

“Talk to me like I’m a Human” – An Interpretative Phenomenological Analysis of the Psychotherapy Experiences of Young People in Foster Care

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Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Psychotherapy (DPsych), is entirely my own work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

Signed:

A handwritten signature in black ink, appearing to be 'M. M. M.', written over a light blue grid background.

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Abstract

Daire Gilmartin

“Talk to me like I’m a Human” – An Interpretative Phenomenological Analysis of the Psychotherapy Experiences of Young People in Foster Care

Many young people in foster care experience significant mental health difficulties, leading to attendance at services where offering psychotherapeutic input that adequately meets their unique and diverse needs is an ongoing challenge. To date, the research on adolescents’ experiences of psychotherapy has mainly drawn on mental health populations. There is a dearth of research exploring the experiences of young people in foster care, specifically, their experiences of therapeutic engagement. Using Interpretative Phenomenological Analysis (IPA), this study reports on the psychotherapy experiences of young people in foster care. Individual interviews were conducted with seven young people in foster care and four superordinate themes were identified: Being Powerless; Risking Relationship; Opening Up; and Finding Connection. Young people revealed complex and individual experiences where they felt disempowered, drew on their courage to gradually build trust in therapists, were able to share their innermost thoughts and feelings and established deeper connections with themselves and others. This lived experience, illustrating a journey of relational connection aligns with recognition theory (Honneth, 1995, 1996) in highlighting young people’s need for authentic recognition as individuals in their totality, who desired psychotherapy that offered emotional connection and opportunities for systemic relational growth. The study illuminates the inherent challenges, as well as informing practice about how to engage with young people in foster care in a meaningful and helpful way.

Chapter 1: Introduction

This research project was borne out of the researcher's background working with young people¹ in foster care and his desire to learn directly from them as experts by experience. In the researcher's experience, psychotherapy^{2 3} always appeared to be a challenging endeavour for many young people and something they frequently avoided. Despite the plethora of studies examining professional practice, mental health difficulties, efficacy of foster care and the challenges faced by young people in foster care, few involved directly asking young people about their psychotherapeutic experiences. It was hoped that investigating their lived experiences of psychotherapy could help develop professional understanding with a view to furthering psychotherapy practice and tailoring interventions in ways that could better meet the therapeutic needs of young people in foster care.

This chapter briefly outlines the background of the study together with the reasons for undertaking this research project. The methodology and methods used as well as the research aim and objectives will be presented in summary form. A synopsis of the subsequent chapters will also be provided as well as a reflexive summary detailing the researcher's special interest in this area.

Background and Rationale for the Study

Commonly, children enter foster care from complex backgrounds of psycho-social difficulties and abuse (Scozzaro & Janikowski, 2015) and often require additional resources due to significant mental health issues (Ford et al., 2007; Raman & Sahu, 2014). Although children may experience a sense of relief at leaving a dangerous and inadequate family environment, their subsequent experience of living in care can contribute to

¹ 'Young people' is used interchangeably with 'children' and 'adolescents' in this study

² 'Psychotherapy' or 'psychotherapist' is used interchangeably with 'therapy' or 'therapist' and 'counselling' or 'counsellor'

³ In this study 'psychotherapy' takes on a broad definition. It refers to individual counselling, psychological therapy and creative arts psychotherapy (including play and art therapy)

additional difficulties due to care placement breakdown and relational instability, lack of service availability, and inadequate inter-agency responses (Lewis, 2011; Simmonds, 2014; Tatlow-Golden & McElvaney, 2015). Studies have consistently demonstrated that more than half of children in foster care have significant mental health difficulties that warrant referral to mental health services (Tarren-Sweeney & Vetere, 2014).

Foster care is a complicated context in which to deliver therapeutic interventions (Cantos & Gries, 2010; Kinsey & Schlösser, 2013) due to the nature and level of difficulties presented by children in care as well as the multiple systemic challenges that demand attention. A marked ambivalence towards accessing mental health services is identified in the literature as a distinguishing feature between children in foster care and other children who attend mental health services (Davies & Wright, 2008). Research suggests that mental health services often do not benefit children in long-term foster care as they frequently do not receive suitable and relevant therapeutic intervention (Bellamy et al., 2014), while professionals with responsibility for caring for these young people often struggle to adequately understand and appropriately respond to their needs (McElvaney & Tatlow-Golden, 2016).

There is a dearth of research examining therapeutic interventions that target adolescents in foster care, their experiences of mental health services and therapeutic engagement (Davies & Wright, 2008; Kinsey & Schlösser, 2013; Leve et al., 2012; Zilberstein & Popper, 2016). To date, the literature has mainly focussed on the experiences of young people using mental health services in general without a specific focus on psychotherapy. Research on the views of young adults with experience of the care system has gleaned important insights about their experiences of mental health services, including psychotherapy, while in care (Tatlow-Golden & McElvaney, 2015). However, although valuable, these views are gathered from young adults remembering what it was like to be a

child in care engaging with mental health services, rather than hearing directly from young people themselves while they are in care.

Children in care are a particularly marginalised group whose views are often not gathered and researched (McEvoy & Smith, 2011). Directly engaging with adolescents in care attends to the values and goals espoused by the UN Charter on the Rights of the Child (UNCRC), which states that children must have a say in matters affecting their lives (United Nations, 2010a), values consistent with Ireland's National Children's Strategy (NCS) (Department of Health and Children, 2000). Despite the fact that children in foster care are frequently referred for and attend psychotherapy, there appears to be no published studies that have directly examined what children in foster care think and feel about their experiences of psychotherapy. In trying to understand the phenomenon of psychotherapy for these adolescents, this research study engaged with young people while they were immersed in the experience of being an adolescent in foster care. It is hoped that by gaining an understanding of how these young people experienced psychotherapy, this study will contribute to the literature and assist therapists in more appropriately responding to their unique life-worlds.

Aim and Objectives of the Study

The aim of this research study was to explore adolescents' (12 – 18 years old) experiences of psychotherapy while in foster care.

The specific objectives were to illuminate:

- Participants' lived experiences of psychotherapy
- If and how psychotherapy was helpful; and
- Participants' perspectives on what influenced the level and nature of their engagement in psychotherapy

Methodology

This study employed Interpretative Phenomenological Analysis (IPA: Smith et al., 2009) as a methodology to explore young people's lived experience of psychotherapy while in foster care. Individual semi-structured interviews were conducted with seven young people, aged between 13 and 18 years old, about their experiences of psychotherapy. IPA is a systematic approach to the gathering and analysis of data and has been frequently used to explore under explored and sensitive phenomena. It applies a rigorous and detailed analytic process that helped build an in depth and rich understanding of the individual psychotherapy experiences of the young people in this study. The researcher's own interpretations and values are acknowledged as central to the research process, contributing to each aspect of the research study, and are reflected in the reflexive notes contained in each chapter.

Outline of Thesis

This chapter summarises the background, rationale, aims and objectives of the study. Chapter 2 provides an overview of alternative care internationally and in the Irish context, while briefly describing the foster care system in Ireland. The reasons children are placed in care, the impact of pre-care experiences and foster care experiences are outlined together with the key role that foster carers can play in children's lives. The complex therapeutic needs of young people in foster care are then outlined, as well as a critical summary of the literature examining therapeutic engagement and practice with this cohort. Finally, literature advocating the importance of closely consulting with young people in care about their experiences is highlighted.

Chapter 3 outlines the study aim, objectives, as well as detailing the methodology and methods used. The rationale for choosing IPA as a methodology for this study is presented, while an examination of the underpinning theories and assumptions of phenomenology, hermeneutics and idiography is presented. Issues regarding researcher

reflexivity and the application of the methodology are then detailed. This includes a description of how the study was conducted from its inception through to writing the thesis. Recruitment challenges are highlighted as well as complex ethical considerations pertaining to conducting research with this cohort of young people.

Chapter 4 presents the findings of the study, noting the similarities and divergences between participant's accounts illustrated with numerous quotations. A master table of the study themes details the four superordinate themes and the subordinate themes nested within. Chapter 5 discusses the study findings in the context of the extant literature. It situates the findings in selected literature in a way that progresses understanding of the young people's experiences with a view to informing psychotherapy practice with this population of young people. Chapter 6 outlines the implications of the study findings for psychotherapy practice, foster carers, training, policy and research. The study's strengths and limitations are considered while its quality is evaluated using Yardley's (2000) framework which Smith et al. (2009) recommends for IPA studies.

Researcher's Reflexive Comment – Why this Study?

I have been working with children and young people in care for over 20 years in my role as a counselling psychologist and previously as a social care worker in a residential setting, as well as in youth and community work. Frequently I have been taken aback by their remarkable courage and resilience while encountering significant adverse life circumstances. In witnessing their therapeutic encounters over the years in my role as a social care worker or directly engaging with them in therapy as a counselling psychologist, I have frequently wondered: what is it really like for them to be 'sent' for therapy? What is it really like to meet yet another professional and be expected to talk about their inner world? It can be difficult at times for professionals (including myself!) to reach these young people and connect with them in a way that is helpful, as understandably, given their histories, they can feel very distrustful. Marginalised young people often do not have

a voice in their family, school or local communities. I have always believed that there is great power and value in carefully listening to what they say as their opinions can make very valuable contributions to society. They possess a natural creativity, energy and wisdom often honed in the adversity they experience. I feel privileged when I am allowed enter their worlds and gain their trust in the therapeutic endeavour but am acutely aware that this therapeutic journey can be a precarious one that requires careful navigation for both the young people and the therapist. Offering therapy to young people in foster care is something that I have found particularly challenging in my role as therapist and clinical supervisor, as there is a requirement to manage multiple perspectives and agendas while maintaining a number of systemic relationships with parents, foster carers, professionals from a range of disciplines and other agencies, all of whom play a role in the young person's life. Keeping the young persons' needs and perspectives to the forefront of this process can be difficult when working with the complex system of which they are a part.

It was my intention in conducting this research to progress understanding of the therapy experience for young people in foster care at this critical developmental period in their lives. By exploring their experiences of psychotherapy in an in-depth way, I believed that much could be learnt. My hope is that this study will help enrich the knowledge base as well as professional practice, by learning directly from young people in foster care about the nature of their therapeutic encounters with a view to improving their experiences of therapy.

Chapter 2: Literature Review

Introduction

Foster care is defined in Ireland as the “full-time or part-time substitute care of children outside their own home by people other than their biological or adoptive parents or legal guardians” (Tusla, 2019, p. 7) and aspires to provide a stable family living environment for children. Children in foster care represent the largest proportion of children placed in alternative care within the Irish state. Due to their oftentimes abusive and traumatic experiences prior to entering care as well as their experiences while in the care system they frequently present with disproportionate mental health and physical health needs by comparison with children in the general population. Referral to services for psychotherapy is common. However, therapists can struggle to adequately help this cohort who commonly experience difficulties in engaging with and participating in services. While researchers in the area have mainly focussed on identifying the difficulties young people face, their prevalence as well as the efficacy of therapeutic interventions, little is known about how young people in foster care experience therapy. By investigating young people’s lived experiences of psychotherapy, this study will provide novel insight and assist in advancing literature in the area with a view to enhancing psychotherapy practice.

In order to contextualise the current research study, this chapter critically reviews and discusses the literature in a number of areas relevant to the core question of this study. Firstly, the various forms of alternative care provision for children worldwide with a particular focus on foster care in Ireland are presented. The reasons children enter alternative care as well as how their experience of the state care system impacts them is then outlined, including the key role of foster carers in this system. The complex therapeutic needs of children in foster care together with a critical summary of the literature examining therapeutic practice are then presented. Finally, literature advocating

the importance of consulting closely with children in care about their experiences as well as the paucity of literature relating to their perspectives of psychotherapy is highlighted.

Search Strategy

A search of selected databases (PsycINFO, Psycarticles, Psycbooks, CINAHL Complete) was undertaken using the keywords “psychotherapy” OR “counselling” OR “counseling” AND “foster care” OR “foster child” OR “foster children” OR “looked after children” OR “LAC” AND “teenager” OR “adolescent” OR “young people” OR “young person” AND “experience” OR “perspective” OR “perception” OR “view”. The initial search yielded over 240 articles. Due to the wide breadth of subject matter not immediately relevant to the study, the search was expanded by adapting the search terms and reviewing the bibliographies of related articles, while recent important reports and key texts were also included for review.

Forms of Alternative Care

Alternative care is the internationally accepted umbrella term used to describe the state provision of care for children who are no longer allowed to live with biological parents or guardians who are deemed unable, incapable or unwilling to adequately meet their parental responsibilities (McHale & O’Brien, 2017). This care is provided by people other than the child’s birth parents in the form of foster care, residential care and in some jurisdictions, adoption (Gharabaghi et al., 2016). Reflecting the hugely variable economic, cultural and social context worldwide, international guidelines for the alternative care of children were adopted by the United Nations General Assembly in 2010 (United Nations, 2010b) with a view to assisting and guiding local agencies in devising and implementing appropriate alternative care policies and procedures in each child’s best interests. This was a significant step forward in highlighting and prioritising the specific needs of children in alternative care worldwide, while promoting their rights. However, much progress still needs to be made in promoting the needs of children in alternative care, as unlike the UN

Convention on the Rights of the Child (UNCRC; United Nations, 2010a), these guidelines are not legally binding (Krenn, 2014), allowing states the freedom to interpret and use them in whatever way they see fit.

Although international statistics regarding the extent of alternative care provision worldwide vary and are inconsistent (Petrowski et al., 2016), it has been reported that there are approximately 8 million children living in alternative care worldwide (Gharabaghi et al., 2016). A recent study suggests that globally, approximately 5.37 million children are living in institutional care, with higher income economies reporting the most significant prevalence rates (Desmond et al., 2020). Family care or foster care is recommended as the most appropriate form of alternative care in most cases (Dozier et al., 2014; United Nations, 2010b), while the historical proliferation of residential group care is in general, decreasing internationally. This appears to be due to high costs as well as the lack of clarity regarding the effectiveness of this way of providing care for young people (Gharabaghi et al., 2016).

Tusla, Child and Family Agency, is the public body responsible for promoting the welfare and protection of children in Ireland (Gilligan, 2019). Tusla, together with the court system, operate under the governance of the Child Care Act 1991, which provides for three forms of alternative care in the Irish state: relative care, residential care and foster care (discussed below). Children may be placed in care in two different ways either voluntarily by agreement with a parent or by court order where a judge deems placement in alternative care to be in the best interests of the child (Joint Committee on Children and Youth Affairs, 2017).

Residential care is a non-family-based modality of care, normally provided by paid staff who work on a shift rotation basis but do not reside in the residential setting. Residential group care is often seen as the “last resort” (Gharabaghi et al., 2016, p. 8) for children being placed in alternative care in member countries of the Organisation for

Economic Co-operation and Development (OECD). It is generally reserved for children who for various reasons are unable to live at home or in another family home such as foster care (Tusla, 2014). Although decreasing in use in many areas of the world, in 2016 there were still approximately 2.7 million children living in residential care globally (Petrovski et al., 2016). While 50% of alternative care arrangements in Germany and Austria were still provided by residential group care facilities, in the UK, France, USA and Canada, it only accounted for 15 to 25% of alternative care provision (Gharabaghi et al., 2016). In Ireland it accounted for 7% of alternative care placements in 2019 (Tusla, 2020).

Foster Care

Internationally, foster care is the dominant form of alternative care provision. For example, statistics for England show that 72% of children in alternative care were placed in foster care as of March 2019 with 13% in relative foster placements (Department for Education, 2019). In the USA and Canada, approximately 70% of children in alternative care were placed in foster care while in Germany, foster care accounted for about 50% of state provision (Gharabaghi et al., 2016). However, these statistics need to be examined carefully as foster care can mean different things in different jurisdictions. For example, in the USA children are sometimes referred to as being in foster care even though they may be placed in group homes or residential centres as well as in family foster placements (Bass et al., 2004). This may go some way to explaining the high statistics quoted for the USA where over 440,000 children are living in foster care on any given day with approximately 6% (1 in 17) of all children estimated as being involved in foster care by age 18, a much higher proportion than many other developed countries (Turney & Wildeman, 2017; US Department of Health and Human Services, 2018; Wildeman & Emanuel, 2014).

Foster care is considered the optimal form of alternative care for children with an intention of providing them with an ordinary family life, that is loving and

developmentally appropriate (Dozier et al., 2014; Laub & Haskins, 2018), until they either return home or move to independent living (Khoo & Skoog, 2014). Fostering services rely on families and individuals in the community who are willing and able to share their homes and lives with this vulnerable group of children (Government of Ireland, 2003), including the large number of extended family members who look after children in relative foster care. In Ireland, at the end of 2019, there were 5,985 children in care, nearly 66.4% (n=3913) of whom were in a general foster care arrangement and a further 25.9% (n=1548) were in a relative foster care placement (foster families with whom the children are related) (Tusla, 2020), statistics that are comparable with the UK, USA and Australia (Furey & Canavan, 2019). Consistent with international figures, statistics regarding the age profile of children in care illustrate the high proportion of adolescents in care in Ireland (Furey & Canavan, 2019). In 2018, 46% of all children in care in Ireland were aged between 12 and 17 years of age, 9% (n=528) of children in care were 17 years of age, the highest number of all ages. One per cent (n=139) were under one year old, the lowest percentage of all ages. With the exception of 11 and 12 year olds, the number of children in care rose with increasing age (Tusla, 2019).

Reasons for Entering Care

Generally, children are placed in foster care from complicated backgrounds of psycho-social difficulties, where families are dealing with a multitude of complex issues. These include: educational and socio-economic disadvantage; domestic violence; parental drug and/or alcohol misuse; significant parental mental health and psychiatric disorders; parental bereavement and ill health; child abuse (physical and/or sexual abuse) and neglect; significant medical issues as well as experiences of other trauma (Scozzaro & Janikowski, 2015). Emphasising the magnitude of adversity children in foster care face by comparison with other children including those who live in significant socio-economic disadvantage, Turney and Wildeman (2017) analysed adverse childhood experiences (ACE's) among

children in foster care. Their findings, based on a nationally representative survey of children in the USA demonstrated that young people in foster care are likely to have suffered more and a higher frequency of cumulative negative experiences with adults in their lives by comparison with those in the general population, including those children with an elevated risk of experiencing ACE's, for example those living in poverty or who are homeless. Further evidence of the extent of these adverse experiences in the care population was highlighted by Romano et al. (2019) who noted that 71.6% of male adolescents in Canada (n=508) had experienced multiple forms of maltreatment (physical/sexual abuse by commission, neglect and emotional abuse) prior to entering care. Although there are no Irish studies that provide precise prevalence information of this nature, young people placed in care in Ireland are likely to have had broadly similar experiences, given the reasons for entry to care outlined by Tusla and provided below (Coulter, 2013; Tusla, 2020).

Many families experience adverse circumstances and challenges but do not become involved in the child protection system. English et al. (2015) identified a number of important factors that predict the likelihood of entry to alternative care including: caregiver depression and alcohol use, impaired child development, the emotional abuse of the child and previous reports of maltreatment as well as the severity of those experiences. In addition, these authors found that a lack of social support and receipt of mental health support were predictive of placement in care. This knowledge can help the development of appropriate services to better support children who are at risk of entry to care or are placed in care, as well as their families. In the majority of cases in Ireland, children are taken into the care of the state due to neglect which is often complicated by parental drug and alcohol use, domestic violence, parental mental illness or disability as well as physical and/or sexual abuse (Coulter, 2013; Tusla, 2020). Clearly young people enter foster care having suffered very high rates of maltreatment and may require psychotherapeutic assistance.

The Foster Care Experience

In addition to the reasons that led to children being taken into care, these young people also commonly experience significant multiple stresses, as well as competing demands that are directly influenced by the unique living circumstances of being cared for in the state foster care system. This section will review literature on the distinctive features of the foster care experience that young people encounter. The role of foster carers is discussed, followed by the child's experience of confusion and loss, placement disruption and breakdown as well as divided loyalties.

Foster Care – A Positive and Negative Experience

Foster care can help provide young people who have suffered maltreatment in their families of origin with opportunities to build emotionally supportive and trusting relationships with adult caregivers. Outcome studies have demonstrated the potential positive benefits of foster care, where children who have been abused or neglected can experience emotionally supportive relationships with adults. In their review of 12 outcome studies conducted between 1991 and 2006, which focussed on the impact of public care on children's welfare in England and Wales, Forrester and colleagues (2009) found that, in general, children's welfare improved over time as a result of being in state care, a finding consistent with international outcome research in the area. Similarly, Biehal (2014), in a mixed methods study of children's experiences of family foster care, found that placement with responsive and attuned caregivers within a family setting and long term foster placement could provide much needed stability to young people, who can begin to experience a sense of belonging and develop new social networks within the community (school, clubs, etc). Supporting this favourable perspective, research studies investigating children's experiences of foster care and more frequently, care leavers' memories of foster care identified many positive aspects of living within a stable and committed foster family. In Ireland, Tobin's (2013) qualitative study of six young people's (aged 19 - 24 years)

experiences of foster care placement breakdown referenced feelings of acceptance and belonging as key aspects of positively experienced foster placements. Likewise, the favourable impact of having an enduring sense of belonging and relationship with foster carers was a primary finding of Sirriyeh and Ní Raghallaigh's (2018) thematic analysis, which explored the use of foster care with 21 unaccompanied refugee minors in Ireland and the UK (17 of whom were under the age of 18). Young people's need for relational stability while in foster care and its potential positive impact is a recurring finding suggesting that foster placements which provide consistent, emotionally warm and secure care can have far reaching benefits for young people.

Learning from young people's experiences of foster care helps inform stakeholders, including psychotherapists, about how to provide optimal care that can promote young people's future prospects. For instance, the significant positive influence of placement stability in foster or residential care emerged as important in facilitating access to and encouragement of educational and vocational attainment in Darmody et al.'s (2013) three phase study which incorporated the findings of interviews with 15 young people (aged 10 to 'in their 20s') about their education. Likewise, the findings of a content analysis study of 22 care leavers (aged between 23 and 33) in Ireland and Catalonia demonstrated the positive influence of carers on: later employment for care experienced young people; the opening up of opportunities for them; providing support; being positive role models; and fostering the young people's sense of agency (Gilligan & Arnau-Sabatés, 2017). These studies underline the importance of positive, consistent and secure relationships in facilitating young people to progress their lives into adulthood. Further illustrating this significant influence, Hyde and colleagues examined the impact of care experiences on 19 young peoples' (aged between 18 and 22) ability to form positive intimate relationships. Continuity of care and the promotion of enduring relationships with trusted adults emerged as key factors that contribute to positive care experiences (Hyde et al., 2017). Studies of

this nature provide important insight into the experience of foster care for young people and have the potential to identify aspects of the care experience that might otherwise remain hidden.

Children in care nevertheless represent a complex client group where commonly there is an interplay of influencing factors that affect young people including: the impact of pre-care experiences of maltreatment and abuse; mental health difficulties; attachment insecurity; experiences of unresolved loss; as well as related trust issues. Some research exploring young people's retrospective accounts of being in care has reported largely negative experiences of being in foster care (Hyde et al., 2017; Miranda et al., 2019). Ahmed et al. (2015) in their IPA study of 12 young people's experiences of foster care, found that although participants spoke more positively about the care provided by their foster carers than by their biological parents, there were both positive and negative themes noted for each care experience. Positive themes comprised: authoritative parenting styles that provided clear and firm boundaries; quality shared time together that was enjoyable; nurturing care; and the positive encouragement of self development. Negative themes comprised: angry, rejecting and inconsistent parenting strategies; parental illness; lack of boundaries or structure; lack of activities in general; and chaotic lifestyles. Young people desired boundaries with a good deal of freedom and interestingly, viewed not being reprimanded as a sign that their parent figure did not care. Directly asking young people specific questions about their experience of being cared for may have facilitated them in potentially overcoming the need to provide "reflex defensive positive representations" of their parents/carers, thus allowing them to provide more genuine and nuanced information (Ahmed et al., 2015, p. 35). Studies of this nature can help illuminate the in-depth and complex lived experiences of young people in care, providing rich understanding about the idiosyncrasies of their lives, which can help advance the practice of caregivers, including psychotherapists.

Removing a child from their parents and placing them in care can be a traumatic event that seriously impacts children, sometimes over and above the negative impact of maltreatment that led to their placement in care (English et al., 2015). While achieving permanence and stability in foster placements can have a beneficial impact on the wellbeing of children, their transition from care, educational achievements and interpersonal relationships, negative outcomes are more likely where permanence and stability is not achieved (Moran et al., 2016; Roarty et al., 2018). Although children may feel relieved at leaving a hazardous and inadequate family environment, their subsequent experience of living in state care can cause further complications due to deficient care (Wald, 2017), care placement breakdown and relational instability, lack of service availability, inadequate inter-agency responses (Lewis, 2011; Simmonds, 2014; Tatlow-Golden & McElvaney, 2015), and stigma and distance from their birth family (Andrew et al., 2014).

Adding to these difficulties, children also frequently blame themselves for being placed in care while minimising the role of their parents (Baker et al., 2016). Baker et al.'s review of 27 research studies found that in the vast majority of studies where foster children's views of their biological parents were examined, children "missed or yearned" for their abusive parent (100% of the studies) while being afraid of being separated from them (83.3%). The children also blamed themselves for being placed in care and/or minimised the abusive behaviour of their parent (93.8%) while also expressing relief at being removed from that parent (93.8%). Baker and colleague's findings reflect the very complex and conflicting emotional experience that confronts many children in care. Although their placement in care may be assessed as being for clear safety reasons it can be a very difficult, confusing and upsetting situation to be faced with, no matter what age the child (Goodyer, 2016). Further research is needed to develop a rich and detailed understanding of how these multi-layered experiences directly influence young people in

foster care and how professionals such as psychotherapists can best respond in helping young people address the impact of such experiences.

The Role of Foster Carers

The role of foster carers in caring for children is crucial and is often not adequately valued (Pasztor et al., 2006; Rock et al., 2015; Wilson, 2006; York & Jones, 2017). They are the people at the coalface who are coping with the extreme and complex behaviours that children in foster care sometimes display (Octoman et al., 2014). They have a significant influence on the well-being of the children in their care (Maaskant et al., 2016) and together with the foster family are their primary therapeutic agent (Gilmartin & McElvaney, 2020; Harkness, 2019; Schofield & Beek, 2009). Washington et al. (2018) in their review of 40 studies, demonstrated the benefit of positive parenting approaches and healthy family functioning for the behavioural health of children in foster care. These psychosocial factors are cited in Ireland's National Policy Framework for Children and Young People 2014 - 2020 as positively influencing child development, children's future prospects and social mobility (Department of Children and Youth Affairs, 2014). Their importance is supported by research on parental reflective functioning (Midgley et al., 2019) and attachment focussed parenting (Garcia Quiroga & Hamilton-Giachritsis, 2016; West et al., 2020) for children in foster care.

The child's relationship with their foster carers is identified as an important contributing factor to positive child outcomes and one that is greatly valued by children in foster care (Morrison & Shepherd, 2015; Rock et al., 2015; Schofield & Beek, 2009). Personal qualities of the foster carer, including being emotionally available, open-minded, child-centred as well as the use of an authoritative parenting style have been identified as predictors of good outcomes for children in foster care (Ahmed et al., 2015; Fuentes et al., 2015). These characteristics were also negatively correlated with placement breakdown (Rock et al., 2015) and contributed to positive behavioural outcomes. Children and young

people in care depend on foster carers to help and support them with the difficulties they encounter as a result of their pre-care experiences as well as those that emerge during their care journey. Schofield and Beek (2009), in their research paper drawing on the findings of a longitudinal study of 52 children's experiences of growing up in foster care over a nine year period, suggest that foster carers who provide a supportive and secure attachment experience to adolescents in care can assist young people in their transition through to adulthood. This mixed methods study was based on interviews with foster carers, biological parents, children and young people, as well as social workers at various stages throughout the care period. Themes that emerged as helpful included: carer availability and helping young people to trust; carer sensitivity in helping young people to manage their feelings and behaviours; accepting young people for who they were as people as well as building their self-esteem; co-operation, helping young people to build a sense of competence and self confidence; and 'belonging', helping young people to build a sense of family membership (foster and/or biological family). Such themes are consistent with the qualities and goals a psychotherapist might aspire to achieving in working with young people. According to the authors, 'belonging' was the most challenging issue for adolescents in this study, at a time in their lives when difficult questions were emerging around identity. The findings support the argument that keeping the multiple attachment needs of the adolescent in care in mind is a critical element for the therapist working with the child and family (Gardenhire et al., 2019). This research on experiences of foster care has implications for how psychotherapists can better respond to young people's needs when they engage in therapy.

Experiences of Confusion and Loss

As alluded to, children often experience repeated separations and losses on entering care and as they move through care (Fahlberg, 2012). When entering care, children ostensibly lose their primary attachment figures even if these people, normally their

parents, have also been a source of fear (Fineran, 2012). They frequently have to start in a new school placement and begin to make new friends, while losing their previous friends, school and community (Fineran, 2012; Goodyer, 2016). In a narrative study examining young people's experiences of moving foster placement, Goodyer (2016), found themes that included: young people not receiving adequate information about moving; the negative impact of sudden placement moves; the intense emotions associated with these moves, for instance anxiety, upset and feelings of injustice; and feelings of loss. Interestingly, the strongest theme was of wanting to talk about these moves to the researcher, indicating the need to talk as well as the potential lack of opportunities to do this elsewhere, such as in psychotherapy. Some children placed in care can feel contradictory and confusing emotions about being removed from their abusive parents and may need help understanding how it is possible to miss their parents while experiencing relief at being in a safer environment with foster carers. These types of losses have been conceptualised in the literature as ambiguous loss (Lee & Whiting, 2007). It is a concept that recognises the unique set of responses that are characteristic of people who have experienced losses that are not clear cut or final. This can be expressed in a myriad of overwhelming feelings and difficulties including anger, shame, ambivalence, confusion, guilt, relationship difficulties, depression and anxiety (Lee & Whiting, 2007). It is important that these difficulties commonly experienced by children in care are not immediately pathologised by carers and professionals. They are often evidence of ego strength and should be understood as active coping strategies in the face of very uncertain, difficult and sometimes traumatic circumstances (Lewis, 2011).

Further loss experiences often occur for children in care as staff turnover is high in the child protection system with children having multiple professionals involved in their lives in relatively short periods of time (Tatlow-Golden & McElvaney, 2015). This can contribute to additional emotional instability (Strolin-Goltzman et al., 2010), exacerbate

attachment difficulties and militate against children investing in relationships with professionals. Frequently, these multiple losses are not adequately recognised even though they have a significant negative impact on children in foster care (Fineran, 2012; Strolin-Goltzman et al., 2010). Children value consistent, genuine and continuous relationships with the adults who work with them (Ridley et al., 2016), however in a system where relationships are ever changing, this continuity is often not possible.

Foster Placement Disruption/Breakdown

Loss in the form of placement breakdown is an all too frequent occurrence with literature reviews reporting its occurrence in 20 to 40% of placements (Minty, 1999; Oosterman et al., 2007) and citing adolescence as a consistent high risk factor (Harkin & Houston, 2016; Rock et al., 2015; Sattler et al., 2018). Many children experience frequent placement moves. Ward (2009), in a study of placement moves of children in the long term care of six local authorities in the UK, found that over a three and a half year period only 19% of children stayed in the same placement throughout this time, with 22% of children having more than five placements in this period, while notably, children and adolescents over the age of ten had significantly more placements than younger children. This type of instability can have considerable negative consequences for children, mirroring their prior experiences of living at home and leading to acute feelings of insecurity that can exacerbate attachment difficulties, while hindering engagement in school, relationships and other activities.

Placements can end for a variety of reasons, some can be for positive reasons, for example, moving children to live with their siblings or to be closer to their biological family, while others are due to less desirable circumstances. As mentioned, placement moves while in care can create an increased sense of instability (Biehal, 2014) and lead to a pattern of difficulties in settling in future placements as understandably, children learn to distrust and protect themselves from investing in placements due to the fear of being

moved again (Hyde et al., 2017). Reflecting these difficulties, research on children's views of care referenced instability as the worst aspect of being in care (Children's Commissioner, 2018). According to Sattler et al. (2018) who investigated the risk factors for placement instability, there are three main reasons for placement disruption: child initiated (for example, a child absconds from their foster placement), below standard care (for example, standards of care not reached or a child is deemed at risk of abuse) and placement mismatch (for example, the foster family is unable to manage or is incompatible with the needs of the child).

Although planned placement moves that are advantageous to the child in care, for example leaving an unsuitable placement, can have positive results, it is an overwhelmingly difficult time of loss and disruption (Unrau et al., 2008). A central and unanimous theme in Tobin's (2013) study of young people's experiences of placement moves and breakdown specifically, was one of intense loss even for those who welcomed the ending. Loss was experienced in various ways: the loss of the foster family relationships, loss of siblings, loss of community relationships including friends, their physical home, their self-identity, and their sense of loss of power over personal destiny as well as normalcy and self-esteem (Tobin, 2013). Placement disruptions and breakdowns have a significant negative and damaging impact on this already vulnerable population, intensifying attachment difficulties, feelings of low self-worth as well as compounding the impact of previous experiences of trauma and abuse (Rock et al., 2015). By their nature each of these situations are difficult for young people to navigate on their own and impact young people in various ways.

Divided Loyalties and Parent Contact

Children in care may also experience additional stress emanating from the experience of divided loyalties, which can place significant emotional strain on children in foster care (Baker et al., 2013; Dansey et al., 2018), where they are frequently expected to

develop and maintain attachment relationships with two sets of caregivers (biological parents and foster carers). The pressure this conflict exerts on children is highlighted by Lewis (2011) in her paper advocating a systemic-relational approach to working therapeutically with children in foster care. Lewis describes how caregivers can behave in ways that significantly increase this divided internal conflict for children. Often carers and parents can become adversarial in their relationship with each other and children have to learn to monitor and censor what they say to each parent. The children can end up 'stuck in the middle' of two sets of conflicting carers/parents (Lewis, 2011), resulting in significant feelings of upset, guilt, shame and associated feelings. As a result children may not personally invest in their foster placement which ultimately exacerbates their difficulties, as placements often breakdown as a result. Baker et al.'s (2013) findings illuminate the significance of this conflict from the perspective of foster carers witnessing the impact on the children in their care, and offers guidance about how therapists should be sensitive to this issue and promote positive parental contact.

The Complex Therapeutic Needs of Young People in Foster Care

As outlined, young people frequently enter foster care having experienced significant psycho-social difficulties that continue to impact them and are commonly exacerbated by their experiences of being in care, oftentimes leading to attendance at psychotherapy. The following section will focus on discussing the mental health needs of young people in foster care, attachment insecurity and trauma related difficulties that contribute to their frequently complex therapeutic needs. Much of the literature presented reflects the high proportion of outcome and prevalence studies that were identified in the review, while a smaller number of studies investigating young people's experiences highlights the general dearth of research in this area.

Mental Health Needs

Children in foster are frequently referred for therapeutic input with a psychotherapist or psychologist (O'Toole, 2015). Reasons for referral to mental health and psychotherapeutic services are commonly due to emotional and behavioural difficulties (Lehmann et al., 2013); attachment difficulties (Lehmann et al., 2016); significant medical issues (Schilling et al., 2015); mental health difficulties including depression (Stoner et al., 2015); educational difficulties (McAuley & Davis, 2009); symptoms of post-traumatic stress (Oswald et al., 2010) and complex trauma (Greeson et al., 2011). Without adequate therapeutic intervention these complex difficulties can have ongoing negative consequences for children (Bruskas, 2010) that can prevail through adolescence into their adult lives (Pecora et al., 2009).

In 2009, 45 percent of children in care in England were recorded as having a diagnosable mental health disorder compared with one in ten of the general population. In addition, carers identified over two fifths of children in care not assessed for a diagnosable mental health disorder as having emotional, behavioural and hyperactivity problems (McAuley & Davis, 2009). Statistics from community Child and Adolescent Mental health services (CAMHS) in Ireland show that 18% (n=1553) of all children who attended CAMHS teams between October 2012 and September 2013 were in the care of the state or were in contact with social services; 5.1% of this number (n=79) were in relative foster care and 15.3% (n=238) were in general foster care (Health Service Executive, 2013). A survey of Irish foster carers conducted by the Irish Foster Care Association (IFCA) in 2015 found that over 50% of foster carers had actively sought psychotherapeutic or psychological support for children in their care within the previous two years with a mixed success rate in obtaining these services. The most commonly sought after services for children in care were those provided by counsellors/psychotherapists and psychologists with a large percentage of carers seeking access to play therapists (O'Toole, 2015).

Attachment Insecurity and Trauma Related Issues

As mentioned, children in foster care often present with insecure attachment patterns, symptoms of post-traumatic stress disorder (PTSD) and complex trauma. This can be due to inconsistent, neglectful and/or abusive parenting, that can frequently lead to the development of negative self-perceptions as not being worthy of love and care (Miranda et al., 2019). Experiences of trauma as well as attachment disturbance and insecurity often correlate with higher rates of social, emotional and mental health difficulties (McMillen et al., 2005; Tarren-Sweeney & Hazell, 2006), that many children in foster care experience. Vasileva and Petermann (2018) found prevalence rates of approximately 40% for developmental difficulties, mental health issues and insecure attachment of children in foster care (n=5,014), while 22% of children were estimated as presenting with disorganised attachment. Similarly, Tarren-Sweeney (2013) found that 20% of children in foster care (n=347) displayed complex trauma and attachment related difficulties. The negative sense of self commonly experienced by insecurely attached children can be exacerbated by the experience of being placed in care as well as their journey through care (Schuengel et al., 2009), where they may experience many transient relationships, further disrupted attachments and sub-optimal care.

Attachment is conceptualised as a long-lasting and consistent bond children develop with their primary caregivers during their early years, which can greatly influence future attachments with individuals (Bowlby, 2005). Children who are insecurely attached may have experienced sub-optimal care where caregivers have been either unwilling or unable to sufficiently respond to a child's normal attachment needs. This can create anxiety and insecurity in the child-parent relationship as well as within subsequent child-carer relationships in the case of children placed in care. Disorganised attachment can manifest as a result of experiencing frightening or chaotic parenting responses from primary caregivers (Howe, 2005; Miranda et al., 2019), that can contribute to the development of

an internal working model or self-perception of self-loathing, insecurity, shame, anxiety and confusion. This model impacts how they behave in the world and react to, or avoid people within it (Granqvist et al., 2017). Children with insecure and disorganised attachments commonly develop their own adaptive strategies to help reduce perceived danger and experience a sense of control. These strategies may include: compulsive self-reliance; compulsive caregiving; compulsive compliance; or a mixture of these behaviours where children switch between these controlling strategies (Howe, 2005). Often these ways of relating are accompanied by emotional dysregulation that inhibits and actively militates against the child forming connected relationships (Miranda et al., 2019). Keeping people at a distance can feel like the ideal self-protection strategy, a strategy they are also likely to employ in the therapy relationship.

Frequently, the attachment difficulties demonstrated by children in foster care are inextricably linked with traumatic events, as they have been neglected or abused by their parents. These are apparent in behaviours that include severe emotional dysregulation, sexualised and violent behaviour, extreme anger and aggression, intense fear and anxiety, numbness and detachment as well as other trauma reactions (James, 1994). Repetitive, intrafamilial and interpersonal trauma inflicted on the developing child and/or exposure to recurrent and severe stressors within the caregiver system (for example, domestic violence) is termed complex trauma or developmental trauma (Lawson & Quinn, 2013). Greeson (2011) found that 70.4% of children in foster care referred (n=2,251) to trauma clinics had experienced at least two of the traumas they defined as complex trauma (physical, sexual, emotional abuse, neglect and domestic violence) while 11.7% reported all five forms of trauma. The impact of exposure to complex trauma experiences can be far reaching for young people who often display symptomatology not adequately recognised within the American Psychological Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM), or the World Health Organisation's (WHO) International Classification

of Diseases (ICD) (Tarren-Sweeney, 2013) including: insecure or disorganised patterns of attachment; difficulties in identifying and regulating core bio-physiological functions, for example, appetite and bodily pain; significant problems with regulation of affect; dissociative processes; problematic behaviours that can include impulsivity or extreme rigidity; difficulties with cognition, including speech and language, sensory integration, reflective capacity and learning; and negative self-concept (Cook et al., 2005). Clearly children who have experienced developmental trauma are at significant risk of not developing in core areas that equip them with the skills to meet the world.

For adolescents in foster care, this frequently difficult developmental stage can bring additional challenges as they may be already struggling with unresolved experiences of trauma, neglect and other abuse (Trickett et al., 2011) as well as attachment disruption and insecurity. These complex issues can mitigate against their ability to successfully navigate this naturally turbulent time in their lives (Fahlberg, 2012). According to Schofield and Beek (2009), the important role of attachment for adolescents is often underrated as young people can increasingly prioritise peer relations over familial connections. This is developmentally appropriate, nevertheless research suggests that young people still heavily rely on family for support and to guide them in the formation of values and identity. This is no different for young people in foster care (Schofield & Beek, 2009). However, developing these kinds of strong attachment relationships in foster care is much more challenging for young people who have experienced attachment insecurity/disruption as well as other trauma. The adaptive strategies they have developed can keep caregivers at a distance and cause problems for those attempting to offer positive attachment experiences. Similarly, this presents a challenge for psychotherapists who also have a caregiving role.

Engagement with Mental Health Services and Psychotherapy

Adolescence is a time of greatest risk for the development of mental illness but, according to Plaistow et al. (2014), it is also the age group that are least likely to seek mental health assistance. In a systematic review of 31 UK studies that examined young people's views of mental health services, Plaistow and colleagues identified a number of themes regarding what young people wanted from services, including: the need for more information about mental health services, as well as what to expect from mental health services; accessibility of services that encompassed location, timing, access without a waiting list, flexibility of approach and an ethos and language that helped young people feel relaxed; workers that were kind, approachable, skilled and knowledgeable; and services that promoted a young person's self-reliance. Issues that could hamper young people accessing services included: mental health stigma and a lack of information or access. In addition, young people who had experience of mental health services cited the medicalisation of their difficulties by professionals as well as lack of continuity of care as being particularly unhelpful. Similar views were found by Coyne et al. (2015), in a thematic analysis of parent and young service user's views of CAMHS services in Ireland. Using a mixture of focus groups and individual interviews, the researchers found that adolescents: had difficulties in accessing information about service availability; wanted to be part of the decision making process but that their voices were not listened to; found frequent staff changes to be particularly hard to manage and needed consistent relationships with staff in order to disclose their thoughts and feelings as well as build trust; and wanted to be offered a flexible approach that offered a mixture of individual and shared parent-child sessions, that was sensitive to both perspectives.

Children in foster care experience similar and, it can be argued, additional impediments to receiving appropriate mental health assistance. Rahilly and Hendry (2014) described a number of barriers to children in care obtaining mental health intervention,

including: inadequate awareness and support from their carers; placement instability; lack of appropriate information; stigma; absence of social work home visits; off-putting clinical settings; and inconvenient appointment times. Carers and professionals who lack the necessary knowledge and support may not recognise the mental health difficulties of these young people and, as a result, do not seek relevant assistance (Strijker et al., 2011). According to Strijker and colleagues, children can develop effective internalising strategies to help them survive and cause few problems for their carers, thus masking their difficulties. Adolescents in particular can become adept at hiding how they are truly feeling. They frequently develop coping strategies in response to abusive and traumatic backgrounds as well as negative experiences while travelling through the care system (Vanderfaeillie et al., 2013). Children who appear to be settling well in their foster placement may in fact be exhibiting clinical levels of difficulty that go unrecognised and untreated, for example, depression, anxiety and psycho-somatic difficulties (Strijker et al., 2011).

A striking ambivalence about attending mental health services is highlighted as a differentiating factor between children in foster care and other children who attend mental health services (Davies & Wright, 2008). Beck (2006), surveyed foster carers and the young people in their care, about their views regarding the young person's mental health, as well as their access to and experience of mental health services. Low motivation, not seeing the need for mental health support, seeing others as responsible for their difficulties, as well as mental health stigma were identified as barriers to engagement. This stigma is significantly exacerbated for young people who already feel stigmatised due to being in care (Dansey et al., 2018; Tatlow-Golden & McElvaney, 2015) and understandably have a marked distrust of professionals as well as adults generally (Jee et al., 2014). In a qualitative study of mental health stigma among children in care, young people cited a negative perception of mental health services, talking to strangers and fear of what might

emerge if they did open up, as factors that would stop them attending (Young Minds, 2012). Young people stressed that they needed time to build relationships with adults before they would confide in them and that they were more likely to seek emotional support from carers than staff in mental health services.

Stigma also emerged as a theme in Jee et al.'s (2014) study of young people's and their foster carer's perspectives of mental health treatment. The study used a thematic framework approach and identified four main themes that impacted engagement: the dual stigma of being in foster care and requiring mental health treatment; the avoidance of psychotherapy; distrust of therapists and others; and the stated desire to have an integrated mental health and primary care service. A limitation of this study was that there was not a prerequisite for participants to have attended mental health services, hence it is unclear if they were talking from experience. Heretofore much of the literature has focussed on young people's views of engagement with mental health services as well as the perspectives of young adults and care leavers. Further research is needed to explore young people's actual lived experiences of psychotherapy while in foster care, which will help inform the profession of psychotherapy about the barriers and facilitators to engagement.

Therapeutic Intervention with Young People in Foster Care

Foster care is a complex context in which to offer therapeutic interventions (Cantos & Gries, 2010; Kinsey & Schlösser, 2013) due to the type and scale of difficulties presented by children in care as well as the numerous systemic challenges that demand attention. Clinicians engaging in therapeutic work in this context are often required to work closely with multiple stakeholders (National Institute for Health and Care Excellence, 2015). These include children in foster care, their foster carers and families, child protection and fostering social workers, birth families as well as other medical and mental health professionals. This work can also involve consultation with the professional systems involved with children in foster care as well as advocating on the child's behalf (Lewis,

2011). All experiences are unique and multi-faceted and children deal with them in their own particular ways, while psychotherapists and other professionals need to be attuned to these diverse responses. It is clearly a challenging task for psychotherapists to undertake and one that requires in depth knowledge and understanding of the unique issues that commonly present when offering psychotherapy to this cohort. This section reviews the research base that to date, has mainly focussed on the efficacy of therapeutic interventions with young people in foster care, while presenting the smaller number of studies examining young people's perspectives of therapeutic services.

Research indicates that mental health services frequently do not adequately assist children in long-term foster care, who commonly do not receive appropriate and suitable therapeutic intervention (Bellamy et al., 2014; Miranda et al., 2019; Tarren-Sweeney, 2010), while professionals often struggle to adequately understand and sufficiently respond to the complex needs of young people in foster care (McElvaney & Tatlow-Golden, 2016). Several literature reviews have examined some of the most promising and evidence based therapeutic interventions (Hambrick et al., 2016; Kinsey & Schlösser, 2013; Landsverk et al., 2009) including multi-dimensional treatment foster care (MTFC); trauma-focussed cognitive behavioural therapy (TF-CBT); the incredible years parenting programme; as well as a number of other models of intervention. While these types of interventions demonstrate some positive results, it is argued that routine evidence-based treatments do not adequately address the unique and complex difficulties experienced by children in foster care (Craven & Lee, 2006; Zilberstein & Popper, 2016), difficulties that are not sufficiently captured within traditional diagnostic systems such as the DSM or ICD systems (DeJong, 2010; Tarren-Sweeney, 2013). According to Hambrick et al. (2016), evidence based treatments are often manualised in their approach which leave little room for flexibility, something that has been highlighted by young people as an important feature of helpful interventions. Manualised approaches may be effective in yielding

positive results for discrete issues, such as symptom reduction, but are likely to be only a partial remedy for the frequently complex difficulties experienced by children in foster care. In general, it is argued, that research designed to ascertain the efficacy of therapeutic interventions used with children does not address their opinions about what helps (Craven & Lee, 2006; Strolin-Goltzman et al., 2010). It is possible, therefore, that research that identifies interventions as effective may clash with the actual views of children (Davies & Wright, 2008) as it does not include their perspectives.

A blended form of intervention involving both the child and the system they are a part of was identified in the literature as most helpful (Harkness, 2019; Luke et al., 2014). Where possible, it is recommended that foster carers are centrally involved in the therapeutic process (Rayburn et al., 2018). Cultivating a sense of safety and security in the fostering relationship is an important task, so that children can begin to heal in the context of a growing attachment relationship (Schofield & Beek, 2009; Van Andel et al., 2014). Similarly, Leve et al. (2012), in a systematic literature review of evidence based interventions with foster families, found that foster carer's central involvement in home-based interventions that addressed behavioural difficulties and used neurobiological underpinnings was central to more successful outcomes. The present study, through learning about what young people in foster care say about their experiences of therapy offers increased insight into how they experience foster carer involvement in psychotherapy.

Zilberstein and Popper (2016) postulate that clinicians need to be knowledgeable and have the ability and experience to think more broadly about the multiple, complex and ever evolving issues that can affect children in foster care. Arguing for this type of comprehensive yet flexible approach, Zilberstein and Popper suggest that therapists who possess a wide ranging knowledge of various treatments are better positioned to appropriately use and adapt varied ways of working to meet each child's individual

circumstances and needs. According to MacKinnon (2012), “every child and every situation deserves a developmentally sensitive, psychologically aware deliberation of the specifics related to their current situation” (p. 217). Convincing support for wraparound, systemically attuned services and relational approaches is indicated in the literature (Kinsey & Schlösser, 2013) as well as the importance of ongoing, consistent, caring and genuine relationships with practitioners (Davies & Wright, 2008; Ridley et al., 2016). Tailored therapeutic interventions (Pinto & Woolgar, 2015) that help children in care understand what foster care is, why they are in foster care and that assist them in adjusting to the new family environment (Craven & Lee, 2006) have also been identified as of significant value. It is argued that services should be offered with empathy and acknowledgement of the trauma and maltreatment young people have experienced and take place in a less formal, comfortable and relaxed way than traditional mental health services (Tatlow-Golden & McElvaney, 2015).

This literature highlights a marked absence of research examining the therapy experiences of young people in foster care. However, findings from studies on the therapy experiences of young people who experienced abuse (McElvaney et al., 2019) and those who experienced trauma-focussed cognitive behavioural therapy (TF-CBT) (Dittmann & Jensen, 2014), as well as research gathering the views of young people in residential care about trauma therapy (Graham & Johnson, 2019) are pertinent to the present study. McElvaney et al.’s (2019) interviews with 16 young people regarding their experiences of therapy in rape crisis services in Ireland identified the following themes: reluctance in attending; having choice and not feeling pressured, the importance of talking about thoughts and feelings as well as the value of having a caring relationship with their counsellor; the availability of a specialist service; psychoeducation; and learning coping strategies to deal with psychological distress. Broadly similar findings emerged in Dittman and Jensen’s (2014) study involving 25 young people, who emphasised the difficulty but

importance of talking about traumatic experiences. In Graham and Johnson's (2019) thematic analysis of six young people's views of what they might need from trauma therapy, it was suggested that they would need therapists to: create the right environment for therapy; take their time in building trust; and centrally involve young people in making decisions in order to help them better understand and respond to trauma experiences. Although these studies did not purposively involve young people in foster care, the findings are of direct relevance to psychotherapy practice with this cohort, who are likely to have experienced abuse and maltreatment. Further research that examines the actual lived experiences of therapy for young people in foster care can bridge this gap in the literature and further develop the literature base.

Recognising the need for tailored services, Tarren-Sweeney (2008, 2010) presents a cogent rationale for a service approach that is aligned with Van der Kolk's (2005) concept of developmental trauma, a framework that recognises the significant impact of attachment/traumatic experiences on children. Given reported international inaction to date regarding improving the lives of children in alternative care (Zeanah & Humphreys, 2020), it offers a very important argument for specialist services that will more adequately meet the therapeutic needs of children in foster care (Tarren-Sweeney, 2010). He contends that professionals should embrace a "clinical/psychosocial developmental scope of practice" with "a strong advocacy role" (Tarren-Sweeney, 2010, p. 617), incorporating new knowledge on the impact of psycho-social difficulties and attachment conditions on children's psychological and neurological development (Tarren-Sweeney, 2010).

The Voice of Children in Foster Care as Experts on Their Own Experience

Ireland ratified the UN Convention on the Rights of the Child in 1992. This bill of rights for children assures that under article 12 "every child capable of forming his or her own views, the right to express those views freely in all matters affecting the child" (United Nations, 2010a, p. 3). These values are compatible with Ireland's National

Children's Strategy (NCS) which specifies that children's lives need to be better understood and that they should have a voice in issues that affect them, while setting a goal that all children receive quality supports to assist in every aspect of their development (Department of Health and Children, 2000). This is a particularly important right for children in the state care system who represent some of the most marginalised and disenfranchised members of society. Consistent with these aspirations, young people have cited that being listened to is the most basic requirement for a positive experience of being in care (Rahilly & Hendry, 2014). In a survey of children in care in England conducted by the Office of the Children's Rights Director (2014), it was found that 10% of children in care said they were "not usually" or "never" asked their opinions on things that mattered to them, a decrease from 14% in 2012. However, according to the same report, findings from surveys of this nature between 2008 and 2013 illustrate that over 50% of children who offered their opinions believed these opinions always or nearly always made an impact on decisions made about their lives. Despite gains in the area there is still clear need for further consultation with young people in care as experts on their own experience, as many of them feel they are not listened to regarding issues directly relevant to their lives (McEvoy & Smith, 2011).

The child in foster care has a unique perspective on what they require to help them through this very challenging time in their lives. Research about children's views of being in care provides valuable guidance for professionals about the positive and negative aspects of being in care from the point of view of the child (Ahmed et al., 2015; Children's Commissioner, 2018; Hadley Centre for Adoption and Foster Care Studies, 2015; McEvoy & Smith, 2011). A number of studies, referenced earlier, have investigated young people's experiences of family belonging (Biehal, 2014), loyalty conflict (Dansey et al., 2018) and moving foster placement (Goodyer, 2016). Additional research has investigated their experiences of trauma, stigma, difference and help seeking behaviour. For instance,

Steenbakkers et al. (2019), in an episodic narrative study of 13 young people in foster care (aged 15 – 23) identified three themes related to trauma experiences: the impact of emotional and social problems such as anger and the loss of relationships; particular coping strategies such as avoidance; and not always experiencing trauma impact. These findings highlight the complex problems young people in foster care can experience. They may suffer significant post-trauma difficulties which could benefit from therapeutic intervention while simultaneously wishing to avoid talking about the trauma, thus hindering help-seeking and engagement with therapy services. Further challenges that emerged in qualitative research that directly interviewed young people in foster care included: young people internalising feelings of care stigma and ‘difference’; alienation; the expectation that they would be bullied due to stigma; and keeping their care status secret (Dansey et al., 2019; Madigan et al., 2013). These studies illuminate the idiosyncratic challenges of being a young person in foster care and illustrate the complex additional difficulties they face which can negatively impact their mental health as well as their engagement with therapy services. Relatedly, Johnson and Menna’s (2017) grounded theory study of seven young people’s mental health help seeking behaviour found that positive help seeking intentions were directly related to the experience of previous help seeking. This is an important finding that underlines the need for research studies that can help develop understanding of the therapy experience, with a view to furthering relevant psychotherapy practice for young people in foster care and thus increase the possibility of future help seeking. While a small number of studies (detailed earlier in the chapter) have researched young people’s perspectives of mental health services while in foster care (Beck, 2006; Jee et al., 2014), there is a dearth of research examining therapeutic interventions that target adolescents in foster care (Davies & Wright, 2008; Kinsey & Schlösser, 2013; Leve et al., 2012; Zilberstein & Popper, 2016), and a marked absence of studies exploring their experiences of psychotherapy. This is despite the fact that

adolescents represent the largest cohort of children in alternative care and often present with the most complex difficulties.

Some authors have argued that children in foster care should be centrally involved in research as hearing what they have to say provides deeper insight into issues of central relevance to them while assisting in the development of child-centred policy and practice (McEvoy & Smith, 2011; Withington et al., 2017). Research suggests that children are eager to share their views about their experiences but that the systems put in place to assist them in being heard are not working (Ahmed et al., 2015; Goodyer, 2016). According to Ahmed et al. (2015), asking specific questions about aspects of children's psychotherapy experiences might be more helpful in assisting children to give more full and honest accounts of their therapy. This could be particularly useful in ascertaining the views of the sizeable number of children in foster care who do not respond to interventions or treatment (Cantos & Gries, 2010), information that could support therapeutic interactions that will better meet their needs.

To date, the literature has mainly focussed on gathering views about mental health, psychotherapy and psychological support from within the general adolescent population (Binder et al., 2011; Dhanak et al., 2020; Dittmann & Jensen, 2014; Gibson et al., 2016; Løvgren et al., 2019). For example, Gibson et al. (2016) studied the commonalities of what a group of New Zealand adolescents valued about psychological supports which included placing a high value on having a friendship type relationship with a counsellor rather than a professional one, while having a level of control over this relationship. Similarly, Binder et al. (2011), in a hermeneutic-phenomenological study of adolescent views of how therapists relate to them found that they preferred reciprocal and emotionally close relationships that were respectful of their personal boundaries. These types of studies provide valuable guidance and advice for practitioners on service delivery. Similarly, research on the perspectives of adults with care experience have gathered important

insights about their experiences of mental health services while in care. For instance, Tatlow-Golden and McElvaney (2015), in a consensual qualitative research study, interviewed eight young adults (aged 18 – 27 years) about their experiences of mental health services in Ireland. The findings illustrated participants' views of their mental health while in care as well as their experience of being doubly stigmatised due to being in care and having mental health difficulties. In addition, the young adults referenced the importance of having child-centred and flexible mental health services where they were related to in a respectful, caring, honest and reciprocal manner. Similarly, Villagrana and Lee (2019) in a content analysis study of the mental health service experience of 13 foster care alumni (average age of 21 years) in the USA found that young people reported positively on experiences of therapy where they felt in control and were met with in a collaborative, genuine and empathic manner. Where young people suffered breaches in confidentiality or they felt forced to talk about issues before they were ready, their trust in the therapy process was negatively impacted. Although helpful, these views are gleaned from adults recalling past experiences of being a child in care engaging with mental health services, services which traditionally in Ireland provide a range of psychiatric and medication review, psychotherapy or more informal psychological support.

As noted, children in foster care are a particularly disenfranchised group in Irish society whose perspectives are commonly not gathered and researched (McEvoy & Smith, 2011). Asking them about their experiences of professional interactions and services is crucial in order to further professional understanding and practice. It is clear that young people in foster care have disproportionate mental health needs by comparison with young people in the general population and by virtue of living in foster care they experience particular challenges unique to them. However, despite the fact that children in foster care frequently attend psychotherapy, there appears to be no published studies that have directly examined what children in foster care think and feel about their experience of

psychotherapy while living in this alternative care environment. The current study aims to address this deficit, while attending to the goals set out by the UN Charter and Ireland's National Children's Strategy, by directly asking young people immersed in the experience of being an adolescent in foster care about their experiences of psychotherapy. It is hoped that this will further our understanding of how it is for young people to attend psychotherapy and how the challenges identified above can be addressed.

Conclusion

It is clear that young people in care frequently experience a number of negative relational and traumatic experiences prior to entering foster care which can have a significant negative impact on them and their experiences of subsequent relationships with others, including psychotherapists. The extant literature base on foster care is largely focussed on prevalence and outcome studies with less emphasis on young people's perspectives of issues impacting them. Nevertheless, some qualitative studies have explored how placement in foster care is experienced by children, highlighting both the positive and more challenging aspects of this experience. Despite children being placed in care by state agencies for safety reasons, it is frequently a turbulent and challenging time for children who often have to contend with a number of stressors including: moving from their family of origin; getting to know and building relationships with a new family; significant confusion and loss; foster placement disruption and/or breakdown; divided loyalties and parent contact; mental health difficulties; as well as attachment insecurity and trauma difficulties. The level of instability and the intensity of the issues young people in foster care are faced with, together with the uniqueness of their circumstances, highlights the significant challenges young people in foster care experience which frequently lead to referral to psychotherapeutic services.

Young people in foster care experience several hurdles to accessing and engaging in therapy. A range of therapeutic interventions has been identified as effective, with some

consensus that familiarity with this range is more helpful for therapists than drawing on a unimodular approach; the involvement of foster carers in therapeutic interventions has been identified as helpful. However, no studies were found that directly examined young people's lived experiences of psychotherapy. As a largely marginalised and disenfranchised group of young people in society, it is important that these young people's voices are heard in designing and developing services that aim to help them. Listening carefully to their views and first-hand experiences will help in informing future psychotherapy practice with a view to offering young people in foster care psychotherapeutic help that may better meet their needs.

Researcher's Reflexive Comment

Reviewing this literature ensured I became even more determined about pursuing this research study. I discovered that there was a sizeable research base that focussed on identifying the multiple issues that impact children in care as well as the types and efficacy of psychotherapeutic intervention. The methodologies employed were frequently of a quantitative nature with less focus on qualitative experiences. I felt excited, as the marked absence of research examining their lived experiences of therapy was heartening in that it identified a gap. It also supported my original rationale for directly asking young people about their individual experiences of psychotherapy and learning about how all of the influencing contextual factors impact these experiences. Reviewing the literature also brought clarity regarding why I wished to pursue this area of research. I noticed how I was much more engaged when reading qualitative research, particularly the literature that focussed on young people's experiences as well as their foster carers. This directly pertains to my work and philosophy of wanting to know about and valuing the human experience. Learning about what works in terms of the efficacy studies felt much more abstract and distant. I felt I had set the scene for a novel study that could be beneficial for everyone involved in working with young people in foster care.

Chapter 3: Methodology

Introduction

This chapter outlines the aims and objectives of the research study and describes the rationale for choosing Interpretative Phenomenological Analysis (IPA) as the methodology most suited to achieving the study aims. The key philosophical underpinnings of IPA are discussed as well as how this methodology informs the study design and method. Finally, issues regarding ethical considerations are addressed.

The central research question in this study was: How do adolescents' in foster care experience psychotherapy while in foster care? It had the following objectives: to illuminate participants' lived experiences of psychotherapy; explore if and how psychotherapy was helpful; and capture participants' perspectives on what influences their engagement in psychotherapy.

Choosing a Research Methodology

Choosing a research methodology was an important task that required careful consideration, as “a judicious choice of method guides the research toward the intended aims and helps ensure that its products are useful and well received” (Starks & Brown Trinidad, 2007, p. 1372). From the outset, the researcher was interested in a qualitative methodology. Qualitative researchers are interested in describing and explaining how people experience the world. They ask questions about processes and are open to learning about the varied tapestry of the human experience (Willig, 2008). They “study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them” (Denzin & Lincoln, 2011, p. 3), allowing their experience to be heard and understood in context. Qualitative research can give voice to people whose views or experiences are often marginalised or discounted, such as young people in foster care (McEvoy & Smith, 2011) and capture the subjective nuances of particular experiences (Willig, 2008). Through developing an idiographic understanding of the complexity of

clients' bio-psycho-social phenomena, qualitative research can prove invaluable in informing clinical practice (Biggerstaff & Thompson, 2008).

As illustrated in the previous chapter, much of the research in the area of psychotherapy and young people in foster care has focussed on presenting difficulties, outcomes and professional experiences rather than the specific views and subjective experiences of the people who experience the phenomenon, young people in foster care. Learning about how young people make sense of their individual experience of psychotherapy rather than what outsiders or other people think about this phenomenon, is the focus of this study. Hearing directly from the young people themselves, who by virtue of living in state care are a marginalised group within society, was a core aim. Gaining an in depth understanding of the phenomenon from their viewpoint, as experts on their own experience, can deepen professional understanding and inform psychotherapy practice (Ahmed et al., 2015) in a very meaningful way.

There are a number of qualitative approaches to inquiry that were considered as potential methodologies for this project including grounded theory (Charmaz, 2014; Glaser, 1998) and narrative enquiry (Riessman, 2008). As the goal of this study was to illuminate the lived experience of participants, neither grounded theory methodology with its focus on developing theory, nor narrative enquiry with its focus on the narrative of people's experiences were considered a best fit with the research question. Rather, a phenomenological inquiry was deemed most suitable. Having considered several possibilities the researcher chose IPA as the methodology most suited to the study aims. IPA is a methodology that has been extensively and increasingly used in the field of psychology, producing hundreds of studies (Smith, 2011) including those investigating the experiences of children and adolescents (Colton & Pistrang, 2004; Griffiths et al., 2011; Pateraki et al., 2018) as well as those in foster care (Ahmed et al., 2015). It is concerned with "giving voice" to the experiences of individual participants while recognising the

inevitability and importance of the interpretive endeavour of the researcher who tries to “make sense” of participant concerns from a psychological perspective (Larkin et al., 2006, p. 102). This is done with a view to advancing professional knowledge and practice regarding particular phenomena. The following section will discuss the theoretical background of IPA while explaining its suitability as the methodology of choice in this research study.

Phenomenology

Phenomenology has its origins in early 20th century European philosophy and is a philosophical movement as well as a range of qualitative research methodologies (Gill, 2014). Phenomenology claims to be a practice rather than a system (Moran, 2000) that seeks to illuminate the essence of lived experience. Founded by Edmund Husserl, it was an attempt to break away from the positivist philosophies of the time (Oxley, 2016). Husserl was interested in engaging directly with phenomena in order to get to their true essence. Husserl’s phenomenology is a scientific inquiry that assumes all human experience comes from consciousness and individual awareness. He believed that there are universal human experiences and sought to describe these in as pure a manner as possible (Glover, 2014). This involves the practitioner “bracketing” or suspending their everyday assumptions, knowledge and interpretations about the world (Husserl, 2012, p. 109). Bracketing allows the practitioner or researcher to understand and describe human experience without any prejudice, analysis or interpretation (Husserl, 1970). By doing this, the researcher adopts a “phenomenological attitude” (Finlay, 2009, p. 8). This suspension of judgement allows a pure focus on experience. Husserl believed that gaining an understanding of the essence of individual human experience is a vehicle to understanding and describing the universal essence of human experiencing (Husserl, 1970).

However, many of Husserl’s students, including Martin Heidegger, were left unconvinced about whether this “reduction” through bracketing was genuinely possible or

useful (Moran, 2000, p. 2). Heidegger diverged from Husserl's view of pure phenomenology on a number of points which he outlined in his major work, "Being and Time" (Heidegger, 1980). Heidegger believed that all human understanding and description involves interpretation, that people cannot be separated from what they already know and have experienced and, he argued, that we can only fully understand a phenomenon through interpretation (Oxley, 2016). As Moran (2000) put it, description is only a "derivative form of interpretation" (p. 20). From these divergent phenomenological philosophies the various modes or groupings of phenomenological enquiry emerged, including IPA (Shinebourne, 2011). Although it shares many of the same philosophical principles of Giorgi's descriptive phenomenology and Van Manen's hermeneutic approach (Giorgi, 1997; Van Manen, 1990), IPA is distinctive because of the three pillars of phenomenology, hermeneutics and idiography that underpin it (Smith et al., 2009).

IPA

IPA is "concerned with the detailed examination of personal lived experience, the meaning of experience to participants and how participants make sense of that experience" (Smith, 2011, p. 9). It was developed by Jonathan Smith (Smith, 1996) as a distinctive approach to qualitative research and has a solid theoretical foundation together with a detailed procedural guide (Brocki & Wearden, 2006; Smith et al., 2009). The philosophical and theoretical underpinnings of IPA were influenced by Husserl, Heidegger, Sartre and Merleau-Ponty who "consider the person as embodied and embedded in the world, in a particular historical, social and cultural context" (Shinebourne, 2011, p. 18). Such an approach enables the researcher to pay attention to the wider context from which and in which young people in foster care live, frequently having moved from living in a context of unsafety and maltreatment within their family of origin to a new cultural context of alternative care with another family, often in another community. It also allows consideration of the young person's experiences of trauma and attachment insecurity as

significant influencing factors on how they might experience psychotherapy. Through the privileging of human experience, IPA allows people's experiences to be expressed in their own terms rather than according to any pre-determined categories (Smith et al., 2009). IPA studies are inductive and grounded in the data rather than in pre-existing knowledge or theories which is consistent with this study's aim of carefully exploring the individual psychotherapy experiences of young people in foster care. The study aimed to try to firstly understand the young person's world and describe it, to get as close to their experience as possible, before moving into a more interpretive stance.

While all phenomenology is true to Husserl's original philosophy and is descriptive by its nature, many theorists and scholars distinguish between purely descriptive phenomenology and interpretative or hermeneutic phenomenology (Finlay, 2009). IPA views the phenomenological enquiry as an interpretative process. Interpretative phenomenology has made adaptations to the phenomenological attitude (Shinebourne, 2011) of Husserl's (2012) phenomenological enquiry as it assumes that there can be no completely pure description, all description incorporates an interpretation. We experience everything as "something that has already been interpreted" (Finlay, 2009, p. 11). The research participant makes interpretations of their own experience as they describe and try to make sense of it during the research interview, while the researcher is interpretative in their role as they try to make sense of the participant making sense of their experience (Smith, 2004). This is referred to as the "double hermeneutic" or "dual interpretation process" (Pietkiewicz & Smith, 2014, p. 362). Instead of bracketing, the interpretative phenomenologist uses their prior knowledge and assumptions in an attempt to advance understanding of the phenomenon (Willig, 2008). IPA combines phenomenological and hermeneutic understanding in this study, by attempting to comprehend as much as possible the personal lived experience of the young person, an endeavour that ultimately becomes an interpretative task for the researcher and participant alike. As Smith et al. (2009) put it:

“Without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen” (p. 37). The dual process allows for the fullest illumination of young people’s experiences of psychotherapy, lived experiences that are situated within the context of living in foster care.

As alluded to, the double hermeneutic allows the researcher to position participant descriptions of their experiences of psychotherapy in relation to wider social, historical, cultural, and theoretical contexts (Larkin et al., 2006). Through this approach, the researcher can adopt a more speculative and creative perspective in attempting to understand the meaning of the concerns, thoughts and feelings expressed by young people about the phenomenon from their “particular situation” (Larkin et al., 2006, p. 104) of living in foster care. In the current study the researcher’s experience as a practicing counselling psychologist working for many years with young people in care as well as their carers has helped contribute to this interpretative process. However, as noted later in this chapter, this is done in a mindful and reflexive manner so that the phenomenon expressed by the young people is not overly interpreted, that the interpretation is used to help illuminate their experience but not overshadow it.

The third pillar of IPA, idiography, refers to a focussing of the research endeavour on the individual person’s unique and idiosyncratic experiences of the phenomenon, where the researcher privileges what participants say in their interviews by analysing each individual case separately, before any attempt is made to generalise findings across the data. Consistent with the research study’s aim of illuminating how young people in foster care experience psychotherapy, IPA’s distinctive idiographic approach of valuing, respecting and learning from each individual is a key element (Pietkiewicz & Smith, 2014) of the methodology. A person’s distinctive micro experiences are valued and seen as valid in contributing to the knowledge base about the phenomena being studied (Smith et al., 2009). IPA allows the individual experiences of each participant to stand alone while being

allowed the latitude to make more general and wider claims as the analysis proceeds. Its focus is the in depth exploration of the convergence and divergence of individual participant experiences (Miller et al., 2018). This separates it from quantitative studies whose focus is on aggregating the data (Shinebourne, 2011) and as a result the individual's unique idiosyncratic experiences can get lost. The IPA researcher takes a pragmatic approach in carefully examining individual data before connecting it with relevant psychological literature that can help deepen professional understanding of these very personal experiences (Smith, 2004). It is this focus on understanding the particular that separates IPA from many of the other phenomenological methodologies that prioritise the illumination of universal commonalities (Gill, 2014; Pietkiewicz & Smith, 2014). The idiographic approach helps illuminate the inherently individual and unique adolescent experiences of psychotherapy while in foster care, thus helping psychotherapy professionals gain a deeper understanding of the subtleties of that experience, before examining what individuals share across those experiences.

Despite the identified utility of the three pillars of IPA for a study of this nature, it is important to note that there have been significant scholarly debates involving Giorgi (2010) as well as Van Manen (2017, 2018) who are critical of IPA methodology. Giorgi (2010, p. 6) suggested it should be termed “interpretative experiential analysis (IEA)” while Van Manen (2017, p. 778) proposed “interpretative psychological analysis” as a more appropriate name. Their main difficulty with the approach is their belief that it is not a true phenomenological methodology or one grounded in science. Smith (2010) strongly contests this accusation, arguing that IPA draws on the interconnecting philosophies of phenomenology and hermeneutics, which are discussed here and in a number of papers (Larkin et al., 2006; Smith, 2004, 2007; Smith, 2019). According to Shinebourne (2011), Giorgi's version of descriptive phenomenology remains closest to the Husserlian approach and it is perhaps the integration of the three pillars of phenomenology, hermeneutics and

idiography in IPA that are most difficult for him, as this integration may be perceived as diluting Husserl's purist descriptive phenomenology. Giorgi additionally posits that IPA is unscientific in nature as it is not sufficiently prescriptive allowing too much latitude to the researcher. He argues that without researchers detailing the use of their methods, other researchers are unable to see the analytic trail and are therefore unable to replicate studies (Giorgi, 2010). However, the replication of qualitative studies is not something many qualitative researchers aspire to nor is something that is possible; for example, no two interviewers can conduct the same interview (Smith, 2010). Furthermore, it is argued that IPA offers reasonable guidelines for analysis that are not overly prescriptive as how they are used depends on the area of research and the researcher's own skill base (Smith, 2010). Van Manen is critical of IPA's focus on the individual's experience of a phenomenon from a psychological perspective rather than focussing exclusively on the experience itself, thus generating findings that are "superficial and shallow" (Van Manen, 2017, p. 778). Smith (2018) disagrees, positing that quality IPA research can and should be both phenomenological and psychological in form. While these scholarly debates remain largely unresolved, IPA, despite the highlighted philosophical tensions, remains comfortably situated as both a phenomenological and interpretative endeavour, that facilitates the illumination of individual participants' experiences while being ever mindful of the researcher's presuppositions.

Researcher Reflexivity

Reflexivity in qualitative interpretative research refers to a stance whereby the researcher is conscious of what they bring to the research process in terms of experiences, biases and values (Creswell & Poth, 2018). This is an important aspect of IPA that recognises the role of the researcher as one who is trying to make sense of the participant's experience in the double hermeneutic (Shinebourne, 2011). In IPA the researcher is required to balance their interpretation of participants' unique subjective experiences while

paying adequate attention to the influence of their own preconceptions, influence and values on all aspects of the research process (Smith et al., 2009). It is an acknowledged tension in IPA research, whereby the researcher moves back and forth between setting aside preconceived ideas regarding the topic under investigation and offering insights and understanding of the data (Finlay, 2009). The importance of having this capacity to move between examining one's own personal assumptions about the topic and then returning to examine the participant's data in a fresh way is emphasised (Finlay, 2009).

Smith offers guidance about how to facilitate checking (Smith et al., 2009) including making use of research supervision, keeping an audit trail and providing sufficient extracts from participant's interviews evidencing the convergence and divergence of themes. The researcher engaged in these processes throughout the study, while also regularly presenting to a peer research group who added another layer of scientific oversight. IPA offers a simultaneously flexible and prescriptive methodology that assists the researcher in rigorously investigating participants' lived experiences in a way that honours their unique subjective experiences while centrally acknowledging researcher influence in the meaning making process.

Procedure

This section will outline the recruitment, sampling, data collection and analysis procedures undertaken in this study. The data analysis process is then outlined, which is in accordance with the stages described by Smith et al. (2009).

Recruitment

Consistent with the theoretical underpinnings of IPA, the study sample was selected purposively. The researcher used a number of recruitment strategies that were executed on a phased basis, as outlined below, and included liaising with the Irish Foster Care Association (IFCA), private practitioners, snowball sampling and in all cases Tusla, Child and Family Agency social workers. A research flyer (Appendix A) as well as a short

promotional video (Appendix B) was produced as a way of assisting in reaching this difficult to access population and appropriately introduce the researcher, as well as the research information to them. This video was available via a link that could be easily distributed via e-mail. Recruitment challenges will be addressed in the next section.

The Irish Foster Care Association (IFCA) is the representative body for foster care in Ireland, with a membership of over 1,500 foster carers. IFCA management agreed to circulate the research information sheet (see Appendix C – I for all information sheets and consent/assent forms) via its ezine and Facebook page to its membership, asking them to make direct contact with the researcher if they had a young person in their care who might be interested in participating and fit the inclusion criteria.

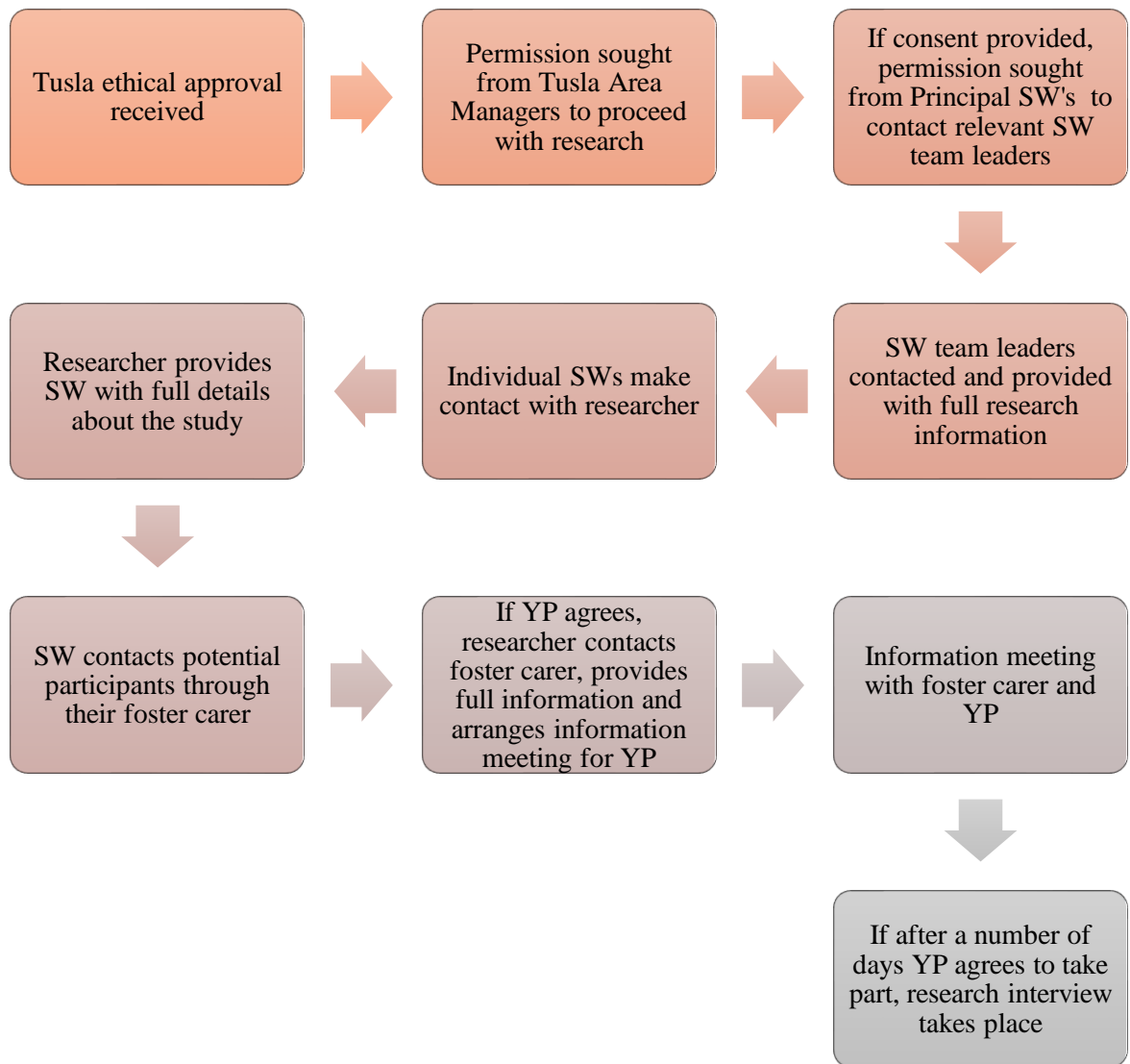
Professional organisations such as the Psychological Society of Ireland (PSI), Irish Association of Counselling and Psychotherapy (IACP), Irish Council for Psychotherapy (ICP) and the Irish Association for Humanistic and Integrative Psychotherapy (IAHIP) as well as the Irish Play Therapy Association (IPTA) and the Irish Association for Play Therapy and Psychotherapy (IAPTP) were asked to circulate research information to their membership. However, for various reasons, including GDPR legislation, the study was only advertised on the IAHIP website. The research information was also forwarded to relevant psychotherapy and psychology clinics, private fostering agencies, professional contacts, the Empowering People in Care organisation (EPIC), Guardian ad Litem services, youth services as well as child and family centres. Snowball sampling was also used insofar as a number of professionals and foster carers contacted the researcher as a result of hearing about the research from other sources.

Following receipt of ethical approval from Tusla (Appendix J), the recruitment process when it ran smoothly, generally proceeded in the following step by step manner (particular consent issues will be attended to separately in this chapter): permission was required from Tusla area managers before contacting social workers in their area (four

Tusla area managers provided consent); contact was then made with principal social workers and social work team leaders, for assistance in directly contacting social workers in particular areas; young people's social workers could then contact the researcher if they were working with a potential participant; on receipt of contact, research information was then forwarded and discussed with the young person's social worker who then contacted the young person and/or the foster carers to ascertain whether the young person was interested in taking part; if the young person was in agreement the researcher then made contact directly with the foster carer to discuss the research; if agreement was made, the researcher then arranged to meet or talk with the young person together with their foster carer to discuss the study further, provide full information and answer any questions the young person had; if the young person assented/consented to taking part in the research after considering it for a number of days, the researcher then met with them to conduct the research interview. Thus, in general, a minimum of ten steps were required before each research interview could take place and often required multiple more contacts by the researcher as follow up (Figure 1 illustrates this 10 step process).

Figure 1

The 10 Steps of Recruitment



Note: SW = Social Worker; YP = Young Person.

Recruitment Challenges

Challenges in recruiting participants became evident in the early stages of the recruitment process. It was a difficult process and initially there was a poor response rate. Similar to obstacles encountered in previous research projects involving young people in foster care and presented in Heptinstall (2000), these obstacles included: social workers not responding; social workers, and in some circumstances, practitioners working with young people, denying access to young people due to concerns that the interview might aggravate

difficulties in the foster placement; and social workers vetoing their participation without consulting with the young people or their foster carers based on the assumption that the young person would not take part or would find it stressful. Explanations regarding this lack of co-operation or non-response rate from social workers and other professionals have been offered in the literature, including the scale of the social work caseload which understandably means, research projects are not prioritised, as well as their possible distrust of researchers who they do not know (Gilbertson & Barber, 2002). Issues of trust were central to the recruitment process in this study, where participants in all cases were eventually recruited through gatekeepers who had received informal positive references from professionals or foster carers as to the professional reputation of the researcher. Given the needs of the population being researched this is hardly surprising, however, this insight is noteworthy in providing essential guidance and support for practitioner led research in the future. If the researcher was not working within the field of interest of this study it seems likely that the recruitment process could have floundered.

Sample

In general, IPA studies are conducted on small sample sizes due to the time intense nature of the analysis and the aim to write in detail about the perceptions and understandings of the participants (Smith et al., 2009). Smith et al. (2009) suggest that a sample size of between four and ten interviews is typical for a professional doctorate study. The sample was “fairly homogenous” (Smith et al., 2009, p. 29) based on their age range and experience of attending individual psychotherapy while living in foster care. Young people had either attended for individual psychotherapy within the previous 12 months or were attending individual psychotherapy at the time of data gathering, having attended for a minimum of six sessions. Participants needed to be in a relatively stable foster placement while taking part in the research interviews, so that they could receive sufficient support in order to fully participate in the research project and in the unlikely situation that they

experienced any upset as a result of participating. The stability of their placement was established in the early exploratory conversations with the young person's social worker and/or foster carer. Participants were not present or former clients of the researcher. This reduced the potential for undue bias, influence or felt coercion, participants may have experienced due to knowing the researcher.

A sample size of seven English speaking adolescents in foster care, aged between 13 and 18 years of age was recruited which allowed sufficient scope for comparison across cases while maintaining the quality of each individual analysis. From a developmental perspective this age group were deemed likely to have acquired the capacity to reflect on their psychotherapy experience and gained adequate language skills that would allow them to articulate their experience (Slater & Bremner, 2017). Participant demographic information is presented in Table 1. Reasons for referral as well as details about the frequency, type and length of therapy were not collected as this would have required access to participants' Tusla case files. Gathering this historical information may have raised issues regarding confidentiality and potentially hindered the research ethics application process. As a result these issues were not included in the original research ethics application and these details could not be gathered.

Table 1*Participant Demographic Information*

Participant	Gender	Age at time of Interview	Approximate age on entry to care	Approximate number of foster/residential placements	Approximate amount of time in current foster placement
Catherine ⁴	F	13	5 years	2	5 years
Nathalie	F	18	9 months	1	17 years +
Jen	F	17	2 years	1	15 years
Beth ⁵	F	14	6 years	1	10 years
Bob	M	16	5 years	6	1 month
Keith ⁶	M	18	6 years	20+	1 year
Luna	F	17	8 years	4	4 years

Data Collection

The data for the study were gathered using individual interviews in an “attempt to understand the world from the subjects’ points of view, to unfold the meaning of their experiences, to uncover their lived world prior to scientific explanations” (Kvale & Brinkmann, 2009, p. 1). Semi-structured interviews were used to allow the participant and researcher engage in a conversation where initial questions could be modified in light of the participant’s responses, which gave scope for the researcher to enquire further about other interesting areas that arose while contributing to achieving the research goals (Smith et al., 2009). In addition, interviews of this nature invite participants to offer rich, detailed and personal accounts of their experiences, consistent with the aims of this study (Smith, 2008). The semi-structured interview process lent itself to rapport being gradually developed in order to help young people tell their stories, a suitable process when meeting

⁴ Catherine requested that her foster carer accompany her to the interview

⁵ Beth and Bob were living with their maternal grandparents as part of a relative foster placement at the time of interview

⁶ Keith was living with his maternal aunt at the time of interview

with a vulnerable population such as young people in foster care and one that fit well with their developmental needs. The duration of interviews ranged from approximately 40 to 90 minutes.

The researcher consulted with young people in foster care as part of the interview schedule (Appendix K) design phase and also conducted a pilot interview as part of his preparation for data collection. The latter was recorded and completed with two research colleagues who provided constructive feedback about the process of the interview. All of the collected data were audio recorded, transcribed and pseudonymised by the researcher. The data were stored on an encrypted and password protected computer in the researcher's home office, while hard copy data, such as consent forms, were kept in a locked filing cabinet in a locked office in the researcher's home. Data were shared with the researcher's research supervisors in DCU, as well as a research colleague in DCU who assisted in ensuring transparency in the data analysis phase. Samples of pseudonymised data were made available to her during the analysis phase in order to lend transparency and credibility to the analysis of the data. In all cases and as agreed with the young people, the research interviews were held in their foster placement in order to create a comfortable atmosphere for them. One young person's request for her foster carer to be present throughout the interview was facilitated.

Data Analysis

Data were analysed by using the seven steps of IPA, described as follows: Step one involved the researcher repeatedly reading and re-reading the transcripts and immersing himself in the phenomenology of the data. This active engagement and concentrated focus on each individual transcript was the beginning phase of "entering the participant's world" (Smith et al., 2009, p. 82). Step two involved taking exploratory notes while reading and becoming more familiar with each transcript as the interpretative process began. Comments were noted in separate columns of an Excel sheet which contained the

transcripts and were categorised as: descriptive comments, referring to data that described the things that mattered to the participant; linguistic comments about how each participant used language to represent both content and meaning in what they said; and conceptual comments where the researcher identified more abstract concepts while trying to make sense of patterns of meaning in each transcript (the double hermeneutic). The researcher became more interpretative and interrogative, at this stage adopting a more questioning and speculative style of thinking, as a way of moving the analysis beyond the purely descriptive or superficial plane, as per guidelines set out by Smith et al. (2009).

Step three involved the researcher primarily working with his initial notes in attempting, through a process of mapping connections, interrelationships and patterns within the notes to produce emergent themes. This was challenging as it demanded a reduction of the volume of detail to themes that still adequately captured the complexity and understanding of the participants' data. These themes were also noted in a separate column of the Excel sheet, which proved to be a helpful way of keeping all of the analysis in one place (see Appendix L and M for examples). Step four involved the researcher beginning to search for connections across the emergent themes. The researcher began to map out how emergent themes might fit together with a view to producing a structure that pointed to the most interesting and important aspects of the participant's experience, leading to the development of superordinate themes. This was done using various processes that were not mutually exclusive and included at various times: abstraction (putting like with like); subsumption (the emergent theme itself gains a superordinate status as it assists in bringing together a number of related themes); polarisation (examining themes for oppositional relationships); contextualisation (examining connections between themes by identifying contextual or narrative elements within an analysis); numeration (frequency of emergent themes within the account); and function (examining the themes for their particular function within the transcript). The researcher

then created a summary document of each young person's transcript together with the list of emergent themes and potential higher order themes (Smith et al., 2009). An example of this is provided in Appendix N.

When this process was completed with each participant's data, the researcher in step five moved on to the analysis of the next participant's data. Consistent with IPA's idiographic commitment, each case was analysed individually and on its own terms by the researcher, while he endeavoured to set aside ideas that emerged from each analysis before working on each subsequent transcript. When the process of analysis was finished with each transcript, the next one took centre stage and the rigorous process of analysis began again. Step six involved the researcher examining the data for connections across cases with a view to developing a master table of structured themes across data sets. The researcher looked for patterns across cases by laying out each table of emergent themes on a large surface and looking across them all. This led to a reconfiguring or re-labelling of themes. Analysing the data at a more theoretical level assisted the researcher in recognising that emerging themes and superordinate themes in individual cases also represented instances of shared higher-order concepts across cases. This was represented in a group table that showed how themes linked and were related to quotes located in the text by Excel line number. Themes were prioritised based on their prevalence within and across the data, their richness as well as their relationship with other aspects of the participants' accounts. The superordinate themes presented in the findings chapter, emerged across participant accounts and encapsulate the subordinate themes captured within. Step seven involved the writing phase where the analysis continued and the double hermeneutic deepened, as the researcher's interpretation developed further during the process of writing. In writing up the study, direct quotes from the raw data were used to illuminate particular themes, while Excel sheet line numbers from the transcripts were included (Smith et al., 2009).

Ethical Considerations

Ethical approval for this study was provided by the Tusla Research Ethics Review Group on November 15th 2018 (Appendix J) and notification of approval was forwarded to the DCU Research Ethics Committee. Tusla is the statutory child protection agency in the Republic of Ireland and the employer of all social workers with responsibility for children in care. Adolescents in foster care are a vulnerable population who often have had difficult and negative experiences with adults. Due to their age, statutory care status as well as overall vulnerability, ethical considerations were understandably complex and challenging. Due consideration was required regarding consent issues, mandated reporting as well as other issues pertaining to ensuring participant welfare during the research process.

The research study adopted the ethics as process model (Ramcharan & Cutcliffe, 2001). This model subscribes to the view that not all issues can be anticipated at the beginning of the research process but commits to addressing any issues as they arise. It recognises the dynamic nature of qualitative research where a broad approach to ethical considerations can be planned for and adopted prior to the study taking place and then adapted as issues that need addressing emerge. The study was underpinned by a number of ethical principles that guided the researcher at every stage of the research process, the principles of: non-maleficence; beneficence; autonomy; and justice (Beauchamp & Childress, 2013). These principles assisted the researcher in planning and conducting the study with the safety and respect of everyone involved at the core of decision making. How this was achieved is summarised below.

Non-Maleficence

Non-maleficence refers to “the obligation to avoid harm” (Ramcharan & Cutcliffe, 2001, p. 360). This involved protecting participants’ identity and confidentiality throughout the research process. Pseudonyms were used and only the researcher and research supervisors were allowed access to the raw data. In addition, peer and research

consultation was actively sought throughout the analysis stage, as is often done in an IPA study. Participants were informed that total confidentiality could not be guaranteed, given certain reporting obligations. The research information sheets highlighted these reporting obligations, referencing the researcher as a mandated person who is required to report child protection concerns in accordance with Children's First, National Guidance for the Protection and Welfare of Children (Department of Children and Youth Affairs, 2017) as well as his adherence to his professional body's code of ethics (The Psychological Society of Ireland, 2011). No child protection risks were identified by the researcher during the study.

Participants were clearly informed through the research information sheets that there was only a small number of participants in the study and that direct quotes would be used in the dissemination of the study findings, including publication. Participant transcripts were "cleaned" so that all identifying information was removed at the time of transcription, and the researcher securely stored all socio demographic information separate to the raw data. Raw data was coded so that only the researcher could know the identity of each data set.

In the event that participants spoke about sensitive and potentially upsetting aspects of their experience, as well as recalling other unexpected and upsetting memories or experiences, arrangements were made for the participant's foster carer(s) to be in the building and directly accessible to offer support during the course of the interview. The location of the interview was determined in each case by consultation with the young person's foster carer/social worker/other professional or if the young person was aged 18, the young person themselves, to help the young person feel secure. The researcher carefully prepared for the research interviews in order to maintain good self-awareness regarding his role throughout the research process, while ongoing research supervision was also helpful in mitigating against the risk of blurred boundaries and role confusion. In

addition, arrangements were made should the researcher have felt the need for support immediately following an interview where he could make contact with one of his research supervisors by telephone to debrief if needed. The researcher's engagement in ongoing research supervision supported and monitored his psychological well-being throughout the process.

Beneficence

Beneficence refers to “the obligation to provide positive outcomes, or benefits” (Ramcharan & Cutcliffe, 2001, p. 360). There was potential for participation in this study to both directly and indirectly benefit participants in a number of ways. Research participants often report an appreciation of the provision of a non-judgmental forum for discussion of what they have been through (McEvoy & Smith, 2011). Alderson and Morrow (2011) highlighted that there is potential harm to be caused by not including children in research that is about them, creating the possibility of research that is unrepresentative of experiences and effectively silencing people in distress. Having avenues like this research study, where young people in foster care can make their opinions known about issues pertinent to them are recommended (McEvoy & Smith, 2011; Överlien & Holt, 2017) and can be beneficial. Consistent with this, many of the research participants explained that their motivation to take part was influenced by their wish to help other young people in foster care who could benefit from the potential positive influence of a study of this nature on future psychotherapy practice. In addition, although the researcher was clear that the research would not be psychotherapeutic in form or nature, it was conducted in an empathic and sensitive manner which may have had positive therapeutic effects for participants. A further potential indirect benefit to participation is the possible and hoped for wider contribution and benefit it can make to other young people who attend therapy services.

Respect for Autonomy

Respect for autonomy refers to the importance of participants being given the opportunity to make informed decisions on their own behalf (Beauchamp & Childress, 2013). This is more complex and less straightforward for young people in care whose sense of autonomy is clearly compromised. Consent was obtained from the young person's social worker (for those under 18 years of age) and/or at least one of their birth parents/legal guardians (unless advised otherwise by their social worker). Written assent to participate was requested from participants under the age of 18 while written consent to participate was requested from adolescents aged 18 years. Several opportunities were thus provided for information sharing about the study and addressing questions raised.

The young person then had the option to assent to participate or to opt out. The researcher informed each young person during the initial phone call/meeting that he did not expect them to immediately assent unless they wanted to, that it was in their best interests to consider over the course of the proceeding seven days whether they wished to participate. If the young person agreed to participate, a meeting time was arranged in consultation with their foster carer/social worker. It was made clear to participants that they could withdraw from participation in the study at any point and were under no obligation to provide an explanation for withdrawal.

Justice

Justice refers to ensuring that research is carried out in a fair and impartial manner (Beauchamp & Childress, 2013). The researcher endeavoured to ensure this by firstly approaching all fostering social workers in a specific geographical area and secondly, asking all potential gatekeepers within organisations to provide the research information to all of those who fit the inclusion criteria, with a view to minimising the risk of prospective participants being filtered out due to bias. In addition, young people who participated in the interview were asked about their motivation for participating to ensure there had been no

pressure, social or otherwise, to participate. All participants were offered the opportunity to review and amend the transcripts of their interviews up until the commencement of data analysis.

Research Rigour

Assessing the trustworthiness of research studies is an important task. This involves assessing its validity and quality in a manner that is appropriate to qualitative research (Smith et al., 2009). If research is to be of practical use it is important that it can be legitimised by using a set of criteria that support the validity and reliability of studies in such a way that the findings can be trusted by the people for whose benefit the study was intended (Yardley, 2000). With this in mind, Yardley's (2000) criteria for validity and reliability are deemed appropriate for use with IPA studies (Smith et al., 2009) and are utilised in this study. Yardley's framework presents four broad principles: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. Recognising the diversity of qualitative approaches, these broad criteria allow for user flexibility. Chapter 6 will expand on how this process of research rigour was operationalised with reference to examples from this study.

Conclusion

IPA was selected as the methodology of choice in this research study on young people's experiences of psychotherapy while in foster care, as it was deemed most suitable for gaining an in depth understanding of these young people's lived experiences. The philosophical underpinnings of IPA influenced how the researcher positioned himself in relation to all aspects of the research study. A purposive sample of seven young people was recruited, and semi-structured interviews were conducted, taking account of the significant ethical considerations needed in exploring such a sensitive topic with a vulnerable population. Although many challenges were encountered in the recruitment process, in particular in accessing young people through gatekeepers, the positive influence of being a

practitioner-researcher in this specialist field was deemed an advantage in conducting this study. Reflexive practice was engaged in through the use of journaling, peer and research supervision and assisted the researcher in critically attending to his pre-suppositions about the phenomenon while demonstrating study rigour. Ethical considerations were attended to throughout the research process, while attending to Yardley's (2000) principles for assessing the quality of qualitative research, ensures the trustworthiness of the study.

Researcher's Reflexive Comment

IPA is a methodology that fits with my own philosophical viewpoint. As part of the Doctorate in Psychotherapy programme I spent a year grappling with the philosophy of psychotherapy, something that was quite challenging for me as I discovered I am quite a pragmatist at heart. However, I found that my existentialist-humanistic approach to psychotherapy was most closely in line with Heidegger's philosophy of phenomenology, believing in the interpretative endeavour. Putting this into practice using IPA was challenging as I tried to balance the hermeneutic elements with the phenomenological aspects, wanting to ensure that the participants' voices shone through. I also discovered early on in the process that my positive bias towards psychotherapy was something that I needed to pay attention to. This was pointed out to me during a pilot interview, as was my tendency to not probe and challenge enough. However, I discovered that using my interviewing skills established from my previous experience of interviewing children about child sexual abuse allegations were very helpful in this regard. Recruitment challenges were frustrating and time consuming, together with the significant ethical considerations that demanded careful thought, drafting and re-drafting. These were issues that I had naively thought would be much easier to complete. I thoroughly enjoyed the interviewing process. By the time I reached this phase I was feeling somewhat cynical about the research process, questioning the time and energy it took to get to this point. Meeting the young people re-ignited my passion for the study as I began to hear their stories, build

connections with them, see how they shared their stories and what it meant to some of them to be asked their opinions. Nevertheless, hearing some of their negative experiences of therapy, where participants described therapists treating them disrespectfully, was challenging at times as I felt angry that professionals could treat such vulnerable individuals in this way.

Chapter 4: Findings

Introduction

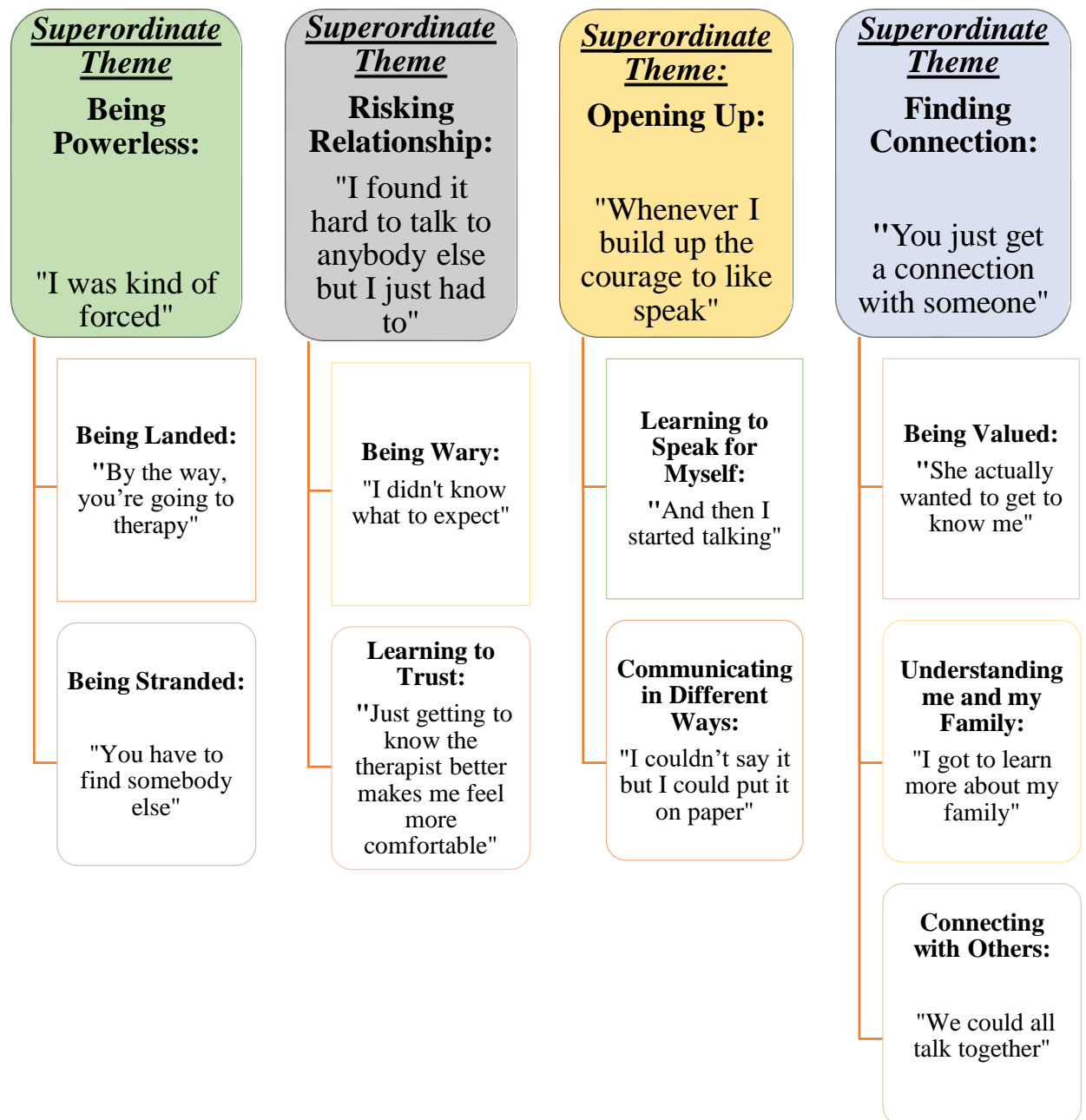
This chapter describes the key findings of this study, detailing the young people's lived experience of psychotherapy as expressed in themes. Four unique and inter-related superordinate themes emerged from the analysis of seven young people interviewed in this study and exemplify their lived experiences of psychotherapy: 'Being Powerless', 'Risking Relationship', 'Opening Up', and 'Finding Connection'. Nested within each of these superordinate themes are sub themes, as detailed in Figure 2. Verbatim extracts from the participants' interviews are presented throughout the chapter to support and illustrate the study findings. In addition, a summary of the advice offered by participants about psychotherapy is provided; the data is tabulated in Appendix O.

Young Peoples' Lived Experiences of Psychotherapy

The first superordinate theme, entitled 'Being Powerless', illustrates participants' experiences of being brought to therapy without being consulted and how therapy endings were experienced. The second superordinate theme, 'Risking Relationship' captures young people's wariness of engaging in psychotherapy as well as the personal risks they took in attempting to establish trust with their therapists. 'Opening Up', the third superordinate theme, reflects how beginning to vocalise about their inner worlds was an important part of the therapeutic process for some of the young people while using creative means facilitated young people to express themselves in different ways. Finally, 'Finding Connection', articulates the young peoples' need to feel genuinely valued as people which helped motivate them to continue opening up about their past and family circumstances, while they learned to connect with themselves and others in their family system.

Figure 2

Overview of Superordinate and Subordinate Themes

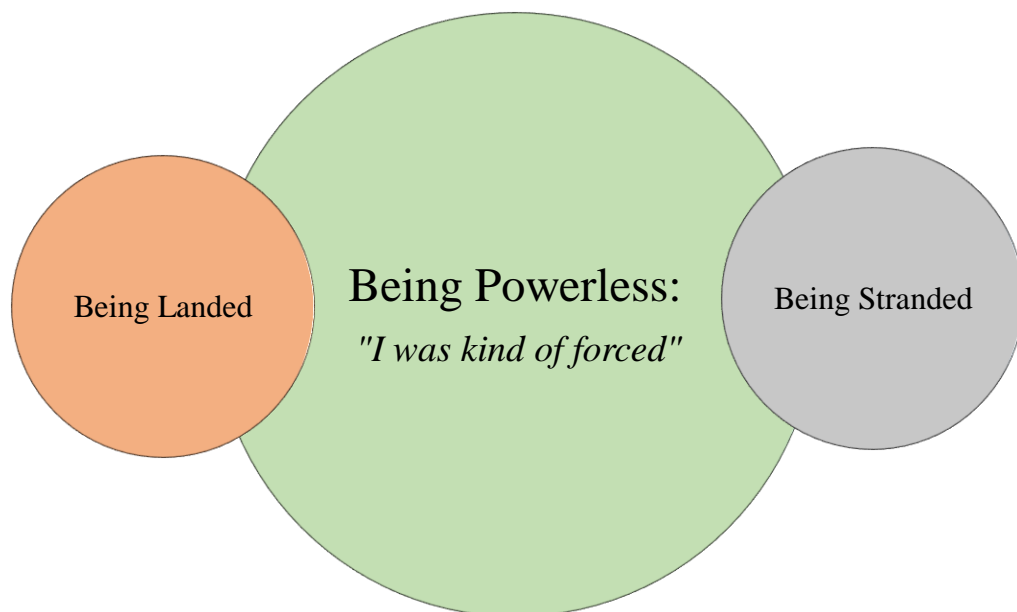


Being Powerless: “I was kind of forced”

The first superordinate theme, ‘Being Powerless’ (illustrated in Figure 3), reflects how all the young people in this study experienced a lack of agency and had little say in starting or finishing the therapeutic relationship. Many of the young people experienced feeling angry and resentful as a result of feeling forced to go to therapy, which in turn negatively impacted their engagement with the therapist. Nevertheless, many expressed gratitude about their positive experiences of therapy and that they were made go. The subordinate theme ‘Being Landed’ articulates how many of the participants had an experience of being brought to therapy against their expressed wishes, while the second subordinate theme entitled ‘Being Stranded’ reflects participants’ experiences of not being consulted or informed about therapy finishing, experiences which had psychological consequences for some.

Figure 3

Being Powerless



Being Landed: “By the Way, You’re Going to Therapy”

Five of the young people (Luna, Nathalie, Catherine, Jen and Keith) had little or no say about going for therapy and offer rich examples of the various experiences encountered. Some were brought with no consultation whatsoever. As Luna (17⁷) put it: “I was kind of forced...you have to go” (352⁸). Without this push by her carers Luna would not have gone to therapy. Her reluctance to going was due to a previous experience:

And it was kind of like oh well that didn't work and she didn't help and I still want to die and blah blah blah blah. So I was like oh why, what's the point she's not, this one's not going to be any better. And I was just in a bad place at the time anyway so I was kind of like yeah I don't want to go and then I went and I was like okay, I might like this (328).

Luna described feeling quite hopeless about therapy, believing it “didn’t work” and “she [previous therapist] didn’t help”. Luna’s use of language, for instance, “blah blah...” perhaps indicated a tendency to minimise how “bad” she was feeling, making light of her desire to die or possibly communicated a sense of frustration or resignation about how people generally tended to let her down. Being “forced” to go to therapy in this way provided Luna with an increased sense of agency as therapy progressed, presenting the possibility of overcoming a growing and determined self-reliance that, if left unchallenged, may have increased her belief that she could not be helped by others. It was only by going back to therapy that Luna could show herself it “might” be better.

Even though Luna did not want to go to therapy initially, she was consulted about it. For Nathalie (18), it came as a complete surprise. When asked how it was decided she go to therapy and what her thoughts were about it, Nathalie explained:

⁷ Ages are presented in brackets after the young person is first introduced

⁸ Excel sheet cell numbers referencing location of the quotes in the analysis

I don't know they just brought me (254)...I didn't know what it was (298)...my mom was just like oh we're going off shopping, we're doing this and so okay and she brought me to a building and I was like, oh no we're not going shopping (301)...I didn't know what it was and then when we got there my mam was like by the way you're going to therapy, oh no (310).

It was quite a shock for Nathalie, she had no idea that she was going to meet a therapist. In her mind she was going shopping with her mother (foster carer) and then in an offhand way she was told, "by the way" she was going to therapy. Nathalie "didn't know what" therapy was and for her this experience was very difficult, she felt "sick again" (226), describing this in her interview. The 'not knowing' appeared to be very stressful for Nathalie making the whole experience "overwhelming" (1036), but her foster carer consulted with her on subsequent occasions, as a result of this experience: "...my mam just landed me there at 14. She talked to me about the other ones [therapists] because she realised how bad that was" (1040). The need for preparation and planning for initial therapy sessions was important for Nathalie and perhaps reflects her need for this type of predictability and agency, having previously encountered unpredictable and overpowering experiences with adults in her life.

Anger was the predominant feeling for Catherine (13) when she was brought to therapy. She felt she had no choice about going:

Well, my mam [foster carer] said that I had to go anyway...(201) at the time, I was really, em, angry and annoyed and upset because I didn't want to go to therapy but after a while I'm really happy and I understand that when I go it really helps me (208).

Catherine was clearly upset by not feeling listened to regarding therapy. Expressing these strong negative feelings about her experience appeared difficult for Catherine as she moved on quickly to more positive commentary of how helpful therapy could be. Having

her foster carer in the room during the research interview may have influenced this reflexive type response, as she may not have wanted to upset her.

For Jen (17), it was hard to build a relationship with her therapist as a result of not being told or consulted about going for therapy. Her carers decided that she needed therapeutic help even though Jen was saying she was fine:

At the beginning I was like oh no I don't wanna to go. And then they like didn't, not that they didn't talk to me or like say anything about it, they were just like okay we'll try. I think they just took it in their own hands to try and get me help when I was there like oh no I'm fine. So they just knew something was up (330).

Jen was denying she needed therapy as she was trying to protect her family from knowing how she really was, not wanting to upset them. However, her carers took control as they recognised she was in distress, hearing about this from other parents in whom Jen's friends had confided their worries. Although it appeared Jen was annoyed by this, she seemed in some ways relieved that they took control of the situation because they noticed "something was up". Jen appeared to mask her vulnerability, was scared to expose it and perhaps weaken her own learned self-reliance for fear that people would get to know and see the real Jen. The risk of potentially being rejected again appeared too great and needed firm and careful navigation by her carers and therapist in order to assist Jen in engaging with the therapist. Jen may have needed to be landed in therapy in this way as she may never have agreed to go if consulted. It reflects a fine balancing act that she needed from the caring adults in her life in order to assist her to overcome her sometimes overwhelming need to avoid. While 'Being Landed' in therapy impacted how she related to her therapist initially, Jen acknowledged she needed to go to therapy, implicitly acknowledging her parents' (foster carers') decision:

At the beginning it was hard for me to kind of have that nice friendly relationship 'cause I wasn't told that I was going in (478)...I wasn't kind of happy about it but I

wasn't in the best like mindset or attitude going in and I was like kind of acting stuck up so yeah (482)...it was difficult but at the same time I kind of like knew that I needed it (498).

This strong encouragement by caring adults who recognised the young person's need for psychological help, even though the young person might be arguing against it, was also a dominant theme for Keith (18). He didn't want to go to therapy initially either but agreed when "incentives" were offered by his carers (staff in a residential home): "so they'd say that if you go we'll bring you out for something to eat afterwards...so that helped me go at the start" (280). Keith was able to build trust with his therapist, realised it was useful and went himself without any incentives.

Being Stranded: "You Have to Find Somebody Else"

All of the young people had an experience of therapy ending for reasons outside of their control. Sometimes these endings were planned as a result of therapist circumstances, for example, maternity leave, while others happened suddenly. Difficult or unplanned endings perpetuated feelings of distrust, being let down and self-blame for the young people while in another example the ending of therapy was a relief for the young person. This subtheme focuses on the experiences of five participants (Bob, Beth, Catherine, Luna and Keith), which best demonstrate the diversity of the theme.

Bob (16) had the experience where therapy involving his foster carers finished with no explanation:

I don't know why it finished (746)...I was devastated (750)...it was the best craic (758)...it was weird because I remember asking 'are we going back up?' and she [foster carer] said no, I said why, she didn't answer, she didn't know like (770).

The language Bob uses gives a sense of just how this ending impacted him. He was truly "devastated" by it. The strength of his language suggests the possibility that 'Being Stranded' in therapy may have rekindled previous powerful feelings related to unexplained

and sudden endings Bob may have experienced with other people in his life, for example, when being placed in care or when placements ended suddenly. The therapy appeared to be so important to Bob, “the best craic” yet no-one spoke to him about it and when he asked his carer she “didn’t answer” him. It seems so lonesome and sad for Bob as he related how much this experience of child-parent therapy meant to him but no-one else seemed to put value on it for him, leaving him to deal with this unexplained ending without any further discussion.

Catherine was aware that her therapy was coming to an end as her therapist was going back to college. This appeared to be a significant loss for her as she described what it was like to have to finish seeing her therapist:

To be honest, kind of hard because I, her name was [therapist’s name] and I’ve known her for like years and she, she moved families with me so it’s like I’ve seen her every week [voice cracks a little]. So like we were really close. So it’s kind of hard. So yeah (186).

The fact that she continued meeting with her therapist even when she moved foster placements meant a lot to Catherine. Catherine’s therapist was a consistent person in her life who she’d known for “years” and that she met “every week”. The sense of loss is palpable for Catherine when she described how her therapist “was probably one of the closest people” (186) she’s been with.

Beth (14) who had reluctantly taken ownership over ending therapy by letting her therapist know she wished to finish, described feeling relieved when it ended with some therapists: “And then some of them I was like ‘yeah oh thank God we’re finished’” (1123). For others who she had connected with there was a sense of loss when therapy had to end due to issues outside of her control: “Because then you wouldn’t go and see them anymore and I was like aw, you’re not able to talk them anymore, you have to find somebody else” (1127). Beth expressed sadness as she could no longer meet with this person who she had

connected with. The transient nature of relationships for many of these young people was apparent as Beth talks about having “to find somebody else” with an air of resignation.

Luna had the experience where she felt huge pressure to finish therapy when she moved foster placement and her foster carer didn’t want to continue bringing her:

My new foster carer decided it was an inconvenience and she didn't like the drive so she basically told me I couldn't go anymore. So it was kind of like ‘I don't want to have to drive’ [mimicking the foster carer]...because it's like 40 minutes or so, she was like ‘I don't want to do it so’ (219)...well she kind of basically was like, ‘you don't really want to go anymore do you?’ [mimicking foster carer] ‘You don't need it anymore right?’ I was kind of like, I guess no (223).

Luna did not have any real say in this decision, she felt the decision was made as it was “an inconvenience” for her foster carer who appeared to be convincing Luna that it was her idea, telling her she didn’t want to go anymore. Luna’s mimicking suggested a sense of anger at her foster carer that may be more easily expressed in this indirect way. She appeared to feel very let down and undervalued as a young person whose foster carer did not “want to have to drive” to get help for her. This is a very clear picture of Luna’s lack of agency as a young person in care who appeared to feel manipulated into agreeing with her foster carer’s wish to end her therapy, occurring at a time when Luna was most likely feeling quite vulnerable and unable to state her real desires and needs as she had just moved foster placements.

Keith’s experience further highlights this lack of power and the unpredictability of therapy endings. Keith described how he attended for a therapy session when he was younger to discover his counsellor had been replaced by someone else who he had never met before:

You didn't know that they were ending (812)...like the next time you'd be in for a session could be a few months down the line and ye'd think you're going to the

same person but then you're like, who's this like (816)...I wasn't been told that me counsellor finished or (820)...it was just weird and that's where the trust issues came in because people come and go like, that's the way I see it that's the way I still see things but (824).

Keith did not know his counsellor was finishing, and stated that no-one had spoken to him about it. This had a significant impact on Keith and reinforced his view that people just “come and go” and can’t be trusted. Sadly, this made Keith question had he done “something wrong”, was it his fault that ‘this happened’? This experience highlights Keith’s vulnerability as a young person in foster care whose apparent negative self image was reinforced by being stranded in this sudden way, leading to feelings of self blame and reinforcing what appears to have been a growing distrust in people:

It was weird at the start like, I was like why did she finish like did I do something wrong personally because I was only about like ten like. And I was like ‘did I do something wrong for this to happen?’ and then I realised then that people just come and go like. That's when every counsellor I met before, after that I just said, ‘you know more about me than I do you know like, I don't trust you one bit’ (844).

It impacted his feelings about “every counsellor” he met. It appears to have made him question if he could believe in anybody again, to be suspicious of people who “know more about” him than he knew himself. This growing realisation of how counsellors who he had not previously met, possessed more knowledge about his life than he did starkly highlighted Keith’s lack of agency as a young person living in the state care system.

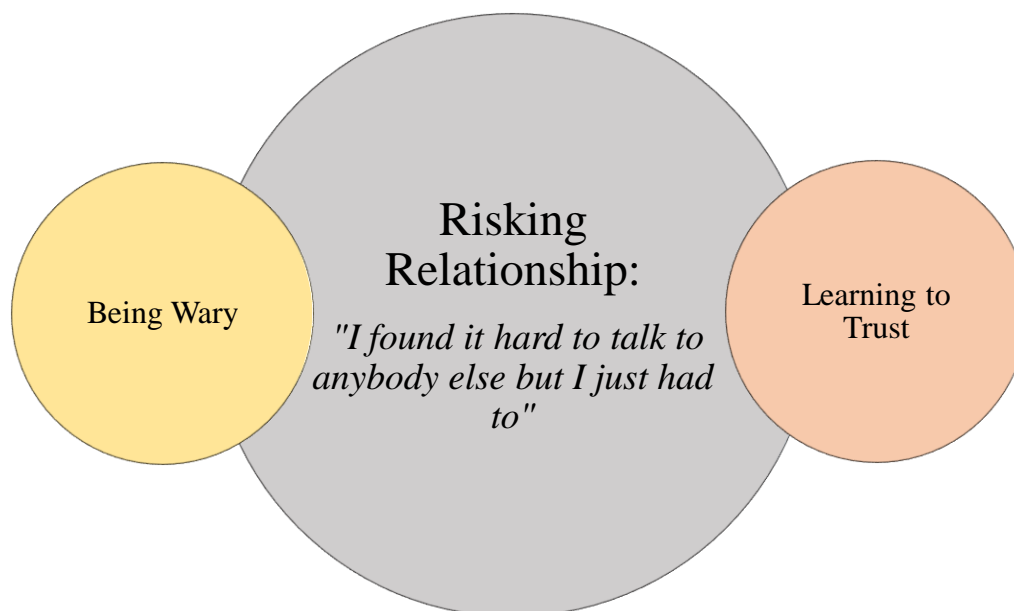
Risking Relationship: “I Found it Hard to Talk to Anybody Else but I Just Had to”

The second superordinate theme, ‘Risking Relationship’ (illustrated in Figure 4), captures the challenge and vulnerability experienced by all the young people in coming to therapy and forming a relationship with a therapist as well as some of the experiences that contribute to the building of this uncertain relational alliance. The subordinate theme

‘Being Wary’ reflects the anxiety and distrust young people experienced when beginning therapy, while the second subordinate theme ‘Learning to Trust’ articulates how young people gradually began to build relationship with their therapist.

Figure 4

Risking Relationship



Being Wary: “I Didn’t Know What to Expect”

All of the young people in this study described how their previous relationships with therapists or other professionals impacted on how they approached subsequent experiences of therapy making them question investing in another relationship. For some, this wariness emerged as a result of negative relational experiences, while others had become jaded with frequently having to form new relationships because of high staff turnover. This subtheme is best exemplified by the experiences of Keith, Catherine, Jen and Beth.

Keith found it particularly hard to engage in therapy as he did not trust people in general. This was borne out of his time in care where he had engaged with a range of carers, professionals and friends. He had been placed in over 20 care placements, including fostering, residential and family fostering and as a result had experienced being in care as

transient and ever-changing. He learned that people should not be trusted as they could betray him and often only stayed in his life for short periods of time. It was an experience of: “bouncing from counsellor to counsellor to counsellor” (408), where he would “get to know someone then they're gone” (540). The scale of these temporary professional relationships was exemplified when Keith related how his “family have been through about 14 different social workers in the past six years” (544).

When Keith realised the psychologist who he recently engaged in working with may have been available to him in the longer term, it opened him up to the possibility of trusting her: “That's what it felt like with [Psychologist] as well. That's why that first session was like no trust whatsoever. But then I realised she's gonna be here for a long time like” (428). It appeared that in order to overcome his wariness of investing his time and energy in relating with another therapist, Keith needed to know that they would stay with him “for a long time” and not just leave or abandon him like so many other adults in his life.

Catherine was filled with apprehension and questions prior to going for her first sessions with a therapist:

...I didn't know what to expect and just all the different things that you pops in your head (222)...of ideas of who person is going to be and (226)...like if they're going to be nice, if they're going to be kind...and like if there's any point in going if it's gonna help you or not (234).

Going to meet a new therapist was a journey of unpredictability, fear and uncertainty for Catherine. The intensity of these thoughts and feelings were apparent in Catherine's ‘what if?’ questions. She noted the importance of the therapist being “nice” or “kind”, as she had first-hand experience of being treated badly by other adults she was supposed to trust. Catherine's anxieties exemplify her wariness of people in general due to frequent past experiences of maltreatment.

Early therapy sessions were most challenging and “difficult” for Jen:

I think it [first sessions] was just difficult because I had to repeat myself all the time [sounds emotional]. I didn't like talking about the situation so I just found that difficult having to go to someone I didn't know and had to keep talking to them about like what happened, yeah I just found that difficult (290)...I think it was the fact I didn't know them and that like there was a not trust, but like I just, there was like a wall put up when I was talking to them (302).

Jen appears to have felt a huge pressure to talk about her experiences in the first few sessions. This may have been as a result of her own felt internal pressure or may have reflected her fear of letting other people down, such as her foster carers or social worker who had arranged this therapeutic space for her. Equally, as a young person in foster care who has likely met with many professionals, Jen may have been expressing impatience and anger at having to “repeat” her story to yet another professional. Thinking back to these early sessions was emotionally charged for Jen who described feeling very wary of talking to someone she didn't know. The depth of Jen's worry about the potential of being rejected if she opened up was palpable:

Researcher: ...What makes it so hard for kids in care to talk, for you, what's there for you?

Jen: I think it was just like because I was in care I thought I was different than others. Like I'd always say, even sometimes now I'd get upset and be like oh I'm in care like, did my parents not want me or something like that. You just, I think it's the feeling of like not being wanted or like wanting people, like that yeah, it's kind of feeling abandoned or alone and that's why I didn't like want to speak about anything, so yeah (718).

Jen appears to feel conflicted as she ‘wants’ people to understand her but as a result could risk people learning how “different” she is and then not ‘wanting’ her anymore,

‘abandoning’ her, perhaps just like her parents did. The internal conflict for Jen appeared profound, where she worried about being upset when she talked about herself, that it would put her in touch with old feelings of ‘abandonment’ and rejection. Understandably, Jen was wary of talking about these difficult issues, illustrating the significant and perhaps increased challenge of engaging in therapy for young people in foster care.

The strength of this uncertainty was clear for Beth when she talks about having to meet another therapist for the first time:

Horrible, because you feel like a real weird and feel like aw I’m going into someone strange, it’s like you don’t know them (1131)...oh God who’s this going to be or oh God what am I going to do or just that you feel like worried or awkward and like what am I meant to talk about (1151).

Beth gives a glimpse of her own inner monologue when she speaks, she has huge faith in God (she spoke about this during her interview) and it is as if she is praying before she goes to meet her therapist. The depth of this fear and terror for Beth was apparent in how she spoke and her tone of voice. Beth experienced high anxiety, worrying about what the person might be like and what might be expected of her. This expectation of what she is “meant” to talk about is something that Beth and other young people in this study worried about. It is very hard for them to talk about personal issues prior to them building trust and establishing a relationship with their therapist. Nevertheless as Beth indicated, sometimes the need to talk overcame this fear: “I found it hard to talk to anybody else, but I just had to” (484).

Learning to Trust: “Just Getting to Know the Therapist Better Makes me Feel More Comfortable”

Being given time and space as well as choice about when and how to talk were important elements in building trust for all the young people interviewed. This gradual building of relationship seemed to help young people feel comfortable when it was done in

a way that the young people could get to know the therapist in a reciprocal manner, where they were offered choice as well as control within the sessions, while experiencing a safe and welcoming therapeutic environment.

For Catherine the trust building process began before she met her therapist. She was extremely anxious about meeting her therapist (which is evident in the hesitancy of her speech as she described this), however, knowing that her foster carer had previously met her therapist helped her feel more emboldened to go:

So like when I went in she did kind of have an idea am I like that because like I wouldn't like to go in, like from scratch and she not knowing anything about me... knowing that my parents [foster carers] talked to them before and she knows a bit about me already made me feel a bit better (482).

Catherine needed her foster carer's reassurance to help her engage, her foster carer's presence helped her feel more secure and begin to risk relating. She needed to 'know' that her foster carers had met the therapist and that the therapist 'knew' about her. Catherine described how this holding or containment provided by her foster carer attending the first few sessions contributed to the growth in her "confidence" of the safety of the therapeutic process: "And then she kind of just gave me a bit of confidence to let me go bit by bit by bit and now I just go in by myself" (290).

Building trust involved a two-way street where many of the young people found learning about their therapist as helpful to building relationship and learning to be more comfortable with them. Catherine summed it up: "just getting to know the therapist better makes me feel more comfortable" (566), while Beth was very clear about how important it was to get to know "each other" rather than it being one way: "Yeah, getting to know each other first, because you're not going to go into a stranger and tell them about your whole life" (568).

Luna detailed the importance of spending time building relationship before talking about more personal issues:

Just chat about video games or something...chat about books chat about anything and...if it reaches a certain point where the child is just, doesn't seem to ever talk about it maybe mention it, maybe talk about it a bit, but don't immediately be like, so I heard your mother beat you. It's like whoa I'm just in the door and I'm about to walk out (756).

Luna advocates the more informal “chat” as a form of rapport building where therapists help young people feel more comfortable and safer while leading up to the potentially more serious, “talk” piece where the reasons the young person is attending therapy are raised when adequate trust has been built.

Striking a balance between getting to know their therapist and talking about issues of importance for the young person was a challenging task. Beth referenced a lack of focus in her therapy as negatively impacting the trust building process:

We were talking about like...she was telling me like ‘I like playing, like spending time with me grandson’...we were having like them kind of chats but that wasn't really about what I was going to see her about (604).

Beth appeared frustrated that she was not given sufficient opportunity to talk about issues of significance to her. She seemed to experience the sessions as more focussed on the life of her therapist and what she enjoyed, rather than on talking about Beth’s experiences. This experience possibly mirrored prior life experiences for Beth, where the needs and wishes of others may have taken precedence, resulting in her being overburdened and taking on inappropriate responsibilities that contributed to her being placed in care. Beth’s experience of this therapist seemed to make her question the value of going to see her, whether she could trust her and may have retriggered feelings associated with previous experiences of not being listened to. Beth soon finished attending this therapist.

Similarly for Keith, this desire for reciprocity in relationship was tempered by the need for boundaries. He spoke about how he only needed to learn a certain amount about his therapist as part of this trust building. It appears that if she (the therapist) had spoken a lot about herself it might have been too much self-disclosure which Keith saw as inappropriate. Knowing his therapist was important for Keith but he also needed reassurance that her role was to help him:

Researcher: And was there, any other things in particular that [Psychologist] did that helped you build up that trust over those few months?

Keith: She she told me certain things about her life but not too much, it was just enough to get me to trust her. Like she'd talk to me instead of her just listening to me, I know she's there to listen to me but she actually talked back to me and initiated in a conversation (564).

Jen noted that part of the trust building process was being given choice: “It felt like really safe because I had like that kind of choice to be like that's okay it's fine like you didn't have to talk about it if you didn't want to, yeah” (587). Being given choice about talking allowed Jen to feel “safe” which was an important part of building trust. In a previous experience of therapy when she was not given this kind of control Jen felt much less trusting:

It's kind of like as soon as you get in the room it's like okay tell me what's going on.

It's very like, it makes you like put up a wall and you're just kind of like scared or anything like that yeah (858).

The physical environs also contributed to helping young people build trust and a sense of safety. Bob remembered when he was younger and the child centred nature of the therapy room appeared to match his developmental stage at that time, contributing to a very strong feeling of safety for him: “It was just very safe, it felt safe...a big ball pool in the corner and toys everywhere...it was like a room with 50 toddlers went into and made a

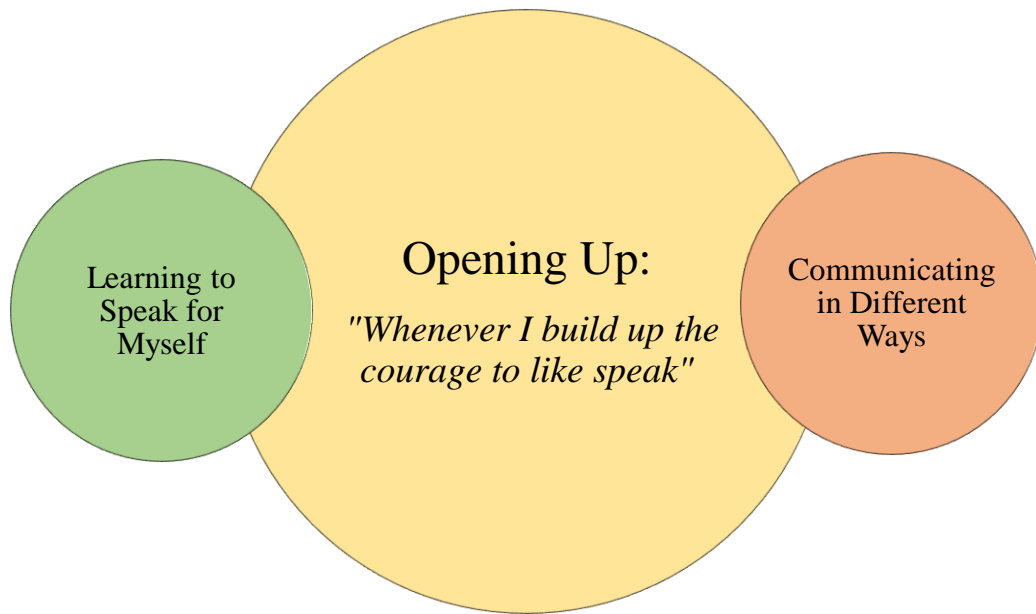
mess and then just left” (838, 842, 846). This feeling of safety was matched for Luna by the use of more teen friendly items: “...she has blankets, she has calming music and candles and stuff. So it's kind of like oh I can just relax. It's like chatting with an old friend and she's old [laughing]” (432). Keith also liked the informality of the physical therapeutic space: “It's not a professional environment like just. I can go in and lie on the couch, just chill out like” (568).

Opening Up: “Whenever I Build up the Courage to like Speak”

The third superordinate theme, ‘Opening Up’ (illustrated in Figure 5), communicates how all of the participants experienced challenges in expressing themselves and letting people know how and who they were. Exposing their inner world by letting their therapist know what they thought and how they felt was something that the young people struggled with due to fear of how it would be received and what people would think. However, gradually learning to give expression to their experiences often provided a sense of relief from feelings of isolation. The subordinate theme, ‘Learning to Speak for Myself’, reflects how verbally articulating their inner world to a therapist was a central aspect of the therapeutic experience for some. ‘Communicating in Different Ways’, the second subordinate theme, illustrates how being able to express themselves using creative means assisted young people’s non-verbal articulation of issues that they felt were too hard to speak about.

Figure 5

Opening Up



Learning to Speak for Myself: “And Then I Started Talking”

This subtheme captures the experience of many (Nathalie, Jen, Beth, Keith, Bob and Luna) of the young people who had significant difficulties in opening up and talking in therapy due to a number of issues, including the challenge of building trust and letting people know how they really were. However, learning to talk with their therapist and articulate their experiences was described as beneficial.

For Jen it was hard to articulate her experiences due to a fear of not being understood: “It was difficult at the beginning...I wanted to open up and just like pour everything out to them and it was just like, no like they won’t understand and then like that makes me feel alone” (appears emotional) (406). However, not talking made Jen feel even more “alone”. She was in a vicious circle where part of her really wanted to “pour everything out” but fear of exposure proved too much. Eventually, having garnered the courage and developed enough of a relationship with her therapist, Jen learned to talk about her experiences: “with [therapist’s name] it was really like nice and friendly...like

whenever I build up the courage to like speak” (854). Jen appeared conflicted between remaining self reliant and avoidant, something she probably learned to do as a young person placed in care. Engaging in therapy demanded she let go of this learned coping strategy by “building up the courage” to open up, to risk vulnerability and the possibility of not being understood.

Receiving a commitment from his psychologist regarding confidentiality, Keith said he began to open up: “and then I started talking” (256). He gradually realised that he needed this objective space to “vent” or let go of his stresses.

So they said I need someone to vent my problems to. And that's what [psychologist] acts as that vent and it does help like. I come out of there with a clearer conscience or something, it's hard to explain but I feel like when I go in and talk to [psychologist] I do feel better after it so (288).

Keith appeared to feel quite stressed at times. He spoke of how he had constantly moved around from care placement to care placement, how he had a difficult life, which included his mother’s drug addiction and incarceration, and he did not appear to have anywhere else he could talk about these issues that were “playing on his head” (344). Having therapy as a “vent” for his thoughts and feelings allowed him to feel better in himself. It seemed like he was carrying the weight of his difficult experiences with him and talking about them made them feel less burdensome. Therapy was a way of gaining perspective on his life when talking to another and appeared to help Keith process issues of import that he may have previously blamed himself for and felt guilty about, thus giving him a “clearer conscience”. It may be that Keith blamed himself for being placed in care and carried some responsibility for his mother’s difficulties.

Bob had a similar experience: “Yeah it’s helpful because there’s someone to talk to like, other than my friends...it just gets things off my chest so I don’t know I have to worry about them” (469, 517). It seemed that Bob did not have anyone else in his life who he

could talk to, he needed “someone” other than his friends. There was a sense of loneliness in what Bob said and him needing someone with whom he could “get things off his chest”, someone he could be more real with as he didn’t have to “worry” about his therapist rejecting him. Therapy allowed Bob a space to articulate his inner thoughts, which gave him some relief from his worries.

Communicating in Different Ways: “I Couldn’t Say it but I Could Put it on Paper”

Many of the young people found verbal expression within therapy particularly challenging and threatening. Some found it hard to put words on their inner experience and experienced significant anxiety about opening up. All the participants described having had experiences of creative therapy modalities, for example art and play therapy, as well as opportunities for non-verbal expression within therapy. This subtheme focuses on the youngest participants’ experiences, Catherine (13) and Beth (14), as they provided the richest examples, while Nathalie (18) and Luna (17), who were older, had contrasting experiences of engaging in play and sand therapy.

Catherine didn’t like talking and attended a therapist who offered her various modes of expression in the form of play and art. She had choices around what she could do in sessions. Being able to use drawing and writing as a mode of expression helped Catherine explore how she was in a safe way that helped her “feel better”:

Well I don’t really like talking a lot with my therapist. I don’t really like saying how I feel but like em, she lets me like kind of decide what I want to do myself. So like if I go in like she asks me what I want to do and like I kind of get to choose what I want to do. Most of the time if I want to talk but I don’t want to speak I kind of like draw on the page or write it out and I feel better (330).

Making her feelings known and potentially feeling vulnerable as a result was difficult for Catherine. Catherine appeared to have felt anxious and worried about exposing her inner

world in therapy. As a result being given freedom to choose what she would like to do was important in terms of helping her feel more comfortable and in control.

Nathalie had the experience of attending therapy as an adolescent where she was expected to play on the floor, which together with little conversation, made her feel very uncomfortable: “Like I was 14 and I had to play with toys on the floor and he didn’t really ask any questions” (206). Nathalie appeared to want more opportunities to verbally express herself. When she did not get this, Nathalie was frustrated and a decision was made not to return to this therapist.

In contrast, Luna, having initially been reluctant to engage in sand tray therapy, discovered she “actually” enjoyed it:

She was doing sand play therapy and I was like that’s really dumb, sand play you want me to play with sand like I’m a 10 year old. And then I was actually like okay, never mind I take that back (368)...I did it for a little bit and I was like you know what this isn’t bad (372).

For Beth it was easier to articulate herself through art. Like Catherine, the creative ways of expression that were open to her helped her feel more at ease and open:

I don’t know I just think I could express my feelings when I was there ‘cause it was like so like it was relaxing and all, we were just doing art (259)...and then she’d just tell you like to express your feelings in the art (380)...and that’d help you a lot, ‘cause say she’d say draw a picture of you and your family and are ye’s happy or are ye’s sad, and then in the picture you’re able to describe it (384)...yeah but I couldn’t say it but I could put it on paper (388).

Beth explained how it was hard to say how she was feeling but she could “put it on paper”. Drawing and using art to describe and name feelings was very helpful for Beth. It meant there was something she could do to help her identify, understand and express her feelings about things like her family. Having multiple alternative ways and opportunities for

expression was an important aspect of therapy allowing her to overcome her fear of talking and feeling vulnerable.

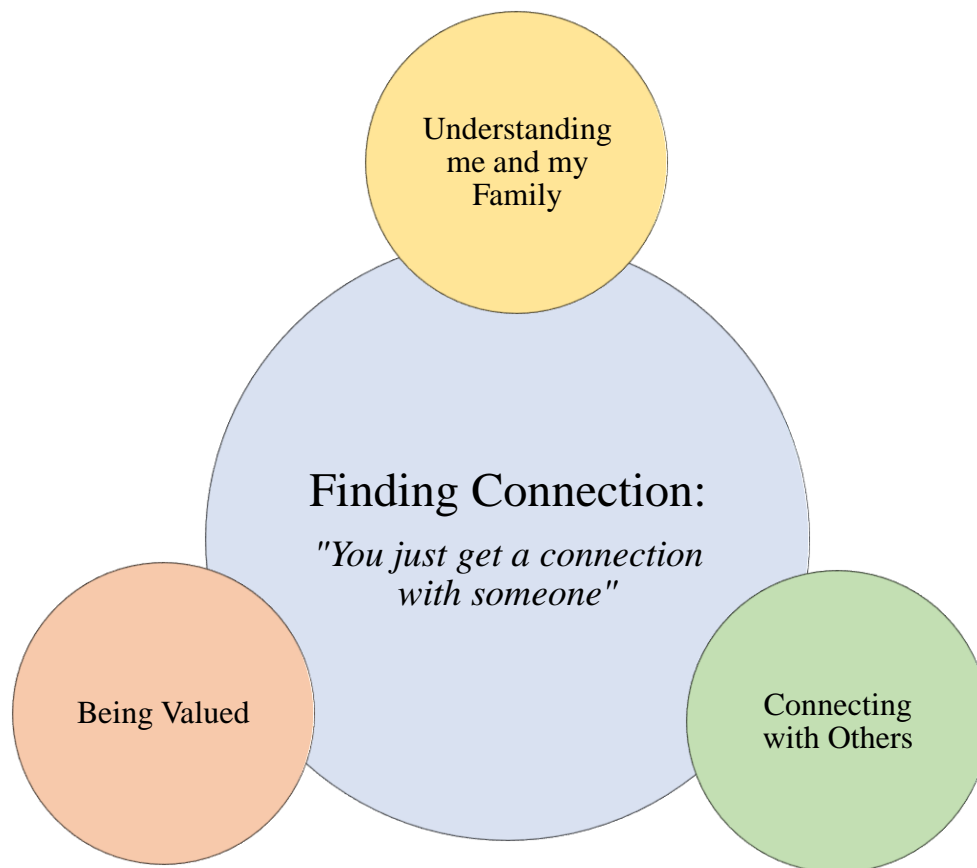
Finding Connection: “You just get a Connection with Someone”

The fourth superordinate theme, ‘Finding Connection’ (illustrated in Figure 6), was a central part of the therapy experience for the young people. It included finding connection with themselves as well as with other people in their wider system. This sense of connection was found after they had taken the risk of relationship with their therapist and opened up to some extent. The first subordinate theme, ‘Being Valued’ within the therapeutic relationship, illustrates how positive experiences of their own self-worth facilitated young people in committing further to the therapeutic endeavour.

‘Understanding me and my Family’, the second subordinate theme, involved learning about their family of origin and exploring the reasons they were placed in care. This helped in developing their own sense of identity as well as a deeper understanding of themselves, their family and relationships within. The third subordinate theme ‘Connecting with Others’, articulates how therapy provided all of the young people with a means of developing meaningful relationships with others, in what could be termed a circle of connection, which most often involved the young person, therapist and foster carer.

Figure 6

Finding Connection



Being Valued: “She Actually Wanted to Get to Know Me”

A sense of being valued in therapy as a unique individual was a sub theme that emerged for five of the young people (Catherine, Nathalie, Jen, Keith and Luna), where they experienced their therapist as genuinely interested in them as people. For some young people it was an experience of being truly understood by another, while for others they experienced this feeling of being valued through the demonstrated commitment of the therapist to them, for example, when their therapist advocated on their behalf. This experience of being genuinely valued within the therapy relationship, positively reinforced young people’s ability to take risks in this relationship which in turn led to connection with themselves and others.

Some of the young people appeared to feel pre-judged as they were acutely aware that their therapist would have information about them in advance of meeting with them⁹. Nathalie had the experience where she felt like she was not being recognised as a unique person in her own right, she experienced her therapist as not valuing her in and of herself. Nathalie wanted to be valued and for the therapist to want to get to know her rather than treat her like an object they have read about in a file:

Researcher: How can a counsellor get to know you better?

Nathalie: They can just sit there and ask about you and then your friends and your family and your interests and hobbies and things not just be like okay so I've read your file and talk like that because that's what one of them did. I read your file and I was like 'yeah it's a big ass file' (1136).

Nathalie was able to contrast this experience with another experience when she had a felt sense that a therapist she met with genuinely valued her and demonstrated how she wanted to get to know her as a person rather than as someone with a problem that needed to be figured out: "I felt like she actually wasn't just being a counsellor, she actually wanted to get to know me" (956). Nathalie felt understood by her therapist: "I'd be saying something and she'd get it out before I'd even say it, so she'd understand what I'm thinking" (1160). Her language was one of surprise that someone would "actually" be like that with her, which could suggest a low opinion of herself that someone would value her in this way, or equally, could allude to her low opinion of previous therapists who did not try and get to know her in this way.

Jen also experienced feeling like an object when her counsellor did not appear to understand her or appear to want to get to know her in any depth:

⁹ By virtue of being in care young people have files kept by Tusla, the Child and Family Agency, that record many details about them and their family.

I think it was just, he would just like sit in his chair and be like okay so tell me what's going on... And then he'd have his like little sheet and kind of do a diagram and try and compare... he had some weird chart things, it was like a, you know like say you're recycling like reduce, reuse, recycle, it was kind of something like that (647).

Jen's experience was one of her needing to fit a "chart". She compared this experience to "recycling", as if she was a thing that did not hold much value as a person and did not warrant any further exploration. She may have felt like a piece of rubbish that needed to be changed in some way in order to fit in with the chart. Similarly, Luna spoke about needing to be treated with respect and not like a theory of some sort: "be nice, talk to me like I'm a human and not a project. I'm not a diagram from your textbook" (728).

For Luna, her therapist's willingness to advocate on her behalf and demonstrated genuine interest helped her find connection with her:

And she's [therapist] also just like, like she's ready to do anything for me, I'm like oh I'm having trouble in school, she's like 'I'll have a meeting with the school' or it's like em. Oh I need to get this and she's like 'I'll, I'll email the Social Worker'...and you know she gets me Christmas presents and she gets me birthday presents and she writes me cards and things like that. So it's literally like family (964)...oh it's so nice. It's nice to know someone cares (988).

A belief that her therapist would "do anything" for her made Luna feel valued and kept in mind. This obviously meant a lot to her, which was apparent in her describing her therapist "like family". The inherent challenges of finding and sustaining connection were apparent for Luna when she experienced believing her therapist had "abandoned" her when she left on sick leave:

I felt like she'd abandoned me a little bit...when she came back she like took me out for lunch in a hotel, a really fancy place...she just kind of eased me back into it and then we started meeting again...(472).

Luna described lapsing into a depression for some time related to a number of issues in her life and did not want to talk anymore. When her therapist reconnected with her in a way that “eased” things, it appeared to demonstrate to Luna how much her therapist thought of her by bringing her to “a really fancy place” which helped address the relationship rupture.

Understanding me and my Family: “I Got to Learn More About my Family”

Having developed connection with their therapist, as Beth stated: “you just get a connection with someone” (600), some of the young people used the therapeutic space to talk and learn about themselves and their families of origin (Beth, Keith, Nathalie and Jen). This opened them up to self-understanding that they previously had not experienced. For Keith it was a space to talk about what happened in his family: “my past and like how I was brought up, me ma especially when she was in prison and then rehab like” (324).

Beth, who lived with her maternal grandfather, said she would have found it hard to talk openly about her mother to him or her aunts as she wished to protect them and not hurt their feelings. Beth believed their view of her mother would be biased, whereas her counsellor came with a more objective viewpoint that was helpful to her and she didn't have to protect her therapist's feelings in the same way. In this instance counselling was helpful for Beth: “It's like you're able to talk to someone else about her” (1031). Learning to understand her mother in a different way in the therapeutic space helped Beth explore if she wanted a relationship with her mother or was open to giving her a “second chance” (1007).

Talking about her family was not always an easy experience but something that helped Nathalie:

It was hard because no one's ever talked about my birth dad because like even my mam doesn't talk about him (490)...she [Therapist] helped me. She made me understand my birth family and like trust and things. And then she talked through the separation anxiety (506)...like no one else did that. They just told me what is wrong with me and why, she actually helped me understand why I was like that (510)...and like if someone does treat me bad I still will treat them good, and she is trying to figure out why and I never noticed that until I went to her (722).

It was like her father was a mystery to Nathalie as 'no-one' ever spoke about him. Therapy allowed her a place to explore this part of herself, to talk about and begin to "understand" who she is, by exploring aspects of herself and her family. This appeared to help her with the key developmental task of self identity, particularly challenging for her given her prolonged separation from her family of origin as well as fractured accounts of her family history. Having a therapy space that centrally acknowledged this, appeared to help her develop a deeper self understanding and sense of connection with herself as well as her history.

Jen had a similar experience where she used therapy as a place to actively seek out information about her parents and began to understand herself more through this learning:

I think my commitment was really good because my mom she, my birth mom she had a difficulty with alcohol and she smokes still now. And she was told to get help and she never did she said 'oh no one brought me, no one did anything for me' or like that...I think when I got to learn more about my family and what my mom's past was like and how she struggled I think with that like me committing I felt pretty brave and better in myself like okay I did that like I was really happy about it yeah (526).

Jen appears proud of herself, that she didn't make the same mistake as her mother who did not commit to making things better for herself. Jen was "brave" and "committed" to

therapy, taking ownership of herself, something she felt her mother was unable to model. Learning about her mother helped her put these pieces together, feel more connected and understand herself in the context of her family:

I used to feel like really isolated (786)...I think it was helpful to find out about my parent's past...understanding like what she had been through makes me kind of more, not worry with her but like kind of makes me understand how she might be feeling or her actions and stuff like that during access...I think she might just be feeling a bit lonely, yeah (806).

Jen appears to feel more connected and understanding of her mother as a result of learning more about her life. She talked about her mother feeling "lonely" at times which Jen can relate to. Learning about her mam has helped Jen be kinder and more understanding of herself as well as her mother, possibly accepting that her mother cannot give her what she previously yearned for. There was the sense that making these connections with herself through learning about her family eased Jen's negative feelings about herself.

Connecting with Others: "We Could all Talk Together"

Finding connection with others was a central part of the therapy experience for all of the young people. Establishing a relationship with their therapist, and thus an experience of connection appeared to facilitate an extended connection with and mutual understanding of their foster carers and wider family.

This was both a difficult and a positive experience for Nathalie:

...it got so bad that my mam (foster carer) came in and she ended up crying because of everything we were talking about...(330) yeah like it wasn't bad like she wasn't a bad therapist it just got like very emotional (334)...it was just really hard seeing her cry because she doesn't like cry a lot (342).

Although this was difficult for Nathalie there is also a sense that seeing her mother (foster carer) so upset helped her connect in a different way with her, possibly in a deeper way. It

was upsetting but it also communicated to Nathalie that she was important as her mother did not “cry a lot”, she only cried when big things were happening to people she cared about. Nathalie acknowledged this was a helpful connecting experience: “she made my mam [foster carer] open up and everything so that was good...yeah then I knew how my mam felt and when we got home that night we all sat down and talked about it” (374, 382). This open expression of difficult feelings by her mother led to them understanding each other more, it helped Nathalie build a different understanding of her mother (foster carer) and opened up larger conversations with the whole family.

Connecting with her foster carers through the therapy experience occurred in a slightly different way for Jen. Her foster dad attended sessions with another therapist parallel to Jen’s sessions. At the end they would come together and discuss issues that came up for them:

Em, I think the thing that was helpful was I went in with my dad [foster carer] here and he went in with Irene and I went in with Mary. He would talk about how I am, in the family and then I’d speak to Mary about our sessions and how school is and how my family is and at the end we’d both join in like into Irene’s office and just speak about...what like would be on my mind or what would be on my dad’s mind or anything like that (555).

Jen begins talking about “I” and “he”, where both were separate and more disconnected at the beginning, not knowing how the other was. Joining together as “we” with her father (foster carer) and the respective therapists allowed them to learn what was on the other’s “mind” which Jen said led to the resolution of bad feelings that were causing difficulties for her. Keith felt similarly and could see the benefit of coming together: “we could all talk together in what was going on in my life and in the house” (684).

Bob had a positive experience of therapy when he was younger that helped him feel much more connected to his foster carers:

It was good, it was the first time really that we actually sat down and played when I was younger like. I was with them for nine years now so they're basically my family (730)...so it just, made me happy to just to sit and play with them. It made me happy to appreciate that they look after me like you know what I mean (734). There is a poignancy in this for Bob who had recently moved out of this foster placement to live with his maternal grandparents. He refers to them as "basically my family" and spoke about how this form of child-parent therapy helped him feel more connected and "happy" with them at that time in his life. This opportunity to connect was very important for Bob. Being provided with an opportunity to connect with his carers in therapy was something that assisted him to feel more settled in his foster placement.

Luna found this type of building connection with her foster carer useful:

It was good because I learned skills for how to talk to her and get her to listen to me which was nice. Because there was a point where I just felt like she wasn't listening to me and it was nice to have that one on one like going to [therapy] and coming back (616).

Learning to communicate with each other was key for Luna. Having therapy as a place where they could "talk" and for Luna to have that space where she was 'listened' to allowed them to gain a better connection with each other. The time spent together on the 'drive' there and back was another important part of this process of connection which emerged in a number of the young people's interviews. In a busy household, having time ringfenced to connect with each other was important for Luna:

I think we, I think she just started understanding me better and I think like the skills, like we did the skills, like and I think we worked on them more. And I think she actually started to listen to me, it's like when I asked for something it was kind of like she was actually listening, instead of just being like aw I'm busy or aw no.

Because a lot of the times I'd be like, [Foster Carer Name], no. It's like ugh [annoyed and frustrated tone], I didn't even get my sentence out (636).

By talking more and taking the time Luna appeared surprised that her foster carer “actually” listened to her and “started understanding” her more as a result, which helped Luna overcome feelings of anger, frustration and possibly resentment of her foster carer.

Advice for Others about Psychotherapy

In the latter part of the research interviews participants were asked, based on their experiences of therapy, what advice they might give to: young people in foster care who are considering going to therapy; foster carers who look after adolescents in care who are attending or considering attending therapy; and therapists/counsellors who meet with young people in foster care. As this advice was not phenomenological in nature, a summary is presented and the relevant data are tabulated in Appendix N.

Young people encouraged other young people in foster care to take a risk and go to therapy. They do not make any promises about a positive outcome but offer hope that therapy can help as it has helped many of them. However, they offer the caveat that therapy takes time and it may involve meeting a few different therapists before they get the right fit. Foster carers are advised to strongly encourage young people to attend and to keep offering this opportunity. One young person encouraged carers to talk with young people in their care about whether they need to go or if there is something they can do to further support them. Foster carers are advised to communicate to young people that they are there to support them, to understand that young people need to tell their story and that being in care is not easy. Therapists are encouraged to be kind, informal, encouraging, humorous, to take their time in getting to know the young person and provide an environment that communicates comfort and promotes self-expression.

Conclusion

This chapter presents the outcome of the analytical (IPA) process undertaken on seven young people's lived experiences of what therapy was like for them while living in foster care, a relational experience that was beset by many challenges and risks. The young people's therapeutic experiences were manifold, oftentimes moving through significant reluctance at the beginning and prior to going to therapy. A lack of control was apparent in many of the young peoples' accounts of being brought to therapy, where they believed they had little say in the matter. This lack of agency was also present at the end of therapy where many therapeutic endings were experienced as unplanned and imposed on the young person, without adequate consultation and preparation for the ending of what was sometimes a very meaningful relationship. Significant misgivings about going to therapy manifested for young people due to previous, often fractured experiences of relationships with others, and as a result the young people were understandably sceptical about therapy. However, the findings show that trust could be established when the right circumstances were provided. The challenging experience of opening up and learning to articulate their inner experience both verbally and through other means gave relief to some, while having access to various modes of expression provided others with the opportunities they needed to communicate. Having established a foundational therapeutic connection, where young people sensed they genuinely mattered to their therapist, significant possibilities existed for further positive and helpful therapeutic experiences that helped young people develop an understanding of themselves, their unique history and background. This led to a sense of increased confidence and self-esteem for some of the young people while creating a different, more integrated understanding of themselves. In turn, with the containment that an established therapeutic relationship provided, the young people were empowered to develop their relationships and ability to talk with their foster carers and families. Young people's advice to others about psychotherapy reflected their overall positive feelings

about these experiences, encouraging other young people to overcome their reluctance to attending and recommending foster carers persist in encouraging young people to attend. Advice for therapists centred on the need to be kind and encouraging, while offering an environment that communicates comfort, informality and promotes self-expression.

Researcher's Reflexive Comment

The analytic process was an arduous one. I did not realise how time intensive it would be and the amount of thought, rumination, reflection and further thought that this process required. It was very important for me to use my research supervision effectively. Here I was guided through the process to realise a more balanced perspective, ensuring that I continually returned to the voices of the participants which was my central goal, while facilitating the interpretative process. There was a tension in this process between the interpretative and the phenomenological aspects of the analysis that was challenging to navigate. In trying to make sense of the young people making sense of their experiences I felt a level of responsibility and pressure in wishing to develop conceptual understanding that could be helpful while endeavouring to remain true to their voices. As the analysis moved on to the cross-analysis phase, I experienced a further tension in balancing the idiographic nature of the case-by-case analysis with seeking out the shared commonalities. This took some time to achieve but my supervisors and peer support group assisted me through this process. I noticed that I began to experience a flow with this at times, while at other times felt quite stuck. This process required time and much thought for themes to emerge; themes that honoured the similarities and divergences in participants' accounts. It was a demanding but stimulating process as I began to see the many commonalities in the participants' stories and felt excitement at the privilege of being given the opportunity to share their experiences with others. While completing this process I was delighted by the richness of the data young people shared. Their accounts of therapy were multi-faceted, contained much depth and focused on both positive and negative experiences. Although it

is possible that knowing I was a therapist may have influenced the young people to talk more about the positive aspects of their experiences, I was heartened to see the divergent experiences they shared. During this phase of the study I also reflected positively on the fact that although these young people spoke about finding it hard to trust people enough in order to talk openly, they successfully navigated a way to do this with me and talk honestly about their experiences. I was asked by research colleagues if the information that young people shared had upset me. Although I experienced some anger on hearing their negative experiences of therapists, I was not impacted beyond this. Perhaps this is because I am used to hearing young people's difficult experiences, it is familiar territory for me from working in the area for many years. As a result I do not have the same sense of outrage that another might feel hearing about these issues. This may have assisted the research process as young people may not have felt that they needed to mind me and were able to talk in more depth as a result. Another reason for their openness may also have been due to the fact that they all had positive experiences of therapy or were working with a therapist they liked. This is something I will discuss further in the 'implications for research' section in chapter 6.

Chapter 5: Discussion

Introduction - A Journey of Relational Connection

The various therapy experiences of young people in foster care that emerged in this study are discussed here with reference to relevant research literature, contextualising them within their particular life experiences of being in foster care and relevant theory. The discussion integrates the four superordinate themes ‘Being Powerless’, ‘Risking Relationship’, ‘Opening Up’, and ‘Finding Connection’, arguing that this synthesis of the superordinate themes, illustrates a journey of relational connection. The discussion explores this journey, beginning with an examination of the challenges of engaging in therapy for young people in this study while they established relational connection with their therapist. Having achieved this task, many of the young people were facilitated to develop their own sense of connection with themselves and their history as well as those they lived with, completing the journey of relational connection.

The chapter focusses on three key issues. Firstly, the challenges to engagement identified in this study together with how young people went about establishing relationship is discussed: how they began this journey with varying degrees of trepidation; built trust with their therapist; and eventually took the plunge by opening up to them. The second issue relates to their experience in therapy once this relational safety was established: how the young person experienced a sense of being a person of worth through being valued; learning about themselves and their history; and building relationships with others. The third issue situates the findings in the context of recognition theory (Honneth, 1995, 1996) with a view to furthering professional understanding and practice.

Establishing Relationship

The journey of relational connection began with the process of establishing relationship, often before meeting with the therapist. Young people experienced many challenges to engaging in therapy that were mainly influenced by prior negative relational

experiences. How participants' established trust appeared to be key to moving deeper into the therapeutic endeavour where young people could begin to experience themselves as people of worth.

The Challenge of Engaging in Psychotherapy

Young people in this study related significant wariness ('Being Wary') about meeting with a new therapist, which had implications for beginning therapy where young people found early sessions particularly anxiety provoking. These are feelings commonly experienced by many young people going to meet a new therapist (Binder et al., 2011; Everall & Paulson, 2002; Midgley et al., 2016). Thus, young people in foster care are in many ways no different to other young people accessing therapy. However, it may be that due to their unique life circumstances these feelings and thoughts were exacerbated for young people in this study, as it is likely they have suffered cumulative negative experiences with adults in their lives, including significant maltreatment (Romano et al., 2019; Turney & Wildeman, 2017) leading to a marked distrust of people (Jee et al., 2014). Understanding the nature and extent of this wariness from the perspective of young people themselves is of significant value in order for psychotherapists to learn how to help them engage more easily in therapy and in a way that helps reduce their concerns.

Considerable prior experiences of rejection and feeling let down, as well as associated low self-esteem negatively impacted therapeutic engagement for many of the young people. Keith referred to having had a very difficult life prior to being placed in over twenty care placements. He found it hard to commit to building trust with professionals and carers alike as experience had taught him that relationships are transient and not to be trusted. As detailed, the literature asserts that frequently, the attachment difficulties (Miranda et al., 2019; Vasileva & Petermann, 2018) demonstrated by children in foster care are intertwined with traumatic events such as domestic violence, abuse and other maltreatment (James, 1994; Tarren-Sweeney, 2013), difficulties that can be further

exacerbated in care by negative relational experiences, including separation and loss (Fahlberg, 2012; Fineran, 2012), transient (Tatlow-Golden & McElvaney, 2015) or impersonal and uncaring professional relationships (Ferguson, 2018), relationship insecurity/instability and sometimes further abuse (James, 1994; VanFleet, 2006). Many young people in this study learned to be wary of people in general and to distrust professional and foster carer involvement leading to an understandable reluctance in engaging in therapy relationships. The findings of this study underline the impact of these interrelated and nuanced experiences for young people, highlighting the necessity for increased therapist sensitivity to their difficulties in 'Risking Relationship'.

Relatedly, several young people in this study experienced a number of placement breakdowns or placement instability (Rock et al., 2015) during their time in care, instability that can leave a legacy of insecurity and distrust in the permanence of relationships (Moran et al., 2016), experiences that were reflected in the findings. For instance, Luna related how moving placement led to her finishing counselling as her new foster carer appeared to not want to bring her. She was upset but appeared to hide her feelings, perhaps not trusting her new foster carer and had to move on. Placement breakdown is referenced many times in the literature as an extremely difficult experience and time of intense loss for children in care (Children's Commissioner, 2018; Tobin, 2013; Unrau et al., 2008) and a common occurrence for adolescents in particular (Ward, 2009). When placements end, young people's trust in others deteriorates further (Biehal, 2014; Hyde et al., 2016; Rock et al., 2015) contributing to a profound fear of 'Risking Relationship'. Their negative feelings about self are reinforced as yet more adults reject them as people, while as Luna illustrated, they can be forced to ignore feelings of intense loss as they negotiate trying to build relationships in their new placement. Although the literature is rich in outlining how placement breakdown and instability generally impacts young people in care, it can be abstract in nature. This study through its use of IPA,

provides subjective, in depth and personal examples of how these experiences of instability can directly impact therapeutic engagement.

Feelings of wariness when beginning therapy were aggravated for a number of the young people who recounted prior experiences where they were not consulted or asked about going for therapy. The findings of this study support and expand previous qualitative research involving children and young people in the general population who attended mental health services that highlighted the importance of knowing about appointments beforehand (Day et al., 2006), what to expect (Plaistow et al., 2014) and being consulted about going (Coyne et al., 2015). According to Coyne and colleagues, advance notice allowed young people to prepare for what might be asked in order to prevent young people feeling overpowered. This resonates with how some of the participants in this study felt, while as suggested by Coyne et al. (2015), being consulted about attending could have potentially mitigated the reluctance they felt about going. It is important to note that for young people in foster care who have frequently experienced maltreatment, feelings of powerlessness can remind them of prior experiences of abuse, thus exacerbating feelings of overwhelm (Howe, 2005; Van Der Kolk, 2014). These findings highlight the importance of paying attention to this increased need for predictability and agency with a view to assisting young people in feeling safe enough to risk engaging in therapy. Interestingly, despite participants' referencing the negative experience of 'Being Landed' in therapy in the current study, many were glad that they had gone even though they had not wanted to attend. This is consistent with Dittman and Jensen's (2014) research with traumatised young people and suggests that young people who suffer maltreatment experience contradictory feelings about therapy, at once wanting to avoid while also wanting to get help.

While all of the young people were anxious and uncertain about going to therapy, many were also wary of being pre-judged by therapists and had a sense of being different

by virtue of being in care. Beth spoke of feeling “weird” going for therapy while Nathalie was acutely aware that her therapist may have read her file prior to meeting with her. These difficulties in beginning therapy are largely consistent with previous research that highlights the significant reluctance experienced by adolescents in the general population in engaging with therapeutic services due to mental health stigma (Plaistow et al., 2014), a reluctance that is even more tangible for young people in foster care who experience the added stigma of being in care (Dansey et al., 2019; Tatlow-Golden & McElvaney, 2015). According to Glück et al. (2017), young people in foster care often possess a large well of shame as a result of their life experiences and commonly feel less than others. For instance, Jen appeared scared of feeling vulnerable, of allowing other people to know her background. Her past history demanded recognition but this came with the risk of feeling helpless again. As Terr put it, “shame comes from public exposure of one’s own vulnerability” (Terr, 1990, p. 113) and many of the young people, including Jen, appeared conflicted about telling their story, possibly worrying that they would lose control of it and risk further rejection. These findings build on previous literature (Beck, 2006; Jee et al., 2014; Young Minds, 2012) that has identified stigma as potentially having a negative impact on therapeutic engagement, while adding novel insight in directly learning from young people about how stigma as well as related fear of exposure were experienced in the therapy relationship.

Building Trust in the Therapy Relationship

The key task of ‘Learning to Trust’, was reflected in the therapy experiences of young people in this study. It involved a gradual building of a reciprocal type of relationship with therapists, where young people were given time to build a sense of safety while being allowed choice and control in the sessions. Catherine, who seemed particularly fearful about meeting someone new, found it helpful that her therapist had some knowledge and awareness of who she was and her past experiences before attending.

Catherine's need for therapist flexibility and sensitivity resonates with the findings of previous studies examining young peoples' perspectives (Dittmann & Jensen, 2014; Graham & Johnson, 2019; McElvaney et al., 2019) but also highlights the attachment needs of young people in foster care who may need tailored approaches in order to facilitate engagement. For Catherine, the presence of her foster carer in the first few sessions provided her with a sense of safety and containment, hallmarks of secure attachment (Bowlby, 2005).

A steady and unhurried building of trust was a key element of establishing a safe therapeutic relationship for the young people. Many young people stressed the importance of taking their time in getting to know the therapist. It appeared important to the participants that they were met and engaged with in a mutually respectful way, that did not make presumptions about them or treat them as problems to be solved. This concept of taking time to build the therapeutic bond is consistent with previous research on adolescents from the general population and those in care (Binder et al., 2011; Young Minds, 2012). Literature examining therapist alliance building and responsiveness with youth in the general population (Midgley et al., 2017) also champions a collaborative, relationally focussed and flexible style of therapy. Therapy that was attuned to the child's emotional capacity while allowing the young person to set the pace of therapy and have control over what she/he talks about, were viewed as positive contributors to building a strong therapeutic alliance (Chu & Kendall, 2009; Creed & Kendall, 2005; Jungbluth & Shirk, 2009). Hughes et al. (2019), writing about young people who have experienced maltreatment refers to the value of working through feelings of "blocked trust" (p. 136). Frequently, young people have learned to fend for and protect themselves from untrustworthy parents/carers while managing the emotional pain of being isolated and feeling unsafe in a world of danger where there is no comforting other (Baylin & Hughes, 2016). Unsurprisingly, when young people in this study felt pressured into talking about

personal issues before they were ready, they resisted 'Opening Up'. However, when they felt in control of the process and were given the choice about when and what, as well as how they spoke or expressed themselves, they felt more comfortable and safe in therapy which facilitated them to begin to express themselves.

A reciprocal relationship with the therapist appeared to be a key facilitator of trust building in this study, where the young person got to know aspects of the therapist's life in an informal and easy-going manner. This finding resonates with literature detailing how appropriate therapist self-disclosure should mirror adolescent communication styles in order to encourage openness in the therapy relationship (Geldard & Geldard, 1999; Rotenberg, 2006; Seiffge-Krenke, 2013). Consistent with the findings of Binder et al. (2011), it was important for young people in this study that therapist self-disclosure was contained. For instance, Beth experienced over sharing by the therapist and a related lack of therapeutic focus which led to a loss of confidence in her therapist's ability to listen to and understand her story. A study by Sagen et al. (2013), examining the relational qualities valued by young people illuminated the importance of achieving therapist-client reciprocity in a way that the young person did not feel overburdened or responsible for the therapist. This is a particularly pertinent issue for young people in foster care who frequently experience being overburdened and responsible for issues impacting the adults in their lives, difficulties that commonly result in placement in care (Lewis, 2011). Similar to guidance outlined in Midgley et al. (2017), it appears that Beth needed help in understanding what therapy could involve, what the focus might include and be assisted by the therapist in remaining on task. Additionally, the current study highlights the importance of limited therapist self-disclosure within the context of a boundaried relationship that implicitly communicates a sense of safety and respect, while potentially mitigating feelings of 'Being Powerless'.

The Challenge of Expressing their Inner World

Difficulties ‘Opening Up’ and talking to therapists about their inner world and experiences (‘Learning to Speak for Myself’) emerged in the findings of this study. Young people appeared reluctant to share with therapists even though they really wanted to, a finding consistent with Gaskell’s (2010) study of young people in care who struggled to talk about personal and family difficulties. Similarly, Hiles et al. (2014), in a study of care leavers, highlighted how breaching the learned and determined self-reliance young people in care often exhibit can be a significant challenge for carers and professionals as well as the young people themselves. This self-reliance is borne out of an adapted defensive strategy which can attune the brain to living defensively (Baylin & Hughes, 2016) and develops as a result of the multiple losses children experience leading to an avoidance of intimacy and dependent relationships (Stein, 2008). When young people are offered help in the form of therapy, for example, they actively avoid it, believing that it is safer to depend on themselves rather than accept support from anyone else (Ferguson, 2018) or, as alluded to earlier, risk further rejection and feelings of shame. Encouragingly, despite these challenges, a number of the young people gradually learned to believe that the therapy relationship was safe enough to risk exposure of their inner selves. They overcame their fear of being vulnerable and exposed, learning that articulating their experiences could be a relief. They valued having a safe place where they did not have to worry about other people’s feelings when confiding in their therapist, findings consistent with McElvaney et al.’s (2019) report about young people’s experiences of therapeutic services in rape crisis services in Ireland. The current study’s findings emphasise the intricacies of establishing relational connection for these young people, while illuminating the profound risk young people took in ‘Opening Up’ to their therapists. This insight can help psychotherapists more ably assist young people in building sufficient relational safety so that they can gradually learn to safely express their inner world.

Using alternative ways of expressing their inner worlds ('Communicating in Different Ways') was an important part of this process for some of the young people. These young people found it particularly challenging and difficult to verbalise and talk about their inner worlds and experiences. Control and choice over how they expressed themselves was highlighted as an important aspect of therapy that helped with their engagement, an understandably common need for young people in care who frequently experience 'Being Powerless' and have little choice or control in their lives (McEvoy & Smith, 2011; Rahilly & Hendry, 2014). Tapping into this creativity is acknowledged as a very important aspect of helping engage young people in therapy (Geldard & Geldard, 1999; Sori & Hecker, 2003) and is consistent with the findings of Allnock et al. (2015), who emphasised the importance of providing opportunities to young people who have been abused to express themselves in diverse ways within therapy, as a means to increase their level of comfort with the therapist. Some of the young people in this study described experiences of therapy where they did not receive adequate or appropriate opportunities to express their inner worlds. These findings underline the importance of providing multiple modes of expression as a way of establishing meaningful therapeutic connection for young people in foster care, while also communicating to them that they are valued and kept in mind by the therapist.

Becoming a Person of Worth

When young people had built a sense of safety, some of them experienced a genuine sense of being a person of value where they felt respected by their therapist, an experience that appeared to help participants' begin to recognise themselves as unique people of worth. Following the establishment of this therapeutic connection, young people's self-worth was facilitated further through developing an understanding of themselves, their family background, as well as building meaningful relationships with other people in their lives.

The Experience of Being a Person who Matters

For some of the young people 'Being Valued' was a felt sense they experienced where the therapist demonstrated their authentic interest in getting to know them as well as their ongoing commitment to them. Jen spoke about being very reluctant to engage in therapy but when her therapist phoned her a number of times and expressed a genuine commitment to helping her she developed a sense of connection, which ultimately facilitated her positive engagement in a therapeutic process. In a study exploring adult client perspectives of critical incidents in therapy that helped develop therapeutic alliance, Bedi et al. (2005) found that therapist flexibility in approach and genuine care was illustrated by the therapist offering to make phone contact if needed. Highlighting the particular needs of children in care, Ferguson (2018) advocates a persistent and determined approach to offering professional help to young people in care as a way to help break through their defensiveness. According to Cooper (2008), an individualised and flexible approach can be an important contributor to positive therapeutic engagement and outcomes with adults. Going beyond the traditional boundaries of what a psychotherapist is perceived to do was valued by the young people in this study, as it appeared to help them overcome their very understandable learned defensiveness. When young people met with therapists who recognised their particular attachment needs and demonstrated this in how they related to them, they experienced a sense of being valued by the therapist, allowing many of the young people to gradually move deeper into the therapeutic process.

Young people outlined many positive aspects of the therapeutic experience, elements that could be defined as humanistic or person-centred in approach, where they spoke of experiencing a genuine acceptance and understanding from their therapists. The young people appeared to value therapists that demonstrated empathy, congruence and unconditional positive regard (Rogers, 1995) that led to a sense of emotional attunement and connection. For some, this was an experience of being genuinely listened to and

understood. Nathalie, for example contrasted a number of her experiences of therapy and noted how some therapists nearly knew what she was going to say before she said it. This feeling of being mentalised and valued as a person appeared to be a very positive one, a finding that mirrors those found in studies promoting the benefits of mentalising or mind-mindedness in foster care (Jacobsen et al., 2015; Midgley et al., 2019). Consistent with young people's expressed need for authentic relationship, Ridley et al. (2016), in a study examining the views and experiences of professional-child relationships of children in care and care leavers, emphasised the importance of consistent, genuine and ongoing relationships to children in care who have experienced so many disappointments, losses and experiences of being let down. Research conducted by McMillan and McLeod (2006), where adult clients' experiences of relational depth were explored, identified comparable experiences where participants valued a sense of their therapist genuinely caring for them. This resonates with the experience of positive regard some of the young people in this study valued within therapy sessions, a feeling that they mattered to their therapists, that the therapist was genuinely interested in them and was willing to go "the extra mile" (McMillan & McLeod, 2006, p. 283) for them. This study's findings, similar to research studies involving adolescents in the general population (Everall & Paulson, 2002; Freake et al., 2006), emphasises the importance of therapists communicating to young people in foster care that they genuinely matter, as a means to affecting positive therapeutic gains. After all, it is only in the context of authentic human relationships that recovery from trauma and maltreatment can occur (Herman, 2001; Van Der Kolk, 2014).

Where young people experienced a lack of thought and consideration, for example where therapy ended without consultation ('Being Stranded'), young people's internal working model (Bowlby, 2005) of feeling 'less than' could easily be reactivated leading to feelings of self-blame and powerlessness. For instance, Keith outlined how he attended for therapy with his counsellor and discovered that she had left without telling him, leaving

him questioning if his counsellor had left because of something he did. As alluded to earlier, internal working models are mental representations of one's sense of worthiness, based on experiences of a caregiver's ability, availability and willingness in providing them with care and protection (Howe, 2005). Many young people in care have negative internal working models, where they view themselves as being not good enough as if they don't matter to others (Golding, 2008). These experiences offer a unique and rare insight into the particular vulnerability of young people in foster care and the potential negative impact of psychotherapy. For instance, when sudden or unexplained endings occur, young people's commonly held negative view of themselves could easily be reinforced and feelings of hurt, abandonment and loss re-activated. Reactions of this nature are important reminders of the child in care's profoundly negative life experiences, revealing the increased need for enhanced and consistent therapist attunement.

The importance of this relational attunement as well as the iterative nature of the therapeutic process was exemplified by Luna. She described familiar feelings of abandonment from her past being re-activated in her relationship with her therapist, leading to relational rupture that required repair. Psychoanalytical theory argues that experiences of past relational experiences can influence present day interactions (Kahn, 1997; Malan, 1979). Luna experienced feelings of abandonment, lapsed into depression and did not want to re-engage in therapy. By virtue of Luna's therapist communicating her worth through treating her to lunch, Luna felt valued and special, an experience that helped her re-engage in therapy and believe in its worth again. Her therapist's consistent attendance to the process of forming and re-forming the therapeutic alliance, while using the therapeutic relationship as a fertile ground for learning about the impact of past relationships was an important aspect of Luna's therapy. In describing this type of 'corrective experience', Malan (1979) made reference to Donald Winnicott's teachings, explaining that:

the therapist can never make up to his patients for what they have suffered in the past, but what he can do is to repeat the failure to love them enough...and then share with them and help them work through their feelings about this failure (p. 141).

Although the findings from the current study are consistent with previous research emphasising the importance of the therapeutic relationship in facilitating positive change (Karver et al., 2006), it is argued that this study's findings highlight the particular and perhaps increased need of 'Being Valued' for young people in foster care.

Building Connection with Self and Others

Having established a sense of being valued in the therapeutic relationship, young peoples' sense of self-worth appeared to be facilitated through increasing their connection with self and family ('Understanding me and my Family'). Therapy allowed Keith an opportunity to explore how he was raised and the impact of familial addiction on him. For Nathalie, therapy appeared to offer a safe place in which she could talk about her father who she had only met on two occasions, while Jen was facilitated by her therapist in examining her past through reading the information that was recorded on her social work files. Children in care are often confused by what has happened in their lives and can blame themselves for being placed in care, finding it difficult to recognise their parents' role in this (Baker et al., 2013). Self-blame together with the significant feelings of ambiguous loss that young people frequently experience as a result of being placed in care (Lee & Whiting, 2007), can lead to ongoing feelings of guilt and shame, which are difficult and upsetting to acknowledge (Goodyer, 2016). In addition, family issues can be challenging to discuss with foster carers due to young people's frequent experiences of divided loyalties where they feel as if they are stuck in the middle of two families (Baker et al., 2013; Lewis, 2011). Young people in care are often not provided with opportunities to explore their identities, including their backgrounds and the reasons they were placed in

care (Gaskell, 2010; Stein, 2008). This lack of opportunity can increase feelings of resentment and rejection, while fuelling young people's belief that people do not care (Gaskell, 2010). Although young people are often reluctant to talk about past trauma (Graham & Johnson, 2019) it can frequently prove beneficial (Dittmann & Jensen, 2014) as it did for young people in this study. These findings provide important direction for psychotherapy in emphasising how therapy can appropriately facilitate young people in increasing self-knowledge at a crucial time in their development and at a point in the therapy process where sufficient relational connection has been established.

This process of identity development is a central task of Erikson's theory of adolescent psychosocial development. One of its main objectives is for young people: to gain an understanding of who they are by learning about and developing an understanding of their past and coming to terms with it (Erikson, 1971). The importance of this process is underlined by the findings of this study, and resonates with the clear message advocating the development of self-understanding for young people in care that emerged from the care experienced conference (Hugman, 2019). This message supported the view that in order for young people to move forward in a way that is psychologically healthy they need to be assisted in learning and understanding where they have come from (Stein, 2008). According to some social theorists, identity formation can only develop in the context of social relations that recognise and acknowledge personal existence in the context of a respectful and validating relationship (Houston & Dolan, 2008), something a well-functioning therapeutic relationship can safely offer the young person in care.

Therapy also appeared to support young people's sense of self-worth through providing a space to help them connect with others in their lives, such as foster carers ('Connecting with Others'). Young people in this study expressed positive experiences of having their foster carers involved in therapy with them. With the establishment of a positive relational connection with their therapist, young people appeared to have

developed enough of a sense of confidence to enable them to risk further vulnerability with the support of their therapist, by talking with their foster carers about their inner worlds. A safe therapeutic space allowed young people to develop an understanding of themselves through the eyes of their carers while also developing understanding of their foster carers. In general, this appeared to improve relationships and increase young people's confidence in themselves as well as their foster carers. Including foster carers as part of the therapeutic process in this way is in line with the recommendations of Luke et al. (2014) who advocate for therapeutic interventions that involve the young person and the system of which they are a part. This might include their carers, members of their family of origin where appropriate, as well as schools and other professionals who have close relationships with the child (Lewis, 2011; Tarren-Sweeney & Vetere, 2014). Emotional connection between young people in care and their caregivers aids in achieving placement stability (Rock et al., 2015) and relatedly the improvement of mental health outcomes among this population (Rayburn et al., 2018), a finding supported by Gardenhire (2019), who recommends that priority should be given to the cultivation of this relationship. In contrast with the findings of this study, Gibson et al. (2016) found that some young people in the general population valued having an objective therapeutic space separate from their parents. It is possible that, unlike the young people in Gibson et al.'s (2016) study, young people in foster care have an increased need for the development of relational stability with their foster carers due to their significant experiences of relational insecurity both prior to and during their care journey. Individual psychotherapy together with opportunities for joining with their foster carers was valued, emphasising the case for therapists to offer increased opportunities for 'Connecting with Others' as part of the therapeutic work.

Contextualising Individual Experiences Within Broader Social Systems

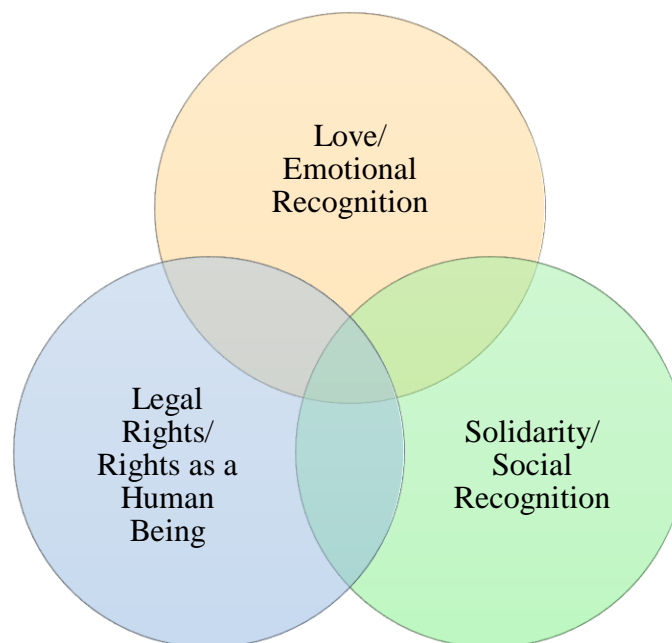
The importance of recognising young peoples' need for: establishing trusting relationships in psychotherapy that appropriately matches their attachment and

developmental needs; developing knowledge and understanding of their family backgrounds; opportunities to expand relational connections of mutual understanding beyond the therapy room; and a strong sense of agency in the therapeutic process were highlighted by this study. These findings are supported by the theoretical framework of recognition theory, a framework used in the discipline of social work as a useful way of conceptualising how to form and maintain respectful professional-child relationships that can encourage inter-dependence, autonomy and self-realisation for children in care (Smith et al., 2017).

Recognition theory was formulated by Axel Honneth, a German social theorist that examined human relationships from three points of view social, political and community contexts (Honneth, 1995, 1996). According to Honneth, there are three separate but inter-related areas of recognition, areas that help in broadening our understanding of the findings of this study: love, or the emotional recognition of a person's need for love and care; legal recognition or respect for a person's rights as a human being; and solidarity or social recognition as part of a person's contribution to a community (Figure 7). These three areas of recognition can lead to various types of relations-to-self: self-confidence, self-respect and self-esteem respectively (Honneth, 1995). It is a theory that focusses on the valuing of human relationship or 'mattering', which may be most appropriate for adolescents who, it is suggested, will fare better in the world if they matter to others and to themselves (Smith et al., 2017). Recognition theory fits the experiences of psychotherapy outlined in this study, as it is interactive, centres on mutuality or the reciprocity of interactions between individual people, between individual people and states and between individuals and communities.

Figure 7

The Three Elements of Recognition Theory



The findings of this study underline the importance of genuine, respectful and reciprocal therapy relationships, where young people are recognised and valued as individual people in their totality. This overall recognition when received in therapy helped many of the young people feel valued, understood and accepted which in turn developed their confidence in taking relational risks and allowed them to increasingly articulate who they truly were. Honneth posited that positive relationships can only be established “in terms of a basic moral demand for recognition of and being recognised by other” (Smith et al., 2017, p. 1614); an important aspect of the therapeutic endeavour identified by participants and underlined by the superordinate theme ‘Finding Connection’. Recognition theory is humanistic in nature, incorporates an active and interactive view about autonomy, inter-dependence, dignity and self-realisation, a worldview that acknowledges struggle within these relationships and one that “lends itself to a more holistic, reciprocal and respectful perspective on professional–child relationships” (Smith et al., 2017, p. 1615)

which resonates with the positive experiences of therapeutic relationships described by the young people.

In this study, when young people were recognised as valuable human beings who mattered and were given the opportunity to get to know the therapist in an atmosphere of mutuality, deep connections were established and self-respect grew. Aspects of this journey of relational connection comfortably fit with Honneth's focus on love or emotional recognition and the individual's need for emotional connection and care, reflected in the positive dynamics of the therapeutic relationship the young people experienced. This emotional recognition refers to the concept of attachment in a recipient-caregiver relationship, where it is the loving recognition of another that helps young people to realise that they matter and exist (Honneth, 1995; Sirriyeh & Ní Raghallaigh, 2018; Smith et al., 2017); this is particularly important for young people who feel stigmatised, have experienced attachment disruption and insecurity as well as maltreatment. Emotional recognition is a concept that is in line with Rogers' emphasis on wishing to communicate full unconditional acceptance to his clients (Rogers, 1951). When young people in this study experienced unconditional positive regard, a factor associated with positive therapy outcomes in adults (Farber & Doolin, 2011), they began to realise they could express previously unloved and unaccepted aspects of themselves (their internal working model). They began to feel safe enough to explore their internal world, revisit their family backgrounds and develop relations with their foster carers. In this study, emotional recognition was communicated through therapist sensitivity that respected the young person's need for agency, gave assistance in helping them risk relationship, provided multiple opportunities to explore their inner world and conveyed full authentic acceptance. The presence of these factors assisted the practice of legal and social recognition, while demonstrating these practices in therapy further strengthened the emotional connection between the young person and their therapist.

Acknowledging how the young person's unique circumstances impacts them and the importance of respecting this in the therapeutic situation is consistent with the second tenet of recognition theory which accepts that a person can only become a bearer of rights when they are socially recognised (Honneth, 1995). Allied to this, the recognition of young people's right to privacy and control within therapy was illustrated. The importance of young people being consulted in advance, prepared for going to therapy, together with control about if and when they spoke of issues of import emerged in this study. This is a consistent finding in studies of maltreated young people's experiences of therapy services (Dittmann & Jensen, 2014; Graham & Johnson, 2019; McElvaney et al., 2019) and highlights the importance of this right to privacy and control being recognised and respected by therapists, as well as those with responsibility for their overall care. In the context of this study, a number of young people expressed the need for their past to be adequately acknowledged and understood, to be offered the opportunity to learn about their background and to gain a sense of who they were as people. It is argued that without gaining a knowledge of who they are and where they come from, young people may remain bereft of self-knowledge that can allow them to feel empowered and equal participants in society, they risk enduring what Honneth (2001) describes as the social pathology of "invisibilisation" (p. 111). Offering opportunities to young people to learn about themselves and their family can help mediate feelings of shame and stigma while developing self-respect, a core concern of psychotherapy.

Advocacy was highlighted as an important aspect of young people's psychotherapy experiences and manifested in therapists assisting young people in fighting for their rights while achieving enhanced legal recognition. Gaining access to her family's social work files within therapy was valued by Jen, while Luna's therapist advocated on her behalf with school staff as well as with her foster carer. Illustrating the importance of advocacy in foster care relationships, Sirriyeh and Ni Raghallaigh's (2018) study of unaccompanied

refugee minors in foster care, stressed the role carers played in the interface between young people and the state. Foster carers who advocated for the young people in their care assisted in ensuring their receipt of appropriate services and their rights being upheld in schools, while facilitating the establishment of more trusting carer-young person relationships. Mirroring these findings, when young people in this study experienced their therapist as being at least willing to go ‘above and beyond’ for them, it is likely they were afforded a sense of self-respect as a result of their rights being recognised and understood, together with their value as human beings.

Developing mutual relationships and understanding with their foster carers was another important part of the therapeutic process for the young people in this study, a finding consistent with the third tenet of recognition theory that references a solidarity as well as rights focus. There is an obvious connection between young people having the right to their voices being recognised and respected within the therapeutic relationship as well as their wider community (this could include recognition by their foster carers, their social worker, their family of origin and beyond). The study findings demonstrate how when genuine recognition was experienced by the young person within the therapeutic relationship, young people were facilitated in becoming more open to building connections within the wider familial system, growing their self-confidence and an expanded sense of themselves. This sense of solidarity is an important consideration for young people in care, who commonly feel disconnected and separate from others. Developing young peoples’ sense of relational connection, attachment and mutuality with some of the main people in their lives is a valuable endeavour which can potentially facilitate the growth of enduring relationships and self-esteem far beyond the lifespan of therapy.

Conclusion

Based on the experiences of seven young people in foster care, the psychotherapy experience is conceptualised as a journey of relational connection. Although there were

many divergences in the findings, most of the young people experienced a process of establishing relationship with their therapist which often started from a place of distrust, lack of choice and wariness. The findings of this study, while similar to previous research that emphasises these barriers to engagement, highlight the subjective, nuanced and perhaps increased challenges young people in foster care face when attempting to establish relationship with therapists. Thus, a greater requirement for sensitivity to the particular attachment needs of this cohort was emphasised. Building on extant literature, this study underlined the importance of therapist flexibility and persistence in communicating to young people that they matter. When participants experienced being valued by their therapist they often progressed to learning more about themselves and processing issues of importance. These findings resonate with studies advocating for young people to be offered consistent opportunities to explore their backgrounds (Gaskell, 2010; Stein, 2008), while highlighting the psychotherapeutic value of this experience for young people in foster care. The profound risk involved in 'Opening Up' in this relational endeavour was underlined for these young people, an endeavour that helped them grow in confidence and develop a stronger sense of themselves as people. Building meaningful relationships with their foster carers and others as part of therapy was a valuable experience that was emphasised and contrasted with previous research on young people in the general population. The findings of this study highlight a possible increased need for young people in foster care, to build secure relational connections with adults in their system, helping complete a journey of relational connection that can extend beyond the therapy room.

Recognition theory (Honneth, 1995, 1996) with its emphasis on a person's right to: love or emotional recognition; legal recognition or respect of their rights as a human being; and solidarity or social recognition, provides a useful framework that supports the findings of this study. Recognising young people in foster care as unique individuals who deserve and require genuine emotional connection within the therapeutic relationship was

consistent with the positive experiences of therapy they shared. This was a crucial aspect of therapy that if successful, provided a springboard for young people to risk becoming recognised as individual people with rights. Through the development of self-knowledge they could come to realise their true value as equal members of society. Helping young people develop relationships within their wider system was underlined as a valuable task that can assist young people in becoming socially recognised and experience genuine solidarity with others, an important task accentuated for young people in foster care who frequently experience marginalisation.

Researcher's Reflexive Comment

Pulling together the findings in a way that enhanced understanding of the experiences the young people shared was a challenging one. I experienced a tension between trying to progress understanding in the context of the literature while being true to the young peoples' voices. The word 'recognition' kept emerging for me and was consistent with my view that the particular and often hidden needs of young people in foster care demand recognition. I believe much of what the young people described in their psychotherapy experiences was about their need to be genuinely recognised as people in their totality. I was both relieved and happy to discover aspects of recognition theory that were truly consistent with my understanding of what the young people shared. Articulating this in a way that adequately honours their voices was the next challenge, as I sometimes strayed into areas that were more focussed on the therapist than the young people. Acknowledging my practitioner hat in this regard was helpful in bringing me back to the phenomenology of the participants' experiences rather than continually jumping ahead to thinking how it impacts practice.

Chapter 6: Conclusions & Recommendations

Introduction

This chapter summarises the key contributions of the study and discusses implications for: psychotherapy practice; foster carers; training; policy; and research. The strengths and limitations of this study are then examined together with an evaluation of its quality using Yardley's (2000) framework. Finally, theoretical transferability and an account of the researcher's learning and reflexivity is detailed.

Contributions of the Study

This study, the first of its kind in Ireland, makes an important and original contribution to the field of psychotherapy by highlighting and privileging the voices of young people in foster care, detailing their lived experiences of psychotherapy. Developing understanding of what these experiences were like in all of their complexity, while young people were still immersed in the lived experience of foster care, is of immense value and addresses a gap in the literature. Heretofore, the research community predominantly focussed attention on: the identification of difficulties; determining prevalence; studying the efficacy of therapeutic interventions; and exploring the inherent challenges of being in care. This study, through a detailed process of Interpretative Phenomenological Analysis, underlines the profound anxiety young people in foster care can experience when embarking on the therapeutic journey, in particular their significant fear and reluctance in meeting with therapists due to their past negative relational experiences. Highlighting the interplay of young peoples' negative relational experiences with therapeutic engagement and participation illuminates the intensity of this experience, providing unique insight into the significant ambivalence and distrust young people commonly demonstrate when meeting psychotherapists. This knowledge builds a nuanced understanding of the challenges faced by young people in foster care, which can help psychotherapists and others with responsibility for their care in more ably assisting them to engage in

psychotherapy that is sensitive to their needs, communicates understanding, and facilitates engagement.

The ‘journey of relational connection’ that emerged from the findings, provides a useful organising structure for understanding, genuinely recognising and highlighting the particular therapy needs of young people in foster care. The framework illustrates what helped young people develop trust as well as gradually open up and confide in their therapist, before starting to process their own experiences. Young people desired time, a sense of control and choice, a careful building of reciprocal relationship as well as access to multiple modes of communicating in order to help establish safety. Therapist behaviours such as remembering birthdays, ‘treating’ the young person to lunch, advocating on the young person’s behalf or simply providing a teen friendly room communicated a sense to the young person that they genuinely mattered to the therapist. These experiences frequently created sufficient relational safety for young people to begin the challenging work of exploring family history and centrally involving foster carers in the therapy sessions.

The findings build on recognition theory, heretofore used in the field of social work, as a framework that can help guide psychotherapy practice with this cohort of young people. This theory is valuable in recognising the young persons’ need for three unique but inter-related facets of the therapy relationship: authentic emotional connection that helps develop a sense of self-acceptance in the presence of another; demonstrated respect and acknowledgement of the young person’s unique legal or social circumstances; and the provision of opportunities to build relational connections with others in the young person’s wider system, when they are ready to do so. These three principles have utility in helping therapists who work with young people in foster care hold a global and systemic view of their complex and individual therapeutic needs, with a view to providing more effective therapeutic intervention.

Implications for Psychotherapy Practice

Viewing psychotherapy as a journey of relational connection suggests the need to focus on two key aspects of psychotherapy practice in working with young people in foster care: establishing the therapy relationship and assisting young people in experiencing themselves as people of worth embedded within a broader system.

Establishing Relationship

In highlighting the unique therapy experiences of the young people in this study, their need for a flexible, tailored, relational oriented, individual as well as systemic focussed therapy emerged. Similar to previous research, the young people in this study highlighted the need for therapists to be comfortable in helping them work through their initial wariness and fear of going to therapy, by being open, relationally focussed and flexible in their approach (Hambrick et al., 2016). Young people require therapists that: recognise, respect and prioritise their needs; offer therapy that is boundaried and negotiated; and allow sufficient time for building trust before they feel able to open up about personal issues.

This relational focus can start before therapists meet the young person. In responding to young peoples' various attachment needs, therapists are encouraged to meet with foster carers and/or the adolescent's social worker; a process that allows for relationship building, information gathering as well as providing an opportunity to discuss what might facilitate the young person to attend in a way that helps them feel relatively comfortable. This could allay young people's fears when they have strong reservations about going to therapy, similar to many of the young people in this study.

A more determined, persistent and flexible approach to helping young people engage in therapy may be required; one that goes beyond the familiar traditional boundaries of psychotherapy. This could include meeting young people in their own home (foster placement) for the first session as suggested by one young person (Appendix O) or

phoning them on a number of occasions in order to build rapport. Similarly, and with reference to young people's negative experiences of therapy endings, it is important that therapy endings are carefully planned, discussed and negotiated, keeping the young person's attachment needs in mind. In addition, given young people's experiences of many transient professional relationships, due consideration needs to be given to the commitment of individual therapists that where possible, sudden endings are avoided.

Young people need to be consulted about going to therapy, be given information about what it might entail, while being strongly encouraged to attend and give therapy a chance. This approach is largely consistent with research findings involving children and young people in the general population, where young people expressed the importance of knowing about appointments beforehand (Coyne et al., 2015; Day et al., 2006; Plaistow et al., 2014). Recognising young people's silence or sullenness during initial therapy sessions as illustrations of anxiety and wariness is important. Understanding that young people may have been brought to therapy without having much say in the matter or due to adult concerns rather than their own, could help allay therapist anxiety when meeting with a difficult to engage young person. Initial conversations need to be centred on the individual interests of the young people, genuine interest communicated, while the purpose and course of therapy is negotiated in a collaborative manner. Informing young people of the types of things that may be helpful to discuss in therapy can help normalise issues, communicate openness and assist young people in overcoming feelings of shame or stigma.

The use of art materials, sand trays and other materials that facilitated the building of relationship, self-expression, as well as a sense of freedom and control were referred to by the young people in this study. Allied to this, providing an environment that is teen-friendly was referenced as creating a sense of comfort, and is something therapists could adapt and negotiate with each young person in order to communicate their value as

individuals. In helping young people establish relational connection, it is recommended that therapists possess a wide ranging knowledge of various therapeutic interventions that can be appropriately used and adapted to each young person's individual circumstances (Zilberstein & Popper, 2016). These diverse ways of working can offer young people multiple and creative forms of expression that can help facilitate a sense of safety while assisting them in articulating their inner world.

Young people expressed a need to be treated as valued individuals, where they were given time and space to build trust and connection with their therapist in a collaborative manner. Therapy is a process that young people do not want to be hurried along, which has implications for offering time limited or short-term therapy to this cohort, and should be communicated to the young person's wider system who may have unrealistic expectations about the course of therapy. The experiences shared by the young people in this study strongly support the proposition MacKinnon (2012) makes: that "every child and every situation deserves a developmentally sensitive, psychologically aware deliberation of the specifics related to their current situation" (p. 217), consistent with Roger's core conditions of empathy, congruence and unconditional positive regard (Rogers, 1951). The building of solid therapy relationships over time, where young people experienced 'emotional recognition' was at the heart of what the young people in this study valued, and appeared to be a prerequisite to 'Opening Up' about their personal experiences.

Knowing when sufficient relational connection is established may be challenging for therapists to recognise. The findings of this study demonstrate that young people can provide rich accounts of their therapy experiences, indicating their ability to reflect and clearly communicate about their experiences. Therapists need to ask young people at frequent intervals about the process of therapy in order to assist in the development of trusting relationships as well as to help gauge whether young people are ready or willing to

discuss more difficult issues in their lives. This is particularly important for this marginalised cohort of young people who are rarely consulted about issues of importance to them, helping boost their sense of agency while recognising their ‘rights as human beings’.

Facilitating Young People to Experience Themselves as People of Worth

In psychotherapy, participants prized emotional recognition and understanding, a strong sense of being valued individuals, as well as opportunities to strengthen connections or their sense of solidarity within the wider family system. Young people need therapists to show them that they genuinely matter to the therapist. This can be demonstrated in various ways, for instance, therapists calling the young person, advocating on their behalf within the wider system or helping them build connections with others. Embracing this type of “clinical/psychosocial developmental scope of practice” with “a strong advocacy role” as posited by Tarren-Sweeney (2010, p. 617) strongly resonates with this study’s findings.

Facilitating young people to learn about themselves and their background was a central part of the therapy process for many of the young people in this study, who wished to be offered opportunities to explore their past when they were ready to do so. Young people may need consistent and gentle encouragement from therapists in order to begin this process. This type of prompting and encouragement communicates to young people that they are valued by the therapist and can help facilitate their exploration of issues they may normally avoid. Communicating to young people how others have found relief and benefit in talking about these issues may assist them in overcoming their reluctance to talk. Helping young people access their Social Work files and learn about their history is also something that can help young people at this time of intense identity formation.

Advocating for young people with their school, social worker, foster carer or parents is something that was also prized by the young people in this study. Young people valued having an objective individual therapy space while also gaining from their foster

carer being part of their sessions, where matters of importance to both parties were discussed. Working with young people in foster care requires therapists to work with a system that can involve their foster carers, social workers, school staff, CAMHS teams, biological parents among others (Lewis, 2011). This need resonates with literature suggesting that parental involvement in therapy is helpful for young people (Diamond et al., 2016; Kaslow et al., 2012; Midgley et al., 2017) and is consistent with research promoting the central involvement of foster carers in helping young people (Midgley et al., 2019; Rayburn et al., 2018; Schofield & Beek, 2009).

Arising from the findings of this study, a booklet will be designed that outlines the various factors to be considered in working therapeutically with this cohort that would be helpful for psychotherapists, including how to: recognise the profound impact of prior negative relational experiences; help young people overcome feelings of wariness; offer appropriate psycho-education about therapy; provide a flexible and tailored therapy; develop trust; offer multiple ways to communicate, offer a teen-friendly space; advocate on behalf of young people; assist young people in learning about their family history; and involve other appropriate adults in the young person's therapy. Also, a booklet for foster carers and young people in foster care that includes relevant advice and guidance about how to help overcome the significant challenges to engaging in psychotherapy that are identified in this study will be prepared. This will include relevant quotes from the young people in this study and clearly outline the importance and rationale for foster carer involvement in young peoples' therapy. As part of the process of dissemination and in addition to conference presentations and future peer reviewed journal articles, the researcher plans to liaise with relevant stakeholders, such as Tusla, IFCA, EPIC and fostering agencies with a view to ensuring widespread dissemination of the main study findings that are particularly relevant for the various stakeholders. Other creative means of ensuring widespread dissemination, for instance across social media platforms, will also be

carefully considered in consultation with young people in foster care as well as professionals working in the area.

Implications for Foster Carers

Young people in this study advised that foster carers should consistently encourage them to attend therapy, to support the therapy, to understand that therapy can be challenging for young people and that some aspects need to be confidential (See Appendix O). Although it may be tempting to bring young people to therapy without consultation, for fear of them being upset or non-compliant, the importance of consulting with them prior to attendance was underlined by the findings. This communication recognises and honours young peoples' rights as adolescents in foster care, addresses their increased need for predictability and preparation, conveys respect, while increasing the likelihood that they will more readily engage in the therapy process. Even though young people may resist attending, it is important that opportunities for therapy are consistently offered and the reasons for how it could be useful explained. Offering incentives for attending can also help with initial engagement.

Understandably, the literature references a wide variation in the capacity of foster carers to adequately provide for the complex needs of children in foster care (Dickes et al., 2018). Foster carers could better access separate therapeutic support for themselves through their involvement in the young person's therapy. In doing so, foster carers can advance their knowledge and understanding of the attachment and trauma needs of the young person, while receiving guidance about how to respond to the varying individual needs of each young person. Encouragingly, many of the young people positively referenced spending quality time with their foster carers. This commonly occurred on the 'drive' to therapy, while others spoke of valuing having time in therapy to work on their communication with each other. The prioritisation of having this regular, dedicated and quality individual time with young people in foster care is important.

It is likely that the key aspects of the journey of relational connection outlined by the young people are similar to the qualities they desire and value in foster carers. Thus, young people need foster carers to demonstrate authentic interest, understanding, flexibility, reciprocity and commitment to young people in their care, while communicating a genuine sense of valuing the young person. Advocating within the young person's wider system, for example with their school or social worker, respecting their privacy and rights, as well as nurturing a genuine emotional connection were highly valued and sought after. For one young person, when her foster carer risked being vulnerable with her in therapy, when she became upset, this communicated that she mattered to her foster carer. The importance of this emotional recognition should not be underestimated, as young people frequently believe they do not matter to others.

In addition, supporting young people in learning about their background and family history could assist in helping them overcome feelings of shame, stigma as well as divided loyalties, while strengthening relationships with their carers. Consistent with the findings of this study, the literature provides important illustrations and recommendations about how to develop, support and utilise the unique and critical role of foster carers in helping vulnerable children (Pasztor et al., 2006; Sirriyeh & Ní Raghallaigh, 2018; Turner & Macdonald, 2011). Training that reflects the qualities desired by the young people in this study may be of optimal benefit to foster carers, while psychotherapy that recognises the value of foster carer involvement should take precedence (Golding, 2008; Hughes et al., 2019).

Implications for Training

Increasing awareness and understanding of the unique and complex therapeutic needs of young people in foster care needs to be integrated into therapist training. Learning about the relationally focussed and humanistic approaches that are necessary to build a valuable therapeutic alliance would help enhance psychotherapy practice with this

population of young people. Recognition theory and the journey of relational connection framework that emerged from the findings of this study, could be helpful in designing psychotherapy modules for working therapeutically with young people in foster care. These frameworks are also likely to have utility in social work and other professional training that work with young people in care.

The findings of this study suggest that training programmes need to address the many complex issues young people in foster care can experience including, the interplay of attachment insecurity, experiences of trauma and abuse, separation and loss, placement disruption/breakdown and mental health difficulties. Developing therapist understanding of these profound experiences appears crucial in providing more adequate psychotherapeutic input with this cohort. Training therapists in line with the recommendations for psychotherapists identified above, could help in more adequately preparing therapists for working with young people in foster care. For instance, the findings of this study indicate that young people in foster care need therapists to offer: increased boundary flexibility that extend beyond the traditional boundaries typically taught in psychotherapy courses; persistence; an individually tailored approach; and genuine emotional connection where young people feel like they genuinely matter. Although these experiences may be valued by many people, it is argued that perhaps young people in care have an increased need for this attuned recognition of their individual needs.

Specialist placements in services that work with young people in care would be helpful for trainee practitioners. Modules focussing on systemic therapies with reference to young people in foster care, would augment therapist knowledge and assist them in meeting young people in ways that could better meet their needs. Commonly therapist training focusses on individual psychotherapy; training that offers practice in working with parents/foster carers and young people together in sessions would provide optimal benefit.

Implications for Policy

The findings of this study support the argument for specialist therapeutic services that offer tailored individual therapy together with consistent opportunities for working together with foster carers and possibly other people within the young person's system. The young people in this study appeared to want a therapy that was collaborative in nature, not time limited, and where their particular backgrounds and needs were adequately understood. Developing specialist therapy services that can more readily and appropriately meet the therapeutic needs of this cohort of young people should be strongly considered. This specialist service approach is supported by McElvaney et al.'s (2019) study, where young people attending rape crisis services valued the specialist approach of therapists in terms of dealing with sexual assault and dealing with young people. The findings of this study, which illustrated young people's complex and idiosyncratic therapy needs, rather than professional viewpoints, strengthens the argument for dedicated services (National Institute for Health and Care Excellence, 2015). Tarren-Sweeney (2010), proposes a suitable framework for this type of specialist service that could better meet the unique therapeutic needs of young people in care. It promotes a clinical/psychosocial-developmental scope of practice with a strong advocacy role, that is offered by therapists who have acquired specialist knowledge and skills in working with young people in care.

Implications for Research

This study is unique in that it explored the lived psychotherapy experiences of young people while they were immersed in the context of living in the Irish foster care system. It indicated that young people found that having their foster carers involved was helpful. Future research exploring the experiences of foster carers, where young people they care for attend therapy, could further contribute to professional understanding. Research regarding social workers and residential care workers experiences of facilitating access to therapy for young people would also be of benefit. Additionally, research on the

perspectives of therapists working with young people in foster care would offer further insight about working with this cohort.

Given the significant challenges to engagement experienced by the young people in this study, further research focussing specifically on exploring issues of engagement for young people in care would be of benefit. Investigating the parallel therapy experiences of young people, their foster carers and therapists could provide a very interesting and helpful multi perspective view of the issues that impact engagement and what may help overcome these challenges. A similar study design could be utilised to explore critical incidents in therapy with young people in foster care that would be helpful in building understanding of how to offer the specialised, supportive and persistent therapy the young people in this study valued. In addition, building on the findings of this research study, specific research that explores the nature and experience of foster carer participation in young peoples' therapy would provide further valuable and useful information to the field of psychotherapy. Learning about the various ways foster carers are involved in young peoples' therapy as well as how this way of working is navigated, understood and experienced by the various parties involved would be of value.

The young people who participated in this study were in stable foster placements and also appeared to have had largely positive experiences of therapy which may have encouraged them to take part and influenced the type of experiences they shared. Future research studies on the therapy experiences of young people who may have had less positive experiences, did not find therapy beneficial, or disengaged from therapy, could provide additional useful knowledge for the field of psychotherapy.

Young people involved in this study ranged in age from early adolescence to late adolescence who most likely had varying developmental needs. Conducting research with young people in separate age brackets, for example 12 – 14 and 15 - 18, as well as younger children, would offer further and more targeted insights about the particular experiences

and needs of different age groups. Although further challenges in recruitment would most likely emerge and would need to be planned for.

As described earlier, recruitment challenges hampered the research process at times, most likely due to gatekeepers' concerns about the potential negative impact involvement in research of this nature may have on participants. Although research ethics as well as gatekeeping are very important in ensuring child safety, balance needs to be attained, as otherwise children's right to their voices and experiences being heard are lost (Överlien & Holt, 2017). As outlined, the researcher's experience and established relationships with professionals in the field, as well as a carefully stepped approach assisted the successful recruitment of participants. Learning from this process, and in order to increase young people's participation in future research of this nature, the development of closer engagement with gatekeepers is recommended. This fostering of collaborative working relationships could develop mutual understanding about the utility and negligible likelihood of harm being caused when participating in ethical studies of this nature.

Quality of the Study

This section outlines the strengths and limitations of the study before evaluating its quality using Yardley's (2000) criteria for evaluating qualitative research studies: sensitivity to context; commitment and rigour; transparency; and coherence; as well as impact and importance.

Strengths

A strength of the study was its focus on hearing directly from young people in foster care, a marginalised population in society, as frequently young people in care are not consulted about their opinions, views or experiences. Thus, the study adds to the literature supporting the view that young people's perspectives can assist in the development of suitable services (Graham & Johnson, 2019). As mentioned, the researcher's professional background and experience proved helpful in accessing young people to participate in the

study. This was also advantageous in assisting young people to build rapport and develop sufficient relational safety in order to provide rich data that illustrated both positive and negative experiences. The diversity and richness of the data was a notable strength of the study, offering important and rounded insight into the psychotherapy experience. Another significant strength is that the research highlighted particular aspects of the therapeutic experience for participants that were directly influenced by their unique experiences of attachment insecurity, maltreatment and living circumstances. Thus, the challenges inherent in risking engagement, building trust with their therapist and others, as well as exploring their history were emphasised in a nuanced and novel way. Learning from young people as to what helped them engage in this work can assist therapists in helping clients navigate the challenging individual journey of relational connection.

Limitations

The findings of the study derive from a small sample of seven individual young people who volunteered to participate, thus, cannot be generalised to other young people in foster care. The study was open to all young people in foster care who met the inclusion criteria. However, recruitment depended on young people being given the information by professionals and foster carers in their lives. As discussed, recruitment proved to be challenging due to a number of factors mostly related to access and gatekeeping.

Understandably, professionals appeared protective of the young people they worked with but as a result they may have precluded some young people participating based on their own preconceptions of the ability, interest or otherwise of young people to participate. As mentioned earlier, there is potential for harm to be caused by not including children in research that is about them as it creates the possibility of research that is unrepresentative of experiences and effectively silence people in distress (Alderson & Morrow, 2011).

Although gatekeepers were asked not to be selective about who they gave the research information to, it appeared that many may have chosen those young people they perceived

most likely to be interested, young people who had positive therapy experiences or potentially those who they believed would provide quality narratives. Young people themselves may also have been reluctant to participate. Details about reasons for referral, the type of therapy as well as the frequency and time spent in psychotherapy were not gathered as the researcher had not included this as part of the research ethics process. This was due to concerns that it could hinder the research ethics application. On reflection, the gathering of this information may have been a useful addition to the research project providing additional information about the therapy experiences of each participant that could have helped augment the findings.

Sensitivity to Context

Sensitivity to context involved adequately considering the distinct nature of the research topic, the study population and setting, as well as the inherent socio-cultural influences. Additionally, careful consideration of the literature that informs the knowledge base in this area of study as well as the methodology that guided how the research was conducted, were essential contributing factors. Researcher knowledge of the unique context of being a young person in care as well as the multiple influencing factors that can impact their lives was very helpful in planning and designing the research project. Navigating this system in a way that gradually built a sense of trust and safety with gatekeepers and the young people themselves was a central part of the process, which involved a number of contacts, sensitive building of relationship over time, provision of information, and building of trust with all concerned.

Young people in foster care are deemed a ‘vulnerable population’ due to their age and circumstances. The specific consent and ethical sensitivities required careful consideration. The inherent flexibility of IPA and the use of semi-structured interviews allowed for the gradual building of rapport suitable to the developmental stage of adolescents. Throughout the interview process the relationship with the interviewees took

priority, their emotional wellbeing was carefully attended to, their story empathised with while the researcher viewed participants as being the “experiential expert” (Smith et al., 2009, p. 180). The analysis privileged the voices of the participants, while any interpretations were offered in order to offer possible alternative meaning and to further illuminate an experience. This is demonstrated through the use of generous verbatim extracts of the participants’ accounts in the findings chapter that support the arguments made.

Commitment and Rigour

There is some overlap between ‘commitment and rigour’ and ‘sensitivity’. Yardley (2000) suggests researchers should demonstrate a commitment to maintaining sensitivity throughout the research study. Commitment is also demonstrated by the significant amount of time and energy given to the overall research process: the arduous research ethics application and the careful attention to ethical considerations throughout; the extensive literature review; the careful negotiation of the recruitment process; attending research methods workshops; the preparation prior to each interview; the researcher’s consistent use of research supervision; paying close attention to participants during data collection (this is apparent in the research interview transcripts); extensive travel to facilitate participation; the sensitive and focussed nature of the interviews; the systematic analysis; as well as the in depth discussion of the findings; and thesis write up.

The rigour of the study is demonstrated through a detailed description of the research process. According to Yardley (2000) and Smith et al. (2009), rigour should also be demonstrated by the similarities and divergences in the participants’ accounts of the phenomenon. Data both supporting and diverging from the key themes are included in the findings. The essential process of reflexivity ensured that the researcher’s pre-suppositions or biases did not adversely impact the research process or overshadow the primacy of hearing what the young people said, helping maintain research rigour.

Transparency and Coherence

Transparency is demonstrated by the clear articulation of the methods used to gather and analyse the data. Demonstrating the clear auditability of the study, a single Excel file was used which contained the transcript of each interview together with separate columns containing the descriptive, linguistic and conceptual analysis as well as columns detailing the emergent themes and other pertinent notes. Excerpts from the transcripts of two participants are provided in Appendix L and Appendix M. Keeping a reflexive journal, supervision notes, supervision records and peer group reflections throughout the research process detailed the thinking and rationale for decisions made at various junctures throughout the process, while also recording the various challenges encountered.

Coherence is described as “the “fit” between the research question and the philosophical perspective adopted, and the method of investigation and analysis undertaken” (Yardley, 2000, p. 222). Exploring participants’ lived experiences of psychotherapy within their unique context of living in foster care is a phenomenon that appears to have been largely ignored in the literature. As IPA is a methodology acknowledged as being particularly suitable to exploring lived experience of phenomena in a way that accounts for the context participants are embedded in, while allowing for in depth meaning making by both participants and researchers, it was deemed a coherent methodological fit in terms of addressing the research question. The completed thesis also demonstrates the coherency of the study by virtue of the detailed account of the research process that it provides as well as the findings and discussion presented.

Impact and Importance

The impact and importance of the study refers to the usefulness of the research findings to their audience, in this context, practitioners in the field of psychotherapy as well as other professionals and researchers working with children in care. This study highlights the idiosyncrasies of the phenomenon of psychotherapy for these young people,

including the profound challenges they experienced when engaging in therapy, while presenting an understanding of the commonalities of this experience for them. The study details the implications of the issues raised for practice, policy, training and research showing the utility and relevance of the study to the field of social work, psychology and psychotherapy in particular. Gaining this knowledge directly from young people themselves strengthens the argument for specialist knowledge, training and therapy services. The findings of this study have been shared locally with colleagues in the field of psychotherapy and psychology and have been received with enthusiasm. Many have commented on the utility of the findings in assisting professional understanding of the barriers and facilitators to young people's engagement. For instance, young people's need for therapist persistence, flexibility and time in establishing therapy relationships was highlighted. As mentioned, it has been suggested that the production of guidelines/information documents based on the findings could be helpful for practitioners/young people in foster care/foster carers, as a way of helping all parties prepare and be mindful of the unique and varied issues that present for many young people in care. The therapist document could, in addition, offer guidance on how to offer tailored therapeutic input to this cohort. The researcher has also noticed that the findings of this study have positively impacted on his practice and sensitivity to the particular needs of young people in foster care as they present in psychotherapy. This has included a greater and more focussed awareness of young peoples' potential need for assistance in exploring their identity and strengthening his belief in the importance of helping young people build quality relationships in their system in a negotiated and gradual way. In addition, his belief in the importance of a person-centred, flexible and collaborative approach to working with young people has been bolstered by the research process, in a way that will help him more persuasively champion with professionals in the field of psychotherapy, the importance of a gradual development of relational safety for young people in care.

Theoretical Transferability

Smith et al. (2009) posit the importance of considering research findings from the perspective “of theoretical generalizability rather than empirical generalizability” (p.51). Although this study focussed on the experiences of young people in foster care, the issues that arose could theoretically be applied to young people in residential care settings as well as other young people who have experienced maltreatment or attachment insecurity. Many of the findings are consistent with those from previous studies with young people who have experienced maltreatment or abuse, including the views of trauma therapy for young people in residential care (Graham & Johnson, 2019), and the perspectives of young people who attended rape crisis services in Ireland (McElvaney et al., 2019). The findings are also of utility to other professionals working with adolescents in care, including social work, social care, psychology, psychiatry as well as foster carers. Knowledge gleaned about: how young people experience professional or adult-child relationships; what assists or discourages their engagement; as well as what helps them develop in psychotherapy, are important teachings for all professionals to learn, in order to progress a deeper understanding of the unique needs of young people in foster care, while furthering professional practice.

Conclusion

This chapter highlighted the importance, value and novelty of this study which presented the lived psychotherapy experiences of seven young people in foster care. The study’s utility for psychotherapists working with young people in foster care was clearly outlined and focussed on practical issues that this study has helped illuminate. In addition, implications for foster carers, training, policy and research underline its contribution to the literature. The study’s strengths and limitations as well as overall quality was described, emphasising the rigorous nature of the study.

In researching the lived psychotherapy experiences of young people in foster care, this study addressed a gap in the literature while gleaning very important knowledge about the process directly from young people themselves. Learning about the depth of uncertainty and wariness young people encounter as they embark on the therapeutic endeavour, as well as the processes they engage in and value as a means of establishing relationship, provide rich insights into the psychotherapy process and what helps them gradually open up. How the therapeutic alliance is solidified through the experience of being valued and developing self awareness, gives novel insight into what it is like to be in psychotherapy. The importance of developing relationships and connections beyond the therapy room and how the therapist can assist in this regard strengthens the argument for systemic approaches to therapy. The young people in this study desired genuine, emotionally connected therapy relationships, where therapists accepted them as valuable people in all their complexity while recognising, nurturing and valuing the relational connections within their systems.

Researcher's Reflexive Comment

Highlighting the implications for practice was enjoyable as it was heartening to discover how the findings from the study could richly contribute to professional knowledge and practice. In thinking about the overall process of this research study I have learned so much both academically and professionally. It has been a very enriching and challenging experience, one where I had to be mindful at all times of my role as a researcher rather than a practitioner. At times I slipped into practitioner mode but the ongoing reflexive practice with my supervisors and peer group greatly assisted in putting me straight again. My hope now is that I have adequately honoured the voices of the participants and done them justice as I know they were motivated to participate in order to make a difference and help other young people. I hope that by sharing these findings, this study will contribute to making a difference, where therapists can learn from what these young people have said

and integrate their teachings into a practice that can more adequately meet their needs, reducing feelings of wariness and discomfort while increasing their relational connections.

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Appendices

Appendix A: Recruitment Flyer

We are studying: **Young People's Experiences of Therapy/Counselling while in Foster Care**

We want to hear from adolescents in foster care about their experiences of counselling/therapy. By carefully listening to what young people in foster care think and feel about their experience of therapy/counselling, we hope to help improve therapy services for them.



We are looking for participants who:

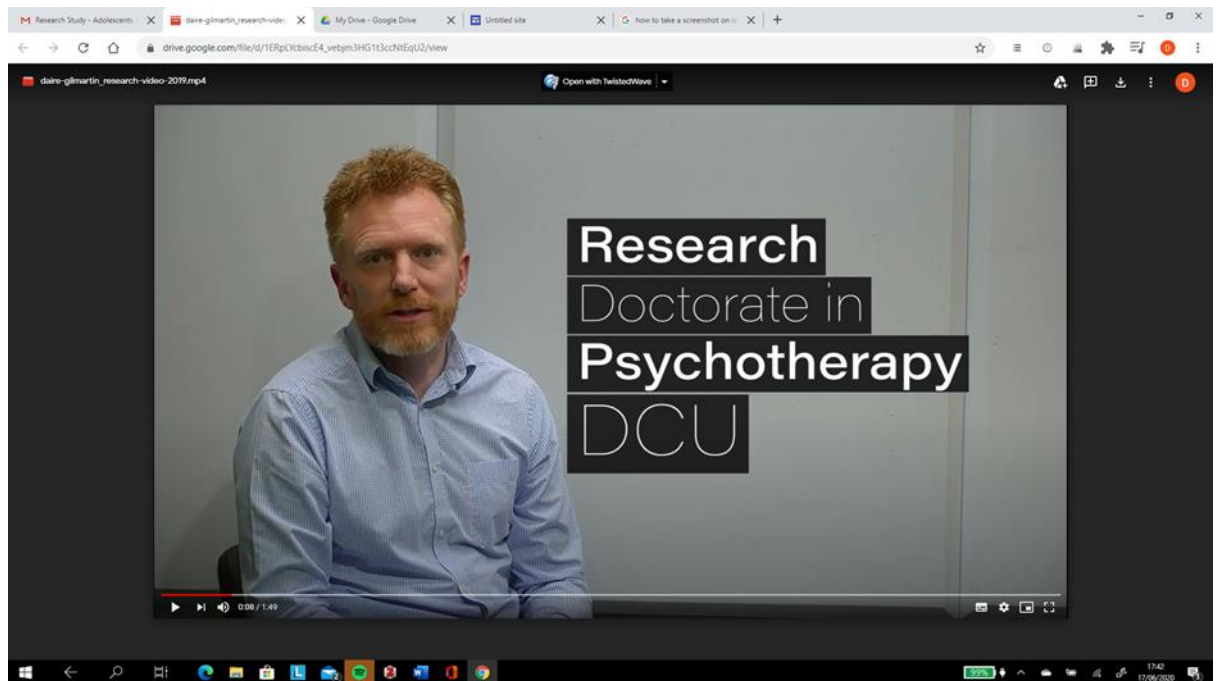
- Are aged 12-18 years
- Are attending therapy/counselling or have attended within the previous twelve months.
- Have attended a minimum of 6 sessions in that time
- Are in their current foster placement for a minimum of 12 months and there are no current plans for this to change.

If you know a young person who may be willing to take part in an interview lasting approximately 30-60 minutes we would be delighted to hear from you. For further information please contact **Daire Gilmartin, (C.Psychol. Ps.S.I)**, Doctorate in Psychotherapy candidate,

Appendix B: Recruitment Video Link

Recruitment Video Link (Released on 22nd March 2019):

https://drive.google.com/open?id=1ERpLYcbiscE4_vebjm3HG1t3ccNtEqU2



Appendix C: Information Sheet for Tusla Area Manager/Social Workers/Foster

Carers

Experiences of Psychotherapy while in Foster Care: Adolescent perspectives.

Research Information Sheet for Area Manager of Tusla, Social Workers, Tusla & Foster Carers of potential participants

Who is conducting this research?

Daire Gilmartin is a Senior Counselling psychologist working with Five Rivers Fostering. He is also a Doctoral candidate on the Doctorate in Psychotherapy programme in Dublin City University. Dr. Rosaleen McElvaney is an Assistant Professor in Psychotherapy at Dublin City University and Dr Melissa Corbally is a lecturer in Dublin City University. They are supervising the research project.

What is the research about?

This study aims to gain an understanding of the experience of psychotherapy/counselling for young people in foster care.

Challenges in engaging young people in psychotherapy while in foster care have been identified, including young people's dissatisfaction with services offered and professionals' struggles to engage and retain young people in therapy.

Much of the research has involved professionals and adults, while the views of young people in foster care have not been included. The aim of this study is to explore young people's experiences of psychotherapy while in foster care. It is hoped that by studying their individual experiences, professional knowledge will be developed with a view to assisting in the furthering of more relevant psychotherapy services that will better meet the needs of young people in foster care.

What will happen if the child or young person takes part in the research?

The young person will first be given information about the research and will then be offered the opportunity to participate. If the young person wishes to take part informed consent to participate will be sought from the young person's parents where appropriate and/or their social worker as well as from any young people aged 18. Informed assent will be sought from young people under the age of 18. It is important that participants are in a stable foster placement in order to ensure that they receive the necessary support to take part. All young people who consent/assent to participate will be asked to take part in an interview lasting approximately one hour. This will involve asking the young person questions about his/her experience of psychotherapy while in foster care. An audio recording of this interview will be made and transcribed. The information will be analysed and used to present ideas about the experience of psychotherapy and how we can improve services. Research supervisors and a research colleague (to help with ensuring transparency of analysis) will have access to this information as well as the external examiner, upon request. All data will be stored securely in the researcher's home office, either in a locked filing cabinet or in a secure computer.

The young person will not be obliged to participate and will not be asked to do so unless it is clear that they want to take part and that they understand what the research is about. He/she may withdraw from participation at any time up to the commencement and during the course of the interview.

Participants may also withdraw any or all of the information they have provided until the time of the commencement of data analysis. They will be contacted by the researcher at that time to remind them of this right. If the child or young person declines to participate or later withdraws from the research, they will not be asked to provide any explanation unless they wish to and it will not in any way affect any service which is offered to him/her, his/her carers or his/her family by any agency.

The interview will take place in a consultation room in the Healthy Living Centre in Dublin City University (DCU) or other agreed location. The researcher will meet with the young person alone unless the young person indicates that he/she would prefer to have someone present in the consultation room. If it is not possible for the interview to take place in DCU due to the young person's wishes, it will take place at another location agreed upon between the young person and the researcher. If the interview takes place in a home environment, it will be in an open room, i.e. a living room or kitchen. In all circumstances arrangements will be made for an appropriate support adult to be in the building and close by during the interview. Who that person is will be agreed on in advance with the young person. The location of the interview as well as the appropriateness of the presence of a named adult support person will be determined by consultation with the young person's foster carers and the Social Work Department.

What will happen to the information the child or young person provides?

Every effort will be made to ensure that the information the young person provides will be confidential to him/her and will not be shared with parents, current foster carers or any person the young person has lived with. However, if information is provided that indicates that the participant or another person might be at risk or in need of intervention from mental health services, this information will be shared with the young person's Social Worker. No other information will be shared directly with Social Workers. Children First National Guidance will be followed at all times.

If participants disclose potentially unethical practice on the part of professionals they are engaging with, the researcher will consult with and take advice on how to proceed from his research supervisors and where necessary his professional body, the Psychological Society of Ireland (PSI). If such unethical practice suggests a risk to children, the researcher will follow the procedures outlined in Children First.

The findings of the research study will be used to prepare an academic report and will be submitted for publication in professional journals. Presentations to psychologists, psychotherapists and other professionals will be made in order to inform best practice in supporting children in foster care. This will include presentations at professional conferences. The young person's name and other identifying information will be changed. However, while all efforts will be made to ensure that there is no identifying data in the dissertation or any published material, total anonymity cannot be guaranteed as there is a small number of participants (approximately 8 – 10) in this study and direct quotes will be used in the dissemination of the study findings. After the completion of the research, all data will be kept securely for a period of five years, after which time it will be destroyed.

Potential Benefits for the young person

The research interview will provide an opportunity for young people in foster care to have their voice heard about their experience of psychotherapy. It is hoped that this will contribute to helping other young people receive more relevant and helpful psychotherapy services in the future.

Are there any risks for the young person in participating?

It is possible that the young person may become upset during the interview. If this happens, they will be offered the opportunity of finishing or postponing the interview. If the young person wishes to discuss their feelings about participating in the research, he/she will be offered the opportunity to do so with the lead researcher during the interview. If it appears at any stage that the young person requires support in relation to their mental health and emotional well-being, contact will be made with the young person's Social Worker, who will be consulted regarding appropriate referral procedures they can follow if indicated.

Who can take part?

Any young person in foster care aged between 12 and 18 years of age that has attended at least 6 sessions of counselling/psychotherapy in the previous 12 months. Approximately eight to ten participants are required. Once ten participants agree to participate recruitment will cease. Prior to any research interviews taking place the researcher will clarify with each young person that they fulfil the criteria to participate.

What next?

If you know a young person that might be interested in taking part I would greatly appreciate it if you could contact the lead researcher for more information.

Lead Researcher: Daire Gilmartin, School of Nursing & Human Sciences, Dublin City University, Glasnevin, Dublin 9. Tel: XXXXXXXXXX. Email: daire.gilmartin3@mail.dcu.ie

The research supervisors can be contacted at rosaleen.mcelvaney@dcu.ie or Melissa.corbally@dcu.ie

If you have concerns about this study and wish to contact an independent person, please contact: The Secretary, Dublin City University Research Ethics Committee, c/o Research and Innovation Support, Dublin City University, Dublin 9. Tel 01-7008000 OR Tusla at <https://www.tusla.ie/about/feedback-and-complaints/>

Appendix D: Information Sheet for Parents

Experiences of Psychotherapy while in Foster Care: Adolescent perspectives.

Research Information Sheet for Parents

Who are we?

- My name is Daire Gilmartin. I am a psychologist. I work with young people in foster care.
- Dr. Rosaleen McElvaney and Dr Melissa Corbally work in Dublin City University. They are supervising me on my Doctorate in Psychotherapy course.

Why am I contacting you?

- I am contacting you because I know that a child of yours is living with a foster family and is/has attended psychotherapy/counselling. I would like to speak to your child and ask him/her about their experiences of going for psychotherapy/counselling.

What is the research about?

- The research is about young people who live in foster care and have gone to or go to a counsellor or psychotherapist.
- I would like to ask your child some questions about what they think about psychotherapy/counselling.

What will I use the information for?

- I will inform people like psychologists and psychotherapists about the research and what counselling and psychotherapy is like for young people in foster care.
- I hope that this will assist professionals in helping young people.

Does your child have to take part in the research?

- Your child can decide whether he/she wants to take part. They **DON'T** have to take part in the research if they don't want to.
- I am asking your permission for your child to take part in the research. If you are in agreement that he/she can take part, I will then ask him/her what he/she wants to do.
- I will ask you to sign a consent form. This means that you understand what the research is about and you agree to your child taking part. Once you have provided consent, the decision to participate will ultimately be the young person's decision.

What happens if your child takes part in the research?

- I will meet your child for about an hour. I will record what he/she says.
- I will tell your child that he/she can take a break if he/she wants. We will be able to finish talking later or on a different day. If he/she doesn't want to talk to me again, that will be fine. It will be up to him or her.

Where will I meet your child?

- Your child can choose where to meet me. This can be in an office in the Healthy Living Centre in DCU or where he/she lives. I could meet your child somewhere else as long as it's safe.
- If I go to your child's foster placement, I will meet him/her in the kitchen, living room or sitting room. I will not go into a child's bedroom.

Will anyone else be there?

- I would normally meet a child on his/her own but there will have to be an agreed adult nearby in the building throughout the interview. I can agree with him/her who that person should be.

What happens if your child tells me something?

- Everything your child tells me will be confidential. I will not tell you or any other person in your child's life what they have said.
- The exception to this will be your child's Social Worker. If I am worried about something your child says, e.g. that he/she or someone else may be at risk, I will have to tell the Social Worker. If your child tells the researcher about possible malpractice on the part of a

professional the researcher will consult with his research supervisors about how to best proceed. If such unethical practice suggests a risk to children, the researcher will follow the procedures outlined by Children First.

What do I do with what your child tells me?

- I will use the information your child gives me to write an academic dissertation, publish the findings where possible and present to conferences.
- My research supervisors and a research colleague will have access to this information as well as the external examiner, upon request. No-one else will have access to this information.
- I will change your child's name and all details to keep it confidential but will directly use some of their words and sentences.
- I will destroy all this information five years after the research finishes.
- Your child can change anything that he/she tells me. He/she can even ask me to delete all of the information that he/she gave to me up until the commencement of data analysis and I will do that.

What happens if your child feels upset when talking to me?

- Your child might feel upset as he/she may choose to talk about some difficult experiences.
- Your child can take a break at any time. I will remind him/her of this if he/she looks upset.
- If your child wants to do so, we can finish the interview on a different day. We can also end the research process and I won't contact him/her again, if that's what he/she wants.
- I might think it would help your child to speak to someone about how he/she feels, e.g. to a psychologist. If I think that, I will tell your child's social worker.

How do you contact me?

You are welcome to contact me if you wish to discuss any aspect of the research:

Researcher:

Daire Gilmartin, School of Nursing & Human Sciences, Dublin City University, Glasnevin, Dublin 9

Tel: XXXXXXXXXX. Email: daire.gilmartin3@mail.dcu.ie

The research supervisors can be contacted at rosaleen.mcelvaney@dcu.ie or Melissa.corbally@dcu.ie

If you have concerns about this study and wish to contact an independent person, please contact: The Secretary, Dublin City University Research Ethics Committee, c/o Research and Innovation Support, Dublin City University, Dublin 9. Tel 01-7008000 OR Tusla at <https://www.tusla.ie/about/feedback-and-complaints/>

Appendix E: Information Sheet for Young People

Experiences of Psychotherapy while in Foster Care: Adolescent perspectives.

Research Information Sheet for Young people

Who are we?

- My name is Daire Gilmartin. I am a psychologist. I work with young people in foster care.
- Dr. Rosaleen McElvaney and Dr Melissa Corbally work in Dublin City University. They are supervising me on my Doctorate in Psychotherapy course.

What is the research about?

- The research is about young people who live in foster care and have gone to or go to a counsellor or psychotherapist.
- I would like to ask you some questions about what you think about psychotherapy/counselling.

What will I use the information for?

- I will speak to people like psychologists and psychotherapists and tell them what counselling and psychotherapy is like for young people like you.
- I hope that this will assist them in supporting young people like you.

Do you have to take part in the research?

- Your parent and/or your social worker said that it is okay for you to take part in the research.
- You **DON'T** have to take part in the research if you don't want to. It is okay if you want to say no. It is your choice.
- You don't have to decide now. You can think about it if you like. If you have any questions I will try to answer them.

What do you do if you want to be part of the research?

- You will need to sign a form. It says that you understand what the research is about.
- Even if you say yes, you can still change your mind. You can say no at any time.

What happens if you take part in the research?

- I will meet you for about an hour.
- I will record what you say.
- I will ask you questions about your life.
- I will ask you questions about how you feel about counselling/psychotherapy.
- You can tell me your answers by speaking to me.
- If you want to take a break, just let me know. We can finish talking later or on a different day.
- If you don't want to finish talking on a different day, that's ok. That will be up to you.
- **Important:** You might tell me something that you want to be different in your life. I will not be able to make sure that it happens but I can tell your Social Worker if you want me to.

Where will I meet you?

- You can choose where you meet me.
- I can meet you in an office in the Healthy Living Centre in DCU, if you want.
- I could meet you where you live. I could meet you somewhere else as long as it's safe.
- If I come to your house, I will meet you in the kitchen, living room or sitting room. I won't go into your bedroom.

Will anyone else be there?

- I would normally meet you by yourself if it is in an office in DCU. This means that it is private so no one else knows what you say.
- But if you want someone else in the room, that will be fine. We can talk about who the best person is.
- Someone else who you know will have to be in the building and nearby when I meet you. We can talk about who the best person is.

What happens if you tell me something?

- I won't tell your social worker or anyone else everything you say. But, if I am worried about something you say, for example, that you are at risk of harm, abuse or neglect, I will have to tell your social worker. Also, if you tell me that a professional you know has been doing something that might be wrong I will have to discuss this with my supervisors.

What do I do with what you tell me?

- I will use the information you give me to write a report, to publish articles in journals and present at conferences. I will make every effort to protect your privacy but may use or quote some of the exact words and sentences that you say.
- I will change your name so no one should know it was you. However there are only a small number of participants so it is possible that what you say may be recognized by someone.
- I will keep your information very safe. No one will see it except me, a research colleague (to help with analysis) my research supervisors and possibly the person who examines my report.
- I will destroy all this information five years after the research finishes.
- You can change anything that you tell me up until when I start analyzing the information. You can even tell me you want me to delete everything you have said up until this time.

What happens if you feel bad when you are talking to me?

- You might feel upset. The things we talk about might be hard for you.
- You can take a break at any time. I will remind you of this if you look upset.
- If you want, we can finish the interview on a different day.
- If you don't want to speak to me again, that will be ok.
- I might think it would help you to speak to someone about how you feel. If I think that, I will tell your social worker. Some support services that can help young people include: Jigsaw www.jigsaw.ie/need-help/find-a-jigsaw OR EPIC www.epiconline.ie.

How do you contact me?

You are welcome to contact me if you wish to discuss any aspect of the research:

Researcher: Daire Gilmartin, School of Nursing & Human Sciences, Dublin City University, Glasnevin, Dublin 9. Tel: XXXXXXXXXX. Email: daire.gilmartin3@mail.dcu.ie

The research supervisors can be contacted at rosaleen.mcelvaney@dcu.ie or Melissa.corbally@dcu.ie

If you have concerns about this study and wish to contact an independent person, please contact: The Secretary, Dublin City University Research Ethics Committee, c/o Research and Innovation Support, Dublin City University, Dublin 9. Tel 01-7008000 OR Tusla at <https://www.tusla.ie/about/feedback-and-complaints/>

Appendix F: Informed Consent Form – Tusla Social Workers

Informed Consent Form

Experiences of Psychotherapy while in Foster Care: Adolescent perspectives.

Consent Form for Social Worker, Tusla

This Research Study has a working title of “Experiences of psychotherapy while in foster care: Adolescent perspectives”. The principal researcher and interviewer is Daire Gilmartin (daire.gilmartin3@mail.dcu.ie), a student on the Doctorate in Psychotherapy at Dublin City University. The study is supervised by Dr Rosaleen McElvaney (rosaleen.mcelvaney@dcu.ie) and Dr Melissa Corbally (Melissa.corbally@dcu.ie).

The aim of this study is to explore the psychotherapy experiences of adolescents in foster care with a view to contributing to the development of relevant practice.

In agreeing to participate in this study I am aware that the named young person will be asked to participate in an interview regarding his/her experience of counselling/psychotherapy while in foster care and will be asked questions that pertain to their experience.

Please complete the following (Circle Yes or No for each statement):

I have read the Research Information Sheet (or had it read to me)	Yes/No
I understand the information provided	Yes/No
I have had an opportunity to ask questions and discuss the study	Yes/No
I have received satisfactory answers to all my questions	Yes/No
I am aware that this young person’s interview will be audio-recorded	Yes/No

I am aware that participation in this study is voluntary and that the named young person can withdraw from the research at any point. I understand that, once I have provided consent, the decision to participate will ultimately be the young person’s and not mine.

The data the named young person provides in the interview will be kept securely by the researcher, their name will be obscured and contact details will be kept separately from the data for confidentiality and to respect their anonymity. I am also aware of the limits of confidentiality, particularly regarding child protection. Should the named young person disclose any information that would be deemed a child protection concern, I am aware that the researcher is mandated to report this information to the Tusla Child and Family Agency if this has not already been done.

I understand that all information that is collected will be retained by the researcher for five years. All information will then be destroyed, as per DCU data protection guidelines.

I have read and understood the information in this form. My questions and concerns have been answered by the researcher and I have a copy of this consent form. Therefore, I consent to the named young person taking part in this research project.

Child’s name: _____

Date of Birth: _____

Social Worker Signature: _____

Name in Block Capitals: _____

Researcher Signature: _____

Date: _____

Appendix G: Informed Consent Form – Parents

Experiences of Psychotherapy while in Foster Care: Adolescent perspectives.

Consent Form for Parents

This Research Study has a working title of “Experiences of psychotherapy while in foster care: Adolescent perspectives”. The principal researcher and interviewer is Daire Gilmartin (daire.gilmartin3@mail.dcu.ie), a student on the Doctorate in Psychotherapy at Dublin City University. The study is supervised by Dr Rosaleen McElvaney (rosaleen.mcelvaney@dcu.ie) and Dr Melissa Corbally (Melissa.corbally@dcu.ie).

The aim of this study is to explore the psychotherapy and counselling experiences of adolescents in foster care with a view to informing practice and contributing to the development of relevant practice.

In agreeing to participate in this study I am aware that my child will be asked to participate in an interview regarding his/her experience of counselling/psychotherapy while in foster care and will be asked questions that pertain to their experience.

Please complete the following (Circle Yes or No for each statement):

- | | |
|---|--------|
| I have read the Research Information Sheet (or had it read to me) | Yes/No |
| I understand the information provided | Yes/No |
| I have had an opportunity to ask questions and discuss the study | Yes/No |
| I have received satisfactory answers to all my questions | Yes/No |
| I consent to my child's interview being audio-recorded | Yes/No |

I am aware that participation in this study is voluntary and that my child can withdraw from the research at any point. I understand that, once I have provided consent, the decision to participate will ultimately be my child's and not mine.

The data my child provides in the interview will be kept securely by the researcher, their name will be obscured and contact details will be kept separately from the data for confidentiality and to respect their anonymity. I am also aware of the limits of confidentiality, particularly regarding child protection. Should my child disclose any information that would be deemed a child protection concern, I am aware that the researcher is mandated to report this information to the Tusla Child and Family Agency if this has not already been done.

I understand that all information that is collected will be retained by the researcher for five years. All information will then be destroyed, as per DCU data protection guidelines.

I have read and understood the information in this form. My questions and concerns have been answered by the researcher and I have a copy of this consent form. Therefore, I consent to my child taking part in this research project.

Child's name: _____

Date of Birth: _____

Parent Signature: _____

Name in Block Capitals: _____

Researcher Signature: _____

Date: _____

Appendix H: Informed Consent Form – Young People

Experiences of Psychotherapy while in Foster Care: Adolescent perspectives.

Consent Form for Young People (18 years of age)

This Research Study has a working title of “Experiences of psychotherapy while in foster care: Adolescent perspectives”. The principal researcher and interviewer is Daire Gilmartin (daire.gilmartin3@mail.dcu.ie), a student on the Doctorate in Psychotherapy at Dublin City University. The study is supervised by Dr Rosaleen McElvaney (rosaleen.mcelvaney@dcu.ie) and Dr Melissa Corbally (Melissa.corbally@dcu.ie).

The aim of this study is to explore the psychotherapy and counselling experiences of adolescents in foster care with a view to contributing to the development of relevant practice.

In agreeing to participate in this study I am aware that I will be asked to participate in an interview regarding my experience of counselling/psychotherapy while in foster care and will be asked questions that pertain to this experience.

Please complete the following (Circle Yes or No for each statement):

I have read the Research Information Sheet (or had it read to me)	Yes/No
I understand the information provided	Yes/No
I have had an opportunity to ask questions and discuss the study	Yes/No
I have received satisfactory answers to all my questions	Yes/No
I consent to my interview being audio-recorded	Yes/No
I consent to direct quotes from my interview being used	Yes/No

I am aware that participation in this study is voluntary and that I can withdraw from the research at any point. I understand that I don't have to take part and that I can change my mind at any time up until the commencement of data analysis.

The data I provide in the interview will be kept securely by the researcher, my name will be obscured and contact details will be kept separately from the data for confidentiality and to respect my anonymity. I am also aware of the limits of confidentiality, particularly regarding child protection. Should I disclose any information that would be deemed a child protection concern, I am aware that the researcher is mandated to report this information to the Tusla Child and Family Agency if this has not already been done.

I understand that all information that is collected will be retained by the researcher for five years. All information will then be destroyed, as per DCU data protection guidelines.

I have read and understood the information in this form. My questions and concerns have been answered by the researcher and I have a copy of this consent form. Therefore, I consent to taking part in this research project.

Child's Initials: _____

Age: _____

Child's signature: _____

Researcher Signature: _____

Date: _____

Appendix I: Informed Assent Form

Experiences of Psychotherapy while in Foster Care: Adolescent perspectives.

Assent Form for Young People

This Research Study has a working title of “Experiences of psychotherapy while in foster care: Adolescent perspectives”. The principal researcher and interviewer is Daire Gilmartin (daire.gilmartin3@mail.dcu.ie), a student on the Doctorate in Psychotherapy at Dublin City University. The study is supervised by Dr Rosaleen McElvaney (rosaleen.mcelvaney@dcu.ie) and Dr Melissa Corbally (Melissa.corbally@dcu.ie).

The aim of this study is to explore the psychotherapy and counselling experiences of adolescents in foster care with a view to contributing to the development of relevant practice.

In agreeing to participate in this study I am aware that I will be asked to participate in an interview regarding my experience of counselling/psychotherapy while in foster care and will be asked questions that pertain to this experience.

Please complete the following (Circle Yes or No for each statement):

I have read the Research Information Sheet (or had it read to me)	Yes/No
I understand the information provided	Yes/No
I have had an opportunity to ask questions and discuss the study	Yes/No
I have received satisfactory answers to all my questions	Yes/No
I give permission for my interview to be audio-recorded	Yes/No
I give permission for direct quotes from my interview being used	Yes/No

I am aware that participation in this study is voluntary and that I can withdraw from the research at any point. I understand that I don't have to take part and that I can change my mind at any time up until the commencement of data analysis.

The data I provide in the interview will be kept securely by the researcher, my name will be anonymised and contact details will be kept separately from the data for confidentiality and to respect my anonymity. I am also aware of the limits of confidentiality, particularly regarding child protection. Should I disclose any information that would be deemed a child protection concern, I am aware that the researcher is mandated to report this information to the Tusla Child and Family Agency if this has not already been done.

I understand that all information that is collected will be retained by the researcher for five years. All information will then be destroyed, as per DCU data protection guidelines.

I have read and understood the information in this form. My questions and concerns have been answered by the researcher and I have a copy of this assent form. Therefore, I assent to taking part in this research project.

Child's
Initials: _____

Age: _____

Child's signature: _____

Researcher Signature: _____

Date: _____

Appendix J: Ethical Approval

Inbox



Fri, 16
Nov
2018,
13:32

to me,

Dear Daire,

On behalf of the Research Ethics Review Group, thank you for your email and for attending to the clarifications sought. I can confirm that the application for ethical review of the study: **Experiences of psychotherapy while in foster care: Adolescent perspectives**, is now fully approved and you can commence the research.

Note: Please forward the signed 3rd party confidentiality agreement when you have it and in the case that you need to seek additional Area Manager approval, please inform the Tusla Research Ethics Review group of same.

Wishing you every success with the study.

Kind regards,

Jean

Jean
Policy and Research Coordinator

Desk 2.31 \ 2nd Floor \ Brunel Building \ Heuston South Quarter \ Dublin 8
Urláir 2 \ Foirgneamh Brunel \ An Ceantar Theas Heuston \ Baile Átha Cliath 8

t. +353 (0)

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☎:

www.tusla.ie

Appendix K: Interview Schedule

Experiences of Psychotherapy while in Foster Care: Adolescent perspectives.

This schedule is intended as a guide for the interviewer, not as a set list of questions. The young person's comfort or discomfort will be attended to during the interview and the questions listed below will not necessarily all be asked.

1. Tell me about your reasons for agreeing to take part in this interview?

Prompts: Who spoke with you about it? What helped you decide?

2. First I want you to tell me about yourself; tell me about your family - who's in your family? (Demographic information)

Prompts: Age? Who is in your foster family? School? Hobbies/sports? How long are you in care?

3. Tell me about your experience of being in care from the beginning to now.

Prompts: This might be a hard question as you might not remember everything but if you could tell me what you do remember. What has it been like? How do you feel/think about it?

4. Tell me about what led you to go for counselling/psychotherapy

Prompts: Whose idea was it? If someone else's, how did they talk about it? What helped you decide to go? What did you expect from it? How did you feel/think about it? How did you feel/think about it?

5. Tell me all about the first time you went for counselling.

Prompts: Tell me about that experience from the very beginning to the end. Describe how you felt/what you were thinking.

6. Tell me about counselling; what is it like?

Prompts: What you liked (if anything?), What you didn't like (if anything?), What was helpful/unhelpful? What could have been better (if anything)? Tell me about a typical session. Tell me about any standout moments that come to mind.

7. Tell me all about your counsellor(s)

Prompts: What are they like? What do you think/feel about them? What do they think/feel about you? What do you like/not like about them? What could they do differently? Tell me all about this. Tell me what advice (if any) you have for counsellors.

8. Tell me about how your foster carers are/were involved in your counselling (if at all)

Prompts: How did they talk about it (if at all)? What helps? What doesn't help? Tell me what advice (if any) you have for foster carers regarding sending young people for counselling.

9. Tell me what advice you have (if any) for young people in foster care who might be thinking of counselling.

Prompts: What might help them? Is there anything they need to be aware of? What is not helpful?

10. Tell me anything else that you need to about your experience of counselling while in foster care

Thank you

Appendix L: Excerpt from Jen's Interview Analysis

Raw Data	Descriptive Note	Linguistic Note	Conceptual Note	Emerging Themes		
P3: I think it was just difficult because I had to repeat myself all the time (sounds emotional). I didn't like talking about the situation so I just found that difficult having to go to someone I didn't know and had to keep talking to them about like what happened, yeah I just found that difficult .	First sessions were hard because J had to say again what happened, how she was feeling and what she was thinking to someone she didn't know	Difficult X3 Had to repeat myself Didn't like talking Had to keep talking Someone J didn't know	J really found it really hard to have to talk. To have to talk to someone she didn't know. To repeat herself. I wonder why it was so hard? What was happening for J, as she is still emotional talking about it?	Fear of the unknown - difficult Going to therapy - first sessions		
D: So you really didn't want to. You didn't really, you weren't really committed to going.						
P3: Yeah.						
D: So then it was quite difficult when you got there to actually have to explain yourself again						
P3: Yeah						

D: People worrying about you and knowing about things going on for you						
P3: I think it was the fact I didn't know them and that like there was a not trust , but like I just, there was like a wall put up when I was talking to them.	J did not know the person and so did not trust them as a result she put a wall up when talking to them	"I didn't know them" "not a trust" "a wall put up"	Not knowing the person made J feel like she couldn't trust them and then she put her wall up and kept herself protected. She did not know what the person would be like, if she wanted to talk to them - to tell them about her personal business so she kept to herself	Vulnerability Going to therapy - Distrust Pressure to talk and repeat your story		
D: Yeah yeah yeah. And what kind of helped with that then?						

<p>P3: Em I think it was the fact when I went to Irene [Pseudonym] I knew her and she got a new em, I think it was like just an assistant, she was only temporary and we got to know each other and I think I just got comfortable with her. At the beginning again like I wasn't comfortable going again, I went once and then. I think it's because she kept contacting me like through the phone. We spoke and everything like we had little sessions over the phone. I kind of liked that like that she still wanted to continue going and everything. So then I was like okay I'll do this. And ever since I've felt like a different person.</p>	<p>Getting to know the person helped J as she became comfortable with her then. At the start she wasn't comfortable but the counsellor kept in touch on the phone. This helped as J liked this contact and it helped her decide to go to counselling which has made a big difference to her</p>	<p>"I think" X4 - hesitant - unsure what helped? Needing to begin to feel "comfortable"? Getting to know...</p>	<p>J needed to gradually get to know her counsellor. She wasn't immediately comfortable and it took some continued and persistent contact from her counsellor before she agreed to go. She needed this to get to know her counsellor a little more and to learn that she wanted to keep in contact with J - that she was wanted? That she was genuinely interested in her?? Feeling like a different person - sounds like a lovely feeling for J I wonder if the phone calls could have felt intrusive? - doesn't appear to be the case for J.</p>	<p>Getting to know therapist - building trust Therapist showing commitment</p>		
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Appendix M: Excerpt from Keith's Research Analysis

<p>P6: I remember the first time I was meeting with Name I said to her, eh she'll tell you this herself that em, I said to her that you already know everything about me but I know nothing about her because the way I see it when I go to meet a new psychologist they already have read my file and they know everything about me and I know nothing about them. So I don't trust my psychologists. I trust me psychologist now but at the start there was kinda trust issues because they get your file, they read everything before they even say they're taking you on, do you know what I mean, get a referral.</p>	<p>K remembers the first time meeting his psychologist. He told her he didn't trust psychologists - that she knows all about him from a file and he knows nothing about her</p>	<p>"know" X4 "trust" X3 "file"</p>	<p>This is a big deal for K. People knowing him from reading his file or at least thinking they know him. It is not relational. One side gets to know about a young person from a file but does not get to know the person. This bugs K. He doesn't like this and it is not a great way to start a relationship - one side knowing so much and maybe K then wondering what do they think of me? It starts things off badly? K does not trust</p>	<p>Learning to trust - getting to know the person not the file</p>		
--	---	--	--	--	--	--

			people - this has to be earned			
D: So they know so much about you but you...						
P6: know nothing about them						
D: To you they're just a complete stranger like you know nothing						
P6: Yeah						
D: And what's that like Keith						

P6: It's weird at first but then you kind of get to know . Since I've been with Name so long and I still continue to meet with Name, only when I'm in school though, so every second week I meet with her but I've gotten know her and like I know. I trust her now like but at the start I didn't	It was weird for K but now he knows his psychologist and has grown to trust her	"know" X2 "trust" "weird"	Meeting someone new at the beginning who you know has read all about you feels weird - unsettling experience for K. But as he's gotten to know her it has gotten easier and he has learned to gradually trust her over time			
D: And tell me about how that trust was built.						
P6: Just through continued meetings . I remember at the start like I didn't want to go to psychology I only went because it got me out of a few classes out of school like and it was in second year like. It got me out of a few classes in school so I went but then I got to build up and then it was like I realised I kind of needed to go. Not that I have to go but I need to go because there is benefits from psychology.	Trust was built by meeting on a continuous basis. K didn't want to go initially but went because he had the incentive of getting off school. But then as he continued to go he realised he needed to go and it could help	"continued meetings" "build up" "have to go" v "need to go"	Gradually getting to know his therapist helped K move from a place of having to go to one of realisation that he needed to go and that it helped.	Gradual realisation - building of trust		

Appendix N: Summary of Emergent and Higher Order Themes for Luna

1. Not having choice about therapy

L has had a number of experiences of counselling/therapy since she was first placed in care at the age of 8. She was sent for therapy and did not know why. It would have helped her open up more if she was told what it was about, but people chose not to in case it upset her. Although she described being “forced” to go she did not regret it. On the first occasion and after moving foster placement she did not have a real choice in her foster carers ending her going to her first therapist. L felt like she had to go along with her foster carer who did not seem to want to bring her the 40 minute journey there. L believes that YP should go to therapy and to stick with it even though they might not get along with their therapist to keep trying. She didn’t want to go back to therapy but again was forced to, even though she thought it wouldn’t help after her first experience. She learned that it can be helpful and is worthwhile.

Summary of emergent themes:

L not having a choice about going - she was sent

L not having a choice about going - Foster carers decides it's finishing

Not being told what counselling is about/for

No choice about finishing

Isolation - lack of access

Loss - Rejection - people not being able for L?

Choice of going taken out of her hands

Needed help and firm guidance to go

No choice - being made go - discovering this is good!

Needing to learn by her experience, to do it - learning to trust her experience of therapy

2. A real relationship/Being valued/supported/thought of

Therapy is a space where L built a relationship with her therapist. Her therapist is someone who has made her feel valued, someone who deeply listens to her, understands her, conveys acceptance and someone she doesn’t have to worry about disappointing. Although they have had difficulties, where L has been upset and annoyed by her therapist, feeling as if she rejected and abandoned her they were able to work this out. Her therapist provides an environment that is comfortable, helps L feel considered, special and someone who is worthy of being looked after. Her therapist feels like family to her. She has choice about when she talks about things and what she talks about. Therapy is a space of freedom and one where L gets advice and learns skills that help her with her anxiety. L has also had more negative experiences of therapy where she received therapy that did not meet her needs while in hospital.

Summary of emergent themes:

Being understood

Having someone I can talk openly with and not risk being a disappointment

Being welcome/nurtured/relaxed/respected

Being in control

Being valued

Being abandoned by therapist

Talking about the hard things - relationship repair

Therapy - learning skills to help manage anxiety

3. Being connected/Human Connection

Therapy was a place where L built a really strong connection with her therapist. Her therapist in turn then helped L build connections and communicate with others outside. She did this by at times having her foster carer in session with L. L completed a skills based therapy with her foster carer and this helped them improve their communication with each other, their understanding of each other and their overall connection as they spent more time together while travelling to and from therapy. This was valuable for L. Also now while her carer does not attend together with L anymore, her therapist meets separately with her carer, this helps her to understand L and L also asks her therapist to convey issues of importance to her carer in this way. L notices that this helps her. In addition her therapist sometimes advocates on her behalf with school or with her social worker – again providing a connection with others for her.

Summary of emergent themes:

Being deeply connected

Therapy - building connection/communication with foster carers

Creating connection opportunities

Building connection - being connected, understood, listened to, valued by her foster carer

Maintaining connection with foster carer

Connecting with foster carer through therapist

4. Being treated as an individual person

L feels like her therapist treats her as an individual and responds to her individual needs and her own way of being. This involves her therapist providing an environment conducive to helping L feel comfortable, that responds to her unique personality. This also includes nurturing food, blankets, candles, and an overall relaxing atmosphere. She does not wish to be treated like something from a textbook, like a project. At times when she has met some

of the medical profession she has felt like this and does not like it – as if she is a hassle for them and one that they want to be finished with.

Summary of emergent themes:

Being valued as an individual person – not as a project

Treat me like an individual

Treat YP as individuals

Being comfortable

Being a chore for people

Being valued as a person

I am more than my difficulties

5. Needing time to get comfortable and open up

Taking her time is very important to L. She values it in terms of its importance to her in learning to feel comfortable with her therapist before feeling okay about talking about more difficult and personal aspects of her life. She valued being given time to get to know her therapist, build her relationship with her therapist. She advises YP to take time before opening up to their therapists about things. There may be a lot of things they need to talk about and therapy can take a substantial period of time. For L that is okay for her and she believes she has needed and still needs time to continue in therapy. She encourages YP to go to therapy but to take their time getting comfortable first before opening up.

Summary of emergent themes:

Being brave - go for it

Being comfortable - taking your time as a YP before opening up

Needing time to unpack

Being given time to develop in therapy

Appendix O: Summary of Advice for Others

In the latter part of the research interviews participants were asked, based on their experiences of therapy, what advice they might give to: young people in foster care who are considering going to therapy; foster carers who look after adolescents in care who are attending or considering attending therapy; and therapists/counsellors who meet with young people in foster care. A summary account of this advice which reflected many of the themes that emerged from the interview data is presented below.

“Take the Leap”: Advice for Young People in Foster Care

Much of the direct advice offered to other young people in foster care encouraged them to go for counselling. Keith encouraged young people not to miss out: “if you get an opportunity to take counselling, take it” (780), while Luna urged them to “take the leap” (852). The young people did not make any promises about a positive outcome but offered hope that therapy could help as it had helped many of them. Jen advised she did not want to go initially but was glad that she did, saying “it’s beneficial” (774) as she felt “more comfortable in herself” and could speak more to her foster carers and family. Nathalie provided a word of caution, advising young people to “research” who they might be going to see and “talk to people if you know someone’s been there” (1108). Young people also advised that therapy can take time, as Luna related: “I think a lot of people have this misconception that they go to therapy once and suddenly they’re cured” (832).

“Keep...bugging them”: Advice for Foster Carers

Foster carers are advised to strongly encourage young people to attend therapy and to keep offering this opportunity. Jen advised foster carers: “keep kind of bugging them to go” (730) even when young people do not seem committed, while Beth felt the same: “tell them they should try it and not to force them to do it” (941). Luna also suggested that

foster carers should support young people and not put them off: “they have to not bitch about taking me” (856). Nathalie encouraged carers to talk with young people in their care about whether they need to go or if there is something they can do to further support them: “see if they actually do really need counselling or if they just want their family to actually listen” (1056). Foster carers were asked to understand that young people have to tell their story and that being in care is not easy. As Jen stated, young people “need to know that their foster carers are there for them...to support them” (714).

“Be Kind”: Advice for Therapists

Therapists were encouraged to be nice, informal, encouraging, humorous, to take their time in getting to know the young person and provide an environment that encourages comfort and items that promote self-expression. Catherine suggested that therapists should “be kind or gentle” (406) and give choices by asking “what would they rather do” (374). The importance of taking time was emphasised by Nathalie: “don’t pressure them...get to know them...first” (1024), while Keith advised therapists should provide “some insight into what you’re there for” (596) as a way of explaining the purpose of therapy and how it might help. The importance of treating each person as an individual with unique needs was stressed by Luna, while providing a comfortable setting that makes young people feel welcome and facilitated self expression was also referenced: “having food is such a great thing...the therapist...has a whiteboard in her room, that’s really helpful” (776). Jen suggested that therapists coming out to the house for “one session at the beginning” (742) could be helpful for young people in overcoming initial wariness.

Advice for Others - Data

Participants	Advice for YP in Foster Care	Advice for Foster Carers	Advice for Counsellors/Therapists
Catherine		<ul style="list-style-type: none"> Encourage YP to go, reassure them it will be fine (514) 	<ul style="list-style-type: none"> Give Choices: Ask YP “what would they rather do” (374) “Be kind or gentle” (406) “Be yourself” (442) “ask” their parents about the YP in advance (450)
Nathalie	<ul style="list-style-type: none"> Research the person or service you are considering attending and talk to people who have gone to counselling before (1108) Consult with fostering advocacy groups and get advice (1108) 	<ul style="list-style-type: none"> Ask YP how they are feeling and explore if they need to go to therapy rather than “landing” them there (1052) Explore if they “actually” need counselling or do they just need their family to listen more (1056) 	<ul style="list-style-type: none"> “Don’t pressure them...get to know them...first” (1024) “don’t...jump into their problems” (1032)
Jen	<ul style="list-style-type: none"> Don’t “bottle it up” – it can make the situation worse (750/758) It’s “good to go”. Jen did not want to go but she looks back now and sees the big positive difference it’s made for her (766) It’s beneficial, you have the therapist to talk to if you don’t want to talk to 	<ul style="list-style-type: none"> Keep “bugging them” (YP) to go (714) Kids in care need to speak about their problems and know their carers are there to support them. To accept that things can be hard for YP in care. It’s good to commit to therapy, it does get better. Need to understand YP 	<ul style="list-style-type: none"> Keep “bugging them” (YP) to go (714) Keep offering it to them even if they don’t seem committed to it (734) Explain the benefits of therapy to YP – encouragement (738) It would be nice if the counsellor could come to the house for an initial session (742)

	<p>friends and family (774)</p> <ul style="list-style-type: none"> You can learn to talk more and be more open with your family (782) You can feel less isolated as a result (786) 	<p>have to tell their story & they might not know certain things (702/710/714)</p> <ul style="list-style-type: none"> Keep offering it to them even if they don't seem committed to it (734) Explain the benefits of therapy to YP – encouragement (738) 	
Beth	<ul style="list-style-type: none"> Everybody should give it a go, try it and see if it helps – it could help a lot. Give it a minimum of 3 sessions before deciding if you want to continue. (905/917/1103) 	<ul style="list-style-type: none"> Talk to the YP about it, encourage them to try it but don't force them (941) 	<ul style="list-style-type: none"> Talk to the YP, smile, be happy (1167) Help the YP feel comfortable, so that they can talk to you (929)
Bob	<ul style="list-style-type: none"> “Go for it” (974) It will help (986) – it might take a few appts in a row (990) 	<ul style="list-style-type: none"> Build connection with children through play therapy if you have not got a connection (870) Let the YP know you're interested in them and want to help them – you're trying to help (954) 	
Keith	<ul style="list-style-type: none"> If you get an opportunity for counselling – take it (780) as it will help 	<ul style="list-style-type: none"> Need to learn about the YP and what their life has been like so they can understand them better and learn about what they might 	<ul style="list-style-type: none"> Discuss with the YP why they've been referred and what therapy is for (596) Keep the meetings informal, help the YP feel

		<p>need (732/736/744)</p> <ul style="list-style-type: none"> • If the YP doesn't want to go initially provide incentives that might help them to give it a go (792) 	<p>comfortable and relate in a reciprocal manner with the YP within boundaries (604/608)</p> <ul style="list-style-type: none"> • Have other things/play items that encourage self expression and help the YP feel comfortable (620)
Luna	<ul style="list-style-type: none"> • “go for it” – “take the leap”. If you don't like the counsellor, try someone else – it can take time (808) • “you'll never know unless you try” (852) • You don't have to start talking about personal issues straight away – take your time and do it when you're ready (820/832) • Therapy can take a lot of time, things don't get better straight away (844) 	<ul style="list-style-type: none"> • Support the therapy, don't give out about it (856) 	<ul style="list-style-type: none"> • “Don't start clinical” – maybe make a joke, “be nice” (728) • Get to know the YP gradually – they're all individuals (764) • Bring food for some, use of other items for self expression e.g. a whiteboard (776)