

Thesis submitted in partial fulfilment of the degree of Doctor of Clinical Psychology (DClinPsych)

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Abstracts

Systematic Literature Review

Title: Systematic Literature review into parenting qualities associated with "positive outcomes" in foster children and young people

Background: Children and young people (CYP) in foster care are at high risk of experiencing emotional, behavioural and relational difficulties, which may increase the risk of foster placement instability. Substantial research in birth families has investigated parenting qualities that may improve CYP's emotional and behavioural wellbeing, however literature in a foster child population is less well-established. This paper aimed to review research into caregiving qualities associated with attachment security, emotional wellbeing, behaviours of concern and placement stability in foster CYP.

Method: Studies investigating the relationship between caregiving qualities and child outcomes were systematically searched and reviewed from six databases.

Results: Out of 28 studies identified, having a good relationship with one's foster carer and integration into the foster family were the most consistent predictors of CYP outcomes. Some research suggested qualities such as sensitivity and authoritative parenting may be associated with improved child outcomes, however results were mixed.

Discussion: Results indicate caregiving factors play an important role in outcomes for foster CYP. Mixed outcomes between studies may be explained by differing study design and measurements of parenting behaviours. Results also suggest a complex interplay between child and caregiver factors, which should be considered in future research and clinical practice.

Service Improvement Project

Title: “They never gave up on me… a lot of people have given up on me before” How can health and social care services across Oxfordshire support care leavers when they become parents?

Background: Care-experienced parents are at a higher risk of their own children being involved with social care. Some research has indicated care leavers do not feel well-supported with parenting, or find support unhelpful, however research into this is scarce. The present study aimed to investigate care leaver parents’ experiences of support in Oxfordshire, and how they feel support could better meet their needs.

Methods: Phase 1: Audit data regarding care leaver parents was collated from routine monitoring data and social care records. Phase 2: Semi-structured interviews were conducted with 11 care leaver parents regarding their experiences of support and analysed using thematic analysis.

Results: Phase 1: Across Oxfordshire one in 20 care leavers are parents, 50% of whom have social care involvement. Phase 2: Three main themes emerged from interviews: 1. Building a positive working relationship, 2. Parent’s mental and emotional wellbeing, 3. Parenting advice.

Discussion: The present study indicates additional support should be available to care leaver parents to reduce the likelihood of a continued cycle of care. Parents indicated they would benefit from additional mental health support and parenting advice, which should be delivered in an individualised, non-judgemental, and collaborative manner.

Theory Driven Research Project

Title: Exploring Internalised Stigma, Negative Self-Schema and Self-Affirmation in LGBTQ+ adults: A Mixed-Methods Approach

Introduction: LGBTQ+ individuals, in particular transgender and gender non-conforming, are at high risk of mental health difficulties, potentially related to internalised stigma and negative self-schema. A model proposed by Wong and Colleagues (2018) argues that self-affirmation may protect against internalised stigma and negative self-schema, however research into this is limited. This study aimed to explore these mechanisms in LGBTQ+ individuals using a mixed-methods approach.

Method: Quantitative questionnaires measured internalised stigma, negative self-schema and self-affirmation in 181 LGBTQ+ individuals across three groups: cisgender/sexual minority (N=66), transgender/sexual minority (N=100) and transgender/heterosexual (N=15). Qualitative interviews explored eight transgender and gender non-conforming individuals' experiences of self-affirmation in relation to being minoritised using Interpretative Phenomenological Analysis.

Results: Transgender and gender non-conforming individuals scored higher in negative self-schema and internalised stigma than sexual minority individuals. Self-affirmation negatively predicted negative self-schema and internalised stigma. Qualitative findings produced three superordinate themes: 1. Transition unveiling self-affirmation, 2. Categorisation and belonging, 3. The internal battery: Energy depleting and re-charging.

Conclusion: Stigmatising experiences such as battling for one's needs, being made to feel like one doesn't belong, and negative societal messages may impact on mental health in transgender and gender non-conforming individuals by increasing negative self-schema and

internalised stigma. Self-affirmation may protect against this by enabling individuals to notice other valued parts of their identity.

Systematic Literature Review

Systematic Literature review into parenting qualities associated with "positive outcomes" in foster children and young people

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Proposed Journal: Journal of family social work

Rationale: This journal has been chosen as it provides a platform to promote research in advancing the wellbeing and welfare for children and families and actively encourages literature reviews.

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Abstract

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Background: Children and young people (CYP) in foster care are at high risk of experiencing emotional, behavioural and relational difficulties, which may increase the risk of foster placement instability. Substantial research in birth families has investigated parenting qualities that may improve CYP's emotional and behavioural wellbeing, however literature in a foster child population is less well-established. This paper aimed to review research into caregiving qualities associated with attachment security, emotional wellbeing, behaviours of concern and placement stability in foster CYP.

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Introduction

In England, almost 84 000 children are looked after (CLA) by local authorities, the majority of whom are taken into care due to abuse and neglect (Department of Education, 2023). The most common placement for CLA is foster care (68%) with almost a quarter of children and young people (CYP) fostered by family or friends, known as kinship care (Department of Education, 2023).

Experiences of early-life adversity, alongside experiences within the care system itself, place CLA at increased risk of emotional, behavioural and relational challenges (Fernandez, 2008; Goemans et al., 2016). CLA are at high risk of emotional and mental health difficulties, or "internalising behaviours/symptoms." Up to 80% of CLA meet the criteria for at least one mental health diagnosis (Engler et al., 2022) and are at increased risk of difficulties with affect dysregulation (Narendorf et al., 2016), sleep (Lehmann et al., 2020), self-harm (Gabrielli et al., 2015), and suicidality (Evans et al., 2017). In addition, a significant number of CLA demonstrate behaviours of concern, or "externalising behaviours/symptoms," such as aggression, controlling behaviour, sexual/risky behaviour, and conduct disorders (Engler et al., 2022; Octoman et al., 2014).

The elevated risk of internalising and externalising symptoms in foster CYP may be explained by early experiences of attachment relationships. Early caregiving responses from primary caregiver(s) lead to the creation of templates for future relationships, known as an "attachment style" (Bowlby, 1969). Early experiences of maltreatment may mean an infant has inconsistent or limited experiences of their internal needs being recognised and met, leading to insecurity in attachment relationships (Bowlby, 1969; Fonagy et al., 1991). For CLA in particular, separation and changes in primary caregiver(s) may create further insecurity in attachment relationships (Hodges, 2008). Research has indicated high levels of

attachment insecurity in CLA, with one in five foster children showing disorganised attachment (Vasileva & Petermann, 2018), potentially increasing CYP's risk of internalising and externalising behaviour (Fearon et al., 2010).

When entering a foster home, caregivers play a key role in supporting CYP with emotional and behavioural difficulties, in part by demonstrating new patterns of caregiving relationships. The complexity of CYP's needs, however, can mean foster parents struggle to cope, leading to compassion fatigue and potential placement breakdown (Ottaway & Selwyn, 2016). In England, almost half of CLA have experienced at least one placement move, with 10% having three or more placements within one year (Department of Education, 2023). Behaviours of concern in particular play a significant role in placement breakdown (Konijn et al., 2019), which may have detrimental impact on CLA's mental health (Okpych & Courtney, 2018). Understanding factors that support foster carers to cope with emotional, behavioural and relational difficulties in CLA is therefore essential to reduce placement instability.

Extensive research has investigated parenting qualities associated with attachment security, emotional and behavioural wellbeing in biological parent-child dyads (For review, see Bornstein (2019)). Research in CLA, however, is less well-established, and has relied heavily on literature from birth families, which may not be wholly representative of the needs of CLA (Shlonsky & Berrick, 2001).The present literature review therefore aims to provide a synthesis of research into foster carer qualities that are associated with attachment security, emotional wellbeing, behaviours of concern and placement (in)stability in foster CYP

Research question

What caregiving qualities and behaviours are associated with attachment security, emotional wellbeing, behaviours of concern and/or placement (in)stability in kinship and non-kinship foster care?

Method

Design

A systematic literature review was conducted in accordance with Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines (Page et al., 2021). This review was registered and published on the PROSPERO register for systematic reviews (CRD42024505593). Due to the heterogeneity of measurement approaches a meta-analysis was not conducted.

Identification of Studies

A systematic search of published studies was conducted by the first author on 4th March 2024 using the following electronic databases: PubMed, CINAHL, PsycInfo, Medline, ASSIA and Web of Science. Search terms were identified via preliminary searches, which supported the identification of additional terms relevant to the search strategy based on relevant literature. A filter was applied to limit results to search terms included in the title, abstract and key terms where this function was available. See *Appendix B.* for full search strategy. Additional articles were sourced by manually searching literature referenced in relevant studies, systematic reviews and studies that had cited key texts.

Inclusion and Exclusion Criteria

Peer-reviewed studies available in English published in any year were included if they met the following criteria:

Participants: Studies including kinship and non-kinship foster carers and their foster CYP under the age of 18. Research including CLA in alternative placements (e.g. residential care homes, semi-independent accommodation) were excluded. Studies including multiple

populations of CLA (e.g. foster and adoptive youth) were included only if analysis differentiated between types of caregiving environment.

Caregiver measure: Studies that used a quantitative measure of caregiver quality (e.g. caregiver sensitivity, parenting style, warmth). Measures could be caregiver-report, youth-report or observational. Studies where caregiver stress was the sole caregiver measure were excluded. Intervention outcome studies were also excluded. In order to prioritise the breadth of relevant caregiver characteristics, non-validated caregiver measures were included.

CYP measure: Studies that used a quantitative measure (caregiver or child-report) of at least one of four child outcomes: attachment security, emotional wellbeing (or "internalising behaviour"), behaviours of concern (or "externalising behaviour"), or placement breakdown/instability. As above, un-validated CYP measures were included.

Analysis: Studies that included quantitative analysis exploring associations between caregiver qualities and child outcomes were included.

Study Selection

Following the removal of duplicates, the first author individually assessed the remaining papers for inclusion in two stages, initially using only the title and abstract, and subsequently the full text. A second rater independently screened 20% of title and abstracts and 25% of the full texts to ensure inter-rater reliability was sufficient (Cohen's Kappa ≥.81). Discrepancies in inclusion/exclusion were discussed and agreed between reviewers.

Data Extraction

The first author collected the following data for all included studies: Author, date of publication, country, caregiver and child characteristics (gender, age, ethnicity, kin/non-kin placement, length of time in placement), caregiver quality and how this was measured, child

outcome and how this was measured. Extracted information was entered into a standardised Excel spreadsheet. A second rater extracted the above data on 50% of included studies for comparison, to ensure agreement and identify discrepancies.

Quality Appraisal

The first author conducted an assessment of study quality of included papers using the "Standard quality assessment criteria for evaluating primary research papers" (Kmet et al., 2004). Raters scored each paper based on a 14-item checklist. Three items (6, 7 and 8) were only relevant to intervention studies and were therefore omitted from quality appraisal. One additional item ("controlled for confounding") was not relevant to cross-sectional studies with only one group and was therefore rated as N/A for such studies. The final quality percentage for each paper was calculated using its total rating and the total possible score. Thirty percent of included papers were rated by a second rater and discrepancies in scores were discussed and agreed. As inter-rater reliability was insufficient at this stage, additional papers were double-rated until inter-rater reliability was sufficient (Cohen's Kappa ≥.81), resulting in all 28 papers being double-rated.

Results

Study Selection

1379 papers were identified from six databases. Five additional studies were identified through citation searching. 532 duplicates were deleted, 852 papers were screened.

Of these, 729 were excluded based on information provided in the title and abstract. Inter-rater reliability of 170 double-screened papers was rated as "near perfect" (Cohen's Kappa=.87). Of the 122 papers sought for retrieval, two did not have full-texts available in

English and were excluded. A further 92 were excluded due to incorrect populations, lack of quantitative caregiver or child measure, not peer-reviewed, no analysis of caregiver quality on child outcome. Inter-rater reliability of 30 double-screened papers was rated as “near perfect” (Cohen’s Kappa=.86).

A final total of 28 studies were included in the present review (see *figure 1.* for diagrammatic representation of the search and selection process).

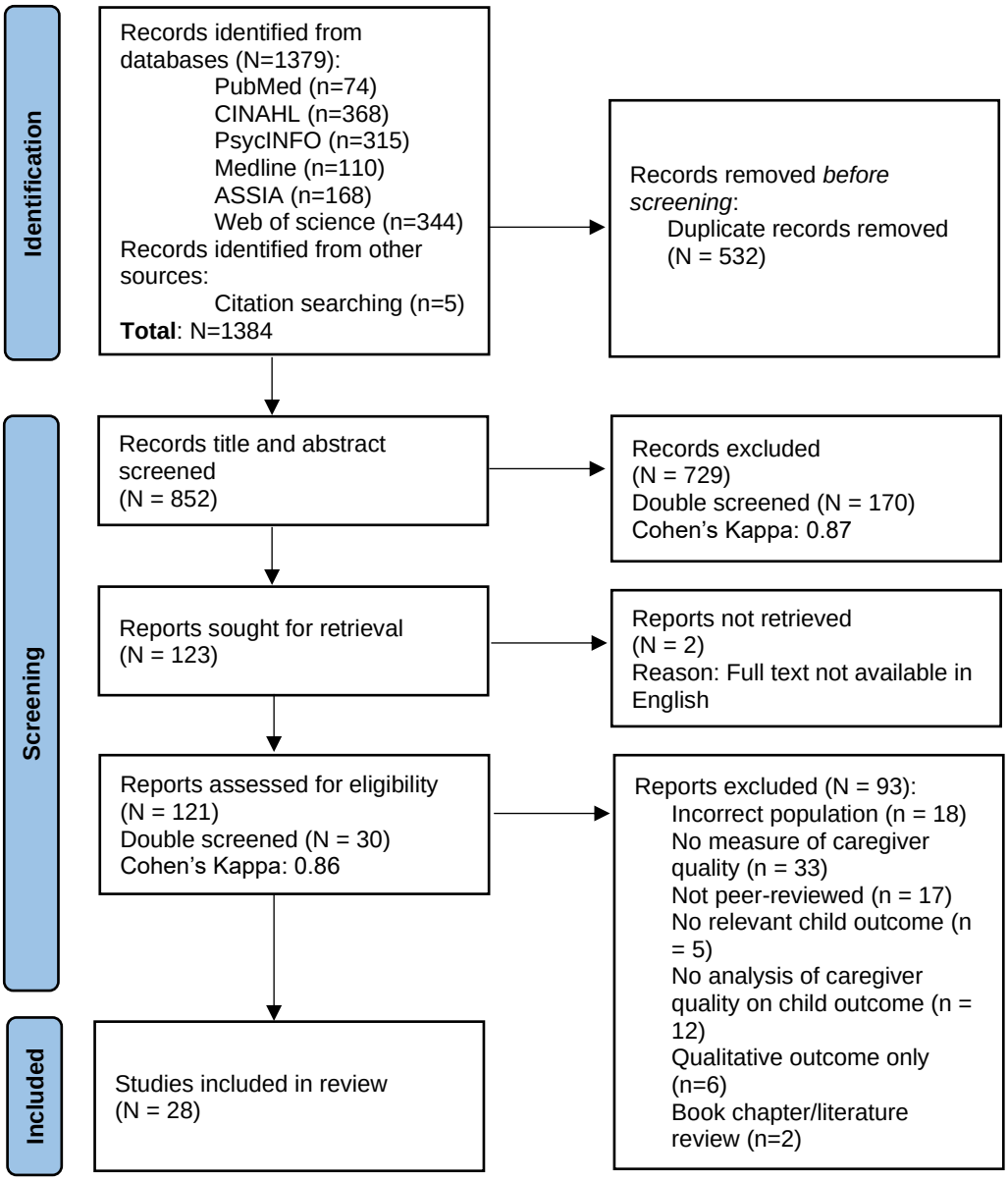


Figure 1. Diagrammatic representation of search and selection procedure from Page et al., (2021)

Description of included studies

All 28 included studies were published between 2000 and 2024, with the majority from 2010 onwards (N=22). Thirteen studies were published in the USA, 11 in mainland Europe, two in Canada, one in Australia and one in the UK. Sample sizes ranged from eight (caregiver-child dyads) to 2636 (foster carers), with the majority between 50 and 150 (N=22). Fifteen studies were cross-sectional and 13 were longitudinal, however one of these did not analyse data longitudinally and was therefore treated as cross-sectional. Longitudinal studies had between two and five time points, with three studies spanning six months or less, five 12-months, and four more than 12-months. Out of the 19 studies that reported caregiver gender, the majority were female (88.4%). Of the 14 studies that reported placement type, 27.5% were kinship.

All CLA were aged under 18. Eight studies were with infants ≤3 years, while two included both infants and young children (≤7y). Nine studies were of children aged 3-12. Eight looked at CYP into late teens (<18), only three of which focused solely on foster youth (aged 10-17). Gender was approximately even between male and female (48.6% female). Nineteen studies reported the length of time CYP had lived at their current placement, which ranged from immediately after the start of placement to 12 years from placement start. One study did not report any child characteristics (15). Study characteristics are shown in *table 1*.

Synthesis of the literature

The narrative synthesis below summarises the findings from the 28 included studies and is organised by child outcome. Measures and key findings from each study can be found in *table 2.*

Table 1. Study Characteristics

Study	Country	Sample Size	Design	Caregiver characteristics				Child characteristics			
				Age (Mean)	**% F**	**Ethnicity**	**% Kin**	**Age year/ months (Mean)**	**% F**	**Ethnicity**	**Time at placement (Mean)**
1. Gomez (2021)	USA	2635 kinship foster parents	Cross-sectional Survey	18-75.	75.68	Not reported	100	0-17y (8.57).	51.0	51.01% white, 33.1% black, 1.69% American Indian or Alaskan, 3.04% Asian, 0.84% Hawaiian or pacific, 3.51% other race, 6.82% mixed	N.R
2. Oosterman & Schuengel (2008)	The Netherlands	61 foster parent-child dyads	cross-sectional	N.R	90.1	N.R	0	26-88m (56.88).	63.9	N.R	3-76m (35.39)
3. West et al., (2022)	Belgium	68 foster mother-child dyads	Cross-sectional Pretest data	N.R	100	N.R	38.2	18-74m (36.43)	50	N.R	<1y
4. Bernier & Dozier (2003)	USA	64 foster mother-infant dyads	Cross-sectional	25-78 (47)	100	63% African American, 35% European American, 2% Hispanic	3.1	*T1:* 6-30m *T2:* 12-24m	35.9	67% African American, 16% European American, 11% mixed race, 6% Hispanic.	N.R
5. Kaylor-Tapscott & Sullivan (2024)	USA	79 grandparent kinship carers	Cross-sectional	44-81 (60.78)	91.1	70.5% white, 10.3% Black American, 6.4% Hispanic, 2.6% Asian, 5.1% American Indian, 3.8% mixed race, 1.3% other.	100	6-12y (8.91)	45.6	N.R	0.5-12y
6. Reindl et al., (2022)	Germany	94 foster care group, 157 biological controls	Longitudinal (3 time points, 6m intervals	*N.R*	*N.R*	N.R	0	M=45.64m	49	N.R	17.68m
7. Miller et al., (2019)	Australia	*Total:* 75 foster carers *Cont*[1]*:* 64 *Break*: 11	Longitudinal (5 time points, 4 month intervals)	*Cont:* M= 47.45 *Break:* M= 45.82	*Cont:* 70 *Break:* 36.4	N.R	N.R	3-17y (10.5).	46.7	N.R	N.R
8. Healey & Fisher (2011)	USA	35 foster children	Longitudinal data collection,	N.R	N.R	N.R	N.R	3-5y	42.9	European American (94.3%), Native American (5.7%)	N.R

			analysed by averaging across time points.								
9. Poitras et al., (2022)	Canada	50 parent-child dyads	Cross-sectional	M=43.96	N.R	N.R	26	12-46m	46	100% Caucasian	M=16.77m
10. Fuentes et al., (2014)	Spain	104 CYP + 86 foster families	Cross-sectional	29.9- 66.3	100F + 82.6M	N.R	N.R	5-17.8y (11)	46.2	67.3% White European, 32.7% "Gypsy or African"	M=3.73y
11. Stovall & Dozier (2000)	USA	8 foster parents + 10 foster infants	Longitudinal (2 time points, 60 days) single subject analysis	39-68 (54)	100	50% European American, 50% African American	N.R	9-19.6m (11.9)	50	60% African American, 40% European American	*T1:* 0m *T2:* 3-14m
12. Bovenschen et al., (2016)	Germany	49 foster parent-child dyad	Cross-sectional	35-68 (46.2).	94	N.R	N.R	36-99m (66.1).	51	N.R	1-93m (46).
13. Gabler et al., (2014)	Germany	48 foster parent-child dyads	Longitudinal (2 time points, 6m interval)	26-51 (41)	89.6	N.R	N.R	9-66m (30.6)	50	N.R	*T1:* 2.5m (81.87 days) *T2:* 6m (198.46 days).
14. Lang et al., (2016)	Germany	55 foster CYP	Longitudinal (3 time points, 6m intervals)	M=41.18	87.3	N.R	N.R	9-79m (33.4)	50.9	N.R	16-164 days (78)
15. Crum (2010)	USA	151 foster parents	Cross-sectional	24-89 (46.2).	66.2	86.0% Caucasian, 11.9% African American, 0.66% Hispanic, 1.32% Native American	N.R	N.R	N.R	N.R	N.R
16. Goemans et al., (2020)	The Netherlands	432 foster CYP	longitudinal (3 time points, 6m intervals)	N.R	N.R	N.R	33.1	4-17y (10.9)	46.8	N.R	M=58.98m
17. Jacobsen et al., (2018)	Norway	60 foster CYP	Longitudinal (2 time	24-49 (37.7)	91.7	95% Norwegian	N.R	*T1:* 22-25m (23.3)	40	76.7% Norwegian	*T1:* 2-23m (15.1)

			points, 1y interval)					*T2:* 34-36m (35.2)			*T2:* 13-35m (27.1)
18. Olson et al., (2019)	USA	91 foster parents	Longitudinal (2 time points, 6m interval)	N.R	N.R	N.R	N.R	*T1:* 18-36m (2.26y). *T2:* 2.87y	44	57.1% European American, 15.4% mixed race, 17.6% Hispanic/Latino, 5.5% African American, 3.3% Native American, 1.1% other.	*T1*:<1m *T2*: 6-7m
19. Panlilio et al., (2020)	USA	45 CYP + 47 foster mothers	Cross-sectional	M=47	100	64% African American, 12% White, 2% Hispanic, 2% mixed race, 18% other	36	M=62m	53	75% African American, 7% white, 2% Hispanic, 11% mixed race, 5% other	M=21.2m
20. Cole (2005)	USA	65 infant-caregiver dyads	Cross-sectional	28-75 (M=46)	98	70% Black/African American	N.R	10-15m.	N.R	N.R	≥6m
21. Schütte et al., (2023)	Germany	86 foster CYP, 148 biological children	Longitudinal (3 time points, 6m intervals)	M=42.71	100F + 93M	N.R	N.R	M= 44.3m	51.2	N.R	<24m
22. Bell et al., (2015)	Canada	N=313 (Conduct), N=312 (Emotion[2]).	Longitudinal (4 time points, 12m intervals)	N.R	N.R	N.R	16.3	M=7.5y	44.4	67.4% European Canadian, 17.3% first nations, 4.8% African Canadian, 8.3% other.	N.R
23. Wojciak et al., (2017)	USA	131 foster youth	Cross-Sectional	N.R	N.R	N.R	32.8	11-16y (12.89)	50.4	34.3% white, 42.7% black, 12.2% Hispanic, 9.92%other	N.R
24. De Schipper et al., (2012)	The Netherlands	59 foster parent-child dyads	cross-sectional	27-58 (43.5).	91	N.R	0	26-88m (57.0).	63	N.R	3-76m
25. Ackerman & Dozier (2005)	USA	59 foster mother-child dyads	Longitudinal (2 time points, 3y interval)	30-66 (45.7)	100	74% African American, 26% European American.	N.R	*T1:* M= 28.3m *T2:* M= 62.2m	46	77% African American, 20% European American, 3% mixed race.	>3y
26. Joseph et al., (2014)	UK	62 adolescents in foster care + 50 control families	cross-sectional	27-28 (49.2)	N.R	46.8% white	0	10.3-17.5y (13.9)	46.8	54.8% white	0.42-12.3y (3.46)
27. Leathers (2005)	USA	179 foster parents	Longitudinal (2 time	N.R	N.R	N.R	0	M= 12.91y	47.6	83.5% African American, 9% white, 6.4% Hispanic, 1% other.	M=2.41y

			points, 5y interval)									
28. Rayburn et al., (2017)	USA	175 foster youth	Cross-sectional	N.R	N.R	N.R	N.R	11-16y (13).	51	41% African American, 43% Caucasian, 11% American Indian, 2% Asian, 3% other.	N.R	

Where desired data was not reported in studies, relevant available data is included. *Abbreviations:* N.R= Not reported. CYP=children and young people. M=mean. In relation to time/age: m=months, y=years. For longitudinal studies, T1=the first timepoint of data collection, T2=second data collection time point. [1]Cont=placement continue group, break=placement breakdown group. [2]Conduct= "Conduct problems" group, Emotion= "Emotional problems" group.

Table 2. Measures and key findings of included studies

Study	Caregiver Quality/Qualities	Caregiver Measure(s)	Child Outcome(s)	Child Measure(s)	Analysis	Main Finding(s)
1. Gomez (2021)	Family resilience	Caregiver report from survey assessing frequency of mutual support and problem solving.	"Internalising disorder" and behaviours of concern	Caregiver report from survey of healthcare provider report of child anxiety/depression and/or child conduct/behavioural problems.	Multiple linear regression	No relationship between family resilience and child internalising disorders *(OR=.94, p=.13).* Increased family resilience was significantly related to decreased child behaviour problems *(OR=.91, p=.02)*
2. Oosterman and Schuengel (2008)	Caregiver sensitivity	Coded Semi-structured caregiver-child interaction (NICHD supportive presence and respect for autonomy sub-scales).	Attachment security, externalizing behaviour	AQS, caregiver-report CBCL, teacher-report C-TRF	Multiple regression	No correlation between caregiver sensitivity and child attachment security (p>.05).
3. West et al. (2022)	Caregiver sensitivity	EA-SR	Attachment insecurity	Caregiver-report AISI	Multiple linear regression	Caregiver sensitivity significantly negatively correlated with attachment insecurity but was not predictive of attachment insecurity *(p=.67).*
4. Bernier and Dozier (2003)	Carer attachment state of mind, mind-mindedness.	AAI, TIMB	Attachment security.	Strange situation classification	Regression mediation analysis	Caregiver mind-mindedness mediated the association between caregiver attachment state of mind and child attachment security *(β=-.34, p<.05*).
5. Kaylor-Tapscott and Sullivan (2024)	Parenting strategies	APQ (negative discipline sub-scale)	Externalising behaviour	Caregiver-report CBCL (age 6-18)	Hierarchical multiple regression	Negative discipline did not significantly predict child externalising behaviour *(β=.07, p=.54)*
6. Reindl et al. (2022)	Parenting quality	ZBQ, caregiver report of relationship, coding of caregiver-child interactions.	Biological indicators of stress, emotional and behavioural problems.	Hair steroid assessment (cortisol), sIgA saliva collection, CBCL	Independent samples t-test.	Children with lower-quality caregiving had increased emotional and behavioural difficulties *(p<.001, d=.79)* and lower cortisol *(p=.039)* and cortisol/DHEA ratio *(p=.008)*
7. Miller et al. (2019)	Caregiving competence, Caregiver empathy, parent-child relationship.	PSOC, BES, P-CRS	Placement breakdown	Foster carer report	Mann-Whitney U test	Caregivers in the placement continuing group were significantly higher in caregiving satisfaction *(p=.02, d=.770),* cognitive empathy *(p=.01, d=.92),* closeness *(p=.01, d=.9)* and lower in conflicts *(p=.01, d=-.83).*

8. Healey and Fisher (2011)	Parenting practices	Caregiver-report Parenting scale	Attachment behaviour, emotion regulation.	Parent attachment diary, caregiver-report ERC	Multiple bivariate correlation	No significant association was found between parenting practices and child attachment behaviour or emotion regulation *(p>.05)*
9. Poitras et al. (2022)	Caregiver sensitivity	Coding of parent-child interactions using MBQS	Externalising behaviour	CBCL	Hierarchical multiple regression	Foster carer sensitivity significantly negatively predicted child externalising behaviour *(β=-.33, p=.03).*
10. Fuentes et al. (2015)	Parenting Style	Affect and Communication Scale, Rules and demands scale	Internalising and externalising behaviour	Caregiver-report CBCL	Multiple linear regression	Authoritarian parenting significantly predicted internalising behaviour *(β=.33 p<.001).* Criticism/rejection *(β=.42, p<.001),* authoritarian parenting *(β=.29, p<.01)* and permissive parenting *(β=-.22, p<.01)* significantly predicted externalising behaviour.
11. Stovall and Dozier (2000)	Attachment state of mind, parenting behaviour.	AAI, parent attachment diaries.	Attachment security.	Strange situation, parent attachment diaries	Single-subject analysis	"Autonomous" caregiver attachment was associated with child attachment security only in infants placed before 12 months of age. Nurturant caregiving responses to insecure behaviour was associated with secure child responses.
12. Bovenschen et al. (2016)	Caregiver sensitivity	Coding of 15-minute caregiver-child interaction (NICHD supportive presence, respect for autonomy and hostility scales)	Behavioural attachment security, representational attachment security, temperament	Semi-structured home observation and rating on AQS, ASCT, CBCL	Bivariate correlation, hierarchical multiple regression	Caregiver emotional support and respect for autonomy positively correlated with attachment security *(p<.05).* Respect for autonomy but not supportive presence predicted attachment security on the AQS *(β=.34, p<.05).*
13. Gabler et al. (2014)	Caregiver sensitivity	Semi-structured observation and coding caregiver-child interaction (NICHD Supportive presence, respect for autonomy and hostility scales)	Attachment security, behaviour of concern.	Child observation and coding with AQS, caregiver-report CBCL (age 1.5-5 or 4-18.)	Bivariate correlation, hierarchical multiple regression	Caregiver sensitivity was significantly associated with child attachment security but not behaviour of concern. Caregiver supportive presence at T1 positively predicted attachment security at T2 *(β=.31, p<.05)* but not behaviour of concern.
14. Lang et al. (2016)	Parenting style	Observation and coding of parent-child interaction (emotional climate and behavioural control scales).	Attachment security	AQS based on semi-structured home observations.	Hierarchical multiple regression	Authoritative parenting was significantly predictive of attachment security *(β=.40, p<.01).*
15. Crum (2010)	Caregiver-child relationship	Caregiver-report PCRI	Placement stability	Caregiver-report.	Multiple regression	Parental support *(β=.179)* and limit setting *(β=-.334)* significantly predicted stability

						(p<.001). Other PCRI sub-scales were not predictive of stability.
16. Goemans et al. (2020)	Positive/negative parenting behaviour.	Caregiver-report APQ	Internalising/ externalising behaviour	Caregiver-report SDQ	Multilevel models	Positive foster parenting significantly predicted child prosocial behaviour *(p<.001)* but not internalising/externalising behaviour.
17. Jacobsen et al. (2019)	Emotional investment to child	TIMB semi-structured interview (acceptance, commitment, and awareness of influence sub-scales)	Social and emotional functioning	Caregiver-report ITSEA	Linear regression	Commitment at T1 predicted externalising behaviour at T1 *(p<.01)* but not T2. Acceptance at T2 predicted dysregulation at T2 *(p<.01).* Acceptance and Commitment predicted social competence at T1 and T2 *(p<.05).* No caregiver factors predicted internalising behaviour.
18. Olson et al. (2019a)	Family routines, harsh discipline.	Caregiver-report Family routines inventory, Discipline questionnaire (harsh discipline subscale).	Behaviour of concern	Caregiver-report CBCL (ages 1.5-5)	Path model	Neither caregiver measure significantly predicted child's behaviours of concern at T2 *(p>.05)*
19. Panlilio et al. (2020)	Emotional responsiveness and modelling	HOME semi-structured interview (Responsiveness and modelling sub-scales).	Fear arousal	Coding of scary mask structured task.	Pearson's Correlation, Odd's ratio.	Caregiver responsiveness but not modelling was significantly correlated to child fear arousal *(p<.05).* Children classified as high fear arousal had caregivers who were significantly lower in responsiveness *(OR=.05, p<.001).*
20. Cole (2005)	Caregiver sensitivity	HOME observation/interview tool (Responsivity, acceptance, and involvement sub-scales)	Attachment security	Ainsworth Strange situation	Logistic regression	Caregiver sensitivity negatively predicted attachment security *(β=-.51, p<.05).* Parent involvement, but not responsivity or acceptance, negatively predicted attachment *(β=-1.817, p<.05).*
21. Schütte et al. (2023)	Parenting behaviour	ZBQ (Warmth and support and psychological pressure sub-scales)	Internalising and externalising behaviour.	CBCL	Correlation, Linear mixed-models	Warmth and support at T3 negatively correlated with externalising problems at all time points *(p<.05)* but not internalising problems. Parenting significantly predicted child internalising and externalising behaviours in combined foster/non-foster populations *(p<.001).*
22. Bell et al. (2015)	Positive parenting	Adapted items from caregiver-report parenting practices scale	Conduct problems, emotional problems.	Caregiver-report SDQ	Multinomial logistic regression	Positive parenting was significantly predictive of behavioural resilience *(OR=1.35, p<.05)* but not emotional problems.

23. Wojciak et al. (2017)	Closeness to caregiver	Youth-report of "how close do you feel to your primary caregiver?" "How much do you feel like your primary caregiver cares about you?"	Internalising and externalising behaviour, trauma symptoms.	YSR (internalising and externalising sub- scales), TSCC	Correlation, Mediation/moderation analysis	Closeness to caregiver negatively correlated with internalising *(p<.01)* and externalising *(p<.05)* behaviour. Closeness moderated the relationship between trauma and internalising *(p<.05)* but not externalising behaviour. No mediation effect was found.
24. De Schipper et al. (2012)	Caregiver sensitivity	Semi-structured caregiver-child interaction (NICHD, supportive presence and respect for autonomy sub-scales)	Attachment security, disordered attachment symptoms shyness	Ainsworth Strange situation, caregiver DAI, Children's behaviour questionnaire (shyness sub-scale)	Logistic regression	Parental sensitivity was predictive of child secure attachment in shy children *(β=.82, p=.03)* but not less-shy children.
25. Ackerman and Dozier (2006)	Caregiver investment	TIMB semi-structured interview (acceptance and commitment sub-scales)	Representations of self, attachment relationships, behaviours of concern	The puppet interview (positive/negative self-representation sub-scale), SAT, CBCL	Partial correlation	Caregiver acceptance but not commitment positively correlated with child self-worth appraisal *(p<.001)* and quality of coping with separation *(p<.05).* Acceptance negatively correlated with behaviours of concern *(p<.05).*
26. Joseph et al. (2014)	Parental sensitivity, parenting behaviour	Observation and coding of caregiver-child interaction (warmth, communication, assertiveness, involvement, anger/rejection and coercion sub-scales), coding of attachment-related parenting sensitivity scale	Attachment style	CAI	Logistic regression	Securely attached adolescents had caregivers who scored significantly higher in positivity *(p<.05)* and sensitivity *(p<.01)* than insecurely attached. Maternal positivity significantly predicted secure attachment to foster mother *(β=1.42, p=.02).*
27. Leathers (2006)	Foster home integration	Caseworker and foster carer report of child's perception of belonging in the home and child's probable reaction to being removed from the home.	Placement disruption, behaviours of concern.	State-recorded placement data at T2, caregiver-report CSI	Logistic regression, mediation analysis	Lower foster home integration was significantly predictive of placement disruption *(OR=.44, p<.01)* and behaviours of concern *(β=-.28, p<.001).* Integration significantly mediated the relationship between child behaviours of concern and placement disruption.
28. Rayburn et al. (2018)	Child-caregiver relationship.	Adolescent-report Abbreviated RAPS-S (emotional security, involvement, and structure sub-scales)	internalising and externalising symptoms, trauma symptoms.	YSR, TSCC	Multiple regression, mediation analysis	foster carer-child relationship inversely predicted mental health symptoms (internalising, externalising, trauma, *p<.01).* Caregiver emotional security and involvement mediated the relationship between exposure to violence and mental health.

Caregiver Measures: EA-SR=Emotional Availability Self-Report measure; AAI=Adult Attachment Interview; TIMB=This is my baby semi-structured interview; APQ=Alabama Parenting Questionnaire; ZBQ=Zurich Brief Questionnaire for the Assessment of Parental Behaviours; PSOC=Parenting Sense of Competence Scale; BES=Basic Empathy Scale; P-CRS= Parent-Child Relationship Scale; MBQS=Maternal Behaviour Q-Sort; PCRI=Parent-child relationship inventory; HOME = Home Observation for Measurement of the Environment inventory; NICHD=National Institute of Child Health and Human Development; RAPS-S=Rochester Assessment Package for Schools Student. **Child Measures:** AQS=Attachment Q Sort; CBCL=Child-behaviour checklist; C-TRF=caregiver-teacher report form; AISI=Attachment insecurity screening inventory; ERC=Emotion Regulation Checklist; ASCT=Attachment Story Completion Task; SDQ=Strengths and Difficulties Questionnaire; ITSEA=Infant-toddler social and emotional assessment; YSR=Youth Self-report; TSCC=Trauma Symptom Checklist for Children. DAI=disturbance of attachment interview; SAT=Separation Anxiety Test; CAI=Child Attachment Interview; CSI=Child Symptom Inventory.

1. Attachment security

Twelve studies looked at child attachment security, with seven focusing on caregiver sensitivity (2, 3, 12, 13, 20, 24, 26), two on attachment state of mind (4, 11) and four on caregiving responses/behaviours (8, 14, 25, 26).

The majority of studies investigated infants and young children (3, 4, 11, 12, 13, 14, 20, 24, 25). Two investigated children under the age of 13 (2, 8), with only one study including foster youth (26). Nine studies measured attachment through observation of caregiver-child interactions (2, 4, 11, 12, 13, 14, 20, 24, 25). Four used caregiver-report measures (3, 8, 11, 24) and one used a youth-report measure of attachment style (26).

1.1. Caregiver sensitivity

Sensitivity was primarily measured by coding caregiver-child interactions, with only one study using caregiver self-report emotional availability (3).

Results from correlational analysis were mixed. Three studies showed a significant positive correlation between sensitivity and attachment security (3, 12, 13), however two found no correlation between sensitivity and attachment (2, 24).

Regression analysis was also mixed, with only one study finding overall observed caregiver sensitivity positively predicted attachment security in adolescents ($p<.05$) (26). One cross-sectional study demonstrated observed caregiver "respect for autonomy" (respect for a child's individuality and perspective), but not "supportive presence" (positive regard and emotional support), predicted attachment security in children ($\beta=.34$ $p<.05$) (12). A second longitudinal study, however, found the opposite, *i.e.,* "supportive presence" but not "respect for autonomy" predicted child attachment security after six months ($\beta=.31$, $p<.05$) (13). One cross-sectional study demonstrated observed caregiver sensitivity predicted attachment security in shy children only ($\beta=.82$, $p=.03$) (24). Of note, one study (2) found child

attachment security predicted caregiver sensitivity (β=.28, p<.05). The inverse relationship between these variables, however, was not analysed (2).

The only study to use caregiver self-report did not find caregiver emotional availability to predict attachment security (3). Authors commented on the possibility that caregivers may score themselves highly on self-report sensitivity, and on the short amount of time children had lived in their current placements (<1 year), which may have impacted the predictive ability of caregiver sensitivity on attachment security.

Surprisingly, one study demonstrated increased observed carer sensitivity *negatively* predicted observed attachment security in caregiver-infant dyads (β=-.51, p<.05) (20). Post-hoc analysis demonstrated caregiver involvement (attentiveness to the needs of the infant) negatively predicted security (β=-1.817, p<.05), while responsivity and acceptance did not predict security (20). Authors suggested caregiver's own experiences of childhood trauma and scrutiny from child welfare services may increase hypervigilance of threat towards their child, potentially decreasing attachment security (20).

Only one study used between-group comparison to identify differences in caregiver sensitivity between secure and insecurely attached CYP (26). This study found significantly higher observed caregiver sensitivity in CYP classified as securely attached than CYP classified as insecurely attached (p<.01) using the Child Attachment Interview (CAI) (Target et al., 2003).

1.2. Attachment state of mind

Two studies measured caregivers' own attachment state of mind using the Adult Attachment Interview (George et al., 1996) (4, 11). The AAI classifies caregivers into one of four attachment categories (secure-autonomous, insecure-dismissing, insecure-preoccupied or

insecure-unresolved) based on how they describe their own caregiving experiences (Main et al., 1998).

In one study (11), single-subject analysis of eight caregivers and their 10 foster-infants demonstrated that infants placed with "autonomous" caregivers before the age of 12-months were likely to form a secure attachment to their caregiver. Diary entries also suggested that "nurturant" caregiver responses were more likely to lead to "secure" infant behaviour, while infants whose caregivers complemented insecure attachment behaviour (e.g. ignoring avoidant behaviour or becoming angry at resistant behaviour) were more likely to respond in an "insecure" way.

A second study (4) indicated higher "autonomous" caregiver state of mind significantly predicted child attachment security and accounted for 13.6% of variance in child attachment security (β=.37, $p<.01$). Furthermore, the relationship between caregiver state of mind and child attachment security was mediated by caregiver mind-mindedness, defined as a caregiver's ability to treat their child as having their own individual mind (Meins, 1997). Combined, caregiver state of mind and mind-mindedness accounted for 15.2% of variance in child attachment security (β=-.34, $p<.01$=5).

1.3. Caregiving responses/behaviours

Out of four studies investigating parenting responses/behaviours, two used observational measures of parenting behaviour during caregiver-child interactions (14, 26). One used a caregiver self-report measure of "dysfunctional parenting" (8), and one used a semi-structured caregiver interview (25).

Three studies found caregiving behaviours were associated with child attachment security (14, 25, 26). One longitudinal study demonstrated higher expressed caregiver acceptance (positive feelings about caring for an infant), but not commitment (emotional investment and

desire to parent a child), significantly correlated with a child's ability to create solutions to cope with caregiver separation (25). A second longitudinal study (14) found higher observed authoritative parenting (high warmth, affection, and limit-setting) at the start of a child's placement predicted attachment security 12-months later (β=.40, p=.007) and explained 20% of the variance in attachment security (14). A third study (26) found caregivers of securely attached foster youth scored significantly higher in observed caregiver positivity (warmth, assertiveness, communication and involvement) than insecurely attached youth. Increased positivity also predicted foster youth attachment to foster mother (β=1.42, p=.02) (26). Foster mother negativity (anger/rejection, coercion), however, did not differ between secure and insecurely attached CYP (26).

Only one study found no association between caregiving responses and attachment security. This study found no correlation between caregiver-report "dysfunctional parenting" and child attachment behaviour, both of which were scored and averaged across three time points (8).

2. Emotional wellbeing ("Internalising symptoms")

In total, 12 studies investigated child emotional wellbeing or "internalising symptoms," with seven focusing on parenting behaviour (1, 6, 8, 10, 16, 21, 22), two focusing on the caregiver-child relationship (23, 28) and three on caregiver emotional investment and responsiveness (17, 19, 25).

Of these, two were studies with infants (<3 years), six investigated children under the age of 13, and four included children and teenagers. More than half of studies (N=9) used a caregiver-report measure of child internalising symptoms (1, 6, 8, 10, 16, 17, 21, 22, 25).

Other measures of emotional wellbeing were biological stress markers (6), coding of a structured child task (19, 25) and youth self-report (23, 28).

2.1. Parenting behaviour/practices

All but one study used a caregiver-report measure of parenting behaviour (1, 8, 10, 16, 21, 22). From these, no association was found between survey responses of family resilience (1), or caregiver-report positive/negative parenting practices (8, 16, 21, 22) on child outcomes of caregiver-report emotion regulation (8) or mental health (1, 16, 21, 22).

One longitudinal study did find caregiver-report warmth and support negatively predicted internalising behaviour six months later (b=-.25, p=.015) in a combined sample of foster and birth families, where preliminary analysis had demonstrated no differences between foster and birth family groups (21). In addition, one study found authoritarian parenting ("imposition of rule compliance coupled with strong demands") predicted increased internalising behaviour (β=.33, p<.001) (10). No other parenting behaviour measured in this study (warmth/communication, criticism/rejection, authoritative parenting, permissive parenting) predicted child internalising behaviour (10).

Only one study (6) used an observational measure of caregiver behaviour. This study combined caregiver-report and observations of nurturing/dysfunctional caregiving behaviour to group participants into a high- and low-quality caregiving group. Independent-samples t-test demonstrated infants in the high-quality care group scored significantly lower on combined internalising and externalising symptoms than infants in the low-quality care group (d=.79 p<.001) (supplementary table 12.). Furthermore, infants receiving lower-quality care had lower cortisol concentration (p=.039) and cortisol/DHEA ratio (p=.008) than infants receiving higher-quality care, as well as decreasing sIgA concentrations. Authors concluded high-quality foster caring may reduce the impact of chronic stress on the HPA axis, while

low-quality foster parenting may lead to persistently high levels of stress and hypoactivation of the HPA axis (6).

2.2. Caregiver-child relationship

Two studies used a youth-report measure of the foster parent-child relationship. Only one of these used a validated measure (28), with the other combining two Likert-scale questions of how close a CYP feels to their caregiver, and how much they feel their caregiver cares about them (23).

Both studies found higher scores of parent-child relationship significantly predicted decreased CYP self-report internalising behaviour. One study (23) found closeness to caregiver significantly moderated, but did not mediate, the relationship between youth-report trauma symptoms and internalising behaviour. The second study (28) found that youth-report caregiver emotional security (e.g. “when I am with my caregiver I feel good”), involvement (e.g. “my caregiver enjoys spending time with me”), and structure (e.g. “I don’t know what my caregiver wants from me”) independently predicted child internalising symptoms (β=-3.90, -4.48, -2.96 respectively, $p<.05$). Furthermore, each of these variables mediated the relationship between a child’s past exposure to violence and mental health symptoms (28).

2.3. Caregiver emotional investment and responsiveness

Two studies used semi-structured caregiver interviews to measure caregiver “emotional investment” to a child (17, 25), using the acceptance, commitment and awareness of influence sub-scales of the This is My Baby (TIMB) interview (Bates & Dozier, 1998). One study found caregiver acceptance significantly negatively predicted caregiver-report child emotion dysregulation, but not internalising behaviour (17). The second study (25) found caregiver acceptance predicted appraisals of self-worth in children, measured using a puppet interview ($p<.001$). No other TIMB sub-scale predicted child outcomes in either study.

One study investigated whether caregiver emotional responsiveness is associated with child fear arousal (19). Results indicated observed caregiver emotional responsiveness significantly negatively correlated to child's fear arousal to a scary mask ($p<.05$). Furthermore, based on the trajectory of a child's fear response, researchers categorised children into low, medium, and high intensity fear responses. Children demonstrating high intensity fear arousal had caregivers who demonstrated lower emotional responsiveness than children classified as low (OR=.05, $p<.001$) or medium intensity (OR=.03, $p<.001$).

3. Behaviours of concern ("Externalising symptoms")

In total, 14 papers investigated behaviours of concern, seven of which focused on parenting behaviours (1, 5, 6, 10, 16, 18, 21), three on caregiver sensitivity (2, 9, 13) and two on the CYP's relationship to the foster carer and foster family (23, 25, 27, 28). Of these, five investigated infants and children under 5 years (9, 13, 18, 21, 25), three investigated children under the age of 13 (2, 5, 6) and six investigated children up to the age of 17 (1, 10, 16, 23, 27, 28). All except two used caregiver-report measures of child behaviours of concern, with the other two using a youth-report measure (23, 28).

3.1. Parenting behaviour/practices

Three studies using caregiver-report of parenting practices found associations between parent behaviours and child outcomes. One found increased family resilience (mutual support and problem solving to cope with challenges), measured using an unvalidated caregiver-report survey, negatively predicted conduct problems identified by healthcare providers (OR=.91, $p=.02$) (1). One cross-sectional study (10) found caregiver-report warmth and communication, but not authoritative parenting, negatively correlated with caregiver-report externalising behaviour. Furthermore, parental criticism/rejection ($\beta=.42$, $p<.001$),

authoritarian parenting (β=.29, p<.01) and "permissive parenting" (β=-.22, p<.01) positively predicted externalising symptoms. Combined, these parenting styles explained 37% of variance in child externalising behaviour (10). One longitudinal study (21) demonstrated caregiver warmth and support significantly negatively correlated with child externalising problems at three time points (21, supplementary table 2.). In addition, child externalising behaviour at T1 negatively predicted caregiver warmth and support at T2 (*b*=-.43, p=.001), which negatively predicted externalising behaviour at T3 (*b*=-.19, p=.018) in a combined sample of foster and biological families (21).

Three caregiver-report studies found no association between parenting behaviour on externalising behaviour (5, 16, 18). One study found grandparent kinship carers' self-report "negative discipline" did not predict caregiver-report child externalising behaviour (β=.07, p=.57) (5). A second study found neither "positive" nor "negative" parenting significantly predicted externalising behaviour in foster youth (16). Positive parenting was, however, significantly predictive of youth prosocial behaviour (p<.001) (16). Finally, one study found no association between caregiver-report harsh discipline (β=-.05) or family routines (β=-.09) on caregiver-report behaviours of concern (18).

Only one study used a combined observation/caregiver-report measure of parenting practices (6). As previously reported in *section 2.1.*, infants classified as receiving high-quality care scored significantly lower on combined emotional and behavioural difficulties than infants classified as receiving low-quality care.

3.2. Caregiver sensitivity

All three studies focusing on caregiver sensitivity used observational measures of caregiver sensitivity and caregiver-completion of the Child Behaviour Checklist (CBCL)

(Achenbach & Rescorla, 2000) to measure externalising behaviour in young children and infants (≤7 years).

Again, results between studies were mixed. One cross-sectional study found foster parent sensitivity negatively predicted infant externalising behaviour (β=-.33, p=.03) (9). Two studies, however, found no association between child behaviour and overall caregiver sensitivity in a cross-sectional study (2) or any sensitivity sub-scale (supportive presence, respect for autonomy, hostility) during a 6-month longitudinal study (13).

3.3. Relationship to foster carer and foster family

All four studies investigating the foster child-family relationship found some association between quality of foster carer/family relationships and externalising behaviour.

In early childhood, one longitudinal study using the TIMB semi-structured interview found foster carer acceptance, but not commitment, negatively correlated to behaviours of concern (p<.05) (25). In foster youth, one study (23) found an unvalidated measure of youth-report closeness to carer (previously described in *section 2.2*.) negatively correlated to youth-report externalising behaviour (p<.01). Regression analysis, however, did not find closeness to caregiver predictive of externalising behaviour. A second study (28) found that youth-report of caregiver emotional security (β=-2.30), involvement (β=-2.48), and structure (β=-2.44) negatively predicted youth-report externalising behaviour (p<.05). Furthermore, this study found the caregiver-child relationship significantly mediated the impact of a child's exposure to past violence on externalising symptoms (28).

One study investigated youth's integration into the foster home on behaviours of concern (27). This study created a three-item measure of integration by asking a child's case worker and foster carer about the child's perception of belonging to the foster home, and the case worker to predict a child's reaction to being removed from the home. Internal consistency of

this measure was reported to be low (α=.60). This study found overall foster home integration significantly predicted case worker report of behaviours of concern (p<.001).

4. Placement (in)stability

In total, three studies investigated foster carer factors that impact placement stability (7, 15, 27). Two investigated foster youth up to the age of 17 (7, 27). One did not report the age of the children (15).

One study (15) used caregiver-report measures to investigate the parent-child relationship on placement stability. Out of seven sub-scales (parental support, satisfaction with caregiving, parental involvement, communication, limit-setting, autonomy and parental gender-roles), two significantly predicted placement stability: increased parent support and decreased limit setting. Combined, these factors explained 15% of variance in placement stability. Authors suggested the inverse relationship between stability and limit setting may suggest caregivers who are flexible with boundaries may be more likely to experience placement stability.

A second study investigated the impact of caregiver/case worker report foster home integration (previously described in *section 3.3.*) on state-recorded placement breakdown (27). This study found lower foster home integration predicted placement breakdown (OR=.44, p<.01) and accounted for 56% of the variance in placement breakdown. This study also found, when taking foster home integration into account, the relationship between behaviours of concern and placement breakdown became non-significant (27).

Only one longitudinal study (7) compared differences in caregiver qualities between placements that continued (N=64) or broke down (N=11) over a 20-month period. In placements that continued, caregivers scored higher in self-report caregiving satisfaction

(p=.02, *d*=.770), cognitive empathy (p=.01, *d*=.92) and closeness (p=.01, *d*=.9), and lower in conflict (p=.01, *d*=-.83) than placements that broke down. No differences were found between groups in caregiving efficacy (p=.49, *d*=.22) or affective empathy (p=.57, *d*=.19). Researchers noted the low rate of placement breakdown in this study may bias the participating foster carers as having high-quality caregiving ability (7).

Quality appraisal

Quality ratings across studies suggested the overall study quality was high, with the majority scoring 90% or above (N=22), eight of which scored 100%. Five studies scored between 80-89%, with only one scoring <80%. All studies set out a clear research question and all relevant longitudinal studies controlled for appropriate confounding variables. All except one study received the maximum rating for sufficient sample size and reporting of results in sufficient detail.

Common items which received "partial" scores were those with insufficient descriptions of participant characteristics (N=9), the majority of which dropped scores for reporting child or caregiver characteristics only. Furthermore, several papers did not sufficiently report estimate of variance, with eight papers receiving either partial (N=6) or no (N=2) score for this. Papers dropping scores relating to subject selection (N=5) did not sufficiently describe how foster families were approached and recruited, potentially subjecting results to selection bias. The majority of studies used appropriate and validated outcome measures. Three studies, however, received either partial (N=2) or no score (N=1) due to the use of at least one unvalidated outcome measure. See *table 3.* For a table of all quality ratings.

Table 3.

Quality appraisal of included studies.

Study	Question/ objective clear	Design evident/ appropriate	Subject selection described/ appropriate	Subject characteristics described	Outcome well-defined/ robust	Sample size appropriate	Analytic methods described/ appropriate	Estimate of variance	Confounding	Results reported in detail	Conclusion supports results	Score (%)
1. Gomez (2021)	2	1	2	2	0	2	2	2	N/A	2	1	80.0
2. Oosterman & Schuengel (2008)	2	2	1	2	2	2	2	2	N/A	2	1	90.0
3. West et al., (2022)	2	2	2	1	2	2	2	2	N/A	2	2	95.0
4. Bernier & Dozier (2003)	2	2	0	2	2	2	1	0	N/A	2	2	75.0
5. Kaylor-Tapscott & Sullivan (2024)	2	2	2	2	2	2	2	2	N/A	2	2	100
6. Reindl et al., (2022)	2	2	2	2	2	2	2	2	2	2	2	100
7. Miller et al., (2019)	2	2	2	2	2	1	2	1	N/A	2	2	90.1
8. Healey & Fisher (2011)	2	2	2	1	2	2	1	0	N/A	2	2	80.0
9. Poitras et al., (2022)	2	2	2	2	2	2	2	2	N/A	2	2	100
10. Fuentes et al., (2014)	2	2	2	1	2	2	2	1	N/A	2	2	90.0
11. Stovall & Dozier (2000)	2	1	2	2	2	2	2	N/A	N/A	2	2	94.4
12. Bovenschen et al., (2016)	2	2	2	2	2	2	2	1	N/A	2	2	95.0
13. Gabler et al., (2014)	2	2	2	2	2	2	2	2	2	2	2	100

14. Lang et al., (2016)	2	2	2	2	2	2	2	2	2	2	2	100
15. Crum (2010)	2	2	2	1	2	2	2	2	0	2	2	86.4
16. Goemans et al., (2020)	2	2	2	1	2	2	2	2	N/A	2	2	95.5
17. Jacobsen et al., (2018)	2	2	2	2	2	2	2	2	2	2	2	100
18. Olson et al., (2019)	2	2	2	1	2	2	2	1	2	2	2	90.9
19. Panlilio et al., (2020)	2	2	1	2	2	2	2	1	N/A	1	2	85.0
20. Cole (2005)	2	2	2	1	2	2	2	2	N/A	2	2	95.0
21. Schütte et al., (2023)	2	2	2	2	2	2	2	1	2	2	2	95.5
22. Bell et al., (2015)	2	2	2	1	2	2	2	2	2	2	2	95.5
23. Wojciak et al., (2017)	2	2	2	1	1	2	2	2	N/A	2	2	90.0
24. De Schipper et al., (2012)	2	2	1	2	2	2	2	2	N/A	2	2	95.0
25. Ackerman & Dozier (2005)	2	2	1	2	2	2	1	1	2	2	2	86.4
26. Joseph et al., (2014)	2	2	2	2	2	2	2	2	2	2	2	100
27. Leathers (2005)	2	2	2	1	1	2	2	2	2	2	2	90.9
28. Rayburn et al., (2017)	2	2	2	2	2	2	2	2	N/A	2	2	100

Discussion

This paper aimed to systematically review the literature investigating foster caregiver qualities associated with attachment security, emotional wellbeing, behaviours of concern and placement (in)stability in CLA.

Summary of key findings

Overall, 28 studies were found, 12 of which investigated attachment security, 12 investigated emotional wellbeing, 14 investigated behaviours of concern, and three investigated placement stability. Quality ratings suggested that the majority of studies used appropriate designs and methodology to answer relevant research questions. Some, however, failed to report important details needed to understand the full narrative, meaning it may not be possible for studies to be replicated.

One of the most consistent findings was the beneficial impact of a child having a positive relationship to their foster parent and being well-integrated into the foster family. While often considered similar, a CYP's relationship to their foster carer/family does not necessarily equate to their attachment style. Attachment style is the template that CYP develop based on patterns of past relationships which inform current relationships, such as responding to separation, seeking and responding to support, and using a caregiver for comfort (Ainsworth et al., 1978; Bowlby, 1969). The foster carer-child relationship, however, relates to day-to-day experiences of care from important adults. Positive foster carer-child relationships have been found to include being made to feel one "belongs" within a family, showing a genuine interest in CYP's lives, providing structure and boundaries, and providing guidance for the future (Storer et al., 2014).

Findings above suggest having a close relationship with a caregiver who is invested in supporting CYP to integrate into the foster family may reduce emotional and behavioural difficulties, increase placement stability, and protect CLA from the impact of past trauma on current wellbeing. This finding is in line with qualitative research, which highlights that a caregiver's commitment, dedication and connection to a child supports a reciprocal sense of "belonging" into the family, enabling more successful foster placements (Berrick & Skivenes, 2012; Clarke et al., 2024; Oke et al., 2013; Withington et al., 2016). Qualitative research also draws attention to potential challenges for foster family integration, as caregivers and CYP may have to navigate complex relationships with birth families and the wider social care system (Berrick & Skivenes, 2012; Clarke et al., 2024; Oke et al., 2013; Withington et al., 2016). Forming close relationships with a new foster family may also be challenging when there is uncertainty around the longevity of a foster placement. Consideration should therefore be made regarding how foster carers can enable CLA to feel like an important part of the foster family regardless of the length of time they will be there.

An additional parenting factor found to predict foster child attachment security is a caregiver's own attachment state of mind, with two papers finding "autonomous-secure" foster parent state of mind is associated with infant attachment security. In biological parent-infant dyads, attachment style is considered to be passed intergenerationally through caregiving responses to a child (Berthelot et al., 2015; Verhage et al., 2016). These studies indicate that the intergenerational transmission of attachment style may also be relevant in foster parent-infant dyads. Importantly, these studies found that caregiving responses to individual child behaviours and foster parent mind-mindedness may be predictive of more "secure" child behaviour, regardless of a caregiver's own attachment state of mind. Supporting caregivers to

recognise a child's own mind to facilitate "secure" responses to "insecure" child behaviour may therefore support increased security in the foster parent-infant relationship.

Findings relating to other caregiving qualities, however, were mixed. Some studies suggested "authoritative" parenting (Baumrind, 1971) and qualities associated with this (e.g. warmth and affection, communication, flexible boundaries, and holding positive feelings about caring for a child) may facilitate attachment security and reduced behaviours of concern. More than half of studies, however, found no or only partial associations between parenting style and child outcomes. In particular, out of studies investigating internalising behaviour, only one found the current parenting style predicts child emotional wellbeing. Similarly, findings relating to caregiver sensitivity were inconsistent, with several studies finding only partial or no association between caregiver sensitivity and externalising behaviours. Given the inconsistency and variability of results reported above, factors that may account for this have been discussed below.

Study design

One factor that may have influenced the variability in results between studies is the use of longitudinal compared to cross-sectional design. In developmental research, longitudinal design is often considered preferable, as cross-sectional studies are not able to inform researchers about the stability of change over time (Robinson et al., 2005). In the present literature review, just under half (N=12) of studies included longitudinal analysis. Within longitudinal studies results remained mixed, with some finding positive associations between caregiver and child variables, and others finding no or limited associations.

One of the reasons for these mixed results may relate to the time between measures in longitudinal design. The Dynamic Maturation Model (DDM) of attachment (Crittenden, 2006) suggests that infants who experience maltreatment learn to adapt their behaviour and emotional reactions to protect themselves from inconsistent caregiving responses (e.g. Displaying extreme emotional reactions to elicit care). Research has suggested that maltreated infants can re-learn alternative relational patterns when they receive sensitive caregiving responses (Crittenden, 1985). Neurobiological research, however, has indicated that early life adversity is associated with a reduction in neuroplasticity during childhood (Miskolczi et al., 2019). This reduction in neuroplasticity may mean it takes longer for environmental changes to foster change in these adaptive reactions in CLA, particularly in older CLA who may have long-term experiences of adversity. In the present review, the majority of longitudinal studies (N=10) took place over the space of one year or less, which may be insufficient to create substantial change for CLA who may have experienced significant early life adversity.

One issue with longitudinal design in a foster care population is the potential for placement changes, resulting in high participant drop out. An alternative method of investigating the long-term impact of the caregiving environment may be through incorporating the length of time a young person has been at their current placement. In the present review, almost half of studies did not specifically report how long participants had lived in their current placement (N=12). Furthermore, several studies reported a large range in placement length between participants, with five spanning more than six years, and two reporting a range of almost 12 years. Drawing conclusions regarding the impact of long-term placements on child outcomes is

therefore challenging. Future research should consider designing studies that investigate the longitudinal impact of the caregiving environment on child outcomes.

Parenting measures

A second factor that may impact the inconsistency in results is the use of caregiver-report compared to observational measures of parenting behaviour. Research has found limited consistency between caregiver-report and observational parenting measures (Zahidi et al., 2019), particularly for measures of "negative" parenting behaviour (Herbers et al., 2017). In self-report measures, caregivers may "edit" responses to appear more favourable (Morsbach & Prinz, 2006). This may be particularly relevant for foster carers, who may experience scrutiny and judgement from the social care system, and research has found foster carers self-report high "positive" parenting and low "harsh punishment" (Vanschoonlandt et al., 2013). In addition, three studies in the present review used unvalidated measures of parenting behaviours, potentially further reducing the reliability of self-report studies. In the present literature review, outcomes from studies using observational measures remained mixed. However, all four studies that found no association between child and caregiver factors used self-report only measures.

While observational measures may be considered more reliable, they are also time-consuming, costly, and may feel intrusive for the caregiver and child. Given a foster-care population is often considered "hard to reach," it is important to consider how the reliability of self-report measures could be improved. In birth parents, researchers have suggested self-report measures can be improved by caregivers self-administering questionnaires, providing memory "cues," and repeating a measure over a short space of time (Morsbach & Prinz, 2006). Furthermore, self-report

measures may be improved by involving multiple informants, such as including youth-report of their experiences of the caregiving they receive. In the present review, only two studies used youth-report measures of the foster parent-child relationship, and only one of which was validated. Future research should consider incorporating child-report measures of their caregiving experiences to increase reliability and incorporate the young person's voice in research.

Interplay of multiple child and caregiver factors

The complexity and inconsistency from results outlined above indicate that, although current caregiving factors play an important role in enabling positive outcomes for CLA, current caregiving experiences alone may be insufficient to predict child outcomes. A previous systematic literature review found child characteristics, such as older age when entering care, having a health problem or disability, and increased mental health difficulties had a significant negative impact on placement stability (Pritchett et al., 2013).

Furthermore, some of the research included in the present literature review provided indications of additional factors that may increase the risk of negative child outcomes. This includes child factors such as being male (Lang et al., 2016; Leathers, 2006; Olson et al., 2019), having lower cognitive ability (Olson et al., 2019) and having an extraverted temperament (Bovenschen et al., 2016; De Schipper et al., 2012; Lang et al., 2016). Risk factors also include pre-care experiences such as increased exposure to violence (Rayburn et al., 2018) and parental mental health difficulties (Bovenschen et al., 2016). Experiences within the care system itself, such as fewer years in current placement (Leathers, 2006), increased changes in caregiver

(Bell et al., 2015) and increased contact with biological parents (Poitras et al., 2022), have also been found to increase the risk of negative child outcomes.

In addition, three studies outlined above indicated child behaviours have an impact on caregiving responses (Oosterman & Schuengel, 2008; Schütte et al., 2023; Stovall & Dozier, 2000). This suggests that there may be a cyclical relationship between child and caregiving behaviours. Over time, this may create "patterns" in interactions between a foster parent and child, thus having the potential to maintain or change a child's internalising, externalising, and relational outcomes. External factors, such as foster carer stress, may also impact on a caregiver's ability to engage in nurturing responses to child behaviour (Gabler et al., 2014; Goemans et al., 2020; West et al., 2022). The inter-relations between child and caregiver factors has been suggested in *figure 2.*

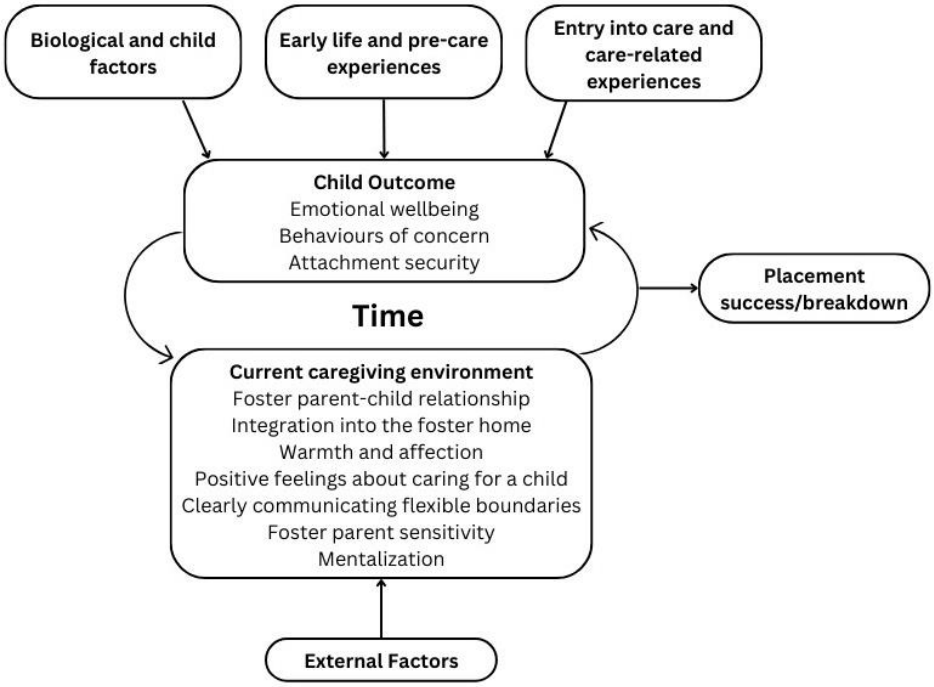


Figure 2. Diagrammatic representation of the relationship between potential variables that may impact on child emotional, behavioural, relational and placement outcomes.

Future research and literature reviews should consider investigating the inter-relationships between child, caregiver and external factors that may impact on a child's overall wellbeing over time. Interventions to support CLA should consider taking a holistic view of CLA's early life, care and current experiences and how these factors may impact overall child outcomes.

Limitations and future directions

Limitations of the above literature review include that, as no studies included a manipulation of caregiving quality, results can only infer associations, rather than any causal relationship, between caregiver and child variables. A recent systematic review into interventions for foster carers found only three interventions have limited or moderate evidence to suggest beneficial child outcomes (Bergström et al., 2020). The present literature review may support pre-existing interventions to identify areas of focus to improve child outcomes, however further research is required to determine whether there is a causal relationship between foster parent qualities and child outcomes.

Furthermore, despite over half of CLA in England being aged 10 and over (Department of Education, 2023), in the present literature review studies primarily investigated infants and children, with only three focusing specifically on foster youth. One reason for this may be that studies researching CLA in placements other than foster care were excluded from the present review. Older foster youth may be more likely to be placed in alternative care provisions, such as residential care homes. It may be beneficial for future literature reviews to consider caregiving factors associated with positive outcomes in foster youth within different placements.

One further limitation of the present review is that it did not investigate differences between kin and non-kin foster placements. Half of studies did not report whether foster placements were kinship, and no study compared differences in kin and non-kin populations. Research has suggested increased financial difficulties, carer health difficulties and single-carers in kinship foster placements (Farmer, 2009). Despite this, kinship placements are associated with increased stability (Koh, 2010). It may therefore be beneficial to investigate the differences between kin- and non-kin foster carers and how this may lead to differential placement outcomes for CLA.

In addition, all studies included in the present literature review were conducted in "WEIRD" (Westernised, Educated, Industrialised, Rich and Democratic) countries. The bioecological model of development suggests that expectations of caregivers and parenting behaviour may be shaped by cultural ideologies, values, beliefs and norms on a community and wider societal level (Bronfenbrenner & Morris, 2006). The present review is therefore limited in informing how foster caregiving practices impact CYP across different cultures, and does not inform how interventions may be adapted for use in non-WEIRD countries.

Conclusions

The present literature review suggests that two of the most important factors associated with emotional, behavioural and relational wellbeing and placement stability for CLA are having a close, positive relationship with a foster carer, and feeling integrated into the foster family. Other caregiver qualities such as sensitivity and authoritative parenting may be associated with child outcomes, however findings are mixed. The foster caregiving environment may therefore interact with multiple early-life and post-care experiences that may contribute to overall outcomes for CLA.

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Service Improvement Project

"They never gave up on me… a lot of people have given up on me before" How can health and social care services support care leavers when they become parents?

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Abstract

Service Improvement Project

Title: "They never gave up on me… a lot of people have given up on me before" How can health and social care services across Oxfordshire support care leavers when they become parents?

Background: Care-experienced parents are at a higher risk of their own children being involved with social care. Some research has indicated care leavers do not feel well-supported with parenting, or find support unhelpful, however research into this is scarce. The present study aimed to investigate care leaver parents' experiences of support in Oxfordshire, and how they feel support could better meet their needs.

Methods: Phase 1: Audit data regarding care leaver parents was collated from routine monitoring data and social care records. Phase 2: Semi-structured interviews were conducted with 11 care leaver parents regarding their experiences of support and analysed using thematic analysis.

Results: Phase 1: Across Oxfordshire one in 20 care leavers are parents, 50% of whom have social care involvement. Phase 2: Three main themes emerged from interviews: 1. Building a positive working relationship, 2. Parent's mental and emotional wellbeing, 3. Parenting advice.

Discussion: The present study indicates additional support should be available to care leaver parents to reduce the likelihood of a continued cycle of care. Parents indicated they would benefit from additional mental health support and parenting advice, which should be delivered in an individualised, non-judgemental, and collaborative manner.

Introduction

In the UK, the legal definition of a care leaver (CL) is any young person (YP) aged 18 or over who has grown out of care and spent at least 13 weeks looked after by the local authority since their 16th birthday (Department of Health, 2001). YP who meet these criteria are eligible for statutory leaving care support until the age of 21. There are, however, many YP who spent time in care as a child but are not eligible for statutory leaving care support. The long-term impact of being care-experienced, however, may persist into adulthood. In this paper, we therefore define CLs as adults who previously spent time in care as a child, in line with previous research (Jäggi et al., 2022; Purtell et al., 2020).

Transitioning into adulthood for a CL can be an unstable and challenging time, and YP transitioning out of care are at elevated risk of mental health difficulties (Butterworth et al., 2017). In addition, CLs are more likely to have children at a younger age than their non-care leaver peers (Botchway et al., 2014; Dixon, 2008). Potential factors contributing to this include missing out on sex education due to placement moves, difficulty navigating sexual relationships due to previous abuse, and filling an "emotional void" (Purtell et al., 2020).

CLs are at increased risk of their own children being involved with social care, creating an intergenerational cycle of care (Roberts, 2021). In Wales, 58% of children placed for adoption had birth parents who were in foster care themselves (Roberts et al., 2017). Research has suggested 15% of children born to care-experienced YP are under child protection, and an additional 19% receive support from the local authority (Roberts et al., 2019). Audit data from UK court records has shown 40% of mothers going through care proceedings spent time in care themselves (Broadhurst, 2017),

highlighting the need for services to provide interventions to break the intergenerational care cycle.

Attachment theory (Bowlby, 1969) is a theoretical framework that can help to understand the psychological processes underpinning the cycle of care. Attachment style is formed in infancy based on the way a caregiver responds to their child (Bowlby, 1969). Infants who are responded to in a consistent and sensitive manner are likely to form a secure attachment, while insensitive and inconsistent caregiver responses, such as maltreatment and neglect, are likely to lead to a child forming an insecure attachment (Bowlby, 1969). Early caregiver attachment informs future attachment relationships, therefore maltreated children who are insecurely attached are likely to form insecure attachments with their own children in adulthood, and thus more likely to maltreat their children (Morton & Browne, 1998). Meta-analytical evidence has demonstrated that insecurely attached parents are significantly more likely to be perpetrators of maltreatment (Lo et al., 2019). This theoretical framework may therefore provide some explanation for how maltreatment, and therefore spending time in care, can continue intergenerationally (Morton & Browne, 1998).

Risk and protective factors for CL parents' own children receiving out of home care have been collated in a recent systematic review (Jäggi et al., 2022). Risk factors for the continued cycle of care include parental mental health difficulties, financial difficulties, lower educational attainment, and substance abuse (Jäggi et al., 2022). This review identified that the most important protective factor to support adjustment to parenthood and break the cycle of care is social support, including having a supportive partner and in-laws, reconnecting with birth families, previous foster carers, peer support and trusted professionals (Jäggi et al., 2022). It has also been suggested that parenthood may be a significant motivating factor for YP to have

a safer and more secure life and is a “turning point” for many YP (Purtell et al., 2020).

Despite the evidence outlined above regarding the additional difficulties for CL parents, as well as the importance of social support for them, evidence regarding the efficacy of support offered to CL parents is scarce (Roberts, 2021). A recent systematic review into professional views regarding support offered to CL parents identified a need for support with mental health difficulties including post-natal depression and trauma, support with relationships and co-parenting, and parenting skills (Gill et al., 2020). Despite this, services offering this support were rarely available (Gill et al., 2020).

CL Parents themselves have reported mixed views about the current professional support available (Roberts, 2021). Some parents viewed both emotional and practical support as helpful, in particular when YP had a positive relationship with professionals (Roberts, 2021). Some parents, however, reflected on a lack of support available, including emotional and practical support. Parents often viewed support as unhelpful and invasive, and were fearful of the consequences of refusing support (Roberts, 2021). The findings from the study described above echo qualitative interviews conducted with CL parents 15 years previously (Chase et al., 2006), suggesting that limited progress has been made regarding support offered to CL parents in the UK.

Due to the general lack of research into CL’s experiences, it is important to involve YP in the co-production of interventions (Pound & Sims-Schouten, 2022). The present study therefore aims to build on the literature and support service

improvement by hearing parents' 'voices' regarding the support they have experienced, and how their support needs can be met by services.

Service context

The Young Person's Supported Accommodation Service (YPSA) offers support to vulnerable YP aged 16 to 24 with accommodation, develop independent living skills and find employment or education. YP in supported accommodation are helped to develop skills to support their mental health and sustain healthy relationships. Many YP supported by YPSA have experienced living in care, and three of the seven supported living providers specifically offer accommodation for vulnerable young parents.

The OCC leaving care team offers support to YP eligible for statutory leaving care provision. Looked after young people are supported by a social worker from the Children We Care For team until the age of 18, when support is transferred to the Leaving Care team. YP are allocated a personal advisor (PA) who offer support including accommodation, education/employment, finances, and health and relationships, up to the age of 21. The leaving care team works closely with other services including social care, the family assessment and safeguarding services (FASS), the family nurse partnership (FNP), Oxford Parent-Infant Project (OxPIP) and the perinatal team. These teams employ multi-disciplinary professionals including clinical psychologists and other therapists, midwives, nurses, social workers and health visitors.

Study aims

- Identify current estimates of CL parents across Oxfordshire County Council (OCC).

- Explore CL parents' experiences of support provision across Oxfordshire, and barriers to accepting support.
- Identify potential interventions and service improvements that could be developed to support CL parents.

Method

Design

This study used a cross-sectional, mixed methods design across two phases.

Phase 1: An audit was conducted regarding the number of CL parents across OCC, including demographic information for parents and their children.

Phase 2: Qualitative interviews were conducted with CL parents regarding their experiences of support with pregnancy and parenting, and suggestions for improvement.

Participants

Participants in phase 2 were parents or expectant parents aged 16+ who had spent time in care as a child (including foster or kinship care, children's homes, and supported living) and were currently open to the YPSA and/or Oxfordshire Leaving Care Team. YP were invited to take part in the project by their PA or supported accommodation staff.

Eleven YP took part in interviews (nine mothers; two fathers). Nine participants identified as white British, one as mixed white British/black Caribbean, one as black British, and one as white European. Ages ranged from 18 to 26. Nine participants had one child, three of whom were expecting a second child. One

participant had two children and was expecting her third, and one participant was pregnant with her first child. Seven participants had current or historic social care involvement for their own child/children, two of whom had a child currently looked after by the local authority. For further demographic details see *Table 1*.

Table 1.
Demographic details for interview participants

Pseudonym	Mother/ Father	Age	Ethnicity	Parent Years in care	Care provision	PA	Current housing	Number of children	Age of child(ren)	Child(ren) in the care of	Co-parent involvement	Current social care support	Historic social care support
Marcella	Mother	19	White British	1	Supported living	Yes	Supported accommodation	1	3 months	Mother	Yes – weekend visits	No	No
Lucy	Mother	21	White British	14-15	Kindship foster (Grandparents)	Yes	Supported accommodation	1	3 years	Mother	Yes – weekend visits	No	Unknown
Kylie	Mother	19	Mixed white/black British/ Caribbean	5	Foster care, residential share house (22 moves)	Yes	Supported accommodation	1, pregnant with second	13 months, 8.5 months pregnant	Foster care, new baby will be placed in foster care when born	No	Yes (looked after)	Yes
Jack	Father	23	White British	5-6	Foster care, emergency care, kinship care, children's home, independent living	Yes	Council house	1, partner pregnant with second	12 months, 5 months pregnant	Mother & Father	Yes – co-parenting	No	Yes
Georgia	Mother	26	White British	2	Unknown	No	Supported accommodation	2, pregnant with third	5 years, 1 year, 26 weeks pregnant	Foster care, Mother & Father, Mother & Father	Unknown, yes – co-parenting	Yes (looked after), no, no	Yes
Myla	Mother	20	White British	2	Residential share house	Yes	Council house	1	12 months	Mother	No	Yes	Yes
Sophia	Mother	18	Black British	3	Supported living, foster care	Yes	Supported accommodation	1	3 months	Mother & Father	Yes	Yes (Child in need)	Yes
Geoffrey	Father	19	White British	5	Emergency placement, kinship foster care, foster care	Yes	Supported accommodation	1, partner pregnant with second	12 months	Mother & Father	Yes – co-parenting	No	No
Paris	Mother	19	White British	5	Foster care, independent living, residential care home	Yes	Supported private rental	1	17 months	Mother	No	No	Yes
Clara	Mother	21	White European	3	Residential share house	Yes	Private shared house	Pregnant with first	15 weeks pregnant	To be born into the care of Mother & Father	Yes – co-parenting	No	No
Toni	Mother	20	White British	7-8	Foster care	Yes	Council house	1	11 months	Mother	Yes – weekend visits	No	Yes

Data collection

In *Phase 1*, audit data was obtained using routine annual monitoring data collected from OCC teams working with CLs, that records whether a YP is a parent. Additional information not routinely collected was gained by searching YP's records on the online social care system (Liquidlogic Children's System, LCS).

In *Phase 2*, a semi-structured interview was created alongside two "experts-by-experience" (CL parents). Questions included: who supports YP with pregnancy and parenting, their experiences of professional support, barriers and facilitators to support, and ideas for additional support. For full interview schedule see *Appendix C*.

The initial interview conducted in-person lasted 10 minutes. Given the short length of this initial interview, interview prompts within the interview schedule were reviewed and additional prompts added to support with information gathering, in line with guidelines for developing semi-structured interview schedules (Kallio et al., 2016). The subsequent 10 interviews lasted between 20 and 40 minutes, either in person (N=7), or over WhatsApp call (N=3) between December 2022 and June 2023.

Interviews were audio recorded on an encrypted device and transcribed verbatim following the interview. Identifying information was omitted and participants were given a pseudonym to ensure anonymity. Interviews took place with the participant and interviewer alone (N= 2), with the participant's child present (N=5), or with a professional/personal supporter present (n=3). Where a supporter was present participants confirmed they felt able to speak freely and supporter(s) predominantly listened, with occasional support to facilitate understanding.

Qualitative analysis

All 11 interviews were analysed using six-step thematic analysis (Braun & Clarke, 2006). After transcription, the interviews were read and re-read while taking familiarization notes. An inductive approach was taken to generate initial codes using NVivo software for data organisation and management. Codes were collated into initial themes that were pertinent to the research questions, which were reviewed to ensure representativeness to the data. Themes and sub-themes were redefined and named. Although parents shared a range of information, this report focused primarily on information relevant to the research questions and service improvement.

Ethics

Approval for the project was gained from the OCC Social Care Research Panel. Participants were provided with a written participant information sheet and given time to ask questions prior to consenting. Informed consent was obtained for all YP prior to the interview and YP were made aware of their right to withdraw.

Self-reflexivity

Data collection and analysis was undertaken by EW, a white British cisgender-female in her mid-twenties. EW had limited personal and professional experience with CL, and was not a parent herself. EW attempted to remain mindful of personal biases by keeping a reflexive log before and after each interview. EW tried to remain mindful of the power she held in the room as a “professional” and to keep questions informal and comfortable for interviewees.

Results

Phase 1: Audit data

Out of 628 CLs open to OCC in July 2022, 32 (5.10%) were parents across Oxfordshire as of July 2022. Of these, 22 were female (68.8%). The mean age of parents was 20.0, with ages ranging from 16 to 24. The average age of children was 29.4 months, ranging from three-weeks to six-years old. The majority of parents had spent time in foster care (N=22, 69%) and/or residential homes (N=16, 50.0%) or the YPSA (N=11, 34.4%). Alternative provisions included children's homes (N=2), special guardianship order (N=2), mother and baby units (N=1) and young offenders (N=1).

At the time of audit, the majority of YP were living in council housing (43.8%) or supported accommodation (19.0%). Only 11 YP had achieved level 2 literacy and numeracy (34.4%), the remaining 21 young people (65.6%) had achieved neither level 2 numeracy nor literacy. Four YP had special educational needs (SEN, 12.5%) and five were receiving support from mental health services (15.6%). The majority of YP were open to the leaving care team (N=27), with a small number from the children we care for team (N=2) and the unaccompanied asylum seeker's team (N=3, see *figure 1.).*

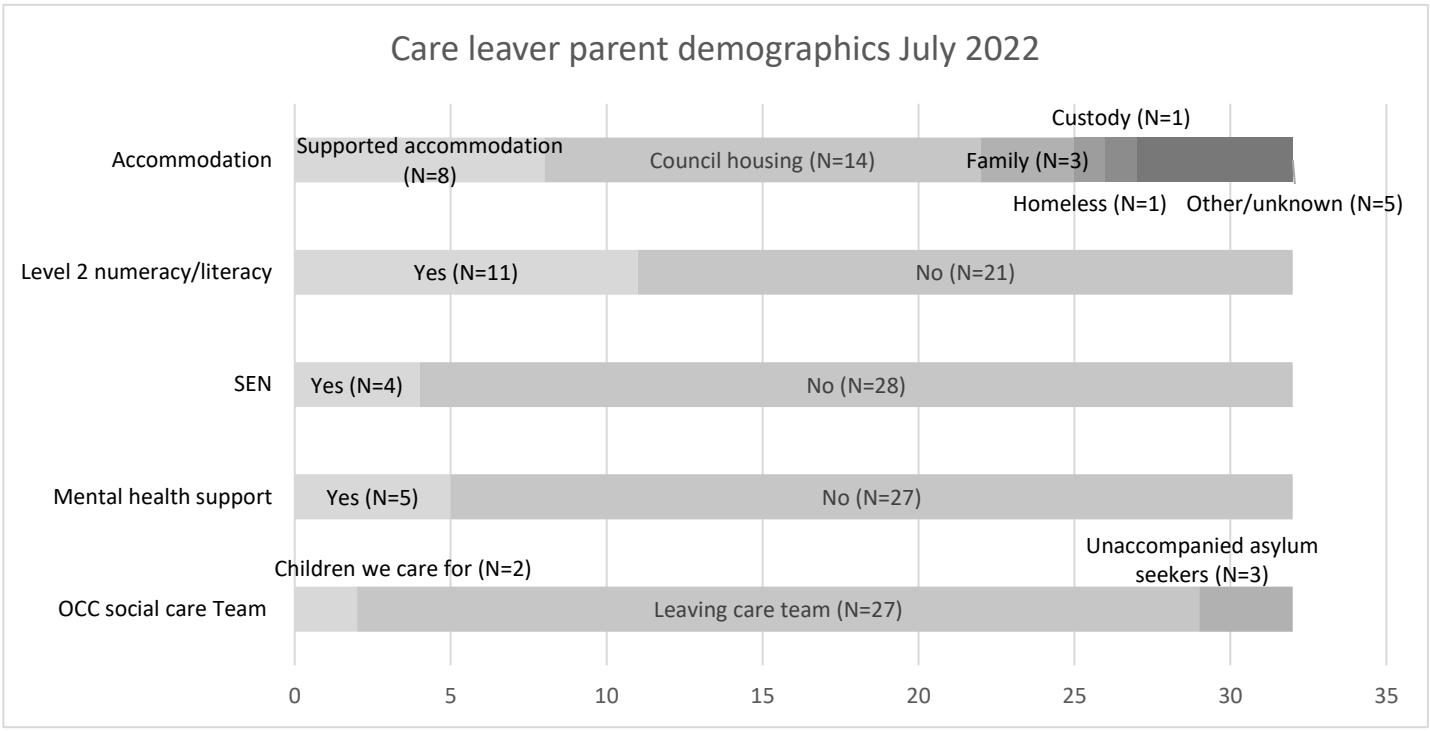


Figure 1. graphic representation of demographic details of care leavers who are parents across Oxfordshire in July 2022.

At the time of audit, half of care leaver parents' children were open to social care (16/32) and one child had been adopted. Of those open to social care, almost a third were looked after by the local authority (N=5, 31.3%) and half were under child protection (N=8, 50.0%). Two were classified as child-in-need (CIN) and one was open for a pre-birth assessment (see *figure 2.*).

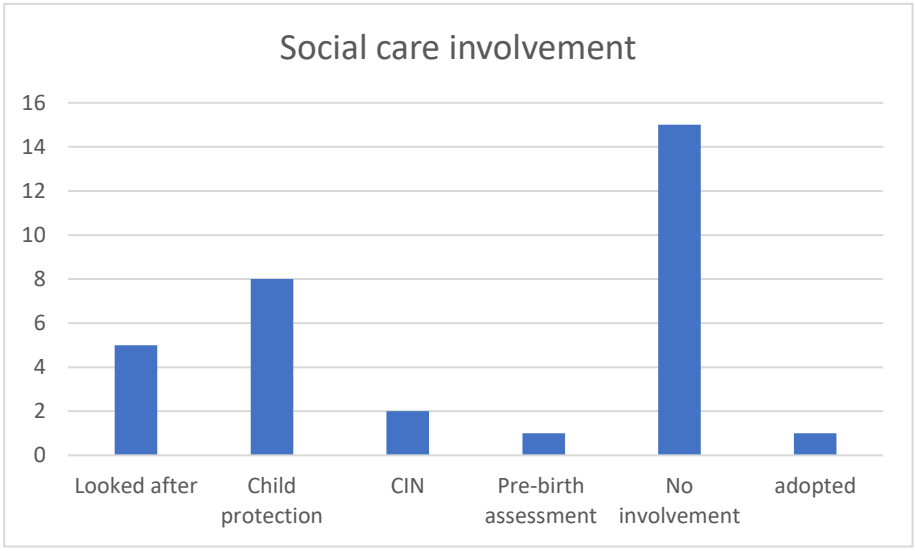


Figure 2. Graph demonstrating social care involvement for children of care leaver parents in Oxfordshire as of July 2022.

Phase 2: Interviews

Three main themes were developed with supporting sub-themes: 1) Building a positive working relationship, 2) Parent's mental and emotional wellbeing, 3) Parenting advice. A graphic representation of themes and sub-themes is shown in *figure 3*., followed by a narrative explanation. Additional supporting quotes are included *Appendix D.*

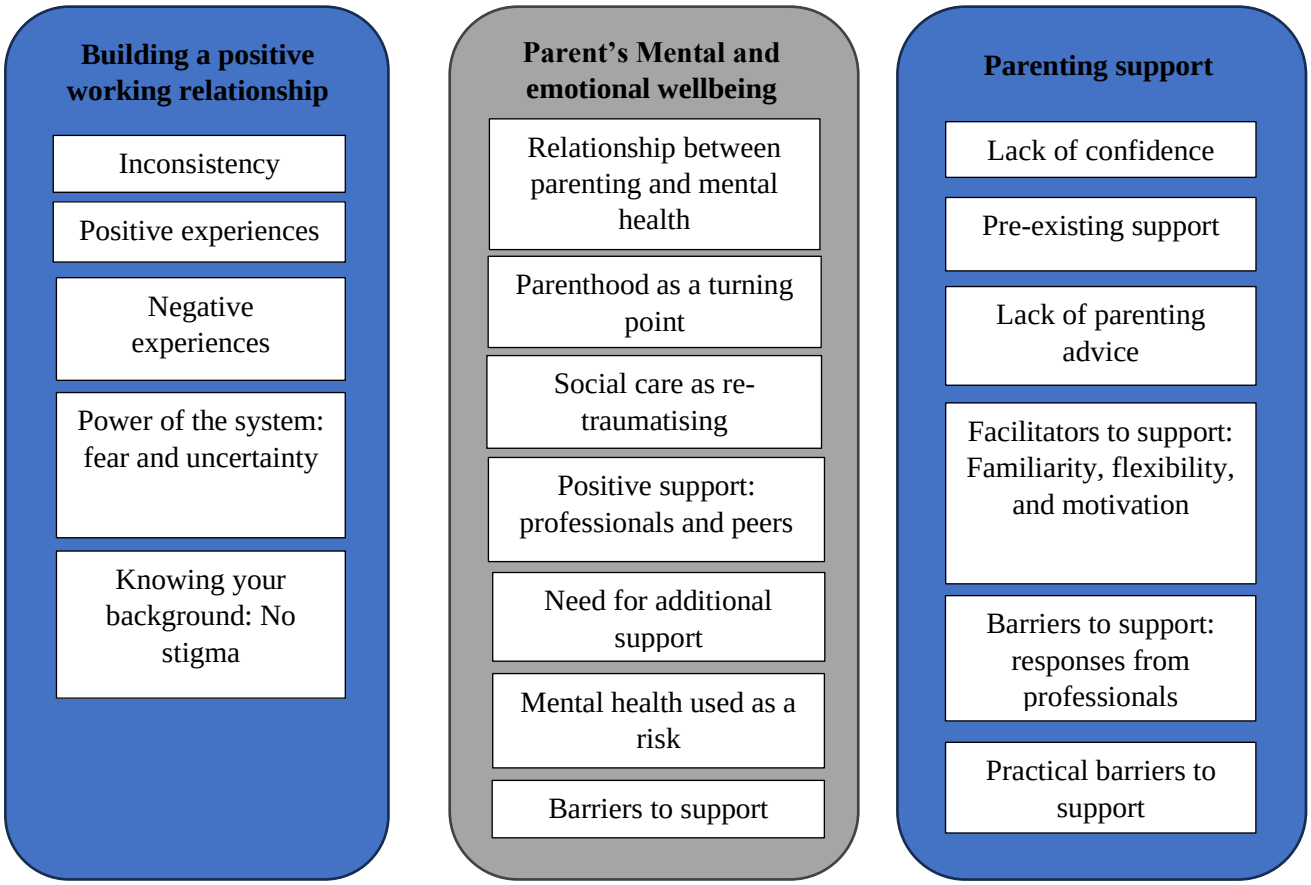


Figure 3. Graphic representation of key themes and sub-themes

1. Building a positive working relationship

Participants reported **inconsistency** in professional approaches, with some being *"really lovely and kind, but then others couldn't give a flying toss (Myla),"* and a high turnover of professionals *"so I never really got to build a relationship with any of my workers (Georgia)."*

Most young people shared at least one **positive experience** with professionals, stressing feeling listened to, being empathetic, responsive and instilling confidence in a young person facilitating trust: *"I think it's the fact that they never gave up on me… a lot of people have given up on me before and that's when I've been like well there's not really a lot of point then (Myla)."*

YP discussed the impact of previous **negative experiences** as a child and as a parent on their trust in professionals *"they put me from an abusive mum into an abusive family again so they failed me completely (Georgia)."* Some parents felt let down by services as *"they don't always do everything they can to help you (Kylie),"* and viewed social care involvement as unnecessary.

Participants held a sense of the **power of the system**, many expressed **fear** that their child would be taken into care, viewing professionals as *"we're here and you're here but even though you're the parent we're like above you and we can snatch your kids (Paris)."* Parents shared difficulties with **uncertainty** over decisions being made around their child's future: *"my whole pregnancy I was like are they going to take him, are they not… I was so anxious… I'm his mum, I'm the parent, but these professionals have a final say. (Myla)."*

Participants acknowledged the potential benefits of professionals **knowing your background** so "*they can think "oh he went through this…" there's parts that we can work on and help with that I might struggle with (Jack)."* Many parents, however, felt judgement and **stigma** because "*they like read stuff on files and they think they know the short story… they just make everything from their assumptions (Kylie)."* Parents stressed the importance of *"[getting] to know an individual for themselves… I'm pretty certain that we're a lot stronger than what we're made out to be… (Myla)."* YP felt their individual experiences were not always taken into account: *"just because our parents were bad to us don't mean we've not had that role model in our lives, because you've put us in care with a role model [foster carer] (Toni)."*

2. Parent's emotional and mental wellbeing

YP indicated a bi-directional **relationship between parenthood and mental health**. Pregnancy and parenthood lead to some YP's mental health deteriorating *"when you give birth so much hormones are just dropping dramatically, and with someone who doesn't understand emotions that's very difficult (Myla)."* This impacted on parenting, "*if you want someone to be a good parent they have to be feeling good in themselves (Kylie)"* and parent/child relationships "*when you've been through stuff you emotionally shut off… I didn't really know what to do and how to read feelings (Georgia)."*

Several parents spoke about parenthood being a **turning point** in their lives, "*you become more of an adult and it's not all about yourself anymore, it's about your baby… (Jack)."* Although many YP expressed worry about becoming a parent, many shared hope for a different future: *"I thought I'm not going to be on my own anymore… I can change her life. I can be a better mum to her than I ever received from my own mum and from the system (Toni)"*

Many parents experienced **social care involvement as re-traumatising** *"it would be like flashbacks to what went on… (Jack),"* further impacting on parental mental health: *"that's not helping my bond with her, its making me want to take a step back because of my trauma." (Toni)"*

Positive experiences of support included *"just having somebody to talk to nothing to do with my baby, like my PA is so supportive… she's here to ask me about me (Sophia),"* as well as facilitating parent/child attachment: "*she did some VIG with me and [daughter] and it bonded us (Toni)."* Three participants highlighted the benefits of having **peer supporters**, due to difficulties of "*going to a play group with*

all the perfect mummies (Paris).” Participants benefitted from peer support “*if you don’t want to go to like some professionals you can talk to another parent that’s been through pretty much the same thing (Geoffrey).”*

More than half of participants highlighted the **need for additional support** for mental and emotional wellbeing. Participants wanted “*someone to talk to, and someone to sort of go “yeah I get it its hard” (Toni)”* to enable “*a lot happier parents, who haven’t got like as much to worry about (Geoffrey).”* Two YP highlighted the need for support with “*bonding and how to be emotionally attached… that’s what affected me the most was not knowing how to bond (Georgia).”*

The most common barrier to seeking support was **mental health being used as a risk**, *“you don’t want them to think like you’re not coping so they like start arranging things (Sophia).”* Four parents shared actual experiences of their mental health being used as a safeguarding concern: “*I said I was struggling, and they just called social services… It just made it worse, and it took longer to bond because of that (Toni).”*

Additional **barriers to support** included internalised stigma, with one dad stating: *“I mean I don’t really talk about my feelings so I don’t really need that type of support for myself (Geoffrey),”* and a lack of knowledge about mental health in the perinatal period *“I didn’t know nothing about [postnatal depression] the first time so… maybe that should be made more of a thing for mums (Georgia).”*

Participants felt let down by a lack of response from professionals “*they just seemed to complain about it instead of actually helping (Kylie),”* and their mental health difficulties going unnoticed *“I didn’t even want to hold the child, I just felt like if they had noticed things straight away… if my depression hadn’t taken over then I would have been able to look after him. (Georgia).”*

3. Parenting advice

Many YP indicated a **lack of confidence** in their ability to look after a baby *"I gave birth to my son, and then I got sent home that night and I sat down with a baby in a car seat, and I looked at the baby and I was like now what… (Myla)."* Some parents also indicated concern that others lacked confidence in their parenting ability: *"I think oh because they know I'm a care leaver they think "oh you're not going to be good enough" (Paris)."*

Many YP had **pre-existing** support, for example *"my older sister, my mum, the midwives obviously my partner… his family's involved as well (Clara),"* although one dad highlighted the difficulty of involving family: *"I went through the care system so we know that [my family is] not the best… they have failed us at that time, so we try and not socialize with all of them. (Jack)."* Parents who had received positive support shared the benefits of this on their confidence "*by the time we left we knew what we were doing… (Jack)."*

Parents with a limited support network reported a **lack of parenting advice** "*because I gave birth to my son, and then I got sent home that night and I sat down with a baby in a car seat and I looked at the baby and I was like now what… (Myla)."* Desired information included routines, weaning, breast feeding, nappies, clothing and responding to illness. For some, professionals acknowledged a need for support, however "*they would accuse you of doing wrong things but they wouldn't help you correct your mistakes (Kylie),"* or professionals did not ask specific enough questions to identify a parent's needs *"rather than just "is it all going ok?" like yeah its all going ok we're both breathing, we're both alive… (Paris)."*

Facilitators to support included **familiarity** with people facilitating and attending support, *"At the end of the day these people are strangers to us and then you're like just supposed to like accept support from them (Sophia),"* as well as encouragement from a trusted professional (e.g. PA). YP also stressed **flexibility** as important *"because some people get very nervous around other people as well, so it could even be things like this like a video call like some people feel more comfortable in their own homes (Myla)."* Most YP stressed their **motivation** for things to be different for their child, which facilitated engagement *"because it's not about me it's about my daughter. As much as I don't really like being in that situation, I would have done it anyway (Kylie)."*

Barriers to support included feared or actual **responses from professionals**. Some YP described feeling forced and looked down on by professionals: *"the more you're in my face the less I'm going to want to engage with you… say it in a way that's more down to earth… like "I'm just here to help you if you need some help, I'm not going to like judge you…" (Sophia)."* Others expressed their wish to do it without support in case *"they'll find that as a reason of like I'm not doing well enough (Paris)"* and "*to prove to people I can do it on my own (Lucy)."*

Practical barriers included location and transport *"So sometimes it could be really far where I need to go and I wouldn't be able to get there (Georgia),"* as well as the referral process: *"only social services can refer you… you can ask them to refer you to it but if they don't there's nothing you can do (Kylie)."* Parents also highlighted the volume of support could be overwhelming *"we just couldn't deal with all the people… maternity offered me dad classes… I just had so much going on, I just didn't make time for it (Jack),"* which was particularly challenging for working parents.

Discussion

This project aimed to identify current estimates of CL parents across Oxfordshire, to explore parent's experiences of support and identify potential service improvements to benefit CL parents.

Audit data identified that approximately one in 20 YP eligible for leaving care support are parents. In line with previous research, a large proportion of CL parents had current social care involvement (Roberts et al., 2019). Half of parents with social care involvement were under child protection, and a third had children who were looked after themselves. This suggests that some CL parents may benefit from additional support to reduce the likelihood of continuing the cycle of care.

Similar to previous research, parent interviews indicated contrasting perceptions of support (Roberts et al., 2021). Some YP felt overall support had been positive, some viewed support as excessive, and some felt support was insufficient. One of the potential differences within YPs experiences is the way support was offered, and whether interventions were universal parenting support, or perceived to be automatic due to care experience. Where YP felt a sense of autonomy, parenting was normalized as hard for everyone, and YP felt their individual situations were taken into account, support was more likely to be viewed as positive. When interventions were perceived as obligatory and assumptions were made about a YP's abilities and needs without them feeling heard, support was perceived as unhelpful or intrusive. Many parents acknowledged a need for support with parenting and expressed high motivation to offer a different life for their child. The perceived power of the system and fear of losing their child induced significant anxiety around

engaging with support for many parents. Professionals working with CL parents must aim to align themselves with YP to build a collaborative working relationship.

Most parents described the impact of parenting on their mental health and endorsed a need for additional mental health support, in particular parents with historic or current social care involvement. As suggested by attachment theory, childhood trauma and mental health impacted some parent's ability to form responsive and consistent relationships with their child, increasing the likelihood of social care involvement (Bowlby, 1969). Despite this, service audit showed only a small proportion of CL parents were accessing mental health services. This discrepancy may relate to parent's beliefs around "coping," with CLs having a unique understanding of the consequences if they are perceived not to be coping. Parenthood is a time for increased mental health risk for all parents, in particular those who have experienced trauma (Morelen et al., 2018). Professionals normalising mental health difficulties in the perinatal period may support CL parents to engage with relevant mental health support. CL dads may be especially at risk of missing out on mental health interventions, as research indicates high levels of stigma amongst fathers experiencing mental health difficulties (McKenzie et al., 2016). CL fathers may therefore experience a double stigma relating to mental health in fatherhood, further preventing them from accessing support. Parental mental health is a significant risk factor for the continued cycle of care (Jäggi et al., 2022), and therefore identifying and offering timely intervention to parents struggling with their mental health is essential.

Recommendations for clinical practice

Recommendations for YP and professionals based on the information outlined above have been summarised into tables below:

Table 1.

Recommendations for young people

Recommendation	Additional information
1. Access to parent groups	We would recommend for parents to be made aware of and supported to access existing parenting groups across Oxfordshire, including via children's centres, home start, health visitor groups, and the SAPlings antenatal group facilitated by OxPIP which offers education and social support to young women with additional social care needs in Banbury, and has received positive initial feedback (Randall, 2019). To reduce anxiety, parents should have the opportunity to meet group facilitators prior to the group and/or encouraged to bring a supportive other to join the group, such as a partner or leaving care PA. Parents should be provided with a variety of group options, such as online and in person, and supported with transport needs where required. Attending groups should be framed in a non-judgemental manner, normalising parenting as difficult and that attending a group is optional.
2. Parenting resources	Parents should be provided with additional parenting resources that they can access in their own time (e.g. Oxfordshire health visiting service website, NHS website, NSPCC, maternal mental health alliance, PaNDAS). A simple visual guide should be created and made available for parents to support with understanding the different systems (e.g. OCC, Physical health services and mental health services), and the services and types of support offered under each umbrella.
3. Parenting care plan	When a CL or their partner becomes pregnant a trusted professional (e.g. PA or health visitor) should create a parenting care plan. This may be based on the Assessment Framework Triangle and include a map of a parent's existing support network including statutory support available to all parents. Where gaps are identified in a parent's support network, consideration should be made as to how existing relationships can be strengthened, and whether additional supporters may be beneficial. When considering additional support within a care plan professionals should collaboratively agree a stepped care approach with a parent. Parents should be provided with information regarding support available to them and supported to select a small number of key interventions.
4. Parenting mentor	If it is identified that a young person may benefit from additional safe, protective others in their support network, young people may benefit from a parenting mentor. Mentors may offer parenting advice, check-in with a parent's wellbeing, normalise difficulties with parenthood, acknowledge a parent's strengths, and instil confidence in a parent. This scheme may be in collaboration with the Oxfordshire Care Leavers Association (OCLA).

Table 2.

Recommendations for professionals

Recommendation	Additional information
1. Guidance for professionals	We would advise for professional groups engaging with CL parents (e.g. Social Care, Leaving Care Teams, FNP, midwifery and health visitors) to be given guidance for working with CL parents to increase consistency within and across services. This may include reducing stigma when working with CL parents, taking an individualised approach, and forming a collaborative, trusting relationship with parents. A referral pathway flow diagram should be created, describing support available within a stepped-care model. This should lay out support available to all parents, and the circumstances by which a parent's care may be stepped up to more specialist support. We recommend for professionals to be afforded the time to build a collaborative partnership with a parent, getting to know the parent, their strengths and motivations, and their individual circumstances. To promote trust and parental empowerment, parents should be involved in decision making and kept informed around all decisions relating to their child. Where parents and professionals have differing views around a YP's support needs, it may be beneficial for a trusted individual to explore barriers to support and to consider ways of overcoming these. Professionals may employ motivational interviewing to draw on YP's strengths and commitment to being a good parent.
2. Mental health training	We recommend for professionals supporting CL parents to receive training around mental health in the perinatal period, with support from the perinatal mental health team. This may include the link between pregnancy, parenting, and mental health, identifying if a parent is struggling with their mental health and how to respond, and the impact of trauma on attachment and how to support with this. Professionals should be made aware of the potential re-traumatising nature of social care involvement and ways of employing trauma-informed approaches.
3. Supervision	We would advise for staff to be offered appropriate supervision around working with CL parents to reflect on dilemmas, power imbalances, taking a balanced approach between risk assessment and transitioning to parenthood, and to consider when it is appropriate for a parent's support to be stepped up/down.

Feedback

Results and recommendations were presented to the multi-agency "Care Leavers and Parenthood work group," and social care research panel. These groups include representatives from the YPSA and other multi-agency teams working with CL parents across social and health care.

Professionals reported that recommendations from this project were "profoundly beneficial in understanding support related experiences, and ways in which support can be improved across Oxfordshire on a multi-agency level." Services shared the value in "enabling the voices of care leaver parents to be heard." This research continues to be used within the working group, providing a framework for discussions regarding future service provision across a range of services. At the time of writing, a parenting resource pack has been created to support new CL parents to with understanding and accessing support that may be available to them, with consideration being made regarding other recommendations from this project. Specific to the YPSA, feedback stated: "This research, and its comprehensive dissemination, has helped the YPSA Clinical Team to raise our presence across the professional network, and it has showcased how beneficial research can be in shaping service improvements."

Limitations

In the audit phase, data recorded only current parents, and did not include expectant parents. Data available was descriptive information regarding CL parents, and therefore it is not possible to determine whether there is a statistically significant difference between demographics of CL parents and non-CL parents. Given the relatively small number of CL parents across Oxfordshire it is unclear whether demographics are representative of CLs across the UK. Furthermore, some relevant demographic information regarding CL parents, including ethnicity, was not routinely collected for inclusion in the audit. Research has suggested there is an over-representation of Black and mixed-race children in the UK child welfare system (Owen & Statham, 2009). It is therefore important to consider whether ethnicity may

play a role in the continued cycle of care amongst CL parents, which is not possible within the present data.

For interviews, parents were recruited via convenience sampling and as such parents with more negative support experiences may not have chosen to take part due to the difficult nature of sharing their experiences. All participants were recruited via professionals, who may have been less likely to invite YP who had a negative experience of support due to concerns around the information a YP may share. Given the professional/parent power differential indicated, YP may not have felt able to fully share their views to the interviewer who was perceived as a "professional."

Furthermore, the prompts within the interview schedule were changed following the first interview, however the first interview was still included in the final analysis. The adaptation in the interview schedule may have created bias in the subsequent interviews based on the discussions within the first interview. Furthermore, including the initial interview in the analysis prior to adapting the interview schedule may have reduced the consistency of data collection between participants, potentially impacting on the final conclusions.

Conclusion

Approximately one in 20 CLs across OCC are parents, and around half of these are open to social care. YP identified they would benefit from additional parenting advice and mental health support, which should be offered in an individualised, flexible, and collaborative manner.

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Theory Driven Research Project

Exploring Internalised Stigma, Negative Self-Schema and Self-Affirmation in Sexual and Gender Minority Adults: A mixed-methods approach

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Proposed Journal: Psychology of Sexual Orientation and Gender Diversity

Rationale: This journal was chosen as it is dedicated to publishing qualitative and quantitative research studies exploring multifaceted aspects of sexual orientation and gender diversity based on psychological theory.

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Abstract

Introduction: LGBTQ+ individuals, in particular transgender and gender non-conforming, are at high risk of mental health difficulties, potentially related to internalised stigma and negative self-schema. A model proposed by Wong and Colleagues (2018) argues that self-affirmation may protect against internalised stigma and negative self-schema, however research into this is limited. This study aimed to explore these mechanisms in LGBTQ+ individuals using a mixed-methods approach.

Method: Quantitative questionnaires measured internalised stigma, negative self-schema and self-affirmation in 181 LGBTQ+ individuals across three groups: cisgender/sexual minority (N=66), transgender/sexual minority (N=100) and transgender/heterosexual (N=15). Qualitative interviews explored eight transgender and gender non-conforming individuals' experiences of self-affirmation in relation to being minoritised using Interpretative Phenomenological Analysis.

Results: Transgender and gender non-conforming individuals scored higher in negative self-schema and internalised stigma than sexual minority individuals. Self-affirmation negatively predicted negative self-schema and internalised stigma. Qualitative findings produced three superordinate themes: 1. Transition unveiling self-affirmation, 2. Categorisation and belonging, 3. The internal battery: Energy depleting and re-charging.

Conclusion: Stigmatising experiences such as battling for one's needs, being made to feel like one doesn't belong, and negative societal messages may impact on mental health in transgender and gender non-conforming individuals by increasing negative self-schema and internalised stigma. Self-affirmation may protect against this by enabling individuals to notice other valued parts of their identity.

Table 1.
Glossary of key terms

Term	Definition
Sexual and gender minority	An umbrella term for populations including individuals who may identify as lesbian, gay, bisexual, transgender, queer (LGBTQ+) and other non-heterosexual/cisgender identities
Transgender and gender non-conforming (TGNC)	An umbrella term for individuals whose gender identity differs from their sex assigned at birth, including but not limited to transgender males and females, non-binary, gender queer, gender fluid and gender-neutral individuals.
Sexual minority (SM)	Individuals whose sexuality differs from the majority, including but not limited to individuals identifying as lesbian, gay, bisexual, pansexual, asexual.
Internalised stigma	Negative beliefs that an individual may hold about one's own minoritised identity based on exposure to negative societal beliefs (Meyer, 2003).
Public stigma	Negative attitudes and beliefs held on a societal and/or individual level which may lead to prejudice or discrimination against a certain group (Corrigan & Shapiro, 2010).
Negative self-schema	Negative beliefs an individual holds about themselves based on past experiences which may impact how one views the world (Beck, 1976).
Self-compassion	The ability to treat oneself with kindness, warmth and understanding during times of stress (Neff, 2003).
Self-affirmation	Acts or cognitions that affirm one's self-worth by reflecting on core values, strengths and qualities (Steele, 1988).
Transition	Steps some TGNC people take to live in line with their gender identity. This can include medical interventions, such as hormones or surgery (known as a "medical transition"), as well as social changes such as changing names, pronouns and clothes, informing others of one's gender identity and changing official documents (known as a "social transition).

Introduction

Sexual and Gender Minority individuals (e.g. Lesbian, Gay, Bisexual, Transgender and queer people; LGBTQ+) are at significantly higher risk of mental health difficulties, including anxiety, depression and suicidal ideation, than their heterosexual, cisgender counterparts (Dawson et al., 2017; Wittgens et al., 2022). This may relate to experiences of public stigma, such as prejudice and discrimination, as well as internal stressors, such as expectation of rejection, concealment of LGTBQ+ identity and internalised stigma (Meyer, 2003).

Transgender and gender non-conforming (TGNC) individuals are at particularly high risk of mental health difficulties (Borgogna et al., 2019), potentially due to TGNC-specific stressors such as non-affirmation of gender identity (Hendricks & Testa, 2012; Testa et al., 2015), and gender dysphoria (Lindley & Galupo, 2020). Interactions between sexual and gender minority identities may also impact on wellbeing, with individuals who hold both sexual and gender minority identities being at increased risk of mental health difficulties (Borgogna et al., 2019). Considering the impact of intersectionality of LGBTQ+ identities on mental health in research is therefore essential (Munro et al., 2019).

Internalised LGBTQ+ stigma is defined as internalising negative beliefs about one's own LGBTQ+ identity based on negative societal beliefs (Meyer, 2003). Internalised stigma has been associated with poorer mental health outcomes in LGBTQ+ individuals (Austin & Goodman, 2017; Newcomb & Mustanski, 2010; Scandurra et al., 2018; Yolac & Meric, 2021), and qualitative research has suggested self-acceptance of LGBTQ+ identity is one of the most important factors in facilitating psychological wellbeing (de Vries et al., 2020). Research into internalised

stigma in LGBTQ+ populations is largely quantitative and personal accounts of the impact of stigma is limited (Abreu et al., 2022)

In addition to internalised stigma, chronic exposure to public stigma may impact on individuals' self-schemata (Hatzenbuehler, 2009). Self-schemas are beliefs about the self, formed from historic experiences, which inform the way individuals interpret current situations (Beck, 1976). Given that the formation of self-schema is linked to past experiences, public stigma experiences may lead to the development of negative self-schemata (Hatzenbuehler, 2009). Increased negative self-schema has been shown in stigmatised groups including men living with HIV/AIDS (Eller et al., 2014; Jalali et al., 2019), and people experiencing psychosis (Collett et al., 2016).

Only one known study has investigated negative self-schema in an LGBTQ+ population (Bränström et al., 2023). This longitudinal study found sexual minority (SM) individuals were significantly higher in negative self-schema than heterosexual individuals, which mediated the relationship between sexuality and depressive symptoms (Bränström et al., 2023). Targeting negative self-schema may therefore be a cognitive mechanism to improve mental health in LGBTQ+ individuals, however research investigating this is limited.

Stigma and Self-Compassion

One factor that may reduce the impact of stigma on mental health is self-compassion (Wong et al., 2018). Self-compassion is a person's ability to connect with and understand their own suffering in a non-judgemental manner, and strive to reduce suffering through kindness (Neff, 2003). In LGBTQ+ individuals, an increasing body of literature has investigated self-compassion as a protective mechanism against

mental health difficulties and internalised stigma (Carvalho & Guiomar, 2022; Helminen et al., 2023; Pipkin et al., 2022; Sessions et al., 2023).

A model that outlines how self-compassion benefits stigmatised individuals has been proposed by Wong and Colleagues (2018). This model states that self-compassion moderates the impact of public stigma on internalised stigma and associated negative outcomes by targeting cognitive, emotional and social pathways (*figure 1.*). Specifically, this model suggests that self-compassion targets negative self-schema via the cognitive mechanism of self-affirmation. Self-affirmation, which was investigated in this study, is explored in more detail below.

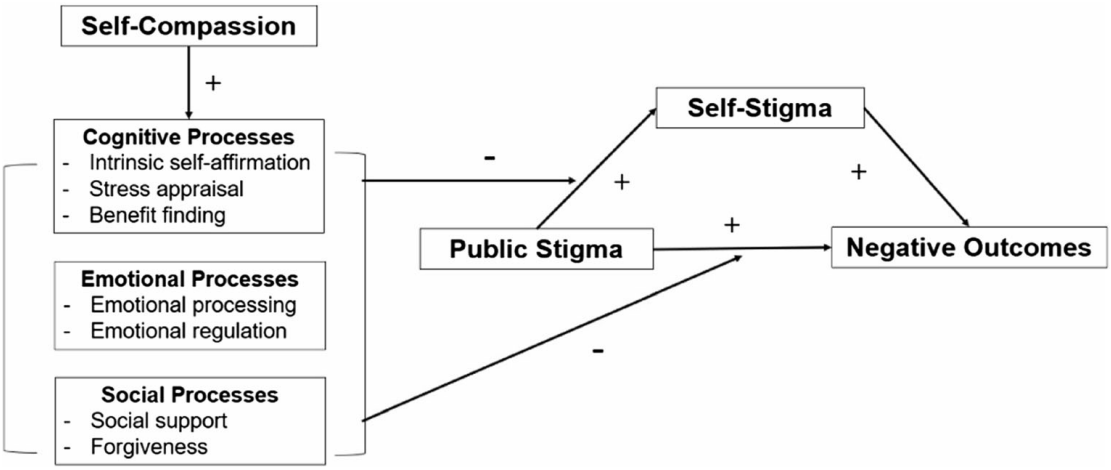


Figure 1. Wong et al., (2018) moderated mediation model of self-compassion and stigma

Self-Affirmation

Self-affirmation theory suggests individuals are driven to sustain a positive view of the self, and situations perceived to contradict this are experienced as a threat (Steele, 1988). Self-affirmation may counteract this threat by shifting an individuals' attention onto strengths and qualities they see as valued (Steele, 1988). In stigmatised individuals, Wong and colleagues (2018) posit that exposure to public stigma could

be considered an ego-threat. Self-affirmation may therefore support individuals to maintain a positive self-identity in the face of public stigma by noticing alternative, valued identities, facilitating the integration of stigmatised identities into one's self-concept (Wong et al., 2018). Self-affirmation has been found to reduce internalised stigma of mental health difficulties (Lannin et al., 2013; Seidman et al., 2022) and increase belonging amongst racial minority students (Cook et al., 2012).

In LGBTQ+ individuals, self-affirmation may be a mechanism to reduce the impact of internalised stigma and negative self-schema on mental health. Research has found increasing self-affirmation reduced internalised homophobia in SM individuals (Li et al., 2023), and reduced the impact of discriminatory experiences on mental health in TGNC individuals (Tan et al., 2022). Qualitative findings have also highlighted how self-affirmation may increase resilience in SM men (Harkness et al., 2020), and support black transgender women to recover from experiences of violence (Sherman et al., 2022). Self-affirmation may therefore be a mechanism to improve mental health outcomes for LGBTQ+ individuals by targeting negative beliefs about the self and one's LGBTQ+ identity. Research into this, however, is in its infancy.

The Present Study

The present study aimed to explore whether internalised stigma and negative self-schema contribute to increased mental health risk in LGBTQ+ individuals, and whether self-affirmation may protect against these. Due to the importance of hearing individual experiences of holding a stigmatised identity, calls have been made to increase qualitative research, particularly with TGNC individuals (Abreu et al., 2022). A mixed-methods design was therefore employed to explore TGNC individuals' experiences of using self-affirmation in the context of holding a stigmatised identity.

Research questions and hypotheses

1. Do internalised stigma, negative self-schema and self-affirmation differ between SM and TGNC individuals?

Hypothesis 1: SM individuals will be lower in internalised stigma and negative self-schema, and higher in self-affirmation than TGNC individuals.

Hypothesis 2: TGNC individuals who identify as SM will be higher in internalised stigma and negative self-schema, and lower in self-affirmation than heterosexual TGNC individuals due to holding both sexual and gender minority identities.

2. Does self-affirmation predict negative self-schema and internalised stigma in LGBTQ+ individuals?

Hypothesis 3: Self-affirmation will negatively predict negative self-schema and internalised stigma.

3. What are TGNC individuals' personal experiences of using self-affirmation and its relationship to public and internalised stigma?

Methods

Design

Quantitative phase

A cross-sectional, between-subjects design was employed.

Independent variable: LGBTQ+ identity (cisgender/SM, TGNC/SM, TGNC/heterosexual).

Dependent variables: Self-affirmation, internalised LGBTQ+ stigma, negative self-schema, and mental health symptoms.

Qualitative Phase

This phase provided an in-depth exploration of how individuals' make sense of experiences relating to being transgender, captured through the lens of the researcher using Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009). IPA has previously been used as a tool to explore experiences of individuals who hold stigmatised identities (Knight et al., 2003).

Participants

Quantitative phase

Participants were English-speaking LGBTQ+ individuals aged 18 and over with access to online questionnaires, with the only exclusion criteria being self-identification as cisgender and heterosexual. A-priori power calculation using G*Power (Faul et al., 2007) estimated a minimum sample size for the planned analysis of MANOVA with five variables (self-affirmation, internalised LGBTQ+ stigma, negative self-schema, positive self-schema and mental health symptoms) and three groups with power of 0.8, medium effect size (f^2=.0625) and α=.05. Participants were separated into three groups based on self-report LGBTQ+ identity: Cisgender/SM, TGNC/SM and TGNC/heterosexual.

Following initial recruitment significantly unequal group sizes were observed, with only one participant self-reporting TGNC/heterosexual identity. Targeted recruitment was therefore employed to recruit additional participants for this group,

leading to a final sample size that exceeded the minimum sample size estimated from A-priori analysis.

Qualitative Phase

Participants were recruited via purposive sampling from TGNC participants in the quantitative phase who expressed interest in participating in an interview.

Additional information regarding the recruitment process can be found in *Appendix F*.

Materials

Quantitative measures

Full measures can be found in *Appendix G.*

Demographic details: Age, gender identity, sexuality, ethnicity, neurodevelopmental diagnoses, and disability were obtained to describe participant details and assess potential confounding variables. Neurodevelopmental diagnoses and disability were measured as these have been shown to be elevated in a TGNC population compared to a cisgender population (Smith-Johnson, 2022; Warrier et al., 2020). Disability and Neurodiversity have also been found to be associated with experiences of public and internalised stigma, and increased mental health difficulties (Çaynak et al., 2022; Han et al., 2022; Silván-Ferrero et al., 2020). These demographic variables may therefore confound the results of the present study.

Internalised stigma: An adapted version of the 9-item internalised stigma of mental illness scale (ISMI-9) (Hammer & Toland, 2017) was used. Originally developed to measure internalised stigma of mental illness, this measure has

previously been adapted to measure internalised stigma of other identities with high internal consistency (α=.89) (González-Domínguez et al., 2018). To measure internalised LGBTQ+ stigma, the term "mentally ill" was changed to "LGBTQ+" (e.g. "I feel out of place in the world because I am LGBTQ+").

Self-affirmation: Measured using the 13-item spontaneous self-affirmation measure (SSAM) (Harris et al., 2019), which asks how often individuals use self-affirming cognitions during threatening situations and has demonstrated good internal reliability (α=.79) and validity (Harris et al., 2019).

Self-schema: Measured using the Brief Core Schema Scale (BCSS) (Fowler et al., 2006). This 24-item scale asks individuals how much they endorse a belief about themself (12 items) or others (12 items) to create four sub-scales: negative-self, positive-self, negative-other and positive-other. The BCSS has high internal consistency (median α=.74), validity and stability (Fowler et al., 2006).

Depression and anxiety: Measured using the 21-item Depression Anxiety Stress Scale (DASS-21) (Lovibond & Lovibond, 1995), which has high internal consistency (depression α=.94, anxiety α=.87, stress α=.91) and validity in clinical and non-clinical populations (Antony et al., 1998).

Qualitative measures

A semi-structured interview schedule *(Appendix H)* was co-created with experts-by-experience (EBE) using guidance on IPA (Smith et al., 2009). For information regarding EBE-involvement see *Appendix J.* Questions focused on experiences of being TGNC and using self-affirmation e.g. "Can you tell me about a time when you have noticed and used your strengths and qualities?," with prompts to support information gathering (Smith et al., 2009).

Procedure

Ethics

This study was approved by the University of Oxford Central University Research Ethics Committee (R84717/RE001, *Appendix I*).

Quantitative Phase

Participants were recruited between June and October 2023 via social media. Participants were provided with a link to an online survey using Qualtrics software (https://qualtrics.com). Following informed consent, participants were directed to online questionnaires, including all quantitative measures above. After completion of the questionnaires, TGNC individuals were invited to leave contact details if interested in the qualitative phase.

Qualitative Phase

Interviews took place between July and August 2023. Participants were contacted via email with additional information outlining the interview process. Following informed consent, semi-structured interviews were conducted over Microsoft Teams, ranging from 45 minutes to two hours (mean=83.75 minutes). Interviews were audio-recorded and transcribed verbatim (excluding identifying information) by the researcher.

Analysis

Initial analysis plans were to use parametric group-comparison statistical tests. Shapiro-Wilk and Kolmogorov-Smirnov tests, however, indicated data violated the

underlying assumptions of normality required for parametric testing. Alternative non-parametric analysis was therefore conducted.

Preliminary analysis

Initial analysis plans were to conduct an Analysis of Variance (ANOVA) for between-group comparison of the continuous variable of age. Due to the violation of normality, Kruskal-Wallis H analysis was conducted, along with Chi-Square analysis of categorical variables, to assess group differences in demographics.

Main Analysis

1. Do internalised stigma, negative self-schema and self-affirmation differ between SM and TGNC individuals?

Initial analysis plans were to conduct a Multivariate Analysis of Variance (MANOVA). Due to the violation of the normality assumption, the analysis approach changed to conduct a univariate non-parametric Kruskal-Wallis H test with Dunn post-hoc analysis to support with understanding individual contributions of variables.

Effect sizes for statistically significant values were calculated using ETA squared for Kruskal-Wallis H. According to Cohen (1988) effect sizes can be interpreted as small (η^2=.01), medium (η^2=.06) and large (η^2=.14). The effect size r was used for Dunn post-hoc analysis which can be interpreted as small (r=.1), medium (r=.3) and large (r=.5) (Cohen, 1988).

In line with the Wong et al. (2018) model, this project specifically aimed to explore self-schema. Group comparisons were therefore conducted on the negative-self (BCSS-NS) and positive-self (BCSS-PS) BCSS sub-scales only to reduce the risk of type II error, as in previous research (Freeman et al., 2023).

2. Does self-affirmation predict negative self-schema and internalised stigma in LGBTQ+ individuals?

Simple linear regression analyses were conducted to determine whether SSAM scores predicted ISMI-9 and BCSS-NS scores. Effect sizes (f^2) can be interpreted as small (f^2=.02), medium (f^2=.15) and large (f^2=.35) (Cohen, 1988).

3. What are TGNC individuals' personal experiences of using self-affirmation and its relationship to public and internalised stigma?

To explore how participants make meaning from their experiences, the researcher (EW) followed six-stage IPA (Smith et al., 2009). The researcher familiarised herself with the data by reading and re-reading individual transcripts. The researcher noted exploratory comments including descriptive, linguistic and conceptual (*Appendix K*). Emergent themes were identified from exploratory comments, which were grouped based on potential connections to create higher-order themes for individual participants (*Appendix L*). Finally, themes were grouped to create superordinate themes and sub-themes conveying patterns of experiences between participants.

An audit trail of analysis was checked by a second researcher (MK) to ensure rigour. For reflexivity and bracketing see *Appendix M.*

Results

Quantitative Phase

Participants

Out of 287 participants who started the questionnaire, 103 were excluded due to incomplete data. Three were excluded due to self-report non-LGBTQ+ identity, leaving a final sample of 181.

Participants were separated into three groups: Cisgender/SM (N=66), TGNC/SM (N=100), and TGNC/Heterosexual (N=15). For group demographic details, see *Table 2*.

Table 2.
Participant demographics for the quantitative phase (N=181)

Demographic detail		**Group**		
		Cis/SM	**TGNC/SM**	**TGNC/Het**
Total Participants		66 (36.46%)	100 (55.25%)	15 (8.28%)
Gender Identity	Female	26 (39.39%)	34 (34.00%)	9 (60.00%)
	Male	40 (60.60%)	13 (13.00%)	4 (26.67%)
	Non-binary	N/A	37 (37.00%)	0 (0.00%)
	Gender Queer	N/A	2 (2.00%)	0 (0.00%)
	Agender	N/A	4 (4.00%)	0 (0.00%)
	Gender Fluid	N/A	2 (2.00%)	2 (13.33%)
	Unsure	N/A	3 (3.00%)	0 (0.00%)
	Other	N/A	5 (5.00%)	0 (0.00%)
Sexuality	Lesbian	13 (19.70%)	20 (20.00%)	N/A
	Gay	33 (50.00%)	5 (5.00%)	N/A
	Bisexual	19 (28.79%)	39 (39.00%)	N/A
	Heterosexual	N/A	N/A	15 (100%)
	Pansexual	0 (0.00%)	8 (8.00%)	N/A
	Asexual	0 (0.00%)	7 (7.00%)	N/A
	Queer	1 (0.02%)	14 (14.00%)	N/A
	Other	0 (0.00%)	7 (7.00%)	N/A
Ethnicity	White British	46 (69.70%)	60 (60.00%)	9 (60.00%)
	Arab	1 (0.02%)	0 (0.00%)	0 (0.00%)
	White Irish	2 (3.03%)	15 (15.00%)	4 (26.67%)
	White European	7 (10.60%)	10 (10.00%)	1 (6.67%)
	White American	2 (3.03%)	1 (1.00%)	0 (0.00%)
	Other Ethnic group	3 (3.03%)	3 (3.00%)	0 (0.00%)
	Multiple ethnic background	5 (7.58%)	6 (6.00%)	0 (0.00%)
	Asian	1 (0.02%)	3 (3.00%)	1 (6.67%)
	Black Caribbean	0 (0.00%)	2 (2.00%)	0 (0.00%)
Age	Average (Range)	31.33 (19 – 71)	31.65 (18 – 76)	32.65 (18 – 54)
Self-report Disability	Yes	11 (16.67%)	41 (41.00%)	3 (20.00%)
	No	53 (80.30%)	56 (56.00%)	12 (80.00%)
	Prefer not to say	2 (3.03%)	3 (3.00%)	0 (0.00%)
ASD diagnosis	Yes	0 (0.00%)	26 (26.00%)	3 (20.00%)
	No	66 (100%)	73 (73.00%)	12 (80.00%)
	Prefer not to say	0 (0.00%)	1 (1.00%)	0 (0.00%)
ADHD diagnosis	Yes	6 (9.09%)	13 (13.00%)	0 (0.00%)
	No	60 (90.91%)	85 (85.00%)	14 (93.33%)
	Prefer not to say	0 (0.00%)	2 (2.00%)	1 (6.67%)

Preliminary analysis

Kruskal-Wallis analysis found no significant difference between groups on age ($\chi^2(2)=2.01$, $p=.365$).

According to Yates and colleagues (1999) for chi square tables larger than 2x2, at least 80% of expected counts should be ≥5, with no expected counts <1. In order to meet this assumption, categories were collapsed. Ethnicity was coded as White British, White Other and Global Majority. ASD/ADHD diagnosis were combined to report between group-differences in self-report one or more neurodevelopmental diagnosis (yes/no). Responses of "prefer not to say" were excluded from analysis due to small observed count.

Chi square analysis found no significant between-group differences in ethnicity ($\chi^2(4, 181)=3.30$, $p>.05$). Significant differences were found in neurodevelopmental diagnosis ($\chi^2(2, 178)=13.7$, $p=.001$), with 9.09% of cisgender/SM participants self-reporting at least one neurodevelopmental diagnosis, compared to 20% of TGNC/heterosexual participants and 33.0% of TGNC/SM participants. Significant differences were also found in self-report disability $\chi^2(2, 176=12.3$, $p=.002)$, with 16.7% of Cisgender/SM participants self-reporting disability compared to 41% of TGNC/SM and 20% of TGNC/heterosexual participants.

Main analysis

Kruskal-Wallis H analysis found significant between-group differences in internalised stigma, negative self-schema, positive self-schema and DASS-21, but not self-affirmation *(Table 3.).*

Table 3.
Kruskal-Wallis H analysis

Variable	Mean Rank			Kruskal-Wallis H	DF	p	η^2	Effect size
	Cis/SM (N=66)	TGNC/SM (N=100)	TGNC/Het (N=15)					
ISMI-9	64.05	102.99	129.67	31.04	2	.001*	.163	Large
SSAM	99.76	86.62	81.70	3.02	2	.221	N.A	N.A
BCSS-NS	74.11	98.39	116.03	12.34	2	.002*	.058	Small
BCSS-PS	107.32	82.21	77.80	10.21	2	.006*	.046	Small
DASS-21	75.28	98.60	109.50	9.92	2	.007*	.045	Small

** Indicates a significant difference between groups (p<.05). Cis/SM = cisgender and SM group, TGNC/SM = TGNC and SM group; TGNC/Het = TGNC and heterosexual group. ISMI-9 = adapted version of the internalised stigma of mental illness scale. SSAM = Spontaneous self-affirmation measure. BCSS-NS = negative self-schema sub-scale of the Brief Core Schema Scale. BCSS-PS = positive self-schema sub-scale of the Brief Core Schema Scale. DASS-21 = Depression Anxiety Stress Scale. Effect size interpretation according to Cohen (1988). N.A= not applicable*

Pairwise analysis (*Table 4.*) demonstrated the cisgender/SM group scored significantly lower in internalised stigma and negative self-schema than both TGNC groups. Cisgender/SM participants scored significantly lower in the DASS-21 than the TCNC/SM group. Differences between the Cisgender/SM and TGNC/heterosexual group did not quite reach significance.

No significant difference was found between TGNC/SM and TGNC/heterosexual participants in internalised stigma, self-affirmation, negative self-

schema or DASS-21 scores. TGNC/SM participants scored significantly higher in positive self-schema than TGNC/heterosexual participants.

Table 4.
Pairwise analysis utilizing Dunn's Post-hoc Analysis for Kruskal-Wallis H test

Variable		Groups		
		Cis/SM-TGNC/SM	**Cis-SM-TGNC/Het**	**TGNC/SM-TGNC/Het**
ISMI-9	**Test Statistic**	-38.93	-65.61	-26.68
	Standard Error	8.29	14.94	14.46
	Significance[a]	<.001*	<.001*	.195
	r	.364	.488	N.A
	Effect Size	Medium	Medium	N.A
BCSS-NS	**Test Statistic**	-24.28	-41.92	-17.64
	Standard Error	8.28	14.94	14.46
	Significance[a]	.010*	.015*	.668
	r	.305	.311	N.A
	Effect Size	Medium	Medium	N.A
BCSS-PS	**Test Statistic**	4.41	29.52	25.11
	Standard Error	14.48	14.96	8.29
	Significance[a]	1.00	.145	.007*
	r	N.A	N.A	.282
	Effect Size	N.A	N.A	Medium
DASS-21	**Test Statistic**	-23.32	-34.22	-10.90
	Standard Error	8.31	14.98	14.50
	Significance[a]	.015*	.067	1.000
	r	.218	N.A	N.A
	Effect Size	Medium	N.A	N.A

** Indicates a significant difference (p<.05) between groups. [a]Significance values have been adjusted by the Bonferroni correction for multiple tests. Cis/SM-TGNC/SM = differences between scores in cis/SM and TGNC/SM groups. CIS/SM-TGNC/Het = differences between scores in cis/SM and TGNC/Het groups. TGNC/SM-TGNC/Het = differences between scores in TGNC/SM and TGNC/Het groups. ISMI-9 = adapted version of the internalised stigma of mental illness scale. SSAM = Spontaneous self-affirmation measure. BCSS-NS = negative self-schema sub-scale of the Brief Core Schema Scale. BCSS-PS = positive self-schema sub-scale of the Brief Core Schema Scale. DASS-21 = Depression Anxiety Stress Scale. Effect size interpretations according to Cohen (1988). N.A = Not applicable*

Simple linear regressions (*table 5*.) found self-affirmation significantly negatively predicted internalised stigma $F(1,179)=13.47$, $p<.001$, $R^2=.07$, indicating self-affirmation predicts 7% of the variance in internalised stigma with a small effect size ($f^2=.08$). Self-affirmation also significantly negatively predicted negative self-schema $F(1, 179)=62.76$, $p<.001$, $R^2=.26$, indicating self-affirmation predicts 26% of the variance in negative self-schema with a large effect size ($f^2=.35$).

Table 5.
Simple regression analyses of self-affirmation on negative self-schema and internalised stigma

Dependent variable	Estimate	SE	95% Confidence Interval		β	t	p
			Lower	Upper			
ISMI-9	-.112	.031	-.172	-.052	-.265	-3.67	<.001
BCSS-NS	-2.310	.292	-2.87	-1.74	-.51	-7.92	<.001

ISMI-9 = adapted version of the internalised stigma of mental illness scale. BCSS-NS = negative self-schema sub-scale of the Brief Core Schema Scale.

Qualitative Phase

Participants

Due to the in-depth nature of IPA, small sample size is recommended (Smith et al., 2009). Eight participants, with no prior relationship to the researcher, took part in this stage. All participants who met with the researcher completed the interview. For demographic details, see *Table 6.*

Table 6.

Demographic details for the qualitative phase

Pseudonym	Age	Ethnicity	Gender	Sexuality	Disability	ASD	ADHD
Alex	34	White British	Male	Asexual & Aromantic	No	No	No
Emma	54	White British	Female	Pansexual	No	No	No
Ben	24	White British	Non-binary	Queer	Yes	No	No
Cowboy	26	White European	Non-binary	Queer	No	No	No
Ava	52	White Irish	Female	Heterosexual	No	No	No
Quinn	20	White British	Non-binary	Bisexual	Yes	Yes	No
Zoe	76	White British	Female	Lesbian	No	No	No

Analysis

Three superordinate themes and sub-themes drawn from IPA are explored in a narrative synthesis below. The terms trans/transgender have been used in line with language used by participants. Representative quotes for themes and sub-themes are presented in *Table 7.* For additional quotes and participant endorsement of themes see *Appendices N and O.*

Table 7.
Superordinate and sub-themes with illustrating quotes

Theme/Sub-Theme	Illustrating Quotes
Superordinate Theme 1: Transition giving space for self-affirmation	
1.1 Pre-transition distress	"Before my transition I was quite angry. I didn't know really know why and just getting frustrated a lot and yeah, I just had a lot of problems mentally." (Alex, age 34) "Knowing that was… a transgender, but the world was still saying OK but your sex was male at birth, you are male birth. And there was this feeling of, well I am transgender but things were building up, building up, building up" (Zoe, age 76)
1.2 Living authentically revealing self-affirmation	"The only thing that's changed is, is, is is the hormones. That's the only thing that's changed. So I've had 30 or 40 years over the whole lifetime of… you're the worst person in the world, to now I actually accept myself, you know. Maybe I'm not quite the worst… [laughs]. Yeah, but the the only thing that's changed is the hormones. Nothing else has changed" (Ava, age 52). "I think sadly I think it took the medical transition to get rid of those views that I had, the sort of hatred about being trans. Umm, but it was just because I was uncomfortable all the time, which is very overwhelming. And yeah, I I guess I umm conflated being trans with being unhappy and, umm hating myself. So that's, that's what it was before, but now that I don't it's, I can separate the two and…. Yeah I, because I feel more comfortable in myself I feel very neutral about being trans most of the time." (Bob, age 22)
Superordinate theme 2: Belonging with society	
2.1 Not fitting into societal categories	"I would walk down the street, look very androgynous, I would see people staring at my chest and between my legs trying to go… What can I see that I can identify you with for a gender…. And… that's uncomfortable" (Quinn, age 20) "Look at what's inside of me, not just this which you've learned to see as female cause like when I look at myself, I don't see a woman. I know most of the world does because that's what we've been trained to do. I was trained the same way. But I look at myself, and I don't see a woman. I really, really don't and when people insist

	that that's what I am… in the past, it made me feel crazy, and it really made me doubt my sanity." (Cowboy, age 26)
2.2 Representation and Education	"trying to figure out how to deal with that and how to still exist in the world and still interact with these people and find a balance between like correcting them and like taking a step back from those who like consistently got it wrong, but then also being gracious and wanting to educate people and wanting to… explain it and like have patience. Umm… But then also knowing that I'm not getting paid for, you know, being a trans educator, I'm just trying to chill. I'm just trying to do my job" (Cowboy, age 26)
2.3 Finding ways to belong	"I think having friends is is so important when your relationships with your family are very difficult now I think to have friends around you is absolutely paramount to make you feel that you're supported" (Emma, age 54) "When I'm feeling my like most confident and most positive about myself, will also be when I'm like… not experiencing dysphoria and I've been around people who are just like very positive to be around gender wise and know me completely, and I feel sort of very fun and confident" (Quinn, age 20)
Superordinate Theme 3: The internal battery: Energy depleting and Re-charging	
3.1 Vigilance as protection from vulnerability	"I'm still kind of in a place where I expect people to have an issue or I expect things to go wrong or for people to… be biased against me and I think that's not umm, you know, it's not necessarily a bad thing to think because there is a lot of kind of misinformation and a lot of scare mongering so I think it's quite essential to be prepared for someone to be very horrible and malicious to you, but it's quite sad to live in sort of a state of fear and anxiety that everyone's gonna hate you, when most people don't only the people that read like the Daily Mail." (Ben, age 24)
3.2 Battling for one's human rights	"Sometimes I do find somethings harder than other people seem to find them and I don't know what that's due to but… it is tough, I think when you… It's so exhausting, sometimes feeling like the whole world is against you and sometimes, especially when I turn up to work, I feel like I'm already turning up having faced a battle and other people might necessarily have, have gone through that that day or that week and I wish, I wish sometimes I didn't already have to start from like a place of exhaustion to, to get stuff done" (Ben, age 24)

3.3 Self-kindness re-charging the battery	“Learning to be more compassionate with myself has just really transformed how I go through life and… how I am able to interact with the world and with other people as well because if I can show myself compassion then I have so much more energy and, positive stuff to give to the rest of the world.” (Cowboy, age 26).

1. Transition giving space for self-affirmation.

This theme captured the psychological impact of living incongruently to one's gender identity, and the impact of self-acceptance of one's gender identity on thinking patterns.

1.1. Pre-transition distress

All participants shared how pre-transition distress impacted on their mental health. For some, this came from suppressing one's feelings prior to accepting one's own gender identity. Others described the pain of *"massive, crippling dysphoria" (Bob)* before commencing a social or medical transition. The power of this experience impacted participants' beliefs about themselves, *"why? Why can't I be normal?" (Emma)* and others: *"if they don't know me, they can't love me" (Cowboy).*

1.2. Living authentically revealing self-affirmation

All participants described self-acceptance of one's gender identity, and making steps towards a social or medical transition, improved their mental health: *"it was a huge weight off my shoulder to actually, you know to accept it, to embrace it" (Zoe).* Some participants expressed surprise when more positive self-thinking was noticed after starting their transition journey:

"I've had 30 or 40 years over the whole lifetime of… you're the worst person in the world, to now I actually accept myself, you know. Maybe I'm not quite the worst…[Laughs]" (Ava).

For some, however, the power of pre-transition distress meant self-critical beliefs were *"Sort of rooted in how I think about myself" (Bob).* Participant narratives demonstrated beliefs about oneself and one's identity may evolve alongside one's transition journey.

2. Categorisation and belonging.

This theme captured how participants made sense of being transgender in a cisnormative society and found spaces where they belong.

2.1 Not fitting into societal categories.

Participants described living in a cisnormative society meant being trans often equated to not belonging: *"there's no space for me" (Alex).* Experiences of non-acceptance by loved ones also meant individuals felt *"not wanted" (Zoe),* or unloved as *"they can't really fully accept you for who you are" (Alex).* One participant described *"squashing"* themselves to be more *"palatable to people,"* making it difficult to *"think positively about myself" (Quinn).*

Participants described a disconnect between their own internal self-image, *"I don't wake up and think "ohh I'm trans" (Bob),* and others making *"a point of being like, but remember that you are trans" (Quinn),* further highlighting difference. Participant's narratives highlighted how reminders of "otherness" may draw attention to one's minoritised identity within one's self-concept. Experiences of being treated like a *"regular human being" (Zoe),* however, facilitated a sense of being *"accepted" (Ava).*

2.2 Representation and Education

Most participants recalled a lack of information or role models when growing up. Some participants valued being the representation they did not have, both to support other trans people and facilitate acceptance amongst cisgender peers: *"because they understand it I think they become more tolerant" (Emma).*

Some participants, however, expressed frustration at the pressure to educate others:

"I've become exhausted with educating people and then now my response is like Google exists" (Ben).

Participants experienced internal conflict between wanting to facilitate others' acceptance, while also trying to *"exist in the world" (Cowboy).* Participant narratives demonstrated the complexity of educating others, which had the potential to highlight one's value, while also further highlighting difference.

2.3 Finding ways to belong.

Participants described how connecting with gender-affirming others facilitated a sense of belonging. For some, connecting to the trans community was important so *"you don't have to like justify umm, why something is painful." (Cowboy).* One participant, however, described avoiding the trans community:

"I hated drawing attention to the fact that I was trans cause it was just overwhelming" (Bob).

Being around gender-affirming others meant participants could *"do myself authentically (Ben),"* which supported with feeling the "*most confident and most positive about myself" (Quinn)*. Participant narratives highlighted how engaging with accepting others may support with noticing and integrating alternative, valued self-identities into one's self-concept.

3. The internal battery: Energy depleting and re-charging

This theme describes participants' experiences of the additional energy burden of being minoritised and how participants have learned to preserve their energy resources.

3.1 Vigilance as protection from vulnerability.

Participants described how prejudice in the media, *"we're a witch subject" (Zoe)*, and personal experiences of non-acceptance created an expectation *"for people to… be biased against me" (Ben).* Participants described attempting to protect themselves by staying *"on guard" (Quinn)*. The unintended consequence of this, however, was participants' attention was focused elsewhere, "*instead of actually focusing on the conversation and what was being said and like connecting with people." (Cowboy).*

Results highlighted how ubiquitous messages of threat may create a sense of vulnerability. While hypervigilance was perceived as a necessary safety measure, participants experienced this as exhausting, and prevented noticing other valued self-identities.

3.2 Battling for one's human rights.

Participants described repeatedly having to fight to have their needs met. Several participants expressed losing trust in healthcare due to services putting up *"little barriers wherever they can" (Ava),* and individuals having to prove their *"competency to consent" (Ben)*. Participants also described fighting for others to accept the legitimacy of their gender identity: *"I changed my name, I changed everything, but she just wasn't buying it" (Alex).*

Participants described learning when it was worth fighting these battles: *"I deserve to be happy" (Ava)*. Participants also acknowledged a need to accept when its ok to preserve one's energy and *"just… exist" (Quinn)*. Narratives highlighted the complexity of recognising and fighting for one's value, while also accepting one's own limitations.

3.3 Self-kindness re-charging the battery.

Participants described being kind to oneself was a coping mechanism that provided respite from self-criticism: *"if you don't see value in yourself, then no one else will." (Ben).*

Participants also described noticing benefits of being trans facilitated the integration of this identity with other valued aspects of the self: *"having that opportunity to deal with the adversity and come back and be stronger" (Emma)*

Participants able to notice positive things about themselves described actively choosing to notice their strengths and qualities *"it was either… Finding something to like about myself or ending my life" (Cowboy).* Participants who expressed difficulty in being kind to oneself shared the automaticity of self-critical thoughts: *"It's much easier to lay into myself than it [laughs] talk about my strengths (Bob)."* One participant described finding it *"hard to forgive myself" (Alex)* due to the impact being trans had on his self-confidence. Participants' narratives indicated the cyclical nature of self-affirmation and self-criticism, where each had the potential to counter the other.

Discussion

The present study aimed to explore whether internalised stigma and negative self-schema contribute to mental health in LGBTQ+ individuals and whether self-affirmation may be a mechanism to buffer against this.

Quantitative analysis partially supported our first hypothesis, demonstrating higher negative self-schema and internalised stigma in TGNC individuals than SM individuals. TGNC individuals also demonstrated higher mental health symptoms, in line with previous literature (Borgogna et al., 2019), indicating negative self-schema and internalised stigma may contribute to mental health risk in this population. Qualitative findings highlighted how stigmatising experiences, such as battling for one's needs to be met, being made to feel like one doesn't belong, and societal messages of non-acceptance may lead to the development of negative beliefs about oneself and being TGNC. TGNC individuals may therefore benefit

from therapies aiming to target these negative cognitions alongside continued societal efforts to reduce public stigma.

Contrary to expectation, no between-group differences were found in self-affirmation. Research has suggested multiple factors may impact on self-affirmation, including taking an approach coping strategy (Sharouni et al., 2022), recognising the benefits of self-affirmation (Reeves et al., 2023), and socioeconomic status (Jessop et al., 2023). Qualitative findings highlighted how engaging with other important self-concepts, such as connecting with affirming others and noticing value in one's stigmatised identity, may facilitate self-affirmation. As connecting with affirming others and benefit-finding is relevant to all LGBTQ+ individuals, self-affirmation may be similar between LGBTQ+ identities.

Contrary to our second hypothesis, quantitative analysis found no differences in negative self-schema or internalised stigma between TGNC/heterosexual and TGNC/SM individuals. This indicates there may not be an effect of "double SGM stigma," however conclusions should be tentative given the small sample size in the TGNC/heterosexual group. Research has indicated that the more central a stigmatised identity is to one's self-concept, the greater the impact on negative outcomes (McCay & Seeman, 1998). Qualitative findings highlighted how pre-transition distress, battling to get one's needs met and pervasive messages of gender non-acceptance may influence beliefs about the self and one's gender identity. These TGNC-specific experiences may increase the centrality of being TGNC compared to one's sexuality in individuals' self-concept. TGNC individuals may therefore demonstrate similar rates of internalised stigma and negative self-schema regardless of sexuality.

In line with our third hypothesis, regression analyses suggested increased self-affirmation may reduce negative self-schema and internalised stigma. Findings provide

support for the Wong et al. (2018) model, which argues that self-affirmation may reduce the centrality of one's stigmatised identity in favour of alternative, valued self-concepts. Qualitative findings also highlighted how recognising value in one's TGNC identity may support the integration being TGNC into one's self-identity. Supporting LGBTQ+ individuals to engage in self-affirmation may therefore reduce the impact of internalised stigma and negative self-schema by supporting individuals to notice their value alongside one's stigmatised identity.

Qualitative findings provided an exploration of the complex and multi-faceted factors influencing beliefs resulting from TGNC-specific experiences. Some participants found self-affirmation, and more broadly self-compassion, to be important in maintaining a positive sense of self in the face of ego-threats. For some, however, the power and emotional weight of these beliefs meant self-affirmation alone was insufficient to maintain an overall positive sense of self. Themes of exhaustion due to being minoritised echo models of burnout in other minoritised groups (Mantzalas et al., 2022; Smith, 2004), which may further inhibit more effortful self-affirmation. Additional elements of self-compassion, such as emotional processing, emotion regulation and forgiveness (Wong et al., 2018), may therefore be required alongside wider societal change to reduce public stigma and the impact this has on one's self-identity.

Limitations and Future Research

In the quantitative phase, the TGNC/heterosexual group was small, thus conclusions from this group should be tentative. Preliminary analysis also demonstrated group differences in sexuality, neurodevelopmental diagnosis and disability, which was not controlled for in the main analysis. Research has suggested individuals who hold an "emerging sexual minority" identity (e.g. pansexual, asexual, queer) are at increased risk of anxiety and depression than

lesbian, gay or bisexual individuals (Borgogna et al., 2019). Furthermore, neurodevelopmental diagnoses and disability are associated with public and internalised stigma, and increased risk of mental health difficulties (Çaynak et al., 2022; Han et al., 2022; Silván-Ferrero et al., 2020). Not controlling for this may therefore have impacted on the results, as between-group differences in study variables could be explained by increased public stigma related to another stigmatised identity. Future research should therefore control for other stigmatised identities, and consider more specific grouping of sexuality to determine whether individual differences may impact variables associated with mental health.

In addition, the quantitative phase is cross-sectional and therefore it is unclear whether the relationship between self-affirmation, internalised stigma and self-affirmation may change over time. Future research should consider whether increasing self-affirmation impacts negative self-schema and internalised stigma in LGBTQ+ individuals.

In the qualitative phase, all interviewees were white-European. Research has suggested black Transgender women are at particularly high risk of experiencing discrimination and may employ self-affirmation as a coping mechanism (Sherman et al., 2022). Future research should consider exploring self-affirmation in diverse LGBTQ+ populations, in particular individuals who hold multiple stigmatised identities.

Conclusion

The present study explored self-affirmation, internalised stigma and negative self-schema in LGBTQ+ individuals. Results suggest that stigmatising experiences such as battling for one's needs to be met, being made to feel like one doesn't belong, and societal messages of non-acceptance may lead to the negative outcomes of internalised stigma and negative self-schemas. Societal and cultural efforts to de-stigmatise LGBTQ+ identities must

therefore continue. Self-affirmation may be one additional mechanism to protect against stigma, by enabling individuals to notice other valued parts of one's identity.

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Executive Summary

Why did we do this study?

Research has shown that lesbian, gay, bisexual, transgender and queer (LGBTQ+) people often experience difficulties with their mental health, especially transgender people. Experiences of homophobia or transphobia might mean LGBTQ+ people hold negative beliefs about themselves and/or being LGBTQ+, which may then impact on their mental health. Right now, there is not much research into whether LGBTQ+ people are more likely to hold negative beliefs about themselves, and how these beliefs might develop.

Something that has been found to help other people who have experienced prejudice or discrimination an individuals' ability to focus their attention onto other parts of themselves that they value or are good at. This is known as self-affirmation, but currently there is not much research into whether self-affirmation might be helpful for LGBTQ+ people.

In this research project, we were interested in finding out whether LGBTQ+ people are more likely to hold negative beliefs about themselves and being LGBTQ+, to help us understand more of the factors that might contribute to higher mental health difficulties in LGBTQ+ people. We were also interested in whether self-affirmation might protect LGBTQ+ people from holding negative beliefs about themselves and their LGBTQ+ identity.

What did we do?

This study had two parts. In the first part, we asked LGBTQ+ people to complete questionnaires about the thoughts that they have about being LGBTQ+, beliefs they hold about themselves, and whether they notice their strengths, qualities and values during stressful times. In the second part, we conducted interviews with transgender people to hear

about their personal experiences of being transgender and whether these experiences impact on how they think about themselves and being transgender. We also asked interviewees about when they can recognise their strengths, qualities and values, and things that might help them to do this.

What did we find?

The study found that transgender people hold more negative beliefs about themselves and being LGBTQ+ than people who hold a minority sexuality (e.g. lesbian, gay, bisexual, queer individuals). This finding might explanation why transgender people are more likely to have difficulties with their mental health.

During interviews, transgender individuals spoke about some difficult experiences that they may have because of being transgender. These were things like experiencing painful "dysphoria," and other people not being accepting of their gender identity. Interviewees also spoke about day-to-day challenges, like having to "battle" to be accepted by others and to access healthcare, being exposed to negative messages in the media about trans people, and not "fitting" into cis-normative categories. Interviewees spoke about how these experiences might impact on the beliefs they hold about themselves, like being unwanted or not normal. These experiences also impacted on the beliefs some interviewees had about being transgender, like being painful or vulnerable. Some of these experiences might, therefore, explain why transgender people are more likely to hold negative beliefs about themselves and being transgender.

This study also showed that LGBTQ+ people who were able to think about their strengths, values and qualities had fewer negative thoughts about themselves and being LGBTQ+. During interviews, transgender individuals spoke about how accepting their

gender identity and transitioning to be more authentically themselves had helped them to notice more positive things about themselves. Individuals also spoke about finding it helpful to notice the value that being transgender has brought to their lives, like being more compassionate and supporting other people to be more understanding of the transgender community. Individuals also shared how spending time with others who are unconditionally accepting of them helped them to notice positive things about who they are as a person, rather than focusing on the difficult things about being transgender.

Interviewees also spoke about how, when they were able to notice their strengths and qualities, it became harder for more critical thoughts to be around. For some people though, the more difficult experiences relating to being trans meant some of the more painful beliefs about themselves were really strong. This meant that they found it harder to think kindly about themselves.

What does this mean?

The results of this study suggest that supporting LGBTQ+ people to notice their strengths, qualities and values may be helpful with supporting individuals to cope with negative thoughts about themselves and being LGBTQ+. For some people, however, this might not be enough to challenge beliefs that are really strongly held. In the future, more research would be helpful to help us to understand other ways that mental health services can support LGBTQ+ people to challenge these negative thoughts.

Connecting Narrative

Coming on to the doctorate I had limited research experience, and so developing and completing three separate projects in areas that interested me and used methodology that suited my style of thinking felt daunting. In my previous clinical work, I developed an interest in hearing and sharing the voices of individuals who are often underrepresented. Throughout my three projects I hope I have been able to use this opportunity to represent individuals who often feel they do not have a voice, or who may feel misunderstood. I hope this knowledge can be used to understand and improve psychological support for these under-researched groups.

Theory Driven Research Project (TDRP)

My interest in this area came from my previous work with transgender young people. I was aware of the increased mental health risk for transgender individuals, and that experiences due to being stigmatised may mean manualised approaches do not fit for this population. I was therefore particularly interested in using this research project to consider protective factors for transgender individuals that may be incorporated into current treatment approaches.

With support from my supervisors and experts-by-experience, we designed a project that explored the variables we were interested in between three LGBTQ+ groups. Recruitment for this study involved some unexpected challenges in groupings. Around two weeks after starting recruitment we already had sufficient participants in our cisgender/SM and TGNC/SM groups, however we only had one participant in the TGNC/heterosexual group. We therefore altered our recruitment strategy to target recruitment of heterosexual TGNC individuals for several months. Targeted recruitment reached an addition 14 participants for this group. The relative ease of recruitment for the other two groups,

however, meant we had a large enough total sample size to reach our a-Priori power calculation. Upon reflection, this finding made sense as heterosexuality is a cis-normative term that is based on how an individual views one's own gender. Some transgender individuals, therefore, may use different terms or have a different understanding of sexuality to cisgender individuals. The term "heterosexual" may therefore not be representative for transgender individuals' experiences of sexuality.

Due to differences in group sizes, I sought support from a statistician who advised that, although similar sample sizes are preferable, the robustness of MANOVA analysis (which we planned on using at the time) means there are no specific guidelines regarding between-group sample sizes. As our total sample size was sufficient, a decision was made to complete analysis with participants reported in the present study.

In relation to qualitative findings, I felt privileged that participants shared such difficult and rich experiences. While I found the process of IPA helped me to dive into their narratives and gain some understanding of how participants made sense of their experiences, at times the amount of information could feel overwhelming. I felt an enormous sense of pressure to do justice to the voices of individuals who had been so generous in giving their time to speak with me, and condensing this information into a handful of themes was a challenge.

Service Improvement Project (SIP)

This project came from my interest in attachment theory and the intergenerational cycle of care. While I anticipated recruitment for this project would be challenging, I was underprepared for how difficult recruiting these young parents would be, and completing interviews took more than six months. As young people spoke about their experiences, I was able to understand why being open to someone viewed as a "professional" may be feel

challenging or unappealing, with many sharing narratives of feeling repeatedly let down by health and social care professionals. I was extremely grateful to the leaving care PAs, supported accommodation staff and support workers who were so invested with this project and supported me to organise meetings with their young people.

While these interviews were shorter than my TDRP interviews, the narratives that they shared were no less valuable. Similar to my TDRP, I felt a massive pressure to be able to "get it right" for these young people, who had gone out of their comfort zone to speak with me with the hope of using their experiences to facilitate change for other young people like them. I continue to feel very attached to the stories that young people shared with me, and I found cutting down on quotes to include in my narrative heartbreaking. Because of this, the dissemination of this project was particularly important to me, and I have continued to attend the "care leavers and parenthood work group" to ensure the voices of these young people are heard. I have also submitted this project for publication to "child & family social work" and am currently awaiting feedback.

Systematic Literature Review (SLR)

Starting my SLR was delayed after I discovered that the SLR I had originally taken to PAS had already been completed elsewhere. With the support of my supervisors, we developed this research question which was of interest to me due to my current specialist placement in an adopted and care-experienced children's team. Throughout my SLR, I was surprised at how much I enjoyed the methodical nature of the literature review process. Out of all my projects, I feel that this one supported my understanding of research the most. As this project went on, I found myself noticing more and more the information within a paper that I need to truly understand the findings and conclusions presented, and to use this to synthesise the results.

Looking Forward

Going forward in my career in psychology, I am keen to continue using the power I hold as a psychologist to provide a voice for people who may be misunderstood or underrepresented. In particular, my SIP inspired me to pursue a career working with care experienced young people, and I continue to hold these young people's stories in my mind in my clinical work.

Acknowledgements

I would like to start by thanking my participants for entrusting me with their stories, and for their generosity in giving up their time to share their personal experiences.

I would like to thank my supervisors Ciorsdan, Kim, Matthew, Alastair and Libby for their advice, guidance and support throughout all of my research projects. I have appreciated their ability to provide positive and constructive feedback which enhanced the projects in a way that I would not have been able to do alone, and for their ability to find time to support me even when they had none. In particular, I would like to thank Ciorsdan for advising me not to train for two marathons during my final year, and for supporting me when I ran them anyway.

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Finally, thanks to Maisie the dog who doesn’t know how important she’s been.

Appendices

Appendix A: SLR and SIP Author guidelines for "journal of family social work"

Full author guidelines can be found here: https://journals.sagepub.com/author-instructions/jsw

Key points:

AIMS AND SCOPE

Child & Family Social Work provides a forum where researchers, practitioners, policy-makers and managers in the field exchange knowledge, increase understanding and develop notions of good practice. In its promotion of research and practice, which is both disciplined and articulate, the Journal is dedicated to advancing the wellbeing and welfare of children and their families throughout the world.

Child & Family Social Work publishes original and distinguished contributions on matters of research, theory, policy and practice in the field of social work with children and their families. The Journal gives international definition to the discipline and practice of child and family social work.

MANUSCRIPT CATEGORIES AND REQUIREMENTS

Original Articles should normally be a maximum of 7000 words, including the abstract and any appendices, although shorter papers will be welcomed. References are not included in the 7000 word limit. The abstract should not exceed 200 words and it should be followed by six keywords.

The Editors also welcome the following scholarly papers:

Review These will be actively encouraged. Prospective authors should initially discuss their proposals with the Editor.

Parts of the Manuscript

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file should be submitted in Microsoft Word (.doc or .docx) format.

Main Text File

The main text file should be presented in the following order:

i. Title, abstract and key words;
ii. Main text;
iii. References;
iv. Tables (each table complete with title and footnotes);

v. Figure legends;
vi. Appendices (if relevant).

Abstract
Please provide an abstract of no more than 200 words. The abstract should be followed by up to six keywords.

References
References in published papers are formatted according to the Publication Manual of the American Psychological Association (6th edition). However, references may be submitted in any style or format, as long as it is consistent throughout the manuscript.

Tables
Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends
Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

General Style Points

The following points provide general advice on formatting and style.

- **Language**: The language of publication is English. Authors for whom English is a second language must have their manuscript professionally edited by an English speaking person before submission to make sure the English is of high quality.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).
- **Trade Names:** Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses.

Appendix B: SRL search terms

"quality caregiv*" OR "quality care" OR "sensitive caregiv*" OR "sensitive care" OR "sensitive parent*" OR "Attune* parent*" OR "mind mindedness" OR "quality parent*" OR "trauma-informed parent*" OR "trauma parent*"OR "mentaliz*" OR "reflective function*" OR "positive parenting" OR "attunement" OR "connected caregiv*" OR "attach* parent*" OR "Attach* informed parent*" OR "attach* caregiving" OR "quality of care" OR "parenting behavio*" OR "attachment behavio*" OR "trauma knowledge" OR "emotional intelligence" OR "empath*" OR "parent child relationship" OR "sensitivity" OR "parent* stress" OR "caregiv* stress" OR "responsiveness" OR "Parent* characteristic*" OR "caregiv* characteristic*" OR "parent* attitude*" OR "Caregiv* attitude*" OR "theory of mind"

AND

"placement breakdown" OR "placement success" OR "placement stability" OR "attach* security" OR "behavio* that challenge" OR "behavio* of concern" OR "challenging behavio*" OR "Externali* behavio*" OR "mental health" OR "mental ill health" OR "quality of life" OR "mental wellbeing" OR "emotion* wellbeing" OR "emotion* regulation" OR "educational attainment" OR "insecure attach*" OR "child outcome" OR "placement satisfaction" OR "behavio* problem" OR "child development" OR "cognitive function" OR "cognitive ability" OR "positive outcome" OR "negative outcome" OR "risk reduction"

AND

"foster parent" OR "foster care*" OR "foster child*" OR "foster mother" OR "foster father" OR "kinship care*" OR "Foster home" OR "foster family" OR "looked after child*" OR "looked-after-child*" OR "special guardian*" OR "Out-of-home care" OR "out of home care" OR "Care experienced" OR "child looked after"

Appendix C: SIP semi-structured interview schedule

1. How did you feel when you found out you were going to become a parent?
    a. did you have any hopes/worries?
    b. Do you think your experience of care had an impact on this? How come?
2. Who are the first people who come to mind who support you with parenting?
    a. How do they support you?
    b. Is there anyone we haven't spoken about?
3. What help, if any, did you think you needed when becoming a parent?
    a. What help did you want?
4. What professional services have you had support from with pregnancy and parenting? (e.g. maternity services, family nurse partnership, health visitors, PAs, social care, GP).
    a. What type of support did these services offer?
    b. Who offered you support for your physical health?
    c. Emotional support?
    d. Practical advice?
    e. Parenting advice?
5. What was your experience of the professional support that you received?
    a. Can you share an example of good support? What made this good? (?content / person / timing / place / etc)
    b. Can you share an example of support that wasn't good? What made this bad? (?content / person / timing / place / etc)
    c. Was there anything that could have been improved about your experience of support from professional services?
6. Did you attend all the support that you were offered by services?
    a. Can you tell me a bit more about the reasons for this?
    b. If answered 'no' to Qu6:
        - Was there anything that got in the way of you taking up the support?
        - Is there anything that would have helped you to take up the support?

        If answered 'Yes' to Qu6
        - Was there anything that helped you to take up the support?
7. Were the professionals who offered you support aware of your experience of spending time in care?
    a. If 'Yes':
        - Who?
        - Was this helpful in any way? (What make it feel helpful?)
        - Was this unhelpful in any way? (What made it feel unhelpful?)
            - Do you have any examples of helpful/unhelpful experiences to share?
        - How did you feel about ~~that~~ professionals knowing about your care experience? How come?
        - What advice would you give to professionals who support parents who have experience of living in care? (things to be aware of/avoid doing)
    b. If 'No':
        - Was this helpful in any way? (What make it feel helpful?)
        - Was this unhelpful in any way? (What made it feel unhelpful?)
        - How would you have felt about professionals knowing about your care experience? How come?

- What advice would you give to professionals who support parents who have experience of living in care? (things to be aware of/avoid doing)

8. Can you think of any other support that would have been helpful with pregnancy and parenting? (for example, support around planning for the future, support around looking after yourself or your baby, or support around important relationships like with family and the baby's father/mother… or something else?)
    a. What would this support help with?
    b. Any ideas about what this support could look like?
    c. What would encourage you to attend?

Appendix D. SIP additional supporting quotes

Theme 1.
Building a positive working relationship

Sub-theme	Supporting Quote(s)
1.1. Inconsistency	"Some of them were good to get on with and helpful, some of them we didn't see eye to eye. (Jack)" "I've had some good experiences with social workers, like the current social worker now, she's the social worker to my daughter, she's great. But my experience with, but my last social worker we didn't get on, and the mother and baby unit place was absolutely horrendous (Kylie)"
1.2. Positive experiences	"She seems like empathetic with like things that like I get upset about, she's been helpful and then there's been a few issues with my daughter in her foster placement and she seems to be taking it really seriously and stuff. (Kylie)" "its just [PA] again, yeah he's always on the other end of the phone if I need him so I know I can call him. (Jack)" "I could literally tell anything to her and not feel judged so… I think she would just reassure me on things, so if I was to say I was struggling with a certain thing she was like "everyone struggles" (Georgia)"
1.3. Negative experiences	"because where I was through the care system I didn't want my son to go through it, because it is traumatizing (Jack)" "Especially like being pregnant and already going through domestic violence and then being treated like that by a social worker who is supposed to be a safe person (Myla)"
1.4. Power of the system: Fear and uncertainty	"So it made me a bit worried like what if she ends up like in care, obviously like I'm planning not to but you know it did just make me a bit worried that I don't want her to end up in the same situations I was in and stuff (Paris)" "I think I had a lot of people at the beginning who were like "if you don't do this it will affect you having the baby" ... nobody is ever going to engage with you if you're like say "if you don't do this then we'll do this" (Sophia)" "when I gave birth they put him on my chest and obviously they have to take him on the bed next to you just to check he's got all 10 toes and all 10 fingers… as soon as they took him I was like where are you taking him what are you doing with him, and that's all because I didn't have a clue about the plan, and I think that's just so unfair (Myla)"
1.5. Knowing your background: No stigma	"it was more like people doing the [safeguarding referral] with her if that makes sense… they're more like "oh well on your record there's this and on your record there's this so how's this going to effect this, how's this going to effect this," so they're like because of like your status of being a leaver it makes it like… because it feels if I was just a normal person who hadn't left I wouldn't have this type of support around me at all (Sophia)" "Just that we're like, we're not bad kids, or adults I guess… I think there's just like a pre-conceived idea… and I think that sometimes you get looked down on because you're a care leaver you might not do a good job, (Paris)" "Stop thinking that we're going to be bad parents just because we may not have had the best upbringing. Because actually we give them a better life because we know what it is like to be in a situation or in a bad parent, we know what it is like. (Toni)"

Theme 2.
Parent's mental and emotional wellbeing

Sub-theme	Supporting Quote(s)
2.1. Relationship between parenting and mental health	"you lose yourself becoming a parent, you do, because you're focused so much on this tiny baby that you forget about your own needs, and it's trying to find that balance and some people need support with that and knowing how to balance things because I didn't have a clue and I had to kind of do it by myself (Myla)" "if my depression hadn't taken over then I would have been able to look after him. That's what happened, I got depressed and then they thought I couldn't… there was just no bond there (Georgia)" "I felt like I couldn't bond with him, I didn't actually even hold him when he was born (Georgia)"
2.2. Parenthood as a turning point	"A lot of people say that becoming a parent is either make or break, and luckily for me it's made me who I am so… yeah. (Myla)" "To be fair though it did give me a new like… it gave me a reason to live. Umm so that was good. (Paris)"
2.3. Social care as re-traumatising	"So when I first give birth it was really good until the 3rd week, and they were really concerned because I was still struggling, and they called social and it just made everything worse, it made everything worse because they re-assessed me, obviously dragged up the past, it dragged up my past and my trauma I didn't need that, and I struggle with post-natal as it was, I really didn't need that (Toni)"
2.4. Positive support: Professionals and peers	"Yeah they had key worker sessions, so you have a key worker who you meet once or twice a week, and they'll just ask how is everything, they'll do paperwork and activity forms, and ask if you're mentally ok, but yeah its really good, strong support (Jack)" "I think a support groups for pregnant mums or dads who have been in the system that would be good to be fair, because I actually don't know one for people who are in the same position, so maybe something like that… Because some of these other groups you just go there and their lives are very relaxed, they've got no support workers and they don't have to deal with any of the other added things (Georgia)"
2.5. Need for additional support	"I feel like maybe they should offer pregnant women more mental health support as well… I feel like, if you want someone to be a good parent they have to be feeling good in themselves as well" (Kylie)
2.6. Mental health as a risk	"Cause I get scared to access support sometimes because of social services. Especially my mental health I was, when she was born like the first 3 weeks I said I was struggling, and they just called social services. That's not what I needed, what I needed was someone to lean on, someone to cry and vent it out to, but they just called social services concerned. And actually it wasn't what I… It just made it worse, and it took longer to bond because of that. (Toni)" "I think in the beginning I thought if I take the support they'll find that as a reason of like I'm not doing well enough (Paris)"
2.7. Barriers to support	"I did feel like I did need a bit of support… Ummm especially with obviously all the emotions changing, because when you give birth so much hormones are just dropping dramatically, and with someone who doesn't understand emotions that's very difficult…. She was also like, when you give birth you can get something called post-natal depression or something, so she helped with all of that and for like if I needed anything (Myla)" "I kept saying to people that I wasn't feeling good and I felt like I couldn't bond with him, I didn't actually even hold him when he was born, so for them to not even notice that I didn't even want to hold the child I just felt like if they had noticed things straight away then some of the stuff… well nothing happened but like if my depression hadn't taken over then I would have been able to look after him. (Georgia)"

Theme 3.
Parenting advice

Sub-theme	Supporting Quote(s)
3.1. Lack of confidence	"So obviously being a first-time mum umm… I was… I had no clue really. I had a rough idea because obviously younger siblings and cousins and whatnot, but when its your own you can't just pass them back to the mum (Myla)"
	"even obviously when like I give birth umm my mum's going to be there because obviously I don't know how to deal with a new-born (Clara)"
3.2. Pre-existing support	"well it was good because there was all other mums and they would bring their kids, so they would sit and tell you about stories and childbirth experiences from everything to… yeah different techniques, safe sleeping, yeah… (Georgia)"
	" I know that, especially my support worker the support if I asked for support with my pregnancy and parenting and stuff like that, I know for a fact they would have done something about it and figured something out, put me through to people that would support me, or they would help themselves but right now its hard for me to say because I don't really need it (Clara)"
	"The first lady that I had before I was pregnant because she was teaching me about breastfeeding, routines and stuff like that and I just found it really helpful. Because some of the stuff that the woman I had first was teaching me I actually use (Kylie)"
3.3. Lack of parenting advice	"I think it would have been good to like, like, bit more… there's always lots of little things that I like want to know, like in the early days like how do I change a nappy properly… umm lots of things that I just needed a little bit of advice on… in the early days I think I just needed a bit more support with breast feeding, obviously we've got the hang of it and its like great but… there was just sort of like oh figure it out yourself (Paris)"
	"umm but there's not really many like groups or anything that like are still running nowadays. My mum used to have like groups that were there when she like when I was born there was like a lot of parenting groups and stuff like that for like each different stuff but there's, I don't really think there's much of that around really but I don't really look. (Geoffrey)"
3.4. Facilitators to support: Familiarity, flexibility and Motivation	"obviously if I could bring like [baby's mum] along as well, just if there's people there that she [partner] might know that its mainly for like care leavers, umm but she's not a care leaver so… (Geoffrey)"
	"if its like just going there for a meeting or to your own just to see how it is for like an hour or something like that I wouldn't mind that at all. (Clara)"
	"I just wanted to become the best mum I could be for my son, so yeah I think that's what it was that obviously pushed me to better myself was for him. (Myla)"
3.5. Barriers to support: responses from professionals	"they turned around to me when I was pregnant and went you don't need a parent assessment cause you're like perfectly capable. So that was a lot of weight off my shoulders… (Marcella)"
3.6. Practical barriers to support	"I'm often working or busy… Umm it depends on where it is because obviously if you haven't got a way to travel you know but if it was nearby then yeah… (Geoffrey)"
	"I think I was given too much help. I think because obviously I was a care leaver and I was so young as well, everyone sort of thought oh you need help because you're young and you've been in care, you need more help than other people, and it was a bit overwhelming because there was so much of it and I was like oh I'm actually really good (Paris)"

Appendix E: TDRP author guidelines for "Psychology of Sexual Orientation and Gender Diversity"

Full author guidelines can be found here: https://www.apa.org/pubs/journals/sgd#:~:text=Language%20guidelines,convey%20respect%20yet%20maintain%20precision.

Key Points:

Psychology of Sexual Orientation and Gender Diversity®, the official publication of APA Division 44 (Society for the Psychology of Sexual Orientation and Gender Diversity), is a scholarly journal dedicated to the dissemination of information in the field of sexual orientation and gender diversity. It is a primary outlet for research particularly as it impacts practice, education, public policy, and social action.

The journal is intended to be a forum for scholarly dialogue that explores the multifaceted aspects of sexual orientation and gender diversity. Its focus is on empirical research (both quantitative and qualitative), theoretical and conceptual articles, in-depth reviews of the research and literature, clinical case studies, book reviews, and letters to the editor.
Many issues include a major article or set of articles on a specific theme of importance to theory, research, and/or practice in the psychology of sexual orientation and gender diversity. In addition, articles address professional issues, methodological and theoretical issues, and comments on previous publications in the journal as well as such topics that advance the psychological knowledge of lesbian, gay, bisexual, and transgender individuals and their families, couples and marriage, health and health care, aging, work, and careers.
The journal includes all areas of psychological research, especially developmental, social, clinical, community, counseling, family, gender roles and gender nonconformity, lifespan and aging, cultural diversity including race and ethnicity, and international issues.

Submission Guidelines

Standard articles containing a maximum of 7,500 words of text (excluding tables and references). These will be the most typical articles.

Qualitative research

PSOGD welcomes a variety of methodologies in its submissions, including quantitative, qualitative, and mixed quantitative/qualitative methodologies.
All submissions are expected to maintain word limits specific to the type of manuscript (see manuscript types); offer replicable methodology; involve an *N* commensurate with the purpose of the research and which allows reasonable inference; and be written in a concise and focused manner.
In particular, extensive quotations from research participants are ill-advised, and should be limited to a few which are especially evocative of key themes. The theme descriptions should be the predominant vehicle for conveying participants' responses in qualitative research.

Abstract and keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page.

Formatting

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.

References
List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the references section.

General expectations of submissions
Given the wide variety of manuscript types that *PSOGD* accepts, all of these recommendations may not be suitable for all submissions, but are most true for standard and longer research articles.

- **Clear description/intro.** Make certain readers are quickly oriented to the purpose and focus of your manuscript. Make sure that the words used to describe your purpose and focus are the same throughout the manuscript.
- **Literature review to set context.** The literature review should situate your work both in the literature on sexual orientation and gender diversity, and in the behavioral sciences more generally. It should include enough to make a compelling argument for why your study was needed, and should lead directly to your purpose and hypotheses/research questions. Too little, too much, or tangential literature review are common errors. Ensure that your sources present credible scientific findings.
- **Clear methodology.** Could others replicate it? Are the chosen methodologies adequately justified? Provide citations to support your rationale for selecting your given methodology and analytical strategy. Are your data appropriate for the study questions and analyses (e.g., adequate sample size)?
- **Information about measures.** Basic reliability/validity of measures should be summarized and, when possible, these data should be obtained from samples consistent with your study sample. Provide reasons for choosing the specific measures. In addition, report the number of items, scoring procedures, the directionality of scores (e.g., higher scores on this measure indicate higher...), and how scores are computed. If measures were modified in your study, describe the rationale for the modification, the specific modification, and whether this modification was guided by any theory or previous study's methods, and how the measure "behaved" in your study (e.g., reliabilities, factor scores).
- **Sample.** Describe clearly sampling and recruitment procedures. Describe demographics and other characteristics. Have you used up-to-date terminology?
- **Statistics.** Are your statistical results presented in a clear and accessible manner? Does your statistical plan map to your hypotheses? When programs other than SPSS

or SAS are utilized to conduct the analyses, report the program (e.g., MPlus). Only identify quantitative results as significant when they meet the generally accepted minimum criterion of $p < .05$ (i.e., do not suggest that scores "trended toward significance" unless you did a trend analysis). Discuss missing data (i.e., amount and whether data were missing at random) and how missing data were addressed. Were the tables/charts/graphs etc. checked for accuracy?

- **APA Style.** Headings, references, citations, and tables/charts are frequently done incorrectly. Please check these carefully.
- **Copyediting.** Your submission should be free of spacing, formatting, grammatical, spelling, and other copyediting errors. Manuscripts judged to contain an unreasonable number of errors will be rejected without review.
- **Conclusions.** Are the conclusions that are drawn clearly supported by the data and congruent with the limitations of your methodology? It is a common mistake to reach beyond your data, especially when discussing implications for practice, advocacy, education, etc. However, not discussing the full implications of one's findings can be problematic as well. Strive for balance, but err on the side of caution. Attempt to relate the findings to conclusions reached in previous research but watch speculating beyond the data.
- **Limitations.** Do not minimize or avoid. Describe limitations directly, and when possible use your limitations as a springboard for recommendations for future research.

Appendix F: TDRP Recruitment Process

Quantitative Phase

In the quantitative phase, participants were recruited via social media and Email. Platforms used were WhatsApp, Facebook, Instagram, X and Reddit.

WhatsApp: The trainee contacted known individuals with connections to LGBTQ+ networks with information regarding the study including a poster and link to the information sheet.

Social media: The trainee created pages specifically aimed at recruiting study participants on Facebook, X, Instagram and Reddit. The trainee regularly posted on platforms (primarily Instagram and X) with information regarding the study aims, the study poster and link for the information sheet. Posts included relevant hashtags to support recruitment. The trainee reached out to local and national LGBTQ+ organisations to request for the study information to be shared with group members. For targeted recruitment, the trainee created a TGNC-specific poster, with specific requests for heterosexual TGNC individuals to take part. The trainee also contacted TGNC-specific networks with requests for the study to be shared amongst heterosexual members. Organisations included local Pride networks, University LGBTQ+ networks, TransActual UK, TransUnite, TransAction, Gendered Intelligence.

Email: The trainee used a university email address to contact local and national LGBTQ+ networks. The trainee provided information relating to the study including the study aims, the study poster and a link to the information sheet. As above, targeted recruitment included a TGNC-specific poster and contacting TGNC-specific organisations. Organisations contacted via email included university and university college LGBTQ+/TGNC networks and named representatives, GIRES, local LGBTQ+ networks with contact email addresses.

Qualitative Phase

Participants in the qualitative phase were identified from participants in the quantitative phase who indicated that they were interested in learning more about taking part in a qualitative interview by leaving an email address. The trainee used purposive sampling to specifically contact participants with different sexualities, gender identities, ages and ethnicities to support with hearing the experiences of individuals with different intersectional identities. Initially a small number of individuals were contacted via email (N=6). Individuals were provided with the information sheet and could request further information from the researcher prior to the interview.

Following initial interviews, additional individuals were contacted via purposive sampling to support with recruitment of individuals with differing characteristics. For example, initial contacts supported the recruitment of two transgender females. Purposive sampling therefore aimed to recruit participants with different gender identities, such as transgender males and non-binary individuals.

The trainee aimed to recruit participants with different ethnicities and contacted all participants who indicated global-majority ethnicity. Despite this, no individual who self-identified with a global-majority ethnicity responded to the recruitment email prior to the completion of interviews.

Appendix G: TDRP Quantitative measures

Demographic details

Question	Response options
How old are you?	Free text
What is your ethnic group?	**White** (1. English/Welsh/Scottish/Northern Irish/British 2. Irish 3. Gypsy or Irish Traveller 4. Any other White background, please describe) **Mixed/Multiple Ethnic groups** (5. White and Black Carribean 6. White and Black African 7. White and Asian 8. Any other mixed/multiple ethnic background, please describe) **Asian/Asian British** (9. Indian 10. Pakistani 11. Bangladeshi 12. Chinese 13. Any other Asian background, please describe) **Black/African/Carribean/Black British** (14. African 15. Carribean 16. Any other Black/African/Carribean background, please describe). **Other Ethnic group** (17. Arab 18. Any other ethnic group, please describe).
How would you describe your gender?	Male/Female/non-binary or other gender (free text)
Is your gender identity the same as the sex you were assigned at birth?	Yes/no/prefer not to say
What is your sexuality?	Lesbian/gay/bisexual/straight/prefer to self-identify (free text)
Do you consider yourself to have a disability?	Yes/no/prefer not to say
Have you been given a formal diagnosis of Autism Spectrum Condition?	Yes/no/prefer not to say
Have you been given a formal diagnosis of attention deficit hyperactivity disorder (ADHD)?	Yes/no/prefer not to say

Internalised stigma of LGBTQ+ identity

We are going to use the term LGBTQ+ for the rest of this questionnaire, but please think of whatever you feel is the best term for your sexuality or gender. With your gender and sexuality in mind, for each question please mark whether you strongly disagree (1), disagree (2), agree (3) or strongly agree (4) with the following statements:

		Strongly disagree	Disagree	Agree	Strongly agree
1.	Stereotypes about LGBTQ+ people apply to me.	1	2	3	4
2.	In general, I am able to live life the way I want to.	1	2	3	4
3.	Negative stereotypes about being LGBTQ+ keep me isolated from the 'normal' world.	1	2	3	4
4.	I feel out of place in the world because I am LGBTQ+.	1	2	3	4
5.	Being around people who are not LGBTQ+ makes me feel out of place or inadequate.	1	2	3	4
6.	People who are not LGBTQ+ could not possibly understand me.	1	2	3	4
7.	Nobody would be interested in getting close to me because I am LGBTQ+.	1	2	3	4
8.	I can't contribute anything to society because I am LGBTQ+.	1	2	3	4
9.	I can have a good, fulfilling life, despite being LGBTQ+.	1	2	3	4

Spontaneous Self-Affirmation Measures (SSAM)

Sometimes when we face difficulties, challenges or problems in our daily lives we can find ourselves thinking about ourselves. We are interested in how often you find yourself thinking about yourself when things start to bother you.

When I start to feel threatened or anxious by people or events I find myself…

	Completely agree						**Completely disagree**
… Thinking about my strengths.	1	2	3	4	5	6	7
…Thinking about my values.	1	2	3	4	5	6	7
…Thinking about my principles.	1	2	3	4	5	6	7
…Thinking about the people who are important to me.	1	2	3	4	5	6	7
…Thinking about what I stand for.	1	2	3	4	5	6	7
…Thinking about my family.	1	2	3	4	5	6	7
…Thinking about my friends.	1	2	3	4	5	6	7
…Thinking about the things I'm good at.	1	2	3	4	5	6	7
…Thinking about the things I like about myself.	1	2	3	4	5	6	7
…Thinking about the people I love.	1	2	3	4	5	6	7
…Thinking about the people I trust.	1	2	3	4	5	6	7
…Thinking about the people I believe in.	1	2	3	4	5	6	7
…Remembering things I've succeeded at.	1	2	3	4	5	6	7

Brief Core Schema Scale (BCSS)

This questionnaire lists beliefs that people can hold about themselves and other people. Please indicate whether you hold each belief. If you hold the belief then please indicate how strongly you hold it by selecting a number. Try to judge the beliefs on how you have generally, over time, viewed yourself and others. Do not spend too long on each belief. There are no right or wrong answers and the first response to each belief is often the most accurate.

Myself	**Does not apply to me**	**Believe it slightly**	**Believe it Moderately**	**Believe it very much**	**Believe it totally**
I am unloved	0	1	2	3	4
I am worthless	0	1	2	3	4
I am weak	0	1	2	3	4
I am vulnerable	0	1	2	3	4
I am bad	0	1	2	3	4
I am a failure	0	1	2	3	4
I am respected	0	1	2	3	4
I am valuable	0	1	2	3	4
I am talented	0	1	2	3	4
I am successful	0	1	2	3	4
I am good	0	1	2	3	4
I am interesting	0	1	2	3	4

Other People	**Does not apply to me**	**Believe it slightly**	**Believe it Moderately**	**Believe it very much**	**Believe it totally**
Other people are hostile	0	1	2	3	4
Other people are harsh	0	1	2	3	4
Other people are unforgiving	0	1	2	3	4
Other people are bad	0	1	2	3	4
Other people are devious	0	1	2	3	4
Other people are nasty	0	1	2	3	4
Other people are fair	0	1	2	3	4
Other people are good	0	1	2	3	4
Other people are trustworthy	0	1	2	3	4
Other people are accepting	0	1	2	3	4
Other people are supportive	0	1	2	3	4
Other people are truthful	0	1	2	3	4

Depression Anxiety Stress Scale

Read each statement and select a number 0, 1, 2, or 3 which indicates how much the statement applied to you *over the past week.* There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0: Did not apply to me at all
1: Applied to me some degree, or some of the time
2: Applied to me a considerable degree, or a good part of time
3: Applied to me very much, or most of the time

I found it hard to wind down	0	1	2	3
I was aware of dryness of my mouth	0	1	2	3
I couldn't seem to experience any positive feelings at all	0	1	2	3
I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
I found it difficult to work up the initiative to do things	0	1	2	3
I tended to over-react to situations	0	1	2	3
I experienced trembling (e.g. in the hands)	0	1	2	3
I felt that I was using a lot of nervous energy	0	1	2	3
I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
I felt that I had nothing to look forward to	0	1	2	3
I found myself getting agitated	0	1	2	3
I found it difficult to relax	0	1	2	3
I felt down-hearted and blue	0	1	2	3
I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
I felt I was close to panic	0	1	2	3
I was unable to become enthusiastic about anything	0	1	2	3
I felt I wasn't worth much as a person	0	1	2	3
I felt that I was rather touchy	0	1	2	3
I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
I felt scared without any good reason	0	1	2	3
I felt life was meaningless	0	1	2	3

Appendix H: TDRP Qualitative interview schedule

All interviewees were asked questions 1-9, with the prompts for each question being used if appropriate or required.

1. Can you tell me a bit about yourself?
    a. Who are the people that are important to you?
    b. Can you tell me about your transition journey?
    c. Are there any significant moments from your transition journey so far that come to mind?
2. Can you tell me about a time when being trans has impacted on a personal relationship?
    a. What happened?
    b. How did you respond?
    c. How did this impact you?
    d. Did this impact your perspective of being trans?
3. Can you tell me about a time when being trans has impacted on a professional relationship (e.g. with a work colleague/client/schoolteacher)?
    a. What happened?
    b. How did you respond?
    c. How did this impact you?
    d. Did this impact your perspective of being trans?
4. Can you tell me about a time when being trans has impacted on a relationship within a healthcare setting?
    a. What happened?
    b. How did you respond?
    c. How did this impact you?

    d. Did this impact your perspective of being trans?

5. If you have had a negative experience due to being trans, what did you do to cope with the experience?
    a. What did you find helpful?
    b. What did you find unhelpful?

I'd now like to ask you a bit more about how you understand yourself…

6. Can you tell me about the aspects of yourself that you value the most?
    a. What are your strengths and qualities?
    b. How easy is it to bring these to mind?
7. Can you tell me about a time when you have noticed and used your strengths and qualities?
    a. How did this impact you?
    b. Did this impact your perspective of being trans?
8. Can you tell me about a time when it has been more difficult to notice and use your strengths and qualities?
    a. What made it more difficult?
    b. How did this impact you?
9. Does the term self-compassion have any personal relevance to you?
    a. Can you tell me a bit more about this?

Appendix I: TDRP Ethical approval letter

MEDICAL SCIENCES INTERDIVISIONAL RESEARCH ETHICS COMMITTEE
Research Services, Boundary Brook House, Churchill Drive, Headington, Oxford, OX3 7GB
Tel: +44(0)1865 616575
ethics@medsci.ox.ac.uk

CONFIDENTIAL

Dr Matthew Knight & Eve Whitwell
Oxford Institute for Clinical Psychology Training
(OxICPTR)
Isis Education Centre
Warneford Hospital
Oxford

28 February 2023

Dear Dr Knight and Eve,

Research Ethics Approval - CUREC 1

Ethics Approval Reference: R84717/RE001

Study title: A mixed-methods study exploring internalized LGBTQ+ stigma, negative self-schema and intrinsic self-affirmation in LGBTQ+ adults

Short title: A study exploring how LGBTQ+ people think about being LGBTQ+, and whether being able to think positively about yourself helps this

The above application has been considered on behalf of the Medical Sciences Interdivisional Research Ethics Committee (MS IDREC) in accordance with the University's procedures for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and approval has been granted for a period of **1 year**, commencing on **28th February 2023.**

Amendments

Should there be any subsequent changes to the study, you should submit details to the MS IDREC for consideration and approval. Details of changes must be listed on an amendment form.

Yours Sincerely

DocuSigned by:
Leah Butts
9F14889D2BC549A...

Mrs Leah Butts
Research Ethics Administrator

for
Dr Helen Barnby-Porritt
Research Ethics Manager

Appendix J: TDRP Statement of Expert-by-experience involvement

Two focus groups were conducted with TGNC individuals with previous experience advising on SGM research for stakeholder development in the project and qualitative and quantitative design. The initial focus group involved three TGNC individuals and took place during the development of the research questions to consider the relevance of the proposed research questions for a TGNC population, information sheet and debrief form, and consideration of quantitative measures, including the adapted wording for the ISMI-9. EBEs supported with ensuring wording that was sensitive and appropriate throughout the quantitative phase. EBEs agreed the ISMI-9 scale would be appropriate for use with SGM populations with adapted wording, and felt the acronym "LGBTQ+" would be the most appropriate for use in the ISMI-9.

The second focus group took place with two TGNC individuals and considered the qualitative interview schedule. Initial aims for questions were presented to EBEs who supported with considering the relevance of questions to the research question and TGNC population, the type of wording used to ensure questions were sensitive and understandable for participants, and the flow of the interview schedule. EBE advice was combined with researcher knowledge and understanding of interview questions in line with IPA (Smith et al., 2009) to create the interview schedule below.

Appendix K: TDRP example section of initial note taking and emerging themes for IPA (step 2 and 3).

Initial notes are organised by descriptive (yellow), linguistic (blue) and conceptual (green) comments. Comment boxes are emerging themes based on initial note taking.



you don't know who I am and I can't tell you who I am. And you're really, you seem really nice and I would love to have a flirt right now, but like, or even just get to know you, but I can't because at what point do I then tell you, hey, actually I have this name and this is my gender, but my mom told me not to tell you. I can't do that because then she's gonna look bad... Umm so it, just felt, and then I just got incredibly drunk and just started waltzing around the whole place. It's just, low key telling other people like ohh, do you know about they them pronouns or look at the crystals in my bag and just like kind of dropping hints. Umm But it just... Yeah, it felt very.... Restrictive and and it just umm, because I had another encounter a little while ago where I was at my friend's engagement party and I overheard him, and he's a cis straight guy and overheard him talking about me in the third person and calling me "she", even though he's known for as long as I've been out, that I am very much not a she. And it was a similar feeling of like it's a, it's almost like an out of body experience. Because you have these people who supposedly care about you and love you, talking about... someone else, because if someone calls me she or if my mum insists that I'm her daughter and I have this other name... to me that says she doesn't see me. And she doesn't actually know who she's talking to and she's refusing to know me. She asked this idea and she's clinging onto it. And that is really, really devastating because... how can you say you love someone if you're refusing to see them and you're you're refusing to know them, like they they love an idea, but they don't actually love me. Umm... Yeah, and that's, not a fun thing to deal with. Umm especially when it comes from parents or people who are supposed to be your friends.

I: Yeah that makes sense, thank you. And do any of those experiences, does that have an impact on your perspective of being trans?

C: Umm... I think, yeah umm... Funnily enough umm all of these experiences kind of just... make me more certain that I am who say I am umm and last year I spent seven months working in a family hotel in Spain on Lanzarote. Umm and I was like the only openly queer person there, and it was like this international team of people and like some of them were amazing with the pronouns and everything and then some of them were just lost causes. But it was like everyone around me was straight and cis, and is it was a weird, it was a great experience, but it was a really weird. I kind of came out of it being like, OK, so I'm definitely not cis because, if this was a choice or a "phase" then spending all this time around only straight and cis people would have made me want to go back. But I, like the more time I spend with them, the more I am certain that I am who I say I am. And the same like with my

Not being able to make genuine connections with people not knowing their true selves
Talking to the person – reenacting what could not happen
Having an inauthentic relationship until coming out
Not able to come out to protect parent's image
Not finishing sentence- avoiding expressing the feeling
Alcohol as way to cope, dampening feelings?
Feeling responsibility to educate people about trans things.
Being yourself restricted by others
Change of direction, avoidance of difficult feelings
Cis/straight as other, not understanding
Experience of being misgendered
Sense of dissociation, trauma of being misgendered
Can't truly love someone if they don't accept true self
Gender as being who you are
Underlying message of non-acceptance = I don't love you
Choosing not to get to know the real person
"clinging" mirrors vocab from earlier- who was clinging first?
Devastating – sentiment being revealed
Others not loving true self
Asked as a question – other's position doesn't make sense, confusion.
Sense of betrayal from others

Others' rejection increasing certainty in identity
Different interpretation of question – justifying gender to self?
Queer as being different
Not expecting others to get pronouns right, basic human experience as "amazing"
Gender acceptance as a "cause" – fighting for own rights?
First experience as being "other"
Being trans not a choice, wanting to "fit in" with others

Whitwell Eve (RNU) Oxford Health
Hiding true self inhibiting relationships
@mention or reply

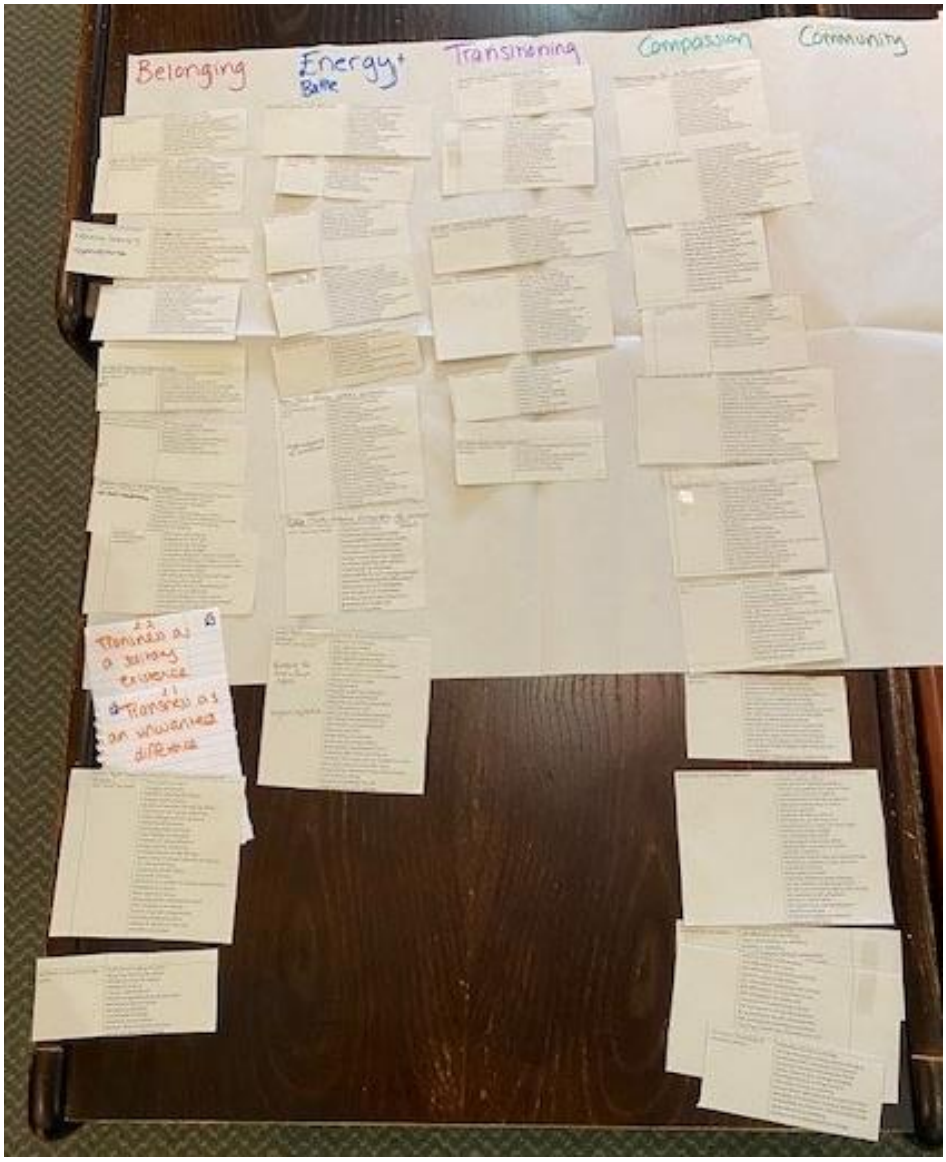
Whitwell Eve (RNU) Oxford Health
Others feelings as more important
@mention or reply

Whitwell Eve (RNU) Oxford Health
Misgendering as traumatic
@mention or reply

Whitwell Eve (RNU) Oxford Health
Non-acceptance as unloved
@mention or reply

Whitwell Eve (RNU) Oxford Health
Betrayal of true self as devastating

Appendix L: Image depicting the process of grouping between-participant higher-order themes to create superordinate and sub-themes



Appendix M: TDRP Reflexivity statement

Data collection and analysis was conducted by EW, a white British heterosexual cisgender female trainee clinical psychologist. EW has 3-years clinical experience working with TGNC young people prior to commencing the doctorate in clinical psychology. EW engaged in a bracketing interview prior to commencing data collection for the quantitative phase of the study with a trainee clinical psychologist to consider potential biases that may impact on data collection and analysis.

Throughout the data collection and analysis process EW received regular supervision from MK, a Consultant Clinical Psychologist with previous clinical and research experience with stigmatised groups, and significant experience conducting and supervising IPA research projects. Supervision included ensuring the interview schedule was adhered to throughout interviews, consideration of the use of prompt questions, identification of emerging themes from the dataset, ensuring an audit trail of the dataset and grouping of themes to convey a coherent narrative representative of participants' experiences.

A closing bracket interview was undertaken with a trainee clinical psychologist prior to write-up to consider any researcher biases or narratives that had not been considered during collation of the superordinate themes.

Appendix N: Table outlining participants whose narratives endorsed each sub-theme

Superordinate and Sub-Theme	Endorsed by							
	Alex	Ava	Ben	Bob	Cowboy	Emma	Quinn	Zoe
Superordinate theme 1: Transition unveiling self-affirmation								
1.1 Pre-transition distress	X	X		X	X	X		X
1.2 Authenticity revealing self-affirmation	X	X	X	X	X	X	X	X
Superordinate theme 2: Belonging with society								
2.1 Not fitting into societal categories	X	X	X	X	X	X	X	X
2.2 Representation and education			X	X	X	X	X	X
2.3 Finding ways to belong	X		X	X	X	X	X	X
Superordinate Theme 3: The internal battery: energy depleting and re-charging								
3.1 Vigilance as protection from vulnerability			X	X	X	X	X	X
3.2 Battling one's human rights	X	X	X		X		X	X
3.3 Self-compassion re-charging the battery	X	X	X	X	X	X	X	

Appendix O: TDRP Additional supporting quotes

Theme/Sub-Theme	Additional supporting quotes
Superordinate Theme 1: Transition unveiling self-affirmation	
1.1 Pre-transition distress	"As soon as puberty hit, I just stopped because I did not wanna exist in my body, I did not wanna be connected to my body. I just wanted to be up here and just live in my head" (Cowboy)
1.2 Authenticity revealing self-affirmation	"I sat down with [my wife] and said look… I'm transgender. And it was a huge weight off my shoulder to actually, you know to accept it, to embrace it" (Zoe) "All this like not being seen and not being seen as valid or not being seen as real, like especially before coming out umm… Really really impacted how I saw myself and and my mental health and umm my self-image" (Cowboy) "The one thing I have noticed about myself is that I'm a lot happier now there are sometimes when I I'm just sitting there just thinking and I feel that sense of happiness coming through and that's really, really good" (Emma)
Superordinate theme 2: Belonging with society	
2.1 Not fitting into societal categories	"Because I feel very uncomfortable going into the gents and I'm sure I'd feel even more uncomfortable going into women's bathrooms." (Ava) "I'd actually spoken to my dad about my feelings back as a teenager, and my dad, saying that wasn't normal" (Emma) "There was very much girls to the right boys to the left, or girls do this boys do that. And the three of us were just stood there like what… What are we doing? Like I know you're pretending we are this or that category, but we're not." (Cowboy)
2.2 Representation and Education	"Media coverage, I see it actually is as umm… err part of awareness, because they are talking about me. I'm not pushing a particular agenda, but saying that you know I am, I am transgender. Umm, starts off from when I was four… and… in other words, I'm human being I just happen to be transgender." (Zoe) "You also feel sort of obliged to educate someone because they might be able to help the next person maybe a bit better. Its not really my job…" (Ben)
2.3 Finding ways to belong.	"But we had a lovely chat and, we just went on our way. And it was just two women talking, it was lovely" (Zoe) "You've got to tap into your community cause… my partner is super supportive and lovely, but he's cisgender and he's never questioned whether he's a man. He's never gonna totally understand it" (Ben)

	"Even just something like heartstopper or… Any queer romance, queer stories is such a beautiful like, yeah, it just helps process my own emotions when I watch someone else who's going through the same thing, umm… And that does, like it makes me feel seen and it makes me feel understood and I love it." (Cowboy)
Superordinate Theme 3: The internal battery: Energy depleting and Re-charging	
3.1 Vigilance as protection from vulnerability.	"It just made me worried about actually encountering somebody who is, who will actually, you know… have a go at me for who I am… and that did just, it did it just shake me for a while, made me worried about, and I do worry sometimes I'm gonna bump into somebody who's actually gonna be, make a transphobic remark at me and that, and how I will cope with that because I think I will… I know that I would find it very difficult initially…" (Emma) "It's mainly in the media and like on social media that I see negative stuff about it. It's not… in real life." (Bob)
3.2 Battling for basic human rights.	"When one transitions err, all ones, if you like male privileges, they get checked in at the door. They go. And what we're trying to do is to claw our way back, umm, at least to get the same as women, but we want to work with women to call them up to the same level as the man." (Zoe) "It was very stressful, but now it's it's pretty, it's not too bad now because I've been doing, I've been on hormones for so long it's just sort of ticking over. And every time I need a blood test it's a bit of a battle" (Ben)
3.3 Self-kindness re-charging the battery.	"The one thing that I do very often is if I… sort of, I'm just feeling so, like stressed about constantly having to do the right thing, and being like under my own judgment is just sort of going "give yourself a break." [laughs], like… How would I feel if somebody else was doing these things? What I say "that's understandable like… go have a nap, you'll be alright" sort of thing." (Quinn). "I think yes, it is important to be compassionate because if if you look after yourself and you look after the self-value, then you grow and then you can look after other people as well." (Emma) I think being trans and having self-compassion for me really goes hand in hand, because it is such a unknown like tapping in, yeah, try trying to find a path that you don't know where it leads and and there's something really exciting about it. (Cowboy)