrition											-.087	-.877
Spiritual growth											-.362	-2.809*
Interpersonal relations											-.028	-.235
Stress management											-.297	-2.395*

*Significant at the $p < .05$ level **significant at the $p < .001$ level

Figure 10. Compassion satisfaction predicted by support and self-care, controlling for challenging behaviour

	β	t	β	t	β	t	β	t	β	t
<i>Step 1</i>										
Total children	-.273	-2.747*								
<i>Step 2</i>										
Total children			-.275	-2.858*						
Challenging behaviour			-.251	-2.608*						
<i>Step 3 (a)</i>										
Total children					-.263	-3.058*				
Challenging behaviour					-.225	-2.350*				
Support					.187	-1.950				
<i>Step 3 (b)</i>										
Total children							-.271	-3.058*		
Challenging behaviour							-.213	-2.392*		
Self-care							.386	4.331**		
<i>Step 4</i>										
Total children									-.209	-2.411*
Challenging behaviour									-.181	-1.872
Health responsibility									.126	1.057
Nutrition									.002	.020
Spiritual growth									.478	3.464*
Interpersonal relations									.002	.017
Stress management									-.024	-.168

*Significant at the $p < .05$ level **significant at the $p < .001$ level

Figure 11. Compassion satisfaction predicted by support and self-care, controlling for prosocial behaviour

	β	t	β	t	β	t	β	t	β	t	β	t
<i>Step 1</i>												
Total children	-.272	-2.750*										
<i>Step 2</i>												
Total children			-.267	-2.761*								
Prosocial behaviour			.217	2.239*								
<i>Step 3 (a)</i>												
Total children					-.254	-2.676*						
Prosocial behaviour					.209	2.200*						
Support					.211	2.223*						
<i>Step 3 (b)</i>												
Total children							-.262	-2.927*				
Prosocial behaviour							.164	1.827				
Self-care							.385	4.281**				
<i>Step 4</i>												
Total children									-.272	-3.000*		
Prosocial behaviour									.173	1.906		
Support									.059	.575		
Self-care									.332	3.242*		
<i>Step 5</i>												
Total children											-.209	-2.406*
Prosocial behaviour											.112	1.252
Health responsibility											.073	.641
Nutrition											.008	.073
Spiritual growth											.472	3.420*
Interpersonal relations											.013	.104
Stress management											.038	.287

*Significant at the $p < .05$ level **significant at the $p < .001$ level

4.3 Qualitative Results

4.3.1 The foster child

All foster carers discussed the foster child's past experiences, including various forms of abuse, such as "*domestic violence*", neglect, such as being "*deprived of food and attention*", perhaps as a way to confirm the need for these children to be in care, and thus legitimise their role as a foster carer. Further, they went on to describe how the children's past experiences shaped their current day-to-day social, emotional and behavioural functioning. Interestingly, some between group differences in child characteristics were reported, with foster carers caring for children with diagnosed medical or neurodevelopmental difficulties experiencing higher levels of compassion fatigue. Below, the subthemes 'past experiences' and 'presentation' are discussed in more detail.

4.3.1.1 Past experiences

There was a consensus between the two groups that foster children had been through extremely adverse and often traumatising experiences prior to entering the care system. Foster carers described foster children experiencing "*physical abuse*", "*sexual abuse*", "*neglect*" and other "*tragic*" circumstances. However, in addition to shaping the child's presentation, for foster carers, the exposure to children's shocking and "*heart-breaking*" stories of cruelty and trauma has a real potential to negatively impact the foster carers themselves through secondary traumatisation.

“There was a lot of sexual abuse, there was a lot of violence, there was a lot of everything, as far as I can see it was nearly a paedophile they were with.”

(Nicola)

“Their father was shot, was killed and their mother went off the rails completely and she became a heroin addict and a drug dealer.” (Sarah)

4.3.1.2 Presentation

All foster carers identified caring for children with *“learning difficulties”*, *“special needs”*, and *“speech delay”*. However, foster carers experiencing high levels of compassion fatigue (CF) were more likely to be caring for children with specific medical conditions or neurodevelopmental disorders, for example *“ADHD”*. While not all foster carers were caring for children with diagnosed medical or neurodevelopmental disorder foster carers from both groups described the foster children engaging in extremely *“challenging”* behaviour that was difficult to manage.

“They’re wired to the moon, they are absolutely wired to the degree where they climb on furniture.” (Lucy)

Challenging behaviour was often also *“destructive”*, with the children causing damage to the foster carer’s home and personal belongings. Nicola talked about how her foster child *“put a hole in the wall in his bedroom”*, while Mary’s *“laptop ended up on the floor”*. For foster carers, the need to constantly monitor and manage these challenging behaviours, due to the unpredictability and the

frequency of challenging behaviour, may be physically and emotionally draining. Furthermore, having their personal belongings damaged may also have both emotional and financial implications in terms of the distress of having their belongings destroyed, and the cost of repairing or replacing the broken objects.

4.3.2 Being a foster 'parent'

This had a number of subthemes and was generated as throughout the interviews foster carers described assuming a parenting role with the foster children. They identified bonding with the foster children, however some between group differences were evident in how this parent-child connection was validated and reciprocated by the children. Foster carers spoke about assuming parental duties with the children, and having ambitions for the children, as would be expected of parents. However, a number of factors that interfere with their role were also highlighted.

4.3.2.1 Parent-child connection

Foster carers from both groups felt a deep *"bond"* and *"attachment"* with the foster children, as would be anticipated in typical parent-child relationships. Further, they spoke about how they *"know them better than anyone"* and can sense when the children are having issues, perhaps as a means to prove the strength and legitimacy of their connection with the child:

"You probably know them better than anyone else at this point. You know when there is something bubbling you know, you get that feeling from them,

you get to really know them so well, better than they know themselves really.”

(Nicola)

There were some differences across groups in the apparent reciprocation of the parent-child connection. For foster carers experiencing high levels of compassion satisfaction (CS), the parent-child connection was clearly confirmed by the child calling them “*mammy*”:

“She has attached really well to me...she calls me mammy.” (Jessica)

In contrast, Foster carer’s experiencing high levels of compassion fatigue (CF) painted a contrasting picture. Foster carers in the CF group described receiving more transient displays of love from the child, compared to the “*endless love*” experienced by foster carers in the CS group, and the children used their first name when referencing them:

“You just are hanging on for these little moments of love if you like that you can get back from the children.” (Eric)

4.3.2.2 The parenting role

Foster carers have to be available “24/7” to respond to the child’s needs, at any time, even during the night, which can be extremely tiring for the foster carers:

“It’s hard work, it’s 24-7, it’s from the minute you wake until you go to sleep and even during the night if the kids wake and whatever or if they wet the bed and you have to get up and strip that and shower them, so it is 24/7.” (Lucy)

Aside from carrying out typical day-to-day parenting tasks such as “*putting them to bed*”, “*potty training*”, and “*cooking dinner*”, foster carers felt that an important aspect of their role was to facilitate emotional and cognitive development. They spoke about trying to “*help them deal with feelings*” and supporting the children’s learning by “*teaching*” and “*reading together*”.

Foster carers have goals and ambitions for the children, as any parent would, which indicates that their role fundamentally transcends beyond that of a ‘carer’ and into that of a ‘parent’. They described their ambitions for the children being the equivalent to those they would have for their own children:

“But the commitment is to treat these children as you would your own children and you want all the things that your own children have for the foster children as well.” (Eric)

Foster carers were also proud of the children’s success and achievements once they had grown up and left foster care. They spoke with pride about the children “*going to college*”, attaining a “*fantastic career*”, in addition to acquiring nice material belongings:

“I have had kids going off to university as well, gone off to live abroad and one of my very first foster daughters she has got two lovely children in town, a lovely partner, and a lovely life and a lovely home, a lovely car.” (Sarah)

4.3.2.3 Role interference

Foster carers identified a number of “*issues outside [their] control*” that interfere with their role as a foster ‘parent’, including interference from the child themselves, from birth parents and from the system. Foster carers identified that foster children don’t have confidence in the ability of adults to provide the necessary care, due to their previous experiences. Consequently, foster carers have to constantly prove their capabilities to the children, which adds an additional pressure for foster carers.

“They came without the assumption that adults know what they are doing, which I think it sounds very simple and yet it is enormous when they are constantly checking have you done this thing, have you remembered this thing, have you got this, do you know what you’re doing.” (Jessica)

“To be challenged about things constantly it’s almost hard to explain but you have to justify everything you are doing...prove you are capable, competent on top of the job of looking after them.” (Sophie)

While some foster carers reported positive and supportive relationships with the children’s birth parents, the majority described the birth parents interfering in their role as foster parents. Foster carers felt that the birth parents found “*fault*” in the children’s presentation, from the way that they were dressed to how their hair was styled, with some birth parents suggesting that the children’s physical appearance was proof that the foster carers weren’t adequately caring for the

children's needs. This placed an additional stress on foster carers in having their parenting abilities questioned:

"She [birth mother] was obviously very negative and we weren't doing things like putting on bobbins and mitts and things like that, that we wouldn't do, but she thought we needed to do even though this would have been a very hot May and June." (Lucy)

Further interference for the foster carers came from the structure of the foster care system. Foster carers from both groups described children in their care being on "12-month care orders", meaning that whether the children would remain in the care system was reviewed yearly. For foster carers this presented a challenge to their role as a parent, as there was a constant "unknown" as to the permanency of their parenting role, and persistent fear that the children could be taken and returned home:

"There is no long term because there's only 12 month care orders, there's always an unknown...there's always that fear." (Lucy)

A final interfering factor raised by foster carers in both groups was "access", which was sometimes "forced". The majority of foster carers (n=8) felt that access visits with the birth parents "unsettled the kids", and lead to physical symptoms including "stomach pains", "behavioural problems". Foster carers identified that the children's behaviour became more challenging for a number of days both before and after

access with their birth parents, which created additional stress for the foster carers themselves in trying to manage the behavioural difficulties:

“During the summer was traumatic as well, because they were meeting mam and dad every two weeks and it was a disaster from that point of view, because they were hyped up two days before and they were hyped up the day after.” (Nicola)

4.3.3 Support

Throughout the interviews foster carers made reference to the influence of various types of support and supportive structures in both positive and negative ways. Although in general support from others is usually seen as beneficial to health; here however, it seems that this is more complex and nuanced and in some instances can be damaging to health and wellbeing. As a result, several sub-themes on support were generated. Moreover, there was variation on how support was experienced across the CF and CS groups.

4.3.3.1 The system

The system was one support structure that frequently arose for both groups of foster carers in relation to support. Participants from both groups talked about “*systemic problems*” within the “*HSE*” and “*TUSLA*”, a likely consequence of staffing issues due to services being “*under-resourced*” and not having enough staff. Foster carers also expressed a difficulty with “*high staff turnover*”, and that this created further problems for themselves in terms of having to continuously update new staff members on the children’s situation and losing supportive relationships, as

well as for the children having to get to know and trust new social workers. Thus, instead of having a positive experience of support from key stakeholders, it seems that this was negatively experienced and frustrating for the foster carers:

“Some of our children could have had, say long term children, could easily have had 25 social workers within that time. And each time a social worker changes you are getting a different approach possibly, different opinions, so we may end up having to explain every time a social worker changes, what the situation is with the children.” (Jack)

In terms of differences across the groups, foster carer’s in the CF group felt that there was *“no team approach”* between professionals within the system, with professionals not *“communicating”* with one another. Foster carer’s found this upsetting:

“I’m disillusioned when I see the likes of child protection teams and fostering teams not able to talk to each other, that upsets me and it upsets me greatly because I feel that what’s happening is there is no team effort.” (Sarah)

Moreover, all foster carers in the CF group described *“constantly fighting the system”*. They felt that it was a *“battle from the beginning”*, having to *“fight for what they [the children] deserve”*. These participants further felt that when they did get support in the form of services for the children, the services had *“long wait times”* and were *“ineffective”*:

“I waited almost eleven months for an occupational therapist for the two year old who had severe speech delay. When I finally got in there she gave me a program to work for 30 days. When we went back she had lost my file, and told me the service had been cut and I would have no more available appointments. (Susan)

A sense of having to fight for services and support was not expressed by any foster carer in the CS group, with participants identifying that the children in their care were getting “support” in the form of “therapy”.

4.3.3.2 Working relationships

Another support subtheme was ‘working relationships’ and these were described as “important” by foster carers in the CF group. Foster carer’s experiencing high levels of CF felt that they “need relationships in the foster care role”, with relationships being considered to have an important support function:

*“Because to feel supported we need to be able to talk to somebody and to be open and honest, and you can only do that if you have got relationships.”
(Sarah)*

The majority of foster carers in the high compassion fatigue group (n=4) felt unsupported in their working relationships with professionals. Foster carers experiencing CF felt that social workers can be too professional, whereas they want to be seen as equal partners within the system.

“Relationships between social works and foster carers are so professional to the point that not even to accept a cup of coffee in a foster carer’s home, I found that very hard” (Mary).

The issue of working relationships did not feature prominently in the interviews with foster carers in the CS group, suggesting that for those experiencing CS, working relationships may not be an issue. The few references to working relationships that were made by these foster indicate the positive nature of their working relationships, suggesting a potential link between supportive and positive working relationships and reduced distress in foster carers:

“I’d have to say now the social worker is brilliant, and our own social worker is super...better than any other social worker I have come across. She’s on the ball full time.” (Nicola)

4.3.3.3 Availability of support

Foster carers in both groups described receiving support from their spouse. They felt that *“talking”* to their spouse was helpful, as it allowed for them to share their experiences and debrief, as a way to process the difficult situations they faced daily, as well as helping them to *“come up with solutions together”*.

There were some between-group differences in the availability of support from extended family. While foster carer’s in the CF group found it difficult to find someone to babysit, foster carers in the CS group received a lot of practical support

from their extended family. They described their extended family spoiling the foster children and always being available to babysit:

“We don’t have to worry about him because I have such great brother and sisters. He loves going to them anyway because they kind of spoil him anyway you know and they’re very fond of him.” (Mark)

Support groups were identified as an important support structure by foster carers in both groups. Peer support groups gave foster carers the opportunity to meet with other foster carers and share their experiences of fostering:

“The coffee mornings once a month where foster parents get together and they talk, its very, very, good.” (Jessica)

In terms of differences across groups, foster carers in the CS group were aware that they could telephone their social worker if they needed support and that social workers would telephone them back if they were unable to answer the phone:

“So if I ring them and I don’t get them, they’ll ring me back.” (Nicola)

In contrast, none of the foster carers in the CF group identified telephoning their social worker when they needed support, but one foster carer did acknowledge that it would be nice if they could telephone their social worker when they were alone and needed support:

“And wouldn’t it be absolutely wonderful to be able to pick up the phone and just talk to a social worker.” (Sarah)

There was agreement between groups that they fundamentally needed more support, particularly from professionals. Foster carers felt that they didn’t have sufficient contact time with professionals to meet their needs for support:

“They’d come and visit but a half hour visit and a chat isn’t going to make it better.” (Lucy)

Finally, foster carers in both groups identified training as a positive source of support. Foster carers in the CS group felt that *“training was a great way to talk to other foster carers”*, to gain reassurance that they are *“not the only one feeling the way you’re feeling”*, and to learn new skills *“to meet kids needs”*. However, difficulties accessing training were noted, with three participants in the CF identifying that there is *“no training”* because *“training is always cancelled”*.

4.3.4 Coping

Throughout the interviews foster carers identified a number of coping mechanisms that they employ as a means of managing the *“emotional and physical demands”* of fostering. The importance of effective coping was highlighted in the context of the stressful situations faced by foster carers in their role. Foster carers acknowledged using a combination of problem-focused coping strategies, emotion-focused coping strategies, and self-care strategies, though differences in the degree

to which these strategies were used, and under what circumstances, varied between groups.

4.3.4.1 Problem-focused coping

Foster carers in both groups identified employing problem-focused coping strategies, including information seeking. Foster carers sought information from “multiple sources”, including “*social workers*”, “*fostering agency*”, “*birth parents*” and “*the eldest child*”. Information was sought about the children’s histories, their behavioural difficulties and how these may relate to the children’s past histories, their care needs and how to effectively meet their care needs and manage their challenging behaviour.

“You have to be able to figure out what is happening, what has happened for them and then when they are behaving a certain way or they are dealing with certain issues you have to try and work out what they need and why they might be doing something or have a problem with a particular thing.”

(Jessica)

Unfortunately, this need for knowledge and information to deal with difficulties wasn’t always met. Foster carers sometimes found that information wasn’t available to them, or that those who had the information were unwilling to share it, particularly birth parents:

“The parents were of no help. They were quick to question when the kids when to access why their hair wasn’t done properly, yet they wouldn’t tell you where to buy the products or what to do.” (Lucy)

Another important way of gaining information acknowledged by foster carers in both groups was “up skilling” and “retraining” through attending courses. They described signing up to attend any course that was offered to them. There was a sense that the relevance of the course to their current circumstances wasn’t a consideration, rather they were interested in acquiring and banking knowledge and skills in case they were needed in the future.

“I was doing a course, probably a parenting course, because any kind of courses that ever became available I would do, always did. Foster carers need to keep up skilling. We need to keep retraining. We need to keep up with everything and all the changes and stuff and that’s how I would work.” (Sarah)

However, as already mentioned above, some foster carers experienced difficulty in accessing training.

4.3.4.2 Emotion-focused coping

Foster carer’s also identified employing emotion-focused coping strategies whereby they attempted to minimise the emotional impact of fostering. Foster carers in both groups engaged in avoidance as a means to coping. However, while foster carers in the CS group identified using avoidance as a short-term coping

strategy, foster carers in the CF group used avoidance as a long-term solution. For example, Nicola, in the CS group described “*ignoring*” her foster son’s difficult behaviour for a short period of time and later addressing it with him, once the situation had become less emotionally fused. In contrast, Jack in the CF group described using avoidance as a long-term coping mechanism, whereby he avoids difficult issues indefinitely:

“I’m constantly thinking but not wanting to address certain issues...it’s just easier.” (Jack)

One emotion-focused coping strategy visible throughout the interviews only with foster carers in the CS group was positive reappraisal. Foster carer’s in this group tended to reappraise challenging and potentially distressing situations in a more positive way:

“I have had very challenging situations where the little girl was hitting her head of the bed, the wooden bed head...I felt it’s good that this is coming out because she was relaxing enough to be able to express distress” (Jessica).

This use of positive reframing was not evident in interviews with foster carers in the CF group, suggesting a potential link between the use of positive reappraisal techniques and lower levels of CF and higher levels of CS.

4.3.4.3 Self-care

Self-care is another means of coping in the foster carer role evident throughout the interviews. However, foster carer's attitude towards and prioritisation of their own needs for self-care appeared to differ between groups. Foster carers in the CS group spoke about the importance of "*recognising*" their own needs and prioritising time for themselves. Some foster carers in the CS group allocated a space in the house that wasn't accessible to the children, to allow themselves a physical space where they could relax and be alone:

"Sometimes say if I need to go and do something, our bedroom is off limits to the children, and that might be just go upstairs and tidy away my clothes or something simple, but it's just a matter of going somewhere, just for ten minutes." (Jessica)

In contrast, foster carers in the CF group seemed less able to prioritise their own needs and acknowledged that they were "*not good at looking after myself*". They neglected their needs for engaging in hobbies and spending time with friends:

"What's the point in me making plans to go out with friends when something could kick off here and I could be demanded to ferry people off to somewhere else random and sure its just easier to not have a life than to sort of stand up for yourself." (Jack)

There was a sense that foster carers in the CF group felt unentitled to engage in activities for their own pleasure or gratification. They felt that they had to "*steal*

time" and *"sneak into town for a coffee"*, as though they weren't entitled to prioritise themselves, and had to conceal it when they did.

Between group differences were also apparent in the use of exercise. Foster carers in the CS group described exercise as an important and effective coping mechanism in the management of stress in the fostering role. They acknowledged that they prioritise exercise due to its stress-reducing benefits. There was an emphasis on the importance of exercising outdoors amongst nature, with a particular preference for cycling and walking:

"I just go outside, I go for a walk, go for a cycle, I just need that exercise outside. That's what I do for me when there is bad times like that...I could be caught maybe until four or five in the evening, but then I will go." (Nicola)

While one foster carer in the CF group described cycling to work, the remainder acknowledged that they did not engage in regular exercise. They admitted that they would like to exercise more, and described having gained weight since fostering, which they felt was an outcome of reduced exercise:

"You let yourself go...I've put on weight because I'm not getting exercise, again [I'm] not looking after myself." (Eric)

4.3.5 The big brother effect

Throughout the interviews with foster carers in both groups there was an overwhelming sense that they were not autonomous, self-governing individuals.

They were constantly providing justification for their role and their ability to effectively carry out the duties expected of their role. Moreover, they were very conscious of how other people judged them. Foster carers felt that they were constantly under surveillance and being controlled by the system. These subthemes of 'justification', 'judgements', 'surveillance' and 'controlled' make up the theme 'the big brother effect'.

4.3.5.1 Justification

Foster carers in both groups appeared to feel the need to justify their reasons for becoming foster carers and demonstrate their capacity and resources to foster. Foster carers spoke about fostering as something that they had always wanted to do. They emphasised the importance of fostering for "*the right reasons*", with the subtext that they were fostering for the right reasons. Moreover, they highlighted some of the incorrect assumptions often made about foster carers motivations for fostering, particularly in relation to financial gains, while emphasising that monetary gains could not be not an incentive for any foster carer:

"It's nothing to do with money or anything like that. Like you wouldn't do it for money. I can't imagine you would do it for money because it's too long, too intense, and all of that and it's either something that you want to do or something that you don't want to do." (Mark)

In addition to defending their motivations for fostering, foster carers further justified their ability to provide the necessary care to the children. They described the resources that they possess, particularly in terms of sufficient time to devote to

the children and having an appropriate physical environment. They described their home being “a safe place”, having a “big house” and a “big garden” where children can have “an outdoor life”. Moreover, some foster carer’s compared their home to the birth parents’ home, highlighting how their home environment was more suitable to meet the children’s needs, thus further justifying the necessity of their role and their adequacy within the role:

“We live out in the country and have a big garden...mum lives in town in an apartment with no outside space at all”. (Jessica)

4.3.5.2 Judgements

Linked to foster carers need to justify their role and their ability to meet the requirements of the role, foster carers from both groups were very conscious of other peoples’ perceptions of them. However, some differences in the types of judgements predicted and the mass given to these judgements were evident across groups. Foster carers in the CS group described expecting people to pass judgement on more trivial matters, such as how the children were dressed, while foster carers in the CF group expected other people to make judgements about them as individuals. Foster carers in the CF group were concerned that they would be viewed negatively by others, with particular concerns about being seen as “unemployed”, “a volunteer” or “only a foster carer”. They expressed feeling that other people viewed them as lesser individuals because of their status as a foster carer:

“You know people look at me like I don’t work. I’m only a foster carer. Most people don’t get it and they look down their nose at foster carers.” (Susan)

Differences were also apparent between groups in their receipt of positive judgements by other people. All foster carers in the CS group acknowledged receiving recognition and praise from a variety of people including; professionals, neighbours and the children themselves. They described *“being told [they’re] doing a great job”* by the social work department, and described receiving great satisfaction from the positive feedback they got from others:

“There’s a restaurant pub down the road here that we go to fairly regularly and the people that own it would come over and they’d be like you know the difference in those kids and everybody in fairness in the community would always be saying oh how well the kids are”. (Lucy)

In contrast, foster carers in the CF group felt a lack of recognition about the difficult aspects of their role and problems specific to the children in their care. This left them feeling unappreciated in their role:

“As a foster carer you’re the help and there’s no acknowledgement that you’re dealing with a difficult case.” (Jack)

4.3.5.3 Surveillance

An experience unique to foster carers in the compassion fatigue group was the feeling of being under surveillance. Foster carers in the compassion fatigue group felt a distinct lack of privacy in their lives as a result of fostering. They had a constant sense of being “watched” and “monitored”:

“It’s like you have got Big Brother on your shoulder if you know what I mean, you feel that, I feel that at times you’d be worried about being watched.”
(Sarah)

This is a very unsettling experience for foster carers, as they can never fully relax, due to concerns about how their actions might be interpreted by “*the system*”. This resulted in a constant fear of being seen as providing inadequate care to the foster children and their own children, and consequently having both the foster children and their own children removed from their care:

“There’s an element of fear, definitely I would have felt fear throughout the years. Fear you are opening your home and your life, your family, everything, to the social work department and you just think am I doing everything right, a fear that if I say, oh gosh, have I said the right thing.” (Sarah)

4.3.5.4 Controlled

Moreover, foster carers in the CF group described being “*controlled*” by “*the system*”. They didn’t feel as though they had control over their own lives, due to the

protocols imposed by the foster care system. There was a lack of autonomy around decision making related to both the foster children and their own family, as though they were puppets acting in accordance with the demands of the foster care system:

“As foster parents we don’t have the rights...you constantly have to go back, you are constantly being controlled if you like by TUSLA and HSE. You have to make sure that you’re doing it properly and that you’re following all the rules and regulations and everything else that is imposed upon you.” (Eric)

This same sense of being controlled by the foster care system and lacking independence in their role was not evident in the interviews with foster carers in the CS group.

4.3.6 Outcomes

Throughout the interviews foster carers identified a number of outcomes from fostering. They highlighted how the fostering experience has a deep impact on themselves as individuals, as well on their wider family. The way in which fostering affects the foster children was also a key areas of discussion amongst foster carers. The outcomes of fostering for foster carers, their family and the foster children are described further below.

4.3.6.1 Personal outcomes

For all foster carers fostering was a profoundly “rewarding” experience. There was acknowledgement that the effects of fostering lead to tangible changes within the

foster carers, with both positive and negative personal growth described. Having witnessed the dysfunctionality of families whose children are taken into care, foster carers felt “more appreciative” of their own family and “upbringing”. Moreover, learning about the abuse and neglect experienced by the children the care, gave foster carers “*perspective*” on the important things in life and the relative significance of stressors that they faced in their lives. This allowed them to adopt a more “*laid back*” approach to dealing with potentially difficult situations:

“It really gave me a massive amount of perspective. Look the thing is any kind of issue in work or whatever nowadays I’m able to be a lot more laid back about it because really like, as an experience a difficult conversation with a co-worker is so minor compared to what people a fraction of my age have to do. So apparently I come across as a lot more laid back since I started fostering.” (Jack)

While foster carers in both groups recognised positive self-growth, only those in the CF group identified negative personal growth as an outcome in fostering. They felt that their experiences of fostering, particularly those related to systemic issues, had made them more “*sceptical*” and “*suspicious*” about people and their motives generally:

“I suppose it makes me feel a bit more, I suppose, sceptical at times and of maybe kind of sometimes a bit suspicious of decision maybe or why something might be. The way decision were made without even consultations, it would have made me an awful lot more suspicious.” (Sarah)

Burnout was another personal outcome that featured strongly in interviews with foster carers from both groups. There was recognition that burnout is a “*major issue*” in the fostering role, with all foster carers in the CF group acknowledging that they had experienced burnout. They expanded on their experiences of burnout by describing the physical, emotional and psychological symptoms that they felt constituted burnout. Foster carers who were experiencing burnout felt “*on the floor physically, mentally and emotionally*”, experienced sleep disturbances and “*withdrew*” from activities that they would have previously engaged in:

“I think it’s fair to say we were burnt out. Not really sleeping, constantly thinking but not even wanting to address certain issues, constant worry, lethargy, and not you know, feeling a certain futility about doing anything.”
(Jack)

Moreover, foster carers in the CF group identified losing interest in the foster children due to burnout. Some foster carers even felt that they no longer liked the foster children at times, demonstrating the profound impact of burnout on foster carers and the likely consequential effect on foster children. However, they clarified that “*systemic issues*” were at the root of their burnout:

“All I could think of was the last thing I wanted to do was fostering but I also didn’t feel like I liked the children and that was the biggest thing for me I just I came to the point where I thought what am I doing why am I doing this

because I don't like them. I go on and I do the thing but I don't like what I'm doing." (Mary)

"The reason why I feel on the floor mentally and physically and emotionally is actually nothing to do with the girls, nothing to do with our foster children. It's to do with circumstances beyond that. Dealing with TUSLA and the fostering agency." (Mary)

Additionally, three foster carers in the CF group identified stressors in their personal life contributing to the development of burnout, including the death of a parent and illnesses in close family members.

While foster carers in the CS group highlighted the risks of burnout in fostering and were aware of their potential to develop burnout in their role, no foster carer in this group identified experiencing burnout. Foster carers in this group focused their attention on ways of preventing burnout, and spoke about engaging in self-care practices and accessing social support:

"Burnout...it's something I could see happening very, very, quickly if you didn't get support and maybe didn't get away for a day or two." (Nicola)

With regards to satisfaction in fostering, all foster carers identified experiencing satisfaction in their role. However, the relative constancy of the satisfaction differed between groups. Foster carers in CS group identified feeling "great

satisfaction” on a daily basis, while for foster carers in the compassion fatigue group satisfaction was an intermittent experience:

“Satisfaction it comes and goes. You don’t feel satisfied all the time, and I think you are more on the defence and as I say trying to cope with situations rather than being satisfied all the time.” (Eric)

4.3.6.2 Family outcomes

Foster carers further recognised that fostering also impacted their family. There was a shared sense between groups that their family had been positively affected by the experience. They felt that their partners and children had *“grown”* as individuals as a direct consequence of the unique experiences afforded by fostering. There was an acknowledgement that fostering had provided opportunities that most families or individuals do not get to experience, and that they were *“better people”* as a result. Foster carers also highlighted specific outcomes for their own children. They noticed that their own children had developed a greater understanding and acceptance of children with *“special needs”* and consequently were less judgemental:

“He has enriched us. My own children are more aware of people with special needs and if there’s a child that’s causing a tantrum or something when we’re out, they don’t judge the parents which is great because they know from the little fella that we have here, when we used to go out he was overwhelmed and he’d act out.” (Sophie)

However, fostering wasn't seen as an entirely positive experience, as foster carers also identified negative outcomes for their family. Sexualised behaviour displayed by foster children appeared to be the primary contributor to negative family outcomes. Foster carers spoke about their own children witnessing sexualised behaviour and consequently questioning the sexualised behaviour. For foster carers this was an unsettling experience, as they felt that their children were too young to understand what it meant and why it happened:

"Like we had a three year old that was acting out sexual things that were being done. My little one at the time was six, going on seven, asked how does his daddy make his willy bigger, and I couldn't explain that to her because I thought she was too young." (Lucy)

4.3.6.3 Foster child outcomes

Foster carers from both groups were acutely aware of how fostering affects the foster children, and were proud of their role in the positive changes that they saw. They described the children making progress across developmental domains, including emotional, physical, cognitive, and language development. They observed the children to be happier and to have made significant advances academically. They further saw improvements in the children's ability to "communicate" and "make choices", likely reflecting improvements in both language and self-confidence:

"He is now able to say what he wants, what he needs and what he'd like. Particularly coming up to Christmas, picking out his own toys, not you having

to pick something for him, that he's able to pick, he can make a choice."

(Sophie)

Furthermore, foster carers felt that fostering had changed the trajectory of foster children's lives. They predicted that foster children had a "*better life*" due to being in care, and were "*less likely to end up in prison*".

CHAPTER 5: DISCUSSION

5.1 Chapter Overview

This chapter will broadly be divided into three sections. The quantitative results will be discussed in the first section. The aims of the quantitative study will be restated and the main findings summarised. Then, the findings related to burnout and secondary traumatic stress (STS) will be discussed in relation to previous research, followed by the findings related to compassion satisfaction (CS). The impact of child behaviour, social support and self-care on burnout, STS and CS will be integrated within these discussions, followed by a discussion of the impact of demographics. In the second section, this chapter will restate the aims of the qualitative study and summarise the main findings. It will then discuss the most salient points of each subtheme in sequential order, in relation to existing literature. Particular emphasis will be placed on differences between the compassion fatigue (CF) group and the compassion satisfaction (CS) group to demonstrate potential contributing and ameliorating factors to their development. Finally this chapter will discuss the combined implications of both the quantitative and the qualitative studies for policy and practice. The strengths and limitations inherent within the study will then be highlighted before suggestions for future research are made.

5.2 Discussion of quantitative results

5.2.1 Aims and summary of quantitative findings

The present study aimed to examine prevalence of, and predictors of, STS, burnout and CS in foster carers. Social support and self-care were examined as potential

predictors of STS, burnout and CS, after controlling for demographic and work related factors and foster child behaviour. Based on normative scoring (Stamm, 2010) using cut-off scores above the 75th percentile, foster carers in the current study were found to have high levels of STS (31%), high levels of burnout (28%) and high levels of CS (25%), indicating that foster carers are highly susceptible to both the negative and the positive effects of caregiving. As hypothesised, results showed that foster carers who reported more child behaviour difficulties experienced higher levels of STS and burnout and lower levels of CS than foster carers who reported less child behaviour difficulties. In contrast, foster carers who reported more child prosocial behaviour reported experiencing significantly lower levels of burnout and significantly higher levels of CS. Surprisingly, foster child prosocial behaviour was not associated with STS, suggesting that child prosocial behaviour does not impact levels of STS in foster carers. As predicted, perceived availability of social support was significantly associated with both burnout and CS, such that foster carers who reported more availability of social support experienced lower levels of burnout and higher levels of CS. Unexpectedly, perceived availability of support was not associated with STS. Self-care was significantly associated with the three outcome variables, such that foster carers who reported more total self-care experienced significantly lower levels of STS and burnout and significantly higher levels of CS.

5.2.2 Secondary Traumatic Stress and Burnout

While no previous peer-reviewed research examining STS or burnout in foster carers could be found, comparison with residential childcare workers has found similar to marginally higher levels of both STS and burnout. Zerach (2013) found

that 31.3% and 23.5% of his sample of 147 residential childcare workers was at 'high' risk for STS and burnout respectively, which is comparable to the findings of the present study. However, Eastwood and Ecklund (2008) found that 26.3% and 14% of residential childcare workers, scored in the 'high' risk category for STS and burnout respectively, suggesting that relatively more foster carers in the present study scored in the 'high' risk category for both STS and burnout. While it is unclear whether this difference would reach statistical significance, it does suggest that foster carers may be at equal or greater risk for both STS and burnout than residential childcare workers.

In terms of predictors, child problematic behaviours were associated with STS and burnout, while prosocial behaviours were not associated with STS, but were predictive of burnout. This is in line with other studies showing challenging behaviours to be predictive of poor health and higher distress in other parenting caregivers (Gallagher & Hannigan, 2014; Gallagher & Wihtelely, 2013). Moreover, this is also consistent with previous research that has demonstrated a link between child challenging behaviour and caregiver burnout (Huang et al., 2014; Mills & Rose, 2011). Specifically, previous research has shown challenging behaviour to act on two components of burnout; personal accomplishment and emotional exhaustion (Chung & Harding, 2009), suggesting a potential mechanism through which challenging behaviour influences burnout in the present study. On the other hand, the current findings may reflect a reporting bias, in that foster carers who experience more burnout may be more likely to report more challenging behaviour. Alternatively, although children in care inevitably bring with them preconceived ideas about caregivers based on previous caregiving

relationships (e.g. biological parents, previous foster carers) and have often experienced difficult and potentially traumatising experiences, both of which can manifest in challenging behaviour, it is also important to note that challenging behaviour can also be impacted (both positively and negatively) by current environment and the parenting style of foster carers. Previous research has shown that parenting style can significantly effect a child's behaviour (e.g. Garber, Robinson, & Valentiner, 1997; Reid, Webster-Stratton & Baydar 2004). Thus, in the present findings challenging behaviour could be merely mediating the relationship between parenting style and burnout.

Previous research examining the link between caregiver burnout and the care recipient's prosocial behaviour has been limited. However, based on Maslach and Jackson's (1981) theory of burnout, the link found in the present study can be easily understood. Maslach and Jackson's (1981) model of burnout emphasises the role of a diminished sense of personal accomplishment in the development of burnout. Therefore, in the present study, foster children displaying prosocial behaviour may increase foster carers sense of personal accomplishment, rather than reduce it, because displays of prosocial behaviour may be interpreted as a sign of their success in their role as a substitute caregiver. With regards to STS, research consistently shows that children who have traumatic experiences, including experiences of abuse and neglect, can present with significantly more behaviour difficulties (e.g. Famularo, Kinscherff, & Fenton, 1992; Cook et al., 2005). Therefore, in the present study, foster carers reporting more challenging behaviour, may in fact be caring for children who have experienced more trauma, thus their increased levels of STS may be attributable to increased trauma

exposure, rather than a direct result of the challenging behaviour. Another potential explanation for the link between STS and challenging behaviour is the increased demands that challenging behaviour places on foster carers' limited resources. According to Figley's trauma transmission model (2002), a key factor in the development of secondary traumatic stress is degree of life disruptions. Thus, it is easy to see that children presenting with more challenging behaviour are likely to cause greater life disruptions for their caregiver, which may explain why foster carers caring for children with increased challenging behaviour experience higher levels of STS. Although it is not possible to determine the precise reasons why child prosocial behaviour was not associated with levels of STS based on the present study, it is possible to speculate. Because STS is theorised to be directly related to exposure to another person's trauma in a caregiving relationship, it may be that prosocial behaviour is in no way related to the trauma experiences of foster children, or how much exposure foster carers have to the children's trauma through story-telling or re-enactments. Therefore, prosocial behaviour may not have any influence on foster carers' indirect trauma exposure, and thus, may not be related to the development of STS.

Another unexpected result in the present study was that contrary to other caring professions (Ariapooran, 2014; Galek, Flannelly, Greene & Kudler, 2011; Ortlepp & Friedman, 2002) social support was not significantly associated with STS in foster carers. Although consistent with these studies social support was associated with burnout in the present study. The reason for the conflicting finding in the present study may be that because those who typically provide social support (i.e. spouses) are also exposed to the foster children's trauma, they too may be experiencing STS,

and therefore the quality of their support may be compromised. Previous research has emphasised the importance of quality in effective social support for buffering the impacts of stress on wellbeing (e.g. Vandervoort, 1999). Moreover, the confidential nature of the children's histories may impinge upon foster carers ability to use social support effectively. While foster carers may have support available to them, they may feel unable to use the social support of their friends and family effectively to process the trauma, for fear of breaking confidentiality.

Self-care behaviours were the strongest predictors of both STS and burnout in foster carers in this study, particularly stress-management in the case of STS and both stress management and spirituality in the case of burnout. Stress management essentially encompasses an individual's capacity to identify and draw upon psychological and physical resources to reduce tension and the effects of stressful life circumstances and events (Walker & Hill-Polerecky, 1996). The benefits of self-care in the prevention of STS and burnout in other professional caregivers is well-established (e.g. Alkema, Linton & Davies, 2008; Eastwood & Ecklund, 2008; Cho & Jung, 2014; Sanso et al., 2015; Neville & Cole, 2013; Ng et al., 2009), and is confirmed in foster carers in the present study.

5.2.3 Compassion satisfaction

Research with residential childcare workers, the group of professional caregivers arguably most similar to foster carers, has shown somewhat conflicting results. While comparison of the current findings with those of Zerach (2013) suggests that foster carers in the present study experience similar levels of CS to residential workers, Eastwood and Ecklund (2008) demonstrated a significantly higher percentage of his sample (42.1%) achieving CS scores in the 'high' potential

category. Nonetheless, the current findings suggest high levels of CS in foster carers, though levels may not be as high as seen in residential childcare workers.

As hypothesised, the behaviour of foster children was significantly associated with foster carer CS. Foster carers who reported more child behaviour difficulties experienced lower levels of CS, while those who reported more prosocial behaviours experienced higher levels of CS. Since CS essentially refers to the sense of meaning and achievement derived from caring for others (Stamm, 2010), the present findings suggest that child behavioural characteristics may interfere with foster carers sense of achievement in their role. Foster children displaying challenging behaviour may leave foster carers feeling inadequate in their role and reduce their sense of fulfilment and success, thus reducing their potential for feeling CS, while those displaying prosocial behaviours would have the opposite effect. Although previous research examining the relationship between challenging behaviour and the specific construct of CS could not be found, other studies have found verbal and physical aggression of care recipients to be associated with job satisfaction in caregivers (e.g. Dougherty, Bolger, Preston, Jones & Payne, 1992). It is also consistent with others studies linking these behaviours to a variety of mental and physical health indicators in parental carers (Gallagher & Hannigan, 2014; Gallagher & Whiteley, 2013).

As predicted perceived availability of social support was significantly associated with CS, such that foster carers who reported more availability of social support experienced higher levels of CS. This finding is consistent with previous research with other professional caregivers, which have shown a link between social

support and increased levels of CS (Killian, 2008; Murray et al., 2009). However, when entered alongside self-care in the regression equation, social support did not remain significant. This suggests that social support does have a role in the development of CS but other factors are more influential, including the child's behaviour and the foster carer's engagement in self-care practices. Interestingly, prosocial behaviour was also no longer significant when self-care was entered into the equation, suggesting that self-care accounts for a larger proportion of the variance in CS. Again, when individual self-care behaviours were analysed, spiritual growth was found to be the biggest predictor of CS, further highlighting the benefits of spirituality for foster carers. Previous research with other formal caregivers has highlighted the importance of self-care in the development of CS (e.g. Alkema, Linton & Davies, 2008; Kraus, 2005; Neville & Cole, 2013). The importance of spiritual growth in the development of CS has also been highlighted in studies with other formal caregivers (e.g. Ng et al., 2009; Zerach, 2013). However, some studies have highlighted a relationship between CS and other self-care strategies, including nutrition (Eastwood & Ecklund, 2008) and physical exercise (Hinderer et al., 2014), which were not found in the present study. This may be a group-specific difference, meaning that nutrition and exercise may not be effective for foster carers, perhaps due to role differences. On the other hand, the previous studies did not control for challenging behaviour, which may account for the differences found.

5.2.4 Demographics

In the present study only length of service as a foster carer and total number of children fostered were to be significantly associated with STS, while only total

number of children fostered was significantly associated burnout and CS. Length of service and number of children fostered can be considered synonymous with trauma exposure since longer service as a foster carer and fostering more children are suggestive of greater exposure to the trauma histories and trauma symptoms of foster children. This is in keeping with the theorised role for exposure to another person's trauma in the development of STS (Figley, 1995). Further, several studies have found that greater number of clients with trauma histories on a clinician's caseload is directly related to levels of STS (Baird & Jenkins, 2003; Nelson-Gardell & Harris, 2003). With regards to both burnout and CS more children fostered indicates a higher turnover of children, which may signify placement breakdowns or other placement disruptions. Previous research with foster carers has highlighted that both the circumstances leading to placement breakdowns and disruptions, as well as the breakdowns themselves, cause significant distress for foster carers (Wilson, Sinclair & Gibbs, 2000). There were no differences between relative and general foster carers across levels of STS, burnout and CS. However, only four participants in the present study identified as relative foster carers, making it difficult to uncover any differences that may exist between relative and general foster carers. Unexpectedly, the amount of respite received did not appear to have an effect on levels of STS, burnout or CS. This is surprising because respite would theoretically provide opportunities to disengage and process the trauma as well as a chance to recuperate and recover from trauma exposure, in the case of STS, and emotional exhaustion in the case of burnout. While this may reflect a true lack of effectiveness, it is noteworthy that, in the present study relatively few foster carers reported receiving respite. Twelve per cent reported receiving some respite in the previous month and 26% reported

receiving respite in the previous 12 months. Other research has highlighted the protective role of training in the prevention of STS and burnout and the promotion of CS (e.g. Flannelly, Roberts & Weaver, 2005; Gentry, Baggerly & Baranowsky, 2003), but training did not appear to have any effect on foster carers in the present study. However, it is unclear what type and quality of training foster carers received in the current study, and therefore it is possible that more specific training on STS, burnout and CS may have a different effect.

5.3 Discussion of qualitative findings

5.3.1 Aims and summary of findings

This study aimed to extend the quantitative findings by exploring and comparing the experiences of foster carers with high levels of compassion fatigue (and low levels of compassion satisfaction) to foster carers with high levels of compassion satisfaction (and low levels of compassion fatigue). As illustrated in the previous chapter, the present study revealed six themes in relation to foster carer's experiences of compassion fatigue and compassion satisfaction, namely 'the foster child', 'being a foster 'parent'', 'support', 'coping', 'the big brother effect', and 'outcomes'. While a number of shared experiences were evident across groups, differences between foster carers experiencing compassion fatigue (CF) and those experiencing compassion satisfaction (CS) were evident, providing some insight into potential contributory and ameliorating factors in the development of CF and CS. Foster carers elaborated on some factors previously explored in the quantitative study providing a more in-depth understanding of how the foster child, support and self-care impact on the development of CF and CS. Moreover,

throughout the interviews foster carers highlighted additional influential factors that were not captured in the quantitative study, providing a more comprehensive account of their experiences of CF and CS, while also adding context as to why some foster carers develop CF, while others develop CS.

5.3.2 The foster child

Foster carers in this study highlighted the complexity of the children in their care, with respect to their trauma histories. Exposure to another person's trauma in the context of a caregiving relationship is a prerequisite for the development of secondary trauma, suggesting that all foster carers in the present study had the potential to be traumatised in their role (Figley, 2002). However, the fact that both groups of foster carers cared for children who had similar experiences of trauma, suggests that caring for children who have been traumatised isn't sufficient alone to cause STS. Therefore other factors were contributing to and/ or protecting against the development of STS in foster carers in this study. This is consistent with findings from the quantitative study showing that abuse or type of abuse did not predict STS.

Where between group differences were noticeable was in the foster children's medical and psychiatric diagnoses, with foster carers experiencing CF being more likely to be caring for children with diagnosed medical conditions and neurodevelopmental disorders, specifically Attention Deficit Hyperactivity Disorder (ADHD). Medical and psychiatric diagnoses typically translate to increased care needs, and consequently increased demand on a caregiver's resources. Similarly, a diagnosis of ADHD requires the presence of clinically

significant hyperactive behaviour (APA, 2013), also suggesting additional demands on foster carers' physical and emotional resources. Previous research has shown that increased role demands on a caregivers limited resources can significantly impact on physical and psychological wellbeing (Coverman, 1989; Schwartzberg & Dytell, 1996), with studies highlighting links between feeling overworked and burnout in other groups of formal caregivers (Garrosa, Moreno-Jiménez, Rodríguez-Munoz, 2011). This suggests increased care needs as a potential pathway through which foster carers in the present study develop CF. Although foster carers in both groups described challenging behaviour, it is possible that the challenging behaviour, in addition to the specific care needs, for those in the CF group was more severe, though this may not have been discernible in their qualitative descriptions.

5.3.3 Being a foster 'parent'

All foster carers developed a deep connection with the children in their care, however differences were evident in the apparent reciprocation of the connection by the foster children. Foster children being cared for by foster carers experiencing CF did not use parental terms when referencing the foster carers, and the foster carers felt that the love they received from the children was transient. Research suggests that children placed in care are more likely to have insecure attachments, and that their attachment behaviour can depend on the age at which they entered care, with older children displaying more difficulties (Howe & Fearnley, 2003). Consequently, there may be differences in attachment style and behaviour of the children fostered between the two groups. However, an alternative explanation could lie in the foster carers' own attachment styles. The present findings could be

reflective of differences in attachment styles between foster carers who experience CF and those who experience CS. It is possible that foster carers who develop CF have an insecure attachment style, and therefore, their experiences of transient love are reflective of their own attachment style, rather than suggestive of differences in the children between the two groups. According to the literature, attachment has a significant impact on an individual's ability to regulate emotions, manage stress and effectively seek and use social support (Bowlby, 1969; Mikulincer & Shaver, 2007). Furthermore, research has demonstrated attachment security to be associated with burnout and STS in other formal caregivers (West, 2015).

A number of factors that interfere with foster carers' role, making it more difficult, were also noted. For example, the children's past experiences were seen as interfering with their sense of safety and their confidence in the abilities of adults. This means that foster carers can't merely complete their parenting duties, they have to reassure the child of their abilities and constantly strive to prove their capabilities. This introduces an additional dimension to the typical parenting role. Previous studies have highlighted the contribution of being doubted and feeling insecure in the development of CF (Shane, 2010). Another source of interference for foster carers in both groups came was the system. Due to the use of twelve-month care orders, foster carers felt on-going uncertainty about the permanency of their role. Moreover, the children having access with their birth parents was experienced as upsetting for the children and increasing their emotional and behavioural difficulties. Consequently, a number of factors interfering with the foster care role are outside of their control. However, because all foster carers

experienced similar interference in their role, this suggests that other factors are more important in the development of CF and CS.

5.3.4 Support

Differences in the perceived availability and functionality of both organisational and social support were apparent between the two groups. With regards to support from the foster care system, foster carers experiencing CF felt as though they were in opposition with the system, having to constantly fight for resources for themselves and the children. According to the literature, having access to adequate resources in the workplace, including materials, space, funds, knowledge and skills is an important support mechanism to prevent secondary traumatic stress (Choi, 2011). The findings of the present study demonstrate that foster carers experiencing CF had difficulty in accessing resources needed to help foster children, in addition to accessing training opportunities for themselves. Therefore, the present findings are consistent with previous studies showing a link between inadequate resources to effectively perform one's role and increased levels of CF (Choi, 2011; Schaufeli & Wilmar, 2004).

Another important support structure is socio-political support, which essentially encompasses support from co-workers, supervisors and the general organisation (Spreitzer, 1996). Foster carers in the compassion fatigue group described feeling unsupported in their working relationships with professionals. Moreover, they felt as though they were not equal partners within the system, suggesting a perceived lack of co-worker support from professionals. Numerous studies have linked perceived co-worker support to reduced levels of STS (Bride, Jones & MacMaster,

2007; Townsend & Campbell, 2009) and burnout (Hamama, 2012), supporting the present findings. Supervision has also been highlighted as an important support structure in the prevention of STS and burnout in caregivers, with both quantity and perceived quality (Pearlman & Mac Ian, 1995; Slattery & Goodman, 2009) being implicated. It has been suggested that a good quality supportive supervisory relationship, as well as good quality co-worker relationships, engenders a feeling of safety and security within caregivers, which facilitates dialogue about the negative impacts of the work on the caregiver, thus preventing or reducing STS and burnout (Slattery & Goodman, 2009). The importance of having work-related stress heard and validated to prevent CF has been emphasised by other authors in the traumatology literature (e.g. Knight, 2004; Sommer & Cox, 2005), supporting lack of organisational support as a potential mechanism for the development of CF in foster carers in the present study.

Peer support groups and training were also identified as positive support structures, because they allow foster carers to meet other foster carers and share experiences. However, because foster carers in the CF group experienced difficulties in accessing training, opportunities to meet other foster were limited. The same barriers to accessing training were not described by foster carers experiencing CS, suggesting that attendance at training, to promote peer support, may be important in the prevention of CF for foster carers. The quantitative study did not find any significant associations between training attendance and burnout or STS, highlighting some differences between the quantitative and qualitative findings. However, one reason why no relationship was found in the quantitative study may be down to a type II error, due to the large variance in the reported

number of hours training attended, or it may be due to the type or content of training offered.

Social support from family and friends is theorised to buffer the negative effects of caring by providing resources (including informational, emotional and practical resources) that promote adaptive responses to the stressful events (Lundstad, Smith & Layton, 2010). Differences with regards to availability of social support outside of the work place were apparent across groups. While both groups described supportive spousal relationships, foster carers in the CF group appeared to have less practical support from their extended family. This suggests that spousal support may not be sufficient to protect against the development of CF and that support from extended family, in particular practical support, may be an important factor in the prevention of CF and the promotion of CS. Previous studies have highlighted the role of social support in preventing CF (e.g. Galek et al., 2011) and the promotion of CS (e.g. Killian, 2008; Murray et al., 2009). Research specifically examining sources of social support in the context of CF development, has been somewhat inconsistent. While some studies have shown family support but not spousal support to be associated with CF (e.g. Haddad, 1998; Bataineh, 2009), others have found both family and spousal support to be associated with CF (e.g. Woodhead, Northrop & Edelstein, 2016). The quantitative study did not examine sources of support to illuminate these findings further.

5.3.5 Coping

Within the coping literature a number of coping mechanisms are identified, with a particular emphasis on problem-focused and emotion-focused strategies (Lazarus,

1993). Information seeking is one form of problem-focused coping (Folkman & Lazarus, 1985), and was identified as a coping strategy employed by foster carers in this study. Foster carers sought information particularly about how to manage the children's behaviour, and how to understand their behaviour in the context of their trauma histories. Training was seen as one means of gaining information, though, as highlighted above foster carers with high levels of CF experienced difficulty in accessing training. Consequently, this lack of available training, and thus insufficiency of information, may impact their ability to employ problem-focused coping, and force them to adopt less effective coping strategies. According to the stressor vulnerability model (Cooper, Russell & George, 1988; Cooper, Russell & Skinner, 1992) individuals can learn to use maladaptive coping strategies, for example smoking, alcohol or denial, when they believe that other adaptive ways of coping are unavailable. Therefore, with regards to foster carers experiencing CF, they may default to less adaptive coping strategies through learnt experiences of training not being available to them, or alternatively, they may be forced to utilise less adaptive coping strategies due to an actual lack of training.

This explanation is further supported by foster carers long-term use of avoidance as an emotion-focused coping strategy. While both groups identified using avoidance, foster carers in the CS only employed avoidance as a short-term strategy, while foster carers in the CF group used avoidance as a long-term solution. Research examining the use of avoidance demonstrates that while avoidance can be beneficial in the short-term, long-term use of use of avoidance is associated with a number of negative psychological and physiological outcomes (Blalock & Joiner, 2000; Taylor & Stanton, 2007). Research has also linked long-

term use of avoidance to increased risk of burnout and STS and reduced CS (Anderson, 2000; Cicognani, Pietrantonio, Palestini & Prati, 2009), consistent with the findings of the present study. Moreover, avoidance is a symptom of STS (Figley, 1995), suggesting that the relationship between avoidance and secondary traumatic stress may be bi-directional. An alternative possibility is that the use of long-term avoidance in foster carers in the CF group may be a consequence of their CF, rather than a mechanism through which CF develops.

Positive reappraisal, another form of emotion-focused coping, was used by foster carers experiencing CS but not by those experiencing CF suggesting that positive reappraisal as a means of coping may reduce CF and increase CS. Positive reappraisal essentially involves reinterpreting potentially stressful situations as benign or beneficial, thereby reducing the emotional impact (Garland, Gaylord & Fredrickson, 2011). Numerous studies have highlighted the benefits of positive reappraisal on the reduction of CF and the promotion of CS in other formal caregivers (e.g. Samios, Abel & Rodik, 2013), substantiating the present finding.

Another coping strategy that has been linked to wellbeing outcomes, including CF and CS is self-care (Figley, 2002; Killian, 2008). The findings of the present study showed substantial differences across groups in the use of self-care. Foster carers experiencing CS prioritised their own needs for self-care with apparent ease, whereas foster carers experiencing CF struggled to prioritise themselves, and appeared to feel unentitled to engage in activities for their own gratification. This supports the findings of the quantitative study linking self-care to increased CS and reduced burnout and STS, and substantiates previous studies highlighting the link

between self-care and CF and CS among other caring professionals (Alkema et al., 2009; Eastwood & Ecklund, 2008).

In addition to highlighting the positive impact of engaging in self-care practices generally, foster carers particularly emphasised the positive benefits of exercise for the reduction of CF and the promotion of CS. This contradicts the quantitative study, which found exercise not to be associated with burnout, STS or CS. This may be due to some of the questions that comprise the physical activity subscale of the HPLP-II questionnaire used to assess exercise in the quantitative study. The questionnaire asks foster carer to rate how often they '*reach [their] target heart rate when exercising*', and how frequently they '*check [their] pulse when exercising*', and therefore may not fully capture foster carers use of exercise if they engage in exercise without consideration of their pulse or heart rate. However, research examining the associations between exercise and CF and CS in other professional caregivers has also shown inconsistent findings (e.g. Killian, 2008; Hinderer et al., 2014).

5.3.6 The big brother effect

All foster carers felt a need to justify their reasons for becoming a foster carer and constantly prove their ability to care for the foster children, suggesting that foster carers feel insecure and inadequate in their role. Previous research has demonstrated associations between feelings of inadequacy in a role, and increased burnout in nurses (Lu, 2008). However, because all foster carers felt a need to justify their position, this suggests that feelings of inadequacy alone are not sufficient to develop CF.

All foster carers experienced other people as judgemental, however, differences between the groups were apparent. Foster in the CS group expected people to make judgements about their actions, but did not consider these judgements to be reflective of them as individuals, whereas those in the CF group expected people to make global judgements about the type of person that they were. While it may be that those experiencing CF truly receive more negative judgements, other potential explanations need to be considered. For example, this finding may reflect a difference in cognitive style between the two groups, with foster carers experiencing CF having a more negative thinking style. Previous studies have shown irrational beliefs and negative automatic thoughts to be significantly associated with higher levels of burnout (e.g. Ohue, Moriyama & Nakaya, 2011). Therefore, the findings of the present study may reflect differences in cognitive styles, with foster carers experiencing CF having a higher propensity to negative cognitive distortions, rather than differences in actual experiences.

Another tangible difference between the groups was in their experiences of feeling under surveillance and under control by the foster care system. Foster carers experiencing CF described a constant feeling of being watched and dictated to. Moreover, they were extremely cautious of their actions at all times, because they were fearful of how their actions would be viewed by key stakeholders. There was a distinct sense of fear that they were inadequate as foster carers and therefore felt that there was a possibility that both the foster children and their own children could be taken from them. This is consistent with previous research with other professional caregivers, which has shown feeling of autonomy and control to be

mitigating factors for the development of burnout (Abu-Bader, 2000; Vredenburgh, Carlozzi & Stein, 1999).

5.3.7 Outcomes

Foster carers in both groups acknowledged positive personal outcomes from fostering, however only foster carers experiencing CF identified undergoing negative growth. Negative growth was described as encompassing changes to their attitude in particular. Foster carers in the CF group became more sceptical and suspicious, and less trusting, of others and their motives. While not the focus of the present study, this suggests that foster carers in the CF may be experiencing more permanent cognitive changes affecting their view of the world and other people, synonymous with vicarious traumatisation. According to Pearlman and Saakvitne (1995, p. 31) Vicarious traumatisation is defined as the *“permanent transformation in the inner experience of the therapist that comes about as the result of empathic engagement with clients’ trauma material”*, and involves disruptions to caregivers schemas about safety and trust. The present findings suggest that the impact of caring on foster carers may extend beyond treatable outcomes including CF, and result in permanent changes to foster carers’ cognitive schemata.

While some descriptions of the negative growth experienced by foster carers in the CF group suggest the presence of vicarious traumatisation, foster carers in this group also acknowledged experiencing CF, particularly burnout. They described symptoms of burnout including emotional exhaustion, lethargy, and a dislike of the children and their work, consistent with both theoretical descriptions (Maslach & Jackson, 1981) and research with other caregiving professionals (Taylor & Barling,

2004). Personal life stressors, such as the loss of a parent, were identified as contributing to burnout. Previous research has also shown personal stressors to be related to both burnout and secondary trauma (Adams, Boscarino & Figley, 2006), with Figley's (2002) model further implicating stressful life events in the development of STS. This finding highlights that external and unavoidable stressors can also play a role in the experience of negative outcomes for foster carers. Foster carers in the CS group were aware of the risks of burnout in their role, and identified using self-care and social support as preventative strategies, further substantiating the protective function of both support and self-care in the prevention of compassion fatigue, discussed above.

Fostering was further recognised to impact the wider family in both positive and negative ways. Foster carers' own biological children were accredited with having a greater awareness and acceptance of other people as a result of exposure to their foster siblings. This is consistent with numerous previous studies with birth children of foster carers, which have shown children of foster carers to feel more sensitive, responsible and caring as individuals as a result of their experiences (Poland & Groze, 1993; Thompson & McPherson, 2011; Twig & Swan, 2007; Watson & Jones, 2002). However, negative outcomes for their own children were also acknowledged. Foster carers felt their own children were exposed to adult themes, including sexualised behaviour, too young.

Finally, all foster carers were acutely aware of how their involvement in fostering lead to positive outcome for the children they foster. They identified the foster children making developmental gains, in addition to having better prospects in life.

This suggests that all foster carers, irrespective of their group, were able to see positive changes and find a sense of meaning in their work, thus increasing their potential of experiencing CS (Stamm, 2010). However, as foster carers experiencing low levels of CS also identified positive outcomes for the children, this suggests that positive outcomes alone are not sufficient to lead to CS. Therefore other factors, such as those highlighted above are also necessary to develop compassion satisfaction in the foster carer role.

5.4 Implications of the integrated findings

Together the results of the both the quantitative and the qualitative studies suggest that foster carers are a group of formal caregivers who are particularly at risk for developing STS and burnout, but equally have considerable potential for experiencing CS. When considered together, the findings of the quantitative and the qualitative studies have a number of potential implications for policy and practice. Firstly, because this study suggests that foster carers are at risk for the negative consequences of caring, interventions need to be implemented at a system level to help foster carers who are already experiencing CF. A number of intervention programmes have been shown to be effective with other professional caregivers experiencing CF (Gentry, Baggerly & Baranowsky, 2003; Potter et al., 2013) and these could provide a framework for intervention with foster carers.

Secondly, more consideration may need to be given to both the number of children, in addition to the presentation of children, placed with foster carers. The quantitative study showed that, for all three outcomes, the total number of children fostered since becoming a foster carer was a significant predictor even

when other factors were added to the equation. Therefore, in terms of protecting foster carer's wellbeing, policies may need to stipulate a maximum number of children foster carer's are requested to care for, or, alternatively, additional precautions and preventative measures may need to be put in place to protect foster carers as they take on more children over time. Interestingly, the length of time served as a foster carer was not a significant predictor of any of the three outcomes, suggesting that foster carers could sustain a long service in their role, providing that the number of children placed in their care is controlled. Additional precautions and preventative measures may also be necessary to protect foster carers in the presence of certain medical and neurodevelopmental conditions. The qualitative study suggests that foster carers providing care to children with medical and neurodevelopmental diagnoses may be at increased risk for CF. Therefore, additional supports may need to be put in place to protect these foster carers. While the qualitative study further found all foster carers to face challenging behaviour in their role, the quantitative study successfully demonstrated measurable differences, with challenging behaviour displayed by the children being significantly associated with all three outcomes for foster carers. This suggests that foster carers who have children with increased challenging behaviour may require additional support or training to maintain their wellbeing. Policies and interventions aimed at targeting foster children's behavioural issues may significantly reduce foster carers risk of STS and burnout, and increase their potential for CS. Specific interventions to target challenging behaviour may include training for the foster carers on how to manage challenging behaviour, as previous research has highlighted a relationship between increased

self-efficacy in managing challenging behaviour and reduced caregiver stress (Morgan & Baron, 2011).

Interestingly, when individual self-care behaviours were entered into the equation in the quantitative study, the influence of foster children's behaviour only remained significant for burnout, suggesting that other factors may be more influential in the development of STS and CS. In terms of specific self-care strategies, differences were apparent across the quantitative and qualitative studies. While the qualitative study emphasised the importance of exercise, the quantitative study found no association between exercise and any of the three outcomes (burnout, secondary traumatic stress or compassion satisfaction). This may be due to the measure used to assess exercise (HPLP-II), which assessed foster carers' monitoring of physiological states during exercise (e.g. pulse), rather than focusing exclusively on recreational aspects of exercise. This highlights the benefits of mixed methods research in gaining a more thorough and accurate understanding of phenomena. The quantitative study showed stress management to be particularly important in preventing STS and burnout, while spiritual growth was shown to be important in preventing burnout and promoting CS. Despite the differences between the two studies, together, they highlight self-care as an important area to target to prevent burnout and STS and promote CS in foster carers. Interventions could be aimed at promoting the importance of self-care and giving foster carers explicit permission to prioritise themselves, due to the difficulty they described in engaging in activities for their own gratification. While spirituality is arguably not something that can be taught, emphasising the importance of spirituality and engaging in spiritual practices may be important.

Perhaps amongst all of the responsibilities of foster carers engagement in spiritual activities may not be seen as a priority. Therefore, emphasising the importance of engaging in spirituality and essentially giving foster carers permission to prioritise spiritual activities may serve to reduce burnout and increase CS in foster carers. Additionally, the implementation of training programmes for foster carers focused on managing stress should be considered.

A deeper insight into coping and its relationship to CF and CS was gleaned from the qualitative study, which highlighted coping strategies that hadn't been considered in the quantitative study, including both problem-focused and emotion-focused strategies for stress management. Based on these findings, stress management training could emphasise the contribution of long-term use of avoidance in the development of CF and highlight other more adaptive strategies, such as positive reappraisal and information seeking. However, the qualitative study highlighted that foster carers in the CF group experienced difficulties in employing information-seeking due to lack of availability of information sources such as training. This suggests that information to deal with difficult situations, particularly related to managing challenging behaviour, needs to be made more available to foster carers. This could be done through organising more frequent and easily accessible training programmes for foster carers, or if this proves difficult in more remote areas, information could be disseminated through online training programmes or directly by professionals working with foster carers within the system.

Contradictory findings on the benefits of support for the prevention of CF and the promotion of CS were found between the quantitative and qualitative studies.

However, as previously discussed, this may be due to the way in which support was assessed in the quantitative study. The quantitative study focused exclusively on perceived availability of support, and did not consider other aspects of support, such as quality of support or sources of support. In interviews with foster carers, the importance of different sources of support was highlighted. Based on the qualitative findings, additional emotional support from professionals and other foster carers and additional practical support from the wider family network may also be beneficial. Foster carers require more supervision, which should hear and validate their experiences of how they are impacted by fostering. Previous research has shown supervision in which caregivers feel their experiences have been validated to be related to reduced CF (Sommer & Cox, 2005). Furthermore, foster carers could be included more within the system, and positioned as a more equal partner, alongside other professionals. Peer support was highlighted as having a positive impact on foster carers in this study, suggesting that more opportunities to meet other foster carers, either through support groups or training should be made available. While it would be impossible for policies to stipulate that a foster carer's family provide additional support, considering the availability of family support during foster carer recruitment may be an alternative. Alternatively, making practical support more easily accessible and readily available, for example by providing childcare to assist foster carers in engaging in leisure and self-care activities, may reduce the risk of CF.

Finally, personal stressors such as the death or illness of a family member were described to have a significant impact on CF in foster carers. While these life stressors are ultimately unavoidable, this finding suggests the importance of

professionals maintaining regular contact with foster carers and extending additional support and resources during times of unavoidable stress as a means of mitigating the negative impact.

5.4.1 Implications for Clinical Psychologists

The findings also have a number of potential implications for the author and other Clinical Psychologists in their professional roles. The findings highlight the risk to wellbeing for foster carers and indicate that Clinical Psychologists need to remain conscious of this risk when working with foster carers, for example, through providing information about compassion fatigue and compassion satisfaction to foster carers, as well as through getting involved in the delivery of workshops for foster carers. The present findings also have implications for Clinical Psychologists working with carers and parents more generally. Although more research is needed to determine whether the present findings extend to biological parents and caregivers of other family members (e.g. elderly parents; children with enduring illnesses etc.), Clinical Psychologists working with those assuming a caregiver role, including parents of children attending mental health services, need to remain conscious of the potential risk for burnout and secondary traumatic stress among caregivers, and provide the necessary support or signposting to appropriate supports to those at risk. Furthermore, Clinical Psychologists should remain mindful of their own potential for developing burnout and secondary traumatic stress, and act accordingly to protect their wellbeing by prioritising self-care.

5.4.2 Strengths and Limitations

In interpreting the present findings a number of limitations of both the quantitative and the qualitative studies need to be considered. Firstly, the cross-sectional design used in the quantitative study limits causality and allows only for establishing associations between variables. Causality could be bidirectional, particularly in the associations between child behaviour, self-care and social support and the three outcome variables (STS, burnout and CS). Secondly, the response rate and the completion rate were relatively low, which may represent an inherent bias in the characteristics of participants who firstly responded to and subsequently completed the online survey. Moreover, because foster carers were recruited through the Irish Foster Care Associations (IFCA) this may further bias the results. It is possible that being involved with IFCA has an impact on STS, burnout and CS in foster carers, and therefore those who are not engaged with IFCA may experience differential levels of the constructs. Thirdly, there is a possibility of type-II errors (failure to detect a true difference) in the present study, due to the small numbers of foster carers in certain categories, for example between relative and general foster carers. On the other hand, given the cross-sectional nature of the study the findings could merely represent a reporting bias. Foster carers who are experiencing greater levels of STS may perceive and report more challenging behaviours in the children that they foster, compared to foster carer experiencing lower levels of STS. Fourthly, by not recruiting a control group the extrapolation of findings may be limited to foster carers only. However, by comparing the results and data to the normative data available for the ProQOL-5 scale and to those of other professional caring groups it helped to assimilate the findings with the wider literature.

The qualitative study also contained a number of limitations. Firstly, interviews ranged in length from 27 to 55 minutes. The shortest interview time was with a male participant in the compassion satisfaction group. Although the precise reason for the shorter interview cannot be determined, it is possible to speculate. It was noted both during the interview that the participant had only had one foster child and did not report any significant difficulties with the child, the child's biological relatives or the professionals involved. Therefore, while the participant spoke freely about their positive experiences of fostering, they struggled to identify negative experiences, and therefore spoke for a shorter time overall. This is in contrast to the majority of foster carers in the study who identified a range of both positive and negative experiences from which they were willing and able to talk about. Furthermore, because the participant was experiencing compassion satisfaction (and perhaps because this was his first foster placement had never experienced compassion fatigue in the context of fostering), he had little to discuss in relation to the two overarching interview questions relating to burnout and secondary traumatic stress, thus his interview was shorter. Secondly, there was some difficulty in establishing whether differences existed for some phenomena highlighted by foster carers based on description alone. For example because all foster carers experienced challenging behaviour, it was unclear from their descriptions alone whether there was a difference in the perceived severity of the children's challenging behaviour. However, this limitation is offset by the examination of challenging behaviour in the quantitative study, which demonstrated significant relationships between challenging behaviour and the three constructs of interest (burnout, STS and CS). Another potential limitation

warranting consideration when interpreting the present findings is the gender imbalance of the current sample of foster carers. The qualitative study included seven females and only three males. This may have impacted the findings of the study, due to possible role differences between males and females. Research suggests that in the case of family caregiving, mothers tend to spend more time daily providing care, and also perceive more burden in their role than males (Heller, Hsieh & Rowitz, 1997). Moreover, the researcher and supervisors of this project have a background in Clinical and Health Psychology, which likely influenced the interpretation of the data. Adoption of another perspective would likely have yielded a different interpretation. Similarly, a different analytic approach, such as Interpretative Phenomenological Analysis may have yielded different findings. However, the present study was primarily concerned with the experiences of foster carers in relation to contributory and preventative factors in the development of CF and CS, and not the meaning foster carers derive from their experiences.

Despite these limitations, this study also had a number of strengths. A major strength of this study was the use of a mixed methods research design to examine CF and CS in foster carers. The integration of quantitative and qualitative methods allowed for a more comprehensive insight into CF and CS in foster carers, than could have been obtained from the use of either method alone. The sequential design was effective in meeting the research objectives of the study. Firstly, the quantitative phase provided strong evidence for the high risk of burnout and STS and the high potential for CS in foster carers. It also demonstrated relationships between child behaviour, social support, and self-care and burnout, STS and CS.

Subsequently, the qualitative phase was able to both substantiate the contribution of, and explore the nuances of the relationships between child behaviour, social support and self-care and CF and CS in richer detail and with context. Moreover, the qualitative phase illuminated additional factors that are important in the experiences of CF and CS that hadn't been gleaned from the quantitative study. The inclusion of a group of foster carers experiencing high CF (and low CS) and a group of foster carers experiencing high CS (and low CF) is a particular strength of this study. It allowed for comparison to be made between groups to gain a more thorough understanding of contributory and protective factors in the development of CF and CS. Finally, the use of a national sample is a strength of this study, as it is likely to be more representative of foster carers generally and be less vulnerable to area-specific difficulties, than if a regional sample had been examined.

5.4.3 Future Research

This novel study exploring STS, burnout and CS in a national sample of foster carers in Ireland offers direction for future research. Firstly, future quantitative research should employ a longitudinal design examining foster carers from the point of application, through initial training, and into fostering to establish a trajectory of STS, burnout and CS in foster carers. Secondly, given the significance of the number of children fostered over time revealed in the present study, future research could also seek to determine whether a floor effect exists, to establish at what point foster carers may need additional support and resources to protect against STS and burnout, or whether there should be a cut-off implemented for the number of children fostered. Thirdly, future research could seek to devise and examine the effectiveness of targeted training programmes to assist foster carers

in managing challenging behaviour and to promote stress-management strategies. Fourthly, given the findings of differences in coping styles across groups in the qualitative study, future research could examine coping styles using quantitative methods, to establish whether measurable differences in coping styles exist between foster carers who develop CF and those that do not. If significant relationships between coping styles and CF were found, this could have further implications for practice and policy. Coping styles could potentially be used as a selection criterion in recruiting foster carers, or, equally, training could be offered to encourage and develop more adaptive coping strategies. Fifthly, future research could examine whether attachment behaviours of the children or attachment styles of foster carers has an impact on the development of CF. The present qualitative findings are suggestive of potential differences, but more research is needed to establish where these differences lie. Sixthly, research is needed to examine whether differences exist in cognitive styles in foster carers who are at higher risk for CF. Moreover, further research is needed to establish whether more negative thinking styles are causative of CF or a consequence of CF. Seventhly, findings from other professional caregiver groups suggest a role for other factors in the development of CF and CS, for example; level of education; personal trauma history; and other commitments which may place additional demands on their resources (e.g. caring for their biological children or aging parents). Finally, the present study suggests that CF is an issue in foster carers, and demonstrates a need for interventions for foster carers who are experiencing CF. Therefore, research is needed to establish effectiveness of any interventions that are implemented with foster carers.

5.4.4 Conclusion

This thesis has successfully addressed a gap in the existing literature by examining the impact of caring on foster carers. It demonstrates both quantitative and qualitative evidence for the high risk of compassion fatigue (both burnout and secondary traumatic stress), as well as the significant potential for compassion satisfaction in foster carers. It has highlighted factors that are related to both compassion fatigue and compassion satisfaction, including the number of children fostered, child behaviour, support, and self-care and coping. Moreover, this thesis has paved the way for future research to further explore the 'cost of caring' for foster carers.

5.5 Reflection on the project

Overall, I feel that this research project was extremely worthwhile. It has highlighted the difficulties faced by a significantly under-researched group; foster carers, and the impact that their caregiving role can have on their wellbeing. If I were to repeat this research again I would consider explicitly asking about other caregiving roles, apart from the foster carer role, (e.g. working outside the home, biological parent, spouse, carer for parents etc.) to determine other potential caregiving roles that could be influencing the development of compassion fatigue and compassion satisfaction. Some of these additional caregiving roles were highlighted during the qualitative interviews, and therefore, on reflection, further exploration of these may have proved beneficial. However, as one of the first studies into compassion fatigue and compassion satisfaction in foster carers I am proud to have highlighted some of the difficulties faced by foster carers, in addition to some strategies that may serve as protective factors for foster carers. The

participants were all very grateful for the opportunity to discuss their experiences and to have both the positive and negative aspects of their roles highlighted.

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Appendices

Appendix A: Invitation email



You are invited to take part in a research study entitled “Compassion Fatigue and Compassion Satisfaction in Foster Carers: A Mixed Methods Approach”.

Claire Reinhardt, Psychologist in Clinical Training, under the supervision of Dr Patrick Ryan, Head of Psychology Department at the University of Limerick, is currently recruiting foster carers to take part in a study exploring both the positive and negative impact of fostering on foster carers.

It is hoped that by exploring the impact of fostering on foster carers that we can gain a greater understanding of your experiences and how your wellbeing can be maximised. Further information on the study is available at the bottom of this email. Further information about the study is available in the participant information sheet below.

If you would like to participate in this research please click on the link below which will direct you to the online survey:

[\[link\]](#)

Participants will be entered into a draw to win an electronic tablet device. The draw will take place on 15th June 2015 and the winner will be notified via email.

Your participation in this study would be very much appreciated.

Best wishes,

Claire Reinhardt.

This research study has received Ethics approval from the Education and Health Sciences Research Ethics Committee (quote approval number).

If you have any concerns about this study and wish to contact someone independent you may contact:

Chairman Education and Health Sciences Research Ethics Committee
EHS Faculty Office
University of Limerick
Tel (061) 234101



Participant Information Sheet

You are invited to participate in a research study of the impact of fostering on foster carers. Before you decide whether you would like to participate, please take time to read the following information, and feel free to contact me if you would like any further information.

Title of research: Compassion Fatigue and Compassion Satisfaction in Foster Carers: A Mixed Methods Approach.

Researcher: Claire Reinhardt, Psychologist in Clinical Training, currently studying at the University of Limerick and employed by the HSE.

Purpose of the Study: The purpose of this study is to explore the impact of fostering on foster carers. In particular I am interested in your experiences of compassion fatigue (the negative impact of caring) and compassion satisfaction (the positive impact of caring).

Why have I been asked to take part in this study? You have been invited to participate in this study because you are an approved foster carer in Ireland.

Procedures:

Should you agree to participate in this research, please click on the link included in this email to complete the questionnaires. It is estimated that the questionnaires will take approximately 30 minutes to complete. There will also be an opportunity to take part in a more in-depth interview study to discuss your experiences of fostering; this will take approximately 45-60minutes and will be audio-recorded. I will randomly select 12 people who have completed the interview consent form at the end of the questionnaire. If you are randomly selected I will contact you via telephone to arrange an interview at a time and venue that is convenient for you. If you are not randomly selected and would like to talk to someone then please indicate this on the consent form below.

If I say no what will happen?

Taking part in this study is entirely voluntary and you do not have to take part if you do not wish to do so. There will be no consequences if you do not participate. If you decide to participate you are free to change your mind and withdraw at any time. Withdrawal from the study will not affect you in any way.

What are the benefits of this study?

It is hoped that this study will provide a greater understanding of the impact and experiences of fostering on foster carers. The information gathered may help highlight additional supports or training needed by foster carers.

What are the risks of taking part in this study?

You may find some of the information you discuss upsetting when talking about your experiences of providing foster care.

Confidentiality:

All information collected, both through questionnaires and interviews, will be treated as strictly confidential. The information you provide will not be shared with other professionals, unless it indicates harm to others. No personal or identifiable data will be used when writing up the research project. Information will be stored in a locked filing cabinet or on an encrypted computer and will only be accessible by the researcher and their supervisor.

Further Information:

If you would like any further information please do not hesitate to contact me by email at; 13027409@studentmail.ul.ie . Alternatively you can contact my research supervisor, Dr. Patrick Ryan by email at; Patrick.ryan@ul.ie or by telephone on; 061-202539.

Thank you.

Claire Reinhardt
Psychologist in Clinical Training

This research study has received Ethics approval from the Education and Health Sciences Research Ethics Committee (quote approval number).
If you have any concerns about this study and wish to contact someone independent you may contact:
Chairman Education and Health Sciences Research Ethics Committee
EHS Faculty Office
University of Limerick
Tel (061) 234101

Appendix B: Online questionnaire

Demographic and Work-Related Questions

Please indicate your answers:

1. **Age** _____

2. **Gender**

Female

Male

3. **Type of care**

Relative

General

4. **How long have you been a foster carer?**

_____ years and _____ months

5. **How many children are you currently fostering?**

6. **How many children have you fostered in total?**

7. **Have any of the foster children currently placed in your care experienced a traumatic or stressful event prior to their admission to care? (please tick all that apply)**

Sexual abuse

Physical abuse

Emotional abuse/neglect

Other

If other please describe: _____

8. **How many hours respite have you received in the past month?**

9. **How many hours respite have you received in the past 12 months?**

10. How many hours foster carer training have you attended in the past 12 months?

11. How many hours foster carer training have you attended altogether?

Professional Quality of Life, Version 5 (ProQOL-5; Stamm, 2009)

When you foster people you have direct contact with their lives. As you may have found, your compassion for those you foster can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a foster carer. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often
1. I am happy.				1 2 3 4 5
2. I am preoccupied with more than one person I foster.				1 2 3 4 5
3. I get satisfaction from being able to foster people.				1 2 3 4 5
4. I feel connected to others.				1 2 3 4 5
5. I jump or am startled by unexpected sounds.				1 2 3 4 5
6. I feel invigorated after working with those I foster.				1 2 3 4 5
7. I find it difficult to separate my personal life from my life as a foster carer.				1 2 3 4 5
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I foster.				1 2 3 4 5
9. I think that I might have been affected by the traumatic stress of those I foster.				1 2 3 4 5
10. I feel trapped by my job as a foster carer.				1 2 3 4 5
11. Because of my fostering, I have felt "on edge" about various things.				1 2 3 4 5
12. I like my work as a foster carer.				1 2 3 4 5
13. I feel depressed because of the traumatic experiences of the people I foster.				1 2 3 4 5
14. I feel as though I am experiencing the trauma of someone I have fostered.				1 2 3 4 5
15. I have beliefs that sustain me.				1 2 3 4 5

16. I am pleased with how I am able to keep up with fostering techniques and protocols. 1 2 3 4 5
17. I am the person I always wanted to be. 1 2 3 4 5
18. My work makes me feel satisfied. 1 2 3 4 5
19. I feel worn out because of my work as a foster carer. 1 2 3 4 5
20. I have happy thoughts and feelings about those I foster and how I could help them. 1 2 3 4 5
21. I feel overwhelmed because my case work load seems endless. 1 2 3 4 5
22. I believe I can make a difference through my work. 1 2 3 4 5
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I foster. 1 2 3 4 5
24. I am proud of what I can do to help. 1 2 3 4 5
25. As a result of my fostering, I have intrusive, frightening thoughts. 1 2 3 4 5
26. I feel "bogged down" by the system. 1 2 3 4 5
27. I have thoughts that I am a "success" as a foster carer. 1 2 3 4 5
28. I can't recall important parts of my work with trauma victims 1 2 3 4 5
29. I am a very caring person. 1 2 3 4 5
30. I am happy that I chose to do this work. 1 2 3 4 5

Health-Promoting Lifestyle Profile, 2nd Edition (HPLP-II; Walker, Sechrist & Pender, 1995)

DIRECTIONS: This questionnaire contains statements about your present way of life or personal habits.

Please respond to each item as accurately as possible, and try not to skip any item. Indicate the frequency with which you engage in each behavior by circling: N for never, S for sometimes, O for often, or R for routinely

- | | |
|--|---------|
| 1. Discuss my problems and concerns with people close to me. | N S O R |
| 2. Choose a diet low in fat, saturated fat, and cholesterol. | N S O R |
| 3. Report any unusual signs or symptoms to a physician or other health professional. | N S O R |
| 4. Follow a planned exercise program. | N S O R |
| 5. Get enough sleep. | N S O R |
| 6. Feel I am growing and changing in positive ways. | N S O R |
| 7. Praise other people easily for their achievements. | N S O R |
| 8. Limit use of sugars and food containing sugar (sweets). | N S O R |
| 9. Read or watch TV programs about improving health. | N S O R |
| 10. Exercise vigorously for 20 or more minutes at least three times a week (such as brisk walking, bicycling, aerobic dancing, using a stair climber). | N S O R |
| 11. Take some time for relaxation each day. | N S O R |
| 12. Believe that my life has purpose. | N S O R |
| 13. Maintain meaningful and fulfilling relationships with others. | N S O R |
| 14. Eat 6-11 servings of bread, cereal, rice and pasta each day. | N S O R |
| 15. Question health professionals in order to understand their instructions. | N S O R |
| 16. Take part in light to moderate physical activity (such as sustained walking 30-40 minutes 5 or more times a week). | N S O R |
| 17. Accept those things in my life which I can not change. | N S O R |
| 18. Look forward to the future. | N S O R |
| 19. Spend time with close friends. | N S O R |
| 20. Eat 2-4 servings of fruit each day. | N S O R |
| 21. Get a second opinion when I question my health care provider's advice. | N S O R |
| 22. Take part in leisure-time (recreational) physical activities (such as swimming, dancing, bicycling). | N S O R |
| 23. Concentrate on pleasant thoughts at bedtime. | N S O R |
| 24. Feel content and at peace with myself. | N S O R |
| 25. Find it easy to show concern, love and warmth to others. | N S O R |
| 26. Eat 3-5 servings of vegetables each day. | N S O R |
| 27. Discuss my health concerns with health professionals. | N S O R |
| 28. Do stretching exercises at least 3 times per week. | N S O R |
| 29. Use specific methods to control my stress. | N S O R |
| 30. Work toward long-term goals in my life. | N S O R |
| 31. Touch and am touched by people I care about. | N S O R |
| 32. Eat 2-3 servings of milk, yogurt or cheese each day. | N S O R |
| 33. Inspect my body at least monthly for physical changes/danger signs. | N S O R |

- 34. Get exercise during usual daily activities (such as walking during lunch, using stairs instead of elevators, parking car away from destination and walking). N S O R
- 35. Balance time between work and play. N S O R
- 36. Find each day interesting and challenging. N S O R
- 37. Find ways to meet my needs for intimacy. N S O R
- 38. Eat only 2-3 servings from the meat, poultry, fish, dried beans, eggs, and nuts group each day. N S O R
- 39. Ask for information from health professionals about how to take good care of myself. N S O R
- 40. Check my pulse rate when exercising. N S O R
- 41. Practice relaxation or meditation for 15-20 minutes daily. N S O R
- 42. Am aware of what is important to me in life. N S O R
- 43. Get support from a network of caring people. N S O R
- 44. Read labels to identify nutrients, fats, and sodium content in packaged food. N S O R
- 45. Attend educational programs on personal health care. N S O R
- 46. Reach my target heart rate when exercising. N S O R
- 47. Pace myself to prevent tiredness. N S O R
- 48. Feel connected with some force greater than myself. N S O R
- 49. Settle conflicts with others through discussion and compromise. N S O R
- 50. Eat breakfast. N S O R
- 51. Seek guidance or counseling when necessary. N S O R
- 52. Expose myself to new experiences and challenges. N S O R

Support Function Scale (SFS; Dunst, Jenkins & Trivette, 1984)

Listed below are 12 different types of assistance which people sometimes feel helpful. This questionnaire asks you to indicate how *much* help you need in these areas. Please circle the response that best describes your needs. Please answer all the questions. How often is each of the following kinds of support available to you if you need it? Tick only one box in each section.

	<i>Never</i>	<i>Once in a while</i>	<i>Some-times</i>	<i>Often</i>	<i>Quite Often</i>
1. Someone to talk about things that worry you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Someone to help take care of your child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Someone to talk to when you have questions about raising your child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Someone who loans you money when you need it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Someone to encourage or keep you going when things seem hard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Someone who accepts your child regardless of how (s)he act	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Someone to help with household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Someone to relax or joke with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Someone to do things with your child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Someone to provide you or your child with transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Someone to hassle with agencies or organisations when you cant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Someone who tells you about services to your child or family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997)

It would help us if you answered all the items as best as you can. Please give your answers on the basis of the child's behaviour over the last SIX MONTHS. Tick only one box in each section

	<i>Not true</i>	<i>Somewhat true</i>	<i>Certainly true</i>
1. Considerate of others people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Often complains of headaches, stomach aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Shares readily with children (treats, toys, pencils etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Rather solitary - tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Generally obedient - usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Many worries - often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Often unhappy, down hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Often argumentative with adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Often volunteers to help others (parents, teachers, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Can stop and think things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Can be spiteful to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



UNIVERSITY of LIMERICK
O L L S C O I L L U I M N I G H

Interview Consent Form

I _____ would like to participate in an interview to discuss how fostering has impacted me as part of the research study "Compassion Fatigue and Compassion Satisfaction in Foster Carers: A Mixed Methods Approach".

Name: _____

Contact Telephone Number: _____

Prize Draw

If you would like to be entered into a draw to win a tablet device please provide your email address below. The winner will be drawn at random on the 31st August and notified via email.

Email address: _____

Appendix C: Participant information sheet for interview



Participant Information Sheet (interview)

Thank you for expressing an interest in participating in an interview as part of my research project titled “Compassion Fatigue and Compassion Satisfaction in Foster Carers: A Mixed Methods Approach”. The interview constitutes the second phase of the research project. Before you decide whether you would like to participate, please take time to read the following information, and feel free to contact me if you have any questions or if you would like any further information.

Title of research: Compassion Fatigue and Compassion Satisfaction in Foster Carers: A Mixed Methods Approach.

Researcher: Claire Reinhardt, Psychologist in Clinical Training, currently studying at the University of Limerick and employed by the HSE.

Purpose of the Study: The purpose of this study is to explore the experiences and impact of fostering on foster carers. In particular I am interested in your experiences of compassion fatigue (the negative impact of caring) and compassion satisfaction (the positive impact of caring).

Why have I been asked to take part in this study? You have been invited to participate in this study because you are an approved foster carer in Ireland. When you completed the survey for this research project you indicated that you would like to take part in an interview to discuss your experiences of fostering further.

Procedures:

Should you agree to participate in this research, I will arrange a telephone interview with you at a time that is convenient for you. The interview will last a maximum of one hour and will be audio-recorded. If you are willing to take part then I will ask you to provide verbal consent. This is to ensure that you understand what is expected of you. Please note that you still have the right to withdraw even after consenting.

What kind of questions will I be asked?

You will be asked to talk about your experiences of fostering, including how fostering impacts you both positively and negatively. You will also be asked about how you are affected by the life experiences of the children in your care, prior to their entry to the care system.

If I say no what will happen?

Taking part in this study is entirely voluntary and you do not have to take part if you do not wish to do so. There will be no consequences if you do not participate. If you decide to participate you are free to change your mind and withdraw at any time. Withdrawal from the study will not affect you in any way.

What are the benefits of this study?

It is hoped that this study will provide a greater understanding of the impact and experiences of fostering on foster carers. The information gathered may help highlight additional supports or training needed by foster carers.

What are the risks of taking part in this study?

You may find some of the information you discuss upsetting when talking about your experiences of providing foster care.

Confidentiality:

All information collected will be treated as strictly confidential. The information you provide will not be shared with other professionals, unless it indicates harm to yourself or others. No personal or identifiable data will be used when writing up the research project. Information will be stored in a locked filing cabinet or on an encrypted computer and will only be accessible by the researcher and their supervisor.

Further Information:

If you would like any further information please do not hesitate to contact me by email at; 13027409@studentmail.ul.ie. Alternatively you can contact my research supervisor, Dr. Patrick Ryan by email at; Patrick.ryan@ul.ie or by telephone on; 061-202539.

Thank you.

Claire Reinhardt
Psychologist in Clinical Training

This research study has received Ethics approval from the Education and Health Sciences Research Ethics Committee (2015_04_13_EHS).
If you have any concerns about this study and wish to contact someone independent you may contact:
Chairman Education and Health Sciences Research Ethics Committee
EHS Faculty Office
University of Limerick
Tel (061) 234101

Appendix D: Interview schedule

- Can you tell me a bit about what fostering is like for you?
- How have you been affected by your work as a foster carer?
- Tell me about what you know about burnout in fostering?
 - Tell me more about this -

- Now I want to talk about the foster child. Can you tell me a little about their reason for coming to you?
 - Tell me more about this – Has their experiences affected you?
 - What kind of things do you feel contributes to this?
 - What kind of things do you feel protects against the impact of their trauma on you? – In what way?

- Can you tell me about the positive aspects of fostering?
 - Can you tell me about satisfaction in fostering?
 - What kind of things do you feel contributes to this?
 - What kinds of things do you feel interferes with this?

Appendix E: Verbal consent transcript



Verbal Consent Transcript (telephone interview)

Before starting the interview I need to ask you some questions to make sure that you fully understand the study and that you give your consent to take part. I am going to record me asking and you answering these questions so that I have a record of you consenting. The interview itself will also be recorded, so after you give consent I will continue to record our conversation until the interview is over. Is it okay with you if I now start the audio-recording? Y/N

Can you please state your name? _____

Have you read and fully understood the participant information sheet? Y/N

Do you have any questions arising from the information sheet? Y/N

Do you have any questions about me, the research or the interview? Y/N

If you have any questions at a later date please do not hesitate to contact me.

Do you have the information sheet with my contact details on it? Y/N

(If no, contact details should be provided now and time given to the participant to write these down).

Do you understand that this interview will be audio-recorded? Y/N

Do you understand that any information that you provide will be kept confidential?
Y/N

Do you understand that your participation in this research is voluntary and that you are free to withdraw at any time, even after the interview has taken place? Y/N

Do you consent to participating in this study? Y/N

Participant's name _____

Researcher's name _____

Researcher's signature _____

Date _____

Time _____

Appendix F: Example of coding using Microsoft Excel

	A	B	C	D	E
1	theme	sub-themes	higher codes	CS/CF	Code
2					
3	being a foster parent	parent-child connection	bond, attachment	cs	I know if something is bothering her
4	being a foster parent	parent-child connection	wants to stay	cs	made him so comfortable that he wants to stay
5	being a foster parent	parent-child connection	wants to stay	cs	wants to stay with us
6	being a foster parent	parent-child connection	wants to stay	cs	doesn't want to go home
7	being a foster parent	parent-child connection	bond, attachment	cs	attached really well
8	being a foster parent	parent-child connection	bond, attachment	cs	she calls me mammy
9	being a foster parent	parent-child connection	bond, attachment	cs	I know what she means
10	being a foster parent	parent-child connection	bonding/ trust	cs	he trusts us
11	being a foster parent	parent-child connection	bonding/ trust	cs	must trust us if talking to us
12	being a foster parent	parent-child connection	bonding/ trust	cs	comfortable enough to talk to us
13	being a foster parent	parent-child connection	bonding	cs	Do things together
14	being a foster parent	parent-child connection	trust./bonding	cs	Sit on my lap
15	being a foster parent	parent-child connection	trust./bonding	cs	Hold like a baby
16	being a foster parent	parent-child connection	trust./bonding	cs	Like you give a baby a bottle
17	being a foster parent	parent-child connection	trust./bonding	cs	Holding on my lap
18	being a foster parent	parent-child connection	trust./bonding/protect	cs	Now husband is being asked for same
19	being a foster parent	parent-child connection	trust./bonding/protect	cs	vulnerability (child's)
20	being a foster parent	parent-child connection	trust./bonding/protect	cs	Lying on someone's lap
21	being a foster parent	parent-child connection	trust	cs	Letting them feed you
22	being a foster parent	parent-child connection	trust	cs	see the love they have for you
23	being a foster parent	parent-child connection	bonding	cs	you know them better than anyone
24	being a foster parent	parent-child connection	role	cs	all he needed was a bit of love
25	being a foster parent	parent-child connection	role	cs	he settled quite well
26	being a foster parent	parent-child connection	role	cs	chat with him about worries
27	being a foster parent	parent-child connection	role	cs	they can talk to me if they want (kids)
28	being a foster parent	parent-child connection	bond	cs	you care about the child
29	being a foster parent	parent-child connection	role	cs	child talked to me about his abuse
30	being a foster parent	parent-child connection	role	cs	I'm an influence on him
31	being a foster parent	parent-child connection	role/ actively involved	cs	he (child) uses same expression as me
32	being a foster parent	parent-child connection		cs	extra set of memories
33	being a foster parent	parent-child connection	bond	cs	satisfaction - hugging you and saying they love you
34	being a foster parent	parent-child connection	bond, attachment	sts	bond with kids grows
35	being a foster parent	parent-child connection	bond, attachment	sts	don't want to break bond
36	being a foster parent	parent-child connection	bond, attachment	sts	talked helped our relationship (with kids)
37	being a foster parent	parent-child connection	bond, attachment	sts	I know the kids, what they've been through
38	being a foster parent	parent-child connection	bond, attachment	sts	bonds you - going through abuse together

Appendix G: Example of brainstorming graph

