An exploration of the help-seeking experiences of adoptive caregivers with children who have emotional and behavioural difficulties: An Interpretative Phenomenological Analysis

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By

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Declaration

I confirm that this thesis and the research reported within it, comprises my own work. It was written and submitted in part-fulfilment of the degree of Doctorate in Clinical Psychology (DClinPsy). It has not been submitted for any other academic award.

An exploration of the help-seeking experiences of adoptive caregivers with children who have emotional and behavioural difficulties: An Interpretative Phenomenological Analysis

Louise Brittenden

Abstract

Children adopted from care are likely to have been exposed to similar adverse, early experiences as those suffered by looked after children, and therefore have an increased risk of developing complex emotional and behavioural difficulties. Consequently, parenting an adopted child may present significant challenges. Despite government commitments to improve support for vulnerable children and their caregivers, post-adoption support is often lacking and therapeutic interventions for adoptive families are currently offered in the absence of a robust evidence base.

The current literature review aimed to explore the efficacy of therapeutic interventions for adopted children and their caregivers. Synthesis of eleven studies found limited support for a positive impact of interventions on children's behavioural functioning and caregivers' confidence and perceived competency. However there was a paucity of evidence for the benefits of interventions for children's emotional and relational functioning, a key reason why adoptive families seek support. Methodological weaknesses indicated multiple evidence requirements would provide a more effective approach to evaluating the efficacy of interventions.

The research study sought to understand the lived experiences of adoptive caregivers' formal and informal help-seeking for their children's emotional and behavioural difficulties. Qualitative interviews were conducted with six adoptive mothers whose children were currently accessing a child and adolescent mental health service (CAMHS).

Interpretive Phenomenological Analysis (IPA) generated four super-ordinate and 12 sub-themes, which enabled convergence and divergence within respondents' experiences to be accounted for. With a view to informing post-adoption intervention, themes were discussed in relation to existing theory including; parental help-seeking, stigma and attachment. Further qualitative research of particular populations of adoptive caregivers and issues highlighted by the current study was recommended.

The critical appraisal presents a reflective account of the research process to maximise transparency and facilitate readers' evaluation of the research process.

Acknowledgements

I would like to express my sincere thanks to the six respondents who so willingly gave their time to participate in the research and share their experiences. Without their openness and honesty this research would not have been possible.

I would like to convey my appreciation to my field supervisor[1], who also acted as my research supervisor, for his support, encouragement and guidance throughout the research process. Your enthusiasm for research and commitment to supporting vulnerable, young people is inspiring. I would also like to thank other members of the CAMHS team who supported the research. I am particularly grateful to Sheila Bonas at the University of Leicester, for her helpful reflections and guidance regarding the research methodology.

Finally, I would like to thank my husband and three daughters for their unfailing support, patience and encouragement.

[1] To ensure the anonymity of respondents, it is with regret that this supervisor cannot be named.

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Addenda

Transcripts have been presented as an Addendum[3]

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Transcript 2: 'Sarah'

Transcript 3: 'Christine'

Transcript 4: 'Rachel'

Transcript 5: 'Emma'

Transcript 6: 'Anne'

[3] Names given are pseudonyms to maintain respondent anonymity

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Part 1: Literature Review

Therapeutic interventions for adoptive families coping with children's emotional and behavioural difficulties: A systematic review.

(Guidelines to authors for journal targeted for Literature Review can be found in Appendix A)

ABSTRACT

Introduction – Children adopted from care have been exposed to early adversity and may face complex and enduring, emotional and behavioural issues. Whilst the need to increase support for adoptive families has been recognised, interventions are currently offered in the absence of a robust evidence base. The current review aimed to explore the efficacy of therapeutic interventions for adopted children and their caregivers.

Method – A systematic review of the literature relating to group and individualised therapeutic interventions for adoptive families, was conducted using electronic databases (PsychINFO, Medline, ASSIA and Scopus) and electronic searching of low impact research journals, from 1998 to 2014. Eleven studies (13 articles), were reviewed and assessed for methodological quality.

Results – The review demonstrated limited support for the positive impact of therapeutic interventions upon children's behavioural problems and caregiver's confidence and perceived competency. There was a paucity of evidence for the efficacy of interventions for emotional and relational functioning. However, there was limited evidence for the effectiveness of individualised interventions in reducing attachment insecurity.

Conclusion – The overall methodological quality of studies was poor, making it difficult to draw firm conclusions regarding efficacy. Future research needs to develop valid measures of emotional and relational functioning and employ developmentally meaningful follow-up. The quality issues identified, indicated that within the complex realities of mental health settings, multiple evidence requirements, would provide a more effective approach to evaluating the efficacy of therapeutic interventions aimed at supporting adoptive families.

1. INTRODUCTION

1.1 Clinical Context

1.1.1 Adoption policy.

Adoption has been defined as 'the legal placement of abandoned, relinquished or orphaned children within an adoptive family' (Juffer & van Ijzendoorn, 2007). During the past 40 years, sociological and political changes, including the legalisation of abortion, have resulted in a global trend for children to be adopted at an older age (Midgen, 2011). Children currently have to wait an average of two years between entering care and being placed with an adoptive family (Children & Families Bill Team, 2013). In 2014, the average age at placement from care, in England, was three years, five months (British Association of Adoption & Fostering Statistics, n.d.). These older children are likely to have experienced early adversity and multiple foster homes prior to their adoption and have an increased risk of developing complex emotional and behavioural difficulties (Nickman, 2005; Syne *et al*., 2012). UK government legislation (Children and Families Bill 2013; Department for Education, An Action Plan for Adoption: Tackling Delay, 2012; Children's Act, 2004; Adoption and Children's Act, 2002) has strived to minimise delay. However, this has generated concern that the support needs of adoptive families are being neglected (Phillips, 2007; Dann, 2011; Golding, 2010; Selwyn *et al.,* 2014). The estimated base cost of adoption is £270,000 and pressure on resources make it difficult to meet the needs of adoptive families, pressure compounded by a lack of evidence to indicate what type or level of intervention could improve cost outcomes (Bonin *et al*., 2013).

1.1.2. Mental health needs of children adopted from care.

Despite increased levels of stability compared to children in care, adopted children have been exposed to similar adverse early experiences including abuse and neglect (Rees & Selwyn, 2009), and face complex emotional issues related to identity and loss (Smit, 2002; Golding, 2010). The main support needs for adopted children are for attachment difficulties, emotional and behavioural disorders, and over activity/restlessness (Bonin *et al.*, 2013). Adopted children are twice as likely to be in contact with mental health services and to have received counselling compared to non-adoptees (Rao *et al*., 2010).

Evidence from prospective, longitudinal studies in the UK, indicates that up to 60% of children placed late for adoption from public care may experience mental health difficulties within six years post-placement (Rees & Selwyn, 2009; Rushton & Dance, 2006; Selwyn *et al.*, 2006).

Compared with non-adopted children, adoptees are more likely to present with behavioural difficulties, particularly externalising problems such as conduct disorder and substance misuse (Golding, 2010; Ingersoll, 1997). Rushton (2004) identified common behavioural problems in late adopted children including non-compliance, aggression, over-activity, lying and stealing. Increasingly, research has highlighted the profound, lifelong impact of early adversity and trauma on brain development in terms of structure, connectivity and hormonal changes, leading to an impaired capacity to regulate behaviour and emotions (Gerhardt, 2006; Schore, 2005). Symptoms arising from neuro-developmental causes such as hyper-arousal, physical over-activity and hyper-vigilance can be difficult to distinguish from attachment difficulties, especially in children with a trauma history (Vostanis, 2014).

Loss and separation from birth parents can limit opportunities to develop selective attachments during critical developmental periods, placing adopted children at greater risk of developing insecure attachments (Palacios & Brodinsky, 2010; Hughes, 1999). Whilst adopted and fostered children are comparable regarding overall attachment security, compared to non-adopted peers, adopted children display more disorganised attachment (Van den Dries *et al.*, 2009). Emotional difficulties associated with impaired attachment including being over-controlling, manipulative and fearful of intimacy, are likely to present as a continuum from mild to severe (Vostanis, 2014). It is important to distinguish between 'attachment difficulties', which refer to problems within the child-carer relationship and 'attachment disorder', a term often widely applied to looked after and adopted children but which is in fact a much rarer phenomenon referring to severe, pathological breakdown of the normal attachment system so the infant fails to discriminate any specific caregiver in order to access safety and protection (Woolgar & Scott, 2014). Such failure of a child's attachment system comprises a more substantial and fundamental deficit than difficulties within the child-carer relationship per se. Consequently, whilst adopted children may exhibit challenging and sometimes bizarre emotional and behavioural problems due to early disruptions in their attachment relationships or exposure to significant and recurrent

trauma, they are unlikely to meet full diagnostic criteria for an attachment disorder (Nickman, 2005; Ratnayake *et al.*, 2014).

1.1.3. Caregiver issues and adoption disruption

Adoptive parenting can be an emotionally draining, frustrating and exhausting experience (Howe, 1998). Associations between adoptive caregivers' reports of stress and dissatisfaction with adopted children's emotional and behavioural problems have been identified (Welsh *et al.*, 2007). Placement stability has been found to be dependent on the skills and perceptions of caregivers (Quinton *et al*., 1998). Adoptive parents may also be dealing with grief associated with infertility, loss of self-esteem and social status (Nickman, 2005; Golding, 2010). Parents, who have been unable to resolve personal losses, may not be emotionally available to provide a reflective model for their child, which may impair bonding (Midgen, 2011). Isolation and loss of confidence in parenting ability can precipitate emotional disengagement and rejection of the child, resulting in placement disruption or breakdown (Wright, 2009). Rushton *et al.* (1995) found the rate of infant adoption disruption to be 3%, compared to 20-27% amongst children adopted from care. Factors associated with adoption disruption include; older age at placement, multiple previous placements, attachment difficulties, separation from siblings, placement delay and lack of adoption support (Selwyn *et al.*, 2014). However, adoption disruption represents only one aspect of unsuccessful adoption. The negative effects on adoptive families continuing to care for a traumatised child need to be considered (Wright, 2009). The impact of secondary trauma within adoptive families is becoming increasingly recognised (DoH, 2004), as is the need for more interventions to enable adoptive families to sustain their caregiving role (Wright, 2009; Selwyn *et al.*, 2014).

1.1.4. Therapeutic interventions

There are a wide range of potential individual, group and systemic interventions which may help to address the emotional and behavioural difficulties encountered by adoptive caregivers and their children (Golding 2006a). Individual therapies commonly focus on enhancing the parent-child relationship within an attachment framework. The most frequently employed individualised approaches are psychotherapy and psycho-education, with some indication that parent-child psychotherapy is more effective in

improving attachment relationships (Cornell & Hamlin, 2008). Individual therapeutic approaches include psychoanalytic psychotherapy, play therapy, filial therapy and theraplay. However, individualised interventions are unlikely to be effective for adoptive children until a degree of security and stability have been established (Golding, 2007). Group based parent-training interventions for adoptive parents are typically adapted from existing programmes for biological parents (e.g. Webster-Stratton Incredible Years Programme). Such programmes aim to enhance adoptive parents' behavioural management skills, confidence and understanding of their child's complex difficulties within the context of attachment theory and the impact of trauma. Despite high levels of satisfaction with parent training reported by adoptive parents, the mechanisms via which group interventions may positively impact child and caregiver functioning are poorly understood (Golding, 2006b). The impact of therapeutic interventions designed for biological caregivers, aimed at reversing poor parenting rather than enhancing relationships, may be limited (Hodges, 2005). It also remains unclear which therapeutic components of parent training packages, which can vary widely in content, are most effective (Golding, 2007). Systemic approaches including family therapy and multi-systemic family therapy aim to understand and address presenting problems within the wider familial, community and social context.

Currently, there is a lack of consensus regarding 'standard' intervention for adoptive families whose children are experiencing emotional and behavioural difficulties (Cornell & Hamrin, 2008; Barth *et al.*, 2005). Global provision has been described as 'largely piecemeal, initiated by a small number of visionary clinicians' (Tarren-Sweeney, 2010, pp.614). Interventions often need to be adapted and delivered within a flexible, holistic approach, according to adoptive families' specific needs (Golding, 2006a). Unfortunately, acute child and adolescent mental health services are often poorly positioned to address the complex and enduring difficulties of children with a trauma history (Golding, 2010; Tarren-Sweeny, 2010). Consequently, whilst there has been an increase in therapeutic interventions and services aimed at supporting adoptive families, the current evidence base is inadequate (Cornell & Hamrin, 2008; Ratnayake *et al*., 2014; Tarren-Sweeney, 2013).

1.2. Previous reviews of the efficacy of interventions:

Whilst comprehensive reviews have demonstrated the efficacy of parent-training interventions amongst biological families (Barlow *et al.,* 2011; Furlong *et al.,* 2012), evidence for their effectiveness amongst foster and adoptive families is limited. A narrative review by Welch *et al.* (2007) of interventions for internationally adopted children with physical and mental health difficulties, highlighted a striking lack of empirical evidence available to inform clinical practice.

A number of recent reviews have focused on therapeutic interventions adapted to the specific needs of foster families (Turner, *et al*., 2007; Dorsey *et.al,* 2008; Everson-Hock *et al.,* 2011), and found little empirical support for their efficacy. Kinsey and Schlosser (2012) conducted a comprehensive review of interventions in foster care, considered a broader range of theoretical models than previous reviews, and evaluated care-giver and child outcomes. The quality of the majority of studies, were rated as good. The review found positive evidence for both 'wraparound' interventions targeting different areas of the family system, and individualised, relational interventions targeting the child-carer relationship. However, evidence for the effectiveness of group training interventions was poor.

Kerr and Cossar's (2014) systematic review of attachment-based group and individualised interventions for fostered and adopted children, focused on children's outcomes. The authors found stronger evidence for the positive impact of interventions on children's behavioural outcomes, compared to emotional and relational functioning. Individualised interventions for parent-child dyads, provided more robust evidence for positive attachment-related outcomes in older and younger children. The review also underlined the benefits of earlier, preventative interventions. However, the authors highlighted the poor methodological quality of studies, which made assessment of the efficacy of interventions problematic.

A systematic review by Wassall (2011), (un-published dissertation), examined the effectiveness of parent-training groups for improving attachment relationships, for fostered and adopted children. The review revealed a wide variation in group formats, theoretical models, outcome measures and a lack of consensus regarding essential therapeutic elements of interventions. Outcomes for caregivers and children were examined. Whilst caregiver satisfaction ratings were high, there was limited evidence of

improvement in children's emotional and behavioural functioning, or caregivers' stress and sensitivity. The majority of studies were considered to be of poor methodological quality and interventions were rated as 'innovative or novel'. Consequently, the author was unable to draw valid conclusions regarding the efficacy of parent-training programmes for foster and adoptive families.

1.3. Rationale and aims of current review

Unlike foster families, adoptive families face a life-long process, interwoven with profound and enduring issues including loss, separation, identity and belonging (Syne *et al.*, 2012), and may consequently present with different needs (Golding, 2006b). It therefore, seemed pertinent to address the lack of review evidence regarding therapeutic interventions for adoptive families. This focus generated three key questions:

1. What can the current literature tell us about the effectiveness of therapeutic interventions for adoptive families coping with children's emotional and behavioural difficulties?

2. What can the current literature tell us about the characteristics of therapeutic interventions that may best predict positive outcomes for adoptive caregivers and their children?

3. What can the current literature tell us regarding methodological and quality issues pertinent to therapeutic interventions targeted at supporting adoptive families?

2. METHOD

2.1. Search strategy

A scoping search was undertaken in September 2014, to determine the range of literature available. This search identified two recent reviews: Kerr and Cossar (2014) and Kinsey and Schlosser (2012), which mainly focused on foster carers. The search strategy for the current review was implemented to identify literature focused on adoptive families. A time limit was set of 1998 to September 2014. The start date of 1998 was chosen to coincide with government legislation to promote the use of adoption for children unable to live with birth families, after which more interventions and support for adoptive families were introduced (Selwyn *et al.* 2014). This timescale is consistent with both reviews by Kerr and Cossar (2014) and Kinsey and Schlosser (2012). The consequent overlap in timescale resulted in the duplication of five studies in the current review. However, due to the focus of the current review being on adoptive families, it was not considered necessary to exclude these.

2.2. Inclusion and exclusion criteria

Included studies were required to be published in peer reviewed journals, in English, between 1998–October 2014, and to have utilised a quantitative methodology.

2.2.1 Population

Studies were included if their target population included domestically or internationally adopted children aged between 0-18yrs and/or adoptive parents/carers. Studies where children had been institutionalised prior to their adoptive placement or were drawn from populations with specialist needs (e.g. severe learning disabilities, neurodevelopmental disorders, substance misuse) were excluded. Studies where the target population included birth parents were also excluded.

2.2.2 Design

Studies were included if they utilised randomised controlled or controlled designs, pre and post interventions, and longitudinal follow-up. Single case studies or evaluations of interventions without quantitative analysis were excluded.

2.2.3 Intervention

Studies were included if they aimed to evaluate interventions aimed at improving or reducing the emotional or behavioural problems of children and/or enhancing child-parent/family relationships/relational functioning. Studies utilising individual, dyadic, family or group-based interventions were included. Interventions that focused solely on children or parents were included. Interventions described as psycho-educational, experiential, therapeutic, didactic, or training were included. Studied involving bio-medical interventions (e.g. amino acid therapy; neuro-endocrine function) were excluded.

2.2.4 Outcomes

Studies were included if they measured adopted children's and/or adoptive parents' behavioural, emotional and relational functioning.

2.3 Identification of studies

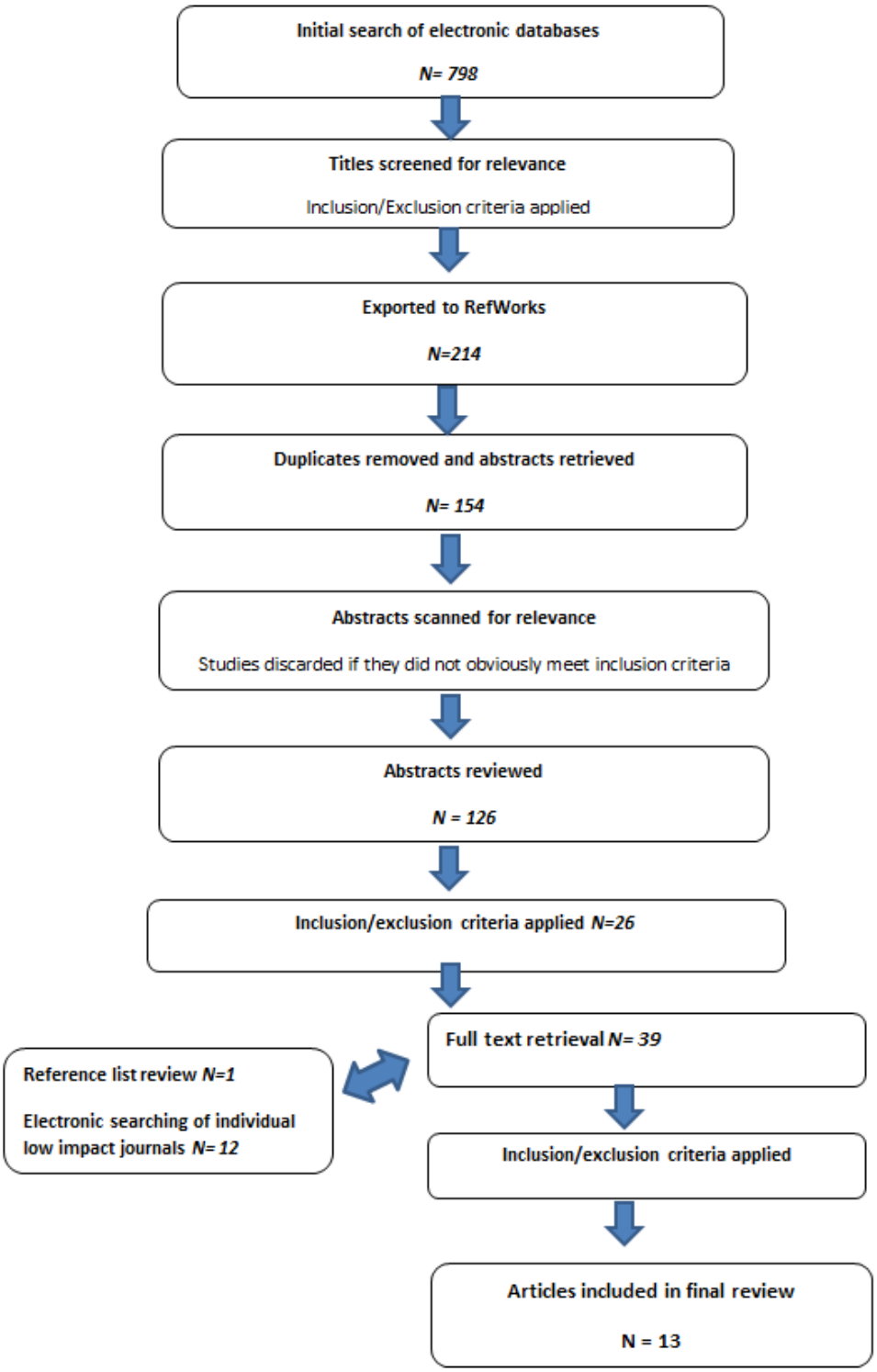
Electronic databases (Psych Info, Medline, Scopus and ASSIA) were searched for published articles evaluating psychological interventions for adoptive families between 1998 and September 2014. Appendices B and C detail the searches undertaken and keywords used. Electronic searching of individual low impact research journals (Adoption & Fostering; Attachment & Human Behaviour; Child & Adolescent Mental Health; Clinical Child Psychology & Psychiatry) was also conducted to identify relevant article titles. Reference lists of articles selected for inclusion were searched for relevant studies.

2.4 Shortlisting

The titles of all references retrieved from the electronic databases and the electronic searching of individual journals were screened for relevance. Studies considered to be appropriate were exported to the reference management software RefWorks. Duplicates were then removed and abstracts retrieved. Abstracts were scanned to remove studies which obviously met exclusion criteria. Full text articles were retrieved and read, including reference lists to identify further suitable studies. Inclusion/exclusion criteria were then applied to full text articles to generate a shortlist of studies for inclusion in the review. Figure 1 outlines the shortlisting process.

Figure 1

Flow diagram of study selection



2.5 Data Extraction

Information from studies, including the country where the study was conducted, the study objectives, methodology, sampling, intervention, outcome measures, findings, limitations and conclusions, were collected using a data extraction pro-forma (Appendix D).

2.6 Data synthesis and quality appraisal

Due to the heterogeneity of the interventions and measures used, it was not appropriate to conduct a meta-analysis, so data were synthesised according to a narrative, qualitative perspective. In order to provide an accessible and immediate overview of the quality of studies, the Downs and Black (1998) checklist was utilised (Appendix E). This checklist has established validity and reliability (National Collaborating Centre for Methods and Tools, 2006) and has been applied in previous reviews of psychological interventions targeted at children and caregivers (Kinsey & Schlosser, 2012; Cheney *et al.*, 2014).

The current reviewer is aware of an absence of any 'gold standard' quality appraisal tool (Katrak *et al.*, 2010) and of inherent difficulties applying quality appraisal tools designed to evaluate experimental studies conducted in a medical context, to complex, practice-based, psycho-social interventions (Katrak *et al.*, 2004; Tarren-Sweeney, 2013). The assumed advantage of numerically grading studies over and above intuitive judgments of intrinsic quality, has been debated (Miller *et al.*, 2007). Consequently, appraisals of quality were also conducted using intuitive judgement, an approach consistent with the narrative synthesis of data.

3. RESULTS

3.1 Excluded studies

Following the initial search and review of abstracts, the full text of 39 articles was retrieved and of these, 26 were excluded (Fig.1). The most common reason for exclusion (n=13), was examination of the population of interest (foster carers/ foster children only, biological families, adoptees from institutions or young-offenders). A further nine studies comprised no quantitative evaluation (discussion only, case study or qualitative).

3.2 Studies included in the Review

In total, 11 studies (13 articles) were included in the review. Tables 1-6 in Appendix F summarise the studies' key characteristics, findings and quality ratings/judgements.

3.2.1 Overview of methodological quality of studies

The overall quality of studies was assessed using the Downs and Black (1998) checklist. The range in rated quality was 81% (7) to 22% (5). Five studies (1,2,3,7,8) had a quality rating of 60% or above, indicating that less than half of the studies were of moderate to good quality. Appraisals of quality using intuitive judgement are referred to below (Table 1, Appendix F).

3.3. Descriptive summary of studies

3.3.1 Participants and setting

Sample sizes ranged from 130 to 13 participants. Children's ages ranged from 5 months to 16 years, (Mean ages ranging from 8 mths. to 9.8 yrs.). Eight studies (2,3,5,7,8,9,10,11) focused on adoptive samples; two of these (3,7) comprising families with an internationally adopted child. Three studies included foster and adoptive samples (1,4,6) including therapeutic and kinship care (6), and special guardianship (4). Studies 7,9 and 10 comprised adoptive families with biological children.

Four studies were directed at caregivers only (4,5,6,9) whilst two studies targeted only children (1,11). Five studies targeted caregivers and children; with two studies focusing on parent-child dyads (7,8), one study targeting mother, father and child (3), one study

being a systemic family intervention (10) and one study involving individualised parent/child dyad supervision, in addition to a group intervention for caregivers (2).

Five studies were conducted in the UK, four in the US and two in the Netherlands. All eleven studies were conducted in community settings including; university campuses, clinics, adoption agencies, counselling centres, church halls and family homes. Sources of recruitment included professional referral, caregiver self-referral or voluntary participation in response to advertising (Table 2, Appendix F).

Interventions were facilitated by a range of professionals including; trainee therapists (1,3,7,8,10), play therapists (2), clinical psychologists (4,6), an adoption support worker (5), trained adoptive parents (9) and university researchers (3,7). The majority of studies reported consistent levels of attendance and compliance with interventions. One study reported high drop-out rates due to withdrawal of private healthcare funding.

3.3.2 Types of interventions

Eight studies were evaluations of adaptations of interventions designed to target biological parents and/or foster carers (1,2,4,5,6,8,10,11). Two studies evaluated interventions for families with an internationally adopted child (3,7). One study evaluated an intervention provided by Adoption UK (9). A range of psychological interventions were employed (Table 3, Appendix F). Table 1 presents an overview of interventions according to mode of delivery, aims, model of therapy employed and theoretical frameworks.

Table 1. Overview of interventions according to mode of delivery, aims, model of therapy employed and theoretical frameworks.

Mode of Delivery	Aims of Intervention	Therapy Model	Theoretical Framework/s
Individualised - (Parent –Child)			
Study 1	Reduce symptoms of RAD and increase attachment security	Dyadic Developmental Psychotherapy	Attachment
Study 3	Improve parent-child relationship and decrease attachment/conduct problems	'Basic Trust Intervention' – Video feedback of parent-child interaction and psycho-education.	Attachment
Study 7	Increase maternal sensitivity and infant attachment security	Video feedback of mother-child interaction and psycho-education	Attachment
Study 8	Improve parenting skills and reduce behavioural difficulties	Adaptation of existing Webster-Stratton Incredible Years parent training programme versus psycho-education	Cognitive Behavioural
Study 11	Reduce RAD symptomology and improve child's functioning in family	Attachment Therapy techniques (e.g. holding, EMDR, parenting skills, narrative therapy & psychodrama)	Attachment
Group - (Parent Training)			
Study 2	Reduce child behaviour problems and increase parental empathy	Child Parent Relationship Therapy – (CPRT -relational focused counselling approach)	Social Learning Theory & Attachment
Study 4	Enhance parental sensitivity to attachment needs of child	'Fostering Attachments Group' model of parent training	Social Learning & Attachment
Study 5	Increase parental confidence, perceived control & behaviour management skills	Adaptation of existing Webster-Stratton Incredible Years parent training programme	Social Learning, Attachment & Cognitive Behavioural
Study 6	Increase parental empathy, attunement and behaviour management.	Adaptation of Webster Stratton and Triple P parent training programmes	Social Learning & Attachment, Cognitive Behavioural & Narrative approaches
Study 9	Enhance parenting skills, confidence & understanding of attachment	'It's a Piece of Cake' parent training programme devised by Adoption UK	Attachment Cognitive Behavioural
Systemic – (Family)			
Study 10	Enhance attachment relationships within whole family	Whole Family Theraplay	Attachment, Object Relations & Family Systems

Five of the six individualised studies, provided comprehensive and detailed accounts of the content of interventions for the purposes of replication and consistency (1,3,7,8,10). However, specific details about the content of group interventions were often lacking. In Study 5 the content of the group intervention evolved in response to successive participant feedback.

3.3.3 Outcome assessments

The majority of studies included multiple outcomes, and were reliant upon caregiver report, in particular, mothers. A wide range of variables were assessed, with all studies employing measures of children's emotional and behavioural functioning, primarily through utilising standardised measures with established reliability and validity; the Strengths and Difficulties Questionnaire (SDQ, Goodman, 2001) and the Child Behaviour Checklist (CBCL, Achenbach 1991). A wide range of standardised and non-standardised measures were used to assess caregiver outcomes, attachment outcomes and the child-caregiver relationship (Tables 4 & 5, Appendix F).

All studies reported statistically significant differences between baseline and post-intervention assessments and relative to control groups, for at least one outcome measure. The majority of studies reported non-significant differences in one or more outcome measure. None of the studies reported any statistically significant post-intervention deterioration of any outcome measure (Table 6, Appendix F).

3.4. Impact of interventions

Due to the complex overlap between child versus caregiver outcomes, modes of delivery and theoretical models, evidence from the studies included in the current review will be synthesised according to themes.

3.4.1 Children's behavioural and emotional outcomes

Seven studies found statistically significant improvement in children's problem behaviours, including overall scores (1,2,4,10,11), externalising behaviours, (e.g. hyperactivity and conduct problems) (4,5,3), and behavioural disturbance (1,11). Two studies reported a statistically significant reduction in specific problem behaviours identified by caregivers, with problem behaviours viewed by caregivers as being less severe post-intervention (4,6). An early, preventative intervention found delayed positive effects on behaviour problems in boys and girls (7). Two studies found no

significant improvement in children's levels of behavioural problems, with SDQ scores remaining stable (8,9).

Regarding emotional outcomes, findings were limited. One study found a statistically significant reduction in disinhibition (clingy and demanding behaviours), but children's overall degree of emotional regulation and internalising symptoms remained unchanged (4). An early preventative intervention found delayed positive effects on personality development and ego resiliency in girls (7). Three studies that used subscales of the SDQ to measure emotional symptomology, found no significant improvement (4,5,8).

3.4.2 Caregivers' outcomes

Regarding caregiver functioning, findings were mixed. Statistically significant improvements were found in parenting skills (4,6,9), confidence managing difficult behaviours (6,9), perceived competency (5), understanding of reasons underlying problem behaviours (4,6), and empathy (2). One study found satisfaction with the parenting role increased significantly between baseline and follow-up, despite having to manage difficult child behaviours (8). Study 10 found a statistically significant increase in caregivers' interpersonal functioning, and non-significant improvements in overall functioning (e.g. feeling worthless). Two studies reported statistically significant reductions in parental stress levels (5,6), whilst two studies found no significant changes (4,10). One study found despite feeling less stressed, caregivers reported feeling more socially isolated following a group intervention (5).

3.4.3 Parent–child relationship outcomes

Findings were focused on attachment or broader outcomes associated with the quality and experience of the parent-child relationship. A complex picture of attachment-related factors was apparent. Study 3 found a reduction in overall maternal attachment insecurity, post-intervention, whilst a reduction in disorganised attachment was associated with both parents. Study 7 found a reduction in maternal disorganised attachment, with no change in ambivalent or resistant attachment. Regarding caregiver sensitivity and attunement, statistically significant increases were found in maternal sensitive responsiveness (7) and caregiver empathy (2). However, increased maternal sensitivity was not sustained at follow-up (7). Two studies found no significant change in caregivers' 'Mind-Mindedness', a measure of parental sensitivity (3,4). However, one of these studies (4), did find a statistically significant increase in 'Mind-

Mindedness' in relation to 'Ruptures in Relationships' and evidence of improved insight into caregivers' own thoughts and feelings. The authors hypothesised that this improved sensitivity may have generalised to children at a later point. Four studies highlighted anecdotal reports of caregivers' improved understanding and positive perceptions of their child's attachment, with caregiver explanations of their child's difficult behaviours being more thoughtful and less blaming (1,6,8,9).

In three group interventions, caregivers found the parent-child relationship to be more rewarding, post-intervention (5,6,9). One study found a statistically significant increase on a Relationship subscale, with parents perceiving their child as being more responsive and easier to communicate with (6). One study found statistically significant improvement in family communication, post-intervention (10). However, caregivers' perceptions of their children being more able to express their feelings remained unchanged in all three studies that measured expression of feelings in relationships (4,8,9). One study found despite caregivers finding their child more rewarding to be with, there was no improvement in caregivers' perceptions of the attachment relationship (5).

3.4.4 Theoretical frameworks and objectives

More interventions prioritised an attachment focus (1,3,4,6,7,10,11), compared to a behavioural, skills-based approach (2,5,8,9). Regarding attachment security, group and individual interventions aimed to increase caregiver understanding (1,4,2,6,8,9), enhance caregiver empathy (2,6) and increase caregiver sensitivity and attunement (1,3,4,6,7,8). Individualised interventions were more explicitly concerned with increasing attachment security (1,3,7,11) and reducing children's behavioural difficulties (1,3,8,11). Group interventions were focused on changing caregivers' thoughts, feelings and behaviours including increasing skills in managing behaviour (5,6,9), confidence (5,9), perceived control (5) and self-care (9).

3.4.5 Therapeutic Factors

Regarding the efficacy of treatment components, only one study demonstrated the video based feedback (VBF) component of the intervention as being directly associated with positive change (7). One study suggested 'interactive repair' as an important element of the group intervention curriculum (4). Two studies highlighted their inability to identify efficacious treatment components in discussion of the studies' limitations (1,8).

Regarding timing of interventions, the majority of studies comprised 'reactive' interventions. Only one study was 'preventative', targeting an infant population of international adoptees considered at risk of developing emotional and behavioural problems (7). The majority of interventions were aimed at children aged below ten years. In relation to adoptive placement, anecdotal evidence from studies 6 and 9, found adoptive parents expressed a preference for interventions to be offered once the adoptive placement had started, which give the relationship time to settle, but before difficulties became unmanageable. In contrast, foster carers, possibly due to their 'professional' caregiving role, favoured intervention prior to the start of placement. Anecdotal evidence indicated adoptive caregivers wanted opportunities to access on-going support, rather than isolated, 'one-off' interventions.

3.4.6 Methodological/design issues

The majority of studies were characterised by small sample sizes. Only three studies made explicit reference to using power calculations (2,3,8). Four studies reported effect sizes including a large effect size for increase in parental empathy (2), a medium to large effect size for improvements in attachment security (3,7) and a medium effect size for increased caregiver confidence (9). Only two studies distinguished clinical from statistical differences in outcomes (1,2). In relation to clinically relevant outcomes, the majority of group evaluations incorporated limited qualitative feedback (4,5,6,9).

Six studies lacked controls (3,4,5,6,10,11), four of which were group interventions. Of five studies which employed control groups (1,2,7,8,9), two were non-randomised (1,9). Blinding of researchers was apparent in two of three randomised studies (2,7). Studies employed 'treatment as usual' controls (1,8,9), waiting list controls (2) and no intervention (7). All studies using control groups considered statistically significant differences between controls and experimental groups prior to intervention. Of three studies that used a mixed sample of foster and adoptive families (1,4,6), only one considered differences between them (6).

The majority of studies did not collect follow-up data. However, four of the individualised interventions were able to demonstrate positive change over longer follow-up periods, ranging from six years to six months (1,7,10,11). Only one group intervention demonstrated sustained positive change, three months post-intervention (4).

4. DISCUSSION

This review aimed to synthesise evidence from evaluations of therapeutic interventions for adoptive families coping with children's emotional and behavioural difficulties. A further objective was to address the paucity of review evidence currently available for this specific population.

The purpose of this review was to evaluate the effectiveness of therapeutic interventions for adoptive families. It aimed to answer the key questions outlined in the summary and discussion below.

4.1. Summary and discussion of key findings

4.1.1. What can the current literature tell us about the effectiveness of therapeutic interventions for adoptive families coping with children's emotional and behavioural difficulties?

All studies reported statistically significant differences between baseline and post-intervention assessments and relative to any control group, for at least one outcome measure. This may be indicative of the positive impact of therapeutic interventions on adoptive family functioning. However, these results need to be interpreted cautiously due to the limited methodological quality of over half the included studies.

The current review supported the findings of Kerr and Cossar (2014) in indicating stronger evidence for the positive impact of interventions on children's behavioural functioning, in particular externalising behaviours, and limited support for children's emotional functioning, which remained unchanged in the majority of studies which assessed this domain. The review findings suggest interventions focused at a behavioural level, are unlikely to produce change within emotional and attachment-related domains, which involve children's internal mental representations of others (Palacios & Brodinsky, 2010; Hughes, 1999). As the majority of studies did not specify length of adoptive placement, it was not possible to determine whether the need to establish placement stability may have impacted the efficacy of interventions (Golding, 2007).

Regarding evidence for positive impact on caregivers, consistent with Wassall (2011), there was limited support for a positive effect of interventions on caregivers' perceptions of the quality of the parent-child relationship, in relation to increased

positive internal attributions for children's behaviours, satisfaction and reward associated with the parenting role, and communication. However, these improvements did not appear to translate directly into increased attachment security. A reduction in post-intervention carer stress may have indicated the benefit of the interventions in facilitating attachment, since carers' stress levels have been associated with impaired ability to deliver sensitive parenting (Welsh *et al.,* 2007). Since only half the studies that measured stress found significant improvement, it was not possible to draw meaningful conclusions.

Regarding relational functioning, findings supported Kinsey and Schlosser (2012) and Cornell and Hamrin (2008), with more robust evidence for an increase in overall attachment security associated with individualised interventions, which aimed to increase parental sensitivity. However, increased parental sensitivity was mainly associated with a reduction in disorganised attachment, with no change in insecure or avoidant attachment styles. This finding may indicate that whilst individualised interventions, explicitly aimed at enabling caregivers to take their child's perspective, are effective in reducing disorganised attachment behaviours, more subtle factors including mutuality, mentalising and synchronicity, pertinent to the continuum of insecure attachment (Hughes, 1999; Nickman, 2005), may be more difficult to impact.

4.1.2 What can the current literature tell us about the characteristics of therapeutic interventions that may best predict positive outcomes for adoptive caregivers and their children?

Since all the interventions evaluated in the current review positively impacted on at least one aspect of adoptive family functioning and were based on a range of theoretical models, there was no strong evidence to support the efficacy of a single approach. However, the review findings reinforced existing evidence that attachment theory-based interventions may have a more sustained and positive impact upon children's behavioural and relational functioning, and caregivers' sensitivity and attunement (Kerr & Cossar, 2014). Study 10, the only systemic intervention, produced short-term, positive effects on children's behavioural outcomes and family communication. These findings may indicate the value of a systemic, relational focus, which supports the positive findings of Kinsey and Schlosser (2012) for 'wraparound' interventions that targeted different areas of the family system. In concurrence with Wassall (2011)

attachment theory elements incorporated within adaptations of group interventions based on Social Learning theory may have been too diluted to be effective, indicated by the lack of evidence for improvements in children's emotional and relational functioning following group interventions.

The review findings indicated interventions which were individualised, relational, and focused on unique parent-child interactions, were most effective in reducing attachment insecurity, which concurs with the findings of Kerr and Cossar (2014) and Kinsey and Schlosser (2012). Consistent with Kinsey and Schlosser (2012) it appears that multiple difficulties faced by adoptive families are not as effectively met via group interventions, which may not adequately address high levels of complexity, or be as effective where a more individualised, intensive and targeted approach is required (Hodges, 2005; Quinton *et al*, 1998). Interestingly, Study 2, a group intervention that included individualised parent-child supervision, found increased levels of parental empathy, essential for developing secure attachments. This finding may indicate the value of integrating group and individualised approaches and incorporating an 'active' relational focus. There was, however, limited evidence that group interventions produced positive, short-term impacts on many aspects of parenting; including stress, competency, confidence and skills, as well as children's behavioural functioning.

It was not possible to reach firm conclusions regarding the efficacy of treatment components since the majority of studies did not assess the impact of individual elements, a reflection of the current lack of clarity in this area (Golding, 2007). However, VFB was used in all three studies (2,3,7) which found statistically significant improvement in attachment-related outcomes. This may indicate VFB as an important element in the effectiveness of therapeutic interventions aimed at improving attachment, because it is personalised, motivational and able to focus carers' attention in a direct, concrete and accurate manner (Juffer *et al.*, 2005).

The review found the majority of interventions were aimed at younger children which highlighted a lack of interventions for adolescents who may present with more complex problems which, as Kinsey and Schlosser (2012) suggest, may not be amenable to single treatment modalities. The review found more robust evidence for earlier, preventative interventions which target younger children and focus on increasing parental sensitivity, which concurred with the findings of Kerr and Cossar (2014). In

the absence of adequate long-term follow-up, it was not possible to draw conclusions regarding the efficacy of interventions in relation to timing of adoptive placement. However, anecdotal evidence indicated a preference for on-going support, once the adoptive relationship had settled but before difficulties became unmanageable.

4.1.3 What can the current literature tell us regarding methodological and quality issues pertinent to therapeutic interventions targeted at supporting adoptive families?

The review highlighted inherent difficulties in measuring therapeutic change within complex relational dynamics (Tarren-Sweeney, 2013). The majority of studies represented novel or pilot interventions, and were often unable to adhere to a manualised framework, raising questions about their fidelity. In the context of attachment/trauma related difficulties, only a minority of studies employed realistic time-frames for pre-post evaluation, within which changes in caregivers' internal representations, key to the process of interactive repair, may have been generalised to their child (Hughes, 2006, Golding, 2008). The lack of follow-up data meant studies were unable to demonstrate sustained positive change or offer evidence regarding mechanisms of change.

Whilst the majority of studies employed standardised measures, a number included a range of non-standardised measures which were not clearly described and had limited internal validity. The majority of studies employed primarily behavioural measures (SDQ; CBCL) to capture emotional changes which compromised internal validity and reflects the current lack of direct, reliable or standardised measures of attachment and emotional outcomes (Ratnayake *et al.*,2014; Rushton *et al.*, 2003). There were differences in how attachment style was assessed in infants and older children; the latter being more likely to rely on measures of attachment disorder (e.g. RADQ) rather than attachment behaviour. The lack of standardised measures of attachment reflects current debate regarding conceptualisations of attachment as healthy behaviour or as dysfunctional pathology and contentions regarding the classification of attachment disorder (Newman & Mares, 2007; Woolgar & Scott, 2014; Zeanah & Gleason, 2015).

According to traditional hierarchies of evidence, the overall methodological quality of the majority of studies was poor. All studies were subject to bias, particularly from caregiver reports. The lack of homogeneity of theoretical models, length of intervention, outcome measures and follow-up, made comparison and synthesis of the

evidence problematic. Small sample sizes, lack of control groups and lack of randomisation protocols, compromised internal and external validity. A further issue was the lack of effect sizes across studies. Regarding multiple evidence requirements, few studies utilised measures of effectiveness in terms of clinical significance or reflected on the impact of contextual factors on therapeutic engagement and process, (e.g. impact of therapists' levels of experience). However, the majority of interventions were grounded in established psychological models, provided within the context of existing service provision, and were acceptable to clients and clinicians. None of the interventions were found to be harmful and a majority were rated as highly satisfactory by caregivers. The findings of the majority of studies indicated they were able to positively impact outcomes considered theoretically important for improving adoptive family functioning.

4.2 Limitations

Whilst the current review attempted to provide a comprehensive overview of the current evidence base regarding therapeutic interventions for adoptive families, it has some key limitations. There were inherent difficulties in appraising studies so diverse in their design, focus, intervention and expected outcome. Assessing the efficacy of one type of intervention over another may be of little value when what is needed is the ability to draw on a range of therapeutic approaches which can be combined to best meet the specific needs of individuals and their families. The inevitable overlap between foster and adoptive populations (domestic and international), due to relatively small numbers of adoptive families, meant it was not possible to distinguish differential outcomes for these distinct groups, and led to inclusion of studies evaluated in previous reviews. The exclusion of qualitative feedback within included studies and exclusion of qualitative studies may have overlooked key evidence in relation to effective clinical practice. The review considered studies from 1998 onwards, so may have excluded relevant and significant interventions before this. Estimates of the studies' quantitative quality ratings, due to constraints of time and resources, were conducted by a single researcher and are therefore open to subjective bias, as are the intuitive judgments of quality. The review included only English language articles in peer reviewed journals, which may have introduced publication bias. Furthermore, only one researcher conducted the literature search, which may have led to bias in study selection.

4.3. Clinical implications and suggestions for future research

4.3.1. Clinical Implications

The current review provides limited evidence that group, individualised and systemic interventions can positively impact child and care-giver functioning. This supports a model of care in which adoptive families are able to access a wide range of interventions, targeting different areas of need, rather than a 'one size fits all' approach. Parenting programmes designed to complement rather than replace wider packages of support, are often the only support available due to service constraints (Kinsey & Schlosser, 2012). Whilst group interventions may enhance the well-being, skills and confidence of caregivers, their impact on the parent-child relationship and child functioning appears limited. The current review highlights the need to consider integrating short-term, group interventions for caregivers, with intensive, longer-term, individualised, relational interventions that can target the complex processes involved in 'interactive repair' (Golding, 2008). This would be consistent with the need to develop a coherent, systemic, 'wraparound' approach in which different parts of the adoptive family system could be supported throughout a lifelong process, accessing a range of evidence based interventions (Smit, 2002; Kinsey & Schlosser, 2012).

Clinicians need to be able to respond to a process which is not linear but rather consists of a complex interplay of multiple factors (Selwyn, 2010). As the majority of interventions targeted younger children, the review findings indicate the need to develop support for teenage adoptees who may face complex issues related to identity, in addition to the usual challenges faced during adolescence. The review evidence also suggests benefits in developing earlier, preventative interventions and the inclusion of a video feedback component within interventions aimed at promoting attachment. Long-term follow-up and recording of clinically relevant outcomes for adopted children and care-givers would facilitate consolidation of an evidence base to enable adoptive families and clinicians to make informed choices regarding interventions. Clinicians need to conduct comprehensive, on-going, family assessments, which incorporate unique adoption related issues, to determine whether generic or targeted attachment-based interventions should be offered (Barth *et al.,* 2005). Creating access to a broader range of interventions, across health, education and social-care would provide a

comprehensive framework of care in a context where mental health services may not always be positioned to deliver effective, targeted support (Golding, 2010).

4.3.2. Future research.

Future research needs to develop and consolidate existing evidence so studies are no longer regarded as 'novel' or 'innovative'. Studies need to employ more robust designs, yet accommodate the realities of complex clinical settings and multiple evidence requirements (Tarren-Sweeney, 2013). External validity relies on the conceptual validity of psychological constructs and how these can be measured in a meaningful, timely way (Tarren-Sweeny, 2013). The current review found evidence of the application of more sensitive measures of emotional and relational functioning (The Carer Questionnaire; Golding, 2006c), but there remains an urgent need to establish reliable, valid and standardised measures of emotional, relational and attachment outcomes. There needs to be consistent assessment of adoptive children's attachment relationships to establish a baseline. The current review found only a minority of studies incorporated long-term follow-up. To capture sustained improvement in enduring, trauma and attachment related difficulties, realistic and developmentally meaningful time-frames need to be employed. Long-term follow-up would enable mechanisms of therapeutic change to be identified. In assessing long-term effectiveness of interventions, it would be helpful to report clinically meaningful outcomes rather than statistical significance (Tarren-Sweeny, 2013). In assessing efficacy, the current review identified the need to explicitly account for the impact of contextual factors upon therapeutic processes. The rigorous application of qualitative research methods would facilitate valuable illumination of the subtle impact of contextual factors and more complex aspects of therapeutic change, such as mutuality and mentalising capacity (Hughes, 1999; Nickman, 2005).

5. CONCLUSION

Currently, evidence suggests interventions for adoptive families are offered in the absence of a strong evidence base (Barth *et al.,* 2005; Tarren-Sweeny, 2013). The current review provides limited support for the efficacy of both individualised and group interventions in relation to children's behavioural functioning and caregiver's confidence and perceived competency, with some evidence for the effectiveness of individualised interventions in reducing attachment insecurity. Barth *et al.* (2005) stressed the child-parent relationship as the central reason adoptive families seek support. Crucially, the review highlights a paucity of evidence to support the benefits of interventions focused on enhancing relational functioning and attachment. Future research needs to develop valid and reliable measures of emotional and relational factors and employ developmentally meaningful time-frames in which to assess relational outcomes. Quality issues identified in the current review indicate that multiple evidence requirements would afford a more meaningful way to assess the efficacy of interventions and facilitate the establishment of a more robust evidence base for a wider range of interventions. This would enable policy makers and clinicians to respond more flexibly, effectively and sensitively to the complex needs of adoptive families.

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Part 2: Research Report

An exploration of the help-seeking experiences of adoptive caregivers with children who have emotional and behavioural difficulties: An interpretative phenomenological analysis.

ABSTRACT

Introduction: Adoption offers an invaluable opportunity for developmental recovery for children who have suffered adverse early experiences however, the realities of a complex, life-long process can present significant challenges for adoptive families trying to establish stable, healthy relationships. Whilst there has been limited qualitative research in to parental help-seeking for children's mental health problems, there appears to be a dearth of research addressing the help-seeking experiences of adoptive parents, whose children may be more vulnerable to developing emotional and behavioural difficulties. By employing a qualitative, ideographic approach, this research aims to develop existing evidence by exploring the help-seeking experiences of adoptive caregivers and any associated psychological impact.

Method: Interpretive phenomenological analysis (IPA) was employed to explore the lived experiences of adoptive mothers' formal and informal help-seeking for their children's emotional and behavioural difficulties. Semi-structured interviews were conducted with six adoptive mothers. Respondents were interviewed following their child's access to a local CAMHS service and initial assessment.

Results: The analysis generated four main themes of 'Having to Battle', 'Managing Internal Conflict', Fragile Connections with Professionals' and 'A Reducing Social Circle'. Twelve sub-themes facilitated exploration of convergence and divergence within respondents' accounts.

Conclusion: The notion of 'having to battle' emerged as a prominent factor in respondents' accounts, which precipitated internal psychological conflict and shaped respondents' informal and formal help-seeking. Discussion of the links between respondents' accounts and theories of help-seeking, stigma and attachment, helped to inform ways in which post-adoption services could be developed to better meet the needs of adoptive children and their families.

1. INTRODUCTION

1.1 Social Context

In 1998, following increasing concerns about poor outcomes for children in care, UK government policy was implemented to promote adoption as an intervention for children unable to remain with their birth families (Sturgess & Selwyn, 2007; Selwyn *et al.*, 2014). Across England and Wales the total number of adoption orders up to the 31st March 2012 was 4,472 with 3,450 of these children adopted from the care system at an average age of three years, eight months (British Association of Adoption and Fostering Statistics, n.d.). Children adopted from care are likely to have been exposed to similar adverse experiences as those suffered by looked after children. Syne *et al.*,(2012) highlighted the negative impact of these disruptive experiences on the ability of children adopted from care to manage transitions into their new families and schools. Despite government commitments to improve support for vulnerable children and their care givers (Children and Families Bill, 2013), the complex support needs of adoptive families can often be over-looked (Phillips, 2007; Dann, 2011), exacerbated by inadequate funding for specialist multi-agency provision (Selwyn *et al.*, 2014).

1.2 Parenting an adopted child

Whilst adoption is clearly regarded as a positive intervention, the realities of a complex, life-long process involving issues of profound loss, separation, identity and belonging, can present significant difficulties for adoptive families trying to establish healthy and stable relationships (Golding, 2006). Attachment security and parental sensitivity have been found to remediate the effects of early adversity and predict good outcomes for children adopted from care (Vostanis, 2014; Golding, 2006). Secure attachment style in adoptive mothers has been associated with securely adopted children post-placement and more successful adoption outcomes (Kaniuk *et al.*, 2004). Negative perceptions of the attachment relationship with their child, amongst adoptive mothers have been associated with increased risk of placement disruption (Dance & Rushton, 2005). Stinehart *et al.*(2012) highlighted the fear, frustration and 'jarring', experienced by adoptive caregivers, as a result of finding that offers of affection could be aversive to their child. Lieberman (2003) highlighted how adoptive parents may misinterpret children's difficult behaviour as personal rejection rather than a communication about underlying anxiety and loss. Dealing effectively with loss and rejection may be

influenced by caregivers' own attachment styles (Wright, 2009). Adoptive parents have often had to face loss associated with infertility (Nickman, 2005) which may interact with social factors to create pressure to be perceived as a 'good' parent (Hudson, 2006). Personal and cultural expectations may also place adoptive parents under pressure to demonstrate a high degree of competency in their parenting role, making them more likely to seek help but more vulnerable to feeling blamed when difficulties inevitably arise (Beek, 1999; Hudson, 2006). Feelings of helplessness, shame and defensiveness may impair the skills and sensitivity needed to care effectively for a child with attachment related difficulties. Consequently, the need for supportive, psychologically informed interventions that address and normalise the needs of adoptive parents in a non-stigmatising manner, has been recognised (Hudson, 2006; Vostanis, 2014).

1.3 Mental health needs of children adopted from care

Whilst adopted children present with a higher level of mental health need compared to the general population, their need is lower compared to looked-after children, due to increased placement stability and difficulties finding adoptive placements for children with high levels of need (Vostanis, 2014). However, compared to non-adoptees, adopted children have been found to be twice as likely to be in contact with mental health services (Rao *et al*., 2010). In a review of psychiatric disorders among domestically adopted children, Ingersoll (1997) found adopted children to be disproportionately represented in child psychiatric populations and more vulnerable to developing externalising disorders such as Attention Deficit Hyperactivity Disorder (ADHD), patterns of aggressive and oppositional defiant behaviour, over-activity, hyperactivity and inattention. Emotional problems may include; being over-controlling, manipulative, lacking empathy, difficulty expressing thoughts and feelings, fear of intimacy and impaired ability to discriminate relationships appropriately (Hughes 1999; Wright, 2009). For a significant minority of children adopted from care, externalising problems and emotional difficulties remain stable over time (Rushton & Dance, 2006).

Research has demonstrated multiple predictors of poorer mental health outcomes for children adopted from care, and that mechanisms underlying adjustment to early adversity are complex. Pre-placement conduct problems, behavioural difficulties, attachment difficulties, multiple moves, neglect and sexual abuse, have all been found

to predict on-going mental health problems and adoptive placement disruption (Rees & Selwyn, 2009; Rushton & Dance, 2006; Rushton *et al*., 2003; Simmel, 2007). Post-adoption predictors of mental health outcomes include issues related to identity formation and the ability to develop healthy family and peer relationships (Vostanis, 2014). Many adopted children experience multiple placement moves and have complex issues of identity to resolve which can increase their vulnerability to developing mental health problems (Smit, 2002). Loss and separation from birth parents and lack of opportunity to develop secure attachments during early development, can place older children adopted from care at greater risk of developing insecure attachments, leading to significant behavioural, cognitive and emotional problems (Midgen, 2011; Palacios & Brodinsky, 2010).

1.4 Parental help-seeking

Rather than a single event, parental help-seeking for children's mental health problems has been conceptualised as a non-linear process, occurring over time (Boulter & Rickwood, 2013). 'Process orientated' or 'pathways models' view help-seeking as a dynamic interaction between the individual and their community (Logan, 2001). Pathways models assume that children rarely take responsibility for help-seeking and recognise the central role of parents, the family, school and wider community (Logan, 2001). Ingersoll (1997) suggested that the over-representation of adopted children in child psychiatric populations may have resulted from the phenomenon that better educated adoptive parents are more likely to seek professional support (Ingersoll, 1997; Nickman *et al.*, 2005). In the case of adoptive parents, factors influencing help-seeking behaviour may be complicated by the interaction of the various systems that surround adoptive families, including the influence of birth families, foster carers, professionals, external agencies, the wider community and society (Bronfenbrenner, 1986; Stott, 2006).

Parents are often the first to identify a problem in their child and therefore play a critical role in facilitating access to services and ensuring their continued receipt (Logan, 2001; Boulter and Rickwood, 2013). Parental recognition and appraisal of their child's problem are key factors in initiating help-seeking and subsequent access to mental health services (Godoy *et al*., 2014; Sayal, 2006). Parents are more likely to seek help if their child's problem is severe, persistent and comorbid; comprises externalising

symptoms; results in significant parental burden; and is attributed to stable, internal, dispositional factors (Boulter & Rickwood, 2013). Research suggests that accessing formal support is associated with stigma and fear (Broadhurst, 2003; Mukolo *et al.*, 2010). High levels of self-efficacy, that is belief in one's own ability to cope effectively with life's challenges, and uncertainty regarding the availability of mental health services for children have been identified as barriers to help-seeking (Boulter & Rickwood, 2013). Current research offers little insight into the processes via which help-seeking is experienced as stigmatising, limiting the ability of services to minimise potential barriers (Broadhurst, 2003).

Parental help-seeking for children's mental health problems remains poorly understood (Boulter & Rickwood, 2013). Quantitative research has focused on the 'formal system' of mental health care (Pescosolido & Boyer, 1999) and has focused on identifying patterns of parental help-seeking, rather than exploring complex, individualised, psychological, social and cultural processes (Broadhurst, 2003; Reid *et al.*, 2011). Zwaanswijk *et al.* (2013) reviewed 47 quantitative studies looking at parental problem recognition and help-seeking for emotional and behavioural problems in children and adolescents. The review highlighted the importance of informal help-seeking, past treatment experiences and the role of school related problems, in determining whether needs were met. Reid *et al.* (2011) and Shanley *et al.* (2008) found patterns of parental help-seeking for children's mental health problems to be complex and non-linear and highlighted difficulties faced by parents trying to navigate a complex system of services. Reid *et al.* (2011) concluded that the concept of a help-seeking 'pathway' was misleading, with more accurate description being a 'labyrinth or a tangled web'.

Despite the broad theoretical consideration of parental help-seeking within the literature, there appears to be a dearth of 'bottom-up' experience driven, qualitative research. Using a grounded theory approach, Sayal *et al.*, (2010) explored parental help-seeking for child and adolescent mental health concerns within primary care. The importance of a trusted relationship with general practitioners; multiple barriers, including stigma; fears about being judged as a poor parent; and children being removed from the family, emerged as key themes. Boulter and Rickwood (2013) employed a thematic analysis and found parents were often confronted with an arduous task in obtaining appropriate mental health support for their child. The study highlighted the importance of the practical and emotional 'fit' between services and

parents in determining whether help-seeking experiences were positive or negative, and found that few parents sought informal support prior to seeking formal help.

This dearth of rigorous qualitative research limits the extent to which the validity of theoretical models of parental help-seeking can be tested. A qualitative approach would enable those seeking help to be conceptualised as active agents in the help-seeking process (Broadhurst, 2003).

1.5 Rationale and Aims of the Current Research

Examination of the literature reveals a paucity of qualitative research exploring parental help-seeking for children's mental health problems. Whilst there are studies that have incorporated qualitative feedback to capture the concerns of adoptive caregivers in relation to post-adoption support (Beek,1999; Selwyn *et al*, 2014), there appears to be a lack of research specifically addressing the help-seeking experiences of adoptive parents, whose children are more vulnerable to emotional and behavioural difficulties. By employing a qualitative, ideographic approach, this research hopes to develop the current evidence base by facilitating an in-depth exploration of the help-seeking experiences of adoptive parents of children placed from care. An increased understanding of adoptive parents' help-seeking experiences will help researchers and clinicians to develop their practice and better serve the needs of this specific group of service users.

2. METHOD

2.1 Design

The current study's aims to describe and interpret the help-seeking experiences of adoptive caregivers indicated the use of a qualitative methodology. An ideographic approach was judged to be most appropriate in facilitating understanding of psycho-social and cultural factors which may influence parental help seeking behaviour, as well as illuminating adoptive parents' concerns and conceptualisations. Furthermore, a qualitative approach is recommended in under-researched areas, especially those involving complex interpersonal processes, such as help-seeking (Elliot *et al.*,1999).

Interpretive Phenomenological Analysis (IPA) was chosen, firstly due to the emphasis it places on empathically exploring the respondent's particular experience of the phenomenon under investigation, and secondly, because of its distinctive focus on the psychological world of the individual (Smith, 2004). By facilitating a detailed examination of how individuals make sense of their particular experiences, IPA is able to capture individual experience and illuminate common conceptual frame-works across human experience (Smith *et al.*, 2009). IPA has been employed to explore the help-seeking experiences of individuals and family members in relation to mental health issues, from a range of under-researched populations (Aisbett *et al.*, 2007; Chang & Horrocks 2006; Mayers *et al.*, 2007; Tuck *et al.*, 1997). The application of IPA in these studies clearly demonstrates its value as a qualitative method that can capture the commonality and complexity underlying human lived experience and its consequent utility in the current study.

2.2 Epistemological Position of the Researcher

The research was conducted in accordance with the epistemological position of a critical realist approach (Appendix G).

2.3 Research Context

The research was undertaken within a specialist adoption service based within CAMHS as part of a wider team, developed to provide mental health support for looked after and adopted children, young offenders and homeless families. The team serves children and families living within a Midlands' health district, comprising rural, semi-urban and inner city areas. The team is multi-disciplinary, including psychiatrists, clinical

psychologists, community psychiatric nurses and primary mental health workers, and is led by a clinical psychologist. The team aims to provide a comprehensive service including; specialist assessments, parent training, group and individualised therapeutic interventions, and professional consultation. Referrals of adopted children can be made via local authority agencies, general practitioners (GP's) and paediatricians.

2.4 Respondents

2.4.1 Sample Size

As an ideographic approach, IPA is committed to detailed analysis of cases rather than making generalisations. Consequently, the examination of fewer respondents in greater depth rather than superficial descriptions of numerous individuals is a priority (Smith *et al.,* 2009). In order to facilitate the development of sufficient and meaningful comparisons within and between respondents, the sample size for the study was expected to comprise three to six respondents (Smith *et al.,* 2009).

2.4.2 Inclusion/Exclusion Criteria

Respondents were purposively sampled from families currently accessing the specialist adoption service. Individuals were eligible to participate if they were parents of children adopted from the care system after the age of two years, and were the main carer for that child. Their child would have undergone an assessment for a mental health problem within the previous six months, prior to the commencement of the study. Parents with adopted children aged between 5-12 years were included in the study. This pre-adolescent age range was specified to facilitate the capture of parental help-seeking experiences associated with initial transitions following adoption from the care system, a time period during which clinical intervention may be of most benefit. Adolescent children may present with different issues (e.g. issues of identity), which may have compromised homogeneity of the sample. Parents of children with a learning disability or severe neuro-biological impairment (e.g. acquired brain injury) were also excluded to maintain homogeneity.

Due to lack of funding for translation, and the potential challenge to homogeneity, respondents whose first language was not English, were excluded. It is hoped that future research will focus on respondents from a range of cultural and linguistic traditions.

2.4.3 Final Sample

Limited demographic information is provided to ensure that respondents' anonymity is maintained. The final sample comprised six respondents, who were all female. Three respondents had more than one adopted child. Three respondents had biological children in addition to their adopted children. Adopted children's ages ranged between five and twelve years. Three respondents were working out of the home, across a range of professional settings, including education and social care. Two respondents had been foster-carers. Four of the respondents had a male partner and two were single.

2.5 Materials

The research materials used in the current study included an Invitation Letter, Participant Information Leaflet (PIL), consent form, and semi-structured interview guide. These are presented in Appendices H-J. Further explanation regarding their use is given below.

2.6 Procedure

2.6.1 Ethical Considerations

The research proposal was peer reviewed by University staff and a service-user reference group. Ethical approval for the research was then sought and gained from a Local Research Ethics Committee (LREC) via the Independent Research Application System (IRAS). Approval was also granted from the local NHS Research and Development department. All relevant correspondence is provided in Appendix K.

Potential respondents were identified by CAMHS clinicians precluding any need for the researcher to access patient information directly. To minimise selection bias, clinicians were asked to select all families that had completed a mental health assessment within the previous six month period, from a consecutive list.

Interview topics would include potentially sensitive issues relating to respondents' experiences of parenting and the impact of their child's mental health difficulties. Consequently, the PIL informed respondents of their right to withdraw from the study up to the point when their data was anonymised, and to take a break during the interview. Respondents were informed about the opportunity to discuss any concerns during de-briefing, and that if required, they could receive support from an appropriate

member of the CAMHS specialist team. Respondents were also made aware that any disclosures made during the interview process which raised concerns regarding the safety of the respondent or others, would necessitate breaking of confidentiality by the researcher and the implementation of appropriate safeguarding procedures.

All respondent information was stored confidentially in accordance with University regulations and NHS guidelines.

2.6.2 Recruitment

Clinicians were asked to identify suitable adoptive families who had been through the child mental health assessment process within the previous six months. CAMHS clinicians requested permission from the main carer for their names to be put forward. Once potential respondents had been identified, clinicians sent out the Invitation Letter and Information Leaflet (PIL) (Appendix H) asking if they would be prepared to participate. Potential respondents were asked to sign and return a reply slip to the researcher (Appendix H). Respondents were then telephoned by the researcher, to arrange a suitable time to conduct the interview. Six individuals who met inclusion criteria expressed an interest in taking part in the study, and all six were interviewed.

2.6.3. Conducting Qualitative Interviews

Smith *et al.*(2009) highlight that both respondent and researcher play an active role within the research process and that semi-structured interviews facilitate this mutual process, by enabling the researcher to set a flexible agenda which can adapt to the respondent's concerns. Consequently, a topic guide with open questions (Appendix J) was employed to facilitate respondents' accounts of their lived experiences and to limit any constraints the researcher's own perceptions might impose (Smith *et al.*, 2009). The interview schedule was developed in consultation with a member of the specialist adoption service team and via informal consultation with an adoptive parent, who was unconnected to the current study.

Respondents were offered the choice of being interviewed within the out-patient clinic or at home. All six respondents chose to be interviewed in their homes. Interviews complied with University and NHS lone-worker and safe working practice policies.

Prior to conducting the interview, the researcher ensured respondents had read and understood the PIL and answered any remaining questions. Immediately prior to the interview, written consent was obtained. All interviews were audio recorded.

Following the completion of the interview, respondents were given the opportunity to raise any concerns. This gave the researcher opportunity to assess whether clinical intervention was appropriate. Respondents were asked if they wanted to receive a summary of findings (address retained if needed). Following the completion of interviews, a written reflection of the interview process was made.

2.7 Analysis

Due to time constraints, digital audio recordings of interviews were transcribed by a third party, who had signed a confidentiality agreement in accordance with University and NHS ethical guidelines (Appendix L). The transcriptions were coded and anonymised by the researcher to ensure anonymity and confidentiality.

Rather than a single prescribed analytic method, IPA is characterised as sharing a set of analytic processes (Smith *et al.,* 2009). These common processes were applied in accordance with the six stages described by Smith *et al*. (2009), but with some flexibility, as warranted by this particular analytic task (Reid *et al.,* 2005). An important aspect of IPA that supports the ideographic stance is that each transcript is analysed individually before there is a tentative look across cases. For the purposes of transparency, further details regarding the analysis undertaken by the researcher are provided in Appendix M. Examples of initial coding ,clustering of themes and visual mapping of themes for an individual respondent, are presented in Appendix N.

2.8 Quality Issues

2.8.1 Quality

Rather than reliability or generalisability, issues pertinent to qualitative research concern coherence, credibility, and transparency (Elliot et al., 1999; Yardley 2000). The quality of the current research was safeguarded by implementing strategies to maximise trustworthiness and coherence. The researcher attended a comprehensive training course to develop their competence in the application of IPA methodology and semi-structured interview techniques. Analysis of the data was discussed within a peer supervision group and with the research supervisor to ensure credibility. An audit trail comprising a record of the steps taken in the research process maximised transparency.

2.8.2 Reflexivity

IPA emphasises the interactive and dynamic nature of the research process, with the interpretations of the researcher playing a critical role (Smith & Osbourne, 2003). Consequently, reflexivity is a fundamental element in the research process. A research diary was kept which enabled reflection upon personal characteristics, perceptions and engagement with the project, as it progressed. The quality checks detailed above also helped to facilitate reflection and questioning of the researcher's assumptions, decisions and conclusions, throughout the research process.

A full chronology of the research process can be found in Appendix O.

3. RESULTS

Following the detailed case by case analysis, looking across cases resulted in emergence of four super-ordinate themes. Each super-ordinate theme was comprised of less frequent sub-themes which were repeatedly re-configured as part of a creative process of identifying connections across cases (Smith *et al.*, 2009). There is no prescribed format for presenting an IPA analysis (Smith *et al*., 2009) so whilst it was expedient to consider super-ordinate themes in logical sequence, it is important to highlight the dynamic overlap between them. A visual representation of the relationship between super-ordinate themes and sub-themes is presented in Figure 2. To facilitate transparency, the frequency of themes across respondents' accounts is provided in Appendix P.

The first two super-ordinate themes are concerned with the physical, emotional and psychological impact of external and internal conflict, resulting from having to manage children's emotional and behavioural difficulties. Respondents' subsequent relating to formal and informal sources of support is explored within the third and fourth super-ordinate themes. Individual sub-themes are considered in relation to relevant super-ordinate themes within sections 3.1 -3.4 below.

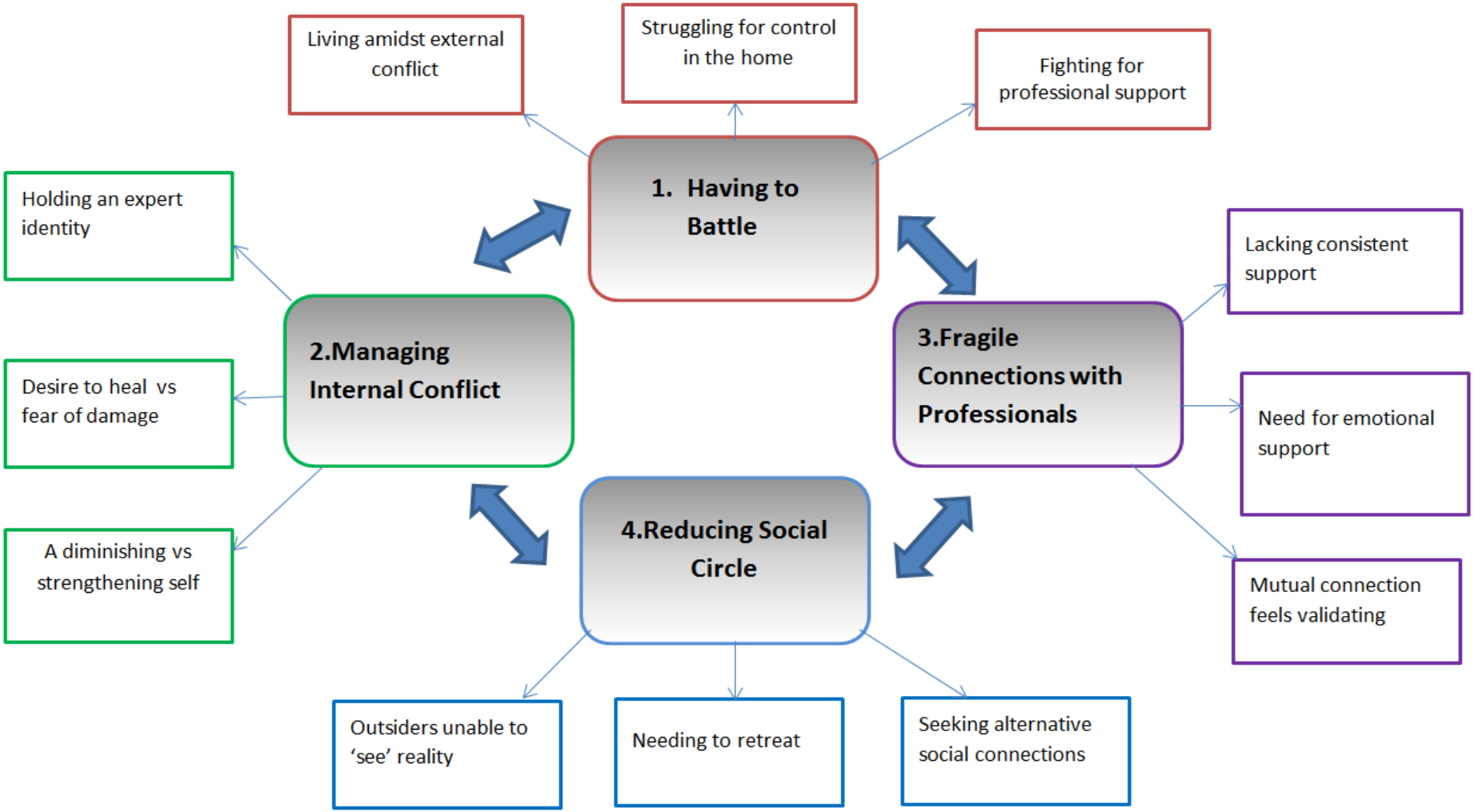
3.1 Having to battle

This super-ordinate theme aimed to encapsulate respondents' sense of struggling to manage their children's difficulties. The image of 'having to battle' arose directly from respondents' frequent use of conflict-related imagery, which conveyed the relentless, exhausting nature of trying to maintain a sense of control and fighting for professional support.

3.1.1 Living amidst external conflict

The immediate physical and emotional impact of coping with enduring conflict, including physical attack, unpredictability and the need to be present, featured strongly. A majority of respondents described physical attacks upon themselves, family members and the home environment. A salient feature was respondents' containment of their emotional distress in response to physical violation.

Figure 2: Super-ordinate themes and sub-themes



Like, we've got a lot of damage that's been done in the house, he's ripping my wall paper, he's urinating and defecating in the bedroom and sinking his teeth into the woodwork of his bunk-bed and just there's things that are damaged and broken. Then he hits me and I'm all marked up and bruised **(Hayley)**

Hayley's use of the present tense, powerfully expresses the destructive and intense nature of her child's distress. The consequences of her child's behaviour are literally *'marked'* upon her skin. Her use of formal language, 'urinating' and 'defecating' to describe the primitive violations of her son may reflect Hayley's striving to contain her distress and maintain a 'professional' detachment. Sarah's externalising of her son's aggression towards her partner, as an overwhelming physical force *'kicking in'*, similarly convey a need to contain emotions.

the most difficult thing about the medication was Daniel's refusal to take it because that's when the control kicked in again. ...I mean Michael would sometimes go to work bleeding, cos it was, he'd bring out every kind of behaviour, he would just scratch Michael, bite him, kick him, everything. **(Sarah)**

Coping with unpredictability was an intrinsic feature of living amidst external conflict. Anne's comparison of her son to being like a '*pressure cooker that would just blow'* and Emma's sense that for her son, *'anything just pushes the button and he goes over the edge'*, were strong images that captured the volatility that pervaded respondents' life worlds. Hayley refers to the uncontainable energy of her son *'launching'* and leaping throughout the house, and her sense of bewilderment as she tries to protect her younger child, which speaks of a loss of perceived control. Her reference to the *'minefield'* is a dramatic image that conveys her sense of unrelenting exposure to an unpredictable external world.

It just, it feels a bit like a minefield, you know, **(Hayley)**

Associated with unpredictability was respondents' need to be present and alert. Christine, Emma and Anne's references to their need to be available '*twenty-four seven', 'forty-eight hours non-stop'* and '*a full twenty four',* convey the intense level of physical and emotional demand in the present moment, which resonates with the psychological impact of being caught up in active warfare. There is a powerful sense of day and night merging, just as it would within a combat situation, where normal cycles of daily living break down. Anne's recollection of living in a '*war zone'* powerfully conveys her unrelenting need to be present.

but it literally was a war zone, it was very emotionally hard. Because you literally couldn't take your eyes off of them without them attacking each other. **(Anne)**

Rachel's reference to being *'shell-shocked'* powerfully captures her remembered sense of her fragility of her internal psychological state resulting from her hyper-vigilance during the early stages of her children's adoptive placement.

Juxtaposed with the need to be 'present', was respondents' conceptualisation of living amidst conflict as a journey. Anne, Sarah and Hayley referred to their battle as being long, enduring, and inevitably life-long. Hayley also speaks of her acceptance that the struggle will be long, but emphasises her need to be supported along the way.

I'm quite happy for somebody to say you know, this is going to take a really long, long time. I'm ready for the long haul but I need to be guided in it I guess and I need somebody to give me support **(Hayley)**

3.1.2 Struggling for control in the home

For most respondents, striving to maintain perceived control was reflected in respondents' descriptions of physical interactions with their children. This was particularly prominent within the accounts of Hayley and Emma.

I'm clinging onto keep Matthew in the pushchair as long as possible, because it's safe and then I've got one child contained and I've only just started trying to walk Matthew to school and we're sort of trying to set up a

routine where they all walk single file and I say that I need to be able to touch you, if I can't put my hand on you, you're too far away. **(Hayley)**

Hayley's *'clinging'* enables her to physically contain her child and keep him safe, but also speaks of her emotional desperation to control and contain her children. Anne describes using her entire body to contain her child's distress.

Tom would contain it all day and literally as soon as we walked out of those school gates he would burst. I would end up carrying him fireman's carry all the way home and he would let go at home. **(Anne)**

The *'fireman's carry'* is a moving image of how Anne uses her whole embodied self to physically contain and control both her child's and her own emotional distress, until they can retreat to a place where it is safe to *'let go'.*

Prominent in Emma's account are her descriptions of feeling physical and emotionally controlled by her child, resulting in an overwhelming loss of perceived control, reflected in her comment that *'you feel like you're not really in control of your own life anymore and he's running it.'*

3.1.3 Fighting for professional support

Accessing formal support was frequently described in terms of a need to 'fight' or 'battle'. This conceptualisation is encapsulated in Sarah's poignant reflection *'that all of those things haven't come without having to battle,*' which speaks of the profound perseverance and personal cost involved in procuring professional support for her son. Sarah describes the pervasiveness of her struggle but identifies a particular area of intense fighting.

And I think the frustration has been sometimes that you do feel that you have to fight, (slight pause) and that hasn't just been around mental health services or social care. We had a real battle with school. **(Sarah).**

Her use of the word *'real'* emphasises the deep emotional impact of this particular battle, which featured prominently in her account. She underlines the unrelenting and

unpredictable nature of the fight when she says '*they just kept throwing curve balls and putting barriers in the way'.*

A striking feature of Rachel's account is her sense of being positioned as an enemy. Exposing her need for help places her in an extremely vulnerable position, which she has no choice but to defend, in order to protect her children.

But that was used as this kind of, I felt, against me, that I was over-anxious, I felt like I was a birth parent being vilified, that's how it felt. I felt like I was on the defensive and I spent then a good six weeks then before they could meet, maybe longer, feeling they were going to take my kids away. **(Rachel)**

For Anne, Christine and Emma, the need to fight for support is less intense and overwhelming. Christine, describes herself as fighting her 'corner', which suggests her battle is more contained.

I suppose I just, I will fight my corner whereas perhaps other parents probably, probably wouldn't. I've not really had to that much, as I say I think I've been quite lucky. (**Christine)**

Christine conceptualises her ability to fight as an advantage rather than a dynamic she has been forced into. Her use of the word 'lucky,' suggests an external locus of control which may serve a protective function.

3.2 Managing internal conflicts

This second over-arching theme endeavoured to capture the internal impact of *'having to battle'* which often involved having to manage conflicting identities.

3.2.1 Holding an expert identity.

'Having to battle' created a need for respondents to hold an expert position. The term 'expert' encapsulates respondents' theoretical knowledge, often reinforced by their professional and/or maternal expertise. Whilst asserting an expert position could provide protection it could also be perceived as threatening, causing respondents to repress this valued aspect of their identity.

Most respondents made reference to their knowledge, research and reading around attachment theory. Respondents used this knowledge as means of empowerment and to mediate communication with professionals. Emma's sharing of her knowledge to open up dialogue and educate professionals, was typical of respondents' experiences.

I gave him some information on working with adopted and fostered children in schools and he actually went through it and made notes and then had a meeting with me and discussed it and I was like blimey, no teacher's ever done that before when I've given it to them. I get the feeling it's probably gone in the bin **(Emma)**

Emma's retrospective surprise at the teacher's positive response implies an underlying self-doubt and suggests that expert knowledge may also serve a protective function, helping to contain her inner vulnerability.

The dismissal of respondents' 'expert' knowledge by professionals was apparent. Hayley's encounter with her G.P. captures how this 'expertise' is swiftly dis-regarded.

I explained that what the children were doing that I knew that it was very highly likely attachment disorder and they definitely needed some intervention of some sort. Um, and, um, (laughter, sarcastic) she was like very, well don't you think that Family Action would be more, (said in posh voice of doctor) you know, I said. In the end I just got very tired of trying to argue the case with her, **(Hayley)**

The degree of resistance encountered by Hayley is conveyed by her weariness as she finds herself engaged in a dynamic similar to that of a legal battle.

Expert knowledge could be reinforced by respondents' professional identities. Sarah and Anne utilise their professional expertise within education and foster care, to defend their positions amidst on-going battles with school. In contrast, respondents could feel the need to supress their 'expertise' which was often experienced as threatening by professionals. This was a salient feature for Rachel, who also worked in education.

I think she was hoping I'd be a bit more, I hate to use the word subservient, but definitely she didn't want me to be so strong in my opinions.

So I'm experienced, I'm actually a teacher, so I know about stuff. But in terms of what they think of me I'm the bottom of the pile and with not a lot to say. (**Rachel)**

Rachel feels that in asserting her professional identity, she is regarded as a potential threat and therefore has to supress her opinions, eroding her self-efficacy.

Respondents were often faced with the shortcomings of their 'expert' identity when it conflicted with lived experience. This conflict is encapsulated by Christine's experience where her professional role in social care, means she is familiar with the 'theory'.

I just feel very inadequate sometimes because I feel that I should know all this and I do know it all but putting it into practice is so hard, you know. So we try all different strategies, um, but nothing seems to work which is why I sort of thought in the first place, this isn't, nothing's the normal behaviour things aren't working, therefore there must be something else. But then how do you address that something else? **(Christine)**

Christine reflects a painful struggle expressed by half of respondents, in which despite providing a sense of emotional containment, holding an 'expert' identity could exacerbate a deeper, underlying sense of personal inadequacy.

3.3.2 Desire to heal versus fear of damage

Located within respondents' maternal identities was a conflict between their reparative role and being positioned as causing damage. These opposing constructions of the self were important factors underlying respondents' desire for support.

Hayley, Anne and Rachel used striking imagery to convey the depth of their yearning to repair, cleanse and heal their children.

I'd sit and we'd start to sing songs because I was hoping I would like wash away that anxiety that they'd come back with. **(Anne)**

Anne's past *'hoping'* that she could wash away her children's anxiety reflects tension between her desire to heal and facing the reality of their difficulties. Hayley's allusion to having believed herself to be a *'Superwoman'* that could *'heal the children by*

herself' similarly suggests an idealised version of herself that she has had to relinquish. Rachel's sense that removing the *'junk'* from within her daughter will take a long time, speaks of her endurance and determination to heal her child.

In stark contrast, respondents' fear of causing damage was apparent so that maternal desire to protect could be cruelly inverted. In Rachel's description of her daughter's aversion to any physical contact, the word *'flinch'* conveys a visceral, embodied way in which she feels experienced as potentially damaging.

You know, she doesn't seek physical contact with me or any contact with me at all. She would flinch if I went to touch her. (**Rachel)**

Christine and Anne identified feeling burdened with responsibility for perpetuating their children's sense of loss, having taken them away from birth parents and foster-carers. Other respondents, expressed how their emotional responses to managing challenging behaviour, conflicted with their desire to nurture and protect their child. Hayley's hatred of her anger reflects an inner conflict between her maternal identity and the negative emotional impact of her struggle.

I hate the way that I'm feeling angry at my own children. **(Hayley)**

3.2.3 A diminishing versus strengthening self

A sense of abandonment, isolation and feeling overwhelmed, served to diminish respondents' belief in their inner strength and ability to cope with their children's difficulties. However, from within this diminishing sense of self-efficacy, the growth of resilience was apparent.

Abandonment and isolation were experienced by Sarah and Emma as being shut out and excluded by services. Implicit in Sarah's account, is a feeling of not being believed and which reinforces her sense of disempowerment.

So that was probably one of the most difficult times actually since we adopted, we just felt like a door had been closed and almost we were making things up that things were that difficult. **(Sarah)**

For some respondents, feelings of isolation and abandonment fed into more pervasive loss of self-efficacy, apparent as a sense of being overwhelmed by the scale of their task. This is powerfully symbolised in Rachel's striking description of herself as;

A teeny figure in front of a huge mountain. That's how life is for an adopter **(Rachel)**

Her use of the word 'teeny', rather than tiny, serves to convey how diminished she feels she has become. Her use of the present tense expresses the inescapable, unrelenting nature of her undertaking. Whilst Rachel appears able to grasp on tightly to a reduced sense of self, Hayley expresses her fear of fragmentation.

I feel like I'm actually very, very close to breaking point.

Because I just feel completely, myself, really emotionally all over the place. **(Hayley)**

For Hayley, her sense of self appears to have lost coherence, as she feels scattered *'all over the place'*. Anne's description of herself as a *'battered wife'* conveys a gradual erosion of her personhood.

The emergence of resilience, amidst struggle and adversity was a striking feature within all respondents' accounts. Tolerating uncertainty, dealing with multiple agencies, and fiercely advocating for their children, were common features of respondents' experiences. Rachel's incisive remark about her need for resilience, encapsulates respondents' need for strength to contend with professionals**.**

but when you go on your prep course they tell you that you need resilience. And you think they mean resilience to deal with your children and you go yes, yes. You don't realise what they meant was resilience to deal with the professionals that you're going to come across, that's where I need my resilience **(Rachel)**

For Emma and Christine, this resilience was characterised by a quieter, more contained hardiness; captured in Christine's comment *'so you take what comes and deal with it, don't you?'* Anne and Rachel displayed a more active stance. Rachel's allusion to her need to *'keep screaming and shouting'* for her children's entitlement, conveys her passion and fortitude.

3.3 Fragile connections with professionals

The third overarching theme relates to the tenuous nature of relationship with professionals. This fragility precipitated frustration and anxiety for respondents, who in addition to needing support to manage their child's difficulties were seeking empathy and emotional containment. There was however, a heterogeneous quality in which fragile connections could yield mutual understanding, creating a powerful sense of validation.

3.3.1 Lacking consistent support

Apparent in respondents' accounts was a desire for consistency regarding the timing, frequency and stability of contact with professionals. This need for reliable support is captured in Hayley's comment, *'I really, really need consistency and Mark needs consistency too.'* Hayley conveys how a lack of predictability regarding appointments makes her task all the more challenging, as she endeavours to provide physical and emotional containment for her children.

the appointments that have come are just all over the place, you know, bearing in mind that what these children really need is structure and routine, the appointments are absolutely terrible. **(Hayley)**

For Rachel, the inconsistency of face to face contact with professionals creates a sense of insecurity and loss of connection, whilst Hayley and Emma identify struggling to manage what can feel like vast expanses of time between contacts. Emma's inability to complete her sentence conveys her struggle to comprehend the timescale**.**

So it's just taken him a whole year for him to actually start some treatment and I just think. **(Emma)**

Respondents often conveyed a sense of superficiality in relation to the quality of contact, particularly with reference to time spent face to face with children, apparent in respondents' sense of neglect and disappointment.

So Hannah has been on the books of CAMHS for ages but as I said she's been seen for that one hour… **(Rachel)**

However, respondents' awareness of the constraints within which professionals were operating was apparent and could mitigate the emotional impact of feeling neglected.

Emma's comments capture the tension between respondents' need for a deeper sense of connection and commitment, alongside their awareness of an inevitable lack of resources and secure support base.

I think the people that are working there are doing their best but there's not really the resources there to be honest with you. And they seem like a very small team and you think well how, you know, how are they possibly going to manage with all these, you know, kids coming through the system. And I assume that contributes to the waits and the difficulties they have when they're trying to schedule appointments in their diaries and all the rest of it. Cos, so you just feel, you know, there needs to be more people in the team **(Emma)**

3.3.2 Need for emotional support

The fragile relational context with professionals generated an implicit need for emotional connection and containment. Respondents' longing for emotional containment is captured in Hayley's recognition of her need to make sense of her internal world.

*I think that somehow, I really need some help to kind of get my own thoughts and my own feelings about what we're going through as well.***(Hayley)**

Hayley's strong desire to invest her '*full trust'* speaks of her need to emotionally connect with a secure and reliable support base.

And what I really want to do is absolutely have my full trust in CAMHS and know that they're going to help me heal my son. **(Hayley)**

Christine expresses a more passive sense of waiting for professionals to open up space in which feelings can be addressed.

I suppose if I've got any sort of criticism or anything I was slightly unhappy about was probably the last time we went when we had really had enough of his behaviour, you know, (L) and it was getting so bad and I wanted to

perhaps discuss that. Um, it was oh, well let's just discuss the medication and that was it,..Maybe that time wasn't really the right time to kind of discuss it, but. **(Christine)**

Her hesitancy in pursuing her need for emotional support was indicative of respondents' tendency to hide their emotional vulnerability, possibly to protect their 'expert' identities, as mothers and professionals.

It was particularly striking how often respondents identified telephone contact as providing emotional containment. For Anne and Christine, the telephone afforded a sense of availability of support enduring over time. For Emma, the regularity of telephone contact from her social worker feels powerfully containing, enabling her to feel more in control of her situation and allaying feelings of abandonment. Her reference to not '*being left in the dark'* is a striking image reflecting her sense of feeling 'held'.

you know, ringing up to let me know that they had been chasing it and, you know, so. I suppose in that sense I was kept informed about that they hadn't completely forgotten about it and something was being done, rather than being left in the dark. **(Emma)**

3.3.3 Mutual connection feels validating

Mutual connection and validation were derived from responsive, face to face contact with professionals and a sense of being freely offered support without needing to fight for it.

Christine's description of her positive relationship with her son's school captures how frequency of direct contact fosters a sense of mutuality, conveyed in Christine's reference to a *'really close liaison.'*

We work closely with the school, um, you know, every morning a teacher comes out to tell me (L) what he's done (L) and, you know, we arrange regular meetings. He's got him, um, individual education plan which, you know, we sort of work to. We are in really close liaison with the school **(Christine)**

Rachel's reference to an image of a *'little bright shining star'* to describe a professional whom she perceives as providing unconditional support and understanding, vividly encapsulates for all respondents the significance of mutual connection. The star's brightness generates hope and empowerment whilst its size speaks of the scarcity of such relationships.

Rachel and Sarah referred to their sense of being on a shared journey with individual professionals, which helped them to feel supported, accepted and understood. Sarah's sense of a professional being *'on our side'* encapsulates the sense of validation generated within all respondents when professionals were perceived to be accepting, empathic and non-judgemental.

And I think we just always felt she was on our side, you know, and I think that makes a big difference when you're living under, you know, quite stressful circumstances **(Sarah)**

3.4 A Reducing Social Circle

The fourth overarching theme is concerned with respondents' perception of others as being unable to recognise the difficulties they were facing, which created a sense of a retreating social world. Respondents' subsequent seeking out of new relationships resulted in a re-configuring of social networks.

3.4.1 Outsiders unable to 'see' reality

This theme strives to make sense of respondents' perception that others were positioned outside their daily struggle and therefore unable to 'see' their lived reality. The majority of respondents identified that the demanding and extreme nature of their children's behaviours were hidden or hard to recognise. This is encapsulated in Hayley's comment that '*They're not seeing what we're living on a day to day basis.'*

For a majority of respondents a need for others to physically bear witness to their children's challenging behaviour was apparent. Anne's need for outsiders to view visual evidence of her lived reality reflects her desire for validation and understanding.

So I videoed it and I took it into school and I said I want you to understand that this is what happens at home, dependent on the sort of day he's got **(Anne)**

For Hayley, the *'watered down version'* of her son's behaviours, precipitates a sense of not being believed by her mum and appears to close off a much needed source of maternal support.

...people like my mum and dad who I really want to lean on and get support from, he gives them a very, very watered down version of the behaviours that he's doing with me. So much so that my mum just doesn't really accept that there's a problem. **(Hayley)**

Feeling misunderstood by peers contributed to respondents' sense of outsiders being unable to 'see'. Hayley, Christine and Emma convey their sense that other parents are unable to comprehend the complexity inherent in containing and managing their children's behaviour, leaving them feeling criticised and vulnerable to self-doubt regarding their competency as mothers.

Um, I think they just see him as a naughty kid, or they think we're probably a bit too, we've let him have his own way. **(Christine)**

Lack of understanding could lead to respondents feeling stigmatised, reflected in Anne and Hayley's sense of feeling shunned and scrutinised by other parents.

Anyway, one day I walked in the cloakroom, morning, everyone just turned away from me, I felt really awful. **(Anne)**

I've, I've felt extremely judged in the playground. **(Hayley)**

For Emma, Rachel and Hayley, a conceptualisation of their identity as adoptive parents being distinct from birth parents, appeared to create a barrier to understanding. This is encapsulated by Emma's sense of feeling unable to share her experiences with birth parents.

But I wouldn't dream of mentioning it to people who have got birth kids because they just don't understand the issues at all (**Emma)**

3.4.2 Needing to retreat

The notion of 'retreat' was conceptualised as a process in which physical and emotional distancing by family and community, could generate a need for respondents to withdraw from their social world. Whilst this theme was especially prominent for Sarah, Rachel and Emma, it was not explicitly apparent within Anne and Christine's accounts, both of whom identified feeling strongly supported by their adult children. For Hayley, there was a sense she had already socially withdrawn.

For Sarah, geographical re-location of family members precipitated feelings of rejection, leading to emotional withdrawal as a means of defending against further pain.

And you know, and you sometimes, you're reluctant to kind of talk about how difficult you're, you know, you're finding things as well because it almost sometimes feels as if you open up too much to parents they kind of say well, I've been waiting for you to say this. I wanted to tell you it was the wrong thing to do. **(Sarah)**

In contrast, Emma's need to distance herself from a particular family member, to preserve her belief in her strength and ability to parent effectively, positions her as being rejecting.

I think she feels that I'm cutting them out of her life **(Emma)**

Both are left with a diminishing sense of family support.

Rachel describes feeling unable to access her support circle which she feels has '*almost vanished'*. Her use of the past tense to explain how those in her support circle '*weren't adoption related'* speaks of a social world that no longer feels relevant.

so I'm struggling on my own, parenting on my own, unable to access my support circle because actually a lot of them weren't adoption related, they couldn't cope with and I didn't feel it was fair to expose the girls' difficulties to all and sundry. So my social circle had reduced right down **(Rachel)**

Rachel, associates her social retreat with a desire to protect her children. She also conveys her sense of not wanting to burden others. She conceptualises her retreat from

her faith community in these terms but also acknowledges a painful awareness of her faith community's withdrawal from her, when she alludes to them staying within their '*comfort zone'*. For Sarah there is a sense of enforced retreat, resulting from her battle with the local school. Her consequent inability to provide a sense of belonging for her child is experienced as a profound loss.

like I said, what we wanted, from a village, is for Daniel, just like Luke has, to feel part of the community and obviously that's been taken away. **(Sarah)**

3.4.3 Seeking alternative social connections

This final theme portrays respondents' experience of seeking out alternative social connections with other adoptive parents which enabled unique access to a shared understanding.

For Emma, contact with other adoptive parents appears to comprise the entirety of her community support, which speaks of its importance and value to her and highlights its scarcity as a resource.

I suppose support networks in the community would really be other adopters, I've got one or two friends who've adopted that I speak to about things but that would be about it **(Emma)**

This support, which Emma minimises as '*just talking'*, enables her to exchange ideas and physical resources, as part of a mutual process that feels safe and validating. For Rachel, connecting with other adopters offers unique relief and opportunity to escape from fear of judgement and pressure to present a false self. Interacting with other adoptive families also helps to normalise her experience.

Oh a relief. Nice because, also for the girls I think it's important because, you know, they know that those children are adopted. Not that we bring it up all the time but they do know, so they kind of know that that's not unusual, it is but you know what I mean, they know there are other people who are adopted. But you don't, nobody has to pretend anything and you don't have to explain anything or let people know why you're doing something, people just. Or even if you're doing things differently to how

they would do it, nobody's going to query your judgement, they're going to support you. So it's, when you've got it, it's fab **(Rachel)**

However, Rachel's reference to *'when you've got it'* speaks of the transitory and limited nature of this support and reflects a feeling that this support is both physically and emotionally distant.

Christine's experience of forming new connections with other adopters is constructed as an extension to her existing social world rather than an alternative. She appears to derive a sense of reparation and empowerment from being able to actively contribute and *'give back'* the adoption community

Yeah, and I think we try and do what we can to help them as well. We've, you know, we support all the events, Andrew's gone on the radio and talked about adoption. You know, we've seen potential, um, adoptive parents to talk to them so I feel like we try and give back a bit, you know **(Christine**)

4. DISCUSSION

4.1 Summary of Research Findings

Four super-ordinate themes emerged including: Having to Battle; Managing Internal Conflict; Fragile Connections with Professionals; and A Reducing Social Circle.

4.2. Theoretical connections

Since IPA shares fundamental concepts and constructs with mainstream psychology in relation to examining how people think about what is happening to them, it can examine and illuminate existing psychological theory (Smith, 2004). This section provides consideration of emergent themes in relation to relevant psychological theory and research (Smith *et al.,* 2009).

4.2.1 The parental help-seeking process

Respondents' conceptualisation of their help-seeking as 'Having to Battle', resonated with Selwyn *et al.*(2014) who found adoptive parents' accounts of 'battles' to obtain appropriate support for their children's emotional and behavioural difficulties to be common. Respondents' perception of themselves as needing to 'fight' for professional help, positioned them as actively enlisting professionals to join with them in their campaign to repair their children, contrasting with the more passive role of a 'help-seeker', suggested by quantitative studies of patterns of parental help-seeking (Zwaanswijk *et al.,* 2003). Respondents' conceptualisation of their help-seeking as an enduring struggle concurred with Boulter & Rickwood's (2013) finding that parents undertook an arduous process, involving persevering for long time periods to find appropriate support. An important perspective illuminated by the current study was respondents' conceptualisation of their help-seeking as being part of a potentially life-long journey, reflecting anticipation of the stressful and enduring nature of the task ahead (Golding, 2006).

Respondents' construction of help-seeking as 'having to battle', reflected that rather than a linear pathway, help-seeking is complex and unfolds over time (Rickwood *et al.,* 2005). Respondents' descriptions of fighting for professional support were indicative of a relentless and often bewildering need to navigate between services, consistent with the notion of a labyrinth or tangled web (Reid *et al.,* 2011). Network-based models of

help-seeking (Pescosolido, 1992) emphasise multiple pathways to support. Respondents' sense of fighting with a range of professionals to break through barriers to access appropriate help reflected attempts to access multiple routes to support, intensifying respondents' perceived vulnerability.

Parental burden , associated with more enduring and complex mental health difficulties (Zwaanswijk *et al.,* 2003) to which children adopted from care are more vulnerable (Golding, 2010), increases the likelihood of parental help-seeking (Boulter & Rickwood, 2013; Zwaanswijk *et al.,* 2003). Within 'Having to Battle' and 'Managing Internal Conflict', respondents' descriptions illuminated the weight and complexity of parental burden. Respondents' accounts of struggling for control in the home and living amidst conflict reflected the intense physical and emotional impact of dealing with high levels of violent and destructive behaviours, often perceived as being minimised by professionals (Selwyn *et al.,* 2014). The psychological impact of respondents' enduring sense of having to battle, was the creation of a vulnerable internal world in which respondents found themselves holding conflicting identities. Respondents conveyed a profound loss of self-efficacy and perceived control. A number of respondents described their desire to heal their children's difficulties whilst feeling positioned as causing damage. Reparation has been conceptualised as a maternal role behaviour extending beyond maternal protectiveness to include behaviours actively implemented by the mother, indicative of unconscious hopes of healing her own emotional wounds (Lesser *et al.,* 1999). Reparation may serve to increase parental burden and help-seeking, particularly within the context of adoption where mothers may be grappling with grief and loss associated with infertility (Nickman *et al.,* 2005) and failure to fulfil dreams of an ideal family life (Beek, 1999).

Whilst it has been suggested adoptive parents' may have an increased propensity to seek help for children's mental health difficulties due to higher levels of education, (Ingersoll, 1997), the current study illuminated a complex interaction of factors. A barrier to help-seeking can be parents' inability or reluctance to recognise a problem (Oldershaw *et al.,* 2008; Thomson *et al.,* 2012). Within 'Managing Internal Conflicts', respondents' valuing of knowledge, training and education around attachment theory as part of their need to hold an expert identity, may have heightened their propensity to anticipate and recognise problems likely to arise in their child (Woolgar & Scott, 2014).

Respondents' intra-personal concerns appeared to be of central importance in influencing decisions to seek help. Boulter & Rickman (2013) found help-seeking was prompted when parents perceived being unable to manage children's behaviour by themselves. A prominent motivation underlying respondents' help-seeking was a desire to 'get things right' and find the best way to repair their child. The realisation of being unable to repair their child appeared to be a critical point in respondents' decision to seek help. Whilst high levels of self-efficacy, the belief in one's own capacity to deal with problems, has been negatively associated with parental help-seeking (Boulter & Rickwood, 2013), within 'Managing Internal Conflict' respondents conveyed how erosion of their self-efficacy served to build resilience and increase determination to seek support.

In contrast to research that has demonstrated the role of other people's concerns in encouraging help-seeking (Boulter & Rickwood, 2013), within 'A Reducing Social Circle', respondents described a powerful sense of 'outsiders' (including professionals, family and friends) being unable to recognise the severity of their children's problems and not being believed. Distinct from birth families where challenging behaviours may be perceived as being 'abnormal', for adopted children there may be an implicit expectation by family and professionals that problems are more likely and therefore become normalised and overlooked (Woolgar & Scott, 2014). Family may be reluctant to point out problems, preferring to deny the presence of mental health difficulties, fearing stigma. In birth families, research shows recognition of existing mental health problems within the family may help to normalise difficulties (Boulter & Rickwood, 2013). Within adoptive families where a child's origins may be unknown, there may be powerful feelings of guilt, personal responsibility, loneliness and a sense of isolation from family (Beek, 1999). Such isolation was apparent in respondents' descriptions of their own and others physical and emotional 'need to retreat'.

4.2.2 The role of Stigma in help-seeking

Stigma has been found to play a critical role in determining attitudes towards help-seeking (Nam & Lee, 2015). Public and self-stigma have been identified, with a strong relationship between the two; public stigma increasing self-stigma (Corrigan, 2004). Whilst it has been recognised that stigma is likely to increase caregiver burden, there is a lack of clarity regarding the multiple dimensions of stigma to which parents and

families might be exposed, and their impact on service utilisation (Mukolo *et al*., 2010). Respondents' accounts illuminated a complex interaction between public and self-stigma in relation to formal and informal help-seeking. Within 'Managing Internal Conflict' respondents appeared to find themselves subject to a double bind so whilst holding an expert position could provide protection and validation, respondents could feel positioned as presenting a threat to professional expertise. Holding an expert position could also exacerbate self-stigma in relation to heightening respondents' perceived inadequacies which then conflicted with high expectations of the adoptive parenting role, possibly inflated by the selection process undertaken by prospective adopters (Beek, 1999). Self-stigma in relation to feeling positioned as damaging was also apparent. Within 'A Reducing Social Circle' respondents identified feeling subjected to social stigma from close family, friends and their wider community, driven by a lack of understanding which respondents attributed to others' inability to recognise or comprehend the complexity of the difficulties they were facing. Respondents often perceived other parents as questioning their competency, which could intensify feelings of inadequacy and vulnerability, leading to social withdrawal.

4.2.3 Attachment and Support Seeking

Adoptive caregivers' help-seeking may be usefully conceptualised in relation to an attachment perspective. Attachment theory identifies the establishment of a secure base as pre-requisite for the regulation of emotional distress and safe exploration of the world (Bowlby 1982). The attachment system is essentially a help-seeking system and determines how individuals seek help and respond to mental health services (Bucci *et al.,* 2015). In relation to mental health service provision, a secure base, providing physical and psychological safety is considered a fundamental requirement for successful intervention (Bucci *et al.,* 2015). Consequently, lack of availability, accessibility and negative attitudes of mental health professionals can present significant barriers to parental help-seeking (Boulter & Rickwood, 2013). Within 'Fragile Connections with Professionals' respondents' need for emotional containment and a secure support base was apparent. Respondents described their need for consistency, emotional containment and a profound sense of relief and validation when professionals were perceived as being sensitive and responsive. Opportunities to establish mutual relationships with professionals, focused on working towards common goals, were particularly valued by respondents enabling them to feel accepted and

respected. In stark contrast, respondents also conveyed feeling dismissed and criticised, perceptions which appeared to be reinforced by the unpredictable and superficial nature of contact with professionals. Respondents' sense of fragile, insecure connections with professionals across mental health, education and social care frequently presented a significant barrier to seeking support.

A central task for adoptive parents is the establishment of a secure emotional base for their child. Whilst therapeutic interventions may focus on enhancing carers' emotional containment of their child, there appears to be less consideration of parents' own need for emotional containment. This relates to the idea that for the mother to hold the baby, she in turn needs to be held by the father (Winnicott, 1960). Within 'Having to Battle' respondents conveyed the adverse impact of living amidst conflict, in a highly unpredictable world which was mentally and physically exhausting. Associated internal, emotional conflict resulted in respondents' need for containment of emotional and psychological distress. However, a perceived lack of available safe space in which to communicate feelings was also apparent. The importance of professionals considering and listening to parents' anxieties in order to restore their ability to think about and manage their child's emotions has been recognised (Naddeo, 2004), and is consistent with the notion of services needing to provide a corrective emotional experience in order to provide opportunities for success and self-efficacy (Bucci *et al.*, 2015).

Within the broader help-seeking literature, attachment theory has been utilised as a framework for understanding social support expectations (Larose *et al.*, 1999; Vogel &Wei, 2005). Attachment security influences social support cognitions which in turn affect process of help-seeking, with secure people being more positively oriented towards their support network (Larose *et al.*, 1999).Within 'A Reducing Social Circle', some respondents described feeling misunderstood by others, needing to be careful who they confided in and their sense of feeling separate and distanced, factors associated with a perceived negative network orientation (Larose, *et al.*, 1999). If individuals perceive less social support from people close to them, their distress experiences may worsen, increasing the likelihood they will need to seek professional help (Cramer 1999; Pierce *et al.*, 1996). Respondents' profound sense of reducing social support from friends and family, within what was often perceived to be a punishing social network, appeared to increase their reliance on professionals to provide a secure base.

4.3 Clinical Implications for post-adoption services

The findings of the current research highlight a range of complex factors which may increase the propensity of adoptive caregivers to seek help for their children's emotional and behavioural difficulties. Despite broad acknowledgement that adoptive families may require professional support across the lifespan (Beek, 1999), help-seeking is commonly constructed within services and society more broadly, as a sign of failure so caregivers often wait too long before requesting help (Golding 2010). In contrast, an attachment perspective conceptualises help-seeking as a positive behavioural response; a sign of independent, exploratory behaviour rather than un-healthy dependence (Bucci *et al.,* 2015). Within an attachment framework, post-adoption support services could utilise a pro-active approach, informing caregivers on a regular basis what services are available and as far as possible operate an open door policy that recognises and normalises the life-long nature of attachment related difficulties (Beek, 1999; Selwyn *et al.,* 2014).

The findings highlighted adoptive caregivers' need for containment of their own emotional distress. In particular, it was apparent that professionals were often perceived as failing to recognise the profoundly painful, physical and emotional impact of the parenting task. Fragile connections with professionals intensified care-givers' sense of vulnerability and distress. In contrast, mutual relationships with professionals were extremely validating and able to provide emotional containment as well as practical support. Within mental health, the dominance of a 'dose-response', medical model may restrict the possibility of providing more creative and responsive therapeutic interventions such as regular telephone contact; a form of communication clearly valued by respondents (Bucci *et al.,* 2015; Golding, 2010). An attachment-informed model of care, (Bucci *et al.*, 2015), implemented across mental health, education and social care, (Ratnayake *et al.,* 2014) could facilitate the provision of a secure base and create a context in which consistency, responsiveness, flexibility and mutuality could develop, providing adoptive caregivers with a sense of being 'held in mind' and cared for by services.

The findings emphasised the skills and expertise of respondents as 'active' agents and 'experts', fighting to secure their children's welfare. However this 'expertise' was often perceived as being threatening to professionals, leading respondents to suppress their

skills and knowledge, eroding self-efficacy. Within multi-agency working, families should be included as an integral element within a partnership framework that values mutual working (Golding, 2010). Rather than feeling dismissed or stigmatised, caregivers' knowledge and skills should be viewed as a valuable resource.

Respondents conveyed a perceived lack of social support resulting from lack of understanding by family, friends and the wider community. Involving the wider family system within post-adoption interventions and improving access to resources and information (Golding, 2010; Selwyn *et al.,* 2014), would serve to strengthen the family support network and reduce the stigma and psychological distress associated with a perceived lack of social support. Respondents were actively involved in seeking out opportunities to share knowledge and experiences with other adoptive parents as part of re-configuring their social network. Post-adoption services could facilitate this type of mutual support, ensuring that the concerns of caregivers rather than professionals are prioritised (Beek, 1999).

Broader policy issues clearly determine the extent to which the recommendations above can be implemented. With regard to mental health, the provision of attachment informed services requires over-arching organisational support (Bucci *et al.,* 2015). Acute, publically funded, mental health services, often lack the flexibility, accessibility and sensitivity to serve the complex and enduring needs of children adopted from care (Golding, 2010; Tarren-Sweeny, 2010). The consequent need for specialist, holistic, multi-agency working, adapted to local need (Vostanis, 2007) is critical, but often compromised by economic constraints, of which respondents were clearly aware. Respondents' conceptualisation of their help-seeking as a long journey reinforces the urgent need for policy makers to consider the adoption journey in its entirety, rather than focussing on initial recruitment. This would facilitate appropriate investment of resources, ensuring that post-adoption support across mental health, education and social care, is adequately funded and supported (Selwyn *et al.,* 2014).

4.4 Strengths and Limitations

Within the context of limited research on parental help-seeking and paucity of literature regarding adoptive parents' help-seeking, the current research has contributed to an increased understanding of the experiences of adoptive care-givers' seeking support for children's emotional and behavioural difficulties. The utilisation of a qualitative

approach offered a richer understanding of respondents' life worlds. In contrast to quantitative literature on parental help-seeking, reliant on questionnaire data to capture complex constructs such parental beliefs and cognitions, the current study was able to empathically explore the psychological complexity of respondents' experiences.

In its concern with the particular, IPA requires sampling to be theoretically consistent (Smith *et al*. 2009). The necessity of a relatively homogenous sample to afford insight into a particular experience, within a specific context can provide depth of understanding but not generalisability (Smith *et al*, 2009). The findings reflect the experiences of women whose children were presenting with high levels of need. Consequently, it is important not to over-interpret their experiences as being indicative of the wider population of adoptive parents. Whilst respondents' children were all in receipt of Tier 3 mental health service provision, they differed in regard to other key characteristics. Four respondents had male children presenting with externalising difficulties. Research suggests parents are more likely to seek help for boys' disruptive, externalising behaviours, which can have a greater impact on parental competency, increasing propensity to seek support (Boulter & Rickwood, 2005; Zwaanswijk *et al.*, 2003). Four respondents had biological children or had been foster carers. Both these sub-groups may present with different needs and experiences compared to adoptive parents without any prior parenting experience. Future research might consider the experiences of these sub- groups separately. The sample consisted solely of adoptive mothers so the experiences of adoptive fathers were not represented, an omission which should be addressed by future research.

4.5 Recommendations for Future Research.

It would be useful to explore the help-seeking experiences of adoptive parents caring for children with internalising difficulties, whose needs can be more easily over-looked by professionals (Golding, 2010). Adoptive parents' help-seeking for adolescents who may present with different issues would also be an important focus for future study. Respondents revealed relatively little about their informal support-seeking, possibly due to its scarcity or respondents' privileging of formal support. Future research focused on this particular dimension of help-seeking would increase understanding of the role and impact of the various layers of informal support which surround adoptive families (Bronfenbrenner, 1986; Stott, 2006). Whilst adoptive caregivers' attachment style has

been explored in relation to attachment security and placement success, (Kanuik *et al.,* 2004; Pace *et al.,* 2012), its impact on help-seeking has not been investigated and is worthy of exploration. The impact of parent-child violence is poorly understood and acknowledged amongst professionals and yet presents the most significant challenge and contribution to parents' psychological distress (Selwyn *et al,* 2014). Research is needed to understand the meaning of this behaviour in the context of adoption, and inform interventions. Finally, more research is needed to discern the cost-benefits of different adoption support models (e.g. attachment-informed service models) to strengthen evidence base and inform policy (Selwyn *et al.,* 2014).

5. CONCLUSION

In exploring the experiences of adoptive mothers' coping with their children's emotional and behavioural difficulties, the current study reveals the complex and profound psychological impact of the help-seeking process. The notion of 'having to battle', emerged as a central and pervasive element in respondents' experiences of seeking help. The relentless need to battle, to maintain control amidst an unpredictable external world, as well needing to fight for professional support, precipitated intense internal conflict and vulnerability. Respondents' perceived lack of informal, social support due to lack of understanding by family, friends and the wider community, appeared to intensify the need for professional help. Respondents' experiences of not feeling 'held' by professionals, with whom connections were perceived to be fragile, alongside the high degree of validation respondents derived from mutual connections with professionals, reveals the importance of providing emotional support and containment for caregivers. Respondents' accounts also reflected expertise and resilience as being important aspects of respondents' identities, which professionals were often perceived to dismiss. The findings of the current study highlight the need to recognise the particular challenges faced by adoptive caregivers, who should be regarded as active participants within a mutual process of support, in which their strengths and vulnerabilities are recognised and validated.

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Part 3: Critical Appraisal

1. Introduction

The aim of this paper is to present personal and professional reflections upon the experience of conducting the research and consider aspects of learning that took place during the course of the research journey. A reflexive diary was kept throughout the research process to record observations, questions and decisions, and forms the basis for this critical appraisal. The diary also facilitated the adoption of a phenomenological attitude (Finlay, 2011) in which attention is given to present experience through bracketing past understandings. This enabled me to engage with the 'hermeneutic circle', central to IPA, in which the researcher's own preconceptions must be continually revised in order to make sense of respondents' meaning-making (Smith *et al*, 2009).

2. The Research Journey

2.1 Choosing a research topic

Before commencing training, I had a particular interest in child and adolescent mental health, having had professional experience of working with children and young people with emotional and behavioural difficulties, both as a secondary school teacher and assistant psychologist. As a mature student, whilst studying for my undergraduate Psychology degree, I engaged in voluntary work within CAHMS, helping to facilitate a parallel parent and adolescent intervention for young people with Autism. Whilst working in the parents' group, some of whom were adoptive parents, I was particularly moved by individuals' accounts of seeking help for their children's difficulties. I also became increasingly aware of debate within the media in relation to government policy that actively seeks to increase recruitment of adoptive families, but often fails to provide adequate post adoption support (Stevens, 2011; Tickle, 2014).

As a parent, I have personally experienced the impact of coping with the mental health difficulties of one of my own children, and the associated quest to access appropriate support. It was as a result of this profound journey that I made the decision to pursue an alternative career in Clinical Psychology. I also have close friends and family members who have adopted children, which has raised my awareness of the complex and enduring issues faced by families who are in the process of building a secure base for

their adopted child, not only within the home, but also in the context of their wider family network, the school environment and local community. Hearing about the personal struggles of friends and family, coping with their children's emotional and behavioural difficulties and trying to access support, consolidated my particular interest in the help-seeking experiences of adopted families.

My initial research interest was in exploring how the psychological needs of adopted children were addressed within an educational context, since literature suggests that compared to looked after children, adopted children 'fall under the radar' (Dann, 2011). I considered using parent-teacher-child triads as a possible approach to conducting qualitative interviews. However, it soon became clear that due to time restrictions associated with the DClinPsy. alongside ethical constraints in relation to interviewing children, such an approach was not going to be appropriate or realistic. Consequently, I narrowed the focus of my research to the experiences of adoptive parents coping with children's emotional and behavioural difficulties. In particular, I was curious to know more about their experiences of accessing both formal and informal support.

2.2 Choosing a methodology.

On investigating the current literature on the mental health needs of adopted children, it became apparent that whilst there is a wealth of quantitative research on mental health outcomes and risk factors for domestically and internationally adopted children, including children adopted from the care system, there is a paucity of qualitative research. I was struck by the absence of any 'voice' of adoptive parents and children in terms of what they might have to say about experiences of placement breakdown, working through issues of identity and relational difficulties, or receiving therapeutic support. My exploration of the literature also revealed that mental health interventions for adopted children are offered in the absence of a robust evidence base (Tarren-Sweeny, 2013). It appeared that in this particular area, the research cycle had not included bottom up data which could be used to validate existing theory. This absence fostered a determination within me to harness my interest in adoptive families and child mental health, and focus on developing a neglected area of research. Due to the lack of research investigating the experiences of families of children adopted from the care system, I felt that a qualitative approach would be most suitable. I was also aware of a

need to establish multiple sources of evidence to better evaluate mental health interventions, rather than relying on traditional evidence hierarchies (Tarren-Sweeny, 2013) which also indicated the value of a qualitative approach.

Prior to training, as part of my undergraduate course, I had undertaken a small qualitative project using Grounded Theory (GT). Otherwise, qualitative research was an approach I was relatively unfamiliar with. It wasn't until teaching on the DClinPsy that I began to understand more about the range of qualitative methodologies available. Having been an English teacher and having always enjoyed analysing literary texts and characters, I was naturally drawn to approaches where analysis of language and meaning in particular contexts, could illuminate psychological processes within and between individuals. I was also keen to utilise the opportunity to develop new skills as well as my understanding of the particular merits of qualitative research.

Prior to commencing the research process, it was necessary to take time to explore issues relating to epistemology. I found it helpful to think about the connections between research methods, epistemology and my role as a clinician. I found myself drawn to critical realism, which is committed to a reality that exists independently of human observers, but which is also multi-layered and must therefore be investigated cautiously (Pilgrim, 2013). In the context of illness and mental health, this approach to knowledge facilitates the validation of individual experience by recognising the importance of impersonal forces as well as subjective meanings. Consequently individuals' experiences of mental health problems are not reduced to diagnostic labels or an idiosyncratic use of language (Pilgrim, 2013). The research was undertaken on the basis of an epistemological assumption that whilst respondents' verbal accounts of their personal experience could reflect their internal world in a meaningful way, such insight would necessarily be mediated by my own assumptions and conceptions.

I explored a range of qualitative methodologies before choosing an Interpretive Phenomenological Approach (IPA). I considered a Narrative approach (Murray, 2003) as a possible methodology for exploring how respondents might construct their help-seeking. However, since the aim of the research was to capture the lived experiences of respondents, eliciting a narrative of events may have risked shifting the focus of the research to historical aspects of adoptive parents' stories about the adoption process itself, rather than more current experiences of help-seeking. I felt also that asking

adoptive parents to construct a narrative about a potentially traumatic life phase in which they were still immersed might be problematic. I considered Grounded Theory (Charmaz, 2003) but subsequently discounted it as an appropriate methodology, due to its focus on identifying common processes within a given social phenomenon rather than an in-depth exploration of individual experience.

From a search of the broader literature in relation to mental health and help-seeking, I discovered that IPA had been employed to elucidate the experiences of individuals with mental health difficulties and their carers, from a range of under-researched populations (Aisbett *et al*.,2007; Tuck *et al.*,1997). The application of IPA in these studies demonstrated its value as a qualitative methodology that could facilitate understanding of the experiences of adoptive parents seeking help for their child's mental health difficulties. I subsequently chose IPA due to the emphasis it places on exploring the life worlds of respondents in relation to particular experiences, and also because of its distinctive focus on the psychological world of individuals (Smith, 2004). IPA is consistent with a critical realist approach, since it aims to capture particular experiences, experienced by particular people, in order to reveal common conceptual frame-works within human experience (Smith *et al.,* 2009).

Regarding some common criticisms of IPA, the lack of generalizability of the current research was an obvious limitation. The research findings reflected the experiences of adoptive mothers whose children were presenting with particularly challenging behaviours so it was important to refrain from over-interpreting their experiences as being indicative of all adoptive parents. However, IPA is committed to ideography (Reid *et al.,* 2005) so that depth of analysis is preferable to broader, superficial descriptions of individuals' experiences (Hefferon & Gil-Rodriguez, 2011). I found generating and preserving a sufficient depth of analysis within structural and time constraints of the DClinPsy to be challenging. I was keenly aware of the risk of becoming subject to a common criticism of IPA, as being no different to standard thematic analysis (Hefferon & Gil-Rodriguez, 2011). Most IPA studies have been based on individual semi-structured interviews with English speaking adults (Smith, 2004). Thus IPA is subject to the same critique as many other qualitative methods in its reliance on a high level of articulateness, an obvious limitation of the current research. With more time I would like to have explored alternative approaches to collecting rich

verbal accounts e.g. audio-diaries. This may have afforded respondents more time to reflect and make sense of their experiences, rather than only being able to access 'in the moment' pre-reflective experiences, expressed within in a single semi-structured interview.

2.3 Collecting Data.

I was reliant on my clinical supervisor and the specialist adoption CAMHS team for the recruitment of participants. Since the CAMHS team functions within an active culture of research, I was able to develop my research question through detailed discussion with my clinical supervisor. This enabled me to feel confident in approaching clinicians within the team to assist with recruitment. Consequently, I had no difficulty recruiting the six participants for the study. I could have recruited more participants, but following discussion with my supervisors, I felt that the richness of the interview data collected was more than sufficient to facilitate a deeper level of analysis and illuminate convergences and divergences within respondents' experiences (Smith *et al.*, 2009).

During the interview process I was moved by the willingness of respondents to share extremely sensitive and intimate aspects of their lives. In common with other qualitative interviewers, I found myself feeling a sense of responsibility for their acts of self-disclosure, which at times blurred the boundaries between my role as researcher and therapist (Birch & Miller, 2000). I became aware of respondents' longing for their own emotional needs to be validated and whilst the interview could be perceived to offer a therapeutic opportunity, I also found myself feeling positioned as yet another 'professional' unable to offer sufficient time and space to explore respondents' concerns. I think at times this made me steer away from asking more explorative and open questions. I was acutely aware of time constraints inherent within the single interview and the need to offer sufficient space for de-briefing. I was struck by the extent to which respondents put in place their own 'protective' measures; for example arranging to meet a friend for coffee immediately following the interview. On reflection, I think conducting the interview process across two sessions may have afforded valuable opportunity for both researcher and respondent to reflect on the interview process. This may have minimised any sense of the single interview as having perpetuated neglectful interactions with professionals, which respondents had often encountered during their help-seeking experiences.

During the interview process, I was keenly aware of the impact of my personal experiences as a mother, seeking help for my own child's mental health problems. I often found myself delaying playing back the interviews, possibly due to the emotional impact upon me. With hindsight, it would have been useful to have accessed clinical supervision following data collection. I was also aware of the possible impact of my professional identity, both as a former teacher and mental health clinician upon the interview process. Three of the respondents also worked in health and education and two had been foster-carers. The data analysis subsequently revealed the prominence of respondents' 'expert' identities as means of mediating communication with 'professionals' during their help-seeking. On reflection, I felt the interview process may have mirrored respondents' need to assert their 'expert' identities in relating to myself as a 'professional' both as a researcher and potential representative of CAMHS, as a means of containing their emotional vulnerabilities.

Some respondents adhered to a narrative chronological account of their child's difficulties and were more reluctant to talk about feelings. On several occasions, respondents chose to resume the conversation once the audio-recorder had been switched off. This made it problematic to capture the more vulnerable aspects of their identities which proceeded to emerge. On reflection, it was apparent that intrinsic to my role as a researcher, was my association with CAMHS, which may have generated feelings of disloyalty and guilt within respondents. Whilst being taped, respondents often appeared keen to balance their frustrations with gratitude for support their families had received from CAMHS. Once recording had stopped, respondents were more open to expressing concerns. Whilst the use of written diaries over a longer time frame may have facilitated respondents' self-disclosure and improved credibility, the absence of non-verbal cues has been associated with poorer quality data (Meho, 2006). Nevertheless, the credibility of the research findings may have been strengthened by complementary use of respondent diaries to supplement semi-structured interview data (Smith, 2004).

2.4 Analysis

Due to time constraints, interviews were transcribed by a third party who had signed a confidentiality agreement in accordance with University and NHS ethical guidelines. The centrality of transcription as a powerful act of representation within qualitative research has been recognised (Oliver *et al.,* 2005). Consequently, it was important to take steps to minimise any potential threat to the integrity of the data, by repeatedly listening to interviews and checking and re-checking for accuracy, prior to analysis (Easton *et al.,* 2000). I also annotated transcriptions to preserve how the spoken words of participants might contribute to interpretations of meaning, (Corden & Sainsbury, 2006). This helped me to become more 'immersed' in the data, important for maximising the quality and coherence of the analysis.

As a novice, it was important to familiarise myself with IPA methodology by attending a two day training course, where I was able to learn about the theoretical underpinnings of IPA, interview techniques and the process of data analysis. I also read key primary sources relating to this particular method of qualitative inquiry (Smith *et al.,* 2009; Smith, 2004).

I found the analysis of respondents' interview data to be far more time consuming than anticipated. I felt overwhelmed by the richness of the data and was conscious of the 'compressed' time-frame in which my analysis needed to be completed, which at times felt frustrating. Since IPA is not a prescriptive approach, but rather a set of flexible guidelines (Eatough & Smith, 2006), I found the analysis of the first transcript to be especially challenging, as I tried to adapt the process to my individual way of working, being mindful of my research aims. Initially, I found myself sticking rigidly to a structured process. However, use of supervision and an IPA peer-group to verify the credibility of my exploratory coding and emergent themes, enabled me to feel more confident and able to free myself up to be more interpretative.

In generating interpretive themes, I was acutely aware of losing any sense of the 'whole' in relation to respondents' accounts, feeling I had 'cut them up' into lots of small parts. I felt a keen sense of responsibility to keep hold of the experiences that respondents had so willingly given me access to. From my IPA training, I was reminded of the use of 'poetic condensation' as a means of representing respondents' experiences (Ohlen, 2003). This is when poetic reflections are constructed out of respondents'

spoken words, in order to deepen interpretation. According to the hermeneutic principle of the whole-the parts-the whole, poetic condensation can assist with capturing 'the whole' (Ohlen, 2003). Consequently, as part of my analysis of individual cases, I constructed a poetic condensation for each respondent (Appendix Q). In re-creating my sense making of respondents' sense-making in this alternative form, I hope to bring readers of the current research into closer contact with respondents' experiences. This addition to the research process was also influenced by my curiosity in relation to bringing scientific and aesthetic approaches to understanding human experience, closer together.

In creating interpretive themes, I was mindful of the extent to which my interpretations were influenced by previous personal experiences and in particular how I was situated socially and emotionally in relation to respondents (Mauthner & Doucet, 2003). As a parent who has sought help for my own child's emotional and behavioural difficulties, there were many aspects of respondents' accounts that resonated. Since all the respondents were females, I was conscious of ways in which my gender, professional identity and maternal role could also shape my response to the data. Mauthner & Doucet (2003) propose that the interplay between the researcher's multiple social locations alongside their personal biographies need to be carefully considered during data analysis. Consequently, I was mindful during analysis of possibly privileging respondents' negative help-seeking experiences due to their particular resonance. Consultation with my supervisor and the IPA peer group, in relation to my interpretive themes, enabled me to acknowledge these reflexive issues and remain transparent in my methodological approach.

2.5 Dissemination

Given recent concern that the support needs of families who have adopted children from care have been overlooked (Selwyn *et al.*, 2014), it will be important to disseminate the research findings beyond the bounds of traditional academic settings to enable the 'voices' of adoptive caregivers to be heard. I will present my findings to the specialist adoption team and the wider community of researchers and clinicians within CAMHS. This will enable clinicians, researchers and service managers to better understand the help-seeking experiences of adoptive caregivers and where possible, adapt service delivery to better meet their needs. I intend to provide a report to the

specialist adoption team and to respondents who previously requested a summary of the research. It may also be of value to disseminate the findings to other areas of the local NHS Trust, by publishing a summary of the research in Trust magazines and/or on the Trust website. It will also be important to provide feedback to the relevant multi-disciplinary services involved in providing post-adoption support, including the local authority adoption teams. Relevant service-user organisations may also appreciate being made aware of the research outcomes.

Following thesis submission, I intend to publish the empirical research. As the qualitative data generated during the research process was so rich, I would like to explore the possibility of reporting separately on individual super-ordinate themes derived from the analysis, in order to facilitate a deeper level of interpretation and subsequent illumination of respondents' experiences (Eatough & Smith, 2006). I am planning to present the research findings at an academic research conference in September 2015.

I also hope to submit the literature review, which comprises a significant part of this thesis, for publication. In its consideration of the efficacy of therapeutic interventions for adoptive families coping with children's emotional and behavioural difficulties, I hope it will add to the evidence base and help clinicians, policy makers and adoptive families to make more informed choices regarding the most appropriate support.

3. Reflections on Professional and Personal Development

Traversing what at times has felt like an extremely long and challenging research journey has enabled me to learn a great deal, both personally and professionally. Applying an unfamiliar research methodology and learning new skills has helped me to build confidence and develop a clearer sense of my identity as a 'researcher' within my role as a clinical psychologist. The research process has invigorated my passion about the need to integrate ways of working across mental health, education and social care to better support families coping with children's emotional and behavioural difficulties; a focus I would like to pursue in my future career. The research process has also directly informed my clinical work in alerting me to the value individuals place upon feeling 'connected' with professionals and the importance of feeling 'held in mind'. However,

at times, the research experience has caused me to seriously question my expectations of the role I am training for, by heightening my awareness of the considerable constraints that services inevitably impose on mental health professionals' ability to provide 'good enough' support.

Exploration of my epistemological orientation has enabled me to reflect both personally and professionally about how I construct my own and other peoples' experiences, particularly in relation to mental illness. In relation to my clinical work, it has helped me to think more about the importance of acknowledging individuals' need to have their experiences validated in relation to an objective reality, often in the form of a diagnostic label. Yet the importance of understanding that reality is multi-layered and therefore must be judged tentatively, has also strengthened my confidence in the unique value of psychological formulation, central to my role as a clinician.

In relation to personal management and organisation, I feel that my ability to balance what have often been conflicting demands between my personal, clinical and research roles, has enabled me to develop skills that will be of immense value in my future career. Throughout the research process I have been very conscious of the need for 'self-care', and importance of utilising clinical and academic supervision as a means of facilitating this. I also feel that I have finally begun to find my own 'voice' as a researcher, which I hope to continue to develop within my future role as a clinician, particularly in relation to the psychological well-being of young people and their families. Part of this discovery has involved recognition of the need to allow myself to view the research process as an on-going dialogue, rather than a perfect end product.

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APPENDICES

Appendix A²: Guidelines for Authors for Literature Review Journal Target

Guidelines Adoption and Fostering retrieved April 2015 from:

http://www.uk.sagepub.com/msg/aaf.htm#JournalStyle

Adoption & Fostering is the only quarterly UK peer reviewed journal dedicated to adoption and fostering issues. It also focuses on wider developments in childcare practice and research, providing an international, inter-disciplinary forum for academics and practitioners in social work, psychology, law, medicine, education, training and caring for children and young children.

1. Peer review policy

Adoption & Fostering operates a strictly anonymous peer review process in which the reviewer's name is withheld from the author and the author's name from the reviewer. The reviewer may at their own discretion opt to reveal their name to the author in their review but our standard policy practice is for both identities to remain concealed. Each manuscript is reviewed by at least two referees. All manuscripts are reviewed as rapidly as possible, and an editorial decision is generally reached within 6-8 weeks of submission.

2. Article types

Articles may cover any of the following: analyses of policies or the law; accounts of practice innovations and developments; findings of research and evaluations; discussions of issues relevant to fostering and adoption; critical reviews of relevant literature, theories or concepts; case studies.

All research-based articles should include brief accounts of the design, sample characteristics and data-gathering methods. Any article should clearly identify its sources and refer to previous writings where relevant. The preferred length of articles is 5,000-7,000 words excluding references.

Contributions should be both authoritative and readable. Please avoid excessive use of technical terms and explain any key words that may not be familiar to most readers.

3. How to submit your manuscript

Manuscripts should be submitted to the editor by e-mail attachment to:
Miranda Davies
BAAF
Saffron House
6–10 Kirby Street
London EC1N 8TS

Telephone and Fax: +44 (0)20 7421 2608
Email: miranda.davies@baaf.org.uk

5. Declaration of conflicting interests

Within your Journal Contributor's Publishing Agreement you will be required to make a certification with respect to a declaration of conflicting interests. *Adoption & Fostering* does not require a declaration of conflicting interests but recommends you review the good practice guidelines on the SAGE Journal Author Gateway.

For more information please visit the SAGE Journal Author Gateway.

7. Acknowledgements

Any acknowledgements should appear first at the end of your article prior to your Declaration of Conflicting Interests (if applicable), any notes and your References.

All contributors who do not meet the criteria for authorship should be listed in an `Acknowledgements' section. Examples of those who might be acknowledged include a person who provided purely technical help, writing assistance, or a department chair who provided only general support. Authors should disclose whether they had any writing assistance and identify the entity that paid for this assistance.

7.1 Funding Acknowledgement

To comply with the guidance for Research Funders, Authors and Publishers issued by the Research Information Network (RIN), *Adoption & Fostering* additionally requires all Authors to acknowledge their funding in a consistent fashion under a separate heading. Please visit Funding Acknowledgement on the SAGE Journal Author Gateway for funding acknowledgement guidelines.

8. Permissions

Authors are responsible for obtaining permission from copyright holders for reproducing any illustrations, tables, figures or lengthy quotations previously published elsewhere. For further information including guidance on fair dealing for criticism and review, please visit our Frequently Asked Questions on the SAGE Journal Author Gateway.

9. Manuscript style

9.1 File types

Only electronic files conforming to the journal's guidelines will be accepted. The preferred format for the text and tables of your manuscript are Word DOC, RTF, XLS. Please also refer to additional guidelines on submitting artwork [and supplemental files] below.

9.2 Journal Style

Adoption & Fostering conforms to the SAGE house style. Click here to review guidelines on SAGE UK House Style

9.3 Reference Style

Adoption & Fostering adheres to the SAGE Harvard reference style. Click here to review the guidelines on SAGE Harvard to ensure your manuscript conforms to this reference style.

If you use EndNote to manage references, download the SAGE Harvard output style by following this link and save to the appropriate folder (normally for Windows C:\Program Files\EndNote\Styles and for Mac OS X Harddrive:Applications:EndNote:Styles). Once you've done this, open EndNote and choose "Select Another Style..." from the dropdown menu in the menu bar; locate and choose this new style from the following screen.

9.4. Manuscript Preparation

The text should be double-spaced throughout and with a minimum of 3cm for left and right hand margins and 5cm at head and foot. Text should be standard 10 or 12 point.

9.4.1 Keywords and Abstracts: Helping readers find your article online

The title, keywords and abstract are key to ensuring readers find your article online through online search engines such as Google. Please refer to the information and guidance on how best to title your article, write your abstract and select your keywords by visiting SAGE's Journal Author Gateway Guidelines on How to Help Readers Find Your Article Online.

9.4.2 Corresponding Author Contact details

Provide full contact details for the corresponding author including email, mailing address and telephone numbers. Academic affiliations are required for all co-authors. These details should be presented separately to the main text of the article to facilitate anonymous peer review.

9.4.3 Guidelines for submitting artwork, figures and other graphics

For guidance on the preparation of illustrations, pictures and graphs in electronic format, please visit SAGE's Manuscript Submission Guidelines.
Figures supplied in colour will appear in colour online regardless of whether or not these illustrations are reproduced in colour in the printed version. For specifically requested colour reproduction in print, you will receive information regarding the costs from SAGE after receipt of your accepted article.

Avoid confusion between ambiguous characters and take care to ensure that subscripts and superscripts are clear. Numbers below 11 should be written out in the text unless used in conjunction with units (e.g. three apples, 4 kg). Full points (not commas) should

be used for decimals. For numbers less than one, a nought should be inserted before the decimal point. Use commas within numbers (e.g. 10,000).

9.4.4 Guidelines for submitting supplemental files

Adoption & Fostering does not currently accept supplemental files.

9.4.5 English Language Editing services

Non-English speaking authors who would like to refine their use of language in their manuscripts might consider using a professional editing service. Visit English Language Editing Services for further information.

Any correspondence, queries or additional requests for information on the manuscript submission process should be sent to the Miranda Davies, Managing Editor, at miranda.davies@baaf.org.uk.

Appendix B: Key Word Search

Searching involved the combination of the key words detailed below:

The key words used in the systematic search were developed and refined with respect to the search terms/headings and in within the relevant electronic databases.

Adoption Terms	Family Terms	Therapeutic Terms	Problem Behaviour Terms
Adopt*	Parent*	Therap*	Attach*
Adoption*	OR	OR	OR
	Carer	Intervention	Attachment Behav*
	OR	OR	OR
	Caregiver	Training	Attachment Disorder
		OR	OR
	AND	Treatment	Attachment Theory
			OR
	Child*		Child Behaviour Problems
	OR		OR
	Adolesc*		Child Behaviour Difficulties
			OR
			Child Behaviour Disorders

*indicates truncation.

Appendix C: Database searches undertaken for systematic review.

Dates Searched	Database	Key words	Limiters	Articles returned
15.10.14 – 24.10.14	ASSIA (Applied Social Sciences Index and Abstracts)	Combination of search terms from each of the four headings detailed in Appendix A	1998 – present English Peer reviewd	123
	Medline (Incorporating EMBASE)		1998-present Articles	164
	PsyINFO (Incorporating PsycArticles and PsycExtra		1998- present Articles Peer Reviewed English	153
	Scopus		1998 – present Journal Articles English	358

Appendix D: Data Extraction Tool.

Article Number:		
Title:		
Author (1st only):		
Publication Date:	Place of publication:	
Journal:		
Volume:	Number:	Pages:
Keywords / Definitions		
Aims:		
Sampling / Participants: *(Total number of participants? Age range, who was studied, how was the sample recruited? Response rate?)*		
Study Type / Design: *(Randomized allocation? Is a control group used?)*		
Outcomes and Measures: *(What outcomes are being measured? What measurements are used? Are measures validated? At what time points are measures completed self-report or clinician-rated?)*		
Intervention: (*Type of intervention? Control group comparable? Format of the intervention? Staff delivering it?)*		
Analysis: *(What statistical methods were used? Was power calculated? Intention-to-treat?)*		
Findings:		
Controls/ Validity / Reliability:		
Conclusions: (W*hat do the findings mean? Generalisability? Implications & Recommendations?)*		
Additional Comments:		

Appendix E: Quality Appraisal Tool: Downs& Black Checklist (1998)

Appendix

Checklist for measuring study quality

Reporting

1. *Is the hypothesis/aim/objective of the study clearly described?*

yes	1
no	0

2. *Are the main outcomes to be measured clearly described in the Introduction or Methods section?*
If the main outcomes are first mentioned in the Results section, the question should be answered no.

yes	1
no	0

3. *Are the characteristics of the patients included in the study clearly described ?*
In cohort studies and trials, inclusion and/or exclusion criteria should be given. In case-control studies, a case-definition and the source for controls should be given.

yes	1
no	0

4. *Are the interventions of interest clearly described?*
Treatments and placebo (where relevant) that are to be compared should be clearly described.

yes	1
no	0

5. *Are the distributions of principal confounders in each group of subjects to be compared clearly described?*
A list of principal confounders is provided.

yes	2
partially	1
no	0

6. *Are the main findings of the study clearly described?*
Simple outcome data (including denominators and numerators) should be reported for all major findings so that the reader can check the major analyses and conclusions. (This question does not cover statistical tests which are considered below).

yes	1
no	0

7. *Does the study provide estimates of the random variability in the data for the main outcomes?*
In non normally distributed data the inter-quartile range of results should be reported. In normally distributed data the standard error, standard deviation or confidence intervals should be reported. If the distribution of the data is not described, it must be assumed that the estimates used were appropriate and the question should be answered yes.

yes	1
no	0

8. *Have all important adverse events that may be a consequence of the intervention been reported?*
This should be answered yes if the study demonstrates that there was a comprehensive attempt to measure adverse events. (A list of possible adverse events is provided).

yes	1
no	0

9. *Have the characteristics of patients lost to follow-up been described?*
This should be answered yes where there were no losses to follow-up or where losses to follow-up were so small that findings would be unaffected by their inclusion. This should be answered no where a study does not report the number of patients lost to follow-up.

yes	1
no	0

10. *Have actual probability values been reported(e.g. 0.035 rather than <0.05) for the main outcomes except where the probability value is less than 0.001?*

yes	1
no	0

External validity

All the following criteria attempt to address the representativeness of the findings of the study and whether they may be generalised to the population from which the study subjects were derived.

11. *Were the subjects asked to participate in the study representative of the entire population from which they were recruited?*
The study must identify the source population for patients and describe how the patients were selected. Patients would be representative if they comprised the entire source population, an unselected sample of consecutive patients, or a random sample. Random sampling is only feasible where a list of all members of the relevant

population exists. Where a study does not report the proportion of the source population from which the patients are derived, the question should be answered as unable to determine.

yes	1
no	0
unable to determine	0

12. *Were those subjects who were prepared to participate representative of the entire population from which they were recruited?*
The proportion of those asked who agreed should be stated. Validation that the sample was representative would include demonstrating that the distribution of the main confounding factors was the same in the study sample and the source population.

yes	1
no	0
unable to determine	0

13. *Were the staff, places, and facilities where the patients were treated, representative of the treatment the majority of patients receive?*
For the question to be answered yes the study should demonstrate that the intervention was representative of that in use in the source population. The question should be answered no if, for example, the intervention was undertaken in a specialist centre unrepresentative of the hospitals most of the source population would attend.

yes	1
no	0
unable to determine	0

Internal validity – bias

14. *Was an attempt made to blind study subjects to the intervention they have received?*
For studies where the patients would have no way of knowing which intervention they received, this should be answered yes.

yes	1
no	0
unable to determine	0

15. *Was an attempt made to blind those measuring the main outcomes of the intervention?*

yes	1
no	0
unable to determine	0

16. *If any of the results of the study were based on "data dredging", was this made clear?*
Any analyses that had not been planned at the outset of the study should be clearly indicated. If no retrospective unplanned subgroup analyses were reported, then answer yes.

yes	1
no	0
unable to determine	0

17. *In trials and cohort studies, do the analyses adjust for different lengths of follow-up of patients, or in case-control studies, is the time period between the intervention and outcome the same for cases and controls?*
Where follow-up was the same for all study patients the answer should yes. If different lengths of follow-up were adjusted for by, for example, survival analysis the answer should be yes. Studies where differences in follow-up are ignored should be answered no.

yes	1
no	0
unable to determine	0

18. *Were the statistical tests used to assess the main outcomes appropriate?*
The statistical techniques used must be appropriate to the data. For example non-parametric methods should be used for small sample sizes. Where little statistical analysis has been undertaken but where there is no evidence of bias, the question should be answered yes. If the distribution of the data (normal or not) is not described it must be assumed that the estimates used were appropriate and the question should be answered yes.

yes	1
no	0
unable to determine	0

19. *Was compliance with the intervention/s reliable?*
Where there was non compliance with the allocated treatment or where there was contamination of one group, the question should be answered no. For studies where the effect of any misclassification was likely to bias any association to the null, the question should be answered yes.

yes	1
no	0
unable to determine	0

20. *Were the main outcome measures used accurate (valid and reliable)?*

For studies where the outcome measures are clearly described, the question should be answered yes. For studies which refer to other work or that demonstrates the outcome measures are accurate, the question should be answered as yes.

yes	1
no	0
unable to determine	0

Internal validity - confounding (selection bias)

21. *Were the patients in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited from the same population?*
For example, patients for all comparison groups should be selected from the same hospital. The question should be answered unable to determine for cohort and case-control studies where there is no information concerning the source of patients included in the study.

yes	1
no	0
unable to determine	0

22. *Were study subjects in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited over the same period of time?*
For a study which does not specify the time period over which patients were recruited, the question should be answered as unable to determine.

yes	1
no	0
unable to determine	0

23. *Were study subjects randomised to intervention groups?*
Studies which state that subjects wererandomised should be answered yes except where method of randomisation would not ensure random allocation. For example alternate allocation would score no because it is predictable.

yes	1
no	0
unable to determine	0

24. *Was the randomised intervention assignment concealed from both patients and health care staff until recruitment was complete and irrevocable?*
All non-randomised studies should be answered no. If assignment was concealed from patients but not from staff, it should be answered no.

yes	1
no	0
unable to determine	0

25. *Was there adequate adjustment for confounding in the analyses from which the main findings were drawn?*
This question should be answered no for trials if: the main conclusions of the study were based on analyses of treatment rather than intention to treat; the distribution of known confounders in the different treatment groups was not described; or the distribution of known confounders differed between the treatment groups but was not taken into account in the analyses. In non-randomised studies if the effect of the main confounders was not investigated or confounding was demonstrated but no adjustment was made in the final analyses the question should be answered as no.

yes	1
no	0
unable to determine	0

26. *Were losses of patients to follow-up taken into account?*
If the numbers of patients lost to follow-up are not reported, the question should be answered as unable to determine. If the proportion lost to follow-up was too small to affect the main findings, the question should be answered yes.

yes	1
no	0
unable to determine	0

Power

27. *Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance is less than 5%?*
Sample sizes have been calculated to detect a difference of x% and y%.

	Size of smaller intervention group	
A	$<n_1$	0
B	n_1–n_2	1
C	n_3–n_4	2
D	n_5–n_6	3
E	n_7–n_8	4
F	n_9+	5

Appendix F:Table 1:Quality Ratings - Quantitative and Qualitative.

Study ID & Author/s	1.Becker-Weidman, (2006;2008)	2.Carnes-Holt & Bratton, (2014)	3.Colonessi *et al.*,(2012)	4.Gurney-Smith *et al.*,(2011)	5.Henderson & Sargent, (2005)	6.Holmes & Silver, (2010
Downs & Black Quality Rating (%)	(70%)	(77%)	(70%)	(52%)	(30%)	(22%)
Qualitative comments	Detailed description of intervention and theoretical underpinnings. Discussion of demographic and clinical differences between controls and treatment group and fostered and adopted children. Lack of detail about how participants allocated to control or treatment groups. Level of experience of therapists specifically in DDP unclear. Measure of attachment based on disorder rather than behaviour. Helpful reflections on value of anecdotal versus statistical evidence.	Detailed and comprehensive description of method and analyses. Clear aims of study outlined. Detailed description of intervention and levels of experience of facilitators. Inclusion of independent raters of parent-child interactions from video feedback. Useful discussion about possible mechanisms underlying effects of interventions and implications for practice. Limitations discussed including highlighting of the author's direct involvement in the delivering the intervention which may have introduced bias.	Clear description of intervention and study's aims. Discussion of outcome measures not just being reliant on care-giver report but use of independent raters. One of few interventions directed at milder range of attachment difficulties. Families invited to participate by therapist who then delivered intervention which may have introduced bias.	Described by authors as 'novel' intervention. Reflective discussion regarding sensitivity of measures employed to theoretical orientation of group and site of change in carer as well as child (e.g. reflective function of carer). Clear and detailed description of measures. Clear distinction in paper between quantitative and qualitative analyses. Only group study to specifically identify and discuss sustained changes over time. Useful discussion of possible mechanisms and distinction between statistical and clinical significance.	Main focus of paper was detailed description of iterative addition of programme components to meet needs of adoptive families in response to carer feedback from successive groups. Acknowledgement of complex characteristics of families attending programmes. Detailed discussion of individual subscales of measure of parental stress and possible mechanisms. Reference to I year follow-up data but no explicit discussion of this so not possible to draw conclusions about changes over time. No specific qualitative methodology employed to analyse carer feedback. No discussion about possible impact of observer researcher present in all groups.	Authors specifically highlighted that study NOT a formal research project but a quantitative and qualitative evaluation of a group programme in a clinical setting. Detailed consideration of rationale for outcome measure used. Separate analysis of two groups due to decision to apply more sensitive measure specifically designed for adoptive carers. Useful discussion of individual subscales of Carer Questionnaire and possible mechanisms of change. Use of specific qualitative methodology to analyse carer feedback – thematic content analysis. Useful discussion about preferred timing of intervention. Discussion of bias due to lack of independent raters.

Appendix F: Table 1 (cont.) Quality Ratings Quantitative and Qualitative

Study ID & Author/s	**7. Juffer *et al.*, (2005) (Stams *et al.*, 2001)**	**8. Rushton *et al.*,(2010)**	**9. Selwyn *et al.*, (2009)**	**10. Weir, *et al.*, (2013)**	**11. Wimmer *et al.*, (2009)**
Downs & Black Quality Rating (%)	***(81%)***	**(77%)**	**(37%)**	***(41%)***	***(26%)***
Qualitative comments	Clear aims. Comprehensive description of methods and analysis. Detailed description of interventions. Useful discussion regarding effective components of intervention. Valuable discussion regarding possible underlying mechanisms involved in effects of interventions.	Clear description of method and analysis. Detailed description about content of both interventions. Fact that facilitators were experienced and trained was identified. Clear identification of study's limitations including fact that children had high levels of psychopathology and may have been unrepresentative. Quantitative analysis of qualitative data regarding parents handling of problems	Detailed discussion of rationale for evaluation. Clear aims outlined for both programme itself and evaluation. Components of programme less clear. Only intervention to be delivered specifically 12mths after adoptive placement - Useful insights into timing of intervention discussed. Useful discussion of difficulties with recruitment and follow up (which necessitated retrospective follow-up, not part of current review) . Comprehensive explanation and description of outcome measures applied to assess cognitive, affective and skill domains. Study contained quantitative, descriptive data, but was mainly comprised of qualitative descriptions of carer feedback and no specific qualitative methodology was identified.	Detailed description of theoretical model but some specific details about the intervention lacking. Participants recruited via advertising and participants able to access free therapy – problematic bias discussed. Acknowledgement that intervention delivered by novice, student therapists but sessions recorded for supervision to ensure standards met. Recognition of barriers to completion of post intervention measure due to length of questionnaires – only 7 out of 12 complete data sets.	Lacking detailed description of intervention. Mention of numerous components of treatment but unclear which were included. Comprehensive discussion of study's limitations and threats to internal and external validity including impact of withdrawal of funding on the project and missing data.

Appendix F:Table 2. Design and Sample of Reviewed Studies

Study ID & Author/s	1.Becker-Weidman, (2006;2008)	2.Carnes-Holt & Bratton, (2014)	3.Colonessi *et al.*,(2012)	4.Gurney-Smith et.al.,(2011)	5.Henderson & Sargent, (2005)	6.Holmes & Silver, (2010	7.Juffer *et al.*, (2005) Stams *et al.* (2001)	8.Rushton et al.,(2010)	9.Selwyn *et al.*, (2009)	10.Weir, *et al.*, (2013)	11.Wimmer *et al.*, (2009)
Country	US	US	Netherlands	UK	UK	UK	Netherlands	UK	UK	US	US
Design	Non-randomised controlled trial	Randomised controlled trial.	Non-comparative	**Non Comparative	**Non Comparative	**Non Comparative	Randomised controlled trial (preventative)	**Randomised controlled trial	**Non-randomised control trial	Non comparative	Non-comparative
Control Group Type	Treatment as usual	Waiting List Control					No intervention	Services as usual	Treatment as usual		
Assessment	-Pre -1 year post - 4 yrs post	-Pre -Post	-Pre -Post -6 months post	-Pre -Post -3 mths post	-Pre -Post	-Pre -Post	Pre- Post- 6yrs	-Pre -Post -6 mths post	-Pre -Post	-Pre -Post	-Pre -Post
Sample Type	Mixed sample of 40 adopted children 14 fostered children (residing with foster parents for at least 1 year.)	Adoptive parents & child dyads	Adoptive families with an internationally adopted child. (mother/father/ child triads)	Mixed sample of 7 adoptive parents 5 foster carers 1 special guardianship	Adoptive parents	Mixed sample of Adoptive parents Foster carers (inc. therapeutic and kinship)	Families with internationally adopted child. 2 subsamples (i)90 families with first adopted child (ii)40 families with birth children plus first adopted child.	Adoptive families of children placed for non-relative adoption	Adoptive families with ¼ of families including biological children.	Adoptive families Including biological children.	Adopted Children
Sample Size	Pre/Post =64 (30 + 34) 4 year follow up =44 (20 +24)	72 parents (37 Experimental group 35 Waiting list control)	20 families (mother, father, child)	13 parents	35 parents	(i)14 parents (ii) 22-27 parents	130 families No. of participants in Book only v Video +book interventions NR	37 families	35 families (16 Exp group - 29 children. 19 Control group – 32 children	12 families(23 parents, 30 children (25 adopted and 5 biological children.)	24 children

*Note: **Reviewed study includes qualitative feedback*

Appendix F:Table 2 (cont.) Design and Sample of Reviewed Studies

Study ID & Author/s	1.Becker-Weidman, (2006;2008)	2.Carnes-Holt & Bratton, (2014)	3.Colonessi *et al.*,(2012)	4.Gurney-Smith et.al.,(2011)	5.Henderson & Sargent, (2005)	6.Holmes & Silver, (2010	7.Juffer *et al.*, (2005) Stams *et al.* (2001)	8.Rushton et al.,(2010)	9.Selwyn *et al.*, (2009)	10.Weir, *et al.*, (2013)	11.Wimmer *et al.*, (2009)
Age of Children	5-16 yrs Treatment group Mean age 9.4 yrs. Control group Mean age = 11.7 yrs.	2-10 years Experimental group Mean age = 5.8 yrs Waiting list control group Mean age = 5.6 yrs	2-5yrs Mean age at pre-test = 3.8yrs Mean age at post- test = 4.7yrs	4-14 yrs. Mean age =9years	3- 11.5 yrs Mean age = 7 years	Less than 10 years Mean age NR	Families in treatment groups visited at 5,6,9 12, months old and 7yrs.	3ys -7yrs, 11mths	Treatment group Mean age =8.6 years Control group mean age =7.2 years	Adopted- *Mean* = 7.52 yrs Biological *Mean* = 13.3 yrs	4-16yrs *Mean* = 9.8 yrs
Age of child at placement	Treatment group *Mean* = 7yrs Control Group = 5.4 yrs	**14 children adopted younger than 1 yr.** (experimental group n=8, control group n=6) **38 children adopted between 1-5 years**(experimental group n=17, control group n=21) **9 children adopted over 5yrs** (experimental group n=7; control group n=2)	*Mean* age = 1.7 yrs	Range 9 mths to 12.6 yrs *Mean* age = 7yrs	Range 6 months – 8 yrs.	NR	Age range 2-23 weeks *Mean age* 10 wks	Children placed for non-relative adoption between 3yrs – 18mths prior to study.	NR	NR	*Mean* = 5.4 yrs

Appendix F:Table 3. Therapeutic Interventions Evaluated by Reviewed Studies

Study ID & Author/s	**1.Becker-Weidman, (2006;2008)**	**2.Carnes-Holt & Bratton, (2014)**	**3.Colonessi *et al.*,(2012)**	**4.Gurney-Smith et.al.,(2011)**	**5.Henderson & Sargent, (2005)**	**6.Holmes & Silver, (2010**	**7.Juffer *et al.*, (2005) Stams *et al.* (2001)**	**8.Rushton et al.,(2010)**	**9.Selwyn *et al.*, (2009)**	**10.Weir, *et al.*, (2013)**	**11.Wimmer *et al.*, (2009)**
Aim of intervention	Reduce symptoms of RAD and increase attachment security	Reduce child behaviour problems and increase parental empathy	Improve parent-child relationship and decrease attachment and conduct problems.	To enhance parental mind mindedness – sensitivity to attachment needs of their child.	Increase parental confidence, perceived control and skills for managing difficult behaviour	Increase parental empathy and attunement as well as skills for managing difficult behaviour	To promote maternal sensitivity and infant security.	Improve parenting and reduce child's difficulties	Affirm and enhance parenting skills; increase parental confidence and understanding of attachment.	To demonstrate efficacy of Whole Family Theraplay (WFT)for adoptive families.	*To reduce severity of RAD Symptomology and improve child's functioning within family.*
Mode of delivery	Individualised Parent/child dyad	**Group** plus parent/child dyad supervision	Individualised (Both parents +child)	**Group**	**Group**	**Group**	Mother/child dyads	(i)Individualised CBT programme V (ii)Educational programme	**Group**	Family (including adopted and birth siblings)	*Parent/child dyad*
Theoretical model/s	Attachment Theory	Child Parent Relationship Therapy (CPRT) Social Learning Theory and Attachment Theory.	Attachment Theory	Attachment Theory Social Learning Theory	Attachment Theory and CBT	Attachment Theory, Social Learning Theory Narrative	Attachment Theory	CBT v Psychoeducation around Attachment Theory	CBT and Attachment Theory.	Family Systems Theory & Theraplay (Social Learning Theory)	Attachment Theory

Appendix F:Table 3 (cont.) Therapeutic Interventions Evaluated by Reviewed Studies

Study ID & Author/s	1.Becker-Weidman, (2006;2008)	2.Carnes-Holt & Bratton, (2014)	3.Colonessi *et al.*,(2012)	4.Gurney-Smith et.al.,(2011)	5.Henderson & Sargent, (2005)	6.Holmes & Silver, (2010	7.Juffer *et al.*, (2005) Stams *et al.* (2001)	8.Rushton et al.,(2010)	9.Selwyn *et al.*, (2009)	10.Weir, *et al.*, (2013)	11.Wimmer *et al.*, (2009)
Intervention schedule	*Mean* no.of sessions = 23 x 2hrs	20hrs (10 groupsessions x 2hrs) plus weekly supervised play sessions	8 training sessions – duration of each session NR. Telephone consultation following each training session.	45hrs (18 sessions x 2.5 hrs)	12 weekly sessions. Total no. of hours N/R	Total hours NR 6 sessions + 1 optional 7th session.	2 Exp (i)(ii)groups + Control group (i)Personal book (i)Personal book + 3 sessions of home based VFB	(i)CBT 10 sessions – duration NR (ii)Education 10 session duration and frequency NR	30 hrs 6 sessions x 5hrs	12-15 50 minute, weekly therapy sessions plus weekly phone or e-mail contact.	10 sessions (duration not specified)
Intervention facilitators	Therapist (Professional background not specified)	Professional play therapist plus co-leaders experienced in play therapy	Therapist (Professional background not specified)	Clinical psychology and social work professionals	Experienced Adoption support worker plus researcher from Anna Freud Inst.	Consultant Clinical Psychologist	Trained university researchers	Child and family social workers	Adoptive parents who are professional trainers.	University researcher and trainee therapists.	Therapists trained in Attachment techniques
Setting of Intervention	Centre for Family Development-Clinic location	Adoption agency, local churches and clinic in community	NR	NR	Adoption Service (Coram Family)	NR	Families' homes and university laboratory	Home based	Training package delivered by Adoption UK in various locations	*University student training clinic-Family Counselling Center*	NR

Appendix F:Table 4. Outcomes Measures Employed by Reviewed Studies

Study ID & Author/s	1.Becker-Weidman, (2006;2008)	2.Carnes-Holt & Bratton, (2014)	3.Colonessi *et al.*,(2012)	4.Gurney-Smith et.al.,(2011)	5.Henderson & Sargent, (2005)	6.Holmes & Silver, (2010	7.Juffer *et al.*, (2005) Stams *et al.* (2001)	8.Rushton et al.,(2010)	9.Selwyn *et al.*, (2009)	10.Weir, *et al.*, (2013)	11.Wimmer *et al.*, (2009)
Child Outcomes	CBCL RADQ	CBCL	AISI SDQ	SDQ CQ	SDQ	SDQ CQ	Perceived Child temperament Ego resiliency CCQ	SDQ EFQ PPP Visual Analogue Scales	SDQ	CBCL Y-OQ	RADQ CAFAS (or PECAFAS)
Carer Outcomes			MBQS	PSI/SF ICQ SQ MM	PSI	(i)PSI/SF MBAM (ii) CQ MBAM	Maternal sensitive responsiveness	PSOC Daily Hassles. Satisfaction with Parenting Advice.	GHQ Description of management strategies	OQ	
Carer-Child Outcomes		MEACI	AQS	EFRQ CQ		CQ	Infant-mother attachment SSP Disorganised infant attachment		EFRQ	FAD	

Note: Attachment Insecurity Screening Inventory (AISI); Carer Questionnaire (CQ);California Child Q-set (CCQ) Child and Adolescent Functional Assessment (CAFAS); Child Behavioural Checklist (CBCL); Expression of Feelings Questionnaire (EFQ); Expression of Feelings in Relationships Questionnaire (EFRQ); General Health Questionnaire (GHQ); Intervention Carer Questionnaire (ICQ); Managing Behaviour with Attachment in Mind(MBAM); McMaster Family Assessment Device (FAD); Mind-Mindedness interview (MM); Measurement of Empathy in Adult-Child Interaction (MEACI); Observation instrument to assess child attachment (AQS) Observation instrument to measure maternal and paternal sensitivity (MBQS); Outcome Questionnaire (OQ); Parent Sense of Competency Scale (PSOC);Parenting Stress Index (PSI); Parenting Stress Index / Short Form (PSI/SF); Post Placement Problems (PPP); PreSchool version of CAFAS (PECAFAS); Randolph Attachment Disorder Questionnaire (RADQ); Satisfaction Questionnaire (SQ);Strange Situation Procedure (SSP)Strengths and Difficulties Questionnaire (SDQ); Youth Outcome Questionnaire (Y-OQ);

Appendix F:Table 5. Narrative summary of outcomes measures employed by reviewed studies

A variety of standardised and non-standardised measures were used to assess caregiver outcomes, attachment outcomes and the child-caregiver relationship.
Four studies (5, 6, 8, 9), assessed caregivers' understanding, knowledge and parenting skills. Four studies (4, 5, 6, 9) measured caregivers' confidence, stress levels and competence and five studies included assessments of caregiver wellbeing (4, 5, 6, 8, 9). Four of the eleven studies assessed children's attachment, with two studies measuring attachment behaviour (3,7) and two studies using a measure of attachment disorder (1, 11). Three studies included measures of parental sensitivity or attunement (3, 4, 7). Four studies incorporated independent observer ratings of parental sensitivity (3, 4, 7) and child attachment style (2, 7), with three studies establishing satisfactory or good inter-rater reliability (2, 3, 7). Six studies (2, 4, 6, 8, 9, 10) assessed the quality of the parent-child relationship, including parental empathy and expression of feelings. Five studies (4, 5, 6, 8, 9) collected qualitative feedback from caregivers regarding the appropriateness and usefulness of interventions and reported high levels of satisfaction. One study used thematic content analysis to analyse qualitative data (6).

Appendix F:Table 6. Key Findings of reviewed Studies

Study ID & Author/s	1.Becker-Weidman, (2006;2008)	2.Carnes-Holt & Bratton, (2014)	3.Coloness i *et al.*,(2012)	4.Gurney-Smith et.al.,(2011)	5.Henderso n & Sargent, (2005)	6.Holmes & Silver, (2010	7.Juffer *et al.*, (2005) Stams *et al.* (2001)	8.Rushton et al.,(2010)	9.Selwyn *et al.*, (2009)	10.Weir, *et al.*, (2013)	11.Wimme r *et al.*, (2009)
Significant improvement in following intervention, relative to baseline/control	Post 4yrs CBCL RADQ Post 1 year CBCL (except Anxious/Depresse d subscale) RADQ	CBCL Total problems CBCL Externalising problems MEACI Total Empathy	SDQ (conduct problems and peer problems) AQS AISI (for insecure attachmen t to mother and disorganis ed attachmen t to both parents)	Post – 3mth SDQ Total EFRQ's disinhibition subscale only ICQ (PSU& CRC) Imm. Post intervention SDQ Hyperactivity/ Inattention subscale ICQ's (PSU & CRC & PB 1&2) MM –child mental attributes for Rupture Question only. High satisfaction ratings	PSI (Child Total Score only) SDQ (Hyperactivi ty and conduct disorder)	(i) PSI/SF Difficult child subscale and Total Stress) (ii)CQ (8 of 12 items – positive parent-child relationshi p and decreased negative perception of problem behaviour)	Reducing incidence of disorganis ed attachmen t. (in VFB condition only) Increased maternal sensitivity for both treatment conditions Delayed positive effects on personalit y developm ent and ego resiliency in girls at 7yrs	PSOC (for combined interventio ns)	Confidence in managing difficult behaviour	FAD Communic ation Subscale OQ Inter-personal Relations subscale Y-OQ Total Score	RADQ CAFAS (or PECAFAS)

Appendix F:Table 6 (cont.) Key Findings of Reviewed Studies

Study ID & Author/s	1.Becker-Weidman, (2006;2008)	2.Carnes-Holt & Bratton, (2014)	3.Coloness i *et al.*,(2012)	4.Gurney-Smith et.al.,(2011)	5.Henderso n & Sargent, (2005)	6.Holmes & Silver, (2010	7.Juffer *et al.*, (2005) Stams *et al.* (2001)	8.Rushton et al.,(2010)	9.Selwyn *et al.*, (2009)	10.Weir, *et al.*, (2013)	11.Wimme r *et al.*, (2009)
Non-significant improvement following intervention relative to baseline/control	CBCL Anxious/Depress ed subscale		MBQS (parental sensitivity) AQS AISI (for ambivalent and avoidant attachmen t insecurity)	SDQ total and remaining subscales (pre-post) PSI-SF EFRQ CQ's PCR subscale/ PB 3. MM caregiver mental attributes	PSI (Parent Total Score) SDQ (emotional symptoms or pro-social behaviours)	CQ remaining items		EFQ PPP Daily Hassles. (for combined interventio ns)	Manageme nt of Behaviours EFRQ – enjoyment of play & reduced stress in household.		
No statistically significant improvement following intervention relative to baseline/control.								SDQ (either for combined or between interventio n groups.	SDQ Total score		
Statistically significant deterioration following intervention relative to baseline/control	N\A	N/A	N/A	N/A	Anecdotal parental report of high levels of social isolation	N/A	N/A	N/A	Increased awareness of child's difficulties. More reported concerns/ Difficulties	N/A	N/A

Appendix G²: Statement of Epistemological Position

The current research was conducted according to a critical realist orientation, which integrates realist ontology with relativist epistemology (Guba, 1990). A critical realist stance retains a central commitment to ontology, but rejects naïve realism, which views reality as universal, objective and quantifiable (Guba, 1990). Unlike constructionism, which proposes that reality is socially constructed between those who experience it (Gergen, 1999), critical realism cautions against linguistic reductionism (Pilgrim, 2013). Rather, critical realism is committed to a concept of reality that is observable, complex and multi-layered and which must be explored cautiously, with an acknowledgment that reality includes the observations and theorisations of researchers (Pilgrim, 2013). Consequently, critical realism integrates the advantages of 'ontological realism, epistemological relativism and judgemental rationality' (Archer, 1995, p.xi) and seeks to give equal weight to both causes and meanings (Bhasker, 1986).

Critical realism provides a suitable framework for mental health research because its assumption about the stratified nature of reality is able to accommodate both distal and impersonal social forces, alongside subjective meaning (Pilgrim, 2013). IPA, in its assumption that the researcher's interpretation of participants' accounts of their life worlds, can illuminate stable and enduring emotional experiences and cognitions (Smith, *et al.*,1999), is consistent with a critical realist stance.

In accordance with this epistemological orientation, in attempting to understand the life worlds of adoptive parents, the researcher is aware of complex and multiple layers of reality. These include the researcher's attempts to interpret respondents' understandings which are inevitably influenced by the researcher's own experiences (Smith *et al.*, 2009). Consequently, the research findings are regarded as the researcher's subjective interpretations of respondents' experiences rather than objective, quantifiable truths. However, the researcher is also aware that the experiences of respondents have the potential to speak to an independent, deep and powerful reality, indicative of a particular context associated with being an adoptive parent managing children's emotional and behavioural difficulties (Pilgrim, 2013).

References

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Smith, J.A., Flowers, P. & Larkin, M. (2009). *Interpretive Phenomenological Analysis:Theory, Method, Research.* London: Sage.

Appendix H²: Participant Information Letter (PIL)

Version 2 27/01/14 14/EM/0007

University of Leicester

School of Psychology
Doctorate in Clinical Psychology
104 Regent Road
Leicester LE1 7LT
UK

T +44 (0)116 223 1639
F +44 (0)116 223 1650

Invitation Letter & Information Sheet

Research Title : Adoptive parents' experiences of seeking mental health care for their child.

Dear Parent/Guardian,

We are writing to invite you to take part in a research study. Before you can decide whether you wish to take part, you need to understand the purpose of the research and what it will involve for you. Please take your time to read the following information carefully and please contact us if anything is not clear or if you would like further information before you make your decision.

Background:

What is the purpose of the study?

The aim of this study is to explore the help-seeking experiences of adoptive parents for their son/daughter with mental health difficulties.

Why have I been invited to take part?

Over the next year, to help us with our research, we will be recruiting adoptive parents from across [redacted] who have experienced a mental health assessment for their son/daughter within the Child and Adolescent Mental Health Service (CAMHS).

Do I have to take part?

It is up to you to choose whether you wish to take part in this research study. If you agree to take part we will ask you to sign a consent form to show your agreement. You are free to withdraw from this research at any time, without giving us a reason for your withdrawal. The standard of care that you and your family receive will not be affected by either your decision to take part or your decision to withdraw from the research at a later stage. If you decide to withdraw from the research, we will destroy any information that may identify you (i.e. address, telephone number) but we will need to use the anonymised data that we have collected from you up until the point of your withdrawal.

What will I have to do?

As a research team, we would like to offer you the opportunity to reflect on your experiences and to share your views in relation to seeking help for your child's mental health difficulties. This will involve taking part in a single face to face interview with a member of the research team. The interview will take place at a time and place convenient for you (e.g. your home or Westcotes House) and will take approximately one hour. You will be contacted by Louise Brittenden (Trainee Clinical Psychologist) to schedule the interview. The interview will be audio-recorded.

If you decide that you would like to take part in the research, please let us know by completing the reply slip at the end of this Invitation Letter and Information Sheet, and return it to the researcher, Louise Brittenden, at the address detailed on the reply slip.

Please note that if you agree to help us with our research we would keep your information on file with the research team exclusively for follow-up contact purposes (your name and any other personal information will not be linked to any information you choose to provide during the interview). Such personal information will be deleted after you complete the interview.

What are the possible disadvantages and risks of taking part?

The interview process may involve discussion of sensitive topics, however the study has been designed to ensure that the possible disadvantages and risks to you from taking part are minimal. This study has also been designed to cause minimal inconvenience to you in relation to your time and travel. Depending on where the interview takes place, at home or on NHS premises, it may be possible to claim travel expenses; this will be considered on a case by case basis.

What are the possible benefits of taking part?

The information that you share with us will help us to better understand the needs and experiences of adoptive parents. Such evidence will support future service improvement and organisation of resources, which will be beneficial to you and other families like yours in their access and use of CAMHS.

Will my taking part in the study be kept confidential?

Yes, all information that you share with us will be handled in confidence and stored securely. Information that you disclose to us that could be used to identify you (e.g. name, address, telephone number) will be stored separately from your research data and will be destroyed within 12 months of the date of completion of the research interview. In addition, any identifiable information in the research data itself (e.g. names of people, places, schools mentioned in the interview) will be anonymised. Access to the research data will only be available to members of the research team. Regulatory authorities will also have access if necessary.

However, if you decide on your own, to tell us about information beyond what is being asked in the interview that could reasonably be considered to put your own or someone else's health at risk, we would not be able to guarantee complete anonymity. In such circumstances, we would need to pass the information you disclosed, along with your name, to your clinician for safeguarding purposes. In circumstances where it would not be appropriate to inform your clinician, [redacted] would act as the alternate person to be informed of any disclosure information.

What will happen to the results of the research?

The results will be presented and circulated through academic publications (i.e. Journal articles) and conferences. As explained above, no personal details that might identify you will be included. Please ask if you wish to receive a copy of the findings of the research study.

Who is funding and organising the research?

This research is funded by the Department of Health. The research team consists of [redacted] (University of Leicester) and Louise Brittenden (University of Leicester).

Who has reviewed the study?

To protect your rights and safety this research has been formally reviewed and approved by the NHS through the NRES Committee - Leicester.

What if there is a problem in the future?

If you have concerns about any aspect of this research study or you feel that you have experienced any harm from taking part, please contact a member of the research team who will do their best to solve any concerns and deal with your complaint.

What if I have any more questions now?

If you would like to request any further information or talk to a member of the research team at the University of Leicester then please contact in the first instance:

Louise Brittenden

Trainee Clinical Psychologist

[redacted]

Tel: [redacted]

Email [redacted]

You can also contact the principal investigator for this research study, [redacted], who is contactable at the same address as above, or on [redacted]; Email [redacted]

Otherwise, you can contact Elaine Benson at the Patient Advice and Liaison Service at:

Leicestershire Partnership Trust

Lakeside House

4 Smith Way

Grove Park, Enderby

Leicester

LE19 1SS

Tel: 0116 295 5817

Email: Elaine.benson@leicspart.nhs.uk

What should I do next if I want to take part?

Simply complete the reply slip below and return to the researcher, Louise Brittenden, at the address indicated on the slip. Please include the name and age of your child. This will help us to ensure we are including parents of children who represent a range of ages.

Louise Brittenden will contact you within six weeks to arrange an interview date suitable for you. Please note that if you choose to have the interview in your home, we will inquire about the availability of a private room in which to hold the interview so that we can ensure that confidentiality is maintained and that the interview cannot be overheard.

We thank you for taking the time to read this information sheet and hope you will be willing to help us with our data collection.

Yours Faithfully,

Louise Brittenden (Trainee Clinical Psychologist)

[redacted] ***(Principal Investigator)***

Version 2 27/01/14 14/EM/0007

Reply Slip:

Research Title: Adoptive parents' experiences of seeking mental health care for their child.

I confirm that I would like to participate in the research study and am happy to be contacted by the researcher, Louise Brittenden, to arrange an interview date.

Your Name: …….. Date……..

Your Preferred Contact Telephone Number……

The name of your child……

The age of your child (in years)……...

Your Signature……....

Please return your reply slip to the following address in the envelope provided:

Louise Brittenden

[redacted]

Many thanks for being willing to help us with the research study.

Appendix I²: Participant Consent Form

Version 2 27/01/14 14/EM/0007

School of Psychology
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104 Regent Road
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T +44 (0)116 223 1639
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University of Leicester

CONSENT FORM

Research Title: Adoptive parents' experiences of seeking mental health care for their child.

This consent form will be signed before the interview takes place.

Please tick or initial the boxes below to confirm your agreement with the following statements:

1. I confirm that I have read and understand the information sheet (Version 2) for the above research study. I have had the opportunity to consider information, to ask questions and have had these answered. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my child's legal or medical rights being affected ☐

3. I understand that relevant sections of my case file and data collected during the study may be looked at by responsible individuals from the NHS, the University of Leicester or from regulatory authorities. ☐

4. I understand that the audio recording of my interview will be transcribed by Louise Brittenden or a third party who will be a member of NHS or University of Leicester administrative staff, who will be bound by strict confidentiality guidelines and who will have signed a confidentiality agreement. ☐

(Please turn over)

5. I consent to taking part in the research study by participating in a recorded research interview. ☐

*Name (Print)*_____

*Signature*_____

*Date*_____

Many thanks for consenting to help us with the research study.

Appendix J: Semi-Structured Interview Schedule

Version 1 20/11/13

Appendix A

University of Leicester

Research Title: Adoptive parents' experiences of seeking mental health care for their child.

Interview Topic Guide for Adoptive Parents:

(The following questions are designed to be flexible rather than prescriptive. Rather than providing a detailed schedule of questions, the researcher will be guided by the participant's reflections.)

Topic 1. Background.

a. Can you tell me about your child (child's name X)?

Prompts: personality traits/strengths/interests/school/peers?

Topic 2. Conceptualisation of child's mental health difficulties.

a. Can you describe how you became aware that X was having difficulties?

Prompts: Can you give me an example? Can you tell me a bit more about that?

b. Can you tell me about how you personally responded to the difficulties?

Prompts: Feelings/thoughts/actions/behaviours? Can you give me an example; What do you mean by that?

c. What was your experience of how other people responded to the difficulties?

Prompts: Partner/ Family/School/Community/Neighbours. Can you give me an example? Can you tell me a bit more about that?

Topic 3. Experiences of informal help-seeking.

a. Can you describe how you went about dealing with the difficulties?

Prompts: Can you give me an example? Can you tell me a bit more about that?

b. How, if at all, did you experience support from other people in dealing with X's difficulties?

Prompts: School/Voluntary organisations/ Friends/Family/Religious or Community groups? Can you give me an example?

Topic 4. Experiences of Formal Mental Health Assessment.

a. Can you tell me about how you came into contact with the CAMHS service?

Prompts School/GP/Self- referral?

b. Can you describe how you experienced the formal CAMHS assessment?

Prompts: Expectations/ Environment/Logistics around attending appointment/Emotions/Interactions with staff/Before v After?

Topic 5. Further Reflections.

a. Can you tell me about something else you would like to add to the account of your experiences?

Prompts: Anything we've not covered/discussed? Any areas you'd like to think more about?

END

Appendix K²: Correspondence from LREC & R&D

NHS
Health Research Authority
NRES Committee East Midlands - Leicester
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839368

18 December 2013

Mrs Louise Maria Brittenden
[redacted]

Dear Mrs Brittenden

Study title:	**Adoptive parents' experiences of seeking mental health care for children adopted from the care system: An Interpretive Phenomenological Study.**
REC reference:	**14/EM/0007**
Protocol number:	**Not applicable**
IRAS project ID:	**141241**

Thank you for your application for ethical review, which was received on 13 December 2013. I can confirm that the application is valid and will be reviewed by the Committee at the meeting on 10 January 2014.

Meeting arrangements

The meeting will be held in the The Belmont Hotel, De Montfort Street, Leicester, LE1 7GR on 10 January 2014. The Committee would find it helpful if you could attend the meeting to respond to any questions from members. Other key investigators and a representative of the sponsor are also welcome to attend. This may avoid the need to request further information after the meeting and enable the Committee to make a decision on the application more quickly.

If you have a disability and need any practical support when attending the REC meeting you may wish to contact the REC office so appropriate arrangements can be made if necessary.

If you are unable to attend the meeting the Committee will review the application in your absence.

The review of the application has been scheduled for 11:45. Please note that it is difficult to be precise about the timing as it will depend on the progress of the meeting. We would kindly ask you to be prepared to wait beyond the allocated time if necessary.

If you cannot attend, it would be helpful if you could be available on the telephone at the time of the review.

Please let me know whether or not you would be available to attend the meeting or be available on the telephone.

Committee meetings are occasionally attended by observers, who will have no vested interest in the applications under review or take any part in discussion. All observers are required to sign a confidentiality agreement.

Documents received

The documents to be reviewed are as follows:

Document	*Version*	*Date*
Covering Letter	Letter from Louise Brittenden	03 December 2013
Interview Schedules/Topic Guides	Appendix A - V1	20 November 2013
Investigator CV	[redacted]	20 November 2013
Other: CV	Louise Brittenden	22 November 2013
Other: CV	[redacted]	23 November 2013
Other: Peer Review	[redacted]	18 October 2013
Other: Feedback from informal peer review	[redacted]	01 June 2013
Other: Email from David Clarke		11 November 2013
Participant Consent Form: Appendix C	1	20 November 2013
Participant Information Sheet: Appendix B	1	20 November 2013
Protocol	3	20 November 2013
REC application	141241/534832/1/827	27 November 2013
Referees or other scientific critique report	Service User Evaluation - V1	20 November 2013

No changes may be made to the application before the meeting. If you envisage that changes might be required, we would advise you to withdraw the application and re-submit it.

Notification of the Committee's decision

You will receive written notification of the outcome of the review within 10 working days of the meeting. The Committee will issue a final ethical opinion on the application within a maximum of 60 days from the date of receipt, excluding any time taken by you to respond fully to one request for further information or clarification after the meeting.

R&D approval

All researchers and local research collaborators who intend to participate in this study at sites in the National Health Service (NHS) or Health and Social Care (HSC) in Northern Ireland should apply to the R&D office for the relevant care organisation. A copy of the Site-Specific Information (SSI) Form should be included with the application for R&D approval. You should advise researchers and local collaborators accordingly.

The R&D approval process may take place at the same time as the ethical review. Final R&D approval will not be confirmed until after a favourable ethical opinion has been given by this Committee.

For guidance on applying for R&D approval, please contact the NHS R&D office at the lead site in the first instance. Further guidance resources for planning, setting up and conducting research in the NHS are listed at ttp://www.rdforum.nhs.uk

There is no requirement for separate Site-Specific Assessment as part of the ethical review of this research.

Communication with other bodies

All correspondence from the REC about the application will be copied to the research sponsor and to the R&D office for Leicestershire Partnership Trust. It will be your responsibility to ensure that other investigators, research collaborators and NHS care organisation(s) involved in the study are kept informed of the progress of the review, as necessary.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

14/EM/0007	**Please quote this number on all correspondence**

Yours sincerely

Ms Wendy Rees
REC Manager

Email: NRESCommittee.EastMidlands-Leicester@nhs.net

Copy to: [redacted] *University of Leicester*

Dr David Clarke, Leicestershire Partnership Trust

NHS
Health Research Authority

NRES Committee East Midlands - Leicester
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839425

21 January 2014

Mrs Louise Maria Brittenden
[redacted]

Dear Mrs Brittenden

Study Title:	**Adoptive parents' experiences of seeking mental health care for children adopted from the care system: An Interpretive Phenomenological Study.**
REC reference:	**14/EM/0007**
Protocol number:	**Not applicable**
IRAS project ID:	**141241**

The Research Ethics Committee reviewed the above application at the meeting held on 10 January 2014. Thank you for attending to discuss the application.

Documents reviewed

The documents reviewed at the meeting were:

Document	*Version*	*Date*
Covering Letter	Letter from Louise Brittenden	03 December 2013
Interview Schedules/Topic Guides	Appendix A - V1	20 November 2013
Investigator CV	[redacted]	20 November 2013
Other: CV	Louise Brittenden	22 November 2013
Other: CV	[redacted]	23 November 2013
Other: Peer Review	[redacted]	18 October 2013
Other: Feedback from informal peer review	[redacted]	01 June 2013
Other: Email from David Clarke		11 November 2013
Participant Consent Form: Appendix C	1	20 November 2013
Participant Information Sheet: Appendix B	1	20 November 2013
Protocol	3	20 November 2013
REC application	141241/534832/1/827	27 November 2013
Referees or other scientific critique report	Service User Evaluation - V1	20 November 2013

Provisional opinion

- The Chair introduced himself and the Committee to the researcher and thanked them for attending the meeting.
- The Committee informed the researcher that people may feel obliged to take part if they are asked by their Clinicians to take part. The researcher said this is possible but it is clear on the Information Sheet that the Clinician will discuss the study verbally with potential participants.
- The Committee asked the researcher to clarify what is meant when they say Clinicians will select suitable people. The researcher stated this relates to the inclusion & exclusion criterion as they are looking at particular age groups and around the characteristics of the child not the parents.
- The Committee asked the researcher to clarify if participants whose first language is not English will be excluded and does this only include non-English speakers. The researcher stated she had picked up on this and non-native speakers can take part. Also she has looked at the adoptive register and mainly families are white/British so this should not be a problem. This will be the initial study and if successful then it could broaden out to other nationalities.
- The Committee asked the researcher that in the Information Sheet they state if something is disclosed this information along with their name will be passed on to their Clinician for safeguarding purposes. What if this information is about their Clinician? The researcher stated she would ask Professor Panos Vostanis to act as advocate as he is the senior member of the team.
- The Committee asked the researcher if this study is part of a doctorate. The researcher stated yes it is. The Committee asked the researcher if people will be making extra visits to attend the interview are there any funds available to pay travel expenses. The researcher stated she has discussed this with Panos and has decided it is would on a case by case decision as some of the interviews will be done at home, but funds are available for additional attendance.
- The Committee asked the researcher why is the consent form being signed and then returned to the adoption service. The researcher stated this is in the protocol as potential families will be recruited from the specialist adoption service. The Committee suggest a reply slip could be added to the Invitation letter & Information Sheet so this can be completed and returned directly to her as it should not go back to the Adoption Service and the Consent Form can be signed at the interview. The researcher agreed this can be changed.
- The Committee asked the researcher why they are asking for the Child's name on the Consent Form. The researcher stated this is so they can make sure the child had met the inclusion criteria, so was just another check. The Committee suggested this request be on the reply slip on the Information sheet and removed from the Consent Form.
- The Committee asked the researcher if the audio tapes are being transcribed by the third party how is confidentiality going to be maintained as personal details should not be given to the transcriber. The researcher explained the transcriber will have to sign a confidentiality agreement to do this but they will be someone who is working at the Greenwood Institute or is from the research department at the university library. The researcher said they could ensure as far as possible that no identifying details such as names or home address were mentioned during the recorded interview
- The Committee asked the researcher to clarify how they will provide the summary of findings of the study to participants. The researcher stated they will email it. The Committee asked will the researcher hold all the contact information from the study. The researcher stated no they would not, this information will be held at the Greenwood Institute and summary of results would be sent by the clinical team.
- The Committee asked the researcher what is meant by care record in point 3 of the

Consent Form. The researcher stated this relates to the case file it is not a medical record. The Committee suggest this be changed on the Consent Form.

The Committee is unable to give an ethical opinion on the basis of the information and documentation received so far. Before confirming its opinion, the Committee requests that you provide the further information set out below.

Authority to consider your response and to confirm the Committee's final opinion has been delegated to the Chair.

Further information or clarification required

The following changes are required to the Invitation Letter & Information Sheet:

1. Details of [redacted] being the alternate person who will be informed of any disclosure information needs to be added to the section 'Will my taking part in the study be kept confidential?'.
2. The name of the Committee needs adding to the section 'who has reviewed the study?'
3. Include the information that travel expenses may be paid and explain this will be looked at on a case by case decision.
4. Insert a reply slip at the bottom including the request of the child's name to check they meet the criteria.
5. Change the section 'What will I have to do? To ask them to complete the reply slip at the end of the Invitation Letter & Information Sheet and return it to the researcher.
6. Change the word 'location' to 'place' under the section 'What will I have to do?'
7. Change the word 'an' to 'the' under the section 'what will I have to do?' in the sentence 'you will be contacted by Louise Brittenden (Trainee Clinical Psychologist) to schedule an interview'.

The following changes are required to the Consent Form:

1. The boxes should be after each point not before.
2. Change point 3 to say my case file instead of my care record.
3. Remove the request of the child's name and age from this as this information will be on the reply slip.
4. Include a line to say this Consent Form will be signed before the Interview takes place.

If you would find it helpful to discuss any of the matters raised above or seek further clarification from a member of the Committee, you are welcome to contact Wendy Rees REC Manager on nrescommittee.eastmidlands-leicester@nhs.net

When submitting your response to the Committee, please send revised documentation where appropriate using tracked changes or underlining the changes you have made and giving revised version numbers and dates.

If the committee has asked for clarification or changes to any answers given in the application form, please do not submit a revised copy of the application form; these can be addressed in a covering letter to the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than **20 February 2014**.

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

14/EM/0007	**Please quote this number on all correspondence**

Yours sincerely

pp. W Reeo

Professor Geoff Dickens
Chair

Email: NRESCommittee.EastMidlands-Leicester@nhs.net

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments.*

Copy to: [redacted]*University of Leicester*
Dr. David Clarke, Leicestershire Partnership Trust

NHS
Health Research Authority
NRES Committee East Midlands - Leicester
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839425

14 February 2014

Mrs Louise Maria Brittenden
[redacted]

Dear Mrs Brittenden

Study title:	**Adoptive parents' experiences of seeking mental health care for children adopted from the care system: An Interpretive Phenomenological Study.**
REC reference:	**14/EM/0007**
Protocol number:	**Not applicable**
IRAS project ID:	**141241**

Thank you for your letter of 11 February 2014, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Ms Wendy Rees, NRESCommittee.EastMidlands-Leicester@nhs.net

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering Letter	Letter from Louise Brittenden	03 December 2013
Interview Schedules/Topic Guides	Appendix A - V1	20 November 2013
Investigator CV	[redacted]	20 November 2013
Other: CV	Louise Brittenden	22 November 2013
Other: CV	[redacted]	23 November 2013
Other: Peer Review	[redacted]	18 October 2013
Other: Feedback from informal peer review	[redacted]	01 June 2013
Other: Email from David Clarke		11 November 2013
Participant Consent Form	2	27 January 2014
Participant Information Sheet	2	27 January 2014
Protocol	4	27 January 2014
REC application	141241/534832/1/827	27 November 2013
Referees or other scientific critique report	Service User Evaluation - V1	20 November 2013
Response to Request for Further Information		11 February 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

14/EM/0007	**Please quote this number on all correspondence**

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee's best wishes for the success of this project.

Yours sincerely

Mr Geoff Dickens
Chair

Email:NRESCommittee.EastMidlands-Leicester@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: [redacted], *University of Leicester*

Dr David Clarke, Leicestershire Partnership Trust

Research Support Service
Community, Mental Health & Learning Disability Services

Leicestershire Partnership NHS
NHS Trust
A University Teaching Trust

Research & Development Office
Lakeside House
4 Smith Way
Grove Park
Enderby
Leicester
LE19 1SS

Direct dial: 0116 295 7641
Email: david.clarke@leicspart.nhs.uk

Tel: 0116 295 7500
Fax: 0116 295 7599
Web: www.leicspt.nhs.uk

DC/Brittenden/PSYC0664

3rd March 2014

Mrs Louise Maria Brittenden
[redacted]

Dear Louise

RE: Adoptive parents' experiences of seeking mental health care for children adopted from the care system: An Interpretive Phenomenological Study.
Trust Ref: PSYC0664
SPONSOR: University of Leicester INDEMNITY: University of Leicester

Thank you for applying for NHS Permission to conduct recruitment for the above study within Leicestershire Partnership NHS Trust. This study has now been validated and reviewed according to the Standard Operating Procedure for research appraisal. Leicestershire Partnership NHS Trust has granted you full approval to conduct this research within the Trust on the condition that the Trust suffers no unforeseen costs as a result of this study being undertaken. Your research has been entered onto the Trust's Research Database.

This study has been classified as research and as such requires formal NHS Research Ethics review, and we are pleased to have received confirmation of a positive review undertaken by NRES Committee East Midlands - Leicester (dated 14th February 2014). This study therefore has:

Full Approval	☒	Approval in Principle	☐	Approval refused	☐
Date Full Documentation Received	9th December 2013	Date of Sponsor Approval	29th December 2014	Sign-off timeline	13 Days
Date of Ethical Confirmation	14th February 2014	Date of Final NHS Permission (from ethics)	3rd March 2014	Sign-off timeline	10 Days

The conduct of your study (including examination of the site file) at this site may be subject to audit for protocol adherence and other monitoring issues. This approval is subject to the accuracy of the following information:

Study Summary			
Chief Investigator (Supervisor):	[redacted]		
Principal Investigator:	Mrs Louise Brittenden		
Other Investigators:	[redacted]		
Indemnity Provider:	NHS (LPT)	Start Date	1st March 2013
NIHR Portfolio:	No	End Date	1st December 2015
Student Project	Yes	Target Recruitment	8
Funding:	None {UoL Student Budget}		£300

Approved Documentation	*Version*	*Date*
Covering Letter	Letter from Louise Brittenden	03 December 2013
Interview Schedules/Topic Guides	Appendix A - V1	20 November 2013
Investigator CV	[redacted]	20 November 2013
Other: CV	Louise Brittenden	22 November 2013
Other: CV	[redacted]	23 November 2013
Other: Peer Review	[redacted]	18 October 2013
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Participant Consent Form	2	27 January 2014
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Protocol	4	27 January 2014
REC application	141241/534832/1/827	27 November 2013
Referees or other scientific critique report	Service User Evaluation - V1	20 November 2013
Response to Request for Further Information	11 February 2014	

Please note that all research with an NHS element is subject to the Research Governance Framework for Health and Social Care 2005. If you are unfamiliar with the standards contained in this document, or the LPT policies that reinforce them, you can obtain advice from the R&D Office, or go to http://www.dh.gov.uk/PolicyAndGuidance/ResearchAndDevelopment/ResearchAndDevelopmentAZ/ResearchGovernance/fs/en

You must stay in touch with the R&D Office during the course of the research project, particularly if/ when:

- There is a change of Principal Investigator;
- The project finishes (please complete a summary report form)
- Amendments are made, whether minor or substantial;
- Serious Adverse Events occur (must be reported within 24 hours of becoming aware of the event).

This is necessary to ensure that your indemnity cover is valid. Should any untoward events occur it is essential that you contact the R&D Office immediately. If patients or staff members are involved in an incident, you should also contact the Clinical Risk Manager. I hope the project goes well, and if you need any help or assistance during its course, please do not hesitate to contact the Office.

Provision against NHS Costs

The Trust reserves the right to invoice the study team for any unexpected costs arising from this study, including, but not limited to:

- Staff Time attending interviews.
- Travel and administrative costs.

Kind regards

Dr. Dave Clarke
[Operational Lead: Research & Development]

Appendix L: Confidentiality Agreement for Transcription

Confidentiality Agreement for the Transcription of Qualitative Data

Name of Researcher:	**Louise Brittenden**
Name of Transcriptionist:	**Jo Welch**

By signing this document, you are agreeing:

- not to pass on, divulge or discuss the contents of the audio material provided to you for transcription to any third parties
- to ensure that material provided for transcription is held securely and can only be accessed via password on your local PC
- to return transcribed material to the researcher when completed and do so when agreed in password protected files
- to destroy any audio and electronic files held by you and relevant to the above study at the earliest time possible after transcripts have been provided to the researcher, or to return said audio files.

Your name (block capitals) Jo Welch

Your signature

Date 25-6-2014

Appendix M: IPA Analytic Process

IPA is not a prescriptive approach but provides flexible guidelines which can be adapted by the researcher according to their research aims (Eatough & Smith, 2006; Smith & Osbourne, 2003). Consequently, the principles and common processes described by Smith *et al.*, (2009) were used to guide the analytic process. Individual transcripts were analysed in sequence. Each transcript was read and re-read several times to facilitate the process of entering into the participants' world and active engagement with the data. During repeated readings, initial underlining of text and noting of comments were made in the right hand margin, to highlight anything of particular interest or significance. Following this preliminary stage, line by line coding was conducted, using the right hand margin to comment on the researcher's responses at descriptive, linguistic and conceptual levels.

The next stage involved re-visiting the transcript afresh and using the left-hand margin to capture the essential qualities of what the respondent had expressed. The initial line by line coding was transformed into more specific themes and phrases, which reflected a higher level of abstraction and/or psychological concepts (Smith *et al.*, 2009). This more interpretive process involved a continual shifting between inductive and deductive positions whereby the respondent's account illuminated themes un-anticipated by the researcher, who was then able to tentatively explore how they might be conceptualised in relation to existing psychological theory (Eatough & Smith, 2006). This stage of the analysis required the researcher to be constantly checking that interpretations or abstractions remained grounded in the words of the respondent.

Following these earlier stages of the analysis, it was necessary for the data to be reduced by looking for connections between emergent themes and clustering them accordingly. This was achieved by listing emergent themes chronologically, then mapping ways in which the themes clustered together. Smith *et al.*, (2009) suggest that some themes may act as magnets, drawing other themes towards them. Clusters were given a descriptive label which tried to capture the conceptual characteristics of the themes within them. Subsequently, a summary table was produced to show each higher order theme and the sub-themes within it, alongside illustrative extracts from the respondent's account to ensure that the outcome of the iterative process was firmly grounded in the raw data.

This process was repeated for each individual transcript in order to adhere to the ideographic nature of IPA. For each new transcript, it was important, as far as possible, to remain open to new ideas and to try to 'bracket' off ideas that had already emerged from the analysis of previous cases (Smith *et al.*, 2009). A visual diagram of higher order and sub-themes was created for each respondent. This helped to create sense of 'gestalt' for each respondent before moving on to the next.

Once the individual analyses had been completed, themes across all six respondents' accounts were explored to discern convergent and divergent patterns in the data. This process of comparing and contrasting clusters across respondents involved the re-labelling and reconfiguring of themes which helped to synthesise the data and move the analysis to a higher level of abstraction. During this stage it was important to ensure that the identified themes and connections remained embedded in the primary data. As a result of this process, four super-ordinate and 12 sub-themes were identified, which were able to capture and organise the majority of the data. The final themes were then translated into a narrative, interpretive account during which the researcher's interpretations continued to develop (Smith *et al.*, 2009).

A reflective journal, kept throughout the research process, helped to capture the researcher's reflections during the process of data analysis.

References:

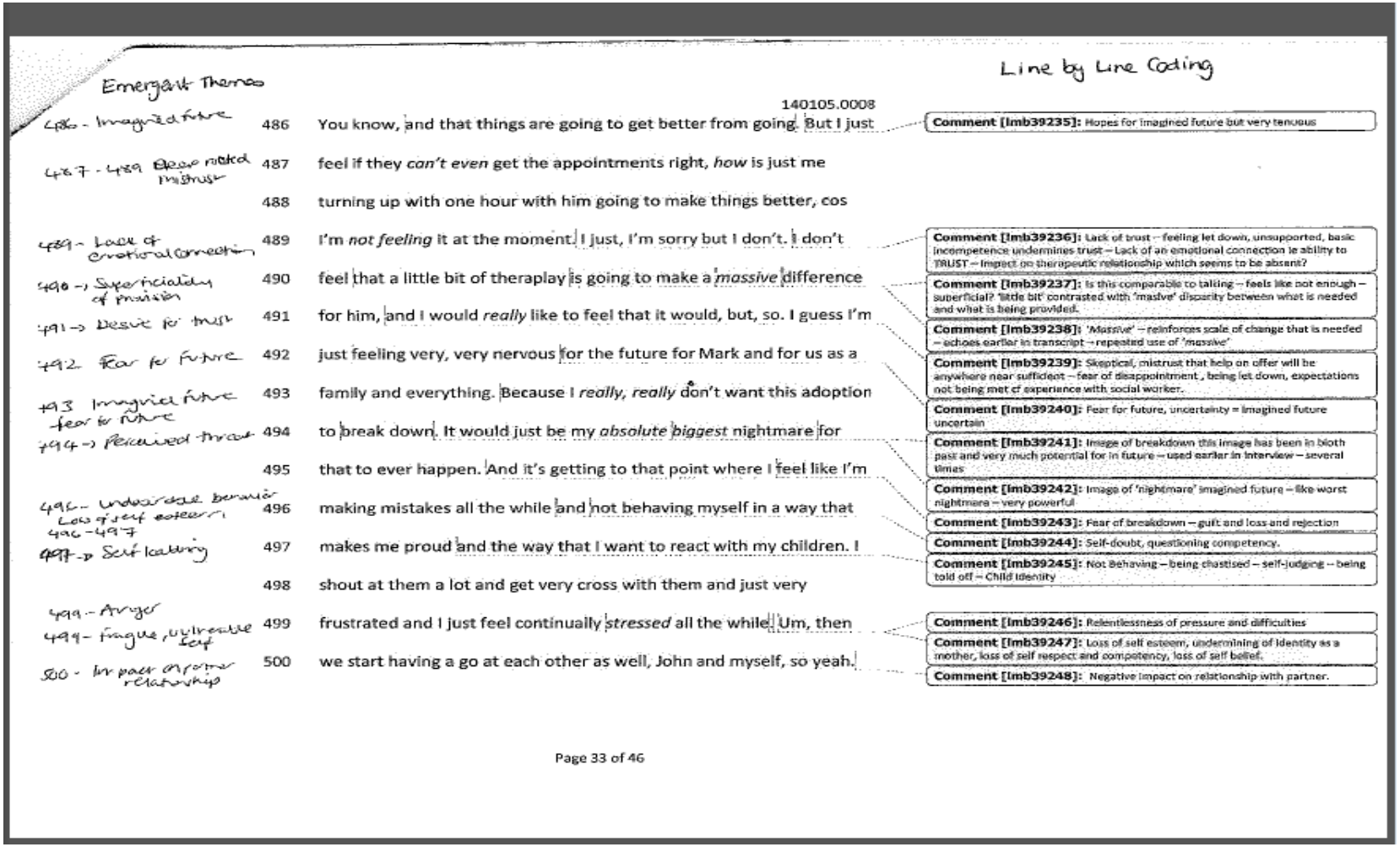
Eatough, V., & Smith, J. (2006). I was like a wild, wild person: Understanding feelings of anger using interpretative phenomenological analysis. *British Journal of Psychology, 97*(4), 483-498.

Smith, J.A., Flowers, P. & Larkin, M. (2009). *Interpretive Phenomenological Analysis: Theory, Method, Research.* London: Sage.

Smith, J.A. and Osborn, M. (2003). Interpretative phenomenological analysis.

In J.A. Smith (Ed.) *Qualitative psychology: A practical guide to research methods*. (pp.51-80). London: Sage.

Appendix N: Example of line by line and emergent coding for respondent 1 (Hayley).



Emergent Themes

Line by Line Coding

140105.0008

486	You know, and that things are going to get better from going. But I just	**Comment [lmb39235]:** Hopes for imagined future but very tenuous
487	feel if they *can't even* get the appointments right, *how* is just me	
488	turning up with one hour with him going to make things better, cos	
489	I'm *not feeling* it at the moment. I just, I'm sorry but I don't. I don't	**Comment [lmb39236]:** Lack of trust – feeling let down, unsupported, basic incompetence undermines trust – Lack of an emotional connection ie ability to TRUST – impact on therapeutic relationship which seems to be absent?
490	feel that a little bit of theraplay is going to make a *massive* difference	**Comment [lmb39237]:** Is this comparable to talking – feels like not enough – superficial? 'little bit' contrasted with 'masive' disparity between what is needed and what is being provided.
491	for him, and I would *really* like to feel that it would, but, so. I guess I'm	**Comment [lmb39238]:** 'Massive' – reinforces scale of change that is needed – echoes earlier in transcript – repeated use of 'massive'
492	just feeling very, very nervous for the future for Mark and for us as a	**Comment [lmb39239]:** Skeptical, mistrust that help on offer will be anywhere near sufficient – fear of disappointment , being let down, expectations not being met cf experience with social worker.
493	family and everything. Because I *really, really* don't want this adoption	**Comment [lmb39240]:** Fear for future, uncertainty = imagined future uncertain
494	to break down. It would just be my *absolute biggest* nightmare for	**Comment [lmb39241]:** Image of breakdown this image has been in bioth past and very much potential for in future – used earlier in interview – several times
495	that to ever happen. And it's getting to that point where I feel like I'm	**Comment [lmb39242]:** Image of 'nightmare' imagined future – like worst nightmare – very powerful
496	making mistakes all the while and not behaving myself in a way that	**Comment [lmb39243]:** Fear of breakdown – guilt and loss and rejection
497	makes me proud and the way that I want to react with my children. I	**Comment [lmb39244]:** Self-doubt, questioning competency.
498	shout at them a lot and get very cross with them and just very	**Comment [lmb39245]:** Not Behaving – being chastised – self-judging – being told off – Child Identity
499	frustrated and I just feel continually *stressed* all the while. Um, then	**Comment [lmb39246]:** Relentlessness of pressure and difficulties
500	we start having a go at each other as well, John and myself, so yeah.	**Comment [lmb39247]:** Loss of self esteem, undermining of identity as a mother, loss of self respect and competency, loss of self belief.
		Comment [lmb39248]: Negative impact on relationship with partner.

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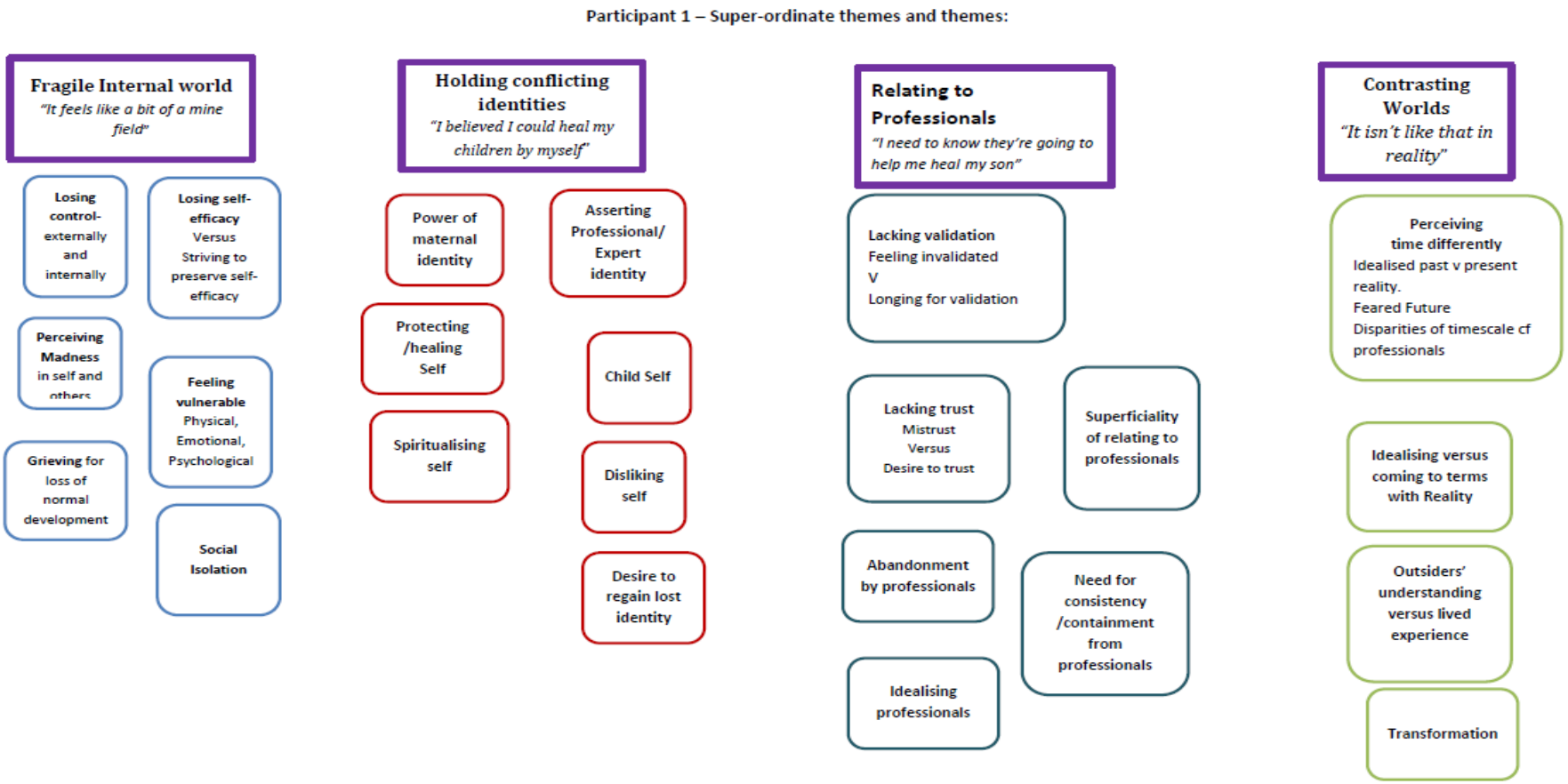
Appendix N: Clustering of super-ordinate and sub-themes, with supporting quotations for respondent 1 (Hayley).

Cluster/Super- ordinate theme?	*Theme/sub-themes*	*Page/line ref*	*Quotation*
2. Holding Conflicting Identities	***Desire to re-gain lost identity***	***p.38, Line 564-565***	***I really need some help to kind of get my own thoughts and my own feelings about what we're going through***
	Asserting Professional identity	*p.3.Line 44-44*	We were just fostering at that stage(minimising past professional identity)
		p.19. Line 293-296	And I think that actually teaching any child with taking into consideration attachment, it would be a beneficial thing for all children, all children would benefit from it, you know. Cos we're just talking about security and safety, aren't we?
		p.22 Line 328-330	I explained that what the children were doing that I knew that it was very highly likely attachment disorder and they definitely needed some intervention of some sort.
	Power of Maternal identity	*p.4 Line 51-52*	I just thought there was no way that other people wouldn't you know love them like I love them
		p.16 , Line 245-246	I know they're my children and nothing, well they are my children, and nothing will ever change that
		p.27 Line 408	I *know* what he is capable of
	Protecting/Healing Role	***p.32 Line 485***	***and know that they're going to help me heal my son***
		p.14, Line 208-209	I believed that I could heal the children by myself. Superwoman if you like (sigh of humour).
	Child-Identity	*p.9 Line 139*	People like my mum and dad who I really want to lean on and get support from
	Spiritualising self	*p.8.Line 116 -117*	By some kind of divine miracle, I have no idea sometimes how we get out of the door, but we manage to.
		p.4 Line 54-54	I can remember praying and thinking you know if it's not meant to be, if this adoption's not meant to be, bring them back to *me*.
	Disliking the self	***p.37 Line 551-552***	***I hate the way that I'm feeling angry at my own children.***

Appendix N: Visual map of Themes for Respondent 1. (Hayley)



Appendix O²: Chronology of Research Process

December 2012

- Consultation with research supervisor
- Initial research proposal

May 2013

- Developing research proposal

July – October 2013

- Internal peer review at the University of Leicester
- Service User Reference Group (SURG) review
- Preparation of application for LREC

December 2013

- LREC application
- R&D application

January 2014

- LREC meeting 10th January 2014, favourable opinion received 14th February 2014
- R&D approval received 3rd March 2014

April-October 2014

- Recruitment and interviewing participants
- Interview transcription

January 2015 - March 2015

- Analysis

December 2015 - May 2014

- Write up period

May 2015

- Submission of thesis to University of Leicester

May 2015 - June 2015

- Viva preparation

July 2014 - Sept 2014

- Dissemination of findings
- Preparation for poster presentation and publication paper

Appendix P: Frequency of themes across Respondents' Transcripts

Themes	**Respondent**					
	Hayley	Sarah	Christine	Rachel	Emma	Anne
Having to Battle	**X**	**X**	**X**	**X**	**X**	**X**
Living amidst external conflict	X	X	X	X	X	X
Struggling for control in the home	X	X	X		X	X
Fighting for professional support		X	X	X		X
Managing Internal Conflicts	**X**	**X**	**X**	**X**	**X**	**X**
Expert identity vs vulnerable self	X	X	X	X	X	X
Desire to heal vs fear of damage	X		X	X	X	X
Diminishing vs strengthening self	X	X	X	X	X	X
Fragile Connections with Professionals	**X**	**X**	**X**	**X**	**X**	**X**
Lacking consistent support	X			X	X	X
Need for emotional containment	X		X		X	X
Mutual connection feels validating		X	X	X	X	X
A Reducing Social Circle	**X**	**X**	**X**	**X**	**X**	**X**
Outsiders unable to 'see' reality	X		X	X	X	X
Needing to retreat		X		X	X	
Forming alternative social connections			X	X	X	

Appendix Q: Poetic Condensations

Hayley

I

There'll be nothing,
No trigger that will start the ball rolling for him to have a morning like that.
He just heaves himself and launches himself all over the furniture,
Running on the dining room table, climbing in the window.
You don't know where to look,
You don't know where to move first.
It's just quickly grab them, get them safe as quickly as you can.
We finally get out the door, somehow,
By some kind of divine miracle.
I say that I need to be able to touch you,
If I can't put my hand on you, you're too far away.
He needs my presence to keep him calm.
But I can't give him what he needs,
I've got three other children and a timescale

II

And there's just me.
I believed that I could heal the children by myself.
Superwoman if you like.
People like my mum and dad who I really want to lean on,
He gives them a very, very watered down version.
They're not seeing what we're living on a day to day basis.
I just feel, I feel desperate for his behavioural difficulties to be less than they are.
I really, really don't want this adoption to break down.
It would just be my absolute biggest nightmare for that to ever happen.

III

You know, he's just a little six year old boy,
None of this is his fault,
He's ill because of things that have happened to him,
Completely outside of his control.
I feel guilty because I feel unable to sort of forgive him for things that he's done.
I really some help to kind of get my own thoughts and my own feelings.
It just, it feels a bit like a minefield.
Because I just feel completely, myself, really emotionally all over the place.
You know, all the training courses in the world wouldn't have the impact.
They said that adoptive parents often have secondary post-traumatic stress disorder,
I feel like I'm actually very, very close to breaking point.

IV

What I really want to do is absolutely have my full trust in CAMHS,
Know that they're going to help me heal my son.
You know, when you really want to put your trust in somebody,
See it as an extremely professional outfit,
Where they know exactly what they need to be doing.
Well, I feel it's incredibly slow,
Slow, slow, slow.
I really, really need consistency and he needs consistency too.
I need to know what's happening,
Trust somebody and depend on somebody,
That they know how to fix things.

V

I'm quite happy for somebody to say you know,
This is going to take a really long, long time.
I'm ready for the long haul,
But I need to be guided in it.
I need somebody to give me support,
But I have no idea
How I would ever get that kind of support.

Sarah

I

Daniel
Was like suddenly an explosion happened.
He was always on the go,
He wouldn't settle to anything.
A lot of Daniel's difficulties
Were almost impossible to foresee.
Well it wasn't a diagnosis, they said.
There was no mental health.
Basically the message was
Just keep therapeutic parenting.
We've read all the literature,
We've always taken on board any suggestions,
Living and breathing therapeutic parenting.
It was just a very difficult message to hear,
Because we had been consistently doing that
But something wasn't…..
We just felt like a door had been closed.

II

The most difficult thing about the medication
Was his refusal to take it,
Because that's when the control kicked in.
We'd been given this hope that things were going to change miraculously.
He'd bring out every kind of behaviour,
He would just scratch, bite, kick..
We didn't know how much more we were able to give.
You can kind of manage the aggression and the tantrums,
But him shouting at the top of his voice the eff word.
Makes actually going out quite nerve-wracking.
I think we've probably unconsciously, sometimes consciously,
Seen less and less of friends as Daniel's got older.

IV

I think one of the most difficult things,
Probably the most unexpected things,
Have been around the way that certain family members
Have accepted and not accepted him.
It's too much to expect I suppose is what I'm saying,
But it would be sometimes nice I think,
Rather than to have the reaction of, yeah, we told you this was a bad idea.

V
We had a real battle with school.
I mean there was just no empathy,
No understanding really of how low things had got at that point.
They just kept throwing curve balls and putting barriers in the way.
Things were said at that meeting that I think will haunt me
Forever.
So traumatic for all of us.

VII
We wanted for him
To feel part of the community.
Obviously that's been taken away.
There's no way for him not to feel like an outsider
When we go down to the park,
He's not going to be known by the children.
Probably very much known by parents
As being that naughty child.

VI
You know, a degree of empathy and understanding
Makes all the difference.
A sort of partnership.
So you just feel that sense of support,
As opposed to 'we think you're not doing this right.'
Just that lack of judgement
It's not about we're untouchable and we don't want advice,
And we're doing everything perfect.
I mean I don't know whether there's a parent in the land that can ever say that.
There is almost ninety nine percent likely
To be some level of difficulty with a child that's adopted today.
I think there also needs to be a level of acceptance that
There are differences with an adopted child.
And you know, you are likely to need services.
And I think the frustration has been
That you do feel you have to fight.

VII
The first time he walked on a beach,
I think he just never looked back.
He would have just kept going and going.
I can see improvement really cos, you know, he does check.
He checks us out a lot more than he did before.
All of those things haven't come without having to battle.
I suppose that's what's been.
Sometimes, you feel are you just being too demanding or?
But it's always about trying to get the best for Daniel,
He's going to need support probably, you know, throughout his life.
He can't do it on his own and we can't do it on our own.

Christine

I

We have to pick our battles otherwise we'd be constantly onto him.
He has not got much left in his room that isn't broken.
We had another screaming tantrum and it ended up with my sister just leaving.
It's this massive rage he gets into which can go on for two hours.
And he doesn't come down from that very easily.
I mean the other night, I was tidying up,
I found a calculator that was completely in thousands of pieces.
The normal behaviour things aren't working,
There must be something else.
But how do you address that something else?

II

He comes out with things like,
'I was never meant to live here
I shouldn't be here,
I don't belong in a family,
I belong on my own, on the street
Because I've got this bad heart,
Maybe someone needs to take it and put in a good heart'.
I don't quite know where that came from.
I've done every parenting course,
There's nothing really that I don't know about the theory.
But how on earth we're going to address that is just beyond us.
I have no idea where we go with that.

III

He said 'there's nothing wrong with me',
I behave this way so you'll hate me
So you'll send me back to my mum
You know, you're not my real mum and all this.
Well whatever you do, we won't be sending you back
You will be here until you're older, until you're grown up.
And it does hurt.

VI

We would never say it's easy.
It's been a lot harder than what we thought
In ways that we never thought it would be.
I suppose you go into it with
We're going to offer this nice home,
They'll be so happy, they won't question.
That was the only home he knew,
I felt like I was taking him away from this lovely home,
I felt we hadn't been prepared for that
He was being taken away twice from people.

V
It was getting so bad and I wanted to perhaps discuss that,
Just that somebody can ask him the right questions
For him to somehow make sense of it in his own way.
Help me out here, you know.
But I do feel 'oh it's me again'.
I've got to burden you with more work,
I suppose I will fight my corner,
Perhaps other parents probably wouldn't.

VI

I believe it is all centred around him,
His feelings about being adopted.
I genuinely believe that.
The thought of him not being here would, is just awful.
It would be like losing one of my children
I just hope he'll kind of pull through it
I'm sure he will do but at the moment I don't know.
I just think he's very complex.
Maybe we'll never get to the bottom of exactly what his issues are

Rachel

I

I knew I was struggling.
All hell broke loose when I mentioned it.
This is what she told me, 'six months of kisses and cuddles and she'll be fine.'
I smiled sweetly, nodded a lot and said 'yes I'll go and do those things for you, of course'.
I'm very subservient.
And yet you have to keep screaming and shouting.
I wish she would go and bite someone, maybe they'd do something then.
Then someone said, 'we believe you'.
Gosh that's bizarre, do you?
They believed me, there was no element of doubt.
Such a relief.
My bright little star.
Access was tricky, but I'm in for now.

II

They tell you, you need resilience.
You don't realise what they meant was,
Resilience to deal with the professionals that you're going to come across.
It's just such a fight.
I have to help them as they're just doing what their bodies are telling them to do,
They don't choose that.
My child is a bucket and she's full of all this junk,
But all this junk can come out.
She's not the junk, just the space that it occupies.
I scaffold our lives around trying to make them successful in whatever way they can be,
But there's no magic wand, it's going to take years.
It's another trick to help things along.

III

My support has almost vanished, a kind of death.
It was okay for me to go over there,
People didn't want to come over here.
It's out of their comfort zone.
Except those who have children of a similar adopted ilk to mine,
We understand,
We don't have to pretend or make excuses.
I'm giving 100 percent but something will give somewhere.
There's a limit to how much you can bear.
It's just the scale of things, impossible to get unless you live it really.
Me as this teeny figure in front of a huge mountain.

Emma

I

Fight or flight mode and standing on the furniture,
Throwing things out the window, running round the room, trying to climb the walls.
Anything just pushes the button and he goes over the edge.
Forty-eight hours non-stop trying to manage him because he was going berserk.
It feels like the whole house has been taken over,
Completely chaotic, you feel like you're not really in control of your own life anymore.

II

But I wouldn't dream of mentioning it to people who have got birth kids because they just don't understand the issues at all.
Some people think it's black and white, you know,
That's the naughty step and there you go.
I do wonder what they must think sitting out in the sunshine listening to this.
They must be thinking 'why's she not taking control of the situation?'
But I'm keeping them close,
Making sure that things are being done the way they need to be done.

III

Because he'd had no problems in the past
She actually didn't really want to make the referral.
That's like saying you've never had a broken leg in the past
So they're not going to fix it.
You're having to deal with this situation and you're a bit stuck really,
You don't know where to go with it from there.
After much badgering we managed to persuade her.
Nowhere on the form were there any boxes for her to tick early trauma,
Adoption and fostering, attachment disorders or anything like that.
Quite how she made the referral I don't know.
Several months wait for nothing really,
Because then we got a rejection letter and we had to start all over again.
If it was a broken leg they wouldn't have done that.

IV

Someone was ill, so they had to scramble another,
Who was upstairs reading the notes as we arrived, I was told.
I wasn't sure whether we got quite the assessment we were supposed to.
It's just taken a whole year for him to actually start some treatment.
You do start to think you might be going mad.
It was an odd experience I suppose
Being in a room full of people playing bizarre games.
All the others had their children wrapped up in blankets and were feeding them.
My child was hiding under stacks of chairs or snatching the bottle and running off.
I was quite pleased really that they were seeing it I suppose.

IV

I think the people that are working there are doing their best,
But there's not really the resources
They seem like a very small team.
You think well how are they possibly going to manage?

Anne

I

Cos they had come on so far, still a long, long way to go.
Physically the things that were happening were going to heal but emotionally?
It literally was a war zone, it was very emotionally hard,
Because you literally couldn't take your eyes off of them.
We'd got them out of that.
It took us a long time to get anywhere with them, it was really a long, slow path.
I'd sit and we'd start to sing songs because I was hoping I would like wash away that anxiety,
You know, I have to give my all.
Everyone was saying how much better they were than when they first came.
We had two hundred balloons that we'd blown up and released,
They all just drifted away and we sort of said say bye bye to your old life,
This is your new life and they remember that.

II

He'd get very angry and attack things and I was in school every day.
It went round the school playground like wildfire,
Cos I was mum they thought it was me.
I didn't want to be looked at like I was a terrible mother.
I think we need to be just totally honest about it with people.
People are more willing to accept it in a sense if they know they can't help it.
When it was explained, I was getting invited round for coffee
Lots of people were offering to help.
But there was really nothing they could do,
Because it was about me being that strong emotional person.

III

And so it was an uphill battle.
He'll have had a lovely day,
Even now, he will drop the bomb at the end of it.
They said at school "he has to learn to be a normal person".
He's never going to learn to be a 'normal' person.
He's going to learn to be a better person for himself,
Never 'normal' in that every-day term.
With children like that you can't take things away,
Because they drop into this time hole of 'it's all being taken away from me'
Literally as soon as we walked out of those school gates he would burst.
I would end up carrying him fireman's carry all the way home.

IV

What he'll do with his attachment disorder is,
He'll reject you before you go and it happens all the time,
And it becomes a life style.
I'd almost become this battered wife.
There isn't a society or a group for this.

V

I don't think I'm going to be able to cope with it for much longer.
Help me because I'm struggling and it's going to break down.
Then all of these things came in,
They actually said things to me that made feel a lot better,
Made me feel not guilty anymore.
I was going to say empowered, I don't mean empowered,
But it made me feel like I'm not doing anything wrong.
Cos they had come on so far, still a long, long way to go.