

THE UNIVERSITY OF HULL

Relationships and Wellbeing

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by

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Acknowledgements

I would like to dedicate this thesis to my wonderful daughter Sophie, for all her patience during the Doctorate course, providing me with much needed fun and reminding me of the things that are truly important in life.

Firstly I would like to thank all the young people who kindly gave up their time to share their stories, without which none of this would have been possible.

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Finally thank you to my family, for ‘sticking with me’ and always believing in me.

Overview

The thesis portfolio is divided into three parts:

Part one is a systematic literature review, in which quantitative literature considering the role of relational connectedness in the recovery process for people with mental health difficulties is reviewed. A systematic search of five databases identified twelve studies in the area. A narrative synthesis of the findings is provided. Methodological quality of the area, as well as implications and directions for future research are discussed.

Part two is an empirical paper which explores relational connections among care leavers. This study has an idiographic focus using semi structured interviews and employing Interpretative Phenomenological Analysis. Nine care leavers took part in the study. Five super-ordinate and eighteen subordinate themes emerged from the data. These themes are discussed in the context of relational aspects of wellbeing, self-identity, emotional coping and barriers to help-seeking.

Part three comprises the appendices supporting the systematic literature review and empirical papers. It also contains a reflective statement.

Total Word Count: 15,885

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Part One:

Systematic Literature Review

What is the role of Relational Connectedness in Recovery for people with mental health difficulties? A Systematic Review

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Please see Appendix A for the Guidelines for Authors

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Abstract

Recovery and the role of connectedness has become an increasingly significant concept within mental health literature. These concepts are beginning to be investigated using quantitative methodology; however there has been no systematic investigation of this emerging evidence base. The aim of this paper was to systematically review the quantitative literature of the role of relational connectedness in recovery for people with mental health difficulties, to see how these factors are related and which aspects of connectedness promote the recovery process. A search of five electronic databases was conducted. Twelve studies met all the inclusion criteria and were included in the review. Relational connectedness including social networks, types of support, family network and qualities in relationships show consistent associations with self-reported recovery. In particular reciprocity, support and positive relationship quality appear to lead to better recovery. Limitations of the review, methodological trends in the area, implications of the findings as well as areas for future research are discussed.

Key Words: Recovery, Relational Connectedness, Social Support, Family, Systematic Review, Mental Health

Introduction

Personal recovery is a concept which is increasingly being emphasized in mental health services and literature (Slade, 2009). This is distinct from biomedical models of mental health which define recovery as an outcome based solely on the remission of psychiatric symptoms (Lieberman, et al., 2008). Personal recovery developed out of the survivor movement and is grounded in the experiences and aspirations of people directly impacted by mental health difficulties (Frese, Knight, & Saks, 2009; Lieberman et al., 2008). This approach emphasises an ongoing process of reclaiming a worthwhile life and is therefore more closely linked with functional outcomes (Corrigan, 2006; Davidson, Schmutte, Dinzeo, & Andres-Hymen, 2008; Harvey & Bellack, 2009; Roberts & Wolfson, 2004). The most widely cited definition of recovery is that of Antony (1993), who describes recovery as a personal and unique process. Recovery involves living a satisfying and hopeful life and developing new meaning and purpose in one's life, irrespective of whether or not one may continue to experience distress (Antony, 1993). Therefore recovery is much more than remission of psychiatric symptoms and does not require a return to a pre-existing state of mental health (Davidson & Roe, 2007). It is widely acknowledged that consideration of outcomes for individuals with mental health difficulties should not focus exclusively on reduction or remission of symptoms, which has led to considerable support for the concept of personal recovery as an outcome in mental health literature (Slade, 2009).

Despite the concept of recovery being a multidimensional construct that is unique to each individual, a number of broad themes have been identified by qualitative studies and systematic reviews. A conceptual review (Leamy, Bird, LeBoutillier, Williams, &

Slade, 2011) of the recovery literature identified five interlinking recovery processes: empowerment and reclaiming control over one's life; rebuilding positive personal and social identities (including dealing with the impact of stigma and discrimination); connectedness (including both personal and family relationships, and wider aspects of social inclusion); hope and optimism about the future; and finding meaning and purpose in life. The current paper is concerned with the role of connectedness and although this can apply to wider connection with society and attendance of peer support groups, this paper particularly examines relational connectedness in both personal and family relationships and support networks.

Narrative accounts of people in recovery have also identified the theme of connectedness with family members, friends and others highlighting the importance of connecting with family or establishing supportive social ties in maintaining a sense of personal wellbeing (Ralph, 2000). The concept of recovery incorporates both autonomous and relational elements (Bellack, 2006). The relational dimensions of recovery integrate the importance of increasing positive interpersonal and family relations, family contact and inter-connectedness with others (Lieberman & Kopelowicz, 2005). Connectedness as a psychological construct is related to attachment and belongingness, and is considered a key feature in identity development, mental health and well-being (Baumeister & Leary, 1995; Townsend & McWhirter 2005). Furthermore, researchers have suggested that lack or disruption of relational connections contributes to psychological distress (Berkman, Glass, Brissette, & Seeman, 2000; Lee & Robbins, 2000).

Developing positive relationships is a central aspect in the recovery process. Relationships shape identity, and contribute to or hinder well-being (Mancini, Hardiman, & Lawson, 2005; Mezzina, et al., 2006). Having one or more personal relationships that provide hope and encouragement can be a critical factor in achieving recovery (Spaniol, Wewiorski, Gange & Anthony, 2002), and many narratives detailing the recovery process speak of the vital support of a family member, friend or care-giver who provides support, hope and love (Leamy et al., 2011).

In the past the association between relational connectedness and recovery has been investigated from a more limited reductionist perspective that considers psychiatric symptoms. Emerging literature is increasingly looking at the role of relationships in the recovery process with a more personal perspective on recovery. However, this evidence base until recently has mostly consisted of qualitative approaches based on people's personal narratives and although this underpins the area, relationships and recovery are beginning to be examined by quantitative studies with larger sample sizes. This enables results to become more generalizable and allows for investigation of the interacting factors between different elements of connectedness and various dimensions of the recovery construct.

Therefore, the rationale for this review is that there has been no systematic examination of emerging quantitative literature of the role connectedness plays in enabling or impeding recovery. The aim is therefore to:-

- examine the quantitative literature on the role of connectedness in recovery from mental health difficulties;

- to see how relational connectedness and recovery are related; and
- determine which aspects of connectedness or social support promote the recovery process.

Method

In order to answer the review question, studies were sought in which recovery was directly measured in relation to defined aspects of relational connectedness.

Literature search protocol

The following five online databases were chosen and accessed (between November 2013 and March 2014)

Via the EBSCOhost service:

- PsycINFO *provides access to behavioural science and mental health citations;*
- Psycharticles, *a source of full text, peer-reviewed scholarly and scientific articles in psychology;*
- CINAHL Plus *provides full text for over 770 nursing and allied health journals.*

Via Web of Science:

- Web of Science Core Collection gateway *provides coverage of general and multidisciplinary titles.*

Via Pro Quest:

- International Bibliography of the Social Sciences IBSS *source of bibliographic references to journal articles and book reviews from 1951 onwards. It covers a wide range of the social sciences including social aspects of health.*

The following search terms were chosen:

- Recover*
- AND mental OR psycholog* OR psychiatr*
- AND health OR illness* OR problem* OR difficult* OR disorder*
- AND “connectedness” OR relation* OR famil* OR network OR support*

Search terms were based on those used in the REFOCUS systematic conceptual review on recovery (Leamy et al., 2011). This included the terms used to define the population of interest, as well as the stem ‘recover’ (to include ‘recovery’ or ‘recovering’). Terms relating to themes of relational connectedness were also included; these search terms were based on how relational connectedness has been defined in the literature (Leamy et al., 2011; Townsend & McWhirter, 2005) and included connectedness, relationships, families, networks and support.

Inclusion and exclusion criteria

For inclusion in the review, articles had to come from a peer-reviewed journal using a quantitative methodology. No geographical, temporal or participant age limitations were applied. Theoretical, policy and qualitative papers were excluded as were those without

a clear direct measure of recovery. All duplicates were removed prior to application of the exclusion criteria. Studies were included if they met all eligibility criteria which included:

- Peer reviewed papers;
- Empirical studies using quantitative methodology;
- Using a direct measure of recovery (rather than proxies such as symptom remission, quality of life);
- Investigating Recovery outcome was one of the main aims of the paper;
- Includes a measure of relational connectedness (e.g. social network, support, attachment).

Articles were excluded from the review based on one or more of the following criteria:

- Not written in English;
- Not peer reviewed;
- Theoretical/ policy/ qualitative investigations;
- Inadequate measure of recovery or recovery outcomes not being the main focus;
- Not investigating a mental health population (e.g. substance abuse/ brain injury).

Figure 1 shows the process by which studies were selected for final inclusion. After all limiters were applied and following the initial searches, abstracts were inspected to determine whether studies met all eligibility criteria. The initial abstract inspection identified 38 potential studies; this number was reduced to 11 once papers had been inspected in full and applying the inclusion and exclusion criteria listed above. In addition, all searches were cross-checked against recent publications by the recovery research team at the Institute of Psychiatry. Further hand inspection of references led to the inclusion of one further paper.

Data Extraction

The following data was extracted from the articles: main aims, descriptive statistics of samples, the measure of recovery, the measure of relational connectedness, the main findings and main conclusions. The data was condensed into Table 1, to facilitate an easier overview of the most relevant findings.

Quality Assessment

A modified scale was devised to specifically assess the methodological quality of included studies, in order to focus on quantitative studies reporting associations or correlations (Appendix B). Items were taken from three existing checklists. Items 1, 2, 3, 5, 6-12, 17, and 18 were adapted from Downs and Black (1998); a checklist for the assessment of methodological quality of health care interventions. Items 4, 13, 14, and 16 were adapted from the quality appraisal checklist for quantitative studies reporting correlations/associations developed by the UK National Institute for Health and Clinical Excellence (NICE, 2012) and items 15 and 19 were derived from Thompson, Diamond, McWilliam, Snyder and Snyder (2005) a scale for assessing quality in correlational research. The final scale contained 18 items. Items could either score 0 (for NO) or 1 (for YES), with item 15 reverse scored. Five studies, randomly selected, were rated by an independent assessor. Cohen's Kappa was found to be .72, indicating good agreement (Landis & Koch, 1977). Discrepancies in ratings were discussed until a consensus was reached.

Analysis of findings

Despite the quantitative nature of the 12 reviewed articles, a meta-analysis could not be used to summarise the review's findings, due to heterogeneity between studies. Sources

of heterogeneity included inconsistent reporting of effect sizes for the variables of interest and the use of different conceptualisations and measures of connectedness. As such, a narrative synthesis was used to summarise the review's findings.

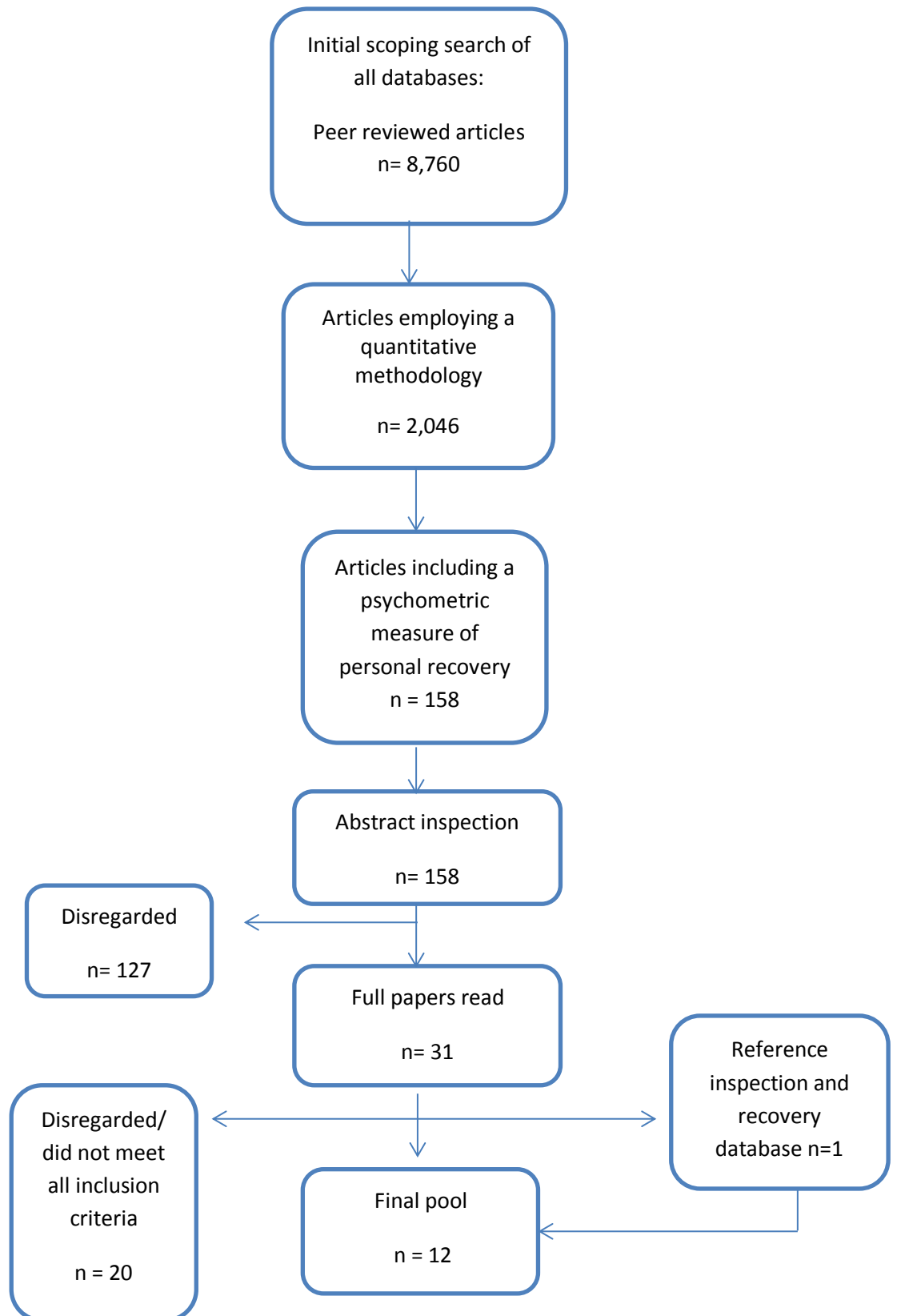


Figure 1. Flowchart illustrating the article selection process

Results

Overview of included studies

Of the 12 papers included in this review, nine used the Recovery Assessment Scale (RAS; Corrigan, Giffort, Rashid, Leary, & Okeke, 1999; RAS-S; Corrigan, Salzer, Ralph, Sangster, & Keck, 2004) as an outcome measure for recovery. Two studies (Chou & Chronister, 2011; Chang, Heller, Pickett & Chen, 2013) employed The Mental Health Recovery Scale (MHRS; Young & Bullock, 2003; MHRS-R; Chang, Ailey, Heller & Chen, 2013) and one (Mulligan & Lavender, 2010) employed the Recovery Style Questionnaire (RSQ; Drayton et al., 1998). Studies were cross-sectional and correlational in design, with some using hierarchical analysis, step-wise regression and variations such as mediation analysis. Only one study employed a longitudinal design. The studies generally contained moderate sample sizes; mean number of participants was 146 with a standard deviation of 62.40. In all the studies participants were aged 16 and over. The majority had an Axis 1 diagnosis (American Psychiatric Association, 2013) or self-reported mental illness and most were accessing mental health services currently. The majority of studies came from the United States (9), with one from Canada, one from the United Kingdom and one from Israel. Although there was some overlap with connectedness measures, a wide variety of tools for conceptualisation of connectedness were included. These have been organised in the results below.

Table 1 shows data extracted from the reviewed studies, summaries of methodological quality scores are included in Appendix C; both were drawn on for the narrative synthesis.

Table 1. Summary of reviewed articles

Study	Aims	Recovery measure	Relational connectedness measure	Sample	Main Results	Conclusion
Biegel, Pernice-Duca, Chang, Chung, Min & D'Angelo (2013) USA	To examine the contribution of family social network variables to recovery.	Recovery Assessment Scale (RAS); Corrigan, Salzer, Ralph, Sangster, & Keck, (2004).	Social network interview (Pernica-Duca & Onaga, 2009) Variables included: Overall Support, Criticalness, Relationship Satisfaction, Quality of relationship with the most supportive network member.	118 Clubhouse members, ¹ with a self- reported mental illness 66.1%, were male; Mean age: 43.6; schizophrenia– spectrum disorder (61%), mood disorder (32.2%)	All family network variables correlated with recovery; Support ($r=.34$, $p<0.001$) Criticalness ($r=-.22$, $p<0.05$) Satisfaction ($r=.25$, $p<0.01$) Positive relationship quality ($r=.36$ $p<0.001$) Negative relationship quality ($r=-.18$, $p<0.05$) Hierarchical regression controlling for psychosocial functioning showed that and family network accounted for, 19% of the variance in total	Greater overall family support and higher Positive Relationship Quality from the most supportive network member were the most predictive variables of recovery these outcomes corroborate other investigations of family network support and recovery.

¹ Clubhouses are rehabilitation programs focusing on work related tasks to address the needs of people living with serious mental illness. The Clubhouse model can be found in 29 countries across the world with the majority in the United States (International Center for Clubhouse Development, 2006).

recovery.

Support and positive relationship were the most significant predictors for total RAS, PCH and R score. Positive Relationship was a significant predictor for WH²

Chang, Pickett & Chen (2013) USA	To examine the relationship between recovery and associated social-environmental and individual factors.	Revised Mental Health Recovery scale (MHRS-R) Chang, Ailey, Heller & Chen (2013).	Social Support Survey (SSS; Sherbourne & Stewart, 1991)	159 Participants were recruited from a large community mental health agency 69% were male; Mean age; 47.04, Schizoaffective disorder (40%) Major depression (20%) bipolar disorder (36%) Other (6%)	A hierarchical multiple regression analysis considering social support, perceived recovery-oriented service quality, psychiatric symptoms, and demographics accounted for a significant amount of variance in recovery. (58%); $F(9, 114) = 17.72, p < .001$, Social support had the positive and highest standardized coefficient in the final	Social-environmental factors play an important role in recovery, even after taking into account psychiatric symptoms. Social support has the most influence on recovery.
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² RAS subscales (PCH= Personal Confidence and Hope, WH= Willingness to ask for Help, GS= Goal and Success Orientation, R= Reliance on Others and D= Level of Dominance by Symptoms)

regression model β 0.49 $p < 0.001$

Chou and Chronister (2011) USA	To investigate the amount of variance accounted for by four social tie characteristics (social network orientation, emotional support, tangible support, and negative exchange in mental health recovery.	Mental Health Recovery Scale (Young & Bullock, 2003)	The Interpersonal Support Evaluation List (ISEL; Cohen, Mermelstein, Kamarck, & Hoberman, 1983) The Network Orientation Scale; Vaux, Burda & Stewart, 1986) The Negative Social Exchange Scale (Newsom, Morgan, Nishishibi & Rook, 2000) The UCLA Loneliness Scale (version 3; Russell, 1996)	101 adults actively attending psychosocial rehabilitation programs in New York City and Boston 60% were male, Mean age: 44 Schizophrenia (42%) Schizoaffective (18%) Major depression (16%) Bipolar Disorder (11%) Other (13%)	Social tie variables accounted for significantly more variance in recovery than symptom distress, $R^2 = .33$, $\Delta R^2 = .23$, $\Delta F(4, 95) = 7.87$, $p < .001$. Specifically, increased tangible support predicted higher levels of recovery, $\beta = .58$, $t = 4.390$, $p < .001$. Mediation analyses showed that tangible support mediates the relationship between symptom distress and recovery.	Although symptom distress continues to be a major predictor of mental health outcomes, addressing social tie characteristics is important to enhancing positive outcomes for persons with mental health difficulties.
Corrigan & Phelan	To examine the	RAS (Corrigan et al. 1999)	Social	176 participants	Overall support network	Recovery as a process

(2004) USA	relationship	Network Scale (Stein,	48% were male;	met the Bonferroni	is associated with
	between objective	Rappaport, & Seidman,	Mean age: 41.3;	criterion for a significant	social support; people
	and subjective	1995).	(no data on diagnosis	correlation with GS ($r=.27$,	with larger overall
	measures of social		provided)	$p<.01$) and R ($r=.28$, $p<.01$)	network size and more
	support with			Size of the family support	network satisfaction
	recovery from			network was mostly not	were likely to report
	serious mental			significantly associated with	higher factors on the
	illness			RAS factors while size of the	Recovery Assessment
				friend support network was.	Scale.
				Satisfaction with one's support	
				system was significantly	
				associated with all five of the	
				RAS factors; these coefficients	
				also met Bonferroni criteria.	
				PCH ($r=.31$, $p<.01$)	
				WH= ($r=.34$, $p<.01$)	
				GS ($r=.28$, $p<.01$)	
				R($r=.33$, $p<.01$)	
				D ($r=.30$, $p<.01$)	
				Perceived mutuality and	

obligation were not significantly associated with any of the five RAS scales.

Hendryx Green & Perrin (2009) USA	This study examined the roles of social support, social network size, and engagement in activities as they relate to recovery from serious mental illness.	RAS (Corrigan et al, 1999)	Both the social support and social network items were taken from the Wisconsin Quality of Life Questionnaire (Becker, 1993)	153-participant from the Study of Transitions and Recovery Strategies 48% were male; Mean age: 48.8; Schizophrenia spectrum disorder (39.9%) Other (61.1%)	Social support and social network correlated with the RAS at 0.44 and 0.36, respectively.	The results add to the evidence base of the importance of social supports in recovery for mental health difficulties
Mulligan and Lavender (2010) UK	To investigate associations between recovery styles, early bonding experiences and	Recovery Style Questionnaire (<i>RSQ</i>) Drayton, Birchwood & Trower (1998) (high scores indicate	Parental bonding (PBI)Parker, Tupling, & Brown, (1979) Attachment Style Questionnaire (ASQ) Feeney, Noller, &	73 participants from community mental health services. 75% were male All participants had experienced symptoms	A significant negative correlation was found between recovery style and the relationships as secondary to achievement scale ($r = -0.41$, $p < 0.01$).	People with avoidant attachment styles that class relationships as secondary to achievement are more likely to have a sealing

current attachment integration, low scores Hanrahan (1994) commonly associated In a regression analysis only over recovery style in
 styles indicate sealing over) with psychosis relationships as secondary to which they will ignore
 (hallucinations, achievement (a measure of illness. The use of
 delusions and cognitive insecure attachment) reached other measures is
 problems) with a significance (β 0.13, $p < 0.01$) recommended for
 duration of at least 1 in predicting recovery style future studies.
 year.

Norman, Windell, Lynch & Manchanda (2013) Canada	To examine the relative importance of symptoms and components of social support in predicting subjective recovery from psychosis.	RAS (Corrigan, et al, 2004).	Interpersonal Support Evaluation List (ISEL) (Cohen et al. 1983)	84 participants from the Prevention and Early Intervention Program for Psychoses (PEPP) in London, Ontario, Canada 69% were male; Mean age: 28; All participants experienced psychosis.	PRES ³ was the most significant and consistent correlate of all the recovery scales GS ($r=0.33$, $p<0.001$) PCH ($r=0.65$ $p<0.001$) R (0.48 , $p<0.01$) WH(0.42 , $p<0.001$) D (0.26 , $p<0.05$) Stepwise regression showed PRES as the most significant predictor of recovery for four of the subscales	Findings indicated that the extent to which an individual perceives himself or herself as being respected by others may be the most important aspect of social support in predicting recovery. This is independent of severity of symptoms of psychosis.
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³ PRE= Perceived Relational Evaluation

					PCH (β 0.295 $p=0.008$)	
					R(β 0.561 $p<0.001$)	
					WH(β 0.300 $p<0.008$)	
					D(β 0.254, $p=0.023$)	
Pernice-Duca (2010)	To describe family support characteristics of mental health service users and to investigate how these domains are important to recovery	RAS -S (Corrigan et al, 2004)	Social functioning scale (SSSNI;)Lovell, Burrow & Hammer, 1984	169 from community clubhouses who identified a family member as part of the social support network Age range: 30-45 Major affective disorder (58%) Schizophrenia spectrum (41.4%)	Family support, ($r=.39$, $p<0.01$) reciprocity ($r=.45$, $p<0.01$) and satisfaction($r=.30$, $p<0.01$) significantly correlated with total RAS as well as all individual subscales. Hierarchical regression showed that reciprocity and support were consistent predictors of each of the RAS subscales. Reciprocity was the variable that accounted for the most variance (20%) in total RAS score.	Qualitative aspects were found to be more important to the recovery process than structural elements (size and frequency of contact). Support and reciprocity with family members are important dimensions of the personal support network which relates to the recovery process
Pernice-Duca & Onaga, (2009)	To explore the relationship	(RAS; Corrigan, et al, 1999)	(SSSNI; Lovell et al., 1984).	A total of 221 clubhouse members	The strongest correlations with RAS were	Quality of social network supports is

USA	between social networks and recovery among a group of clubhouse consumers.			completed the first interview and 179 clubhouse members completed a second interview between 12 to 15 months later. Participants were between the ages of 36 and 55, Half were living with Schizophrenia or a related condition, and a third were living with a mood disorder.	support (r.37, p<0.01); reciprocity (r.43 p<0.01)and satisfaction (r.31, p<0.01) Model 1: social network variables accounted for 29% of the variance in recovery scores at baseline. Support, reciprocity, satisfaction and the number of peer supports were all significant predictors Model 2: social network variables contributed to 19% of the variance in recovery scores at follow up. Support, reciprocity, and size of the family network at baseline were significant predictors.	more important predictors of recovery than the number of supports. Clubhouse members who experienced greater recovery were also more likely to experience greater reciprocity with their network members. This pattern was also replicated over time.
Roe, Mashiach-Eizenberg & Lysaker, (2011)	To investigate the relationship between objective	(RAS; Corrigan et al, 1994)	Multidimensional scale of perceived social support (MSPSS)	159, participants from residential rehabilitation centres in	Social support was significantly correlated with self-reported recovery (r=.33, p<.001)	Results suggest that lower levels of loneliness and greater

Israel	clinical recovery and subjective personal recovery		(Dangoor and Florian, 1994). Hebrew version Social and emotional loneliness scale—short version (S-SELAS) (DiTommaso & Spinner, 1993)	Israel. 66.7% were male; Mean age=43.2; participants were diagnosed with schizophrenia spectrum disorder	Loneliness was negatively correlated with self-reported recovery ($r=-.32$, $p=.001$;	perceived social support are associated with a greater sense of personal recovery.
Townley, Miller & Kloos (2013) USA	To consider distal support and traditional social support networks as predictors of recovery	RAS-Short form (RAS-S) (Corrigan et al. 2004).	10-item scale adapted from the SAMHSA ACCESS protocol (Lam & Roshenheck, 1999)	300 adults using outpatient mental health services. 43% were male; Mean age (46). Schizophrenia spectrum disorder (46 %). Major depression (25 %), Bipolar disorder (22 %), and Other (7 %)	Demographic/diagnostic variables accounted for 1.8 % of the variance in Recovery, $F(4, 295) = 1.30$, $p = .27$. Traditional social support network variable explained an additional 15.6 % of the variance, $F(1, 294) = 54.36$, $p < .001$. Distal support variable explained 1.2 % of additional variance in recovery $F(1,$	Having traditional social support is more influential in the recovery process; however, the establishment of casual ties with community members plays a unique role in supporting this process.

293) = 4.15, $p < .05$.

Webb, Charbonneau, McCann and Gayle (2011)	To assess the relationship between religiosity and recovery from severe mental illnesses	(RAS; Corrigan et al, 1999)	The Religious Support Scale (RSS) Fiala, Bjorck, & Gorsuch, (2002).	81 participants with self-reported severe mental illnesses. 45% were male; Mean age (43); Multiple diagnoses (22%) Depression (41%) Bipolar (19%) Schizophrenia spectrum (15%) Other (4%)	Religious support significantly correlated with recovery. ($r = .30$, $p < .01$)	Religious variables, including religious support and feeling connected to God might be linked with recovery from severe mental illnesses, for people with religious beliefs.
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Measuring recovery

The RAS or RAS-S (Corrigan et al., 1999; Corrigan et al., 2004) was used for nine of the included studies as a measure of recovery. The development of the RAS was based on the analysis of narratives among people with severe mental illness and their recovery process. Overall, a study of the scale yielded test–retest reliability of .88 and a Cronbach’s alpha of .93 for internal consistency (Corrigan et al., 1999). The RAS measures recovery as a multidimensional construct composed of five factors: personal confidence and hope; willingness to ask for help; goal and success orientation; reliance on others; and the level of domination by symptoms. The RAS-S is a 24 item version based on items that best represent each of the five factors (Corrigan et al., 2004).

The MHRS and MHRS-R (Young & Bullock, 2003; Chang et al., 2013) are based on a conceptual model of mental health recovery that is grounded in the experiences of persons with mental health difficulties. Reliability and validity evidence has been reported to be strong (Chang et al., 2013; Rogers, Chamberlin, Ellison, & Crean, 1997).

The RSQ (Drayton et al., 1998) is a self-report questionnaire developed to measure recovery style in people with psychosis. The RSQ is based upon the Integration Sealing Over Scale (ISOS) (McGlashan, 1987) which has been shown to be reliable and valid (McGlashan, Doherty, & Siris, 1976) however, the reliability of the RSQ was found to be somewhat lower ($\alpha = 0.52$).

Trends in methodological quality

The papers overall were of reasonable quality with a mean rating of 71% on the quality checklist. Key areas which arose from the review of methodological quality were that

all studies were non-experimental, using correlations and most data was taken at one time point. The majority of studies were exploratory with only three (Corrigan et al., 2004; Mulligan & Lavender, 2010; Webb et al., 2011) making a priori assumptions. Some of the studies showed limited data for the reliability and validity of measures used. These mostly related to the connectedness measures (Biegel et al., 2013; Corrigan et al., 2004; Hendryx et al., 2009; Mulligan & Lavender, 2010; Pernice-Duca, 2010; Pernice-Duca & Onaga, 2009). It has long been reported that there is limited evidence for social network measures (Dean, Holst, Kreiner, Schoenborn & Wilson, 1994); also some items on measures in the reviewed studies were adapted or created for the purpose of the study. Eight papers did not adjust analyses for multiple correlations (Biegel et al., 2013; Chou et al., 2011; Mulligan & Lavender, 2010; Pernice-Duca, 2010; Pernice-Duca & Onaga, 2009; Roe et al., 2011; Townley et al., 2013; Webb et al., 2011) introducing the possibility of type I errors. Only three papers reported a power calculation (Chou et al., 2011; Mulligan & Lavender, 2010; Pernice-Duca, 2010) and out of these only Chou et al., (2011) included a sample size with adequate power to detect significance. Despite a lack of reporting power calculations it cannot be assumed that the other studies had insufficient power.

Social support network

Four studies found a positive correlation between social support network and self-reported recovery (RAS), (Corrigan & Phelan, 2004; Hendryx et al., 2009; Roe et al., 2011; Townley, 2013).

Townley et al. (2013) conducted a hierarchical regression analysis of predictive variables of recovery considering demographics, social network and distal supports. They found that social network accounted for the most variance in recovery and

significantly more than demographics and distal community supports. Chang et al. (2013) also conducted a hierarchical multiple regression analysis and showed that social support accounted for the greatest amount of variance in recovery over both psychiatric symptoms and how much a service was perceived as being recovery orientated.

Corrigan & Phelan (2004) investigated how different variables of social network were related to different dimensions of the RAS. After applying the Bonferroni correction, (a correction applied when several comparisons are considered simultaneously, in order to control for type I error, (Miller, 1981)), it was shown that size of the overall support network was significantly associated with Goal and Success Orientation and Reliance on Others. In regard to qualitative aspects, satisfaction with one's own support system was significantly associated with all five of the RAS factors; however, perceived mutuality and obligation were not significantly associated with any of the five RAS scales.

Despite different measures of social support being used, there seems to be some evidence for the association between social support network and recovery, with some emerging evidence that satisfaction with support network rather than the actual size of the support network is the most important.

Family network

Pernice-Duca (2010) looked at different elements of the family network (support, reciprocity, satisfaction, size of network, frequency of contact, and importance of family). Zero order correlations indicated that the total RAS score was positively correlated with family support, family reciprocity, and satisfaction. The relationship

between family network variables and the different sub-scales of the RAS was also considered, and the variables that were consistently positively correlated with all the subscales were support, reciprocity and satisfaction. No correlations were found between the structural variables of network size and frequency of contact with any of the RAS subscales.

Pernice-Duca (2010) also conducted separate multiple regression analyses examining the contribution of family network support variables to different subscale of the RAS, whilst controlling for level of social functioning. Each model was significant in predicting aspects of recovery. Reciprocity and support were shown to be the consistent significant predictors of all dimensions of recovery. When considering total RAS, reciprocity was the most important factor, accounting for 20% of variance.

Beigel et al. (2013) also considered the relationship between different elements of the family network (overall family support, criticalness, satisfaction, positive relationship quality and negative relationship quality) and recovery. Overall family support, satisfaction, and positive relationship quality were positively correlated with all RAS subscales. Criticalness was correlated negatively with Personal Confidence and Reliance on Others; and negative relationship quality was correlated negatively with Reliance on Others. Positive relationship quality and overall support showed the highest correlations with total RAS score.

Results for the multiple regression analysis with total RAS indicated that family network variables significantly predicted recovery over social functioning. Network variables explained an additional 19% of the variance in overall recovery. Greater overall family support and higher positive relationship quality from the most supportive

person were significantly associated with higher levels of recovery. These factors were also found to be important predictors for all the RAS subscales when considered individually.

Overall, family network variables which were qualities of the relationship were more important for understanding aspects of recovery than the actual size of network and frequency of contact. In particular reciprocity, positive relationship quality and support emerged as important. It appears that negative relationship quality and criticalness may impact on recovery, by preventing people from feeling they can rely on others in their support network. Again, this mirrors Corrigan and Phelan's (2004) study which showed satisfaction to be more consistently and strongly related to recovery and with all its subscales over actual size of network. A difference emerging is that Pernice-Duce (2010) found reciprocity to be the most important factor in predicting recovery, whereas Corrigan and Phelan (2004) found that a similar construct (mutuality) was not correlated with recovery. This difference could arise due to various factors such as different measures being used to measure the constructs, and examining different types of networks (general social networks vs family networks).

Types of support

In regard to different forms of support the literature has considered appraisal support, tangible support, emotional support and specific elements of emotional support such as perceived relational evaluation (PRE) and loneliness (Chou et al., 2012; Norman et al., 2013; Roe et al., 2011).

Chou et al. (2012) found that mental health recovery was positively correlated with emotional support and tangible support, but was not correlated with negative social

exchange or social network orientation. Hierarchical regression analysis showed that all these social support characteristics significantly added to the amount of variance accounted for in recovery above and beyond that accounted for by symptom distress. Specifically, increased tangible support was found to predict higher levels of recovery. Further, tangible support was found to mediate the relationship between symptom distress and recovery.

Norman et al. (2013) also examined components of social support and how these correlate with subscales of recovery. However, this study found that PRE was the aspect of social support that was most consistently related to subjective recovery. A stepwise regression procedure identified that the PRE score emerged as the most important independent predictor of each index of recovery, except the RAS Goal and Success Orientation subscale. For this subscale negative symptoms were the most important predictor followed by PRE.

In the literature some authors have conceptualised loneliness as a measure of emotional social support (Townsend & McWhirter, 2005) and this was shown to be negatively correlated with self-reported recovery (Roe et al., 2011; Chou et al., 2012).

These studies have allowed for examination of the relative importance of different elements of social support. Emotional support was correlated positively across the studies, with higher levels of loneliness relating to lower levels of self-reported recovery. One study (Chou et al., 2012) indicated the importance of tangible support over emotional support in predicting variance in recovery and also mediating the relationship between symptom distress and recovery. However, another study, (Norman et al., 2013) employing the same measures, found that PRE was the most consistent

correlate and individual predictor of recovery. This suggests that the extent to which an individual perceives themselves as being respected by others is the most important aspect of social support in predicting recovery. This relates to factors such as relationship quality and reciprocity which have already been identified as important. The differences observed in the various studies could be due to different samples, as Norman et al. (2013) considered participants with psychosis from an early intervention programme, which was a younger cohort than the sample included in the Chou et al. (2012) study, whose sample included a range of AXIS 1 diagnoses (schizophrenia, major depression and bipolar disorder, (APA, 2013)). Therefore, it remains difficult to draw firm conclusions about the relative importance of different elements of social support from the current available studies.

Recovery over time

Pernice-Duca & Onaga (2009) were the only researchers employing a longitudinal design. They considered social network variables and their association with recovery at a baseline and a follow up time 15 months later. The strongest correlations with total RAS at baseline were shown for qualitative aspects. Reciprocity showed the strongest positive correlation, followed by support, satisfaction and then network size. Weaker correlations were shown for number of friends, clubhouse members and staff. No correlation between number of family members and total RAS was found.

At Time 2 (15 months later) total RAS was positively correlated with the number of family supports, the number of clubhouse staff, size of network, support, reciprocity and satisfaction. Reciprocity again was found to have the strongest correlation.

Two multiple regression analyses were performed using social network variables at Time 1 to predict total RAS scores at both Time 1 and Time 2, social functioning was used as a control. Social network variables accounted for 29% of the variance in recovery scores at Time 1. Level of support, reciprocity, and satisfaction with contact and the number of friends in the support network, were the factors shown to significantly contribute to the variance in recovery scores.

When predicting recovery at Time 2, social network variables contributed to 19% of the variance in recovery scores. Level of support and reciprocity at Time 1 were the qualitative social network features to contribute significantly to predicting recovery over time. The size of the family network measured at Time 1 was also shown to be important.

This study demonstrated some initial evidence that various social network features influence a subjective process of recovery, specifically, the size of the network, the extent of support, and reciprocity. Reciprocity with network members had a stronger positive correlation than received support, suggesting that participants who experienced greater recovery were also more likely to experience greater reciprocity with their network members. Predicting recovery revealed that social network support as well as reciprocity with network members significantly contributes to understanding the recovery process over time. The extent of social contact did not demonstrate any association with recovery constructs, indicating again that quality, not quantity of contact was more important to this process. Number of friends in the support network was significantly associated with higher levels of recovery at Time 1, whereas number of family supports emerged as the significant predictor for the recovery process at Time 2, this may reflect the permanence of family support. Although peer support seems to be

important this may be more susceptible to fluctuation over the recovery process. This highlights the need for more research investigating kin and non-kin relationships and how these relate to the recovery process.

Others

Religious support

Webb et al. (2011) investigated the relationship between recovery and religious support (defined as God support, congregational support and church leader support) and reported that recovery and total religious support were significantly correlated. However, the extent that people felt 'connected' to God confounded the measure of religious support, as differing levels of strength of religious belief was collected but not factored into analysis.

Attachment

Only one study looked at attachment style and the relationship with recovery (Mulligan & Lavender, 2010). This study showed a significant relationship between people who tended to dismiss relationships (conceptualised as an avoidant attachment style) and a recovery style in which people were more likely to minimise and ignore any illness or symptoms. Mulligan and Lavender (2010) argue that this leads to a less relational process of recovery.

Discussion

The aim of the review was to investigate the role of relational connectedness in recovery from mental health difficulties. This area is showing consistent positive correlations between elements of connectedness (such as social network, types of support and qualities in relationships) and recovery, as well as some evidence for a negative correlation between loneliness and recovery. In addition factors such as social network size, social support, reciprocity, satisfaction and positive relationship quality were shown to be more strongly associated with recovery than symptom distress, diagnosis and overall level of functioning. What emerged and seems important in the recovery process are the qualities of relationships, such as positive relationship quality, reciprocity and how one is perceived and respected rather than simply the size of support network or frequency of contact with network members. These are qualities that have been reported in past literatures to be indicative of more effective support networks (Hardiman & Segal, 2003). Further there is some preliminary evidence that negative relationship quality and criticalness may be linked with lower levels of recovery. Reciprocity was shown to be important in a number of studies this may play a role in equalizing a relationship by increasing the capacity to share with others as well as being of assistance to others. Reciprocal relationships and support have been shown to increase self-esteem (Bracke, Christiaens, & Verhaeghe, 2008) as well as allowing for development of self-efficacy and self-agency (Knox, 2010), which have been highlighted as central aspects of personal recovery (Abbott, 2008; Mancini, 2008 & Rogers et al. 1997).

Currently there are not enough studies to determine what type of support may be most associated with recovery, however, both emotional and tangible support were indicated

as important. This finding is consistent with the robust literature body that reveals emotional support to be linked with a wide array of outcomes, and with the assertion that emotional support is the most beneficial type of support across various types of stressors (Cohen & McKay, 1984; Cutrona & Russell, 1990). However alongside emotional support, tangible support was also considered important in the recovery process. This was shown to mediate symptom distress and recovery in one study (Chou et al. 2011), suggesting that people may find concrete and direct forms of support to be more important than emotional support in the recovery process. Taken together these findings are consistent with long-standing psychological models, which emphasize the particular importance of acceptance and respect received from those in one's social network and the quality of connections in determining a positive sense of self (Baumister & Leary, 1995; Mancini et al., 2005; Mezzina et al., 2006; Williams & Zadro, 2001) and the importance of emotional support for those dealing with a disadvantaged or stigmatized identity (Vanier, 2008).

Only one study (Mulligan & Lavender, 2010) considered attachment and how this relates to a person's recovery style. More consideration of attachment is important, as it results in how one utilises supports and relates to others. Further studies are needed to examine how differences in how people relate to others facilitate or hinder the recovery process. Webb et al. (2011) considered religious social support including feeling connected with God, again showing a possible link with self-reported recovery. Not much can be drawn from individual studies but further research would illuminate this relationship, as there is much literature considering the importance of religiosity and connections people find through faith among people recovering from mental health difficulties (Kang & Kim, 2014; Prout, Cecero & Dragatsi, 2012; Walker, Mazurana, Warren, Scarlett & Louis, 2012).

Recovery as a construct is continually expanding. Integrating the notion of reciprocity, relationship quality, as well as the form of support people receive, will capture these important dynamics of social relationships and how they impact on the recovery process. However, these factors alone do not account for variability in recovery, recovery is a process that takes time and is multi-faceted and it still remains unclear what directly influences one's recovery.

Methodological quality of the area

Due to the correlational design used by all the studies in this area causation and directionality of relationships cannot be inferred. Also since cross-sectional designs were employed across the majority of studies this only accounts for data taken at one time point. Relational connections, social support and recovery will fluctuate over time and at present there are no details of this except from one single study (Pernice-Duca & Onaga, 2009) which used a longitudinal design. However, the results of this study should be interpreted with caution, given the limitations of non-experimental designs. The methodological caveat still precludes one from making conclusions based on the direction of effects. That is, without a uniform baseline measure established at Time 1, and the lack of social network data collected at Time 2 it is still unclear whether a supportive social network assists in the recovery process or whether a certain level of recovery also allows for the development of additional social network supports (Pernice-Duca & Onaga, 2009). Furthermore, it should be noted that studies used non-random convenience sampling and all but one study recruited from rehabilitation programmes or included people in contact with mental health services currently, who were reported to be "in a stable condition". This poses a threat to external validity as

results cannot be generalised to others, such as those with acute difficulties, or people refusing treatment or those not currently supported through mental health services.

All of the measures used were self-report, therefore there is the possibility that correlations were due to common response bias, such as social desirability which can cause overestimation or underestimation results (Huang, Liao, & Chang, 1998). Although, it is important to consider the individual's perceptions of relational connections, the subjective and unique experiences of the participants pose a methodical dilemma in that responses could be argued to be compounded by the fact that participants experience mental health difficulties. Fluctuation of symptoms could affect responses at a given time and self-report taken at one time point may not be representative of the normal level of overall functioning. However, to address this, diagnosis, distress or level of functioning was controlled for in most regression analyses. Further, not all studies applied Bonferroni criteria to multiple correlations, therefore the results presented may be subject to type I error. On the other hand due to the lack of reporting power calculations it is difficult to ascertain if all studies had adequate power to detect significance, introducing the possibility of type II errors. There were a range of measures used, however, some were of questionable reliability and validity which limits the strength of conclusions which can be drawn from these papers. Also there was variable reporting of effect sizes for individual predictors, so although evidence for the overall role of social support could be drawn it limited investigation of the factors of social support included within some studies.

Limitations of the review

Only peer-reviewed articles were included in the review. Although this increases the quality of reviewed articles, it may mean that the review's findings are subject to

publication bias (Rothstein, Sutton, & Borenstein, 2005). Also only papers written in English were included which may have resulted in selection bias. The review was weakened by the fact that only one rater assessed articles' suitability for inclusion. As such, it is impossible to determine the reliability of the article selection process. This review was interested in relational connectedness, however connectedness can also include wider social inclusion and attendance of peer support groups, the review could be criticised for the exclusion of these elements. A review of the research considering these aspects would further add to the knowledge area.

Future research

The main shortcoming in this area of reviewed literature is the dominance of cross-sectional correlational data. Further studies in this area should employ longitudinal designs to investigate the role of relational connectedness in the recovery process over time. Also establishing clear baselines and collection of consistent data sets over time would allow testing for directionality of effects. This would enable investigation of whether recovery leads to greater relational connectedness or whether indeed relational connectedness promotes greater recovery.

Although there appears to be a consistent relationship between connectedness and recovery, it will be beneficial to have further empirical studies to corroborate these results and increase the reliability of research in this area. Future research should ensure the use of valid and reliable measures of relational connectedness as well as use and further development of valid social support network measures. Also, data should be collected from various mental health agencies and attempt to reach people with limited access to services. Larger and more diverse samples will expand the generalization of

research findings. Further, to counteract self-report bias future research in this area should triangulate self-report measures with observer-generated assessments, reports from social network members or functional outcomes to add to the reliability of findings.

As recovery is multidimensional and relational connectedness contains many elements, further investigation of how various elements of connectedness relate to recovery as a whole and its different aspects are warranted. Analyses such as structural equation modelling or path analysis would shed light on how these variables interrelate.

Further, it is worth noting that measures such as the RAS may not adequately capture the dynamic process of recovery from mental health difficulties. Therefore further development of recovery measures in general is required in order to support future quantitative investigation in this area.

Implications and conclusions

Assuming that further research substantiates this relationship and establishes the direction of the association, these findings support interventions that facilitate relationships and social networks. Family, support networks and having positive connections are a significant positive aspect of the recovery process and it is important to integrate and encourage these in clinical practice. Interventions concerning social support primarily focus on increasing a person's social support network, however it is important to address the quality of the connections within the network and work towards increasing and developing the quality of these relationships. In addition, there is a need to consider gaps in particular forms of support (i.e., emotional, tangible) as it

may be that they impact outcomes differently. Therefore, it is important to identify not only who is in a person's network and the nature of the connection (i.e., supportive/non-supportive) but also the particular type of support being provided. This will provide a clearer picture of a person's social environment leading to better tailored interventions.

These research results are useful for mental health service design and policy-making; they expand the knowledge base of the recovery literature and support interventions in social areas as well as just the simplified model of "symptom control". Findings showed that connectedness was predictive of recovery often over and above psychiatric symptoms. Therefore, this supports the notion that interventions in these areas will be useful in promoting recovery and helping people improve their lives and personal goals. Results also add to the evidence that people continuing to experience mental health difficulties can pursue personal recovery with the right support.

Despite some methodological shortcomings, results for this review can be taken to suggest that relational connectedness and the quality of relationships are associated with better recovery. The results contribute important quantitative evidence for connectedness and the recovery process, which complements qualitative research in this area and people's personal narrative of the recovery process.

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Part 2:

Empirical Paper

Exploring Relational Connections among Care Leavers

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Abstract

Background: There remains a dearth of literature related to concepts of how to achieve successful outcomes for care leavers, particularly in terms of relational aspects of well-being, and resistance to help-seeking. Therefore, this qualitative study aimed to explore what facilitates and hinders relational connections, barriers to help-seeking and emotional coping strategies in a group of care leavers.

Method: An idiographic approach was used. Semi-structured interviews were conducted with nine young people who had been in care; the transcribed data was interpreted using interpretative phenomenological analysis (IPA).

Results: Five super-ordinate themes emerged; being there, protective distancing, coping with strong emotions, seeing me as me and equal relationships.

Conclusion: The current study highlights the importance of relational continuity despite the adoption of distancing strategies many youth use. Accepting and reciprocal relationships may help develop a resilient identity and more positive self-beliefs which may overcome some of the barriers to help-seeking in this group. Theoretical and clinical implications are discussed.

Keywords: *care leavers, experiences, connectedness, relationships, help-seeking, coping.*

Introduction

Young people who have experienced growing up in care are considered a particularly vulnerable group and many care leavers are subject to poor life outcomes (Lonne, Parton, Thomson, & Harries, 2008). These include greater likelihood of involvement in the criminal justice system and higher rates of mental health difficulties, as well as being more likely to experience unemployment, poverty, homelessness and social exclusion compared with their peers (Berridge, 2007; Stein, 2006a; Wade & Dixon, 2006; Utting, 1997). Looked After Children (LAC) are often exposed to persistent risk factors from an early age as well as the inflating effect of cumulative risk factors during their time in care (Luthar & Cicchetti, 2000; Newman, 2004), which in turn impact on emotional development, resilience levels (Coleman & Hagell, 2007) and the ability to successfully develop and maintain relationships.

The benefits for youth being connected to supportive adults, has long been reported in general resilience and youth development literature (Samuels & Pryce, 2008). These benefits include positive effects on self-esteem, psychological wellbeing, educational achievement and social skill development (Massinga & Pecora, 2004; Perry, 2006). Supportive social networks and relationships function as protective factors against many negative outcomes predicted for this population (Massinga & Pecora, 2004; Perry, 2006; Propp, Ortega & Newheart, 2003). Foster youth without supportive connections experience risks related to their emotional well-being with increased incidence of mental health and behavioural problems. The risks associated with lack of connections include risks of school drop-out; unemployment and homelessness (Hook & Courtney, 2011). Conversely other studies indicate that youth who reported higher levels of social support from friends and family had improved health, developmental outcomes and

increased resilience (Daining & DePanfilis, 2007) as well as higher life satisfaction as adults (Ahrens et al., 2011; Greeson, Usher, & Grinstein-Weiss, 2009; Munson & McMillen, 2009). Success in establishing and maintaining social relations is important for healthy development, as social relations provide a fundamental source of positive wellbeing and fulfil the basic need for connectedness and belonging (Bamba & Haight, 2007; Cook, 1994; Courtney, Piliavin, Grogan-Kaylor & Nesmith, 2001; Perry, 2006).

Attachment theory is highly applicable in exploring the nature of supportive relationships. Attachment theory posits that our early relationship with our primary caregiver leads to the development of an 'internal working model' of beliefs and expectations in relation to ourselves and others (Bowlby, 1969). This model underpins our early relationships, and leads to the development of characteristic 'patterns' of relating ('attachment'), which are designed to ensure that our essential needs are met (Ainsworth, Blehar, Waters, & Wall, 1979). Therefore care giving experiences from the past underpin the relational strategies which are drawn upon when seeking support in the present (Dallos & Comley-Ross, 2005; Schofield, 2002; Stein, 2006a).

Yet experiences of being in care may pose challenges to one's sense of interpersonal connection (Bamba & Haight, 2007) and the development of attachment styles, which in turn impact on patterns of relating to others and one's use of, or openness to, receiving or requesting support (Bamba & Haight, 2007; Samuels & Pryce, 2008). Literature of care leavers' experiences of leaving care highlights a strong theme of a desire for autonomy and in particular the idea of a strong sense of self-reliance (Cameron, 2007; Dixon, Wade, Byford, Weatherly, & Lee, 2006; Samuels & Pryce, 2008). This idea of self-reliance is thought to arise from lacking both the real or symbolic presence of biological parents and a perceived early transfer to adult

independence compared to peers. This leaves youth feeling responsible for their own development and safety (Samuels & Pryce, 2008). Such self-reliance may be indicative of resilient coping strategies (Cameron, 2007; Dixon et al., 2006). However, despite this, young people leaving care repeatedly identify that the greatest challenges when leaving care are a lack of emotional support, a fear of dependence, resistance to seeking and receiving emotional support and feelings of isolation and disconnection (Ahrens et al., 2011; Chittleburgh, 2010; Goodkind, Schelbe, & Shook, 2011; Geenen & Powers, 2007; Kools, 1997; Morgan, 2012; Morgan & Lindsay, 2006; Munro, Lushey, Maskell-Graham & Ward, 2012; Rogers, 2011; Samuels & Pryce, 2008).

However, when one takes into consideration the research indicating high rates of mental health difficulties and other negative outcomes (Courtney & Hughes-Heurting, 2005), there is currently little evidence that self-reliance alone creates emotional strength and encourages adaptive coping in care leavers. These findings raise questions over the successful pursuit or achievement of emotional health and wellbeing. Analysis of care leavers' reports suggests that over time this self-reliant coping style can emotionally and psychologically disconnect youth from others (Samuels & Pryce, 2008). Furthermore, it may also undermine the making of supportive relationships, which have been identified as protective factors promoting resilient adaptation.

Researchers have raised doubts about whether a healthy or successful adult truly lives "independently" from others and is self-reliant in meeting most needs (Inglehart, 1994; Reindal, 1999) and the field has begun to propose interdependence (Propp et al., 2003) as an alternative goal in adulthood. In the context of relational-cultural theory interdependence and help-seeking are viewed as empowering and necessary to enhance growth and well-being across the life course (Stiver, 1991). This further indicates the

importance of youth being connected to others as not only a protective factor against risk (Collins, 2004; Perry, 2006) but also central to healthy development (Samuels & Pryce, 2008).

However, when considering relational cultural theory and interdependence, one must consider these ideas in the context of what functions as resilient adaptation for foster youth. Particularly the different ways in which young people in care form attachments and how these emotional connections are expressed (Samuels & Pryce, 2008). Additional research is needed to understand how to encourage and promote positive and meaningful relationships (Stiver, 1991) for youth growing up in care. This will help promote relational aspects of wellbeing and resilient adaption which can be continued into adulthood.

Rationale for study

There remains considerable conceptual gaps surrounding key concepts and outcomes related to concepts of independence for care leavers and how to achieve successful outcomes for this population (Horrocks, 2002), particularly in terms of relational aspects of well-being (Samuels, 2008). Adopting a qualitative approach for this line of research could promote the understanding of how people make sense of their experiences in ways which may complicate or help their abilities to seek emotional support and form relationships.

Therefore, it is important to explore what the factors are that help and hinder relational connections for care leavers. Also, it is important to further explore the barriers to seeking emotional support and how best to support resilient relational adaption. The questions central to this paper are therefore:

- What are the factors that facilitate and hinder relational connections in care leavers, and
- What are the barriers to help-seeking and relationship use for emotional coping?

Method

Design

An idiographic qualitative approach was applied using a semi-structured interview. An epistemological statement detailing the assumptions underpinning this approach can be found in Appendix F.

Participants

The participants were recruited through a leaving care team in the North of England and represent a reasonably homogeneous, purposive sample (Smith & Osborn, 2003). People were eligible for the study if they were over 18 and considered themselves to have been in care (foster, residential or on a care order). Due to practical constraints this study had to exclude non English speaking individuals. Nine care leavers took part in this study with a ratio of 4:5 male to female.

Measures

- Demographic questionnaire (Appendix G)
- Relational network map (Antonucci, 1986; Appendix H)
- Semi-structured interview (Appendix I)

Procedure

In the first stage participants completed the demographic questionnaire followed by the relational network map with support offered by the researcher. The aim was to identify

the participant's relational network, (people included in the network map and the relativeness closeness they felt to these people). This also provided an aid to some of the questions on the interview schedule. The second stage was the semi-structured interview which was audio recorded with consent. The interviews lasted an average of 50 minutes. The interviews were semi-structured in that the researcher was informed by the schedule but participants were encouraged to talk in detail about their particular experiences and were probed on important individual topics which arose. The interviews were designed to explore the young people's current relationships, as included on their relational map. In addition their time in care and their past relationships were explored. The interview was particularly focused on how people cope emotionally, what constrains or facilitates relational connections with others and barriers to help-seeking. All interviews closed with collecting advice for people who support children in care and after. Participants were also given a debrief pack. Anonymous verbatim transcripts of the semi-structured interviews served as the raw data for the study. Ethical approval was granted by the Faculty of Health and Social Care (FHSC) Research Ethics Committee at The University of Hull.

Analysis of data

The data was examined using interpretative phenomenological analysis (IPA) as the study's focus was on understanding people's personal experiences and how they give meaning to them. The analysis followed the four-stage process described in detail in Smith and Osborn (2003). Analysis began with a close interpretative reading of the first case where initial responses to the text were annotated in one margin. These initial notes were translated into emergent themes at one higher level of abstraction and recorded in the other margin (see Appendix J for a worked example of IPA). The themes were

cross-examined in order to make connections between them. This resulted in a table of super-ordinate themes for the first case within which were nested the subordinate themes with identifying information. This process was repeated for each case. After analysis had been conducted on each case, patterns were established across cases and documented in a master table of themes for the group. The researcher reviewed and audited the themes to ensure that they were grounded and well represented in the transcripts. Attendance of an IPA group with three researchers enabled discussion of emerging themes to ensure these were grounded and representative of the transcripts, as has been recommended to ensure validity (Morrow, 2007). The master table was then transformed into a narrative account; the analytic account is supported by verbatim extracts from each participant.

Table 1: Participant demographics⁴

Participant	Demographic details								
	Age	Sex	Ethnicity	Period of time in care	Types of placements experienced	Marital status	Children	Employment status	Previous professional support
Laura	18	F	White British (WB)	2 years	Emergency placements (2) Foster (1) Respite	Single	0	Student	None
Tom	19	M	WB	7.5 years	Foster (8)	In a relationship	0	Unemployed	Counselling CMHT (community mental health team)
Liam	19	M	WB	10 years	Foster (6)	Single	0	Unemployed	CAMHS (child and adolescent mental health service)
Lucy	18	F	WB	5 years	Care home (3) Foster (7)	In a relationship	0	Student	Counselling Youth Offending Team
Tammy	21	F	WB	9 years	Foster (5) Residential (5)	Single	1 (in care)	Unemployed	Counselling Lifeline worker Inpatient stay
Sarah	18	F	WB	2.5 years	Foster (3)	Single	0	Student	Counselling
Mike	19	M	WB	10 years	Foster (1)	Single	0	Temporary worker	None
Rosie	18	F	WB	2 years	Foster(5)	Single	0	Unemployed	CAMHS
Carl	19	M	WB	18 years	Kinship (1) Respite (regular) Residential (1)	Single	0	Unemployed	None

⁴ Participant names are pseudonyms for anonymity

Table 2: Master table of themes

Super-ordinate themes	Subordinate themes
Being there	<ul style="list-style-type: none"> Relational continuity Shared experiences Reconnecting with family Continued family loyalty
Protective Distancing	<ul style="list-style-type: none"> Repeated experiences of loss Ambivalence towards others Busy isolation Continued disruption
Coping with strong emotions	<ul style="list-style-type: none"> Drug abuse Self-harm Anger (towards others and self) Containment from others
Seeing me as me	<ul style="list-style-type: none"> Underlying beliefs of “I’m too much/ bad/ unlovable” Listening and getting to know me – taking an interest and investing in me Accepting me as me
Equal relationships	<ul style="list-style-type: none"> Helping others Mutual support Respect

Results

An overview of participant demographics is provided in Table 1. Appendix K contains information from the relational network maps, which was used to guide some of the interview questions. The analysis generated 18 themes which clustered into five super-ordinate themes these results are presented in Table 2.

Being there

One of the strongest themes which emerged throughout the young people's accounts was the importance of having someone to "be there for you". All of the young people interviewed used this phrase to either refer to someone who had been supportive towards them or to state that this was something important they felt they had lacked in their experience of relationships.

'Just literally being there for me. Like everyone else was like looking at it as if to say, he's just lost his mum, we'll give him some space, but they weren't like that they were like constantly there helping me, making sure that I was alright, making sure that I had everything I needed, everything that I wanted, doing everything like that. And they were literally just there for me. Everyone else like I say just backed off and gave me space, which yeah was nice, but in a way it wasn't.' (Liam, 19, line 311-317)

'They was just there for me when I needed them, with my Mum leaving me and they was always there'. (Rosie, 18, line 279-280)

'Because I've got all my friends and they've always been there and supportive. They were there for me for all my life.' (Carl, 19, line 45-46)

'He's always been there, like with all my family he's always been there for me forever. I can't remember. It's like we're pretty close.' (Tom, 19, line 115-116)

(Talking about foster dad) 'It was like a, he was like a second Dad I guess. But he was just there for me just as much as she (foster mother) was.' (Mike, 19, line 268-269)

'Erm, well she's always been there for me.' (Tammy, 21, line 92)

What emerged from the narratives was the importance of relational continuity, amid all the other disruptions in life while growing up in care. Everyone mentioned that either having someone there, who you could go to whenever you needed them was helpful, or they wished that they had a special person to turn to. This person would always be there; whatever was happening and support young people through hard times. As one person stated “not giving up on you”. Some of the people interviewed had maintained friendships or connections with family while they were in care, which they had found helpful. Also some had mentioned continuing connections with foster carers after they had left care allowed a sense of belonging and continuity after leaving care.

'I still regularly go my foster Mum, because I'm pretty much part of that family... Well if she's ever doing anything, if she actually goes, if she ever goes for a family meal she'll ring and say do you want to come? Just if she's ever doing anything she just lets me know'. (Mike, 19, line 171-174)

'When I first moved back. So every week when I first moved, he'd come, pick me up, and take me to the Newcastle match... Cos I do, I do see them as

like a parent, parent figure sort of thing. Like I know they're not my parents, but they are the next best thing sort of thing'. (Liam, 18, line 841-845)

People mentioned frequently that it takes time to develop relationships and this is complicated with frequent moves and life disruptions. The importance of these continued connections seemed to link to getting to know people and the idea of sharing experiences. Sharing similar experiences creates a platform to relate to each other and develop a closer connection. One person mentioned how her sister had been a continued support for her. They had shared one foster placement together, and had similar experiences before going into care. She reported how they had a close relationship because they could relate and understand each other, with a sense of them being there for one another.

People who had maintained links with family had found this useful and some had continued links with foster carers as well, making them feel part of a family through continued connections.

Within this idea was the idea of strong family loyalty, or being there for family if they needed them, even if this was not reciprocated. However, others appeared to be wrestling with the idea of family loyalty but also feeling abandoned by them, this was shown through repeated phrases such as; “they could have been there for me, but they weren’t”.

Many of the young people talked about trying to reconnect with family on leaving care. Some of this may be about making sense of the past breakdown and to reconnect with a family to create a sense of belonging. However, the importance of continuity and

sharing experiences again emerged, with it being hard to reconnect or form close relationships without experiencing these elements.

'We will never really have a very close relationship, because I grew up without him for eight years, nearly nine years. It's not the same when you're trying to get to know somebody'. (Sarah, 18, line 1962-1964)

Protective Distancing

Cutting connections and distancing oneself from relationships was a protective coping mechanism which emerged from the interviews. One account is included which appears to encapsulate the many accounts of the young people concerning this theme.

(Talking about biological family) 'I just don't get on with any of them. It's too much heartbreak every time I do, it goes wrong. That's, so there's no point, I just don't, I'd rather not put myself through it, do you know what I mean? That's why I've got no friends and that ...I'm just, it seems like, everyone I get close to and that seems like I end up losing them. Like I think it does go from like being in care as well, like with losing your family and that, I know it's not like losing them, it's not like they're dead or anything cos they're still there. It's like not being able to live with them and see them anymore, it's like losing them and then. So it's like I'd rather not, I don't, I'd rather not have any relationships at all, it all drains me. As far as I'm concerned when I got um, put in care and took off my mum ... I was on my own'. (Laura, 18, line 525-536)

This account echoes what many of the interviewed people described. Phrases such as “drains me” and “heartbreak” highlight the pain that is experienced as a result of the

breakdown of relationships or feeling rejected repeatedly. It seems that people disconnect and separate as a protective behaviour. From this account we get a sense of despondency and the idea of “giving up” and “not being bothered” which also suggests an attempt to cut off from emotions towards others as a way of preventing further hurt. This can also be seen in other people’s accounts.

‘I’m not bothered. He’s not bothered with me so I’m not bothered with him.

I couldn’t really care less’. (Tom, 19, line 197-198)

The young people’s accounts referred to the experience of going into care and the idea of “losing your family” which relates to unresolved grief which has been referred to as ambiguous loss (Samuels, 2009), in that family members often were not physically but still psychologically present. This prevents processing or making sense of relationship breakdowns which then acts as a barrier to moving on to develop healthy relationships. This can result in people relating to others in a disconnected way to prevent further disappointment.

What arose from the young people’s accounts was the idea of continued disruptions and being moved away from important connections such as siblings and friends in the area, which reinforced the idea of impermanent connections, which are fragile, can break and be lost. This therefore can result in a mentality of avoiding forming further close relationships. People who mentioned lasting connections or positive connections in care were those who had experienced less disruption, or had experienced one longer placement allowing them stability and opportunity for carers to be a part of their life. A few people mentioned not having any lasting connections in care. They had experienced it as a bit of a “blur”, in that there was lots of disruption and had met lots of different people but that they had not formed any meaningful or lasting connections. This again

highlights the hindering effect disruption and repeated moves have on relational connections.

'I can't remember much of my placements'. (Danielle, 21, line, 35)

'Stop moving people out of area all the time as much. Because that just destroys people'. (Lucy, 18, line 952-953)

Coping with strong emotions

A strong theme which emerged throughout was coping with strong emotions. In particular people referred to anger, with some describing themselves as an 'angry person'. Many people talked about emotions building up, becoming overwhelming and not knowing how to cope with these.

Many people talked about either not wanting to ask for help or finding it difficult to verbalise how they were feeling.

'I'm really bad to talk to anybody. I don't like talking to nobody. I keep everything to myself' (Rosie, 18, line 494-495)

Despite people saying they found it hard to ask for or would not want help from others, some spoke of external signs they would give off such as knuckle cracking, listening to loud music, or being increasingly restless, and that if people knew them well they would be able to pick up on these signs. Therefore, this suggests that it is easier to accept support if it is offered rather than asking for help.

Researcher: 'Have you ever needed to ask anybody for their support before'?

'Well I've accepted support before but it is not something that I would ask for. I don't know why but I feel uncomfortable asking other people.... I try not to'. (Mike, 19, line 570-573)

When talking about controlling emotions many of the young people talked about self-harm and drug use. Much of this was focussed on controlling anger. They would take this out on themselves through self-harm or by using drugs to control overwhelming experiences.

'That helped me stop taking my anger out on other people when I harmed myself'. (Rosie, 18, line 330-331)

'Sometimes when I need to calm myself down, like, I've cut myself before to calm myself down. Um, I smoke weed. I smoke weed. So that's, I suppose that's my way of coping to be fair'. (Lucy, 18, line 506-508)

This pattern of avoidant coping could suggest intolerance to emotions or a lack of emotional awareness which is a factor which develops through secure attachments with others (Bowlby, 1969).

People also spoke about the experience of someone accepting their expression of strong emotions without repercussions. This provided containment, showing that emotional expression is acceptable and provided a space for people to calm down and experience containing these emotions. The people who talked about experiences like these also found it easier to turn to people for support or to speak about how they were feeling.

'The one I had before I moved out of care, she was lovely, she was a single parent but she was amazing and I used to talk to her about anything. When I used to get angry (like I said to her I was going to smash her house up and everything) she used to just make a joke out of it and not take it personal. She'd just know to leave me to calm down and everything. So, it was really good and she would come and sit down and talk to me and ask me if I was alright and everything'.

Researcher: 'Mmm. Alright. So was it easier - To talk to her about stuff?'

'Yeah. - I used to talk to her a lot more than I did any of my family'. (Rosie, 18, line 391-399)

(Talking about managing overwhelming emotions) 'I go to the police, so I can calm down, and they'll give me a cup of coffee and they'll give me – and I'll be alright after a couple of hours. If I have any problems or if I think I'm going to do something stupid I'll go and talk to them and they can always help me out'. (Carl, 19, line, 521-525)

Accepting me as me

As far as hindering connections is concerned, negative self-beliefs were captured in all of the young people's accounts to various degrees, for example people saying the reason they were in care was because they were a "bad kid" and particularly that they were "too much to handle" and therefore that was the reason they were in care.

'My Mum said she couldn't handle me. So she put me into care'. (Rosie, 18, line 617)

'I think, the only reason why I was in care I was a bit of a mischievous child and it got a little bit too much for everyone.' (Liam, 18, line 414-415)

'I was like and I was not a nice child. I wasn't a nice child but I was sometimes, half the time maybe.' (Sarah, 18, line 1915-1916)

In attempting to make sense of the breakdown of relationships or being in care, many people concluded that it was because of something to do with them and internalised this idea. This may relate to internal working models of the self as bad, and the idea that "I'm too much for other people to handle" therefore "I am unlovable or unworthy of care". It seems that these underlying beliefs impact on navigating relational connections throughout growing up. The young people spoke about a fear of being rejected if they became close to others or if people knew the real them. They also spoke about feeling unimportant or undeserving, which impacted on their relationships.

It emerged that some people had experienced positive experiences in their relationships of being accepted as they were.

(Foster parent accepting his personality) 'He was just like, that's just me, cheeky chap sort of thing'... They, they could see like the goodness sort of thing, in me when I was doing all the bad things that I was. Like they could see further into me'. (Liam, 18, line 800-804)

What we can see from these accounts, which was echoed in others, was that the young people were accepted despite what else was going on.

One of the themes which arose relating to facilitating relationships was feeling really listened to and understood, or people investing time in them and really getting to know

them. Alongside this was the idea of people showing an interest in them rather than just providing support when it was needed.

'People should listen to (children in care) more and get to know them a bit. And that's it really'. (Lucy, 18, line 947-948)

'Like obviously you have a social worker and that but it would be nice just to like, talk to you more than that or take you out more and take your mind off things. Sometimes you know, you just need your mind taken off things, like that does help a lot, I think. It's like not just making you think about all the bad things innit'. (Laura, 18, line 910-914)

'Like today when we went to MacDonalds she asked about the course...she was like asking me what I want to do after and that. So it's like not just looking at now, she's looking at long-term'. (Sarah, 18, line 121-123)

What emerged was the importance of getting to know the person and spending time with them and to show an interest, rather than the relationship just being about support or help. This idea of people investing in the young people and showing a genuine interest in them is as a way to challenge the idea they were unworthy or unimportant. This was also repeated through accounts of support and encouragement through school or college, particularly when young people were struggling. All of this helps to develop a sense of personal worthiness which has been highlighted as a factor of developing a resilient identity (Rutter, 2006).

However, this need to be accepted or people knowing them as they really are, also explained a barrier to seeking support, as young people did not want to be perceived as a dependant person, or for relationships to be defined around receiving support.

'Yeah. I don't just want to come across as a person that's just there for help so... I don't like being looked at like that'. (Tammy, 21, line 633-634)

Researcher: 'Do you ever let people see when you are upset'?

'I try not to. I try not to because I just want them to see me as me, a normal me you know, happy you know a bit jokey and a bit of this and a bit of that you know'. (Sarah, 18, line 1089-1091)

'It's like (my foster mum) I could go and see her for the weekend. I prefer not to talk to her about (problems or financial worries) because I don't want her to think that I'm showing up just for that type of support because I'm not. I'm not there for that. It's just because I want to see everyone. Do you know what I mean?' (Mike, 19, line 584-585)

This reluctance may explain some of the barrier to help-seeking. It also highlights the importance of people feeling they have been accepted and bringing worth to relationships, this may place people in a position to easier request help or utilise support networks.

Equal relationships

What also emerged was a need for equality in relationships; people had experienced negative relationships and described how this created an environment where there would be a lack of respect or desire to relate to the person.

*'Like, and they treat you like sh*t. So obviously you're going to treat them like sh*t. You're not going to listen to them are you, if they're horrible to you'. (Lucy, 18, line 542-544)*

However, people also spoke about experiencing respectful relationships as helpful.

Researcher: 'What was helpful about them that maybe you wish you'd had earlier on?'

'They were straight forward. Like, they never spoke to me like I was a child, or a looked after kid, they spoke to me like I was an adult. And like they basically treat me like an adult, never treat me like a kid or anything like that. They'd let me make the mistakes, to learn from them'. (Liam, 18, line 561-564)

'I think young people like it when they're not treat like kids sort of thing...like yeah, just treat them like adults I think. I think they're more responsive sort of thing. Whereas if you're just like sort of treating them like kids they'll probably just like shut up, they'll like probably not even bother'. (Tom, 19, line 905-909)

Most of the people interviewed talked about respect being an important valued quality in relationships. As we can see from the account above this seems to create a more balanced relationship and models how to respond to the other person. As another person

described, respect created a more responsive environment. There is also something in the account about being allowed to make mistakes, relating to a trusting relationship allowing the person to develop a sense of self efficacy.

Closely related to this idea of self-efficacy is the idea of reciprocity. This was another subordinate theme which emerged and many people stated the importance of being able to help others and used phrases such as “I’ll be there if ever they need me” and “I feel I’m good at helping others”.

Also, someone talked about experiencing a relationship in which they could offer support to others as being a confidence boost.

‘Which sort of like helped as well. And you get given like a confidence boost as well, and like when she used to talk to me, and I used to think to myself, well, if she can talk to me about that, then she can talk to me about this, then I must be good at something, I must be doing something right, so it was a confidence boost, more than anything’. (Liam, 18, line 397-341)

Equal relationships, that offer respect and either mutual support or being able to help others are therefore seen as important. This idea of being dependable seems to be a quality that nearly everyone interviewed valued. This may be the result of more negative experiences with others in which this quality has not been experienced. However offering support may also provide a safe way to navigate supportive relationships without feeling dependent on others. The idea of being in a respectful environment and being able to help others also seems to boost self-esteem, perhaps again relating to the idea of personal worth and being valued and important.

Discussion

All the young people in this study discussed the idea of “people being there” and continuity in relationships. Relational continuity can also be understood as youth experiencing a stable relationship and being able to develop a sense of belonging and a deeper understanding of themselves and how they fit into the world (Brown, Léveill   & Gough, 2006; Samuels, 2009). This continuity also provides links to the youth’s own history and experiences and these relationships help youth in understanding their identity and sense of self (Barn, Andrew, & Mantovoni, 2005; Samuels, 2009). Furthermore, the importance of experiencing continuity and stability in a relationship allows for the development of trust, which can then be generalised to the formation of new connections (Dallos & Comley-Ross, 2005). Equally, it is important to have some shared personal experience which facilitates closeness in a relationship (Clayden & Stein, 2005; Munson, Smalling, Spencer, Scott, & Tracy, 2010; Tyrer, Chase, Warwick, & Aggleton, 2005). The literature has long stated that those who most successfully moved on from care were more likely to have stability and continuity in care. However, despite this and the importance placed on this by the young people in this study the narratives of the young people also showed that distancing or disconnecting from others was helpful to protect themselves from the pain of further breakdowns in relationships. This way of coping emerges from experiences of repeated loss, separation from family members and experience of disruptions in placements. This disruption was described as feeling like “being passed from pillar to post” by one of the young people interviewed. Therefore it is easier to distance oneself and not become close to people to protect from the pain of the perceived inevitable breakdown of that relationship. These results have been echoed elsewhere (Johnson et al., 2010; Quest, Fullerton, Geenen & Powers, 2012).

This separation and disconnection links to a self-reliant identity in care leavers, which has been suggested to operate as a healthy and resilience factor (Samuels & Pryce, 2008). However, although on one level this self-reliance may be helpful, it also poses a challenge for building connections and mutually supportive relationships in adulthood. Samuels (2009) applied concepts of ambiguous loss to the experiences of youth in foster care and described the feelings of grief that many foster youth are never able to resolve after such a traumatic experience. The lack of stability in placements and relationships prevalent in the foster care system further exacerbates this feeling, making it difficult for youth to go on to build support networks and positive connections with others. This ambiguous loss results from the lack of closure some youth experience in the breakdown in relationships, as there still remains a psychological presence of the parent (or person they are separated from) but not a physical presence. Phrases such as “it’s not like they were dead, but they were lost” and “they could have been there but they weren’t” exemplify this. Ambiguous loss and complicated feelings over the breakdown of relationships hinder the future development of healthy relationships, without the opportunity for this to be resolved to help in making sense of family relationships.

Reconnecting with birth family was an important subordinate theme of ‘being there’. This relates to the need to make sense of family relationships, which is an important task for many care leavers (Henry, 2005; Mendes & Moslehuddin, 2006; Stein, 2006b). This suggests that foster youth need assistance in processing the loss and grief that result after separation from biological families, by either establishing connections with family members or other significant people in their support network. Alternatively an important task would be to make sense of family relationships if it is not possible to reconnect. This could be through professional support such as counselling or therapy or

through informal means such as through the help of a supportive adult or peer, who the young person has a close connection with. This may allow foster youth to be better prepared for further relational connections and to avoid the disconnection detailed in many accounts.

How do experiences in relationships affect coping patterns?

This study also looked at how experiences in relationships impact on emotional coping patterns. Coping strategies are an expression of psychological defence mechanisms that develop in childhood as protective responses that accentuate, limit, or block perceptions of inner and outer reality (Cramer, 1998).

The findings of this study show that many of the interviewed young people cope with strong emotions by using drugs and engaging in self-harm, similar to accounts in previous literature (Dixon, 2008). There was a strong sense of anger among the narratives. This was directed towards other people who had let the young people down, but this was often taken out on themselves through the use of self-harm or the use of drugs, which was reported to numb and help cope with overwhelming emotions. This pattern of coping with strong emotions can be related to past experiences in relationships. Qualities needed for successful or healthy emotional development are a secure attachment and containing and empathic relationships (Bowlby, 1980). When this is lacking, difficulties emerge in being able to identify and interpret internal emotional experiences as well as difficulties in being able to modulate and express these emotions safely (Ainsworth, 1989; Kafetsios, 2004; Mallinckrodt & Wei, 2005). Interestingly, the young people's narratives demonstrated that when they had experienced someone accepting strong emotions, they found it easier to talk with them. Therefore, experiencing a containing relationship may provide a means of learning how

to handle strong emotions. This experience shows that emotions can be expressed safely, as a normal human experience, without the need to avoid strong emotions using methods such as substance abuse and self-harm.

What are the qualities which may overcome barriers to help-seeking?

The narratives uncovered negative self-beliefs (internal working models), such as believing they were ‘bad’ or that they were ‘too much to handle’, leading to ideas of being unworthy and unlovable. These feelings arose from attempts to make sense of why they were in care, as well as past experiences in relationships, and relate to identity formation and the process of developing a sense of self (Barn et. al 2005). These underlying beliefs may cause distancing from others and a resistance to forming close connections, with a fear that people will become rejecting when knowing the real person. What was important in experiences in relationships was the idea of being accepted. Acceptance in relationships has long been identified as a necessary factor for healthy development (Rogers, 1961): further having experience of being accepted relates to ideas of belongings (Baumister & Leary, 1995) and encourages healthy relating with others. Positive relationships people recounted included feeling they had been really listened to and people investing something in the relationship, either by providing encouragement and support through school, college or other activities, or people simply spending time with them outside of a solely supportive relationship. Therefore, this reinforces the idea about people wanting to spend time with the whole of the person, rather than just perceiving them as “a foster kid who needs help”. However, this need to be accepted and seen as a whole person, may also work as a barrier to seek support, in that the young people did not want to be seen as a dependent person or solely seeking supportive relationships. Accepting relationships could function as a corrective experience (Zaccagnino, Cussion, Saunders, Jacobvitz & Veglia, 2012),

showing the person that they are important. This in turn has the effect of challenging underlying negative beliefs and could increase a sense of personal worth which is needed for a resilient identity (Rutter, 2006).

Closely related to the theme of acceptance and seeing the whole person, was the importance of equal relationships and respect in facilitating relational connections. Respect was seen to create a more responsive environment encouraging positive relating. Respect, equal relationships and feeling important in them leads to an increase in self-esteem and encourages a positive sense of self (Baumister & Leary, 1995; Williams & Zadro, 2001) which in turn likely challenges the negative self-beliefs prevalent in people's accounts. Many of the young people talked about the importance of mutually supportive relationships and helping others. It is noticeable some of the qualities identified as important in their relationships, such as consistency, acceptance and demonstrating a desire to help, closely mirror that which might have been unavailable within early attachment relationships (Hiles, Moss, Wright & Dallos, 2013). Offering help or experiencing a relationship as reciprocal provides a safe way to navigate relationships without being in a dependant role or threatening a self-reliant identity. Being able to offer support to others also increases a sense of being valued. Therefore, providing support to others may allow for the safer development of relational connections and reciprocity and equality are key elements for developing healthy relationships (Striver, 1991). In line with social capital and social exchange theory (Bracke, Christiaens & Verhaeghe, 2008) perceiving oneself as giving back is an important element of balancing a relationship, and supports an increase in self-esteem, self-efficacy, and may make it easier to ask for support or help when this is needed.

Limitations and areas for future research

The sample size was small and selected opportunistically; therefore participants may have had a particular bias in taking part. Also all participants were from the same locality and part of the same Leaving Care Team. Participants were not involved in questioning and sense making of the data after collection was complete, which would have added to the validity of the results. Further, it is worth noting that although participants were encouraged to talk widely and in detail about their experiences, some people found this harder than others. The qualitative approach of this study means that the results do not aim to be generalizable, however, the fact that all participants spoke about similar themes and in many cases in great depth, indicates the importance and strength of the impact of these themes on the individuals involved and suggest that further research may allow wider applicability. Despite these limitations, the study allowed for a detailed examination of relational connections in care leavers and the qualities which facilitate these.

Due to the dynamic and changing nature of relationships it would be of interest to employ longitudinal designs investigating how care leavers' relational connections change over time. Also it may be useful to further explore different sub-samples, such as people who felt they had stability or strong connections during their experience in care and those who experienced many disruptions in placements to consider how this impacts on the ability to form relationships and relational forms of coping. In addition it would be useful to investigate how wider relational connections such as friends, school and community supports can deliver continuity during care. Also, research should look further into accepting relationships and equality and how these can be encouraged during young people's time in care. Finally, it is important to further

explore how these qualities impact on relational aspects of wellbeing and help to develop a resilient identity.

Clinical and theoretical implications

This study adds to the evidence base stressing the importance of relational continuity throughout the care process and the importance of making sense of previous breakdowns in family relationships to be able to move on to develop healthy relationships.

Further, it adds to the literature around supporting relational aspects of wellbeing, notions of interdependence and resistance to help-seeking in care leavers. Alongside promoting continuity and stability, acceptance and equality in relationships may help to overcome barriers to help-seeking. Negative self-beliefs and a fear of not only being dependent but other people perceiving them in this role acted as barriers to seek support for this group.

The implications from the results suggest that challenging negative self-beliefs and encouraging acceptance and equality in relationships may be helpful during care, during the transition of leaving care and through support provided afterwards. This may involve specific interventions tailored for this purpose, for example cognitive behavioural therapy (Beck, 1979). Also, encouraging a wider base of relationships and connections is important in order for young people to experience these aspects in different situations. These could involve mentoring systems or opportunities for young people to provide support to others or involvement in community groups or activities with others that can act as permanent connections. It also further suggests the importance of professionals following young people throughout their journey in care.

Conclusion

The current study highlights the importance of relational continuity, despite the adoption of distancing strategies many youth use. Barriers to asking for help involve negative self-beliefs of being unworthy of care and a fear of being dependent on others resulting in young people distancing themselves from others. These barriers arise as a way of coping after early life disruption as a protection mechanism from repeated experiences of loss. Containing and empathic relationships may make it easier for young people to express emotions and lead to more relational and adaptive ways of coping. Further, experiencing accepting, reciprocal relationships may help develop a resilient identity alongside more positive beliefs and make it easier to seek support if needed.

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Part three:

Appendices

Appendix A

Journal of Social and Clinical Psychology: Information for Authors

JOURNAL OF SOCIAL AND CLINICAL PSYCHOLOGY—INFORMATION FOR AUTHORS

The JOURNAL OF SOCIAL AND CLINICAL PSYCHOLOGY is devoted to the application of theory and research from social psychology toward the better understanding of human adaptation and adjustment, including both the alleviation of psychological problems and distress (e.g., psychopathology) and the enhancement of psychological well-being among the psychologically healthy. Topics of interest include (but are not limited to) traditionally defined psychopathology (e.g., depression), common emotional and behavioral problems in living (e.g., conflicts in close relationships), the enhancement of subjective well-being, and the processes of psychological change in everyday life (e.g., self-regulation) and professional settings (e.g., psychotherapy and counseling). Articles reporting the results of theory-driven empirical research are given priority, but theoretical articles, review articles, clinical case studies, and essays on professional issues are also welcome. Articles describing the development of new scales (personality or otherwise) or the revision of existing scales are not appropriate for this journal.

All submissions must be made electronically (preferably in Microsoft Word format) to Thomas E. Joiner at joiner@psy.fsu.edu. Only original articles will be considered. Articles should not exceed 8,000 words (text and references). Exceptions may be made for reports of multiple studies. Abstracts should not exceed 200 words. Authors desiring an anonymous review should request this in the submission letter. In such cases identifying information about the authors and their affiliations should appear only on a cover page.

TABLES should be submitted in Excel. Tables formatted in Microsoft Word's Table function are also acceptable. (Tables should not be submitted using tabs, returns, or spaces as formatting tools.)

FIGURES should be submitted separately as graphic files (in order of preference: tif, eps, jpg, bmp, gif), in the highest possible resolution. Figure caption text should be included in the article's Microsoft Word file. PERMISSIONS: Contributors are responsible for obtaining permission from copyright owners if they use an illustration, table, or lengthy quote (100+ words) that has been published elsewhere. Contributors should write both the publisher and author of such material, requesting nonexclusive world rights in all languages for use in the article and in all future editions of it.

REFERENCES: Authors should consult the publication manual of the American Psychological Association for rules on format and style. All research papers submitted to the *Journal of Social and Clinical Psychology* must conform to the ethical standards of the American Psychological Association. Articles should be written in nonsexist language. Any manuscripts with references that are incorrectly formatted will be returned by the publisher for revision.

SAMPLE REFERENCES

Davis, C. G., & McKearney, J. M. (2003). How do people grow from their experience with trauma or loss? *Journal of Social & Clinical Psychology*, 22, 477-492.

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Appendix B

Quality Assessment checklist

1) Is the aim/objective of the study clearly described?

Must be explicit

YES/NO

2) Are hypotheses formulated and explicitly stated prior to conducting analyses (i.e. a priori)?

YES/NO

3) Are the main outcomes to be measured clearly described in the Introduction or Methods section?

If the main outcomes are first mentioned in the Results section, the question should be answered no. ALL primary outcomes should be described for YES

YES/NO

4) Was the selection of explanatory variables based on a sound theoretical basis?

YES/NO

5) Were the main outcome measures used accurate (valid and reliable)?

Where outcome measures are clearly described, which refer to other work or that demonstrates the outcome measures are accurate = YES. ALL primary outcomes valid and reliable for YES

YES/NO

6) Are the characteristics of the patients included in the study clearly described?

In cohort studies and trials, inclusion and/or exclusion criteria should be given. In case-control studies, a case-definition and the source for controls should be given. Single case studies must state source of patient

YES/NO

7) Were the subjects asked to participate in the study representative of the entire population from which they were recruited?

The study must identify the source population for patients and describe how the patients were selected. If Source is not identified = NO

YES/NO

8) Were those subjects who were prepared to participate representative of the entire population from which they were recruited?

The proportion of those asked who agreed should be stated. If not stated= NO

YES/NO

9) Are the main findings of the study clearly described?

Simple outcome data (including denominators and numerators) should be reported for all major findings so that the reader can check the major analyses and conclusions.

YES/NO

10) Does the study provide estimates of the random variability in the data for the main outcomes?

In non-normally distributed data the inter-quartile range of results should be reported. In normally distributed data the standard error, standard deviation or confidence intervals should be reported

YES/NO

11) Have actual probability values been reported (e.g. 0.035 rather than <0.05) for the main outcomes except where the probability value is less than 0.001?

YES/NO

12) If any of the results of the study were based on “data dredging”, was this made clear?

Any analyses that had not been planned at the outset of the study should be clearly indicated. Retrospective = NO. Prospective = YES

YES/NO

13) Were the analytical methods appropriate?

YES/NO

14) Were multiple explanatory variables considered in the analysis?

Yes/NO

15) Are univariate methods inappropriately used in the presence of multiple outcome variables?

YES (0 points) NO (1 point)

16) How well were likely confounding factors identified and controlled?

- *Were there likely to be other confounding factors not considered or appropriately adjusted for? (Also has Bonferroni criteria been applied for significance levels in multiple correlations if not=NO)*
- *Was this sufficient to cause important bias?*

YES/NO

17) Did the study report a power calculation?

YES/NO

18) Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance <5%

If unable to determine =NO

YES/NO

19). Effect sizes are reported for each independent variable- dependent variable relationship, even when the outcome was not statistically significant.

Examples of effect categories include: (a) standardized differences (e.g., Cohen's d, Glass's Δ); (b) "uncorrected" variance-accounted-for (e.g., η^2 , R^2); and (c) "corrected" variance-accounted-for (e.g., adjusted R^2 , ω^2)

YES/NO

Appendix C

Summary of Methodological Quality Assessment Scores

Study	Checklist Items																			Total Score
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	
Biegel et al. 2013	1	0	1	1	0	1	1	1	1	1	0	1	1	1	1	0	0	0	1	13
Chang et al. (2013)	1	0	1	1	1	1	1	1	1	0	1	1	1	1	1	1	0	0	1	15
Chou & Chronister (2011)	1	0	1	1	1	0	1	0	1	1	1	1	1	1	1	1	1	1	1	14
Corrigan & Phelam (2004)	1	1	1	1	0	0	1	1	1	0	0	1	1	1	1	1	0	0	1	13
Hendryx et al. (2009)	1	0	1	1	0	1	1	1	1	1	1	1	1	1	1	1	0	0	1	15
Mulligan & Lavender (2010)	1	1	1	1	0	1	1	0	1	0	0	1	1	1	1	0	1	0	1	13
Norman et al. (2013)	1	0	1	1	1	1	0	0	1	1	0	1	1	1	1	0	0	0	1	12
Pernice-Duca & Onga (2009)	1	0	1	1	0	1	1	0	1	1	1	1	1	1	1	0	0	0	1	14
Pernice-Duca (2010)	1	0	1	1	1	1	1	1	1	1	0	1	1	1	1	0	0	0	1	14
Roe et al. (2011)	1	0	1	0	1	1	1	0	1	0	0	1	1	1	0	0	0	0	1	11
Townley et al. (2013)	1	0	1	1	0	1	1	1	1	1	0	1	1	1	1	0	0	0	1	14
Webb et al. (2011)	1	1	1	1	1	1	0	0	1	1	1	1	1	1	1	0	0	0	1	14

Appendix D

References of excluded studies after full paper was read

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Appendix F

Epistemological statement

The aim of this statement is to detail my own personal stance as well as considering the epistemological underpinnings of the current research project.

I consider myself to hold a broadly relativist view point (Morrow, 2007), which I feel has developed more so throughout my clinical training. Relativism assumes that there is no true single reality. Truth therefore is always relative to a particular frame of reference, such as a language, culture or context (Morrow, 2007). Similar to constructionist ideas (Burr, 2003) relativism holds that each individual views the world differently and as such different and multiple versions of reality exist (Ponterotto, 2005).

Relational cultural theory (Striver, 1991) is in keeping with relativist ideas and is worth considering as it underpins the assumptions of the empirical paper, as well as aligning with my own personal views which are detailed at the end of this statement. This links with ideas of reality being relational (Bourdieu, 1968) and that psychological growth is linked with development of individual cultural and social identities and experiences of these in different contexts and relationships (Striver, 1991).

The objective of the research project was developed from a stance of curiosity in which the main question was to explore the relational connections among care leavers. It was interested in focusing on individual perceptions, as well as

considered how people make sense of their experience in a way which impacts on relationships and coping. Therefore, it was questionable whether quantitative measures would be able to capture the richness and diversity of people's experiences to fully answer the research question. Based on this the positive stance represented by quantitative research was rejected (Willing, 2001). Positivism suggests there is one true reality about phenomena in the world that can be measured to achieve objective knowledge (Willing, 2001). As this study was interested in the individual's experiences of relationships a qualitative approach was chosen to best fit with the aims of the study.

Four different qualitative approaches were considered; Thematic Analysis, Discourse Analysis, Grounded Theory and Interpretative Phenomenological Analysis (IPA). This section will briefly describe these approaches and reasons for arising at the chosen methodology.

Thematic Analysis

Thematic Analysis is perhaps one of the most common approaches in qualitative analysis. The aim is to categorise and code data in order to describe qualitative data (Anderson, 2007). This could be argued to be a relatively superficial level of analysis. It is concerned with common features across participants rather than individual experiences. This approach does not readily allow for engaging in a deep process of interpretation in order to discover and explore people's experiences. Therefore this approach was rejected as the study aimed to understand and explore care leavers relational connection rather than merely describe them.

Discourse Analysis

The aim of discourse analysis is to analyse the use of language. Although this is useful for exploring socio-cultural contexts and considering issues power, it is more focused on language used to describe experiences rather than focusing on the experience itself (Willing, 2001). Therefore, this approach was also rejected as the study was interested in the young peoples lived experiences rather than how this is described through language.

Grounded Theory

Grounded Theory was considered in more depth than the above two approaches, and it was discussed in supervision with a qualitative researcher. Grounded Theory is suggested to require a large sample and it was acknowledged that recruitment may be difficult in this area. The main aim of Grounded Theory is to generate, develop and refine a theory (Strauss & Corbin, 1994). However it was discussed that the main aim of the study was to come from an open exploratory approach in order to gain an insight into experiences, due to limited research in the area. Therefore it was felt generating theory around relational connections would be a potential for a future study and not best suited for the aim of the current empirical paper.

Interpretative Phenomenological Analysis (IPA)

Therefore, this lead to selection of IPA, as the aim of IPA is to explore how people understand and make sense of a particular life experience (Smith, Flowers & Larkin, 2009). This fit best with the current aim of exploring relational connections

and how people make sense of their experiences with impact on future relationships and coping.

There are three key theoretical foundations of IPA; phenomenology, hermeneutics, and idiography.

Idiography is the interest in the particular where the aim is to understand the details of the specific experience. IPA prioritises the voice of the individual and therefore fits with the importance of care leaver's views being represented in research. The idiographic commitment of IPA is aligned with a relativist position as analysis begins with situating people in their own contexts and moves from a detailed examination to more general themes (Smith & Orson, 2003).

Phenomenology refers to the study of individual's experience which is a process that is unique to the person and their existence in the world and hermeneutics refers to theory and process of interpretation of the phenomenology. IPA recognises that people may not be able to express their inner processes and therefore promotes further interpretation of the data. Therefore, IPA involves a double hermeneutic in that the researcher is trying to make sense of how participants make sense of their experiences (Smith, Flowes and Larkin, 2009). Consequently the research must acknowledge that IPA cannot ever access a person's true experience and that findings are partial representations of the researcher's experience (Smith et al, 2009). Therefore it is necessary for the researcher to declare their own assumptions and seek the opinions of others during analysis to ensure interpretations are valid (Morrow, 2007). Therefore, to allow the reader to consider my values and assumptions and how these may have influenced interpretation some are briefly outlined below

Firstly, it is worth acknowledging that the current study was undertaken in the context of practicalities and deadlines imposed by the doctoral course. As this study involved understanding care leaver's experiences in relationships, these inevitably lead to consideration and reflection on my own personal experiences in relationships, including both positive and negative experiences. Also, importantly I fully acknowledge I approached this research sensitised to a strong personal belief that support networks and feeling connected to others plays a huge role in people's wellbeing and resilience levels. This is backed up by numerous findings in the literature as well as drawing on my own experiences of going through challenging experiences with a lack of social support as well as mostly being lucky enough to be able to draw on a strong close network. All of the above may have influenced interpretation of the research, however by stepping back and acknowledging my own assumptions and the use of independent reviewers of transcripts and emerging themes, this allowed me to more closely attempt to make sense of the experiences that were detailed to me by the participants of this study.

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Appendix G



Demographic Questionnaire:

What is your age? _____

What is your gender? *(Please circle)* Male Female

How would you describe your ethnicity? *(Please circle)*

White

British

Irish

Any other white background (please specify)

Mixed

White Caribbean

White Asian

White & Black Africa

Any other mixed background (please specify)

Asian or Asian British

Pakistani

Indian

Bangladesh

Any other Asian background (please specify)

Black or Black British

Caribbean

African

Any other Black background (please

Chinese or other ethnic group

Chinese

Any other (please specify)

What is your marital status? *(Please circle)*

Single, never married

Married

Divorced

Separated

Civil Partnership

Widowed

Co habiting

Do you have any children? (Please circle) Yes No

If Yes, how many? _____

What is your employment status? _____

What length of time were you in care for? _____

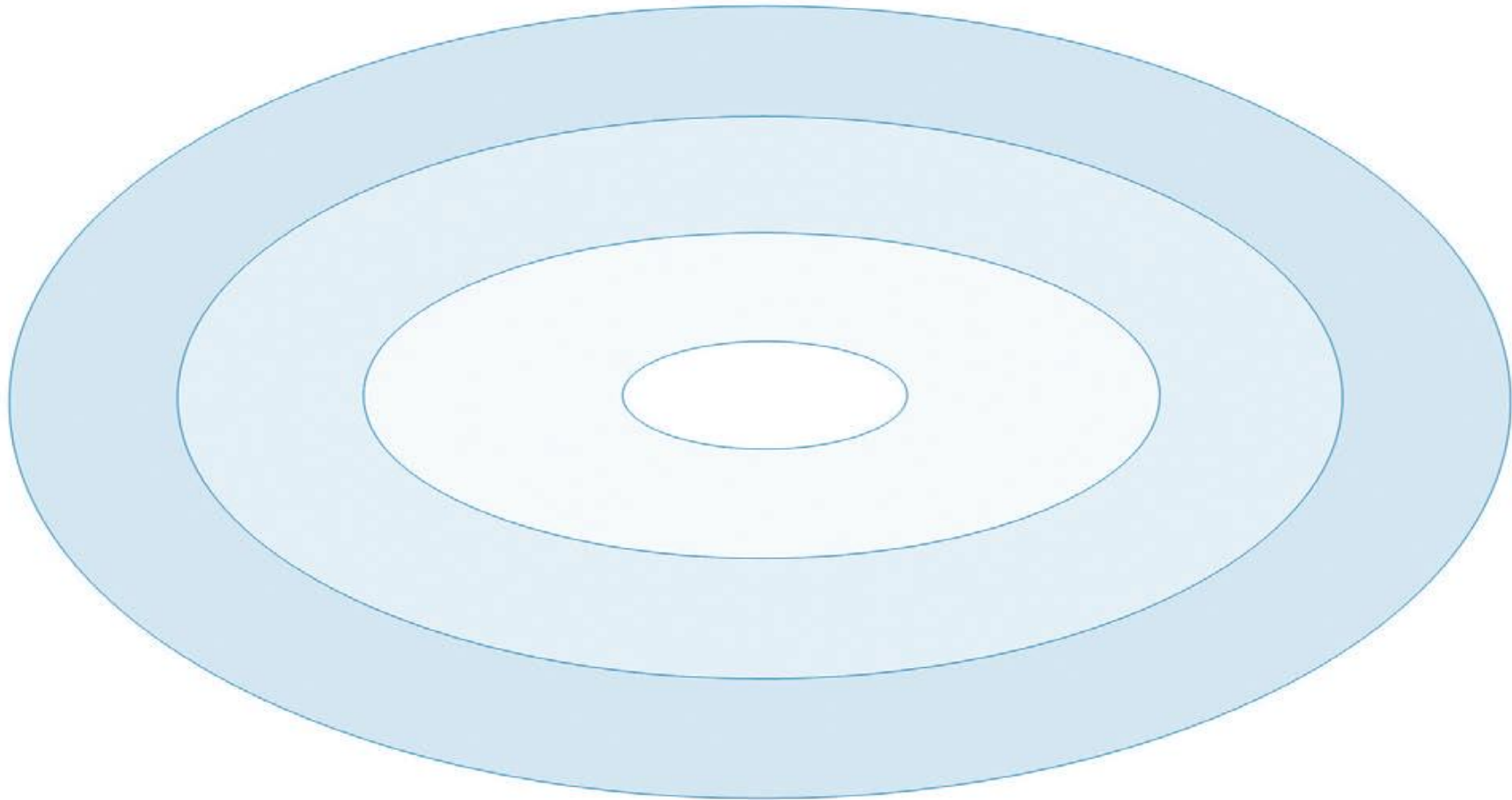
What was the number of placements you had and what type (e.g. foster/residential)

Have you ever sought or received any support in the past? E.g (Counselling/ psychological therapy/ GP/support worker/through pathway team or similar)

Thank you for taking to time to fill this in.

Appendix H.1

Relational Network Map (Antonucci, 1986)



Appendix H.2

Relational Network Map directions

Relational network map - Directions:

First, choose a “fake name” and write that in the centre. Then:

Inner circle: List those people to whom you feel so close that it is hard to imagine life without them.

Middle circle: List people to whom you may not feel quite that close but who are still important to you.

Outer circle: List people whom you haven’t already mentioned, but who are close enough and important enough in your life that they should be placed in your personal network.

Appendix I

Semi-Structured Interview Schedule

Question 1) let's start by discussing your current relationships, that you have included on your map.

(Prompts will involve asking the participant who the people are on the map and asking how they define the different relationships)

Question 2) what does "supportive" mean to you, do you know others who have needed support?

(Prompts may involve asking the participants to describe on occasion when someone they know has needed support).

Question3) how do you cope when you are under a lot of stress or having a bad time?

(Prompts will include asking about coping strategies and how they seek emotional support. Participants may be asked to describe an ideal person (real or imagery) they believe would be good to help them or talk to during difficult times. Also participants may be prompted to discuss what things stop them asking for support when they feel they need it).

Question4) Shall we spend some time discussing your experiences in care and the relationships you had?

(Questions will lead from the information given on the demographic questionnaire. E.g this may involve asking about different foster placements, or time spent in residential care etc. Prompts will include talking about specific relationships during this time.).

Question 5) what has not been helpful during your time in care and after leaving care?

(Specific prompts will be around relationships or people who have been involved in their care)

Question 6) What have you found helpful to get you where you are now?

(Specific prompts will be around current and past relationships and support, with reference made to network map if appropriate).

Question 7) could I ask you what advice you would give to people who support people in care and after they leave?

Appendix J.1

A worked example of IPA

Exploratory notes

Emerging themes

R) Alright, well the next thing that I was going to ask is,
can you tell me what the word supportive means to you?

Support =
help, being
around you

L) Supporting, it's like when, I don't know how to explain it,
it's like when people are helping you and being supporting
around you. I'm bad at explaining.

Being around you?

Hard to put
experiences
into words?

R) No you're not. Do you know anybody, is there anybody
that you've mentioned so far or anybody in the past that's
been particularly supportive to you

Similar to ideas of
continuity – being
there?

Experience of
sister being
supportive

L) My sister, she used to be really supportive, and my

R) Mmm hmm.

Friends
supportive

L) and my friends...

Helped stop
taking drugs
→ "bad
drugs"

R), what kind of - What kind of things did they do then that
has been supportive in the past?

Drug use

L) My sister, she helped me get off bad drugs.

	R) Right.	
All the time → constantly	L) She helped me all the time. But my Mum she didn't but my sister she did. She helped me through it.	"All the time" – continuity
Mum not helping supportive (didn't care??)		
Support through hard times	R) Right.	Staying with you through hard experiences – being there
Sister didn't think this but mum did? Don't want anything to do with you – cutting you out of life/ rejecting being left to cope on own/ abandoned?	L) She didn't like think well you're on drugs I don't want f*ck all to do with you. R) Mmm.	Mother rejecting again
Something bout sister - Sticking with you through bad times not abandoning	L) So – R) So did your relationship with your Mum start to break down when you were taking harder drugs?	(Messages of not being worth support/ care)
Ups and downs – turbulent relationship?	L) No, when I was in care, when I fell out with her, we always had our ups and downs and when I took drugs she told that she didn't ever want to speak to me again. We sorted things out after a couple of months. So -	Drug abuse Rejection/ loss
Rejected/ abandoned → "don't want anything to do with you" – conditional care	R) Right, OK, but your sister helped you through that, and did your friends as well or were they supportive in other ways.	But Reconnecting/"sort ing things out"

There for me

(Echoes the phrase of other accounts)-

Mum leaving – being left feeling abandoned?

Friends not giving up/ leaving/ abandoning?

Mood – reaction to these experiences

Self-harm as coping

Killing – extreme emotions – suicidal attempts/severe self-harm?

Sister there to prevent –

Helping/ stopping – shows you are cared for?

There to help you cope contain these strong emotions and reactions

Not talking to people – isolating self –

Upset for trying to be in contact...

L) Yeah. They was, I don't know, they was just there for me when I needed them, with my Mum leaving me and they

was always there. And I used to get really depressed and self-harm and stuff.

R) Mmm.

L) And if it weren't for (friend) I would probably be dead by now.

R) Right.

L) She stopped me from killing myself so many times, it's unbelievable.

R) So what was it that (friend) did?

L) She's done all sorts. I've tried overdosing. She came and literally pinned me down and took 'em off me. And then I tried slicing my wrist and she just took the blade off me and everything. She did all sorts for me.

R) Yeah.

L) She helped me, like because sometimes I had like won't talk to none of my family when I was in care. I won't talk to anybody and then sometimes I would because when I spoke

Being there

Loss/ being left

Depression – strong emotions

Self-harm to cope with emotions

Others to help contain/ stop escalating emotions

Showing that someone cares enough to stop you
→challenging beliefs of not being worthy of care/ deserving care?

Distancing/

Cutting connections

reminders of
loss – wanting
to be dead →
extreme pain at
reminders of
loss and
breakdown of
relationship?

Hard saying
goodbye

Repeating
experiences of
Leaving/ being
left separated

Protecting self
from more pain

to 'em and especially when I got moved out of York, when I
was speaking to 'em and then it upset me more and that's
when I'd like to be dead and stuff. And that's why I stopped
myself from speaking to 'em.

R) What made it so hard to speak to them or kind of other
people for help during that time, do you think?

L) I don't know it just made it hard to speak to 'em, and
when I was having to say goodbye and that was just the
worst bit and I didn't like it.

Stop
connection
to protect
from pain
→

Protective
distancing

Repeated
experiences
of loss/
separation

Appendix J.2

Table with Super-ordinate and subordinate themes with supporting quotes⁵

Super-ordinate Theme	Subordinate theme	Example of a supporting quote
Being there	Relational continuity	"Yeah, no matter what they've stuck there. They've always been there".
	Shared experiences	"She's gone through everything I've gone through. (laughter) Just about, maybe worse, I don't know. You know, and I respect her for that because she's brought me up"
	Reconnecting with family	"I didn't speak to my Dad for well, I got back in touch with my Dad about two or three years ago".
	Continued family loyalty	"They may not have been great but they're still your family. You can't just turn your back on them".
Protective Distancing	Repeated experience of loss	"I'm just, it seems like, everyone I get close to and that seems like end up losing them".
	ambivalence	"I can't be bothered with anyone".
	Busy isolation	"I've got friends in York, Leeds, Manchester and Scotland". <i>Researcher - Are there any names that spring to mind of the people who are particularly important to you? Who you have a close relationship with?"</i> "Not in particular".
	Continued disruption	"I got passed around from pillar to post to everywhere, and no-one ever looked after me, anywhere I went. And like, I lived at my Grandma's for a bit, but they couldn't cope with me, so they like kicked me out after like three weeks".

⁵ Quotes included are examples and are not the only supporting quotes.

Coping with strong emotions

Drug abuse	"I've just recently got over a heroin and crack addiction"
Self-harm	"I cut my wrists"
Anger (towards others and self)	"I used to want to kill my Mother. Literally rip her head off and leave it" "I've got anger problems"
Containment from others	"They'll put you in the cells if you ask. So I can calm down"

Seeing me as me

Underlying beliefs of being unlovable/ bad	"they couldn't cope with me, so they like kicked me out" "I weren't a nice kid".
Listening to me – taking an interest and investing in me	"And sometimes you just need somebody to sit there and talk to you know like generally about anything" "They talked about my potential"
Acceptance	"I just want them to see me as me,"

Equal relationships

Respect	"I think that it's all about respect because you obviously start with respect, keeping respect but like you get on with people if you have respect for people".
Mutual support	"I look after her, she looks after me". we used to be there for each other
Helping others	"Whatever time of day it is, if they needed me I would be there for 'em". "I'm good at helping other people"

Appendix K

Table with information and relationships included on participants network maps

Participant	Inner Circle	Middle Circle	Outer Circle
Carl	"Friends as family"	Police	None
Rosie	Close family	Friends	Ex-boyfriend
Mike	Foster family, biological father	Close friends	Half and step siblings
Sarah	Family/Step family	1 friend	Support Worker
Tammy	Close family and friends	Sister and nephews	None
Lucy	Boyfriend, cats	Foster mother and foster Aunty, 1 friend and boyfriends parents	Youth Offending Team worker Worker providing support for domestic violence
Liam	Close family	Friends	Extended family
Tom	Girlfriend and granddad	Dad and brother	Mum and brother
Laura	None	None	Pathway worker 1 friend

Appendix L



Participant Consent Form

Participant ID:

Title of study: Exploring Relational Connections Among Care Leavers

Researcher: Rachel Crabbe

Please read the statements below carefully and if you agree to them please complete your details in the spaces below.

Please initial the boxes

1. I confirm I have read the information sheet about the research project and would like to participate in the study. ☐
2. I understand what the project is for and what it involves. ☐
3. I understand that participation in the project is voluntary and that I can withdraw at any time for no reason. ☐
4. I understand that my participation, information about myself and contact details will be kept confidentially. ☐
5. I have had the opportunity to ask any questions I had and confirm I have had satisfactory replies to these. ☐
6. I agree to the publication of direct quotes from my interview, which will be kept anonymous ☐
7. I agree to my interview being recorded ☐
8. I have considered all of the information provided and would like to participate in the above study. ☐

Name of participant

.....

Signature of participant

Date

Contact telephone number

.....

Name of

researcher.....

Signature of researcher

.....

**If you have any queries please phone me on 07527254663 or email me on
R.V.Crabbe@2011.hull.ac.uk**

When completed: 1 for participant; 1 for researcher site file.

Appendix M



Participant Information Sheet

Exploring relational connections among care leavers

My name is Rachel Crabbe and I am a Trainee Clinical Psychologist on the Doctorate in Clinical Psychology course at the University of Hull. I have to carry out research as part of my course. I have chosen to look at the different types of relationships care leavers have and ways in which they cope with difficult emotions or stress. As someone who has previously been in care, I would like to invite you to take part in the study.

Before you decide to take part, it is important for you to understand why the research is being carried out and what it will involve. This information sheet gives you information about the research. Please read it carefully while deciding if you'd like to take part. If there is anything you are unsure about or you have any questions, please contact me using the details provided below. Please feel free to talk to other people about the research if you wish.

Part 1 – information about the study and what it involves

Part 2 – more detailed information about the research

Part 1

What is the study about?

This study aims to explore care leavers' relationships, and methods for coping.

Why am I being invited to take part?

As someone who has previously spent time in care we are interested to hear your experiences for the purpose of this research study.

Do I have to take part?

No, you are under no obligation to take part in this study. It is up to you whether or not you would like to participate. If you decide you would like to participate, you will be asked to sign a consent form. You are free to withdraw from the study at any point and you do not have to give a reason why.

What will happen if I take part?

If you decide to take part in the study, please contact the researcher using the details provided below. A meeting will be arranged at a time and place which is convenient for you and her.

At the beginning of this meeting the researcher will explain in more detail what the research involves. You will then need to sign a consent form that states that you agree to take part in the study.

The researcher will then ask some questions about your care history, such as number and length of previous placements. This will also be an opportunity to ask any questions you may have.

You will be asked to complete a “relational network map”. This involves you writing your name or a fake name in the middle of a circle and listing some of the different people in your life around the circle.

After this the research interview will begin. This is expected to last approximately one hour. The interview will involve talking about your current relationships which will be on your “relational network map”, your methods for coping and past experience in care. This conversation will be audio recorded and then transcribed anonymously. Quotes from the interview may be used in publication of this study, however all quotes will be anonymous so you will not be identified in any way.

Will it cost anything?

No, there is no cost involved in taking part in this study.

Will it benefit me in any way?

There may not be any immediate benefit for you in participating in the study. However, your contribution to the study will increase understanding of relationships in care leavers and will inform ideas of how professionals can best support and work with young people like you. Also your advice will be sought for people who support people in care and how to encourage people to use this after they leave care.

Are there any advantages?

Your participation and the ideas will help inform professionals about supporting wellbeing and relationships during care and continuing support after leaving care.

Are there any disadvantages?

It is possible that in talking about the past and current relationships, emotions and memories may be evoked. You may find this distressing. If this were to happen, we would talk things over and suggestions could be made of people who may be able to provide further support.

If after reading the information in Part 1 you are still interested in taking part, please continue to read Part 2 for further details.

Part 2

Will my information be kept confidentially?

Yes, your participation in the study and all information about you will be kept strictly confidentially. Information will be stored in a locked cabinet at the University of Hull. Only the researcher and one other authorised person (research supervisor) will have access to the information. Once the study has been completed, the information will be kept for 10 years before being destroyed.

Confidentiality may be broken, in line with current legislation, only if information is shared that raises concerns for your safety or anyone else's. If this happens, it will first be discussed with you and an appropriate course of action decided.

What will happen with the results of the study?

The results will be collected and analysed by the researcher. She will then write up the results and submit them for publication in an appropriate professional journal. If you would like to find out about the results of the study once it has been completed, please fill out the question about this on the demographic sheet, alternatively contact the researcher on the details provided below and she will feed this back to you.

What if I change my mind?

You are free to change your mind and withdraw from the study at any point before or during the interview without giving a reason. Also, if you change your mind at a later date you can request to withdraw your interview from the study up until the write up of the study which begins 1st March 2014.

What if there is a problem?

If at any point during the study you had any questions or concerns you could contact the researcher on the details that are provided below. The researcher will do her best to try to answer any questions you have.

Are there any risks in taking part in the study?

No risks have been identified for participants to take part in the study.

Has anyone reviewed the study?

The study has been reviewed and approved by the Faculty of Health and Social Care Research Ethics Committee at The University of Hull.

Thank you for taking the time to read this information sheet.

If you have any further questions please contact me using the details below:

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Appendix N

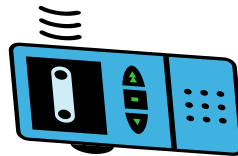


Are You a Care Leaver?

+We are interested in hearing the experiences of people who have previously been in care and their past and current relationships. This is for a research project at the University of Hull.

What's involved?

An audio recorded research interview.



Opportunity to give advice about supporting people in care and after leaving.



All information will be kept **confidential** and **anonymous**.



Contact Rachel on 07527254663 or R.V.Crabbe@2011.hull.ac.uk for more information

Appendix O

Sources of support:

If you feel you need some support please either speak to a member of the pathway team or contact your GP or alternative sources below.

Samaritans

Samaritans 24h General number: 08457 90 90 90

York Samaritans

89 Nunnery Lane, York, North Yorkshire, YO23 1AH

T: 01904 655888

Relate

York : Relate Centre Outpost

14 Pavement, York, YO1 9UP

North Yorkshire

YO1 9UP

01904 625 971

enquiries@relatamid-yorkshire.org.uk

Mind

York Mind

Highcliffe House

Highcliffe Court

York

YO30 6BP

Tel: 01904 643 364

Email: office@yorkmind.org.uk

Appendix P

(Removed for hardbinding)

Appendix Q

Participants' advice for people supporting people in care and after they leave⁶

Laura: Spend time with the people you work with and get to know them so it is not all about the negative thing.

Tom: Treat children and young people in care with respect and appreciate them.

Liam: Hard to give general advice as everyone is different but don't treat young people like "just foster kids", treat them with respect

Lucy: Get to know the child/ young person you are working with –stop moving people out of area

Sarah: Listen to them and understand their view point even if you don't agree

Tammy: Be easy to talk to so people know they can come to you

Mike: Don't let care leavers go into hostels and support them to finish college, help people with the transition, so they can do things for themselves

Rosie: Put them with a good foster carer! And listen to them

Carl: Help us get a job or volunteering, something which we like

⁶ Much of this advice and information was incorporated into the empirical study

Appendix R

Reflective statement

As I sit down to write this statement I realise how much has gone into this process. Despite feeling exhausted, I feel a sense of achievement and remaining enthusiasm for my research. I hope this statement will provide a picture of my experience of this process.

Background and development of research idea

At the beginning of the research process I was quickly drawn towards considering ideas of attachment and resilience. I was enthusiastic about the area and found myself being pulled in many directions, but also pressuring myself to quickly narrow down my ideas and commit to an idea for a research project. Originally I decided on looking at emotional intelligence in looked after children and how this related to resilience. I quickly became quite rigid and fixed with this idea to the exclusion of other areas. I was also determined to apply a quantitative methodology to exploring this relationship. Quantitative methodology was my comfort zone at the time, and was the approach I had used in previous research. I had limited knowledge of qualitative methodology, and was under the impression that quantitative research had the most scientific relevance and was the most accepted approach in psychological research. However, gratefully looking back now, this original idea was not considered feasible, causing me to reconsider my research approach and ideas. Initially I found myself disheartened with a lapse in my initial enthusiasm, nevertheless, this was perhaps one

of the most important experiences in the research process and I was lucky enough for this to happen early on. From here I felt I almost went 'back to the drawing board' and carried on reading the literature which interested me. I allowed myself time to be gradually guided by what really interested me and which I was curious to know more about. I did not pressurise myself to have a concrete plan set up as quickly as possible and therefore became more flexible in my thinking. I was pulled towards ideas of relationships and how these function and relate to wellbeing, much of this was in keeping with the attachment and resilience literature. During this process I also became more familiar with qualitative research; this opened a new way of researching for me and allowed me to adopt an exploratory approach from a stance of curiosity. A qualitative approach to research allowed time to reflect on my own values and beliefs which I believe we become increasingly more aware of through clinical training. I soon realised that qualitative approaches and taking a relativist stance actually more closely reflected my personal view points as well as my general approach in clinical practice (see Appendix F for epistemological statement). I found that slowly progressing my research idea and refining it allowed for it to develop into something I was truly interested in and passionate about. It evolved alongside much of my developing interest in clinical training such as the recovery model and relational approaches. A key statement that has stuck with me in my clinical practice as well as reflecting personal views was stated by a clinical psychologist who I was inspired by: "people can overcome any adversity in the presence of a supportive network" Rufus May.

Recruitment and the interview process

Once my final ideas had been developed and my final research proposal accepted I began making links with the Leaving Care Team. In this respect I believe I was very lucky, liaising with the team was a pleasure, I met some lovely workers who were enthusiastic about the research and were extremely helpful in recruiting people to take part. The recruitment process ran rather smoothly and I think I was lucky compared to many people's experiences of recruitment for research. Also, the interview process was an enjoyable experience as well as eye opening. I have much respect for the young people who kindly took time out to come and speak to me about their experiences, it was a privilege to hear people's stories and sit alongside them as they detailed them. I was touched at how open people were particularly about difficult experiences, and amazed at people abilities to cope and the resilience these young people showed to come through such difficult experiences, and in particular their urge and willingness to help and support others. This certainly put the stressors of the Doctorate course into a much needed perspective. However, alongside this I did feel some tension being in the role of a researcher when hearing these young people's stories and experiences, as opposed to in a clinical role, where they would be more opportunity to take an active role in helping people make sense of their experiences and thinking about further support. In regards to this it was useful to have the presence of members of the leaving care team for debriefing after interviews, as well as having the comforting knowledge that these young people had the team around them as a support if needed.

Data analysis and write up

The data analysis really opened up Interpretative Phenomenological Analysis (IPA) to me, this again was very different to previous experiences of data analysis and it was great to be able to sit down with data sets and spend much time analysing and interpreting what was being said in people's interviews. Although, I allowed plenty of time for this to ensure an in-depth analysis, the realities of pressures and deadlines of the course, mean that I had to factor that in. I felt the major themes emerged clearly as they demonstrated much depth and breadth across participants. Research supervision was invaluable during write up especially with frequent reminders to keep my writing style focused, as I found there was much I could have spoken about in depth. Although the richness of the data was useful in continued discussion and will be in future dissemination, it was important to be able to communicate the key finding clearly.

Systematic Literature Review (SLR)

My SLR question emerged from the background process detailed above and was something I was particularly interested in. I was initially surprised at how little research there was pertaining to the specific research question. Although there is plenty of research on relationships and wellbeing much of this has been studied in a reductionist format, thinking about clinical symptoms rather than specifically recovery as was defined in the current SLR. Although I enjoyed the SLR, there was some conflict over the approach to the question and the idea of researching recovery. The SLR was focused on quantitative research and much of this is actually in conflict with my own personal views as well as the view that the recovery is personal and unique to each person. However, the SLR had a place in the research and findings did mirror those

themes which have emerged from personal narratives. Also, quantitative findings remain those that are more heavily relied on for policy and service design. Despite this, I believe it is important to consider and acknowledge the potential conflict of researching recovery in a positivist way. I found the write up of the SLR harder than the empirical paper (although I enjoyed much of the reading around the area). I did find it difficult writing the SLR up for publication and the terminology used such as 'serious mental illness', which do not fit personally with me. It was good to see some papers refer to distress which is a better way of framing people's difficulties.

Final reflections

I think one of the things I have learnt and would encourage others to apply, is to take a step back in the research process and let your ideas evolve naturally (as much is possible!) compared with my initial approach to dive straight in and create quite a fixed idea early on. I truly believe my later approach allowed my research to develop into something I have remained passionate about and adds an enjoyment to the research process. I can honestly say my enthusiasm for this area has only continued to grow throughout the research process despite external pressures we all experience in writing up and completing in time. One of the main difficulties I faced, as I am sure is the case with most people, is time constraints, and a feeling that I did not have enough time to give the justice to aspects of the portfolio as I would have liked with impending deadlines. Much of this relates to time management (which has been an ongoing learning process for me) as well as family commitments. I have realised that small amounts of consistent focused attention are much more productive than lengthy periods which are not as focused, although the temptation is to devote long periods at

once if we have time, it is better to organise and structure in smaller amounts of time and use it productively. If something is not making progress put it to one side and work on something else or return later with fresh eyes and a clear head.

The research process as detailed above certainly challenged my views of qualitative research and it was an enjoyable experience to use IPA, which I certainly would like to apply to future research.

Thank you for everyone's support and good luck to people embarking on the research process.