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An exploration of self-concept development in care-experienced children and young people.

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Submitted in partial fulfilment of the requirements for the degree of

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A Note on Language

The researcher wishes to acknowledge the recent change in terminology used to describe individuals who are or have been in the care system. In line with The Promise, there is recent emphasis on use of the term "care-experienced" to refer to these young people. This is due to young people reporting that they dislike the term "looked after child", or "LAC", because of its connotation that they are lacking in something. The researcher uses the term "care-experienced" throughout chapters one and two, however, in order to capture research that was conducted prior to this change in terminology, the terms "looked after" and its derivatives were used during the systematic review search process and by participants in the research study, and is not a reflection of the researcher's personal views.

Chapter 1: Systematic Review

"I am who others think I am and I will behave accordingly": A qualitative synthesis of the influence of relationships on the self-concept development of care-experienced children and young people.

Prepared in accordance with the author requirements for the Children and Youth Services Review:

https://www.sciencedirect.com/journal/children-and-youth-services-review/publish/guide-for-authors

Abstract

Self-concept, defined as the knowledge and beliefs one holds about oneself, develops within relational contexts. This systematic review examines the potential impact of relationships on self-concept in care-experienced children and young people (CECYP). A systematic search of the databases PsycINFO, PubMed, Web of Science and CINAHL was conducted between November 2025 and January 2026, alongside citation chaining and grey literature searching. Following PRISMA guidelines, 14 qualitative studies met the inclusion criteria for this review. Data were synthesised using Thematic Synthesis, and study quality was appraised using the CASP checklist. All studies had moderate to high quality. Six inter-related sub-themes were identified and grouped under positive and negative relational influences. Positive influences included stability, turning points and supporting mastery. Negative influences included loss, systemic stigmatisation and chameleon identity. Notably, all studies described negative relational influences, while fewer discussed positive influences. Limitations of this review include the exclusion of studies not published in English, and possible over-reliance on attachment theory as a synthesising framework. Overall, findings indicate that self-concept development in CECYP is relationally influenced. Stable, positive, enduring relationships can foster coherent and positive self-beliefs while repeated losses and stigma can undermine identity formation. The implications of these findings for practice and future research are discussed.

Keywords: self-concept, relationships, care-experienced, young people

1. Introduction

Determining a clear definition of self-concept is challenging because it is used interchangeably with related terms such as “self-image”, “self-esteem”, “self-efficacy”, “self-awareness” and “self-identity” (Kouvelis & Kangas, 2021). This review will consider self-concept to be an over-arching framework which encompasses each of these related terms (Crone et al., 2022). Baumeister’s (1997) definition of self-concept as the knowledge and beliefs one holds about oneself will be used as it is broad enough to capture each of these aspects of the construct.

From an attachment perspective, self-concept is fundamentally relational in origin. Bowlby (1988) suggests that early interactions with caregivers give rise to internal working models (cognitive and emotional representations of the self, others and the world). When caregiving is consistent, responsive and emotionally attuned to a child, they are more likely to develop a secure attachment and positive internal working models of the self as worthy and others as reliable. Conversely, inconsistent or neglectful caregiving can result in the development of an anxious or avoidant attachment and negative internal working models of the self as unworthy and others as unpredictable (Martín Quintana et al., 2023; Nishad et al., 2024).

Although attachment relationships lay the foundation for self-concept, from an Eriksonian standpoint (Erikson, 1968) self-concept development continues into adolescence. Erikson conceptualised adolescence as a time when young people explore and integrate aspects of the self. This period involves revisiting and reorganising earlier internal working models in light of new social, cognitive and emotional experiences. Maturation of the prefrontal cortex and anterior cingulate cortex during this time is associated with the development of social evaluation and self-awareness (Crone et al., 2022). These changes may increase sensitivity to social cues, making relationships especially important in self-concept development during this time (Crocetti et al., 2017).

Research had shown that when an adolescent is experiencing an identity crisis, support from family and peers positively influences identity exploration and overall wellbeing (Audet et al., 2021). In school contexts, validating teacher relationships may help to foster positive self-concept (Rotschild, 2025), which has been associated with academic achievement, positive social relationships, psychological wellbeing and reduced risk-taking behaviours (Corte et al., 2020; Crone et al., 2022). The importance of relationships for self-concept development is particularly salient among care-experienced children and young people

(CECYP). The definition of a "care-experienced" child varies across policies, legislation and practices (The Scottish Government, 2024). In the UK, children are generally considered "care-experienced" when they reside in kinship care, foster care or residential care. In some cases, young people may also reside at home with a supervision order in place. The term can also include those who have previously been in care, and are now considered "care leavers" (Evans et al., 2024). Between 2023-2024, children became care-experienced in Scotland due to domestic abuse, neglect, parental substance use, parental mental ill-health and emotional abuse (The Scottish Government, 2025).

Reviews of therapeutic interventions highlight the importance of trusting, consistent adult relationships as mechanisms of therapeutic change with this population (MacDonald et al., 2014). Quantitative research consistently reports that CECYP have lower self-concept than the general population (e.g., Hicks & Nixon, 1989). CECYP who were separated from their biological families and have limited contact with them rate lower on measures of self-esteem (Salahu-Din & Bollman, 1994), suggesting instability in relationships may impact self-concept. Among adoptees, positive parent-child relationships are important for identity formation (Ranieri et al., 2021) while supportive sibling relationships have been associated with self-concept and resilience in young people in residential care (Mota & Matos, 2015). Peer relationships may also provide a source of belonging and validation for CECYP (Farineau et al., 2011). Collectively, this research indicates the potential protective role of stable, continuous relationships for self-concept in CECYP. Nevertheless, there are several limitations to this research. Some of the studies are dated, rely on insufficiently validated self-appraisal measures, or form part of unpublished doctoral research, raising questions about validity and generalisability. In addition, quantitative analyses cannot fully capture how CECYP make sense of relationships and their impact on self-concept. Standardised measures can capture trends, but may overlook nuanced, lived experience.

Qualitative research provides richer insight into how CECYP's self-concept is constructed within relational contexts. Studies drawing upon the voices of CECYP suggest that adoptive identity is influenced by caregivers' openness with the young person about their life story and origins, therefore facilitating the young person's ability to integrate this information into a coherent narrative about themself (Grotevant et al., 2017; Henze-Pederson, 2019). For young people placed in transethnic or transracial placements, ethnic identity development was influenced by the extent to which the caregiver supported cultural

socialisation (Crowley et al., 2019). These findings highlight the positive role of relationships in constructing self-concept through communication and validation.

However, multiple factors may interfere with this process. From an attachment perspective, trauma within a caregiving relationship can destabilise internal working models, making it difficult for young people to develop a positive sense of self. Adverse childhood experiences (ACE's) are associated with disturbances in self-identity (Kouvelis & Kangas, 2021). CECYP are disproportionately exposed to ACE's in comparison to the general population (Madigan et al., 2025). Beyond this pre-care adversity, experiences within the care system itself may further disrupt self-concept. Placement instability, limited access to information about family and personal history, and uncertainty regarding reasons for being in care can all contribute to identity confusion (Staines & Selwyn, 2020; Woodall et al., 2023). In addition, a recent thesis indicates that adoption itself may be experienced as a relational trauma (Whatson, 2023). CECYP also encounter stigma, bullying and marginalisation for having a "care identity" (Melamed et al., 2024; Mullan et al., 2023). These experiences impact their need for belonging, which threatens self-concept clarity (Preston & Rew, 2022). From this research we can see that early adversity pre-care, experiences within care and social experiences as a result of care interact to negatively influence self-concept in CECYP.

Taken together, this literature highlights the potential ways that relationships positively or negatively influence self-concept in CECYP. While qualitative studies on this topic offer valuable insight, to date, there has not been a systematic synthesis of this qualitative evidence. This review therefore aims to address this gap by exploring the impact of relationships on self-concept in CECYP.

1.1. Research question

How do relationships influence the self-concept of CECYP?

2. Methods

2.1. Registration

The review protocol was registered on PROSPERO (registration no. CRD420250634682). The PRISMA guidelines (Page et al., 2021; Appendix 1) and ENTREQ guidelines (Tong et al., 2012; Appendix 2) were followed.

2.2. Data sources

A systematic search of PsycINFO, PubMed, Web of Science Core Collection and CINAHL was conducted between November 2025 and January 2026. These databases were

selected for their coverage of psychological and social science research relevant to the review topic. Citation chaining of relevant studies and systematic reviews was also conducted.

2.3. Search strategy

The key search concepts for this systematic review were "self-concept", "care-experience" and "relationship". The search strategy was created in consultation with a specialist librarian from the University of Glasgow and can be found in Appendix 3.

2.3.1. Inclusion criteria

- Original research;
- Published in English or with English translation available;
- Sample currently or previously "care-experienced";
- Qualitative research;
- Participants discuss how relationships impact on their self-concept;
- Any relationship;
- Grey literature;
- Mean age <26 years.

2.3.2. Exclusion criteria

- Studies that don't use CECYP's perspective;
- Quantitative or mixed-methods;
- Literature reviews;
- No access to full text.

2.4. Screening

Search results were exported into and de-duplicated by Rayyan, an online systematic review platform. Titles and abstracts were screened against the eligibility criteria, followed by full text screening by the primary researcher (SW). A random 20% of studies were doubled-screened by an independent reviewer on Rayyan. Inter-rater agreement during the screening process was facilitated by Rayyan, which automatically highlights any discrepancies in the screening by the primary researcher and independent reviewer. Inter-rater agreement was 100% during the screening process. A PRISMA flowchart (Page et al., 2021) (Figure 1) outlines the numbers of studies included and excluded at each stage with justification.

2.5. Data extraction

A data extraction form based on the PRISMA 2020 Checklist (Page et al., 2021) was created to record:

- Study characteristics: study title, authors, year of publication, journal, country, study aims, methodology, theoretical orientation;
- Sample characteristics: sampling strategy, sample size, age range, gender, ethnicity;
- Care context: type of care, length of time in care, number of placements,
- Relationship characteristics: type of relationship, quality/stability of relationship;
- Self-concept: aspect of self-concept described, definition of self-concept;
- Findings: all text from the "results" or "findings" section of the included studies which related to this review's research question.

Data extraction was verified by the same independent reviewer for 20% of papers (n=3) to increase the reliability of the extracted data.

2.6. Quality appraisal

Included studies were appraised using the CASP qualitative studies checklist (CASP, 2024) (Appendix 4). An independent reviewer appraised 20% of studies (n=3) to ensure reliability of ratings. Inter-rater agreement was obtained through discussion between the primary researcher and the independent reviewer. The CASP includes 10 questions which the assessor rates "yes", "no" or "can't tell", but provides no quantitative cut-offs. For the purpose of synthesis, the primary researcher assigned two points for "yes", zero for "no" responses and one for "can't tell" responses, with a maximum score of 20 points. Scores of 0-7 indicated low quality, 7-13 moderate quality and 13-20 high quality.

2.7. Data synthesis

Following data extraction and quality appraisal, significant variation in care context, study quality, early life history, current care status, ethnicity, types of relationships and aspect of self-concept was observed. This indicated that a meta-ethnography (Noblitt & Hare, 1988) was not appropriate. Thematic synthesis (TS) (Thomas & Harden, 2008) was used to synthesize data and produce themes describing how relationships influence the self-concept of CECYP. Relevant text from the "results" sections of each study was extracted and coded line-by-line. Similar codes were grouped together and assigned a new code name. From this final set of codes, broader descriptive themes and sub-themes were identified.

2.8. Reflexivity

An important aspect of TS is researcher reflexivity which can help to identify areas of bias which may impact synthesis (Thomas & Harden, 2008). I (SW) am a white, Irish, female Trainee Clinical Psychologist. I have worked with CECYP prior to my doctoral training and am currently on placement in a specialist mental health team who work with this population. I thoroughly enjoy this work, and it's this passion that drew me towards this dissertation topic.

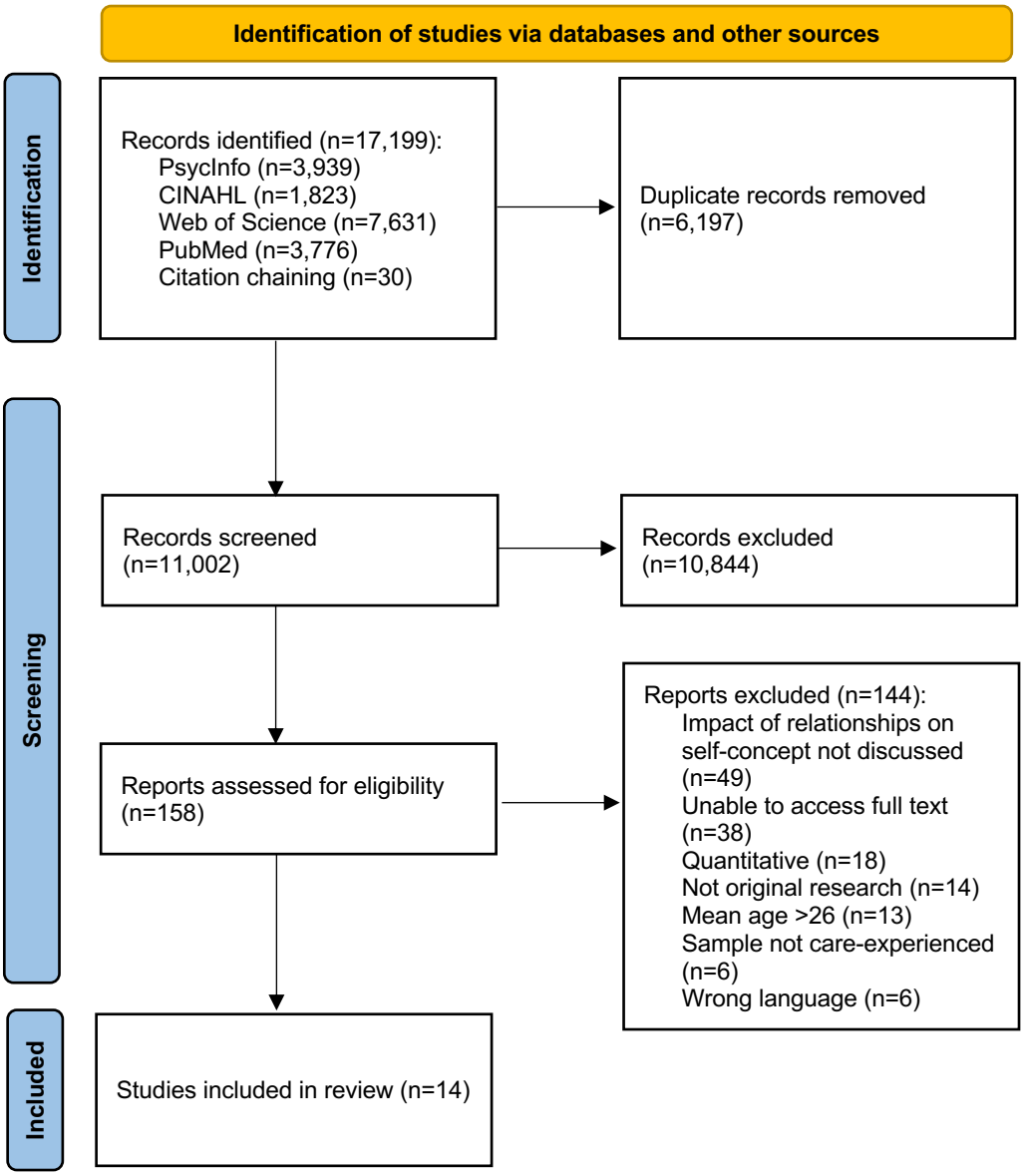
Whilst working with these young people has afforded me some insight into their interpersonal experiences, I personally have no lived experience of being in care. Someone with different life experiences to me may interpret the data differently, and there is every possibility that there is pertinent information that I failed to interpret. Secondly, Attachment Theory is highly relevant to my clinical work, and it is likely that this has influenced my interpretation of the data in this review. Someone who aligns with a different theoretical perspective may interpret the data differently. Using supervision and maintaining a reflexive research diary I attempted to bracket any biases that may interfere with this review.

3. Results

3.1. Identification of studies

The search yielded 17,199 papers. After de-duplication, 11,002 papers remained. Following title and abstract screening 10,844 were excluded. The full texts of 158 articles were screened against the eligibility criteria, leaving 14 articles for data synthesis and quality appraisal (Figure 1).

Figure 1 *PRISMA Flow Diagram*



3.2. Study characteristics

Studies were conducted in the UK (n=8), US (n=5) and Israel (n=1) between 1997 and 2025. Thirteen studies were peer-reviewed articles and one was a dissertation (Sowers-Zabelski, 2021). Data was gathered using semi-structured interviews (n=10), focus groups (n=1) and mixed methods (n=3). Methods of analysis included thematic analysis (TA)(n=4), RTA (n=2), IPA (n=2), naturalistic enquiry (n=1), dimensional analysis (n=1), grounded theory (n=1), qualitative secondary analysis (n=1), emerging thematic coding (n=1) and extended case model design (n=1). Samples ranged from 4-44 participants with a diversity of care contexts. The length of time spent in care and number of placements was inconsistently reported across studies (Table 1).

Table 1 *Study characteristics*

Author(s), Location	Sample characteristics (n, age range, gender , ethnicity)	Methodology	Care context (Type of care, years in care, no. of placements)
1. Ben-Shlomo et al., (2025) Israel	N=14 16-30 years Gender=N/R Ethnicity=N/R	SSI TA	FC N/R M=3
2. Colbridge et al., (2017) U.K.	N=8 19-25 years Female (8) Black Caribbean (1), Black British/Caribbean (1), White British (3), Black British (1), Black African (1), Black British African (1)	SSI IPA	N/R N/R 3+
3. Crowley (2019) U.K.	N=4 10-16 years Female (4) White British (3), Ethnic minority (1)	SSI IPA	A N/R N/R
4. Geenen & Powers (2007) U.S.	N=27 14-17 years Female (13), Male (14) African American (7), Caucasian (8), Native American (2), Hispanic (1), Bi-racial (1)	FG NE	FC, KC, GH N/R N/R
5. Kennedy et al., (2024) U.K.	N=16 Age & gender unclearly reported Ethnicity=N/R	SSI RTA	A N/R N/R
6. Kools (1997) U.S.	N=17 15-19 years Female (9), Male (8) African American (11), Mixed ethnicity (2), Asian/Pacific Islanders (2)	MM DA	FC, GH 2-11 years (M=5.7) 2-8 placements (M=4.1)
7. Lo et al., (2022) U.S.	N=30 Age range N/R (M=15.2 years) Female (18), Male (12)	SSI TA	A N/R N/R

	White (29), Hispanic/Mexican American (1)		
8. Macleod et al., (2021) U.K.	N=19 12-27 years N/R N/R	SSI QSA	FC, RC, KC, respite care, residential school N/R N/R
9. McMurray et al., (2010) U.K.	N=13 12-16 years Female (7), Male (6) British Caucasian (13)	SSI GT	RC, FC N/R N/R
10. Miller et al., (2020) U.S.	N=18 Age range N/R (m=21.63) Female (72%) Non-white/mixed race (78%)	SSI TA	FC N/R N/R
11. Neagu & Sebba (2019) U.K.	N=40 20-31 years Female (18), Male (22) N/R	SSI ETC	RC, FC, A N/R N=23 had >1 placement
12. Samuels & Pryce (2008) U.S.	N=44 Age range N/R (M=20 years) Female (27), Male (17) African American (27), White (9), Multiracial (6), Latino/a (1), Native American (1)	SSI ECM	FC >6 years 1-3 placements
13. Sowers-Zabelski (2021) U.S.	N=8 18-25 years N/R N/R	MM TA	A, FC N/R N/R
14. Wagner & Heberle (2024) U.S.	N=9 18-24 years Female (9) Non-Hispanic White (3), Hispanic (30), African-American (1), Multi-racial (2)	SSI RTA	A, FC 1.5-11 years in care N/R

Key: N/R=not reported, M=mean, SSI=semi-structured interview, TA=thematic analysis, IPA=interpretive phenomenological analysis, FG=focus groups, NE=naturalistic enquiry, RTA=reflexive thematic analysis, MM=mixed methods, DA=dimensional analysis, QSA=qualitative secondary analysis, GT=grounded theory, ETC=emerging thematic coding, ECM=extended case model, FC=foster care, A=adoption, KC=kinship care, GH=group home, RC=residential care

3.3. Quality appraisal

An independent reviewer assessed the quality of three papers. Inter-rater disagreements occurred for CASP items 5, 7 and 8 on the Crowley (2019) paper, CASP item 6 on the Kools (1997) paper and CASP item 8 on the Lo et al., (2022) paper. Therefore, the initial inter-rater agreement was 83.33%. Disagreements centred on whether there was sufficient evidence of researcher reflexivity and the impact this had on analysis. Following discussion between the primary researcher and the independent reviewer, inter-rater agreement reached 100%.

Studies were of moderate to high quality (Table 2). Most studies had a clear statement of aims, however Neagu and Sebba (2019) state the aim briefly in the abstract, but this was not included in the main body of the article. Qualitative methodology and analysis methods were appropriate for all included studies but lacked justification and sufficient description (Geenen & Powers, 2007; McMurray et al., 2010). Purposive sampling was the most commonly used method of recruitment, but this lacked justification and consideration of how it might impact results. Semi-structured interviews were commonly used to collect data. High quality studies were transparent about interview length, interviewer role, interview location and shared the interview topic guide. In five studies, researcher reflexivity wasn't considered and most studies lacked sufficient transparency on ethical considerations e.g., the potential impact of incentives on responder bias (Geenen & Powers, 2007; Miller et al., 2020). Studies with lower quality data analysis and results failed to consider potential alternative explanations of results or contradictory findings and have poorly detailed analytic processes, making replication difficult.

Table 2 *CASP Ratings*

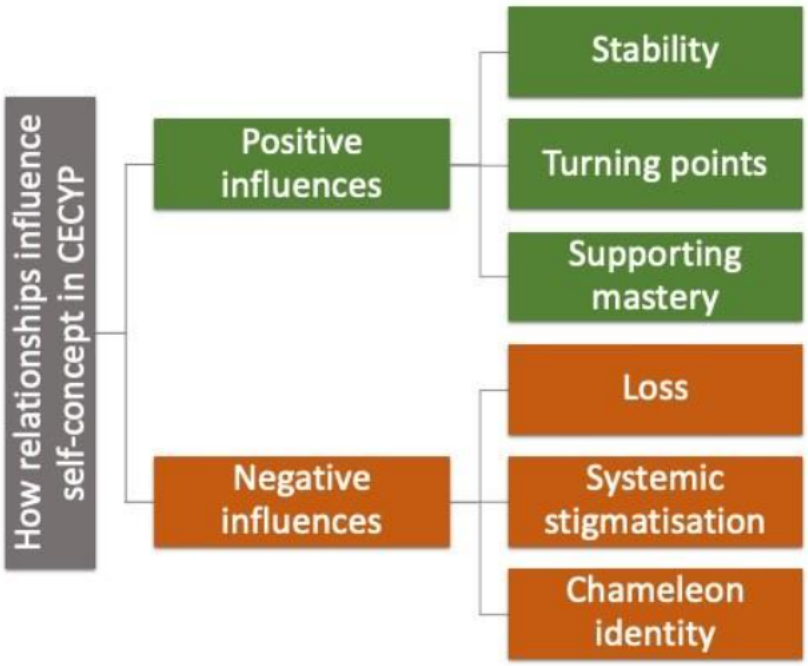
CASP Question number	Ben-Shlomo et al., 2025	Colbridge et al., 2017	Crowley, 2019*	Geenen & Powers, 2007	Kennedy et al., 2024	Kools, 1997*	Lo et al., 2022*	Macleod et al., 2021	McMurray et al, 2010	Miller et al., 2020	Neagu & Sebba, 2019	Samuels & Pryce, 2008	Sowers-Zabelski, 2021	Wagner & Heberle, 2024
Q1	2	2	2	2	2	2	2	2	2	2	0	2	2	2
Q2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Q3	2	2	2	1	2	2	2	2	1	2	2	2	2	2
Q4	2	2	2	1	2	2	2	1	1	2	1	2	2	1
Q5	2	2	2	2	2	2	2	1	1	2	2	2	2	2
Q6	2	2	0	0	2	0	2	1	0	1	0	2	2	2
Q7	2	2	1	1	2	2	2	2	1	1	2	2	2	2
Q8	2	2	1	1	2	2	1	2	1	2	2	2	2	1
Q9	2	2	1	2	2	2	2	2	2	2	1	2	2	2
Q10	1	2	2	1	2	1	1	2	1	2	1	1	2	2
Total	19	20	15	13	20	17	18	17	12	18	13	19	20	18

Key: Yes = 2, No = 0, Unclear = 1; High quality = 13-20, Moderate quality = 7-13, Low quality = 0-7, *co-rated paper, **Q1** Is there a clear statement of the aims of the research? **Q2** Is a qualitative methodology appropriate? **Q3** Was the research design appropriate to address the aims of the research? **Q4** Was the recruitment strategy appropriate to the aims of the research? **Q5** Was the data collected in a way that addressed the research issue? **Q6** Has the relationship between research and participants been adequately considered? **Q7** Have ethical issues been taken into consideration? **Q8** Was the data analysis sufficiently rigorous? **Q9** Is there a clear statement of findings? **Q10** How valuable is the research?

3.4. Thematic synthesis results

Six sub-themes were identified which capture how relationships influence self-concept in CECYP. These sub-themes can be grouped under “positive" and “negative" influences (Figure 2). The contribution of each of the included studies to the sub-themes is shown in Appendix 5.

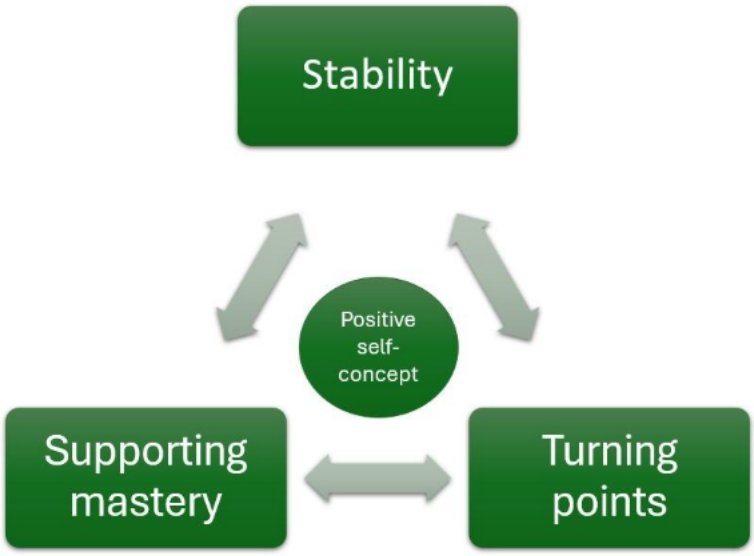
Figure 2 *Themes and sub-themes identified by TS*



3.4.1 Positive influences

This theme captures how relationships positively contribute to the development of self-concept in CECYP. The three sub-themes are stability, turning points and supporting mastery. There are bi-directional effects between these sub-themes which highlights the interactional nature of these experiences (Figure 3).

Figure 3 *The bi-directional positive influences of relationships on self-concept*



Stability. Consistent relationships emerged as a positive influence on self-concept development in CECYP. Being in the one placement for an extended length of time allowed CECYP to remain in the same school, maintain friendships and gradually build trust which allowed for the development of a clear self-concept. As Elizabeth progressed through school, *she developed a more positive sense of self* (Crowley, 2019, p.172). Sustained friendships helped John share his *true self* (McMurray et al., 2010, p.215):

> *"I do talk about myself like but it is only certain people that I talk to. Couple of mates from primary know the real John".*

Once their friends got to know them, young people were seen as *funny* (McMurray et al., 2010, p.215) and *caring* (Macleod et al., 2021, p.31), positive traits that could be internalised into their self-concept:

> *"I am a good friend...I like making other people feel good about themselves"* (McMurray et al., 2010, p.215).

Stability within caregiving relationships enabled a young person to develop a *secure attachment* which was important for developing a *positive sense of self and positive self-esteem* (Crowley, 2019, p.175). As a result, the young person felt safe to explore connections with their biological family, helping them to piece together family history and maintain a sense of where they came from. Maintaining contact with biological role models such as siblings and grandparents was also helpful. Gary spoke about *visiting his grandfather's house*

which was something that *made him feel good about himself* (McMurray et al., 2010, p.214). Outside of the family context, young people also found a *shared identity* through religion (Wagner & Heberle, 2024, p.6) and religious leaders acted as mentors for these young people (Neagu & Sebba, 2019).

Turning points. Relational interactions provided turning points for CECYP, allowing opportunity for identity development and reconstruction. For some, attending higher education offered a chance to meet new people, build new relationships and re-invent themselves. Fiona described university as a *"re-birth"* and her academic success became an important component of her self-concept *which transcended her care status* (Macleod et al., 2021, p.31).

The opportunity to re-connect with cultural heritage offered another turning point for self-concept development. When adoptive families encouraged engagement with ethnic communities and cultural traditions, this gave CECYP a sense of belonging and continuity of self. Elizabeth was encouraged to attend *ethnic festivals and meet up with others from her ethnic culture* which helped her develop *a positive cultural identity and sense of belonging* (Crowley, 2019, p.172).

Some young people described that the death of people in their life became a turning point for self-reflection. For one young person it was *the loss of key figures in their life* (Colbridge et al., 2017, p.7) which acted as a catalyst for self-concept development. When their grandfather died, they recognised that they could not continue their life in the same way and they needed to take an active role in re-inventing it moving forward. Two young people identified their own pregnancy as a turning point. When Neebin became pregnant, she underwent a process of *self-invention* (Wagner & Heberle, 2024, p.6), and Freya felt like she finally found herself when she became pregnant and developed an identity separate from her care status:

> *"…that's when I found myself actually, when I was pregnant...cos I was never a reliable person but it, that all changed as well when I was pregnant, I was reliable, on time, organised just everything got into shape…"* (Colbridge et al., 2017, p.5).

Supporting mastery. Young people developed self-efficacy when adults nurtured their skills and talents. When their academic achievements were admired by others, they internalised this praise into their self-concept. When Fiona skipped a grade, she became v*alued among her peers and teachers as a successful student* (Macleod et al., 2010, p.31). Some CECYP internalised the perception of being a *"motherly figure"* (Kennedy et al., 2024, p.2926) and later sought employment in caring professions such as nursing and support work.

This provided *personal value* (Colbridge et al., 2017, p.8) and *high levels of satisfaction* (Kennedy et al., 2024, p.2927):

> *"I really enjoy* [my work]*, and that's always what I've wanted to do; was do care."* (Kennedy et al., 2024, p.2927).

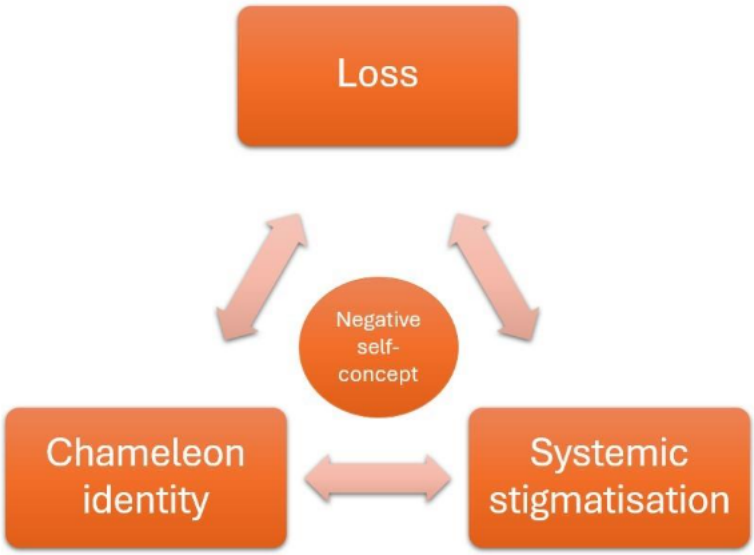
Participating in sports clubs and youth groups provided a social network and goals for the future. When Craig's keyworker linked him into his sports group it changed his life. He won several world titles and built up his sense of *achievement* (Macleod et al., 2021, p.30). For Tiana and Sophie, they developed a *strong athletic identity* as someone who is *"good at* [gym]*nastics"* (Crowley, 2019, p.172). Gary had a shared interest in cars with his grandfather, and was able to develop his skills fixing cars when he visited him:

> *"I like going up to my grandad's…you can just work on cars and get on with it"* (McMurray et al., 2010, p.214).

3.4.2. Negative influences

Across all studies it was clear that relationships can have a negative impact on self-concept development. The three sub-themes were: loss, systemic stigmatisation and chameleon identity. The inter-related nature of these sub-themes is illustrated in Figure 4.

Figure 4 *The bi-directional negative influences of relationships on self-concept*



Loss. Loss of relationships emerged as a pervasive experience which shaped self-concept for CECYP. Entry into the care system marked the beginning of these losses

following removal from birth families. For adopted young people this was accompanied by legal identity changes (Neagu & Sebba, 2019). New birth certificates often removed original birth names and citizenship, which reflected a discontinuity in CECYP's life narrative and sense of belonging. Without access to information about their family or country of origin, CECYP felt *incomplete and unworthy at times* (Lo et al., 2022, p.1611). Some young people came to accept this loss of personal history as an enduring feature of their self-concept (Wagner & Heberle, 2024). Others felt compelled to find answers:

> *"It's a part of me that's missing; I need to find it, confront it"* (Lo et al., 2022, p.1608).

CECYP experienced additional relational losses within the care system. Being placed in foster and adoptive placements required them to trust a new caregiver and try to develop a bond with them. However, frequent placement breakdowns disrupted the development of secure attachments. Each placement breakdown represented another lost relationship, resulting in CECYP feeling *bad, undeserving and unlovable* (Colbridge et al., 2017, p.8). Some young people internalised this lost relationship as rejection:

> *"The mother of my [foster family] did not love me, so why would others love me?"* (Ben-Shlomo et al., 2025, p.5).

This persistent unpredictability in placement longevity and recurring loss of caregiving relationships meant a young person was unable to predict how long they would remain in a given placement. This kept them in a constant state of hypervigilance, focused on survival rather than self-exploration:

> *"You aren't given the space to learn who you are because you're in such survival mode..you're just thinking "how long am I going to be living here?"* (Wagner & Heberle, 2024, p.8).

Continuous placement changes made it difficult for CECYP to develop a sense of self when the rules in each placement were different. Moving between households required adapting to different value systems, further impacting ability to develop a coherent and clear self-concept:

> *"...by having someone move around too much... they're learning all these different morals and values from all these different people so... it kind of gets them confused.."* (Geenen & Powers, 2007, p.1092).

This repeated, cumulative experience of loss reinforces a CECYP's core belief that *"you are not wanted and that you do not have anyone to reply on"* (Ben-Shlomo et al., 2025, p.5). In response they developed a survivalist self-reliant identity as a protective strategy against future relationship losses (Samuels & Pryce, 2008), which involves building up and

maintaining hyper-independence. Stereotypically "adult" roles are often *conferred* onto a CECYP early in their life (Samuels & Pryce, 2008, p.1202) making them seem mature for their age. When they age out of care, they lose their *"foster child identity"* (p.1204) and access to essential supports. This confirms the young person's views that other people are untrustworthy, reinforces their survivalist self-reliant identity, creating an unhelpful cycle.

Systemic stigmatization. CECYP experienced stigmatization across relationships and contexts. The word "*different*" was consistently used to describe how they felt in comparison to others. For some, this difference related to visible ethnicity and culture, particularly where adoptive or foster carers did not share the young person's background (Crowley, 2019; Neagu & Sebba, 2019). Having these differences *set them apart immediately* (Sowers-Zabelski, 2021, p.115) from their peers and family, leading to feelings of not belonging within their current communities. In addition, their status as a child in the care system marked them as different from their peers. CECYP described feeling "*icky*" (Lo et al., 2022, p.1611), *akin to being an outsider* (Lo et al., 2022, p.1608) and that they simply *don't fit* (Miller et al., 2020, p.3), thus highlighting the negative self-concept internalised from others.

Within peer relationships, this difference left them vulnerable to bullying and victimisation. CECYP felt de-valued and were called derogatory names such as "*the weirdo"*,*"psycho kid"* (Macleod et al., 2021, p.30), and *"crazy boy - looney tunes"* (Kools, 1997, p.266). Outside of peer relationships, CECYP experienced stigmatisation within the education system. They felt misunderstood and underestimated by education staff and were reduced to a *statistic* rather than being treated as an individual (Miller et al., 2020, p.3).

This perceived judgement from others also existed in the care system. Young people felt judged by the professionals involved in their care. Sally felt that her social worker viewed her in a *negative light* and she was "*blamed*" when things went wrong (McMurray et al., 2010, p.214). This perceived judgement from professionals was internalised by CECYP and became a part of their self-concept:

> *"I am so determined to get the hell out of here! Here, they see me as a depressed, unreasonable girl. Of course I'm depressed! Of course I'm unreasonable! Who wouldn't be the way they treat you - like a criminal!"* (Kools, 1997, p.266).

Chameleon identity. As a result of repeated negative relational interactions, CECYP feeling diminished and de-valued, lacking a clear sense of self. As a protective mechanism against ongoing judgements, they protected their true identity and became a reflection of other people:

> *"I am who others think I am and I will behave accordingly"* (Kools, 1997, p.267)

The absence of secure relationships meant that self-concept could not be safely explored, resulting in the development of a dynamic and fluid self-concept that changed depending on the relational context, similar to a chameleon:

> *"I am like a chameleon...always trying to please..."* (Ben-Shlomo et al., 2025, p.5).

One way that CECYP adopted this chameleon identity within relationships was through the intentional concealment of their care status (Neagu & Sebba, 2019). CECYP were intentional in who they chose to reveal their care status to, and this depended on the degree of perceived safety within the relationship. They tried to adapt their identity to fit different relational environments (Kennedy et al., 2024). They mirrored the traits, interests and behaviours of their peers, and changed their physical appearance to *blend in* and avoid standing out (Sowers-Zabelski, 2021, p.115). This resulted in young people taking on conflicting identities, for example they may be learners whilst also being forced to be their own teachers, and the child whilst also being their own parent (Wagner & Heberle, 2024). Their self-concept could therefore be considered temporary and relationally motivated, as opposed to a more *enduring* feature (McMurray et al., 2010, p.214):

> *"...you get really good at being fluid...like personality-wise…because you're trying to just fit in with wherever you're at. So, you don't get the opportunity to build or learn the foundation of yourself. And then you become an adult and you're like, 'Oh, crap, I don't know who I am"* (Wagner & Heberle, 2024, p.8).

This chameleon identity was further reinforced through external validation from others, resulting in the young person becoming more and more of a reflection of other people's views of them:

> *"I tend to get most of my identity from external validation. So what I think of myself, tends to be what other people tell me"* (Macleod et al., 2021, p.30).

4. Discussion

4.1. Overview of findings

This review synthesised qualitative evidence to explore how relationships shape self-concept in CECYP. Six inter-related sub-themes were identified which capture the positive and negative ways that relationships influence self-concept: stability, turning points, supporting mastery, loss, systemic stigmatisation and chameleon identity.

Stable placements facilitated positive relationships with caregivers, peers, schools and communities. This created trust and safety which are necessary for identity exploration.

Turning points in relationships offered the opportunity for CECYP to reconsider aspects of their self-concept and re-construct these. Within trusting relationships, mastery of skills and talents was encouraged, thus contributing to increased self-efficacy.

Conversely, relationships had the potential to negatively impact the self-concept of CECYP. Repeated and pervasive loss was experienced by CECYP, which extended beyond the loss of biological families, and included the loss of legal identity, personal history and value systems. Systemic stigmatisation occurred across peer relationships, the care system, professionals involved in a young person's care and educational contexts. CECYP were consistently positioned as different from other people, leaving them feeling devalued and misunderstood. Over time, the negative views of others were internalised and shaped how they viewed themselves. To protect themselves against ongoing negative relational interactions, CECYP developed a survivalist self-reliant and/or chameleon identity, dependant on external validation rather than being internally constructed.

4.2. Relevance to existing literature

The central role of enduring relationships in shaping self-concept in CECYP aligns with attachment theory (Bowlby, 1988). Placement stability, secure attachments with caregivers and trusting friendships allowed young people to internalise positive self-beliefs, which is consistent with previous findings (e.g., Farineau et al., 2011). When stability was missing, CECYP experienced high degrees of relational loss. Existing literature links relationship instability with poorer mental health outcomes for CECYP (Martín Quintana et al., 2023; Nishad et al., 2024; Pinquart, 2023) and suggests that fostered and adopted youth may have more difficulty making and maintaining friendships than the general population (DeLuca et al., 2019). For transracially fostered and adopted young people, loss extended to a disconnection from culture and heightened awareness of being "different", often exacerbated by stigmatising messaging from peers. Prior research has also identified challenges in ethnic identity development within transracial placements (Degener et al., 2022). This review reinforces the relational nature of ethnic identity formation, emphasising the importance of caregiver openness, cultural engagement and protection against stigma. Stigma and bullying were common experiences for CECYP generally, which undermined belonging and safety, contributing to the concealment of aspects of self-concept (Madigan et al., 2013). This is consistent with research which has identified that CECYP feel they need to negotiate between various and often conflicting identities across contexts (Harrison et al., 2025; Marlow et al., 2023).

Much of the existing literature adopts a problem-focussed lens emphasising the impact of trauma and risk on the development of CECYP. This was evident in this review. Every study included in this review contributed to the "negative influences" theme, but just nine studies made any reference to positive influences of relationships. Given CECYP's disproportionate exposure to ACE's (Madigan et al., 2025), this may be a reflection of the number of negative interactions these young people have in comparison to positive interactions. It may also be a reflection of a possible problem-focussed perspective shared amongst researchers. Given the lack of transparent researcher reflexivity, it's not clear how researchers positioned themselves in relation to their findings. It appears that this review is novel in its attempt to offer a more balanced strengths-oriented perspective. Rather than solely identifying what services should avoid (e.g., multiple placements for young people, stigmatising language, concealment of personal information), this review highlights the active ingredients that services should cultivate more of: stability in placements, cultivation of young people's strengths, open communication and collaboration, and cultural validation.

The theme supporting mastery is an important contribution to this field of research. This present review suggests that engagement in sports teams, youth groups and community activities provide relational environments in which young people can develop competence and identity separate from their care status. Previous research has demonstrated that participation in structured activities enhances self-esteem and provides social capital (Drozdikova-Zaripova et al., 2021; Quarmby et al., 2019; Sandford et al., 2024), however further research is needed to explicitly understand the link between mastery and self-concept in CECYP. Most of the studies that contributed to the turning points sub-theme involved older adolescents and young adults, which raises the questions about how younger children with less developed cognitive skills and reflective capacity might interpret and integrate turning points into their self-concept. Nevertheless, the identification of turning points as relational opportunities also advances the literature. While research highlights the prevalence of ACE exposure in CECYP, the present findings illustrate how positive relational experiences with mentors, teachers, cultural communities and other supportive adults can redirect adverse trajectories and create space for CECYP to reflect and re-construct their self-concept.

4.3. Strengths and limitations

A major strength of this review is its attempt at synthesising qualitative research, pulling out themes directly from those with lived experience of being in care. The inclusion of grey literature such as dissertations helps to combat possible effects of publication bias.

The dissertation included is one of the highest rated papers in this review in terms of quality (Sowers-Zabelski, 2021). One of the inclusion criteria for this review was for samples to have a mean age of less than 26. This is a significant strength of this review, bringing it in line with policy (e.g., The Promise) which advocates for the continuity of care for CECYP up until their 26th birthday, research which suggests that self-concept development continues alongside brain maturation until the mid-20's (e.g., Crone et al., 2022) and legislation (e.g. The Children and Young People Scotland Act 2014). Furthermore, this review followed PRISMA guidelines and the Thematic Synthesis procedure, which enhances the reliability of the findings.

However, there are some limitations. Studies that were not published in English were excluded which may mean that relevant research was excluded from this synthesis. As mentioned previously, there is a risk that the main researcher may have identified more strongly with themes related to attachment and trauma and someone adopting a different theoretical perspective may synthesise the data differently. Furthermore, the quality appraisal tool used does not have a scoring framework, therefore the primary researcher assigned numerical values to the CASP ratings for the purpose of summarising the quality of the included studies. This approach has not been validated by previous research, and may compromise the reliability of the quality ratings.

4.4. Implications for practice, research and policy

Findings from this review reinforce guidelines (NICE, 2021) emphasising the need for mentoring, positive relationships and system change models when supporting CECYP. Minimising placement disruption should be a priority when care-planning for these young people. Services can cultivate positive peer relationships for CECYP by developing a peer mentor programme where young people who enter the care system are linked in with peers with similar lived experience, or youth groups where these young people can socialise together and develop a sense of belonging. It is hoped that this could serve to reduce the isolation these young people report feeling and stop the development of survivalist self-reliant and chameleon identities. Training for carers, social workers, education staff and other professionals should explicitly address stigma. Public health campaigns may help to reduce wider systemic stigmatisation in society and increase awareness of CECYP's needs.

Future research in this area needs to focus on improving transparency with regards to researcher reflexivity. This is a vulnerable group of young people who are highly susceptible to the views of those around them. The lack of reflexivity in some of the included studies makes it difficult to ascertain the credibility of the findings, as its possible some participants

adopted their “chameleon identity” to reflect back to the researcher what they thought was the right thing to say. Once peer mentor programmes and youth groups are established, future research could focus on exploring their impact on self-concept for CECYP.

5. Conclusion

This systematic review highlights the important role relationships play in the construction of self-concept in CECYP. TS highlighted that self-concept development in this population is highly dependent on relational interactions. Stability, turning points and opportunities for skill mastery can foster positive and coherent self-concept. In contrast, repeated relational loss and the experience of systemic stigmatisation can undermine self-concept formation, often leading these young people to adopt fluid and changeable “chameleon” identities which are reinforced through ongoing loss and stigma. By synthesising qualitative accounts of lived experience, this review extends upon existing knowledge and highlights the active ingredients required to cultivate relational environments which can support self-concept development in CECYP.

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Chapter 2: Major Research Project

Clinicians' experiences of using a novel model of self-concept development in their clinical work with care-experienced children and young people.

Prepared in accordance with the author requirements for the Children and Youth Services Review:

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Plain Language Summary

Title: Clinician's experiences of using a novel model of self-concept development in their clinical work with care-experienced children and young people.

Background: Our "self-concept" is how we think and feel about ourselves. This includes how we see our abilities, what we look like, our role in society and our beliefs and values. It is sometimes called "self-image", "self-esteem", "self-efficacy", "self-awareness" and "self-identity". Research shows that difficult or upsetting life events can affect how self-concept develops. Young people who grow up in the care system often experience more stressful life events, which means they may be more likely to have difficulties with their mental health and self-concept than other young people. The McIntyre Model of Self-Concept (MMSC) was created to help clinicians to understand what factors influence self-concept development in young people who have been in care.

Aims: This study aimed to find out clinician's experiences of using this new model in their clinical practice.

Research Questions:

1. What are clinicians' experiences of using the MMSC?
2. What do they see as the strengths and weaknesses of the MMSC?
3. For what purpose(s) are they using the MMSC in their clinical work?
4. If they have used similar models in their clinical work, how does the MMSC compare?

Methods: Five clinicians working in a specialist CAMHS service in NHS Lanarkshire took part in interviews about their experience of using this new model in their clinical work. Interviews were recorded, written up and carefully analysed using Reflexive Thematic Analysis to find common themes and patterns.

Findings: Four main themes and ten sub-themes were identified which capture clinicians experiences of using the MMSC in their clinical work. These themes are: 1) A multi-purpose model, 2) A different approach, 3) Challenges and recommendations, and 4) Varied emotional experiences.

Conclusion: Overall, clinicians have had a positive experience of using the MMSC in their clinical work. Future research should include young people's views of the model to develop clear guidance on how it can be used, and test how well the model can be applied in other mental health services.

Abstract

Care-experienced children and young people (CECYP) are at an increased risk of adverse childhood experiences (ACE's) which can negatively impact the development of their self-concept. Traditional theories and models of understanding self-concept development fail to consider that CECYP experience more ACE's than their typically developing peers. Therefore, these theories and models are insufficient for understanding how self-concept develops in this population. A novel model of self-concept was recently developed which visually highlights the factors that contribute to self-concept development in CECYP. It is being used clinically in a specialist child and adolescent mental health service for CECYP, but little is known about how this model is being implemented in this team and how clinicians are experiencing the model to date. This study aimed to qualitatively explore clinicians' experiences of using the McIntyre Model of Self-Concept in their clinical work. Five clinicians from a specialist CAMHS service in NHS Lanarkshire participated in semi-structured interviews. Four themes and ten sub-themes were identified using Reflexive Thematic Analysis. The four overarching themes capturing clinicians' experiences of using the model were: "A multi-purpose model", "A different approach", "Challenges and recommendations" and "Varied emotional experiences". The findings indicate that clinicians have had a favourable experience of using this model in their clinical work. Future research is needed to incorporate young people's perspectives, develop implementation guidance, and evaluate the model's effectiveness and mechanisms of change across other service settings.

Keywords: self-concept, care-experienced young people, qualitative research, child psychology

1. Introduction

1.1. Defining self-concept

The term “self-concept” is a complex construct that researchers often use interchangeably with terms such as “self-image”, “self-esteem”, “self-efficacy”, “self-awareness” and “self-identity” (Kouvelis & Kangas, 2021). Whilst these concepts are frequently treated synonymously in the literature, socio-cognitive researchers conceptualise “self-concept” as an overarching framework which encompasses each of these components (e.g., Crone et al., 2022).

Self-image refers to an individuals' subjective perception of their appearance and personality (Rogers, 1959). It is reflected by the question “how do I see myself?”, with responses such as “I look professional and confident”. Self-esteem refers to an individual's evaluation of their own value or worth (Crone et al., 2022) and can be understood with the question “how do I feel about myself?”. Responses may include “I’m worthy” or “I’m not good enough”. Self-efficacy is the judgements someone makes about their own abilities (Bandura, 1977). It’s reflected by the question “am I able to do this?” and the answer “I can/can’t cope with this situation”. Self-awareness reflects conscious awareness of one's own thoughts, feelings, behaviours and traits (Crone et al., 2022). It may be understood by the question “what am I thinking/feeling/doing right now?” and answered with “I’m feeling anxious about this”. Self-identity refers to the sense an individual has of who they are, shaped by social roles, group membership, and values (Branje et al., 2021). It’s captured with the question “who am I?” and the response “I’m a good friend”.

Together these components form an integrated self-concept through which social experiences are interpreted and integrated into the self (Crone et al., 2022). This research paper will adopt Baumeister’s broad definition of self-concept as the knowledge and beliefs one holds about oneself (Baumeister, 1997) as it captures all these dimensions.

1.2. Theoretical perspectives on self-concept

There are multiple theoretical perspectives which explore self-concept. The discussion below is intended as a broad summary as opposed to an exhaustive list.

1.2.1. Psychoanalytic perspectives

Although they are not formal theories of self-concept, Freud and Jung offered some of the earliest influential perspectives on the self. Freuds psychoanalytic theory (1923) proposed that the mind comprises the id, ego and superego, with the ego representing the conscious self. Jung introduced the notion of archetypes such as the persona (the public self) and the shadow (the hidden self). These early perspectives are critiqued for their vagueness and lack of scientific rigour (e.g., Giannoni, 2003; Roesler, 2013).

Erikson's psychosocial theory (1968) proposed that the self develops across the lifespan, with identity emerging during adolescence through the resolution of key developmental conflicts. Though his theory extends upon early psychoanalytic perspectives, it has been criticised as androcentric due to its male-centred development and for potentially overestimating the necessity of an adolescent "identity crisis" (Branje et al., 2021; Sorell & Montgomery, 2001).

1.2.2. Cognitive and developmental perspectives

With a similar emphasis on adolescence, Piaget (1952) proposed that self-concept develops as a product of cognitive development during this time. However, this theory overlooks the roles of social and cultural factors on self-concept development. In contrast, Vygotsky (1978) didn't explicitly address self-concept but argued that learning occurs through social interactions which shape understanding of the self, others and the world.

The possible selves theory (Markus and Narius, 1986) suggests that people hold cognitive representations of potential future selves which guide motivation and behaviours. These possible selves are shaped by cultural and social contexts, personal experience and external influences. This perspective rejects that self-concept is determined solely by past experiences and promotes a more fluid and dynamic nature of self-concept. This theory has been frequently applied in social work research (e.g., Bond, 2025).

1.2.3. Ecological perspectives

Bronfenbrenner's ecological systems theory (1989), though not specifically proposed as a theory of self-concept, can be helpful for understanding how self-concept is influenced by multiple, embedded contexts or "systems" (Oh & Sung, 2018). A bi-directional relationship occurs whereby the systems influence the individual, and the individual therefore influences the systems. It was further developed by Minnis and colleagues (2024). Though this theory acknowledges biological, social and cultural influences on self-concept, it lacks specificity about the mechanisms of positive or negative influence on self-concept.

1.2.4. Social learning and attachment perspectives

Bandura's social learning theory (1977) proposes that self-efficacy (a component of overall self-concept) is shaped through observational learning and positive reinforcement in social interactions. This theory highlights the reciprocal relationship between a child and their environment. While this provides insight into the role of social relationships in shaping self-concept, it underemphasises internal factors such as motivation.

Attachment theory (Bowlby, 1988) also highlights the influence that early relationships can have on self-concept. It suggests that early interactions with a caregiver provide a foundation for the development of a child's internal working models. Research has demonstrated that different attachment styles lead to different views of the world. Secure attachment in childhood is linked to positive self-concept development in adulthood and insecure attachment in childhood can lead to negative self-concept development in adulthood (Martín Quintana et al., 2023). The development of negative self-concept in this way has been linked to perceiving the self as "worthless" or of little value. Whilst attachment theory is widely accepted as a sound explanation for self-concept development and forms the foundation of many therapeutic interventions for young people and their carers (e.g., Golding, 2019), it's considered to over-simplify complex human experiences, over-emphasise the parent-child bond in human development, and doesn't generalise across cultures (Mehdiabadi, 2023).

1.2.5. Humanistic perspectives

Carl Roger's (1959) proposes that discrepancies between a person's ideal self-image and their actual self-image leads to identity confusion. This theory suggests that this confusion may be resolved by receiving unconditional positive regard. This ideology was reflected in Higgins (1989) self-discrepancy theory in which he suggests that individuals have an actual self (how they see themself), an ideal self (who they want to be) and an ought self (who they believe they should be) and conflict between these "selves" results in emotional distress. These humanistic theories focus largely on self-image as opposed to overall self-concept and may negate the external socio-cultural and socio-economic influences on self-concept development.

1.2.6. Summary

Theoretical perspectives on self-concept are wide-ranging, but limited. Many lack generalisability to diverse populations and may oversimplify the complexity of human experience. They address some key elements of self-concept but lack a comprehensive account of the overall construct. Additionally, limited attention is given to environmental and

contextual influences, highlighting the need for further research into the factors that influence self-concept development in young people.

1.3. Self-concept development in care-experienced young people (CECYP)

Creating supportive conditions for self-concept development is associated with positive outcomes in academic achievement, social relationships, identity formation and psychological wellbeing (Crone et al, 2022). Evidence from a systematic review guided by the possible selves theory highlights the protective function of a positive self-concept in reducing risky health behaviours such as smoking and drinking alcohol (Corte et al., 2020). Factors which may contribute to the development of a positive self-concept include safe and stable caregiving and peer relationships, support for skill mastery, and relational turning points (Crowley, 2019; Macleod et al., 2021; McMurray et al., 2010). Conversely, adverse childhood experiences (ACE's) may negatively impact the development of self-concept in young people (e.g., Colbridge et al., 2017; Kouvelis & Kangas, 2021; Morstead & DeLongis, 2023). Cumulative exposure to adversity may alter the neurodevelopment of brain regions associated with self-regulation, such as the prefrontal cortex and the anterior cingulate cortex. These neurobiological changes may increase sensitivity to social cues, reduce capacity for emotional regulation, and increase anxiety and depression, therefore possibly further impeding the development of a healthy sense of self (Crone et al., 2022).

CECYP face significant barriers to the development of a positive self-concept. They are more likely to have experienced ACE's than the general population. A recent systematic review and meta-analysis found that the mean prevalence of four or more ACE's in CECYP is 40%, in comparison to 14.8% in the general population (Madigan et al., 2025). Nevertheless, this is a striking discrepancy between CECYP and their typically developing peers. Beyond these adversities, additional systemic and relational barriers within the care system may further compromise self-concept development. Living away from birth families, multiple placement changes, limited or fragmented knowledge of personal and family history, transracial and transethnic placements and a lack of clear understanding regarding the reasons for being in care can contribute to ongoing identity confusion and disruption (Colbridge et al., 2017; Degener et al., 2022). Collectively, these experiences may inhibit the formation of a coherent sense of self, negatively affecting self-concept clarity and increasing the risk of poor mental health outcomes.

Cummings and Shelton (2024) suggest in their systematic review that the prevalence of mental health disorders in CECYP ranges from 1-82%, however most studies have failed to

use a comparison group, making it difficult to determine how these rates compare to the general population. This range is also so broad that it is difficult to make meaningful conclusions based on this. In a study which did use a comparison group, researchers found that the prevalence of mental health difficulties in CECYP was 1% in comparison to 0.2% in the general population (Fleming et al., 2021). In Scotland between the 1st August 2023 and the 31st July 2024 11,844 children had a current care status (The Scottish Government, 2025). Scotland has the highest rate of CECYP per 10,000 than anywhere else in the UK. This highlights that there is a significant proportion of our young people who are care-experienced, and therefore at an increased risk of experiencing ACE's, developing mental health difficulties and a negatively developed self-concept. It's therefore important to develop a body of research which can contribute to understanding the mental health needs and improving mental health services for these young people.

1.4. Clinical approaches to self-concept development

The theories above fail to account for the nuanced experiences CECYP have had. Researchers have been attempting to understand how CECYP make sense of their self-concept, and what the long-term impact of the care experience itself has on self-concept. The Identities In-flux Framework (Cheruvallil-Contractor et al., 2024) was developed specifically with CECYP in mind. It utilizes the image of an identity see-saw to emphasize the fluid and changeable nature of identity. Although it was developed for this population, much of the methodology was focused on specific elements of identity such as religious and ethnic identity rather than overall self-concept. The Possible Me Tree (Bond, 2025) is a visual tool based on the possible selves theory (Markus and Narius, 1986). It is primarily used in social work settings to support young people to explore their self-concept. It utilizes the image of a tree to depict a young person's goals, strengths, challenges, hopes, expectations and fears. However this tool is a lengthy five-step activity using separate worksheets. Both models have been used primarily in social work settings and their application to mental health settings is less understood.

The House-Tree-Person model (H-T-P; Buck, 1948) was developed to assess the self-image of vulnerable young people by exploring their unconscious self-representations. The young person is invited to draw a house, a tree and a person, each symbolising different aspects of the self, safety and interpersonal dynamics. A recent study in India found this model helpful for understanding CECYP's self-concept and inner world (Srivastava & Bharti,

2025), although several limitations impact its generalisability to a Scottish context. The drawings made by young people were coded by the researcher with a significant degree of subjectivity and the researchers position in relation to the data is not clear, thus increasing the possibility of biased analysis. Secondly, young people were excluded from this study if they had a significant mental health difficulty, therefore it's not clear whether this model is appropriate for CECYP who experience a higher prevalence of ACE's and mental health difficulties than the general population. Therefore, this model may not be appropriate for use in a specialist mental health team. Thirdly, the sample were recruited via purposive sampling from an orphanage in India, therefore may have specific unique characteristics which influenced their engagement with the model that were not controlled for.

The McIntyre Model of Self-Concept (MMSC; McIntyre, 2022) provides a novel theoretical perspective on the self-concept development of CECYP. It hypothesises that there are various positive and negative factors which influence self-concept development in this population, from early pre-care life experiences to ongoing experiences of loss. A one-page worksheet was created to aid with the application of this theory in clinical practice (Appendix 6). The model utilises the image of a tree to represent self-concept as a dynamic changeable construct and communicate this in clinical settings. The "Roots" signify the experiences pre-care which influence self-concept such as the absence of stable placements, potentially leading someone to feel different and lacking a sense of belonging. The "Trunk and Branches" signify the ever-growing, ever-changing aspect of self-concept. Their growth is influenced by the "Roots" and external factors such as "Sun" and "Bad Weather". The "Sun" signifies the positive, nurturing factors which help self-concept to grow, such as secure attachment with a caregiver, positive peer interactions and stable placements. The "Bad Weather" signifies the factors which may hinder or negatively impact ongoing self-concept development, such as lack of input into decision making, stigma, and relationship difficulties. As the "Trunk and Branches" grow and are influenced by the various weather system, the "Leaves" may fall to the ground, decompose and get reabsorbed by the roots. This represents the multiple losses that are experienced by CECYP such as loss of childhood, growing up too fast and loss of family.

During the development of the MMSC, research participants with a care history were asked about their experience of how being in care impacted their self-concept. Grounded theory was used to develop the model; thus, no predetermined theory was used to influence the model that was developed, giving it the potential to be used transdiagnostically in

psychological therapy. A strength of this new model of self-concept development is that participant and service user feedback was obtained on it, therefore enhancing the face validity of the model, and a one-page worksheet was developed to visually explain the model, which is currently used in a specialist NHS mental health service. A current limitation of the MMSC is that it remains unpublished to date. Due to the lack of evidence on the MMSC, it is unclear how it is being used in clinical practice. In order to determine whether this model and the worksheet have clinical utility, it is important to explore and understand the experiences of the professionals applying it in their clinical work.

1.5. Aims and research questions

The current study will explore how the MMSC (i.e. this new theory of self-concept and its associated worksheet) is experienced in clinical practice with CECYP by answering the following research questions:

- What are clinicians' experiences of using the MMSC?
- What do they see as the strengths and weaknesses of the MMSC?
- For what purpose(s) are they using the MMSC in their clinical work?
- If they have used similar models in their clinical work, how does the MMSC compare?

2. Methods

2.1. Design

A qualitative design using semi-structured interviews is appropriate for in-depth exploration of clinician's experiences using the MMSC. Reflexive Thematic Analysis (RTA; Braun & Clarke, 2021a) was used to identify shared patterns of meaning across the dataset and was selected for its theoretical flexibility and emphasis on researcher reflexivity, which is particularly important given the researcher's dual role as a clinician and researcher. RTA was considered more suitable for this study than Interpretative Phenomenological Analysis, which focuses on individual lived experiences rather than shared meaning across participants.

2.2. Recruitment

As the research questions relate to the experiences of a specific group, purposive sampling was used. Clinicians were recruited through professional contacts within the NHS Lanarkshire CAMHS for Care-Experienced Young People (CCEYP) team. This is a multi-disciplinary team comprising of clinical psychologists, mental health clinicians, clinical associates in applied psychology, and child and adolescent psychotherapists. Staff in this team have worked in various other professions prior to this role, including nursing, social work. The researcher attended a team meeting to introduce the study, share the participant information sheet and privacy notice. The inclusion criteria for this study required participants to be qualified client-facing clinicians in the NHS Lanarkshire CCEYP team who had used the model with at least two clients. Clinicians who used the tool with only one client were excluded to ensure sufficient breadth and depth of experience.

2.3. Sample size

Choosing a sample size in qualitative research is an area of debate, with researchers previously aiming to recruit enough participants to draw accurate conclusions from i.e., data saturation (Morse, 1995). However, this approach is inconsistent with the reflexive principles of RTA, which views that meaning is generated through interpretation of information, therefore judgements about when to stop data collection and analysis are difficult to determine in advance (Braun & Clarke, 2021b). Qualitative researchers are encouraged to aim for *information power* by recruiting participants who can provide rich and relevant data (Malterud et al., 2016). There was a maximum number of 9 eligible clinicians within the population of interest, therefore this study aimed to recruit 6-8 participants to capture the majority of relevant perspectives and therefore fulfil the recommendations for information power.

2.4. Ethical approval

Ethical approval for this study was granted by the University of Glasgow's College of Medicine, Veterinary & Life Sciences (MVLS) Ethics Committee (Project no: 200240393; Appendix 7). Management approval was granted by NHS Lanarkshire Research and Development (Reference no: L25074; Appendix 8).

2.5. Materials

Study materials include the participant information sheet, consent form, privacy notice, demographic questionnaire and interview schedule in Appendix 9, and the MMSC in Appendix 6.

2.6. Procedure

Clinicians were already using this model in their clinical practice therefore no training was provided by the researcher prior to data collection. During recruitment, potential participants received the information sheet, privacy statement, consent form and interview schedule, allowing them to consider their answers to the questions in advance. Interviews were scheduled between participants and the researcher once written consent was received. One participant opted for a face-to-face interview, and four for a video call via MS Teams. At the beginning of each interview participants were reminded about confidentiality and their right to withdraw their data up to one-week post-interview. Interviews lasted between 33 and 54 minutes (M=42 minutes) and comprised of open-ended questions exploring their experience using the model in their practice. Interviews were audio recorded using an encrypted recording device. At the end of the interview, participants were given the opportunity to clarify or withdraw information though none chose to do so. Recordings were transcribed, pseudonymized and stored in the University of Glasgow's OneDrive system. The researcher made reflective notes after interviews and during the transcription process.

2.7. Data analysis

RTA is a method for developing and interpreting patterns across a dataset and was used in this study to analyse interview transcripts. It involves systematically coding qualitative data and developing these codes into themes. Reflexivity within RTA is crucial and requires the researcher to reflect upon ways in which they may influence study outcomes. The six phases of RTA can occur in a non-linear fashion - data familiarisation, data coding, theme generation, theme development and review, theme refining, defining and naming, and writing up. A detailed data analysis plan can be found in Appendix 10.

2.8. Participants

Staffing issues at the time of recruitment significantly reduced the potential pool of participants. One potential participant expressed interest but did not respond to follow-up contact, and one expressed interest but left their post within the team. Five clinicians

participated in this study, and while this was less than anticipated, it was deemed sufficient to fulfil information power (Malterud et al., 2015).

2.9. Epistemological perspective

The researcher aligns with a critical realist epistemology, recognizing that there is a form of "truth" which exists that can be partially accessed through research. The researcher acknowledges that participants have their own lived experience of using this model which the researcher can strive to understand but can only ever partially access through careful analysis of the interviews. This analysis will inevitably be influenced by the researchers' own training and experiences.

2.10. Reflexivity statement

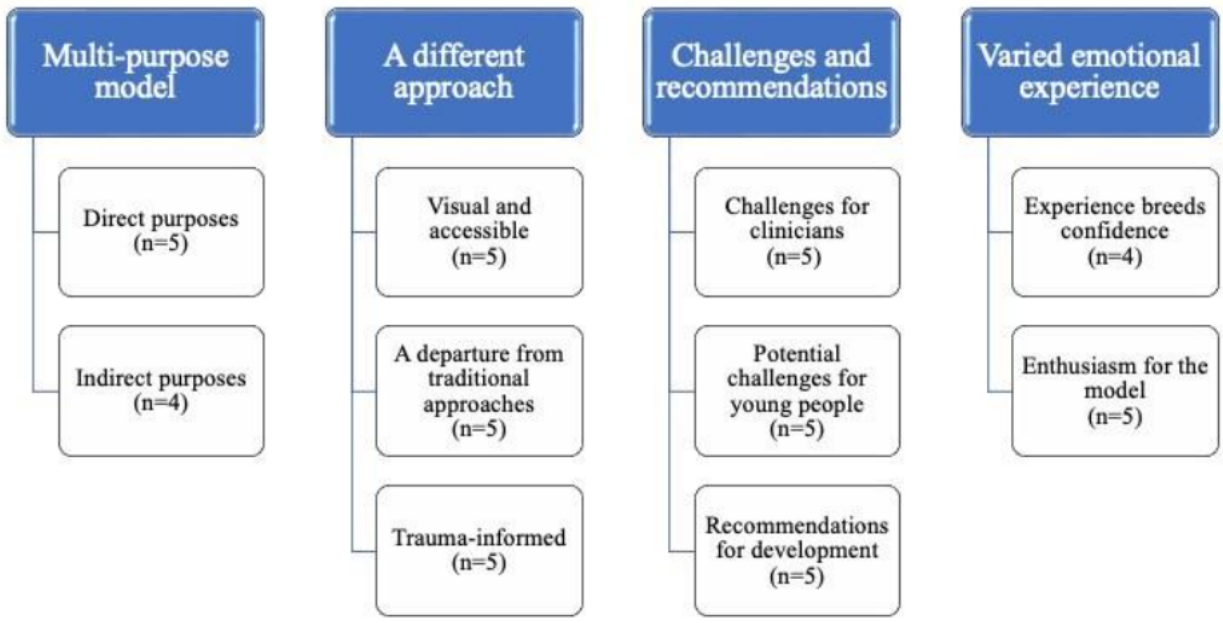
I am a white, Irish, female Trainee Clinical Psychologist currently on placement in the NHS Lanarkshire CCEYP team. I am keenly interested in working with CECYP. This interest is what drew me to this research project early on and has kept me motivated throughout the duration of the study. Over the course of my placement in this team, I have seen first-hand the impact that trauma and difficult early life experiences can have on the mental health and self-concept development of these young people. In my clinical work in this team, I regularly utilise theory and research to explore trauma and attachment with the young people that I work with, and this will inevitably have impacted my interpretation of the data. Having been present in the office and in team meetings, I am somewhat familiar with some of the cases referenced by participants during the interviews. Looking back on transcripts, I can see where this familiarity helped me explore participants' experiences deeper, but I can also see where I had assumed meaning, which was a barrier to me exploring something further. At times I found it challenging to interpret participants narratives when local terminology or "slang" words were used which were unfamiliar to me. When this occurred, I tried to remain aware of this and ask for clarification when necessary but it's possible my interpretation of the data is influenced by this. I implemented structures to maintain a boundary between my role as a clinician in the team and my role as a researcher. At times this was challenging. I kept my research supervision separate from my clinical supervision and tried to avoid discussing research during clinical placement time. Throughout the research process I kept a reflective journal and made notes after every interview. I acknowledged this dual role at the beginning of each interview with every participant

however it is still possible that participants did not share the full extent of their experience using the MMSC.

3. Results

Limited demographic information was collected on participants as this is a small team and publishing detailed information increased the possibility of participants being identified. Information was gathered on the length of time participants had been in their current post, how many times they used the MMSC, and what they used the MMSC for. Participants had worked in this team for 18-60 months (M=37.2 months). Most used the model with two cases, with one participant using it for four cases. The model was used for assessment and formulation (n=4), consultation (n=2) and intervention (n=2). The analysis process identified four themes and ten sub-themes. All participants are represented in the main themes. The numbers of participants (n) represented in each sub-theme is represented in Figure 5.

Figure 5 *Themes and sub-themes identified by RTA*



3.1. A multi-purpose model

Participants felt the model has multiple direct and indirect clinical uses.

3.1.1. Direct purposes

The model was used directly with CECYP with varying ages, genders and presenting problems for assessment, formulation and intervention. It provided "*structure*" (Sam) and "*focus*" (Sam & Robin) to clinical work when participants felt "*stuck*" (Charlie & Alex). Robin wondered if it could be a helpful way of "*exploring risk*" with a young person though didn't elaborate on this. Sam described it as "*good starting point*" for psychological assessment, facilitating engagement and disclosure. This was echoed by Alex:

> *"I introduced this model as a way of getting more information. I didn't call it an assessment, just a model for me to get more information to help me understand him and help us to understand what he needs to help himself feel better".*

The model facilitated collaboration during formulation. The "Sun" highlighted the positive, protective factors which are sometimes left out. The structured, visual aspect of the model ensured no information was missed:

> *"I do think that the main thing is about this sort of overall picture of having something that, when you've completed it, you've talked about all the parts of it, you've not missed anything"* (Charlie).

Sam felt that the structure of the model helped to "*steer away from some of the focus on risk"* and concentrate on the therapeutic work. Alex suggested that information gathered could be "*pulled out and put into a safety plan*" and used to guide intervention:

> *"..because her stormy bit was so full, it really highlighted that this girl not got nothing, no coping strategies, no sense of self, no support...so this is where the difficulty lies and this is what we need to be doing, we need to be thinking about ways that she can have positive relationships..".*

3.1.2. Indirect purposes

The model was used in indirect work for consultation, team formulation and systemic working. Participants used the visual of the tree to communicate complex information about self-concept to multi-agency systems involved in a young person's care:

> *"So for example, one of the young people had said she's always wondered why she was put back to her family after she was first removed...it was able to kind of direct the social worker to say this is part of her story that she's struggling to understand or she*

needs to go back and revisit. So in that sense, emm I guess it influenced the work of the system around the child aswell" (Blair).

During a team formulation session, the model facilitated a more thoughtful case discussion:

"So then one of my colleagues actually was saying that "would that fall into sunshine, her ability to form relationships? Would it not go, would that not go to the stormy bit? Coz actually it's not something that she can do" and I found that really interesting, it made me think" (Alex).

Charlie attempted to use this model with foster carer's but found that it wasn't as helpful in that context because clinicians speak more directly with foster carer's than they do with a young person and so a visual metaphor wasn't necessary. Robin used the model with a care worker and found that it helped them to reflect on how their own self-concept was impacting their relationship with the young person:

"I think there was a reflection actually from the worker... she actually reflected on "actually I've had my own share of good and bad weather"...I wonder if that helped land that yes these are difficult things that can happen, and if we don't have the right parts in that, it makes it a bit harder" (Robin).

3.2. A different approach

All five participants reflected on how this model felt new and different.

3.2.1. Visual and accessible

Every participant emphasised the visual aspect of the model being enjoyable and different from their usual ways of working, making it easy to pick up and apply in busy clinical settings. Alex thought the model looked "*therapeutic*" and "*fun*", and Blair described it as "*child-friendly*". The "Roots" made it easier for young people to have difficult conversations about their past, and the addition of the "Sun" and "Bad Weather" helped to balance conversation. Participants were creative in how they used it in session. Three participants brought in pens, paper and coloured markers to their sessions and drew the model out with their young people:

"So what I did is I got a big A4 piece of paper, put on the floor, cut out the all the symbols of the tree et cetera and I made it really interactive with me and that young person, had felt tips" (Alex).

3.2.2. A departure from traditional approaches

All participants used the word "*different*" to describe the model. In some ways it overlapped with another model that explores professional identity, however the MMSC differed in that it has both "Sun" and "Bad Weather" which felt "*more specific*" (Sam) for CECYP. Using the term "self-concept" also felt more "*powerful*" (Alex) and "*tangible*" (Blair) than language used previously. There was a flexibility in this model which felt appropriate for CECYP and different from the "*rigidity*" (Robin) of some manualised approaches. Ultimately, the visual and interactive aspect of the model meant that the work extended beyond "*just talking*" (Robin). It allowed young people to share information that was not captured using conventional approaches, such as the impact of the loss of friendships:

"..the leaves was an interesting section for me as well, because actually for looked after children, there is so much loss, and I think a lot of the loss that we think about is like the loss of your biological parents which is obviously huge, or the loss of siblings, but actually it was interesting how much came out about the loss of friends, you know like the amount of moves and moves of school and move of clubs and just how much loss is even out with the big ones that we usually think about..." (Blair).

Participants acknowledged that self-concept is a topic that comes up regularly in their clinical work, but they were not aware of any other model that could be used to explore self-concept with CECYP. Blair felt that having the MMSC made the complexity of self-concept less "*ambiguous*".

3.2.3. Trauma-informed

Across all accounts, the trauma-informed principles of safety, trust, choice, collaboration and empowerment could be identified which made the MMSC feel unique from traditional ways of exploring care experiences. Sam felt that the model provided a "*sensitive*" way to explore young people's difficult histories, and having the image in front of the young person provided them with an "*anchor*" as safety to explore "*as much or as little as the young person felt comfortable with*". Alex echoed this and felt young people had the choice to "*just*

focus on one area" if they wanted. It allowed for the development of a *"shared formulation"* (Charlie) thus encouraging collaboration.

Having a trusting relationship with a young person before using the MMSC was seen as crucial. Using this model appeared to externalise shame from the young person and empower them to open up about their trauma history:

> *"So I wanted to try and put something that's about her, but maybe presents as a wee bit removed..and as I say the weather, this might be a nicer way to do it* [discuss the impact of young persons past on her current mental health difficulties] *because it seems like an external thing*" (Robin).

3.3. Challenges and recommendations

Several actual and potential challenges were identified by participants, as well as some recommendations on how the MMSC could be developed for future use.

3.3.1. Challenges for clinicians

Without any guidance, participants spent a lot of time familiarising themselves with the MMSC. They relied upon their knowledge of similar frameworks when implementing this model and this didn't always go to plan. They also used their clinical judgement to decide when to use the model and who to use it with, leading to differences in opinions regarding this:

> *"I suppose then with [my colleague] kind of suggesting using it and for an assessment..and actually weighing that up because I suppose I was thinking..this has been my experience of it, actually, I don't feel, I don't feel comfortable using it in this kind of situation.."* (Sam).

While some areas of the model were pretty "*self-explanatory*" (Blair), participants encountered difficulty explaining the "Roots", "Trunk", "Branches" and "Leaves". Although young people seemed to like the model and engaged with it, it was difficult for participants to identify the mechanism of change. Without any unit of measurement, it was impossible for clinicians to know whether any positive impact observed was due to the model itself or due to other variables:

"He did surprise me with the amount of information he gave. So I don't know what is that, is that the model and how I was talking about the roots that prompted that, or was it the fact that we met a few times?" (Alex).

They also found that time pressure and systemic issues such as young people moving out of area or not attending appointments impacted their ability to utilize this model effectively.

3.3.2. Potential challenges for young people

Participants felt that it was important for young people to have emotional regulation skills and a good rapport with their clinician before using this model. Without these, engagement was more challenging. For those who did engage with the model, it was hard for them to think about what information to include in each section, especially for the "Roots" and the "Sun":

"I wonder as well if it's difficult to think about that on the spot, you know.." (Blair).

Staff who used the model with neurodiverse young people and young people with a lower IQ felt that because of their black and white thinking style they struggled with the metaphorical aspect of the model. For young people who were already participating in a manualised treatment programme, participants were concerned that using this model would impact the fidelity of that treatment approach and therefore they were not offered the opportunity to engage with this model. Despite Robin's earlier proposal that this model could help with risk assessment, Sam and Alex actively chose not to use this with risky cases, though their reasoning for this was not explored.

3.3.3. Recommendations for development

Participants emphasised that they would benefit from some additional guidance. Suggestions included a training programme, some sample questions to ask in each section of the model and some role plays to demonstrate how the model could be used in a session:

"Maybe just, I don't know, like, some words or instructions around [the model]*, so that it was a bit more self-explanatory, possibly, so that people could use it maybe unguided.."* (Charlie).

To combat time pressures clinicians felt and difficulty young people experienced thinking about what to put in each section, it was suggested that the model could be split across multiple sessions rather than trying to fit it all into one, or offering the model as a between session task:

> *"Like maybe be more, let's just see how much space each section takes up and if we need more sessions, let's do that"* (Blair).

Although some clinicians felt the A4 format of the model was "*fine*" (Sam), others found it inconvenient to print out. A recommendation was made about converting the format of the model from a PDF into an interactive electronic document which would allow each section of the model to be edited to reflect the young person's individual story.

3.4. Varied emotional experience

Clinicians experienced a range of emotions before, during and after using this model in their clinical work.

3.4.1. Experience breeds confidence

There was some initial anxiety from participants about how to use the model and what information to include in each section due to the lack of guidance. Robin felt "*self-conscious*", and Blair and Sam felt "*unsure*" when they were explaining it to a young person. Alex felt "*anxious*" about explaining the "Roots" to a young person with a significant trauma history and Sam found this part "*invasive*". Ultimately, participants worried about using the model correctly:

> "*..it left me with that thing of, I better, I hope I've done that right"* (Robin).

However, participants felt like the flexibility of the model helped to ease some of this initial anxiety:

> *"I like the fact that it wasn't really constrained. It was like present it how you want to. I think that really did ease my anxiety*" (Alex).

After using the model for a second time, they felt "*more confident"* (Alex & Blair) due to the experience and knowledge they had built up. For those who did not yet feel confident in their use of the model, they acknowledged that this would likely come with more practice:

"I suppose maybe if I was to have used it in supervision or as a formulation myself for a young person, so had that kind of practice in doing it like that without the young person to then be able to do it more kind of seamlessly in session might have actually been helpful" (Sam).

3.4.2. Enthusiasm for the model

Despite initial anxiety, all five clinicians liked the MMSC overall. They particularly liked the novelty of it and remarked on it being aesthetically pleasing. During interviews there was a sense of excitement and eagerness that was conveyed by participants in their tone of voice, facial expressions and explicitly expressed verbally. Blair liked that it is "*containing*". Charlie felt "*really optimistic about it"*. Both Sam and Blair shared that they would "*definitely*" use the MMSC again in their clinical work with CECYP, and this eagerness was echoed by Alex and Robin also:

"Would I use it again? I would. I would use it again" (Robin).

4. Discussion

This study explored clinician's experiences using the MMSC in their clinical work with CECYP. Using RTA, four overarching themes and ten sub-themes were identified which illustrate the benefits and drawbacks of the model, how it is being used by mental health professionals in a specialist CAMHS team, and how it compares to other clinical approaches. In general, participants had positive experiences using this model in their practice, however, there was some concern shared. This was largely due to the absence of formal guidance or training, and concerns about exploring trauma-related material within the "Roots" section too early in the clinical work. This finding is consistent with broader literature around clinician anxiety when delivering trauma-informed interventions. Research shows that clinicians are concerned that patients will become re-traumatised during trauma-informed work, meaning clinicians may be likely to avoid using trauma-informed approaches (Purnell et al., 2024). The importance of a good therapeutic relationship is an important pre-requisite to any trauma-informed work (Ehlers et al., 2021) which was also supported by participants in this study.

Some of the themes identified in this study mirror the findings from Srivastava and Bharti (2025). The idea of a weak trunk and the absence of stable roots represent the disrupted foundations these young people experience and unresolved loss, thus impacting self-concept. Both the H-T-P model and the MMSC offer beneficial visual representations of self-concept, but the MMSC appears more focussed on overall self-concept.

The finding that the MMSC lacked guidance is understandable given it is in very early stages of development and participants were not provided with any prior training on how to implement this model. Instead, the researcher was curious to explore how these experienced clinicians felt it could be used. The finding that participants found the visual/metaphorical aspect of the model helpful for engaging young people is expected and reflects the wider literature. It's been suggested that visual material helps to break down complex information into understandable chunks (e.g., Lazard et al., 2016). This is particularly important for CECYP with high numbers of ACE's who may be operating in survival mode, thus limiting their capacity for processing and retaining information (Hawkins et al., 2021). The MMSC therefore has the potential to support these young people to engage with the complex psychological construct self-concept. In addition to lack of guidance, clinicians in this study highlighted some organisational challenges which interfered with their ability to implement the model in their clinical work, such as a lack of time. These findings are supported by Peters-Corbett and colleagues (2024) who found that systemic and organisational barriers can prevent clinicians from adopting novel clinical innovations.

The finding that clinicians found it difficult to identify mechanisms of change is consistent with research across psychotherapeutic modalities (Johansson & Høglend, 2007). It has been suggested that psychological flexibility may operate as a primary mechanism of change, although this remains unclear (Salkovskis et al., 2023) and requires further exploration.

4.1. Strengths and limitations

A primary strength of this study is its qualitative exploration of clinician's experiences. This offers rich and in-depth insight into both the potential benefits and limitations of the MMSC from the perspective of experienced clinicians who have an average of 37.2 months working in this clinical field. These results can now be used to develop the model and worksheet further and provide the foundations for future empirical research. During the analysis process, codes were triangulated between the researcher and academic supervisor's,

therefore increasing inter-rater reliability. The reflexive approach of RTA demands that any biases held by the researcher are acknowledged, which further enhances the credibility of the findings. The themes that resulted from the analysis were supported by vivid and representative quotes from the participants, further improving the reliability of the results. However, there are several limitations within this research. Unforeseen staffing issues in the team impacted the recruitment process and resulted in a smaller than anticipated sample. The sample was recruited from a specific service context. Despite efforts to reduce responder and researcher bias, the risk of this occurring cannot be eliminated. Therefore, it is not clear whether these experiences would be reflected by clinicians working in another mental health service or in another health board. Additionally, there is an absence of young people's voices in this study as the goal was to explore clinicians' perspectives. Determining how young people experience this model is a crucial direction in future research.

4.2. Implications for practice and future research

Based on the results of this study, this model is viewed as a valuable resource by clinicians and considered helpful to have in their "toolkit" to explore self-concept in a strengths-based way. The model could be enhanced by further validation studies. First and foremost, it will be important for this model to be published to allow for further clinical testing. It would be beneficial to explore young people's experiences of using the model during their psychological therapy and compare this to clinicians' experiences. Secondly, implementation science tells us that just because a model is seen as being helpful doesn't guarantee that it will be used on an ongoing basis. Uptake of a model depends upon multiple factors. The barriers and facilitators to uptake need to be examined to enhance uptake. In this study, some of the barriers included lack of time, training and guidance. By adopting an implementation science approach, a future direction for this model could be to develop a training package to accompany the model and a peer supervision group, deliver this and monitor use of the model over time.

It will also be important to disseminate this model to other services such as locality CAMHS and explore clinicians' experiences of using it in this different environment. These experiences can then be compared to the clinicians included in this study. This will help to determine what kinds of services the model can be used in. It may be helpful in the future to consider a randomised control trial of this model to help identify its effectiveness for

increasing a young person's understanding of self-concept, and to consider what the potential mechanisms of change might be for this model.

5. Conclusion

This study aimed to qualitatively explore clinicians' experiences of using the McIntyre Model of Self-Concept in their clinical work with care-experienced children and young people. The results highlight that this model is a promising, flexible tool for exploring self-concept with this population. Clinicians valued its visual and dynamic aspects and appreciated its novelty. While challenges were identified, these did not outweigh clinicians' enthusiasm for the model. Instead, they highlight next steps for the model in terms of the development of training and structured guidance, further research incorporating young people's voices, and examining implementation and effectiveness more closely. Overall, these findings suggest clinicians have a favourable experience of using the MMSC in their clinical work.

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Appendices

Appendix 1: PRISMA Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	p.8
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	p.9
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	p.11
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	p.12
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	p.13
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	p.12
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	p.13, 80
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	p.13
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	p.13
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	p.14
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	p.14
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	p.14
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	n/a
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	p.13
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data	n/a

Section and Topic	Item #	Checklist item	Location where item is reported
		conversions.	
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	p.16, 17, 20
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	p.14
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	n/a
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	n/a
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	p.13, 14
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	n/a
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	p.16
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	p.16
Study characteristics	17	Cite each included study and present its characteristics.	p.17
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	p.20
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	n/a
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	p.15
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	n/a
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	n/a
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	n/a
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	n/a
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	n/a
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	p.28
	23b	Discuss any limitations of the evidence included in the review.	p.29

Section and Topic	Item #	Checklist item	Location where item is reported
	23c	Discuss any limitations of the review processes used.	p.29
	23d	Discuss implications of the results for practice, policy, and future research.	p.30
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	p.12
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	p.12
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	n/a
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	n/a
Competing interests	26	Declare any competing interests of review authors.	n/a
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	n/a

Appendix 2: ENTREQ Guidelines

No	Item	Guide and description	Location
1	Aim	State the research question the synthesis addresses.	p.12
2	Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology (e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis)	p.14
3	Approach to searching	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until they theoretical saturation is achieved).	p.13
4	Inclusion criteria	Specify the inclusion/exclusion criteria (e.g. in terms of population, language, year limits, type of publication, study type).	p.13
5	Data sources	Describe the information sources used (e.g. electronic databases (MEDLINE, EMBASE, CINAHL, psycINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists) and when the searches conducted; provide the rationale for using the data sources.	p.12
6	Electronic Search strategy	Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits).	p.13, 80

7	Study screening methods	Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies).	p.13
8	Study characteristics	Present the characteristics of the included studies (e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions).	p.17
9	Study selection results	Identify the number of studies screened and provide reasons for study exclusion (e,g, for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications t the research question and/or contribution to theory development).	p.16
10	Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings).	p.14
11	Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope [25]; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting).	p.14
12	Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.	p.14
13	Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.	p.19, 20
14	Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (e.g. all text under the headings “results /conclusions” were extracted electronically and entered into a computer software).	p.13

15	Software	State the computer software used, if any.	p.13
16	Number of reviewers	Identify who was involved in coding and analysis.	p.14
17	Coding	Describe the process for coding of data (e.g. line by line coding to search for concepts).	p.14
18	Study comparison	Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary).	n/a
19	Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive.	p.14
20	Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations of the author's interpretation.	p.21
21	Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct).	p.21

Appendix 3: Search Strategy

1. ("self concept" OR "self identity" OR "identity" OR "self esteem" OR "self worth" OR "self perception" OR “Self efficacy” OR “self image” OR “self awareness” OR "self")
2. ("care experience*" OR "CEYP" OR "CECYP" OR “care leaver*”)
3. ("LAAC" OR "LAC" OR "looked after child*" OR "looked after and accommodated")
4. ("foster care" OR "foster child*")
5. ("kinship care")
6. ("residential child care" OR "residential children* home*")
7. ("adopted" OR "adoption")
8. 2 OR 3 OR 4 OR 5 OR 6 OR 7
9. ("relationship*")
10. 1 AND 8 AND 9

Links to database searches:
https://osf.io/8qznd/overview?view_only=ce4a295e76454b9c94cc50087457ff0a

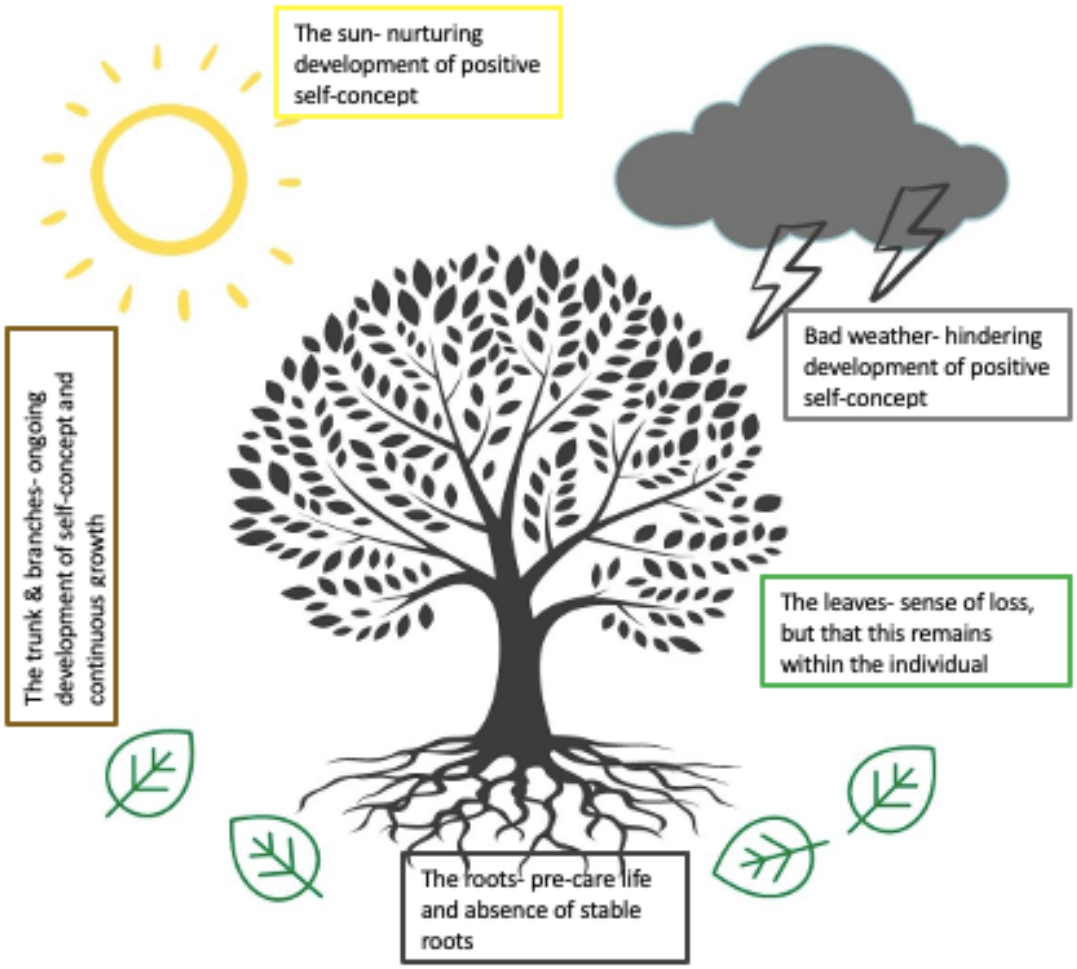
Appendix 4: CASP

https://casp-uk.net/casp-tools-checklists/qualitative-studies-checklist/

Appendix 5: The contribution of each study to the sub-themes identified

Study	Stability	Turning points	Supporting mastery	Loss	Systemic stigmatisation	Chameleon identity
Ben-Shlomo et al., 2025				✓		✓
Colbridge et al., (2017)		✓	✓	✓	✓	✓
Crowley (2019)	✓	✓	✓		✓	✓
Geenen & Powers (2007)	✓			✓	✓	
Kennedy et al., (2024)			✓		✓	✓
Kools (1997)				✓	✓	✓
Lo et al., (2022)				✓	✓	✓
Macleod et al., (2021)	✓	✓	✓		✓	✓
McMurray et al., (2010)	✓		✓		✓	✓
Miller et al., (2020)		✓		✓	✓	
Neagu & Sebba (2019)	✓			✓	✓	✓
Samuels & Pryce (2008)				✓		
Sowers-Zabelski (2021)					✓	✓
Wagner & Heberle (2024)	✓	✓		✓	✓	✓

Appendix 6: The McIntyre Model of Self-Concept (McIntyre, 2022)



Appendix 7: MVLS Ethical Approval

University of Glasgow

24th June 2025

MVLS College Ethics Committee

Project Title: Clinician's experiences of using a novel model of self-concept development in their clinical work with care-experienced young people – A feasibility study.
Project No: 200240393

The College Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to the proposed study. It is happy therefore to approve the project, subject to the following conditions:

- Please check and ensure version control of all documents
- Project end date: End December 2026
- The data should be held securely for a period of ten years after the completion of the research project, or for longer if specified by the research funder or sponsor, in accordance with the University's Code of Good Practice in Research: https://www.gla.ac.uk/media/media_490311_en.pdf
- The research should be carried out only on the sites, and/or with the groups defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.
- You should submit a short end of study report to the Ethics Committee within 3 months of completion.
- For projects requiring the use of an online questionnaire, the University has an Online Surveys account for research. To request access, see the University's application procedure at https://www.gla.ac.uk/research/strategy/ourpolicies/useofonlinesurveystoolforresearch/.

Yours sincerely

Jesse Dawson
MD, BSc (Hons), FRCP, FESO
Professor of Stroke Medicine
Chair MVLS Research Ethics Committee

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Appendix 8: Management approval

Dr Lynda Russell
Lecturer in Clinical Psychology
University of Glasgow
Clarice Pears Building,
School of Health and Wellbeing,
College of Medical, Veterinary and Life Sciences
90 Byres Road, Glasgow
G12 8TB

R&D Department
David Matthews Building
University Hospital Monklands
Monkscourt Avenue
AIRDRIE
ML6 0JS

Date	29/08/2025
Enquiries to	Elizabeth McGonigal, R&D Facilitator
Direct Line	01698 752386
Email	elizabeth.mcgonigal@lanarkshire.scot.nhs.uk

Dear Dr Russell

Project title: Clinician's experiences of using a novel model of self-concept development in their clinical work with care experienced young people – A feasibility study

R&D ID: L25074

I am writing to you as Chief Investigator of the above study to advise that R&D Management approval has been granted for the conduct of your study within NHS Lanarkshire as detailed below:

NAME	TITLE	ROLE
Sarah Walsh	Trainee Clinical Psychologist	Principal Investigator

For the study to be carried out you are subject to the following conditions:

Conditions

- Refrain from offering NHS Lanarkshire staff any incentives for participating in the study.
- You are required to comply with Good Clinical Practice, Ethics Guidelines, Health & Safety Act 1999 and relevant UK-GDPR and Data Protection 2018 legislation
- The research is carried out in accordance with the Scottish Executive's Research Governance Framework for Health and Community Care (copy available via the Chief Scientist Office website: http://www.cso.scot.nhs.uk/ or the Research & Development Intranet site: http://firstport2/staff-support/research-and-development/default.aspx

Appendix 9: Study Materials

All study materials can be accessed from:
https://osf.io/7efm3/overview?view_only=49281211dcc54396a2a2a93887f243d5

Appendix 10: Detailed analysis plan

https://osf.io/7efm3/overview?view_only=49281211dcc54396a2a2a93887f243d5

Appendix 11: Data availability statement

The data for this study is not publicly available. The team that the data was obtained from is a small, specialist mental health team in NHS Lanarkshire and participants may therefore be identifiable through specific turns of phrases and information shared related to their job role. Furthermore, participants did not consent for their data to be shared with anyone other than the researcher and academic supervisors. Reasonable requests in relation data can be made to the named author.

Appendix 12: Detailed account of the actual analysis process

The semi-structured interviews were audio recorded and transcribed verbatim. Pseudonyms were allocated to participants from a pre-generated list of gender-neutral names. After each interview, the researcher made reflective notes in a research reflexivity diary which helped to identify what went well in the interview, initial thoughts and feelings, and areas for adjustment for the next interview.

RTA was used to analyse the interview transcripts and identify common themes across the dataset. The researcher read and re-read the interview transcripts to familiarise herself with the data. During this process, initial thoughts and reflective notes were made to begin identifying potential codes and patterns. Initially the researcher tried making familiarisation notes in a MS Word document but found it easier to make hand-written notes instead and so continued using this method during this initial phase of analysis.

The second phase of analysis involved coding the data. Using MS Word, the researcher highlighted pieces of text and used the *comment* function to label the text. A triangulation meeting was arranged between the researcher and academic supervisors. During this meeting, two transcripts were reviewed and coded by both supervisors. The codes identified by each supervisor and the researcher were discussed, which helped with data familiarisation and enhanced the validity of the data being extracted. The researcher then created a Code Book in MS Excel and imported all the codes from each transcript into this. As there were hundreds of codes, a second round of coding at this stage helped to organise the codes. When codes had been organised, a Theme Book was created in MS Excel. All codes were imported into this Theme Book. Similar codes were given a new tab and labelled with a potential theme name. In each tab, similar codes that grouped together were colour coded and given a sub-theme name.

The next phase of analysis involved reviewing and refining the themes. The tentative themes were discussed in supervision and further explained in a written draft of the results section. Following feedback from supervisors, some themes were further refined or collapsed. For

example, the theme “a trauma-informed approach” was collapsed into the theme “a different approach” as a sub-theme as it was felt these overlapped. Once it was felt that the themes and sub-themes accurately reflected the data and answered the research questions, these were written up fully in the final report and a thematic diagram was created to visually represent the themes and sub-themes.

Appendix 13: COnsolidated criteria for REporting Qualitative Research Checklist (COREQ)

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	61,62
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	1
Occupation	3	What was their occupation at the time of the study?	1,63
Gender	4	Was the researcher male or female?	63
Experience and training	5	What experience or training did the researcher have?	1,63
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	63
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	63
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	63
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	61,63
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	61
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	61
Sample size	12	How many participants were in the study?	62,63
Non-participation	13	How many people refused to participate or dropped out? Reasons?	63
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	62
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	62
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	64
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	62
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	n/a
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	63
Field notes	20	Were field notes made during and/or after the inter view or focus group?	63
Duration	21	What was the duration of the inter views or focus group?	63
Data saturation	22	Was data saturation discussed?	62,63
Transcripts returned	23	Were transcripts returned to participants for comment and/or	n/a

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	104
Description of the coding tree	25	Did authors provide a description of the coding tree?	n/a
Derivation of themes	26	Were themes identified in advance or derived from the data?	109
Software	27	What software, if applicable, was used to manage the data?	104
Participant checking	28	Did participants provide feedback on the findings?	n/a
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	65
Data and findings consistent	30	Was there consistency between the data presented and the findings?	64
Clarity of major themes	31	Were major themes clearly presented in the findings?	65
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	65

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.

Appendix 14: Final MRP Proposal

https://osf.io/7efm3/overview?view_only=49281211dcc54396a2a2a93887f243d5

Appendix 15: Relevant themes and sub-themes from the studies included in the systematic review

Author	Relevant themes & sub-themes
Ben-Shlomo et al., (2025)	• "Why would others love me?": Damaged Self-Worth and identity confusion. • "They didn't want me either": Breakdown as repetition of childhood trauma.

Colbridge et al., (2017)	• **Construction of identity – How I became me**
	  • No sense of a secure base
	  • Protection of identity
	  • Positive influences and turning points
	• **Understanding of identity – Who am I?**
	  • I am an outsider
	  • I am bad, undeserving and unlovable
	  • I help and care for others
	• **Experience of identity – How my identity plays out**
	  • Doing it alone
	  • Taking back control
	• **The mosaic/fragmented self**

Crowley (2019)	• Identity and self • Relationships • Attachment • Adoptive status
Geenen & Powers (2007)	• Importance of relationships

Kennedy et al., (2024)	• **Strong desire for social relationships, but struggles with navigating their norms**
	  • *"Losing oneself" in social relationships*
	  • *Impact on self esteem*
	• **Alternative/adaptive strategies for developing social relationships**

	• *Finding social acceptance in older peers* • *Gaining social interactions through work*
Kools (1997)	• **The Process of Devaluation of Self by Others** • The institutional structure • The diminished status of "foster child" • Stereotypical view of foster child • Impact on the self • Impact on interpersonal relationships • Impact on independence
Lo et al., (2022)	• **Self** • *Feeling Different* • *Incomplete* • *Unwanted* • *Self-Esteem* • *Negative Attribution* • *Reason for Adoption* • *Mental Burden* • **Family and self** • **Birth relative and self**
Macleod et al., (2021)	• Negotiating social identities • Creating and embracing alternative identities
McMurray et al., (2010)	• Identity shaped by family and social relationships • Presented identity as a protective mechanism not the real them • Rejection of identity that may lead to social stigmatization • Identity on standby
Miller et al., (2020)	• Feelings of otherness • Self-reliance vs support seeking

Neagu & Sebba (2019)	• Making sense of the self in foster and residential care • Making sense of self in domestic and intercountry adoption
Samuels & Pryce (2008)	• Premature conferral of adult status and independence • Growing up without parents: learning to take oneself through life • Survivor pride and the disavowal of dependence: making meaning of loss and hardship

Sowers-Zabelski (2021)	• **Blending in**
	  • Camouflage: Changes to Physical Appearance
	  • Belonging

Wagner & Heberle (2024)	• **Recognizing uncertainty, instability and isolation in relationships: where do I fit in with others, and where do they fit in with me?**
	  • Forced to be independent and to take on multiple roles for self (e.g. protector and protectee)
	  • Identity development is shaped by our connection to others and intersects with foster care involvement
	• **Navigating ambiguity in understanding one's past, present and future: foster care experiences make it challenging to create a cohesive self-narrative.**
	• **Managing dialectics throughout development and one's life story, especially regarding adverse experiences: what will I do with painful and less painful experiences?**