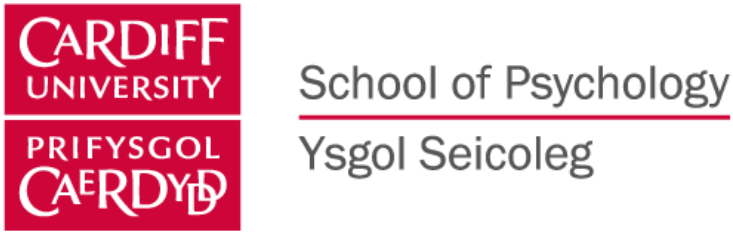

The Interpersonal Psychological Theory of Suicide and Sexual Minority Populations: A Systematic Review

and

A Sense of Belonging in Children's Residential Homes: A Qualitative Exploration of Staff Members' Perspectives

Thesis submitted in partial fulfilment of the requirement for the degree of:

Doctorate of Clinical Psychology (DClinPsy)

South Wales Doctoral Programme in Clinical Psychology

Cardiff University

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Supervised by: Dr James Stroud & Dr Aimee Pudduck

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Acknowledgements

Thank you to all of the participants who gave up their time to take part in this research. I feel privileged to have had the opportunity to listened to your stories and insights. Thank you also to the different residential homes who opened their doors to me and helped with recruitment.

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I couldn't have done this work without the continued support of my loving family and girlfriend who have always believed in me, especially when I couldn't believe in myself. Thank you for everything.

Preface

The first paper within this thesis is a systematic review of research which has explored the applicability of the Interpersonal Theory of Suicide (IPTS) to people who identify as a sexual minority. The terms sexual minority refers to any person who identifies with a sexual orientation other than heterosexual, is sexually attracted to and/or engages in sexual behaviour with the same (or both) sex(es). The IPTS is an eminent theory of suicide within the psychological literature. This theory hypothesises that people consider or attempt suicide because of elevated experiences of Thwarted Belongingness, Perceived Burdensomeness, Hopelessness and Acquired Capacity. Considering the applicability of this theory to sexual minority population is pertinent as research has shown that people who identify as a sexual minority are much more likely to experience suicidal thoughts and to make suicide attempts, in comparison to their heterosexual peers.

Following a systematic literature search of five different research databases (PsychINFO, MEDLINE, CINAHL, SCOPUS, ASSIA), relevant papers were synthesised. Studies mainly focused on the relationships between Perceived Burdensomeness and suicidal thoughts and Thwarted Belongingness and suicidal thoughts. Results showed that the relationships between experiencing Perceived Burdensomeness and suicidal thoughts may be particularly pertinent in sexual minority populations in comparison to their heterosexual peers. Additionally, these experiences may be most pertinent for bisexual populations and those who identify as both a sexual and gender minority. The role of Thwarted Belonging however is less predictable and requires further examination. Finally, some studies included also demonstrated that the constructs within the IPTS can also help to explain the link between general known risk factors for suicide (such as problems with sleep) and sexual minority specific risk factors (such as experiencing discrimination).

The findings within this review extend the current literature by considering the application of this theory to a population of people considered to be at great risk for suicidal thoughts and behaviours. Results also suggest that constructs identified by the IPTS (in particular Perceived Burdensomeness) could be helpful targets for clinical assessment and intervention for sexual minority populations who are at risk of, or who are experiencing suicidal thoughts. Finally, preventative, and supportive interventions which consider how to improve the experiences of sexual minority populations at a community, policy and legislative level could also be beneficial.

The second paper within this thesis presents a grounded theory analysis of a sense of belonging in children's residential homes. As stated above, research has shown that experiences of belonging can be important to well-being. Nevertheless, theoretical understandings of this construct remain somewhat limited. In addition, children's residential care homes look after some of the most vulnerable children and young people in our country. However, research into the processes within residential homes and the associated outcomes remain limited. Research which does exist rarely includes voices of key stakeholders (such as children and young people and residential care staff).

This study explored a sense of belonging in residential care from the perspectives of the residential care staff. Eight participants were asked to consider 1) how they understand and experience a sense of belonging as part of their role and 2) how the children and young people they support experience a sense of belonging within residential care. Using grounded theory, the results led to the development of a theory of belonging in residential care. This theory outlined that residential care staff and children, and young people develop a sense of belonging within the residential home through three main processes: establishing safety,

(specifically by building trust and having consistent boundaries), engaging in reciprocity with other people and surroundings and forming your identity. In addition to the processes involved in developing belonging in residential care, residential care staff also identified key processes which influence the development of belonging. These included the context of care, a child or young person's journey through care and specific relational dilemma regarding displays of love and affection and being a "transient family".

This research extends and supports current literature by further expanding on the theoretical understanding of belonging and applying this to an under-researched context and population. The theory also points to important clinical recommendations which could help foster a sense of belonging for both staff and children and young people in residential care.

Paper 1

The Interpersonal Psychological Theory of Suicide and Sexual Minority Populations: A Systematic Review

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[1]Cardiff University

2 This paper is prepared in accordance with the author guidelines for the Journal the *Archives of Sexual Behaviour* (Appendix 1). For the purposes of thesis submission, the DClinPsy word limit of 8000 words has been used to ensure all relevant information could be demonstrated.

To ease readability, tables and figures are included in the main body of text and will be removed and placed at the end for journal submission.

Abstract

Purpose: Elevated rates of suicidal thoughts and behaviours have been consistently found within populations who identify as a sexual minority (SM[3]). The Interpersonal Theory of Suicide (IPTS; Joiner, 2005; Van Orden et al., 2012) attempts to explain the reasons why certain people are at greater risk of suicide.

Method: This review included 16 papers which applied elements of the IPTS to the understanding of suicidal ideation and attempts in SM populations.

Results: Results showed that experiences of perceived burdensomeness may be particularly important in understanding suicidal ideation and attempts within this population (compared to their heterosexual peers). Additionally, these experiences may be most pertinent for bisexual populations and those who identify as both a sexual and gender minority. Thwarted belonging appears to be a less reliable predictor of suicidal ideation and attempt; however, it is also a construct that remains not as well understood. Finally, the IPTS appears to offer utility in understanding how both general and SM specific risk factors influence suicidal thoughts and behaviours.

Conclusions: There is a need for further research which considers the additional facets and pathways hypothesised by the IPTS. Clinical implications and avenues for future research are discussed.

Keywords: sexual minority, Interpersonal Psychological Theory of Suicide, perceived burdensomeness, thwarted belonging, acquired capacity.

[3]A summary of all abbreviations used throughout this review can be found in Appendix 2.

Introduction

The World Health Organisation (2019) estimated that over 700,000 people worldwide die by suicide every year. In addition, for every completed suicide there are many more people who attempt suicide (World Health Organisation, 2019) and an unknown quantity of associated family, friends and communities impacted. Research has consistently demonstrated that, in comparison to people identifying as heterosexual, people who identify as a sexual minority (SM) are at least twice as likely to engage in non-suicidal self-injury, experience suicidal ideation and/or to attempt and complete suicide (Batejan, Jarvi, & Swenson, 2015; Marshal et al., 2011; King et al., 2008; Miranda-Mendizábal et al., 2017). The term 'sexual minority' refers to individuals whose sexual identity differs from heterosexual (Pate and Anthesis, 2020). SM people may identify themselves with labels such as lesbian, gay, bisexual (LGB), pansexual or queer. SM also refers to anyone who reports sexual attraction and/or behaviour with the same or both sexes (Saewyc et al., 2004).

The aetiology of suicide is multifaceted (Hjelmeland & Loa Knizek, 2019), involving a complex web of factors that theorists, researchers, practitioners, and anyone touched by the pain of suicide endeavour to decipher. In 2017, Franklin and colleagues completed a large-scale meta-analysis, examining longitudinal risk factors for predicting suicide. The authors concluded that, unfortunately, there has been little improvement in our ability to predict suicidal thoughts and behaviours over the last 50 years. The authors suggested that future research attempting to understand the complex combination of factors relevant to suicidal thoughts and behaviours may benefit from examining specific 'at-risk' populations (Franklin et al., 2017).

Several systematic reviews and meta-analyses have reviewed risk and protective correlates of suicide in SM populations (Haas et al., 2010; Hatchel et al., 2021; Gorse et al., 2020). Findings have discussed both SM specific factors (i.e., discrimination) and those which appear pertinent irrespective of SM status (i.e., social support) (Meyer, 2003; Gnan et al., 2019; Hatchel et al., 2021; Hatzenbuehler, 2009). Such research is necessary but may not be sufficient in explaining the risk of suicide in SM population (Plöderl et al., 2014) as it is unable to untangle whether explored correlates are additive, precipitants, and/or mitigators of suicide risk (Hatchel et al., 2021). Additionally, this research cannot explain why most people who experience suicide-associated risk factors do not attempt or die by suicide (Van Orden et al., 2012). Therefore, turning our attention to theoretically driven constructs and pathways which underpin these factors may help to advance the understanding and prevention of suicide (Hatchel et al., 2021; Haas et al., 2009; Joiner, 2005).

There are several theoretical models of suicide (Selby, Joiner & Ribeiro, 2014). Amongst perhaps the most "significant" and "preeminent" (Westefeld & Rinaldi, 2018, p. 532) is the Interpersonal Theory of Suicide (IPTS; Joiner, 2005; Van Orden et al., 2010). This paper hopes to build on the current literature base by systematically reviewing research which has applied the IPTS to the understanding of suicidal ideation and attempts in SM populations.

The Interpersonal Psychological Theory of Suicide

Joiner initiated the development of the IPTS, writing about his personal and professional experiences of trying to understand the aetiology of suicide. The theory was then further refined by Van Orden and colleagues in 2010.

Core Constructs and Hypotheses of the Interpersonal Theory of Suicide

The IPTS makes the distinction between suicidal ideation (SI) and suicidal behaviour and posits a causal and testable pathway through which ideation can arise and manifest into lethal behaviour (Van Orden et al., 2010). The core constructs and hypothesised pathways which form the relationships between them are summarised in Figure 1 and the text below.

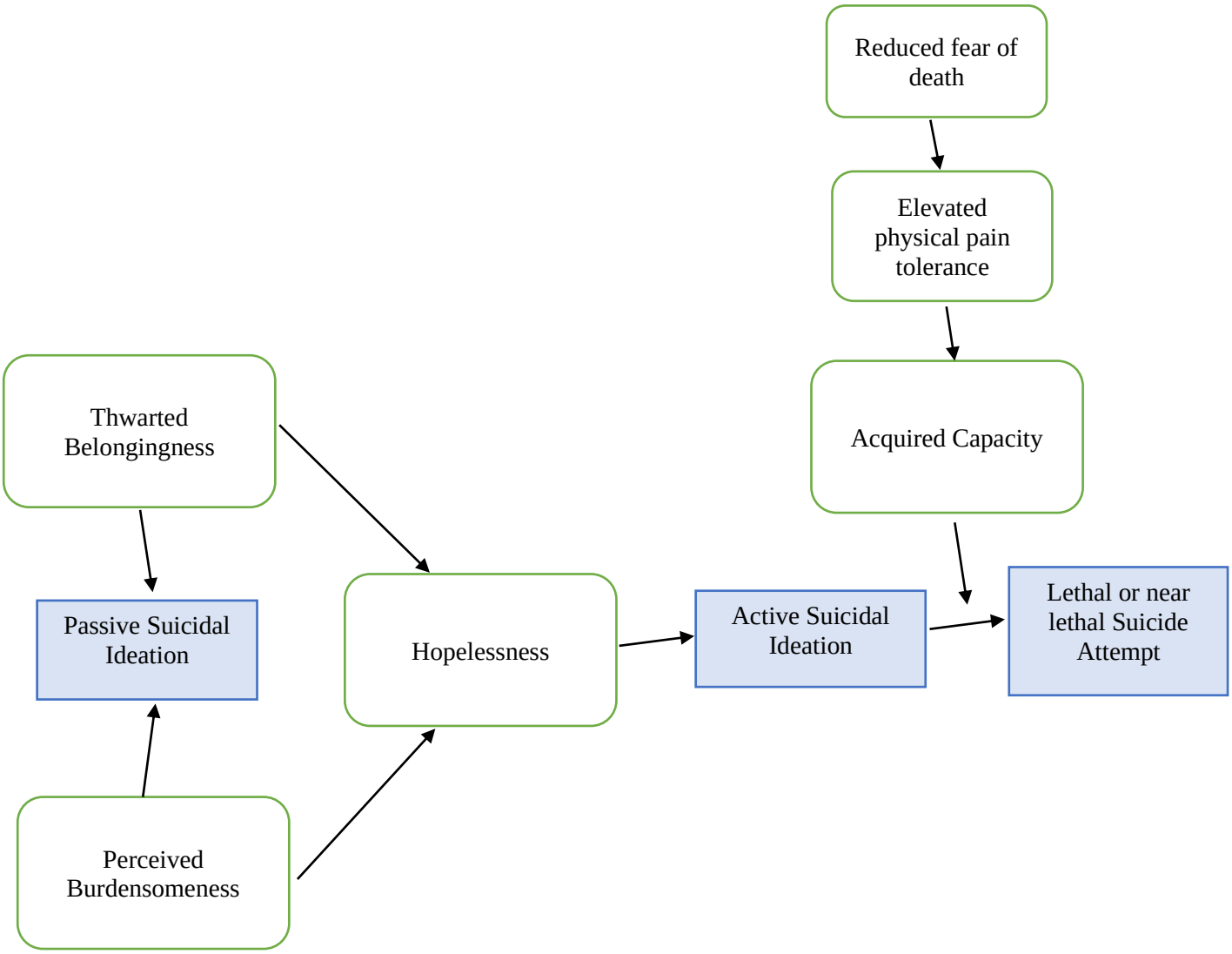

Figure 1. Diagrammatic depiction of the core constructs and hypothesised pathways of the Interpersonal Theory of Suicide. Adapted from, Van Orden et al. (2010), Chu et al. (2017) and Selby, Joiner & Ribeiro (2014).

Passive Suicidal Ideation (SI) – Hypothesis 1

According to the IPTS, passive SI involves the experience of cognitions such as, "I wish I was dead" or "I would be better off dead." (Van Order et al., 2010, p. 20). This state is caused by the presence of thwarted belonging and/or perceived burdensomeness; dynamic cognitive-affective states influenced by intra-and-interpersonal experiences.

Thwarted Belongingness

Building on influential theories of belonging, such as that postulated by Baumeister and Leary (1995), the IPTS considers the need to belong as "a fundamental human motivation" (p. 1). When this need is not met, one experiences great psychological pain, feeling disconnected, alienated, or non-integral to important others (Joiner et al., 2010; Joiner, 2007; Baumeister & Leary, 1995).

The constructs within the IPTS were developed through structural equation modelling of factors considered pertinent in theoretical and empirical literature on the aetiology of suicide (Van Orden et al., 2010). As a result, the IPTS conceptualises thwarted belongingness (TB) into two dimensions: loneliness and the absence of reciprocally caring relationships (Van Orden et al., 2010). Many of the social isolation factors specific to TB have been identified in a LGB populations. For example, limited social support, experiencing emotional abuse (Schönfelder et al., 2019)**,** violence (Gnan et al., 2019), and/or family discord (Ryan et al., 2009).

Perceived Burdensomeness

Building on Sabbath's (1969) family systems theory of adolescent suicidal behaviour, the IPTS also considers perceived burdensomeness (PB) to be a critical construct in the aetiology

of suicide. PB refers to the misperception that one is a burden on close others, others would be "better off if I was gone" (Van Orden et al., 2012 p. 2) and that one's death is worth more than one's life (Joiner, 2005; Joiner et al., 2009). Van Orden et al. (2010) describes two facets of PB: self-hatred and the belief that the self is a liability to others. Similarly to TB, many of the associated factors specific to PB have been studied in LGB populations. For example, homelessness (Hatchel, Merrin, & Espelage, 2019), unemployment (Blakely, Collings & Atkinson, 2003), serious physical illness (Gürhan et al., 2019) and incarceration (Zhong et al., 2021).

Active Suicidal Ideation – Hypothesis 2

The IPTS postulates that the process of moving from passive to active SI involves the simultaneous experience of both TB and PB, coupled with a specific sense of Hopelessness that TB and PB will change. In contrast to passive SI, active SI involves an active desire to engage in behaviours to take one's life, including thoughts, communications, and behaviours that involve some degree of intent to die. For example, experiencing thoughts such as "I want to kill myself" (Van Orden et al., 2010, p.20).

Suicidal Intent – Hypothesis 3

Active SI can become serious suicidal intent via the process of acquired capacity (AC), specifically a reduced fear of death. When these experiences described above co-occur with AC, people can imagine, plan or decide to engage in suicidal action (Van Orden et al., 2010).

Acquired Capacity

Evolutionary theorists argue that suicide transgresses human intrinsic motivations for self-preservation and survival (Joiner, 2005). Thus, to engage in active suicidal behaviour, one

must acquire the capacity to overcome these obstacles (Ribeiro et al., 2015). Acquired capacity is conceptualised as a lowered fear of death and/or self-injury, and an elevated tolerance of physical pain (Van Orden et al., 2010). Principles of habituation (i.e., to pain from repeated self-harm) and opponent process theory (Solomon & Corbit, 1974) are thought to facilitate the acquisition of capacity over time. Contributing risk factors to developing AC include previous suicide attempts (Van Orden et al., 2008), combat exposure (Byran et al., 2010b) and physical and sexual abuse in childhood (Schönfelder et al., 2019; Van Orden et al., 2010).

Lethal (or near-lethal) Suicide Attempts – Hypothesis 4

Finally, the IPTS postulates that one is at serious risk for engaging in a lethal (or near-lethal) suicidal attempt (SA) when a combination of TB, PB, Hopelessness regarding both states, a reduced fear of death, *plus* an elevated physical pain tolerance are present (Van Orden et al., 2010).

Additional Variable Configurations

In addition to the four main hypotheses outlined above and described in detail by Van Orden and colleagues (2010), additional configurations of theory variables have been proposed and tested (Chut et al., 2018). The theory predicts the core constructs of the IPTS are proximal predictors of suicidal thoughts and behaviours. As such PB, TB, Hopelessness and AC may account for the relationship between various (distal) suicide risk factors and suicide related outcomes (Van Orden et al., 2010; Chu et al., 2017). This means that the IPTS theorises *why* it is that people consider or attempt suicide (because of elevated TB, PB Hopelessness and AC), whilst also considering *what factors* put people at greater risk of experiencing these.

Previous Research & Reviews: IPTS

The pathways stipulated by the IPTS have been examined within a wide variety of populations. For example, psychiatric outpatients (Van Orden et al., 2008) and inpatients, (Schönfelder et al., 2019)**,** prison populations (Mandracchia & Smith, 2015), military personal (Bryan et al., 2010b) firefighters, (Chu et al., 2016a), physicians, (Fink-Miller, 2015), older adults (Guidry & Cukrowicz, 2016), adolescents, (Stewart et al., 2017) and across different cultures and ethnicities such as with American (Van Orden et al., 2008) and Chinese students (Zhang et al., 2013). Studies have also found evidence for the IPTS while controlling for mental health diagnoses, including depression (Joiner et al., 2009; Schönfelder et al., 2019). A range of research methods have also been employed to test this theory, including cross-sectional (Van Orden et al., 2008), retrospective (Van Orden et al., 2016) and prospective (Ribeiro et al., 2015) methodology.

Two recent systematic reviews and a meta-analysis have collated research across this heterogenic literature (Ma et al., 2016; Chu et al., 2017). Both reviews concluded that the association between PB and SI may be more robust than the pathway identified between TB and SI. Other constructs and pathways have been much less frequently examined (Ma et al., 2016). More comprehensive tests of this theory which do exist, have revealed weak-to-moderate associations between PB, TB, AC and suicide attempt history (Chu et al., 2018). However, the need for further research is paramount.

Objectives of the Current Review

This paper systematically reviewed the literature which applied the IPTS (Joiner, 2005; Van Orden et al., 2010) to the understanding of suicidal thoughts and behaviour in SM minority populations. Study results are summarised in line with the specific IPTS hypotheses that were

tested. Additionally, research has suggested that comparisons between populations of people with different sexual orientations can help develop effective theory and prevention strategies (Hatzenbuehler, 2009; Meyer, 2003; Hatchel, Polanin & Espelage; 2019). Therefore, comparisons with heterosexual populations and comparisons between SM populations relevant to the IPTS are also considered. The review concludes with a discussion of potential theoretical and clinical implications.

Methodology

This review was developed according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Protocols (PRISMA-P; Moher et al., 2010).

Literature Search

Several initial scoping searches were conducted to provide an overview of the literature and to identify key search terms. Key words, subject and medical subject headings identified in initial searches, in addition to terms used in recent related reviews (Ma et al., 2016; Chu et al., 2017), were used to build the main search. Titles and abstracts of papers were also screened for associated additional terms. Filters were used to search only titles, abstracts and key words of papers published in English language journals. The search process was supported by a Cardiff University Librarian.

After several scoping searches, five bibliographic databases (PsychINFO, MEDLINE, CINAHL, SCOPUS, ASSIA) were searched. Table 1 details the main search terms, with the appropriate syntax to search PsychINFO and MEDLINE. Databases were searched from the date of their inception until April 2021.

Search Group	Search Terms
Interpersonal Theory of Suicide	"interpersonal* psych* theory of suic*" or "interpersonal* theory of suic*" or Joiner* or thwarted belong* or perceived burden* or acqu* cap or interpersonal needs quest*
	AND
Suicide related thoughts and behaviour	Suic* or life threat* behav*
	AND
Sexual minority populations	gay or queer or lesbian*or male homosexual* or sexual orientation or bisexual* or homosexual* or minority group* or sexual minorit* or sexuality or sexual* or same sex* or female homosexual* or LGB* or sexual identit* or "men who have sex with men" or "women who have sex with women"

Table. 1. Main search terms and syntax used for PsychINFO and MEDLINE.

Study Selection

Titles and abstracts were screened by the first author. Irrelevant papers and/or those which did not meet the inclusion criteria were excluded. Full texts of the remaining papers were then acquired and screened. Further studies were excluded at this point for reasons outlined in Figure 2. Any queries were discussed with a second reviewer. Two authors were contacted in the hope of obtaining further information about data presented. Full texts were acquired for all included papers. References of included papers and associated literature were also searched to ensure no relevant studies were missed. A summary of the study selection process is outlined in Figure 2.

Eligibility Criteria

A 'PICOS' framework was used to outline inclusion criteria, as shown in Table 2 (Moher et al., 2009).

'PICOS' Approach for Inclusion Criteria	
Population	Focus analyses on participants who identify as any SM, either defined in their own terms or as LGB.
Intervention	Aim specifically to test any or all IPTS hypotheses/constructs.
Comparators	Consider suicide-related processes within and/or between groups (Hatchel et al., 2021), including: • Studies which measure processes within SM populations • Studies which compare processes between SM populations, such as comparing gay, lesbian, and bisexual populations • Studies which compare SM populations with heterosexual populations
Outcomes	Measure core construct(s) of the IPTS using direct or proxy measures. Include a measure of suicidal thoughts or behaviours (either ideation, attempt, or a composite measure).
Study Design	Any study design

Table 2. Inclusion criteria as summarised by the 'PICOS' framework.

Additional Considerations: Sexual Orientation, Gender Identity and Sex Assigned at Birth

This review wishes to acknowledge the distinction between sexual orientation (SO), gender identity (GI) and sex assigned at birth (SAB). SO is thought to have at least three dimensions, including one's sexual attraction and sexual behaviour towards others, as well as one's sexual self-identification (Saewyc et al., 2004). GI refers to one's own conceptualisation of gender,

which is not dependant on one's biological SAB (Suen et al., 2020). These aspects of one's identity can for some be distinct (Nuru, 2014); one can identify as gay and cisgender or heterosexual and as a gender different to their SAB. For other people, these identities can intersect; for example, one could identify as transgender and lesbian, having previously been assigned a male SAB (Sinclair-Palm, 2018; Clements-Nolle et al., 2001; Haas et al., 2011). Additionally, SO and GI can be fluid, dynamic and/or non-binary (Katz-Wise, 2015; Katz-Wise et al., 2016; Diamond, Dickenson & Blair, 2017).

A proportion of research continues to inadequately consider and/or measure the spectrum of LGBTQI+ identities (Nuru, 2014; Suen et al., 2020). Suicide research specifically has been criticised for "conflating sexual orientation and gender identity" (White, 2018, p. 398). Considering the unique challenges faced by specific LGBTQI+ populations in more detail may help to improve knowledge, understanding, the clinical utility of interventions and the current health discrepancies between LGBTQI+ and heterosexual populations (Cahill et al., 2014; Nuru, 2014).

This paper aimed to thoughtfully consider these issues. Papers in which all participants self-identified as a SM, regardless of their GI or SAB were included. Papers which presented data comparing SM, gender minority (GM) and combined populations (SGM) are acknowledged, and applicable results discussed. In addition, papers identified during searches which focus on GM participants and the IPTS were screened for any separate analyses of SGM participants. Papers which included aggregated samples of SM and heterosexual individuals were excluded.

Evaluating Methodological Quality of Studies

Recent reviews collating IPTS literature (Chu et al., 2017; Ma et al., 2016) did not report the use of a quality appraisal tool. Therefore, the wider literature was consulted to identify a relevant tool. The AXIS (Downes et al., 2016) tool was selected as all the studies within this review are of analytic cross-sectional design. Also, AXIS addresses risk of bias as well as reporting quality (Ma et al., 2020).

Quality assessment was conducted by the first author. 25% of studies were discussed with the second author and an independent researcher until agreement was at 100%. This tool does not provide a numerical score for study quality and therefore requires a subjective judgement of overall quality and risk of bias (Downes, et al., 2016). However, articles with fewer criteria should be interpreted with caution. A summary of the quality appraisal for each study can be found in Appendix 3.

Data Extraction & Synthesis

Data extraction was piloted by the first author and adapted in consultation with fellow authors. Extracted data was summarised in Microsoft Excel. Table 3 displays this information.

Measures of Suicidal Thoughts and Behaviours

As outlined above, the IPTS considers a continuum of suicidal ideation and behaviours (Van Orden et al., 2010). Some studies used specific measures for SI or SA. However, other studies included composite measures such as suicide proneness (Cramer et al., 2014; 2015) and suicide behaviour measures (Riley & McLaren, 2019; Chu et al., 2018; Muehlenkamp et

al., 2015). In line with previous review (Ma et al., 2016), these measures all included some measure of SI and therefore were classified as such in the results.

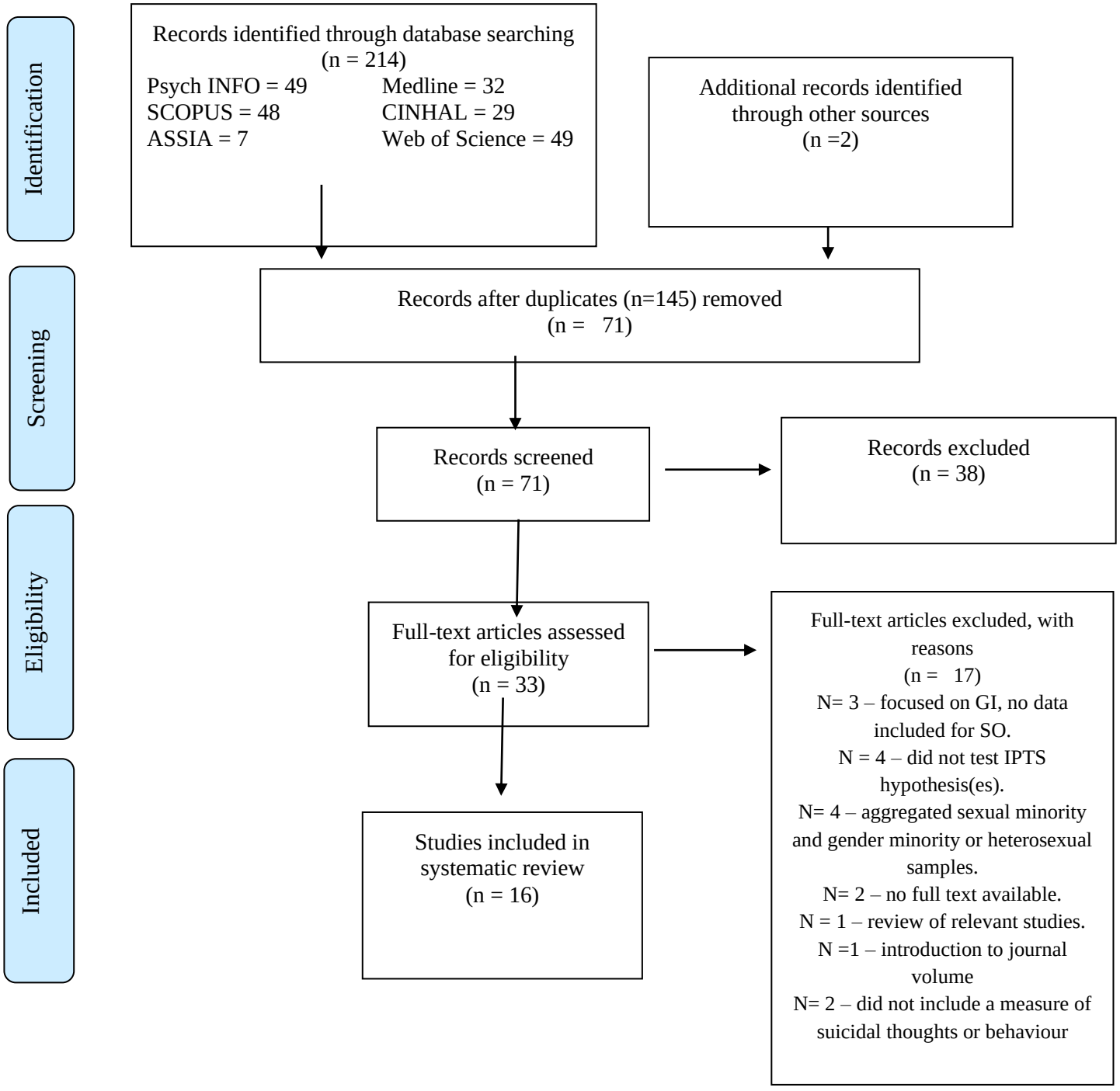

Figure 2. A PRISMA flow diagram summarising the study selection process.

Results

A total 16 studies were included in this review. Study characteristics are outlined in Table 3. Two studies shared data, with the second publication including details on additional variables (Cramer et al., 2014; Cramer et al., 2015). Combined, the 15 individual studies included 3,755 SM participants. Most studies were conducted in the US (N=11), including nationwide and specific regions samples. Other studies were conducted within the UK (N=1), South Korea (N=1) Germany (N=1) or within a mixture of countries (N=1). Several samples were university or college students (N=6) whereas other samples were recruited via online LGBTQI+ support groups (N=1), social media (N=3), a mixture of these (N=2), a study recruitment website (N=1), a primary health care setting (N=1), or an LGBTQI+ youth-focused suicide crisis prevention provider (N=1).

Across all studies the mean age of participants was 25.71. Regarding ethnicity and/or race 12/15 studies reported this data. Across these studies, 52.4% of participants identified as White/Caucasian. The remaining participants self-identified their ethnicity and or race as Hispanic, Latino, Black/African American, Asian, Native American, Asian/Pacific Islander, Alaskan Native, Native Hawiian, Indian or Middle Eastern American, Hmong, multi-racial and/or biracial.

Studies included a variety of people identifying as SM, most participants self-identified as LGB, however a small number of pansexual, questioning, queer or other identities were reported in some studies. Sex and/or gender of participants was not reported in every study. A total of 6/15 studies reported including non-cisgender SM participants in their analyses. Two studies conducted separate analyses for SM, GM and/or SGM participant.

No study identified in this review tested the IPTS model fully. Instead, studies mainly focused on individual predictions of the IPTS. Only one study differentiated between measures of passive or active SI, however results were very similar and so were collated (Plöderl et al., 2014). Results are synthesised in line with the closest IPTS hypotheses. Where possible and meaningful, effect sizes have been extracted and can be found in Appendix 4.

First Author, Year, Country/Location	**N or %*, SM Identity, Sex and/or Gender, Mean Age, Demographics**	**Additional Comparison Group, N**	**IPTS Constructs Measures, Measure Used**	**Suicide Outcome, Suicide Measure**	**IPTS Hypothesis (H) Considered or Partially Considered**	**Additional Relevant Tests**
Plöderl 2014 Germany – Bavaria	N = 255 **SM Identity:** Any SM identity **Sex/Gender:** Male & Female (N/% not specified) **Age:** 27 **Race/Ethnicity:** Not reported **Recruited From:** LGB social media **Other:** Heterosexual comparators were significantly younger and had higher levels of education	Heterosexual 183	TB, PB, AC IPNQ-12, ACSS-5 (Van Orden et al., 2008)	SI, SA Beck's Scale for Suicide Ideation (Beck & Steer, 1991). One item on this scale was used to measure previous SA(s).	H1, H3/H4 (partial)	Comparison between SM and heterosexual populations.
Cramer 2015 USA – South	N = 336 **SM Identity:** LGB identities **Sex/Gender:** Not reported. **Age:** 42.3 **Race/Ethnicity:** 41.6% = Caucasian, 41.3% = African America, 3.6% = Native American, 3.3% = Biracial, 8.4% = Hispanic, 0.6% = Asian American, 1.2% = Other (1.2%) **Recruited From:** Primary care health centre **Other:** Participants were considered to have low socioeconomic status	n/a	TB, PB IPNQ-12 (Van Orden et al., 2008)	SI (Suicidal Proneness) Life Attitudes Schedule - Short Form (Rohde et al., 2003)	H1	PB & TB as (proximal) mediators for SI and distal factors (MST Variables). Comparisons between SM populations.
Cramer 2014 As above	As above	n/a	As above + AC	As above	As above + H3 (partial)	PB, TB & AC as (proximal) mediators for SI and distal factors

			As above + ACSS-5 (Van Orden et al., 2008)			(Five-Factor Personality Model variables).
Silva 2015 USA – South East City	N = 58 **SM Identity:** 24 = Lesbian/Gay, 24 = Bisexual **Sex/Gender:** Male & Female (N/% not specified) **Age:** 19.5 **Race/Ethnicity:** 57.6% = Caucasian /European American, 20.7% = Hispanic/Latino, 11.4% = Black/African American, 0.7% = Asian, 8.6% = other. **Recruited From:** University	Heterosexual 92	PB IPNQ-15 (Van Order, Cukrowicz, Witte & Joiner, 2012)	SI Beck's Scale for Suicide Ideation (Beck & Steer, 1991).	H1 (partial)	Comparisons between SM populations. Comparison between SM and heterosexual populations. PB & TB as (proximal) mediators for SI and distal factors (SM status).
Pate 2019 USA – Rural South	N = 141 **SM Identity:** Any SM identity **Sex/Gender:** 79.9% = Female, 19.3% = Male 0.8% = Other **Age:** 21.04 **Race/Ethnicity:** 60% =White/Caucasian, 34.4% = Black/African American, 2.4% = Hispanic/Latino, 1.6% = Asian/Pacific Islander, 0.3% = Native American, 1.3% = Other **Recruited From:** University	Heterosexual 1,058	TB, PB, AC IPNQ-15 (Van Order, Cukrowicz, Witte & Joiner, 2012) ACSS-20 (Bender et al., 2011)	SI The Positive and Negative Suicidal Ideation Inventory (Osman et al., 1998)	H1, H2 (partial) H3/H4 (partial)	Comparisons between SM and heterosexual populations. Considered differences between cisgender and gender minority populations.
Woodward 2014 USA	N = 210 **SM Identity:** 89 = Gay 76 = Lesbian	n/a	TB, PB IPNQ-18 (Joiner,	SI Depressive Symptom Index Suicidality sub scale	H1	Comparisons between SM populations.

	35 = Bisexual Female 13 = Bisexual Male **Sex/Gender:** 62% = Male, 38% =Female **Age:** 36.11 **Race/Ethnicity:** 77. % = White, 7.6% = Hispanic/Latino American, 7.1% = African American/Black **Recruited From:** Online LGB support group **Other:** ~50% of participants were considered to have low socioeconomic status and were in an exclusive relationship		2005)	(Metalsky & Joiner, 1997)		
Hill 2012 USA – South East City	50 **SM Identity:** LGB identities **Sex/Gender:** 62% = Male, 38% = Female **Age:** 21.28 **Race/Ethnicity:** 74.2% = Hispanic, 67.2% as Caucasian, 13.6% = African American, 5.6% = Asian, 0.5% = Native Hawaiian or Pacific Islander, 1.5% = Native American or Alaskan Native, 12.6% = Other **Recruited From:** College	Heterosexual 148	TB, PB IPNQ-12 (Van Orden et al., 2008)	SI Adult Suicidal Ideation Questionnaire (Reynolds, 1991)	H1	Comparisons between SM and heterosexual populations. PB & TB as (proximal) mediators for SI and distal factors (SM status).
Wolford-Clevenger 2020 USA – South	N = 82 **SM Identity:** 27 = Lesbian/Gay 44 = Bisexual 12 = Other **Sex/Gender:** 79.3 % = Female, 20.7% = Male **Age:** 19.56	n/a	TB, PB IPNQ-15 (Van Order, Cukrowicz, Witte & Joiner, 2012)	SI The Hopelessness Depression Symptom Questionnaire - Suicidality Subscale (Metalsky & Joiner, 1997)	H1	Comparisons between SM populations.

	Race/Ethnicity: 72% = White, 11% = Black, 4% = Native American, 4% = Asian American, 2% = Middle Eastern or Indian American, 4% = Hispanic or Latino, 4% = Other, 4% = Not answered. **Recruited From:** University **Other:** Been in a relationship for at ≥ 1 month					
Baams 2015 USA	N = 876 **SM Identity:** 30.7% =Gay 21.8% =Lesbian 15.5% =Bisexual Men 31.9% = Bisexual Women **Sex/Gender:** Male, Female and Transgender (N/% not specified) **Age:** 18.31 **Race/Ethnicity:** 20.3 = White, 24.9% = Black or African American, 4.9% = Asian, 2.9% = American Indian or Alaskan Native, 0.8% = Native Hawaii or Other Pacific Islander, 22.5% = selected more than one option, 23.7% = No response **Recruited From:** College groups, community-based organisations	n/a	TB, PB IPNQ-12 (Van Orden et al., 2008)	SI The positive and Negative Suicidal Ideation - Negative SI Sub-scale (Osman et al., 1998)	H1	Comparisons between SM populations. PB & TB as (proximal) mediators for SI and distal factors (MST Variables).
Riley 2019 USA, UK, Canada, Australia	370 **SM Identity:** Gay **Sex/Gender:** Men **Age:** 26.13 **Race/Ethnicity:** Not reported.	n/a	TB, H IPNQ-15 (Van Order, Cukrowicz, Witte & Joiner, 2012)	SI (Suicidal behaviours) Suicidal Behaviours Questionnaire-Revised (Osman et al., 2001).	H1 (partial)	TB as (proximal) mediator for SI and distal factors (Relationship status variables).

	Recruited From: Social media					
Chu 2018 USA	305 **SM Identity:** 49.2% = Lesbian/Gay 19.3% = Bisexual 31.5% = Other **Sex/Gender:** 40.8% = Female, 33.2% = Male 5.4% = Transgender Male, 3.6% = Transgender Female, 5.4% = Gender Queer, 5.1% = Non-Binary **Age:** 35.7 **Race/Ethnicity:** 82.8% = White/Caucasian, 1.8% = Black/African American, 0.6% = American Indian/Alaskan Native, 2.4% = Asian, 6.3% = Multiracial, 1.8% = Other, 1.2% = Missing/declined to answer **Recruited From:** support organisations, social media	n/a	TB, PB IPNQ-15 (Van Order, Cukrowicz, Witte & Joiner, 2012)	SI (Suicidal behaviours) Suicidal Behaviours Questionnaire-Revised (Osman et al., 2001).	H1, H2 (partial)	Comparisons between SM, GM and SGM participants. PB & TB as (proximal) mediators for SI and distal factors (Sleep problems).
Taylor 2020 UK	119 **SM Identity:** Gay or Bisexual **Sex/Gender:** 79.3 % = Female, 20.7% = Male **Age:** 23.05 **Race/Ethnicity:** 83% = White, 7.9% = Asian, 4.6% = Mixed ethnicity, 3.3% = Black, 1.1% = Other/no response **Recruited From:** University	n/a	TB IPNQ-7 (TB subscale of INPQ-15) (Van Order, Cukrowicz, Witte & Joiner, 2012)	SA, NSSI Two questions taken from: The Self-Injurious Thoughts and Behaviours Interview (Nock et al., 2007). SA = “Have you ever made an actual attempt to kill yourself in which you had at least some intent to die?”. NSSI = “Have you actually	H1 (partial)	TB as (proximal mediator) for SA & NSSI and distal factors (SM status).

				purposely hurt yourself without wanting to die?"		
Kim 2014 South Korea	201 **SM Identity:** 118 = Gay 83 = Lesbian **Sex/Gender:** 40.8% = Female, 33.2% = Male, 54 % = Male Transgender, 3.6% = Female Transgender, 5.4% = Gender Queer, 5.1% = Non-binary **Age:** 25.8 **Race/Ethnicity:** Not reported **Recruited From:** Gay and Lesbian social media **Other:** Over 85% of participants had graduate from or were in college	Heterosexual 227	TB, PB, Hopelessness IPNQ-15, (Van Order, Cukrowicz, Witte & Joiner, 2012) Hopelessness Scale (Shin et al., 1990)	SI Korean Suicidal Ideation Questionnaire (Choi & Kim, 2011; Reynolds, 1991)	H1, H2	Comparisons between SM populations. Comparison between SM and heterosexual populations.
Muehlenkamp 2015 USA	N = 137 **SM Identity:** 13% = Gay 18% = Lesbian 29% = Bisexual Other = 49% **Sex/Gender:** 74% = Female, 16% = Male, 3% = Transgender, 3% = Intersex, 3% = Gender Fluid, 37% = Cisgender **Age:** 19.86 **Race/Ethnicity:** 89% = White, 6% = Asian, 5% = Multi-racial, 4% = Black, 3% = American Indian/Alaska Native, 1.5% = Hmong, 1.5% = Hispanic/Latino,	n/a	TB, PB, AC IPNQ-15 (Van Order, Cukrowicz, Witte & Joiner, 2012) ACSS-20 (Bender et al., 2011)	SI, NSSI SI = one question taken from the Suicidal Behaviours Questionnaire (Osman et al., 2001): "Have you ever seriously thought about or attempted to kill yourself?" NSSI =Inventory of Statements About Self-Injury (Klonsky & Glenn, 2009)	H1, H3/H4 (partial)	PB, TB & AC as (proximal) mediators for SI, NSSI and distal factors (MST Variables).

	1% = Pacific Islander. **Recruited From:** University **Other:**					
Fulginiti 2020 USA	N = 564 **SM Identity:** 25.5% = Gay 15.2% = Lesbian 17 % = Bisexual 26.3% = Other **Sex/Gender:** 26% = Cisgender male 35% = Cisgender Female, 3.2% = Transgender Female 12.1% = Transgender Male 8.9% = Gender Queer, 6.2% = Questioning 9.2% = gender identity other or not listed **Age:** 17.63 **Race/Ethnicity:** Not reported **Recruited From:** LGBTQI+ youth-focused suicide prevention provider	n/a	TB, PB IPNQ-10 (Van Order, Cukrowicz, Witte & Joiner, 2012)	SI, SA SI = Columbia-Suicide Severity Rating Scale (Posner et al., 2011). SA = one question, “Have you ever tried to kill yourself?”	H1, H2 (partial)	PB & TB as (proximal) mediators for SI, SA and distal factors (MST Variables).
Velkoff 2015 USA	N = 51 **SM Identity:** Any SM identity **Sex/Gender:** Females only **Age:** 29.23 **Race/Ethnicity:** 60.8% = White, 17.6% = Asian, 7.8% = Black or African American, 3.9% = Native Hawaiian or Other Pacific Islander, 2% = American Indian/ Alaska Native **Recruited From:** Study recruitment website **Other:** 66.7% of participants had partners	n/a	TB, PB IPNQ-15 (Van Order, Cukrowicz, Witte & Joiner, 2012)	SA One or two question(s): "Have you ever attempted suicide?", if yes, "How many times?"	H2 (partial)	n/a

Table 3. Characteristics of studies included in the review.

SM – Sexual minority, LGB – lesbian, gay, bisexual, TB – thwarted belongingness, PB – perceived Burdensomeness, AC – acquired capacity, SI – suicidal ideation, SA – suicidal attempt(s), NSSI – non-suicidal self-injury.

IPNQ – Interpersonal Needs Questionnaire, ACSS – Acquired Capacity for Suicide Scale.

MST - Minority Stress Theory, LGB – lesbian, gay, bisexual, GM – gender minority, SGM – sexual and gender minority.

*Percentages were used where participants could select more than one option. Therefore, not all % add up to 100% or could be directly converted to exact figures.

Hypothesis 1 – The Relationship between Thwarted Belongingness/Perceived Burdensomeness and Passive Suicidal Ideation

Perceived Burdensomeness and Suicidal Ideation

Bivariate correlations assessing the association between PB and SI were reported in 11/15 studies. All of these studies found that there was a significant positive relationship between PB and SI, as predicted by the IPTS (Plöderl et al., 2014, Cramer et al., 2015; Cramer, Stroud, Fraser & Graham, 2014; Silva et al., 2015; Pate & Anestis, 2020; Woodward et al., 2014; Hill & Pettit, 2012; Wolford-Clevenger et al, 2020; Baams et al., 2015; Chu et al., 2018; Muehlenkamp et al., 2015; Fulginiti et al., 2020). Using Fisher's-Z transformation calculations, the average weighted effect size of the relationship between PB and SI was r = 0.49, signifying a medium-large effect size (Lenhard & Lenhard, 2014).

Woodward et al. (2014) found that PB remained a relevant predictor of SI after accounting for associated covariates (gender, sexual identity, depressive symptoms, a romantic relationship, and annual income). In a similar model, Wolford-Clevenger et al. (2020) showed that PB significantly predicted SI, when controlling for depression. Effect sizes displayed in Appendix 4.4.

Perceived Burdensomeness and Suicide Attempts

Although not a specific prediction of the IPTS, three studies examined the relationship between PB and SA at a bivariate level. All of these studies found a significant correlation (Cramer, Stroud, Fraser & Graham, 2014; Silva et al., 2015; Fulginiti et al., 2020). Effect sizes are displayed in Appendix 4.1.

Thwarted Belongingness and Suicidal Ideation

Considering the relationships between TB and SI, 12/15 studies conducted bivariate correlations. Ten of these studies found a significant positive relationship (Plöderl et al., 2014, Silva et al., 2015; Pate & Anestis, 2020; Woodward et al., 2014; Hill & Pettit, 2012; Wolford-Clevenger et al., 2020; Baams et al., 2015; Riley & McLaren, 2019; Chu et al., 2018; Fulginiti et al., 2020). Using Fisher's-Z transformation calculations, the average weighted effect size of the relationship between PB and SI was r = 0.37, signifying a medium effect size (Lenhard & Lenhard, 2014).

Muehlenkamp et al. (2015) found no significant bivariate correlation between these variables. Cramer et al (2014; 2015) found a significant negative correlation between TB and SI. The authors considered whether this may have been a statistical anomaly or if the internalisation of TB may serve as a protective function for LGB people living in difficult circumstances (referring to low socioeconomic status of participants in this study). For example, TB may instil a sense of resilience or motivation to find where one can belong.

However, despite being related at a bivariate level, when considering the relationship between TB and SI in a regression model, Woodward et al. (2014) found that the relationship between TB and SI was no longer significant when controlling for gender, sexual identity, depressive symptoms, romantic relationship, and annual income. Similarly, Wolford-Clevenger et al (2020) showed that TB no longer significantly predicted SI when controlling for depression.

One study however found that, in a sample of 370 gay men, the relationship between TB and suicidal behaviour did remain significant when controlling for age, education, employment status and level of disclosure of sexual orientation. The study also collected data on relationship status but did not include this in the analysis (Riley and McLaren, 2018).

Thwarted Belongingness and Suicide Attempts

Although not specifically hypothesised within the IPTS, five studies examined the relationship between TB and SA. Three of these studies found a significant relationship at a bivariate level (Plöderl et al., 2014; Silva et al., 2015; Fulginiti et al, 2020) and one did not (Cramer et al., 2014; 2015). Effect sizes are displayed in Appendix 4.1. Taylor et al. (2020) also showed that TB was associated with a higher risk of having made a previous SA with an intent to die, however this result only neared significance (exact p value not reported).

Silva et al. (2015) commented that, in their study, the correlations between PB and SI and TB and SI were greater than those between PB and SA and TB and SA. This is also supported in other studies who considered both SI and SA correlates (see Appendix 4.1). This appears to offer support for the specific predictions of the IPTS (Silva et al., 2015).

Hypothesis 2 – The Interaction between Thwarted Belongingness, Perceived Burdensomeness, Hopelessness and Active Suicide Ideation

Four studies considered how the interaction between PB and TB impacted SI and/or SA.

Exploring the relationships between TB and PB, Pate and Anthesis (2020) demonstrated that the interaction between TB and PB account for a significant increase in the variance explained within the TB-SI and PB-SI pathways. Available effect sizes can be seen in

Appendix 4.4. It was also found that the relationship between PB and SI strengthened as TB increased.

Chu et al. (2018) demonstrated that the interaction between TB and PB significantly explained the relationship between sleep problems and suicidal behaviour. PB was a significant mediator at all levels of TB, however TB was only a significant mediator at low or average levels of PB.

Velkoff et al. (2015) showed that in a sample of sexual minority women, the interaction between TB and PB was able to predict the number of previous suicide attempts. On further examination of this interaction, PB only predicted number of previous suicides attempts at high levels of TB (versus low levels). To a lesser extent, PB as a single variable also significantly predicted previous SA.

Fulginiti et al. (2020) found the interaction between PB and TB was significantly associated with SI, but not SA.

Hopelessness

A sense of hopelessness that one's experience of TB and PB will ever change, is the hypothesised mechanism facilitating progression from passive to active SI. Only one study in this review considered hopelessness in their design.

Kim and Yang (2014) examined whether hopelessness mediated the relationship between PB and SI and TB and SI. For gay (N=118) and lesbian (N=83) and heterosexual samples (227),

TB was only significantly associated with SI when mediated by Hopelessness. PB was significantly associated with SI via direct and indirect effects in the model.

Hypothesis 3 & 4 – Considering Acquired Capacity (AC)

Four studies included the construct of AC in their design. Using bivariate correlations, three studies demonstrated that for SM samples, AC was significantly associated with SI (Plöderl et al., 2014; Pate and Anthesis, 2020; Muehlenkamp et al., 2015). However, Cramer et al (2014) did not find a significant association between AC and suicidal proneness. Available effect sizes displayed in Appendix 4.1.

Plöderl and colleagues (2014) found that within a sample of N=255; SM people who had previously made a SA had significantly great levels of PB, TB and AC in comparison to a SM sample with no previous SA(s). This study also highlighted SM specific risk factors which may influence AC; general and sexual orientation-based experiences of physical violence were higher amongst SM people who had made a SA in comparison to those who had SI but had made no attempt. Available effect sizes can be seen in Appendix 4.4.

Additional Variable Configurations

As hypothesised by Van Orden and colleagues (2012), distal risk factors can influence suicidal ideation and/or behaviour through the proximal constructs of the IPTS. Nine studies included in this review assessed this hypothesis using mediation models.

Minority Stress Theory (MST) and Suicidal Ideation

Four studies considered how TB and PB may mediate the relationship between specific minority stress factors and SI. The Minority Stress Theory (Meyer, 2003) proposes that health inequalities between LGBTQI+ populations and their peers can be explained by experiences of stigmatizing stressors (such as discrimination, victimization, and stigma) (Hatchel, Polanin & Espelage, 2019). These experiences, in addition to typical stressors possibly experienced by any population, lead to reduced well-being. MST also considers minority specific internal processes which may result from stigmatizing stressors, for example internalised homophobia, anticipated rejection, and concealment of SM status (Meyer, 2003).

Muehlenkamp and colleagues (2015) found that in a parallel mediation model, only PB and AC partially mediated the relationship between MST, SI and NSSI, TB did not.

Similarly, Cramer et al. (2015) found that PB mediated the relationship between internalised homophobia and suicide proneness. However, this effect was only significant for males with clinical (mild-severe) levels of depression. TB was not a significant mediator.

Baams et al (2015) also considered PB and TB as parallel mediators. Results showed that for an LGB sample, when controlling for age, others' perceived knowledge of sexual identity, and membership in a community-based organization, links between SM status, and SI were mediated by PB. For LGB women specifically, PB also mediated the relationship between LGB-coming out stress and SI. TB was not a significant mediator.

Fulginiti et al. (2020) demonstrated that as a parallel mediator, PB significantly explained the relationship between SM factors and SI and SA. This study also identified a novel sequential mediation pathway, when TB preceded PB in the mediation analysis, this model partially mediated the relationship between minority stress and SA and fully mediated the relationship between minority stress and SI.

Sexual Minority (SM) Status and Suicidal Ideation and/or Attempt

Three studies considered how TB and/or PB mediate the relationship between SM status and SI, SA and/or NSSI.

Silva and colleagues (2015) showed that PB fully mediated the relationship between SM status and SI for women only in a college sample, when controlling for anxiety and negative and positive affect.

Hill and Pettit (2012) demonstrated that PB (and not TB) partially mediated the relationship between SM status and SI. The interaction between PB and sexual orientation was found to be conditional on the level perceived or anticipated rejection from others due to sexual orientation; this effect only remained significant when perceived rejection was greater and was only found for LGB participants (in comparison to heterosexual).

Taylor and colleagues (2020) demonstrated that in a sample of 119 LGB UK University students, TB was not significantly associated NSSI or SA, nor was TB a significant mediator between NSSI and SM status or SA and SM status.

General Risk Factors and Suicidal Ideation

Three studies included in this review assessed the role of TB and PB in the relationship between general suicide risk factors (sleep problems, being unpartnered and certain personality facets) and SI.

Chu et al (2017) examined TB and PB as separate, parallel and moderated mediation analyses, examining the relationship between sleep problems and suicidal behaviour. Age, anxiety and depression were considered as covariates. As individual mediators, TB and PB partially mediated the relationship between sleep problems and SI for all groups. As parallel mediators, TB and PB fully mediated this relationship. The moderation-mediation analyses showed that the interaction between TB and PB significantly explained this relationship. The study also differentiated between samples identifying as a SM, gender minority (GM) and those identifying as both (SGM) and showed that the indirect effect of sleep problems on SI through PB was descriptively "stronger" SM samples, and TB was "stronger" in GM and SGM samples (p. 29).

Riley and McLauren (2019) found that in a sample of gay men (N=370) TB mediated the relationship between relationship status and suicidal behaviour; being unpartnered was associated with higher levels of TB, which in turn was associated with higher levels of SI.

Cramer et al., (2014) integrated the five-factor personality model (Costa & McCrae, 1992) considering how personality traits interact with interpersonal experiences outlined in the IPTS, which in turn lead to SI. The results showed that TB and PB separately mediated the relationship between high neuroticism and suicide proneness (SP) and low extraversion and

SP. TB also mediated the relationship between low agreeableness and SP. AC did not significantly mediate any relationship.

Comparisons

Sexual Minority and Heterosexual Sample Comparisons

Six studies included in this review made compared results between SM and heterosexual populations. See Appendix 4.2 for available effect sizes.

Wolford-Clevenger et al., 2020 compared rates of PB, TB and SI to an undergraduate sample reported by Cero et al., 2015. SM had higher scores on all measures, however p vales were not reported.

Kim and Yang (2014) explored a partial mediational model, which hypothesised that PB and TB would predict SI, mediated by Hopelessness. Multigroup comparisons between sexual minority and heterosexual samples revealed that the only significant difference between heterosexual and lesbian and gay participants was found within the PB–SI pathway; for gay and lesbian participants this pathway coefficient was significantly greater. The authors hypothesised that SM populations could be more vulnerable to experiences of PB due to experiences such as coming out and concerns regarding acceptance. However, these results may have been influence by the collectivism and Confucianism cultural context of this study (Kim and Yang, 2014).

Similarly, Pate and Anestis (2020) found that for SM participants, when controlling for gender, race, age, and TB, SM participants had significantly higher levels of PB than their heterosexual comparators. When controlling for gender, race, age and PB, SM and

heterosexual participants did not differ significantly on levels of TB. Also, when controlling for gender and race, SM and heterosexual samples did not different on measures of AC but did differ significantly on measures of SI.

Hill and Pettit (2012) demonstrated that, when controlling for age and ethnicity differences between groups, LGB participants showed significantly greater scores for PB and SI but did not differ on measures of TB.

Silva and colleagues (2015) showed that PB, TB, SI were significantly higher in SM populations in comparison to heterosexual college students. LGB participants were also significantly more likely to have engaged in NSSI and made a SA.

In addition, Plöderl and colleagues (2014) compared rates of SI and SA between SM and heterosexual populations. More than twice as many SM men and three times as many SM women had attempted suicide. Three times as many SM participants who had made a SA had intended to die. SI was also marginally higher in the SM sample ($p = .08$). However, between group samples were not matched in this study.

Comparisons Between Sexual Minority Groups

Six studies in this review considered how samples with different SM identities compare regarding experiences of SI and SA in relation to IPTS constructs. See Appendix 4.3 for available effect sizes.

Kim and Yang (2014) found there were no significant differences between gay and lesbian participants when considering different pathways between TB, PB, Hopelessness and SI.

Cramer et al. (2015) found PB significantly mediated the relationship between internalised homophobia and suicide proneness for SM males only (compared to females).

Silva and colleagues (2015) considered dimensional measures of SM status. Results demonstrated that mid-range Kinsey scores (reflecting bisexual orientation) were associated with greater PB, SI, NSSI and previous SA, in comparison to high (exclusively gay or lesbian) or low (exclusively heterosexual) scores. The authors hypothesised that responses of bisexual females were hypothesised to be influencing the overall collated results for LGB participants within this study.

Similarly, Wolford-Clevenger et al (2020) demonstrated that bisexual participants had greater TB and PB than gay and lesbian participants. However, no significant differences were found between levels of SI.

Baams et al. (2015) demonstrated that gay men had significantly lower experiences of PB than bisexual girls. No other differences were found when considering gay men, lesbians, bisexual men and bisexual women.

Woodward et al. (2014) considered whether PB and TB would predict SI in gay men, lesbian, and bisexual women samples specifically. PB accounted for a significant proportion of the variance in all groups, TB did not. Gay men were three times, lesbians were seven times and bisexual women were five times more likely to experience SI when levels of PB were high compared to low.

Two papers considered differences between cisgender and gender minority SM populations (Chu et al., 2018; Pate & Anestis, 2020). Experiences of PB, TB and SI were greater in GM and SGM samples compared to cisgender SM samples.

Discussion

This paper systematically reviewed literature examining how elements of the IPTS (Joiner, 2005; Van Orden et al., 2010) can be applied to the understanding of suicidal thoughts and behaviours in SM populations. Results were collated based on the hypotheses outlined by Van Orden and colleagues (2010), considered additional variable configurations, comparisons between SM and heterosexual samples and comparisons between different SM identity samples.

Main Findings

The Four Hypotheses of the IPTS

Within this review, no study tested the whole IPTS model configuration with a SM population. Most studies focused on the relationship between PB-SI and TB-SI. These results seem to suggest that PB has an important association with SI. This was also supported in studies that considered covariates and included samples from different areas of the world. PB was also found to consistently correlate with SA, not a formal prediction of the IPTS but further evidence of the important role that this construct plays in regard to suicide.

TB appears to be a less reliable variable for predicting SI and SA in SM samples. This echoes results found in other IPTS systematic reviews and a meta-analysis (Ma et al., 2016; Chu et

al., 2017; Smith, Kuhlman & Wolford-Clevenger, 2020) and is considered in more detail below.

Few studies considered the roles of other crucial constructs and pathways identified within the IPTS. Therefore, it is difficult to draw conclusions on the applicability of these constructs and pathways for SM populations specifically.

Other Variable Configurations

Results from studies considering different variable configurations also highlighted the possible significance of the relationship between PB and SI. Direct and indirect relationships found between PB and SI when combined with general factors (such as sleep problems) and factors specific to SM populations (such as minority stress factors), provides further insight into specific factors to target in suicide prevention and intervention.

Interesting differences were found between studies using different models of mediation. Fuginiti and colleagues (2020) showed that in a sequential model, TB was significantly implicated between minority stress and PB. In addition, studies which considered the interaction between TB and PB identified a variety of moderating effects between these variables (Chu et al., 2018; Velkoff et al., 2015; Pate & Anestis, 2020). These finding are somewhat supported by the IPTS and suggest that the interaction between PB and TB may operate differently in SM populations. Research which continues to explore different configurations of these relationships and pathways in more detail, whilst considering other IPTS constructs (Hopelessness, AC) would be beneficial.

Comparisons with heterosexual samples

All studies which compared levels of PB and SI between groups found that these experiences were significantly greater in SM as compared to heterosexual samples. Therefore, PB may be a more important factor associated with SI for SM populations (Kim and Yang, 2014).

Differences between SM and heterosexual population appear consistent across different countries and cultures, including those varying in terms of legal and cultural acceptance of LGBTQI+ people. For example, two studies were conducted with samples living in the large cities in the east of the US, one in 'deep rural south' of America and another in South Korea. However, three studies used university student samples and in the fourth study, 85% of participants were in or had graduated college. Therefore, results may be less generalisable outside of such populations.

This review supports findings that SM people experience elevated rates of suicidal thoughts, behaviours and attempts compared to heterosexual peers. It also suggests that PB may play a key role in this.

Comparisons Between Sexual Minority Samples

Only a limited number of studies compared SM samples. Often sample sizes were too small to produce meaningful results. Studies which did make comparisons produced mixed results. Three of these studies which specifically looked at differences between LGB participants found that female bisexual participants may have an increased risk of experiences of PB (Silva et al., 2015; Baams et al., 2015; Wolford-Clevenger et al., 2020), SI, NSSI and previous SA (Silva et al., 2015). These results are consistent with a recent meta-analysis comparing mental wellbeing between these populations (Ross et al., 2017). Again, the IPTS may help to explain the underpinning mechanisms of these effects. Silva et al. (2015)

hypothesised that bisexual women may perceive a greater sense of burdensomeness due to feeling misunderstood by, and unaccepted in, heterosexual and lesbian/gay social spheres (Herek, 2002). Recent studies suggest these experiences may be even greater for bisexual men (Dodge et al., 2016). No study within this review considered bisexual males as a distinct sample. Individual examinations of other SM identities (other than LGB) were also not considered or were not possible. Thus, more diverse, and larger samples are needed before formal conclusions can be drawn between different SM identities and the IPTS.

Thwarted Belongingness, a lesser role?

TB appears to be a less predictable correlate of suicidal thoughts and behaviours in SM populations. It is possible that this is a Type II error, that current studies designs have led to an erroneous conclusion. For example, the IPTS postulates a continuum of suicidal thoughts and behaviours and makes several predictions along this continuum (Chu et al., 2018). However, only one paper in this review considered the different effects that TB and PB had on passive or active suicidal ideation (Plöderl et al., 2014). Only one study considered how experiences of TB and PB interact with a sense of hopelessness, finding that the relationship between TB and SI was only significant for gay and lesbian participants when mediated by hopelessness (Kim and Yang, 2014). In addition, only one study considered the relationship between PB, TB and AC and SA, again finding significant results (Plöderl et al., 2014). Finally, a large proportion of the studies included in this review used college or university samples, where opportunities for LGBTQI+ belonging may be increased compared to the general population (Kim & Yang, 2014). Therefore, to draw strong conclusions, future research would benefit from more theoretically sensitive measures and study designs (Smith, Kuhlman & Wolford-Clevenger, 2020).

TB being an unreliable predictor of SI appears somewhat inconsistent with wider findings discussing the importance of social support and relationships on mental health and suicide (Riley & McLaren, 2019; Velkoff et al., 2015; Haas et al., 2011; Hatchel, Polanin & Espelage, 2019; Gorse, 2020). It may be that studies in this review (and those in the wider IPTS literature) are not accurately measuring participants experiences of belonging (Ma et al., 2016). This is a criticism and a frustration shared with the wider and multi-disciplinary research considering both the definition and measurement of the construct of belonging (Mahar, Cobigo, & Stuart, 2013). Also, within this review, all studies measured PB and TB with versions of the Interpersonal Needs Questionnaire (Van Order, Cukrowicz, Witte & Joiner, 2012). Shared measurement tools used across all studies within this review somewhat strengthens the reliability and validity of the collated results. However, this questionnaire assesses only one of two dimensions which makeup the construct of TB as postulated by the IPTS (Chu et al., 2017; Van Orden et al., 2010). Therefore, future research may benefit from further theoretical exploration of the concept of TB and the development of a more detailed measurement tool.

Finally, it is possible that different experiences of belonging are given different psychological and/or emotional weights, and as such experiences of TB, can still be buffered by the power of belonging to one particular important place or person. For example, a longitudinal study showed that parenthood was associated with reduced risk for lethal-suicidal behaviour (Qin & Mortensen, 2003). Future research would benefit from qualitative research considering the link between belonging and suicide (Hjelmeland, & Loa Knizek, 2010).

Future Research

Intersectionality

Considering how multiple facets of identify impact on IPTS, constructs and pathways may help improve understanding of suicide and help target interventions and prevention (Opara et al., 2002). Studies have shown that non-White LGBTQI+ youth are at greater risk of suicide than their White LGBTQI+ peers (Cochran et al., 2007; Meyer et al., 2008). One study in this review supported these findings; Pate and Anestis (2020) showed that participants who identified as a race other than White/Caucasian or Black/African American reported significantly higher level of TB, PB, SI and AC. Over 50% of participants included in this review were White/Caucasian, a similar statistic to studies included in other related reviews (63% in Chu et al., 2017). Therefore, future research examining the relationships between, race and/or ethnicity, SM status and the IPTS would be beneficial.

Study Designs

A limitation of this review includes the cross-section design of all studies. This prevents assumptions of causality between variables and pathways. Longitudinal prospective study designs would help to rectify this criticism. Such studies could facilitate understanding of the development of suicidal thoughts and behaviours across a temporal trajectory. For example, elaborating on how SM specific processes such as age of coming out and first acknowledgment of same-sex attraction impact on IPTS constructs and pathways (Baams et al., 2015; Mustanski & Lui, 2013). Studies could also consider how these processes may integrate with other acute risk factors (such as impulsivity or substance misuse) (Chu et al., 2017). Finally, including continuous rather than categorical measures of SI and behaviours and sexual identity would also help to capture the complexity of SM experiences and possible fluidity over time (Silva et al., 2015). Such designs are ambitious, and it is recognised that

prospective tests considering suicidal behaviour may not be feasible (Velkoff et al., 2015). However, these study designs could help improve the empirical and clinical utility of the IPTS in its ability to predict *when* SM individuals may be at greater risk of suicidal thoughts and/or behaviours (Chu et al., 2017).

Limitations of this review

In addition to limitations already acknowledged, this review only included papers which specified their intent to test or consider the IPTS model specifically (Chu et al., 2017). This may have led to the exclusion of other relevant literature and important findings.

This review chose to include samples of SM individuals, regardless of their gender identity (GI). Pate and Anestis (2020) and Chu et al. (2018) showed that in their samples of SM individuals, participants who self-identified with a GI other than male or female reported higher levels of PB, TB, SI. Given these suggested differences, it is possible that some results are not applicable to cisgender SM populations.

Results from the quality assessment tool used in this review (Downes et al., 2016) identified that most studies did not justify sample sizes. Although difficult in cross-sectional research, there was also limited information on non-responders or people that dropped out of research. Additionally, although the aims and objective of the individual papers were clear, often the papers attempt to test (elements of) the IPTS did not closely align with specific theoretical predictions postulated in the theory. This study also included all relevant papers in the review regardless of their rated quality. This decision was made due to limited available research and, in the hope that lower quality papers can be used to inform future research.

Finally, only one study in this review included participants who had specifically recently sought support for being acutely suicidal (Fulginiti et al., 2020). The IPTS is designed to explain why most people who experience suicidal thoughts do not die from suicide and therefore is designed to explain the causal pathways of lethal suicide which (thankfully) is not relevant to most people (Joiner, 2005). Therefore, lack of consideration of clinical samples is important to acknowledge and conclusions pertaining to the clinical utility of the IPTS with actively suicidal people must be interpreted with caution. This criticism is acknowledged in the wider IPTS literature (Smith, Kuhlman & Wolford-Clevenger, 2020) and this review extends this criticism to SM research.

Clinical Implications

This review of the IPTS suggests that for SM populations, targeting experiences of PB and TB with micro and macro levels interventions may be of benefit (Fulginit et al., 2020). For example, at an individual level, PB could be a potential target for assessment and intervention. When working with SM individuals who reports suicidal thoughts or behaviours and/or appear low in mood, assessing PB may be a helpful clinical indication of risk (Woodward et al., 2014). The IPNQ is a short measurement tool which has been used as a clinical tool to predict reductions in SI (Allen et al., 2018). Additionally, subjective perceptions of one's burdensomeness (and belonging) could be targets for cognitive and/or behaviours interventions. In a sample of adults at increased risk of suicide, Allan et al. (2018) demonstrated that three computerised sessions (focusing on psychoeducation and cognitive bias modification) reduced perceptions of PB (but not TB), reductions which predicted lower rates of SI after six months. Further studies have found similar results in interventions with older adults and adolescents (Van Orden, Tu et al., 2016; Hill & Pettit, 2016). Research which tests interventions with acutely suicidal participants and those which consider TB more

specifically are needed. Evidence has also previously shown that "gay-tailored" interventions may be more acceptable, retentive, and effective for LGB people (Haas et al., 2010, p. 34; Jaffe et al., 2007). Therefore, these results may not directly translate to SM people.

A conference abstract outlining an intervention focusing on reducing PB and TB with LGBTQI+ youth involved in treatment following reported SI and/or SA(s) was identified within the main search. At six months, the young people were found to have reduced levels of TB and PB. No further intervention details were reported, nor were any possible changes in SI/SA (Michaels et al., 2020). The authors have been contacted for further detail; however, this data is suggestive of clinical utility of elements the IPTS in a SM clinical sample.

In addition, the goal of therapy should not be to help people change because of experiences of oppression and marginalisation. Therefore, working at community, policy and legislative levels is also imperative. Schools with protective LGBTQI+ practices, policies and cultures have shown that disparities in rates of suicidal thoughts and attempts between LGB and heterosexual adolescents are significantly reduced (Hatzenbuehler et al., 2014; Hatzenbuehler & Keyes, 2013). Haas et al., (2010) provides a comprehensive list of helpful recommendations for interventions at different system levels. An example, which is directly supported by the results in this review, includes ensuring that mental health practitioners are aware of specific LGB minority stress factors that may influence interpersonal perceptions and suicidal thoughts and/or behaviours (Haas et al., 2010; Hatzenbuehler, 2009; Alessi, 2013).

Conclusion

This paper aimed to review the literature which assesses the applicability of an eminent theory of suicide to a marginalised population considered to be at greater risk of suicide related thoughts and behaviours. In line with previous reviews (Chu et al., 2017; Ma et al., 2016) PB appears to be an important predictor of SI, an experience that could be partly explained by SM specific and general suicide risk factors. This relationship also appeared to be more pronounced in SM populations when compared to heterosexual samples and maybe most prominent in bisexual populations. Much more research is needed to improve understanding of how other facets of the IPTS interrelate to affect suicidal thoughts and behaviours in SM population. In addition, the small number of associated clinical interventions show interesting initial results, however much more attention is required to truly assess whether the IPTS offers a useful clinical framework for supporting SM people who consider, desire and attempt suicide.

Declarations

Not Applicable.

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Paper 2

A Sense of Belonging in Children's Residential Homes: A Qualitative Exploration of Staff Members' Perspectives

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6 This paper is prepared in accordance with the author guidelines for the Journal the *Children & Youth Services Review* (Appendix 5). For the purposes of thesis submission, the DClinPsy word limit of 8000 words has been used to ensure all relevant information could be demonstrated.

To ease readability, tables and figures are included in the main body of text and will be removed and placed at the end for journal submission.

Highlights

- The study explored belonging in residential care from the perspectives of staff.
- A theory concerning developing belonging and processes which influence this is outlined.
- Staff members play a key role in residential care processes.
- Clinical recommendations rely on a whole system approach.

Abstract

Purpose: A sense of belonging is an experience which has been associated with a spectrum of important outcomes. However, it is also a construct which lacks theoretical clarity. Additionally, children's residential care is a context which is under-researched. As such, care processes within residential homes and the impact of care remain poorly understood. This study was designed to explore a sense of belonging in children's residential care from the perspective of residential care staff.

Method: Constructivist Grounded Theory methodology was used to develop a theory of belonging in residential care. Eight residential care staff were interviewed about 1) their own experiences of belonging within their role and 2) what they understand about how the children and young people they support experience a sense of belonging in residential care.

Results: The interpretive theory proposed that there are three key stages involved in the process of developing a sense of belonging for children and young people and residential care staff within children's residential care: Establishing a Sense of Safety, Engaging in Reciprocity and Forming Your identity. In addition, key processes which influence the development of belonging were also highlighted: The Context of Care, A Child or Young Person's Journey Through Care and Relational Dilemmas.

Conclusions: This study concludes by considering the application of this theory to adjacent literature and by making specific recommendations for residential care practice.

Keywords: *Belonging, children's residential care, residential care staff,*

Introduction

In 2019, the Welsh Government estimated that there were 6,846 children who are looked after (CLA) in Wales, an increase of 7% from the previous year (CoramBAAF, 2019). The term CLA refers to any child or young person (CYP) who is, by law, under the official care of the Local Authority (Children's Act, 1989). This often involves CYP being removed from their family of origin and being placed in a temporary or permanent alternative care setting (Tomkin, 2015). A proportion of these CYP are accommodated in residential care homes (RCHs). A recent review revealed that 435 Welsh CYP resided in RCHs in 2019 (Care Inspectorate Wales (CIW), 2019).

Residential Care (RC) has been described as a "last-resort" option for CYP (James, 2011, p. 308). Frequently, RCH support is sought when foster or kinship care placements have been unable to meet the CYP's needs (Gallagher & Green, 2012). As such, RCHs are often challenged with caring for CYP who have suffered huge adversities and are some of the most vulnerable and traumatised in the country (James, 2011).

The limited research which considers RCHs has been widely acknowledged both in terms of outcomes (the impact of care) and processes (what care is received) (Whittaker et al., 2016; Gallagher & Green, 2012). Voices of key stakeholders, such as CYP and the staff who support them, are also infrequently included in research (Anderson & Johansson, 2008; Moriston, Taylor & Gervais, et al., 2020; Colton & Robert, 2006).

Within RCHs in the UK, CYP are supported most frequently by staff members (from here referred to as residential caregivers or RCGs). RCG is multifaceted and complex role. They support individual CYP with their (often complex) educational, physical, social and

emotional needs. RCGs also fulfil the role of parent, friend and trusted ally, all whilst upholding legal and professional boundaries and duties (Parry et al., 2021).

This paper aimed to qualitatively explore RCGs experiences and understanding of belonging in RC.

Belonging – a definition?

A sense of belonging is considered notoriously difficult to define (Mahar, 2013; Levett-Jones et al., 2007). Belonging can be a cognitive, emotional, relational and social experience, associated with people, groups, time, space, ideas and/or processes. It is both private and public; and an intra and inter-personal experience. It is considered an active and fluid everyday process, continuously impacting and being impacted by the complex systems in which we exist (Halse, 2018).

Many social science disciplines offer definitions of belonging; however, the construct remains in theoretical infancy (Youkhana, 2015). Within the psychological literature, Baumeister and Leary (1995) proposed the "belonging hypothesis" which outlined two criteria for experiencing a belonging. Firstly, experiencing frequent and affectively pleasant interactions. Secondly, feeling assured that the interpersonal bond is stable and ongoing and that the other(s) care for one's welfare.

Belonging – Theoretical perspectives

Belonging has been deemed a fundamental human need, one that we are innately motivated to establish and maintain.

Evolutionary psychology considered belonging to be advantageous for human survival. By seeking, developing, and maintaining belonging in social groups, one's chances of survival are enhanced (Over, 2016).

The pivotal work of Maslow (1943, 1954) considered the innate and fundamental function of belonging, defining it as a need to be accepted, valued, and appreciated by others. Maslow theorised that humans are habitually motivated to meet their need to belong, following the satisfaction of physiological and safety needs. When one experiences belonging, the focus can turn to meeting esteem and self-actualisation needs. As belongingness is considered an intrinsic part of one of the most well-known and influential theories within psychology, one could conclude that there is wide-spread agreement that belonging is essential for our ability to survive and thrive.

What is the impact of belonging?

The idea that belonging is intrinsically vital is supported by research which examines its implications (Halse, 2018). This paper briefly discusses a selection of research exploring the impact of belonging on CYP and health and social care staff.

Impact of Belonging: CYP

Within CYP populations, a substantial proportion of research surrounding belonging has focused on the impact of school belonging on a range of social, educational, psychological outcomes (Strayhorn, 2019). In a meta-analysis, Korpershoek and colleagues (2020) found small positive correlations between school belonging and academic functioning and moderately strong positive correlations between school belonging and improved self-esteem, self-efficacy, and academic engagement. Results remained significant after controlling for year group and socioeconomic status.

Belonging can also impact on emotional health outcomes for CYP, including reduced anxiety and depression, improved self-esteem and general well-being (Anderman, 2002; Hascher & Hagenauer, 2010). Belonging has also been considered a critical factor in suicidal ideation and behaviour. Several theories of suicide emphasise the role of belonging (Joiner, 2005; Klonsky & May, 2015; O'Connor & Kirtley, 2018). The Interpersonal Theory of Suicide predicts that suicidal ideation can result from belonging being 'thwarted' (Joiner, 2005; Van Orden et al., 2010). A recent review of this theory concluded that interventions targeting belonging could be particularly beneficial for adolescents experiencing suicidal ideation (Stewart et al., 2015).

Despite some compelling findings, varied definitions and the lack of theoretically and empirically validated measures of belonging make accurate and meaningful collation of evidence challenging (Mahar et al., 2013; Hatcher & Stubbersfield, 2013; Kidger et al., 2012; Stewart et al., 2015).

Impact of Belonging: Health and Social Care Workforce

Research has also examined implications of belonging for health and social care workers. Significant positive associations between one's sense of belonging and work engagement (Bishop, 2013), positive teamwork (McKenna & Newton, 2008), job satisfaction (Winter-Collins & McDaniel, 2000), motivation, confidence and reduced anxiety (Levett-Jones & Lathlen, 2008) have been identified. However, this research focused on qualified or student nurses in physical health care environments. In a qualitative study including managerial teams (including nurses, social workers and doctors), Lampinen et al (2018) outlined several factors influencing belonging within a work environment. Facilitators of belonging included open interaction and common values, barriers included a negative work atmosphere and lack

of opportunity to know colleagues. Processes involved in establishing these factors and the perceptions of non-senior staff were not included. However, this research supports the importance of belonging within a health and social care workforce, suggesting potential positive outcomes for staff well-being, service delivery and service outcomes (Ansmann et al., 2020).

A Sense of Belonging in Residential Care – CYP and RCGs

Despite the "powerful" and "fundamental" (Baumeister and Leary, 1995, p. 497) nature of belonging, there is limited research which considers belonging within RCHs. A small pool of research has qualitatively considered the importance of belonging in foster or kinship placements from the perspectives of CYP. These studies highlight the importance of factors such as close relationships with carers and social workers, placement, and school stability, and feeling included in everyday family rituals and tasks (Skoog, Khoo & Nygren 2015; Hedin, 2011).

Relationships between CYP and RCGs are considered one of the best predictors of positive outcomes for CYP in RC (Moore et al., 2017). Qualitative papers have explored RCGs perspectives on these relationships through the lens of attachment theory (Moriston, Taylor & Gervais, 2020; Moses, 2010; Tomkin, 2015). Belonging and attachment are not necessarily mutually exclusive concepts (Baumiester & Leary, 1995). Belonging has been described as more than attachment (Lee & Robbins, 1995), and thus important relationships with RCGs may be only one important facet of experiencing belonging (Baumeister & Leary, 1995).

To the author's knowledge, no research has considered the role of belonging in children's RC in the UK.

Current Study Aims

Considering the above, this study aimed to explore a sense of belonging in RC from the perspective of RCGs. To achieve this, RCGs were interviewed about 1) their own experiences of belonging within their role and 2) what they understand about how the CYP they support experience a sense of belonging in RC.

Implications of this research include a preliminary theory of belonging in RC. Clinical implications include the translation of these theoretical processes into RC practices, potentially benefitting CYP, RCGs and services.

Methodology

Design

Grounded Theory (GT) methodology allows researchers to explore and interpret under-researched phenomena through the process of developing preliminary theories (Strauss & Corbin, 1998; Bitsch, 2005). Constructivist grounded theory (CGT) (Charmaz, 2014) was selected for this study. CGT emphasises the processes of the researcher and participants co-constructing concepts, rather than the researcher discovering a theoretical truth within the data (Charmaz, 2014). This process fits with the complexity and subjectivity of belonging, helps maintain authentic representations of voices from an under-researched population and facilitates consideration of specific contextual implications for RC.

CGT was also selected as there was a clear ‘fit’ between this strand of GT and the epistemological assumptions of the researcher; the importance of which as emphasised by

Willig (2013). Further details on the researchers' perspectives are discussed in the Reflexivity section.

Ethical Considerations

Ethical approval was sought and obtained from Cardiff University School of Psychology Ethics Committee (Appendix 6). The ethics proposal explained that interview questions may evolve throughout due to the nature of the methodology.

Recruitment

Participants were recruited from three different private care organisations operating in South and West Wales. Within these organisations, staff from six homes took part in interviews. Job titles have been removed to protect anonymity. Recruitment was approved by senior managers/clinicians within organisations. Participants were recruited via dissemination of project details through email and team meetings.

Inclusion Criteria

Participants were included in the study if their role was to directly support CYP within a RCH. The main author contacted potential participants expressing interest to discuss their main role to ensure appropriateness for the study.

Participants were required to have worked within their current role for at least three months. Due to lack of guidance within the literature, this criterion was calculated based on anonymised employment data collated by one RCH. This revealed that, on average, RCGs who prematurely leave their role tend to do so within three months of starting. Thus, it could be hypothesised that after this time RCGs have started to feel they belong in their role.

Informed Consent

In line with the BPS Code of Human Research Ethics (2014), written consent was obtained from participants (Appendix 7). Each participant was provided with an information sheet outlining details on study aims, ethical procedures, anonymity, withdrawal procedures, possible benefits and/or disadvantages of partaking and data management processes (Appendix 8). A narrated video by the first author outlining the information sheet was also provided to encourage involvement of RCGs who may be less confident in their literacy abilities and to initiate rapport building.

All information was managed in line with the Data Protection Act (1988). Interviews were recorded via an encrypted device, transcribed and deleted within one month of recording. Participants were sent a debrief form and given time to reflect on this with the researcher following interview completion (Appendix 9).

Interview Schedule Development

Interview questions were developed based on a brief review of relevant literature and initial research aims (Charmaz, 2014; Sbaraini et al., 2011). The questions focused on capturing RCGs understanding of belonging and the processes crucial to both staff members and CYPs. A Service User Consultant at Cardiff University and a Consultant Clinical Psychologist with CLA were contacted to review the interview schedule and procedure. Considerations for establishing a safe space to talk, monitoring participant well-being and providing encouragement throughout were discussed.

The final initial interview schedule included 20 questions with optional prompts to help participants expand answers (Sbaraini et al, 2011). The interview schedule was altered during

the data collection and analysis process, in line with the CGT approach (Charmaz, 2014) to help explore emerging themes (Appendix 10).

Participants

A total of eight participants took part in the study. Four participants were interviewed from Organisation One (across two different homes), two from Organisation Two (two homes) and, two from Organisation Three (two homes).

Participant demographic information was collated (Appendix 11). Gender and age demographics are outlined in Table 1. All participants considered themself to be White and/or British. Average length of employment within the organisation was 4.4 years, ranging between 8 months-10 years. Average time spent in relevant employment outside of the current organisation was 7.9 years, ranging between 0-20 years. Similar to figures reported by CIW (2019), participants highest level of qualification varied from GCSE to undergraduate university degree. Names used for participants in the Results section are pseudonyms.

Theoretical Sampling

Recruitment paused following the first four interviews and initial coding was undertaken. Researchers discussed initial codes, focused codes and memos concerning common themes and gaps within data. To further explore emerging concepts, data was then theoretically sampled from different organisations. Additionally, individuals with a wider overview of the context of RC and could comment on how these systems influence belonging were sought. As such, individuals who had slightly more senior direct caring roles were included. Such participants were theoretically sampled for the final four interviews.

Demographic	Number of Participants
Gender	
– **Male**	4
– **Female**	4
– **Any other gender identity**	0
Age range (years)	
– **18-24**	1
– **25-30**	3
– **32-38**	0
– **39-45**	1
– **46-52**	2

Table 1. Gender and age demographics for participants included in the study.

Data Collection Process

Two interviews were conducted privately within RCHs. All other interviews were conducted online via secure video-platforms due to national restrictions during the COVID-19 pandemic. Interviews lasted between 52-130 minutes. Data was collected over a six-month period. Data collection continued until the researchers felt that theoretical sufficiency was reached.

Data Analysis Process

Data analysis processes are outlined in Table 2.

Data Analysis
Interviews were transcribed verbatim. Interviews were collected and analysed simultaneously. This allowed for ongoing conceptualisation of the data which can be tested, revised, and qualified throughout (Urquhart, 2013).
Line by line Coding
Initial coding used a line-by-line approach and focused on labelling data in a way which captures the participant's meaning and experience using the participant's own words where possible. All codes and raw data were constantly compared, within and between interviews (Charmaz, 2014). This process allowed for the emergence of tentative and more abstract categories and sub-categories.
Focused Coding
Focused coding was then conducted, collating initial codes which appeared significant, were common and shared ideas (Charmaz, 2014). These processes indicated theoretical direction for the research through the emergence of tentative and more abstract categories and sub-categories.
Theoretical Sampling
Theoretical sampling was undertaken alongside data analysis to explore emerging concepts (Charmaz, 2014).
Memo Writing
Data collection and analysis was supported by theoretical memo writing; reflective opportunities for the researcher to document thoughts and ideas throughout the research process (Charmaz, 2014). The researcher also wrote a "case-based memo" after every interview, reflecting on impressions of the participant's comments and experiences and the interviewer's position (Sbaraini et al., 2011, p.5). Examples of memos can be seen in Appendix 12.
Conceptual Category Development
Focused codes, initial codes and raw data were continually compared and codes with most theoretical weighting became conceptual categories and other codes were collapsed into these. Categories were reviewed and renamed throughout until they were considered theoretically sufficient, there was sufficient data in each code for theory development (Charmaz, 2014).
Development of Theory
The emergence of categories allowed for theoretical coding; the generation of hypotheses concerning the relationships between categories. This led to the development of an interpretive theory (Figure 1.).

Table 2. Process of Grounded Theory

Quality Assurance

This study followed recommendations proposed by Elliot et al (1999) designed to improve the validity and reliability of qualitative research. These are outlined in Table 3.

Recommendations	Applications
1. *Owning one's perspective*	Transparency of the authors relevant theoretical and personal orientations, as evidenced through memos (Appendix 12), keeping a reflective journal (Appendix 13), and the Reflexivity section.
2. *Situating the sample*	Providing participant demographic information to help contextualise the generated theory.
3. *Grounding in examples*	Providing examples of participant quotes alongside categories in Results section. Additionally, providing examples of transcripts with coding procedures (Appendix 14) and a table of categories and codes (Appendix 15).
4. *Credibility checks*	The evolving process of data collection and analysis were discussed with the research supervisors and another clinical psychology trainee throughout. The lead researcher was also part of a grounded theory working group. Each participants contribution to the categories is outlined in Appendix 16.
5. *Coherence*	A summary of the analysis is presented via narrative and diagrammatic formats in the Results section.
6. *Accomplishing general vs specific research tasks*	Limitations and discussions regarding generalisability of results are outlined in the Discussion.
7. *Resonating with readers*	Drafts and final version were reviewed by two clinical research supervisors to assess the clarity and standard of this study. Literature discussed throughout the paper and a discussion of clinical implications (see Discussion) helps the reader to consider how the study resonated within research and clinical landscapes.

Table 3. Quality Assurance Process.

Reflexivity

CGT invites researchers to be reflexive about how and why they personally interact with the data in a certain way (Charmaz, 2014). To maintain a critical and curious stance throughout the research process, it was important to consider how the researcher's epistemological stance, existing knowledge, experience and preconceptions may influence the research process.

The lead author wrote from the perspective of a 27-year-old, white-Welsh female, currently undertaking a doctorate in clinical psychology. She has no experience of being a CLA. She previously worked as an Assistant Psychologist with CYP in a low-secure unit and currently works within a developmental trauma service for CLA. During both roles, she worked alongside staff members who support CYP in a residential capacity. The author also undertook professional training in Dyadic Developmental Psychotherapy (DDP) during the data collection and analysis process. Keeping a reflective journal helped maintain awareness of these factors throughout.

It is also acknowledged that the epistemological positions of the research supervisors may have influenced interpretive direction. However, final decisions about theoretical development were always made by the first author.

Results

A theory outlining RCGs' perspectives on belonging in RC was created. The theory first explores the processes involved in developing a sense of belonging for both RCGs and CYP. Wider interacting processes which influence the development of belonging are then considered. Figure 1 summarises conceptual categories and the proposed interactions. Following this, a narrative account of categories is discussed, including examples of direct quotes to illustrate categories in context.

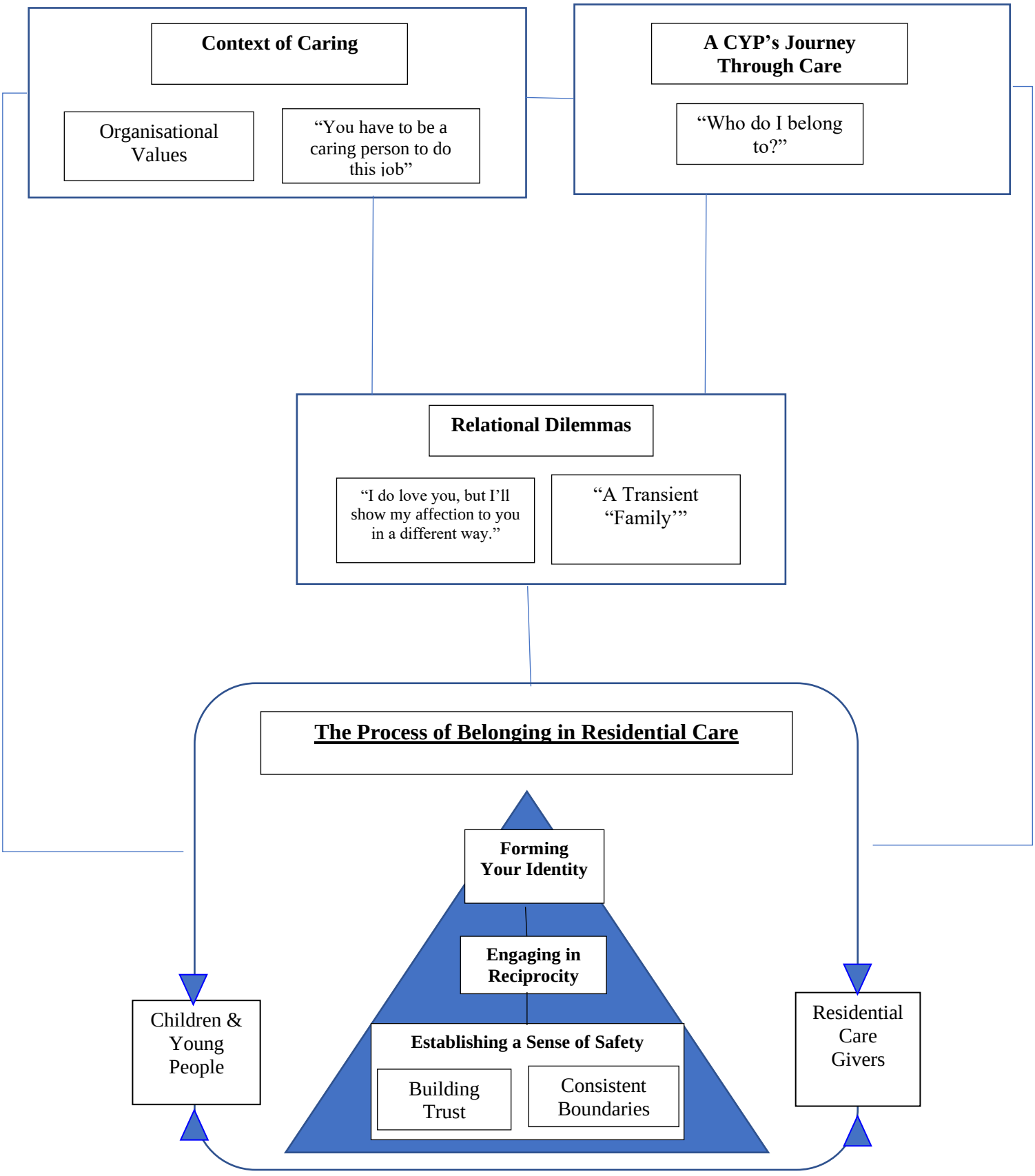

Figure 1. Diagrammatic summary of results.

The Process of Belonging in Residential Care

The process of developing a sense of belonging within RC was described as *"extremely important"* (Billy) and a *"fundamental"* (Daphne) part of RCGs' role. Across interviews, there was strong consensus on crucial ingredients of belonging. These were interpreted as three main stages of belonging. Stages were summarised in a triangle-shaped model, reflecting the emphasis placed on the processes in each stage. There was a sense that not everyone will reach each stage, with possibly fewer CYP accessing the identity formation stage. The triangle model also reflects the sequential nature of the stages of belonging, that each stage is built on the foundations of that which comes before it. One's sense of belonging does not necessarily develop on a linear trajectory, but can process upwards, or diminish downwards depending on factors influencing this process. The process of belonging is continuous, it is not a goal that can be completed, but a constant and active experience. The author felt that RCGs' perceptions of developing their own sense of belonging within their role, very much mirrored the experiences of the CYP they support. The three stages in the process of developing a sense of belonging are: establishing a sense of safety, engaging in reciprocity and forming your identity.

Establishing a Sense of Safety

All interviewees spoke about the importance of establishing a sense of safety as the key foundation of belonging for both themselves and CYP.

> Referring to CYP perspective…*If we're talking about a child feeling like they belong, I think a safe environment is the absolute epitome of where you want to begin that basis and you want to build that structure from…*(Bryan)

> Referring to RCG perspective…*I wouldn't actively think 'I'm safe here', but in the work I do, I suppose I am and that's what makes me feel sort of a sense of belonging…*(Billy)

Establishing a sense of safety comprised of two main processes, building trust and consistent boundaries.

Building Trust

Building trust was considered one mechanism for establishing a sense of safety for CYP and RCGs:

> Referring to CYP…*I think trust is the basic need for any child to feel safe…*(Bryan)

RCGs facilitate this process for the CYP through providing unconditional, warm, genuine, sensitive, responsive care, which consistently meets CYPs' physical and emotional needs:

> *…It's the genuine care; not the fake care, these kids can see through bullshit every day…it's providing meals every day and sitting down together as a family…*Billy

> *…It's staying with them, throughout the really ugly warts, of their behaviours, personalities, their beliefs, their own relationships…I will be with you through it, whatever it is today…and I will still be there when it is done…*Daphne

Building trust within RCG teams and for CYP can be facilitated through RCGs being open, honest and transparent:

> Referring to CYP...*The other thing is honesty…there are things that you can't talk about…I would rather say… 'I can't discuss it now but so soon as we can of course we will'…I know it is important to you and I am…telling you that it is important to me...all of that feeds into that sense of trusting that they belong...*Daphne

> Referring to RCGs...*My manager will say…I don't know. I'll find out for you…that gives the team high moral because I think...if she doesn't know then I don't feel bad for not knowing...*Carla

Being made to feel that others are interested in you, they notice you, want you and that you are important, also facilitates this process:

> Referring to CYP... *they've got photos of me and they are asking me about me...and they actually thought about me on their days off. And, like, little things like that. It goes noticed...*Dawne

> Referring to RCGs...*a simple thank you goes a massive way…you leave shift feeling like…I've worked hard, and it's got noticed. I can feel proud of myself...*Oscar

Using playfulness and humour were also key elements for building trust and belonging:

> Referring to CYP...*Play works massively for our children for them to start to feel safe and trusting...*Joan

> Referring to RCGs...*You need to have a laugh and a joke…that's where I began to really trust my team...if you feel secluded...work will be a lot harder*...Oscar

Consistent Boundaries

Alongside building trust, foundations of safety involve fair and consistent structures, routine and boundaries:

> Referring to CYP...*They need to trust you. They need boundaries…They need routine and structure, fun, play, acceptance*...Dan

> Referring to RCGs and CYP...*We all have our own jobs and we do have a routine and it is...very regimented sometimes but the kids buy into it and...love it*...Bryan

For CYP, adults upholding consistent boundaries and taking responsibility for repairing relationships builds relational safety:

> *...I've always found the people who maintain the boundaries as they should be are the ones who go on to have stronger relationships…because I think the children actually know that that person will keep them safe…and that's through maintaining those boundaries…I would say you are actually improving the relationship by working that way*...Billy

<u>Engaging in Reciprocity</u>

As safety increases CYP and RCGs take a more reciprocal role in their relationships and surroundings, building a further sense of belonging.

CYP start to transition from being a recipient of care to a more active agent:

> Referring to CYP...*When they first come in, they like I don't want to come down at dinner time...don't want to join in on activities. But when they feel like they belong more, they ask for things...they're having input at like mealtimes...*Dawne

Becoming increasingly more engaged and vulnerable with others, helps establish connection, leading to shared interests and emotions:

> Referring to RCG relationships...*First you talk about football...and a few weeks later your ex-wife and three kids. The more you start to share the more sense of belonging you get...*Oscar

> Referring to CYP...*they will want to engage and play with others...*Joan

> Referring to RCGs and CYP...*When they are low, you are and when you are good, they are good…you bounce off each other...*Carla

RCGs spoke about matching levels of reciprocity, while also trying to ensure they maintain their professional boundaries:

> Referring to CYP and RCG relationships...*When you ask them to invest in those relationships with you, you can't ask them to do that if you are not willing to do the same. But you measure yours out safely...*Daphne

This process also involves feeling one provides valued contributions; people want to hear you, respect what you say and where possible there is collective decision making and shared influence over surroundings:

> Referring to CYP...*Giving them a voice in as many things as they physically can…anything they can have a say in they need to...*Oscar

> Referring to other RCGs...*They take your input on board, and you think, oh, they actually need me…I feel I'm wanted by you and my opinions matters and I'm valued*....Dawne

> Referring to RCGs and CYP...*The team have got to feel valued for them to give 100% and for it to work for the children*...Dan

CYP's sense of responsibility for keeping themself safe starts to grow when they start to feel valued:

> ...*It is so much easier to do the right thing when you know you've got that responsibility of being a valued person…that's what we're providing to them, with the sense of belonging*...Dan

Engaging in reciprocity interlinks with and deepens the establishing sense of trust and safety:

> Referring to CYP...*They trust you to make tough decisions when they can't...I think that's where their sense of belonging really starts to flourish...*Bryan

> Referring to RCG relationships...*[to co-worker] I'll say..."time out?"... when they are in a really tricky situation...we as a team do not feel affronted by that...when you have an established team there is trust*...Daphne

RCGs also spoke about CYP starting to engage with the environment, wanting to establish somewhere that reflects you and you it.

> *After a while you feel this is your home now…so obviously we need to put in their footprint, their bedroom, make sure they have it how they want it…to make them feel at home*...Bryan

<u>Forming your Identity</u>

Building on establishing safety and engaging in reciprocity, belonging continues to develop through the process of forming one's identity.

One is free to be different and to be themselves while still fitting in and feeling a valued part of something shared with others. Others accepting and not judging you facilitates this:

> Referring to RCGs team...*It is not giving up your identity and who you are, but knowing that there has to be a compromise zone that you go into together*...Daphne

> Referring to RCGs approach to CYP...*our non-judgemental approach to allow them to be who they are and to establish a sense of belonging within the house, but still remaining their own personalities and their own likes and dislikes*...Dan

There is a shift in the way that CYP and RCGs start to feel about themselves and their sense of safety in the home and with others deepens:

> Referring to CYP...*I think the children being safe and secure and part of the home, they will be happy and they will achieve more – that's when they have a sense of belonging*...Oscar

> Referring to RCGs...*I'm part of a team...staff feel safe and happy in work...*Dan

With support from trusted others, reflective capacity expands for CYP and RCGs:

> Referring to CYP...*they start to think I am different but not less than others [children]…but those things are often way further down the road…they take a long time to achieve…the ability to reflect. But there are couple of kids who have got to that stage, and that is a value*...Daphne

There is a sense of empowerment for CYP and RCGs within and beyond the RCH. One can make decisions, set boundaries and goals, pursue interests, engage in education, express needs, build relationships and to look to the future:

> Referring to CYP...*The more they belong they'll...input into the conversation…actually stand up for themselves….it's nice to see them having a voice*...Dawne

Referring to CYP...*It's not just a paper exercise then…they gain more independent skills because they are working with you…behaviours in the home are changing and their relationships with the team improving even more...it gives them more of a deep-rooted sense of belonging within the home then...[belonging] improves everything for the child then, now and the future...*Joan

Referring to CYP & RCGs...*It's the end goal isn't it, to feel like you completely belong...that's when most people thrive...*Carla

Influencing Contextual Factors

Several factors which influence the process of developing a sense of belonging were discussed.

The Context of Caring

The organisational values in addition to what RCGs felt that they need to bring to their roles themselves were summarised as the context of care.

"You have to be a caring person to do this job"

RCGs spoke about how their personal values influence belonging. Several participants considered their role as a vocation or lifestyle choice rather than a job and discussed the importance of being a genuinely caring person as a means of facilitating CYP belonging:

...you have to be caring person to do this job...Oscar

...She is my key child when I am in work and when I'm not...Daphne

An openness and investment in developing reciprocal relationships with CYP and other RCGs was considered a crucial process involved in CYP and RCGs belonging:

> Referring to relationships with CYP...*You do get those staff...say "three o'clock halfway through the shift thank God"...I hate that attitude…If you think like that, and want to be in a job like that, this is not the place for you...you have to be invested or involved all the way...It is quite unique I think*....Daphne

> Referring to relationships with RCGs...*this job is utterly exhausting, even on the good days...you need to draw from it later on...these people do not need to be your best buddies...but you do need to be, at your own pace, open to investing in them and accepting the investment back, in a professional sense*...Daphne

RCGs also discussed needing to balance their dedication and commitment to the CYP and their role with maintaining their own resilience:

> ...*I had to ask for help and I was embarrassed to begin with*...Dan

Organisational Values

Participants outlined several factors within the context of the organisation which can help RCGs to feel supported, understood, and competent, subsequently influencing the process of belonging for CYP and RCGs.

Organisations providing training opportunities, specifically about the impact of trauma, can impact the process of belonging for CYP and RCGs. Without such training, team

disagreements can occur and RCGs can fail to understand CYP's perspectives, thus impacting on establishing safety, and belonging:

> *...training could be a barrier [to building belonging]...staff not having the right training to be able to...understand that child....their perception and...seeing the child for the child...not for the behaviours...*Billy

> *...you always have the characters...whose belief system roughly fits with yours...Then you get the one, and it is incredibly difficult to have that relationship with them...*Daphne

The importance of time to debrief after difficult experiences, providing an opportunity for a safe emotional release with co-workers to support relational repair with CYP was discussed:

> *...I had to hold someone that was biting, kicking...and immediately afterwards...I move to...supporting them to repair their relationship with me...the relationship is repaired, from their point of view. At no point, have I had the opportunity to say, he's bitten me, and he said this...you need that debrief... without that, how can you...think that person should or can or could go on work with that same child again? As a service it is irresponsible...*Daphne

Organisational structures which provide opportunities for reflection can help build RCGs' belonging by giving people the experience of being valued and building one's identity as an individually recognised member of the team:

> *...We have supervisions...which can be for good things...you've done well...and you feel, oh, I'm very important, people actually want me to stick around and they know that I can work well and...they want me to train the carers now, to be the way that I am...*Dawne

Receiving a compassionate response and support from the organisation following disclosure of personal and/or work-related concerns helps build safety and reciprocity between RCGs and the wider organisation and helped to maintain resilience within their role to continue to support CYP:

> *...I felt able to approach work and tell them I was struggling, and they were brilliant...I got that time off granted...and now, it is a hugely close bond...there is an awful lot I would do for this company...*Oscar

Providing opportunities for RCGs to start building relationships with their co-workers also positively influences the process of belonging for RCGs and CYP:

> *...At the end of the day, the company has given us the opportunity to make friends with our team, and we have and that's had a positive impact on the kids...*Joan

A CYP's Journey Through Care

"Who do I belong to?"

The journey that CYP take through relationships and the care system was considered an important influencing factor on the process of belonging in RC:

> *...their past experiences have a huge impact on the way they are and their belonging...*Oscar
>
> *...some people have moved 20/30 homes they must think I don't know who I belong to. My mother and father don't want me...my old foster-carer can't have me...why should I behave? I'm only going to get moved...*Dawne

The developmental, emotional and educational consequences of these experiences and the impact on belonging was also considered:

> *...They are…behind on education…or can't use a knife and fork…they don't know personal hygiene...when they are 14 years old, really they've got a mental age of like seven….it's trying to find out what best suits them and trying to meet the needs of the individual child to build belonging...*Billy

Relational Dilemmas

RCGs also spoke about two key 'relational dilemmas' which influence the process of belonging.

"I do love you, but I'll show my affection to you in a different way."

RCGs considered how to, and whether they should, show love and/or affection towards the CYP. How this influences CYP and RCG belonging was considered.

There were inconsistent policies and practices around physical affection. These varied between and within homes, with different rules for certain CYP and RCGs. Inconsistency in these boundaries could destabilise safety for RCGs and CYP:

*...We cwtch our young one on the sofa...*Billy

*...It's definitely different for male members of staff...*Carla

*...I can see why historically people are concerned about allegations...*Bryan

Current guidance did not appear to support the day-to-day complexities of RCG and CYP relationships, nor were they sufficient in supporting RCGs to facilitate belonging:

*...You have to look at the broader picture for these children instead of working within the very little very safe health and social care boundaries, like for the investment in relationships...*Dan

There was a dispute for some RCGs between the level of love and affection they felt CYP need to belong and thus what they wanted to provide, versus what they felt they should provide. This was an ongoing dilemma for RCGs:

*...for a child who be in residential care for 7-8 years, they may grow up their whole life without ever once being told, love you. I can't imagine what that must do to someone, that level of affection and how they feel could belong...*Daphne

*...they ask, do you love me? I'm like – you do, of course you do because you're living with them day in, day out and – but it's trying to word it in an appropriate way…I'm like, no, I do love you but I'll show my affection to you in a different way...*Dawne

*...for these children…there is a level of affection…emotions do develop but we have to base it in something other than true familial love because that is not appropriate here. But without it, children won't flourish either...*Billy

"A Transient 'Family'"

Participants considered the impact of the transient nature of RC on the process of belonging. More specifically, RCGs considered the impact of living as a 'family' in the context of perpetual change, uncertainty about placements, with the knowledge that eventually key RCG-CYP relationships will end.

*...The difficulty here of course is that they have a transient "family"...staff come in and some may stay forever...[some] may stay for two mins...how can we build that base and pull the rug out from underneath?...*Bryan

*...I will have been in that child's life for 6-7 years…But when [the CYP] has to leave, I will have no contact with him…Who else do we know in our lives that we have that much of an invested relationship with, and at the end it's bye, don't contact me…You don't say to your children when they leave home at 18, off you go see you never…I do think the stark reality that is nothing to do with that base that you have built everything on is difficult and not how it should be...*Daphne

However, others felt that the model of family within RC is helpfully flexible, allowing CYP to have they needs met depending on their individual circumstances:

> *...you can class us as your family and class this as your home, or you say it's where you're living right now...some kids still class their family home as their home...*Dawne

Some felt that despite the transient context, achieving a sense of belonging and the positive outcomes associated was still possible:

> *...I think the family sense of belonging we have...even the transient nature of the way that they live...I suppose...the benefits of that...they carry with them through their life outside of being in care...*Dan

Discussion

This study aimed to explore a sense of belonging in children's RC from the perspective of RCGs. A theory was developed, outlining the processes involved in developing a sense of belonging and the crucial factors which influence these. Processes involved in both CYP and RCGs developing a sense of belonging included: establishing a sense of safety, engaging in reciprocity and forming your identity. Crucial processes which influence these included: RCG and organisational values, CYP's journey through care and specific relational dilemmas regarding displays of love and affection and being a transient family.

Application of Findings to Current Literature Base

There was strong consensus across interviews regarding the importance of belonging and the crucial ingredients involved.

These findings were supported by other theoretical perspectives on belonging. For example, Strayhorn's (2012; 2019) comprehensive model of CYP's belonging at school, reflects many of the psychological, social, and systemic processes considered relevant for CYP and RCGs

in this study. For example, Strayhorn conceptualises the importance of "feeling cared about, accepted, respected and valued" (p. 3) for belonging. Additionally, Strayhorn (2008) and Tillery et al. (2013) also highlighted the important role of key adults in this process and how belonging can change depending on contextual circumstances (Johnson, Strayhorn and Parler, 2013). A study applying this model to CYP in foster care further supports the current results, highlighting additional barriers these CYP face regarding school belonging, including the impact of difficult past experiences and the anticipation of being moved schools (Johnson, Strayhorn and Parler, 2020).

In a recent meta-synthesis of CYP's perspectives on school belonging, Craggs and Kelly (2018) conceptualised belonging as "being free to be yourself in and through relationships with others" (p. 1421); echoing facets of belonging identified within the current study for CYP and RCGs. One noticeable distinction for CYP in school includes the description of others "accepting one's identity" (Cragg & Kelly, 2018, p. 1417), in comparison with the process of "forming your identity" outlined in the current study. Although overlapping, this difference suggests that forming identity and thus the process of belonging may be a more arduous process in RC. CLA may face additional challenges, such as intertwining reflections on experiences of trauma and experiences of being a CLA with their identity (Johnson, Strayhorn and Parler, 2013). RCGs must navigate supporting CYP with this process while also trying to form their own identities as professional carers, parents, friends, trusted allies and part of a team.

This study also supported the belonging hypothesis (Baumeister & Leary, 1995). For example, the importance of "frequent affectively pleasant interactions" (p. 1) was echoed in the importance of humour and playfulness for establishing safety in RC in the current study.

Additionally, concerns regarding the impact of the ‘transient ‘family’’ in RC critically considers the importance of “temporal stability in key relationships” asserted by the belongingness hypothesis.

Finally, this study supported research which highlights the crucial role of RCGs-CYP relationships in RC (Moore et al., 2017; Steels & Simpson, 2017). This study extended these findings by specifically considering the role of belonging and how relational processes interact with wider systemic influences in RC.

Comparing results of this study to related empirical work and similar theories supports the validity of the current findings. This study also weaves facets of belonging considered in multiple theories into one model. Additionally, this study includes unique hypotheses about the sequential (yet fluid) stages of belonging. This may help to improve the clinical application of belonging. Finally, this study extends the literature base by considering specificities of belonging within an under researched context and population (Gallagher & Green, 2012; Parry, Williams, Oldfield, 2021).

Mirrored Processes for RCGs and CYP

The majority of processes associated with developing belonging were mirrored between CYP and RCGs. Some differences were noted. RCGs spoke less about how consistent boundaries influence RCG belonging. However, this process did interlink with relational dilemmas considered. Additionally, only the CYP’s journey through care was considered an influencing factor for belonging. Exploring how RCGs’ own early life experiences and/or how their personal/professional journey into RC may impact on relational processes (such as belonging) requires further attention (Moriston, Taylor & Gervais, 2020).

The overlapping processes between RGCs and CYP possibly reflect wider generalisability of the core process of belonging. However, it is unknown whether these findings would generalise to processes outside of RC, or to other RCHs.

Interviewing RCGs about CYP's Sense of Belonging

This paper acknowledges that there are both positives and negatives involved in exploring CYP's sense of belonging from the perspective of RCGs.

Carers who spend frequent and prolonged time with CYP can provide a unique and valuable perspective on the experiences of CYP they care for; one which can help inform how policies, services and practitioners can best support RCGs to look after CYP (Luke & Banerjee, 2012; Tomkin, 2015).

In addition, RCGs may have an awareness of additional contextual factors that may influence a CYP's sense of belonging. For example, RCGs may be able to reflect how service processes or past traumas can impact on CYP's sense of belonging in a way which CYP may struggle to do at their current developmental stage (Pear & Fisher, 2005).

Parent or carer proxy measures of psychological functioning tend to focus on observations of CYP's behaviour (Moens et al., 2018). However, belonging is both an internal and connective experience (Halse, 2018). Therefore, the way that others understand and interpret others sense of belonging in relationships, shared environments and/or contexts form an important part of understanding belonging. Future research may benefit from examining the use of observer-perspective questioning in qualitative research.

However, belonging is also a complex, subjective and deeply personal experience (Halse, 2018). Therefore, it is possible that CYPs' perspectives on belonging may differ from RCGs'. For example, this study did not consider the impact of relationships with wider family and friends, something which CLA in previous research considered a key factor for their subjective well-being (Wood & Selwyn, 2017). A sister study exploring belonging from the perspectives of CYP in RC has been concurrent with this study. Further research comparing views of CYP with key stakeholders (such as family and/or previous carers) would be valuable.

Future Research

Measurement

There is currently no gold standard measure of belonging (Stewart et al., 2015; Allen et al., 2021). Mahar et al. (2014) reviewed measures of belonging, identifying a range of outcome measures for specific types of services. One commonality between these measures included measuring subjective connections to a *chosen* group or place. Such measures may be appropriate to assess RCG belonging, however, as CYP within RCHs often do not chose to be in care, this requires careful additional consideration. A recent review by Allen et al (2021) also highlighted limitations of individual outcomes measures of belonging. Allen et al (2021) discussed how one's motivation to belong, which may be influenced by repeated experiences of rejection, is rarely measured. In accordance, this study highlighted the influence of traumatic past experiences of CYP's sense of belonging. As such, the development of a specific measure of belonging for CYP in RC could be beneficial.

Developing a specific measure of belonging for RCGs could also be beneficial. RCGs have been shown to be uniquely susceptible to burnout and attrition (Seti, 2008; Colton & Robert, 2006; McMillian, 2020). Burnout affects emotional availability and has been associated with reduced work satisfaction, quality of care and is one of the largest contributors to staff turnover (Mor Barak et al., 2001; Adams et al., 2006; De Guzman et al., 2020; Parry et al., 2021) It is also an issue which has been further exacerbated by COVID-19 related challenges (Goldman et al., 2020). Measuring the relationship between RCG burnout and belonging could have therapeutic and economic impacts for RC (Parry et al., 2021; Colton and Robert, 2006).

Clinical Implications & Recommendations

Considering key influencing factors outlined within this study, a selection of clinical implications and recommendations are discussed.

RCG and Organisational Values

Considering 'the context of care' category, this study supports findings that motivations for working in RC frequently stem from a desire to do socially meaningful work (Moses, 2000). Research has also demonstrated the importance of shared values between organisations and RCG (McMillan, 2020). Mismatched individual and structural values can prevent people from doing what they believe is the right thing to do, and can lead to moral distress (Jameton, 1984). Moral distress engenders a sense of powerlessness, anxiety, no confidence and is linked with staff turnover (McMillan, 2020). This highlights that, even RCGs with the best intentions, need to be effectively supported by the organisation in which they work. In this study, participants outlined the importance of a range of organisational values and structures that can influence belonging for CYP and RCGs; these included opportunities for training, debrief, reflection, supervision, accessing external support, building relationships with co-

workers and receiving compassionate genuine caring responses to personal and work-related concerns. In addition, organisations utilising values-based interviewing processes, helping to consider individual and organisational fit, may be beneficial for facilitating belonging in RC (Hay & Kendrick, 2005; Patterson & Zibarras, 2018).

A CYP's Journey through Care

RCGs identified a CYP's journey through care as an influencing factor on processes of belonging. RCGs spoke about the impact of trauma on CYP's psychological, social, physical, behavioural, and academic development. Conflicting attributions of understanding CYP complex needs were also highlighted as point of contention between some RCGs. Considering how to facilitate belonging in the face of these challenges, this study suggests training for RCGs in trauma-informed models of care. Such models may include, Dyadic Developmental Psychotherapy (Hughes, 2011), Circle of Security (Marvin et al., 2002), The Restorative Parenting Recovery Programme (Robinson & Philpot, 2016) and Emotional Warmth Model of Professional Child-Care (EWMPC) (Cameron & Das, 2019).

A recent study considered the application of the EWMPC to 53 CYP in RC in England (Cameron & Das, 2019). This model focuses on empowering people with the most frequent contact with CYP, combining carer knowledge of CYP with training and frequent consultation from a psychologist. The aim is to support RCGs to understand and respond to CYP's needs effectively. Behavioural and affective measures showed significant improvement for CYP following this model's implementation. Interestingly, this model places 'achieving belonging' as a key outcome for CYP (Cameron & Magin, 2008; Cameron & Das, 2019). However, measurement specificity of this construct does not appear well defined.

Enhancing RCG competence can help prevent placement breakdowns, which could positively impact individual and service outcomes (Parry Williams & Oldfield, 2021). However, levels of training and experience of RCGs in Wales vary dramatically (CIW, 2019). A recent review highlighted the need for increased training of RCGs to improve the quality of care (Steels and Simpson, 2017). A review of Welsh RCHs published in 2019, stated that "Some providers recognised the value of implementing models of care where staff are trained and skilled; have an understanding of the impact of early life trauma" (p. 25). However, the only specific suggestions for training made by this report were for safeguarding and physical restraint. Therefore, there is a clear need for improved trauma-informed psychological understanding at individual and systemic levels of RC in Wales (Parry, Williams & Burbridge, 2020).

Relational Dilemmas

The specific relational dilemmas involved in belonging highlighted within this study, may offer additional insights into training, practice and policy development.

Brown et al., (2018) described RCGs as operating in a "culture of fear" (p. 657), echoing certain concerns highlighted in the present study regarding physical affection. Research has also support concerns raised by RCGs in this study that opposing views about "correct" care can result in inconsistency and instability in RC, both crucially associated with establishing belonging (McLean, 2013; Steels & Simpson, 2017).

Providing RCGs with opportunity for reflective practice sessions could offer a contained space in which dilemmas could be named, shared and discussed safely; helping to improve team relationships and professional practice (Thomas and Isobel, 2019). In addition, forums

such as team formulation may also provide improved understanding and management of care dilemmas at an individual and child-focused level (Milson & Phillips, 2015).

Additionally, providing RCGs with structured input opportunities into policy and legislation consultation, could help the development of guidance for staff which better support them with relational dilemmas. For example, RCGs could help inform guidelines and the wider care system on the complexity of issues such as 'the touch taboo' (Green, 2017), managing placement transitions and RCG-CYP contact after RC.

These recommendations rely on 'whole system approaches' (Parry Williams & Oldfield, 2021), requiring legislation, policies and organisations which value the crucial role of RCGs and invest in systems which empower them. However, this does not reflect how most RC organisations operate currently within the UK (The Children's Home (Wales) Regulations, 2002; Parry, Williams & Burbridge, 2020).

One pronounced barrier to the recommendations outlined above, is the lack of professional recognition and representation for RCG in the UK. In May 2021, Parry and colleagues published a Wellbeing Charter for RCG which takes a step towards establishing formal recognition and support for this crucial professional group. The charter concluded that "whilst there is often an organisational commitment to create an environment of belongingness for the children, there is also an organisational and statutory need for belongingness within the profession" (Parry, Williams & Oldfield, 2021, p. 10). This study supports these conclusions, the implementation of this charter and provides additional theoretical, psychological, social and systemic considerations as to why and how it should be operationalised.

Limitations

This study has several limitations. All participants defined themselves as White/Caucasian. Additionally, all RCHs were in Wales. This may limit the generalisability of results to people of other races, ethnicities or cultural groups. Research has outlined the important connection between language and belonging within Welsh (Selleck, 2018) and global contexts (Livingstone et al., 2009; Lebreton, 2011). However, the current study did not collect data on participants' preferred language nor were thoughts on language and belonging explicitly explored.

Results may also be limited by sample recruitment biases. RCGs who volunteered to take part in a study about belonging may be somewhat more psychological minded and/or passionate about these concepts and their role. Thus, these results may only reflect views and processes relevant to specific RCGs.

The process of theoretical sampling led to the inclusion of participants who had more senior roles within homes. Holding increased responsibility in a home may be conducive to a greater sense of belonging and higher levels of social desirability bias.

The amalgamation of the RCG and CYP's sense of belonging into one theory may be considered a limitation of this study. A key component of GT methodology is to ensure that the researcher is not attempting to force data into a particular hypothesis or preconceived idea, but instead to continuously reflect on what the data is saying (Urquhart, 2012). The suitability of combining RCGs and CYP experiences of belonging into one theory was reflected on through data collection and synthesis. However, the methodology and quality assurance processes outlined above helped the researchers to feel confident that this model

reflected a true interpretation of the data. Future research may wish to compare this theory to data recorded from RCGs solely interviewed about either their own or CYP's sense of belonging.

Finally, this research was conducted during the COVID-19 pandemic and the Black Lives Matter movement, psychological and social experiences which have bought belonging to the forefront of our nation's attention (Allen et al., 2021). Participants were asked to think about the impact of COVID-19 on belonging in RC, however there is possibility that this, and other social influences, may have impacted results.

Conclusion

This study explored a sense belonging in children's RC from the perspective of RCGs. This led to the development of a theory concerning the processes involved in developing belonging in RC and the key factors which influence these processes. This theory expands current literature from a theoretical perspective, further exploring the construct of belonging in under-researched contexts and populations. Additionally, this theory hopes to influence future research and care practices by highlighting the crucial role that both belonging and RCGs play in CYP's experiences within RC and providing practical ideas about how RCG and CYP belonging can be facilitated at micro to macro levels of the RC system.

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Appendices

Appendix 1 - Journal Author Guidelines Paper 1

For the purposes of thesis submission, this paper has been prepared to the standards set by the South Wales Doctorate in Clinical Psychology guidelines of 8000 words. This word limit does not include tables, figures, references or appendices. Where possible, chosen journal guidelines have also been followed.

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ICMJE, Defining the Role of Authors and Contributors,

Transparency in authors' contributions and responsibilities to promote integrity in scientific publication, McNutt at all, PNAS February 27, 2018

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A Graduate Student's Guide to Determining Authorship Credit and Authorship Order, APA Science Student Council 2006

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Antibody: Luciferase antibody DSHB Cat# LUC-3, RRID:AB_2722109

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Software: ImageJ Version 1.2.4 RRID:SCR_003070

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Summary of requirements

The above should be summarized in a statement and placed in a 'Declarations' section before the reference list under a heading of 'Ethics approval'.

Examples of statements to be used when ethics approval has been obtained:

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• This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee of University B (Date.../No. ...).

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• The questionnaire and methodology for this study was approved by the Human Research Ethics committee of the University of D (Ethics approval number: ...).

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• This research study was conducted retrospectively from data obtained for clinical purposes. We consulted extensively with the IRB of XYZ who determined that our study did not need ethical approval. An IRB official waiver of ethical approval was granted from the IRB of XYZ.

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Summary of requirements

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Please see the various examples of wording below and revise/customize the sample statements according to your own needs.

Sample statements for "Consent to participate":

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Informed consent was obtained from legal guardians.

Written informed consent was obtained from the parents.

Verbal informed consent was obtained prior to the interview.

Sample statements for "Consent to publish":

The authors affirm that human research participants provided informed consent for publication of the images in Figure(s) 1a, 1b and 1c.

The participant has consented to the submission of the case report to the journal.

Patients signed informed consent regarding publishing their data and photographs.

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Appendix 2 – Paper 1 Abbreviations

Abbreviations in order of first use throughout the review.

Abbreviation	Full Term
SM	Sexual minority
NSSI	Non-suicidal self-injury
LGB	Lesbian, gay, bisexual
LGBTQI+	Lesbian, gay, bisexual, transgender, questioning/queer and intersex
IPTS	Interpersonal Theory of Suicide
SI	Suicidal ideation
TB	Thwarted belonging
PB	Perceived burdensomeness
AC	Acquired Capacity
SA	Suicide attempt
SO	Sexual orientation
GI	Gender identity
SAB	Sex assigned at birth
GM	Gender minority
SGM	Sexual and gender minority
MST	Minority Stress Theory
SP	Suicide proneness

Appendix 3 - Quality Assessment Table

Intro	Taylor et al., 2020	Plöderl et al., 2014	Cramer et al., 2015	Cramer et al., 2014	Silva et al., 2015	Pate & Anestis, 2019	Wood-ward et al., 2014	Wolford-Clevenger et al., 2020	Baams et al., 2015	Muehlen-kamp et al., 2015	Riley & McLaren, 2019	Kim & Yang, 2014	Hill & Pettit, 2012	Chu et al., 2018	Fulginiti et al., 2020	Velkoff et al., 2015
1 Were the aims/objectives of the study clear?	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Methods																
2 Was the study design appropriate for the stated aim(s)?	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
3 Was the sample size justified?	✗	✗	✗	✗	✔	✗	✔	✗	✗	✗	✗	✗	✗	✔	✔	✔
4 Was the target/reference population clearly defined? (Is it clear who the research was about?)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
5 Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
6 Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔

7 Were measures undertaken to address and categorise non-responders?	✗	✔	✗	✗	✔	✗	✗	✗	✗	✗	✗	✗	✔	✗	✗	✗
8 Were the risk factor and outcome variables measured appropriate to the aims of the study?	✔	✔	✔	✔	✔	✗	✔	✔	✔	✔	✔	✔	✔	✗	✔	✗
9. Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialled, piloted or published previously?	✔	✔	✔	✗	✔	✔	✔	✔	✔	✗	✔	✔	✔	✔	✔	✗
10. Is it clear what was used to determined statistical significance and/or precision estimates? (e.g. p-values, confidence intervals)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
11. Were the methods (including statistical methods) sufficiently described to enable them to be repeated?	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
12. Were the basic data adequately described?	✗	✔	✗	✗	✔	✔	✔	✗	✔	✔	✔	✔	✔	✔	✔	✔

13. Does the response rate raise concerns about non-response bias?	✔	✔	DK	**DK**	✔	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK
14. If appropriate, was information about non-responders described?	✗	✔	✗	✗	✔	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
15. Were the results internally consistent?	✗	✔	DK	**DK**	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
16. Were the results presented for all the analyses described in the methods?	✗	✗	✔	✔	✔	✔	✗	✔	✔	✔	✔	✔	✔	✔	✔	✔
Discussion																
17. Were the authors' discussions and conclusions justified by the results?	✗	✔	✔	✔	✔	✔	✔	✔	✗	✔	✔	✔	✔	✔	✔	✔
18. Were the limitations of the study discussed?	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Other																
19. Were there any funding sources or conflicts of interest that may affect the authors' interpretation of the results?	DK	DK	DK	DK	DK	DK	DK	DK	DK	✗	DK	DK	DK	✔	DK	DK
20. Was ethical approval or consent of participants attained?	✔	DK	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	**DK**	**DK**	✔	✔

Appendix 4 – Available Effect Sizes

Available and meaningful effect sizes extracted from studies reviewed.

Appendix 4.1

Available effect sizes (Pearson's *r* and Spearman's r_s correlations) for bivariate correlations between perceived burdensomeness (PB) and suicidal ideation (SI), thwarted belonging (TB) and suicidal ideation, acquired capacity (AC) and suicidal ideation, perceived burdensomeness and suicide attempts (SA), thwarted belonging, suicide attempts and acquired capacity and suicide attempts, perceived burdensomeness and hopelessness, thwarted belonging and hopelessness and suicidal ideation and hopelessness for LGB samples.

First Author Year	PB – SI	TB – SI	AC – SI	PB – SA	TB – SA	PB – H	TB – H	H - SI
Plöderl 2014	r_s = .42	r_s = .43	r_s = .17					
Cramer 2015	.53	-.26						
Cramer 2014	As above	As above	**ns**	.26	**ns**			
Silva 2015	.727	.554		.384	.359			
Pate 2019	.720	.483	.081					
Woodward 2014	.671	.444						
Hill 2012	.56	.42						
Kim 2014	β = .60	**ns**				β = .33	β = .45	**ns**
Wolford-Clevenger 2020	.55	.45						
Baams 2015	.57	.34						
Riley 2019		.49						
Chu 2018	.60	.48						
Muehlenkamp 2015	.38	**ns**	.45					
Fulginiti 2020	.396	.225		.284	.126			

NB. Grey shaded cells symbolise untested relationships.

Guide for interpretation for Spearman's r_s correlation as effect size: very weak = 00 - .19, weak = .20 - .39, moderate = .40 -.59, strong = .60 - .79, very strong = .80 - 1.0.

Guide for interpretation of Pearson's r correlation as effect size: small = .1, medium = .5, large = .3.

Guide for interpretation of beta (β) as effect size: weak = <0.2, moderate = 0.2 - 0.50, strong effect = >0.5.

Appendix 4.2

Available effect sizes (Cohen's *d, partial eta squared & Cramer's V)* for comparison between samples identifying as a sexual minority and as heterosexual.

First Author Year	**PB**	**TB**	**SI**	**AC**	**SA**	**NSSI**
Pate 2020	Partial η^2 = .016	Partial η^2 = < .001 **ns**	Partial η^2 = 0.18	Partial η^2 = < .001 **ns**		
Hill 2012	*d* = 0.51	*d* = 0.28 **ns**	*d* = 0.82			
Silva 2015	Partial η^2 = .07		*r* = .27		V = .36	V = .29
Wolford-Clevenger 2020	*d* = 1.73	*d* = 1.84	*d* = 0.72			

NB. Grey shaded cells symbolise untested relationships.

Guide for interpretation of Cohen's d as effect size: small = .2, medium = .5, large = .8.

Guide for interpretation of (partial) eta squared (η^2) as effect size: small = .01, medium = .06, large = .14.

Guide for interpretation of Pearson's r correlation as effect size: small = .1, medium = .5, large = .3.

Guide for interpretation of Cramér's V as effect size: weak = .05-.10, moderate = .10 - .15, strong = > .15.

Appendix 4.3

Available effect sizes for comparisons between SM groups. Only significant comparisons with available effect sizes noted.

First Author Year	Significant Comparison Conducted	Effect Sizes For:		
		PB	**TB**	**SI**
Silva 2015	Bisexual sample compared with Gay or Lesbian sample (SM measured on dimensional scale)	β = -.56		β = -.56
Wolford-Clevenger 2020	Bisexual and Gay or Lesbian sample comparison	*d* = .70	*d* = .72	

NB. Grey shaded cells symbolise untested relationships.

Guide for interpretation of beta (β) *as effect size: weak = <0.2, moderate = 0.2 - 0.50, strong effect = >0.5.*

Guide for interpretation of Cohen's d as effect size: small = .2, medium = .5, large = .8.

Appendix 4.4

Additional available and meaningful effect sizes.

First Author Year	Test conducted	Variables considered	Effect Size
Wolford-Clevenger 2020	Relationship between PB and SI when controlling for depression	**PB – SI**	β = .38
		TB - SI	**ns**
Pate 2020	Interaction between PB and TB and association with SI	**PB x TB - SI**	R^2 = .510 (R^2 change .017)
Plöderl 2014	Comparison between two SM samples, those who had previously attempted suicide and those who had not	**PB**	*d* = 0.40
		TB	*d* = 0.54
		AC	*d* = 0.45

NB. Grey shaded cells symbolise untested relationships.

Guide for interpretation of beta (β) as effect size: weak = <0.2, moderate = 0.2 - 0.50, strong effect = >0.5

Guide for interpretation of R^2: .small = .02, medium = .13, large = .26

Guide for interpretation of Cohen's d as effect size: small = .2, medium = .5, large = .8.

Appendix 5 - Journal Author Guidelines Paper 2

For the purposes of thesis submission, this paper has been prepared to the standards set by the South Wales Doctorate in Clinical Psychology guidelines of 8000 words. This word limit does not include tables, figures, references or appendices. Where possible, chosen journal guidelines have also been followed.

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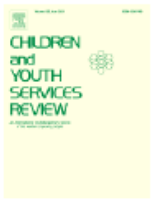

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Figure captions
Ensure that each illustration has a caption. A caption should comprise a brief title (not on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.
Tables

Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules and shading in table cells.
References
Citation in text
Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.
Web references
As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.
Data references
This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, version (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. The [dataset] identifier will not appear in your published article.
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Text: Citations in the text should follow the referencing style used by the American Psychological Association. You are referred to the Publication Manual of the American Psychological Association, Seventh Edition, ISBN 978-1-4338-3215-4, copies of which may be *ordered online*.
List: references should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters 'a', 'b', 'c', etc., placed after the year of publication.

Examples:
Reference to a journal publication:
Van der Geer, J., Hanraads, J. A. J., & Lupton, R. A. (2010). The art of writing a scientific article. Journal of Scientific Communications, 163, 51–59.
https://doi.org/10.1016/j.sc.2010.00372.
Reference to a journal publication with an article number:
Van der Geer, J., Hanraads, J. A. J., & Lupton, R. A. (2018). The art of writing a scientific article. Heliyon, 19, Article e00205. https://doi.org/10.1016/j.heliyon.2018.e00205.
Reference to a book:
Strunk, W., Jr., & White, E. B. (2000). The elements of style (4th ed.). Longman (Chapter 4).
Reference to a chapter in an edited book:
Mettam, G. R., & Adams, L. B. (2009). How to prepare an electronic version of your article. In B. S. Jones, & R. Z. Smith (Eds.), Introduction to the electronic age (pp. 281–304). E-Publishing Inc.
Reference to a website:
Powertech Systems. (2015). Lithium-ion vs lead-acid cost analysis. Retrieved from http://www.powertechsystems.eu/home/tech-corner/lithium-ion-vs-lead-acid-cost-analysis/. Accessed January 6, 2016
Reference to a dataset:
[dataset] Oguro, M., Imahiro, S., Saito, S., & Nakashizuka, T. (2015). Mortality data for Japanese oak wilt disease and surrounding forest compositions. Mendeley Data, v1. https://doi.org/10.17632/xwj98nb39r.1.
Reference to a conference paper or poster presentation:
Engle, E.K., Cash, T.F., & Jarry, J.L. (2009, November). The Body Image Behaviours Inventory-3: Development and validation of the Body Image Compulsive Actions and Body Image Avoidance Scales. Poster session presentation at the meeting of the Association for Behavioural and Cognitive Therapies, New York, NY.
Reference to software:
Coon, E., Berndt, M., Jan, A., Svyatsky, D., Atchley, A., Kikinzon, E., Harp, D., Manzini, G.,

Shelef, E., Lipnikov, K., Garimella, R., Xu, C., Moulton, D., Karra, S., Painter, S., Jafarov, E., & Molins, S. (2020, March 25). Advanced Terrestrial Simulator (ATS) v0.88 (Version 0.88). Zenodo. https://doi.org/10.5281/zenodo.3727209.
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To foster transparency, we encourage you to state the availability of your data in your submission. This may be a requirement of your funding body or institution. If your data is unavailable to access or unsuitable to post, you will have the opportunity to indicate why during the submission process, for example by stating that the research data is confidential. The statement will appear with your published article on ScienceDirect. For more information, visit the *Data Statement page*.

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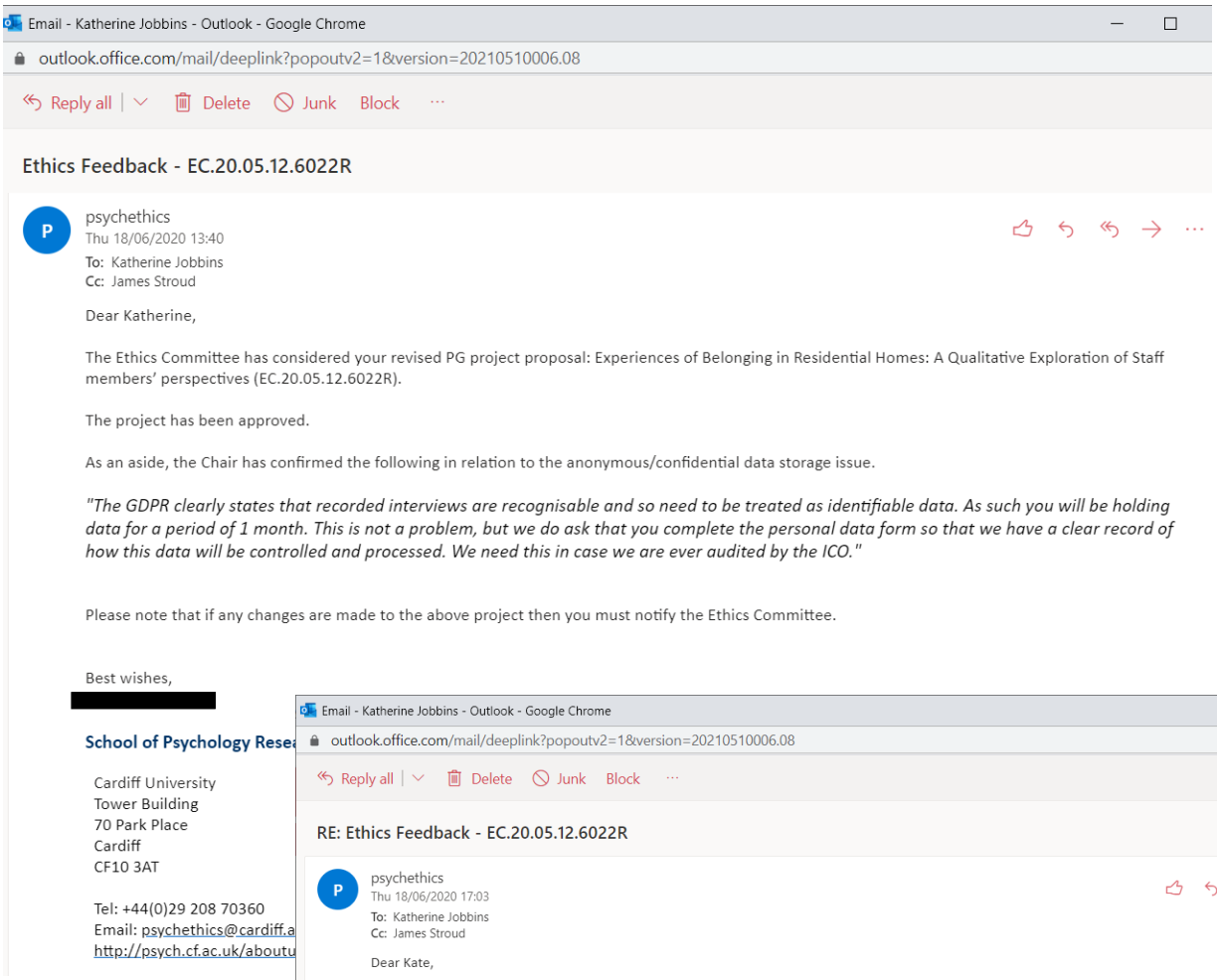
Appendix 6 - Ethical Consent from University



Email - Katherine Jobbins - Outlook - Google Chrome

outlook.office.com/mail/deeplink?popoutv2=1&version=20210510006.08

Reply all | Delete | Junk | Block | ...

Ethics Feedback - EC.20.05.12.6022R

psychethics
Thu 18/06/2020 13:40
To: Katherine Jobbins
Cc: James Stroud

Dear Katherine,

The Ethics Committee has considered your revised PG project proposal: Experiences of Belonging in Residential Homes: A Qualitative Exploration of Staff members' perspectives (EC.20.05.12.6022R).

The project has been approved.

As an aside, the Chair has confirmed the following in relation to the anonymous/confidential data storage issue.

"The GDPR clearly states that recorded interviews are recognisable and so need to be treated as identifiable data. As such you will be holding data for a period of 1 month. This is not a problem, but we do ask that you complete the personal data form so that we have a clear record of how this data will be controlled and processed. We need this in case we are ever audited by the ICO."

Please note that if any changes are made to the above project then you must notify the Ethics Committee.

Best wishes,

[redacted]

School of Psychology Resea

Cardiff University
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CF10 3AT

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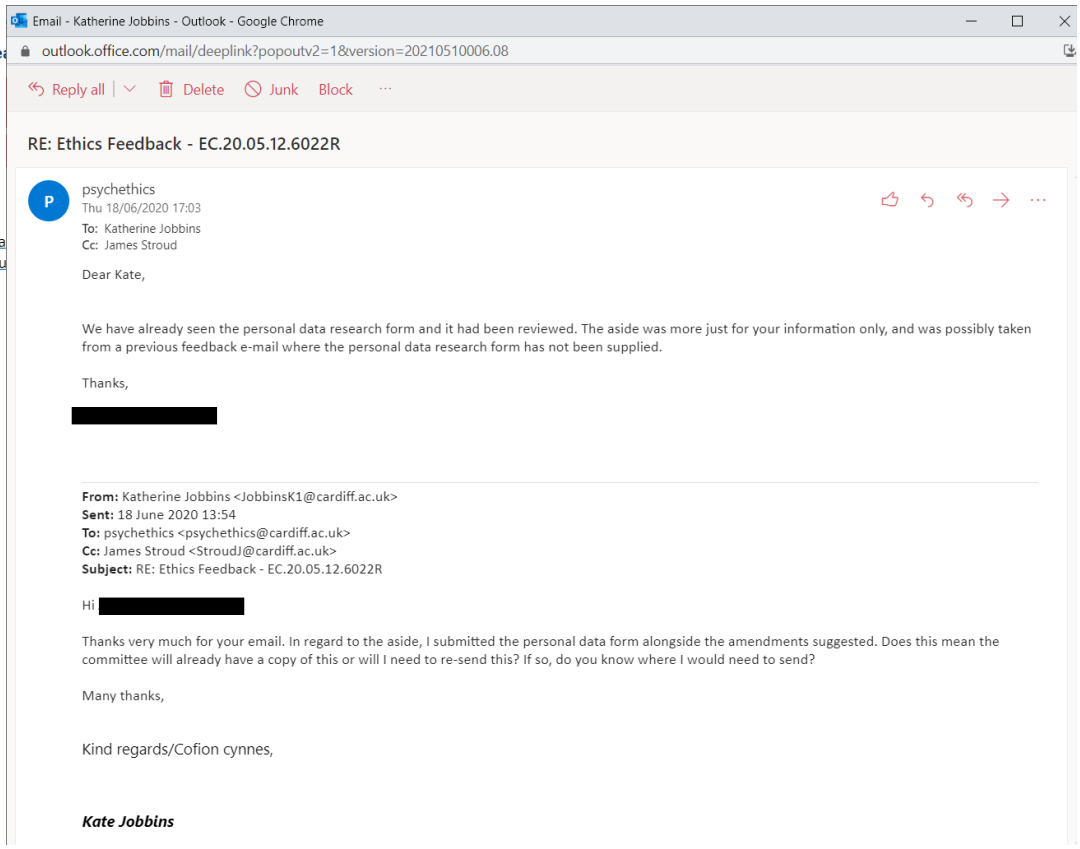
Email: psychethics@cardiff.a
http://psych.cf.ac.uk/aboutu



Email - Katherine Jobbins - Outlook - Google Chrome

outlook.office.com/mail/deeplink?popoutv2=1&version=20210510006.08

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RE: Ethics Feedback - EC.20.05.12.6022R

psychethics
Thu 18/06/2020 17:03
To: Katherine Jobbins
Cc: James Stroud

Dear Kate,

We have already seen the personal data research form and it had been reviewed. The aside was more just for your information only, and was possibly taken from a previous feedback e-mail where the personal data research form has not been supplied.

Thanks,

[redacted]

From: Katherine Jobbins <JobbinsK1@cardiff.ac.uk>
Sent: 18 June 2020 13:54
To: psychethics <psychethics@cardiff.ac.uk>
Cc: James Stroud <StroudJ@cardiff.ac.uk>
Subject: RE: Ethics Feedback - EC.20.05.12.6022R

Hi [redacted]

Thanks very much for your email. In regard to the aside, I submitted the personal data form alongside the amendments suggested. Does this mean the committee will already have a copy of this or will I need to re-send this? If so, do you know where I would need to send?

Many thanks,

Kind regards/Cofion cynnes,

Kate Jobbins

Appendix 7 – Participant Consent Form

School of Psychology
Ysgol Seicoleg

South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol

Cardiff University
Tower Building
70 Park Place
Cardiff CF10 3AT
Wales UK
www.psych.cf.ac.uk

Prifysgol Caerdydd
Adeilad y Tŵr
70 Plas y Parc
Caerdydd CF10 3AT
Cymru Y Deyrnas Unedig

Title of Study: "Experiences of Belonging in Residential Homes: A Qualitative Exploration of Staff members' perspectives"

Principal investigator: Kate Jobbins, Trainee Clinical Psychologist.
Supervisors: Dr James Stroud, Clinical Psychologist.

Please read each of the following statements carefully. If you agree with the statement, please tick ✔ the box to the right of each statement.	**Please ✔ and initial if you are in agreement**
I understand that my participation in this project will involve answering some questions about my role, my experiences in work and the young people I help to support and that this will last approximately 1-2 hours.	
I have read and understood the information sheet and have been able to ask any questions I have.	
I understand that participation in this study is entirely voluntary and that I can withdraw from the study at any time without giving a reason. I can also choose not to answer particular questions if I so wish without giving a reason. This will not affect my job.	
I understand that I am free to ask any questions at any time. I can discuss any concerns with the principle investigators, supervisors tor he University Ethics Committee.	
I understand that the information provided by me will be kept securely and anonymously.	
I understand that this information will be held no longer than necessary for the purposes of this research.	
I understand that the interview will be audio recorded on a secure Dictaphone and transcribed (typed-up). At this point, the audio recording will be permanently deleted. The transcript will be held anonymously, using made-up names so that it is impossible to trace this information back to me individually.	
I understand that any quotes used from my interview included in the research will be kept anonymous with my name and any other personal information changed where necessary to make sure this is achieved.	
I understand that the researcher will share information with their research supervisor and appropriate staff within the home if they are worried that I am at risk of harming myself or if someone else is in danger.	
I understand that if I feel distressed during the study that I discuss avenues for gaining extra support with the researcher.	
I also understand that at the end of the study I will be provided with additional information and feedback about the purpose of the study.	
I agree to take part in the above study.	

I, ……..consent to participate in the study conducted by Kate Jobbins School of Psychology, Cardiff University with the supervision of Dr James Stroud.

Signed: Date:

Appendix 8 - Information Form

NHS WALES GIG CYMRU

School of Psychology
Ysgol Seicoleg

South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

Cardiff University
Tower Building
70 Park Place
Cardiff CF10 3AT
Wales UK
www.psych.cf.ac.uk
Prifysgol Caerdydd
Adeilad y Tŵr
70 Plas y Parc
Caerdydd CF10 3AT
Cymru Y Deyrnas Unedig

22nd of May 2020

To whom it may concern,

We are Postgraduate Clinical Psychology Doctoral students in the School of Psychology at Cardiff University. As part of our professional qualification, we are carrying out a study exploring experiences of belonging in residential care homes for looked after children (LAC). We are writing to enquire whether you would be willing to allow us to speak with both children, young people and the staff members within your organisation.

We have briefly outlined further details regarding this research below.

What is the project?

The project titles are

- "Experiences of Belonging in Residential Homes: A Qualitative Exploration of Staff members'
- "What does the sense of belonging mean to children who are looked after in residential care? A qualitative exploration"

These projects aim to explore how children, young people and staff members within residential care homes experience a sense of belonging. We hope to interview children, young people and staff members in order to gain insight into their perspectives. This project is being supervised by Dr James Stroud, Clinical Psychologist.

Why are we doing this project?

A sense of belonging has been described as "the most important psychological resource for overall human well-being" (Baumeister & Leary, 1995, p.497). Research has supported these bold claims, demonstrating the bio-psycho-social implications afforded by a positive experience of belongingness in adolescence. This includes improved educational and learning outcomes, lower levels of depression, anxiety, challenging and high-risk behaviours (including suicidality) and higher emotional well-being and self-esteem (Anderman, 2002; Buhrmester, 1990; Joiner, 2005; Van Order et al., 2012).

At present, research exploring belonginess within the context of residential care for young people is in its infancy. By further developing an understanding of

belongingness within this context, we hope to help inform research and clinical practice by amplifying the voice of looked after children, and staff members who support them, in order to help maximise their well-being.

What we ask of you

It would be brilliant if you felt that your service felt they would be able to take part. If so, we can send you further information about the study to provide the children, young people and staff members within your organisation so that they may decide whether they would like to take part. It will be important that staff members, or the Researchers read through the sheet to the child or young person to ensure that they understand the content and are able to give informed consent to take part. The Researchers are also more than happy to present the research at a home/organisation meeting.

If people are interested and are suitable for the project, we would need to meet with children, young people, and staff members individually in order to undertake interviews. These interviews involve asking people to reflect on their experiences of belonging, both personally and (for staff members) professionally. We estimate that the interviews will take between 1-2 hours, but can be spaced over a few interviews. Anonymity of all participants and services involved in the study will be strictly upheld, subject to Cardiff University's Ethics Procedure.

We will of course provide you with further details regarding research procedures should you be interested in the project.

Many thanks in advance for your consideration of this project. Please let us know if you require further information, or would like to discuss further.

We very much look forward to hearing from you.

Regards,

Kate Jobbins, & James Stroud

Kate Jobbins & Rachael Hitchiner
Trainee Clinical Psychologists

South Wales Doctoral Programme
in Clinical Psychology

School of Psychology,
Cardiff University,
Tower Building,
70 Park Place
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Telephone: 02920 876804
Email: jobbinsk1@cardiff.ac.uk
Email: HitchinerRA1@cardiff.ac.uk

Dr James Stroud
Clinical Psychologist

Senior Clinical Tutor
South Wales Doctoral Programme
in Clinical Psychology

School of Psychology,
Cardiff University,
Tower Building,
70 Park Place
Cardiff, CF10 3AT.
Telephone: 02920 876804
Email: stroudj@cardiff.ac.uk

Appendix 9 - Participant Debrief Form

NHS WALES GIG CYMRU
School of Psychology
Ysgol Seicoleg
South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol
CARDIFF UNIVERSITY
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www.psych.cf.ac.uk
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70 Plas y Parc
Caerdydd CF10 3AT
Cymru Y Deyrnas Unedig

Debrief Form

Title of Study: **"Experiences of Belonging in Residential Homes: A Qualitative Exploration of Staff Members' Perspectives"**

Thank you for taking part in this study.

The information that you have provided in your interview will be analysed along with the other interviews collected for this research. We hope that the results of this study will help us to improve our understanding of who people experience belonging in a residential care home setting. This information could be useful for future research as well as for positive developments in practice.

If the interview has caused you any distress, at the end of this letter we have included information regarding organisations you may wish to contact if you feel are you in need of further support. We have also included our contact details if you have any further concerns or questions.

All of the information that you have given us will be stored and reported on in a way which means that it cannot be traced back to you.

- The consent form is the only form that will have your name on it. This form will be scanned into the computer and kept within a password protected document that will be separate from all of your interview and your 'participant information data' form. Only the researcher and her supervisor will have access to this form.
- Your interview will remain stored on a secure Dictaphone until it is transcribed (typed-up). Your interview will be transcribed within one month of today's date at which time, the audio recording will be permanently deleted. You can ask for your interview to be withdrawn from the research up until the audio file has been deleted.
- The transcripts will be stored in password protected computer files. The transcripts will be held anonymously, using made-up names, so that it is impossible to trace this information back to anyone individually.
- Any quotes used from your interview which are included in the write-up of the research will be anonymous. Your name and any other personal information will be changed to make sure this is achieved.

If you wish to have information about the results of the study, please let Kate Jobbins know and she will send you a summary of the results as soon as they are available. There will also be a feedback session organised to give all staff members the opportunity to discuss the anonymised results. All staff members will be invited to this session, even if they did not take part in the study.
If you have any further questions, please feel free to contact us.

Researcher:
Kate Jobbins
Trainee Clinical Psychologist, Postgraduate student
jobbinsk1@cardiff.ac.uk
02920 876804

Academic supervisor:
Dr James Stroud
Clinical Psychologist
StroudJ@cardiff.ac.uk
02920 876804

South Wales Doctoral Programme in Clinical Psychology, 11th Floor, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT

If you have any concerns or complaints about the research, you can contact the School of Psychology Research Ethics Committee in writing at:
Secretary to the Research Ethics Committee School of Psychology, Tower Building 70 Park Place, Cardiff, CF10 3AT psychethics@cardiff.ac.uk

Places to go for further support

- Within your organisation, you should have access to a line manager or appointed staff member with whom you can talk with if you are worried about something or someone within your workplace.
- C.A.L.L is a mental health help line for Wales offering community advice and a listening line. Free phone 0800 132 737 or text help to 81066 to contact. They are available 24 hours a day, 7 days a week, 365 days a year.
- Samaritans are a charity offering a space for people to talk openly about whatever they may be struggling with. You can freephone 116 123 or email jo@samaritans.org for support. They are available 24 hours a day, 7 days a week, 365 days a year. There is also a Welsh language line: 0808 164 0123, open every day from 7pm-11pm.
- You can also contact your General Practitioner (GP) for help and support.
- Should you feel that you require urgent input outside working hours, that cannot be met by the above means; you should attend A&E so that your needs can be assessed.

Appendix 10 - Interview Schedule

Alterations to interview schedule made during data collection and analyses are highlighted in yellow.

1. **What does belonging mean to you?**

2. **When you think about belonging, what comes to mind?**
    - Can you think of a specific example in life when you felt like you did/or didn't belong?
    - What words come to mind?
    - What images?

3. **In a situation in which you felt you belonged, what made you feel like that?**
    - What were you thinking?
    - What were you feeling?
    - How did you act?
    - How did others act towards you?
    - How would you know if someone else belonged to a group or place?
        - What would they be thinking?
        - How would they be feeling?
        - How would they act?
        - How would you know if someone didn't belong to a group?

Staffs' perspectives on a sense of belonging in the Child and Young Person (CYP) they help to support

4. **Do you think it is important for the young people to feel a sense of belonging?**
    - Why?
    - What would be the difference if they felt a sense of belonging?
    - What would be the difference if they did not feel a sense of belonging?

5. **How would you know if a child felt they belonged in care/in the home?**
    - How would they act?
    - What would they look like?
    - What images come to mind?
    - How might they be feeling?
    - How might they make you feel?
    - How long do you think it takes for a YP to feel they belong?
    - What are the characteristics/behaviours of a CYP that does **not** belong?

6. **What do you think helps young people gain a sense of belonging?**

- Who, what, when, how?
- Inside the home and outside of the home?
- Has this been affected by COVID-19?

7. **What are the barriers or obstacles that prevent young people from feeling as if they belong?**
   - Who, when, what, why, how?
   - Inside the home and outside of the home?
   - Has this been affected by CoVid-19?
   - How do you overcome these barriers?
   - How do you support CYP/RCGs to overcome these barriers?

8. **What do you think the impact is of having a sense of belonging?**
   - The way CYP feel about themselves?
   - The way they feel generally – mood, anxiety?
   - How they feel towards other people?
   - How might they act differently?
   - How might others act towards them?
   - How do you think they perceive you?
   - What is the impact on staff when CYP have a sense of belonging?

9. **Are there any downsides or challenges associated with belonging?**
   - What happens when there are changes in the home (e.g. staff changes or other young people coming/going)?
   - What happens when CYP leave the home?

10. **How do you help young people feel like they belong?**
    - Do you feel you are able to do this as part of your role?
    - Have there been key moments that stand out where you've helped someone feel like they belong?
    - What helps/support you to be able to do this?
    - If a child that was new to the home, and felt they trusted you enough to ask you to help them develop a sense of connectedness/belonging, what advice would you give them?
    - Has this been affected by CoVid-19?
    - How does the wider organisation or context support this?

11. **What do you think could be different that would help CYP to have greater sense of belonging?**
    - Who, what, when, how?
    - What would you change? - Have/do more of, less of?
    - Did Covid-19 produce or highlight any helpful/unhelpful differences?
    - Anything in the system that would need to change?
    - Anything in the wider organisation/community

12. **Do you think other staff members perspectives would be similar or different to yours?**
    - Can you tell me more? Why do you say that?

13. **Do you think the young people you support would agree with the ideas you have spoken about?**
    - Can you tell me more? Why do you say that?

Questions about Staff Members own Sense of Belonging in Work

14. **Can you tell me a little bit about your experience of working here?**

15. **Do you feel you belong in work?**
    - As an Individual
    - Staff team
    - Home
    - Wider staff team
    - Organisation
    - Wider service context
    - National level policy
    - Does your sense of belonging in work change depending on the context you are in?
        - For example, do you feel you belong in the organisation as you do within the team?
    - Was this at all affected by CoVid-19?

16. **Do you think it is important for staff members to feel as if they belong within their work team?**
    - Why?
    - What impact would this have on you?
    - What impact would it have on the CYP?
    - What impact would it have on the team / organisation?

17. **What helps you feel like you belong within your team?**
    - Now or in the past?
    - Who, when, what, why?
    - Examples?
    - Past: have you had an experience before? when was this? What was it about this place that made you feel you belonged? How did it change? How was the process of moving?
    - Is there anything that you think is specific to working in a residential home?

18. **What are the benefits of belonging to the team?**

- How do these benefit staff? CYP? The organisation?

19. **What are the challenges associated with belonging to the team?**
    - How do you overcome these?
    - How do you support others to overcome these?

20. What advice would you give a new staff member who wanted to feel connected?
    - About the team
    - About the CYP

Appendix 11 - Participant Demographic Questionnaire

Participant Data Sheet

Participant # _____

Gender: _____

Age: _____

Ethnicity: _____

Job Role: _____

Highest Qualification: _____

Length of time working at current organisation (up until date that the first interview is conducted):

_____

_____

_____

Details and length of any other relevant experience (such as working in a different residential home and/or with young people)

_____

_____

_____

_____

Appendix 12 - Examples of Memos

Memo 1
Considering similar processes between RCGs and CYP involved in developing belonging

This interview provided further examples of the parallel or mirrored processes between staff and CYP when thinking about how belonging is developed. Maybe one model for staff and CYP would make sense? What are the differences between staff and CYP?

Thinking about genuine care: ["they've got my back" (trust?) – Interview 3], having a responsibility to one another ["there is an awful lot I would do for this company" – Interview 1], celebrating difference in staff team ["staff are like different grades of sandpaper – Interview 2] – these contribute to staff belonging. How do these pieces fit together?

What do staff need from organisation to belong? Do they feel they belong as part of the organisation as well as their teams? Is that important?

This is important as impacts CYP = "if they are happy we are happy" – Interview 1

Memo 2

Following first 4 interviews

This first 4 interviews have focused a lot on the internal processes of belonging - what happens within individuals and the way they interact with the home and in relationships. How do the common themes outlined here map on to the larger picture of residential care? Are wider elements as important for belonging? Or are these internal processes most crucial to their role and their understanding of belonging? I wonder if other people within the organisation who perhaps have an overview of how systems operate would be able to expand on contextual elements to belonging?

Appendix 13 - Extracts from Reflective Journal

February 2021

I am repeatedly struck by my admiration for the staff members absolute dedication to their role and to the genuine feelings they have for the children and young people that they work with. I am reflecting on what a privilege it feels like to hear these staff members speak so openly and passionately about their work. It also makes me wonder about biases – my own, those of other professionals and possibly within my sample. It is important for me to try and hold my positive experience of interviewing, the less positive narratives I have observed through my clinical practice (including working with children who are looked after), as well as the potential that participants who agreed to take part in my study likely consider belonging to an important concept to consider (in comparison to others who may have a different view and thus would not consider taking part). I feel it is important to try and hold this in mind through the process of collecting and analysing results.

January 2021

This is my first interview where I feel the participant was perhaps not speaking so honestly and I could not unpick certain parts of their own personal experiences about the more challenging or difficult elements of their role. Perhaps this reflects the participants experience: is talking about emotional and/or difficult experiences not encouraged in their organisation/staff team, perhaps there is a fear of being judged or being disloyal? Would it have been appropriate to share some of these thoughts with the participant? What about desirability bias? Maybe I needed to work harder to build rapport? I will hold this in mind during upcoming interviews and discuss these thoughts in my next research supervision.

April 2021

I am taking the opportunity to reflect on the process of data collection and analysis now that I am in the final stages of formulating my theory. I have been able to hold off undertaking a full literature review for my empirical paper and my systematic review and I am feeling relieved that many elements of seem to be echoed within the current literature on belonging. I feel excited to share my contribution to the literature and the application to staff members and CYP in RCs.

Appendix 14 – Example of Transcripts with Coding

Dawne (pseudonym)

Focused Codes	Transcript	Line-by-Line Coding
	KJ: So, do you think it's important for the children and young people you support to feel a sense of belonging?	
Belonging takes time	Dawne: Massively. Like, the kids that we've got, I think when they first come to us they are so up in the air they don't – they feel they don't belong anywhere; because some people have moved 20/30 homes in I think like, I don't know, who do I belong to? Like, my mother and father don't want me, or can't have me. My old foster-carer can't have me or didn't want me, and like, we need to say, like, you are wanted here. You belong here. You were here until this time, and like we, we want you now and you are staying here. This is where you are now.	Belonging is "massively" important Feeling don't belong anywhere at first Moving through 20/30 different homes Questioning "who do I belong to?" Feeling unwanted in by parents and foster carers Needing to help CYP feel wanted Saying you are wanted, you belong here Explaining journey Staying in one place
Difficult experiences moving through care system "Who do I belong to?" Painful experiences in relationships Feeling wanted	KJ: Yeah, yeah.	
Feeling wanted>feeling relaxed>establishing safety>belonging Environment reflecting your presence Feeling others are interested in you Feeling that other care about you	Dawne: And I think it makes sense, you know, like sit here when they are safe and they start relaxing more then because they think, oh, they do want me and I do belong here. And like, photos up on the walls and stuff, they are like, oh this – this is my home now because they've got photos of me and they are asking me about me and like, we're going on the days out and they're like, oh, they actually thought about me on their days off. And, like, little things like that. It goes noticed.	Feeling safe over time because feel wanted and belonging Being reflected in the environment Others are asking about me Doing things together as a home Being kept in mind by others Noticing little things over time

	KJ: Yeah, yeah. Thank you.	
	Dawne: That's all right.	
	KJ: And, how do you think you would know if a child felt like they belonged in the care home?	
Not trusting of others initially	Dawne: When a child first comes to us, they are more tend to vary up and down. They can either be very like closed off and don't want to talk to anyone, don't trust anyone, things like that. But, the more you are with them, the more you teach like, this is your home, this is where you belong. You find like their anxieties relax, they open up more to you, they feel like more comfortable with you. They'll say, like, oh can I talk to you privately? And tell you things about their past or tell you things that they are feeling now and like – it's just, you learn so much more about them when they feel like they belong. They feel like they can talk to you, they can trust you.	Noticing differences between CYP Being closed off when first arrive (CYP) Not wanted to talk to others initially Not trusting others Being with CYP Overtime teaching this is your home Starting to relax overtime Starting to open up Feeling more comfortable with staff Wanting to talk privately Making disclosures Talking about feelings Learning more about CYP when feel belonging Feeling can talk to staff Feeling can trust staff overtime
Building trust with staff overtime		
Learning more about CYP when they belong		
Feeling safe links to belonging	KJ: Yeah, yeah	
	Dawne: Yeah, and I think like safety and belonging links together. When they feel safe they feel like they belong and vice versa then.	Feeling safe>feel belonging Feeling you belong>feel more safe
	KJ: Okay, yeah, yeah, thank you.	
	Dawne: That's all right.	
	KJ: What do you think the children and young people need to develop that sense of belonging?	
Needing to build trust initially		
Staff repairing	Dawne: Trust, massively; I think just give them the trust straightaway and if they break it then we start at	Needing trust to develop belonging Repairing trust when broken
Providing unconditional		

support Providing security Providing love Sharing experiences CYP & staff Understanding emotions and experiences		the beginning and work our way back. Support to get through anything, which they are going through. Security, love, and just talk to them and find something out, like find a common ground on their level. I think, like, they are fed up of people talking to them as if they are the child. And I know they are children, but like, we've all got similar things going on sometimes and they don't feel like, oh, maybe I'm weird because I feel like this. And I'm like, no, we all get upset, we all get angry and -	Re-starting process of building trust Unconditional support Providing security Providing love Talking together Finding a common ground between CYP & staff Engaging in relationship not talking down to them as children Staff sharing own experiences to normalise emotions/experiences for CYP Helping CYP not to feel weird Trying to see world from CYP perspective
Feeling safe to share emotions with staff Showing care>Needing to show love to CYP Showing love in a different way Defining love between staff and CYP Caring and relationships after residential care	KJ: Dawne:	Yeah. And then they're like, oh, I am normal. There's no such thing as normal but, and like, and just try to show that, you know, everyone if trying and you care for them. And I think then you've got to show love in a way. But, like, obviously, in a different way to a mother and father, but love as in like, I do care and I am interested and value, like, you are valuable to me and I am interested in what happened to you and where you go in 20 years down the line. I still care, I still want to know.	Helping to see differences as ok Helping CYP to feel they can share emotions Showing that you care for CYP "Got to show love" Showing love in a different way to family Showing love through care Showing love through you are valuable to me Showing love through being interested now and in the future Relationship over time is important Caring when left residential care
CYP wanting to know staff love them	KJ:	Yeah, yeah. I think you touched on something really tricky there with that – that sort of professional boundary with love. It must be so hard to get that right?	CYP asking staff "do you love me" "Of course" staff love CYP Living together, proximity grows love

Showing love in a different (appropriate) way Considering physical displays of affection	Dawne: Yeah, it's like when they ask, do you love? And, I'm like – you do, of course you do because you're living with them day in, day out and – but it's trying to word it in an appropriate way. Like, I give them a hug, like that's absolutely fine. But then, where do you draw the line?	Trying to say staff love CYP in an appropriate way Hugging okay way to show affection Questioning where to draw the line with physical affection
	KJ: Yeah, yeah.	CYP trying to show staff physical affection
Considering physical displays of affection	Dawne: You know what I mean?	Staff needing to reject certain forms of physical affection from CYP
	KJ: Absolutely.	CYP not understanding why staff reject physical affection
Showing love in a different (appropriate) way	Dawne: It's like some kids like, when they first come to us, they try and kiss you on like the cheek and stuff because that's what they're used to with it, and I'm like, and they're why? Why? You don't love – and I'm like, no, I do but I'll show my affection to you in a different way.	CYP equating physical affection with love Staff needing to show affection in a different way
Considering individual wants for affection	KJ: Yeah, yeah.	Some children don't want physical contact from staff
	Dawne: And I think that's the difference and kids, sometimes, I mean we've got children with us who don't like physical contact, don't like hugs. So, we'll give like, like a fist bump or a high-five or something quite non-touchy feely, just to try and find the – what the child likes really.	Finding own ways to show affection physically Considering CYP's individual needs
Impact of past experiences of trauma	KJ: Yeah, yeah. And I guess find out, yeah, what they like, their individual kind of ways of showing affection and, yeah.	Staff should not show physical affections straight away Being aware of CYP's abuse histories Impact of past history on physical affection with staff
	Dawne: Yeah, like I definitely would not go in for a hug straightaway because some kids have been sexually assaulted and	Letting CYP find what most comfortable with in terms of affection

Influence of moving through care system on belonging Providing placement certainty Considering impact of moving through care system on belonging Who am I>where do I belong?	things and they don't want that close. And I think that, you've got to let them come to you and find what they feel more comfortable with, is the main thing. KJ: Yeah, yeah, absolutely. And what are the barriers or obstacles do you think that prevent children and young people in care feeling like they belong? Dawne: I think it is more the movement. Like, obviously with us, we are kind of different, we are a long-term placement and nine out of ten children stay here for several years. KJ: Right. Dawne: But, in the care system as a whole, you look at the kids, they are moving millions of times. Like, the children that we've got with us now have moved six, seven, eight, and like upwards and like, they think they haven't got that sense of, well who am I? And that's the belonging then; like, where do I belong?	Moving CYP as barrier to belonging Being able to provide long term placements for CYP Systems moving CYP countless times CYP having to move repeatedly Moving so many times means CYP do not know who they are Moving so much > questioning "who am I? Knowing who you are linked with belonging

Appendix 15 – Table of Categories and Codes

Core Category	**Process of Belonging**	
Category	**Sub-category**	**Examples of Codes**
Establishing Safety	Building Trust	Being genuine, being sensitive and responsive Providing unconditional support Being open and honest Others are taking interest and are noticing you Being playful, having fun
	Consistent Boundaries	Needing boundaries to feel safe and secure (children), discussing the importance of consistency (for children), being fair is important, improving relationships through boundaries,
Engaging in reciprocity		Becoming more involved in environment, building connections, being more vulnerable, taking responsibility, needing others to match your efforts to engage, "flourishing" belonging when included in decisions, feeling "we are in this together"
Forming your Identity		Developing a narrative of what it means to be in care, using voice, feeling other value and accept your differences, being part of a team, being able to look to the future, feeling empowered, fitting in.
Core Category	**Influencing Factors**	
Category	**Sub-category**	**Examples of Codes**
Context of Care	"You have to be a caring person to do this job"	Needing to bring your whole self, needing to look after yourself too, genuinely wanting to do role, being open to others, "You have to be a caring person to do this job"
	Organisational Values	Needing time to reflect, needing support from top down, training as a barrier to belonging, reflecting on positives, valuing access to external support, organisation being understanding and compassionate
A CYP's Journey through Care	"Who do I belong to?"	Considering impact of trauma, considering impact of moving through care system.
Relational Dilemmas	"I do love you, but I'll show my affection to you in a different way."	Needing to show love, Showing love in a different (appropriate) way, consequences of lacking affection, lacking guidance for showing love and affection, inconsistencies in showing affection.
	"A Transient 'Family'"	Uncertainty in care, being a transient 'family', considering transitions, thinking about relationships after care, considering individual needs of CYP and family relationships, cultural ideas about family, residential care as in institution or family home.

Appendix 16 – Participant contribution to categories

Core Category	**Process of Belonging**				**Influencing Factors**				
Category	**Establishing Safety**		**Engaging in Reciprocity**	**Forming Your Identity**	**Context of Care**		**A CYP's Journey Through Care**	**Relational Dilemmas**	
Sub-Category	**Building Trust**	**Consistent Boundaries**			**"You have to be a caring person to do this job"**	**Organisational Values**	**"Who do I belong to?"**	**"I do love you, but I'll show my affection to you in a different way."**	***"A Transient 'Family'"***
Oscar	X		X	X	X	X	X		
Daphne	X	X	X	X	X	X	X	X	X
Bryan	X	X	X	X	X	X	X	X	X
Carla	X	X	X	X	X	X	X	X	X
Dan	X	X	X	X	X	X	X	X	X
Joan	X	X	X	X		X	X	X	X
Dawne	X	X	X	X	X	X	X	X	X
Billy	X	X	X	X	X	X	X	X	X

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