'Caring for the carers': Compassion fatigue and associated factors in foster and kinship carers

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ABSTRACT

Foster and kinship carers often care for traumatised children, and thus may be at risk of compassion fatigue (comprising burnout and secondary traumatic stress). This study aims to add to the emerging literature around whether compassion fatigue is present in foster and kinship carers and explore potential factors that may be associated with it. An online cross-sectional survey of 180 foster and kinship carers from the United Kingdom included measures of compassion fatigue, attachment, reflective functioning, self-efficacy, and social support. Results suggest higher levels of compassion fatigue amongst foster and kinship carers compared to helping professionals, and equivalent levels of compassion satisfaction, confirming previous findings. Regression analysis showed higher compassion fatigue was associated with lower levels of parenting satisfaction, higher attachment avoidance and higher discrepancies between perceived and enacted emotional support. Post hoc analysis showed a significant difference between source of social support for alternative caregivers with formal supports less likely to meet expectations. Descriptive statistics also highlighted low levels of reflective functioning training and low levels of household income of kinship carers within the sample. The findings are discussed in light of the timing of data collection and sampling strategy during COVID-19 restrictions. Associations between social support and attachment avoidance in relation to accessing entitled supports has implications for clinical and social services.

1. Introduction

There is growing evidence regarding the impact of caregiver well-being on social, emotional, and behavioural (collectively, psychosocial) outcomes for children in alternative care. Low mood among caregivers has been shown to result in poorer outcomes for the young person (Garcia et al., 2015) and increased caregiver stress predicts placement disruption (Rock et al., 2015) which in turn is associated with worse psychosocial outcomes for the young person (Konijn et al., 2019). Despite this, research has only recently begun to focus on caregiver wellbeing within this context, what impact looking after traumatised children may have on alternative caregivers themselves and their ability to meet the needs of the children placed with them. This study is a cross-sectional survey on the role of compassion fatigue, self-efficacy, social support, attachment and reflective functioning. Data was collected in the UK during the Covid-19 pandemic, when schools were closed, strict social distancing rules were in place, and services paused routine care to provide emergency support and adapt to distance working.

1.1. Background and context

Approximately 70–85 % of children (aged 0–18 years) removed from their birth home are placed in foster and kinship care across the UK (The Scottish Government, 2019; The Fostering Network, n.d.). Under Looked After Children (Scotland) Regulations (2009), a kinship carer is defined as a person who is related to the child or with whom the child has a pre-existing relationship, whereas a foster carer has no prior relationship with the child. In England and Wales, foster and kinship care are not mutually exclusive – people asked by the local authority to provide kinship care must be approved as foster carers (UK Government, n.d.), and in Northern Ireland, kinship care is a sub-type of foster care. Despite these nuanced differences between nations, UK census data suggests approximately 95 % children in kinship care are being looked after through an informal arrangement and are unknown to social care services (Selwyn & Nandy, 2014), with impacts on the type and level of support kinship families receive. Both foster and kinship carers will be referred to as 'alternative caregivers' throughout this paper unless otherwise stated but equivalence between the roles should not be

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assumed.

Foster and kinship carers in Scotland and Northern Ireland have the same entitlements to support as foster carers. England and Wales has a more diversified model with some kinship carers receiving means-tested benefits, those with particular legal arrangements being eligible for a pilot equivalence scheme, and others being treated as foster carers. In practice, kinship carers can face different challenges to foster carers. Kinship carers tend to be older, are more likely to have health problems and disabilities (Kidner, 2016), and to have entered into kinship care arrangements amidst a crisis, without initial training and supervision and through a sense of obligation to a child in their family rather than as an active career decision (Irizarry et al., 2016). Regular or ad hoc birth family contact during the placement is a phenomenon that will likely affect kinship and foster carers differently due to complex family dynamics (Rose et al., 2022). Kinship carers may be managing their own emotional ties with the birth parents, including grief or distress at their circumstances (Healy et al., 2024); or have been impacted by the same financial and emotional hardships as the birth family (Taylor et al., 2020). Both foster and kinship carers must negotiate a relationship with a child whose primary attachment relationships have been significantly disrupted and who may struggle to trust new adults (Heyman et al., 2020). By deliberately including both within a sample, similarities and differences between groups can be explored.

1.2. Literature review

1.2.1. Compassion fatigue

Compassion fatigue is the overarching term for behavioural and emotional responses as a result of an individual knowing about, and helping, a traumatised or suffering person (Fig. 1; Figley, 1995). The helping response can contribute to both positive (compassion satisfaction) or negative reactions in the carer (Stamm, 2010). The negative reaction of this caring is made up of two parts. Firstly, burnout is the feeling of physical and emotional exhaustion arising when an individual cannot achieve their goals (Stamm, 2010). Secondly, secondary traumatic stress arises from a rescue-caretaking response emerging directly from hearing the trauma of others when an individual cannot save the other person from harm, and has similar symptoms to post traumatic stress disorder such as guilt and distress (Stamm, 2010). These negative consequences can be mitigated by compassion satisfaction, the pleasure that comes from helping others (Stamm, 2010; Circenis and Millere, 2011).

Evidence has identified the presence of elevated compassion fatigue levels (lower compassion satisfaction and higher burnout and secondary traumatic stress) and its negative impact on 'helping professionals', such as nurses and emergency staff (e.g. Hooper et al., 2010; Mooney et al., 2017). However, less is known about compassion fatigue in alternative caregivers, such as foster and kinship carers. It is important to note, although parallels can be drawn from other 'helping professions', caring for a kin or foster child is a unique and complex responsibility, and suggestions of this being a "profession" are not intended to simplify this important role. Children in alternative care can have complex trauma histories and caregivers will be exposed to this trauma explicitly through disclosures and/or implicitly through distressed and distressing behaviour, increasing the risk of developing compassion fatigue (Greeson et al., 2011). Additionally, the caregiving role is situated in the caregiver's own home full-time, somewhat different to a helping professional's caring role and so it may be expected that for this population compassion fatigue will be elevated. However, as alternative caregivers build an attachment relationship with the child placed in their care or already have this bond, as is often the case with kinship carers, this may provide a protective element for the placement by increasing compassion satisfaction and overriding compassion fatigue. Lynch and Lobo (2012) identified systemic work factors, such as physically and emotionally demanding assignments and extra workdays as risk factors for compassion fatigue, and this may be of particular importance for alternative caregivers. Recent research identified elevated compassion fatigue in foster carers, showing it is associated with increased desire to leave the profession (Hannah & Woolgar, 2018; Ottaway & Selwyn, 2016). However, little is known about the nature or determinants of compassion fatigue, especially in kinship carers, and whether this is similar to their foster carer counterparts.

Berzoff and Kita (2010) described possible cognitive, behavioural, interpersonal, and emotional consequences that compassion fatigue can lead to including lowered concentration, decreased self-esteem, feelings of powerlessness and depression, irritation, sleep disturbances and hypervigilance. If alternative caregivers have compassion fatigue, it is likely to reduce their ability to provide adequate care to those they look after, or 'blocked care' (Hughes & Baylin, 2012). This could then negatively affect the attachment relationship between caregiver and child, with potential harm to the carer and child (Seti, 2008). Understanding the causes of compassion fatigue in alternative caregivers allows for targeted interventions to prevent or ameliorate negative effects of caregiving.

Effectiveness of interventions to support or prevent individuals developing compassion fatigue is limited. In a review of 13 studies, Cocker and Joss (2016) found mixed or no effects for improvement following compassion fatigue interventions, with no study reporting positive changes on all three compassion fatigue elements (secondary traumatic stress, burnout, compassion satisfaction), highlighting the need to further understand factors that might influence compassion fatigue initially. However, interventions involving an element focused on increasing resilience and self-efficacy were found to be the most promising, having the largest effect on at least one compassion fatigue element.
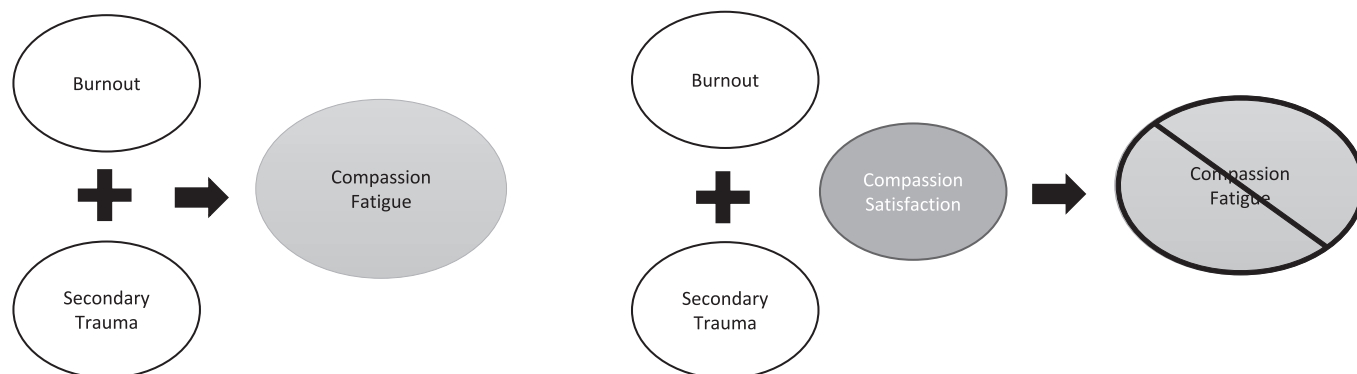

Fig. 1. Outline of compassion fatigue reproduced from Cocker and Joss (2016).

1.2.2. Self-efficacy

Self-efficacy, the belief in one's self to be able to perform difficult tasks, is only one aspect of the construct of resilience (the ability to adaptively cope with traumatic stressors) (Schwarzer & Warner, 2013). In a *meta*-analysis, Shoji et al. (2015) showed significant negative relationships between self-efficacy and burnout; and reduced self-efficacy has been determined as a risk factor for the development of compassion fatigue (Sorenson et al., 2016). Self-efficacy in parenting is also closely related to sense of competency as a parent. A large body of evidence (see Albanese et al., 2019 for a review) links parental self-efficacy (beliefs about competency) with benefits for parental mental health, parent–child relationship, parenting competency, and child development. Parenting self-efficacy is affected by parental mental health, household income, parenting stress, social support and child temperament, all relevant to the alternative caregiver context (Fang et al., 2021). It is plausible to hypothesise that self-efficacy and associated variables are implicated in compassion fatigue in alternative caregivers. Social support is considered more closely here.

1.2.3. Social support

Social support, such as increased time spent with family and friends outside of work, has been associated with reduced burnout in residential care staff (Eastwood & Ecklund, 2008). Similarly, social support networks have been identified as potential resiliency factors against compassion fatigue in those exposed to trauma (Larsen & Stamm, 2008), with clear work-family boundaries within social care professionals reducing vulnerability to developing compassion fatigue (Finzi-Dottan and Berckovitch Kormosh, 2018). In 'helping professions' such as nurses, social support is negatively correlated with compassion fatigue (Ariapooran, 2014). Whether there will be a similar association in alternative caregivers, where their work-home environment is so interlinked, is unclear. Additionally, although the amount of social support has been associated with compassion fatigue levels, understanding the spontaneity (freely offered rather than requested) of this support is of interest. If social support is spontaneously provided, this reduces effort from the recipient to seek this themselves. Gage (2013) found support offered to parents was most effective when it required little organising from them and did not need to be asked for. Caring for a foster or kin child can often require additional skills and effort above typical parenting, such as advocating for the child in educational and health contexts, and so the effort required to mobilise social support may impact on the perception of support received.

1.2.4. Attachment and reflective function

Linked to the ability to engage social support, attachment theory is embedded in the theory and practice of alternative care for children. The attachment dynamic has been operationalised as reflective functioning. Reflective functioning refers to one's ability to hold others' minds in mind, also called mentalisation (Bateman & Fonagy, 2012). Mentalising capacity in the caregiver is associated with attachment security in offspring (Katznelson, 2014). Schwarzer et al. (2021) identified higher levels of reflective function as a protective factor against parenting stress. This is supported by McMahon and Meins (2012) who showed higher reflective function was related to lower levels of perceived stress in parenting in birth parents. Reflective function, and curiosity in particular, may help alternative caregivers to understand their child's difficult behaviour, as opposed to seeing it as defiant (Staines et al., 2019). Within alternative caregivers, reflective function has been mooted as influenced by child characteristics, in which caregivers are overwhelmed by the child's expression of early trauma (Luyten et al., 2017). Fortunately, reflective function appears amenable to change, and several programmes have been developed (e.g. Family Minds, Adkins et al., 2022; the Reflective Fostering Programme, Midgley et al., 2019; Nurturing Attachments, Taubner et al., 2013). Understanding whether there is an association between reflective function and compassion fatigue in alternative caregivers develops our understanding of how to

make such interventions most effective and starts to address an evidence gap between theory and intervention.

Alternative caregivers' own attachment styles may also be linked to the development of compassion fatigue. Studies have shown high levels of attachment anxiety to be related to increased vulnerability to stress reactions (West, 2015), and lower levels of compassion satisfaction amongst residential staff (Racanelli, 2005). Studies with dementia care staff have also shown an association between insecure attachment and higher levels of burnout (Kokkonen et al., 2014). As such, Staines et al. (2019) suggested future research with those looking after foster and kinship children should consider the use of adult attachment measures alongside measures of reflective function. Additionally, external resiliency supports such as increasing social support, may also be impacted upon by alternative caregivers' own attachment styles (Dark-Freudeman et al., 2020).

Finally, demographic variables, such as age and years in the role, have been shown to impact upon compassion satisfaction in 'helping professionals', but these findings are not replicated in foster carers. For example, neither Reinhardt (2016), McLaren et al. (2024) nor Bridger et al. (2020) found an association between compassion satisfaction and age or experience in foster carers, whilst Hannah & Woolgar (2018) did not test for such associations. Caring for non-traumatised as well as traumatised individuals, may mitigate compassion fatigue risk, and systemic differences may also play a role. Most of the research in helping professions to date has stemmed from the USA and so understanding how compassion fatigue presents in different cultures, with their own values, implicit norms, language and caregiving approaches, helps us understand whether context may play a role in the presentation of compassion fatigue. Understanding compassion fatigue in UK alternative caregivers is therefore of interest.

1.3. Gap and rationale

Overall, various interpersonal and coping variables have been implicated in the development of compassion fatigue in helping professions, but any association for kinship and foster carers remains hypothetical. Due to the unique nature of foster and kinship care relationships, these associations cannot be assumed to apply to alternative caregivers. It is important to build on the limited evidence to ascertain whether alternative caregivers in the UK are experiencing compassion fatigue and what may be associated with this experience. This will give further understanding as to where potential interventions to reduce compassion fatigue should be targeted. Previous research has implicated cognitive variables (Hannah & Woolgar, 2018) and self-care (Reinhardt, 2016) in compassion fatigue; the current study focuses on self-efficacy and interpersonal variables, including attachment, reflective function and social support.

1.4. Aims and objectives

This study aims to provide further evidence as to whether the presence of compassion fatigue is comparable to other helping professions to provide evidence around compassion fatigue levels in not just foster carers, but also kinship carers. This study will examine risk of compassion fatigue levels in alternative caregivers and whether reflective functioning, attachment, social support, and self-efficacy are associated with increased risk.

Research question 1) Is compassion fatigue present in UK foster and kinship carers?

Hypothesis 1: Compassion fatigue will significantly differ between foster and kinship carers and from helping profession population norms.

Research question 2) What contributes to compassion fatigue in foster and kinship carers?

Hypothesis 2: Reflective functioning, attachment insecurity, social support discrepancy and parenting self-efficacy will be significantly associated with indicators of compassion fatigue (compassion

satisfaction, burnout, secondary traumatic stress) in foster and kinship carers.

2. Material and methods

2.1. Participants

A cross-sectional survey design was used. Participants were 180 foster and kinship carers from the United Kingdom. The majority of participants were female (95.53 %), had been caring for 5–10 years (32.96 %), were caring for one child (41.9 %) and had no birth children at home (74.3 %), with a mean age of 51.28 years (SD 9.86); see Table 1. Kinship carers could be family members or close family friends and the placement could be formal (through a Guardianship Order in England and Wales or Residence Order in Scotland) or informal. There is currently no comprehensive data on the demographic profile of kinship carers in the UK however limited data suggest that the current sample is of a similar age, gender, and marital status to foster carers in the UK (McDermid et al., 2012; The Fostering Network, 2019) The comparatively high mean age of 51.28 years is in line with Wijedasa's (2017) analysis of census data, in which grandparents comprised the largest proportion of kinship carers (71 % in Scotland and 51 % in England), whilst the UK Government (Ofsted, 2020) report that 65 % of foster carers in England are over 50 years old.

An a-priori power analysis was calculated using Soper's (2019) online calculator for multiple regression. With alpha = 0.05 and power = 0.80 the projected sample size for a medium effect size was N = 122. Previous studies investigating compassion fatigue (Perron & Hiltz, 2006) and compassion fatigue in foster carers (Hannah & Woolgar, 2018) utilised sample sizes of 102 and 131 respectively. As such, power was deemed to be at an acceptable level in this study.

2.2. Measures

2.2.1. Professional quality of life questionnaire (ProQOL; Stamm, 2005)

The ProQOL is a 30-item, 6-point Likert-type scale measuring three components based on experiences in the prior 30 days: compassion satisfaction, burnout and secondary traumatic stress. This measure has good psychometric properties from a range of populations including social work and nurses (Adams et al., 2006; Potter et al., 2010). For this study, Cronbach's alpha indicates good internal reliability for all subscales: secondary trauma (α = 0.85), burnout (α = 0.81) and compassion satisfaction (α = 0.89).

2.2.2. Revised adult attachment scale (RAAS; Collins, 1996)

The RAAS is an 18-item measure of attachment styles in close relationships. The RAAS consists of two subscales measuring 'avoidant' and 'anxious' attachment. The scale has shown good internal consistency on both subscales (Collins & Read, 1990; Kong et al., 2018) and correlates strongly (r = 0.98) with the original Adult Attachment Scale (Collins & Read, 1990). In this study, avoidance had good reliability (α = 0.88) and anxiety had excellent reliability (α = 0.91).

2.2.3. Significant others scale – short form (SOS; Power et al., 1988)

The SOS is a four-item self-report measure assessing actual and ideal emotional and practical support for the most important people in the alternative caregivers' social network, on a seven-point scale. Discrepancy between the two scores is calculated; high scores indicate dissatisfaction with support. The SOS has good criterion and concurrent validity, using the General Health Questionnaire, and good test–retest reliability (alpha between 0.73 and 0.83; Power et al., 1988). For this study, the following additional questions were also asked: what type of support this person provides (informal or formal), and perception of and enacted spontaneity of support. In this study, internal consistency was at acceptable levels for emotional support α = 0.78 and practical support α = 0.71.

Table 1
Participant characteristics.

		Total sample N = 180[1]	Foster Carers n = 98	Kinship Carers n = 75
Age	Mean (SD)	51.28 (9.86)	51.65 (8.33)	50.81 (11.52)
	Range	22–71	30–68	22–71
		N(%)		
Gender	Male	8 (4.44)	4 (4.08)	3 (4.0)
	Female	172 (95.56)	94 (95.92)	72 (96.0)
Annual household income	Less than £9,999	9 (5.0)	4 (4.08)	5 (6.67)
	£10,000-£19,999	46 (25.56)	14 (14.29)	30 (40.0)
	£20,000-£29,999	38 (21.11)	16 (16.33)	21 (28.0)
	£30,000-£39,999	36 (20.0)	22 (22.45)	12 (16.0
	£40,000-£49,999	22 (12.22)	18 (18.37)	4 (5.33)
	£50,000 +	29 (16.11)	24 (24.49)	3 (4.0)
Years caring	16+	23 (12.78)	23 (23.47)	0
	15–10	29 (16.11)	22 (22.45)	6 (8.0)
	5–10	60 (33.33)	27 (27.55)	30 (40.0)
	1–4	55 (30.56)	22 (22.45)	32 (40.67)
	<1	13 (7.22)	4 (4.08)	7 (9.33)
Received reflective functioning training	Yes	43 (23.89)	39 (39.8)	4 (5.33)
	No	126 (70.0)	49 (50)	70 (93.33)
	Unsure	11 (6.11)	10 (10.2)	1 (1.33)
Co-habiting birth children	0	133 (73.89)	76 (77.55)	52 (69.33)
	1	27 (15.0)	13 (13.27)	12 (16.0)
	2	14 (7.78)	8 (8.16)	6 (8.0)
	3	5 (2.78)	0	5 (6.67)
	4	1 (0.56)	1 (1.02)	0
Co-habiting adoptive children	0	155 (86.11)	79 (80.61)	69 (92.0)
	1	17 (9.44)	12 (12.24)	5(6.67)
	2	4 (2.22)	3 (3.06)	1 (1.33)
	3+	0	0	0
Co-habiting foster/ kinship children	0	14 (7.78)	12 (12.24)	2 (2.67)
	1	75 (41.67)	31 (31.63)	40 (53.33)
	2	64 (35.56)	36 (36.73)	25 (33.33)
	3	24 (13.33)	17 (17.35)	7 (9.33)
	4	1 (0.56)	1 (1.02)	0
	5+	2 (1.11)	1 (1.02)	1 (1.33)
Type of caregiver	Local Authority foster carer	73 (40.56)		
	Kinship carer (including SGO, and connected carers)	75 (41.67)		

Table 1 (*continued*)

	Total sample	Foster Carers	Kinship Carers
	N = 180[1]	n = 98	n = 75
Independent agency foster carer			25 (13.89)
Kinship carer AND independent foster carer			5 (2.78)
Kinship carer AND local authority foster carer			2 (1.11)

[a]Seven participants were both kinship and foster carers. They are included in the total sample column and not in subsequent columns.

2.2.4. The parental reflective functioning questionnaire (PRFQ; Luyten et al., 2017)

The PRFQ is an 18-item measure in which participants rate statements regarding their child over three subscales (pre-mentalizing or difficulties in recognising mental states and their impact on behaviour in the child; certainty of mental states; interest and curiosity in mental states). Each statement is rated using a 7-point Likert-type scale. The PRFQ has good internal consistency for all subscales (Rutherford et al., 2017). In this study, internal consistency for pre-mentalizing subscale was questionable ($\alpha = 0.67$) with acceptable levels for certainty about mental states ($\alpha = 0.77$) and curiosity ($\alpha = 0.72$).

2.2.5. Metacognitions questionnaire 30 (MCQ-30; Wells & Cartwright-Hatton, 2004) cognitive self-consciousness subscale

The MCQ-30 uses a 4-point Likert response scale, to assess dysfunctional metacognitions with higher scores showing higher dysfunction. The MCQ-30 demonstrates good construct validity, internal consistency and good test–retest reliability in non-clinical samples (Wells and Cartwright-Hatton, 2004; Fergus & Bardeen, 2019). In this study, reliability of the CSC subscale used was deemed good ($\alpha = 0.825$). The cognitive self-consciousness subscale from the MCQ, the ability to be aware of and monitor thinking, was used in this study to also capture mentalizing due to the PRFQ only recently being validated in one large normative community sample (Anis et al., 2020) and Williams et al. (2016) identifying the use of this subscale as a proxy for reflective function. Correlations between the PRFQ subscales and the MCQ resulted in weak correlations in this study, justifying the use of both within the data analysis plan: MCQxRF Pre-mentalizing $r = -0.043$, MCQxRF certainty $r = 0.263$, MCQxRF curiosity $r = 0.268$.

2.2.6. Parenting sense of competence scale (PSOC; Gibaud-Wallston and Wandersman, 1989, cited in Johnston & Mash 1989)

The PSOC is the most widely used measure of parental self-efficacy consisting originally of two subscales (Parental Satisfaction and Parental Self-Efficacy) with a third factor 'Interest in Parenting' latterly emerging as a new factor analytic structure (Rogers & Matthews, 2004; Gilmore & Cuskelly, 2009). Satisfaction examines parents' anxiety, motivation, and frustration, while Self-Efficacy reports parents' competence, capability levels, and problem-solving abilities in their parental role. Acceptable levels of internal consistency (range $\alpha = 0.75$ to $\alpha = 0.88$) have been reported for the PSOC (Johnston and Mash 1989; Ohan et al., 2000). In this study, satisfaction ($\alpha = 0.783$) and efficacy ($\alpha = 0.798$) were at acceptable levels, however interest showed poor internal consistency ($\alpha = 0.519$).

Due to the poor alpha level of the interest scale, and its recent addition as a separate PSOC subscale (Rogers & Matthews, 2004), we conducted an exploratory factor analysis. This resulted in a two-factor solution, with these two factors matching the two factors (satisfaction and efficacy) as described by Johnston & Mash (1989). The two-factor solution explained 41.03 % of the variance, the Kaiser-Meyer-Olkin measure of sampling adequacy was 0.795, above the commonly recommended value of 0.6, and Bartlett's test of sphericity was significant (χ^2 (136) = 715.25, p < 0.01). We therefore used the two factor

structure in analysis.

2.3. Procedure

The research was approved by [anonymised] University Ethics Committee (Ref. CLIN681, Date: 13/01/20) and information and debrief sheets were available via the online survey. The exit page of the survey and debrief pages both contained information for accessing further support for those who experienced distress as a result of taking part.

Participants were recruited primarily through convenience and snowball sampling, initiated by the research team via online social media platforms due to COVID-19 restrictions at the time of recruitment. Multiple methods were used in the hope of reaching informal kinship carers, recognising that they are poorly identified and therefore significantly under-represented in research. Alternative caregivers were contacted via cascaded emails and newsletter communications to local authorities across Scotland and the North of England, and UK-wide third sector organisations such as Grandparents Plus, as well as through social media. Data collection was conducted between March and December 2020. This period was during the initial COVID-19 pandemic in the UK and the start of multiple lockdowns, of varying severity across the four UK nations, which began in March 2020. For the majority of this period, schools were closed and children were often learning from home with carers, and all social contact outside the family home was significantly reduced. The online survey was kept open as long as possible to gain a broad range of responses across varying time periods of national and local lockdowns and restrictions.

Active recruitment to the survey was paused following imposition of the first lockdown as per institutional protocol, although the survey remained open. Once active recruitment was permitted the following question was added to the survey to understand what impact the pandemic may have had on the data: *"We are aware that we are all part of a global pandemic (COVID-19) at present. Do you feel your answers to the previous questions would be different if asked at a different time* e.g. *before the pandemic occurred?"*.

2.4. Data preparation

Quantitative data was exported from Qualtrics into SPSS (v.25) for analysis. Descriptive (mean, SD) and inferential statistics appropriate to the level of measurement (Spearman's correlations, multiple regression) were employed. Caregiver type was reduced to a dummy dichotomous variable (foster vs kinship carer) as a precondition for regression analysis. ProQOL cut offs of: total sum of 22 or less were determined as a 'low-risk'; between 23 and 41 indicative of 'moderate-risk', and 42 or more of 'high-risk', in line with Stamm (2010).

2.5. Data analysis

The data was suitable for parametric testing. Where relevant, effect sizes were calculated to provide further information regarding strength of association. Descriptive information on the number of carers with high levels of compassion fatigue markers was derived from Stamm's (2010) cut-offs. Comparisons with population norms (Hypothesis 1) were made using De La Rosa et al's (2018) *meta*-analysis of scores for professionals working with trauma survivors.

Parsimony was a guiding principle in developing the regression models. This avoids overfit to the current sample and therefore improves generalisability. However, sufficient variables need to be included initially to avoid over-simplification. Establishing this balance is referred to as Simpson's Paradox and is a common challenge in psychology research (Kievit et al., 2013). Pearson correlations were conducted to determine initial association between variables and compassion fatigue subscales. Whilst significance can be used as a selection criterion in well-powered sample, negligible effect sizes ($\leq r = 0.2$) will achieve significance. Therefore, variables with an r value

greater than 0.3 were entered into subsequent regression models. Stepwise multiple regressions were used to identify the predictors of burnout, secondary traumatic stress and compassion satisfaction. Variables of attachment, reflective functioning, sense of competency, social support were entered into the model, with demographic covariates entered second. The relative contribution of each set of predictors was calculated as the increase in R^2 (ΔR^2). The relative importance of each variable to the model was compared using computed standardised coefficients (β). The data was checked for multi-collinearity, using the tolerance and variance inflation factor (VIF). VIF-values between 5–10 and tolerance values <0.10 may indicate the presence of multi-collinearity (Kleinbaum et al., 2013). There was no evidence of multi-collinearity in any of the regression models in this study. Residual plots were created to assess normality, and normality assumptions were held. Due to the number of tests completed a more stringent p value was set for all tests, at p < 0.01 (Jafari and Ansari-Pour, 2019).

3. Results

Although 209 alternative caregivers completed initial demographic information, only 180 completed further measures. See Table 1 for overview of descriptive statistics of the total sample. T-tests were performed between the group who did not complete measures compared to those who did and no significant difference in demographics were found (all p values >0.05).

Mann-Whitney U-Tests were performed to compare demographics between foster and kinship carers. Foster carers scored significantly higher on annual household income (n = 172, U = 1889.0, p < 0.001); years caring (n = 172, U = 2042.0, p < 0.001]; and whether reflective functioning training had been accessed (n = 172, U = 4580.0, p < 0.001). No other significant differences were found. No differences on any subscales, including reflective function, were found based on having received reflective functioning training.

Of the 130 (72.6 %) that responded to the COVID-19 question, 73.1 % reported there would be no change to their answers, with 23.8 % reporting things being worse. No significant difference was found between foster and kinship carers (p > 0.05).

3.1. Hypothesis 1: compassion fatigue will significantly differ between foster and kinship carers and from helping profession population norms

Overall, 5.59 % (n = 10) of participants reported high levels of secondary traumatic stress and 1.68 % (n = 3) for burnout, with 26.26 % (n = 47) of participants reporting high compassion satisfaction (See Supplementary Fig. 1 for distribution of scores). Compared with De La Rosa's (2018) *meta*-analysis, foster and kinship carers reported equivalent compassion satisfaction to helping professionals, and significantly higher burnout (t(5790) = 14.43, SE = 0.41, p < 0.001, d = 1.02) and secondary traumatic stress (t(5790) = 29.90, SE = 0.43, p < 0.001, d = 2.03). See Table 2 for full details.

T-tests on the raw data were used to compare compassion fatigue levels between foster and kinship carers. Foster carers expressed significantly higher compassion satisfaction [F = 5.89, t(2.67), p = 0.008] with a medium effect size (Cohen's d = 0.41). No significant differences were found for secondary traumatic stress or burnout (see Supplementary Table 1 for means). Therefore, the first hypothesis is partially supported.

T-tests were also performed between foster and kinship carers on all independent variables, however no significant difference was found for any other variables (see Supplementary Table 1). As such, it was decided not to separate foster carers and kinship carers in subsequent correlational analysis and include caregiver type as a covariate in regression analyses.

Table 2
Norms for helping professionals working with trauma survivors compared to the current sample.

ProQOL subscale	This sample M (SD) N = 180	Reference sample[a] M(SD) N = 5612	T test	Cohen's d
Compassion satisfaction	37.36 (6.22)	37.7 (6.5)	t(5790) = 0.69, SE = 0.49	0.05
Burnout	28.73 (6.25)	22.8 (5.4)	t(5790) = 14.43, SE = 0.41*	1.02
Secondary traumatic stress	29.71 (7.03)	16.7 (5.7)	t(5790) = 29.90, SE = 0.43*	2.03

*p < 0.001.
[a] De La Rosa (2018).

3.2. Hypothesis 2: Reflective functioning, attachment insecurity, social support discrepancy and parenting self-efficacy will be significantly associated with indicators of compassion fatigue (compassion satisfaction, burnout, secondary traumatic stress) in foster and kinship carers.

Correlations were conducted between compassion satisfaction, burnout, secondary traumatic stress, and the 3 PRFQ subtests and CSC subscale of the MCQ (see Table 3).

Correlations were conducted to determine any prior relationships between demographic variables and compassion fatigue subscales prior to conducting further analyses. Household income and compassion satisfaction were significantly correlated (Spearman's rho = 0.163, p = 0.029). Significant associations were found between age and compassion satisfaction (Pearson's r = −0.196, p = 0.011). No other significant effects were found. Although effect sizes were very small, household income, carer age and carer type were included in the compassion satisfaction regression analysis.

Regression results indicated that three predictors explained 58 % of the variance (R2 = 0.58, F(1,136) = 15.09, p < 0.001) for compassion satisfaction. Parenting satisfaction significantly predicted compassion satisfaction (β = 0.41, p < 0.001), as did parenting efficacy (β = 0.28, p < 0.001) and reflective function interest/curiosity (β = 0.30, p < 0.001). Age, household income and carer type did not contribute to compassion

Table 3
Correlations between compassion fatigue and other variables.

	n	Compassion satisfaction	Burnout	Secondary traumatic stress
Burnout	180	−0.687**	–	–
Secondary traumatic stress	180	−0.464**	0.707**	–
RF pre-mentalizing	153	−0.496**	0.392**	0.367**
RF certainty	153	0.245**	−0.101	−0.090
RF curiosity	153	0.414**	−0.133	−0.048
MCQ: CSC	153	0.170*	0.073	0.136
Attachment anxiety	156	−0.090	0.080	0.208**
Attachment avoidance	156	−0.325**	0.495**	0.487**
Emotional support discrepancy	168	−0.186*	0.351**	0.406**
Practical support discrepancy	168	−0.237**	0.353**	0.381**
Spontaneity discrepancy	168	−0.180*	0.319**	0.347*
Parenting efficacy	150	0.517**	−0.213*	−0.167*
Parenting satisfaction	150	0.629**	−0.608**	−0.577**

Note. RF = Reflective Function; MCQ-CSC – Metacognitions Questionnaire Cognitive Self-Consciousness Subscale.
*significant at p = 0.05 level, **significant at p < 0.01 level (2-tailed).

satisfaction.

Three predictors explained 50 % of the variance (R2 = 0.50, F (1,146) = 12.62, p < 0.001) for burnout. Parenting satisfaction significantly negatively predicted burnout (β = −0.38, p < 0.001), and discrepancy in spontaneous support (β = 0.97, p < 0.001) and attachment avoidance (β = 2.35, p = 0.001) positively predicted burnout. The same three predictors explained 49 % of the variance (R2 = 0.58, F (1,146) = 11.28, p < 0.001) for secondary traumatic stress (STS). Parenting satisfaction significantly negatively predicted STS (β = −0.41, p < 0.001), and discrepancy in spontaneous support (β = 0.1.33, p < 0.001) and attachment avoidance (β = 2.25, p = 0.001) positively predicted STS. See Table 4 for a summary of the stepwise regression analysis and model summaries.

3.3. Post hoc hypothesis: does social support source (whether informal or formal) affect social support discrepancy score?

Post-hoc t-tests were conducted to determine whether there was any difference between discrepancy scores for formal sources of support and informal sources. Independent sample t-tests were completed to assess differences between the two groups of support and significant differences were found for all social support domains (see Table 5). In all cases, there were significantly greater discrepancies between desired and actual support for formal support than for informal support with a large effect for emotional support. Emotional support showed the lowest level of discrepancy between desired and actual levels of informal support but all effect sizes were large.

4. Discussion

4.1. Levels of compassion fatigue elevated in foster and kinship carers

This study investigated levels of compassion fatigue in a sample of 180 foster and kinship carers in the United Kingdom, using an online cross-sectional survey to measure compassion fatigue and associated variables. Results showed that kinship and foster carers present a different profile of compassion fatigue to those employed in helping professions. Compassion satisfaction is equivalent to that of paid helping professionals working with trauma survivors, but burnout and secondary traumatic stress are significantly higher. The absolute levels were lower than in previous studies of foster carers (Hannah & Woolgar, 2018) who showed 25.2 % and 30.5 % of their foster carer sample at

high risk of secondary traumatic stress and burnout respectively, but both studies show higher levels than for paid helping professionals.

A reason for the difference to Hannah & Woolgar's sample may be indicative of the timing of data collection and sampling strategy for this sample of foster and kinship carers. The ProQOL asks about the previous 30 days and as most data was collected over lockdown this may represent a very different period of coping for these alternative caregivers. The ongoing global pandemic may have resulted in participants' general re-evaluation of stress and difficulties, resulting in a potentially different picture of compassion fatigue at this time. Pre-existing fears, such as financial pressures, may have been amplified (e.g. Grandparents Plus, 2020). Additional pressures around the alternative caregiver role may have increased during this time. Schools were shut for a significant portion of this period, and whilst school can be a source of stress for children who have behavioural and emotional problems as a result of trauma-exposure, it also provides valuable respite for carers. Restrictions on travel and socialising during this time might have entailed less planned physical contact time with birth families and less incidental contact, especially for kinship carer families. Contact with birth parents is a known source of stress (Taylor et al., 2020), with unmanaged contact appearing especially problematic, despite potential longer-term benefits to the child's identity and attachment patterns (Boyle, 2017), largely undifferentiated for kinship and foster children (Hassall et al., 2021). However, as 73.1 % of the sample felt their answers would be the same regardless of the pandemic, and 23.8 % felt their caring experiences were more difficult at present, it suggests these findings generalise beyond the pandemic context. Lockdown will also have compromised access to helpful formal and informal support networks, which can offset other stresses.

The number of participants reporting high compassion satisfaction levels (26 %) was consistent with helping profession norms (25 %; Stamm, 2010) and the mean level was equivalent to more recent findings (De La Rosa, 2018). This may reflect mitigation of compassion fatigue through the positive aspects of such care and the bonds formed between carer and child, also found in Hannah & Woolgar's (2018) study.

4.2. Predictors of compassion fatigue

Across the three facets of compassion fatigue, parenting satisfaction consistently made a significant contribution. Attachment avoidance and emotional support discrepancy made a significant contribution to both

Table 4
Final solutions for stepwise regression analyses for variables predicting compassion fatigue.

Variable	Stepwise changes			β	SE	Standard β	t	p
	R²	ΔR²	F for change in R²	Compassion Satisfaction - Model 3				
Parenting satisfaction	0.43	0.43	105.74**	0.41	0.05	0.50	8.48	<0.001
Parenting efficacy	0.54	0.53	30.92**	0.28	0.06	0.28	4.60	<0.001
RF interest/curiosity	0.58	0.58	15.09**	0.30	0.08	0.23	3.89	<0.001
Excluded variables in model 3: Age, household income, RF prementalising, Attachment avoidance, carer type								
				Burnout – Model 3				
Parenting satisfaction	0.37	0.37	86.70**	−0.38	0.05	−0.48	−7.65	<0.001
Spontaneous support discrepancy	0.46	0.45	23.67**	0.97	0.24	0.25	4.04	<0.001
Attachment avoidance	0.50	0.49	12.62**	2.35	0.66	0.23	3.55	0.001
Excluded variables in model 3: RF prementalising, Practical support, Spontaneous support								
				Secondary Traumatic Stress – Model 3				
Parenting satisfaction	0.33	0.33	73.74**	−0.41	0.06	−0.45	−7.03	<0.001
Spontaneous support discrepancy	0.45	0.44	31.36**	1.33	0.28	0.30	4.80	<0.001
Attachment avoidance	0.49	0.48	11.28**	2.55	0.76	0.22	3.36	0.001
Excluded variables in model 3: RF prementalising, Practical support, Spontaneous support								

Note. R², ΔR² and F are shown for each step of the regression model, all other statistics are for the final model. RF = Reflective functioning.
*p = 0.05, **p = <0.001.

Table 5
Differences in social support discrepancies between informal and formal supports.

	Support source	N contacts	Mean	SD	t (df = 311)	p	d[a]
Emotional support	Informal	242	1.51	2.45	−6.62	<0.0001	−0.89
	Formal	71	3.85	3.13			
Practical support	Informal	242	0.94	1.45	−5.53	<0.0001	
	Formal	71	2.11	1.92			
Spontaneous support	Informal	242	1.35	1.79	−3.28	0.001	
	Formal	71	2.18	2.15			

[a] Cohen's d.

negative facets of compassion fatigue, suggesting that where participants perceive a bigger gap between the emotional support they need and receive, they are at higher risk for burnout and secondary traumatic stress, but also that their ability to mobilise social support might be impaired by attachment avoidance. By contrast, perceptions of parenting efficacy and reflective function both contributed to compassion satisfaction. The biggest predictor of compassion fatigue (lower compassion satisfaction, and higher burnout and secondary traumatic stress) was parenting sense of competency (satisfaction), consistent with previous literature (e.g. Sorenson et al., 2016). Likewise, the role of emotional social support discrepancy in burnout and secondary traumatic stress, is also consistent with previous literature (Larsen & Stamm, 2008; Ariapooran, 2014) and support findings from Cocker and Joss's (2016) review of interventions aimed at reducing compassion fatigue. Their review noted interventions focused on increasing resilience (defined as social support by some within the review) and self-efficacy were found to be the most promising, having the largest effect on at least one element within the compassion fatigue model. This suggests the use of interventions from other populations may also be applied to foster and kinship carers. In practice, kinship carers currently receive little in the way of training for the caregiving role, and these findings suggest that parent training as well as education about trauma and attachment more routinely provided to foster carers would benefit both groups.

Reflective functioning has been identified as a potential resiliency factor and can mediate against stress (Bateman & Fonagy, 2012; Schwarzer et al., 2021), and in this study the 'interest and curiosity in mental states' subscale was found to be a significant predictor within the compassion satisfaction model. This may result from those who are more able to understand and be curious about a child's underlying need interpreting emotional and behavioural difficulties as evidence of need in the child rather than failure in the caregiver. This might support self-efficacy such that alternative caregivers will be more satisfied with their parenting approach. This is supported by Staines et al. (2019) in a sample of potential adoptive parents.

4.3. Foster and kinship carer differences

Results also show that, despite only small differences between foster and kinship carers on the ProQOL, being a kinship carer was a predictor of higher burnout. In 'helping professionals', organisational support (Dugani et al., 2018), higher financial support and more knowledge of burnout (Malik et al., 2016) were shown to be protective factors against developing burnout. Descriptive statistics show key differences between caregiver types in this sample: kinship carers reported significantly lower annual household incomes, fewer years' caring experience, and significantly fewer had accessed reflective functioning training. It appears that within this sample, although kinship carers are entitled to the same financial supports as foster carers, many kinship carers may not be accessing this, with 44.44 % of kinship carers having a household income of <£20,000pa. The poverty threshold in 2020–21 was £18,840pa (Office for National Statistics, 2022) so many kinship carers were at or below this threshold. These findings reflect problems identified by Kinship UK (n.d.) in which more than three-quarters of survey respondents were struggling financially after receiving allowances, and a

large proportion were not receiving allowances to which they were entitled. They suggest local authorities are not transparent about entitlements and may even provide misinformation. At a minimum, the process of getting financial support is a complex and bureaucratic process (Citizen's Advice Scotland, n.d.) with specific legal orders such as Special Guardianship Orders, criteria for funds (e.g. Adoption Support Fund) and approval processes for kinship carers all affecting entitlement to financial support.

There was significant correlation between burnout and lower household income, and less chance of reflective functioning based training being accessed (4.94 % of the sample). Given that research has shown financial stability and social support are key protective factors against child maltreatment, it is necessary to actively support carers to access financial and informational support, rather than just entitling them to it (Conrad-Hiebner & Byram, 2020; Ridings et al., 2017).

Based on the findings of this study, caregiving experiences and their association with compassion fatigue are similar in kinship and foster carers. Additionally, the nature of being a kinship carer and having to manage the dynamics of the relationship between the kinship child and their birth parents, and their own relationship with the birth parents may bring additional stress and potential increase in burnout. Therefore, they would therefore benefit from at least the same level and type of support, as stated in policy (Scottish Government, 2016; Department for Education, 2011). When looking at years caring and age of each sample, kinship carers are less experienced in their role despite being the same age as their foster carer counterparts and should be offered as much support, if not more, to address this gap in experience. With this extra support and information, we may then expect that kinship carers are better protected against the risk of burnout.

4.4. Social support, attachment, and compassion fatigue

The finding of higher social support discrepancy scores for formal supports in this study suggests that these supports, such as social services, are not meeting the needs of alternative caregivers. The survey design restricted participants to reporting three people acting as social supports, and 77 % of those identified were informal. That nearly a quarter of the top three social supports should be formal may reflect insufficient informal social networks or the importance of formal supports, such as social workers for alternative caregivers. The mismatch between desired and actual support from formal supports is concerning – alternative caregivers appear to need more than services are resourced to give. Our analysis suggests that emotional support discrepancy is associated with secondary traumatic stress. This in turn may put the placement under strain, leading to more resource demands on social services. To effectively support alternative caregivers in all circumstances, properly targeted social support which matches support needs is needed, rather than just increasing levels of support in general. Additionally, measuring the perception of support being offered is essential and should be routinely captured.

The impact of attachment avoidance as a predictor on compassion fatigue in this study supports previous research in dementia care staff which indicated insecure attachment styles were related to burnout (Kokkonen et al., 2014). It also supports previous research with foster carers, such as Hannah and Woolgar (2018) who found an association

between compassion fatigue and avoidant cognitive styles in foster carers. The ability to engage social support from a network will be affected by attachment style of the person seeking support. Adults with avoidant styles of attachment have been shown to have higher levels of self-reliance, often withdrawing socially even under conditions where this is not adaptive to the individual, such as times of stress (Edelstein & Shaver, 2004; Ravitz et al., 2008). This may mean they might not seek support and thus their perceived social support discrepancy may increase, putting them at an increased risk of compassion fatigue. Consistent with the findings of the current study, improving reflective functioning could be a protective factor, helping alternative caregivers to understand their own and the child's mental states and to be able to communicate this to others. The use of reflective functioning training to help increase mentalization abilities could be a focus for future training. Likewise, expression of attachment styles in social contexts was shown by Sheinbaum et al. (2015) to be dependent upon the subjective appraisal of the closeness of social contacts, and not merely upon the presence of social interactions. It was found that as closeness with a support diminished, those with anxious avoidant styles felt less cared for by others in their overall network. This suggests that it is not enough to just make support available to alternative caregivers, or increase supports, but that they must be matched to their needs, and alternative caregivers have to be supported to engage with support.

4.5. Limitations and implications for future research

Although the sample was adequately powered for planned analyses, it may not have been large enough to accurately capture differences between foster and kinship carers, and by virtue of having a non-systematic sampling strategy, may have missed informal kinship carers, those with more limited resources or who are struggling more. Including a qualitative component through interviews would have introduced a deeper insight into the caregiver experience, the motivations behind completing the survey, and help make sense of other factors affecting the caregiver role such as social support and 'navigating the system' (Geiger et al., 2013). Due to restrictions caused by lockdown, interviews that were originally planned could not take place. It would be beneficial for future qualitative research to explore the implied nuances of these findings in more depth, especially to understand potential differences in social support between kinship and foster carers. There is a bigger challenge in accessing kinship carers who are not known to services and who are almost invisible in research.

As COVID-19 restrictions meant all questionnaire completion had to take place online, the sample may not be representative of older alternative caregivers who may not have the same digital access and literacy. The sampling strategy may also have only attracted alternative caregivers who felt able to engage in a 20–30-minute survey, although the high levels of burnout do not support this hypothesis, and Hannah and Woolgar (2018) used a similar online survey method and found similar results, albeit more diluted.

Attempts to capture the potential impact of Covid were unsuccessful. The question may have been too vague, participants may not yet have had the opportunity to gain perspective at the time of responding, and it may have been too early for some impacts to be visible. Kinship carers were surveyed from various quarters during this period (e.g. Kinship UK), but there has been little follow-up to understand the longer-term impacts on children, carers and the wider support system would be valuable, especially given initial evidence of wide-ranging developmental impacts on children and wellbeing, support and financial impacts on caregivers (Townsend et al., 2023).

Ethnicity was not included as part of the demographics asked of this sample. It would be helpful to investigate this in the future as it is evidenced that being part of a minority group brings additional daily life stressors and discrimination (Potter et al., 2019). However, previous research has shown mixed results on whether minority status increases risk of burnout (Lawrence et al., 2021) and no significant differences

have been found between ethnicities of foster carers on any of the Pro-QOL subscales in previous research (Ottaway & Selwyn, 2016). In Scotland, where White people constitute 96 % of the population (Scotland's Census, 2021) and study recruitment was focused, a lack of ethnic diversity typically prevents statistical comparisons. Other studies have indicated differences in levels of burnout and secondary traumatic stress in 'helping professionals' from minority backgrounds, possibly due to less social support in the workplace or feeling less able to vocalise true feelings of burnout due to stigma (Garcia et al., 2020). Associations of minority status (not just ethnicity) of alternative caregivers and compassion fatigue levels should be assessed to resolve disparities for this population and would also be of interest to services when planning effective support.

Equally, the survey did not investigate the potential impacts of neurodivergence or disability. There is evidence for under-recognition of neurodevelopmental disorders in foster children (Cawthorne & Woolgar, 2025) so survey methods may not accurately capture prevalence and, therefore, any valid differences in carer experience.

Finally, whether findings can be extrapolated to informal kinship carers is unknown. It was unclear whether any kinship carers in this study were informal, however given the recruitment strategy it is unlikely. Formal kinship carers are entitled to the same financial and informational support and may be more similar to the foster carer population than informal kinship carers, do not have the same access to support as other alternative caregivers are. Although a more 'hidden' group compared to known formal kinship carers, future research should seek to actively recruit from this population e.g. through schools and communities, to begin to understand whether findings can be applied accordingly.

4.6. Conclusions and recommendations for practice

It would be beneficial to implement evidence-based interventions targeted at preventing and intervening with compassion fatigue, increasing self-efficacy and perception of social supports, and reducing the negative impact of attachment avoidance, with appropriate evaluation. Pre- and post-intervention studies would enable further exploration of the compassion fatigue model with this population to identify population-specific characteristics and mechanisms of change within interventions. Additionally, as this survey was cross-sectional and correlational in design it would be helpful to evaluate compassion fatigue and factors over time as, for example, reflective functioning is a context-dependent skill (Górska, 2018). As well as establishing causal relationships more confidently, longitudinal designs would allow for mediational analysis to allow for more direct comparison with existing research in other populations.

The current study found levels of compassion fatigue above those of helping profession norms for UK foster and kinship carers. Parenting sense of competence, emotional support, and attachment avoidance were all significant predictors of higher compassion fatigue in alternative caregivers. There was evidence that kinship carers might be at higher risk of burnout, which may also increase their risk of compassion fatigue. A concerted effort should be made to ensure alternative caregivers, especially kinship carers, are accessing support they are entitled to. As attachment avoidance highlighted within the research may also impact upon help seeking behaviours, those supporting alternative caregivers should be aware of attachment styles and provide training on how, and when, to access available supports, and evaluate perceptions of this support.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgement

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.childyouth.2025.108692.

Data availability

Data will be made available on request.

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