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# ‘No-one told us it was going to be like this’:

Compassion fatigue and foster carers.

**Dr Heather Ottaway and Professor Julie Selwyn**

School for Policy Studies, Hadley Centre for Adoption and Foster Care Studies

CARERS CHILD  
FOSTERING SUPPORT  
COMPASSION  
FATIGUE TRAUMA  
FEAR SOCIAL BURN OUT RESPITE  
STRESS RELENTLESS  
CARE FAMILY GROUPS FRIENDS  
PAIN WORK





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We are particularly grateful to the foster carers who gave their time and energy to answer the survey and take part in the focus groups. Their honesty and forthrightness about very difficult and hidden issues in fostering has provided a powerful narrative about the realities of fostering traumatised children.

Our thanks also go to Dr Tabetha Newman who designed the survey and Mim Cartwright, our research assistant who attended the focus groups.

## Foreword by Sarah Naish



Compassion fatigue is a lonely, desperate place to be. It destroys confidence, relationships and even whole families. How do I know? Well, I have been there.

I have also worked as a trainer with hundreds of parents and carers who have all shared similar experiences with me. I realised that my own experiences of compassion fatigue, (sometimes referred to as 'blocked care' within the sector), was not an unusual one. I decided to incorporate some data and research into our training, and I set about finding out how widespread the problem was. To my surprise, I found a great deal of research into compassion fatigue was available relating to other caring services, i.e. nurses, doctors, social workers, but could find nothing useful relating to fostering or adoption.

The parenting model most widely recognised in relation to caring for traumatised children, is one of 'Therapeutic Parenting' which is:

a deeply nurturing parenting style, with a foundation of self-awareness and a central core of mentalization, developed from consistent, empathic, insightful responses to a child's distress and behaviours; allowing the child to begin to self-regulate, develop an understanding of their own behaviours and ultimately form secure attachments.

Our training in this field naturally brought us into contact with foster carers, adopters, kinship carers, and supporting professionals. At almost every training event we hosted, we encountered a substantial minority of carers who were clearly suffering from the effects of compassion fatigue. They reported feeling unsupported, misunderstood, blamed and judged. Naturally this had negative implications not only for the carers, but for the traumatised children they were looking after AND the agency they were working for.

Through my experiences of running a successful IFA, I already had some ideas about the best ways to identify and manage compassion fatigue, but noticed that supporting professionals seemed unable to pause and recognise the scale of the problem. I felt that the impact of compassion fatigue was so great, that it was essential that evidence based research was conducted. I was therefore delighted when the experienced research team from The Hadley Centre, University of Bristol, agreed to undertake this project with us, and would like to sincerely thank Professor Julie Selwyn and Dr Heather Ottaway for their professionalism and support.

Sarah Naish

Managing Director, Fostering Attachments Ltd provides training nationwide to foster carers, adopters and social work teams throughout the UK regarding therapeutic parenting, child trauma and compassion fatigue, through Inspire Training Group [www.inspiretraininggroup.com](http://www.inspiretraininggroup.com)

Sarah Naish

- Formerly owned and ran an Ofsted 'Outstanding' therapeutic Independent Fostering Agency.
- Is an adopter of five siblings, former foster carer & Children and Families social worker
- Is an Author of therapeutic parenting books
- Runs the international Facebook group 'Therapeutic Parents'

## Introduction

Foster care is the most frequently used placement for looked-after children and young people in England. On 31<sup>st</sup> March 2016 there were 70,440 children in public care aged 0-18 years, with 75% (53,600) in foster placements (Department for Education, 2016). Children in care often have early adverse life experiences associated with abuse and neglect (Department for Education, 2016). These experiences, alongside being removed from their birth families and having multiple care-givers can lead to difficulties associated with trauma and loss (Howe, 2009). As a result, looked-after children require a different, therapeutic form of parenting which promotes their developmental recovery from the complex trauma they have experienced (Schofield & Beek, 2009; Hughes & Baylin, 2012; Milot *et al.*, 2015). However, little attention has been given to understanding the impact on foster carers of caring for traumatised children, and none on whether foster carers experience compassion fatigue. This is surprising given the growing literature on the presence and impact of compassion fatigue on other helping professions such as social workers, nurses, fire fighters and humanitarian workers (Stamm, 2016). This study therefore aimed to explore compassion satisfaction and compassion fatigue in foster carers. Although this study of compassion fatigue in foster carers does not evaluate interventions, recommendations will be made at the end of the report, based on the current evidence and the data collected, which will aim to identify a range of approaches, which may be helpful in reducing compassion fatigue and increasing compassion satisfaction.

### Trauma and looked-after children

Early adverse life experiences can result in children experiencing complex trauma (van der Kolk, 2005; Milot *et al.*, 2015). The experience of complex trauma can be described as:

*situations ... in which children grow up in chaotic, scary and unpredictable environments, requiring constant adaption in order to cope with the threats.* (Milot *et al.*, 2015: 93-94).

The consequence for children of living in such environments under constant stress is that healthy development can become compromised (Courtois & Ford, 2009; Howe, 2009; Woolgar, 2013).

Children struggle with feeling both physically and emotionally safe (Golding 2008; Hughes & Baylin, 2012), have great difficulty regulating their emotions (Cairns, 2002), and struggle to find words and reasons for their feelings (Beeghly & Cicchetti, 1994). As a result, children can present difficult and challenging behaviour which requires a therapeutic approach to parenting from foster carers in order to promote developmental recovery. This is immensely challenging work, and requires foster carers and those who support them to have a good understanding of trauma and the demanding reality of caring for traumatised children.

Interventions to support foster carers in their care of traumatised children are relatively recent and usually attachment-focused. The evidence base regarding their efficacy is relatively small but building (Hughes *et al.*, 2015), although it has also been contested (Mercer, 2014).

### Compassion fatigue

Compassion fatigue (CF) is experienced, by those working in helping professions, as a response to being exposed to the trauma which the people they are supporting have suffered (Figley, 1995). It is sometimes referred to as 'blocked care' in the context of fostering and adoption (e.g. Alper & Howe, 2015). Blocked care is used to describe parent's emotional, physical and biological responses to children's insecure attachment behaviours resulting in parents no longer able to make a healthy connection to the child (Hughes & Baylin, 2012). Baylin's work (2015) in particular emphasises the biological changes that take place, as a result of stress, and the damaging effects this can have on the carer. In contrast compassion fatigue is widely understood to have three separate but related dimensions; burnout, secondary traumatic stress and compassion satisfaction (Stamm, 2010):

**Burnout** can be described as feelings of physical and emotional exhaustion, anger, frustration, hopelessness, depression and feeling inefficient in your job (Stamm, 2010). It is usually slow to develop, through prolonged exposure to working with traumatised people, but its effects on the individual and those they work with can be significant.

**Secondary traumatic stress** (STS) develops when the individual becomes directly affected by the trauma experienced by those they are caring for and/ or supporting at work. Although rare (Stamm, 2010; Figley, 1995), the symptoms are often characterised by rapid onset. Symptoms include fear, intrusive thoughts and images about the traumatic events experienced by those they are supporting, avoiding people or situations which evoke reminders of the traumatic experiences, sleep difficulties, problems with concentration, irritability and anger.

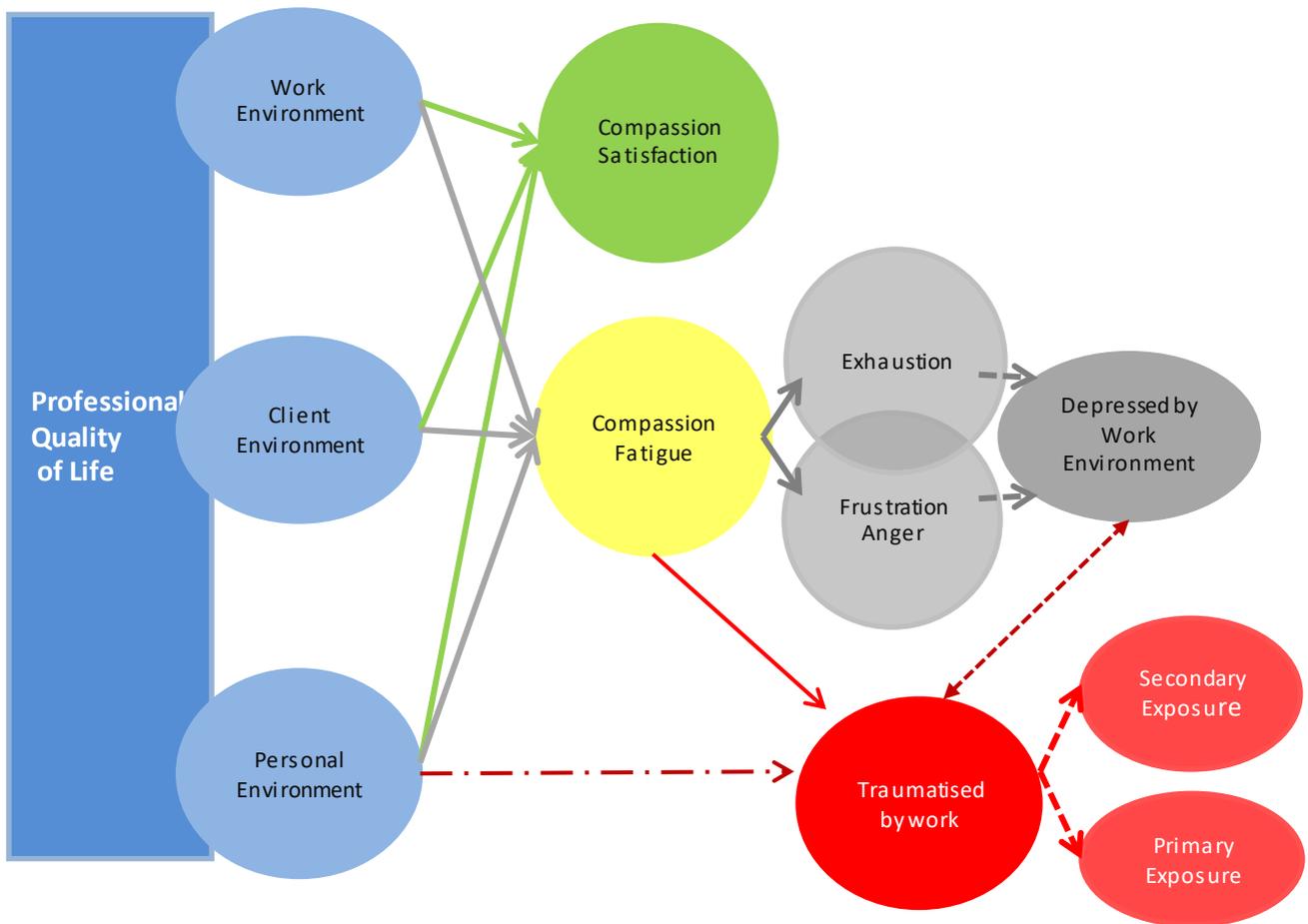
Symptoms of secondary traumatic stress essentially mirror those of post-traumatic stress disorder, with the difference being that those who have STS are affected by the trauma of others. In contrast, primary trauma is a direct experience of traumatic events (Figley, 1995).

Alongside compassion fatigue it is also necessary to consider compassion satisfaction, as this is thought to interact with compassion fatigue, moderating its effects (Stamm, 2010).

**Compassion satisfaction** is associated with the positive aspects of providing care and support to others within the working environment, and includes such features as altruism, satisfaction with the work undertaken with those affected by trauma, and the support derived from team members (Stamm, 2010). Understanding the role compassion satisfaction plays in moderating burn out and STS is a relatively recent development.

The three elements of burnout, secondary traumatic stress and compassion satisfaction are present in a powerful and well validated measure known as the Professional Quality of Life measure (Stamm, 2010). The measure is helpfully illustrated by Stamm's (2010) diagram below:

*Figure 1 The Elements of a Professional Quality of Life (Stamm 2010)*



The model argues that for those in helping professions, there are three elements which influence the professional quality of life and therefore levels of compassion satisfaction/ fatigue: the work environment, the client environment and the personal environment of the professional. The work environment includes aspects such as the physical space of work, and the support present from managers and colleagues. The client environment includes what the traumatised individual brings with them in terms of their background, living experiences and how they relate to others. The personal environment of the professional acknowledges that there are personal factors which impact on how the individual professional works. These can include both positive and stressful life experiences and previous trauma, alongside aspects which promote resilience (Stamm, 2010).

These three factors have been shown to influence levels of compassion satisfaction and compassion fatigue in different ways. For example, a supportive work environment with regular supervision was a

predictor of higher compassion satisfaction in a study of emergency nurses in the USA (Hunsaker *et al.*, 2015). Being female was associated with higher levels of compassion satisfaction in a study of mental health providers, as was specialist knowledge of trauma (Sprang *et al.*, 2007).

Conrad and Keller-Guenther (2006) explored the presence of compassion fatigue and compassion satisfaction in child protection social workers in the USA. That study is particularly relevant because social workers are also working with the trauma experienced by the abused and neglected children whom foster carers parent. They found that half the sample of 363 social workers had high levels of secondary traumatic stress, but also high levels of compassion satisfaction, which seemed to lessen the impact of STS. Burnout was surprisingly low, but the authors concluded that this may have been because those who were burnt out had already left the profession, as turnover rates were high. However, the study did not explore with social workers the reasons for the findings.

Foster carers as helping professionals are, however, different and unique because there is a strong overlap between work, client and personal environments. The foster carers' home is also their workplace, and they (and their family) get little or no respite on a day-to-day basis from caring for the children they foster.

Whilst work-related trauma can be both primary and secondary, measures of compassion fatigue only consider secondary traumatic stress (Stamm, 2010). This is of concern, because both may be present and interact. For example, in a study of local and international humanitarian workers in Darfur (Musa & Hamid, 2008), the local Sudanese workers had higher levels of burnout and secondary traumatic stress than the international workers. Most were victims of war themselves, and the authors suggested that the combination of primary and secondary trauma may have contributed to their symptoms. Foster carers too may have experienced traumatic events in their own lives, and may also be subject to primary trauma in their work because of being assaulted by a foster child. Understanding the link between primary and secondary trauma is therefore important, and this will be explored further in this study.

## Reducing compassion fatigue

Whilst many studies have focused on measuring compassion fatigue and compassion satisfaction within stressful occupations, there is a dearth of evidence regarding how best to intervene to reduce compassion fatigue. A recent systematic review (Cocker & Joss, 2016) identified just 13 studies that evaluated specific interventions that had been used, predominantly with nurses. The interventions were person centred and did not consider organisational elements such as the quality of supervision. Interventions used yoga, mindfulness, music therapy, structured meditation and education about compassion fatigue. Only two studies (Berger & Gelkopf, 2011 and Flarity *et al.* 2013) included more than one element in the intervention, combining information on compassion fatigue and interactive materials (e.g. CDs on guided imagery).

Only Flarity and colleagues (2013) reported significant decreases in secondary traumatic stress and burnout, alongside significant increases in compassion satisfaction. In their evaluation, emergency nurses had a four-hour interactive education session and were provided with information about the signs, symptoms and risk factors of compassion fatigue. Material from the accelerated recovery approach (Gentry *et al.*, 2002), which focuses on preventing and treating compassion fatigue was also incorporated into the intervention. Participants were introduced to this approach within the session, and then provided with a wide range of resources to consolidate and build on what they had learned. However, the evaluation only had a four week follow-up and positive changes may not have been sustained.

The accelerated recovery approach (Gentry *et al.*, 2002) focuses on the individual's approach to their professional role. It considers issues such as self-care, building resilience and self-regulation. The approach explicitly focuses on the individual and excludes organisational factors. The authors argue that organisational factors are often discipline specific and they wanted to devise a programme appropriate for all. However, ignoring the work environment risks placing responsibility for change solely on the individual. As the next section outlines, organisational factors such as support provided

to foster carers and professional attitudes towards them can increase stress and strain, and therefore potentially their levels of compassion satisfaction and compassion fatigue.

### Compassion fatigue and foster carers

A search of Stamm's (2016) comprehensive bibliography of over 2,000 scholarly publications on compassion fatigue and compassion satisfaction yielded three references to empirical studies with foster carers. Two of these were PhD theses in the USA which had very small samples and could not therefore comment on prevalence.

Many studies have examined the stress and burden of foster care (e.g. Jones, & Morrissette 1999; Farmer *et al.*, 2005; Sinclair, 2005; Fuentes *et al.*, 2014). Foster carers who report strain caring for adolescents were found to be less likely to be engaged with their foster children and were less effective at parenting with limits (Farmer *et al.* 2005)

Farmer and colleagues (2005) found that four factors particularly related to increased strain. Firstly, stressful life events happening in the foster carer's life in the six months prior to the placement (such as bereavement, moving house, separation from a partner). Secondly, young people who were violent to peers, those with conduct problems and those who were hyperactive (as measured by the SDQ). Contact difficulties for the young person that had an impact on the whole foster family were also significant. Finally, difficulties in the foster carer's relationship with the young person's social worker was related to increased strain. Difficulties in contacting the worker, changes of worker and a perceived lack of respect were particularly significant. These difficulties had an impact on the foster carer's ability to respond sensitively to the young people in their care, on the quality of the placement and on the likelihood of disruption. Although not explicitly framed within the context of compassion fatigue, Farmer's study may indicate that elements of secondary traumatic stress and burnout were potentially present in the foster carer population.

Understanding whether and how foster carers experience compassion fatigue, and the elements which contribute to compassion satisfaction, is therefore important in order to be able to effectively support and retain them.

### Supporting foster carers

Foster care has become increasingly professionalised in recent years following growing understanding of the complex care needs of looked-after children, as a result of their early adverse life experiences (Schofield et al., 2013). The importance of therapeutic parenting has been stressed (Hughes et al., 2015), with an emphasis on foster carers being supported to provide a safe, stable and secure base for the children in their care (Schofield and Beek, 2009). Achieving this is seen as an important part of promoting developmental recovery from the complex trauma many children in care have experienced (van der Kolk, 2005), but the extent to which foster carers are trained and supported in this is questionable.

A range of studies have identified different aspects of carer burden and satisfaction that have an impact on carer retention (Berridge & Cleaver, 1987; Triseliotis et al., 1999; Sinclair, 2005; MacGregor et al., 2006; Whenan, 2009; Murray *et al.*, 2011). An understanding of these factors is important; firstly to place foster carers' experiences of compassion fatigue/ satisfaction within the context of current evidence, and also to inform best practice going forward.

Carers report increased levels of satisfaction and on-going motivation to foster when they feel they are contributing to positive changes in the children they care for, and are well supported in their role by knowledgeable professionals (Macgregor *et al.*, 2006). Given the demands placed on foster carers in caring for traumatised children, it is unsurprising that foster carers also report feeling a high burden of care (Murray *et al.*, 2011), which can affect carer retention (Sinclair, 2005; Triseliotis *et al.*, 1999). Aspects of burden include managing the complex and difficult behaviour children present, managing contact with birth families, the impact of fostering upon family life and the quality and type of support available.

One common factor across a range of studies is the quality of the foster carer's relationship with the supervising social worker, the children's social worker and the agency. Foster carers consistently report that being respected and having their expertise and input valued is essential. The absence of professional respect is an important contributory factor in carers deciding whether or not to continue fostering (Berridge, 1997; Triseliotis et al., 1999; MacGregor et al., 2006; Whenan, 2009).

Studies have also reported that foster carers often feel they have received more training on attachment and trauma than have social workers. This places them in a vulnerable situation where they can feel judged and blamed for the child's difficulties, as a result of a lack of knowledge from supporting professionals. Furthermore, this can lead to misunderstandings about the support required. For example, in the Multi-Dimensional Foster Care evaluation report (Biehal et al., 2012), the importance of regular respite (and with the same foster carer) was recognised and supported, as well as regular 'check-ins' by phone with a qualified professional, but this is rare.

Little is currently known about how best to support foster carers with their work. This study will therefore provide a window of understanding about how foster carers experience parenting the traumatised children in their care, explore how they feel they can best be supported, and what actions professionals and agencies can take to increase compassion satisfaction and reduce compassion fatigue.

## Conclusion

This brief literature review has explored what compassion fatigue is and why it is relevant to foster carers parenting traumatised children. An examination of the evidence base regarding foster carers' experience of support has also identified a number of areas which may be related to, and have an impact upon, compassion satisfaction and compassion fatigue. Consideration of foster carer support needs through the conceptual frameworks of compassion fatigue/ satisfaction and child trauma therefore has the potential to provide helpful insights into what foster carers need and how to support them more effectively.

## Online Survey

The overall aim of the study was to consider the impact on foster carers of caring for traumatised children and, more specifically, to examine whether carers reported feelings associated with compassion fatigue. The research was divided into two phases. In the first phase, an online survey was created to establish whether compassion fatigue was occurring in a sample of foster carers. The second phase extended and developed the survey findings by listening to foster carers' views on the impact on themselves and their families of caring for traumatised children and the support they had found helpful/unhelpful. The study was funded by Fostering Attachments Ltd. Ethical approval for the study was given by the ethics committee in the School for Policy Studies at the University of Bristol.

### Survey development

The survey contained demographic questions, space for free text and two standardised measures: the Professional Quality of Life Scale (*ProQOL*) and the Warwick Edinburgh Mental Well-Being Scale (*WEMWBS*).

### Measures

The *ProQOL* ([www.proqol.org](http://www.proqol.org)) is the most widely used evidence-based assessment of compassion fatigue (Stamm, 2010). It was developed from data collected from people in the helping professions such as nurses, social workers, teachers and aid workers in disaster zones. It contains 30 self-report questions with six response categories that ask the carer how frequently they have experienced each item in the last 30 days. The questions ask about the positive and negative feelings associated with the helping role and combine to form three discrete subscales. The first subscale is *compassion satisfaction*, defined as the pleasure derived from helping others and from being able to do one's work well. The second subscale, *burnout*, assesses feelings of hopelessness, frustration and anger and feeling that it is very difficult to do one's work well. The third subscale measures *secondary traumatic stress*; the negative effects of which may include difficulty sleeping, intrusive images or thoughts, or avoidance of any reminders. All the scales have a mean of 50 with a standard deviation of 10.

In this study, all three sub scales had high reliability: Compassion scale Alpha .92; Burnout scale Alpha .70 and Secondary Trauma scale Alpha .81. The reliability is as good or higher than the published reports of the scales' internal consistency. It is therefore a very appropriate measure for use with foster carers. Indeed researchers reported that that when comparing professions, those workers dealing with children and families in trauma tended to experience the highest levels of burnout of any professional group (Stamm 2010).

The *WEMWBS* was funded by the Scottish Government National Programme for Improving Mental Health and Well-being. It was commissioned by NHS Health Scotland, developed by the University of Warwick and the University of Edinburgh, and is jointly owned by NHS Health Scotland, the University of Warwick and the University of Edinburgh. The *WEMWBS* is a validated measure of mental well-being (age 13-74). It is a 14 item scale with five response categories, summed to provide a single score ranging from 14-70. The items are all worded positively and cover both feeling and functioning aspects of well-being. The findings can be used to establish whether a specific population or group of people has low, average or high mental well-being and can be used to measure change over time. (<http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/>)

#### Piloting and launch

The online survey was piloted with six foster carers before being more widely distributed. There were no changes made to the survey following the pilot. The survey ran between 31<sup>st</sup> January and 5<sup>th</sup> May 2016. Carers were made aware of the survey through social media such as Twitter and Facebook. Fostering agencies were supportive and in particular Fostering Attachments, the National Fostering Agency, Fostering Network and CoramBAAF promoted the survey through their own websites and by alerting their carers. The survey was open to any approved foster carer in England but foster carers completed the survey who did not meet the criteria. For example, there were several responses from Australia that were identified by their text responses. These were deleted before analysis but because the survey was confidential, it is possible that some surveys were included in the analysis that were completed by foster carers from outside England.

### Limitations of the survey

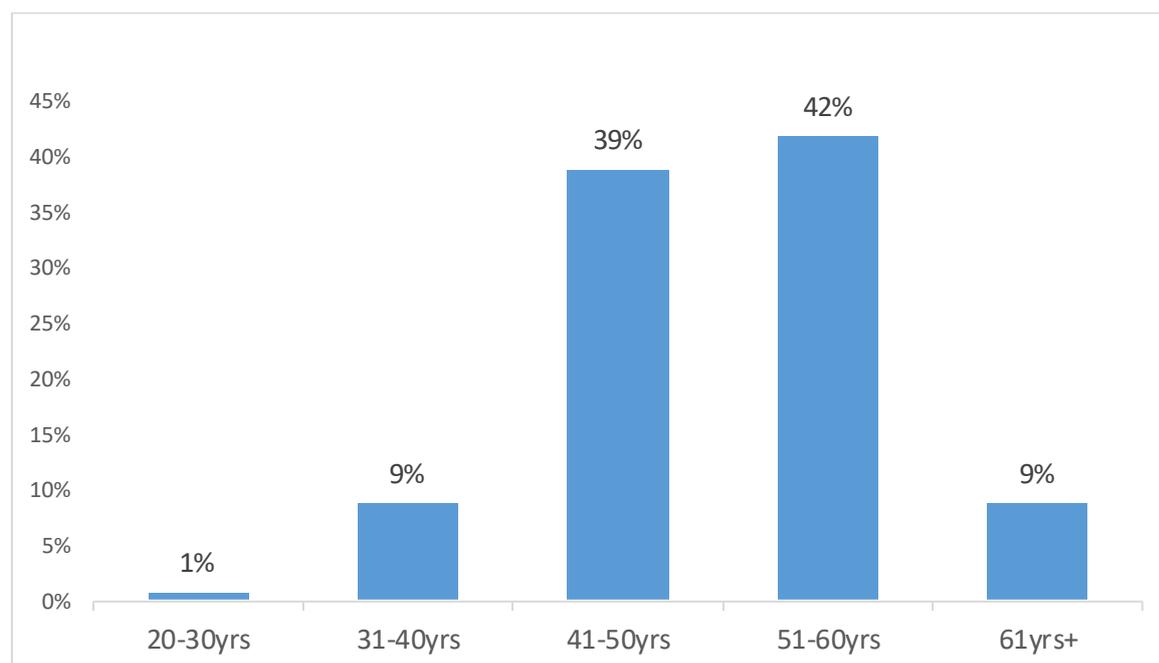
The survey has a number of limitations. The ProQol asks about the last 30 days and may pick up experiences that are not currently being experienced (Bride *et al.*, 2007). The measures are for screening to detect the likelihood of compassion fatigue and low well-being and are not diagnostic. Further clinical assessments would be necessary for diagnosis. A survey has to be short and therefore we chose not ask whether partners were experiencing the same symptoms/feelings or to ask about the impact on the wider family. Further research is needed to understand the impact if one or both partners are suffering from compassion fatigue.

We will now turn to the findings of the survey.

## Survey Findings

The online survey was completed by 546 foster carers: 481 (89%) females and 62 (11%) males. The majority (95%) were of white ethnicity and over 40 years old (Figure 1). A few carers chose not to give information on the composition of their household but did complete the measures and 300 carers also provided additional detail through text responses.

**Figure 2: The age of foster carers who completed the survey (n=546)**



The majority (64.5%) were working for an independent fostering agency (IFA) and 35.5% for a local authority (LA). All except two of the 25 ethnic minority carers were working for an IFA.

### How does this sample compare with all foster carers in England?

There is not much information on the characteristics of all foster carers in England. Ofsted (2015) reported that there were 36,890 fostering households in England during the financial year 2014/5 and that the majority (60%) worked for a LA. The majority of all carers in England were white but IFAs (19%) had a slightly higher proportion of ethnic minority carers than did LAs (13%). In comparison our sample has an over-representation of IFA carers and those of white ethnicity.

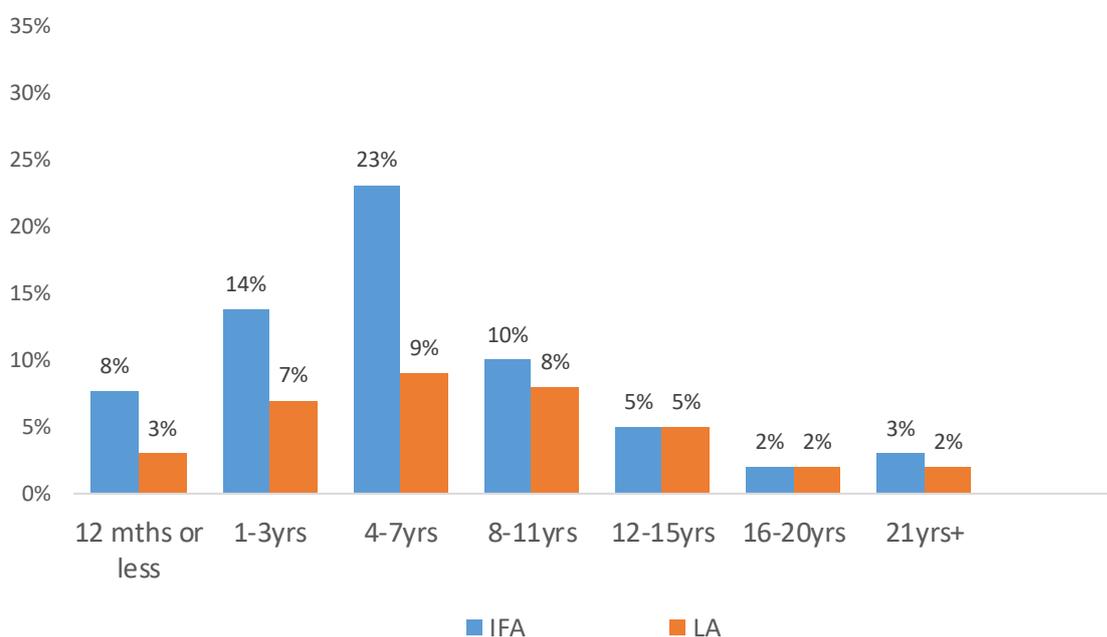
A Fostering Network survey *State of the Nation's Foster Care* (2012) of 868 foster carers in the UK provides some more comparisons. That survey was completed by 90% female and 10% male: a similar

gender split to our survey. The age profile of the Fostering Network carers, size of households, number of foster children in the households, and proportion employed outside the home were all similar to this sample. The one difference was that more foster carers (39%) had birth children living at home in our sample in comparison with the Fostering Network survey (20%).

### The foster carers

The carers were asked how many years they had worked as a foster carer. Most had been fostering for 7 years (range less than 6 months to 45 years) (Figure 2). However, those working for an IFA had been fostering for less time (average 6 years) compared to those fostering for a LA (average 8 years).<sup>1</sup> However, there was a similar proportion of very experienced carers (about 5%) who had been fostering for over 15 years in both LAs and IFAs.

**Figure 3: The number of years employed as a foster carer by type of agency**



Carers were asked if they were currently caring for a child outside their scope of approval. Seventy-one carers (13%) stated that this was the case. Those carers were statistically more likely to be working

<sup>1</sup> Mann Whitney 25,724.00, -2.904,  $p < .004$

for an IFA<sup>2</sup> and be the least experienced: 22% of the 60 carers who had been fostering for less than a year stated they were caring for a child outside their approval.

### Households

Carers were asked who was living in their households. Most carers (78%) had a partner whilst 22% were single foster carers. There were also other adults in households: 3% were caring for elderly relatives and in 27% of households there were other adults too. We did not ask about their relationship to the carer but they may have been adult birth children living at home.

The foster carers were fairly evenly split between those (51%) caring for one child and those caring for more than one. There was a small group of foster carers (n=45) who did not have a foster child at the time they completed the survey. Some of these were respite carers, might have been between placements and others had recently experienced a disruption. A third of carers had two foster children at the time of the survey, 12% had three foster children and 3% had four or five foster children. Carers (39%) also had birth children and 13% had adopted children living in the household. Households were, as reported in previous studies (Fostering Network 2012), larger than the average (2.33 people) with 50% of fostering households containing more than four people (range 3-15).

### Employment

Carers were asked if they were employed outside the home. Seventy-two percent of carers worked solely in the home and had no other employment, 18% worked elsewhere part-time and 10% had a full time job. There were no differences in working outside the home by type of fostering agency. There were gender differences. Males were more likely to work outside the home: nearly half of the 62 males who completed the survey were employed outside the home.

### Carers well-being -results from the WEMWBS

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) comprises 14 items that relate to an individual's state of mental well-being in the previous two weeks. Responses are made on a 5-point

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<sup>2</sup>  $\chi^2$  4.876, df1,  $p < .03$

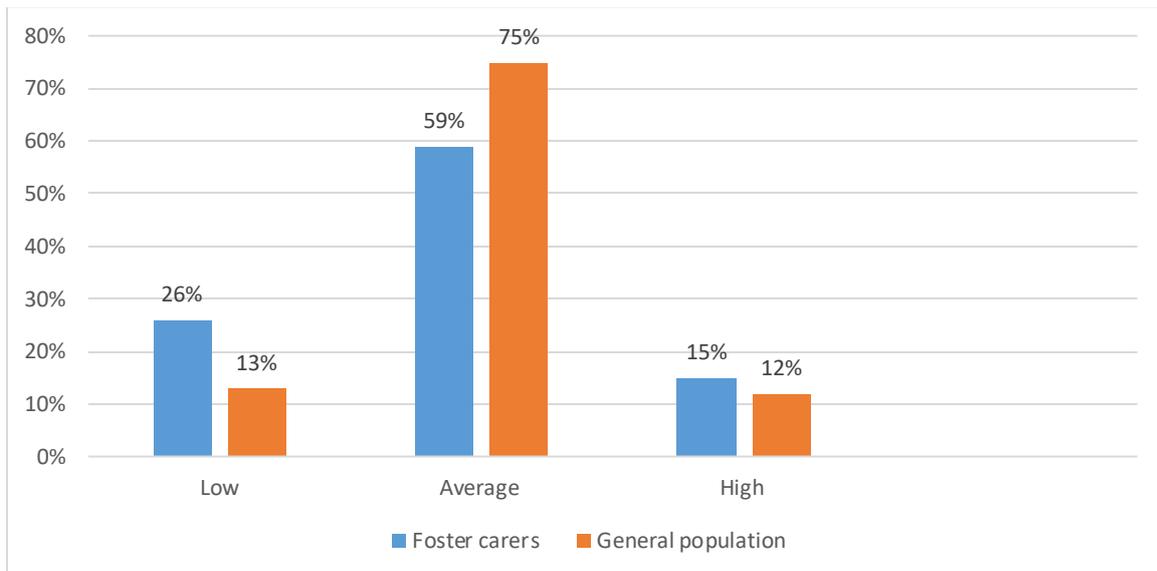
scale ranging from 'none of the time' to 'all of the time'. Scores vary between 14 and 70 with lower scores (scores below 41) indicating low well-being, scores of 42-58 indicating moderate well-being and 58 or more high well-being. In the general population, the vast majority (75%) fall into the average well-being category, about 12% have high well-being and 13% low well-being.

The general population mean score is about 51 (SD 8.70) for people aged 35-54 years of age (Health Survey of England 2011), In this sample of foster carers the mean score was lower at 47.8 (SD 9.6).

Scores covered the whole range from 14 to 70:

- 144 (26%) of the foster carers had scores below 40 indicating low well-being,
- 319 (59%) had scores indicating moderate well-being
- 83 (15%) had high well-being.

**Figure 4: The well-being of foster carers**



## Compassion fatigue-results from the ProQoL compassion fatigue scales

All the foster carers (n= 546) completed this measure. The ProQoL scale was analysed using the recommendations as set out in the manual (Stamm, 2010). The analysis creates t-scores on all three scales so that the average is always 50. Previous research with helping professions (e.g. psychotherapists, aid workers in disaster zones, end of life nurses, social workers) have found that 25% of those in helping professions are expected to score below 43, 50% are expected to be in the middle (moderate) range and 25% expected to score higher than 57 (Table 2).

*The Compassion Satisfaction scale* measures the pleasure carers get from their work in terms of feeling satisfied with the job and also satisfaction from the helping itself. Higher scores represent greater satisfaction. The scores of the foster carers ranged from 17 (very low compassion satisfaction) to 67 (high compassion satisfaction). If this sample of foster carers was similar to other helping professionals we would expect about 50% to be in the moderate range, 25% high and 25% low. Instead, 45% of carers scored in the moderate range, 27% had low compassion satisfaction and 28% high.

Examples of all levels of compassion satisfaction were found in the text comments within the survey.

Carers talked about satisfaction with their role but also feelings of loss as children moved on:

## FOSTER CARER'S COMMENTS

*You obviously take their pain on board and sometimes it's difficult to take it. Especially when moving from one traumatised child to another. There simply isn't time to process thoughts and feelings before moving onto the next child.*

*Parenting these children is mentally and physically draining and it is the foster carers who are affected the most because we are the ones that have them 24 hours a day in our own homes.*

*It's hard!!!! You feel like you're getting it wrong a lot!!! Having someone to talk to, who 'gets' it, is essential.*

*The helplessness that you feel when things don't work out for the children ...*

*I've never had a more challenging role in life but equally never had such a rewarding role. When the children move on there is such a huge mix of emotions .... Have to deal with a huge hole they leave in our lives. It's at this point I feel emotionally empty and alone.*

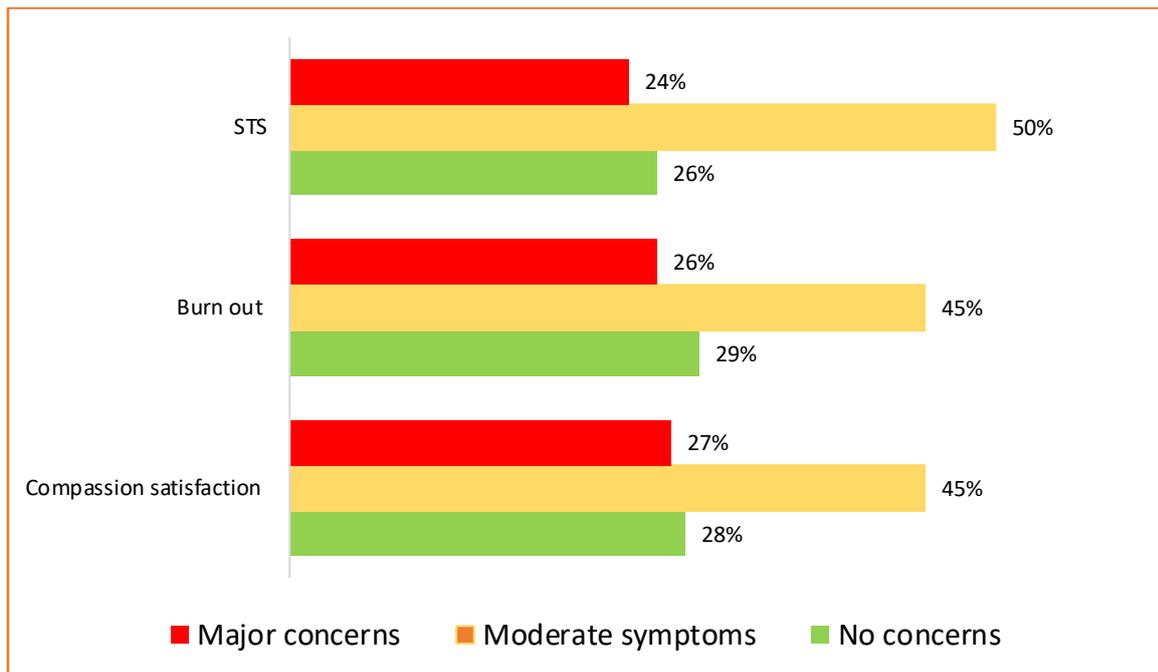
*The Burnout scale* measures some of the negative effects of being in a helping profession and is also associated with an unsupportive work environment. It is characterised by feeling hopeless, inadequate, disconnected and overwhelmed. These negative feelings usually start gradually and can lead to carers feeling that their efforts make no difference. The scale differs from the compassion satisfaction scale in that the higher the score the more concerning the result.

In this study, worryingly, 26% of carers had scores near the top of this scale, suggesting a high degree of burnout. Just under half (45%) had scores in the mid-range, suggesting that there were some issues around burnout present, and only 29% showed a low risk of burnout. Scores ranged from 26 (little risk of burnout) to 75 (high risk of suffering from burnout). However, there were no carers near the bottom of the scale (i.e. below 18), which would have indicated that they had very positive feelings about being an effective foster carer.

*The Secondary Traumatic Stress (STS) scale* measures another element of compassion fatigue. It is characterised by being pre-occupied with thoughts about a child that the carer has helped. Developing problems due to exposure to another's trauma is rare but does happen to those who care for others who have experienced traumatic or stress experiences. Unlike burnout, the symptoms of STS are usually rapid in onset and include being fearful, having difficulty sleeping, and having uncontrollable negative thoughts and images. In this sample of foster carers, the scores ranged from 27 to 83. The cut off for a high score is 56 and nearly a quarter of carers were above the cut off and therefore of concern. There were 96 carers who scored at the highest end of the range.

Table 2 shows scores from all three scales. Red indicates high risk of suffering from burnout or STS or having low compassion satisfaction.

Figure 5: Foster carer's scores on the three scales of the ProQol (n=546)



#### Within group differences

- There were no statistical differences on any of the three scales by gender, by ethnicity or whether the carer was single or had a partner or if the carer had birth children living at home.
- There were no statistical differences in the compassion satisfaction or STS scales by the age of the foster carers. However, the older carers (60 years plus) were *less likely* to be showing symptoms of burnout in comparison with younger carers.<sup>3</sup> This may be because older carers who were still fostering were more resilient and those most affected by burnout had stopped fostering.
- The type of agency was associated with scores on all three scales. A comparison of means found that the scores of IFA carers on the compassion satisfaction scale were significantly higher and scores on the burnout and secondary trauma scale were significantly lower compared to carers working for a LA.<sup>4</sup> The effect size was very large for the compassion

<sup>3</sup> Kruskal Wallis test 14.509, df4,  $p < .006$

<sup>4</sup> Compassion satisfaction  $t = -273$ ,  $df 539$   $p < .006$   $r = .996$  Burnout  $t = 5.002$ ,  $df 539$   $p < .000$   $r = .210$  STS  $t = 4.994$   $df 539$   $p < .000$   $r = .210$

satisfaction scale but a small effect size for burnout and STS. **This suggests that the agency had a key role in enabling carers to remain committed to fostering and enjoying their work.**

- Length of time working as a foster carer was correlated with the secondary traumatic stress scale (STS). Carers who had been a foster carer for eight or more years were more likely to have high scores.<sup>5</sup>

### Typologies

Stamm (2010) has identified five combinations (types) of scores that are typically seen in the helping professions. In this sample of foster carers, those combinations only applied to the minority of carers and only three of the five 'types' were present. The most common combination (n=180: 33%) was moderate scores on all three scales or a combination of moderate compassion satisfaction with low burnout and low STS scores. While moderate levels of compassion satisfaction may be assisting carers, they are at increased risk of compassion fatigue.

The combinations identified by Stamm (2010) are set out below.

#### *1) High compassion satisfaction, moderate to low burnout and moderate to low STS (n=128:23%)*

- This combination of scores is the most positive combination of scores and was the case for 23% of the foster carers. This group of carers carry no significant concerns about suffering from compassion fatigue or their feelings about satisfaction with their work. However, within this group it should be highlighted that only 55 of the 128 carers (42%) had high compassion satisfaction levels combined with low burnout and/ or STS. A high level of compassion satisfaction may mitigate some of the moderate symptoms of compassion fatigue. Foster carers in this group were more likely to work for an IFA (73%) in comparison with carers working for a LA (27%).

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<sup>5</sup> Pearson .130 ( two tailed)  $p < .002$

### *2) High burnout, moderate to low compassion satisfaction and moderate to low STS (n=56:10%)*

Carers who score high on burnout in combination with the other scales are at risk and often benefit from taking a break. There was a low number of carers in this sample where this combination applied. There was no difference by type of agency that the foster carer worked for.

### *3) High STS, high burnout and low compassion satisfaction (n=50:9%)*

This combination is described by Stamm (2010) as the most negative and distressing for the carer. Not only are carers likely to feel overwhelmed and inadequate as a foster carer, but they are also frightened by it. Further assessment for PTSD and depression would be recommended. There was no statistical difference by the type of agency that the carer worked for.

More unusually there was also a combination of high/moderate compassion satisfaction with high/moderate burnout and high STS (n=68:12%). The scores suggested whilst carers might be very effective in their work and get a lot of satisfaction from it, they had fears and anxieties that they were not being supported. Perhaps the satisfaction they got from being a foster carer kept them going.

There was also a group of foster carers (n=46:8%) who had very low compassion satisfaction scores but with average/low scores on the other two scales. It suggests that this group were not enjoying their role as a foster carer, but at the same time did not have any symptoms of burnout or secondary traumatic stress. A small group of foster carers (5%) did not fit in to any of the above combinations.

### *Low well-being and compassion fatigue*

There was a statistical association between the ProQOL measure and having low well-being scores.

The carers with concerning scores:

- On the burn out scale were 17 times more likely to have low well-being.
- On the compassion satisfaction scale were 15 times more likely to have low well-being.
- On the STS scale were 5 times more likely to have low well-being

## Training

Carers were asked in the survey if they had completed a specific list of training programmes, which might have given them information on compassion fatigue and strategies to manage challenging behaviours (Table 1). Nine carers had completed a Fostering Attachments workshop ‘*Is it just me?*’ that is specifically about compassion fatigue and six of these carers had also done the same course online. A further three foster carers had completed only the online course.

**Table 1: Training courses completed by the foster carers**

	IFA carers (n=332)	LA carers (n=181)
<b>Strategies to manage challenging behaviour</b>	86%	69%
<b>Therapeutic parenting</b>	67%	45%
<b>Understanding attachment</b>	93%	89%
<b>Support for carers living with a child with attachment difficulties</b>	56%	30%
<b>Managing feelings-identifying compassion fatigue</b>	21%	16%

Some carers chose not to answer these questions and many others wrote that they had had to educate themselves, finding books, paying for their own training or therapy. For example, one carer wrote:

*Training they offer is never relevant or current and they have stopped training in the region where I live, which makes attending near impossible... I source most of my own training and support groups.*

We asked carers if they knew whether their supervising social worker had completed any training on compassion fatigue. Only 7% of IFA carers and 2% of LA carers were sure that their social worker had. More often carers wrote about social worker’s lack of training and lack of basic knowledge on attachment difficulties and trauma. Carers wrote:

*The total lack of understanding of the most basic rudiments of attachment theory displayed by my supervising social worker (she has never heard of Louise Bomber, Dan Hughes, Amber Elliot, etc. etc. etc.) has completely put me off attempting to access (support).*

*The social workers and their lack of understanding/training cause me far more problems than the children I care for.*

*Life is much easier now I understand how to look after children with attachment problems. I just wish the social workers came to training too!*

The perceived lack of understanding about trauma and attachment from social workers is very concerning, as without this foster carers are not able to be appropriately supported in their role, and the needs of children may go unrecognised. It is also likely that lack of understanding contributes to lower compassion satisfaction and greater levels of compassion fatigue. In terms of their own support, some foster carers received excellent, knowledgeable support from psychologists, or paid for their own independent supervision.

## Summary

The survey found that foster carers had similar levels of secondary traumatic stress as people working in stressful helping professions such as nurses, social workers and fire fighters. However, they had slightly higher levels of symptoms of burnout and lower satisfaction with their jobs. More than one in four had low well-being suggesting that if they visited their GP they would receive further assessment and treatment for depression or anxiety. The survey also provided valuable information about the training carers accessed, and their perspectives on its usefulness. Part 2 of the study explored compassion satisfaction, compassion fatigue and the day-to-day life of foster carers through conducting focus groups with a sub-sample of the survey respondents. The findings are reported in the subsequent sections of this report.

## Focus groups

Four focus groups were held with foster carers, each with 5-6 participants (n=23). The carers who took part in the focus groups were recruited from those who had completed the survey. There were three male and 20 female participants, who came from a range of agency settings: 11 were local authority carers, 10 were from independent fostering agencies and 2 were from voluntary agencies. Most carers were very experienced, with over 5 years' fostering experience, although a small number had been fostering for less time. Their placement profile ranged from emergency/ short term, respite, parent and child, to long term placements. Most carers currently had children in placement. The locations of the focus groups comprised a combination of urban and rural areas, within four counties of England. The focus groups ran for between 1 ½ - 2 hours, and provided in-depth information about the foster carers' day to day experience of caring for traumatised children, their support needs, and the support they received from professionals and peers.

## Focus group findings

### Experience and impact of compassion fatigue

Carers who attended the focus groups commented on the effects of compassion fatigue. Effects were described as sometimes severe, having a negative impact on: the quality of care provided to children, the stability and continuity of placements, foster carers' mental and physical well-being and carer retention.

One of the most powerful aspects to impact on compassion fatigue was the relentlessness of the daily caring task. Many of the foster carers spoke of the permanent lack of physical and emotional space in their lives that resulted from meeting the children's complex needs. Carers spoke of feeling exhausted, ground down and burnt out:

*Some of them they're like limpets, you can't prise them off. I have literally said I'm going to the toilet, and they have been stood outside the bathroom window talking to me, and I was like 'For God's sake, I can't even go to the loo in peace!'*

*I was literally yawning all the way up here. I had a good night's sleep last night, but I'm just exhausted, emotionally exhausted, and that's quite a biggie. I feel like a punch bag and there's no stuffing left.*

*It was almost Groundhog Day every day.*

Full-time foster carers were particularly affected, and those who worked outside the home commented that work often gave them some relief from the constant pressures of caring. Carers also talked about not appreciating the impact on themselves until the child had left, of feeling blamed if the placement broke down, and of not having time to spend on self-care.

The carers' experience of secondary traumatic stress paints a concerning picture for those who experience it, with symptoms reported which included anxiety, fear, panic attacks, heightened emotions such as frequent crying and anger, and re-experiencing previous trauma in the carers' own lives:

*Have you ever woken in the morning and thought 'I can't do this again'? ... I even had one morning where I got out of bed, got into the shower, and it must have been about half five in the morning, because I wanted to bawl my eyes out in the shower with no-one banging on the door, because I was still sad about the child's history.*

*I'm on the edge all the time, hyper-alert when around the child I foster.*

*My husband I would wake up in the morning, look at each other and sigh and not actually want to get out of bed ... As soon as you sat up that started your day, and then the anxiety would kick in, and it would be like it for both of us.*

*I'm exhausted ... not just from the lack of sleep ... and the demands of the job ... but from the secondary trauma at having to hear awful, awful things and receiving little or no help, and the crushing sense of despair at the slowness of the process.*

*I do think it brings up stuff from your own childhood that you've forgotten about or put away. So a lot of stuff comes back to you I think, and that takes you by surprise. As a family you just have to work out a strategy in the end.*

The foster carers' experience of burnout and secondary traumatic stress had a significant impact on the care they were able to provide to children. In particular, many carers talked about only being able

to meet the children's basic needs at these times. The experience of being in compassion fatigue meant that they had to shut down their own emotions so that they could simply get through each day.

Carers spoke about self-preservation:

*I've been there with children when you're just meeting the basic needs, and you're doing what you think they need, but you've took on their trauma, and actually you can't cope with that as well as looking after this person, so we've put a lid on it. We can't take any more in that glass, so you literally are protecting yourself.*

*I will look after her basic needs, I'll make sure she's clothed and she's had something to eat, but that's as far as it goes.*

*You switch off. I think there comes a point somewhere along the line where you switch off your emotions to that child because that's enough.*

Foster carers also found it, unsurprisingly, more difficult to regulate their emotions when experiencing compassion fatigue, so responded less sensitively to the children in their care:

*The difficulty is when you're actually in compassion fatigue, shouting is easier, and that's the problem, we actually damage our kids a tiny bit more. We don't do a very good job in that minute, then we feel guilty about it because we lost the plot over something stupid.*

Professionals compounded carers' feelings of compassion fatigue when they failed to recognise why carers were struggling. Carers explained:

*It's very hard when you're talking to a social worker about the reasons a placement is going to break. You give these reasons, and they look at you and say 'Oh that's not a big thing, and that's not a big thing', and you just think but you don't understand! This is relentless ... it's 300 small things.*

*I said [to the social worker] I'm so angry it's either scream or cry, so I think I'll cry. I'll bang my head on the wall a few times and then I'll be better. But they couldn't grasp that, and then you think, 'Well I wonder what they think about me really?' Are they going away thinking that woman is a fruit loop?*

*We're looked down upon if we show our true emotions.*

Foster carers recognised that, in the absence of support, their experience of compassion fatigue could turn into dislike for the child. The foster carers had strong feelings of guilt when this happened, and felt horrified that they could feel like this.

Symptoms of burnout and secondary traumatic stress also had an impact on the carers' physical well-being, with some carers developing physical health problems. The combination of physical and emotional health issues had an impact on their ability to provide a high standard of care to the children. In some cases, carers reported that they had ended placements as a result of compassion fatigue and their inability to provide the care that the child needed.

### Primary trauma and compassion fatigue

Within the focus groups, many of the foster carers spoke of the direct primary trauma they experienced, as a result of fostering. Primary trauma occurred from physical assaults on themselves and family members (including their own children), assaults on family pets, and emotional/psychological abuse. The literature on compassion fatigue in stressful helping professions notes that primary trauma should be addressed first in order for interventions that target compassion fatigue to be effective (Figley, 2002). However, for foster carers and their families, who are unable to remove themselves from the source of the primary trauma, this is not a realistic possibility as their home is also their workplace. It is inevitable that there will be occasions when primary trauma is present for foster carers, alongside secondary trauma and/ or burnout, given the complex needs of the children they care for and the challenges they can present. The support provided to foster carers should therefore acknowledge this reality and take account of it. The presence of primary trauma could also help explain some of the difficulties in placing the foster carers within the existing typologies of compassion fatigue above.

### Compassion satisfaction

Compassion satisfaction appeared to moderate some of the effects of compassion fatigue. Satisfaction with being a foster carer was gained from having a commitment to and love for the child, and seeing a child's progress, however small:

*You've got to look for the little things. One little child was probably with us six months before they smiled, and it was just like the sun came out. Because sometimes it's hard, very hard, and you've got to look for the little things that make you think it's worth carrying on.*

*Seeing little changes, little changes. You have to... you just have to appreciate the tiny steps that they make while they're with you, and that's by far the most satisfying part of it.*

Carers' love and commitment to the children appeared to be the strongest moderator for compassion fatigue, and acted as a powerful motivator to keep going even when things got difficult:

*The one person I keep going for is her ... I love her and that's what makes it worthwhile. Looking after her its 95% hard work and 5% reward, but that 5% reward makes every day that's hard worthwhile.*

The confidence gained from successfully managing difficult situations and building experience also appeared to influence compassion satisfaction, particularly in terms of increasing carer's resilience:

*I think for me it's what I've gained from my own confidence I think. I've been in some really tricky positions with them, and yet we've managed to survive it, and nothing has gone catastrophically wrong.*

High quality support from knowledgeable professionals was also said to contribute to compassion satisfaction. However, it was rare for the foster carers in this study to feel that they were well supported by their supervising social workers. Instead support came from other professionals and fellow foster carers. These issues will be explored in more detail within the section examining foster carer support.

### Impact of fostering on day-to-day life

In order to understand carers' support needs, it is important to have an understanding of the day-to-day life of foster carers who are parenting traumatised children. As we have already seen, the foster carers in this study were very committed to the children they cared for, and some derived high levels of satisfaction with the caring task, although by no means all the time. However, the relentlessness of the demands placed upon them by the children in their care, and the effects of hearing about the

traumatic experiences which had happened to them (alongside witnessing their aftermath in the children's behaviour), had a significant impact.

Many foster carers commented on the detrimental effect fostering had on friendships and social activities. Carers stated that there had been a reduction in friendship networks and in the amount of time they spent socialisation as a result of exhaustion and/or concerns from others about the fostered children's behaviour, particularly in public. Feelings of isolation for some resulted, which placed additional stress on the foster carers. Carers said:

*It does make it very difficult. We've lost friends over looking after this child. People were pulling away, and it's really hard because you do feel very isolated, and we don't have any other carers within our local area.*

*The friends who have stuck by us and who will come and visit, and talk to our foster children, and treat them as part of the family – I am so grateful to those friends for sticking with me. And then we've got other friends who say 'Can you get respite so that we can get together?' And it's like they still want us to be friends but actually they're ignoring part of our family. It's been quite a re-assessment of friendships.*

Furthermore, the support networks identified at the outset within the fostering assessment often changed over time. Examples were given of relatives not being able to manage the demands of caring for traumatised children on a respite basis, even for a few hours, and the relatives' frustration at not understanding the children's needs. Some carers reported that their relatives had a 'it worked for me and it will work for them' approach to parenting (which usually did not work), and struggled to understand that the fostered children's needs were different. The lack of understanding from relatives had come as a surprise to most of the carers, and they highlighted the importance of not simply expecting existing support systems to stay the same once fostering. Carers emphasised that changes in support networks should be anticipated and explained by the social worker during the preparation and home study process.

Social contact outside the home was also affected in a practical way, as many of the foster carers (particularly single carers) had difficulty taking a break, even if just for a few hours in the week. A carer explained:

*I can't remember the last time we [foster carer couple] went out together – years ago – and in 15 years we've had three nights off, because the children all have very complex needs.*

Lack of a break is concerning, especially in the light of existing knowledge about compassion fatigue and the importance of removing oneself from the causes of stress, even if just for a short while. Although school provided an opportunity for a break for some during the day, not all the children were either in school or old enough for school. Several foster carers commented about the regular liaison required with teachers during the day in order to support the children. They were therefore not able to 'switch off' for a few hours on a regular basis.

Where foster carers had good support networks they were highly valued and nurtured. In particular, friends and family gave foster carers that much-needed opportunity to rest and recharge and do something else (either through spending time together or by caring for the foster children), in order to go back to the caring task refreshed, both in themselves and their own relationships. Carers said:

*I think it's really important to have friends that have absolutely nothing to do with fostering. Sometimes you can just rehash problems over and over again and get nowhere fast, and what you really need to do is just forget them for an hour or two and do something completely different.*

*My own space is really crucial for my well-being, so I've got to find a way to look after this child but still manage to look after myself as well.*

Becoming foster carers could have a significant effect on a couple's relationship, and on the children in the family, in positive and negative ways. Positive aspects were described as working together as a team, which often drew the couple, and the family, closer together. However, several carers commented that at times it felt like they simply had a working relationship with their partner, and that

their relationship as loving partners in life, as well as their intimate relationships, could be affected due to the caring demands placed upon them:

*My daughter gives my husband and I a night off every now and then. That gives us a chance to be just me and him and remember why we're together and why we love each other because sometimes I forget.*

For the children of foster carers, their views of fostering were reported by their parents to ebb and flow over time, often depending on the demands placed on their parents by the children living with them. Children were reported to be a great help, a useful mediator and friend/ sibling to the children in their care. Equally, children could be distressed and upset by the foster children's behaviour. Some children were said to have been physically assaulted by a foster child and others felt neglected by not getting as much parental attention as they wanted. Children's upset was an enormous source of guilt for the foster carers, and it was a frustration to many that respite, even for a few hours regularly, was often not able to be provided to nurture their relationships with their birth children.

However, for many of the foster carers within the focus groups, their family life had been tested to the limits on occasions, as a result of fostering. The stress sometimes resulted in placements breaking down, or coming close to breaking point, couple's relationship being at risk of disintegrating, and birth children feeling very alienated. Carers explained:

*There have been moments of warmth with the child, but there isn't enough in me to watch my family disintegrate... we're crumbling.*

*I think when you're really up against it and it's so hard, it either pulls you apart or pushes you together.*

*We were at loggerheads, and actually I did wonder if I would be better off on my own doing fostering.*

The carers in these circumstances felt that these feelings could have been avoided if:

- professionals had a better understanding of the demands fostering traumatised children places on individuals and families;

- better matching had been undertaken at the outset; and
- appropriate support, individualised for the child and the family, had been put in place.

Almost without exception, the foster carers in the focus groups felt that they had not been adequately prepared during the three-day preparation programme and their home study. As one carer said, *'fostering is about normalising the most extreme behaviours and pretending it's a normal life, and it just isn't a normal life at all really'*. Another said, *'No-one told us it was going to be like this'*.

The following sections explore the different forms of support and training available to foster carers, or that they would like to access, in order to reduce the risk of compassion fatigue and increase their compassion satisfaction.

### Support and training

The focus groups considered the support received from friends, family and peers as well as from their agencies and other professionals. Foster carers were also asked about their 'ideal' support package when caring for traumatised children. The support received from social workers and their agencies strongly influenced how carers felt about fostering.

#### Support groups run by the agency

Some foster carers very much enjoyed and got support from their agency's groups. However, there were mixed views about their focus and structure. Some liked and appreciated a structured approach to the group, with input about a particular topic followed by a more informal support aspect where carers spent time talking together by themselves. Others disliked this approach, seeing it as encroaching on their capacity to give and receive informal support from one another. In many cases, underlying these attitudes were views about the presence of social workers at the support groups. Some carers found their presence very useful and social workers were seen as supportive and a good sounding board. Others felt it meant they were not able to speak freely about some issues for fear of being judged, undermined or told what they should do. Carers said:

*Support for us isn't about solving. Social workers, a lot of professionals, try to solve a problem, and when we support each other we're not actually trying to solve the problem.*

*Foster carers are humans too have feelings and emotions, can be hurt and feel anger and distress. Support groups tend to be for a coffee and chats about nothing relevant, it would be more beneficial for people to be able to share feelings and emotions without being judged or feeling inadequate*

Other carers did not attend support groups because they felt that many of the other foster carers at the groups were “*negative and exhausted*”, which affected the mood of the whole group.

Confidentiality rules were often reported as being used in a way that prevented foster carers sharing their experiences and gaining support:

*The support groups aren't what they used to be. We're now having to sign confidentiality sheets saying we can't discuss our children within this setting ... Even if we don't use names, we should be able to talk freely about the problems we're having.*

Being able to access support groups was not always easy, with foster carers citing distance and timing of the groups as a problem. For those who worked, they found the timing of groups particularly problematic because they were usually held during the day. Carers explained:

*As we are out of county carers ... we are not in a position to attend support groups given that it would take 3 1/2 hours to drive to venue. Facebook has been invaluable!*

*My IFA 'support group' is a 50-mile return journey away and they have no access to support groups.*

There was a diversity of views about the purpose and role of support groups, which suggests that independently run groups with a more flexible approach would be preferable.

### Peer support

One of the most important forms of support, perceived as under-recognised, viewed with suspicion by social workers and insufficiently utilised by agencies, was that received from fellow foster carers.

Carers repeatedly commented that the mutual understanding of the fostering task led to feelings of greater support without feeling judged without feeling judged:

*It's like having a sounding board ... and we sit and cry sometimes because we've had really bad weeks. We all understand each other and we've all been there ... I could not pick up the phone to my supervising social worker because I would feel judged, or I would feel like a failure.*

However, many of the foster carers believed that their agencies were uncomfortable with informal peer support, especially when it took place outside of the agency support groups. Some carers also commented that friendships with carers from different agencies were often discouraged due to concerns about other agencies 'poaching' carers.

Spending time with friends who also fostered allowed foster carers to feel more relaxed in public with the children, as they felt supported rather than judged or blamed for any challenging behaviour. Carers said:

*I definitely relax more with fostering friends, because if the children are doing something slightly wild, or that I might be embarrassed about if I was with other families, I don't need to be because the chances are their kids are doing something worse!*

*You are not judged if your child is kicking off ... you just look at it and go 'oh well it could be worse'.*

More opportunities for informal peer support were particularly recommended by the foster carers. Peers could mentor and were also an excellent way to offload and gain support from one another without any expectation of a 'quick fix'. Foster carers reported that buddying schemes were under-utilised, usually because of a lack of facilitation by the agencies.

#### [Support from social workers and agencies](#)

The support received from social workers and their agencies strongly influenced how carers felt about fostering. A few carers talked about the excellent support they were receiving:

*The kids SW has now organised for me to take NVR/CAMHS Therapeutic Parenting Courses - which are a PHENOMENAL HELP but before that, I believed I was totally alone.*

*I am well supported at the moment and have good friends and a good supporting social worker.*

*I have support from CAMHS who I have found are excellent in this area. Foster child's social worker is very very good. Child's LAC team is very supportive (medical doctor in particular). Without this I probably could not continue to care for child's extreme needs.*

*My agency is key. Knowing that my SSW is there to protect my well-being is the crucial part of me being able to foster.*

However, the majority of comments were about lack of support from social workers. Some foster carers blamed 'the system' describing the care system as broken and dysfunctional with social workers not having enough time to listen or support because of high caseloads, financial cuts and lack of experience. Several commented on the high turnover of social work staff. Carers said:

*The system currently does not allow enough time for social workers to support either carers or looked after children properly. Social workers are always desperate to place children then we don't see them for weeks on end, so it does not feel like a partnership at all ... Most of the social workers I have met are good people committed to the children they work with but the system is overstressed, inefficient and clearly underfunded.*

*Supervising social workers do not have the skills to help you debrief properly and process what you are going through. When they come for supervision, they are just ticking boxes and don't have the time to ask how you really are, or maybe it's because they don't want to know the answer or are afraid of opening up a can of worms that they don't have the time or skills to deal with.*

*There is no space or time to really talk to anyone especially during the holiday or weekends as I am always aware the child could overhear any conversation i.e. supervising social worker.*

Other foster carers attributed lack of support to individual social worker's lack of respect, empathy, skills and knowledge. Carers complained about social workers who were suspicious of foster carers, did not respect their views, did not work in partnership and did not trust them with the child's chronology unless the placement was in crisis. Carers said:

*I often find that social workers do not appreciate me as an equal in a professional role. I have a level 5 qualifications and have worked in a professional role for 30 years, yet I often feel patronised.*

*It's a thankless task. Social workers just think we are machines.*

*Sometimes I feel that if I am honest how I feel it will reflect on me negatively with my fostering agency and social worker. Sometimes it is so upsetting what these children have gone through that it is forgotten that the foster carers feel pain too.*

*Despite the rhetoric of foster carers being part of the professional team around the child, the reality couldn't be further from the truth.*

The importance of an empathic approach was emphasised, as this supported foster carers to feel listened to and respected. However, many foster carers talked about social workers wanting to 'solve' problems rather than simply listening and being empathic, and this is not what they needed:

*I would just like the social worker to say 'it must be really hard to look after these children'.*

*Support for us isn't about solving problems. Social workers, a lot of professionals, try to solve a problem.*

*Foster carers are humans too have feelings and emotions, can be hurt and feel anger and distress.*

Some foster carers felt judged and blamed by social workers for the difficulties they experienced in caring for traumatised children. Feeling judged led to a reluctance to ask for help and concerns from carers that if they were honest about the way they were feeling they might get de-registered. Lack of support is likely to have contributed to the moderate to high levels of burnout and secondary traumatic stress, and moderate to low levels of compassion satisfaction which many foster carers reported.

Many carers also talked about the lack of help and support for children and a failure of agencies to recognise the child's trauma. Carers spoke of having to battle with other professionals on behalf of the child. They said:

*My LA does not accept that under 5s can have challenging needs or behaviours (as evidenced by the fact that a higher level of skills payment is not available to those who foster under 5s) and CAMHS will not accept referrals for under 5s.*

*Dealing with the young person is actually the easier part of fostering. The difficulty comes in dealing with other professionals for whom the child is just another case. We are always fighting for the best for the child against both the system and lack of funds.*

*Sadly, most of our battles are with the child's corporate parents and other agencies who are supposed to be helping the children. Unless we challenge decisions, the children would have even less chance of positive outcomes in life than they do now.*

### Respite

Foster carers were clear that the challenges of caring for traumatised children meant that they needed to be supported to have breaks in order to rest and recharge their batteries. Having respite gave carers the opportunity to stand back and regain perspective, as one carer explained:

*I think foster carers need to realise, 'Hang on, I'm not super human, I need support'. Because you're dealing with some fairly traumatic situations sometimes, and we have to own up and say we need some help here.*

However, carers were equally clear that respite, as understood and operated by most of their agencies, was not child-centred because the children were often going to people they did not know. The foster carers felt very guilty about having respite in these situations because of the effect on the foster children, despite the fact that they needed it. One foster carer explained the impact of taking respite:

*I used a respite carer and they were lovely, but when I got them back I just felt so guilty. I knew I shouldn't, and I knew I deserved that break, and it was important for my own children that we had that break. But when I got them back they were like these little broken people, just the way they looked at me, it was like the trust had gone.*

Many foster carers talked about feeling like they were in a Catch-22 position. They needed respite in order to be able to continue caring, but respite did not take into account the needs of traumatised children. Some agencies emphasised that friends and family should be caring for the children while

the foster carers were away, and in some cases this worked well. However, the needs of the children were sometimes too much for friends and family to manage, and some foster carers felt that more investment was needed to enable friends and family to become respite carers.

Foster carers were more positive about respite care when they could work with the same respite carer over time. Informal arrangements could be put in place to allow visits until the child felt comfortable and safe. Only at that point were suggestions made to the child about staying with the respite carer. This approach emphasises the importance of traumatised children feeling safe and secure, and underlines that respite needs to be conceptualised and organised differently if it is to meet children's needs.

Most carers emphasised that respite should be used creatively. For example, the day-to-day demands of caring for the children meant that a few hours of free time per week was immensely valued when offered by agencies. It meant that there was a regular space they could look forward to every week, when needed. However, again emphasis was placed on this being child-centred, with children being involved in regular activities for example, or spending time with the same person every week.

Another way for carers to be able to rest and recharge, which felt like respite for them, was for practical assistance in the home when needed, as suggested in the following quote:

*Someone who comes in, who understands your weird life, who understands there might be baked beans down your wall because a child lost the plot yesterday ... When you're looking after a complex child it's the laundry and the cooking, those little things ... a temporary cleaner would have meant I could switch off one part of my brain and guilt. Because I also know my foster child operates better when the house is clean and well organised.*

Whilst most of the IFAs emphasised the importance of respite, foster carers felt that the approach to it was somewhat inflexible. As well as a maximum number of weeks per year, a minimum number was also required, often with significant notice. The requirements meant that foster carers sometimes felt under pressure to take a break when they didn't need it, or not to have a break when they needed one urgently. The carers also emphasised that flexibility in terms of respite would also give them time

with other children in placement, or with their own children, and that there was not enough recognition of the importance of this.

There were also many instances of respite being seen as the carers not coping (often from LA carers), and they felt judged and blamed for this. Behind this, the carers felt that there was a fundamental lack of understanding about the realities of fostering traumatised children, which meant that either the need for respite was not supported, or a flexible understanding of respite was not present.

### Finance

Financial pressures were a source of worry for a number of the foster carers, particularly where agencies required one person to be at home full-time. Although the survey reported that those not working outside the home were less stressed, lack of money could place financial strain on the family. The foster carers were at great pains to emphasise that they were fostering because they were committed to the children they cared for. However, the lack of a guaranteed income led to foster carers sometimes accepting placements, because of needing to make mortgage payments etc., when they knew it may not be the right thing for themselves or other children in placement. Accepting inappropriate placements was especially the case for single foster carers who were required to be at home full-time. One foster carer stated:

*There are foster carers who are trapped, because they can't afford to stop, because they lose their house, they lose everything if they stop so they have to keep going.*

The foster carers also reflected on the view that some carers 'do it for the money'. The over-riding view was that they would not do fostering if they were not committed to the children in their care and demonstrated a lack of understanding about having no separation of home and work. As one foster carer stated:

*There are people out there who think we shouldn't be paid at all. I'd love them to come and live my life for a week! We don't do it for the money... We'd be absolute fools to do it for the money! I don't get weekends off, don't get annual leave... I love my foster children, and that's what makes it worthwhile.*

## Conclusions

This study has provided significant insights into what day-to-day life is like for those fostering traumatised children. It has identified that compassion fatigue is present for a substantial minority of foster carers, and some of the ways in which it impacts on them. Research with stressful helping professions has underlined the importance of providing support, which recognises the presence of compassion fatigue, and acts to moderate its effects (Cocker and Joss, 2016). It is therefore vital to begin to re-conceptualise the support foster carers require in the light of this.

The foundation stone of support here is the recognition and acceptance that compassion fatigue is a risk for foster carers because they care for children who have experienced a range of adverse life experiences, including abuse, loss and trauma. As we have shown in this study, the effects of compassion fatigue can be severe, impacting negatively on the quality of care provided to children, the stability and continuity of placements, and on foster carers' mental and physical well-being. Furthermore, it was rare for the foster carers in this study to feel that they were well supported by their supervising social workers. Instead support came from other professionals and fellow foster carers.

In order for foster carers to be able to receive appropriate support, those supporting them have an understanding of:

1. the effects of trauma and attachment difficulties on children and young people
2. the challenges these issues can bring for those caring for these children
3. the impact of the fostering task on foster carers.
4. symptoms of compassion fatigue
5. how to reduce compassion fatigue and increase compassion satisfaction

The findings from this study also indicate that foster carers feel that the professionals supporting them do not generally have the appropriate knowledge and understanding of these issues. As a result, the support provided does not meet their needs, and may in fact contribute to compassion fatigue.

Training would be very beneficial both for professionals and foster carers in order to raise awareness about compassion fatigue, including how and why it develops, and what moderates its effects. It is also important that the expertise of foster carers is recognised, particularly in terms of their in-depth knowledge and experience of the children they are caring for, and how fostering impacts on them and their family.

We know from research into trauma and post-traumatic stress disorder (PTSD) that being able to talk about the traumatic event(s) as often as wished, can help people to process traumatic memories and reduce the risk of PTSD (Archer and Gordon 2013; Perry 2014). Professional practice which enforces strict rules about, for example, what can and cannot be discussed in support groups, does not enable carers to talk about upsetting and troubling situations, and could be contributing to compassion fatigue. Creating a safe space for carers to process the child's and their own trauma, and to offload about difficult issues without the threat of judgement or sanction, is therefore vital. This safe space is needed within the context of support groups, peer support and in the supervision and support received from professionals. Without this, carers will risk continuing to be and feel judged and blamed for their own difficulties, and those of the children they care for, and their needs will continue to go unrecognised.

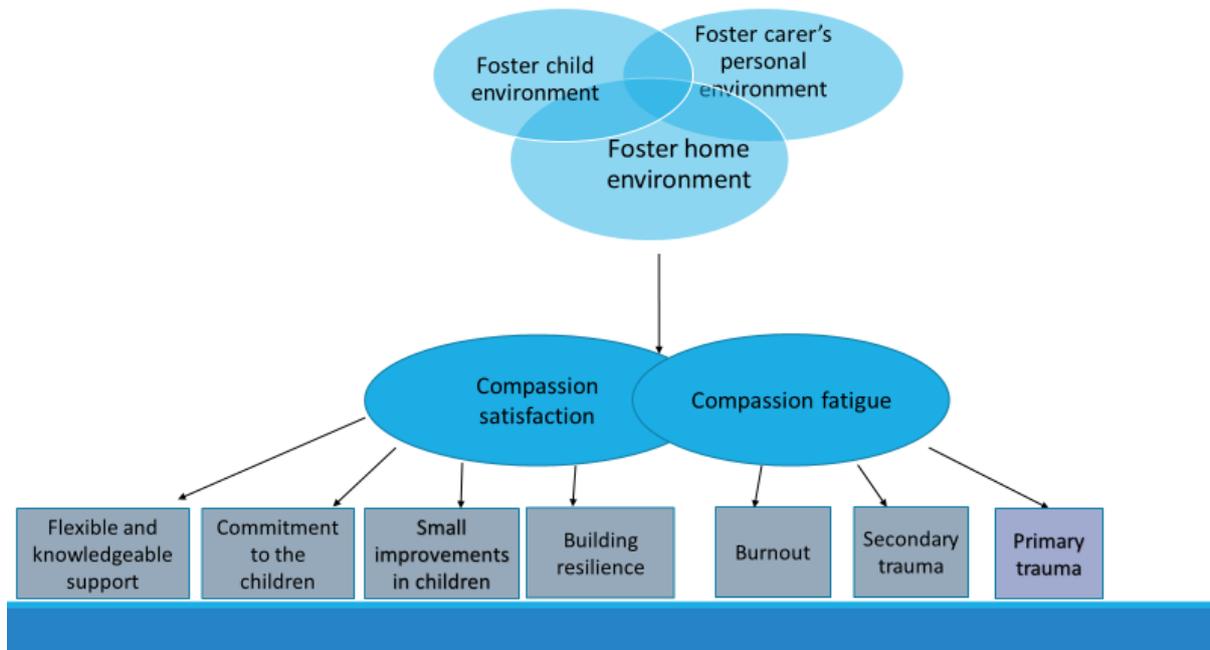
The relentlessness of the caring task, often with little or no physical and emotional space for the carers, was seen as a particular contributor to compassion fatigue. We know from previous research within stressful helping professions that being able to access some physical and mental space is vitally important in order to address its effects (Figley 2002; Stamm 1995). A lack of separation between the home and work environment in fostering means that creating some space is particularly challenging. Added to this is the increased isolation and lack of practical support many carers felt as a result of a decreasing support network due to the challenges the children's behaviour presented. A reconceptualization of respite is therefore required, where carers can be afforded some 'time out' on a flexible basis, and in a child-centred way.

One approach, that might improve respite provision, is the Mockingbird Family Model, which was developed in the USA by the Mockingbird Society, and is being piloted in the UK. It operates a hub and constellation model whereby one fostering family, which has been specially recruited and trained, acts as a 'hub' to a constellation of 6-10 foster and kinship families. The 'hub' family offers respite, social activities and peer support to the constellation families (Fostering Network, 2016), and the emphasis is on relationship-based peer support which is flexible and responsive to need (Northwest Institute for Children and Families, 2007).

An independent evaluation of the Mockingbird approach in the USA (Northwest Institute for Children and Families, 2007) highlighted that foster carers felt flexible access to respite and regular peer support had reduced their feelings of isolation and prevented placements breaking down. Placement stability rates were increased, but this finding should be treated with caution as the evaluation follow up was less than a year. The UK Mockingbird model is currently being evaluated. The findings from the present study would suggest that an approach to respite/ peer support which is flexible and relationship focused for the children and foster carers has the potential to be a positive resource.

We have discovered that foster caring is different and unique in terms of measuring compassion fatigue. The carers' place of work is also their home, the children they work with are resident with them, and the foster carer's family is involved and affected. The different aspects of the environment therefore intersect in a manner unlike other caring professionals, who have both a separation from work and home, and work and other family members. Furthermore, the presence of primary trauma for some foster carers means that it needs to be included and recognised as a factor contributing to compassion fatigue alongside burnout and secondary traumatic stress. The Professional Quality of Life model as it is currently conceptualised (see Figure 1) does not therefore accurately represent what we have found in our study. We have adapted it in the light of our findings (Figure 2), and further work will be beneficial in order to explore how the different elements interact with one another.

Figure 6: Professional Quality of Life for foster carers



## Recommendations

- ❖ Recognition and acceptance by fostering agencies that compassion fatigue will be present amongst foster carers
- ❖ Agencies should provide carers with information on the symptoms and consequences of compassion fatigue and useful self-help strategies. Carers also need to know how to access support for compassion fatigue.
- ❖ Agencies should ensure that their staff have a good knowledge of compassion fatigue and are able to identify and support (without judgement) foster carers who are suffering.
- ❖ The content of the 3-day preparation course for foster carers needs to be re-examined to place greater emphasis on the impact of fostering traumatised children and the need for a therapeutic approach to parenting.
- ❖ Training needs to be developed for social workers and carers on compassion fatigue. We recommend joint training as both social workers and foster carers may have experienced symptoms and they have much to learn from each other.
- ❖ Further research is needed on 'what works' to increase compassion satisfaction and reduce compassion fatigue in foster carers.

- ❖ The commissioning of inter-agency locally based and independently run support groups that promote a safe space for carers.
- ❖ Peer support for foster carers should be actively promoted and supported within and across fostering agencies in order to provide local informal support that addresses issues of isolation.
- ❖ Greater investment in respite provision which is creative, relationship-focused and responsive to need, in order to reduce the effects of compassion fatigue. Family and friends who are potential respite carers should be better informed and included in training.
- ❖ Consideration should be given to reviewing the remuneration of foster carers and their conditions of service.

In light of the findings from this study, we recommend that the following amendments are made to the Fostering Services: National Minimum Standards (2011):

1. **Standard 13: Recruiting and assessing foster carers who can meet the needs of looked after children.** Standard 13.3 states should be amended in order to explicitly state that the issues carers will encounter occur as a result of their role. We are suggesting that the amendment could read as follows:
 

*Prospective foster carers are prepared to become foster carers in a way which recognises, addresses, and gives practical techniques to manage the issues they are likely to encounter through the demands of the foster carer role and the needs of the children they care for. The preparation should also identify the competencies and strengths they have or need to develop.*
2. **Standard 21: Supervision and support of foster carers.** This standard would benefit from the addition of a clause which explicitly requires that support is provided in order to promote and protect foster carers' well-being. As it currently stands, the emphasis is on support being given to foster carers in order to meet children's needs. The additional clause will encourage agencies to include a specific focus on emotional well-being as part of regular support meetings. A great emphasis is also placed on supervision within this standard, rather than recognising and addressing support needs.

## References

- Archer, C & Gordon, C. (2013) *Reparenting the Child Who Hurts*, Jessica, Kingsley Publishers, London
- Baylin, J (2015) The Parenting Brain ( p131-149) In Alper J. and Howe D. (2015) *Assessing adoptive and foster parents* . London Jessica Kingsley Publishers
- Berridge, D. (1997) *Foster care: A research review*. London: The Stationary Office.
- Berridge, D. and Cleaver, H. (1987) *Foster Home Breakdown*, Oxford: Basil Blackwell Ltd.
- Beeghly, M. and Cicchetti, D. (1994) 'Child maltreatment, attachment and the self-system: Emergence of an internal state lexicon in toddlers at high social risk, *Development and Psychopathology*, 6, pp. 5–30.
- Berger, R. and Gelkopf, M. (2011) 'An intervention for reducing secondary traumatization and improving professional self-efficacy in well baby clinic nurses following war and terror: A random control group trial', *International Journal of Nursing Studies*, 48, pp 601–610.
- Biehal, N., Dixon, J., Parry, E., Sinclair, I., Green, J., Roberts, C. et al. (2012) *The Care Placements Evaluation (CaPE) Evaluation of Multidimensional Treatment Foster Care for Adolescents (MTFC-A)*. London, Department for Education Research Report, RR 194
- Bride B. Radley, M., & Figley, C. (2007) 'Measuring compassion fatigue', *Clinical Social Work Journal* 35: pp155–163
- Cairns, K. (2002) *Attachment, Trauma and Resilience: Therapeutic caring for children*, London: BAAF.
- Cicchetti, D. (1996) 'Child maltreatment: Implications for developmental theory', *Human Development*, 39, pp 18-39.
- Cocker, F. and Joss, N. (2016) 'Compassion fatigue among healthcare, emergency and community service workers: A systematic review', *International Journal of Environment Research and Public Health*, 13, pp618-636.
- Conrad, D. and Kellar-Guenther, Y. (2006) 'Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers', *Child abuse & neglect*, 30(10), pp 1071-1080.
- Courtois, C.A. and Ford, J.D. (2009) *Treating complex traumatic stress disorders: An evidence-based guide*, New York: The Guildford Press.
- Department for Education (2016) *Children Looked After in England including Adoption*, London: Department for Education Retrieved from:  
<https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2015-to-2016>
- Farmer, E., Lipscombe, J., & Moyers, S. (2005) 'Foster carer strain and its impact on parenting and placement outcomes for adolescents', *British Journal of Social Work*, 35, pp 237–253
- Figley, C.R. (1995) *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatised*, New York: Brunner-Routledge
- Figley, C.R. (2002) *Treating Compassion Fatigue*; New York: Brunner-Routledge.

Flarity, K.; Gentry, J.E. and Mesnikoff, N. (2013) 'The effectiveness of an educational program on preventing and treating compassion fatigue in emergency nurses'. *Journal of Advanced Emergency Nursing*, 35, pp 247–258.

Fuentes, M.J., Salas, M.D., Bernedo, I.M., and GarcíaMartín, M.A. (2014) 'Levels of burden and satisfaction among Spanish foster carers', *European Journal of Social Work*, 18 (5) pp 731-74

Gentry, J.E.; Baranowsky, A.B.; Dunning, K. (2002) *Arp: The accelerated recovery program (arp) for compassion fatigue*. In Figley, C.R. (2002) *Treating Compassion Fatigue*; New York: Brunner-Routledge; pp. 123–137.

Golding, K.S. (2008) *Nurturing Attachments: Supporting children who are fostered or adopted*, London: Jessica Kingsley Publishers.

Howe, D. (2009) 'The impact of histories of abuse and neglect on children in placement'. In: Schofield, G. and Simmonds, J. *The Child Placement Handbook: Research, theory and practice*. London: BAAF, pp. 47-62.

Hughes, D. and, Baylin, J. (2012) *Brain-based parenting: The neuroscience of caregiving for healthy attachment*, New York: W.W. Norton and Company

Hughes, D., Golding, K.S. and Hudson, J. (2015) 'Dyadic Developmental Psychotherapy (DDP): the development of the theory, practice and research base', *Adoption & Fostering*, 39(4), pp.356-365.

Hunsaker, S., Chen, H.C., Maughan, D. and Heaston, S. (2015) 'Factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses', *Journal of Nursing Scholarship*, 47(2), pp186-194.

Jones, G. and Morrissette, P. J. (1999). 'Foster parent stress', *Canadian Journal of Counseling*, 33 pp 13 –27.

MacGregor, T. E., Rodger, S., Cummings, A. L., and Leschied, A. W. (2006) 'The needs of foster parents: A qualitative study of motivation, support, and retention', *Qualitative Social Work*, 5, pp 351–368

Mercer, J. (2014). Examining Dyadic Developmental Psychotherapy as a Treatment for Adopted and Foster Children. *Research on Social Work Practice*, Vol. 24(6) 715- 724

Milot, T., St-Laurent, D. and Éthier, L.S. (2015) 'Intervening with Severely and Chronically Neglected Children and their Families: The Contribution of Trauma-Informed Approaches', *Child Abuse Review* 25 (2) pp 89-101

Murray, L., Tarren-Sweeney, M., & France, K. (2011) 'Foster carer perceptions of support and training in the context of high burden of care', *Child and Family Social Work*, 16(2) pp 149–158.

Musa, S. A., & Hamid, A. A. R. M. (2008). Psychological problems among aid workers operating in Darfur. *Social Behavior and Personality*, 36, 407–416.

Northwest Institute for Children and Families (2007) *Mockingbird Family Model Project Evaluation*, Seattle: Northwest Institute for Children and Families

Ofsted (2015) *Children's Social Care in England 2015* London: Ofsted.

Perry, B. (2014) *The cost of caring*. Retrieved from: [https://childtrauma.org/wp-content/uploads/2014/01/Cost\\_of\\_Caring\\_Secondary\\_Traumatic\\_Stress\\_Perry\\_s.pdf](https://childtrauma.org/wp-content/uploads/2014/01/Cost_of_Caring_Secondary_Traumatic_Stress_Perry_s.pdf)

- Schofield, G. and Beek, M. (2009) 'Growing up in foster care: Providing a secure base through adolescence', *Child and Family Social Work*, 14 (3) pp 255-266.
- Schofield, G. and Simmonds, J. (2009) (eds) *The Child Placement Handbook: Research, theory and practice*. London: BAAF
- Schofield, G., Beek, M., Ward, E. and Biggart, L. (2013) Professional foster carer and committed parent: conflict and role enrichment at the interface between work and family in long-term foster care, *Child and Family Social Work*, 18 pp 46-56.
- Sinclair, I. (2005) *Fostering Now: Messages from Research*, London: Jessica Kingsley Publishers.
- Sprang, G., Clark, J.J. and Whitt-Woosley, A. (2007) 'Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life', *Journal of Loss and Trauma*, 12(3), pp 259-280.
- Stamm, B.H. (1995) *Secondary traumatic stress: self care issues for clinicians, researchers and educators*, Maryland; Sidran Press.
- Stamm, B.H. (2010) *The Concise ProQOL Manual* (2nd Edition), Pocatello, ID: [www.ProQOL.org](http://www.ProQOL.org).
- Stamm, B.H. (2016). 'The Secondary Effects of Helping Others: A Comprehensive Bibliography of 2,017 Scholarly Publications Using the Terms Compassion Fatigue, Compassion Satisfaction, Secondary Traumatic Stress, Vicarious Traumatization, Vicarious Transformation and ProQOL', <http://ProQOL.org>.
- The Fostering Network (2012) *The State of the Nation's Foster Care*, London: The Fostering Network
- The Fostering Network (2016) *The Mockingbird Family Model*. Retrieved from: <https://www.thefosteringnetwork.org.uk/policy-practice/projects-and-programmes/mockingbird-family-model>
- Triseliotis, J., Borland, M and Hill, M. (1999) *Fostering Good Relations: A study of foster care and foster carers in Scotland*, Edinburgh: The Scottish Office 1998 and Part II
- Van der Kolk, B.A. (2005) 'Developmental trauma disorder: Towards a rational diagnosis for chronically traumatized children', *Psychiatric Annals* 35 (5) pp 401-408.
- Whenan, R., Oxlad, M. & Lushington, K. (2009) 'Factors associated with foster carer well-being, satisfaction and intention to continue providing out-of-home care', *Children and Youth Services Review*, 31 (7), 752-760.
- Woolgar, M. (2013) 'The practical implications of the emerging findings in the neurobiology of maltreatment for looked after and adopted children: recognising the diversity of outcomes', *Adoption & Fostering*, 37(3) pp 237-252.