

**We Love Them With All Our Heart:
The Lived Experience of Fostering a Child with ADHD
Where the Placement Breaks Down**

A Thesis

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Andrew Holman Field, candidate for the degree of Master of Social Work, has presented a thesis titled, ***We Love Them With All Our Heart: The Lived Experience of Fostering a Child with ADHD Where the Placement Breaks Down***, in an oral examination held on December 19, 2016. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

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Abstract

This study used an interpretative phenomenological analysis methodology to understand the lived experience of foster families providing care for children with a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) where the foster placement broke down. The data was collected through a semi-standardized interview process with foster parents representing five foster families. The essence was found to be a deep and enduring love between the families and their foster children. Four key themes emerged to express the foster families' lived experience. *Behaviours* was the first theme representing the ever-present, persistent, overwhelming, and ultimately defeating behaviours participants experienced. The second theme was *Anguish* representing the intensity of emotion experienced by all participants in the presence of the behaviours. The third theme, *Exhaustion and Failure*, was a temporal theme representing the way all placements seemed to "fade into breakdown." The breakdowns did not occur in response to culminating events but seemed to collapse with a final admission of failure. Finally, the theme *Connection* represents an enduring bond that existed between the foster children and parents in every family. An average of eight years after the breakdowns occurred, the participants were all having regular, positive, supportive, and typically parental contact with every child.

This thesis is informed by an understanding of children's rights that includes the right of and, it is contended, a legal obligation to ensure the successful care of all children, including children in care, to adequate health care designed to address mental health issues and, in particular, ADHD. The right of children to adequate health care

includes the right to receive all necessary means to ensure their placement as “wards of the state” enhances their overall well-being and protects their inherent dignity.

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Dedication

I would first like to dedicate this work, with great respect, to all of the children and youth in care in this province of Saskatchewan and in Canada. Your courage in the face of so many obstacles has given me the inspiration to undertake this thesis.

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Table of Contents

<i>Supervisory and Examining Committee</i>	<i>Error! Bookmark not defined.</i>
<i>Abstract</i>	<i>i</i>
<i>Acknowledgements</i>	<i>iii</i>
<i>Dedication</i>	<i>iv</i>
<i>Table of Contents</i>	<i>v</i>
<i>Introduction</i>	<i>1</i>
<i>Literature Review</i>	<i>6</i>
Introduction	6
Child Welfare in Canada	6
A brief history.	6
Children in out-of-home care.	9
Foster care outcomes.	10
Placement stability as a contributor to improved foster care outcomes.	11
Placement breakdown.	11
ADHD	166
Introduction.	166
History.	16
Diagnosis.	188
ADHD can lead to potentially serious consequences.	199
Prevalence.	222
Etiology.	244
Treatment.	33
Treatment barriers.	333
ADHD and risk for child maltreatment.	355
ADHD, maltreatment, and externalizing behaviours.	377
Summary	388
<i>Conceptual Framework</i>	<i>40</i>
Research Question	40
Conceptual Framework	40
International Human Rights Treaties	41
The Universal Declaration of Human Rights.	41

The Convention on the Rights of the Child.	42
The Convention on the Rights of Persons with Disabilities 2006.	433
United Nations Resolution on Guidelines for the Alternative Care of Children 2009.	455
The Canadian Human Rights Framework.....	477
Canadian Charter of Rights and Freedoms.	477
Canadian common law.	477
Social Work Ethics.....	499
Summary.....	50
<i>Methodology.....</i>	<i>51</i>
Introduction.....	51
Research Paradigm.....	51
The research task: intention, meaning and understanding.	52
Research Question.....	52
Interpretive Constructionist Theory.....	52
Reflexivity and the Role of the Researcher.....	53
Interpretative Phenomenological Analysis.....	54
Participants.....	566
Data Collection.....	58
Data Analysis.....	60
Ethical Considerations.....	62
Credibility and Trustworthiness.....	64
<i>Findings.....</i>	<i>666</i>
The Essence: We Love Them With All Our Heart.....	666
Four Themes Emerging from the Lived Experiences.....	677
Figure 1: Four Themes Emerging from the Lived Experiences.....	688
Figure 2: Lived Experiences / Love Them With All Our Heart Themes and Sub-themes.....	699
Behaviours.....	699
Figure 3: Theme 1: Behaviours.....	70
Similar for all participants.	70
Overwhelming.....	72
Intensified upon adolescence.	73
Coping with stress.....	74

Defeat	755
Loss and relief	788
Anguish	799
Figure 4: Theme 2: Anguish	799
Powerlessness.....	799
Frustration with child welfare agency support.....	81
Isolation.....	84
Family.....	877
Exhaustion and Failure	899
Figure 5: Theme 3: Exhaustion and Failure.....	90
Confusion.....	90
Lack of emotional intensity.....	90
Time.....	92
Grief.....	92
Connection	95
Figure 6: Theme 4: Connection.....	95
Continue to have a relationship.....	95
My child.....	96
Summary	98
Discussion	99
Discussion and Implications of the Findings	999
The behaviours.....	999
Gradual and complex breakdown.....	102
Support needs.....	103
The potential of enduring attachment.....	1077
ADHD Literature and Parent Stress	1099
ADHD and Placement Breakdown.....	110
Social Work and the ADHD Evidence.....	11111
Social Work and Neuroscience	11616
The Human Rights Context	1188
Conclusion.....	12121
Limitations.....	12222
Appendix A.....	<i>Error! Bookmark not defined.23</i>

Participant Consent Form.....	12323
<i>Appendix B.....</i>	<i>1288</i>
Questions	1288
<i>References</i>	<i>1299</i>

Introduction

This qualitative study explores the lived experience of foster parents who cared for children with Attention Deficit Hyperactivity Disorder (ADHD) where the child's placement with them broke down. The intent of the study is to (1) understand the participants' (foster parents) lived experience of the ADHD symptoms of children in their home, (2) examine how this meaning may have contributed to the breakdown of the foster placement, and (3) learn what these foster families believe would have prevented a placement breakdown.

ADHD is a persistent pattern of inattention, hyperactivity, and/or impulsivity that is more frequent and severe than is typically observed in people at a comparable level of development and which causes impairment (American Psychiatric Association, 2013).

Children coping with ADHD are at risk for significantly diminished life outcomes.

Throughout childhood and adolescence ADHD increases the risk for greater difficulty regulating emotion, maintaining focus, controlling impulsivity, and frequently displaying poor coping and decision-making skills when compared to their peers (Barkley, 2006; Chaplin & Modesto-Lowe, 2013). There is evidence that these difficulties lead to poor outcomes in school programs (DuPaul & Stoner, 2014), difficulty developing and maintaining relationships (Mikami & Normand, 2015), higher rates of delinquency (Walther et al., 2012), risky sexual behaviour (Huggins, Rooney, & Chronis-Tuscano, 2015), alcohol consumption and drug misuse (Brooke et al., 2012; Carpentier, 2012). In adult life ADHD places individuals at risk for achievements significantly below their potential in areas of health, work, finances, relationships, and pro-social

behaviour (Knorth, Harder, Zandberg, & Kendrick, 2008a; Litner & Mann-Feder, 2009; Oosterman, Schuengel, Wim Slot, Bullens, & Doreleijers, 2007; Trout et al., 2010).

A 2014 epidemiological meta-analysis of 135 ADHD prevalence studies placed the overall prevalence of ADHD at just over 5% (Polanczyk, Willcutt, Salum, Kieling, & Rohde, 2014). In a report of the major findings of the *Canadian Incidence Study of Reported Child Abuse and Neglect* (CIS), child welfare workers reported that a diagnosis of ADHD was present in 11% of the sample (Public Health Agency of Canada, 2010). This is just over twice the prevalence in the general population indicating that ADHD appears to be more prevalent in children who are in contact with child welfare services.

Treatment strategies for ADHD have been developing since the 1930s along both medical and psychosocial dimensions with general agreement that a combination of the two provides the greatest efficacy (Canadian Attention Deficit Disorder Resource Alliance, 2011; Klein, Damiani-Taraba, Koster, Campbell, & Scholz, 2015). Psychosocial dimensions include supportive strategies for parenting which not only affect treatment outcomes (Heath, Curtis, Fan, & McPherson, 2015; Yousefia, Far, & Abdollahian, 2011) but may also affect the intergenerational transfer of this disorder (Tung, Brammer, Li, & Lee, 2015). Through effective treatment most children coping with ADHD can access the opportunities enjoyed by their peers (Kapur, Srinath, Oommen, & Rejani, 2012; Swanson et al., 2002).

Children entering the child welfare system with ADHD face a double jeopardy. Not only are they subject to the trauma and disruption of leaving their family home and being in care (Pecora et al., 2006), but there are implications for the treatment of ADHD. If their [foster] parent milieu does not include support and treatment strategies for

ADHD, overall treatment success is likely to be reduced (Tancred & Greeff, 2015). Poorer treatment outcomes place the child at risk for poor life outcomes as described earlier. Additionally, the child's foster placement may be placed at risk since, when symptoms of a child's ADHD are not treated successfully, behaviours stressful to others often result (Biederman et al., 2012). Children living in out-of-home care who are deficient in emotion self-regulation, a common symptom of ADHD (Chartier, Connor, Kaplan, & Preen, 2010; Dowson & Blackwell, 2010; King & Waschbusch, 2010), are at higher risk for placement breakdown (Brown & Bednar, 2006; Brown, Bednar, & Sigvaldason, 2007). A two-year-old throwing a tantrum is unremarkable. A teenager throwing a tantrum is seen as a threat and the continuity of care may be placed in jeopardy. Insufficient support and education for foster parents who are engaging children with severe behaviours, particularly those associated with emotion dysregulation, have been shown to elevate the risk for a placement breakdown (Khoo & Skoog, 2014; Modesto-Lowe, Danforth, & Brooks, 2008).

The continuity of out-of-home care and the prevention of foster placement breakdown is an issue critical to successful outcomes for children who are in care (Oosterman et al., 2007; Riggs & Willsmore, 2012; Rostill-Brookes, Larkin, Toms, & Churchman, 2011; Unrau, Seita, & Putney, 2008; van Santen, 2015). Studies have also demonstrated that when a foster placement breakdown occurs, the risk of future breakdowns increases (Rostill-Brookes et al., 2011).

By exploring the lived experience of foster parents who parent children with ADHD and the meaning they attribute to ADHD symptoms, some insight into the contribution of the symptoms to foster home placement breakdown has been achieved. A

qualitative approach using an interpretative phenomenological analysis (IPA) method was used to gain an awareness of this particular fostering experience. The themes emerging from this study suggest protective strategies to help social workers better support children in their care who are coping with ADHD and their caregivers.

The rights of the child provide a context for the examination undertaken in this thesis. Children with ADHD who are living within the care of the state are afforded human rights protections under no less than three United Nations agreements: the *UN Convention on the Rights of the Child*, the *Convention on the Rights of Persons with Disabilities*, and the *2009 Guidelines for the Alternative Care of Children*. Indigenous children are also afforded protections under the *Declaration on the Rights of Indigenous Peoples*. ADHD has been recognized as a disability by the Canadian Tax Court (*Collins v. Canada*, 1998), Canadian Human Rights Tribunals (*Gaisiner v. Method Integration Inc.*, 2014), and Canadian Queen's Bench, Family Law Court (*P.M v. T.M.*, 2010). It has been listed in the *Diagnostic and Statistical Manual of Mental Health Disorders* since 1980 (American Psychiatric Association, 1980). A child's right to be free from discrimination and an assurance of equality are also found in provincial and territorial human rights legislation, the *Canadian Charter of Rights and Freedoms*, and international human rights laws such as the *UN Convention on the Rights of the Child* (Johnson, 2008; Watkinson, 2006).

Equality of outcomes recognizes that a person with a disability may require special considerations or special measures to mitigate the effects of their disability. Special measures may include additional supports such as medical services, tutorial/educational services, adjustments to rules and regulations, physical design of

buildings, additional training sessions, and alternative methods of evaluation. The old adage that “in order to be fair we have to treat everyone the same” no longer applies since treating everyone the same may result in unequal outcomes (Watkinson, 2006). Ensuring that these types of consideration or special measures exist brings with it a duty to provide all such measures so that the individual can flourish. In the case of children, the duty rests with the parents and government agencies, including child protection, education, and health (Johnson, 2008).

In cases of children in care, the fiduciary duty rests with the government and its agents, (including social workers, medical personnel) to adequately address the child’s treatment and support for the foster family who are standing in the place of the government (*Eldridge v. British Columbia (Attorney General)*, 1997). This raises the question: What are the implications for those with a “fiduciary duty to act as a ‘prudent parent’ to ensure that the rights and entitlements of children in his or her care are protected” (Bernstein, 2009)? What ethical and legal responsibility do social workers and mental health professionals have to ensure their competence extends to the nosology of ADHD, an issue affecting so many children in care? This discussion forms much of the context for this thesis.

Literature Review

Introduction

This qualitative study explores the lived experience of foster parents who cared for children with Attention Deficit Hyperactivity Disorder (ADHD) where the child's placement with them broke down. The scope of the study spans both child welfare in Canada and the ADHD nosology, and the literature important to each area is reviewed in this chapter.

Child Welfare in Canada

A brief history. Canadian child welfare policy has its roots in philanthropic responses to the plight of children in Central Canada who were suffering from the social consequences of industrialization in the 19th century (Jones & Rutman, 1981). A discussion of children in care in the Canadian Prairie provinces, however, must be seen in the historical context of Indigenous peoples and colonization (Barker, Alfred, & Kerr, 2014; Blackstock & Trocmé, 2005). One of the most enduring historical intersections between Indigenous and colonizing Europeans involves Indigenous children (Bennett, Blackstock, & de la Ronde, 2005). According to the 1996 Royal Commission on Aboriginal Peoples, the origins of child welfare for Canadian Indigenous peoples had assimilative versus protective goals (Canada, 1996). The residential schools' era in Canada is seen by many as the most appalling in Canadian history, an instrument for an attempted cultural genocide (Neeganagwedgin, 2014; Truth & Reconciliation Commission of Canada, 2015). This history is seen to have had devastating effects on Indigenous families, culture, and society, the reverberation of which continues to this day (Aboriginal Healing Foundation, 2006; Truth & Reconciliation Commission of Canada,

2015). Out of the residential schools' era developed Canadian child welfare policy, and by the 1960s child welfare agencies had replaced residential schools (Armitage, 1995; Bennett et al., 2005). Strong arguments are made that the move away from residential schools did not change this historical pattern of removing children from their homes but served to perpetuate the assimilative system (Sinha & Kozlowski, 2013). At the end of the 1960s, 30 to 40% of children in care in Canada were Indigenous and more than 11,000 Indigenous children with Indian status were adopted and placed outside of their cultural communities (Maurice, 2003; Saskatchewan Child Welfare Review Panel Report, 2010). A 2005 study by Blackstock and Trocmé reveals that the number of Indigenous children in care has continued at more than seven times the rate one would expect based on population size. This amounts to 27,000 Indigenous children (Blackstock & Trocmé, 2005) or 40% of the children in care in Canada.

In Canada today “all Canadian provinces with large Aboriginal populations have higher than expected percentages of Aboriginal families in their child welfare systems, and even higher percentages of Aboriginal children in care” (Blackstock, 2011; Saskatchewan Child Welfare Review Panel Report, 2010). More recently, the Truth and Reconciliation Commission reported that 3.6% of Indigenous children were in foster care compared to 0.3% of non- Indigenous children. The Commission said, “Canada’s child-welfare system has simply continued the assimilation that the residential school system started” (Truth & Reconciliation Commission of Canada, 2015, p. 146).

The Indigenous peoples historical experience is germane to my thesis for several important reasons. First, this history in many ways continues to define the relationships between Indigenous peoples and current child welfare practice (Blackstock, 2011;

Sookraj, Hutchinson, Evans, & Murphy, 2012; Truth & Reconciliation Commission of Canada, 2015). Second, there remains a sense of skepticism and mistrust of Canadian institutions in general and child welfare agencies in particular within Indigenous communities (Barker et al., 2014; Blackstock, 2015; Saskatchewan Child Welfare Review Panel Report, 2010; Woons, 2008). Third, my research exists within this child welfare context. I believe the acknowledgement of this historical context is important from a social justice perspective. However, it is also important since ADHD, as will be seen, continues to be viewed against a backdrop of controversy. Treatment options for ADHD occur throughout childhood and adolescence and require the support of families. In almost all cases where children are in out-of-home care their natural families continue as a primary source of influence. Attainment of the support required for the treatment of ADHD becomes more complex when both a natural family and a foster family are involved. Added to this is the Canadian historical context itself that mitigates against the development of trust and co-parenting between an Indigenous family and any local child welfare authority (Johnson, 2014).

A description of this history is also important to my thesis since, increasingly, discoveries in neuroscience have been able to provide new knowledge that may be helpful to support children who have experienced the effects of trauma, including the effects of intergenerational trauma (Bombay, Matheson, & Anisman, 2014; Kirmayer, Gone, & Moses, 2014). The contribution of the relatively new fields of epigenetics and neuroimaging and the science of neurobiology may help to explain how trauma can become behaviour (Kirmayer et al., 2014) and how children displaying these behaviours can be supported (Klein et al., 2015).

Children in out-of-home care. There are approximately 67,000 children each year in Canada who, as a result of maltreatment, experience out-of-home care (Cheung, Goodman, Leckie, & Jenkins, 2011). The 2011 Canadian national household survey conducted by Statistics Canada revealed that there were 47,885 children living in foster care in Canada (Statistics Canada, 2011). These numbers show that approximately two thirds of children in out-of-home care rely on foster families for their care. Children living in out-of-home care have histories that include experience with physical abuse, neglect, sexual abuse, exposure to intimate partner violence, and being the victim of violence (Stewart, Leschied, den Dunnen, Zalmanowitz, & Baiden, 2013). This history is seen to place children at a high risk for developing mental health problems (Raviv, Taussig, Culhane, & Garrido, 2010). The 2008 *Canadian Incidence Study of Reported Child Abuse and Neglect* (Public Health Agency of Canada, 2010) reports that 59.4% of males and 49.1% of females on child protection caseloads were functionally impaired as a result of mental health concerns as reported by their child welfare worker (Afifi et al., 2015; Fallon, Trocmé, & MacLaurin, 2011).

All Canadian provinces with large Indigenous populations have disproportionately high percentages of Indigenous families within their child welfare systems, and even higher percentages of Indigenous children in out-of-home care (Saskatchewan Child Welfare Review Panel Report, 2010). In a major Canadian study of child maltreatment investigations involving analysis of 85,440 substantiated investigations, Indigenous children were involved four times more often than non-Indigenous children (Public Health Agency of Canada, 2010). Forty-six percent of children involved in the child maltreatment investigations had at least one child

functioning concern. A diagnosis of ADHD was reported by child welfare workers in 11% of the sample of 85,440 substantiated child maltreatment investigations (Public Health Agency of Canada, 2010, p. 39). This rate is twice that in the general population.

Foster care outcomes. Foster families, as mentioned previously, provide just over two thirds of the out-of-home care response in Canada for children who are unable to live with their biological parents (Blythe, Wilkes, & Halcomb, 2014). Research on the success of foster parenting however, when measured by outcomes for children exiting from care, is mixed. There are two recent large-scale studies in the United States reviewing foster care outcomes. The *Midwest Evaluation of the Adult Functioning of Former Foster Youth* was undertaken at the University of Chicago (Courtney, et al., 2011) and the second, the *Northwest Foster Care Alumni Study*, was sponsored by Casey Family Programs (Pecora et al., 2010). Both studies were concerned with how foster-care youth are faring as adults and the key factors or program components that are linked to better outcomes (Pecora et al., 2010). Common themes from these studies include poorer outcomes than peers raised in their family home in areas of education (Viadero, 2010), involvement in criminal behaviour (Hook & Courtney, 2013), homelessness (Dworsky, Napolitano, & Courtney, 2013), mental health and addictions (Thompson & Hasin, 2012), lower rates of employment (Naccarato, Brophy, & Courtney, 2010), and early parenthood (Dworsky & Courtney, 2010).

There are some who seriously question the continued use of foster care as a response to child maltreatment given the well-documented poor outcomes (Ainsworth & Hansen, 2014). Ainsworth and Hansen write:

What continues to surprise us is the pride of place foster care occupies in the child welfare sector. Any other intervention would, in the light of substantial evidence of ineffectiveness, and in some instances of harmfulness, have been radically altered, if not completely discarded (p. 90).

Placement stability as a contributor to improved foster care outcomes. The issue of placement stability and permanence has been widely studied and is linked to more positive outcomes for foster care (Ainsworth & Hansen, 2014; Schofield, 2013; Stott, 2012; Tregeagle & Hamill, 2011). Pilkay and Lee see the relationship between permanence and improved outcomes for foster care being tied back to what we know about the development of human attachment (2015). Attachment theory highlights the importance of permanence as a requirement for healthy psychological development (Bowlby, 1969, 1988). A child develops a template for relationships during the first several years of life and this will be used to guide the maintenance and establishment of all future relationships (Lefmann & Combs-Orme, 2013; van der Horst, 2011). Not only are these early years seen to be important for the development of relational skills but in the development of many other key templates for perceiving and relating to the world (Perry, 2009). Many researchers in the fields of neurology and epigenetics are now revealing the impacts of environment in the early stages of childhood when brain systems are rapidly developing. This work is providing insight into the neurobiology of human development (Perry, 2009; Petronis & Mill, 2011) and holds promise to yield novel therapeutic approaches (Erickson, Creswell, Verstynen, & Gianaros, 2014; May, 2014).

Placement breakdown. If placement permanency can be seen as an important variable contributing to successful outcomes for children living in foster care, then it

follows that it is important to avoid placement breakdowns. Placement changes are described in the literature as causing children emotional trauma, reducing the capacity for forming relationships, and exacerbating mental health disorders (Tregeagle & Hamill, 2011). Issues affecting the breakdown of permanency also occupy an important place in the child welfare literature. Foster placement breakdown is a focus for this thesis and this literature will be reviewed.

Incidence of foster placement disruption and breakdown. The incidence of placement breakdowns and disruption is alarmingly high. Pecora et al. report that 77% of children in foster care in one California study had more than three changes in placement over the course of their care in foster programs (2010). In a South Australian study, 80% of children experienced seven or more placements over a period of 10 years (Tregeagle & Hamill, 2011). An Ontario study showed that 49.4% of all placements into foster care ended with the child moving to another out-of-home placement (Perry, Daly, & Kotler, 2012). A Quebec study indicated 44% of all children placed into foster care moved two or more times to other foster homes (Esposito et al., 2014). A review and meta-analysis of literature describing placement disruptions in foster care for a population of 20,650 children in the United Kingdom, Ireland, Australia, Canada, and the USA was conducted by Oosterman et al. (2007). The review found that between 20 and 50% of long-term foster-care placements resulted in breakdowns.

Risk factors contributing to foster placement disruptions and breakdowns. In a child and family service review of placement stability management conducted in 48 states in the United States, Blakey et al. identified four broad categories for placement breakdown (2012). These were system/policy-related factors, foster family-related

factors, biological family-related factors, and child-related factors. Examples of system-related factors included using emergency placements while arranging for a longer-term placement, overcrowded homes, moving children to assemble sibling groups, or moving children into kinship placements. Foster family-related factors included such things as a death or illness in the foster family, a mismatch between parenting style and child needs, a lack of experience concerning a child with particular needs, and finally discouragement with their role as foster parents. Biological family-related issues included conflict with biological families and substance abuse causing problems during visits. Child-related factors were defined as “disruptions associated with certain characteristics of the child and/or result from something the child does or does not do while in foster care” (Blakey et al., 2012, p. 371). This last category is the one that directly pertains to my thesis. The majority of the child-related disruptions identified by Blakey et al. have been identified to include severe behavioural and emotional disturbance. This is particularly the case with children displaying externalized behaviours which include aggression, disruptive or destructive behavior, and oppositional behaviours. The DSM-5 describes oppositional behaviours as repeated angry, defiant, and disobedient behaviour with authority figures (American Psychiatric Association, 2013). This is of interest since, as we will see later in this review, many children with ADHD have comorbid disorders displaying externalizing and disruptive behaviours, including oppositional defiant disorder and difficulty regulating emotion (Corbisiero et al., 2013; Kuja-Halkola et al., 2015; Surman et al., 2013).

Brown and Bednar asked 63 foster parents from 50 families, “What would make them end a placement?” (2006). Reasons given were similar to the findings of Blakey et

al. (2012) and included complex health needs of the foster child, problems dealing with the foster agency, several failed attempts to make a placement work, if their own health or circumstances changed, and if they failed to get the support they needed (Brown & Bednar, 2006, p. 1497). Specific mention was made in this study of the severity of violence displayed by the child and the authors concluded that this externalizing behaviour had the potential to not only end a placement but to also cause a family to stop fostering altogether (Brown & Bednar, 2006, p. 1509). The authors pointed out a need for more research in this area and particularly into any moderating strategies available through external supports. Once again emotion self-regulation issues appear as risk factors in this literature.

A New Mexico study of predictors of placement instability revealed the category “emotionally disturbed” was by far the greatest indicator for increasing a child’s likelihood of experiencing three or more placements (Courtney & Prophet, 2011). Courtney and Prophet make the observation that placement instability may be due to “a combination of their special needs and the challenges in identifying and providing appropriate services to them” (2011, p. 136).

A University of Chicago study examined the relationship between distance from resources, both clinical and recreational, and placement breakdown for high-risk youth in foster care. The results confirmed the hypothesis that the further the foster family lived away from resources the greater the likelihood of a placement breakdown (Weiner, Leon, & Stiehl, 2011). Further predictors of placement disruption were the child’s age, trauma experience, and risk behaviours. They saw the impact of demographic and clinical

variables upon risk behaviours as somewhat contingent upon the type of area in which a child resides (Weiner et al., 2011, p. 767).

Eposito et al. (2014), in a Quebec longitudinal study including 29,040 children admitted to out-of-home care between April 1, 2002, and March 31, 2011, found that older youth have the highest risk of experiencing placement change. The risk was elevated within this group of 10-to-13 year olds by “being a male, having behaviour problems, school truancy and school neglect, residential or group care at initial placement, request for youth criminal justice services, number of investigations, and neighbourhood area socioeconomic disadvantages” (Esposito et al., 2014, pp. 17, 18). This group of researchers posed three questions they believe reflect their findings and which they feel will guide best practice with respect to placement stability. They are:

(1) Have we assessed the appropriateness of the placement based on the age and needs of the child? (2) Have we mobilized mental health services needed to address the special needs of children, specifically youth with behavioral and emotional difficulties and a history of delinquency? (3) Have we mobilized community support services for birth families for younger children following initial maltreatment investigation and foster families immediately following the initial out-of-home placement? (Esposito et al., 2014, p. 18).

In conclusion, all of the literature reviewed covering risk factors for placement breakdown included externalizing behaviours, emotion dysregulation, and mental health needs as three key contributing factors. Externalizing behaviours are defined as a general acting-out style of behaviour that includes aggression, coercive behaviours, emotion

impulsivity, and noncompliance (Farrell, 2011). The second key factor, emotion dysregulation, is described as an inability to control or regulate emotional responses to provocative stimuli such as normal conflict in a relationship or personal criticism. The reactions are exaggerated and often include bursts of anger, crying, accusing, passive-aggressive behaviours, or creation of chaos or conflict (Johns & Levy, 2013). The third factor, mental health needs, refers to the heightened level of stress involved with supporting a child with a mental illness (Miodrag, Burke, Tanner-Smith, & Hodapp, 2015). All three of these factors appear when parenting children with ADHD.

ADHD

Introduction. ADHD is one of the most common neuropsychiatric disorders with a childhood onset (Kieling & Rohde, 2012). ADHD is known to be more prevalent among children within the child welfare system (Klein et al., 2015) and these children generally have a higher level of needs and risk than their non-ADHD-diagnosed peers (Casey et al., 2008). The literature dealing with the mental health needs of children in care will be reviewed with a specific focus on the needs of children in care with a diagnosis of ADHD. There is a growing body of knowledge involving brain research and the impact of early childhood trauma and neglect. This area of research has implications for both a review of the etiology of ADHD as well as the profile of children in foster care.

History. The origins of the concept of ADHD are contained in the idea that the symptoms were caused by damage to the brain. Early literature theorized origins such as encephalitis seeing that this illness often left children with diminished powers of concentration (Palmer & Finger, 2001). When the brain damage theories were called into

question by epidemiological science and were unable to be substantiated, they were set aside (Sadek, 2013). A reliable description of problems at a behavioural level became the focus with the first iteration being found in the American Psychiatric Association's diagnostic scheme, DSM-II, and the World Health Organization's diagnostic guide, the "International Classification of Diseases" (ICD-9), (Lange, Reichl, Lange, Tucha, & Tucha, 2010, p. 251; National Collaborating Centre for Mental Health, 2009). To this date, even though extensive biological investigations, neuroimaging, and molecular genetic associations and neurocognitive theories continue to look for biological diagnostic markers for this disorder, it remains one that is defined at a behavioural level (National Collaborating Centre for Mental Health, 2009). This is significant given some of the recent literature on the influence of environmental factors on behaviour, particularly childhood maltreatment. This will be explored in detail further along in the review of literature.

The first behavioural description of what is now called ADHD appeared in the American Psychiatric Association's *Diagnostic Statistical Manual of Mental Disorders* (DSM), second edition (II), in 1968. The label used was the *Hyperkinetic Reaction of Childhood* (American Psychiatric Association, 1968).

In 1980 the symptoms of ADHD were recognized as a related group or medical construct by the American Psychiatric Association and officially included as *Attention Deficit Disorder with or without hyperactivity* in the publication of the DSM-III (American Psychiatric Association, 1980).

The publication of the DSM-IV in 1994 introduced the term *ADHD with subtypes*, further refining the behavioural view of this disorder (American Psychiatric

Association, 1994). Three sub-types were included to describe a predominantly inattentive presentation, a predominantly hyperactive and impulsive presentation, and a combined presentation.

The fifth edition of the DSM was released in 2013. It is written as DSM-5 and not with the traditional roman numerals indicating a break with tradition. DSM-5 is slated to be the first DSM that is a living document and able to be changed online as new evidence emerges (Wakefield, 2013). There were some refinements of diagnostic criteria for ADHD in the DSM-5; however, the fundamental conceptualization of the disorder was maintained (American Psychiatric Association, 2013). This conceptualization of ADHD by the American Psychiatric Association has been in place now for more than two decades and it remains a behavioural description.

Diagnosis. There are five major criteria used to assess for a diagnosis of ADHD in accordance with the *Diagnostic and Statistical Manual of Mental Disorders DSM-5* (American Psychiatric Association, 2013). They are organized as criterion A through E. Criterion A describes three categories of symptoms: attention, hyperactivity, and impulsivity. An individual must have difficulty with symptoms in at least one category. For the purpose of diagnosis, the three categories are combined into two groups, one being problems with attention and the other problems with impulsivity and hyperactivity. The DSM-5 includes age as a factor in criterion A. This is the first time age has been a consideration in determining the number of symptoms that need to occur before they are considered impairing. For children up to the age of 16, impairment is seen to exist when there are six or more symptoms present in either group. For adolescents 17 and older (and adults), this is represented by the presence of five or more symptoms in either group.

Criterion B addresses the age of onset of symptoms at a level that is impairing. Symptoms must have had an onset before age 12. Criterion C addresses the pervasiveness of the impairment. There must be evidence of symptoms in two or more settings and they must have been present for more than six months. Criterion D examines impairment. The presence of symptoms must reduce the quality of social, academic, or occupational functioning. If the symptoms are not impairing, then a diagnosis cannot be made. Finally, Criterion E looks at exclusionary conditions. The diagnostician must be sure that the symptoms are not occurring from one of a specific list of other disorders, for example depression (Epstein & Loren, 2013).

ADHD can lead to potentially serious consequences.

Children and adolescents. The impact of ADHD is not just felt by the child but also by those around the child, for example parents (Tancred & Greeff, 2015; Theule, Wiener, Tannock, & Jenkins, 2013) and teachers (DuPaul & Stoner, 2014; Rogers & Meek, 2015). Supporting teenagers through the developmental stages for establishment of independence, identity, and peer affiliation is a task faced by all parents and teens (Williamson, Koro-Ljungberg, & Bussing, 2009). Parenting teens who have ADHD can be considerably more difficult due to teens having greater difficulty regulating emotion, maintaining focus, controlling impulsivity, and frequently displaying poor coping and decision-making skills when compared to their peers (Barkley, 2006; Chaplin & Modesto-Lowe, 2013). Teens with ADHD may also display a higher level of defiance and be resistant to parenting (Modesto-Lowe, Chaplin, Godsay, & Soovajian, 2014). This can lead to high levels of parental stress and maladaptive parenting strategies as a means of coping (Modesto-Lowe et al., 2014; Sibley et al., 2013).

There is evidence that ADHD in teenagers is a predictor for a higher frequency of alcohol consumption (Brooke et al., 2012), risky sexual behaviour (Huggins et al., 2015; Nylander, Tindberg, & Fernell, 2015), drug misuse (Carpentier, 2012), delinquency (Walther et al., 2012), and poor outcomes in school programs (DuPaul & Stoner, 2014). Adolescents with ADHD are known to be at greater risk for other mental illnesses such as anxiety (Tsang et al., 2015), depression, and oppositional defiance disorder (Yüce, Zoroglu, Ceylan, Kandemir, & Karabekiroglu, 2013).

The literature describing behaviours and risks associated with ADHD is not meant to imply parenting a child with ADHD is an insurmountable task. The risks are higher and the parent stress is generally greater (Modesto-Lowe et al., 2014), but the outcomes can be very good provided the parent has sufficient support and the child has access to best practice treatment (Felt, Biermann, Christner, Kochhar, & Harrison, 2014; Haydicky, Shecter, Wiener, & Ducharme, 2015; Sciotto, 2015).

Adults. This thesis examines foster care breakdown which has been shown to be a risk factor for difficulties in adult life (Pérez, Di Gallo, Schmeck, & Schmid, 2011). The adult outcomes associated with untreated or poorly treated ADHD have also been shown to pose a serious risk to adult success when measured against cohorts of peers without a diagnosis of ADHD (Arnold, Hodgkins, Kahle, Madhoo, & Kewley, 2015).

The worldwide prevalence of ADHD in adults is approximately 4% (Polanczyk, de Lima, Horta, Biederman, & Rohde, 2007). Close to 35% of individuals diagnosed with ADHD as children will not qualify for a diagnosis as adults while 65% carry the symptoms into adulthood (Shaw et al., 2012). These individuals are at a higher risk of becoming involved in criminal behaviours (Bange, 2011), experiencing chronic

employment difficulties (Gjervan, Torgersen, Nordahl, & Rasmussen, 2012), achieving a lower educational status than their peers (Eyre, 2013; Gjervan et al., 2012), and experiencing financial difficulty, including failing to pay bills on time, impulse purchasing, and excess debt (Brod, Pohlman, Lasser, & Hodgkins, 2012). They carry a greater risk of poor driving habits, including accidents and suspensions (Lichtenstein, Chang, D'Onofrio, Larsson, & Sjölander, 2014). If they have children, they are more likely to perceive themselves as poor parents (Mazursky-Horowitz et al., 2015), create chaotic personal and home routines, and experience higher rates of marital breakdown (Eyre, 2013). They are likely to be less conscious of their health and more prone to addiction to alcohol, nicotine, other drugs, and gambling (Asherson et al., 2012). There is also reported a higher risk of teen pregnancy, unsafe sex, and a riskier sexual lifestyle (Kooij, 2013). Finally, adults with ADHD have a greater risk for experiencing a major depressive disorder (Gjervan et al., 2012), emotional dysregulation (Corbisiero et al., 2013), any anxiety disorder, any eating disorder (Biederman et al., 2010), learning disorders (Asherson et al., 2012), and are at a higher risk for suicidal ideation and suicide (Furczyk & Thome, 2014).

For the 35% of individuals no longer displaying the symptoms of ADHD once they enter adulthood the outcomes are better but fall considerably short of a comparable non-ADHD group of peers (Shaw et al., 2012). This is understood to occur for two reasons. First, any adult who has lived with ADHD through all of the developmental milestones of childhood and adolescence will have experienced diminished success completing these developmental tasks (Barkley, Fischer, Smallish, & Fletcher, 2006; Sadek, 2013). Second, adults are thought to no longer need to meet as many criteria for

ADHD in order to experience impairment (American Psychiatric Association, 2013). This is something that has been reflected in the DSM-5 diagnostic criteria with adults being required to present five symptoms in either inattentiveness or hyperactivity and impulsivity versus six symptoms required for anyone younger than 17 (Epstein & Loren, 2013). Consequently, an adult who qualified for ADHD as a child will likely still have some symptoms causing difficulty and now, even with fewer symptoms, may still qualify under the new DSM-5 criteria (Solanto, Wasserstein, Marks, & Mitchell, 2012).

Prevalence. The way a disorder is defined, and the methodology used to study it, plays an important role in the measurement of its prevalence in any given population. This concept dominates the discussion of the prevalence of ADHD (Polanczyk et al., 2007; Skounti, Philalithis, & Galanakis, 2007).

As with most areas of the ADHD literature, there is a wide divergence of opinion concerning prevalence rates. There are those who report that the diagnosis of ADHD among children is rapidly increasing (Watson, Arcona, Antonuccio, & Healy, 2014) and those who report the diagnosis of ADHD is, if not below the estimated prevalence rate, only a reflection of true incidence (Biederman, 2012).

This variance in prevalence estimates for ADHD has been occurring since at least its inclusion in the DSM-II with several literature reviews reporting rates that have ranged from as low as 1% to as high as 20% among school-age children (Polanczyk et al., 2007).

In 2007 Polanczyk et al. conducted a meta-regression analysis of 102 studies comprising 171,756 school age subjects from all world regions. This research team found a worldwide-pooled prevalence of ADHD of 5.29% (Polanczyk et al., 2007, p.

942). Their findings suggest that the variability among prevalence estimates can be explained primarily by the methodological characteristics of the studies. This was a significant finding since changing prevalence rates have contributed to controversy and led to much speculation concerning a wide range of explanations for the variance in the ADHD literature (Polanczyk et al., 2014).

Polanczyk led a second major meta-regression analysis in 2014. This analysis involved 135 ADHD prevalence studies conducted over a span of 30 years and sought to understand if the true prevalence of the disorder had increased over time as reported in numerous findings. Once again this team of epidemiological researchers concluded that the methodological characteristics of the studies largely accounted for variance. They write: “In the past three decades there has been no evidence to suggest an increase in the number of children in the community who meet criteria for ADHD when standardized diagnostic procedures are followed” (Polanczyk et al., 2014, p. 434).

While the overall prevalence of ADHD is seen to be approximately 5% amongst school-aged children, variance does exist around a number of specific factors within populations. Males show higher rates than females (Arnett, Pennington, Willcutt, DeFries, & Olson, 2015; Willcutt, 2012); however, the reported magnitude of this difference varies from as much as a boy-to-girl ratio of 9:1 to a more commonly quoted ratio of 3:1 (Barkley, 2006; Polanczyk et al., 2007; Sadek, 2013). Although gender differences have been reported in the literature, the nature of these differences, and in particular how ADHD presents in girls, is seen to be under-studied (Skogli, Teicher, Andersen, Hovik, & Øie, 2013). There is a theme within the literature that girls are under-identified (Waschbusch & King, 2006). A suggested reason for this is the nature

of the ADHD presentation in girls. In a meta-analysis that included a combined study number of 772 boys and 325 girls with ADHD, Hasson and Fine (2012) found that impulsivity was more prevalent in boys than girls while inattentiveness occurred at approximately the same rate. It follows therefore that girls, with fewer disruptive externalizing symptoms, could remain unnoticed by teachers and parents and yet still be struggling with ADHD (Skogli et al., 2013).

Etiology.

Introduction. For anyone familiar with the study of ADHD it will not be a surprise to hear that the ADHD etiology is a source of controversy. Controversy surrounds not just the etiology but also the diagnosis and treatment of ADHD. In what the authors call a descriptive exploration, Oster, Conway, and Szymanski (2011) offer a succinct description of the nature of this controversy in their paper on ADHD and complex trauma. They suggest that the debate is framed in a nature vs. nurture battle with some arguing for genetic causes and others suggesting the key is “environmental/social insults” (Oster et al., 2011, p. 61; Rafalovich, 2005). The position taken is important since it will influence the treatment approach. The first perspective highlights the need for pharmacological interventions while the latter favours responding to a child’s psychological experience within his or her environment. This either/or polarization has, for some time, been dismissed as too simplistic by most clinicians and researchers in the field (Keating, 2011). The position most commonly accepted today is that the answer is extremely complex and involves some of both nature and nurture (Harold et al., 2013; Wermter et al., 2010).

In a literature review exploring the principles of brain plasticity in children, Kolb and Gibb (2011) provide the following understanding of the nature/nurture argument:

The development of the brain reflects more than the simple unfolding of a genetic blueprint but rather reflects a complex dance of genetic and experiential factors that shape the emerging brain. Understanding the dance provides insight into both normal and abnormal development (p. 2).

The symptoms grouped within the ADHD diagnostic criteria cannot be completely accounted for by any single etiological factor (Nigg, 2012). The etiology of ADHD is thought to involve a complex interplay of genetic, neurocognitive, and environmental factors (Barkley, 2006, p. 219; Nigg, 2012). Research in these fields continues to contribute to our understanding of the disorder and treatment options (Sadek, 2013). For this reason, I have undertaken a review of the literature concerning both biological and environmental factors in this etiology section.

Biological factors: Genetics and epigenetics. ADHD is among the most heritable phenotypes (Sun, Yuan, Shen, Xiong, & Wu, 2014). Genetic studies show a heritability of between 60% and 75% (Cortese, 2012). A recent meta-analysis by Nikolas and Burt estimated that genetic factors accounted for 71% and 73% of the variance in inattention and hyperactivity symptoms respectively (2010). This was thought to suggest a direct causal link between human DNA and ADHD psychopathology. This view is now understood as failing to take into account the complex interplay between genes and environmental factors (Nigg, 2012).

Study of the interplay between genes and environment is known as epigenetics (Petronis & Mill, 2011), and this may well be an area of common ground between social work knowledge and practice and neuroscience (Bernstein & Gioia, 2015; Farmer, 2009).

The specific role of early childhood experiences operating through mechanisms such as epigenetics is, and will continue to be, an important direction in ADHD research. It is replacing more simplistic views of genetic heritability (Nigg, 2012, p. 530). To date, however, there are only a few studies examining the epigenetics of ADHD. One such study reported an association between parenting behaviour and the “turning on” of elements within the ADHD genotype (Li & Lee, 2012), supporting previous work on the relationship between parenting and ADHD (Martel et al., 2011). However, in a qualifying statement that underlies the challenge of a full understanding of the complexity of the ADHD etiology, Li and Lee state: “negative parenting is influenced by environmental and genetic factors (Martel, Nikolas, Jernigan, Friderici, & Nigg, 2010), including in response to the child’s negative behaviour (Lytton, 1990)” (Li & Lee, 2012). The sorting out of some of the complex associations inherent in the epigenetic contribution to an understanding of ADHD etiology will take some time but may well yield much to its prevention and treatment (Nigg, 2012).

Environmental factors.

Developmental insult through maltreatment. The impact of child maltreatment on psycho-social development is an area of study that has been pursued by a number of writers interested in mental health treatment issues (Cicchetti, 2013; Howe, 2010; Perry, 2009). Early childhood maltreatment has been implicated generally in the emergence of psychopathy across the life course (Cicchetti, 2013). It is also being studied for its

possible contribution to the ADHD etiology through studies of attachment deprivation (Roskam et al., 2014). Roskam et al. were able to show that an increase in the intensity of ADHD symptoms could be predicted by exposure to early attachment deprivation (2014, p. 123). Similar findings were seen by Scholtens, Rydell, Bohlin, & Thorell where children with disorganized attachment had significantly higher levels of ADHD when compared with children with secure attachment characteristics (2014). Research in the field of neurobiology is now beginning to identify how human experience influences neurological development and functioning which in turn leads to individual behaviour (Sun et al., 2014; van der Kolk, 2005; Walters et al., 2011).

The influence of childhood maltreatment is also identified by Klein et al. (2015) who conducted an extensive literature review of ADHD and children in foster care. They found that children with maltreatment histories “are much more likely to have other factors contributing to behavioural and attentional regulation difficulties that may overlap with or mimic ADHD-like symptoms” (Klein et al., 2015, p. 184). They have provided recommendations for the use of multi-disciplinary diagnostic teams and the establishment of diagnostic and practice guidelines for children in child protective services care. This area of ADHD research is important to the field of child welfare since the majority of children in care have experienced disruptions of early childhood development (Casey et al., 2008; Leve et al., 2012; Trocmé, 2010).

As the understanding of brain development progresses, treatment strategies to “retrain” impaired brain function in maltreated children are also being developed (Barfield, 2011; Perry, 2009). This area of research offers the hope of new treatment

options for maltreated children coping with impairments resulting from trauma and neglect during their early formative years (Barfield, 2011).

Historical trauma. Just as trauma from early childhood experience is a factor in the ADHD etiology there is now a body of work discussing the psycho-social impact of intergenerational or historical trauma. Walters et al. define historical trauma as that “which consists of traumatic events targeting a community (e.g., forced relocation) that cause catastrophic upheaval” (2011, p. 179). Hartman and Gone offer a well-defined construct of historical trauma in what they refer to as the four Cs of indigenous historical trauma. These are colonial injury, collective experience, cumulative effects, and cross-generational impacts (2014, p. 275).

In a review of papers exploring intergenerational effects of the Indian Residential School (IRS) system in Canada, Bombay et al. state “these findings provide empirical support for the concept of historical trauma, which takes the perspective that the consequences of numerous and sustained attacks against a group may accumulate over generations and interact with proximal stressors to undermine collective well-being” (2014, p. 320). The recently released report into the impact of Canada’s residential school policy on indigenous peoples also highlights the intergenerational effects of trauma (Truth & Reconciliation Commission of Canada, 2015). The Truth and Reconciliation Commission noted that “the effects of this trauma were often passed on to the children of the residential school survivors and sometimes to their grand-children” (p. 158).

The literature on historical trauma is mentioned briefly because the ADHD literature tells us that one environmental variable associated with this disorder is trauma.

The literature on historical trauma may provide some insight into the disproportionately higher numbers of children in care carrying a diagnosis of ADHD (Public Health Agency of Canada, 2010). Aboriginal children are reported to be involved in the Canadian child welfare system four times more often than non-Aboriginal children (Public Health Agency of Canada, 2010).

Diet and lifestyle. Finally, mention needs to be made of some of the literature connecting diet to the etiology of ADHD since this occupies a persistent, albeit small, research focus (Stevenson et al., 2014). Lifestyle issues such as the impact of exercise seem to also consistently appear in the ADHD literature (Ratey & Hagerman, 2008).

Diet was long reported not to have a relationship with ADHD (Barkley, 2006); however, several more recent studies and meta analyses are showing that there is a small sub-group within the ADHD population where nutrition and diet is a factor (Heilskov Rytter et al., 2015). Most studies are reporting tentative results and recommending the need for further study, with particular attention being given to rigorous methodologies. Sufficiently dependable methodologies within the research on diet have been seen as a limiting factor for its general acceptance in the past (Nigg, 2012). As discussed earlier, the etiology of ADHD is seen to be complex with no single cause (Sadek, 2013), and factors such as diet and exercise (Lenz, 2012) are a small piece of the environmental puzzle interacting with genetics (Sadek, 2013).

Other environmental factors thought to play a role in ADHD are maternal smoking while pregnant (Ball et al., 2010; Motlagh et al., 2011) and exposure to toxins such as lead and other heavy metals (Hong et al., 2015). Heavy metals have been studied as a component of air pollution found in some heavily populated cities and have been

shown to exacerbate symptoms in children with ADHD (Arruda, Querido, Bigal, & Polanczyk, 2015) and to increase the risk of a child being born with ADHD (Gong et al., 2014). These findings continue to be tested and have not been fully substantiated (Forns et al., 2014).

Ethnicity. The profile of children who are living within the Canadian child welfare system includes a disproportionately high number of Aboriginal children (Public Health Agency of Canada, 2010). Consequently, it is necessary to review some of the literature that is currently involved in a debate as to whether psychiatric disorders, including ADHD, are universally the same or differ in their fundamental definitions and symptoms as influenced by cultural factors (Bauermeister, Polanczyk, Rohde, & Canino, 2010; Canino & Alegría, 2008). While ADHD has been widely studied over the past 45 years, the understanding of ADHD in ethnic groups remains quite limited (Lefler, Hartung, Bartgis, & Thomas, 2015).

Epidemiological studies have evaluated the reliability of ADHD as a construct across cultures and have generally concluded it to be valid. A meta-analysis of 86 studies of children and adolescents (N 163,688 individuals) and 11 studies of adults (N 14,112 individuals) examined the prevalence of the DSM-IV ADHD. Results of this analysis were reported to “argue against the hypothesis that ADHD is a cultural construct that is restricted to the United States or any other specific culture” (Willcutt, 2012, p. 490).

While the ADHD construct may be felt to be reliable across cultures, the DSM-5 states that cultural variations may affect prevalence estimates (American Psychiatric Association, 2013) and cross-cultural variations of prevalence have been reported in the

literature (Lee, 2008). This area of the literature calls for more study (Lefler et al., 2015) and is of particular importance in reference to Canadian child welfare.

Treatment.

Effective treatment of ADHD is of considerable importance since, as described above, ADHD is said to be predictive of negative outcomes across a wide range of human functioning (Modesto-Lowe et al., 2014; Richards, 2013).

Treatment for ADHD is available and has been shown to be effective (Barkley, 2006). As can be seen by the literature covering etiology, the origins of ADHD are a complex interaction of genetic, epigenetic, and environmental factors. A large body of research concerning ADHD has been undertaken over the past 45 years with over 2,000 peer-reviewed studies completed between 1970 and 1979 alone, the first decade of intense research interest (Barkley et al., 2006). Over this period, research has led to a general agreement that using multiple treatments in combination is the most effective approach to meeting the needs of children with ADHD (Kapur et al., 2012). This is described as a multimodal approach and combines psychopharmacological interventions (Antshel et al., 2011) with psycho-social interventions involving schools, parent support and training, and patient support (Barkley, 2006, p. 453; Bokor & Anderson, 2014). The absence of any one component is thought to reduce the effectiveness of the treatment overall and treatment is recommended throughout the child's development (French, 2015; Litner & Mann-Feder, 2009).

Within the literature there is a reflection of the larger societal debate concerning the use of psycho-stimulant medications to treat children with ADHD. On one side of the debate are those who claim psycho-stimulants are potentially dangerous and over-

prescribed with claims of large increases in rates of diagnosis to figures such as 14% “of all American children” (Watson et al., 2014, p. 43). On the other side of the debate are those such as Daniel Connor, professor of psychiatry at the University of Connecticut. In an argument favouring trust in science, Connor writes, “Despite more than 250 randomized controlled medication trials attesting to the efficacy and safety of stimulant use in patients with ADHD there continues to be controversy” (Connor, 2011). A detailed description of this debate is beyond the scope of this literature review. It is sufficient to say that the debate that continues within the literature on etiology and prevalence also exists within the ADHD treatment literature.

There is an element in this literature calling for caution where early childhood maltreatment is apparent (Klein et al., 2015). There is now considerable research showing links between ADHD and environmental factors such as attachment disorders, post-traumatic stress disorder (PTSD), parental mental illness, and child maltreatment (Richards, 2013). For this group, while psychopharmacology may help in the short term to control symptoms that prevent a child benefiting from education or relationships, etc., in the long term this literature is advocating for what is described as “a holistic treatment approach” (Klein et al., 2015). Klein et al. write that for vulnerable populations, including children in out-of-home care, there is “a need for comprehensive assessment, including mental health, cognitive and academic evaluations, because functional problems in one or more of these domains are likely to be contributing to presenting clinical picture” (2015, p. 183).

In Canada an influential treatment resource is the Canadian ADHD Resource Alliance (CADDRA), a national not-for-profit association with a mandate to support

individuals with ADHD and their families. CADDRA draws its voting membership from medical doctors practising in the area of ADHD including pediatricians, psychiatrists, and child psychiatrists. A key practice guideline in the most recent edition of their publication *Canadian ADHD Practice Guidelines* states, “The diagnosis needs to reflect an understanding of multi-systemic issues” (Canadian Attention Deficit Disorder Resource Alliance, 2011). CADDRA’s five principles for intervention are titled *The Five Tiers of Holistic-based Care* and include:

- (1) Adequate education of patients and their families
 - (2) Behavioural and/or occupational interventions
 - (3) Psychological treatment
 - (4) Educational accommodations
 - (5) Medical management (as a way to facilitate the other interventions)
- (2011)

In Canada the standards established by CADDRA appear to embrace all the voices expressed in the literature.

Treatment barriers. Even though treatment options are well developed and available, there are barriers to effective treatment for children at risk at the individual, organizational, and societal levels (Wright et al., 2015). A meta-analysis of 27 journal articles by Wright et al. identified societal stigma toward mental illness in general and ADHD in particular as a barrier at the family and individual level. A study by Mueller, Fuermaier, Koerts, & Tucha had a similar finding (2012).

Families are more likely to support successful treatment options and less likely to accept treatment myths when more information is available to them (Gapin & Etnier,

2014; Scitutto, 2015). Researchers have found that supporting families through education in areas germane to ADHD and involving parents in a review of the options for treatment are important to the overall success of treatment interventions (Crea, Chan, & Barth, 2014; Davis, Claudius, Palinkas, Wong, & Leslie, 2012). In other words, if parents are provided with clear evidence-based information concerning ADHD and treatment options, they are more likely to adopt and support effective strategies to help their children. The literature also points to increased treatment efficacy when children themselves are helped to understand their ADHD, its impact, and their options for treatment (Brinkman et al., 2012; Nussey, Pistrang, & Murphy, 2013). At an organizational level, teachers are viewed as having an important role in effective treatment. Teachers' willingness to embrace evidence-based interventions with their ADHD students is believed critical (Elik, Corkum, Blotnick-Gallant, & McGonnell, 2015).

With respect to children in child welfare programs this broad holistic approach to ADHD treatment places an onus upon social workers to ensure the children's medical needs are met. In the role of guardian, the protection of a child's medical rights and entitlements must fall to the social worker responsible for their care by ensuring out-of-home care providers are willing and able to perform their needed role in treatment. The literature reviewed on the role of social workers and ADHD treatment suggests that we are not immune to the influence of popular belief.

A British study surveyed 174 social work practitioners for children regarding their knowledge and perceptions of ADHD (Pentecost & Wood, 2002). The authors found that, as the length of experience increased, the social workers in their study displayed

“skepticism about the value of medication.... that generally the value of medication for young children and teenagers with ADHD-type presenting problems is a source of considerable controversy” (Pentecost & Wood, 2002, p. 938).

ADHD and risk for child maltreatment. Parents are generally the primary influence in the environment of any child or adolescent; however, adverse familial environments are common in ADHD families (Deault, 2010). The difficulties experienced by children diagnosed with ADHD also have an adverse reaction on relationships with all members of their families and particularly their mothers and fathers (Gerdes, Hoza, & Pelham, 2003; Kadesjö, Stenlund, Wels, Gillberg, & Hägglöf, 2002; van Aken, Rommelse, Oerlemans, Buitelaar, & Steijn, 2014).

Parents who have children with ADHD report having lower self-esteem, poor control over the child’s difficulties, poorer coping, and high levels of stress (Hernández-Otero et al., 2015; Podolski & Nigg, 2001; Treacy, Tripp, & Baird, 2005).

The experience of high levels of stress within families of children coping with ADHD has led to the exploration of a possible relationship between children with ADHD and child maltreatment. Multiple studies have established that ADHD behaviours do indeed place children at higher risk of maltreatment (Alizadeh, Applequist, & Coolidge, 2007; Ghanizadeh, Yazdanshenas, Nasab, Firoozabadi, & Farrashbandi, 2014; Oosterman et al., 2007; Prayez, Wodon, Van Hyfte, & Linkowski, 2012).

Ghanizadeh et al. (2014) assessed for parental abuse in a cohort of 108 children between the ages of 6 and 15 years. They found that children with ADHD were more prone to experiencing both psychological and physical abuse by their parents than their non-ADHD peers. They hypothesize two causes. First, parents of children with ADHD

are known to be seven times more likely to have ADHD themselves than parents of children who do not have ADHD (Boomsma et al., 2010). They surmise that these parents would, as a result of their own ADHD, have lower emotional self-regulation ability expressed as low frustration tolerance, temper outbursts, and emotional impulsivity (Surman et al., 2013). The second theorized explanation for the higher incidence of child maltreatment is the suggestion that higher amounts of disruptive behaviour, common for children with ADHD (Pokhrel et al., 2013), may trigger harsh parenting practices (Ghanizadeh et al., 2014). The discussion of parental ADHD as a factor in child maltreatment in the Ghanizadeh et al. (2014) study is supported by a study conducted by Theule, Wiener, Rogers, & Marton (2011). They identified a diagnosis of adult ADHD in the parent as the strongest predictor of parental distress out of a number of variables tested (Theule et al., 2011).

A 2008 population-based study investigated the relationship between ADHD symptoms and supervision neglect, physical neglect, physical abuse, and contact sexual abuse (Ouyang, Fang, Mercy, Perou, & Grosse, 2008). This team used a sample of 14,322 youth in grades 7 through 12 in three waves: 1995, 1996, 2001. Respondents with ADHD, 8.4% of the total sample, were compared to the non-ADHD category. The category of any type of ADHD was significantly associated with all four types of child maltreatment.

The presence of ADHD in children places the parent-child relationship under much greater stress than the norm (Alizadeh et al., 2007; Kaiser, McBurnett, & Pfiffner, 2011; Modesto-Lowe et al., 2014; Treacy et al., 2005; van Aken et al., 2014). It increases the risk of child abuse and maladaptive parenting (Modesto-Lowe et al., 2008;

van Aken et al., 2014). This literature points to the need for support for foster families caring for children with ADHD.

ADHD, maltreatment, and externalizing behaviours. Child maltreatment by itself is a risk factor for the development of externalizing behaviours (Villodas et al., 2015) ranging from “nuisance behaviours (e.g. calling out in class) to more severe and even criminal behaviours (e.g. physical assault)” (Villodas et al., 2015, p. 205). In a study involving a birth cohort of 2,600 twins, Kuja-Halkola et al. (2015) found a correlation between ADHD and externalizing traits. Both childhood maltreatment and ADHD are risk factors for development of externalizing behaviours. Externalizing behaviours have been shown earlier to be one of the most significant risk factors for foster placement disruption and breakdown (Corbisiero et al., 2013; Courtney & Prophet, 2011; Esposito et al., 2014; Stott, 2012) as well as leading to further maltreatment. Generally, children are placed in out-of-home care due to some form of maltreatment, a risk factor for the development of externalizing behaviours. If children living in out-of-home care also have a diagnosis of ADHD, this then is a second risk factor for the development of externalizing behaviours. This must, based on the literature, put foster placements for these children at a higher risk for placement breakdown and thus behavioural interventions to support these foster parents are important (Vanschoonlandt, Vanderfaeillie, Van Holen, & De Maeyer, 2012). A Belgian study showed that externalizing behaviours were prevalent among foster children in that country yet only 13.9% of foster parents received professional help (Vanschoonlandt, Vanderfaeillie, Van Holen, De Maeyer, & Robberechts, 2013). A North American study (Smith, Leve, &

Chamberlain, 2011) confirms low professional intervention rates in the USA for foster parents, despite research findings demonstrating the need for such supports.

Summary

Children who live in out-of-home care and who are coping with ADHD have been shown to be at a higher risk for placement breakdown than their non-ADHD peers due to the higher incidence of externalizing behaviours found in this cohort (García-Martín, Salas, Bernedo, & Fuentes, 2014; Sallnas, Vinnerljung, & Kyhle Westermark, 2004). Experiencing a placement breakdown is itself a risk factor for a child experiencing future placement breakdowns (Rostill-Brookes et al., 2011; Unrau et al., 2008; van Santen, 2015).

The symptoms of ADHD have been shown to be a source of significant stress for foster parents (Cicchetti & Toth, 2005) and ADHD in children is frequently associated with comorbid disorders that involve externalizing behaviours and problems with emotional dysregulation (Ercan et al., 2014). Higher levels of foster parent stress is known to elevate the risk for a placement breaking down (Gerdes et al., 2003; Kadesjö et al., 2002; Kaiser et al., 2011; Matos, Bauermeister, & Bernal, 2009; Modesto-Lowe et al., 2008; Oosterman et al., 2007) as does the existence of externalizing behaviours and emotion dysregulation (van Santen, 2015, p. 200).

Should a placement break down, the literature reveals that the psychological impact on the child tends to be long-lasting, negative (Knorth, Knot-Dickscheit, & Strijker, 2008b; Riggs & Willsmore, 2012; Unrau et al., 2008), and one of the key contributors to poor outcomes for foster care in general (Stott, 2012; Tregeagle & Hamill, 2011). Similarly the long-term life outcomes for a child with a diagnosis of ADHD who

does not receive treatment are significantly diminished in relation to their peers (Arnold et al., 2015).

The literature indicates there are effective treatment options available for children with a diagnosis of ADHD (Barkley, 2006). Numerous studies point to the benefits children and families gain through parental support, including support of foster parents (Trillingsgaard, Trillingsgaard, & Webster-Stratton, 2014; Vanschoonlandt et al., 2012; Vanschoonlandt et al., 2013).

Conceptual Framework

Research Question

The research topic for my study examines “the lived experience of foster parents caring for children with a diagnosis of ADHD and where the placement broke down.”

The intent of the study was to: (1) understand the meaning that foster parents give to their lived experience of the ADHD behaviours of children in their home, (2) examine how this may contribute to the breakdown of the foster placement, and (3) learn what supports foster families believe would prevent a placement breakdown.

Conceptual Framework

The conceptual framework informing this research is influenced by human rights principles. It proceeds from the following assertions:

- Every child in care has a right to medical care (General Assembly of the United Nations, 2009; Johnson, 2008; Turpel-Lafond, 2012);
- Any ministry or agency responsible for the care of children has a legal responsibility to ensure their needs for health care are met (Eldridge v. British Columbia (Attorney General), 1997; Johnson, 2008);
- Social workers in Canada, working within the child welfare system, have an ethical responsibility to ensure the health care rights of children in care are protected (Canadian Association of Social Workers, 2005).

These assertions and their influence informing my work will be explored in this chapter.

International Human Rights Treaties

The Universal Declaration of Human Rights. In 1948 the United Nations' General Assembly adopted the *Universal Declaration of Human Rights*. This action is seen to represent an international milestone in human rights, marking a historical consensus on human rights norms, principles, standards, and obligations (Backman et al., 2008). The Declaration defines every person as being born with human rights that cannot be violated or revoked regardless of characteristics such as location, gender, or age (United Nations, 1953). International treaties, on their own, are not legally binding, meaning that a country cannot be held legally responsible to a treaty's provisions simply because it exists. Each country must make the decision to sign a treaty and then ratify it, generally through discussion in parliament. Once a country ratifies a treaty, it enters into a legal agreement to uphold the treaty's provisions and obligations (Abban, 2015).

Governments, "as duty bearers, have a particular responsibility to ensure that people are able to enjoy their rights" (Office of the High Commissioner for Human Rights, 1996-2016). Whether or not governments actually do this, it is generally accepted that this is the government's responsibility and citizens can call them to account if they fail to ensure their rights (Turpel-Lafond, 2012).

Following the establishment of the United Nations and the *Universal Declaration of Human Rights*, other treaties and conventions were drafted and approved by the UN General Assembly. These treaties and conventions cover the rights of women and racialized minorities, standards for the treatment of prisoners, and other wide-ranging human rights issues. Canada has ratified all of the major conventions, including the *Convention on the Rights of the Child*.

The Convention on the Rights of the Child. In 1989 the United Nations' General Assembly adopted the *Convention on the Rights of the Child (CRC)* (United Nations, 1989), which is seen as the primary international instrument for addressing the rights of the world's children (Mama, 2010). Canada became a signatory May 28, 1990, and ratified the convention on December 13, 1991 (UNICEF Canada, 2016).

The Convention is based on the best interests of the child and for the first time in history it defines children as separate human beings with rights. The Convention can be used to hold signatories legally responsible for the protection of children's rights.

A number of articles within the Convention speak to the rights of children to access health services. Article 3.3 states:

Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision (Canada. Department of External Affairs, 1992).

Article 23 states:

1. Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.
2. Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition

and to the circumstances of the parents or others caring for the child (Canada. Department of External Affairs, 1992).

ADHD is a disability and has been recognized as such by the Canadian courts. That ADHD is a disability requiring special attention has been argued in the Canadian Tax Court (*Collins v. Canada*, 1998), Canadian Human Rights Tribunals (*Gaisiner v. Method Integration Inc.*, 2014), and Court of Queen's Bench, Family Law Court (*P.M v. T.M.*, 2010). ADHD has been listed in the *Diagnostic and Statistical Manual of Mental Health Disorders* since 1980 (American Psychiatric Association, 1980). Consequently, given both the legal and medical standing of ADHD, access to effective treatment falls within the right to adequate health care as outlined in Article 23. Article 24 states:

1. Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.
2. Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services (Canada. Department of External Affairs, 1992).

As a signatory to the *UN Convention on the Rights of the Child*, Canada has proclaimed a recognition of these human rights for children and a commitment to their application within the Canadian context.

The Convention on the Rights of Persons with Disabilities 2006.

The UN Convention on the Rights of Persons with Disabilities (CRPD) (General Assembly of the United Nations, 2006) was adopted in 2006 and ratified in the Canadian Senate in 2010. This convention sees all States Parties having as a general obligation “to

take into account the protection and promotion of the human rights of persons with disabilities in all policies and programs” (General Obligations). It recognizes that “disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others” (Preamble). It seeks to “eliminate discrimination on the basis of disabilities” (Article 4(1)(c)) and extends “to all parts of federal states without any limitations or exceptions” (Article 4(5)), (Kaiser, 2012).

The *Convention on the Rights of Persons with Disabilities* recognizes that children with disabilities should have full enjoyment of all human rights and fundamental freedoms on an equal basis with other children (Article 7). In all actions concerning children with disabilities, the CRPD asserts that the best interests of the child shall be a primary consideration (Article 7(2)).

With respect to health the CRPD asserts that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability (Article 25). Article 26 on habilitation and rehabilitation requires that signatories shall take effective and appropriate measures to enable persons with disabilities to attain and maintain maximum independence and full inclusion and participation in all aspects of life (Article 26 (1)). Article 26 further requires that signatories shall “promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services” (Article 26 (2)).

As has been discussed, ADHD in Canada is defined within the courts as a disability. As such the far-reaching implications of the CRPD apply directly to the care and treatment of ADHD. As will be seen next in the UN *Guidelines for the Alternative Care of Children*, the implications are even greater where a child in care has ADHD.

United Nations Resolution on Guidelines for the Alternative Care of Children 2009. The *Guidelines for the Alternative Care of Children* (General Assembly of the United Nations, 2009) are a series of recommendations for policy and practice designed to enhance the UN *Convention on the Rights of the Child* and promote the wellbeing of children deprived of parental care (Munro et al., 2011). Several guidelines have a direct bearing upon the child-in-care's human right to health care and are as follows:

84. Carers should promote the health of the children for whom they are responsible and make arrangements to ensure that medical care, counselling and support are made available as required.

87. The specific safety, health, nutritional, developmental and other needs of babies and young children, including those with special needs, should be catered for in all care settings, including ensuring their ongoing attachment to a specific carer.

104. The role and specific responsibilities of the designated person or entity should include:

(a) Ensuring that the rights of the child are protected and, in particular, that the child has appropriate care, accommodation, health-care provision,

developmental opportunities, psychosocial support, education and language support (General Assembly of the United Nations, 2006)

By signing on to the UN *Convention on the Rights of the Child*, the *Convention on the Rights of Persons with Disabilities*, and the 2009 *Guidelines for the Alternative Care of Children*, Canada has made a commitment to uphold this framework of principles for the treatment and care of children who are living in the care of the state. They provide an outline of the international community's consensus for best practice for children living in out-of-home care and the basic human rights entitlements for those living with a disability. As presented in this section this includes best practice for the role of caregivers and the state's responsibility to ensure caregivers are adequately equipped to meet the needs of children in their care.

The Canadian Human Rights Framework

Canadian Charter of Rights and Freedoms. The *Canadian Charter of Rights and Freedoms* is this country's paramount instrument for the protection of human rights. A long-standing debate concerning human rights embraces two broad conceptualizations of human rights protections. These are positive rights or those things to which an individual is entitled and negative rights preventing interference based on listed criteria such as religion, disability and gender (Macfarlane, 2014).

The Charter has been successful in expanding upon the rights of equality-seeking groups, including for persons with a disability (*Eldridge v. British Columbia (Attorney General)*, 1997). The implications of the Charter for children in care, and particularly their access to health care, amounts to protection from any unequal or discriminatory provision of health care (David, 2014). The Charter also obliges governments and their agents to provide accommodation for persons with disabilities who face systemic and physical barriers so as to assist them in overcoming the barriers and providing them with the chance to fulfill their true potential.

Canadian common law. Common law in Canada establishes guidelines for the standard of care in relationships where one party is the guardian of another. This is described as a fiduciary relationship and is defined in *Black's Law Dictionary* as follows:

A relationship in which one person is under a duty to act for the benefit of the other on matters within the scope of the relationship. Fiduciary relationships — such as trustee-beneficiary, guardian-ward, agent-principal, and attorney-client — require the highest duty of care (Garner & Black, 1999).

This definition of the fiduciary relationship within common law principles provides another approach to the standard of care requirements placed upon ministries and agencies providing child welfare services. The standard of care defined within common law is of the “highest duty of care.” What is the requirement for health care to satisfy the requirement of the “highest duty of care”? This question will be considered within the discussion of findings.

Precedent-setting rulings have been made in Canada regarding the standards of care for children living within the child welfare system. The Supreme Court of Canada has ruled on several cases dealing with the principle of vicarious or indirect ministry liability in respect of historical sexual and physical abuse. These rulings have provided guidance with regard to the standard of care required of those exercising control over a child in state care. The court direction is as follows:

The standard for direct negligence for those exercising control over a child in State care is a high one and is that of “a prudent parent” caring for the welfare of his or her child. This standard does not make the government (or a child welfare agency) a guarantor against all harm, but this standard does hold the [ministry or] agency responsible for harm sustained by children in foster care, if judged by standards of the day, it was reasonably foreseeable that the [ministry or] child welfare agency conduct would expose these children to the harm ultimately sustained (Kanani, Regehr, & Bernstein, 2002).

This “prudent parent” ruling is particularly relevant to my thesis and will be discussed in detail in relation to the research findings. In essence the implications are

that an agency or ministry responsible for children in care must ensure no harm comes to them by failing to address health care issues where failure to do so was reasonably foreseeable to cause harm. Given the abundance of research concerning treatment best practice for ADHD as well as the harmful life outcomes in the absence of treatment, there is arguably a clear requirement for child welfare authorities to address ADHD health care issues.

Social Work Ethics

The Canadian Association of Social Workers' *Code of Ethics and Guidelines for Ethical Practice* is binding upon all registered social workers and states as follows:

1.1.6 Social workers seek to safeguard the rights and interests of clients who have limited or impaired decision-making capacity when acting on their behalf, and/or when collaborating with others who are acting for the client (see section 1.3), (2005, p.4).

Where the rights of children in care are not upheld, social workers have an ethical responsibility to advocate for redress. This includes issues affecting children's health. The ethical standard to which a social worker is held is designed to regulate professional practice. This necessarily includes practice concerning children in care with a diagnosis of ADHD.

In addition, the CASW Code of Ethics calls upon social workers to uphold "the human rights of individual and groups as expressed in the *Canadian Charter of Rights and Freedoms* (1982) and the United Nations *Universal Declaration of Human Rights* (1948)" (2005, Value 1).

Summary

The ADHD literature is clear in showing that a failure to address the health issues connected with a diagnosis of ADHD will result in poor life outcomes when compared to a non-ADHD control group. The child welfare literature demonstrates that placement breakdown also heightens the risk for poor life outcomes. If the symptoms of ADHD are not managed and hence contribute to placement breakdowns, there is arguably a compounding of harm to a child in care. The literature reveals that a core requirement for effective treatment is parenting that is attuned and responsive to the needs of the child coping with ADHD (Kaiser et al., 2011; Modesto-Lowe et al., 2014; Spielfogel, Leathers, Christian, & McMeel, 2011; van Aken et al., 2014).

The human rights of children in care, the obligation to children in care-serving organizations, and the ethical responsibilities of social workers all informed and provided a theoretical context for my research. The discussion of findings includes a review of the degree to which the experience of the foster families interviewed reflected the parental care required by children coping with ADHD. This discussion will shed light upon the degree to which these families were able to contribute to the medical care of the children and hence the degree to which their entitlement to medical care was protected.

Methodology

Introduction

Methodological congruence and purposiveness is the process of selecting a methodology with the purpose for the research, the question being asked, the epistemological and ontological beliefs of the researcher, and the research demands of the question being examined (Morse & Richards, 2013). This process has guided my choice of methodology and provides the outline for this section.

Research Paradigm

This study is undertaken using a qualitative research paradigm. Qualitative research seeks fundamentally to uncover how people understand their world (Jensen & Moran, 2014). Typically, qualitative analysis relies on an inductive process, identifying themes and patterns within the data (Merriam, 2002), rather than seeking to reduce or discover an underlying cause through an empirical analytical process of reduction (van Manen, 1990). Within this broad definition there are numerous traditions and each can be characterized by its treatment of epistemology, ontology, and the role of the researcher.

The research task: intention, meaning and understanding. Within the qualitative research method, understanding meaning and intentionality are a particular focus of the phenomenological tradition. Phenomenology focuses on people's perceptions of an object (Langdrige, 2007, p. 11) and is often defined in terms of the study of phenomena as people experience them (von Eckartsberg, 1998). My need to understand the meaning and intent the participants in my study attributed to the children in their care was responsible for my adopting a phenomenological approach.

There is an extensive body of research describing how the behaviour of individuals with ADHD can be affected by this disorder. The intention and meaning attributed [by others] to the behaviours of children with ADHD, for example parents or teachers, is frequently different from the intention and meaning the children themselves place upon their behaviour (Blythe et al., 2014; Larson, Yoon, Stewart, & DosReis, 2011). It is also different from explanations provided by the research (Bussing et al., 2012). This incongruence in intention, meaning, and understanding is key to the examination of my research question. A qualitative analysis seeks to provide understanding in situations where meaning and intent are key to increasing knowledge about the research question (Merriam, 2002).

Research Question

The question asked in this study is, “What is the lived experience of foster parents caring for children with ADHD where the placement has broken down?”

This research seeks to: (1) understand the meaning that foster parents give to their lived experience of ADHD behaviours of children in their home, (2) examine how this meaning may contribute to the breakdown of the foster placement, and (3) learn what supports foster families believe would prevent a placement breakdown.

Interpretive Constructionist Theory

The interpretive constructionist approach is a philosophy of research that is congruent with my understanding of how people realize truth (Morse & Richards, 2013) and one that has shaped and guided my research. An interpretive constructionist perspective sees knowledge as constructed and subjective as opposed to it existing independently of the observer and as an absolute. Interpretive constructionist research

seeks to understand how people construct and give meaning to their world (Goodsell & Zvonkovic, 2015). A main goal for the interpretive researcher is to gain “access to the conceptual world in which our subjects live so that we can, in some expanded sense of the term, converse with them” (Geertz, 1973, p. 24).

Reflexivity and the Role of the Researcher

Within the qualitative tradition there are distinct views concerning reflexivity, a term used to encompass the role and influence of the researcher (Darawsheh & Stanley, 2014). On the one hand, there are those descriptive approaches viewing the researcher as someone who manages the research process to ensure rigor but who exists outside of the findings and with a role of providing an accurate description of them. On the other hand, there are interpretive approaches that view the researcher as inseparable from the object world. The researcher is seen as having a role in interpreting the world being viewed and is thus a co-creator in the research findings. Each approach embodies a distinct set of beliefs about epistemology (Morse & Richards, 2013).

For researchers, epistemology is the way sense is made of the knowledge produced (Smith, 2011). The descriptive approach has an epistemological view seeing the object world as distinct and separate from the researcher. In this view the researcher must do all they can to ensure the process of observation captures a clear picture of the object world and does not interfere with it. The descriptive qualitative tradition sees knowledge as separate and distinct from the researcher. Consequently, within this tradition the researcher strives to eliminate any influence of the act of research upon the world. The goal is seen as capturing a pure picture of the world.

The interpretive tradition on the other hand sees a world that “does not consist of separate things but of relationships which we co-author. We participate in our world, so that the “reality we experience is a co-creation that involves the primal givenness of the cosmos and human feeling and construing” (Reason & Bradbury, 2001, pp. 6-7). The interpretive tradition, taking the view that it is not possible to separate the researcher from the object world, says instead that the researcher should use their skills to create understanding.

This distinction exists both between methodologies and within some methodologies (Morse & Richards, 2013). The distinction is seen clearly within the phenomenological tradition where a researcher can adopt a descriptive approach (Husserl, 1958, 1960) or an interpretive approach (Heidegger, 1959).

Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) is a qualitative research approach with a primary goal of understanding how individuals experience and make sense of their personal and social worlds (Smith, 2003). IPA is interpretative; it understands human beings as sense-making creatures and is therefore informed by hermeneutics, the theory of interpretation (Van Manen, 1990). I found the active role IPA attributes to the researcher congruent with my own epistemological beliefs that knowledge is more about a consensual explanation of an object than it is a description of something separate and existing independently of the observer. IPA sees the researcher making an interpretation of meaning or “mediating” between different meanings. I felt that my own experience as a long-time social worker working within child welfare settings could be an asset interpreting the experience of the participants. IPA’s belief that reflection upon the data

by a sensitive and knowledgeable researcher is an enhancement to the research process was also congruent with my own experience.

Seeing human beings as needing to make sense of their world, IPA understands the accounts participants provide as a reflection of their attempts to find meaning in their experience (Smith et al., 2009). By “engaging with these reflections” (Smith et al., 2009) the researcher attempts to reveal their meaning. This is more than an attempt to define or categorize an experience and arrive at an objective statement. Influenced by the work of Edmund Husserl, IPA seeks to explore an individual’s experience on its own terms and to “grasp the very nature of the thing” (Van Manen, 1990, p. 177) arriving at the essence of its meaning.

Essence can “be understood as a structure of essential meanings that explicates a phenomenon of interest. The essence or structure is what makes the phenomenon to be that very phenomenon” (Dahlberg, 2006). Where more than one participant is involved essence reflects the common underlying invariant structure of the experience. It is that unifying essence experienced at the core of the phenomenon by all participants (Cresswell, 2013).

The rich and powerful descriptions that emerge through IPA research can challenge and influence the assumptions of those engaged with a particular object, example child maltreatment, in more theoretical ways. This challenge can lead to change when these descriptions are able to influence individuals engaged in, for example, policy development, law, or treatment by providing insight into the experience of others. This ability to provide rich descriptions of lived experience and to uncover essence made IPA well suited to my research undertaking.

Participants

The goal of qualitative research is to collect extensive detail about each specific individual studied (Cresswell, 2013, p. 126). There was value using this approach for my research. By providing an in-depth and detailed examination of the lived experience of a small group of individuals it was possible for readers to make links between my findings, their own experience, and claims existing within the literature.

The concept of reliability in connection with sample selection in IPA research is concerned with finding individuals who have had experience with the phenomenon or object of the study (Smith, 2011; Smith, 2003). In this study, the phenomenon is foster parents who have experienced raising a child with a diagnosis of ADHD where the placement broke down. For qualitative research generally, and IPA in particular, there are no specific rules governing sample size. The optimal sample size is specific to the individual research project and takes several factors into consideration. Given that IPA is intent upon providing a detailed qualitative analysis of each personal account there is the practical consideration of how many cases a researcher's available time can include (Smith, 2011). IPA interviews produce a large amount of detailed data and samples of even one are thought to be useful. The availability of cohorts with experience of the phenomenon is another consideration. In some instances, the number of people with a given experience may be very small.

In my research, participants were found through a nonprobability purposeful sampling strategy. To examine the meaning attributed by foster parents to ADHD behaviours where a placement broke down I recruited participants who were foster parents in good standing with the provincial accreditation authority. This was to ensure

that they were formally recognized as foster parents in the region where my research was undertaken. To be included in my research participants also needed to have experienced a placement breakdown that involved a child with a diagnosis of ADHD.

To recruit foster parents that met these inclusion criteria I consulted with a foster family association in a large prairie city explaining my research and need for participants. The foster family association identified five foster families. They were initially contacted by a member of the Saskatoon Foster Families Association's executive. If the prospective candidate wished for more information and/or was considering participation, the Saskatoon Foster Family Association sought their permission for me to contact them directly. I contacted each interested family, explained the research study, verified that the inclusion criteria were met and that they were willing to participate in my research. This process was outlined in my ethics review board application as were the principles of confidentiality and support in the event the interview triggered a traumatic response (*see Appendix A*). All five families expressed enthusiasm for the research and were then provided with a copy of the participant consent form. The consent form was reviewed with each participant and they provided a signature as a formal indication of consent prior to being interviewed (*see Appendix A.1*).

A final task was to establish who would be participating. One family was a single foster parent family and the foster parents in the other four were couples. In four instances the foster mother chose to participate and in one instance both the foster mother and father wished to participate as a couple. My interest in this final task was to ensure participation was not seen to be a burden and hence cause participants to withdraw or to participate reluctantly. Participant interest and enthusiasm has been identified as being

important to the integrity of phenomenological research (Moustakas, 1994). Further, my research question was not focused on the gender of the foster parents or any influence that may have resulted from the nature of the family structure. In my study I was seeking to recruit any foster parent meeting the inclusion criteria. I have for convenience used the more general term “foster family” throughout this research. However, it must be pointed out that the findings are specific to the foster parent and in one instance foster couple who were interviewed.

Data Collection

My data collection process was guided by phenomenological method. I sought a full description of each participant’s lived experience of caring for a foster child with ADHD where the placement broke down. Data collection could have been completed within the phenomenological research tradition in a number of different ways such as free-flowing unstructured interviews of personal accounts, researcher journals, and participant diaries (Smith, 2003). I chose to use a semi-structured interview guide as a systematic process in my data collection (see *Appendix B*). This format allowed me to ask those questions I thought would lead to a description of the lived experience I wished to understand. However, it also allowed me to probe areas of interest that arose during the interview and it allowed the participants to tell their own story without being constrained by my questions (Berg, 2007).

My data collection also included contextual questions pertaining to the gender of the children, their age at the time the placement broke down, and the length of time they had been in the foster parent’s home. This provided me with more information with which to think about the themes generated, including ideas for further research. For

instance, would different lengths of time fostering have an impact on the experience of the participant? Although not specifically asked, I was also interested in the ethnicity and socio-economic status of the participants as well as the foster child in question. This information was gained through observation during the interview process. Observations were recorded in field notes as data that might serve to generate insights during analysis. This speaks to the interpretative nature of IPA where the researcher is a participant in the research rather than simply describing events or perceptions. The questions needed to provide data that would help me “give meanings to the meanings” (Smith et al., 2009).

Foster families were given the choice as to whether both parents (if there were two parents) or one parent would be interviewed. They were advised that the important element was that the family story was told. Of the five families interviewed, one family chose to have both parents participate in a joint interview. In the other four interviews the foster mother shared their story.

Each participant chose the location for the interview so that they would feel comfortable relating their experience. The more at ease and relaxed a participant feels, the more likely they are to touch upon the depths of their experience. I was also concerned about privacy and confidentiality as I did not want anyone able to connect the participant with my research. Two interviews were conducted in an office I provided; one occurred in the participant’s home; and two were conducted by telephone. Interviews lasted approximately 60 minutes and were recorded using a digital recorder and then transferred to a password-protected computer.

Data Analysis

The audio recordings were transcribed verbatim following the interviews and then deleted from the audio recorder. The data was analyzed through a process described as a hermeneutic circle, a common method in IPA research. Hermeneutics is an interpretive process seeking meaning in what people experience rather than a record of what they know (Lopez & Willis, 2004). The hermeneutic circle involves moving back and forth between the specific sections of the account and the whole account and then connecting this with other accounts into a whole integrated set of meanings (Smith, 2003).

In my data analysis I began with a single transcript and carefully read through it highlighting sentences and making notes whenever I found anything I thought to be interesting or significant. In this way I began to make sense of what was important in the participant's experience. I did this with the first transcript several times. Once satisfied that I had identified everything of significance I then went through the transcript again only this time I began to identify emerging themes. By so doing my analysis took on a slightly higher level of abstraction moving a step away from simply identifying descriptions. At this point the lived experience of the researcher begins to intersect with the lived experience of the participant to create a third entity, an understanding of meaning which is not entirely belonging to one or the other (Smith, 2003). My challenge was to use my own knowledge and experience to articulate the meaning embedded in the transcript. Meaning is not the same as a description of an object. Meaning is a reflection of the lived experience of an object. The participants I interviewed spoke of their own experience and did not provide a detailed abstraction of their lived experience. The

meaning was embedded in the language; it was my task to gather it up through my analysis into a higher level of abstraction and to provide themes of meaning.

As themes emerged I listed them separately. When I had gleaned all of the themes I could from this first transcript I recorded them on a separate page. I then began to cluster similar themes into groups and provided a name or description for each group. While doing this I was careful to make sure that this overarching description did in fact represent the true meaning of the text by referring back to the transcripts.

Once the process of teasing out themes and organizing them into group themes was completed, I moved to the second transcript and undertook an identical process. When all five transcripts were analyzed through this interpretive process I listed all group themes in a final master table of group themes. My final task was to reduce this list into a final set of themes.

The task of identifying a small group of master themes was not simply a matter of noting which themes were most prevalent in the transcripts. This is where my record of participant's passion, as expressed through body language, eye contact, tone and volume of voice, and facial expression, helped to identify the most important themes. Other factors that helped to identify these master themes were their ability to reflect all of the other themes and particularly those seeming to represent the most passion and expressed in particularly rich passages of text.

The final section of the data analysis procedure was to write up a final statement that outlined the meanings embodied in the participant's experience. This involved creating a narrative that expanded each theme by drawing upon the coded transcript

extracts that led to their creation in a way that would enable the research reader to understand their meaning and have confidence in the analysis.

The concept of the heuristic circle was presented at the beginning of this section and identified as central to the analysis of meaning. Throughout the analysis I kept moving from the micro view as expressed in particular transcript extracts to the macro view expressed as themes and then group themes and finally master themes. This involved continually thinking about the essence of what was being expressed and how this essence of meaning could be connected to other expressions within the same transcript to create a theme. An essence “could be understood as a structure of essential meanings that explicates a phenomenon of interest” (Dahlberg, 2006). I then sought connection with other transcripts to form group themes. Finally, I needed to go back to the detail expressed in the transcripts and be certain that the richest expressions of meaning were well represented by several master themes. The master themes emerged not on the basis of prevalence but through their ability to represent the richness and depth of the integrated lived experience of the participants. Each step required analysis and this analysis was more than intellectual. It also involved using my own lived experience to identify meaning within the record of the participant’s experience.

Ethical Considerations

Developing and adhering to strategies during the research process for protecting participants from harm and ensuring confidentiality was an ethical priority. First, research ethics approval was granted by the University of Regina’s Research Ethics Board. All participants were provided with a detailed explanation of the research study and signed a consent form upon their involvement. It was explained to each participant that any

involvement in the research would be voluntary and there would be no repercussions should they choose not to participate.

Although this study was deemed to be low risk to participants, some questions did elicit emotion. I was required to develop a process that included connecting participants with support services in the community if needed. This plan involved ensuring a registered social worker practising at a local family therapy clinic was available to see any participant if need emerged. The contact information was provided to each participant at the interview.

A final consideration concerned confidentiality. The names of the participants were not included in the recorded interviews. The recorded interviews were transcribed by a third person who signed a confidentiality agreement prior to receiving the recordings. Participants were assigned a code number. As the sole researcher, I was the only person with access to the master list and corresponding codes. Any passages of text containing potentially identifying information, including gender of participant and/or the child they may have been describing, were altered. I knew the foster parent community in the region from which the participants were selected. Consequently, I knew how others might identify them through things such as length of time the child was in their care, gender of the foster child, schools attended, or descriptions of incidents that may have occurred. Whenever I included a quotation from a transcript I was careful to alter anything that could compromise confidentiality.

The Social Work Code of Ethics and the Research Ethics Board approval provided ongoing guidance regarding ethical conduct throughout the research process.

My thesis supervisory committee was also available to field questions concerning ethical protocols as they arose.

Credibility and Trustworthiness

The degree to which research is accepted as credible and trustworthy is of importance to those with an interest in research findings. One strategy for enhancing research validity is triangulation. Triangulation can be generally defined as “ a process that involves corroborating evidence from different sources to shed light on a theme or perspective” (Cresswell, 2013). In my research I looked carefully for corroboration between participants, between participant experience and the literature, and between participant experience and my own personal experience with foster families managing adolescents with challenging behaviours. Corroboration at this level did not look for the same accounts from participants since experience is unique to the individual. However, I looked for corroboration at a more abstract level, for example, expressions of concern, intensity of response, and similarity in descriptions of behaviours.

At each step of the research process from design, to gathering data, to establishing and then analyzing findings, I debriefed with both social work peers with experience in the field and with my supervisory committee. This process continually challenged me to be present to the voices of the participants and to be vigilant against the influence of my own bias. I found this to be difficult and at times intense but ultimately revealed findings that embraced a novelty and uniqueness I found surprising. The findings were not my findings; they were the voice of the five participants involved and consequently reflect a rigor that contributes to the overall trustworthiness of the research.

Finally, I have sought to follow the principles for establishing quality in interpretative phenomenological analysis (Smith, 2011). These included: (1) demonstration that the principles of IPA were subscribed to: “phenomenological, hermeneutic and idiographic” (2) transparency to ensure the reader was able to follow how the research was undertaken (3) presentation of rich examples of participant dialogue to support “a coherent, plausible and interesting analysis,” and (4) sufficient sampling to show “density of evidence for each theme” (Smith, 2011, p.17).

Findings

As discussed in Chapter 4, the phenomenological method seeks to understand lived experience and how participants see and make sense of their world. My goal was to understand the lived experience of the participants, all of whom went through a placement breakdown involving a child with a diagnosis of attention deficit hyperactivity disorder (ADHD). In this chapter I describe the overarching themes and sub-themes that surfaced in this study.

I begin the chapter by providing an overview of the essence, or central organizing concept (Smith, 2003), of the participants' combined experience. Next, I introduce a visual representation of this essence: *we love them with all our heart*. I then present a visual representation of the four key themes and provide in-depth accounts of each theme. The chapter concludes with a brief summary of the findings.

The Essence: We Love Them With All Our Heart

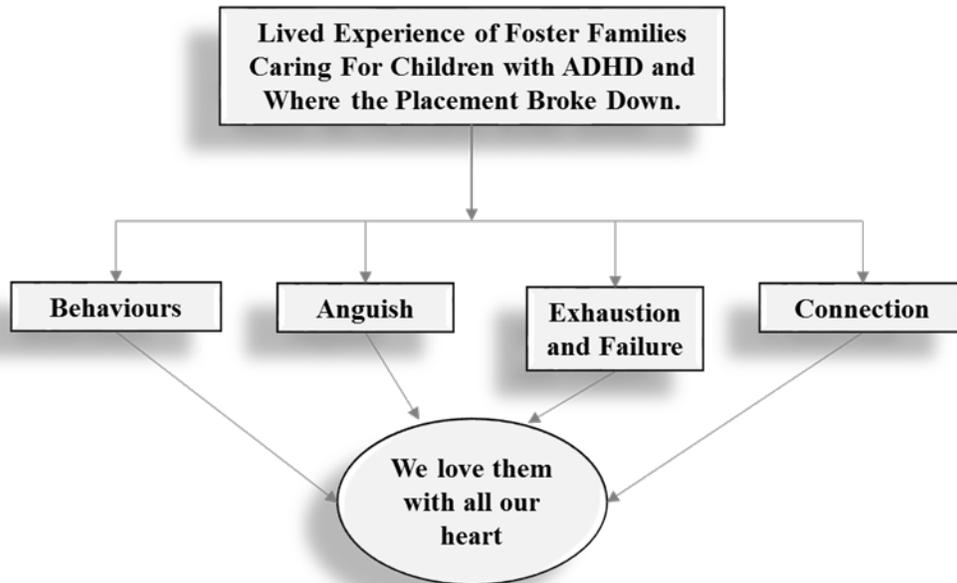
The findings of this study emerged from the stories shared by the five participants. At the heart of this research is the essence *we love them with all our hearts*. An essence "could be understood as a structure of essential meanings that explicates a phenomenon of interest. The essence or structure is what makes the phenomenon to be that very phenomenon" (Dahlberg, 2006). The essence at the core of the experience for all participants was the love they felt for the children for whom they provided care. All participants stated that they loved their children. Through the many stories told, this love for their children emerged to be the central enduring constant and the context for all experience.

The stories shared by the participants describe a love that was deep enough to sustain them through many years experiencing difficult behaviours and through anguish as they experienced what they describe as a failure to parent these children, to influence their healthy development, and to keep them safe. Their stories are told throughout this chapter and describe a love that was not broken by the eventual experience of failure and loss when the foster child left their home. Finally, in every home, this bond between child and parent endured beyond the breakdown and its accompanying grief to a place where, an average of eight years after the placement had ended, every parent described having frequent and loving contact with the child.

What emerged in this study was that these relationships did not have an end. The essence of this lived experience was about how the participants loved their children and how this love endured. This is best described by Catherine, soft spoken and always thoughtful in sharing her story. She stated: “I mean, I love him, he is my son. He always will be.”

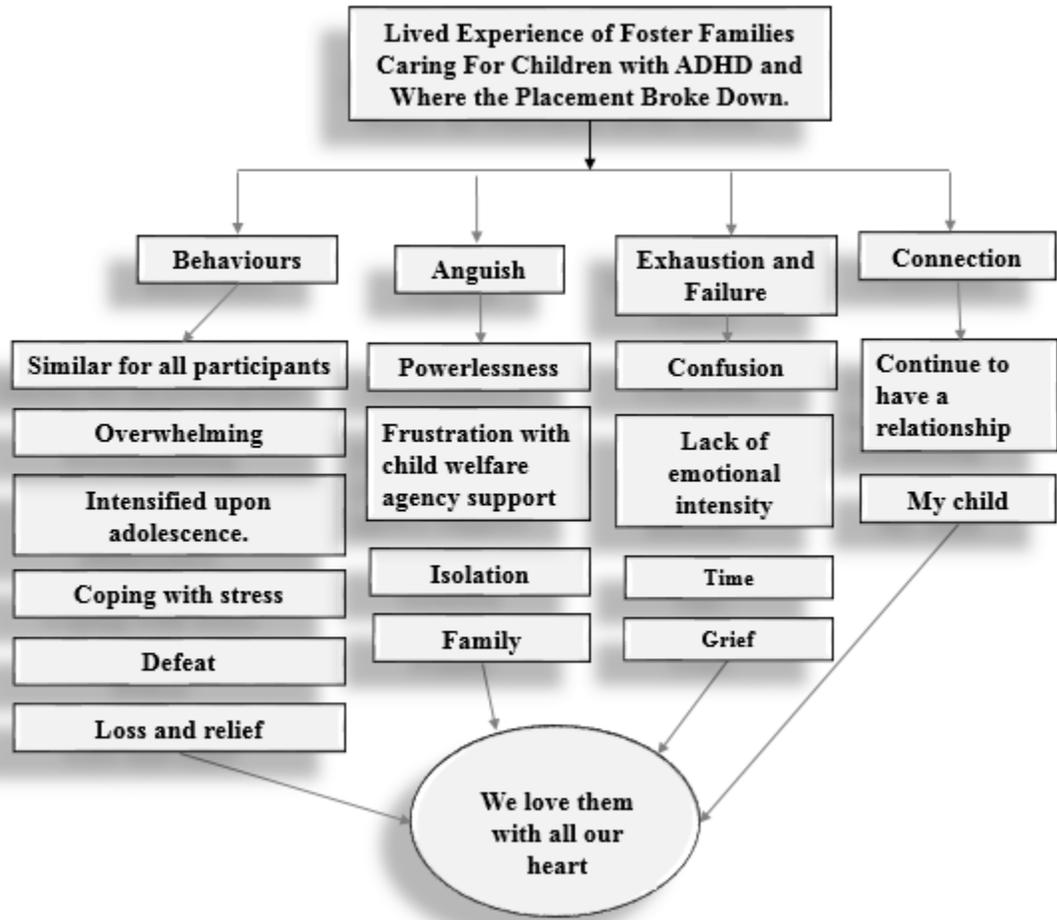
Four Themes Emerging from the Lived Experiences

As I worked through the stories of the five participants, four themes emerged. These are *behaviours, anguish, exhaustion and failure, and connection* (see *Figure 1*). Each theme will be presented here individually and in depth.

Figure 1: Four Themes Emerging from the Lived Experiences

Working with the hermeneutic process, it gradually became clear that each of the main themes was comprised of a number of sub-themes (see *Figure 2*). Together as a whole, these themes and sub-themes provide a holistic account of the lived experience of the foster parents.

Figure 2: Lived Experiences / Love Them With All Our Heart Themes and Sub-themes



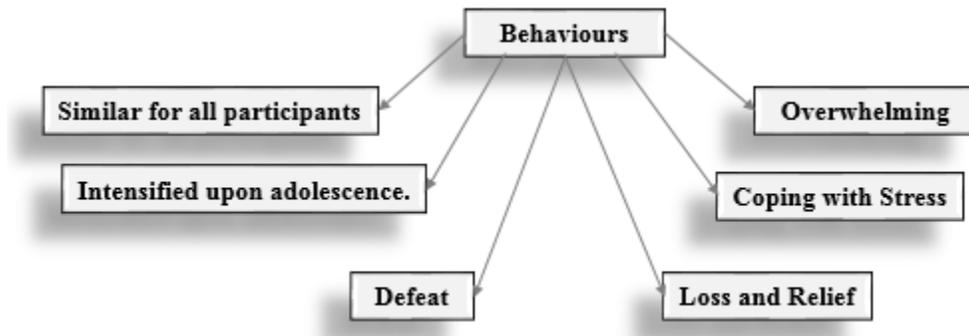
Behaviours

All participants shared in detail the behaviours that they observed displayed by the child in their home. To understand the meaning foster parents’ attributed to the behaviours of their foster children I went back to the transcripts and the hermeneutic process, circling back again and again looking for deeper meanings and the essence.

Behaviour emerged as a theme that was interdependent with the theme of *anguish* and with the theme of *exhaustion and failure*. This interdependence occurred inasmuch as the behaviours experienced by the participants were the energy that generated and

sustained the themes dealing with *anguish* and *exhaustion and failure*. What became evident from the participants' stories is that the themes of *anguish* and *exhaustion and failure* emerged as by-products and in response to the behaviours.

Figure 3: Theme 1: Behaviours



Similar for all participants. All five participants described what is understood as an externalizing type of behaviour. While some participants mentioned specific behaviours described by only one or two other participants, all spoke of impulsivity, expressions of anger, and having things stolen. For example, Joanne described “Swearing, screaming, name calling, you know – down the street screaming at the top of her lungs. Swearing at us. And then not coming home for the night.” She went on to provide more detail and described a connection she saw between her foster child’s inability to form and maintain relationships with her peers and her aggression at home.

She didn’t know how to behave with other people around. And then she became like, she lied a lot. And of course, having no friends made her so, I don’t know what the word is, but she was uh, I don’t know. She was aggressive. She was aggressive to the other kids in our house.

Janice also describes the behaviours she experienced frequently when her foster daughter was in the home.

Okay, stealing, lots of stealing. Anger, total rages. Like, she would break property. Breaking her bedroom door. Um, obsessive lying really. You know, phoning me in tears saying something that I would find out later was completely untrue and, but, really kind of getting you with all of the emotion behind all the stories you know. She used to steal which went along with it. Just a matter of obsessive personality at the time and it yeah. [voice trails off].

Catherine talked about poor impulse control, stealing, poor judgement or immaturity, lying, and addictions.

Oh my goodness: intrusiveness, impulsivity, poor judgment, stealing, lots of stealing, lying. He got into addictions. Severe, beyond the norm teen drinking behaviour. Severe addictions [pauses] behaviours, I mean, they affected my family [pauses] it certainly wore my husband down. It wore my kids down [pauses]. We're how many years past that placement breakdown? Several. So clearly it impacted them hugely despite the fact that they all managed.

Mary spoke of aggression, stealing, and lack of impulse control.

Like for instance they would smash things. Like we bought five vacuum cleaners in eight years. Now that's one example. They would smash things and the one boy out of the two that left was extremely aggressive; my God someone was always getting hurt. He would push my little guy off of the trampoline and broke his leg and ugh, constant stealing. I mean, this started when he was eleven. He would be invited to a neighbour's party and two

days later the neighbours would call the police because of all the stuff he stole. He would steal shoes at school, oh man, it was incredible. Fighting on the bus, beating kids up, and getting kicked off the bus.

Roger and Heather described their child's behaviours as "Anger and acting out. Well he was not necessarily angry at us, but someone else, and then he stole our vehicle and actually totaled it."

This sub-theme is a list of behaviours – impulsivity, aggression, stealing – as described by participants and demonstrates how they were described similarly by the five participants. The following sub-themes discuss how the participants experienced the behaviours.

Overwhelming. The behaviours experienced by the participants were present as a force in every domain of their lives. They were relentless, pervasive, and every participant found them to be overwhelming and in some instances traumatic. Janice described the experience of her child's behaviour as placing her in a state of trauma that eroded her confidence in her ability to parent. She stated: "I see it now that I look back. I lived in a state of trauma myself. And you know, certainly never felt peaceful. Never felt confident in my parenting."

All participants struggled with the behaviours presented by their children. The participants' experience of the behaviours was expressed through feelings of frustration, anger, fear, anxiety, and often a sense of foreboding. Janice described how she waited for her daughter to return home from school each day almost with a sense of dread: "Our house felt always in turmoil, always so chaotic. When she came home from school it was

‘oh God, all hell is going to break loose now’.” Joanne related being torn by conflicting emotion as she struggled to deal with her child’s behaviours.

You know what, it is like they say that love and hate are such a fine line.

There were moments when I was so angry with her I felt like I hated her. But I guess, I loved her so much, but I just could not live with her. It was so hard. There was anger; there was hate; there was everything because I thought, you know.

Mary, who had foster children diagnosed with ADHD, also spoke of the exasperation she felt through constant exposure to very difficult to manage behaviours. She shared how she needed to take “time outs” just to manage: “[I would] try and keep my cool because there were times when I had to go into my own bedroom and shut the door for two minutes just to get a breath because it was safer for them if I did that.”

Intensified upon adolescence. Several of the participants spoke of their child’s behaviours increasing in frequency and intensity as the children entered adolescence. This added to a sense of losing ground or losing control. Janice spoke of her foster daughter’s behaviour becoming “more rebellious” and Mary described strategies “that helped me for a long time, until the boys got older.” Joanne’s child left her through a breakdown after being in her home for thirteen years. The very hard to manage behaviours only surfaced at the onset of adolescence as described through Joanne’s story:

When she was little we really didn’t see a lot of behaviours. As she got older and near to puberty her behaviours were... her one thing she had no social skills. She had no idea of social cues. She didn’t know how to behave with other people around.

Janice's child was nine when she joined her family and the placement broke down seven and a half years later in adolescence. She said:

The older she got and the more power she kind of had, because she had to have more independence and all that of course, and then the more um, I don't know. Just sort of, the less control I had.

All participants welcomed the children into their home as young children and in every case the breakdowns occurred when the children were adolescent. The older the children became, the greater the impact the behaviours had on the participants and their families.

Coping with stress. Several participants spoke about trying to develop strategies for dealing with the stress of the behaviours occurring every day. Mary approached it by learning new approaches and by being aware of her child's history:

One of the things I used to do when I finally got them all to sleep, I had to encourage myself and I would read some of the stuff like Barbara Coloroso. I've gone to see her three times; anyways I would take out some of the books and encourage myself and I was always looking for new and different ways to do things.

They made me very angry but I still, I could look at them and I could see, because I knew their history [pauses]. And I, I, would think for a minute, I would be really upset and then I would think about where they came from and why this was happening.

Other coping strategies were shared by Roger and Heather. They turned to their faith and its community for support. They also spoke of finding support in a commitment

they made to the child and their natural family. Roger and Heather shared this commitment with their natural children and extended family and friends.

I mean, we have a circle of friends who share the same faith that we do and I think that was probably one of the stronger points of us being able to handle whatever came our way. When we started, well I don't know if it would have been when we started fostering, but it wasn't long afterwards that we made a commitment to being there for this family. And that, that was our goal for as long as we were alive.

Despite being aware of the stress and attempting to cope through various strategies in every family, it finally wore them down. Inevitably the frequency and intensity of the behaviours resulted in exhaustion and defeat, the next sub-theme.

Defeat. Eventually this struggle, over many years, led to a sense of defeat in all participants. Joanne described feeling overwhelmed and powerless to have any effective influence upon what seemed to be pervasive and destructive behaviours. She related, “We just said, ‘We can't do it anymore, it is hurting our family, and it is hurting us. Our house is always in turmoil, always so chaotic.’”

All participants described reaching a point where they felt unable to influence the behaviours and so had feelings of being out of control, overwhelmed, or “in over their heads.” Mary expressed this sense of being out of control as a desperate feeling of knowing she only had a little strength left: “I knew it was over my head and that I couldn't handle it for long.” She described eventually getting to a place of defeat where she knew it was over and she could not go on.

Okay, it got to the point where I just couldn't take anymore. And you know, I, when you first called me. I was thinking to myself, I will try and be as positive as I can about everything but you know what, I'm a very honest person and I can't say a bunch of stuff that isn't true. And it was very unfortunate. I went to hell and back with those two boys so many times.

Mary gives voice to the conflict she still feels more than six years after the placement broke down. On the one hand, Mary begins to share a story that offers a veiled appearance of a happy ending. However, as stated by all other participants, living with a child with ADHD carries with it experiences that are likened as "going to hell and back." As described by all the participants, going to hell and back meant that the relentless struggle to manage behaviours resulted in tremendous stress, sometimes trauma and fear, and finally, in every family, failure. All participants seemed to fall victim to a relentless exposure to traumatic behaviours and the accumulation of failures to support positive change. Roger and Heather described their stress and their sense of helplessness in the following example.

Yeah I think probably more so was that we could feel that the stress was getting to a point where we felt helpless and the stress was getting stronger and stronger and there was just nothing you could do.

Another participant explained that the breakdown was caused by behaviours but says "it was for different reasons" (Janice). This statement was repeated over and over again as the participants explained that it was not "bad kids" that caused the breakdowns but rather their inability to effectively support the expression of safe and healthy behaviour in their children. Catherine also spoke about repeatedly seeing her foster son

getting into a “snowballing” series of behaviours and described how this occurred on several occasions at school. This snowball would begin with behaviours that would create some confusion or difficulty. This would lead to something bigger and the child would not make a correction but would continue to contribute to the dysfunction until the problem became too big to solve. Poor impulse control seemed to be the central concern and is illustrated in the following passage:

Starts sleeping in, starts to not do well. Does a couple of dopy things at school and gets called into the principal’s office and starts getting that label, especially in high school. They get away with it quite a bit in elementary school and it’s not so ... but in high school you know, like taking his knife to school, his pocket knife. He carried it all the time anyways. My husband is a hunter, he hunted, and my other kids hunt. But he took it out of his pocket, it’s like... you know, something impulsive, he wasn’t thinking. He pulled it out and he was already on the radar because he had missed so much school, so into the office ... just stuff like that you know. And then they start watching you. Then he thought it would be a great idea to look up some gag for, he was thinking about doing a gag and to make a homemade smoke bomb and he was looking that up on the school computer. And just dumb ass stuff – it was like really!? What were you thinking? You clearly weren’t thinking!

Catherine is dumbfounded that her child just does not “get it.” Hence her comment “What were you thinking?” She expresses a sense of frustration with the behaviour but also with her inability to influence it. This was a boy who had been a part

of her family for almost 10 years and yet failed to be influenced by her guidance in the face of these impulses.

Loss and relief. Finally, beyond this expression of feeling overwhelmed and being pushed beyond an ability to endure, all participants, exhausted and in despair, described a despondent acknowledgment of failure as context for the decision to move the child. The behaviours created intense feelings of being. In the end the behaviours were responsible for tremendous pain and loss but also relief once they were removed. Janice said:

You know, if I had to do it over again, I wouldn't be a hero. And you know, at first that's what you think you are or you have to be. No. But, eventually it was those behaviors, but it was for different reasons I guess. I don't think it was the wrong thing that it happened; it just didn't happen the right way that's for sure.

After living with Joanne for 11 years, the placement broke down and her foster daughter moved to another foster home. Joanne's feelings are complicated as she continues to want to be connected to her but is relieved her home is now calm.

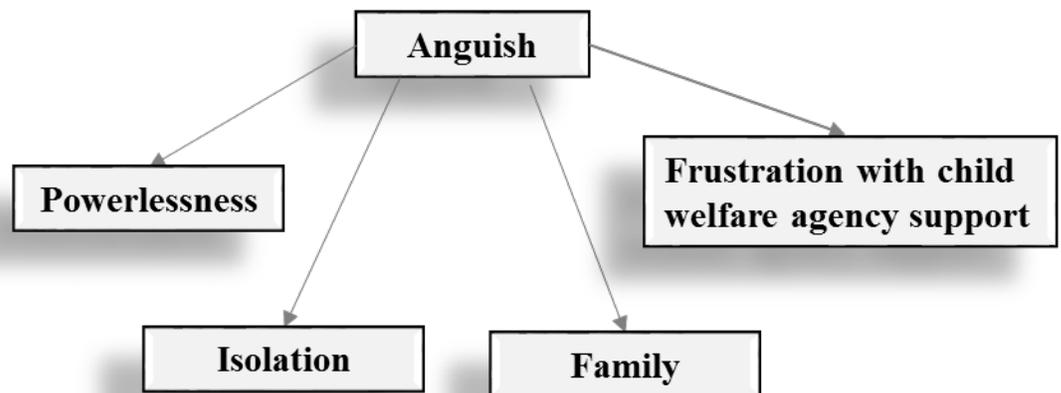
She moved to another foster home and you know what. Our visits were so much better and all I could think, there was a huge relief and our home was so quiet. Even though we had three or four kids in it, but it was just so different and all I could think is we should have done this a long time ago.

All participants expressed a tension between loving and wanting to be with their foster children and the stress caused by their behaviours. This powerful feeling of being torn was expressed through the next theme *Anguish*.

Anguish

The word anguish is used to describe this theme since it conveys a sense of tension or conflict, of being torn, of wanting one thing desperately but seeing it just beyond grasp. This describes a state of being that was evident as the lived experience for all participants over many months or even years. It occurred over a period leading up to the placement breakdown and for some was still present at the time of the interview. Anguish was expressed through a number of sub-themes, the first being powerlessness.

Figure 4: Theme 2: Anguish



Powerlessness. All of the participants stated that they experienced feeling powerless to succeed in the face of a desperate need to parent their foster child. Roger and Heather described the developing sense of powerlessness as “We could feel that the stress was getting to a point where we felt helpless and the stress was getting stronger and stronger and there was just nothing you could do.”

Participants talked about feeling powerless to keep their children safe, to help them experience success at school and with friends. Catherine described an incident at school and voiced her incredulity at her foster son’s inability to recognize that this would create difficulty:

Then he thought it would be a great idea to look up some gag for, he was thinking about doing a gag and making a homemade smoke bomb and he was looking that up on the school computer. And just dumb stuff – it was like really!? What were you thinking? You clearly weren't thinking!

Catherine had been supporting this child for many years working to help him develop successful skills. This illustration shows that Catherine felt limited success.

Joanne talked about trying to help her foster child manage her behaviours at school and how difficult this was:

In fact, this poor kid. By grade eight, she got kicked out of her elementary school and moved because she just couldn't even function at the school. And the kid, she always thought it was everybody else not her. She was just very hard to be with.

Joanne's frustration is evident by the comment, "she couldn't even function at school." Nor could Joanne see any success with friends and said, "The other kids did not really like her because she acted so hyper silly."

Roger and Heather spoke clearly about feeling unable to keep their foster son safe saying, "And the thing is, we were supposed to be protecting them and we weren't able to do that then."

Janice describes how she felt when her foster daughter was at school and unable to self-regulate. Janice was unable to help her and the school did not know where to turn. She said:

Ugh. God I just remember even at the school things were so bad. Even at the school you know. Teachers weren't even sure about what was going on. It

was just hell. God, yeah. My life had never felt at a lower point and then everything kind of erupted. So I wasn't in any shape to deal with that. I can't deal with that. How am I supposed to deal with that? I can't be a parent of this kid if I am in this situation right?

The last few sentences of Janice's experience convey a sense of feeling overwhelmed by what was happening and of her eroding confidence as a parent. There is also present in her words an unstated request for absolution in the face of this failure. Janice says, "So I wasn't in any shape to deal with that. I can't deal with that. How am I supposed to deal with that? I can't be a parent of this kid if I am in this situation right?" More than seven years after the breakdown these questions are important to Janice and seem to remain unanswered.

Discussion of this experience of powerlessness often included accounts of difficulties receiving support from child welfare workers and this is presented in the next section.

Frustration with child welfare agency support. Of the five participants, only one felt supported by her child welfare support staff. For the others, their experience was another source of anguish.

Mary's disappointment and frustration concerning her request to have someone come in to her home to help with cleaning and cooking after she became ill is one illustration. She said:

If I could have had home help to help me with the laundry and even some meals and vacuuming and stuff, then when the boys came home after school we could have had more time to do things. There were still a lot of

appointments with psychiatrists and stuff like that so I wasn't home that much during the day. That would have helped me an awful lot.

She went on to explain that she believed a minimal amount of additional support would have prevented the breakdown. As it turned out, Mary discovered several months after the breakdown that the support had been approved but never communicated to her due to worker turnover and the approval being mislaid. She explained:

Then three months after that I found out that I had been, um, the worker that left had put through and they [pause] that happened all the time. The worker had put through home help from January until the end of August and also contract workers ten hours a week for each of the boys. This was after they left our home I found this out.

Many participants felt powerless to influence case plans. Roger and Heather spoke of feeling “powerless in what we said or wanted to have done. Be implemented.” They said they felt “there wasn't anything, there was absolutely nothing [they could do to influence the case plan]. We were only fulfilling a job that the [child welfare agency] allowed us to do and that's it.”

Some participants spoke of feeling as though they were viewed with suspicion for not being able to manage as a parent. The more their foster child's behaviours escalated, the less they felt support and the more they felt a sense of blame. A portion of Janice's following account has already been provided to explain her experience as her foster child entered adolescence. As can be seen, she is describing a general sense of feeling without support as well as being viewed with suspicion regarding her child's behaviours. She said:

Then the older she got and the more power she kind of had, because she had to have more independence and all that of course, and then the more um, I don't know. Just sort of, the less control I had and the less support from [the social welfare agency] basically. Her workers would kind of side with her and say, "What is going on here? There is something wrong with the woman she is with because." You know... that kind of stuff.

Much of the frustration expressed with the child welfare agency support revolved around the inexperience of support staff and staff turnover. All participants spoke of new workers coming on and changing the direction of the case plan without consultation and leaving the foster parent feeling abandoned. Janice described how this affected her family:

And when this new person came along with their passion and ideals they really didn't have a clue what was going on and saw it through the eyes of a really, you know, a kid with a lot of issues.

In this excerpt Janice is talking about her experience with new and inexperienced workers failing to talk to her about why her child was displaying the behaviours she was at that time or what support she needed to help her child. Janice saw workers basing case planning and decisions only on input from the child in her care who was functioning with many distortions. This led to an experience of exclusion and feeling isolated.

Most of the participants cited worker turnover as a cause for feeling isolated and without support. In fact, many participants described occasions where the worker/foster parent relationship felt adversarial. Mary described child welfare worker turnover this way:

And another thing that doesn't do foster parents any good is having these young kids come in and they have a job for three or four months – like you know for a while there I had, the one year, the year before those boys left I had five workers. Five workers. Now you tell me how are you going to try to reach that poor young girl [worker] that has had no experience with these terrific situations? You know, it was just ludicrous to think that. And then you, poor you, try to explain and then you get a call two months later, well, she was transferred. And I understand that those things happen, but what I am saying is it doesn't do us any good either.

Janice talked about her sense of loss of direction and planning as workers changed.

There were so many workers at that period. We went through so many workers. I guess people just didn't know. You know, every time you get a new worker they have a new perspective and they go in and do not know the history of the kid.

One consequence of a perceived lack of support from the child welfare agency was a sense of feeling isolated. The feeling of isolation did not rest solely with the child welfare agency relationship. As will be seen in the next sub-theme, there was an experience of isolation on a number of fronts.

Isolation. Isolation and the sense that they were “on their own to sink or swim” was expressed by every participant. As the stress increased due to escalating behaviours, participants spoke about feeling there was nowhere to turn for help. Catherine talked

about feeling at a loss when she turned to a youth mental health agency for help with her foster child's behaviours:

And, um, you know when I take a child into [mental health agency] and he clams up and curls in a ball on the floor and nobody knows what to do except for me – and then they you know, they write off he is this and this and this [pause] Okay [gestures what am I supposed to do with that].

Catherine had been looking for someone to take the lead and provide direction. She felt abandoned.

The sense of isolation extended to other needed supports including extended family and friends. As Joanne continued to parent her foster child, her friends, extended family, and her own children all distanced themselves from her. She explained that they could not understand what was happening or why it was happening because her foster daughter looked “normal.”

It was just crazy, and the other part of that was that most people, even our own family members, they didn't understand it because she looked like she should be like everybody else.

It was hard. And then our own kids were growing up and they were not enjoying being around. They had already left home actually. And they didn't even like visiting.

Turning to a family member for help, Joanne sought some respite; however, this was short-lived and once again she was left feeling alone and without relief.

The last year I tried with one of my sisters who was single, her kids gone, had her own apartment and she said she could have her on the weekends

easy. I said I'd pay her and, um, so we paid my sister. She took her for a few months, every second weekend. And this helped, just that she was out of the house. But then even my sister said, "I can't do it anymore, I can't even stay with her for a weekend, she is driving me crazy." So that would have been a big thing, respite, someone to help us. Because we had nowhere for her to go for a break.

Janice spoke of not knowing how to manage but of experiencing a need to feel it was okay, that there were others who had been through a similar experience:

I didn't know. I needed support. I needed, ugh, I needed someone to know what I was going through with her, so maybe some group of family counselling that would have included my son as well. Some group, some family who had gone through what we had gone through... something like that so that my son could be heard. So that all of us could feel that there is something about this that isn't totally abnormal. You know.

Janice's sense of desperation is evident as she needs to understand what went wrong and to receive some support for "what we had gone through." This anguish is expressed in her interview with me seven years after the placement breakdown. This need to come to terms with the placement breakdown was evident with every participant.

Mary also described a need to feel supported by others who saw what she was going through. She said, "And you know what else would have helped me, maybe a phone call once every two weeks. Like how are you doing? I never ever got that. Ever!"

The intensity of the emotional pain, the anguish, was striking and was expressed as a state of being by every participant an average of eight years after the placement

breakdown. The participants all spoke of the toll the experience had on their families and this is explored in the next sub-theme.

Family. Fostering a child is an action that involves, and has an impact upon, the experience of every person living within the family home. All but one participant spoke of their experience of other family members who had their own relationship with the foster child. Joanne explained that at times helping her child manage her behaviours led to conflict within her family. This contributed to the overall sense of chaos and conflict within the home. She said:

It was really hard on our family. I guess we were at a very high stress level. Back in especially the last year she was with us. We couldn't, it took a long time to reach the decision that she had to go. For our own good, for our marriage. We had to see the councillor ourselves a lot too because he would think I am too soft on her; I would think he was too hard on her. You know what I mean, in a marriage, it's um. It was getting really difficult to see which way, what we were doing with this kid and who was right and who was wrong, you know. Stuff like that.

Janice described how she lived in a state of trauma herself and of how her foster child's behaviours eroded her confidence as a parent. Janice exclaimed, "You wouldn't believe it. Yeah, totally. Completely. Um, I see it now that I look back. I lived in a state of trauma, myself. And, you know, certainly never felt peaceful. Never felt confident in my parenting." Janice explained that this experience of trauma also extended to others in her home. In this excerpt she is talking about her seven-year-old

biological son feeling caught in the emotional trauma of his home. Janice was aware of how much he was being affected by his foster sister's behaviours and said:

When we would talk it would, I would find out okay, he was getting a lot of stuff stolen from him. He was being physically abused. But he would never say anything. He was certainly being bullied. And yet, he kind of sucked it up in some way and he always [pauses] and you know what he said, I talked to him when he was a couple of years older, there was a certain point and I said you know I'm just not sure we can do this anymore and he goes, "Mom if the child leaves, then all the kids at school are going to think it's my fault." And you know, I, my heart really went out for him because I could see. He was struggling with a lot of things, but that was another truth that he was struggling with.

Catherine spoke of the experience her foster son's behaviours created within her family, particularly during the year leading up to the placement breakdown.

It certainly wore my husband down. It wore my kids down. It is interesting because the kids that lived sort of that part at the very end when we ended, when the placement actually broke down with the boy that was with us for so long, they still remember a lot of what he was doing. They still refer to I'm not going to be a... you know... I'm not going to do... So, and that was how many years past that placement breakdown? Several.

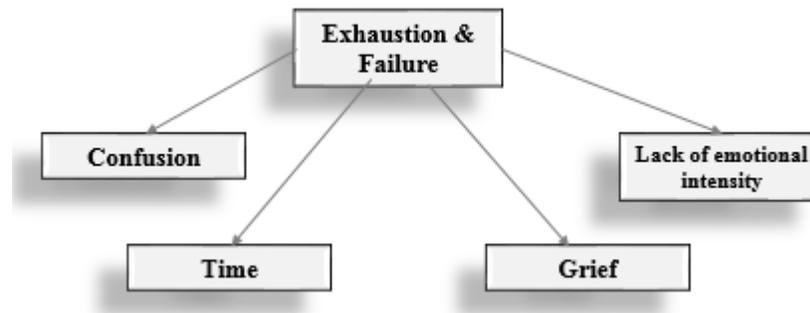
Mary's comments provided insight into her isolation. She had been a foster parent for many years before her partner truly understood her challenges. This occurred at a time when his work, that usually took him away from home, remained local.

It is a good thing that we have a strong marriage because let me tell you, we still had the youngest one and then the two little guys that we still have now. And once my husband was home for a whole year before we had the two newest little fellows that joined our family and he could just not believe what was going on with one child. He just couldn't get over it because of the behaviours and just the unreal stuff so, it made our marriage even stronger because he said to me many times he would have never taken work away from home had he known. You know and you don't know that when you first start out with this. You think your love and understanding and patience will solve everything and it doesn't.

All families were integral to the lived experience of the participants. As the breakdown grew closer the experience of failure and a feeling of being exhausted and without any more energy emerged. It is described as the subject of the next theme.

Exhaustion and Failure

This theme emerged as it became apparent that none of the placement breakdowns occurred as a result of any key or dramatic precipitating event. Instead, the impression was more of someone turning out a light and slowly walking away in a state of confusion, exhaustion, grief, and relief.

Figure 5: Theme 3: Exhaustion and Failure

Confusion. In every case the placement breakdown appeared to happen as if in slow motion, sometimes leaving in its wake a sense of confusion or uncertainty as to what had happened. When participants tried to explain when or why the breakdown occurred, they did not describe a culminating event that was irreconcilable or the last straw. Instead their stories conveyed a recognition of overall failure. Janice remembers the end of the seven-year stay of the child who came to live as her foster daughter at nine years of age this way:

Then one day, you know, I phone and they said, “I think we are just going to come and get her right now.” There was no [pause] I wasn’t part of any team. There was no [pause] nothing going on.

Lack of emotional intensity. We have seen intensity of emotion describing difficult behaviours in other themes. This theme gives voice to the experience of the end, how the experience is remembered, and it is notable for a *lack* of intensity. When asked to describe how their breakdown happened, Roger and Heather were not certain.

Heather: “I really don’t know that a specific thing, that there really was anything.”

Roger: “Just all the events that connected together.”

All the events connected together, high stress, feeling helpless and unable to keep the child safe, and a sense that the breakdown “just sort of happened.” This somewhat confused, despondent acknowledgement of failure was evident in all of the interviews.

When asked if there was a culminating event, Catherine replied: So, I am guessing probably yes; it was the behaviours for both decisions. But in the end I am not exactly sure why the department chose to remove him at that time when they did move him. I don't know exactly.

Catherine felt she did not know exactly why a child who had lived as her son, in her home, for 10 years was moved. As will be shown in the last theme, this is the participant who said of this child, “I mean, I love him, he is my son. He always will be.”

Mary spoke of the last days she had with her child, her being refused in-home help and how she experienced frustration with a struggle that went “on and on.” At the end of this statement her voice trailed off.

So anyway then when he came home [husband worked away] things just continued and then it was summer holidays and there was always trouble, sneaking out and everything that you could think of because there wasn't enough for them to do. And they refused to help out with anything at home; it went on and on and on. So then I just phoned and I gave them a deadline. So then they came and they [voice trails off].

This account was Mary's memory of how the experience of caring for a child in her home for 12 years came to an end. The lack of energy in this statement is in sharp contrast to the intensity of energy expressed in the previous theme of *Anguish*. However,

it was evident that this experience was still emotionally charged and was too painful to talk about.

Time. The previous theme, the anguish of powerlessness, was filled with frenetic accounts involving the participants, the child in their care, and others who were a part of the narrative. The theme *Exhaustion and Failure* is also a theme about time. All participants described a tremendous expression of emotion and the outflowing of energy seeking solutions leading up to the placement breakdown. Co-occurring was the experience of a silent, gradual, and relentless movement in time toward the inevitable precipice of failure and placement breakdown.

Mary reached the end of her endurance in the description presented in the previous sub-theme. Important for this theme is her experience of the struggle going “on and on and on.”

The experience Joanne and her partner had leading up to the decision to have their foster daughter leave their home was presented in the sub-theme *Family*. A portion of this description is provided here to identify the use of time. Joanne talks about the “last year she was with us” and that, “We couldn’t, it took a long time to reach the decision that she had to leave.”

Mary described how the turmoil and stress of experiencing the very difficult behaviours of the child in her care felt as though it was “just, endless” and she stated that “that is how we lived for years.”

Grief. *Exhaustion and Failure* is a theme describing a human tragedy occurring over time as if in slow motion. Memories of the end are unclear. However, memories of the aftermath were very clear and are embraced by the sub-theme *Grief*. The expressions

of grief by participants were profound and this voice must be honoured as the final sub-theme of *Exhaustion and Failure*.

Joanne remembered the grieving and support she had from her child welfare worker:

And to be put in this position where you have to make this decision is so hard. And like I said, thank God for the two social workers who really helped me through, I remember this one day when one of them sat with me and I cried and she just made me feel better. That the decision had to be made basically.

Janice spoke of the emotional state she experienced at the time her child left her home. The statement feels like a plea for agreement, for an absolution from the grief and guilt Janice felt for her failure.

It was just hell. God, yeah. My life had never felt at a lower point and then everything kind of erupted. So I wasn't in any shape to deal with that. I can't deal with that. How am I supposed to deal with that? I can't be a parent of this kid if I am in this situation right? ... And I was just an emotional kind of, you know [voice trails off].

At the time of the interview the breakdown in Mary's home had occurred eight years previously yet despite this passage of time her experience of sadness and regret is clearly evident in the following statement:

I can tell you honestly it is one of the hardest things I have ever done in my life and I almost had a nervous breakdown because of it.

Mary told of how much she felt regret over the breakdown and of how afraid she continued to be for her now adult foster child. She said:

I wanted so much, you know, when you go to the foster parent meetings and support groups you hear these horrible stories about what happens to kids on the street and stuff like that and I didn't want my boys to leave and I didn't want that to happen.

Mary is still a foster parent and she spoke of how her experience has been given meaning by teaching her "how to try and do things differently" for other children:

But anyway, that's over and done with. As long as I am doing this I will never stop trying, that's for sure. And you know I have learned an awful lot over the years on how to try and do things differently.

Janice spoke of the things she thought might have made a difference for her child and between the words is an expression of regret.

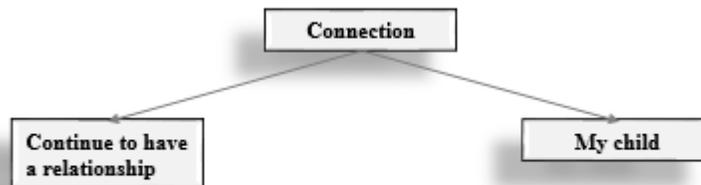
I really wish that there were really... sort of, full out resources for kids. If there had been with this one girl so much would have changed for her. ... I just wish there would have been, I wish I would have known about the supports. We need more connections.

While this chapter on findings may seem overwhelming with the pain and anguish of the five participants, this is only a part of the lived experience. As explained in the section describing *essence* there is a deeper meaning involving the love of a parent for a child. This meaning began with *Connection*, the next and last theme.

Connection

The final theme to emerge involves the depth of connection between every participant and their foster child. It was perhaps the most unexpected. That there would be a strong bond between a foster parent and a foster child was not surprising, but the intensity and endurance was something I had not previously considered.

Figure 6: Theme 4: Connection



Continue to have a relationship. The breakdowns being discussed occurred on average more than eight years prior to the interview. However, despite this lapse of time, every participant described their experience with deep emotion and continued to have a connection with the child. The lived experience of all participants included the children they had cared for as loved and remaining a part of their family.

Janice explained that, although it took some time to build the relationship, she now had at least monthly contact with her daughter. Her contact provides support and encouragement to her now adult daughter who is herself a parent.

It took a few years, but now I see her at least once a month. I go out with her and her babies and have coffee and talk and she said something to me that really, that I didn't even respond to. It left me with my mouth open. She said, you know, because her little guy was out and roaring through Walmart

yelling. And I said, “He’s just two,” and she goes – “I guess you’re used to it. I was a really bad kid.” And my mouth just dropped because I really didn’t expect her... I don’t know... it just came out of nowhere and I thought, she wasn’t a bad kid. She wasn’t. It wasn’t about her being a bad kid.

My child. Catherine described her current relationship with her foster child in a matter-of-fact and thoughtful way. To Catherine this is a story about one of her children, someone who always will be her child. This simple statement was used to express *essence* at the beginning of this chapter: “We still have contact; he has come back to us in a way. He is an adult now so he has come back and yeah. I mean, I love him, he is my son. He always will be.”

Janice is the participant who described the anguish of her experience as living “in a state of trauma myself. And you know, certainly never felt peaceful. Never felt confident in my parenting.” Yet, seven years later she is still connected to her now adult foster child and supporting her with her own children. She said:

She is doing okay now; she is parenting well, which is a huge surprise to me. She is 24 now and really very good at looking after her children and my biggest fear was that she wouldn’t actually be able to bond with them and she is doing an amazing job. I am so pleased about that.

Mary explained that all of the children she has fostered over the years are her children and she loves them all. Mary said “Everybody that knows me – I love my kids with all my heart and I show it and I tell my kids everyday – ALL my kids – I love you with all my heart.” Mary’s experience with her child and the placement breakdown led to

her being hospitalized, but at the core of her experience is love. Mary's reference to the "three boys" in the following narrative describes the three boys she was caring for at the time of the breakdown. She continues to follow their lives, offering support, encouragement, and guidance wherever possible as she would to her own child.

All three of the boys, those two that left in 2006. The one is working full time, he has a good job downtown and I talk to him every week and I see him, especially on his birthdays. He invited me for supper, he is a great cook and I am happy to say he did lots of practicing here. And the oldest one, the other one is in jail. And the youngest one, he is going to be nineteen and he is living on the street right now. He left on his own accord after the other two left. One of them was his half-brother and when the other two boys left the last year that he was here, when my husband was home, it was very hard on him because he was so terribly lonely and he got into an awful lot of trouble and he wanted to leave and be with kids his own age so he left. But I see him all the time as well. Like I just saw him again last week and I am thankful that I have that connection and sometimes I think to myself, well you know Lord. Maybe I did do something right? I don't know. But it hurts very much that the other two are not successful. But I don't know, I just didn't know what else to do.

Joanne has regular contact with her foster daughter and is happy and a little surprised to be so close to her.

So anyway, we do have a good relationship and it's funny to me that she still really likes me because... yah. To her, like what she tells me is I am her best friend and I suppose I probably am because I am the only constant.

Roger and Heather also remain connected with their foster son who, now in his twenties, was living at their home at the time of the interview. They spoke of their relationship and commitment.

When we started, well I don't know if it would have been when we started fostering but it wasn't long afterwards that we made a commitment to being there for this family. And that, that was our goal for as long as we were alive and that was something that we also let the kids know, that this is what we have intended and whatever we can do we will do. It doesn't always work out the way we want, but so be it. We will battle through it.

How and why this connection exists is beyond the scope of this work. That it does exist is made clear by its endurance, the frequency of contact, and the depth of these relationships.

Summary

The findings in this chapter give voice to the lived experience of five participants who, as explained at the beginning in *Essence*, loved in a very simple, human way, as parents love a child. The essence of living with a foster child with ADHD where there has been a breakdown is love. Through the four themes of *Behaviours, Anguish, Exhaustion and Failure, and Connection* we see the *Essence* of love.

Discussion

This chapter provides a discussion of the findings of this research and examines the implications, particularly in regard to foster families caring for children with ADHD and for children in care with an ADHD diagnosis. A section is also devoted to an examination of the findings within the context of child human rights.

Discussion and Implications of the Findings

The essence emerging from the findings, *we love them with all our heart*, conveys a deep love and attachment between the participants in this study and their foster children. This was expressed in a number of ways but particularly through the supportive relationships that continued to be maintained with the now adult children. The relationships have been maintained an average of eight years after the placement breakdowns. The intensity and endurance of this human attachment was dramatic, yet it was not enough to prevent the placement from breaking down.

The behaviours. The participants' experience of their foster child's behaviours emerged as a key theme in the breakdown of every placement. This is a finding consistent with foster placement disruption literature going back more than 30 years (Octoman & McLean, 2014; Taylor & McQuillan, 2014). The behaviours were experienced as overwhelming and frequently traumatic for families. They fell into two categories, emotion dysregulation and externalizing behaviours. Both categories of behaviour are addressed extensively within the ADHD literature (Bunford, Evans, & Wymbs, 2015) and effective treatments exist (Evans, Owens, & Bunford, 2014).

Emotion dysregulation occurs at a rate of 25 to 45% among those coping with ADHD. It is a major contributor to impairment throughout life and is frequently

associated with reactive aggression and temper outbursts (Shaw, Stringaris, Nigg, & Leibenluft, 2014). Externalizing behaviours also commonly occur among individuals with ADHD (Yoshimasu et al., 2012). The expression of externalizing behaviours includes a general acting-out style of behaviour including aggression, coercive behaviours, emotional impulsivity, and noncompliance (Farrell, 2011; White, Jarrett, & Ollendick, 2013). It is important to note that neither emotion dysregulation nor externalizing behaviour are currently included as criteria for an ADHD diagnosis but are commonly found occurring among those coping with ADHD. Examples of these behaviours were provided by all participants within the themes of *behaviours*, *anguish*, and *exhaustion and failure*.

The diagnostic criteria for ADHD organize behavioural symptoms within three categories; inattention, hyperactivity, and impulsivity. Several participants described behaviours that were impulsive. Some of the examples discussed included substance misuse, risky sexual behaviours, and poor decision-making at school. Inattentive behaviours were mentioned but were not presented as creating any overwhelming difficulty for participants. These behaviours created a need for constant reminders, structure, and supervision: difficult and tiring but not overwhelming. The behaviours participants spoke about in the category of hyperactivity were similar, demanding constant attention and supervision but not placement-ending by any means. Some of these behaviours presented as an inability to play quietly or to occupy themselves and constantly requiring adult attention to create, direct, and encourage play.

All of the placement breakdowns occurred with adolescent children that participants had been caring for prior to reaching adolescence. Some of the participants

identified pre-adolescent behaviours as tiring and demanding but none experienced them as overwhelming. However, all of the children would have been presenting ADHD behaviours given all had an ADHD diagnosis. The DSM-5 criteria requires that symptoms be present at least since the age of 12 (American Psychiatric Association, 2013), but these children were all diagnosed using pre-DSM-5 criteria which required the presence of symptoms beginning at least as early as age 7 (American Psychiatric Association, 1994). So at first glance, the severe, intense, constant, and overwhelming behaviours described by participants leading to placement breakdown did not emerge until adolescence and are not listed within the ADHD diagnostic criteria. They are commonly, but not exclusively, occurring among those with ADHD.

This finding is consistent with other findings in the fostering literature where multiple references have been made to conduct problems as contributors to placement breakdown (Brown & Bednar, 2006; Davies, 2009). The majority of the child-related disruptions, i.e. resulting from something the child does or does not do while in foster care (Blakey et al., 2012, p. 371), have been identified to include severe behavioural and emotional disturbance. This is particularly the case with children displaying externalized behaviours, including aggression, disruptive or destructive behaviour, and oppositional behaviours (Blythe et al., 2014).

The study undertaken in my research was interested in the lived experience of foster parents caring for children with ADHD where the placement broke down. The participants provided a vivid account of the lived experience as caregivers of children with extreme, high risk, and chaotic behaviours. The participants were deeply affected and their accounts are instructive, providing an insight into what supports might be

required to sustain the relationships the participants had with their children. The participants were not so much afraid of the behaviours as they were traumatized and distraught at not being able to keep their children safe. Finally, the efforts to manage these relentless, intense, and chaotic behaviours led, over time, to a sense of exhaustion, failure, and defeat.

Gradual and complex breakdown. The breakdowns described by participants in this study did not occur in response to a single event but were complex and occurred in every instance over the space of more than a year. This finding points to a need to think about placement breakdown as a complex process rather than a single event. This finding is supported by the finding of a Swedish study by Khoo and Skoog (2014) where data was collected from eight foster parents who had experienced a placement breakdown. The study found that “Foster parents’ descriptions depict placement breakdown as a consequence of a long series of events preceding children actually leaving their care” (p. 260).

When I first contemplated this finding I found it alarming since I was aware of the intense distress experienced by the participants. In every case the breakdown took place over more than a year. However, my focus began to change to where I saw this as representing an important opportunity and a key finding. This finding concerns time. If placement breakdowns occur over a long period of time, then there is opportunity to intervene. If placement breakdowns were a sudden response to a single culminating event, this would not be so. By understanding placement breakdown as a process rather than an event it is possible to conceptualize a whole menu of reparative interventions.

Currently, considerable attention is being placed upon an initial matching of the needs of children to strengths of families through standardized assessments and decision tools (Epstein, Schlueter, Gracey, Chandrasekhar, & Cull, 2015). This initial process of matching is an endeavour to reduce placement disruption, and outcome studies suggest that the approach is helpful (Epstein et al., 2015). The complex breakdown finding from my study indicates that ongoing assessment to monitor critical areas of need throughout the placement may also be helpful for breakdown prevention.

Further study to develop effective, evidence-based ongoing assessment processes to accurately monitor those factors known to elevate risk for placement breakdown is needed. Also required are effective evidence-based strategies to support foster parents as they encounter difficult mental health and behavioural issues. This recommendation is supported by the findings of a Flemish study of foster family support needs (Vanschoonlandt, Van Holen, Vanderfaellie, De Maeyer, & Andries, 2014). The study found that support needs were variable and dependent upon factors such as the needs of the foster child and the experience and confidence of the foster family. The authors call for “the monitoring of support needs in different kinds of foster care situations and using this information to further develop pre-service training and ongoing support of foster parents” (p. 84).

Support needs. There are a number of studies in the literature describing key areas of foster parent need where an absence of support is likely to increase the risk of a placement breakdown (Octoman & McLean, 2014). As discussed, children’s behaviours are the most frequently cited reason for placement breakdown in the literature and were key in this study. However, several studies have found other themes as well, including

problems dealing with the foster agency, several failed attempts to make a placement work, changes to their own health or circumstances, and failure to get the support they needed (Brown & Bednar, 2006, p. 1497; Gilbertson & Barber, 2003). The participants' experiences in this study generally supported the themes identified by the authors. For instance, Mary spoke of having her doctor advise her against continuing to care for her foster children for health reasons. It was the deterioration of her health that eventually forced the end of the placement. However, if the level of stress associated with this care had been significantly lower, her health might not have deteriorated to the point where the placement needed to end. When asked what support she felt she needed, Mary spoke of both practical help in the home, with tasks like housekeeping, and moral support and encouragement. She spoke of never receiving any indication from professionals that her level of stress and the effort she was making to support her child was understood or appreciated. This was Mary's lived experience; she felt alone and overwhelmed.

Knowledge, skills and practical help. A recent South Australian study approached foster parents for their views on support needs. The most highly rated supports specifically targeted the understanding and management of behavioural issues and mental health needs of children (Octoman & McLean, 2014). Octoman and McLean's findings provide a little more context to the "extreme behaviours cause breakdowns" notion and lends support to the findings in my study. None of the participants in my study were surprised or particularly distressed by the behaviours themselves. This in itself is significant since it was indicative that all five participants were very tolerant and willing to endure the hardship parenting a child with high needs involves. The distress occurred when the participants were unable to impact the

behaviours that continued to relentlessly place their foster child and others at risk. As with Octoman and McLean's findings, participants described a lack of support to understand and manage the behavioural issues and mental health needs of their foster children, understanding and managing being the key.

The feeling of isolation and abandonment and the accompanying confusion and fear at the realization that no one would or could help was well illustrated by Catherine. She told of taking her child to see a mental health professional seeking some practical help to manage his behaviours. As soon as the interview began her child curled up into the fetal position on the office floor. Catherine's experience was that no one knew what to do to help her child in that moment except for Catherine. She felt her child was officially regarded as "beyond help" yet she was taking her son home and would continue to care for him, albeit alone and without knowledge or help. Participants were clear in expressing their belief that practical support to understand and manage difficult behaviours would have made a difference and perhaps prevented the placement breakdown.

The absence of practical help was also discussed in the context of friends and family. Four of the five participants reported that family members were unable to understand what was happening or to help them. Several mentioned that they had very few friends because they were so busy providing care and their child's behaviours discouraged others from visiting. The ability to take a break through respite care was something all participants expressed as something that would have helped. These findings are well documented within the literature.

Emotional support. When the placement finally ended participants in this study, while relieved by the absence of stress, felt an overwhelming sense of loss. While a sense of loss was by no means surprising, I was unprepared for the intensity of feeling the participants experienced. In most cases the intensity expressed felt as one might expect the emotions accompanying the death of a participant's natural child. This finding supports the findings of a recent US study documenting that foster parents were affected by grief at separation from their foster children (Hebert, Kulkin, & McLean, 2013). Forty-five percent of respondents "agreed or strongly agreed that they had periods of tear-fullness and that no one would ever take the place of their foster child(ren)" (p. 258). Emotional support for foster parents is an example of a need that is unique to foster care. The participants in Herbert et al.'s study all expressed an extraordinary intensity of emotional pain. The authors conclude that:

Social workers who were trained to recognize the symptoms of anticipatory grief could help foster parents prepare for what life would be like without the child.

The benefit of this type of intervention could increase the resilience of carers and enable them to continue to look after children in the future. (Hebert et al., 2013, p. 264)

Support and the child welfare agency. Support provided by child welfare staff was a concern for four of the five participants in my study. Child welfare staff were looked to by participants as a source of educational, practical, and emotional support. Only one participant spoke of this kind of support occurring. High staff turnover was seen to be the greatest impediment to receiving support from the child welfare agency. One participant spoke of having five different workers in a one-year period. If case plans

changed without input from the foster parents as new staff assumed responsibility for a case load, this led to participants feeling devalued and isolated. Further, if the new case plan failed to meet either the child's needs or the participant's support needs to care for the child, another and more practical problem was created. In addition, given the complex needs of the foster children, a high staff turnover made it difficult for new staff to understand both the difficulties faced by the caregiver and hence ways to support them. Again, one result was a sense of isolation and a feeling of not being understood or valued. In some instances, the child welfare worker was seen as an authority figure and as a threat to the child placement. In fact, two of the participants spoke of having their home reviewed, a process that was interpreted as a loss of confidence on the part of the child welfare agency.

This study lends further confirmation of the need to support foster parents as members of the child welfare team (Brown, Anderson, & Rodgers, 2015; Delgado & Pinto, 2011).

The potential of enduring attachment. The attachment all participants had with their children endured through the placement breakdown and remained intact into the children's adulthood. The stories shared by the participants described a love that was deep enough to sustain them through many years of experiencing difficult behaviours. In every home, this bond between child and foster parent endured beyond the breakdown and its accompanying grief to a place where, an average of eight years after the placement had ended, every parent described having frequent and loving contact with the child. The strength and endurance of this attachment was a key finding and worthy of more study. A similar finding was seen by Khoo and Skoog (2014) who reported that the

eight foster parent participants in their study “all described a continuing relationship between their families and child which was of lasting significance” (p. 255).

The essence at the core of the experience for all participants was the love they felt for the children for whom they provided care. All participants stated that they loved their children. Through the many stories told, this love for their children emerged to be the central enduring construct and the context for all experience. The attachment and love for these children reflects foster caring as more closely aligned with a natural family or kinship paradigm than to other more formal out-of-home care approaches. While this may appear to be stating the obvious, the endurance of the attachment formed between the participants and their children illustrates the potential of foster care as a resource for children.

The five participants in this study showed tremendous commitment to their children, had cared for them for an average of 11.5 years, but the placements did break down. The breakdowns occurred when participant exhaustion and failure to maintain child safety was finally acknowledged. Supports that may have made a difference have already been discussed. There remains a need to go back to the ADHD literature to learn the extent to which a diagnosis of ADHD should have been sufficient warning of what was to come.

ADHD Literature and Parent Stress

The difficulties experienced by children diagnosed with ADHD are known to place stress on the relationships with all members of their families and particularly their parents (Gerdes et al., 2003; Kadesjö et al., 2002; van Aken et al., 2014). Parents who have children with ADHD report having lower self-esteem, poor control of their child's difficulties, poorer coping, and high levels of stress (Hernández-Otero et al., 2015; Podolski & Nigg, 2001; Treacy et al., 2005). Expressions of feeling inadequate and of being concerned about how others perceived the failure to manage child behaviours were common among the participants. The findings of this study support the findings of others showing stress and an inability to manage difficult symptoms, particularly aggression and emotional dysregulation, led to the breakdown of relationships within the family.

Multiple studies have demonstrated that ADHD behaviours do place children at higher risk of maltreatment (Modesto-Lowe et al., 2008; van Aken et al., 2014). While there were no reports of maltreatment by any of the participants in this study, all five children experienced the breakdown of their home after an average of 11 years of being with these families. In addition, it is evident that treatment, if it existed, was ineffective. Hence these children were left to experience the life impact of both ADHD and placement breakdown.

The Canadian Attention Deficit Disorder Resource Alliance's principles for intervention advocate for a holistic treatment approach and include adequate education of patients and their families, behavioural and/or occupational interventions, psychological treatment, educational accommodations, and medical management (as a way to facilitate the other interventions) (2011). The absence of any one component in this holistic

approach is thought to reduce the effectiveness of the treatment overall and treatment is recommended throughout the child's development (French, 2015; Litner & Mann-Feder, 2009).

Studies examining the development of youth with ADHD have emphasized parenting style and child ADHD symptoms. Research continues to focus on the delineation of specific causal relationships between individual parenting styles and differential outcomes for children with ADHD (Jones, Rabinovitch, & Hubbard, 2015). Parenting and ADHD severity have been shown to be independently associated with child social skill and aggressive behaviour (Kaiser et al., 2011). This finding has led to the assertion that treatment targeting both symptom reduction and improved parenting may be especially effective for the treatment of social problems related to childhood ADHD.

None of the participants in this study expressed any involvement with the parent ADHD psychoeducation support recommended as an essential component for the treatment and management of ADHD in children and youth (Barkley, 2006; Barkley, 2000; Felt et al., 2014; Haydicky et al., 2015; Sciotto, 2015). Hence the outcomes for the children cared for by the five participants are consistent with the ADHD literature in that the symptoms and comorbid symptoms led to serious impairment. In other words, the outcomes were predictable. These findings point to the need for mental health support for foster families caring for children with ADHD.

ADHD and Placement Breakdown

When the literature describing the behavioural symptoms of ADHD and the impact on parental stress is juxtaposed with what we know about the causes of foster placement breakdown, it should be evident that ADHD places parents and children at a

higher risk for placement breakdown. As discussed, this is largely brought about by the poor emotion self-regulation and externalized behaviours commonly occurring in conjunction with ADHD. The lived experience expressed by the five participants in this study described the anguish of failing to help their children manage their behaviours and keep them safe, the exhaustion, and finally feelings of failure and loss. Given the abundant literature on this subject, the outcome of placement breakdown should not be seen as surprising. That is not to say that placement breakdown is inevitable and a number of protective strategies have been discussed. What then are the barriers to ensuring the effective treatment of ADHD and support for foster families?

Social Work and the ADHD Evidence

I was interested to see if there was literature indicating how social workers negotiated the complexities concerning ADHD diagnosis and treatment. My objective was to see if social work practice itself constituted a barrier to evidence-based treatment. In my study social workers, as child welfare workers, occupied a pivotal role in the access to treatment. While there is a paucity of research dealing with the issue of ADHD and the management of client treatment by social workers (Pentecost & Wood, 2002), there is some and a brief examination is germane to this study.

The pursuit of social justice is a core value for social workers and is stated as such in the Canadian Association of Social Workers' Code of Ethics (2005). Within the context of this social justice framework exists a discussion in the literature concerning "psychological justice" (Wakefield, 2010, 2013). Wakefield, a social worker, writes:

Diagnosis of a disorder in our society has many ramifications not only for treatment choice but for broader social reactions to the diagnosed individual.

In particular, mental disorders impose a sick role on individuals and place a burden upon them to change; thus, disorders decrease the level of respect and acceptance generally accorded to those with even annoying normal variations in traits and features. Thus, minimizing false positives is important to a pluralistic society (2010, p. 5).

On the other hand he writes, “problems of living and emotional suffering, even if not true disorders, may benefit from support and treatment” (Wakefield, 2010, p. 5).

Wakefield identifies what he sees as a fine line between helping and harming. There are dangers and injustices committed by incorrectly labelling a behaviour as an illness, but there are also dangers in not addressing “problems of living and emotional suffering.” Where support and treatment lead to demonstrable improvements in coping with problems of living and emotional suffering, it must follow ethically that a social worker, responsible for the care of a child, has a professional obligation to advocate for the occurrence of such support and treatment.

Wakefield, a bioethicist, is one voice of caution in this discussion; there are others. There is an argument that brain research has taken us beyond the neuropsychiatric labels found in the diagnostic and statistical manual of mental disorders (Perry & Dobson, 2013). Perry and Dobson reference their work with child trauma and the complex impact on the developing brain saying:

The result is a complex clinical picture with increased risk of physical health, sensorimotor, self-regulation, relational, cognitive, and a host of other problems (e.g., Felitta et al., 1998; Anda et al., 2006). The current DSM neuropsychiatric labels do not capture this complexity (p. 249-250).

Perry and Dobson are representative of a perspective held within the mental health nosology that challenges the usefulness of the DSM. A growing body of neurological, epidemiological, and epigenetic scientific evidence is contradictory of fundamental DSM organizing principles (Voosen, 2013). This view has been gaining traction over the past four decades culminating in a 2013 decision by the US National Institute of Mental Health to no longer fund mental health research based on DSM categories alone (Voosen, 2013).

Both the Wakefield (2010) and Perry and Dobson (2013) arguments provide cautions around too heavy a reliance upon the DSM diagnostic approach but for different reasons. Wakefield uses labelling theory to caution against the damage a label of mental illness may inflict. Perry and Dobson suggest that mental health science has now taken us beyond the DSM's symptom-based approach (Perry, 2009).

Social workers working within the child welfare system are required to advocate in the best interests of children in their care. That it might be difficult to confidently follow "best interests of the child" principles concerning ADHD diagnosis and treatment would not be surprising given the previous discussions. Social workers also have an ethical responsibility for *Competence in Professional Practice* (Canadian Association of Social Workers, 2005) and are required to "uphold the right of clients to be offered the highest quality of service possible" and to "maintain and increase their professional knowledge and skill" (Value 6, Principles, p. 8). How social workers have negotiated this area is not well described in the literature; however, this discussion is important since it outlines some of the difficulties social workers face understanding the best course of action for a client and provides context for the findings of this study.

A 2002 study by Pentecost and Wood is of interest since it documented social work practice regarding ADHD including opinions about the use of medication as a treatment option for children. The authors surveyed 174 social work practitioners for children regarding their knowledge and perceptions of ADHD (Pentecost & Wood, 2002). They found that, as the length of experience increased, the social workers in their study appeared to be “more pluralistic but retained their skepticism about the value of medication that generally the value of medication for young children and teenagers with ADHD-type presenting problems is a source of considerable controversy” (Pentecost & Wood, 2002, p. 938). This result is consistent with the findings of a 2015 literature review investigating the research evidence related to factors which influence children accessing services for ADHD (Wright et al., 2015). Wright et al. identified a “wider political dimension to the existence/nonexistence of ADHD” (p. 653) and a reluctance to expose children and families to harm borne out of misconceptions regarding ADHD. They found only limited evidence of effective interventions to improve access to evidence-based treatment (p. 598). The small amount of literature discussing the role of professional support for evidence-based treatment for ADHD in children suggests that social work practice lacks clarity on this issue and has the potential to be a barrier to effective treatment.

One solution to this dilemma is offered by the editor of the *Journal of Social Work Education* in an editorial document titled “From the Editor—The DSM-5 and Its Role in Social Work Assessment and Research” (Robbins, 2014). Robbins’ treatise cites a lack of evidence to support DSM diagnoses and defines it as a process vulnerable to

political, economic, and social interests. In the end, however, Robbins finds some ground from which she feels social workers can operate. She writes:

Although diagnosis based on a medical model may be part of the assessment process, it should never be seen as the primary function. If we are to gain a comprehensive and holistic view of our clients and their lives, it is crucial that we retain a broader perspective that uses not only a focus on both the person and the environment, but also assesses their strengths and capabilities. And we must remain open to assessing and engaging in systemic level change when oppressive practices, such as faulty diagnostic practices, compromise our client's well-being (2014).

A Canadian paper, published in 2015 by Klein et al., presents a position concerning ADHD assessment that may also help social workers concerned with issues such as social justice, labelling, and the use of psychotropic medications for children. Klein et al. make a strong case for exercising caution concerning any psychiatric diagnosis for children who have experienced early life trauma. They call for a multi-faceted assessment to include mental health, cognitive and academic evaluations, and a team approach to the assessment and formulation of a treatment plan. Klein et al. also recommend "Increased education for caregivers, teachers and child welfare staff on the effects of maltreatment and often perplexing relationship with ADHD-like symptoms and co-morbid disorders is also necessary" (p. 183). Klein et al.'s recommendations would have made a significant improvement upon the outcomes presented by each of the five participants in this study.

Social Work and Neuroscience

The discussion concerning ADHD, the DSM, and barriers to treatment for children can be seen as a subset of a broader discussion concerning social work and neuroscience. If social workers are either unwilling or unmotivated to embrace this rapidly developing field, I suggest the result will be a significant barrier to mental health treatment. A brief examination of social work and neuroscience is hence directly related to a discussion of the findings of this study. This thesis has reviewed some of the developments in neuroscience as they pertain to ADHD and mental illness. One critical view of neuroscience sees it as reductionist, diverting attention from an understanding of the whole person, and with the potential to rationalize socially unjust forces into individual psychopathology (Garza & Smith, 2009; Pirruccello, 2012). This view presents the embrace of neuroscience as an abandonment of the social justice tradition of social work and one to be avoided.

Increasingly human service professions such as social work are being challenged to integrate some knowledge of the rapidly expanding field of neuroscience into their practice (Bernstein & Gioia, 2015; Lefmann & Combs-Orme, 2013; Matto & Strolin-Goltzman, 2010). In a book review of *Neuroscience and social work practice: The missing link* (Farmer, 2009), reviewers Bernstein and Gioia (2015) identify the following as an example of why the integration of neuroscience into social work practice is important:

Addiction is a good example in which the notion of learning about biological processes applies. Here, it may be seen that the problem behaviors stem from a lack of motivation to break the habit when in reality the person

becomes programmed to behave differently. In other words, “the result is an addicted brain in which the reward circuitry malfunctions or becomes dysregulated, and ever larger amounts of the drug are required for the person to feel a reward” (Farmer, 2009, p. 142). Although social workers have long been working with these issues, incorporating neuroscience would simply improve practice and raise the level of quality work within the profession (p. 137).

This discussion is germane to my thesis when considering the support role of the social worker with the foster family caring for a child with an ADHD diagnosis.

Lefmann and Combs-Orme (2013) write, “Despite social work’s claim of a biopsychosocial approach to human behavior and development, the profession fails to incorporate important physiological knowledge into practice, research, and education” (p. 640). They point to the emphasis upon evidence-based practice and suggest fields such as psychology have recognized that clinical competence relies, at least in part, on an up-to-date understanding of the science of human biology. Lefmann and Combs-Orme point to Saleeby’s 1992 article, “Biology's challenge to social work: Embodying the person-in-environment perspective,” and suggest that even though this challenge was made more than 20 years ago it is one the social work profession has yet to heed (p. 640). Saleeby’s work is important not just because it helps to frame the history of this discussion but also because he has provided a thesis that continues to represent the core of this issue today. He writes:

Although the profession of social work credits itself for using a biopsychosocial perspective in theory and practice, the body (the "bio") is virtually absent from the

profession's knowing and doing. If social workers are serious about understanding and marshaling elements of person-in-environment transactions, then to disdain the body results in a lack of appreciative reach, the possibility of egregious errors of assessment, and missed opportunities to aid in the process of regeneration for clients (p. 112).

Bernstein and Gioia (2015) offer some optimism and believe social work is beginning to incorporate neuroscience into its practice albeit at an infancy stage.

The Human Rights Context

The Canadian Supreme Court has ruled that children in care have a legal entitlement to care of at least the level expected from a prudent parent (*K.L.B. v. British Columbia*, 2003). The prudent parent standard:

Does not make the government (or a child welfare agency) a guarantor against all harm, but this standard does hold the [ministry or] agency responsible for harm sustained by children in foster care, if judged by standards of the day, it was reasonably foreseeable that the [ministry or] child welfare agency conduct would expose these children to the harm ultimately sustained (Kanani, Regehr, & Bernstein, 2002).

The stories told by the participants in this study all described outcomes that were reasonably foreseeable. Children who live in out-of-home care and who are coping with ADHD have been shown to be at a higher risk for placement breakdown than their non-ADHD peers due to the higher incidence of externalizing behaviours and emotion dysregulation found in this cohort in conjunction with the resulting parental stress (Cicchetti & Toth, 2005; García-Martín et al., 2014; Sallnas et al., 2004).

None of the families spoke of receiving the supports that could reasonably be expected to lead to the successful treatment of ADHD or to reduce the risks of breakdown-causing behaviours. Examples would be parental psychoeducation, respite, or in-home behavioural consultation and support. The ADHD literature is clear in showing that a failure to address the health issues connected with a diagnosis of ADHD results in poor life outcomes when compared to a non-ADHD control group (Knorth et al., 2008a; Litner & Mann-Feder, 2009; Oosterman et al., 2007; Trout et al., 2010).

The children in these stories experienced outcomes that harmed them and the outcomes, based on the literature, will continue to affect them over the course of their lives. This occurred despite numerous safeguards.

It occurred despite loving foster parents, all of whom were committed to caring for their children. All had endured hardships for more than a year as relationships that had been established for an average of 11 years eventually failed to keep them safe and ended in a placement breakdown. The attachment the participants had to their foster children endured beyond the breakdown and all participants maintained strong relationships with them an average of eight years after the children had left their home.

These largely avoidable outcomes occurred despite Canadian *Charter of Rights and Freedoms* guarantees to the same access to health care as any other Canadian child.

The Guidelines for the Alternative Care of Children under the UN *Convention on the Rights of the Child* did not keep these children safe even though it decrees that “carers should promote the health of the children for whom they are responsible and make arrangements to ensure that medical care, counselling and support are made available as required” (General Assembly of the United Nations, 2009) and further that “special

needs, should be catered for in all care settings, including ensuring their ongoing attachment to a specific carer” (General Assembly of the United Nations, 2009).

The foster families and the children they cared for were not protected by the UN *Convention on the Rights of Persons with Disabilities* (General Assembly of the United Nations, 2006). Nor was there protection by social workers in Canada being required to “seek to safeguard the rights and interests of clients who have limited or impaired decision-making capacity when acting on their behalf, and/or when collaborating with others who are acting for the client” (Canadian Association of Social Workers, 2005, p. 4).

Conclusion

This study examined the lived experience of five participants fostering a child with ADHD where the placement broke down. I have presented a number of possible contributors to the placement breakdowns examined in this research. These include social work practice and the ongoing debate around the validity of the DSM, the fear of psychotropic medication use for children, the reluctance of the social work profession to remain current with advances in mental health research and best practice in mental health evidence-based treatment. I have made some mention of other issues such as foster families' need of a number of different supports and the need for consideration and respect as members of the team caring for children. Several key findings have been discussed and these could contribute to the support of foster families, the care of children with ADHD, and the prevention of placement breakdown. However, I am confident that for as many potentially mitigating factors as have been identified through this research and review of the literature there are as many more left to discover. This discussion however is subordinate to the basic children's human rights context that has helped to guide my research. Put simply, the lived experience of the participants in this study has demonstrated that the human rights of these children were not protected. The legal mechanisms to protect them existed, the mental health knowledge existed, and the commitment and love from the families existed. The task was not a simple one and certainly not one with any guarantee of success. Evidence of treatment and support, commensurate with current evidence-based understanding of the needs, was not apparent. All families and the five children they cared for experienced tragic outcomes. In the absence of parents, and when a child is in the care of the state, to whom should it fall to

ensure the rights of these children are protected? In honour of the participants to whom this study gave a voice and to the children they continue to *love with all our heart*, this question urgently begs an answer.

Limitations

This qualitative study employed a non-probability purposeful sample of five foster parents who had cared for children with ADHD where the placement broke down. The findings of this study are specific to the participants and are not generalizable to the wider population.

Appendix A

Participant Consent Form

University of Regina

Faculty of Social Work

153-111 Research Drive
Innovation Place
Saskatoon, SK S7N 3R2
Phone: (306) 664.7370
Fax: (306) 664.7131

Project Title:

**We Love Them with All Our Heart:
The lived experience of fostering a child with ADHD where the placement breaks
down.**

Researcher(s):

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Supervisor:

Dr. Ailsa Watkinson
Faculty of Social Work
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Purpose(s) and Objective(s) of the Research:

- To understand the experience of foster parents fostering children with a diagnosis of ADHD. To learn if the symptoms of ADHD had any bearing on the breakdown of foster placements and to understand what supports might have prevented the breakdown.

Procedures:

- The research will be conducted through an interview with you that will take between an hour and an hour and a half.
- The interview can occur in your home or in my office space at the Family Counselling Centre, whichever is most convenient for you.
- The interview will be recorded with a data recorder and later transcribed into writing.
- Once your interview is transcribed it will be shared with you for accuracy verification.
- Please feel free to ask any questions regarding the procedures and goals of the study or your role.

Potential Risks:

- There are no known or anticipated risks to you by participating in this research.
- Should the interview cause you to question the process concerning your foster placement breakdown a debriefing will be made available to you. This will take the form of a follow up meeting with Andrew Field to answer any questions concerning ADHD, its symptoms and treatment.

Potential Benefits:

- This research will be made available to those caring for children in out of home care. It is known that the percentage of children in care with a diagnosis of ADHD is significantly higher than that of children within the general population. By understanding the difficulties foster families face through

ADHD symptoms we will be able to provide better support to both the foster families and the children. In this way it may be possible to reduce the number of foster placement breakdowns and hence trauma to both foster children and foster families. This will have long term benefits.

Confidentiality:

- The identity of foster family members will be kept confidential. My data recording will not include your last names, only first names. As the data is being transcribed your name will be reduced to an initial only. It is not necessary to my research to have your name(s) written anywhere and they will not be. In this way your contribution to the written research will be anonymous. There will not be any record connecting your family to this research.
- The only limit to this guarantee of anonymity is the disclosure of any criminal activity where by law I am obligated to relay this information to the authorities.
- I will not ask you to name the foster child at the center of this inquiry and I request that you do not mention their name to me under any circumstances.

Storage of Data:

- The recordings of our interviews will be stored on my own personal computer and in my personal backup file. As mentioned above the only reference to you will be through your first name and there will be no identification of the child you provided care for. The only persons other than myself who may have access to this data (although it is

unlikely) is my supervisor and or members of the University of Regina's Ethics committee.

- The data will be kept for five years and will then be destroyed.

Right to Withdraw:

- Your participation is voluntary and you can answer only those questions that you are comfortable with. You may withdraw from the research project for any reason, at any time without explanation or penalty of any sort.
- I have no standing with the Ministry of Social Services and whether you choose to participate or not will have no effect on your position as a foster parent or how you will be treated.
- Should you wish to withdraw for any reason the data you have provided to the point of withdrawal will be destroyed provided the data has not already been pooled. After this date, it is possible that some form of research dissemination will have already occurred and it may not be possible to withdraw your data

Follow up:

- A final copy of this research study can be made available to you. To obtain results from the study, please call Andrew Field.

Questions or Concerns:

- Contact the researcher using the information at the top of page 1;
- This project has been approved on ethical grounds by the University of Regina Research Ethics Board. Any questions regarding your rights as a participant may be addressed to the committee at (585-4775 or

research.ethics@uregina.ca). Out of town participants may call Toll Free:
866-966-2975

Consent

Your signature below indicates that you have read and understand the description provided;

I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

_____	_____	_____
<i>Name of Participant</i>	<i>Signature</i>	<i>Date</i>
_____	_____	
<i>Researcher's Signature</i>	<i>Date</i>	

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix B

Questions

1. Gathering basic qualifying data:
 - a. You are both currently foster parents in good standing with the Saskatchewan Ministry of Social Services; correct?
 - b. I understand that you were caring for a child in your home and that this placement broke down; is that correct?
 - c. What was the child's gender and age?
 - d. How long did this child stay with your family?
2. Can you tell me in your own words what behaviours the foster child displayed in your home?
3. How did they respond to coaching and checking?
4. How did these behaviours affect you and your family?
5. Did they contribute to the decision to have the child removed from your home?
6. How did your thoughts and feelings toward your foster child change over the time leading up to the culminating event?
7. What was the culminating event that precipitated the request to have the child moved?
8. What supports may have helped to prevent this placement breakdown?

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