Oxford Doctoral Course in Clinical Psychology

Adoptive Families: Working with Parent and Child

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Abstract

The literature on parenting emphasises that, not only does parental behaviour influence child development, emotions and behaviour, but child behaviour influences parents' behaviour and well-being. Such dyadic interactions may be particularly important in the case of adoption, where research has shown that children are likely to have had difficult early attachments or separations and where parents are likely to experience unique stressors. Therefore, understanding the effects of parenting stress and understanding how to best work with early trauma are important in adoptive families.

The first paper provides a systematic review of quantitative research on parenting stress in adoptive parents. Results showed adoptive parents to have parenting stress scores within the normal range. However, adoptive parents tended to have higher scores than non-adoptive parents, particularly if their child had lengthier exposure to adverse pre-adoptive environments, special needs or if parents perceived child difficulties.

The second paper aimed to gather the experiences of adoptive parents who had undergone dyadic developmental psychotherapy (DDP), an attachment-focused therapy for families where the child has experienced complex trauma or attachment difficulties. Interpretative Phenomenological Analysis revealed four superordinate themes: increased understanding, "it's a different method of parenting generally", the DDP journey and "it's a shared kind of experience you go through and come out together". Discussion of implications for clinical practice, policy and research is provided.

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Paper A

A Systematic Review of Parenting Stress in Adoptive Parents

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Abstract

Parenting stress results when perceived demands of parenting exceed perceived resources. High levels of parenting stress not only negatively impact on parents, but also on the children and parent-child relationship. Adoptive parents are thought to have increased levels of parenting stress and this review aimed to critically examine the quality of research on parenting stress in adoptive parents whilst exploring levels of parenting stress across different adoption groups. A systematic search of six electronic databases, Internet searches and reference list checking identified 23 studies that quantitatively measured parenting stress in adoptive families using a validated measure. A quality assessment tool was adapted to support assessment of study quality. Twelve studies considered international adoption, four focused on adoptive parent's sexuality, five considered domestic adoption, one considered special needs adoption and another considered mixed adoption types. Twenty studies were cross-sectional and three longitudinal. Results showed that adoptive parents tended to have parenting stress scores within the normal range. However, adoptive parents tended to have higher scores than non-adoptive parents, if their child had longer exposure to adverse environments, if their child had special needs or if parents perceived significant child difficulties. Generally studies were of good quality. The review highlights methodological issues in the literature and implications of the review are discussed in terms of clinical practice, policy and future research.

Keywords: Parenting, Stress, Adoption, Systematic review, Adoptive families

Proposed Journal: Journal of Family Psychology (See Appendix A for author guidelines)

Introduction

Parenting Stress

Parenting stress has been defined as the stress resulting when perceived demands of parenting exceed perceived resources (Deater-Deckard, 1998). There are a number of hypothesised theoretical models of parenting stress. The most prominent is a relationship-focused model, which encompasses child-related factors, such as temperament, health or behaviour and parent-related factors, such as parental functioning and mental health (Abidin, 1990; 1995). Parenting stress is thought to result from an accumulation of factors associated with both child and parent (Abidin, 1995), whilst other models are hassle-focussed and consider the contribution of everyday stressors (Crnic & Greenberg, 1990).

More general biopsychosocial models can also be applied to parenting (Deater-Deckard, Chen, & El Mallah, 2013), by considering the biopsychosocial factors involved in parental stress. These may include biological and psychological aspects of the parent and/or child, such as mental or physical health, past experiences and cognitive style. Still, parent-child dyads do not exist in isolation. Social support, community and cultural context also influence parenting stress. Consequently, we can see models of parenting stress in much the same way as other biopsychosocial models of stress and health. Additionally, risk-protective factor models can help with our understanding of the factors that contribute to but also protect against parental stress (Lamis, Wilson, Tarantino, Landford, & Kadlow, 2014). Protective factors, for example, may include parental self-efficacy, self-esteem, social support and adaptive social strategies (Lamis et al., 2014).

Research has considered multiple factors associated with parenting stress. Parent and child factors, such as having a child with a diagnosis can increase parenting stress, possibly due to increased responsibility, associated behaviour problems and worry (Cousino & Hazen, 2013). Increased stress related to a child's special needs may also be associated with increased demands due to support needs

(Baker, McIntyre, Blacher, Crnic, Edelbrock, & Low, 2003). Parental factors are also crucial to understanding stress levels. For example, parents suffering from their own mental ill health report increased stress (Leigh & Milgrom, 2008) whilst parents who report higher levels of self-esteem and more internal locus of parenting control experience less parenting stress (Hassall, Rose, & McDonald, 2005). It is hypothesised that these cognitive appraisals will influence the ways in which parents interpret and respond to their child's behaviour, increasing or decreasing levels of parenting stress. Social factors that increase levels of parenting stress include unemployment (Jackson, 2000), having less social support (Koeske & Koeske, 1990), high workload and childcare difficulties (Östberg & Hagekull, 2000).

There are a number of tools used to measure parenting stress. The Parenting Stress Index (PSI; Abidin, 1990) is the most commonly used measure of parenting stress in the literature. The PSI is useful as it fits with theoretic understanding of parenting stress by encompassing subscales that assess a range of factors including difficult parent-child interactions, child factors and parental factors. In this way the PSI looks at stress as part of the parent-child system. The PSI is able to recognise child adjustment difficulties, dysfunctional parenting and identify parental behaviour problems. Shorter forms of the PSI are also available (PSI-SF) and both are designed for parents of children up to 12 years of age. Alternative measures that can be used to look at parenting stress tend to be used less frequently than the PSI. For example, the Nijmegen Child-Rearing Questionnaire (Wels, & Robbroeck, 1996) is a Dutch questionnaire looking at family stress, but which can be used to measure more specific stress of parents with children up to 14 years old. Another such measure is the Stress Index for Parents of Adolescents (SIPA; Sheras, Abidin, & Konold, 1998), which looks at parenting stress in parents raising young people between 11-19 years of age. Similarly to the PSI, it looks at parenting stress in relation to factors associated with the adolescent and parent. Alternatively, the literature has also used measures of general stress, such as the Depression-Anxiety-Stress-Scale (DASS; Lovibond & Lovibond, 1995), which can gauge parent's level

of stress, without necessarily understanding the contribution of parenting toward this level of stress. Other studies have considered parental self-esteem, sense of mastery, parenting tasks, emotional distress and ways of coping as an alternative to understanding the stress placed on a parent and their ways of managing (e.g. Bird, Peterson, & Miller, 2002). This review does not however consider these additional aspects of parenting and focuses on measures that capture specifically defined parenting stress. Further information on measures of parenting stress can be found in Appendix B.

The Impact of Parenting Stress

High levels of parenting stress can negatively affect parents, children and parent-child interactions (Deater-Deckard et al., 2013). Parenting stress is linked to poorer parental physical (Neece, Green, & Baker, 2012) and psychological health (Sidor, Kunz, Schweyer, Eickhorst, & Cierpka, 2011), and poorer parental relationship stability (Halpern-Meekin & Turney, 2016). Parents with high stress are more likely to label their child as 'difficult', show inconsistent discipline (Crawford & Manassis, 2001; Pinderhughes, Dodge, Bates, Petit, & Zelli, 2000), spend less time completing relational tasks (Karrass, VanDeventer, & Braungart-Riker, 2003), and expect developmentally inappropriate child-behaviour (Anthony et al., 2005). Parenting stress therefore negatively impacts on parent-child interactions, leading to poorer outcomes for children (Deater-Deckard et al., 2013).

Key theories can give us a clearer understanding of how and why high levels of parenting stress can impact on the child and child development. Deater-Deckard (1998) hypothesises that high levels of parenting stress negatively impact on parent-child interactions, which is associated with maladjustment in children. Attachment theory can help further this understanding. The theory argues that children require caregivers to provide consistent and regular care over time. If a parent is stressed, they are more likely to behave in inconsistent ways (Hughes & Baylin, 2012). Hughes and Baylin (2012) have put forward a model of 'blocked care', which describes how at a neurobiological level, stressed parents are vulnerable to

misreading their child's cues, questioning their relationship with their child, have difficulties remaining close when the child is distressed and struggling to manage their strong emotions, which may arise from the child's profile of difficulties, the stage of the child's development or their own attachment histories. Children require caregivers who provide well-regulated care (Hughes & Baylin, 2012) and appropriate response to emotion (Steele, Steele, & Croft, 2008). If stress causes parents to be less attuned it can have a detrimental impact on the child, with research showing parenting stress to be associated with a child's ability to regulate emotion (Mathis & Bierman, 2012). Increased parenting stress is therefore associated with poorer child development, less social competence, and increased internalizing and externalizing behaviours (Anthony et al., 2005). Furthermore, the relationship between parenting stress and child health and behaviour is a dynamic and reciprocal process (Mackler et al., 2015), with increased parenting stress associated with greater child problems, which in turn contributes to further parenting stress (Stone, Mares, Otten, Engels, & Janssens, 2016).

Adoption

It is hypothesised that adoptive parents experience similar stress to non-adoptive parents but have additional, unique stressors placed upon them (Groza & Ryan, 2002) and yet, there is less research into stress in adoptive parents. Similar to biological parents, adoptive parents will go through the process of integrating the new child into the family, adjusting to the child's needs and changes to the family's economic situation and structure (Bird et al, 2002). Also similar to biological parents, adoptive parent's stress is exacerbated by parental depressive symptoms, high expectations of child development and child behavioural and emotional problems (Viana & Welsh, 2010). However, adoptive parents may have additional stressors. For example, to reach the point of adoption, parents must undergo assessment, police checks, and medical examinations before being evaluated by an adoption panel (Department of Education, [DoE], 2015). Unlike biological parents, who have nine months to prepare for the arrival of their child,

adoptive parents have to cope with the uncertainty around if and when their child will arrive (Brodzinsky & Huffman, 1988). Furthermore, there is reported stigma around adoption (Baden, 2016) and some evidence that adoptive parents receive less social support (Brodzinsky & Huffman, 1988). Adoptive parents may feel they have fewer role models on which to base expectations and to turn to for advice (Brodzinsky & Huffman, 1988). They may also have additional concerns about bonding and managing pressures of instant parenthood (Bird et al., 2002). With homosexual couples increasingly looking to adopt, parental sexuality is also a factor being considered within the literature. Homosexual adoptive parents report similar stressors to heterosexual parents. However there are unique factors associated with being a homosexual adoptive-parent, such as stigma sensitivity and disclosure (Tornello, Farr, & Patterson, 2011).

Post-adoption there may be unique child factors that enhance parenting stress, such as difficulties from the child's history or medical, development or educational needs (Bird et al, 2002). Of children who come from care in particular regions of the United Kingdom, 45% show symptoms of a mental disorder, 37% of a conduct disorder and 12% an emotional disorder (Meltzer, Lader, Corbin, Goodman, & Ford, 2004). Negative pre-adoption histories are associated with child behaviour problems (Merz & McCall, 2010) and adoptees with a history of maltreatment are also more likely to find it difficult to develop healthy relationships with caregivers (Zeanah et al., 2004). It is therefore often the case that older children, who have been subjected to difficult pre-adoption environments for longer, tend to be at increased risk of insecure attachment (Van den Dries, Juffer, van IJzendoorn, & Bakermans-Kranenburg, 2009). These difficulties have then shown to interact with and enhance parenting stress (Neece et al., 2012). It is therefore unsurprising that adoptive parents report higher levels of parenting stress than non-adoptive parents and that this is linked to parents' reports of increased child difficulties and attachment-related problems (Harris-Waller, Granger, & Gurney-Smith, 2016).

Rationale

Since parenting stress can have negative outcomes for parent, child and family (Deater-Deckard et al., 2013) it is important to understand how parenting stress is experienced in high-risk populations. Parenting stress reviews have been carried out on non-adoptive parents (Cousino & Hazen, 2013) and adoptive parent's adaptation to parenthood (McKay, Ross, & Goldberg, 2010). Although McKay et al. (2010) considered parenting stress in their review, there is yet to be a review that critically examines the quality of up-to-date research using validated measures across different adoption populations.

Aims

This review aims to critically evaluate the research on parenting stress in adoption and examine adoptive parents parenting stress scores. It is hoped this will improve current understanding and highlight implications for research, care and policy.

Since the studies reviewed here differed in their aims they are somewhat disparate in their focus, for example some studies were epidemiological in nature with the aim to measure adoptive parenting stress whilst others gathered parenting stress scores as part of a larger research question. They all have in common the fact that they gathered parenting stress scores in adoptive parents.

Method

Protocol and Registration

A current review protocol does not exist for this topic to the researcher's best knowledge.

Inclusion Criteria

- Articles measuring adoptive parenting stress using a complete validated measure.
- Quantitative studies.
- Articles published in a peer-reviewed journal.

- Articles written in English.
- Longitudinal and cross-sectional designs.

Exclusion Criteria

- Articles exclusively on non-adoptive parents.
- Articles where adoptee is over 18 years (as adult children have different parenting needs; Fingerman, Miller, Birditt, & Zarit, 2009)
- Review papers.
- Dissertations and articles outside of peer-reviewed journals.
- Qualitative studies.

Search Strategy and Study Collection

The search followed The Preferred Reporting Items for Systematic reviews and Meta-Analyses guidelines (PRISMA, Liberati et al., 2009). The online databases AMED, EMBASE, HMIC, BNI, Medline, PsycInfo, CINAHL and Health Business Elite were searched. The final search was completed in November 2016. Relevant terms were combined systematically. Terms included:

- parent*; maternal; paternal; famil*; caregiv*;
- stress*; "Parenting Stress";
- adopt*

Table 1. shows the electronic search strategy as described. No limits were applied at this stage to gather a wide range of studies. Initial searches of electronic healthcare databases elicited 2,187 articles. Duplicates were removed electronically (*n*=352) and by hand (n=735) resulting in 1,100 articles. Screening of titles and abstracts based on eligibility criteria gave 81 articles. Full-text reading established 14 articles met eligibility criteria. Google Scholar and reference lists of relevant articles were searched and provided

another nine articles. Overall, 23 articles were included. Figure 1 presents a flow diagram of the search process.

Table 1.
Electronic Search

Line	Databases Searched	Search Term	Results
1	AMED, EMBASE, HMIC, BNI, Medline, PsycInfo, CINAHL, HEALTH BUSINESS ELITE	parent*.ti,ab	988237
2	AMED, EMBASE, HMIC, BNI, Medline, PsycInfo, CINAHL, HEALTH BUSINESS ELITE	maternal.ti,ab	489404
3	AMED, EMBASE, HMIC, BNI, Medline, PsycInfo, CINAHL, HEALTH BUSINESS ELITE	paternal.ti,ab	47313
4	AMED, EMBASE, HMIC, BNI, Medline, PsycInfo, CINAHL, HEALTH BUSINESS ELITE	famil*.ti,ab	2323157
5	AMED, EMBASE, HMIC, BNI, Medline, PsycInfo, CINAHL, HEALTH BUSINESS ELITE	caregiv*.ti,ab	167058
6	AMED, EMBASE, HMIC, BNI, Medline, PsycInfo, CINAHL, HEALTH BUSINESS ELITE	1 OR 2 OR 3 OR 4 OR 5	3564643
7	AMED, EMBASE, HMIC, BNI, Medline, PsycInfo, CINAHL, HEALTH BUSINESS ELITE	stress.ti,ab	1382878
8	AMED, EMBASE, HMIC, BNI, Medline, PsycInfo, CINAHL, HEALTH BUSINESS ELITE	"parenting stress".ti,ab	5287
9	AMED, EMBASE, HMIC, BNI, Medline, PsycInfo, CINAHL, HEALTH BUSINESS ELITE	7 OR 8	1382878
10	AMED, EMBASE, HMIC, BNI, Medline, PsycInfo, CINAHL, HEALTH BUSINESS ELITE	adopt*.ti,ab	467089
11	AMED, EMBASE, HMIC, BNI, Medline, PsycInfo, CINAHL, HEALTH BUSINESS ELITE	6 AND 9 AND 10	2187

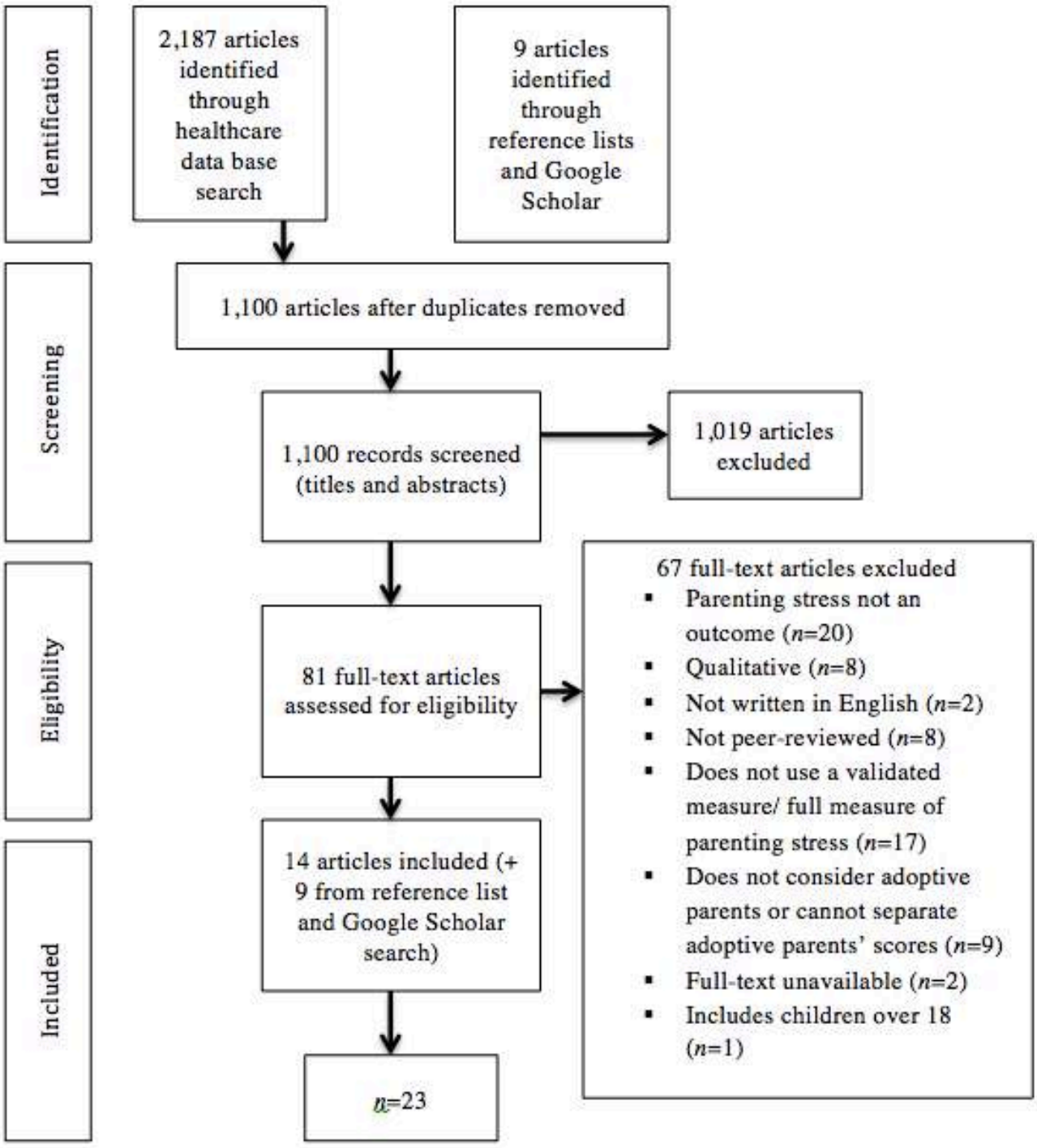


Figure 1. Flowchart of Search Strategy adapted from PRISMA guidelines (Liberati et al., 2009).

Procedure

A data extraction tool (Appendix C) enabled relevant information to be extracted from papers. Although multiple factors were investigated in studies, only results pertaining to parenting stress were reviewed. There is no one specific method best suited to assessing quality within systematic reviews (Chapter 8; Higgins, Altman & Sterne, 2011). In this review, quality assessment was guided by Downs and Black's checklist (1998), which has been identified as one of the most useful tools for assessing quality of risk of bias in non-randomized studies (Higgins & Green, 2011). Downs and Black's (1998) grading system was not used since the use of scales providing scores of quality are discouraged (Chapter 8; Higgins, Altman & Sterne, 2011). However, a modified version of Downs and Black's checklist supported critical review of studies by using the items most relevant to this review and removing those that were unrelated (Appendix D). The Cochrane Handbook of Systematic Reviews of Interventions (Higgins & Green, 2011) also provided guidance on methods for conducting the analysis and synthesis.

Results

Overview

Twenty-three studies were included in this review. These are organised by the focus of the study. Study characteristics for the 23 studies can be seen in Table 2. Table 3 provides a summary of findings. Twelve studies considered international adoption, four considered parents' sexuality, five domestic adoption, one adoptee's with special needs and one considered a mix of adoption types. Twenty studies were cross-sectional and three were longitudinal. Results discuss descriptive statistics related to parenting stress. Further analysis is only discussed where relevant to parenting stress scores. As discussed previously, the disparate nature of the studies' focus could have impacted on parenting stress scores. For example, some studies focused on parenting stress in parents who had adopted children from institutionalised environments, which may be associated with increased levels of parenting stress.

Therefore, the differing focus of each study may have itself impacted on findings related to parenting stress.

Table 2.

Table of Study Characteristics

Topic	Authors, date. (Locations)	Parents	Children	Study Objective	Design Method	Measure
IA	Farina, Leifer, & Chasnoff, 2004. (USA)	*n* = 29 **Sex:** 28 female, 1 male **Mothers' age:** *M*=39.8 (*SD*=5.7) **Fathers age**: *M*=42.1 years (SD=6.3) **SES/education**: 57% earned > $75,000, 3.5% earned $25,000-34,999. **Time since adoption:** *M*=23.5 months **Number of children**: 25% one child, 43% two children, 14% 3 children, 18% four children (data missing for one family).	Internationally adopted Russian Children (n=29) **Age at study:** *M*=41 months (*SD*=17.9) **Age at adoption**: *M*=17 months (*SD*=13.3) **Sex:** 48% male, 52% female **Health:** 34% diagnosed with ARNDs **Length of institutionalisation**: *M*=13.8 months (*SD*=9.5)	To evaluate effects of institutionalization and PS on the quality of attachment and behaviour of Russian children adopted in the USA.	Cross-sectional	PSI-SF
IA	Gagnon-Oosterwaal et al., 2012. (Canada)	*n* = 95 **Sex:** all female **Age:** *M*=44.4 years **SES/education:** 61% university graduates, 93.6% income over $40,000	International adoptees (*n*=95) **Age at adoption:** 4-18 months **Age at study:** *M*=7.4 years **Sex:** 69 female, 26 male **Ethnicity:** 47 Chinese, 28 East Asian, 17 Russian, 2 Haitian, 1 Bolivian. **Pre-Adoptive history:** 92% orphanages, 8% foster care.	To examine the effect of pre-adoption adversity and PS on children's behavior problems at school age.	Cross-sectional	PSI
IA	Helder, Mulder, & Gunnoe, 2016. (USA)	Time point 1 *n*=25 Time point 2 *n*=21 Time point 3 *n*=19 **SES/education:** 88% mothers and 82% fathers had college degrees **Length of adoption:** *M*=15.12 months (*SD*=9.68)	International adoptees at school age (*n*=19-25) **Age at adoption**: *M*=7.7 years (*SD*=3.4) **Age at study:** *M*=8.93 years (*SD*=3.31) **Sex:** 10 male, 15 female **Ethnicity:** 8 Chinese, 6 Russian, 5 Ethiopian, 2 Haitian, 2 Ghanaian, 1 Columbian and 1 Ukrainian.	To longitudinally track cognitive, behavioral, emotional, attachment, and family functioning, in children who had been internationally adopted at school age.	Longitudinal	RFI from the PRQ
IA	Judge, 2003. (USA)	*n*=218 **Sex:** 109 female, 109 male	Adoptees from Eastern Europe (*n*=109) **Age at adoption:** *M*=31.5 months (*SD*=33)	To investigate sources of variation in PS and	Cross-sectional	PSI

		Age: Mothers: *M*=38 years (*SD*=6.8), fathers: *M*=40 (*SD*=7.1) **SES/education:** 74% well-educated **Marital status:** married *M*=10 years **Length of adoption:** *M*=6.25 months (*SD*=2.1)	**Sex:** 56 male, 53 female **Ethnicity:** Eastern European	the effects of early institutionalization.		
IA	Judge, 2004a. (USA)	*n* = 255 **Sex:** 136 female, 119 male **Age:** Mothers: *M*=38 years (*SD*=6.7). Fathers: *M*=40 years (*SD*=7.1). **SES/education:** mothers: *M*=16.43 years education (*SD*=2.18). Fathers: *M*=16.15 years (*SD*=2.07) **Marital status:** 117 two-parent families, 21 single parents. **Number of children**: 86.3% one adopted child, 13% two adopted children, .7% four adopted children.	Children adopted from orphanages (*n*=159) **Age at adoption:** *M*=35.5 months **Age at study:** *M*=41.8 months (*SD*=34.03) **Sex:** 80 male, 79 female **Ethnicity:** Russian, Ukrainian, Latvian, Belarusian, and Kazakhstani	a) To characterize over-all functioning of children adopted from orphanages during first year of placement b) To examine impact of adoption on families c) To identify types of support and services used by families.	Cross-sectional	PSI
IA	Judge, 2004b. (USA)	*n*= 230 **Age:** Mothers: *M*=38 years (*SD*=6.7), fathers: *M*=39 years (*SD*=7.1) **SES/education**: 73% mothers, 77% fathers college graduates. Middle-upper class. **Marital status:** 106 two-parent families (married *M*=9.5 years), 18 single-parents **Number of children:** 84.7% adopted one child, 13.7% adopted 2 children, 1.6% adopted 4 **Time since adoption:** *M*=6.33 months (3-13 months)	Eastern Europe Adoptees *(n*=124) **Age at adoption:** *M*=20.7 months (*SD*=15.32) **Age at study:** *M*=26.97 months **Sex:** 52% male, 48% female **Country of Origin:** Russia, Ukraine, Latvia, Belarus, Kazakhstan **Time in institution:** *M*=18.4 months (3-64 months)	To extend previous work on attachment outcomes of previously institutionalised children by examining a large population of recently adopted children from state-run institutions.	Cross-Sectional	PSI
IA	Katzenstein,	No information	Adoptees from non-English speaking countries	To examine the role of	Cross-sectional	PSI

	LeJeune, & Johnson, 2016. (USA)		(*n*=46) **Age at adoption:** *M*=13.89 months (*SD*=5.69) **Age at study**: 5-14 months after adoption (time 1) and 12 months later (follow-up) **Sex:** 36 female, 10 male **Country of Origin:** China, Russia, Guatemala, South Korea, Kazakhstan **Time in Institution:** 76% spent time in institution *M* = 13.09 months (*SD*=5.11)	parenting and family factors (e.g. parenting stress) in predicting cognitive and linguistic catch-up beyond the effects of age at adoption and the child's cognitive abilities near the time of adoption in a sample of recently adopted IA children.	(PSI only measured at follow-up)	
IA	Mainemer, Gilman, & Ames, 1998. (Canada)	RO parents (*n*=39) **Age:** mothers: *M*=35.5 years (*SD*=6.2), fathers: *M*=37.2 years (*SD*=6.6) **SES/education**: mothers education: *M*=13.9 years (*SD*=2.4); fathers: *M*=14.7 years (*SD*=3.5) **Number of children:** *M*=2 **Number of single parents:** *M*=3 **Number of mothers at home:** *M*=16 RC parents (*n*=23) **Age:** mothers: *M*=37.0 years (*SD*=5.5), fathers: *M*=38.9 years (*SD*=6.3) **SES/education**: mothers education: *M*=15.1 years (*SD*=2.3); fathers: *M*=16.2 years (*SD*=3.5) **Number of children:** *M*=2 **Number of single parents:** *M*=2 **Number of mothers at home:** *M*=8 CB parents (*n*=41) **Age:** mothers: *M*=34.8 years (*SD*=4.0), fathers: *M*=36.6 years (*SD*=4.2) **SES/education**: mothers education: *M*=14.3	RO group (*n*=43) **Age at adoption:** *M*=17.5 months **Age at study:** *M*=30 months **Sex:** 20 male, 23 female RC group (*n*=23) **Age at adoption**: median=2 months **Age at study:** matched as above +/- 1 month **Sex:** matched as above CB group (*n*=41) **Age at interview:** matched as above **Sex:** matched at above **Country of origin:** Canada	To evaluate the impact of the adoptive experience on families that adopted institutionalised Romanian orphans.	Cross-sectional	PSI

		years (*SD*=2.4); fathers: *M*=15.3 years (*SD*=2.8) **Number of children:** *M*=2 **Number of single parents:** *M*=3 **Number of mothers at home:** *M*=13				
IA	Rijk, Hoksbergen, ter Laak, van Dijkum, & Robbroeckx, 2006. (The Netherlands)	*n*=72 **Age:** 36-40 years **SES/education**: SES average-high	<u>Adoptees from Romania (*n*=80)</u> **Age at adoption:** *M*=2.10 years (*SD*=2.1) **Age at interview:** *M*=8 years (*SD*=2.3) **Sex:** 55% male, 45% female **Health:** 29 children had not received any professional help, 51 received professional mental health care. Split into Clinical Adoptive group and Non-Clinical Adoptive group. <u>Matched control groups</u> Split into non-clinical controls and clinical controls	a) To examine the degree to which parents perceived raising children as a burden compared with non-APs. b) To compare APs stress with non- APs. c) To assess adoption satisfaction and its relation to burden of upbringing. d) To investigate the impact of child behavioral problems on burden and satisfaction.	Cross-sectional	The Nijmegen Child-Rearing Questionnaire (Part A)
IA	Salcuni, Miconi, Altoè, & Moscardino, 2015. (Italy)	*n*=180 **Sex:** 90 male, 90 female **Age:** mothers: *M*=43.44 years (*SD*=4.44); fathers: *M*=45.28 years (*SD*=4.58) **SES/education**: 74% well-educated and upper-middle class **Number of children:** 81% only one adopted child, 19% two or more.	International adoptees (*n*=90) **Age at adoption:** 3-10 years **Age at interview:** *M*=6.52 (*SD*=2.36) **Sex:** 51 males, 39 females **Country of origin:** 40% Eastern Europe, 33% Latin American, 19% Asian, 8% African.	To explore whether adult attachment avoidance and anxiety mediate the effect of dyadic functioning on PS in internationally adoptive couples who adopted in the last 36 months.	Cross-sectional	PSI-SF

IA	Tirella, Tickle-Degnen, Miller, & Bedell, 2012. (USA)	*n*=9 **Sex:** 8 female, 1 male **SES/education**:100% had one parent with college level education **Number of children:** 1 had 3 children, 2 had 2 children, 6 had 1 child	Newly adopted children (*n*=9) **Age at adoption:** 13-35 months **Age at study:** *M*=17.6 months (12-27 months) **Sex:** 4 female, 5 male **Country of origin:** 4 China, 2 Russia, 1 Kazakhstan, 1 Korea, 1 Ethiopia **Health:** 3 diagnosed with Fetal Alcohol Syndrome	One of four aims: to provide case examples of stress levels of parents of newly adopted children.	Cross-sectional	PSI
IA	Viana, & Welsh, 2010. (USA)	*n*=143 **Sex:** 143 female **Age:** *M*=38.04 (*SD*=5.12) **SES/education**: all income >30,000, 52.4% graduates, 30.1% college, 15.4% some college, 2.1% high school **Marital status:** 88.1% married/co-habiting heterosexuals, 10.5% single parent, 1.4% married/cohabiting female couple **Number of children:** 64.3% other children, 35% no other children, 0.7% not reported	Internationally adopted children (*n*=143) **Age at adoption:** *M*=1.37 years (*SD*=1.53) **Sex:** 39.2% male, 60.1% female, 0.7% unreported **Ethnicity:** 37.1% Chinese, 30.1% Korean, 12.6% Latin American, 10.5% Eastern European, 9.1% other Asian, 0.7% not reported **Health:** 37.8% reported to have special needs, 62.2% no special needs reported.	To examine predictors and correlates of PS among internationally adopting mothers.	Cross-sectional	PSI-SF
Parents' Sexuality	Farr, Forssell, & Patterson, 2010. (USA)	*n* = 212 **Sex:** 52 female, 54 male **Age:** *M*=42 years **Ethnicity:** 80% White **Sexual orientation:** 27 lesbian couples, 29 gay father couples, 50 heterosexual couples. **SES/education:** Most work full-time and family incomes above national average **Marital Status**: All two-parent families	Young adoptees (*n*=106). **Age at study:** *M*=3 years **Age at adoption**: Birth-a few weeks old. **Ethnicity:** 41% White	To examine associations between parental sexual orientation and children's development, parenting styles, PS, and couples' relationship adjustment.	Cross-sectional	PSI-SF
Parents' Sexuali	Goldberg & Smith, 2014. (USA)	*n*=296 first time parents **Sex:** 158 female, 138 male **Ethnicity:** 91% White, 9% "of colour"	Young adoptees (*n*=148) **Age at adoption:** *M*=5.61 months (*SD*=10.26)	To examine parent-reported child characteristics and	Longitudinal	PSI-SF

ty		**Sexual Orientation:** 50 lesbian couples, 40 gay father couples, 58 heterosexual couples **SES/education:** *M*=$130,208 (*SD*=$79, 605). On average had a bachelor's degree **Adoption type:** 16% Public domestic, 62% Private Domestic, 22% International. **Couples relationship duration:** *M*=8.10 years (*SD*=3.88)	**Age at follow-up:** *M*=2.49 years (*SD* = .85) **Sex:** 49% male, 51% female **Ethnicity:** 37% White, 63% "of colour" **Health:** 15% 'health problems'	parent and family characteristics as predictors of post-placement PS and change in PS during the first 2 years.		
Parents' Sexuality	Golombok, Mellish, Jennings, Casey, Tasker, & Lamb, 2014. (UK)	*n*=260 **Sex:** 131 male, 129 female **Age:** Gay fathers: *M*=40.37 (*SD*=5.73) Lesbian mothers: *M*=42.43 (*SD*=7.28) Heterosexual parents: *M*=43.16 (*SD* = 5.32) **Ethnicity:** 244 White, 16 other **Sexual Orientation:** 41 gay father families, 40 lesbian mother families, 49 heterosexual parent families **SES/education:** majority employed in professional/ managerial positions	Adoptees (*n*=148) **Age at adoption:** Gay fathers: *M*=39.88 months (*SD*=19.93) Lesbian mothers: *M*=35.85 months (*SD*=23.49) Heterosexual parents: *M*=26.71 months (*SD*=18.87) **Age at study:** 3-9 years **Sex:** 73 male, 57 female	To examine parent-child relationships and child's psychological adjustment in adoptive gay father families in the UK.	Cross-sectional	PSI-SF
Parents' Sexuality	Tornello, Farr, & Patterson, 2011. (USA and District of Columbia)	*n*=230 **Sex:** 230 male **Age:** *M*=43.9 years (*SD*=6.7) **Relationship length:** *M*=13.5 years (*SD*=7.3) **SES/education**: 88.2% college degree, household income: *M*=211K (*SD*=514) **Number of children:** 56.6% 1 child, 36.1% 2 children, 7.4% 3+ children **Ethnicity:** 89% Caucasian **Religiosity:** 84% Christian, 23% no religious affiliation **Adoption type:** 76% domestic	Adoptees *(n*=351) **Age at adoption:** *M*=2 years **Age at study:** *M*=7 years **Sexr:** 75.7% male, 24.3% female **Ethnicity:** 34% Caucasian, 23% Biracial or Multiracial, 17% Latino, 14% Black or African American, 11% Asian, 1% other	To examine correlates of PS among gay adoptive fathers.	Cross-sectional	PSI-SF

DA	Golombok, Murray, Brinsden, & Abdalla, 1999. (UK)	*n*=55 **Ethnicity:** predominantly white **Marital status:** 54 married, 1 divorced	Adoptees (*n*=55) **Age at adoption:** < 6 months **Age at study:** 4-8 years **Sex:** 28 male, 27 female **Country of origin:** Born in UK	To examine parents' emotional well-being, quality of parenting, and children's socioemotional development in families with a child who is genetically unrelated to the parents.	Cross-Sectional	PSI-SF
DA	Harris-Waller, Granger, & Gurney-Smith, 2016. (UK)	*n* = 87 **Sex:** 95% mothers **Age:** *M*=42 years, *SD*=5.56 **Ethnicity:** 88% White British **Sexual Orientation:** 92% heterosexual **Marital Status:** 76% Married/Civil Partnerships **SES/education**: Annual Income £10,000-81,000; 71% higher education qualifications **Service Involvement:** 31% involved in mental health services.	UK Adoptees (n=87) **Age at study:** *M*= 7 years, *SD*=2.42 **Age at adoption**: *M*=4 years; *SD*=2.27 **Sex:** 48 females, 38 males **Pre-adoption history**: 55% suffered neglect, 24% suffered abuse	To investigate PS, internalising, externalising and attachment-related behavioural difficulties and their interactions in adoptive and NAPs.	Cross-Sectional	PSI-SF
DA	Palacios & Sánchez-Sandoval, 2006. (Spain)	*n*=104 **Sex:** 104 female **Age:** *M*=34.6 years **SES/education**: 37.5% primary studies, 32.7% more than primary and less than university, 29.8% high or university education level. **Family type**: 92.3% two-parent families, 7.7% single-parent families	Adoptees below 12 years (*n*=104) **Age at adoption:** 92% < 1 year old **Age at interview:** *M*=9.39 years (*SD*=1.38) **Sex:** 52.9% male, 47.1% female **Health:** 90.4% no special psychological needs, 13.5% suffered from chronic illness.	To evaluate stress in parents after adopting a child nationally.	Cross-Sectional	PSI
DA	Sánchez-Sandoval, &	*n*=156 **Sex:** 156 female, 107 male	Adolescents adopted domestically as children (*n*=156)	To evaluate the role of the child-, parent- and	Cross-Sectional	SIPA

	Palacios, 2012. (Spain)	**Age:** mothers: *M*=37.91 years (*SD*=6.83), fathers: *M*=40.27 years (*SD*=6.88) **SES/education**: 1.3% primary studies; 17.9% > primary but < university, 30.8% high or university educational level. **Family type:** 90.4% two-parent families, 9.6% single-parents **Number od children:** 17.9% sibling adoption	**Age at adoption:** *M*=3.15 years (*SD*=3.47) **Age at study:** *M*=15.42 (*SD*=3.98) **Sex:** 48.1% male, 51.9% female **Health:** 10% had special needs	family-related characteristics as predictors of PS in adoptive families.		
DA	Smith-McKeever, 2006. (USA)	*n*=141 **Sex:** 81 female, 60 male **Age at study:** mothers: *M*=45 years; fathers: *M*=46 years. **Age at adoption:** mothers: *M*=39 years; fathers: *M*=38.4 years **SES/education**: mothers: 30.4% graduate degrees, fathers: 21.7% graduate degrees. Mothers: 72.2% professionals, fathers: 62.9% professionals **Family type:** 69.9% two-parent families, 27.7% single parent (only 2 adoptive fathers), 2.4% unknown	African-American adoptees (*n*=83) **Age at adoption:** females: *M*=21.8 months, males: *M*= 22.5 months **Age at study:** *M*=8.7 years **Sex:** 42 female, 39 male, 2 unknown **Ethnicity:** ¾ African-American, 12 African-American/Caucasian, 7 African-American/Hispanic, 1 African-American/Asian **Health:** 63% considered to have special needs	To examine whether factors associated with adoption satisfaction in the literature are also associated with satisfaction in adoptions involving African-American children, families and African-American adoption agencies.	Cross-Sectional	PSI
Special Needs Adoption	McGlone, Santos. Kazama, Fong, & Mueller, 2002. (Hawaii)	*n*=46 **Sex:** 23 female, 23 male **Age:** 27-68 years **SES/education**: 20 fathers employed, 16 mothers employed **Marital status:** 20 married, 1 unmarried couple, 4 single parents **Household size**: 2-8 people	Adoptees with special needs (*n*=35) **Age at study:** 12 months-11.5 years **Sex:** 16 female, 19 male **Ethnicity:** 32 mixed race, 3 other **Prior placements:** *M*=3 **Health:** 8 asthmatic, 4 hearing loss, 13 language delays, 9 cognitive impairments, 6 motor delays.	To explore the nature and extent of PS among a group of new APs of special-needs children.	Longitudinal (Time 1- four months post placement. Time 2 - one-year follow-up)	PSI-SF
Mixed	Lionetti,	*n*=100	Adoptees (*n*=50, 49 institutionalised)	To investigate a set of	Cross sectional	PSI-SF

Pastore, & Barone, 2015. (Italy)	**Sex:** 50% male, 50% female **Age:** mothers: *M*=41.39 years (*SD* = 2.34), fathers: *M*=44.10 years (*SD*=1.43) **SES/Education-level**: 3% junior high school. 56% high school, 41% university degree	**Age at adoption:** *M*=22.06 months, (*SD*=20.14) **Sex:** 62% male, 44% female **Country of Origin**: 32% Italy, 21% Eastern Europe, 25% Asia, 22% South America.	individual and dyadic parental candidate risk factors that may identify what best explains stress perceived by parents.

Notes. IA= international adoption; DA = domestic adoption; PS = parenting stress; SES= socioeconomic status; PSI-SF = PS Index-Short Form (Abidin, 1995); PSI =PS Index (Abidin, 1990); ARND = Alcohol Related Neurodevelopmental Disorder; RFI = Relational Frustration Index; PRQ = Parenting Relationship Questionnaire (Kamphaus & Reynolds, 2006); AP = Adoptive Parents; NAP = Non-adoptive Parents; RO = Romanian Orphans who spent 8 months or more in an institution; RC= Romanian orphans who were not institutionalised for more than 4 months; CB group = non adopted children; SIPA = Stress Index for Parents of Adolescents (Sheras, Abidin, & Konold, 1998)

International Adoption

Ten studies on international adoption found average parenting stress scores were generally below clinical levels (Farina, Leifner, & Chasnoff, 2004; Gagnon-Oosterwaal et al., 2012; Helder, Mulder, & Gunnoe, 2016; Judge, 2003; Judge, 2004a; Judge, 2004b; Katzenstein, LeJeune, & Johnson, 2016; Salcuni, Miconi, Altoè, & Moscardino, 2015; Tirella, Tickle-Degnen, Miller, & Bedell, 2012; Viana & Welsh, 2010). Most studies included parents from Western society (Farina et al., 2004; Gagnon-Oosterwaal et al., 2012; Helder et al., 2016; Judge, 2003; Judge 2004a; Judge, 2004b; Katzenstein et al., 2016; Salcuni et al., 2015; Tirella et al., 2012; Viana & Welsh. 2010). Adoptees had a variety of pre-adoption histories, which might impact on parenting stress. Farina et al. (2004) studied parents of Russian adoptees who spent an average of 13.8 months in an institution pre-adoption. Although parenting stress was normative, stress levels were linked to reported insecure attachment and child behavioural difficulties. Some of the children had specialist diagnoses but the impact of this on parenting stress is not discussed.

Gagnon-Oosterwaal et al. (2012), Helder et al. (2016), Katzenstein et al. (2016), Tirella et al. (2012), Salcuni et al. (2015), and Viana & Welsh (2010) examined parenting stress in parents of adoptees from a variety of backgrounds including Asia, Europe, South America, the Caribbean and Africa. Viana & Walsh (2010) completed a longitudinal study but unfortunately parenting stress scores were not collected longitudinally. Helder et al. (2016) completed the only longitudinal study in international adoption, tracking parenting stress in 25 families over three time points. Although the authors found average levels of parenting stress were not clinically significant and there was no significant change over time, more adoptive families had clinically elevated scores than the standardized sample at Time 3. This may be because adoptees were showing significantly higher levels of cognitive impairment and developmental difficulties.

Two of Judge's (2003; 2004b) papers examined parenting stress in parents of Eastern European adoptees, with the second including adoptees from orphanages (Judge, 2004b). Judge's third study (2004a) investigated the effect of institutionalization in a large sample of parents of Soviet Union adoptees. Although average scores were normative, 7.8% of mothers and 3.7% of fathers scored at or above the cut-off.

Two studies on international adoption found parenting stress was higher for adoptive parents than other groups (Rijk, Hoksbergen, ter Laak, van Dijkum, & Robbroeckx, 2006) but still within the normal range (Mainemer, Gilman and Ames, 1998). Parents in both studies were from Western societies and adopted Romanian children. Mainemer et al. (1998) found parents whose children spent at least eight months in institutions had higher parenting stress scores than non-adoptive parents or adoptive parents of children who were institutionalized for less than four months. Although adoptees were matched on demographics, there were slight differences between parents. For example, adoptive parents of Romanian orphans had fewer years of education, were slightly older and had lower social economic status than non-adoptive parents. Rijk et al. (2006) also found adoptive parents perceived higher parenting stress than non-adoptive parents. However, compared to a clinical control group they experienced less stress except for on the "child as a burden" scale. Few of the parents' demographics were matched meaning contributing parental factors are not well understood.

Overall, studies on parenting stress in international adoption showed adoptive parents did not have average parenting stress scores outside the 'normal' range but scores were elevated compared to non-adoptive parents or when adoptees were institutionalised for an extended period.

Adoption and Parents' Sexuality

Four studies explored adoptive parenting stress in relation to parents' sexuality and found scores within the normal range. These included a mix of international and domestic adoption. Farr, Forssell, &

Patterson (2010) found sexual orientation was not significantly associated with parenting stress but that there were some significant differences between groups, with lesbian and heterosexual parents having more daughters, gay father couples being more interracial, and homosexual couples demonstrating more transracial adoptions. Parenting stress scores within this study have also been reported elsewhere (Farr & Patterson, 2009). Similarly, Goldberg and Smith (2014) found adoptive homosexual and heterosexual couples did not have average parenting stress scores over the clinical cut-off. They used a large sample of 50 lesbian mothers, 40 gay fathers and 58 heterosexual couples, but there were significant differences between groups in relation to earnings and adoption type, which again may impact on scores. Golombok et al. (2014) also found homosexual and heterosexual adoptive parents had average parenting stress scores below the clinical cut-off but the authors did not account for significant differences between groups in regards to child gender, age at adoption and length of placement. Tornello et al. (2011) only looked at a sample of gay fathers. Stress was associated with various family, adoption and gay-related variables. The majority of parents within these four studies were part of two-parent families. Only a small percentage (15%) of the parents in Tornello et al. (2011)'s study were single.

Domestic Adoption

Four studies on parenting stress in domestic adoption demonstrate that adoptive parents had parenting stress scores similar to or lower than non-adoptive parents (Golombok, Murray, Brinsden, & Abdalla, 1999; Palacios & Sánchez-Sandoval, 2006; Sánchez-Sandoval & Palacios, 2012; Smith-McKeever, 2006), although adoptive parents scored higher on the adolescent domain (Sánchez-Sandoval & Palacios, 2012). Although Golombok et al. (1999) do not state their sample underwent domestic adoption, communications with the author suggest this is the case (S. Golombok, personal communication, December 5, 2016). Two studies on domestic adoption were carried out in Spain (Palacios & Sánchez-Sandoval, 2006; Sánchez-Sandoval & Palacios, 2012) and the others were specific to

African-American (Smith-McKeever, 2006) and UK families (Golombok et al., 1999). Therefore, results cannot be generalised to adoptive parents outside of these cultures and ethnicities.

In contrast, Harris-Waller et al. (2016) showed adoptive parent's stress was higher than non-adoptive parents; explained by their reports of greater child difficulties and attachment difficulties. It is important to note, one adoption in this sample was not identified as domestic. Overall, studies on domestic adoption showed parenting stress was within the normal range. However, adoptive parents reported greater stress in relation to their experience of adolescent and child difficulties.

Adoptive Child's Special-Needs

One study focused on parenting stress in parents of children with asthma, hearing loss, language delays, cognitive impairments, and motor delays (McGlone, Santos, Kazama, Fong, & Mueller, 2002). The study included a mix of adoption types and found adoptive parents did have elevated mean parenting stress scores compared to normative data, particularly on parental-child dysfunctional interactions and difficult child subscales. However, it is important to note that although the PSI-SF is often used in research on parents of children with special needs, the standardized sample were parents of healthy, typically developing children (Dardas & Ahmad, 2014).

Mixed

Lionetti, Pastore, and Barone (2015) conducted the broadest study including both international and domestic adoption and there is not enough clear description of parents' sexuality or child's needs to place them in either of the main categories. This study looked at whether parent's attachment styles and parenting alliance contributed to parenting stress. Although unresolved attachment and low parenting alliance predicted greater parenting stress, adoptive parents provided mean PSI-SF scores below clinical cut-offs on all domains.

Table 3.
Table of Results

Topic	Author (date)	Findings	Additional findings on PS	Conclusion
International Adoption	Farina, Leifner, & Chasnoff (2004)	**Total PSI-SF**: *M*=63.9 (*SD*=19.2), range=35-116 **Defensive responding scale:** *M*=12.7 (*SD*=5.1), range=7-27 **Parental Distress scale:** *M*=21.2 (*SD*=7.7), range=12-41 **Parent–child dysfunctional interaction scale:** *M*=17.7 (*SD*=6.2), range=11-37 **Difficult child scale:** *M*=25 (*SD*=9.8), range=11-56	PS significantly correlated with insecure attachment and increased child behavioural difficulties. Attachment insecurity significantly correlated with severity of behavior problems. No differences with regard to gender or diagnosis.	Total PSI-SF scores below clinically significant cut-off. Parents generally respond in a non-defensive manner suggesting valid results. Individual child characteristics contributed most significantly total PS.
International Adoption	Gagnon-Oosterwaal et al. (2012)	**Total PSI:** Not reported **Child-domain:** *M*=90.13 (*SD*=24.41) **Parent-domain:** *M*=104.46 (*SD*=21.76)	Children's characteristics at time of adoption were significantly related to their behavior problems at school age, and maternal stress was found to have a mediating effect on this relationship.	Adoptive mothers' mean score of PS child-domain and parent domain were in the normal range. Parent and child characteristic contribute to and interact with PS.
International Adoption	Helder, Mulder, & Gunnoe, (2016)	**Score on RFI** **Time 1:** *M*=51.32 (*SD*=8.95) **Time 2:** *M*=52.30 (*SD*=13.09) **Time 3:** *M*=54.42 (*SD*=14.17) There was no significant change in PS over time, *F*(2,36) =0.55, *p*=.59.	Decreased PS was predicted by having multiple adopted children.	Average levels of PS were not clinically significant apart fror Time 3, where PS was clinical elevated in a larger number of adoptive families than the standardization sample.
International Adoption	Judge (2003)	**Mothers' scores** **Child Domain:** acceptability, *M*=12.46 (*SD*=4.00); adaptability, *M*=23.05 (*SD*=5.28); demandingness, *M*=17.45 (*SD*=4.69); mood, *M*=8.86 (*SD*=2.51); distractibility/hyperactivity, *M*=23.07 (*SD*=4.74); parent reinforcement, *M*=9.06(*SD*=3.41). **Parent Domain:** competence, *M*=24.31 (*SD*=5.65); isolation, *M*=11.38	Child behavior problems highly associated with PS for mothers and fathers. Fathers reported more mood problems and social isolation, than mothers.	APs reported no greater stress than mothers and fathers of a normative group. 8.3% of mothers and 3.7% fathers scor with clinically significant leve of stress.

		(*SD*=3.37); attachment, *M*=12.00 (*SD*=3.26); health, *M*=11.47 (*SD*=3.44); role restriction, *M*=17.14 (*SD*=4.65); depression, *M*=17.44 (*SD*=5.28); spousal relationship, *M*=15.65 (*SD*=3.96). **Fathers' Scores** **Child Doman:** acceptability, *M*=12.87 (*SD*=4.10); adaptability, *M*=24.04 (*SD*=5.14); demandingness, *M*=17.56 (*SD*=4.43); mood, *M*=9.55(*SD* =2.35); distractibility/hyperactivity, *M* =23.65 (*SD*=4.27); parent reinforcement, *M*=9.49 (*SD*=2.97). **Parent Domain** competence, *M*=22.75 (*SD*=4.62); isolation, *M*=12.68 (*SD*=3.57); attachment, *M*=12.81 (*SD*=3.44); health, *M*=10.78 (*SD*=2.90); role restriction, *M*=15.99 (*SD*=4.20); depression, M=16.02 (SD=3.69); spousal relationship, M=14.66 (SD=3.91).	Mothers reported more problems than fathers on depression, and sense of competence.	
International Adoption	Judge (2004a)	**Mothers total PSI** *M*=202.62 (*SD*=40.23) **Fathers total PSI** *M*=205.89 (*SD*=32.49) (Scores provided by author, not provided in paper)	Fathers reported significantly more child-related stress than mothers. No significant differences between fathers and mothers parent-related stress and total PS scores.	Mean PS scores within normal range for mothers and fathers. 7.8% mothers scored at or abo cut-off compared to 3.7% fathers. Four couples reported scores exceeding clinical cut-o for the same child.
International Adoption	Judge (2004b)	PSI scores by attachment group: **Low Secure** Mother child domain: *M*=111.25 (*SD*=17.40) Mother parent domain: *M*=121.33 (*SD*=30.23) Father child domain: *M*=111.50 (*SD*=23.08) Father parent domain: *M*=115.00 (*SD*=18.83) **Mid Secure** Mother child domain: *M*=91.84 (*SD*=12.95) Mother parent domain: *M*=108.94 (*SD*=18.13) Father child domain: *M*=92.71 (*SD*=14.37) Father parent domain: *M*=104.31 (*SD*=18.42) **High Secure** Mother child domain: *M*=83.04 (*SD*=12.20) Mother parent domain: *M*=100.33 (*SD*=21.51) Father child domain: *M*=92.38 (*SD*=10.63) Father parent domain: *M*=101.96 (*SD*=16.57)	Low-secure children had more atypical behavior problems, more developmental delays, and parents who reported significantly more parenting stress than children classified as mid-secure and high-secure.	Mean PSI scores within norma range for mothers and fathers across all attachment groups.

International Adoption	Katzenstein, LeJeune, & Johnson (2016).	**PSI Total** *M*=189.10 (*SD*=32.13) **PSI Child Domain** *M*=88.63 (*SD*=16.30) **PSI Parent Domain** *M*=100.12 (*SD*=16.86) All parents scored within normal limits on a social desirability subscale.	Parenting stress did not predict cognitive catch-up in adoptees.	Total PSI and child and parent domains were not significantly elevated.
International Adoption	Maineme r, Gilman, & Ames (1998).	RO Group (*n*=41) **Total PSI:** *M*=223.6 (*SD*=41.1) **Child-domain:** *M*=102.3 (*SD*=20.9) **Parent-domain**: *M*=121.3 (*SD*=25.7) CB Group (*n*=41) **Total PSI:** *M*=210.9 (*SD*=33.0) **Child-domain:** *M*=94.9 (*SD*=16.5) **Parent-domain:** *M*=116 (*SD*=19.3) RC Group (*n*=23) **Total PSI:** *M*=208.3 (*SD*=29.3) **Child-domain:** *M*=94.5 (*SD*=11.3), **Parent-domain:** *M*=113.8 (*SD*=20.8)	RO parents had higher child-domain stress scores and total stress scores than CB parents. RO parents reported higher scores on subscales of acceptability and distractibility/hyperactivity. No significant differences between RC and CB parents.	PS was higher in RO group tha comparison groups but within the normal range. Predictors o PS in RO group included aspe of child behavior (e.g. attachment security and numb of behavior problems) and family factors (e.g. income, mothers' age and number of R adopted). The relationship between PS and behavior problems was particularly strong.
International Adoption	Rijk, Hoksberg en, ter Laak, van Dijkum, & Robbroec kx, (2006)	Nijmegen Child-Rearing Questionnaire scores: **Fathers** Acceptance, *M*=1.55 (*SD*=.68); coping, *M*=1.77 (*SD*=.54); experiencing problems, *M*=2.05 (*SD*=.74); need for change, *M*=1.76 (*SD*=.68); child as a burden, *M*=2.49 (*SD*=.99); managing on ones own, *M*=2.06 (*SD*=.60); pleasure, *M*=1.57 (*SD*=.59); relation, *M*=1.88 (*SD*=.69) **Mothers** Acceptance, *M*=1.58 (*SD*=.71); coping, *M*=1.91 (*SD*=.62); experiencing problems, *M*=2.13 (*SD*=.79); need for change, *M*=1.81 (*SD*=.69); child as a burden, *M*=2.53 (*SD*=.98); managing on ones own, *M*=2.18 (*SD*=.74); pleasure, *M*=1.67 (*SD*=.64); relation, *M*=1.97 (*SD*=.79)	For both mothers and fathers, a higher level of stress was associated with less adoption satisfaction. Fathers perceived stress as less problematic than mothers. Compared to the clinical control group, APs experienced less stress except for on the "child as a burden" subscale. APs who had sought professional help	APs perceived higher PS than NAPs, especially when seekin clinical help.

			showed more stress than non-clinical controls but less stress than a clinical-control group.	
International Adoption	Salcuni, Miconi, Altoè, & Moscardino (2015)	**PSI-SF Total Score Mothers:** *M*=69.76 (*SD*=17.26), **PSI-SF Total Score Fathers:** *M*=71.10 (*SD*=16.55), There was no significant difference between mothers and fathers PSI-SF scores, $t = –0.88$; $p = 0.381$, d=0.09.	For mothers, a direct, negative relationship between dyadic adjustment and PS was found. Better dyadic adjustment was related to lower levels of attachment anxiety, which in turn associated with less PS. For fathers, increased dyadic adjustment was related to lower levels of attachment avoidance, which in turn associated with reduced PS.	Average adoptive PS scores were within the normal range. range of variables influence P and these were different for mothers and fathers.
International Adoption	Tirella, Tickle-Degnen, Miller, & Bedell (2012)	**Total PSI:** *M*=40.66 (*SD*=29.12)	N/A	Parents had scores falling with the typical range. Two familie had scores falling in the highe end of typicality (between 75th and 80th percentiles).
International Adoption	Viana & Welsh (2010)	**Total PSI-SF (6 months post adoption):** *M*=68.34 (*SD*=15.38) No between-group differences in mothers' PSI-SF scores according to child gender, special needs status, pre-adoption environment, country of origin, mothers' education, marital status, or income. Mothers who already had children reported significantly higher PSI-SF scores than those without.	**Child characteristics:** Special needs status and gender not related to PSI-SF scores. **Mother characteristics**: pre-adoption depression symptoms and expectations of developmental and behavioral/ emotional problems significantly, positively related to PSI-SF scores. Pre-adoption expectations of child acceptance significantly negatively related to PSI-SF scores. **Other characteristics**: Perceived social support at pre-adoption significantly, negatively related to PSI-SF scores. Number of children significantly positively related to PSI-SF score.	Average PS levels were normative and below clinical levels. Child, parent and family characteristics affect levels of PS.

Parents' Sexuality	Farr, Forsell & Paterson (2010)	**Lesbian Mothers** Total PSI-SF (*n*=27) *M*=59.94 (*SD*=11.36) **Gay Fathers** Total PSI-SF (*n* = 29) *M*=61.14 (*SD*=15.19) **Heterosexual Parents** Total PSI-SF (*n* = 50) *M*=60.26 (*SD*=14.23)	PS was significantly positively correlated with children's internalizing problems, externalizing problems, and total behavior problems. Increasing child age was related to increased PS and less effective discipline techniques. PS emerged as more strongly associated with child behavior problems than parental sexual orientation, discipline, or couple relationship adjustment.	APs had PSI-SF scores below the clinically significant level. Parents' sexual orientation wa not significantly associated wi PS.
Parents' Sexuality	Goldberg & Smith (2014)	PSI-SF Total (3 months) **Full sample**: *M*=63.50 (*SD*=16.75) **Lesbian Mother Couples**: *M*=65.06 (*SD*=17.32) **Gay Father Couples**: *M*=62.64 (*SD*=17.18) **Heterosexual Couples**: *M*=64.22 (*SD*=15.97),	PS increased significantly at 2.01 units per year. Effect of time on PS no longer significant after predictors were added. PS decreased for parents who reported behavior problems but increased for those reporting developmental problems. No other characteristics were significant predictors of change in PS. Partner's reports of PS were highly correlated, while partners' trajectories of changes over time were not. Parents of older children, with severe behavior problems, more depressive symptoms, less love, and lower perceived support reported higher post-placement PS.	APs did not have clinically significant average PS scores. PS increased over time. A ran of variables influenced PS.
Parents' Sexuality	Golombok, Mellish, Jennings, Casey, Tasker, & Lamb (2014)	**Gay Fathers** Total PSI-SF *M*=66.81 (*SD*=17.21) **Lesbian Mothers** Total PSI-SF *M*=69.68 (*SD*=18.55) **Heterosexual Parents** Total PSI-SF *M*=75.86 (*SD*=19.85)	There was no significant difference between gay fathers and lesbian mothers. Homosexual parents showed lower levels of PS than heterosexual parents. PS was found to predict child-externalizing problems.	No average PS scores above clinically significant cut-off.

Parents' Sexuality	Tornello, Farr, & Patterson (2011)	**Total PSI-SF**: *M*=72.71 (*SD*=19.59)	**Family-related variables:** Fathers who had older children, more children and less social support from friends and family reported more PS. **Adoption-related variables:** fathers who adopted older children, who adopted in the context of a former relationship and who adopted through foster care systems reported more PS. **Gay-related variables:** Fathers who reported more stigma sensitivity, more identity uncertainty, less disclosure and a more difficult process with understanding their identity reported more PS.	Average PS levels were normative and below clinical levels.
Domestic Adoption	Golombok, Murray, Brinsden, & Abdalla (1999)	**Mother Total PSI-SF**: *M*=67.2 (*SD*=13.3) Parent Distress: *M*=21.9 (*SD*= 5.1) Dysfunctional Interaction: *M*=19.3 (*SD*= 4.8) Difficult Child: *M*=25.8 (*SD*=6.0) Defensive Responding: *M*= 3.3 (*SD*= 3.5) **Father Total PSI-SF:** *M*=65.8 (*SD*=13.9) Parent Distress: *M*=21.9 (*SD*= 6.2) Dysfunctional Interaction: *M*=18.9 (*SD*= 4.4) Difficult Child: *M*=25.0 (*SD*= 6.7) Defensive Responding: *M*=13.1 (*SD*=3.8)	Lower levels of PS among mothers and fathers when child was genetically unrelated to mother.	APs did not have clinically significant average PS scores.
Domestic Adoption	Harris-Waller, Granger & Gurney-Smith (2016)	**PSI-SF Scores** *M*=102.60, *SD*=25.78 70% very high stress (>85th percentile), 20% high average stress, 9% low average stress, 1% low stress.	APs scored 30 points higher than the standardization sample. They reported higher levels of PS than NAPs. When children's difficulties were controlled for there was no main effect of adoption status on PSI-SF scores.	Average adoptive PS was high and higher than NAPs.
Domestic	Palacios,	**Total PSI**: *M*=186.21 (*SD*=43.60)	Significant effects of the following on	Average scores similar to or

Adoption	& Sánchez-Sandoval (2006)	**Child domain:** *M*=93.17 (*SD*=24.79) **Parent domain:** *M*=92.29 (*SD*=22.64) Mothers and fathers scores highly correlated so only mothers scores analyzed. Mothers did not have a higher than average stress than normative data (*M*=222), $t(103) = -8.370$, $p < .001$.	PS: child difficulties, having a male child, previous parent–child relationship, child-rearing style highlighting affection/communication, high perception of differences and support from organizations. Child age did not have a significant effect. Average scores for child domain were lower than the normative sample (*M*=98). Average scores for parent domain were significantly lower (*M*=92) than normative sample (*M*=123).	lower than that of normative data. Features of child and par are linked to stress scores.
Domestic Adoption	Sánchez-Sandoval & Palacios (2012)	**Total SIPA Score**: *M*=185.38 (*SD*=46.06) **Adolescent Domain**: *M*=90.66 (*SD*=24.97) **Parent Domain**: *M*=62.53 (*SD*=17.35) **Parent Adolescent Relationship:** *M*=32.56 (*SD*=11.13) Total stress and parent domain scores lower than the normative sample. Mean score in adolescent domain higher than the normative data,	Child's age, siblings, environment before adoption, acknowledgment of differences, child-rearing styles (affection and communication), and induction and search for/use of adoption services, professional help and printed materials on adoption were significantly related to total PS. Also significant differences associated with mother's low educational level.	Compared with NAPs, stress c APs was lower in total stress scores but higher in the adolescent domain. Child, parent, support and resource variables made a 49.2% contribution to the regression model.
Domestic Adoption	Smith-McKeever (2006)	**Total PSI:** *M*=186.08 (*SD*=33.89).	Non-significant correlation with adoption satisfaction but in regression analysis PS accounted for 39% of the variance in adoption satisfaction.	African-American adoptive families had PS scores within normal range.
Special Needs Adoption	McGlone, Santos, Kazama, Fong, & Mueller (2002)	**Total PSI-SF:** *M*=76.89 (*SD*= 19.80) **Parental Distress:** *M*=21.88 (*SD*= 5.26) **Parent-Child Dysfunctional interactions:** *M*=24.06 (*SD*= 7.75) **Difficult Child:** *M*=30.06 (*SD*= 9.93) Mean total score elevated compared to normative data (*M*=69). Parents scored lower on parental distress than normative sample (*M*=25), but	On PSI defensive responding scale 24% of parents responded in a defensive manner compared to normative sample. Family adjustment and cohesion were inversely related to PS. Child behavior significantly correlated with parent-child dysfunctional interactions subscale and	Higher than normative sample on average levels of stress fou particularly on subscales relate to parent-child dysfunctional interactions and to raising a difficult child, but average scores still below clinically

		higher on parental-child dysfunctional interactions (normative sample M =19), and difficult child subscales (normative sample *M*=25).	difficult child subscale as did internalizing behavior. No significant change in total stress, parent-child dysfunctional interactions and difficult child scores over time. PS scores at times 1 and 2 highly correlated (*r*=.63).	significant cut-off. 34.3% of sample had clinically significa score. Higher stress linked to poorer family adjustment and increas child behavior problems. Stres levels remained similar at foll up.
Mixed	Lionetti, Pastore, & Barone (2015)	**Mothers PSI-SF Total:** Not reported Parent distress: *M*=22.40 (*SD*=5.30), Dysfunctional interaction: *M*=19.60 (*SD*=5.32) Difficult child: *M*=22.40 *(SD*=5.14) **Fathers PSI-SF Total:** Not reported Parent distress: *M*=22.30 (*SD*=5.12), Dysfunctional interaction: *M*=19.40 (*SD*=5.02) Difficult child: *M*=22.10 (*SD*=6.02)	Unresolved attachment predicted PS to a greater extent than insecure attachment and, together with low parenting alliance, significantly contributed to explaining levels of PS. In mothers, parenting alliance moderated the effect of an unresolved state of mind on PS.	Mean PSI-SF scores for mothe and fathers fell below clinical cut-offs on all domains. Unresolved attachment was a significant predictor of PS. Parenting alliance was negatively associated with PS.

Notes. PS = Parenting Stress; PSI-SF = PS Index-Short Form (Abidin, 1995); PSI =PS Index (Abidin, 1990); RFI = Relational Frustration Index (Kamphaus & Reynolds, 2006); AP= Adoptive Parents; NAP = Non-adoptive Parents; RO = Romanian Orphans who spent 8 months or more in an institution; RC= Romanian orphans who were not institutionalised for more than 4 months; CB group = non adopted children; SIPA = Stress Index for Parents of Adolescents (Sheras, Abidin, & Konold, 1998); T = time; ANOV = Analyses of Variance; MANOVA= Multivariate analysis of variance; NCC = non-clinical control group; CC= clinical control group; NCA= non-clinical adoptive group; CA = clinical adoptive group

Critique

Downs and Black's (1998) quality checklist was completed for each of the 23 studies. Studies were considered better quality when they met more of Downs and Black's (1998) criteria. However, as discussed previously, studies were not graded since this is discouraged (Chapter 8; Higgins, Altman & Sterne, 2011). Instead, the checklist was used as a guide to aid discussion of study quality under the following six headings: participants, recruitment, measures, design, analysis and results and ethical considerations. Critical review follows below, describing the main ways in which studies did or did not meet the criteria.

Participants. Overall, the wide variation in demographics made it difficult to generalise any results to all adoptive parents. Of studies that provided ages, parents tended to have average ages between 30-40 years, which is fairly typical of adoptive parents (DoE, 2016). Tirella et al. (2012) had the smallest sample (n=9). However, they only collected parenting stress scores with no further analysis so this did not impact on effect size, but may have reduced the likelihood of getting a true depiction of adoptive parenting stress. Judge (2004a) had the largest sample of parents (n=255) increasing the likelihood that they gathered an accurate representation of parenting stress in adoptive families. Studies on parents' sexuality overall had the largest sample sizes with Goldberg and Smith (2014) recruiting 296 parents, though parents were split into groups according to sexuality.

A number of the studies included only mothers or tested significantly fewer fathers meaning results could not be generalised to fathers (Farina et al., 2004; Gagnon-Oosterwaal et al., 2012; Harris-Waller et al.. 2016; Judge, 2004a; Palacios, & Sánchez-Sandoval, 2006; Sánchez-Sandoval, & Palacios, 2012; Smith-McKeever, 2006; Tirella et al., 2012; Viana & Welsh, 2010). Five studies reported an equal mix of mothers and fathers (Farr et al., 2010; Judge, 2003; Lionetti et al., 2015; McGlone et al., 2002, & Salcuni et al., 2015). One study used only fathers (Tornello et al., 2011) and so results are only applicable to gay fathers.

In studies that discussed socioeconomic status or education, parents tended to be high earners or professionals. Families on lower income or less well-educated parents were not well represented. However, it is likely samples are representative of adoptive parents who tend to have incomes above the poverty threshold and are educated beyond high school (Vandivere & Malm, 2009). Of those studies identifying family type, many were two-parent homes (Farr et al., 2010; Goldberg & Smith, 2014; Helder et al., 2016; Judge 2004a; Judge 2004b; Mainemer et al., 1998; Palacios & Sánchez-Sandoval, 2006; Sánchez-Sandoval & Palacios, 2012; Smith McKeever, 2006; Tornello et al., 2011) with less than three children (Farina et al., 2004; Judge, 2004a; Judge, 2004b; Mainemer et al., 1998; Salcuni et al., 2015; Tirella et al., 2012; Tornello et al., 2011) and parents were together or married (Golombok et al., 1999; Harris-Waller et al., 2016; Judge, 2003; McGlone et al., 2002; Salcuni et al., 2015; Rijk et al., 2006; Viana & Welsh, 2010) making results less applicable to single, unmarried parents with four or more children. Of single-parent families, most were mothers (Judge, 2004a) meaning single fathers were underrepresented.

Most parents were from Western cultures and so it cannot be assumed that results are applicable to Eastern cultures. Few studies discussed parents' ethnicities specifically and those that did identified parents as White or Caucasian (Farr et al., 2010; Golombok et al., 1999; Golombok et al., 2014; Harris-Waller et al., 2016; Tornello et al., 2011). Adopted children (outside of domestic adoption) tended to be from Eastern Europe or particular regions of Asia, South America, the Caribbean and Africa. Studies on domestic adoption were based in the United Kingdom, United States of America or Spain making it difficult to generalise to adoptions outside of these regions. One study gave no details of parents' demographics or characteristics, other than their parenting stress scores (Katzenstein et al., 2016).

Additionally, it is important to consider demographics of the adoptees, which could impact on parenting stress. A number of studies noted children had specific diagnosis or health problems (Farina et al., 2004; Goldberg & Smith, 2014; Palacios & Sánchez-Sandoval, 2006; Sánchez-Sandoval & Palacios, 2012; Smith McKeever, 2006; Tirella et al., 2012; Viana & Welsh, 2010). Others identified histories of

neglect, abuse or institutionalisation and Golombok et al. (1999) specifically excluded children with health complications. The one study including special needs adoptions included a mostly African-American sample with predominantly male children younger than 11.5 years. Parents were receiving support from a special-needs adoption programme (McGlone et al., 2002). Results may therefore not be applicable to non-African-American parents of children with special needs who receive less support and those with older, female children. Additionally, child age and length of time since adoption varied greatly across studies. Clearly these variables could impact on parenting stress and since these were not kept constant it is difficult to ascertain how much these affected scores. Overall, results cannot be assumed to represent adoptive parents from ethnic minority groups, single parents, or parents with low income or fewer years of education.

Recruitment. Overall a selection bias may be present since all samples were self-selecting. Parents might have participated because they perceived greater parenting stress or alternatively because they were less stressed and thus had more availability. These samples could therefore be representative of the least, or conversely, most stressed adoptive parents. Nearly all parents were recruited from adoption agencies and other specialist support services meaning families were likely to have had at least some specialist support, likely to reduce parenting stress. Some researchers recruited from multiple sites to ensure data came from geographically dispersed families, making the sample more varied but including more potential confounding variables. It would have been helpful to know that samples from different sites were not significantly different by checking for differences between groups, but this was not done in the included studies. Four studies used online advertisement (Harris Waller et al., 2016; Judge 2004a; Judge 2004b; Tornello et al., 2011), which has multiple benefits but possible consequences, such as generalizability to those who do not use the Internet (King, O'rourke, & DeLongis, 2014).

Three studies targeted entire populations, including all adoptive parents with a Romanian child in the Netherlands (Rijk et al., 2006) and parents adopting in Andalusia, Spain at time of recruitment (Palacios & Sánchez-Sandoval, 2006; Sánchez-Sandoval & Palacios, 2012). Both studies acquired

reasonably high response rates, suggesting populations were well represented. Research on special needs and mixed adoption gave little information on recruitment (Lionetti et al., 2015; McGlone et al., 2002), lacking details on who chose not to take part and why.

Lack of availability, interest (e.g. Gagnon-Oosterwaal et al., 2012), time (e.g. Farr et al., 2010), and difficulty contacting and rescheduling (Katzenstein et al., 2016) were often reasons for dropout, suggesting final samples may have had lower stress scores than those who dropped out. Although Viana and Welsh (2010) found participants lost to follow-up were not significantly different on parenting stress scores, other studies did not discuss characteristics of non-responders making it impossible to know whether dropouts were fundamentally different to participants. Although Katzenstein et al. (2016) looked at characteristics of children whose families were lost at follow-up, they did not look at any parental factors. Farr et al. (2010) found homosexual couples were more likely to participate, which may be supported by Golombok et al. (2014) acquiring a 71% response rate, including almost all adoptive homosexual parents in the United Kingdom at time of data collection.

Measures. All but three studies used the PSI or PSI-SF (Abidin, 1990). This unfortunately makes it difficult to compare studies that did not. The PSI is a commonly used measure with reliability and validity supporting it as useful across diverse populations. There are available norms for non-English-speaking respondents and manuals in various languages (Abidin, Austin, & Flens, 2006). The PSI demonstrates good reliability on both the child (.78-.88) and parent (.75-.87) subscales. The PSI-SF is also applicable across diverse samples (Aracena et al, 2016; Reitman, Currier, & Stickle, 2002). The PSI and PSI-SF are therefore applicable and reliable measures within this context. However, test-retest reliability for both has only been tested after one year so it is not clear how reliable the measures are longitudinally.

Other studies used the Relational Frustration Index (RFI) from the parenting relationship questionnaire (PRQ, Kamphaus & Reynolds, 2006), the Nijmegan child-rearing questionnaire (Wels & Robbroeckx, 1989) and the stress index for parents of adolescents (SIPA; Sheras, Abidin, & Konold,

1998). Reliability for each scale of the PRQ is fairly high with coefficient alpha ranging from .82 to .87 (Rubinic & Schwickrath, 2010). Correlations between the PRQ-Preschool and the PSI were found to be mostly negative and weak (Rubinic & Schwickrath, 2010). The authors believe this is because the scales measure stress in different manners, raising questions about the face validity of each measure. However, correlations between the PRQ-child/adolescent form and PSI were found to be moderate to high. The PRQ-child/adolescent forms were also found to correlate highly with the SIPA (Rubinic & Schwickrath, 2010). It is not clear how well the RFI specifically correlates with the PSI. Helder et al. (2016) tested the RFI on parents of Eastern European, Southern American, Asian and African adoptees but the PRQ's standardized sample included mostly American parents (Rubinic & Schwickrath, 2010), meaning results should be interpreted with caution.

The SIPA has been shown to have good test-retest reliability, internal consistency and validity (Sheras, Abidin, & Konold, 1998). Since the normative sample did not appear to include Asian or Latino individuals results should be interpreted with caution as Sánchez-Sandoval and Palacios (2012) used the SIPA on Spanish families with 10% of children who had special needs.

The Nigmegan child-rearing questionnaire (Wels & Robbroeckx, 1989; 1991) is a Dutch questionnaire. Part A determines subjective parenting stress. The measure has shown to be reliable and valid (Wels & Robbroeckx, 1991), although much of the research is written in Dutch and it is unclear whether the test is applicable for use with families of Romanian adoptees, as used by Rijk et al. (2006).

A limitation across all studies is use of self-report measures. Increased parenting stress may reduce accuracy of reporting, meaning scores may not be a true reflection of stress levels (Gagnon-Oosterwaal et al. 2012). Adoptive parents also go through initial thorough assessments to demonstrate their suitability prior to adoption and therefore may have felt the need to answer questionnaires in a socially desirable manner (Smith-Mckeever, 2006). A benefit of self-report is that it can reduce risk of researcher bias as the experimenter cannot influence responses given. Cultural differences may also affect how parents answered questions, depending on their interpretations. Ultimately it appears that the

measures used are appropriate in capturing parenting stress but results from less well-established measures must be interpreted with care.

Design. Twenty studies were cross-sectional and three were longitudinal (Goldberg & Smith, 2014; Helder et al., 2016; McGlone et al., 2002). The longest longitudinal study was over three years (Helder et al., 2016) and therefore little is known about parenting stress in the longer-term. Furthermore, there are many variables that can impact on stress and most studies consider only a handful.

Analysis and Results. Statistical tests used in each of the 23 studies were appropriate based on the reported aims. Although probability values were not required when calculating parenting stress scores, the majority of studies completed further analysis, such as comparing adoptive parents to non-adoptive parents, which required significance values. The majority of papers provided *p* values, with only a few providing *p* is less than/more than values (Farr et al., 2010; Golombok et al., 1999; Judge, 2004a; Judge, 2004b; McGlone et al., 2002; Rijk et al., 2006; Tornello et al., 2011; Palacios & Sánchez-Sandoval, 2006). Few studies reported on statistical power. Other than Farr et al. (2010), Katzenstein et al. (2016) and Lionetti et al. (2015), suitability of sample sizes was not discussed. The majority of studies, apart from Tirella et al. (2012), reported inter-quartile ranges for non-normally distributed data and standard errors, standard deviations or confidence intervals for normally distributed data. Judge (2004a) only provided the percent of parents scoring above clinical cut-off but provided descriptive statistics when contacted (S. Judge, personal communication, June 6, 2016). Other authors who did similarly were not contactable and therefore omitted from the review. Tirella et al. (2012) did not provide an average parenting stress score for their sample, which had to be calculated from individual scores by the reviewer.

Ethical considerations. In regards to ethical considerations, over half of the studies discussed informed consent (Farina et al, 2004; Farr et al., 2010; Gagnon-Oosterwaal et al., 2012; Golombok et al., 2014; Harris-Waller et al., 2016; Helder et al, 2016; Judge, 2004a; Judge, 2004b; Katzenstein et al., 2016; Salcuni et al., 2015; Tirella et al., 2012; Tornello et al., 2011; Viana & Welsh, 2010; Mainemer et al., 1998) and one outlined how confidentiality was discussed (Farina et al, 2004). A number of studies do

not report on ethical approval (Farr et al., 2010; Farina et al, 2004; Golombok et al., 1999; Helder et al., 2016) making it difficult to know to what extent this was done. Some studies scarcely discussed ethical issues (Goldberg & Smith, 2014; Judge, 2003; Lionetti et al., 2015; McGlone et al., 2002; Palacios & Sánchez-Sandoval, 2006; Rijk et al., 2006; Sandoval & Palacios, 2012; Smith-Mckeever, 2006) making it difficult to know to what extent participants were protected.

Discussion

Overall studies showed adoptive parents generally have parenting stress scores within the non-clinical range, but have average scores higher than non-adoptive parents. Parents' scores tended to be elevated when adoptees had longer exposure to adverse pre-adoption environments (e.g. Mainemer et al., 1998), special needs (e.g. McGlone et al., 2002) or if the parent perceived significant attachment or child/adolescent difficulties (e.g. Helder et al., 2016). This fits with current literature, suggesting adoptive parents experience similar stress to non-adoptive parents but face additional stressors (Groza & Ryan, 2002). It also fits with evidence that later adoptions lead to poorer child outcomes (Van den Dries et al., 2009) and more parenting stress (Mainemer et al., 1998). This may explain why Harris-Waller et al. (2016) found higher stress levels in adoptive parents, since children were adopted later (*M*=4 years) and parents reported more child difficulties. This is typical of domestic adoptions in the United Kingdom, where most children are adopted over one year of age (DoE, 2015). Although, recently published research found parenting stress in parents of children adopted from foster care increased in parents of younger adoptees, overall parenting stress was higher for parents of older adoptees. The increase in stress could be linked to younger adoptees increasing behaviour problems after the first year of placement. The authors hypothesise that this may be because younger adoptees start to feel more comfortable 'testing the limits' once they have been in their adoptive home for longer. (Nadeem et al., 2017). This study was not included in the review since it was published after the final study selection.

Overall research quality was good. Particularly those studies that sought a larger sample size, such as Goldberg and Smith (2014), those that attempted to acquire an equal mix of mothers and fathers (Farr

et al., 2010; Judge, 2003; Lionetti et al., 2015; McGlone et al., 2002, & Salcuni et al., 2015), those that used a well-established, validated measure of parenting stress such as the PSI or PSI-SF and those that thoroughly discussed ethical issues (Farina et al, 2004; Farr et al., 2010; Gagnon-Oosterwaal et al., 2012; Golombok et al., 2014; Harris-Waller et al., 2016; Helder et al, 2016; Judge, 2004a; Judge, 2004b; Katzenstein et al., 2016; Salcuni et al., 2015; Tirella et al., 2012; Tornello et al., 2011; Viana & Welsh, 2010; Mainemer et al., 1998). Due to limitations in the research, results cannot be generalized to all adoptive parents, particularly fathers, single parents, less-educated parents, ethnic minorities, lower income and larger families. This fits with research showing that fathers, especially ethnic minorities, less educated and working class are under-represented in family studies (Costigan & Cox, 2001). Additionally, parents were self-selecting introducing selection-bias (Braver & Bay, 1992) and few studies were longitudinal providing less information about parenting stress over time.

Limitations

There is likely to be incomplete retrieval of all evidence as papers could have been undetected by electronic databases or missed during hand searches (Jadad & McQuay, 1993). It is known that selection criteria impacts on review outcome, with similar reviews generating conflicting conclusions based on studies selected (Jadad, Cook, & Browman, 1997). However, excluded studies were read and contributed to the theoretical understanding of this review. Non-English studies were excluded due to resource restrictions meaning particular perspectives on parenting stress may be neglected. Dissertations and unpublished papers were also excluded introducing publication bias (Bartolucci & Hillegass, 2010). Inclusion of studies using un-validated or subsections of measures may have also enhanced understanding since these elements of stress may contribute to parenting stress. The wide range of participant demographics, adoption types and pre-adoption histories, was a strength of the research but made direct comparison within the review problematic, limiting ability to make conclusions. The diverse use of measures also meant no attempt was made to synthesise outcome data.

Implications for Research and Theory

When taking into account the quality of current research, it does not provide enough information about parenting stress in single parents, fathers and ethnic minorities. It is important to establish how adoptive parents from these groups experience stress, since evidence shows these groups are likely to experience more stress in general (Cairney, Boyle, Offord, & Racine, 2003). Longitudinal studies examining adoptive parenting stress over an extended period are also needed, especially as there is a call for longer-term perspectives on adoption (Rushton, 2003). Parenting stress as children grow older and parents age is generally under-reported. It is known that non-adoptive parents of adult children with learning disabilities experience parenting stress in relation to level of disability, diagnoses, physical health and functional skills (Seltzer & Krauss, 1989). It is therefore not unreasonable to propose that adoptive parents of older children and adults may experience increased stress, given the higher incidence of mental, emotional, and developmental disorders seen in children who come from care (Meltzer et al., 2004; Zeanah et al., 2004).

Unfortunately it was beyond the scope of this review to thoroughly examine the specific factors associated with parenting stress. The review does however support current theories, suggesting parenting stress is an accumulation of child and parent factors (Abidin, 1995). It would be useful to now review the factors that alleviate or exacerbate adoptive parenting stress. It would be useful for a single, culturally sensitive, standardised measure to be used in future research to allow consolidation of conclusions.

Implications for Clinical Practice

It is hoped that better awareness of parenting stress in adoptive parents will allow staff working with families to look out for and more appropriately respond to stress. Whilst many adoptive families have good family functioning (Rushton, 2003), this can be difficult to maintain during periods of stress such as loss events or acute stress, such as financial difficulties (Hughes & Baylin, 2012). Stress management strategies may be a useful early intervention for parents prior to the arrival of a child, especially since low levels of parenting stress increase parental competence (Trifan & Stattin, 2014).

Post-adoption, treatments specifically focusing on parenting stress or that incorporate parents' ability to self-regulate, such as mindfulness (Gurney-Smith, Glossop, & Granger, submitted) or Dyadic Developmental Psychotherapy (Hughes, 2011), are likely to be useful. Results show that stress is highest when adoptees have longer exposure to difficult pre-adoption environments, which is often the case with domestic adoptions in the United Kingdom, when adoptees have special needs and when parents perceive significant child or attachment difficulties. Interventions should therefore be especially considered for these groups.

It is hoped these results are encouraging by demonstrating that the majority of adoptions are successful in relation to parenting stress, particularly for international adoptions and regardless of parent's demographics and sexuality. For the majority of adoptions, clinicians can use findings to normalise stress and ensure parents do not feel alone, particularly since it is hypothesised that adoptive parents may feel more isolated in their experiences (Brodzinsky & Huffman, 1988). However, risk of increased stress appears to be associated with child factors, including length of time prior to adoption and profile of needs, for which the Adoption Support Fund (DoE, 2013) should be considered to provide appropriate therapeutic support. Results may also be useful for clinicians who work with homosexual adoptive parents, who may contend with sexuality-related stigma during the transition into parenthood (Goldberg & Smith, 2014).

Implications for Policy

Results of this review are applicable to future policy on adoption. At present, policy encourages stability for children adopted from care by ensuring adoptive families get the support they need (DoE, 2015). This was linked to an increase in the adoption support fund from spring 2015 to help families access high-quality services (DoE, 2015). However, much of the support highlighted focuses on support for the child (DoE, 2013) rather than parents. The National Institute for Health and Care Excellence (2015) identifies that foster carers who feel supported are better able to incite healthy relationships and

provide a more secure base for their child. It may be that more needs to be done to acknowledge adoptive parents in a similar sense.

Conclusion

It is important to understand parenting stress because of its association to both parental and child health outcomes. Although evidence has shown adoptive parent's stress is usually outside of the clinical range, it can be elevated by factors such as length of time before placement, special needs or perception of child's difficult behaviour. Future research should explore causes more specifically and think about how intervention can place an emphasis on managing parenting stress as well as supporting the adoptee.

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Paper B

Adoptive Parents' Experiences of Dyadic Developmental Psychotherapy

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Abstract

Dyadic developmental psychotherapy (DDP) is an attachment-focused therapy aimed at working with families where the child has experienced early complex trauma or other issues with attachment. DDP is therefore frequently used in adoptive and foster families. Despite frequent use in the UK there is limited good-quality evidence for DDP and national guidance has called for further trials and qualitative evidence. This study aimed to understand the experience of adoptive parents who have completed DDP. Semi-structured interviews with 12 adoptive parents were analysed using Interpretative Phenomenological Analysis. Four superordinate themes were identified: (1) Increased understanding; (2) "It's a different method of parenting generally"; (3) the DDP journey; (4) "It's a shared kind of experience you go through and come out together". Parents felt they had a better insight into their child's mind, thus knowing how to better support their child. They felt DDP was a good fit to their unique situations and appeared to promote acceptance of them. The DDP journey started with parents feeling uncertainty and questioning DDP's effectiveness. However, generally parents became committed to the therapy once they saw change and expressed fear and sadness at ending treatment. Parents acknowledged the dyadic nature of DDP, feeling it helped build trust and security, supported co-regulation and the parents acknowledged therapist's role in conveying core DDP principles. Results have implications for clinical practice, policy and research.

Keywords Adoption, Dyadic Developmental Psychotherapy, Attachment, Parent-child psychotherapy, Childhood trauma

Proposed Journal The Journal of Child and Family Studies (see Appendix E for author guidelines)

Introduction

In 2015 the National Institute for Health and Care Excellence (NICE) outlined several interventions that are thought to be useful for supporting young people with attachment difficulties. Despite these interventions being frequently used in the UK there is limited good-quality evidence for them. NICE (2015) have therefore recommend that randomised control trials (RCTs) and qualitative research are conducted into parent and children's experiences of attachment-based interventions. Although there are number of interventions aimed at working with children likely to have attachment difficulties (Appendix F), one intervention specifically noted by NICE (2015) is Dyadic Developmental Psychotherapy (DDP; Appendix G).

DDP aims to reduce attachment difficulties in adopted and fostered children (Hughes, 2011). It aims to work with "a specific type of complex trauma that primarily focuses on the effects on a child who experiences abuse and neglect early in life at the hands of his/her parents or caregivers" (Hughes, 2014, pp. 2). This type of trauma is likely to have occurred for children who are fostered or adopted from care as they are more likely to come from families with disordered lifestyles (Golding, 2010). There are more likely to be increased risk factors, such as living with families where parents experience mental illness, domestic violence or drug and alcohol use (McAuley & Davis, 2009), which can impact on a parent's ability to look after their child (Cleaver, Nicholson, Tarr, & Cleaver, 2007). Bowlby's (1988) attachment theory outlines how such maltreatment or neglect can impact on an individual's sense of self, affect regulation, behaviour, and relationships. Attachment theory suggests that early child-caregiver interactions are internalised as working models, which the individual may use to understand themselves, others and the world (Bowlby, 1988). There is ample evidence that early disruptions can lead to a range of maltreatment associated psychiatric problems (Mikulincer & Shaver, 2013), as described in Appendix H. DDP aims to support families where these difficulties are present.

DDP is somewhat different to other attachment-based interventions in that it focuses on the relationships between therapist and child, caregiver(s) and child, and caregiver(s) and therapist (Hughes, 2014). This therapeutic relationship is thought to help facilitate a good relational experience, which the child may have missed in their early years (Hughes, 2014). Therefore, the child, caregiver(s) and therapist are actively involved. The therapy space is one of playfulness, acceptance, curiosity and empathy (PACE), to attempt to mirror that of a secure attachment as based on theoretical underpinnings described by Hughes and Baylin (2012). The therapy aims to change unhelpful internal working models that may have developed, in accordance with attachment theory, by modelling healthy attachment, reducing shame, increasing containment and regulation of affect (Hughes, 2011). The therapist endeavours to recognise the child's emotional experiences and help them regulate these by responding to them as would occur in a healthy attachment relationship. DDP is widely used in UK services and staff argue it incorporates all the necessary components for treating maltreatment associated psychiatric problems (Turner-Halliday, Watson, Boyer, Boyd, & Minnis, 2014).

Becker-Weidman's (2006) empirical research examined the effectiveness of DDP for children with Reactive Attachment Disorder; often diagnosed in children with a history of abuse and neglect (see Appendix I; Hanson & Spratt, 2000). DDP (*n*=34) was compared with a control group who experienced "usual care" (*n*=30), which encompassed evaluation only and, for 53%, another form of therapy including family therapy, play therapy and individual therapy. Although the control group was older than the treatment group they were similar on all other demographic and clinical measures. Participants were selected based on the treatment they were already receiving. Results indicated a significant reduction in symptoms of attachment disorder, withdrawn behaviour, anxiety, depression, social problems, attention problems, rule breaking and aggressive behaviour compared to the control group who showed no significant changes. Reductions in attachment disorder symptoms, aggressive behaviours, social problems, anxiety and depressive symptoms, thought problems and attention were maintained in the DDP group four years post-treatment. These effects occurred with an average of 23 sessions. The study is limited however by its lack of suitable control group, lack of randomisation and un-validated outcome measure (Randolph, 2000) making a clear rationale for conducting further RCTs (Turner-Halliday et al., 2014). This is recognised by the DDP institute (DDPI Board, 2014).

Becker-Weidman and Hughes (2008) have since provided verification for individual components of DDP and there is support in the neuroscience literature to suggest DDP ought to be effective for attachment difficulties (Hughes, 2014; Hughes & Baylin, 2012). Further qualitative and quantitative evidence has also been provided for a DDP-informed group (Selwyn, Golding, Alper, Gurney-Smith, & Hewitt, 2016) in which parents reported understanding their children's behaviour differently, having better abilities to regulate and reflect on their children's minds, improved attunement with their children and a perception of improved relationships with them. Recent qualitative research into the views and experiences of DDP clinicians has also been completed (Turner-Halliday et al., 2014). It now feels relevant to gather the experiences of those service users who have been involved in DDP. Without understanding families' experiences, fundamental information, which may not be captured through quantitative measurement (Black, 1994), may be missed.

This study will aim to understand the experience of adoptive parents (APs) who have completed DDP. It is hoped that this will help to establish a better understanding of the experience of this therapy and identify areas for further research. Although DDP is used frequently with both adoptive and foster families it is felt adoptive and foster parents may have different experiences of DDP since in adoption the legal relationship between child and birth parents is terminated and an equivalent relationship is made with the APs (Cretney & Masson, 1997). This is different from foster parents who share parental responsibility between birth parents and/or a local authority (Schofield, 2000). This fundamental difference may mean APs have different motivation and goals in therapy compared to foster parents. Although it would also be useful to gather the

experience of foster parents, since it is felt DDP is a suitable intervention for foster families (Craven & Lee, 2006), it is hoped that by studying APs in the first instance, a homogenous experience can be gathered.

Method

Design

Semi-structured interviews with 12 parents were analysed using interpretative phenomenological analysis (IPA). IPA allows for the interpretation of peoples' lived experience and the personal meaning given to them (Smith, Flowers, & Larkin, 2009). Appendix J gives further information on IPA.

Participants

The following inclusion criteria were used to enhance sample homogeneity (Smith et al., 2009):

- APs who completed DDP with a certified DDP clinician or clinician becoming certified.
- APs who completed at least six DDP sessions.
- APs who completed DDP within twelve months of interview to ensure good recall.
- APs who had capacity to give informed consent as judged by the clinician and interviewer.

Participants were excluded if they were biological or foster parents or if their children were over 18 years old.

Measure

A semi-structured interview schedule (Appendix K) was established in line with IPA guidance (Smith et al., 2009) ensuring questions were open and expansive. A DDP clinician and an AP who was undergoing DDP reviewed the interview schedule to ensure relevant questions were included. The clinician contributed an additional question and the parent reported the schedule was relevant. This parent also underwent a pilot interview resulting in a number of the questions being reviewed to allow for more open responses. This interview was not included in the data.

Procedure

Recruitment. DDP practitioners were identified using the online DDP network (https://ddpnetwork.org/professionals/find-a-practitioner-or-therapist). Clinicians were emailed about the project (Appendix L) and asked to provide information to potential participants (Appendix M). Parents were able to opt in by contacting the researcher or clinician. If interest was expressed, the clinician gained the parent's consent to pass on contact details to the researcher (Appendix N) or the parent was able to contact the researcher directly. Participants were given at least 24 hours before they were contacted to allow the researchers to answer any questions. If parents were happy to partake they were given a consent form (Appendix O). Participants were offered £10 for participation.

Interviews. The researcher conducted all interviews, lasting between 41 minutes and one hour 19 minutes (M = 57.85 minutes). Interviews were conducted via video call (n=10) or face-to-face (n=2). Research has shown that video calling is an

acceptable and valuable way to collect qualitative data (Sullivan, 2013). On completion of the interview, participants were offered the contact details of the research supervisor who could provide further support if required.

Data Analysis

Analysis was carried out in accordance with Smith et al. (2009). Each transcript was considered individually to ensure analysis remained idiosyncratic (Smith et al., 2009). Initial listening to and transcribing of recordings helped enter the participants' world (Smith et al., 2009). Transcripts were read several times before notes were made against the data looking at language, content and providing comments on the individuals' experience. Emergent themes developed by reducing notes into portions of data that represented key concepts (Appendix P). This process was repeated with each transcript and similar patterns across cases were noted. Themes that were not confirmed by other transcripts were removed or assimilated into other themes. Connections across themes were then mapped to produce a set of superordinate and subordinate themes. Convergences and divergences were recognized in line with the IPA principle that participants' experiences have similarities and differences (Smith et al., 2009).

Reflexivity. IPA recognises that researcher biases, values and interests can impact upon interpretation. A bracketing interview was conducted (Appendix Q) prior to interviews to allow the researcher to bracket prevailing assumptions, biases and to understand how their subjective experience may impact on analysis (Rolls & Relf, 2006). Additionally, the researcher completed a reflexive log throughout (Appendix R). This helped enhance transparency, allowing for the researchers' process of thinking to be followed. An IPA peer supervision group was also attended. These reflexive procedures allowed the researcher to acknowledge their biases, values and interests prior to analysis. These included, for example, prior experience and interest in mentalization-based therapy (Bateman & Fonagy, 2009) and therefore a potential bias towards focusing on parents' descriptions of differentiating their own thoughts and feelings as separate from their child's and the topic of emotion regulation and how this impacts on relationships. The researcher's reading into the PACE method and other DDP techniques may also influence how the researcher interprets parents' descriptions of their sessions, for instance they might see parents' descriptions of sessions in terms of the techniques being used by the therapist. Given the researcher's interest in attachment-based interventions it may also be the case that they are likely to look for positives in parents' accounts and may need to remember that the aim of the research is to gather all adoptive parents' experiences and not just evidence of DDP's effectiveness. The research will need to remain open to a potential 'blind spot' to more negative interpretations of DDP, and discuss these with colleagues and IPA peers.

Quality and Credibility. Yardley's (2000) quality criteria for qualitative research were followed (Appendix S). IPA supervision groups allowed for discussions on credibility and for peers to complete credibility checks on themes. A DDP clinician also completed a credibility check. This supported triangulation, allowing different perspectives and interpretations of

the data to be captured. Quality and credibility was also checked at two IPA workshops (Appendix T) attended by an IPA expert, Michael Larkin (February 23 and April 6, 2017), which provided opportunity for transcripts to be reviewed.

Ethical Considerations. The Oxford Central University Research Ethics Committee (CUREC; Appendix U) and Oxford Doctoral Course in Clinical Psychology (Appendix V) approved the project. Participants were informed that the study was voluntary and their care would not be affected by their decision around taking part. Participants were told the researcher may need to disclose information if there was concern of harm to self or other. Participants were given a brief idea of the topics covered in interview and informed they did not have to answer any questions they did not want to. Support was offered post-interview if needed. Transcription omitted any identifiable information.

Results

Situating the Sample

In accordance with IPA, a small, homogenous sample of 12 APs (7 mothers and 5 fathers) were recruited, with the aim of understanding the idiographic experience of each individual (Smith et al., 2009). Demographic details of parents can be found in Table 1. The average age of parents was 47 years (37-61 years). The majority of parents were heterosexual and married (*n*=8). Two parents were in homosexual relationships, one parent was a heterosexual widower and one was a single parent. Eleven parents identified as White British and one parent identified as Indian. The number of estimated sessions ranged from eight to 43 sessions. Time since adoption varied from one year to 12 years. One family had immediate DDP support from the point of adoption and the longest a family had between adoption and the DDP referral was 11 years. Time since therapy ended to interview date ranged from less than one month to 12 months. It is important to note that this could impact on parents' level of recall and meant that parents were at different points in their journey, which may have impacted on their narrative. Unfortunately this data could not be gathered for one participant (Ben).

Table 1.

Participants' demographic information

Participant Pseudonym	Gender	Age	Sexual Orientation	Ethnicity	Time since adoption	Time since adoption to DDP referral	Gender of child involved in DDP	Estimated number of sessions	Estimated time since therapy ended
Sam	Female	40	Heterosexual	White British	2 ½ years	6 months	Son	15	3 months
Stan	Male	52	Homosexual	White British	2 ¼ years	Immediately	Son	43	6 months
Mike	Male	45	Heterosexual	White British	9 ½ years	9 years	Daughter	12	2 months
Chloe	Female	37	Heterosexual	White British	6 years	4.5 years	Daughter	12	< 2 months
Mark	Male	61	Heterosexual	White British	12 years	11 years	Daughter	8	6 months
Marie	Female	56	Heterosexual	White British	7 years	2 years	2 daughters, 1 son	24	< 1 month
hAndy	Male	48	Heterosexual	White British	2 ½ years	1 ½ years	Daughter	36	2 months
Laura	Female	47	Unknown	White British	3 years	2 years	Son	28	2 months
Lina	Female	45	Heterosexual	Indian	1 year	3-4 months	Son	15	12 months
Ben	Male	43	Homosexual	White British	8 years	6 years	Daughter	20-25	Unknown
Rachel	Female	44	Heterosexual	White British	3 years	2 years	Son	30	6 months
Jess	Female	51	Heterosexual	White British	5 ½ years	6 months-1 year	Daughter	34	7 months

Overview of themes

Analysis revealed four superordinate themes and ten subthemes, which can be seen in Table 2. The degree to which participants endorsed these is demonstrated in Table 3.

Table 2.

Superordinate and subordinate themes

Superordinate Themes	Subordinate Themes
Increased understanding	"You get that glimpse into his mind" (Stan, 618-619)
	A new way to help
"It's a different method of parenting generally"	DDP fits
(Chloe, 11)	Acceptance
The DDP journey	The unknown: "I need to see the evidence" (Andy, 447)
	Commitment to the journey
	Significance of endings
"It's a shared kind of experience you go through	Trust and security
and come out together" (Lina, 483)	Emotion regulation
	The therapist's stance

The first theme captured participants' sense that they had a better understanding of their child. This included insight into their mind and therefore their behaviour. This understanding gave parents a new way of working to support their child. The second theme captures the way in which parents described DDP as different to anything tried before, but that it fit their situation. The therapy appeared to be different in the way it promoted acceptance. The third theme highlights how parents' feelings towards DDP were described as a journey. This journey included not knowing the model before starting and feelings of uncertainty in the early stages of the therapy. This included questioning DDP's effectiveness before seeing change, becoming committed to the therapy and then feeling sadness and fear about ending the intervention. The final theme acknowledges the dyadic nature of DDP as a shared experience. It included the importance of building trust and security, parent-child emotion regulation, and the importance of the therapist in actively conveying the core principles of DDP.

Table 3.

Endorsement of superordinate (in bold) and subordinate themes by participants

Themes	Total	Sam	Stan	Mike	Chloe	Mark	Marie	Andy	Laura	Lina	Ben	Rachel	Jess
Increased understanding	11	*	*	*	*	*	*	*	*	*	*		*
"You get that glimpse into his mind"	12	*	*	*	*	*	*	*	*	*	*	*	*
A new way to help	10	*	*	*	*		*	*	*	*	*		*
"It's a different method of parenting generally"	12	*	*	*	*	*	*	*	*	*	*	*	*
DDP fits	12	*	*	*	*	*	*	*	*	*	*	*	*
Acceptance	9	*		*	*		*	*	*		*	*	*
The DDP journey	9	*	*	*	*	*	*		*	*			*
The unknown: "I need to see the evidence"	12	*	*	*	*	*	*	*	*	*	*	*	*
Commitment to the journey	12	*	*	*	*	*	*	*	*	*	*	*	*
Significance of endings	12	*	*	*	*	*	*	*	*	*	*	*	*
"It's a shared kind of experience you go through and come out together"	12	*	*	*	*	*	*	*	*	*	*	*	*
Trust and security	11	*	*	*	*	*	*	*		*	*	*	*
Emotion regulation	10	*	*	*	*	*	*	*	*		*		*
The therapist's stance	12	*	*	*	*	*	*	*	*	*	*	*	*

Increased understanding

All but one parent described gaining a better understanding of their child and increased curiosity about their child's mind. This fresh insight provided parents with a new way of working in terms of strategies, skills and techniques to support their child.

"You get that glimpse into his mind" captures the way in which parents spoke about an increased sense of understanding their child:

> *"Part of it was understanding why Lilly was feeling the way she was feeling, why she was presenting the way she was presenting…Richard drew a picture of the brain and talked about the three parts of the brain…so we understood that actually, for the first time, that because of how Lilly's brain is different, normal sort of parenting doesn't work"* (Mike, 87-93)

Mike highlights what many parents explained, that developing a deeper understanding of his daughter allowed him to be curious about what her behaviour was communicating. This curiosity may be something particularly prominent for APs who do not experience their child's early life and so are left trying to understand their history and the impact. Neurobiological explanations appear to have provided an organic basis for Lilly's behaviour, removing blame and helping Mike to realise he may need to respond to Lilly differently.

Parents linked increased understanding to a better awareness of their child's pre-adoption history. In many cases, the significance of their child's past was brought to light during DDP:

> "*But because she was 14 months when she came here, naively I thought she'd have no recollection necessarily of what went before and wouldn't have experienced things that would cause her problems going forward, at first."* (Chloe, 185-188)

In Chloe's case, understanding the past helped her make sense of current 'problems'. Parents often spoke of assuming their child would not recall early experiences, which may have unconsciously been preferable to accepting that they may still struggle with their trauma. It may also be that accepting the effects of the trauma means acknowledging more deep-rooted difficulties with longer-term implications. For many parents, accepting and gaining insight into their child's history helped them to see how their child saw themselves:

> "*Luke's biggest problem is that he doesn't like himself…he thinks he has a dark heart, his heart must be black because they made him*" (Sam, 108-111)

For Sam, understanding how Luke saw himself enabled her to recognise that his difficulties may come from a place of self-loathing.

Exploring the child's past relationships also helped parents make sense of the child's current relationships, "*the trauma was predominantly from his mother so he was very, has been very, very frightened of me at times*" (Sam, 61-62). Sam identifies that their relationship can be difficult, due to the influence of Luke's harmful relationship with his birth mother. Many parents also gained insight into what was missed in their child's early life and the importance of trying to address this in therapy:

> *"And there's quite a lot of pampering so, um, rubbing moisturiser into feet or hands or arms and stroking and combing hair and things. Lots of kind of, just, physical touching, sensory stuff and just the kind of things you might do to a baby. Um, to give her that sort of nurturing that she missed"* (Andy, 303-307)

A new way to help emerged as parents gained increased understanding. Parents spoke about originally using techniques that did not fit:

> "*It's lovely to have a formula because we had nothing before...Whereas now there is, there is a bit of security as parents as well. You know, you're just going along following how your parents were and how you've watched other parents and it don't fit, it doesn't fit our children"* (Marie, 94-99)

Marie describes now having a 'formula', suggesting a logical solution to something that was initially incomprehensible. Knowing how to support her children also provided security for her, suggesting parents felt more contained. She describes responding to her children in the same way she had been responded to, but realising this did not fit her children, given their traumatic histories. Increased understanding overall appeared to allow parents to respond in a new way. This included the ability to stop, reflect and attempt to understand behaviour:

> "*It's that ability to reflect, that ability to sort of stop, that ability to not, not assume that actually Katie's just doing it to be a bit bloody-minded, that actually she can't help herself, you know, this is pre-determined, this is about her own, her own early trauma and the impact that early trauma is having on her now"* (Ben, 527-531)

Here Ben describes seeing Katie in a different light. By understanding her history, blame is reduced and he becomes more forgiving. Ben has been given the autonomy to stop and reflect rather than feel he urgently has to respond. He later describes that this is different to how he responded before:

> "*For us, it was vital, it was vital for the success of this placement, you know? It gave us the skills and the tool sets we needed to understand Jack and try and help him on his life journey, you know?….and for us to remain sane really and to understand where he was coming from"* (Stan, 718-724).

Stan's 'tool' kit included various tangible techniques but mostly, simply having a better understanding of Jack. Overall, most parents described feeling better prepared and Stan even attributes the success of the placement to this.

"It's a different method of parenting generally"

This theme incorporates parents' descriptions of DDP as different, experiencing a "*eureka moment"* (Mike, 111) where something 'clicked' and DDP felt like a fit for their family. Parents cited acceptance as a key component, which made DDP different to other interventions or parenting approaches.

Every parent described getting to a place where they felt **DDP fit** their situation. This was linked to DDP being described as unique and different to "*traditional child methods*" (Sam, 69), which Sam felt were difficult for her son because "*he wasn't a traditional child*" (Sam, 69). Jess describes how her daughter's "*brain ticks a bit differently to everyone else's*" (Jess, 646) and therefore required different intervention. Mike explains using traditional forms of parenting as:

> "*Like trying to bang a square peg into a round hole. The only way it would work is if you smashed it so hard that you just turn the square peg into a round peg by breaking things off it and that's not right*" (Mike, 539-542)

Mike describes discomfort at attempting to force-fit other approaches for Lilly using the brutal metaphor of banging a square peg into a round hole, whereas DDP was described as:

> "*a very natural approach. It felt as though it was very focused on our situation and the challenges we were facing, so it didn't feel like something was being force-fit*." (Mike, 8-10).

Mike's language in regards to DDP feels much less forceful and natural, describing it as personal to the families' difficulties. It may be that the responsive, reflective parenting style that emerges from DDP's roots in attachment theory feels less forced as opposed to alternative behavioural or child-focused methods.

Acceptance was a key element of DDP that differentiated it from other approaches. This included accepting difficult emotions, rather than trying to fix them, as parents may have done previously:

> *"And realising that when they're having a meltdown it's not a matter of telling them 'stop having a meltdown', it's about sitting next to them and being very sorry that that's how they are feeling…and going through the PLACE. To start off with it was not my style, at all. I wanted to put a band-aid over it and say 'come on lets go and sing'… let's make everything fun*." (Marie, 541-548)

Marie describes realising that trying to stop distress was not helpful and learning to validate and sit with her children's emotions, supporting them with playfulness, love, acceptance, curiosity and empathy (PLACE). Some parents described feeling initially uncomfortable about not reassuring their children straightaway and worried that their child might be having an experience that made them feel worse.

Children were also described as seeing themselves differently but starting to accept themselves:

> *"Katie is better able to tackle life day-to-day, she's more open and she is um, she has a better understanding of who she is, of her own identity and how she works. And actually she knows that in certain situations she will freeze but actually that's ok, these are the strategies she can use to be able to move on from that*." (Ben; 590-594)

Here Ben notices his daughter's increased insight into who she is and how she works. He acknowledged enhanced acceptance and that this has helped her to know that she is 'ok'. She is described as more open, possibly because she feels safer to express herself, knowing others can support her. Child self-acceptance also emerged when children gained insight into how their parents saw them, realising that their parents loved them just as they are:

> "*He knows we know that story and we know everything and we're still there and we still love him*" (Marie, 335-336)

Overall, increased acceptance allowed challenges to become a part of family life rather than a struggle:

> "*It's about accepting it for what it is and not trying to make it something different. You're just trying to make it feel better for everybody. And until we got to that, I think all this other lovely stuff has come from it…As opposed to 'I will make that happen because that's going to be lovely' it was more 'oh this is happening and it just is lovely' and that spontaneity has just become a really big part of our family now*" (Chloe, 794-801)

Here Chloe describes accepting life with her daughter as she is and eventually struggling less with trying to always 'make it feel better'. This ethos appears to have disseminated into everyday life.

The DDP journey

Most parents described undergoing a 'journey'. Parents described initially knowing very little about DDP and questioned its validity. This phase seemed to come to an end when parents saw evidence of its progress, becoming committed, despite difficulties. All parents also spoke about having significant feelings about ending treatment.

The unknown: "I need to see the evidence," describes parents' initial scepticism towards a treatment they knew very little about. Although DDP was unfamiliar, parents reported experiencing a "*cry for help*" (Rachel, 468) and feeling so "*overwhelmed*" (Mike, 192) that they accepted DDP "*willingly*" (Mike, 75) despite, in some cases, having never heard of it. This 'unknown' naturally fostered some scepticism, which for most receded over time:

> "*And we were sceptical for a while, until something clicked…We went willingly, feeling very lucky that we got access to it, we didn't let our cynicism, scepticism, whatever it is, sway us*" (Mike, 72-76)

Mike's scepticism may be linked to the experience of other approaches that had failed them before. This may also be linked to more general stigma and cynicism associated with therapy. Despite this, Marie highlights the vulnerability in making a decision about what help she needed:

"*We would have jumped off the Empire State Building if someone had told us it would have worked for them*" (Marie, 151-152)

All but one parent felt that after some time, progress became evident. This was in the way their child started to feel about themselves and others, their improved ability to name and regulate emotions, increased empathy, openness, and sense of security. These changes led to more tangible progress such as improved sleep, less behavioural difficulties, placement stability and better peer relationships. Progress led a handful of parents to conclude that DDP ultimately kept the family together:

"*The placement would have likely broken down because I don't think I could've coped with it having no understanding what was going through his head*" (Stan, 300-302)

However one parent, Rachel, still felt she hadn't seen the progress she had hoped for at the end of therapy. Rachel later questioned whether DDP had been the right approach for her and the needs of her son:

"*I realise that I'm a fixer, I want to fix things and I understand that the treatment wasn't ever to fix these things but to bring them up and kind of explore them…but ultimately the issues that we had are the same, they haven't changed*." (Rachel, 312-315)

She put this down to wanting a 'fix', which contradicts the feelings of acceptance that other parents identified.

Commitment to the journey encompasses the idea that therapy was difficult but, in most cases, considered worthwhile. Since parents were actively involved, difficulties included the practicalities of making time for sessions and therapeutic work outside of sessions, as described by Mark:

"*I've got a demanding job and finding time in the diary, to, to do this amidst all else was challenging but worthwhile"* (Mark, 145-146)

Mark highlights that the therapeutic process takes time, linking back to the idea that there is no 'quick fix' for attachment difficulties, given the 'fix' is likely to be relational. A number of parents also described some discomfort during sessions, learning to speak to their child in a different way and completing therapeutic activities, which felt odd and unnatural to certain parents, "*I think some of the things we were kind of having to do did feel quite unnatural*" (Lina, 185-186)

DDP was also described at emotionally difficult for both parent and child during and after sessions:

"We'd both be exhausted afterwards, you know? I'd keep him off school afterwards because he'd just be so upset… And I found it really hard seeing how difficult it was to hear from another person, the stuff that had failed him (cries). I found that really, really hard " (Laura, 582-596)

Here Laura highlights how emotionally exhausting DDP was for her son after sessions. Laura also highlights how difficult it was for her, emphasising the dyadic nature of therapy in that both felt the agony of his trauma. Some also described how

difficult it was to acknowledge their own attachment histories and to be reappraising themselves as parents. Despite the difficulties, all but one parent stated or alluded to DDP being worthwhile:

> "*You've got to stick with it. Because whilst it may not seem to be going anywhere or may not seem to be right, it's preparation that's well worth investing in*" (Mike; 250-252)

Like an investment, Mike suggests that commitment and trust in the process are required to get a profitable return. Furthermore, it seemed that the hard work continued after sessions as described by Ben's swan analogy:

> "*I use that swan analogy that our children do glide through, um, and everybody goes "they're so wonderful, they're so engaging, they're so brilliant" and you go 'you have no idea how hard the legs are going underneath to be able to, just to be able for them to keep up*'" (Ben, 254-257)

The **significance of ending** was described as important for parents who experienced fear of managing post-therapy or sadness at it being over:

> "*Do you know it was really nervy because you get used to knowing you've got that sounding board, knowing that she'd always impart a gem of wisdom…and just knowing we were going it alone almost was a little bit daunting. But very quickly you then get home and you realise that you're the master of your own destiny and you just crack on*" (Chloe, 671-675)

Here Chloe describes anxiety that others confirmed, possibly linked to feeling that the 'therapist's wisdom' may have not become internalised. Parents perhaps lacked confidence in their ability to progress alone. However, Chloe soon realised she is a 'master' in her own way and takes control. She identifies with feeling able to maintain progress, which many linked to feeling DDP had become ingrained:

> "*So it's not just the therapy happens in that room, the therapy happens, not continuously…I'm not that good, you know what I mean (laughs)… but it happens more generally through our lives*" (Laura, 53-55)

The therapy appears to have been focused on families' day-to-day lives and therefore could be continued even once the sessions ended. In some cases the therapist was mindful of the impact of endings and treated them as a celebration, providing the child with a positive experience of ending a relationship. Most parents were also mindful that their children may require therapy in the future and that DDP provided a good grounding for this, "*DDP aint the end, that's the thing as well, DDP is the beginning"* (Marie, 848)

"It's a shared kind of experience you go through and come out together"

Parental involvement appeared important to all, mainly because it enabled strengthening of the parent-child connection and allowed parents to support children in regulating themselves. However, the therapist was also identified as an important part of the process and relationship.

Trust and security was described as key to improving the parent-child relationship**.** Mark describes how his involvement in therapy was considered important given the nature of his daughter's difficulties and the importance of building a secure attachment:

> "*Well, I think there are very specific issues faced by adopted children aren't there, to do with attachment...and it effects behaviour, attitudes towards relationships…so finding that security in relationships is doubly important really*" (Mark; 386-401)

Mark senses that attachment is at the core of his daughter's difficulties, realising that the remedy is in their relationship. He felt that as their relationship improved, so did his daughter's sense of security with others:

> "*My hunch is it's because she feels more secure with me, that she feels more able to be relaxed and out-going towards others…I think it's her feeling of security which enables her to open up and to blossom really*" (Mark, 367-371)

Mark describes his daughter building a safe base with him, providing a security from which she can flourish. Lina describes how such trust was built during exercises, which had a great deal of importance to her and her son:

> "*He had to jump off the cushions into Will's (adoptive father) arms and my arms or whatever. And that might seem like fun but there was an element of risk there for him, you know? He'd kind of get through and see you know, actually they will be there for me and catch me*" (Lina, 302-305)

Lina describes how her son physically had to let go and trust his parents but that this transcended into beginning to trust them emotionally.

Emotion regulation was described as a core part of the process and outcome of therapy. It was described as something shared between parent and child, for example in the way that Chloe supports her children to regulate their emotions:

> *"I want them to recognise they've been heard and because I've just done that and I've just articulated to Bella that I totally get what she's just been feeling and what she's described to me, but I'm not fixing it, it means she feels she's at one with me, so she is there with me'* (Chloe, 875-878).

Chloe and others described that children's expression of emotion could feel extreme, unpredictable or even 'shut off'. However, here she notices that her children need to feel heard, possibly because they have had experiences of not feeling heard

in the past. Skimming over their experience and 'fixing it' did not seem to help but confirming the emotion, sitting with it and managing it together did. Additionally, parents described gaining better insight into their own emotional reactions and how this affects their child, such as in Stan's case:

> "*The adrenaline goes up and the natural instinct is to shout at them...And it's reining that back and it takes a lot of self-control… And again Sonya was able to teach a lot of techniques, you know? Singing nursery rhymes, yes it calms him but it actually calms yourself as well*" (Stan, 181-186)

Stan notices that the therapy has also helped him. He becomes aware that he can be quick to react and implies that his daughter is affected by or even adopts this heightened emotion. Better understanding of his own reactions helped with self-control, and this was truly a shared experience in that emotion regulation techniques were effective for both parent and child.

Every parent spoke about **the therapist's stance** as crucial to making the therapy effective. This involved the therapist conveying core aspects of DDP. Parents described the therapist as creating a safe environment that was accepting of whatever the child bought, "*whatever goes, goes in this room, this is a safe place*" (Sam, 629). This often involved the therapist ensuring that sessions were child-led. PACE was also described as part of the therapists' stance. Mark described how his therapists' ability to make sessions playful supported his daughter to feel less guarded:

> *"Tina was quite skilled at pitching it at a level that Eloise wouldn't find too threatening because, of course, if someone's defended the last thing you want to do is challenge that defendedness too early. So she was very good at making it um, including sort of playing of games and making it fun really and Eloise responded to that"*(Mark, 126-130)

Mark highlights how difficult it must have been to accept, face and openly discuss Eloise's early life. It was therefore important that Tina made the environment comfortable, safe and playful. Jess describes how the therapist's curiosity helped to enhance her own curiosity about her daughter's mind:

> "*So if I watch Jade talking to Jasmine I can see that she's genuinely trying to think of why she's thinking, why she's feeling like that, which made me think why is she feeling like that, why is she thinking like that?"* (Jess, 363-365)

Parents also spoke about the therapist being an important support for them. For instance, Chloe describes how her therapist's non-judgemental attitude helped her feel reassured about her ability to parent:

> "*Very accepting and non-judgemental, which we had hoped for but not necessarily expected… she never made us feel in any way that we weren't competent parents*" (Chloe, 517-522)

Other parents described that having another separate mind helped them to think:

> "*But I mean the main thing is, it's somebody sitting outside, so, you know, we're too close to it and we're trying to react to our child, and we don't have the brain space, I suppose*" (Andy, 329-331)

This links with parents' abilities to think and manage their reactions when emotionally aroused. Andy describes the therapist as someone able to think when his thinking became clouded by emotion.

Discussion

This study aimed to understand experiences of APs who have completed DDP. IPA of 12 APs data revealed four superordinate themes. These included parents feeling DDP gave them increased understanding of their child and that DDP was different to anything they had tried before. Parents alluded to their feelings about DDP shifting and developing, like a journey. Finally, DDP was reflected on as a shared experience. A strength of the study is that although the sample and interventions varied in terms of time since adoption and length of DDP treatment, relatively consistent experiences were described. Each superordinate theme will be considered in relation to theory and research. Finally, limitations will be considered and implications for policy, care and research discussed.

All but one parent explained that DDP helped give them a better understanding of their child. Caregiver's understanding of the child's mind and emotional state is characteristic of many attachment-based interventions (Midgley & Vrouva, 2013) and is consistent with the DDP approach (Hughes, 2011). The relational learning framework within foster care, suggests parents' access to child's mental representations may be pivotal in understanding the child's behaviour and consequently managing it (Kelly & Salmon, 2014) and it is likely that parents were expressing a similar concept within DDP. It is hypothesised by Goldfinch (2009) that increasing parents' understanding of their child can reduce blame and "increase their effectiveness in managing the behaviour…helping the child learn to calm down and better regulate emotions" (pp. 292). This theoretical understanding is echoed in parents' experiences of DDP in that better understanding helped to remove blame, as well as help parents know how to best help their child.

Parents acknowledged feeling that their child's brain was *"different*". This fits with neurobiological research and the DDP approach which emphasises the importance of loving, early attachments as essential to brain development and ability to manage distress (Hughes & Baylin, 2012). Difficult attachment relationships are also known to have an impact on self-worth and developing self-cohesion (Mikulincer & Shaver, 2013) and parents spoke about getting a better insight into how their child saw themselves, allowing them to empathise but also respond to their child effectively.

Parents experienced DDP as a very different approach to anything they had tried or heard of before. This fits with DDP's development, where Dan Hughes identified that a different approach was required for treatment of developmental trauma (Hughes, 2014). This also fits with suggestions that traditional approaches do not give enough consideration to the neurological effects of maltreatment and neglect or emotion regulation (Casswell, Golding, Grant, Hudson, & Tower, 2014). Parents' experiences may also be reflective of the fact that many UK clinicians report using the model to fit with the

multifaceted difficulties associated with maltreatment associated psychiatric problems (Turner-Halliday et al. 2014). Parents' descriptions of DDP 'fitting' also suggest that the theories underpinning DDP have face validity.

DDP's difference included acceptance as a key concept. Parents spoke about acceptance of their child's distress and not trying to "*fix it*". Similarly, Turner-Halliday et al. (2014) discovered therapists found it helpful to remove focus on the child as the problem and support parents to accept that there is no 'quick fix'. This fits with various other theoretical and therapeutic approaches, which place acceptance at their core. Examples include, mindfulness or acceptance and commitment therapy, both of which focus on acceptance of private events as opposed to changing them (Baer, 2015).

The DDP journey was described as beginning with an initial "*cry for help*", linking to the emotional, behavioural and relational difficulties we may expect to see in children who have experienced difficult or disruptive early attachments (Mikulincer & Shaver, 2013). APs identified with feeling so overwhelmed they were willing to try DDP despite it being unknown. This fits with recent research showing that although APs report increased stress and perceived child difficulties, very few parents were receiving service input (Harris-Waller, Granger, & Gurney-Smith, 2016). Parents identified with initial feelings of scepticism about how DDP could help. Given that there is still a lacking evidence base for DDP (Turner-Halliday et al., 2014), it is reasonable that parents may have felt initially uncertain. Parents' cynicism may also be linked to more widespread stigma associated with mental health and help-seeking (Clement et al., 2015).

Over time, all but one parent felt DDP fit their situation and led to positive change. The DDP logic model (Turner-Halliday et al., 2014) identifies a number of long-term attachment goals including self-regulation, acceptance of comfort and support, managing conflict, "facing up to mistakes" (pp.4), attunement (shared affect), making sense of experiences and a coherent life story. As part of the DDP journey parents recognised progress. Many of the ways in which progress was identified link with the goals identified in the model including joint affect regulation, acceptance of comfort, feeling better able to manage conflict, making sense of the child's experiences and gaining insight into the child's history. Alternatively, Rachel felt she did not see the progress she had hoped for. This may be explained by the diverse range of complex needs experienced by looked after and adopted children, meaning there is still not complete certainty about who is most suitable for DDP (Turner-Halliday et al., 2014). As with all psychotherapy, one size will not fit all (Roth & Fonagy, 2013).

Parents also referred to DDP being emotionally challenging but worthwhile. Parents reported that DDP brought about difficult emotions for their child, emphasising the importance of the therapist maintaining a 'therapeutic window' to avoid either insufficient or overwhelming activation of affect (Becker-Weidman & Hughes, 2008). Additionally, given that DDP encompasses resolution of caregiver and therapist attachment strategies before supporting the child with theirs (Hughes, 2014), it is unsurprising that DDP was emotionally difficult for parents. It is therefore important that parents feel supported during therapy since their emotional states are likely to impact on the child, as described in transactional and dynamic approaches

(Mackler et al., 2015). Like DDP, these approaches also stress the importance of focus on parents' affect regulation when working with the parent and child.

Each parent also spoke about having significant feelings about ending treatment, and there could be multiple meanings behind this (Schlesinger, 2013). Anxiety experienced could be due to parents feeling ill equipped to continue the work or sadness might have reflected a more general struggle with ending relationships. Parents may have also come to accept the longer-term nature of attachment difficulties as shown in research, which suggests that although many adoptees 'catch-up' with their peers in terms of physical growth they may have more attachment insecurity and disorganisation in the longer term (Van Ijzendoorn & Juffer, 2006). However, along with difficult feelings about ending, most parents described also experiencing a readiness to move on.

The shared experience of DDP was relevant to every parent's story. This fits with the significance of 'intersubjectivity' within DDP to create a shared, reciprocal experience that is often missed in early neglectful or abusive relationships (Casswell et al., 2014). An environment in which trust and security between parent and child could develop was crucial to the process, supporting the idea that the child's relationships are key to helping them (Turner-Halliday et al., 2014). There have been concerns in previous writings that attachment-informed therapies, such as DDP, may encompass practices to establish adult authority, such as the child having to request everything needed from the parent to create the child's attachment to the adult who displayed authority (Mercer, 2015). Such practices did not seem to be part of the therapy experience reported by parents, which many identified as being child-led and focused on the child's needs.

The majority of parents spoke about joint emotion regulation. This is another key element of DDP, referred to as co-regulation, since many children who have experienced early trauma have difficulty with self-regulation (Hughes, 2011). It is important since theory suggests that when parents' stress levels rise they can lose their capacity to provide "empathic, attuned caregiving", described as blocked care (Casswell et al., 2014, pp. 22; Hughes & Baylin, 2012). DDP therefore aims to support co-regulation of affect through parent-child attunement, which is crucial to developing self-regulation (Schore, 2001). This also supports the DDP logic model, in which increased co-regulation is one of the core mechanisms of DDP (Turner-Halliday et al., 2014).

Finally, parents spoke about the importance of the therapist creating safety, modelling PACE and being a separate mind when parents became overwhelmed. Mikulincer and Shaver (2013) suggest that if attachment insecurities are risk factors for psychopathology then creating a sense of security, especially within attachment relationships, is important for improving resilience and mental health. Parents' experiences of therapists creating a safe environment highlight a setting within which secure relationships could flourish. Connecting with an emotionally available and responsive other allows a child to see that naming and showing emotions is acceptable (Mikulincer and Shaver, 2013). The therapist was considered to be someone who

had the "*brain space*" to support the child with this when parents became overwhelmed. The therapist also helped children manage difficulties through PACE, with the intention for this to become part of the family's approach for relationship repair and affect regulation (Casswell et al., 2014).

Findings have a range of clinical implications. They support Casswell et al.'s (2014) suggestion that there is a need for different, more relational approaches for attachment difficulties, as opposed to more traditional, behaviour-focused interventions. DDP should therefore be an accessible option for families who do not respond to more widely available approaches. However, DDP is not without difficulties. Parents identified struggling to fit DDP into busy lives and DDP being an emotional experience for them, which may not be unique to DDP (Levitt, Butler, & Hill, 2006). Parents should be given advice about the level of commitment required and help with making time, for example support with accessing time off work. DDP usually involves initial parent sessions and this may be a good time to problem solve around this and provide initial information giving. This may also help to alleviate initial feelings of uncertainty or scepticism. It may be the case that showing parents these findings helps give them an understanding and increase awareness of the level of commitment. Nevertheless, findings also highlight DDP is not likely to be the right approach for every child with attachment difficulties. For example, Rachel did not feel it was the right approach for her son, highlighting the need for regular therapy reviews that foster openness and honesty so that parent and therapist are on the same page.

Policy needs to highlight the utility of DDP for adoptive families, as made apparent in parents' accounts. Currently, policy incites stability for adoptees by advocating that adoptive families get the support they need. This became particularly evident following an increase in the adoption support fund from 2015 (Department of Education, [DoE], 2015). Given that many parents described DDP as unknown, and there was more general uncertainty about options for support, policy needs to highlight the options available, including developing an evidence base, and make them easier for families to access.

This research also has implications for future research. It provides further evidence to support a large scale RCT as requested by NICE (2015) given parents' generally positive experiences. It provides support for the idea that outcome measures may want to focus on both relational and behavioural change. NICE (2015) have recommended including measures of attachment, parental sensitivity (knowledge, understanding and emotion regulation), placement disruption and behavioural problems, all of which are supported by parents' experiences. Given acceptance was also a significant part of the experience; this may also be an important outcome to be measured. As identified by Boyer, Boyd, Turner-Halliday, Watson, & Minnis (2014) it would be difficult to find an instrument that measures all the elements of DDP and therefore a variety of measures will need to be used. The research would need to ensure consistent intervention was provided across all participants, providing transparent methods, analysis and results. Larger-scale research is especially important given parents reports of initial scepticism, which may have been exacerbated by lack of evidence.

Although much effort was made to ensure maximum reflexivity, quality and credibility, there are some limitations to this research. For instance, the sample may consist mostly of parents who had good experiences of DDP since clinicians may have put forward clients whose therapy was a 'success'. Alternatively, parents who had good experiences may have put themselves forward. Furthermore, DDP is not a manualised treatment and therefore it is difficult to ascertain the degree to which treatment varied. The sample itself was not particularly diverse, including mainly White British, married (or co-habiting) parents between 37-61 years meaning the experiences of younger parents, single parents and ethnic minorities were not captured. However, the demographics captured within this sample are somewhat typical of APs in the UK (DoE, 2016). Other demographics such as social-economic status, level of education, length and stability of relationship and children's pre-adoption histories were not captured and may have impacted on how parents responded to therapy.

In conclusion, interpretation of APs' experiences of DDP found four superordinate themes encompassing increased understanding of the adoptee's mind and how to help. DDP was seen as different in regards to how well it fit and the focus on acceptance. It was spoken about as a journey, starting with uncertainty, scepticism and wanting to see the evidence. However, once parents saw evidence of change they became committed to, what some described as, a difficult journey. Endings were also a significant part of parents' experience, invoking a range of feelings. Finally, DDP was seen as a shared experience, which was crucial in building trust and security and for co-regulation. The therapists' stance was also an important part of the experience. There are implications for clinical practise and these results warrant further investigation into DDP.

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Appendix A

Author Guidelines: Journal of Family Psychology

Submission

Please submit manuscripts electronically, either using Microsoft Word (.doc) or Rich Text Format (.rtf) via the Manuscript Submission Portal.



Barbara Fiese, Incoming Editor
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General correspondence may be directed to the Editor's Office.
Do not submit manuscripts to the Editor's email address.
In addition to addresses and phone numbers, please supply electronic mail addresses and fax numbers, if available, for potential use by the editorial office and later by the production office.
Keep a copy of the manuscript to guard against loss.

Article Requirements

For general guidelines to style, authors should study articles previously published in the journal.
All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.
The manuscript title should be accurate, fully explanatory, and preferably no longer than 12 words. The title should reflect the content and population studied (e.g., "family therapy for depression in children"). If the paper reports a randomized clinical trial, this should be indicated in the title, and the CONSORT criteria must be used for reporting purposes.
Research manuscripts and review and theoretical manuscripts that provide creative and integrative summaries of an area of work relevant to family psychology should not exceed 30–35 pages, all inclusive (including cover page, abstract, text, references, tables, figures), with margins of at least 1 inch on all sides and a standard font (e.g., Times New Roman) of 12 points (no smaller). The entire paper (text, references, tables, figures, etc.,) must be double spaced. References should not exceed 8 pages.
Brief reports are encouraged for innovative work that may be premature for publication as a full research report because of small sample size, novel methodologies, etc. Brief reports also are an appropriate format for replications and for clinical case studies. Authors of brief reports should indicate in the cover letter that the full report is not under consideration for publication elsewhere. Brief reports should be designated as such and should not exceed a total of 20 pages, all inclusive. References should not exceed 8 pages.
Manuscripts exceeding the space requirement will be returned to the author for shortening prior to peer review.
All research involving human participants must describe oversight of the research process by the relevant Institutional Review Boards and should describe consent and assent procedures briefly in the Method section.
It is important to highlight the significance and novel contribution of the work. The translation of research into practice must be evidenced in all manuscripts. Authors should incorporate a meaningful discussion of the clinical and/or policy implications of their work throughout the manuscript, rather than simply providing a separate section for this material.

Masked Review

The *Journal of Family Psychology*® uses a masked reviewing system for all submissions. The cover letter should include all authors' names and institutional affiliations. However, in order to permit anonymous review, the first page of text should omit this information. This cover page should only include the title of the manuscript and the date it is submitted.

Please make every effort to see that the manuscript itself contains no clues to the authors' identities.
Please ensure that the final version for production includes a byline and full author note for typesetting.

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Authors should indicate in their cover letter that the work has not been published previously and is not under consideration for publication elsewhere. The relationship of the submitted manuscript with other publications and/or submissions of the author, if any, should be explained.
The cover letter should include a statement indicating that the manuscript has been seen and reviewed by all authors and that all authors have contributed to it in a meaningful way.
The cover letter must include the full mailing address, telephone, fax, and email address for the corresponding author.

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The *Journal of Family Psychology* requires the use of the CONSORT reporting standards (i.e., a checklist and flow diagram) for randomized clinical trials, consistent with the policy established by the Publications and Communications Board of the American Psychological Association.
CONSORT (Consolidated Standards of Reporting Trials) offers a standard way to improve the quality of such reports and to ensure that readers have the information necessary to evaluate the quality of a clinical trial.
Manuscripts that report randomized clinical trials are required to include a flow diagram of the progress through the phases of the trial and a checklist that identifies where in the manuscript the various criteria are addressed. The checklist should be placed in an Appendix of the manuscript for review purposes.
When a study is not fully consistent with the CONSORT statement, the limitations should be acknowledged and discussed in the text of the manuscript. For follow-up studies of previously published clinical trials, authors should submit a flow diagram of the progress through the phases of the trial and follow-up. The above checklist information should be completed to the extent possible, especially for the Results and Discussion sections of the manuscript.
Visit the CONSORT Statement Web site for more details and resources.

Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* (6th edition).
Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).
Review APA's Checklist for Manuscript Submission before submitting your article.
Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*.
Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.
To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

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- **Authored Book:**
  Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach*. Cambridge, MA: MIT Press.
- **Chapter in an Edited Book:**
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Appendix B

Measures of Parenting Stress in the Adoption Literature

Parenting stress index

Use: To identify parent-child problem areas

Age Range: 0-12 years

Estimated completion time: 20-30 minutes

Number of Items: 120

Normative data: Normative data includes mothers (n = 534) and fathers (n = 522) stratified to match the demographic composition of the 2007 U.S. Census.

Reliability: Test-retest reliability coefficients ranged from .55 to .82 for the Child Domain, from .69 to .91 for the Parent Domain, and from .65 to .96 for the Total Stress score. Reliability coefficients for the two domains and the Total Stress scale were .96 or greater.

Validity: Validity investigated in studies focused on at-risk children, attachment, ADHD, child abuse, forensic contexts, medical treatment adherence, substance abuse, parental depression, and more (Abidin, 1990).

Scoring:

Normal Range = raw score of 180-250 (total score) i.e. approx. 15-80th percentile

Raw score > 260 = high

Extremely low score (raw score <175) can be false negative

Child domain

Overall high score = 122 (associated with children who make it difficult for parent to fulfil their role)

Adaptability: 31 = high score

Acceptability: 17=high score

Demandingness: 24=high score

Mood: 13=high score

Distractibility/hyperactivity: 31= high score

Reinforcement: 12=high score

Parent domain

Overall high score =153 (indicates source of stress/dysfunction related to parents' functioning)

Depression: 27=high score

Attachment: 16=high score

Role restrictions: 26 = high score

Competence: 37 = high score

Social isolation 18=high score

Spouse Relationship: 23 = high score

Health: 16=high score

Defensive Responding is clinically significant when the score is 24 or less.

Parenting Stress Index-Short Form

Use: Used to identify parent-child problem areas in a shorter time

Age Range: 0-12 years

Estimated completion time: 10 minutes

Number of Items: 36

Domains: Parental Distress (PD), Parent-Child Dysfunctional Interaction (P-CDI), and Difficult Child (DC). Also provides an overall Total Stress Scale and calculates a defensive responding score (clinically significant when raw score is 10 or lower).

Normative data: 570 mothers selected from a well-care paediatric practice in Virginia, US and 270 mothers from the same practice. Age of Children: 10-84 months (M=43, SD=9.7); Gender: 47% female, 53% male; Children's ethnicity: 87% White, 10% African American, and 3% Other; Marital status: 88% married, 6% single, 4% divorced, and 2% separated; Education: 8th grade or less (22.5%), 9th-12th (37.4%), vocational or some college (37.4%), and college graduates (37.4%) (Abidin, 1995)

Reliability: Normative sample Chronbach's Alpha: Total Stress (.91), Parental Distress (.87), Parent-Child Dysfunctional Interaction (.80), Difficult Child (.85) (Abidin, 1995)

Validity: The PSI/SF was developed from factor analysis of the PSI-Full-Length Version. Principal components factor analysis with a varimax rotation was conducted, and items were retained based on the criteria of having factor loadings >.4 on only 1 factor (although some exceptions were made to this criteria). Data from a second sample was used to replicate the factor analysis. The PSI/SF has been found to correlate with the Full-Length form: Total Stress and Total Stress=.94, Parental Distress and Parent Domain=.92, Difficult Child and Child Domain=.87. Evidence of reliability and validity in the following populations: developmental disability, lower socio-economic status, rural populations, African Americans. ((Abidin, 1995).

Scoring:

16th-84th percentile=normal range

85th-89th percentile=high range

> 90th percentile= clinically significant range

Cut-off for Raw Scores:

Defensive Responding <11

Parental Distress > 35

Parent-Child Dysfunctional Interaction (PD-CDI) >32

Difficult Child (DC) >35

Total Stress >101

Relational frustration index (RFI) in the Parenting Relationship Questionnaire (PRQ)

Use: to capture a parent's perspective on the parent-child relationship.

Age Range: preschool (PRQ-P) 2-4 years; child/adolescent (PRQ-CA) 6-18 years

Estimated completion time: 10-15 minutes

Number of Items: 36

Normative Data: 4,130 parents of males and female students that matched U.S. census

Reliability: The median test-retest correlation for PRQ-P is .81 and PRQ-CA is .79

Scoring: T score above 60 = significantly above average range, T score above 70 = upper extreme range. On the RFI scores two or more standard deviations above the mean signify elevated stress.

Is the RFI a measure of parenting stress? : The authors define relational frustration as "The parent's level of stress or distress in relating to or controlling the behaviour and affect of the child, along with the tendency to be over-reactive and frustrated in common parenting situations"

The Nijmegen Child-Rearing Questionnaire (NCSQ)

Use: to measure parental stress. The NCSQ is a Dutch instrument composed of several parts, each of which represents a different aspect of a problematic child-rearing situation. Part A measures subjective parental stress.

Age Range: Children up to 14

Number of items: Part A includes 46 items

Normative Data: Unable to establish information on the normative sample

Reliability: The Dutch Test Committee judged the reliability of the NVOS as "good," referring to internal consistency reliabilities of > 0.90 and test-retest stability of > 0.70.Construct validity was judged as sufficient (Evers, Van Vliet-Mulder,&Groot, 2000).

Subscales: (1) whether she (or he) accepts the child, (2) the way she copes with the situation at home, (3) the amount of problems she has with the child, (4) her need for change, (5) the amount of strain from interacting with the child, (6) whether or not she has to manage in the parenting situation alone, (7) whether she derives pleasure from interactions with the child, and (8) whether she has a positive relationship with the child. Adequate internal consistency, test-retest reliability and adequate validity of these subscales have been demonstrated according to the authors.

Stress Index for Parents of Adolescents (SIPA)

Use: measure parenting stress in parents of adolescents

Age Range: 11-19 years

Estimated completion time: 20 minutes

Number of Items: 112

Domains: Adolescent Domain (moodiness/emotional lability, social isolation/withdrawal, delinquency/anti-social, failure to achieve or persevere), Parent-Domain (life restrictions, relationship with spouse/partner, social alienation, incompetence/guilt), Adolescent-Parent Domain, Life Stress Scale, and Total Parenting Stress.

Reliability: 778 parents of adolescents in the US. Attempted to meet 1997 U.S. census but overall sample not 'representative for race and socioeconomic status (SES)'. More mothers and parents with higher SES. 79% parents Caucasian (Lambert, 2001).

Validity: Factorial validity for two subscales (Parent Domains, Adolescent Domains) was tested from two approaches: principal component and maximum likelihood factor analysis with varimax rotation. The SIPA's Adolescent Domain, Parent Domain, Adolescent Parent Relationship Domain, and Index of Total Parenting Stress correlated -.42, -.65, -.63, and - .67, respectively, with the Dyadic Adjustment Scale. These same SIPA scales correlated -.33, -.49, -.57, and - .53, respectively, with the Family Adaptability and Cohesion Evaluation Scales-Ill. Additionally, the SIPA scales correlated -.50, -.71, -.79, and -.74, respectively, with the Index of Total Parenting Stress and the Parenting Alliance Inventory (Lambert, 2001)

Scoring:

Less than 85th percentile = within normal limits

Above 85th percentile = borderline

Above 90th percentile = clinically significant

Above 95th percentile = clinically severe.

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Appendix C

Data Extraction Tool

Data
Study Information
Citation - Authors - Date - Title - Journal, volume, page - DOI
Location
Method
Study objective (in relation to parenting stress)
Participants (parents) characteristics - *n* - Age - Sex - Ethnicity - Socio-economic status - Education - Number of children - Length of time as adoptive parent - Marital status/ relationship duration - Sexual Orientation - Religiosity - Health/service involvement - Household size/number of parents
Adoptive child characteristics - *n* - Age at adoption - Age at study - Sex - Health/diagnosis - Pre-adoption history (including institutionalisation) - Ethnicity or country of origin
Recruitment Procedure
Design Method

Parenting Stress Measure

Time points

Who completed the measure?

Analysis
Statistical Analysis

Results
Parenting Stress Scores

Additional Findings (relevant to parenting stress)

Discussion
Conclusions

Limitations

Further information

Appendix D

Quality Checklist Based on Downs & Black (1998)

Study:	
Aim clearly described?	
Main outcomes to be measured clearly described? Characteristics of patients clearly described? Confounders described?	
Main findings clearly described? (simple outcome data should be given) Non-normally distributed data: Are inter-quartile ranges reported?	
Normally distributed data: Are standard error, standard deviation or confidence intervals reported?	
(Where relevant to parenting stress)	
Have characteristics of participants lost to follow-up been described?	
Have actual probability values been reported? E.g. p=	
(Where relevant to parenting stress)	
Was the sample representative of the population?	
Was the sample who *actually* participated representative?	
If any of the results of the study were due to data dredging was this made clear?	
Were the lengths of follow-up the same for all?	
Were the statistical test used to assess the main outcomes appropriate?	
Were the main outcome measures used accurate (valid and reliable)?	
Were participants in difference groups recruited from the same population?	
Was there adequate adjustment for	

confounding in the analyses from which the main findings were drawn?

Were losses of participants taken into account?

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%.

(where relevant to parenting stress)

Appendix E

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Book:

McBee, L. (2008). Mindfulness-based elder care: A CAM model for frail elders and their caregivers. New York: Springer.

Book Chapter:

Singh, N.N., Winton, A.S.W., Singh, J., McAleavey, K., Wahler, R.G., & Sabaawi, M. (2006). Mindfulness-based caregiving and support. In J.K. Luiselli (Ed.), Antecedent assessment and intervention: Supporting children and adults with developmental disabilities in community settings (pp. 269-290). Baltimore, MD: Paul H. Brookes.

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Appendix F

Treatment of Developmental Trauma

As acknowledged within the paper, there are a number of interventions aimed at working with children who are likely to have experienced some form of developmental trauma and their families. Most treatment with children who have experienced developmental trauma will involve other members of the family in some capacity (Hoyle, 1995). This is likely to be because attention will need to be paid to interpersonal and attachment issues (Pearlman & Courtois, 2005). The therapeutic relationship is also therefore a crucial element of the therapy to help in providing new/different internal working models of other (Pearlman & Courtois, 2005).

Given the importance of the interpersonal relationship in therapy, there is a great deal of evidence supporting systemic or family therapy for 'child-focused problems' that may be associated with developmental trauma; including difficulties with sleeping and eating, attachment difficulties, previous child abuse and/or neglect, conduct disorders, mental health difficulties including depression, anxiety, psychosis, self-harm, eating disorders and somatic difficulties (Carr, 2014). Family therapy is therefore a well-supported intervention for use in families where an adopted child may experience one or more of the above. However, there is also some evidence for individual treatments for the child suffering from traumatic memories, such as eye movement desensitization and reprocessing (EMDR; Greenwald, 1998) and for treatment that focuses on interventions specifically for parents. One such example is the Nurturing Attachments Group, which may help to increase attachment-focused parenting skills (Golding, 2013).

In recent years cognitive behavioural approaches have been demonstrated as useful with children who have experienced developmental trauma. One systematic review found trauma-focused cognitive behavioural therapy to be the best-supported treatment for this group (Leenarts, Diehle, Doreleijers, Jansma, & Lindauer, 2013). There has also been recent evidence for third wave approaches, such as dialectical behavioural therapy, to working with developmental trauma (Andrew, Williams, & Waters, 2014).

Attachment-based interventions are also frequently used with foster and adoptive families who experience difficulties (Kerr & Cossar, 2014). They almost always involve the child and their primary caregiver(s). A form of play therapy known as Theraplay (Booth & Jernberg, 2009) is one such intervention, which aims to develop or improve attachment relationships between caregiver and child. It is a short-term therapy in which the caregiver leads and encourages the child to play and interact in a way that is indicative of a secure attachment. It is hoped that this will enable the child to feel comfortable with a caregiver taking the lead in a safe way. Theraplay has shown to improve children's self esteem, emotion regulation and trust in themselves and others (Wettig, Franke, & Fjordbak, 2006). There is also evidence to suggest it is useful with adoptive families (Weir, Lee, Canosa, Rodgrigues, McWilliams, & Parker, 2013).

Attachment and biobehavioural catch-up is another attachment-based intervention aimed specifically at working with disorganized attachments. It helps caregivers to create a predictable world for their child and assists them to understand their child's behaviour. The treatment has shown to increase levels of secure attachment and reduce levels of disorganized attachment (Bernard, Dozier, Bick, Lewis-Morrarty, Lindhiem, & Carlson, 2012). As well as those outlined above there are numerous other specific attachment focused interventions available, including mentalization-based therapies (Midgley & Vrouva, 2013) and other specific child-parent psychotherapies (Lieberman, Ippen, & Van Horn, 2006). Dyadic Developmental Psychotherapy is one of these.

References

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Appendix G

Further information of Dyadic Developmental Psychotherapy

Dyadic Developmental Psychotherapy (DPP) is a form of psychotherapy created for families of children, either fostered or adopted, who have experienced developmental trauma, which may include neglect and/or abuse (DDP Network, 2017). It is a family-based treatment and involves the child and their caregiver(s). DDP helps to identify the adaptive ways of thinking, feeling and behaving that children have learnt to help them survive in their early life, which may be identified as challenging or distressing in the context of a new family (DDP Network, 2017). It helps parents and children to understand these thoughts, feeling and behaviours, where they have come from and how parenting around these might be different from traditional methods, which often pre-assume that the child trusts and feels safe with their parents (DDP Network, 2017).

DDP aims to facilitate attachment security between the child and parents (Casswell, Golding, Grant, Hudson, & Tower, 2014). It teaches parenting through playfulness, acceptance, curiosity and empathy (PACE; DDP Network, 2017). It is hoped that if a parent can show curiosity into their child's mind, emotional world and behaviour and demonstrate empathy and acceptance of this, the parent will not only get a better understanding of their child but may feel better able to regulate their own emotions when behaviours may feel challenging for them. This can also help the child to feel accepted, as part of a process of developing trust and security. DDP uses present subject and concerns arising in the therapy space to "discover positive qualities in the child, provide emotional regulation and facilitate a new understanding of why the child has needed to use distrustful, defensive and controlling behaviours in order to keep safe" (Casswell et al., 2014, pp. 20). The therapist uses the PACE stance to try and understand the child and communicate their understanding back. The therapy space promotes co-regulation of emotion and co-construction of meaning in relation to the child's past or present experiences. The therapist will tend to use an affective-reflective dialogue. That is, speaking about feeling and thinking. The therapist will support the parent and child in doing this together so that is becomes "a shared process between parents, child and therapist" (Casswell et al., 204, p. 20). The idea is that parents will be supported to expand the strategies that they learnt in the therapy room outside into their day-to-day parenting. This can require parents gaining insight, with support of the therapist, into their own attachment history and needs to develop a better understanding of the triggers that may reduce their mentalizing ability and emotion-regulation (Casswell et al., 2014).

The structure of therapy usually begins with individual sessions for parents to promote engagement, gain insight into the therapeutic approach and process and for parents to start to understand the role they play in parenting. The child later joins sessions for all of the above to take place.

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Appendix H

Maltreatment Associated Psychiatric Problems

Bowlby's (1988) attachment theory focuses on the significance of the caregiver-child relationship in the early stages of life. It emphasises that safety is a core theme in all good attachment relationships and that the caregiver-child relationship helps the child to construct an internal working model of themselves, others and the world. If this relationship is disruptive or unsafe, as in the case of early developmental trauma, the child may learn to develop negative understandings of self and see others as frightening, incompetent or unpredictable. Lack of parental responsiveness and warmth may make a young person doubt their self-worth and fail to develop self-cohesion, influencing how they relate to others (Mikulincer & Shaver, 2013). Children with a history of early trauma are also at risk of social withdrawal, rejection and feelings of incompetence (Finzi, Cohen, Sapir, & Weizman, 2000). There is also greater risk of externalizing behaviours (Fearon, Bakermans-Kranenburg, Van IJzendoorn, Lapsley, & Roisman, 2010).

Children who have experienced maltreatment or neglect may also have more difficulty understanding and regulating emotions since their emotional needs may not have not been adequately understood and responded to (Steele, Steele, & Croft, 2008). Therefore, developmental trauma is strongly associated with risk of mental illness. Links have been found between insensitive attachment figures and development of personality disorder, schizophrenia, depression, anxiety, suicidal tendencies, eating disorders, post-traumatic stress disorder and obsessive-compulsive disorder (Mikulincer & Shaver, 2013). These children are more likely to be diagnosed with an attachment disorder (Hanson & Spratt, 2000) and these effects are not just seen in childhood but can impact an individual for the rest of their life (Becker-Weidman & Hughes, 2008).

These difficulties can also lead to disorganised attachment behaviours, causing difficulties in forming and sustaining relationships (McAuley & Davis, 2009). It is common for children who have been through the care system to have multiple caregivers and placement instability (McAuley & Davis, 2009), which may increase difficulty in trusting others, particularly caregivers. Therefore, although the care system, fostering and adoption are processes developed to safeguard children and provide opportunities for safe relationships, newly developing attachments can be disrupted due to the child's difficulty trusting caregivers.

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Appendix I

Additional Information on Reactive Attachment Disorder

Reactive attachment disorder (RAD) is "a markedly disturbed and developmentally inappropriate social relatedness in most contexts that began before age 5 and was associated with grossly pathological care" (American Psychiatric Association, [APA], 2000, p. 127). RAD was previously split into inhibited and disinhibited types (APA, 2000). Inhibited RAD is diagnosed if a child demonstrates inhibited, emotionally withdrawn behaviour towards caregivers and others. The child may not seek or respond to comfort and may show unexplained irritability, fear or sadness in nonthreatening caregiving situations. Disinhibited RAD is diagnosed when a child approaches and interacts with unfamiliar individuals, becoming overly-familiar and not checking back with their caregiver. The most recent diagnostic manual however no longer differentiates between the two types (APA, 2013) and a diagnosis of RAD is given if a child is emotionally withdrawn in regards to adult carers. There may be minimal social response to others, reduced positive affect, unexplained irritability, sadness or fear when interacting with caregivers (Leroux, Terradas, & Grenier, 2017). If a child presents as more disinhibited in relationships they are now given an alternative diagnosis of Disinhibited Social Engagement Disorder. Many agree that attachment disorders are a useful construct to describe young people with severe relational difficulties whilst others doubt the construct validity of the diagnoses (Leroux, Terradas, & Grenier, 2017).

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Appendix J

Theory of Interpretative Phenomenological Analysis (IPA)

What is IPA? IPA is "a qualitative research approach committed to the examination of how people make sense of their major life experiences" (Smith, Flowers, & Larkin, 2009, p. 1). IPA is especially interested in the lived experience of an individual and the particular significance this takes on. IPA aims to engage in individual's reflections of these significant experiences and then make sense of this experience (Larkin & Thompson, 2012). This making sense involves some interpretation and thus, IPA is informed by hermeneutics; the theory of interpretation (Smith et al., 2009). Since the researcher then attempts to make sense of the account given by the participant, IPA is said to be 'double hermeneutic'. IPA is also said to be idiographic as it attempts to capture the unique individual experience and sense made of it. It is therefore also important that IPA acknowledges the similarities and differences between cases. Semi-structured interviews are also important to allow for the participant to take the lead in directing the conversation, since it is their experience that is to be captured and not shaped by the researcher. The following are seen as the core theoretical underpinnings of IPA.

Phenomenology. Phenomenology is "a philosophical approach to the study of experience" (Smith et al., 2009, pp.11). It is key to IPA as it is the philosophy of examining and understanding a lived experience. The work of Husserl, Heidegger, Merleau-Ponty and Sartre are described by Smith et al. (2009) as core to phenomenological philosophy. Their ideas help to establish the importance of understanding experience but importantly the individual perceptions of experience. They highlight the importance of not just understanding individuals' descriptions of experience but their interpretation, meaning-making and involvement in the experience.

Hermeneutics. This is the theory of interpretation. Hermeneutics takes the view point that humans attempt to make sense of experiences and therefore, individual's accounts of experience will give insight into the sense they have tried to make of it. Early theorists, such as Schleiermacher (Smith et al., 2009) spoke of the importance of grammatical and psychological interpretation of script as well as understanding the techniques and intentions of a writer, giving consideration to the context within which text has been produced. Smith et al. (2009) suggest that the researchers ability to do this, from a different perspective, can produce analyses of data that both goes beyond and includes the experience explained by the author/participant. It is hoped that IPA can capture both what the participant speaks about explicitly and that which may be more latent (Larkin, Watts, & Clifton, 2006).

The hermeneutic circle is also relevant to IPA. This takes into consideration the importance of the relationship between parts (of a transcript or piece of text) and the whole. It considers how individuals words, sentences, pauses, and extracts contribute to understanding the whole, whilst grasping the overall meaning of the whole is important to making sense

of particular parts of the transcript. IPA attempts to use this idea by interpreting not just the overall meaning of a piece of text, but making sense of its individual parts.

Idiography. Idiography is "concerned with the particular" (Smith et al., 2009, pp. 29). This encompasses gathering a rich detail throughout analysis as well as understanding the particular experiences of one person. This is why IPA emphasises the importance of a small, homogenous sample, so as to commit to gather the perspective of a particular type of person in a particular situation.

Why was IPA chosen for this study?

When wanting to gather an in-depth, detailed understanding of a phenomenon there are numerous qualitative methods that can be used. These may include ethnography, discourse analysis, grounded theory and narrative analysis. Ethnography is an "eclectic methodological choice, which privileges an engaged, contextually rich and nuanced type of qualitative social research, in which fine grained daily interactions constitute the lifeblood of the data produced" (Falzon, 2016, pp.1). It involves field techniques, such as observation and note taking and typically involves a relatively long-term absorption in the field site of choice. Thus, ethnography may not be appropriate for research into therapeutic techniques, such as Dyadic Developmental Psychotherapy (DDP), which emphasises the importance of the therapeutic relationship between the parent, child and therapist. Involvement of the researcher as an additional participant in therapy could undermine the entire therapeutic process.

Discourse analysis focuses on the use of language around a certain experience and its function. Some forms of discourse analysis look at the content of language used to describe a particular phenomenon and others look at the grammar and structure used (Gee, 2014). Since the current study was not particularly interested in the use of parent's language around DDP, but rather their experiences of DDP, discourse analysis was not felt to be appropriate by the researcher.

Grounded theory aims to develop a theoretical-level explanation of a certain phenomenon (Strauss & Corbin, 1997). It usually therefore begins with a question about theory that is answered by building up from the data. It does not tend to be used with research on phenomenon which have an existing theoretical framework. Given that the theoretical basis and grounding for DDP is well understood, grounded theory was not felt to be a useful way of interpreting the experience of families undergoing DDP.

Narrative analysis focuses on the process of storytelling in and of itself (Labov & Waletzky, 1967) with a specific focus on the content of what is being said. Although this could be helpful in gaining a narrative perspective of DDP for parents, the current study is primarily focused on the lived experience, personal meaning and sense making of parents within DDP. Therefore, IPA was considered by the researcher to be the most appropriate method for analysing interviews with adoptive parents who had undergone DDP when wanting to gain insight into their experiences of the treatment.

Limitation of IPA

Although IPA was felt to be the most appropriate form of analysis for the current study, it is not without its limitations. The limitations of a method of analysis are important to understand before starting on the journey to ensure the researcher understands all potential pitfalls and complications that may arise along the way.

Overall, there are variations in the way in which IPA is used within the literature, as outlined by Clarke (2009), and therefore there is not one specific way of undergoing IPA. It has been identified that it has not always been clear to researchers how much they should interact with the data and participant at each stage and at what point to start interpreting data during collection, transcription and analysis (Brocki & Wearden, 2006) meaning that there can be variations in the level of depth that different researchers go in to. However, as identified by Brocki and Wearden (2006) this is an issue with many forms of qualitative research in that if strict guidelines are offered, the argument often arises that good qualitative research cannot be completed by following strict guidelines. This does mean that what counts as 'good' qualitative research can be somewhat ambiguous, idiosyncratic and indefinable (Brocki & Wearden, 2006). However, there is consistent agreement that good IPA involves the researcher openly identifying their own preconceptions and the role of their own interpretations in the analysis (Brocki & Wearden, 2006).

Although not necessarily presented as one of the core features of IPA, another criticism of the method is that IPA cannot support a researcher in identifying causal explanations (Willig, 2008). Given that the current research is not interested in identifying causal factors, this is not anticipated to be a problem. However, in regards to the practicalities of completing IPA, the data analysis can be a lengthy process due to the level of depth of interpretation required (Clarke, 2009). Therefore, it is important that sufficient time is set aside to ensure detailed engagement with and interpretation of data.

Finally, to date IPA has been mostly used within health psychology. Its use in other fields of psychology and health care is still relatively new and therefore unexamined (Clarke, 2009). This means new or different difficulties may emerge during data analysis and that the researcher may need to be open-minded about this.

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Appendix K

Semi-structured interview schedule

Interview Schedule

Adoptive Parent's Experiences of Dyadic Developmental Psychotherapy

Introduction and Engagement:

Explain the study and the rationale. Explain what sort of questions will be asked. Gain consent and explain confidentiality (and when this might need to be broken). Ask if the participant has any questions or if they would like breaks during the interview. For example: "You have been invited to take part in this study as an adoptive parent who has completed DDP with your child. This piece of research aims to understand your experience of DDP since very little research has been conducted on this. I will ask you some questions to try and encourage discussion of your experience of DDP but I will mainly leave you to discuss your experience and views openly. For this reason, many of the questions will be open-ended and broad.

Everything discussed in this interview will be stored on this encrypted Dictaphone and transcribed using pseudonyms. If I feel I need to share anything that we speak about here today, In the interest of your own safety or that of others, I will discuss this with you first. Before I ask you the first question, I have some information about you to gather. This will be kept separately from your recording and transcript so that you remain anonymous (collect demographics). Before we begin do you have any questions? And would you like breaks during the interview (and if so how frequently)?"

Record Demographics:

Age, gender, ethnicity, time since adoption, how far into adoption did referral to DDP occur and number of DDP sessions.

Interview:

Main questions in bold; prompts (not in bold) to be used if participant is struggling to provide information

Introductory questions:

What does DDP mean to you?

How did you come to be involved in DDP?

What were you initial thoughts and feelings about DDP?

What did it mean to you to be offered DDP and what did you think it would be like?

What happened next?

About the therapy:

What was your experience of starting DDP?

What were your thoughts/feelings/emotions toward DDP/yourself/your family at this stage?

What was it like for you to do this work?

How did you experience sessions?

What did you make of the skills/techniques given?

How did you experience the DDP therapist?

What was your experience of DDP compared to other therapies (if received)?

How did you experience DDP as impacting on your parent-child relationship?

What thoughts/feelings/emotions did you experience in regards to your relationship?

What was it like to be an adoptive parent completing DDP?

Ending therapy:

What was your experience of ending DDP?

How would you describe your thoughts, feelings and emotions related to ending DDP?

Tell me about the impact of DDP for you.

Has your experience of DDP changed over time?

How would you sum up your experience of DDP?

Is there anything else important about your experience of DDP that you want to tell me?

Prompts throughout: Could you tell me more? Could you tell me what you mean by... What did that mean to you? What did you think/feel about that? How did you make sense of that?

Ending Session:

Offer participant opportunity to ask questions or discuss any issues that have been raised. Ask participant if they would like any further support regarding completion of the interview.

Debrief:

For those who require signposting for further support provide contact details of Dr Ben Gurney-Smith: ben.gurneysmith@adoptionplus.co.uk.

Appendix L

Email to DDP clinicians

Subject: DDP research

Dear …

Hello, my name is Megan Wingfield and I am a trainee Clinical Psychologist on the Oxford Doctoral Course in Clinical Psychology.

I am emailing you as I am planning to undertake some research looking into adoptive parents' experiences of DDP with Dr Ben Gurney-Smith (DDP Board Member). I am therefore looking for practitioners to help me with recruitment.

It is likely that you already know that some quantitative research on DDP has and is being undertaken. However, there is currently no qualitative research looking at the experiences of those who have completed DDP. I am hoping to do this by interviewing adoptive parents who have completed the treatment either in person or over Internet video calling (such as Skype).

I am aiming to gather the experiences of around 12 adoptive parents and it would be a great help if you would be willing to help me to identify participants. If you may be able to help me to recruit please contact me via email (**megan.wingfield@hmc.ox.ac.uk**) or on my mobile: **07771735152.**

Please find attached an information sheet that can be given to potential participants.

The information gathered from this study can help to provide further insight into the experience of DDP for this population and help us to better understand why and how it can be helpful.

Many thanks for taking the time to read this.

I look forward to hearing from you,

Megan

Appendix M

Participant Information Sheet



Doctoral Course in Clinical Psychology

Megan Wingfield

Oxford Doctoral Course in Clinical Psychology

Isis Education Centre, Warneford Hospital, Oxford OX3 7JX

PARTICIPANT INFORMATION SHEET

Adoptive parents' experiences of Dyadic Developmental Psychotherapy (DDP).

You are invited to take part in a research study looking at adoptive parents' experiences of DDP. This information sheet provides you with the relevant information about the study before deciding to take part.

Please take time to read this information carefully and discuss it with others if you wish. If you have any queries, please do not hesitate to contact me, Megan Wingfield, via email megan.wingfield@hmc.ox.ac.uk.

What is the purpose of the study?

This study aims to understand the experiences of adoptive parents who have completed DDP and to develop our understanding of how this increasingly widespread intervention can be evaluated.

Why have I been invited?

You are being invited to take part because you have been identified by a DDP clinician as having experienced DDP. I am hoping to involved at least 8-12 parents who have undergone DDP.

Do I have to take part?

There is no obligation to take part in this research. If you choose to take part, please send an email to Megan.Wingfield@hmc.ox.ac.uk or telephone **07771735152** as soon as is conveniently possible. I will arrange a time to speak over the telephone, Skype or meet with you to go through the information sheet and for you to ask any questions you might have.

If you are happy to proceed, I will ask you to sign a consent form and arrange a date to interview you about your experiences of DDP. If we meet over Skype or the telephone I can scan or post the consent form for you to sign.

You will be given £10 for your time. You will be free to withdraw without giving a reason at any time during the interview. If you decide not to take part, there will be no consequences for you and this will not affect your care.

What will happen to me if I decide to take part?

You will be contacted to arrange a face-to-face interview or an interview over video call. If we meet in person this can occur either at your home or at AdoptionPlus, MK16 0FJ.

The interview will be semi-structured and will ask questions that are aimed at encouraging you to share your own views and experiences of DDP. The interview will last no longer than 90 minutes. The interview will be audio recorded (or potentially video recorded if over the internet).

Prior to the interview you will be asked to sign a consent form, which you will be given a copy of, along with the information sheet. The interview will be recorded on a secure encrypted dicta-phone. This interview will then be transcribed anonymously at a later date by the researcher or an individual transcriber. All data will be securely stored and later destroyed in accordance with University of Oxford ethics. After the interview you will have time for questions.

Once the research is complete, if you are interested, I will share the findings with you and offer you a written summary of the results.

Are there any possible disadvantages or risks from taking part?

One potential disadvantage of taking part in the interviews is that it will take up some time and given that this is a sensitive topic, you may choose to reflect on difficult times. You will not be made to talk about anything that you do not want to. If this is the case the interview can be stopped at any time and you can discuss the impact of the interview with us. You will also be given information on available support after the interview.

What are the possible benefits of taking part?

The information gathered from this study will provide information about DDP to researchers, which will help to inform understanding of DDP and encourage further research. The findings may affect future clinical practice for foster and adoptive children and parents, like yourselves. We do not know what the outcome of this research with be.

Will my taking part in the study be kept confidential?

All recordings will be kept on an encrypted dicta-phone meaning that access to recordings will require a password. Only the researcher and the research team will have access to the interviews. The only other person who may hear your interviews is an independent transcriber. All information about you will be kept anonymous and a pseudonym

will be used throughout the research in place of your name and any personal details associated with your recording and transcript will be kept separate. Recordings will be destroyed once written up.

Any quotes or references used will not be identifiable; though it is possible you may recognise your own quotes. No one else will be able to identify it as yours. If there is a need to disclose information you provide, because there is concern of harm to yourself or others, this will be explained to you first.

Responsible members of the University of Oxford may be given access to data for monitoring and/or audit of the study to ensure that the research is complying with applicable regulations.

What will happen if I don't want to carry on with the study?

Participation in this study is voluntary and you may change your mind prior to the interview. Withdrawal will not affect the care that you receive.

What will happen to the results of this study?

The aim is for the research findings to be published in a peer-reviewed research journal. It may also be presented to other professionals in the field. If you would like the final paper to be shared with you this can be arranged. You will not be identified from any report or publication placed in the public domain, although you yourself may recognise your quotes. The research being undertaken will also contribute to the fulfilment of a doctoral thesis.

What if you find something unexpected?

If the interviews produce findings of clinical significance for you or your relatives you will be referred on to and/or provided with the details of appropriate services.

What if there is a problem?

If you have a concern about any aspect of this project, please speak to Megan Wingfield (07771735152) or Dr Gurney-Smith (01908 218251) who will their best to answer your query. The researcher should acknowledge your concern within 10 working days and give you an indication of how he/she intends to deal with it. If you remain unhappy or wish to make a formal complaint, please contact the chair of the Research Ethics Committee at the University of Oxford (Chair, Medical Sciences Inter-Divisional Research Ethics Committee; Email:ethics@medsci.ox.ac.uk; Address: Research Services, University of Oxford, Wellington Square, Oxford OX1 2JD). The chair will seek to resolve the matter in a reasonably expeditious manner.

How have patients and the public been involved in this study?

Individuals who have also been involved in DDP have helped to develop certain parts of the research, including the questions that you will be asked. The following links provide general information about taking part in research:

- www.crn.nihr.ac.uk/can-help/patients-carers-public/how-to-take-part-in-a-study/

- www.nhs.uk/Conditions/Clinical-trials/Pages/Introduction.aspx

Who is organising and funding the study?

The research is being conducted as part of my (Megan Wingfield) Doctorate in Clinical Psychology. I am supported in my application by the University of Oxford who have provided ethical approval and sponsorship. The research is being supervised by Dr Ben Gurney-Smith (Consultant Clinical Psychologist) who has many years of practice and research with adoptive families. Any costs incurred will be covered by the Oxford Institute of Clinical Psychology Training.

Who has reviewed the study?

The study has been reviewed by, and received ethics clearance through, the University of Oxford Central University research Ethics Committee.

Further information and contact details:

If you have any questions or would like further information about this study please email Megan Wingfield (megan.wingfield@hmc.ox.ac.uk)

Thank you for reading this information and considering taking part.

Appendix N

Consent to Pass on Contact Details



Doctoral Course in Clinical Psychology

Study Title: Adoptive Parent's Experiences of Dyadic Developmental Psychotherapy

I have spoken with ……..[1] about the above study. I give permission for my personal details to be passed on to the researchers in order for them to contact me with further details about the study.

Parent's signature……..……

Parent Print Name ……..……

Date……..……..

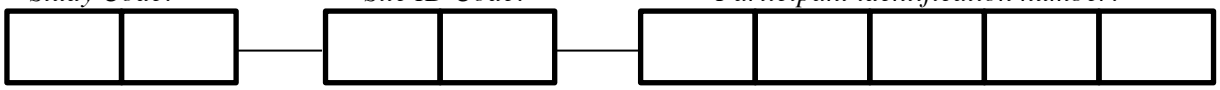
[1] Insert clinician's name here

Appendix O

Consent Form



Study Code: *Site ID Code:* *Participant identification number:*



CONSENT FORM

STUDY TITLE: Adoptive Parent's Experiences of Dyadic Developmental Psychotherapy

RESARCHER DETAILS: Megan Wingfield, Trainee Clinical Psychologist,

Megan.Wingfield@hmc.ox.ac.uk, Oxford Doctoral Course in Clinical Psychology, Isis

Education Centre, Warneford Hospital, Oxford OX3 7JX

PURPOSE OF STUDY: This study aims to understand the experiences of adoptive parents who have completed DDP

If you agree, please initial box

1. I confirm that I have read the information sheet for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw without giving any reason, without my medical care or legal rights being affected. Once the interviews have taken place and I have reviewed the content, I understand that I will not be able to withdraw.	
3. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from University of Oxford, from regulatory authorities, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
4. I agree to audio/video recording and the use of anonymised quotes in research reports and publications. I understand that all transcripts of these recordings will be kept securely whilst the project is ongoing in accordance with University of Oxford Ethics.	
5. I understand that this study has been reviewed by and received ethical clearance through the University of Oxford Central University Research Ethics Committee.	

6. I give consent for my interview to be seen by an independent transcriber and am aware that my details will be kept separate from this recording.	
7. I give permission for my anonymised quotes from my interview to be included in the write-up of results for illustration purposes.	
8. I am aware that those supervising this research may also see my anonymised transcription.	
9. I understand how to raise concerns or make a complaint.	
10. I understand what will happen to the audio/video recordings at the end of the study.	
11. I understand that the research data will be written up as part of a student's' thesis.	
12. I agree to take part in this study.	
Additional:	

_____ _____ _____

Name of Participant *Date* *Signature*

_____ _____ _____

Name of Person taking Consent *Date* *Signature*

If you would like a copy of the results once the project has been completed (July 2017). Please provide contact details.

……

……

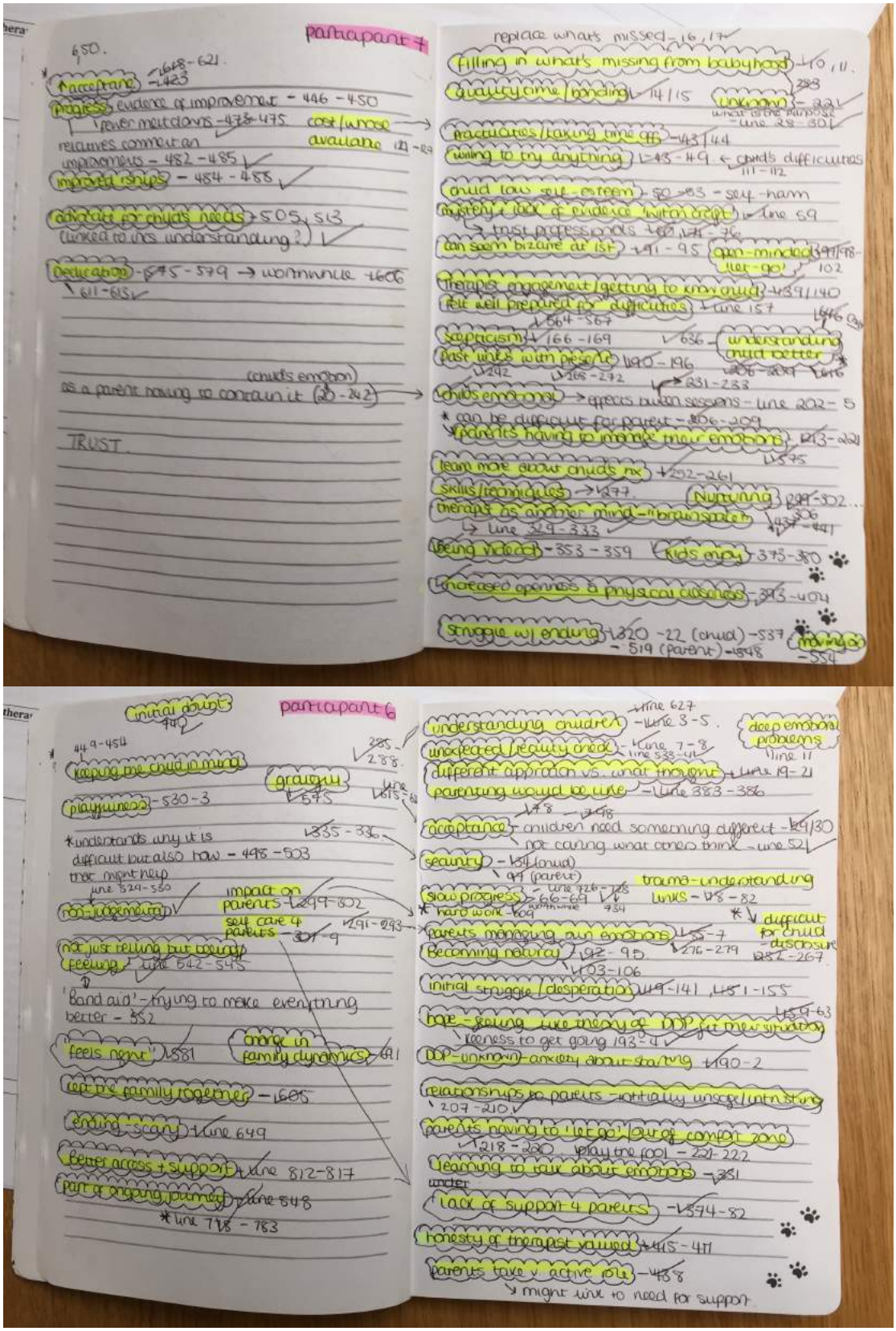
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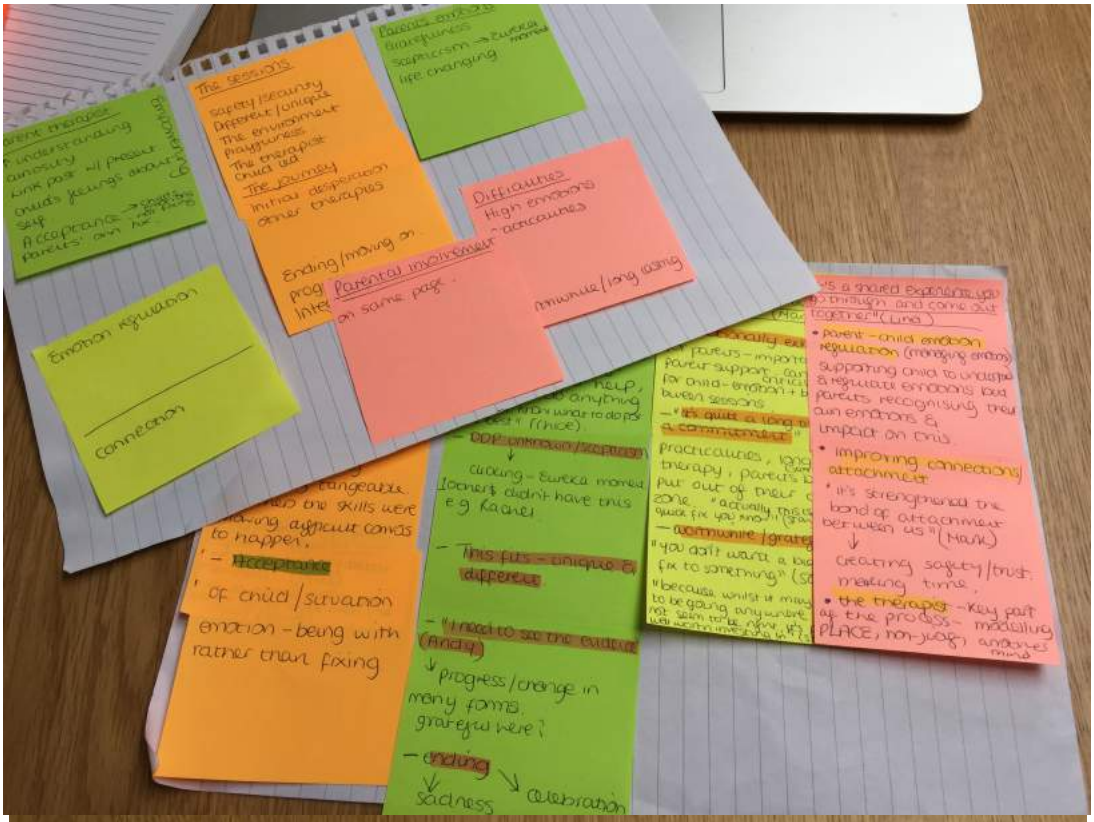
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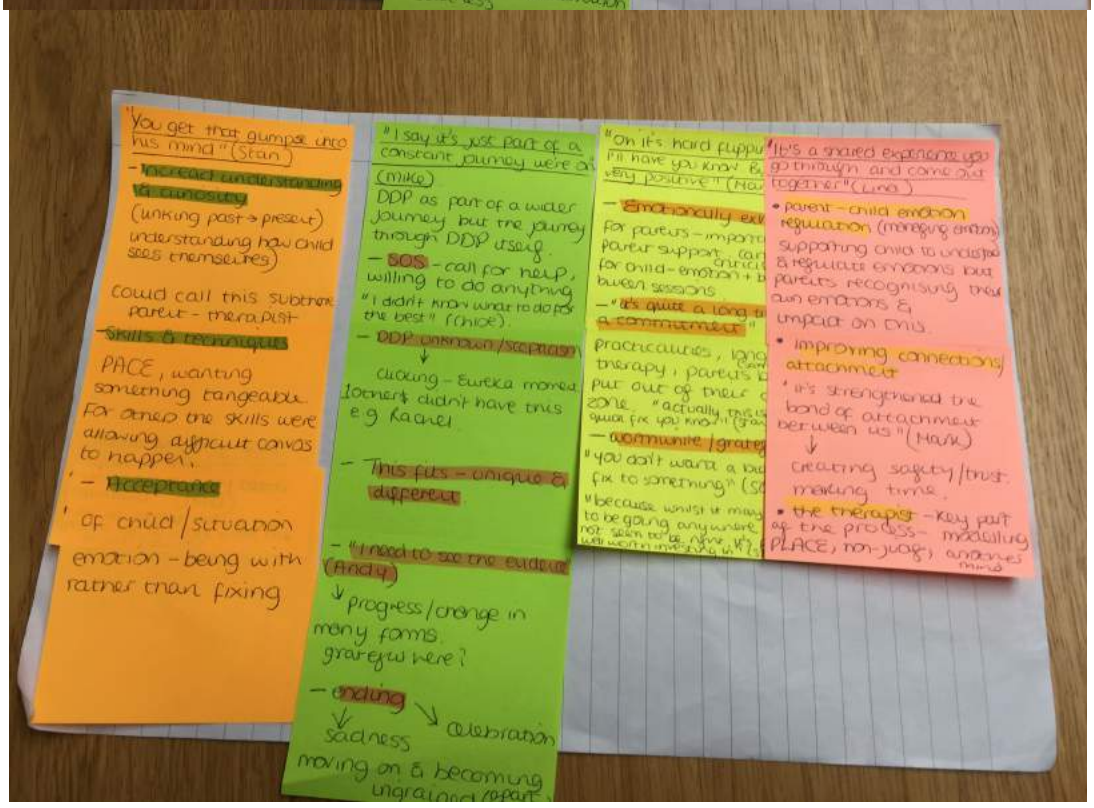
Appendix P

Emerging Themes for Individual Participants



Clusters of Emerging Themes for Each Participant





Appendix Q

Excerpt from Bracketing Interview

Interviewer: Why don't you start by telling me a bit about why you chose the dissertation topic that you did?

Interviewee: I picked the topic that I did, ummm…it possibly goes back actually, ummm…my interest in the importance of early attachments started in a job in a complex needs service because it became clear that many people's difficulties were very interlinked with their early relational experiences and then the patterns of relating following on from that…and then, I think, ummm, it's been a theme that runs throughout all of the work that I've done, even in training. Even in my CAMHS placement, I couldn't help but think about how the family and immediate relationships were impacting upon the individuals I was working with. After all of that I knew I wanted to, to look into something related to early attachment. And then…ummm….I met (supervisor) at the placement fair who had some ideas about…well…most of the children he works with have had very difficult early lives and developmental trauma and he thought of some projects and when he was describing his service I heard that they did DDP, which is something I'd heard about and was interested in knowing more about, because of it's links to attachment and developmental trauma…I was really interested about that and emphasised how keen I was on doing that and that's sort of how we got there.

Interviewer: …and having got more involved in the project has anything come up that you weren't expecting?

Interviewee: Ummm…I think practicality wise…ummm…. I've read a lot about DDP but I haven't actually sat in on a session. I mean I'm going to in June, but even having read a lot…ummm, I still feel really naïve about what actually goes on in DDP. It's taken a lot of reading and trying to understand what goes on. Ummm….another thing is, I was actually surprised by how helpful all the clinicians I have spoken to have been…they've all been really helpful which is a surprise as I thought because, well, this type of therapy can cover very sensitive topics of very private matters, I'd imagined recruitment might be really difficult…and it still might be **…** but the clinicians have been really willing to help me up to this point.

Interviewer: And is there anything else you're worried about?

Interviewee: Knowing how my own biases could impact upon my interpretation of the data, with it being qualitative. I have only been involved with one piece of qualitative work before and I worried about how objective it was. Like with this…my own biases about, I guess like, ummm…what it's like to be a parent. Hearing the

difficulties within the family and having my own opinions on perhaps how parents might have managed it, and how they understand their child, which really I can't even, I can't even imagine what they've probably had to go through…

Interviewer: And what other views do you have that might impact upon the work?

Interviewee: So like I said, to me, that early attachment stuff is really important and if I hear of situations in which the child was not treated in a appropriate way…I know that will probably happen for most of the children I hear about and although that might be an important part of the process, I don't want it to, ummm, get my caught up and pull me away from hearing about what the parents are really saying about their experiences of DDP. Ummm…I think there's also a part of me that's hoping to find out that DDP is really useful, because ummm, I've heard excellent things about it from clinicians so I'm like "oh this seems to really work", but I've got to remember I'm not trying to promote it…ummm…I really believe in the theory so I think oh, well, it should work, especially if some of the parents seem to be really enthusiastic about it. If someone says oh, yeah it really wasn't useful to me, I'm probably going to wonder why but I want to try to remember that actually, their negative experience is as valuable as any other positive ones I need to be open-minded, even though I'd like to hear that it's useful. I've also got to be mindful that my supervisor is on the DDP board so is likely to have his own thoughts and feelings about DDP, so I need to hold that in the back of my mind and discuss this with him….

Interviewer: Is there anything else?

Interviewee: I guess because I'm a female I guess I'm more likely to identify with a mum more than a dad. I also grew up mostly with a mum as the primary caregiver with a dad who was often at work so I'm probably going to automatically assume that mum is the primary caregiver when that might not be the case. I need to be aware of that. I also imagine in my mind families with younger children but I need to remember that we could be talking about teenagers and young adults here so there will hopefully be a real variety of parents.

Appendix R

Reflexive Log Excerpt

Excerpt from Interviews

13.06.16

Participant 1 (Sam)

I was nervous about my first interview today, although it turns out there was no need to be. I felt so much pressure about getting it 'right' by the time I got to the front door as I had been building it up all day. However, once I arrived, I met with mum and dad. Their son was not in today. I automatically felt at ease in their home. I also felt slightly connected to this family (perhaps more so than I will families later on) as they completed their DDP work with my supervisor; so we had something in common. I therefore felt I automatically warmed to them. Both mum and dad were willing to be interviewed. In the end they agreed that they would probably have very similar perspectives and therefore, only one was probably needed. I was aware that because I felt so warmly towards this family, I was likely to quickly take to their perspectives, and therefore was conscious of remaining open-minded and broad in my questioning. This was exceptionally hard to do, especially when mum was so enthusiastic. I found it difficult to not get swept away by how wonderful the family has found DDP.

Mum decided to give the interview. Throughout, whenever I asked about her perspective, she often gave responses about her son, and how he was finding DDP. It made me realise that with this dyadic relationship you can't really expect mum to separate her experience from that of her child's – they were so interlinked. Many of her feelings and thoughts were linked to her son's feelings and thoughts. She was incredibly positive about DDP and I remember wanting to ask her about the negative aspects. However, as the interview went on this never got brought up as this was not the way her interview took us. This has made me mindful to perhaps ask next time, if I am curious.

This mum was also incredibly talkative and I found it really easy to sit and listen and get very wrapped up in her story, almost forgetting that I was doing an interview at all. This meant that when I did realise I hadn't spoken in a while I felt a strong urge to ask a question. I tried to kerb this but on occasions felt I needed to ask something since mum told me from the start "I can speak for England and will just keep going on if you don't stop me". I had initially felt very relieved by this as I was concerned parents wouldn't have enough to say about their experiences but I realised towards the end of the interview that we probably could have said even more.

14.06.16

Participant 2 (Stan)

This was my first interview over Skype and it did have a slightly different feel. Perhaps because I wasn't in the family home I didn't get as much of a sense of the family and I didn't get the same warmth, but again maybe this is to be expected when I wasn't sat with them. Also this father is on an adoption panel and so knew a lot of technical terms and practicalities around adoption so at times it felt more like I was talking to him in that role (on the adoption panel) more than in a father role. He was also well read on the various ways of working with adopted children and so at times it felt like I was talking to another professional, a social worker or something. This one was much quicker as well and I think this may come from the slightly lesser interaction that can be had over Skype. It was useful to speak to a parent who had more than one child, as he was able to consider the impact of DDP on the whole family. However, I couldn't help but notice that this was described individually, as in child X, Y, Z and interactions between people were not really discussed. I felt an urge to ask about this but did not get round to it in the end as I had forgotten by the end. Towards the middle/end of this interview the warmth did start to come through and I began to warm to the relationship between this father and child that has clearly been incredibly difficult. I started to think that perhaps this mans methodical and slightly clinical approach to talking about his child was perhaps a way of managing how difficult it really was.

Excerpt from transcribing interviews 1 & 2

In between these two interviews and the third I had some time to start transcribing. Through this I started to notice things that had come up that I had totally forgotten since the interviews. Those little comments or ways of speaking that tell you something more than just the content. I started to notice some common themes coming through. The first: the contrast between DDP and traditional therapy or parenting methods – how unique DDP was and how it seemed to fit with the child's/families' specific difficulties. The second, how tightly DDP was linked to the child's history (and parents ability to link the past to present with support of the therapist) and how this was something that parents felt made it successful. Thirdly, this idea of the child gradually "opening up" or sharing nuggets of love/information/"normal" behaviour and the joy of the parents at seeing this gradual change. The main thing was increased understanding of the child. I'm aware that even in this initial stage of coding I am leaning toward finding

the benefits of DDP and need to make sure I also extract the difficulties, the unhelpful bits, the awkward moments etc. and therefore will go through these two again with this in mind.

Further reflections on interviewing

20.06.16

Participant 3 (Mike)

This interview was again over the Internet but had a very different feel to the other two in that the therapy was very different for this family. They had been with their daughter much longer and had a different experience in that they weren't actually aware until quite a bit further into therapy that it was DDP that they were having. They also had split sessions as well as joint sessions (parent/child) so it was a little different.

However, similar themes to the other two interviews did already start emerging and I found myself wanting to jot these down and getting quite excited by these. I also found this interview came a little more naturally, perhaps because I am getting more used to them and feeling more confident (?). I noticed I asked more questions that in some of the others and I'm not sure if that's because I was more confident or because I felt this gentleman might speak less? I think the fact that this gentleman was perhaps more shy or less forthcoming with information I took on a much more 'interviewee' role whereas in the other two I sat back and listened.

In the end this interview turned out to be one of the longer interviews and I got to feel like I knew him and the family quite well from just an hours discussion. This man's already well developed relationship with his teenage daughter meant I got a totally different perspective than from those whose children were still relatively young, which I was grateful for. I think this interview will be important in analysis since this families' daughter was a teenager and therefore experienced DDP in a slightly different way to the younger children in interview 1 and 2. This family's DDP sessions also had a slightly different structure so will be helpful in reminding me that DDP can look different for different people, as is the case, I guess, with all therapies!

20.06.16

Participant 4 (Chloe)

This interview was with a mother over Skype again. Immediately I realised that I spoke more confidently and freely with mothers. I felt like I developed a relationship or 'kinship' much more quickly with this mother and could understand her perspective and emotions much more easily.

This mother was very enthusiastic about DDP and again it was difficult not to get swept away by this. She was extremely positive, open and keen to talk about her family, who she obviously thought the world of. These made it all really easy to connect with her. However, it did mean that it was slightly more difficult to have a structure to the interview as she began talking about her DDP experience almost at once before I had started recording and she also continued to say more useful things once we had finished and I turned the recorder off (which was a huge shame!!) She also asked me a few personal questions; such as did I have my own children, which made me wonder whether I would relate differently to these families because I was not a mother myself. This is something that might be useful to reflect on with the qualitative group?

This was my longest Skype interview as this mother had lots to say, which I was glad for. As she spoke I noticed more and more themes that linked with what other parents had said. These included having tried traditional parenting approaches (and the contrast with DDP), how closely DDP and the referral reason to DDP was interlinked with the child's history, the gradual change in the child that was slow but also 'dramatic' when it happened, a sense of the difficulties experienced by the families that are constant and on-going (this idea that there will always be ups and downs – but then again isn't this the case for all families?), a sense of DDP "feeling right" for the child, scepticism at first about 'therapy' or at best not really having a clue what they'd signed up for, almost all families so far have also spoken about the brain or the neurological aspects (this made me wonder whether this is something that has been discussed in every DDP sessions or whether this is just something that becomes naturally evident through DDP) and an idea of DDP techniques, such as PACE feeling very unnatural at first but eventually becoming part of everyday life/woven into the day to day.

Excerpt mid-process:

Transcribing these five interviews had a similar experience to transcribing the others (see above). I think I felt much more rushed at this point and therefore spent less time really engaging and actively listening whilst typing them out. Acknowledging this really helped and encouraged me to re-listen to these interviews before deleting them. Also important to perhaps highlight that I had some anxieties here about how long I needed to keep recording for once written up.

Meeting with research tutor 29.07.16

This was a really useful opportunity to discuss interviews and analysis with my research tutor. I was able to discuss any anxieties I had: e.g. how much my own interests were influencing the direction of interviews, how much semi-structured interview questions were shaping the interview, how to continually bracket any additional thoughts, assumptions etc. Also made me feel a little relieved as I realised I was doing well in regards to recruitment and interviews.

Excerpt during analysis:

After analysing the first few transcripts I feel there are themes emerging already (see notebook). As has been the case throughout this project I'm inclined to look for the positive experiences of DDP, people discussing the benefits etc. There was one parent in particular whose feelings about DDP were very different from others (e.g. she didn't feel the initial scepticism/uncertainty went away). I've found myself trying to explain why this was the case. She was the lady who worked for a famous children's charity that deals with adoptions and said herself that she often used therapeutic strategies/parenting/skills before the DDP. She was also well versed in DDP, Dan Hughes and therapy in general and so what was done during the sessions was not new to her. This may be why she didn't experience that initial 'click' or eureka moment that many parents spoke about. It also felt like the acceptance element, that so many parents spoke about in DDP wasn't present so much in this interview. However, her experience is still an adoptive parents' experience of DDP and so I must be mindful of this and make sure that this alternative perspective also comes through (especially because many of the other parents' experiences were so similar). I spoke about this with (supervisor) and he too is similar to me, in that he is looking for positive experiences. We spent most of our meeting getting excited about all the progress and benefits parents spoke about and little time on the difficulties (although we did discuss them briefly). So we are both aware we need to be careful about this. I have therefore sent of a transcript to one of my IPA peers to look through and see if she notices something different to me. I also had a chance in an IPA meeting with Michael Larkin to go through one of my transcripts. I was able to share the first two pages of one of the transcripts with Michael and four other trainees. It was a great opportunity for triangulation and it helped confirm some of the themes that had already emerged and gave me some thoughts about themes that other trainees noticed and where these might have come from (e.g. their interests). However, on the whole emerging themes were very similar which I found reassuring.

30.5.17 – had a meeting with research tutor to discuss how far to go into level of interpretation. Was very helpful although still feeling cautious about putting too much of my own subjective interpretation onto the data. Feel I need to be bolder in my interpretations and have greater confidence in them.

Appendix S

How this study meets Yardley's (2000) characteristics of good qualitative research.

Sensitivity to context

Thorough research into the theoretical underpinnings of DDP and understanding of the empirical data and evidence-base for DDP gathered. Understanding of the difficulties experiences by adoptive parents as well as different therapeutic interventions for adoptive families was investigated and written up within introduction. Sociocultural setting, possible perspectives and ethical issues thoroughly discussed with a clinician working with adoptive parents, research tutor and during bracketing interview. Continued attention paid to context throughout reflective log.

Commitment and rigour

To ensure in-depth engagement with topic participants' interviews were transcribed by the researcher and read and re-read several times. Knowledge of topic outside of the interviews was held in mind throughout the research. Methodological competence was enhanced by reading relevant guides and engaging with IPA peer-reflective group and online forums. Meetings with IPA expert Michael Larkin enabled rigour of research to be tested and checked. Transcripts were shared with IPA peers and a DDP clinician to check credibility of emerging themes.

Transparency and coherence

Transparency and coherence were enhanced through the use of a reflexive log, which recorded the researchers descriptions and arguments during data collection, analysis and write up. This also enhanced reflexivity along with a bracketing interview and attendance at a qualitative peer-support group.

Impact and importance

The introduction to this paper helps to outline the theoretical, research, socio-cultural and practical importance of this research.

Appendix T

Minutes of group meeting with Michael Larkin (February 2017)

1. Went over two transcripts – one annotated with initial codes. Coded individually then discussed as a group.

- Reflected on quality of transcription e.g. use of punctuation, comments on emotional state
- Compared coding techniques
- Advised to think when coding "what is being talked about?" *then* "what is the meaning?"
- Discussed what to do with strong images/phrases that stand out but don't "fit" with the rest of the interview/experience. Depends on the level of interpretation – what is this telling us about their experience?

2. Discussed how to manage emerging themes at a case level – consolidate and organise your thinking but allow "multiple routes out" and don't finalise themes at this stage.

3. Reflected on becoming "attached" to data and how difficult it might feel to have to collapse/cut down data into fewer overall themes. Consider whether themes answer the question we are asking.

4. Discussed how we can learn from past interviews/current transcripts to improve future interviews e.g. how to make best use of time, are there topics which seem worth focussing in on/spending a bit more time exploring?

5. Discussed the use of the reflective diary e.g. note if something really strikes you or feels unresolved, interpretations which feel more speculative, insights into the process.

6. Discussed practical considerations of how to present data and looked at examples of summary tables from previous publications.

7. Discussed how to name themes –should be something that draws out a pattern of meaning in the data and clearly communicates the content on its own. Suggestions were something that captures an experience of or relationship to something, a metaphor, or an illustrative quote.

Appendix U

Approval from CUREC

CONFIDENTIAL Ref: R45432/RE001

Ms Megan Wingfield 6th May 2016

Oxford Doctoral Course in Clinical Psychology

Isis Education Centre

Warneford Hospital

Oxford

Dear Megan

Research Ethics Approval - CUREC 1

Project title: Adoptive parents' experiences of dyadic developmental psychotherapy (DDP)

The above application has been considered on behalf of the Medical Sciences Inter-divisional Research Ethics Committee (IDREC) in accordance with the procedures laid down by the University for Ethical Approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and approval has been granted for a period of **2 years**, commencing on **6th May 2016**. The reference number for this project is **R45432/RE001**.

This is **subject to:**

a) **your following the BPS guidelines for online research**

b) **it is your responsibility to comply with the requirements for administering any tests or questionnaires and if in doubt to contact the publisher of those tests or questionnaires.**

c) **if new staff are engaged MS IDREC should be informed of their names, status and ethics training.**

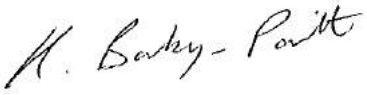
Please may I remind you that your project may be reviewed at some stage during an annual audit of projects.

Amendments

Should there be any subsequent changes to the project, which raise ethical issues not covered in the original application, you should submit details to the IDREC for consideration and approval.

Please do not hesitate to contact me if you have any queries.

Yours Sincerely



Dr. Helen Barnby-Porritt

Research Ethics Manager, Medical Sciences

Appendix V
Approval from the Oxford Course in Clinical Psychology

Oxford Health NHS
NHS Foundation Trust

The Oxford Institute of Clinical Psychology Training

UNIVERSITY OF OXFORD

Oxford Doctoral Course in Clinical Psychology
An NHS Course validated by the University of Oxford

Isis Education Centre, Warneford Hospital, Oxford OX3 7JX
Tel: +44(0)1865 226431
Website: www.oxicpt.co.uk

24th March, 2016

Megan Wingfield
Trainee Clinical Psychologist
Oxford Doctoral Course in Clinical Psychology
Isis Education Centre
Warneford Hospital

Dear Megan,

Thank you very much for you detailed reply to the RSC's questions. You now have full approval for your research.

We wish you all the best with our project.

Yours sincerely,

Myra

Dr Myra Cooper
Chair, Research Sub-Committee

c.c. Olivia Hewitt
Ben Gurney-Smith