

**Exploring Psychological Interventions for Adoptive Families**

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A thesis submitted in partial fulfilment of the requirements for the award of Doctorate in Clinical Psychology at the University of Sheffield

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**Declaration­**

I, the author, declare that the thesis is my own work. The thesis has not been previously presented for an award at the University of Sheffield, or any other institution. I am aware of the University of Sheffield’s Guidance on the Use of Unfair Means ([www.sheffield.ac.uk/ssid/unfair-means](http://www.sheffield.ac.uk/ssid/unfair-means)) and declare that the thesis presented is original and all other sources have been referenced accordingly.

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**Lay Summary**

Prolonged experiences of pre-adoptive abuse place some adopted children at a greater risk of enduring a wide range of neurobiological and psychosocial difficulties. Adoptive parents must manage these difficulties whilst possibly having to cope with their own personal challenges. It is important for families seeking post-adoption support to be informed about the effectiveness and experiences of psychotherapies which can meet the needs of all members of the adoptive family unit. The objective of this thesis project was to complete a comprehensive review of scientific literature examining family-based psychotherapeutic interventions for adoptive families and to evaluate the feasibility and acceptability of one specific family-based psychotherapy for this cohort.

The first chapter presents the systematic literature review which examined studies of domestically adopted families who received a family-based psychotherapeutic intervention. The review identified 17 studies, comprising of 13 different psychological interventions. A narrative synthesis indicated that there is promising preliminary support for integrative psychotherapeutic interventions which include sensory activities, attachment-based play therapies such as Theraplay®, Eye Movement Desensitisation and Reprocessing (EMDR), and Dyadic-Developmental Psychotherapy (DDP). These were most promising within therapeutic formats which provided separate therapeutic input for adoptive parents and/or adopted children, alongside the family-based therapeutic input for the adoptive family. However, this research area lacks quality, and most studies reported a moderate-to-serious risk of bias. Therefore, these findings should be seen as exploratory and not unequivocal.

The second chapter explores the feasibility and acceptability of integrating Theraplay®, DDP, and EMDR with adoptive families. Feasibility was determined by examining recipient attendance patterns and post-therapy assessment measure completion rates. Acceptability was explored through a framework analysis of semi-structured interviews with intervention deliverers (therapists) and recipients (adoptive parents). Overall, the integration of these approaches was deemed both feasible and acceptable. Therapists reported that the integration of Theraplay®, DDP, and EMDR allows them to respond more meaningfully to needs in therapy, that it makes sense, that they feel confident integrating these models, and that the increased freedom makes the therapy easier to administer. Therapists also reported the risk of integrating models for unsuitable reasons at unsuitable times, the presence of uncertainty relating to how to integrate effectively, self-doubt, and feeling increased pressure to make the right decision during therapy. Adoptive parents reported that the integrative therapy was valuable, that it made sense in the context of their child’s early history, and that the therapy is physically and emotionally burdensome but is a burden worth bearing. Issues for parents included the therapy being unable to ameliorate all their difficulties, aspects being difficult to understand, aspects feeling uncomfortable, and the therapy requiring a high level of effort.

Together these chapters provide preliminary evidence demonstrating promise for integrative family-based psychotherapies and that integrative Theraplay®, DDP, and EMDR is both feasible and acceptable as a post-adoption psychotherapeutic intervention. These studies are exploratory in nature and further high quality, controlled, and randomised research examining the efficacy of integrative family-based psychotherapeutic approaches is warranted. Additionally, research developing measures of therapeutic competence and adherence for integrative approaches is also required.

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# **Section One: Literature Review**

**Psychological Interventions for Adoptive Families: A Systematic Review**

## **Abstract**

**Objectives:** This review (PROSPERO: CRD42021266076) aimed to synthesise the literature exploring family-based psychological interventions for adoptive families, appraise the strengths and weaknesses of the evidence, and report characteristics of promising interventions.

**Methods:** Seven electronic databases: CINAHL, Cochrane Library, MEDLINE, ProQuest, PsycINFO, Scopus, and Web of Science, four grey literature databases: EThOS, Grey Literature Report, OpenGrey, and Social Care Online, two journals: Adoption Quarterly and Adoption and Fostering, and five relevant websites were searched up to 19.05.2022. Two groups of search terms were searched for within titles, abstracts, and keywords with the terms relating to (a) the population and (b) the intervention. Included studies recruited domestically adoptive families receiving psychotherapeutic interventions delivered to at least one parent and one child. Risk of bias was assessed by the quantitative Risk of Bias in Non-Randomised Studies of Interventions tool and the qualitative Critical Skills Appraisal Programme checklist. A narrative synthesis approach was applied.

**Results:** The synthesis presents 17 studies including over 682 adopted children and 782 adoptive parents. Findings provide preliminary support for integrative interventions which include aspects of sensory activities, attachment-based play, Eye Movement Desensitisation and Reprocessing, and Dyadic-Developmental Psychotherapy with therapeutic input being provided to children and parents independently, alongside the adoptive family.

**Conclusions:** Overall, risk of bias was high, certainty of evidence was low, and there was significant heterogeneity across studies, limiting the conclusions that can be drawn. Research examining the acceptability and efficacy of integrative therapeutic approaches for adoptive families is required to provide conclusive implications for clinical practice.

**Practitioner Points**

* This is the first systematic review of literature evaluating family-based psychotherapeutic interventions for adoptive families with domestically adopted children.
* There is preliminary support for family-based interventions which integrate sensory activities, attachment-based play, Eye Movement Desensitisation and Reprocessing, and Dyadic-Developmental Psychotherapy with adoptive families.
* There is preliminary support for family-based interventions which deliver direct therapeutic support to the adopted child, the adoptive parents, and the adoptive family within one therapeutic approach.
* The overall quality of research in this area is low and there is a high risk of bias. There is a need for higher quality research evaluating the feasibility, acceptability, and efficacy of integrative interventions for adoptive families before clinical practice can be implicated.

**Keywords:**

Adoption; Therapy; Family; Psychological intervention; Systematic review.

**Psychological Interventions for Adoptive Families: A Systematic Review**

Meta-analytic evidence of over 270 studies indicates that adoption is an effective intervention which can facilitate physical, socio-emotional, and cognitive development in adopted children (van Ijzendoorn & Juffer, 2006). Therefore, many adopted children present within normal ranges of adjustment compared to non-adopted counterparts (Haaguard, 1998; Sharma et al., 1996). Despite this, adopted children continue to be overrepresented in mental health settings and exhibit greater levels of externalising and internalising difficulties compared to non-adopted children (Juffer & van Ijzendoorn, 2005; Palacios & Brodzinsky, 2010; van den Dries et al., 2009).

Evidence suggests that greater severity of pre-adoptive maltreatment contributes to difficulties in adjustment for adoptive children (Jiménez-Morago et al., 2015; Julian, 2013). Prolonged experiences of pre-adoptive abuse, neglect, and developmental trauma place some adopted children at a greater risk of enduring a wide range of neurobiological and psychosocial difficulties (Cyr et al., 2010; Mehta et al., 2009; Perry et al., 1995; Rees & Selwyn, 2009; Twardosz & Lutzker, 2010; van der Kolk & D’Andrea, 2010; van der Vegt et al., 2009). The adoptive parents of these children are required to manage these difficulties whilst possibly having to cope with several of their own personal challenges. Many adoptive parents must overcome the loss associated with infertility (Daniluk & Hurtig-Mitchell, 2003; Kohn-Willbridge et al., 2021; Wang et al., 2021), cope with expectancy violations between their imagined child and their actualised family life (Goldberg et al., 2021; Santos-Nunes et al., 2018), and manage pressures to demonstrate perfect parenting (Daniluk & Hurtig-Mitchell, 2003). These challenges can result in feelings of anger, doubt, guilt, and confusion (Follan & McNamara, 2014).

The individual challenges experienced by adoptive parents and adopted children can intersect and manifest in difficulties within the attachment relationship (Bruce et al., 2019; Cyr et al., 2010; van den Dries et al., 2009; Zeanah & Gleason, 2015). Prolonged exposure to pre-adoptive abuse and neglect can lead to some adopted children developing dysregulated, hypersensitive defensive systems and supressed social engagement systems (Balu & McLean, 2019; Porges, 2015). Adoptive parents who repeatedly experience these hypersensitive and supressed interactions with their adopted child(ren) risk moving into a psychological state conceptualised as blocked care (Baylin & Hughes, 2016; Hughes & Baylin, 2012). Blocked care is an experience akin to compassion fatigue and burnout (Harris-Waller et al., 2016), in which adoptive parents engage in the “suppression of caring feelings for the child to blunt the pain of rejection” (Baylin, 2017, p.608). Blocked attachment relationships ensure that adoptive parents are less able to positively influence their child(ren)’s further development (Baylin & Hughes, 2017).

Recent advances in affective neuroscience and neurobiology have acknowledged the importance of ‘attunement’ (see Stern, 1985; Legerstee et al., 2007; van Bakel & Riksen-Walraven, 2008), ‘social (co)regulation’ (see Coan et al., 2006; Fosha, 2001; Schore, 1996), ‘intersubjectivity’ (see Ammaniti & Trentini, 2009; Cortina & Liotti, 2010; Trevarthen & Aitken, 2001), and ‘interpersonal neurobiology’ (see Schore, 2001; 2012; Siegel, 2001; 2006) within parent-child relationships. Each of these concepts necessitates the importance of the intersubjective resonance and co-creation of socio-emotional realities between parent and child, in developing healthy attachment relationships and stimulating the self (Fonagy et al., 2002) and social engagement systems (Porges, 2009). A recent review of 52 studies examining risk and protective factors to mental health and behavioural difficulties in adopted children corroborates these advances (Duncan et al., 2021). The review suggests that more attuned parental responsiveness, greater quality within the intersubjective parent-child relationship, and levels of cohesion, expression, and conflict within family environments each mediate outcomes for adoptive families (Duncan et al., 2021). Therefore, it is important for adoptive families to have access to acceptable and effective family-based adoption support which meets the individual needs of the adoptive child(ren) and parent(s), whilst also facilitating the development of family-based attunement, co-regulation, intersubjectivity, and adaptive interpersonal relational processes within the parent-child attachment relationship.

There has yet to be a systematic review synthesising literature on family-based psychological interventions for domestically adoptive families. Prior reviews have explored interventions for internationally adopted children (O’Dell et al., 2015; Welsh et al., 2007), attachment-based interventions for adoptive and foster families (Kerr & Cossar, 2014; Rose & O’Reilly, 2017), therapeutic interventions supporting parental preparedness, parental behaviour, and improving the parent-child relationship by intervening through caregivers (Drozd et al., 2018; Harris-Waller et al., 2018; Schoemaker, et al., 2020), and psychological interventions completed with adoptive parents (Ní Chobhthaigh & Duffy, 2019). These reviews collate and synthesise a combined total of 74 unique studies however, only 3 studies (4.05%) contribute to the evidence base for families with placed domestically adopted children seeking to access family-based therapeutic approaches (see appendix A). This highlights a gap in the literature which is important to address.

Therefore, this systematic review aims to synthesise and critically appraise research which evaluates family-based psychological interventions for adoptive families with domestically adopted children who seek therapeutic support. The review aims to:

1. Outline and synthesise the current evidence base for family-based psychological interventions for domestically adoptive families.
2. Appraise the strengths and weaknesses of the literature.
3. Explore the characteristics of promising interventions.

**Method**

The review protocol was registered in the international prospective register of systematic reviews (PROSPERO) on 19.07.21 registration number: CRD42021266076, <https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42021266076>. The protocol was amended on 08.12.21 and 11.02.22 to provide further methodological detail and updated progress reports. The review has been completed in line with the Cochrane Collaboration’s 2021 handbook for systematic reviews of interventions (Higgins et al., 2021) and the updated Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines (Page, McKenzie, et al., 2021; see Appendix B). The review did not receive any sources of funding or support and the authors declare no competing interests. In line with the British Medical Journal (BMJ) Patient and Public Partnership strategy (BMJ, 2014), three adoptive parents were invited to share their reflections towards this systematic review with a particular focus on language and sensitivity. The review was co-constructed accordingly which aimed to enhance the presence of therapy experienced adoptive parents within this review.

**Inclusion and Exclusion Criteria**

In July and August 2021 initial scoping searches took place on Google Scholar. These searches helped formulate the inclusion and exclusion criteria (table 1). The PICO tool (population, intervention, comparator, outcome) was selected to guide this process as it is endorsed by the Cochrane Collaboration (Higgins et al., 2021) and is commonly utilised to categorise components of clinical evidence for systematic reviews (Methley et al., 2014).

The population sought were families with domestically adopted children. This is because challenges associated with attachment difficulties and developmental trauma can uniquely intersect with challenges associated with acculturation and “reculturation” (Baden et al., 2012, p.387) for international adoptees (Davies, 2011; Mounts & Bradley, 2020). The unique experiences of internationally adopted children and families warrants an independent evaluation of the available therapeutic interventions to ensure findings are specific and sensitive to their distinctive needs.

The interventions sought were psychotherapeutic interventions which took place with one or two adoptive parent(s) and their adoptive child(ren). This is because experiences of intersubjectivity, co-regulation, and attunement are processes which take place within-and-between the parent and child (Shore, 2012; Siegel, 2020; Stern, 1985). The therapist is required to facilitate these parent-child interpersonal experiences through their own interpersonal therapeutic relationships with both the parent(s) and their child(ren). Therefore, more directive therapeutic interventions which included adoptive parent(s) and their adoptive child(ren) but only provided therapeutic presence to adoptive parents via video feedback, ‘bug-in-the-ear’ feedback, or other such approaches were excluded.

**Table 1**

*Inclusion and Exclusion Criteria*

| PICOS dimension | Inclusion Criteria | Exclusion Criteria |
| --- | --- | --- |
| *Review question:* What are the effects and/or experiences of current family based psychotherapeutic interventions for adoptive families? | | |
| Population | Adoptive families included any adoptive parent (mother, father, or couple) with a domestically adopted child between birth and 18 years of any gender. Mixed sample studies were included if the majority (>50%) were domestically adoptive families. | Biological parents. Studies in which the majority (>50%) of the sample were: approved adopters yet to be matched with a child, foster carers and fostered children, residential care workers, special guardianship carers, case vignettes and/or internationally adopted children. |
| Intervention | Family based psychological interventions grounded in psychological theories that were delivered to at least one adoptive parent and at least one adopted child. | Interventions delivered to parents only, including bug-in-the-ear approaches. Preparatory training pre-adoption. Interventions that promote physical techniques and coercion (e.g., holding therapy). Studies that do not report interventions. |
| Comparator (Controls) | Intervention controls, care as usual, retrospective controls, non-equivalent controls, no control. | Contrasting populations such as biological parents and special guardianship order families. |
| Outcome | Any scientific method assessing the experience or effectiveness of the psychotherapeutic intervention | Studies which present anecdotal reports of intervention outcomes |
| Study Design | All empirical evaluative designs: quantitative and qualitative. | Review studies, descriptive case reports, reflective reports, theoretical reports. |
| Publication | All years of publication. Published and unpublished. | Full-text reports not available in English. |

**Search Strategy**

The systematic search strategy was developed following consultation with a university liaison librarian and was informed by the inclusion and exclusion criteria and initial scoping searches. The search strategy was also guided by previous reviews examining therapeutic interventions within this field (Drozd et al., 2018; Harris-Waller et al., 2018; Ní Chobhthaigh & Duffy, 2019; Schoemaker et al., 2020). Two groups of search terms were searched for within articles titles, abstracts, and keywords, with the keywords and Boolean terms relating to (a) the population ("adopted infant\*" OR "adopt\* child\*" OR "adopted adolescen\*" OR adoptee\* OR "adoptive parent\*" OR "adoptive carer\*" OR "adopt\* famil\*" OR postadoption OR post-adoption OR “post adoption”) AND (b) the intervention (famil\* OR "parent and child" OR "child and parent" OR parent-child OR child-parent OR systemic) NEAR/10 (therap\* OR psycho\* OR intervent\* OR program\* OR education\* OR support\* OR train\* OR counsel\* OR attachment).

Studies were collated across seven electronic information databases: CINAHL, Cochrane Library, MEDLINE, ProQuest (including ERIC, ProQuest Dissertations & Thesis AI, ProQuest One Literature, and Social Science Database & Sociology Collection which includes ASSIA Sociological Abstracts, Social Services Abstracts, and the Sociology Database), PsycINFO, Scopus, and Web of Science. Additionally, the journals Adoption Quarterly and Adoption and Fostering were hand searched. To reduce publication bias alternative search methods and grey literature sources were also searched which included: Action for Children, Adoption UK, EThOS, Family Futures, First4Adoption, Grey Literature Report, PAC-UK, OpenGrey, and Social Care Online. For all included studies forward citation searches were performed via Google Scholar and reference lists were backwards citation searched. See appendix C for full search strategies and dates of searches for all databases, registers, and websites, including filters and limits used.

**Study Selection**

The researcher completed the search process which yielded 3,336 studies. Results were transferred to a reference management system: Endnote 20.2. Where *k* represents number of studies, *k*=412 duplicate records were removed prior to transferral via ProQuest’s ‘remote duplicates’ limiter. Endnote 20.2’s automated ‘remove duplicates’ tool was utilised for the remaining studies resulting in a further *k*=670 being removed. Articles identified on Endnote 20.2 as books or book chapters were removed (*k*=138) which resulted in 2,116 studies progressing to title and abstract screening.

The researcher completed the title and abstract screening against the predetermined inclusion and exclusion criteria. A research assistant independently screened 10% of titles (*k*=211) and 25% of abstracts (*k*=30). Inter-rater agreement at title screening was 91.4% (kappa coefficient, k*=0.76*) and inter-rater agreement at abstract screening was 93.3% (kappa coefficient, k*=0.85*). Disagreement was discussed and a consensus was met for both screening levels. Final inter-rater agreement was 100%. This resulted in 38 studies progressing to full-text screening. Full-text screening was completed by the researcher with a research assistant independently reviewing 52.6% of the texts (*k*=20). Inter-rater agreement was 95% (kappa coefficient,k*=0.88*). Disagreement was discussed and a consensus was met. Final inter-rater agreement for full-text screening was 100%. This resulted in 14 studies being included within the systematic review. Twelve studies were discovered via the alternative search methods. Following full-text screening seven were excluded and a further five studies were included within the review. These 19 studies included two cases in which an unpublished dissertation had reached publication under a different title and/or authorship. These articles Hunsley (2019) and Hunsley et al. (2021), and Wingfield (2017) and Wingfield and Gurney-Smith (2019), were each treated as one study. Therefore, a final total of 19 articles reporting on 17 studies were included within this review. See appendix D for references of all studies excluded at full-text screening and reasons for exclusion.

**Data Extraction & Data Synthesis**

In line with Li et al. (2021) the researcher extracted relevant information from the included studies utilising a predetermined data collection form: an adapted version of the Cochrane Collaboration data collection form for systematic reviews of interventions (Higgins et al., 2021; see appendix E). The information extracted included general information such as the study’s authors, year of publication, and country of origin, methodological characteristics including aims and research design, participant characteristics including sample size, age, and gender, intervention characteristics including a description of the intervention, the theoretical underpinnings, treatment duration, and treatment providers, and outcome characteristics including measures used, time points collected, statistical analysis and/or qualitative findings, and general conclusions. If information known to have been available to the study investigators was unavailable (known unknowns), the corresponding author was contacted to retrieve this information. To measure the effect of quantitative findings, effect sizes were extracted or converted using Cohen’s d formula. If effect sizes were not reported, these were calculated via an online tool: psychometrica (Lenhard & Lenhard, 2016), where possible.

Heterogeneity of interventions and assessment measures is to be expected within this research area and has prevented previous systematic reviews from engaging in meta-analytic syntheses (Drozd et al., 2018; Harris-Waller et al., 2018; Ní Chobhthaigh & Duffy, 2019). Therefore, in line with Ní Chobhthaigh and Duffy (2019) and Harris-Waller et al. (2018), a qualitative systematic review approach was utilised in which studies were narratively synthesised with results presented in the following areas: description of study characteristics, risk of bias, effects and/or experiences of interventions, and characteristics of promising interventions. Due to heterogeneity and the narrative approach to synthesis, subgroup and sensitivity analysis could not be completed.

**Risk of Bias Assessment**

This systematic review utilised the updated Cochrane Collaboration’s 2021 risk of bias in non-randomised studies of interventions (ROBINS-I; see appendix F) tool for quantitative studies (Sterne et al., 2021) and the qualitative Critical Appraisal Skills Programme checklist for qualitative studies (Critical Appraisal Skills Programme [CASP], 2018; see appendix G). Both appraisal tools are publicly available. The researcher discussed the mixed-methods studies with a research assistant, to determine which methodological design was most prominent and then the appropriate risk of bias tool was then administered.

The ROBINS-I requires reviewers to rate quantitative studies as either ‘low’, ‘moderate’, ‘serious’, or ‘critical’ risk of bias, or no information, across eight domains: bias due to (1) confounding, (2) selection of participants, (3) classification of interventions, (4) deviations from intended interventions, (5) missing data, (6) measurement of outcomes, (7) selection of the reported result, and (8) overall bias. The researcher completed the ROBINS-I assessment for all quantitative studies. A research assistant independently completed the ROBINS-I for 85.7% (6/7) of the quantitative studies. Inter-rater agreement for each domain across the 6 studies was 79.1% (kappa coefficient, k=0.60). Disagreements were discussed and a consensus was met. Final agreement between raters was 100%.

The CASP qualitative checklist applies 10-items to assess study quality. The first six items evaluate whether the results of the study are valid, items seven to nine evaluate what the results are, and the final item evaluates whether the evaluator believes the findings are helpful (CASP, 2018). When appraising qualitative research for systematic review, it is important to complete an assessment of methodological strengths and limitations as opposed to (or alongside) a general assessment of study quality (Noyes et al., 2021). Noyes et al. (2019) defines this as a risk of rigour assessment. Therefore, only the first eight-items of the CASP appraisal tool were applied within this review as these specifically seek to evaluate methodological strengths and limitations. Item nine ‘Is there a clear statement of findings?’ was excluded on the basis that methodological quality is independent to the quality of reporting and item ten ‘how valuable is the research?’ was also excluded. The researcher completed the CASP assessment for all qualitative studies. A research assistant independently completed the CASP for 90% (9/10) of the included studies. Inter-rater agreement for each domain across the nine studies was 88.8% (kappa coefficient, k=0.78). Disagreements were discussed and a consensus was met. Final agreement between raters was 100%.

**Certainty of Evidence Assessment**

In addition to the risk of bias assessment it is important to perform an assessment on the certainty of the findings reported. The Cochrane Collaboration have adopted the publicly available Grading of Recommendations Assessment, Development, and Evaluation (GRADE; see appendix H) approach to assessing the certainty of a body of quantitative literature (Schünemann et al., 2021). The GRADE-CERQual (see appendix I) has been adopted for qualitative literature. The researcher completed the GRADE and GRADE-CERQual for all studies. The researcher completed the appropriate certainty of evidence assessment for 88.2% (15/17) of the included studies with the research assistant. Inter-rater agreement for overall GRADE score across the 15 studies was 100%.

**Publication & Reporting Bias**

Quantitative techniques to determine the risk of publication bias such as funnel plots (Mavridis & Salanti, 2014) were not deemed viable for this review due to the expected heterogeneity and qualitative approach to synthesis. However, following the initial electronic database searches which included a search for theses and dissertations, four further grey literature databases and five websites of organisations operating within the area of interest were searched to identify additional unpublished research. One additional study was identified that met the inclusion criteria for this review. To reduce the risk of duplicate publication bias studies which utilised the same primary data were reported on, and the search strategy was designed to maximise the opportunity of locating studies which may have been more difficult to access, minimising location bias (Page, Higgins, et al., 2021).

**Results**

A PRISMA flow-diagram (Page, McKenzie, et al., 2021) detailing the search and selection process is displayed in figure 1. The 17 studies meeting inclusion criteria are detailed in table 2.

**Sample Characteristics**

The sample includes >682 adopted children (M=42.62, R=1-481) and >782 adoptive parents (M=46, R=1-525). Precise figures cannot be calculated as certain studies reported only the total number of adopted children or adoptive parents. Samples were skewed in distribution with 12 studies recruiting <12 families. Most quantitative studies employed a pre-post intervention design with no control group (*k*=5) and most qualitative studies utilised interpretative phenomenological analysis (*k*=4). Interventions ranged in duration from 30 hours of therapy delivered over two weekends to engagement in sessions for between 9-15 years. Most interventions (*k*=9) took place for between 6-16 sessions and/or weeks. Four studies collected data at follow-up, the average follow-up period was 13 months (R=1-36). The most frequently used assessment measures were the Child Behaviour Checklist (CBCL; Achenbach & Rescorla, 2000) and versions of the Assessment Checklist measures (Tarren-Sweeney, 2007; 2013) which were each utilised in four studies. Versions of the Trauma Symptom Checklist measures (Briere, 1996; Briere et al., 2001) were utilised in three studies. In contrast, a total of 21 measures were employed in one study each.

**Interventions**

Integrative therapeutic approaches were the most common interventions utilised (*k*=6). McCullough et al. (2016) and McCullough and Mathura (2019) examined Neuro-Physiological Psychotherapy (NPP), a psychotherapy which integrates Theraplay® (Booth & Jernberg, 2010), Sensory Integration (SI; Ayres, 2005), Somatic Experiencing (SE; Levine, 2010), dramatherapy and creative arts (Jones, 2007; 2010), Dyadic-Developmental Psychotherapy (DDP; Hughes et al., 2015), and life story work. Hunsley et al. (2021) examined a therapeutic day camp entitled Hope Connection 2.0 (HC2.0) which integrated body-based somatosensory activities (Ayres, 2005; Levine, 2010; Ogden et al., 2006), life skills, speech, and art sessions for children, nurture and play sessions for families, and a Trust-Based Relational Intervention (TBRI) for parents (Purvis et al., 2014; Purvis et al., 2015). Ulasińska et al. (2020) integrated Multi-Family Therapy (MFT; Asen & Scholz, 2010) with socio-therapy, art therapy, video training communication (VTC; Klein Velderman et al., 2006), psychoeducation, fairy tale therapy (Vachkov, 2016), and relaxation. Weir et al. (2013) integrated Theraplay® with family systems theory (Nichols, 2009). Finally, Wesselmann et al. (2018) integrated Eye Movement Desensitisation and Reprocessing (EMDR; Shapiro, 2018) and family therapy.

**Figure 1**

*Prisma flow diagram (Page, McKenzie, et al., 2021)*

**Identification of studies via other methods**

**Identification**

**Identification of studies via databases and registers**

Records identified through database searching: (n = 3,336)

CINAHL (n = 374)

Cochrane (n = 2)

MEDline (n = 159)

ProQuest (n = 1,646)

PsycINFO (n = 460)

Scopus (n = 20)

Web of Science (n = 675)

Records removed *before screening*:

Duplicate records removed (n = 1,082)

Records removed for other reasons:

Books or book chapters

(n = 138)

Reports sought for full-text screening (n = 12)

Records title and abstract screened (n = 2,116)

Reports full-text screened for eligibility (n = 12)

Reports sought for full-text screening (n = 38)

Reports not retrieved

(n = 0)

**Screening**

Reports full-text screened for eligibility (n = 38)

Total studies included (n = 19):

Reports yielded from systematic database search (n = 14)

Reports yielded from other search methods (n = 5)

Records excluded following title screening (n = 1,997)

Records excluded following abstract screening (n = 81)

Records identified via other methods (n = 12):

Grey literature databases (n = 1)

Hand searching Adoption and Fostering (n = 2)

Hand searching Adoption Quarterly (n = 1)

Included studies backwards citation searching (n = 4)

Google Scholar forwards citation searching of included studies (n = 1)

Database update alerts between 29.10.2021 to 19.05.2022 (n = 2)

Preliminary scoping searches on Google Scholar (n = 1)

Reports not retrieved

(n = 0)

Reports excluded (n = 7):

Sample included <50% domestically adopted children (n = 3)

Study detailed descriptive case report (n = 1)

Study did not report an intervention (n = 1)

Intervention delivered to parents only (n = 1)

Article had been retracted (n = 1)

Reports excluded (n = 24):

Intervention delivered to parents (n = 7)

Results reported <50% domestically adoptive children and data could not be separated (n = 7)

Intervention unclear or poorly defined (n = 3)

Full text not available in English (n = 3)

Study detailed a descriptive case report (n = 2)

Sample unsuitably recruited (n = 1)

Intervention utilised holding therapy (n = 1)

**Included**

**Table 2**

*Description of Studies*

| First author (Year) Country | Aim of Study | Population – data extracted for domestically adoptive families only where possible [% of placed domestically adopted families] | Design, time points data collected | Intervention [theoretical model], length of therapy, content, providers. | Outcomes Assessed |
| --- | --- | --- | --- | --- | --- |
| Agbayani (2014)  USA | To explore how AFFT, coupled with attachment-specific parenting strategies, helps adoptive families preserve adoptive placements. | Two adoptive families. Parents: two mothers, one father.  Children: three male, two female. Age at adoption (M=3.6 years, R=2-5 years) [100%]. | Qualitative collective case study, data collected following therapy. | DDP [attachment theory, IPNB, and family therapy], 9-15 years, Hughes’ (2004; 2007) AFFT model, attachment therapists from local counselling agencies. | Parent interviews. |
| Draper et al. (2021) UK | To examine whether the FFF protocol can address the complexities of an adoptive child’s experience of trauma, through use of bilateral movements to facilitate well-being. | Eight adopted children and their parent(s). Children: six female two male, age (M=10, R=8-15). [100%]. | Within subject pre/post design, data collected at session 1, 6, 10, and 12. | FFF [EMDR, bilateral stimulation], 12 sessions, Draper (2020) FFF protocol which includes elements of Shapiro (2018) EMDR protocol, qualified EMDR therapists psychotherapists, and psychologists. | Non-standardised self-report SUD and VOC scores |
| Harrison-Stewart et al. (2018) UK | To explore adoptive parents’ lived experiences of MST in relation to their context as a family: strengths and limitations and what helped or hindered positive change. | Ten adoptive families. Parents: seven mothers, two fathers, one couple, age R=42-62 years. Children: six female, four male, age at adoption (M=3.3, R=0.5-8.5), age at intervention (M=13.8, R=11-17) [100%]. | Qualitative thematic analysis, data collected M=2.63 years following therapy (R=1-84 months). | MST [systems, social ecological, and attachment theories, and family therapy], length not reported, standard MST procedures (Henggeler & Schoenwald, 1998), therapists from five MST services in UK. | Parent interviews. |
| Hodgdon, et al. (2016) USA | To describe the application of the ARC model with adopted families impacted by complex trauma. | 525 parents and 481 children. Children age M=11.04 R=6-12. 50.9% female and 49.1% male. [60%, 289 domestically adopted children]. | Within subject pre/post design, baseline, post-intervention, and 12 month follow up | ARC [attachment theory, IPNB, and theories of resilience], 16 individual sessions and 6 group sessions in 16 weeks, followed the ADOPTS program, master’s level practitioners in psychology or related fields. | BASC-2, CAPS, PSI-SF, TSC-C, TQ. |
| Hunsley et al. (2021)  USA  [Hunsley, (2019) thesis] | To examine the preliminary effectiveness of a therapeutic day camp in improving the trauma-related challenges of adopted children and adoptive family relationships. | Nine adoptive families. Five intervention and four waitlist control. Intervention condition: 9 parents age M=41.56, 6 children age at adoption M=3.68, age at intervention M=7.83 [88%, eight domestically adopted children]. | A two-group (intervention versus waitlist condition) pre/post study, data collected pre and post intervention. | HC2.0 (integrative) [attachment theory, IPNB, SI, and family therapy], 30 hours over two weekends, integrative approach utilising principles of TBRI, sensory regulation, play, art, and parental psychoeducation, providers not reported | PRQ, SDQ, SRQ, TSCYC, FACES IV. |
| Jaffrani et al. (2020)  USA | To explore how epistemic trust can be established in the context of MBT work with adoptive families. | One adoptive family.  Single parent father and two daughters. Child age at adoption: 2 and 7. Child age following intervention: 11 and 16 [100%]. | Qualitative single-case IPA study, data collected following therapy | MBT [attachment theory, IPNB, and family therapy], six sessions, adapted from the Adopting Minds program, experienced systemic therapist trained in MBT. | Parents interviews. |
| Lewis et al. (2021)  Canada | To explore the efficacy of LI therapy for addressing attachment processes with adopted children in middle childhood was investigated. | One adoptive family, mother and son. Child age at adoption 9.5 months, child age at intervention: 12 years [100%]. | Mixed-methods hermeneutic single case design, data collected weekly and post therapy | LI therapy [attachment theory, IPNB, ego-state therapy, body-mind integration, and imagery guidance], ten sessions, standard LI procedures (Pace, 2012), provider not reported. | PSDQ, PQ, PRQ, HAT, BASC-2, TSNQ, KSS, & parent interviews. |
| McAlpin, (2013).  USA | To discover how community-based family music groups could foster bonding development in adoptive families | 11 adoptive families. 19 adoptive parents aged M=37.8 R=32-52. 14 adopted children, age at adoption M=12.7 months R=birth-4 years, age at intervention M=1.5 R=5 months to 6 years [50%, seven domestically adopted children] | Qualitative heuristic grounded theory study, data collected pre, mid, & post-intervention | Kindermusik® [attachment theory and music therapy], 8 weeks, standard Kindermusik® wiggle and grow program, certified Kindermusik® practitioner. | Parent interviews, journals, & intervention observation. |
| McCullou-gh & Mathura (2019) UK | To ascertain whether gains from an NPP intervention are significantly different to a control group. | 37 adoptive families, intervention n=21, control n=16. 49 adoptive parents. Intervention condition: child age at assessment M=9.47, child age at retest M=14.6, 53% female 47% male [100%]. | A two-group (NPP intervention versus non-equivalent control) pre/post study, data collected pre and post intervention | NPP (integrative) [attachment theory, IPNB, NMT, SI, and family therapy], M=47 sessions, integrative SI Theraplay® SE dramatherapy DDP and life story work, one therapist per child and one per parent with masters or doctoral level training. | ACC, ACA, CBCL, BRIEF, Parent interviews. |
| McCullou-gh et al. (2016) UK | To evaluate the impact of NPP on changes in behavioural, emotional and executive functioning difficulties in adoptive children. | 21 adoptive families. 31 children, 19 post-therapy, 12 mid-therapy. Child age pre-therapy M=9.47, child age at retest M=14.6, 55% female 45% male. Quantitative data reports on all 31 children, qualitative data reports on the 19 children in the post-therapy condition. [100%]. | Mixed methods within subject pre/post quasi-experimental design, data collected pre and mid/post therapy. | NPP (integrative) [attachment theory, IPNB, NMT, SI, and family therapy], number of sessions not reported, integrative SI Theraplay® SE dramatherapy DDP and life story work, one therapist per child and one per parent each with masters or doctoral level training. | ACC, BRIEF, CBCL, TRF. |
| Midgley et al. (2018)  UK | To provide initial evaluation of the application of MBT for adoptive families. | 36 adoptive families, 59 parents 42 children. Only 32 families completed demographic data. Median child age = 9, R=2-17, n=33), 15 male 14 female (of the 29 children in which this data was available). Five families engaged in interviews [100%]. | Mixed method: pre/post evaluation for all families & IPA with a sub-sample, data collected following therapy. | MBT [attachment theory, IPNB, and family therapy], >six sessions, adapted from the Adopting Minds program, therapist was experienced in systemic family work and well trained in MBT-F. | BAC, BPSES, and parent interviews. |
| Salamino & Gusmini (2017) UK | To explore the advantages of adopting a socio-constructionist approach when dealing with discourse about attachment, mutual belonging, and individual development with an adoptive family. | One adoptive family. Mum, dad, and son. Child was aged 9 at time of adoption and aged 15 at time of first consultation [100%]. | Mixed method single-case study, data collected pre and post intervention. | Family therapy [post-Milanese systematic family therapy], seven two-hour sessions, family therapy focused on current family relationships offering triadic explanations, provider not reported. | Stratton (2003) attribution scheme, session transcripts & parent interviews. |
| Turner (2012) UK | To explore adopter’s experiences of DDP and their perspectives of the changes it had helped their family make. | Six adoptive families. Six adoptive mothers aged between 35 and 50, and at least six adopted children aged between 8 and 15 at the time of therapy [100%]. | Qualitative IPA, data collected following the intervention | DDP [attachment theory, IPNB, and family therapy], at least three months of sessions, Hughes’ (2004; 2007) AFFT model, qualified DDP practitioners within the NHS. | Parent interviews |
| Ulasińska et al. (2020)  Poland | To explore the impact of an original program aimed at supporting adoptive families. | Six adoptive families, eight adopted children. Children age at intervention: R=5.5-10. Time in adoptive placement R=5-18 months [100%]. | Qualitative thematic analysis, data collected following the intervention | MFT (integrative) [attachment theory, relaxation, art, socio, fairy tale, and family therapy], 43 hours of therapy over eight days, group and play therapy with video training for parents, provider not reported. | Feedback from parents. |
| Weir et al. (2013) USA | To provide a preliminary report of a pilot study demonstrating the efficacy of WFT. | 12 adoptive families, 23 parents and 25 adoptive children. Child age at intervention M=7.52, 14 girls and 11 boys [100%]. | Pre-test/post-test quasi-experimental design, data collected pre and post intervention | WFT (integrative) [attachment theory, FST and family therapy], 12-15 weekly sessions, integrating FST, SFT, ET and Theraplay®, two student co-therapists for each family. | CBCL, FAD, OQ, Y-OQ. |
| Wesselma-nn et al. (2018) USA | To examine the effectiveness of an integrative EMDR and family therapy approach, specifically IATP-C, for adoptive families. | 20 adoptive families, 23 children and their adoptive parents. Children age: M=10, R=7-12, 13 males and 10 females [75%, 15 domestically adoptive families]. | Case series, data collected pre intervention, at 6 months, post intervention, and follow-up | EMDR (integrative) [attachment theory, AIP model, and family therapy], M=12.7 months in length, IATP-C protocol was followed, two co-therapists per family one certified in EMDR and the other was a licensed counsellor. | ADAS, CBCL, PBQ, RADQ, TSCYC. |
| Wingfield & Gurney-Smith (2019) UK  [Wingfield, (2017) thesis] | To understand and explore the experience of adoptive parents who have completed DDP with their child. | 12 adoptive parents from 12 separate adoptive families, at least 12 children. Parent age M=47 R=37-61, seven adoptive mothers and five adoptive fathers [100%]. | Qualitative IPA, data collected following intervention | DDP [attachment theory, IPNB, and family therapy], 8-43 sessions, Hughes et al. (2015) DDP model, certified DDP clinicians or clinicians becoming certified. | Parent interviews. |

M: Mean average, R: Range  
ACA: Assessment checklist for adolescents, ACC: Assessment checklist for children, ADAS: Attachment disorder assessment scale-revised, AFFT: Attachment focused family therapy, AIP: Adaptive information processing, ARC: Attachment regulation and competency, BAC: Brief assessment checklist, BASC-2: Behavioural assessment system for children, BRIEF: Behaviour rating inventory of executive function, BPSES: Brief parental self-efficacy scale, CAPS: Clinician administered PTSD scale, CBCL: Child behaviour checklist 6–18, DDP: Dyadic-developmental psychotherapy, EMDR: Eye movement desensitisation and reprocessing, ET: Experiential therapy, FACES IV: Family adaptability and cohesion scale IV, FAD: Family assessment device, FFF; Fast feet forward, FST: Family systems theory, HAT: Helpful aspects of therapy, HC2.0: Hope connection 2.0, IATP-C: Integrative attachment trauma protocol for children, IPA: Interpretative phenomenological analysis, IPNB: Interpersonal neurobiology, KSS: Kerns security scale, LI: Lifespan integration therapy, MBT: Mentalisation-based therapy, MBT-F: Mentalisation-based therapy for families, MFT: Multi-family therapy, MST: Multisystemic therapy, n: Number of participants, NMT: Neurosequential model of therapeutics, NHS: National health service, NPP: Neuro-physiological psychotherapy, OQ: Outcome questionnaire-45, PBQ: Postpartum bonding questionnaire, PQ: Personal questionnaire, PRQ: Parenting relationship questionnaire, PSDQ: Parenting styles and dimensions questionnaire, PSI-SF: Parenting stress index – short form, RADQ: Randolph attachment disorder questionnaire, SDQ: Strengths and difficulties questionnaire, SE: Somatic experiencing, SFT: Structural family therapy, SI: Sensory integration, SRQ: Sibling relationship questionnaire, SUD: Subjective units of disturbance, TBRI: Trust-based relational intervention, TQ: Trauma questionnaire, TRF: Teacher report form, TSC-C: Trauma symptoms checklist for children, TSCYC: Trauma symptoms checklist for young children, TSNQ: Therapist session notes questionnaire, VOC: Validity of cognition, WFT: Whole family Theraplay®, Y-OQ: Youth outcome questionnaire.

Three studies utilised DDP, two examined Mentalisation-Based Therapy (MBT: Bateman & Fonagy, 2004), and the remaining studies implemented Multi-Systemic Therapy (MST: Henggeler & Schoenwald, 1998), Attachment Regulation and Competency (ARC: Blaustein & Kinniburgh, 2010), Lifespan Integration therapy (LI: Pace, 2012), Kindermusik® (Kindermusik® International, 2022), post-Milanese family therapy (Campbell, 1999), and the Fast Feet Forward (FFF) EMDR protocol.

**Developmental Status**

Seven studies reported child age at adoption (M=3.69, R=0-9) and 15 reported child age at intervention (M=9.84, R=0.75-15). Seven studies reported both statistics with average time between placement and intervention being 6.2 years (R=0.5-11.25). Ten interventions, including all six integrative interventions, ARC, DDP, MBT, and the FFF-EMDR protocol took place with predominately primary school aged adoptive child between 6-11.5 years old. McAlpin’s (2013) Kindermusik intervention aimed to promote attachment bonds in developmentally younger children (M=1.5 years), whereas Lewis et al.’s (2021) LI study explored attachment processes with a 12-year-old child, and Harrison-Stewart et al. (2018) examined the impact of MST on antisocial behaviour problems in adolescents (M=13.8 years). Finally, Jaffrani et al. (2020) explored the development of epistemic trust following the use of MBT with adoptive parents of an 11- and 16-year-old and Salamino and Gusmini (2017) applied post-Milanese family therapy focusing on resources and ongoing relationships to strengthen emotional ties within an adoptive family with a late-adopted 15-year-old child.

**Risk of Bias & GRADE Assessments**

Table 3 details the ROBINS-I (Sterne et al., 2021) and CASP (2018) risk of bias assessments. Two quantitative studies reported a moderate risk of bias (Hunsley et al., 2021; McCullough & Mathura, 2019) and five reported a serious risk of bias. Collectively, the main sources of bias resulted from a lack of control of confounding variables and lack of blinding when measuring outcomes. Conversely, risk of bias relating to the classification of interventions was seen as an area of strength within the quantitative research. Three qualitative studies reported an overall low risk of bias (Agbayani, 2014; Midgley et al., 2018; Wingfield & Gurney-Smith, 2019), four studies reported an overall moderate risk of bias, and three reported a serious risk of bias. Collectively, the main sources of bias were seen in the absence of reporting the researcher-participant relationship which was seen in eight of the ten studies and the absence of a suitable recruitment strategy which was seen in five of the ten studies. Additionally, all quantitative studies were reported to have very low quality of evidence ratings. This was largely due to the fact that none of the studies were randomised controlled trials and there was an absence of upgrading factors such as no plausible confounding or the presence of a dose response. The qualitative studies were reported to have very low to low certainty of evidence ratings, with the exception of Midgley et al. (2018) and Wingfield and Gurney-Smith (2019) which were reported as moderate.

**Synthesis of Findings**

A summary of the key findings for each study is presented in table 4.

**Table 3**

*Risk of Bias Assessments ROBINS-I (Sterne et al., 2021) & CASP Qualitative Checklist (CASP, 2018)*

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|  | Draper et al. (2021) | Critical | Serious | L | M | Serious | Serious | M |  | Serious |
| ROBINS-I | Hodgdon, et al. (2016) | Critical | M | L | Serious | L | Serious | M |  | Serious |
| Hunsley et al. (2021) | Serious | M | L | Serious | M | Serious | M |  | M |
| McCullough & Mathura (2019) | M | Serious | L | M | M | M | Serious |  | M |
| McCullough et al. (2016) | Critical | Serious | L | Serious | M | Serious | M |  | Serious |
| Weir et al. (2013) | Critical | M | L | M | Serious | Serious | M |  | Serious |
| Wesselmann et al. (2018) | Critical | M | L | M | Serious | Serious | Serious |  | Serious |
| CASP | Agbayani (2014) | Y | No | Y | Y | Y | Y | Y | Y | L |
| Harrison-Stewart et al. (2018) | Y | Y | No | Y | Y | No | Y | Y | M |
| Jaffrani et al. (2020) | Y | No | Y | Y | Y | No | Y | Y | M |
| Lewis et al. (2021) | Y | No | Y | Y | Y | No | No | Y | Serious |
| McAlpin, (2013) | Y | Y | Y | Y | Y | No | No | Y | M |
| Midgley et al. (2018) | Y | Y | Y | Y | Y | No | Y | Y | L |
| Salamino & Gusmini (2017) | Y | No | Y | Y | Y | No | No | Y | Serious |
| Turner (2012) | Y | No | Y | Y | Y | No | Y | Y | M |
| Ulasińska et al. (2020) | No | Y | No | Y | Y | No | No | No | Serious |
| Wingfield & Gurney-Smith (2019) | Y | Y | Y | Y | Y | Y | Y | Y | L |

ROBINS-I Items: CASP Items: Response Key:

1. Risk of bias due to confounding. 1. Was there a clear aim of the research? Low risk: L

2. Risk of bias in selection of participants. 2. Was the recruitment strategy appropriate? Moderate risk: M

3. Risk of bias in classifications of investigations. 3. Was the research design appropriate? Serious risk: Serious

4. Risk of bias due to deviations from interventions. 4. Is a qualitative methodology appropriate? Critical risk: Critical

5. Risk of bias due to missing data. 5. Was the data collected appropriately? Yes: Y

6. Risk of bias in measurement of outcomes. 6. Is the researcher-participant relationship considered? No: No

7. Risk of bias in selection of the reported result. 7. Was the data analysis sufficiently rigorous?

8. Question intentionally left blank. 8. Have ethical issues been considered?

9. Overall risk of bias 9. Overall risk of bias.

**Table 4**

*Summary of Key Findings*

| Study [therapy] | Control | Findings that support the intervention | Findings that do not support the intervention | Primary conclusions | Risk of Bias  (GRADE) |
| --- | --- | --- | --- | --- | --- |
| Agbayani (2014)  [DDP] | No control | Qualitative analysis of parent interviews: DDP helped increase parental understanding, validated parental concerns, and provided parents with a different set of tools to help their children. | Qualitative analysis of parent interviews: certain struggles continued post-therapy into adulthood (sexualised, aggressive, and criminal behaviour) | Parents seem more likely to preserve adoption by using DDP as a framework to approach problems, a way to add tools to their parenting strategies, a resource to access adjunct therapies, and a source of validation. | M (++) |
| Draper et al. (2021) [EMDR] | No control | One session of FFF-EMDR protocol (n=8): pre/post VOC: p=.05, d=-.65, pre/post SUD: p=.05, d=.80. Six sessions (n=8): pre/post SUD: p=.05 d=1.15. Ten sessions (n=6) pre/post SUD: p=.05 d=1.57. Twelve sessions (n=3) pre/post VOC: p=.05 d=-2.88, pre/post SUD: p=.05 d=1.28 | Six sessions of FFF-EMDR protocol (n=8): pre/post VOC: d=-.26. Ten sessions (n=6) pre/post VOC: d=-.36. Only 3 children attended all 12 sessions, reason for drop out not discussed. | The intervention demonstrates promising effects for decreasing the level of distress and disturbance associated with trauma. The results evidence the potential efficacy of this protocol for adopted children and families. | Serious (+) |
| Harrison-Stewart et al. (2018)  [MST] | No control | Qualitative analysis of parent interviews: MST changed the parent’s expectations of the young person’s behaviour, increased parental confidence and strength, and provided a foundation for further change. | Qualitative analysis of parent interviews: The MST programme did not act as a ‘fix’ to anti-social behaviours and often the context of adoption and associated trauma was overlooked. | The study suggests MST practice needs to be advanced to meet the needs of adoptive families. MST must incorporate adoption related theory, be sensitive to working with adoption, and MST therapists must take on appropriate training, supervision, and consultation. | M (++) |
| Hodgdon, et al. (2016)  [ARC] | No control | Baseline to 12-month follow up improvements in: TSC-C anxiety p=.001 d=-.39, depression p=.001 d=-.29, PTS p=.001 d=-.29, dissociation p=.001 d=-.19, and anger p=.001 d=-.33. BASC: father externalising p=.01 d=-.20 and mother externalising p=.001 d=-.56, internalising p=.001 d=-.15, adaptability p=.001 d=.32 and adaptive skills p=.001 d=.33. PSI: mother total stress p=.001 d=-.19, parent distress p=.05 d=-.11, parent-child dysfunction p=.001 d=-.06, and perception of difficult child p=.001 d=-.31. | TSC-C: mean sexual concern score increased from baseline to follow-up. BASC: father internalising, adaptability, and adaptive skills did not report significant changes. PSI: mean scores on the father total stress, distress, and parent-child dysfunction scales increased. | ARC treatment was associated with significant decreases in child symptoms including internalizing, externalizing, PTS, depression, anxiety, anger, and dissociative symptoms. ARC was also associated with improved caregiver functioning including significant reductions in caregiver perception of child difficulty, as well as on all measured domains of maternal reported stress and caregiver stress. These changes were maintained over a 12-month follow up period. | Serious (+) |
| Hunsley et al. (2021)  [HC2.0] | Waiting list control | Advanced statistical analysis not possible due to sample size. Within intervention condition children reported preliminary mean score reductions in TSCYC anxiety (-2.0), depression (-5.6), and aggression (-6.5) and trending reductions in SDQ peer problems (-1.2). Parents reported improvements in PRQ attachment (+5.7), confidence (+2.9), communication (+2.4), and relational frustration (-3.3). Families reported increased communication (+8.3) and satisfaction (+5.5) on the FACES IV. | Within intervention condition mean score increases were reported in emotional (+.3) and hyperactivity problems (+.7) and no change in conduct problems or warmth/closeness in sibling relationship. Within control group mean reductions in aggression (-2.0), emotional problems (-.1), hyperactivity (-.2), and sibling conflict (-.9) were reported. | The results revealed the intervention’s preliminary effectiveness in reducing some trauma-related emotional and behavioural struggles, improving the parent-adopted child relationship, and improving communication and satisfaction in adoptive families. | M (+) |
| Jaffrani et al. (2020)  [MBT] | No control | Qualitative analysis of parent interviews: MBT therapist’s empathetic and curious stance helped the family to feel safe. Trust took time to build and the MBT treatment facilitated the development of this. | Qualitative analysis of parent interviews: Potential mistrust of services could impede the development of trust within this intervention. | The study highlights the importance of establishing epistemic trust in the context of adoption services. In doing so, findings indicated that providing a safe environment is imperative. | M (++) |
| Lewis et al. (2021)  [LI] | No control | BASC-2: pre-therapy to follow-up interpersonal relationships improved from a t-score of 35 (at risk) to 51 (average), attitude to school improved from a t-score of 60 (at risk) to 44 (average). PRQ: relational frustration decreased from a t-score of 78 (upper extreme) to 59 (average). Overall PQ also improved. Qualitative analysis of child & parent interviews: Child reported being able to control their emotions better, parent reported child as happier. | Minimal changes in most of the PRQ domains.  Qualitative analysis of child & parent interviews: the baby-self aspect of the intervention was difficult | LI therapy was judged to have been helpful and effective in addressing the child’s presenting concerns considering their adoptive and attachment trauma. The use of timelines and baby-doll experiences were deemed useful. | Serious (+) |
| McAlpin, (2013)  [Kinder-  musik] | No control | Qualitative analysis of parent interviews: Parents reported increases in understanding and awareness relating to healing, acceptance, and compassion. Parents reported relationship repair, attachment security, communication, and inter-subjective experiences. | None reported | Participation in the Kindermusik® Wiggle and Grow classes created a platform which encouraged and promoted secure parent-child attachment bonds. | M (++) |
| McCullo-ugh & Mathura (2019)  [NPP] | Non- equivalent control group | Relative to control group BRIEF: GEC reduced p=.008 d=.147, BRI reduced p=.001, d=.435. ACC: Total shared item score reduced p=.020 d=.212, Composite self-esteem reduced p=.008 d=.330. Improvements in parent-child p=.005 Cramer’s v=.444 and child-peer p=.003 Cramer’s v=.486 relationships. | Non-significant reductions on BRIEF: MCI p=.077 d=.426, CBCL: total p=.071, d=.072, and externalising problems, p=.084 d=.066. ACC: negative self-image p=.073 d=.169 and sibling relationships p=.082 Cramer’s v=.337. | Findings provide encouraging support for the effectiveness of the NPP approach. Especially noteworthy is that the areas of significant change are within the affective, relational, behavioural, and self-concept domains. | M (+) |
| McCullo-ugh et al. (2016)  [NPP] | No control | BRIEF: reductions on BRI p=.001 d=.66, inhibit p=.002 d=.68, and emotional control p=.000 d=.77. ACC: reductions on total score p=.038 d=.58, indiscriminate p=.022 d=1.03, and food maintenance p=.033 d=.88. CBCL reductions on total score p=.002 d=.40, externalising problems p=.011 d=.40, social problems p=.048 d=.39, thought problems p=.044 d=.31, attention problems p=.050 d=.41, and aggressive behaviour p=.001 d=.58. Qualitative analysis of parent interviews (n=19): 84% of parents reported improvements in parental relationships, 69% reported improvements in sibling relationships, 95% reported the absence of further mental health diagnosis, 89% reported the absence of involvement in criminal justice system, and 95% reported the absence of exclusion from school following therapy. | BRIEF: increases in mean score on scales of metacognition, initiate, and plan/organise. ACC: increases in mean score on scales of pica and low confidence CBCL: increase of mean score on withdraw/depressed scale. Non-significant reductions on all other scales across these three measures. Qualitative analysis of parent interviews (n=19): 53% of families continued accessed additional therapy for the child after completing the NPP treatment. | Analysis of the repeated measures received statistically significant changes in behavioural regulation, executive functioning and externalising and internalising difficulties, alongside an improvement in thought and social problems. However due to the absence of a control group, pre–post reductions in symptoms cannot be attributed as evidence of treatment effectiveness. | Serious (+) |
| Midgley et al. (2018)  [MBT] | No control | Mean reductions in BAC from 21.7 to 16.5 (-4.2) and mean improvements in BPSES from 18.7 to 20.3 (+1.6). Qualitative analysis of parent interviews: parents reported receiving support and containment, not feeling judged, and being supported with difficult past experiences were important aspects. | Qualitative analysis of parent interviews: It was not always clear to families to what extent the changes could be attributed to therapy. Some parents reported that therapy on its own was not enough to achieve improvements. | Findings suggest that the Adopting Minds approach, as an adaptation of MBT-F in the context of post-adoption support, deserves further investigation as a therapeutic contribution to adoptive families presenting with a range of difficulties. | L (+++) |
| Salamino & Gusmini (2017)  [Post-Milanese family therapy] | No control | Attributions relating to stress within the family system changed from being more stable, global, internal, personal, and uncontrollable, to being unstable, specific, external, universal, and controllable. | Some attributions in the final session of therapy and at follow up remained stable, global, and internal. | Findings support the idea that focusing on current relationships and patterns of mutual connection in the present can be a valuable strategy when dealing with well-developed perspectives. | Serious (+) |
| Turner (2012) [DDP] | No control | Qualitative analysis of parent feedback: Parents reported the benefits of in-vivo coping, the utility of PACE, improved understanding of the child, and increased awareness that they need to adapt their parenting approaches. Parents also found it helpful that their own needs were seen as important and recognised in the therapy. | Qualitative analysis of parent feedback: Parents had trouble with playfulness, found it hard to incorporate DDP into their normal family routine, and emphasised that it is important to feel ready for DDP. | DDP was reviewed positively in terms of outcomes and the changes it had contributed to within the families. Experiences of DDP helped to influence parenting techniques and improved understanding of the child and their behaviour. All parents felt the therapeutic relationship was important. | M (++) |
| Ulasińska et al. (2020)  [MFT] | No control | Qualitative analysis of parent feedback: Parents valued the mutual support of those with similar experiences, parents reported reductions in anxiety and gained more realistic views of their child. | Qualitative analysis of parent feedback: The provision of therapy may not be sufficient for parents who require their own psychological support. | Most participants evaluated the MFT program positively. Parents highlighted the benefits of sharing experiences, mutual support, and eliminating feelings of guilt. | Serious (+) |
| Weir et al. (2013)  [WFT] | No control | FAD: reductions in problems relating to communication p=.027 d=1.09. OQ: reductions in problems relating to interpersonal relations p=.040 d=.98. Y-OQ: reduction in total score p=.026 d=1.106. | No significant changes on the scales of FAD: total, problem solving, roles, affective involvement, and general functioning, OQ: symptoms distress, and social role, Y-OQ: intrapersonal distress, somatic, interpersonal relations, critical items, social problem, and behaviour dysfunction. | These initial findings indicate that WFT is a practice model that shows promising potential. Findings suggest it might have some level of clinical efficacy in at least three key areas: improving family communication within adoptive family systems, enhancing adult parents’ interpersonal relational skills, and assisting children in adoptive families to have better overall clinical outcomes. | Serious (+) |
| Wesselm-ann et al. (2018)  [EMDR] | No control | Overall reductions on the following measures pre-therapy to post-therapy: ADAS: p=.00 d=3.20, RADQ: p=.00 d=2.48, CBCL: p-.00 d=1.95, TSCYC-PTS: p=.00 d=1.44, PBQ: p=.003 d=.84, OQ-45: p=.048 d=.43. | None reported | IATP-C shows promise as an effective treatment for this population. IATP-C significantly decreased behavioural and traumatic stress symptoms and improved attachment relationships in children and increased the mothers’ positive feelings toward their child. | Serious (+) |
| Wingfield & Gurney-Smith (2019)  [DDP] | No control | Qualitative analysis of parent interviews: Parents reported that DDP helped them to develop an increased level of understanding, DDP could be a new way to help, DDP is a different way of parenting and fits, acceptance helps, and DDP builds trust, security, and emotional regulation. | Qualitative analysis of parent interviews: Some parents were initially sceptical towards the treatment methodology and wished to see the evidence base. | Parents felt they had increased insight into their child’s mind. They felt DDP was a good fit and it appeared to promote acceptance. Parents felt DDP helped build trust and security and supported co-regulation. Parents also acknowledged the therapist’s role in conveying the core DDP principles. | L (+++) |

ACC: Assessment checklist for children, ADAS: Attachment disorder assessment scale-revised, ARC: Attachment regulation and competency, BAC: Brief assessment checklist, BASC: Behavioural assessment system for children, BPSES: Brief parental self-efficacy scale, BRI: Behavioural regulation index, BRIEF: Behaviour rating inventory of executive function, CBCL: Child behaviour checklist DDP: Dyadic-developmental psychotherapy, EMDR: Eye movement desensitisation and reprocessing, FAD: Family assessment device, FFF: Fast feet forward, GEC: Global executive composite, HC2.0: Hope connection 2.0, IATP-C: Integrative attachment trauma protocol for children, LI: Lifespan integration, MBT: Mentalisation-based therapy, MBT-F: Mentalisation-based therapy for families, MCI: Metacognition index, MFT: Multi-family therapy, MST: Multi-systemic Therapy, NPP: Neuro-physiological psychotherapy, OQ: Outcome questionnaire-45, PACE: Playfulness, acceptance, curiosity, and empathy, PBQ: Postpartum bonding questionnaire, PQ: Personal questionnaire, PRQ: Parenting relationship questionnaire, PTS: Posttraumatic stress, RADQ: Randolph attachment disorder questionnaire, SUD: Subjective units of disturbance, TSC-C: Trauma symptoms checklist for children, TSCYC: Trauma symptoms checklist for young children, VOC: Validity of cognition, WFT: Whole family Theraplay®, Y-OQ: Youth outcome questionnaire.

Risk of Bias Ratings: GRADE Quality of Evidence Ratings:

Low risk: L Very low: +

Moderate risk: M Low: ++

Serious risk: Serious Moderate: +++

Critical risk: Critical High: ++++

***Synthesis of Quantitative Evidence***

Nine studies reported quantitative evidence. Six of these reported effect size calculations or presented data in which effect sizes were then calculated. The integration of EMDR and family therapy reported that measures of attachment, trauma symptomatology, and behavioural and emotional difficulties each improved to a large effect (Wesselmann et al., 2018). These findings provide preliminary support for the integrative attachment trauma protocol for children as a promising intervention for adoptive families due to the improvements in symptomatology, attachment relationships, and in adoptive mothers’ positive feelings towards their child. Separately, the use of the FFF-EMDR protocol produced improvements of a large effect on self-reported non-standardised measures of discomfort and cognition following one and twelve sessions (Draper et al., 2021). However, this failed to improve cognition scores following six or ten sessions and reported high levels of unexplained dropout. Although these are promising results, further research which utilises standardised measures is required.

The integration of Theraplay® and family therapy into Whole Family Theraplay® (WFT; Weir et al., 2013) also produced changes of a large effect on measures of communication difficulties, interpersonal relations, and total difficulties. However, across 11 further items relating to general functioning and social, emotional, and behavioural distress WFT failed to produce significant changes. Despite this, WFT also demonstrates potential.

NPP, which also utilises Theraplay® but integrates this approach with SI, SE, DDP, dramatherapy, and life story work, reported more moderate effect sizes across a broader range of outcomes (McCullough et al., 2016). McCullough et al. (2016) reported significant changes of a large effect relating to improvements in emotional control, reductions in indiscriminate interpersonal behaviour, and reductions in maladaptive eating. Significant changes of moderate effect were also reported in domains of inhibiting impulsivity, regulating behaviour, total mental health score, attention problems, aggressive behaviour, externalising problems, and total psychological wellbeing and behavioural functioning score. Small to medium effects were reported on the domains of social and thought problems. However, NPP also produced mean score increases in difficulties relating to metacognition, initiating and planning, pica, low confidence, and presenting as withdrawn/depressed.

McCullough and Mathura (2019) presented the effect of an NPP intervention relative to a non-equivalent control group, reporting that the intervention significantly improved the parent-child relationship to a large effect, reduced difficulties associated with behavioural regulation and self-esteem to a moderate effect, and reduced global executive functioning and total mental health difficulties to a small effect. Conversely, the intervention failed to produce significant changes on scales relating to metacognition index, total and externalising problems, negative self-image, and sibling relationships. It is worth nothing that the intervention group in both NPP studies is the same 21 family sample. However, both studies provide an indication that NPP is a promising approach for adoptive families.

Hodgdon et al. (2016) reported effect sizes following application of the attachment, regulation, and competency (ARC) model with 405 adopted children. A post-hoc power analysis on each outcome suggested that with the alpha set at .05, results with an effect size of *d*=>.29 achieved >95% power. Therefore, the small to moderate effects on trauma related anxiety, depression, posttraumatic stress, and anger, and maternal ratings of adaptability, adaptive skills, and perceptions of their child’s difficulties can be interpreted with greater reliability. The ARC model also obtained a medium effect on maternal ratings of child externalising difficulties. However, the study also reported mean score increases following therapy on scales of sexual concerns, father total stress, distress, and parent-child dysfunction and the absence of a control group should still be noted as a cause for concern.

Three studies presented quantitative data without effect sizes. HC2.0 was found to reduce post-therapy mean scores on measures of trauma related anxiety, depression, and aggression, problems with peers, and relational frustration. HC2.0 also improved parent ratings of attachment, confidence, and communication (Hunsley et al., 2021). However, the waitlist control also reported mean score reductions in measures of aggression, emotional problems, hyperactivity, and sibling conflict. LI therapy was found to reduce difficulties relating to interpersonal relationships and attitude to school from at risk levels to average levels and reduced relational frustration between parent and child from upper extreme levels to average levels (Lewis et al., 2021). However, LI reported minimal changes on most domains on the parenting relationship questionnaire. Finally, MBT was found to produce a mean reduction in general mental health difficulties and improvements in parental self-efficacy at post-therapy (Midgley et al., 2018).

***Synthesis of Qualitative Evidence***

Eleven studies presented qualitative findings. Three studies explored parental experiences of DDP. All three studies (n=21 participants) reported that DDP helped parents to develop an increased level of understanding of their child’s mind and behaviour and that DDP is a different approach to parenting which can facilitate positive outcomes (Agbayani, 2014; Turner, 2012; Wingfield & Gurney-Smith, 2019). Two of these studies (n=18) highlighted the importance of the therapist’s role and the therapeutic relationship within DDP (Turner, 2012; Wingfield & Gurney-Smith, 2019) and two (n=9) reported that the validation of parental concerns within DDP was a particularly significant feature (Agbayani, 2014; Turner, 2012). Conversely two studies (n=18) reported themes relating to challenges associated with commencing DDP. Turner (2012) highlighted participants emphasised the importance of feeling ready for DDP and Wingfield and Gurney-Smith (2019) discovered an initial scepticism towards the treatment methodology. Additionally, Turner (2012) reported that certain parents had trouble with playfulness and found it hard to incorporate DDP into their normal family routine.

Two studies explored MBT (Jaffrani et al., 2020; Midgley et al., 2018). Both studies (n=6) highlighted the importance of the therapist’s empathic and curious stance which helped parents to feel accepted, alongside reporting on the importance of establishing trust within MBT to help parents feel supported and contained. However, Midgley et al. (2018) reported that certain parents felt MBT was not enough on its own to achieve improvements and others were unclear to the extent they would attribute positive changes to the therapy. Findings suggest that adapting MBT within the context of post-adoption support requires additional research.

Two studies explored qualitative findings of integrative interventions. McCullough et al. (2016) reported that following NPP parents expressed that their relationship with the adopted child and their adopted child’s relationship with their sibling(s) had both improved. Adoptive parents also shared the absences of further mental health diagnosis, involvement in the criminal justice system, and exclusion from school. Despite this more than half the children in the post-therapy condition continued to access additional therapy after completing the NPP intervention. Following the integration of MFT, group discussions, socio-therapy, art therapy, VTC, fairy tale therapy, and relaxation, Ulasińska et al. (2020) reported that parents expressed they were experiencing reduced levels of anxiety and that they had gained a more realistic view of their child. Parents also highlighted the importance of experiencing the mutual support of those who had similar experiences to them.

Four studies provided qualitative evidence for single interventions. Harrison-Stewart et al. (2018) reported that following MST parents shared an increase in parental confidence and strength, that their expectations of their child’s behaviour had changed, and that MST helped to provide a foundation for further change. However, parents reported that the MST programme did not achieve the intended focus which was to ameliorate their child’s anti-social behaviours. MST practice requires further investigation and advancement to meet the needs of adoptive families. McAlpin (2013) explored parental experiences of participation in 8 weeks of Kindermusik® Wiggle and Grow classes. Parents reported increases in healing, acceptance, and compassion awareness alongside experiencing relationship repair, enhanced attachment security, and inter-subjective experiences. Salamino and Gusmini (2017) explored changes in attributions of stress within the family system following post-Milanese family therapy and reported that attributions predominantly shifted from being stable, global, internal, personal, and uncontrollable, to being unstable, specific, external, universal, and controllable**.** However, in the final session of therapy four of the seven attributions made remained stable and three remained global, internal, and personal. Finally, Lewis et al. (2021) found that following LI therapy, adopted children reported being better able to control their emotions and adoptive parents reported their child as happier. The adoptive family also reported finding the baby-self aspect of the LI intervention to be particularly difficult but meaningful.

**Discussion**

The review identified 19 articles reporting on 17 studies which evaluated and/or explored the use of 13 psychological interventions with at least 682 domestically adoptive children and at least 782 adoptive parents.Six studies examined integrated psychotherapeutic approaches, three explored DDP, two explored MBT, and the remaining six reported on ARC, EMDR, Kindermusik®, LI, MST, and post-Milanese family therapy. The heterogeneity between studies necessitated that a meta-analytic review would not be appropriate. Therefore, a narrative approach was utilised to synthesise findings. This review evidences that this research area remains well in its infancy. Findings provide preliminary support for the feasibility and promise of utilising family-based psychotherapeutic interventions with adoptive families seeking therapeutic support. The review indicates family-based interventions may facilitate worthwhile changes for an adoptive child’s trauma, behavioural, emotional, and relational symptomatology, for adoptive parent’s understanding, confidence, and communication, and for the adoptive family’s attachment relationships. However, the poor methodological quality underpinning the primary research limits the conclusions that can be drawn. This necessitates that higher quality research determining the feasibility, acceptability, and efficacy of these interventions is warranted to provide more conclusive recommendations.

**Features of Promising Interventions**

Two studies reported promising results compared to waitlist and non-equivalent control groups. Hunsley et al. (2021) and McCullough and Mathura (2019) provided support for integrating sensory activities, attachment-based play, art therapy approaches, and attachment-based relational interventions such as TBRI and DDP into one cohesive therapeutic package for adoptive families. The application of integrative interventions which provide therapeutic input with the adopted child(ren), the adoptive parent(s), and the adoptive family over the course of short intensive interventions and medium to long-term interventions were found to positively impact trauma, behavioural, emotional, and relational difficulties and develop a parental felt sense of understanding, security, and acceptance.

DDP acquired the most substantial body of qualitative evidence with 21 adoptive parents being interviewed across three studies with low-to-moderate risk of bias ratings. Agbayani (2014), Turner (2012), and Wingfield and Gurney-Smith (2019) support the use of DDP for increasing parental understanding, providing a new approach to parenting, helping parents move towards acceptance, and building trust, security, and emotional regulation. The findings across these studies were predominantly positive which provides preliminary support for the feasibility and potential acceptability of DDP with this population.

Of the remaining studies, the strongest statistical changes were reported in 12 months of integrative EMDR and family therapy (Wesselmann et al., 2018), 12-15 weekly sessions of integrative Theraplay® and family systems theory (Weir et al., 2013), and between 1-12 sessions of the FFF-EMDR protocol (Draper et al., 2021).

**Theoretical Underpinnings**

Most interventions (*k*=11) were based in attachment theory. Interventions also utilised concepts of adaptive information processing and bilateral stimulation (Shapiro, 2018), attunement (van Bakel & Riksen-Walraven, 2008), developmental trauma (van der Kolk, 2015), interpersonal neurobiology (Schore, 2012; Siegel, 2020), intersubjectivity (Trevarthen & Aitken, 2001), the neurosequential model of therapeutics (Perry & Hambrick, 2008) and social (co)regulation (Coan et al., 2006).

Over one third of interventions utilised integrative approaches. Three of these: HC2.0 (Hunsley et al., 2021) MFT (Ulasińska et al., 2020), and EMDR and family therapy (Wesselmann et al., 2018), best align with Technical Eclecticism in which a selection of promising interventions for both person and presenting problem were utilised, without necessarily subscribing to the individual theories that spawned them (Norcross, 2005). One integrative intervention, WFT (Weir et al., 2013), was underpinned by Common Factors Integration in which a series of non-coercive attachment-based play therapies were considered for suitability for integration with family therapy models, based on best-fit commonalities (Seymour, 2011; Weir, 2011). Weir et al. (2013) utilised Theraplay® and family systems theory as the directive nature of Theraplay® aligned with the directive posture of classical family systems models, and thus was deemed the best fit when integrating family counselling and play therapy approaches. Finally, two studies examined NPP (McCullough et al., 2016; McCullough & Mathura, 2019), which appears to adopt an Assimilative Integration approach in which the model has a firm grounding in DDP as a ‘home theory’ with a willingness to selectively incorporate practices from other approaches, including Theraplay® and somatosensory interventions (Messer, 1992; Norcross, 2005).

The variety in integration approaches mirrors the variety in interventions within this area. This re-affirms the juvenile nature of this field at present and further emphasises the importance of this review in consolidating current understanding and guiding future research towards building a less disparate field of evidence.

**Methodological Considerations**

The GRADE and GRADE-CERQual assessments highlight an absence of high-quality research in this field and the ROBINS-I and CASP risk of bias assessments indicated that five of seven quantitative studies reported a serious risk of bias, and seven of ten qualitative studies reported a moderate or serious risk of bias. It is important to appraise research against the highest standards of evidence and more robust, randomised, and controlled research is certainly warranted. However, the benefit of examining interventions in clinical practice is that these findings incorporate service user and therapist preferences and other naturalistic intervention effects which are minimised in randomised and controlled studies, but ubiquitous across real-world settings (Black, 1996). The quantity of practice-based evidence is a strength of the research area. These findings should be utilised to complement, direct, and inform more robust and stringent evidence-based practice (Barkham & Margison, 2007).

An additional methodological consideration is the discrepancies in outcome measurements. The included studies utilise a combined total of 30 different assessment measures. The most common assessments were the CBCL, and versions of the Assessment Checklist measures which were each utilised in four of the nine quantitative studies. In contrast, 21 assessment measures appeared only once. There is a wide variety of tools to assess for changes in attachment relationships, behavioural emotional and relational difficulties, trauma symptomatology, and parental experiences. An evaluation of the strengths and weaknesses of all 30 measures is beyond the scope of this review. Findings point towards the need for future research to evaluate the available assessment measures to deduce the most robust, valid, and adoption-specific tools for interventions with adoptive families.

**Strengths of Review**

This is the first systematic review to evaluate family-based psychological interventions designed for adoptive families. The review has been completed in line with the Cochrane Collaboration’s 2021 handbook for systematic reviews of intervention studies (Higgins et al., 2021), and the updated PRISMA 2020 guidelines (Page, McKenzie, et al., 2021) which safeguards the scientific rigour and methodological quality of the synthesis. The search strategy was constructed in consultation with a liaison librarian following initial scoping searches and was also informed by previous reviews within the area. The database searches were augmented via hand searching of two prominent adoption journals, forward and backwards citation searches, and the searching of several additional grey literature sources. These steps refined the precision, scope, and depth of the search strategy alongside minimising publication and location bias which enhances the reliability of the findings. Unlike prior reviews in this area (Harris-Waller et al., 2018; Ni Chobhthaigh & Duffy, 2019), no contact was made with experts or authors within the field to discover additional sources. This promotes the systematic and scientific nature of the review by ensuring ease of replication. To reduce researcher bias two researchers completed the screening and study selection process with a research assistant independently reviewing 10% of titles, 25% of abstracts, and 52.6% of full texts. Additionally, the ROBINS-I and CASP assessments were independently reviewed by two researchers for 15 of the 17 studies. Following discussions agreement on all decisions was 100%.

**Limitations of Review**

The review exhibits certain limitations. Foremost the dearth of quality within the primary studies, including significant risk of bias, low certainty of evidence, small samples, and few control groups each ensure that conclusions cannot be made unequivocally. This limitation is equally the most important finding as it illuminates the desperate need for higher quality evidence in this area, particularly given the needs of adoptive families seeking therapy.

The application of the GRADE tool, although recommended as best practice for systematic reviews, applied standards which were too stringent to identify merits within the existing quantitative literature. For quantitative research the GRADE assessment awards all non-randomised controlled trials a starting rating of low quality before applying six criteria which can each demote this rating. These predominately retrospective routine practice-based studies were all reported with ‘very low’ certainty of evidence scores and therefore, the assessment could not distinguish differences in value within the quantitative research. However, the body of work synthesised within this review is representative of the current research area and would not be deemed very low quality in comparison to studies in similarly innovative and emergent areas. It may be increasingly beneficial to apply more general overall quality assessment tools as opposed to the GRADE assessments within this field at this time. The appraisal tool for cross-sectional studies (Downes et al., 2006) or the strengthening the reporting of observational studies in epidemiology tool (von Elm et al., 2007), could each provide an assessment of overall study reliability, worth, and relevance which could complement specific methodological risk of bias appraisals.

Additionally, the ROBINS-I and CASP assessments adopt different approaches to critically appraising research. The ROBINS-I provides an overall risk of bias score whereas the CASP advises against such scoring systems. Therefore, the researcher applied the ROBINS-I scoring system to the overall CASP results to facilitate comparison between the quantitative and qualitative research. It may have been increasingly beneficial to have applied a quantitative CASP checklist to facilitate such comparison. Moreover, due to the difference in assessment approaches it is unclear whether the current quantitative studies are at an increased risk of bias, or whether this divergence has been constructed or exacerbated by the difference in assessment tools.

A further limitation includes the exclusion of three descriptive case reports at full-text screening. Although these descriptive case reports were devoid of methodological rigour and failed to report details of the sample, method, design, and data collection. Each provided relatively detailed overviews of how to practically apply integrative play therapy (Weir, 2008), multi-dimensional relational family therapy (Webster, 2018), and attachment theory (Golding, 2007) in therapy for adoptive families. These practitioner insights may have added value to this systematic review.

The potential uncertainty regarding the fidelity of intervention delivery across the included studies is an additional limitation. The ROBINS-I indicated that risk of bias due to deviations from interventions within the quantitative studies was moderate-to-serious. The qualitative studies also failed to report competence and adherence checks. Children who have experienced high levels of pre-adoptive developmental trauma and exhibit attachment difficulties often find it hard to trust others. Therefore, adopted children in therapy seeking adoptive families can find it challenging to engage in psychotherapy. It is not uncommon for older children to refuse to attend therapy whilst their parents continue to engage. Therefore, in the absence of fidelity checks, it is possible that some studies reported to be examining and/or exploring a family-based intervention however, delivered psychotherapeutic input only to parents. This potentially limits the overall validity of the findings.

Finally, the review excluded studies which were not written in English, presenting the possibility that certain studies may have been omitted and due to the nature of the studies within this research review, conclusive recommendations cannot be made. Findings are tentative and can only be used to suggest directions for future research and highlight themes found within promising approaches for clinical practice.

**Implications for Research**

There is a need for higher quality research including randomised and non-randomised controlled trials. Future research should control for confounding variables such as age at adoption and intervention, length of placement, nature of pre-adoptive developmental trauma, and presence of adoptive siblings. Further research should also include and report intervention fidelity checks and seek to recruit samples via more robust probability sampling techniques. The use of control groups is particularly pertinent for therapy seeking adoptive families with adopted children who have experienced pre-adoptive abuse, neglect, and developmental trauma as their experiences can be highly influenced by times of the year, anniversary dates, birth family contacts, school holidays, and so on. Therefore, changes in presentations may be much less reliably attributed to the experience of therapy depending on when the pre-post therapy questionnaires are completed.

Further studies evaluating interventions for adoptive families should consider assessing child psychological wellbeing and behavioural functioning with the CBCL, child mental health via one of the Assessment Checklist measures (Tarren-Sweeney, 2007; 2013), and trauma symptomatology via one of the trauma symptom checklist measures (Briere, 1996; Briere et al., 2001). However, there is also a need for research to evaluate current assessment measures to provide direction towards the most appropriate measures within this field. Additionally, follow-up assessments need to become a consistent feature. Future research should seek to include 6-month, 12-month, and 24-month follow-ups.

The inclusion of longer follow-up periods represents an additional need for a paradigm shift within research area. Current literature emphasises that a therapy is only successful if it ameliorates all the difficulties experienced within the adoptive family and demonstrates remission on all post-therapy assessment measures. However, the true nature of the experiences for many therapy seeking adoptive families with adopted children who have experienced pre-adoptive abuse, neglect, and developmental trauma is that the difficulties and challenges they face are ongoing. It is well recognised in children bereaved of a parent, that they will re-experience grief in different ways as they progress through developmental milestones (Arnold & Buschman-Gemma, 2008). However, appreciation for the life-long nature of the challenges experienced by adoptive families was not pronounced within this literature. Future research examining family-based therapeutic interventions for adoptive families would be more representative of the true experiences of therapy seeking adoptive families if the research acknowledges the enduring and long-term difficulties experienced within these adoptive families.

There is a promising indication that integrative interventions which provided separate therapeutic input for adoptive parents and/or adoptive children alongside therapeutic input for the adoptive family whilst integrating sensory activities, attachment-based play, EMDR, and DDP could provide the most meaningful changes for adoptive families. Future research should seek to explore the integration of these therapeutic approaches. However, integrative interventions are comprehensive, time consuming, and expensive. Considering costs and internationally varying health and social welfare systems, research evaluating the feasibility and acceptability of integrative family-based interventions for adoptive families should be prioritised (Diepeveen et al., 2013; Moore et al., 2015).

Finally, this field contains a wide range of interventions, targeting a range of developmental stages and experiential challenges. Certain psychotherapies are further advanced in their intervention development and therefore each present with different needs for future research. Figure 2 presents an overview of the intervention development paths for the 13 psychotherapies included within this study. The intervention mapping diagram is adapted from Czajkowski et al.’s (2015) ORBIT model and highlights what the next steps are for each intervention in this research area.

**Figure 2**

*Intervention Mapping*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | Individual Psychotherapeutic Approaches | | | | | | | | Integrative Psychotherapeutic Approaches | | | | |
| Attachment, Regulation, and Competency (Hodgdon et al., 2016) | Dyadic Developmental Psychotherapy (Agbayani 2014; Turner, 2012; Wingfield & Gurney-Smith, 2019) | Eye Movement Desensitisation and Reprocessing (Draper et al., 2021) | Kindermusik (McAlpin, 2013) | Lifespan Integration Therapy (Lewis et al., 2021) | Mentalisation-Based Therapy (Jaffrani et al., 2020; Midgley et al., 2018) | Multi-Systemic Therapy (Harrison-Stewart et al., 2018) | Post-Milanese Family Therapy (Salamino & Gusmini, 2017) | Integrated Eye Movement Desensitisation and Reprocessing and Family Therapy (Wesselman et al. 2018) | Hope Connection 2.0 (Hunsley et al., 2021) | Multi-Family Therapy (Ulasińska et al., 2020) | Neuro-Physiological Psychotherapy (McCullough et al., 2016; MuCullough & Mathura, 2019) | Whole Family Theraplay (Weir et al., 2013) |
| Significant Clinical Question | | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| Phase I Design | Define (a) | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | Next Steps | Next  Steps | ✔ | Next Steps | ✔ | ✔ |
| Refine (b) | ✔ | ✔ | ✔ | ✔ | Next Steps | Next Steps | Next Steps | Next Steps | ✔ | Next Steps |
| Phase II Preliminary Testing | Proof of Concept (a) | ✔ | ✔ | Next Steps | Next Steps |  |  |  | Next Steps |
| Pilots (b) | Next Steps | Next Steps |  |  |  |  |  |  |  |  |
| Phase III Efficacy | Efficacy Trial |  |  |  |  |  |  |  |  |  |  |  |
| Phase IV Effectiveness | Effectiveness Research |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Implications for Clinical Practice**

There remains a need for services to continue to collect and report evidence to translate localised service-based knowledge into the wider evidence base. To support this, services should collect routine outcome measures. The findings from this review support the use of the Assessment Checklist measures, CBCL, and Trauma Symptom Checklist measures with these having the greatest face-validity within the field. Finally, services should continue their current clinical practices as standard whilst more robust evidence can be completed.

**Conclusion**

The synthesis of 17 studies reported data on 13 interventions with at least 682 domestically adoptive children and at least 782 adoptive parents. The findings are clear that the research area remains well in its early infancy and higher quality studies are necessary. The overall quality of the research was reported as ‘very low’ with a ‘moderate-to-serious’ risk of bias. A general lack of control for confounding variables, blinding, a lack of consideration regarding the researcher-participant relationship, and the use of non-probability sampling techniques represented areas of significant methodological weakness within this field. The synthesis of findings indicates preliminary support that integrative interventions which include sensory activities, attachment-based play, EMDR, and DDP within a therapeutic format which can provide separate therapeutic input for adoptive parents and/or adoptive children alongside family-based therapeutic input for the adoptive family could be the most promising approach for psychological interventions for adoptive families seeking therapeutic support. However, the high risk of bias and preliminary nature of this field limits the conclusions that can be drawn. Further research examining the feasibility, acceptability, and efficacy of these interventions is necessary to optimise therapeutic provision for adoptive families.

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**Appendices**

**Appendix A**

*Details of previous systematic reviews within the field of psychotherapeutic interventions for adoptive families*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Year of Publication, Author | Title of Review | (a) No. studies in review  (b) No. unique studies & [no. studies included in previous reviews]  (c) Accumulative total no. unique studies | No. studies with family focused interventions for domestically adoptive families (Reference) | Limitations of review in the context of domestically adoptive families and therapists seeking information on family-based psychotherapeutic interventions. |
| 2014, Kerr and Cossar | Attachment interventions with foster and AP: ASR | (a) 10, (b) 10[0], (c) 10 | 0 | Included both adoptive and foster families. Lacks precision for adoptive families due to differences between groups. |
| 2017, Rose and O’Reilly | ASR of attachment-based psychotherapeutic interventions for AC | (a) 3, (b) 2[1], (c) 12 | 0 | Only synthesised three studies. One included holding therapy, one foster children, and one international adoptees |
| 2018, Drozd et al. | ASR of courses, training, and interventions for AP. | (a) 10, (b) 7[3], (c) 19 | 0 | Reviewed courses, training, and interventions for adoptive parents. Limited for domestically adoptive families. |
| 2018,  Harris-Waller et al. | PI for AP: ASR | (a) 18, (b) 9[9], (c) 28 | 2  (Agbayani, 2014; McAlpin, 2013) | Mainly focused on supporting parental preparedness, parental behaviour, and improving the parent-child relationship through the adoptive parent. |
| 2019, Ní Chobhthaigh and Duffy | The effectiveness of PI with AP on AC and adolescents’ outcomes: ASR | (a) 15, (b) 8[7], (c) 36 | 1  (Weir et al., 2013) | Only 3 studies were family based, 2 with international adoptees and only 1 study of use for domestically adoptive families. |
| 2020, Schoemaker et al. | A meta-analytic review of parenting interventions in foster care and adoption. | (a) 53, (b) 38[15], (c) 74 | 0 | Same focus as Harris-Waller et al. 2018. |
| Total |  | (a) 109, (b) 74 [35], (c) 74 | 3 |  |

*AP: Adoptive parents, AC: Adopted children, ASR: A systematic review, PI; Psychological intervention*

**Appendix B**

*PRISMA 2020 for abstracts checklist and PRISMA 2020 checklist*

**PRISMA 2020 Abstract Checklist**

| **Section and Topic** | **Item** | **Checklist item** | **Reported** |
| --- | --- | --- | --- |
| **TITLE** | | |  |
| Title | 1 | Identify the report as a systematic review. | Yes |
| **BACKGROUND** | | |  |
| Objectives | 2 | Provide an explicit statement of the main objective(s) or question(s) the review addresses. | Yes |
| **METHODS** | | |  |
| Eligibility criteria | 3 | Specify the inclusion and exclusion criteria for the review. | Yes |
| Information sources | 4 | Specify the information sources (e.g. databases, registers) used to identify studies and the date when each was last searched. | Yes |
| Risk of bias | 5 | Specify the methods used to assess risk of bias in the included studies. | Yes |
| Synthesis of results | 6 | Specify the methods used to present and synthesise results. | Yes |
| **RESULTS** | | |  |
| Included studies | 7 | Give the total number of included studies and participants and summarise relevant characteristics of studies. | Yes |
| Synthesis of results | 8 | Present results for main outcomes, preferably indicating the number of included studies and participants for each. If meta-analysis was done, report the summary estimate and confidence/credible interval. If comparing groups, indicate the direction of the effect (i.e. which group is favoured). | Yes |
| **DISCUSSION** | | |  |
| Limitations of evidence | 9 | Provide a brief summary of the limitations of the evidence included in the review (e.g. study risk of bias, inconsistency and imprecision). | Yes |
| Interpretation | 10 | Provide a general interpretation of the results and important implications. | Yes |
| **OTHER** | | |  |
| Funding | 11 | Specify the primary source of funding for the review. [Not report due to work count limitations] | No |
| Registration | 12 | Provide the register name and registration number. | Yes |

**PRISMA 2020 Checklist**

| **Section and Topic** | **Item** | **Checklist item** | | **Location where item is reported** |
| --- | --- | --- | --- | --- |
| **TITLE** | | | |  |
| Title | 1 | Identify the report as a systematic review. | | Page 1 |
| **ABSTRACT** | | | |  |
| Abstract | 2 | See the PRISMA 2020 for Abstracts checklist. | | Page 2 |
| **INTRODUCTION** | | | |  |
| Rationale | 3 | Describe the rationale for the review in the context of existing knowledge. | | Page 4-6 |
| Objectives | 4 | Provide an explicit statement of the objective(s) or question(s) the review addresses. | | Page 6 |
| **METHODS** | | | |  |
| Eligibility criteria | 5 | Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses. | | Page 7 & Table 1 |
| Information sources | 6 | Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted. | | Page 9 |
| Search strategy | 7 | Present the full search strategies for all databases, registers and websites, including any filters and limits used. | | Page 9 & Appendix C |
| Selection process | 8 | Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process. | | Page 9-10 |
| Data collection process | 9 | Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process. | | Page 10-11 |
| Data items | 10a | List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect. | | Page 11 |
| 10b | List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information. | | Page 11 |
| Study risk of bias assessment | 11 | Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process. | | Page 11-13 |
| Effect measures | 12 | Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results. | | Page 11 |
| Synthesis methods | 13a | Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)). | | N/A |
| 13b | Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions. | | Page 11 |
| 13c | Describe any methods used to tabulate or visually display results of individual studies and syntheses. | | N/A |
| 13d | Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used. | | Page 11 |
| 13e | Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression). | | n/a |
| 13f | Describe any sensitivity analyses conducted to assess robustness of the synthesized results. | | n/a |
| Reporting bias assessment | 14 | Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases). | | Page 13-14 |
| Certainty assessment | 15 | Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome. | | Page 13 |
| **RESULTS** | | | |  |
| Study selection | 16a | Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram. | | Page 14-15 & Figure 1 |
| 16b | Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded. | | Page 10 & Appendix D |
| Study characteristics | 17 | Cite each included study and present its characteristics. | | Page 16-21 & Table 2 |
| Risk of bias in studies | 18 | Present assessments of risk of bias for each included study. | | Page 24 & Table 3 |
| Results of individual studies | 19 | For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots. | | Page 26-32 & Table 4 |
| Results of syntheses | 20a | For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies. | | Page 24 |
| 20b | Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect. | | Page 33-37 |
| 20c | Present results of all investigations of possible causes of heterogeneity among study results. | | N/A |
| 20d | Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results. | | N/A |
| Reporting biases | 21 | Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed. | | Table 3 |
| Certainty of evidence | 22 | Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed. | | Page 24 & Table 4 |
| **DISCUSSION** | | | |  |
| Discussion | 23a | Provide a general interpretation of the results in the context of other evidence. | | Page 37-39 |
| 23b | Discuss any limitations of the evidence included in the review. | | Page 39-40 |
| 23c | Discuss any limitations of the review processes used. | | Page 41-42 |
| 23d | Discuss implications of the results for practice, policy, and future research. | | Page 42-44 |
| **OTHER INFORMATION** | | | |  |
| Registration and protocol | 24a | Provide registration information for the review, including register name and registration number, or state that the review was not registered. | | Page 6 |
| 24b | Indicate where the review protocol can be accessed, or state that a protocol was not prepared. | | Page 6 |
| 24c | Describe and explain any amendments to information provided at registration or in the protocol. | | Page 6 |
| Support | 25 | Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review. | | Page 7 |
| Competing interests | 26 | Declare any competing interests of review authors. | | Page 7 |
| Availability of data, code and other materials | 27 | Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review. | Template Data Extraction Form = Appendix E  Data used in analyses: Table 2, 3, &4  ROBINS-I & CASP = Page 12 statement on their public availability also in appendix F & G  GRADE = Page 13 statement on its public availability also in appendix H & I | |

*From:*  Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

For more information, visit: <http://www.prisma-statement.org/>

**Appendix C**

*Full search strategy and dates of searches*

| **Database** | **Date** | **Search Strategy & Limiters** |
| --- | --- | --- |
| **Scoping Search** | | |
| Scopus | 12.05.2021 | "Family Therapy" OR "therapeutic parenting" AND "adopt\* child\* OR "adopt\* famil\*" |
| **Electronic Databases** | | |
| CINAHL | 18.10.2021 | Advanced search field one:  "adopted infant\*" OR "adopt\* child\*" OR "adopted adolescen\*" OR adoptee\* OR "adoptive parent\*" OR "adoptive carer\*" OR "adopt\* famil\*" OR postadoption OR post-adoption OR “post adoption”  Advances search field two (joined with AND operator):  (famil\* OR "parent and child" OR "child and parent" OR parent-child OR child-parent OR systemic) N10 (therap\* OR psycho\* OR intervent\* OR program\* OR education\* OR support\* OR train\* OR counsel\* OR attachment)  Limiter: Linked full-text available |
| Cochrane Libaray | 18.10.2021 | Advanced search field one:  "adopted infant\*" OR "adopt\* child\*" OR "adopted adolescen\*" OR adoptee\* OR "adoptive parent\*" OR "adoptive carer\*" OR "adopt\* famil\*" OR postadoption OR post-adoption OR “post adoption”  Advances search field two (joined with AND operator):  (famil\* OR "parent and child" OR "child and parent" OR parent-child OR child-parent OR systemic) NEAR/10 (therap\* OR psycho\* OR intervent\* OR program\* OR education\* OR support\* OR train\* OR counsel\* OR attachment) |
| MEDLINE | 18.10.2021 | Advanced search one:  adopted infant\* or adopt\* child\* or adopted adolescen\* or adoptee\* or adoptive parent\* or adoptive carer\* or adopt\* famil\* or postadoption or post-adoption or post adoption  Advanced search two:  (famil\* or parent and child or child and parent or parent-child or child-parent or systemic) adj10 (therap\* or psycho\* or intervent\* or program\* or education\* or support\* or train\* or counsel\* or attachment)  Selected both searches from search history and combined using the AND operator. |
| ProQuest | 29.10.2021 | Advanced search field one:  "adopted infant\*" OR "adopt\* child\*" OR "adopted adolescen\*" OR adoptee\* OR "adoptive parent\*" OR "adoptive carer\*" OR "adopt\* famil\*" OR postadoption OR post-adoption OR “post adoption  Advances search field two (joined with AND operator):  (famil\* OR "parent and child" OR "child and parent" OR parent-child OR child-parent OR systemic) NEAR/10 (therap\* OR psycho\* OR intervent\* OR program\* OR education\* OR support\* OR train\* OR counsel\* OR attachment)  Limiters: Anywhere but full text, Full text articles, and excluding duplicates |
| PsycINFO | 29.10.2021 | Advanced search one:  adopted infant\* or adopt\* child\* or adopted adolescen\* or adoptee\* or adoptive parent\* or adoptive carer\* or adopt\* famil\* or postadoption or post-adoption or post adoption  Advanced search two:  (famil\* or parent and child or child and parent or parent-child or child-parent or systemic) adj10 (therap\* or psycho\* or intervent\* or program\* or education\* or support\* or train\* or counsel\* or attachment)  Selected both searches from search history and combined using the AND operator. |
| Scopus | 29.10.2021 | Advanced search field one:  "adopted infant\*" OR "adopt\* child\*" OR "adopted adolescen\*" OR adoptee\* OR "adoptive parent\*" OR "adoptive carer\*" OR "adopt\* famil\*" OR postadoption OR post-adoption OR “post adoption”  Advanced search two:  (famil\* OR "parent and child" OR "child and parent" OR parent-child OR child-parent OR systemic) N/10 (therap\* OR psycho\* OR intervent\* OR program\* OR education\* OR support\* OR train\* OR counsel\* OR attachment) |
| Web of Science | 29.10.2021 | Advanced search field one:  "adopted infant\*" OR "adopt\* child\*" OR "adopted adolescen\*" OR adoptee\* OR "adoptive parent\*" OR "adoptive carer\*" OR "adopt\* famil\*" OR postadoption OR post-adoption OR “post adoption”  Advanced search two:  (famil\* OR "parent and child" OR "child and parent" OR parent-child OR child-parent OR systemic) NEAR/10 (therap\* OR psycho\* OR intervent\* OR program\* OR education\* OR support\* OR train\* OR counsel\* OR attachment)  Limiters: Searched for within Topic which covers Title, Abstract, and Keywords and Keywords Plus |
| **Grey Literature Databases** | | |
| Action for Children | 12.11.2021 | Website search engine searched the term “family therapy” which retrieved 9 results, none were relevant. |
| Adoption UK | 12.11.2021 | Website search engine searched with term “family therapy” which retrieved 356 results, none were relevant. The research area of the website was also searched. |
| EThOS | 14.12.2021 | Basic search of: adoptive family AND therapy retrieved 64 records. One relevant, Turner (2012), this thesis was obtained as an inter-library loan request from the first authors affiliated institution. |
| Family Futures | 12.11.2021 | Website searched separately with terms “research” and “family therapy” = 3 items alluded to McCullough’s research on neurophysiological psychotherapy, these research papers were already included in the study following database searches. |
| First4 Adoption | 12.11.2021 | Website searched with term “family therapy” which retrieved 6 results, none were relevant. The adoption support services and therapies section of the website were also searched. |
| Grey Literature Report | 19.11.2021 | Full search term was utilised which retrieved 0 studies. The terms “adoptive family therapy” was then searched which retrieved 2 items, neither were relevant. |
| PAC-UK | 12.11.2021 | Website searched with the term “family therapy”, 10 items were retrieved none were relevant. |
| OpenGrey | 19.11.2021 | Searched for with full search terms which retrieved 797 items, no new studies were found. |
| Social Care Online | 19.11.2021 | Searched with the terms “adoptive family therapy”, 35 research articles were retrieved, 4 articles were relevant but were already included within the study following database searching and therefore were not taken. |
| **Other Methods** | | |
| Alerts on Databases | Set up 29.10.2021  Ended  19.05.2022 | Monthly database alerts were set up on each electronic database. This resulted in the databases using an algorithm to re-run the search at selected intervals. On 02.12.2021 an additional study was retrieved from Web of Science which was included in the review: Hunsley et al. (2021). On 30.12.2021 an additional study was retrieved from Web of Science which was included in this review: Draper et al. (2021) |
| Backwards citations | 03.12.2021 | Reference lists of all included studies were searched which retrieved four additional studies based on titles, however all four of these were excluded following full-text screening. |
| Forward citations | 03.12.2021 | Google scholar was utilised to completed forward citation searches, one relevant additional study was identified, and this was included within the review: Jaffrani et al. (2020). |
| Hand searching | 26.11.2021  and  19.05.2022 | Hand searching of the journals Adoption & Fostering and Adoption Quarterly retrieved 3 relevant studies based on titles, all three were excluded follow full-text screening. |
| Initial scoping searches | 01.07.2021 to 31.08.2021 | Initial scoping searches took place with a number of different search terms relating to adoptive families and therapeutic interventions. One search of "Family Therapy" OR "therapeutic parenting" AND "Looked after children" OR LAC OR "adopt\* child\* OR "adopt\* famil\*" retrieved Hodgdon et al.’s (2016) study, which was retrospectively included in the review after the systematic search strategy did not retrieve it. |

**Appendix D**

*References for all studies excluded at full-text screening alongside reasons for exclusion*

**Reports identified following systematic database searching and excluded at full-text screening (24)**

1. Allen, B., Timmer, S. G., & Urquiza, A. J. (2014). Parent-child interaction therapy as an attachment-based intervention: Theoretical rationale and pilot data with adopted children. *Children and Youth Services Review, 47*, 334-341 [https://doi.org/10.1016/j.childyouth.2014.10.009](file:///C:\Users\timmc\Downloads\ https:\doi.org\10.1016\j.childyouth.2014.10.009 )

Excluded on the basis that the application of the intervention within this study was delivered to the parents. PCIT within this study was utilised a coaching therapy for parents only.

1. Baker, M., Biringen, Z., Meyer-Parsons, B., & Schneider, A. (2015). Emotional attachment and emotional availability tele-intervention for adoptive families. *Infant Mental Health Journal, 36*(2), 179-192.<https://doi.org/10.1002/imhj.21498>

Excluded on the basis that the application of the intervention within this study was delivered to the parents. The intervention was targeted just for the parents.

1. Burke, R. V., Schlueter, C., Vandercoy, J., Authier, K. J., & The Prevention Group Research Team. (2015). Post-adoption services for families at risk of dissolution. *Clinical Case Studies, 14*(4), 291- 306.<https://doi.org/10.1177/1534650114556696>

Excluded on the basis that the intervention is poorly defined. The paper details the ‘A Step Further (ASF)’ program which includes a multitude of services which the study presents in table 2. However, these remain too vague for example the table (page 297) states “referral to adoption therapist” and later in the ‘Course of Treatment’ section the article states “Michael’s parents indicated that they had been in contact with the therapist.” Page 298, however it is not clear what therapy was provided.

1. Burke, R. V., The Prevention Group Research Team, Schlueter, C., Bader, E., & Authier, K. J. (2018). Post-adoption services for high-risk families and their children: Preliminary results of a state-wide intervention. *Journal of Family Therapy, 46*(2), 122-138 [https://doi.org/10.1080/01926187.2018.1450687](file:///C:\Users\jackp\Documents\2%20DClinPsy\Coursework\Thesis%20-%20Systematic%20Review%20WRITE%20UP\%09https:\doi.org\10.1080\01926187.2018.1450687 )

Excluded on the basis that the intervention is poorly defined. The paper details a total of six core services available to families within the study: Intensive Case Services, Parent2Parent Network, Respite Care Connections, Mental Health Connections, Trainings and Workshops, and Support Groups and Family Activities. However, does not provide clarity regarding which families engaged with which service and therefore it is not known which services/interventions contributed to the positive change.

1. Carnes-Holt, K., & Bratton, S. C. (2014). The efficacy of child parent relationship therapy for adopted children with attachment disorders. *Journal of Counseling & Development, 92*(3), 328-337. [https://doi.org/10.1002/j.1556-6676.2014.00160.x](https://doi.org/10.1002/j.1556-6676.2014.00160.x )

Excluded on the basis that the application of the intervention within this study was delivered to the parents. Although play was taking place between parent and child, the intervention sessions were for the adoptive parents only to discuss video tapes of the play and parenting styles.

1. Chakawa, A., Frye, W., Travis, J., & Brestan-Knight, E. (2020). Parent-child interaction therapy: Tailoring treatment to meet the sociocultural needs of an adoptive foster child and family. *Journal of Family Social Work, 23*(1), 53- 70.<https://doi.org/10.1080/10522158.2019.1681336>

Excluded on the basis that the application of the intervention within this study was delivered to the parents. PCIT was utilised as a bug in the ear coaching method for parents and therefore not a whole family therapy.

1. Chang, K-P. (2012). Intervention Effect and Therapeutic Factors with Filial Therapy in Out- of-Home Placement Treatment. *Bulletin of Educational Psychology, 44*(2), 295-322. <http://epbulletin.epc.ntnu.edu.tw/contents/manage/detial.asp?id=235>

Excluded on the basis that a full-text English version was unavailable.

1. Chizk, G. (2018). The experience of using filial play therapy from the perspective of adoptive parents: A case study of family adjustment. (Publication No. 10904809) [Masters dissertation, East Carolina University]. ProQuest Dissertations Publishing.

Excluded on the basis that the sample was poorly recruited. The study included individuals who had received filial therapy up to 5 years before interview, this time scale of exposure is too broad.

1. Colonnesi, C., Wissink, I. B., Noom, M. J., Asscher, J. J., Hoeve, M., Stams, G. J. J.M., Polderman, N., & Kellaert-Knol, M. G. (2013). Basic trust: An attachment-oriented intervention based on mind-mindedness in adoptive families. *Social Work Practice, 23*(2), 179-188<https://doi.org/10.1177/1049731512469301>

Excluded on the basis that the population was recruited from exclusively internationally adopted children.

1. Hunsley, J. L. (2021). Effectiveness of an online intervention to improve understanding, well-being, and connection in adoptive families. (Publication No. 28418415) [Doctorate Thesis, Texas Christian University]. ProQuest Dissertations Publishing.

Excluded on the basis that the population included less than <80% domestically adopted children. Only 10% of the sample were domestically adopted.

1. Lourens, J. A. E. (2002). The application of family therapy in families with adopted children. (Publication No. 0666896) [Masters dissertation, University of South Africa]. ProQuest Dissertations Publishing.

Excluded on the basis that a full-text English version was unavailable.

1. Moore, J. E. (2019). ‘The storying spiral’: A narrative-dramatic approach to life story therapy with adoptive/foster families and traumatised children. *International Journal of Play, 8*(2), 204-218. <https://doi.org/10.1080/21594937.2019.1643994>

Excluded on the basis that the population reported on is not an adoptive family. The report only present results from a case study of a foster family.

1. Opiola, K. K., & Bratton, S. C. (2018). The efficacy of child parent relationship therapy for adoptive families: A replication study. *Journal of counselling & Development, 96*(2), 155-166.<https://doi.org/10.1002/jcad.12189>

Excluded on the basis that the application of the intervention within this study was delivered to the parents.

1. Pace, C. S., D’Onofrio, E., Guerriero, V., & Zavattini, G. C. (2016). A proposal for a brief-term post-adoption intervention in the attachment-perspective: a single case study with a late-adopted child and his adoptive mother. *Research in Psychotherapy: Psychopathology, Process, and Outcome, 19*(1), 31- 40.<https://doi.org/10.4081/ripppo.2016.197>

Excluded on the basis that the application of the intervention within this study was delivered to the parents. Two intervention sessions were completed with the adoptive parent only.

1. Puvis, K. B., & Cross, D. R. (2006). Improvements in salivary cortisol, depression, and representations of family relationships in at-risk adopted children utilizing a short-term therapeutic intervention. *Adoption Quarterly, 10*(1), 25-43. <https://doi.org/10.1300/j145v10n01_02>

Excluded on the basis that the population included only 33.33% domestically adopted children. The sample included 8 internationally adopted children of a total 12.

1. Ribaudo, J. (2016). Restoring safety: An attachment-based approach to clinical work with a traumatised toddler. *Infant Mental Health Journal, 37*(1), 80-82 [https://doi.org/10.1002/imhj.21549](https://doi.org/10.1002/imhj.21549 )

Excluded on the basis that the population included less than <80% domestically adopted children. The case study explores work which took place with a foster family who went onto adopt the children once birth parent rights had been removed and therefore the children did not have the legal status of adoption at the time therapy commenced.

1. Ryan, S. D., & Madsen, M. D. (2007). Filial family play therapy with an adoptive family: A response to preadoptive child maltreatment. *International Journal of Play Therapy, 16*(2), 112-132.<https://doi.org/10.1037/1555-6824.16.2.112>

Excluded on the basis that the application of the intervention within this study was delivered to the parents. The intervention is mainly skills teaching for parents only

1. Shin, H., Chung, I., Min, S., & Kwon, J. (2011). The development and evaluation of a program to improve parent-child attachment in families adopting an older child. *Journal of the Korean home economics association, 49*(2), 85-95. <https://doi.org/10.6115/khea.2011.49.2.085>

Excluded on the basis that a full-text English version was unavailable.

1. Simpson, D. (2016). Examining the lived experiences of families who have adopted children and received occupational therapy services. (Publication No. 10142976) [Masters dissertation, Eastern Kentucky University]. ProQuest Dissertations Publishing.

Excluded on the basis that the intervention is poorly defined. Occupational therapy services are broad, and the paper does not distinguish what sort of occupational service each family received.

1. Swan, A. M., Bratton, S. C., Ceballos, P., & Laird, A. (2019). Effect of CPRT with adoptive parents of preadolescents: A pilot study. *International Journal of Play Therapy, 28*(2), 107-122. [https://doi.org/10.1037/pla0000095](https://doi.org/10.1037/pla0000095 )

Excluded on the basis that the application of the intervention within this study was delivered to the parents.

1. Webster, J. (2018). Securing an adolescent’s attachment to her adoptive family: The use of multi-dimensional relational family therapy. *Clinical Social Work Journal, 46*(1), 57-68. <https://doi.org/10.1007/s10615-017-0627-4>

Excluded on the basis that this study was a descriptive case report. The paper was a self-reflective case study which did not provide suitable details of the sample, recruitment, methodology, research design, data collection, or findings.

1. Weir, K. N., (2008). Using integrative play therapy with adoptive families to treat reactive attachment disorder. *Journal of Family Psychotherapy, 18*(4), 1-16 [https://doi.org/10.1300/j085v18n04\_01](https://doi.org/10.1300/j085v18n04_01 )

Excluded on the basis that this study was a descriptive case report. The paper was a self-reflective case study which did not provide suitable details of the sample, recruitment, methodology, research design, data collection, or findings.

1. Wimmer, J. S., Vonk, E., & Bordnick, P. (2009). A preliminary investigation of the effectiveness of attachment therapy for adopted children with reactive attachment disorder. Child and Adolescent Social Work Journal, 26(4), 351- 360. <https://doi.org/10.1007/s10560-009-0179-8>

Excluded on the basis that the intervention utilises holding therapy.

1. Wydra, M. A. (2013). Does adoption therapy work?: Evaluating a therapy program for adopted children and their families. (Publication No. 3599561). [Doctorate Thesis, University of Maryland]. ProQuest Dissertations Publishing.

Excluded on the basis that the population included only 34% domestically adopted children. Some 66% of the sample were internationally adopted children.

**Reports identified via other methods and excluded at full-text screening (7)**

***Hand Searching Adoption and Fostering (2)***

1. Golding, K. (2007). Attachment theory as a support for foster carers and adoptive parents. *Adoption & Fostering, 31*(2), 77-79.

[https://doi.org/10.1177/030857590703100214](https://doi.org/10.1177/030857590703100214 )

Excluded on the basis that this study was a descriptive case report. The paper was a self-reflective case study which did not provide suitable details of the sample, recruitment, methodology, research design, data collection, or findings.

1. Purvis, K. B., Cross, D. R., Federici, R., Johnson, D., & McKenzie, L. B. (2007). The hope connection: A therapeutic summer day camp for adopted and at-risk children with special socio-emotional needs. *Adoption & Fostering, 31*(4), 38-48. <https://doi.org/10.1177/030857590703100406>

Excluded on the basis that the population included less than <80% domestically adopted children. Some 16 of the 19 children were internationally adopted.

***Hand Searching Adoption Quarterly (1)***

1. Weir, K. N., & Brodzinsky, D. M. (2013). Treatment and therapy considerations for adopted children and their families. *Adoption Quarterly, 16*(3-4), 153-1f55.

[https://doi.org/10.1080/10926755.2013.843926](https://doi.org/10.1080/10926755.2013.843926 )

Excluded on the basis that this article did not report an intervention.

***Backwards Citation Searches (4)***

1. Arvidson, J., Kinniburgh, K., Howard, K., Spinazzola, J., Strothers, H., Evans, M., Andres, B., Cohen, C., & Blaustein, M. E. (2011). Treatment of complex trauma in young children: Developmental and cultural considerations in application of the ARC intervention model. *Journal of Child & Adolescent Trauma, 4*(1), 34- 51. <https://doi.org/10.1080/19361521.2011.545046>

Report excluded on the basis that it is unclear whether the sample is adoptive families or foster families. The corresponding author was contacted on 02.01.2022 to ask for the raw data for the adoptive families however no response was provided.

1. Becker-Weidman, A. (2006). Treatment for children with trauma-attachment disorders: Dyadic-developmental psychotherapy. *Child & Adolescent Social Work Journal, 23*(2), 147-171. <https://doi.org/10.1007/s10560-005-0039-0>

Excluded on the basis that the sample included foster children, internationally adopted children, and domestically adopted children. The report fails to determine the percentage of foster children compared to rest of the sample. It is therefore unclear whether the majority of the sample are domestically adopted children. The email address for the corresponding author was contacted to clarify this, however this email box is no longer in use. Therefore, the study could not be included.

1. Becker-Weirdman, A. (2008). Treatment for children with reactive attachment disorder: Dyadic-developmental psychotherapy. *Child and adolescent mental health, 13*(1), 52-52.[https://doi.org/10.1111/j.1475-3588.2006.00428.x](file:///C:\Users\timmc\Downloads\ https:\doi.org\10.1111\j.1475-3588.2006.00428.x )

Excluded on the basis the paper was retracted from publication.

1. Purvis, K. B., Cross, D. R., Dansereau, D. F., Parris, S. R. (2013). Trust-based relational intervention (TBRI): A systemic approach to complex developmental trauma. *Child & Youth Services, 34*(4), 360-386. [https://doi.org/10.1080/0145935x.2013.859906](file:///C:\Users\jackp\Documents\2%20DClinPsy\Coursework\Thesis%20-%20Systematic%20Review%20WRITE%20UP\ https:\doi.org\10.1080\0145935x.2013.859906 )

Excluded on the basis that the application of the intervention within this study was delivered to the parents. The intervention was a training video delivered to parents.

**Appendix E**

*Cochrane Collaboration data collection form for systematic reviews of interventions (Higgins et al., 2021)*

**Cochrane Collaboration**

A picture containing text

Description automatically generated

Data collection form for intervention reviews: RCTs and non-RCTs

This form can be used as a guide for developing your own data extraction form. Sections can be expanded and added, and irrelevant sections can be removed. It is difficult to design a single form that meets the needs of all reviews, so it is important to consider carefully the information you need to collect, and design your form accordingly. Information included on this form should be comprehensive, and may be used in the text of your review, 'Characteristics of included studies' table, risk of bias assessment, and statistical analysis.

Using this form, or an adaptation of it, will help you to meet [MECIR standards](http://www.editorial-unit.cochrane.org/mecir) for collecting and reporting information about studies for your review, and analysing their results (see MECIR standards C43 to C55; R41 to R45).

## Notes on using data extraction form:

* Be consistent in the order and style you use to describe the information for each report.
* Record any missing information as unclear or not described, to make it clear that the information was not found in the study report(s), not that you forgot to extract it.
* Include any instructions and decision rules on the data collection form, or in an accompanying document. It is important to practice using the form and give training to any other authors using the form.

|  |  |
| --- | --- |
| Study ID *(surname of first author and year first full report of study was published e.g. Smith 2001)* |  |
| Country of Publication |  |
| Report ID |  |
| Notes | |

# General Information

|  |  |
| --- | --- |
| Date form completed *(dd/mm/yyyy)* |  |
| Name/ID of person extracting data |  |
| Reference citation |  |
| Study author contact details |  |
| Publication type *(e.g. full report, abstract, letter)* |  |
| Notes: | |

# Study eligibility

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Study Characteristics | Eligibility criteria  *(Insert inclusion criteria for each characteristic as defined in the Protocol)* | | Eligibility criteria met? | | | Location in text or source *(pg & ¶/fig/table/other)* |
|  |  | | Yes | No | Unclear |  |
| Type of study | Randomised Controlled Trial | |  |  |  |  |
|  | Quasi-randomised Controlled Trial | |  |  |  |  |
|  | Controlled Before and After Study  Contemporaneous data collection  Comparable control sites  At least 2 x intervention and 2 x control clusters | |  |  |  |  |
|  | Interrupted Time Series  At least 3 time points before and 3 after the intervention  Clearly defined intervention point | |  |  |  |  |
|  | Other design (specify): | |  |  |  |  |
| Participants |  | |  |  |  |  |
| Types of intervention |  | |  |  |  |  |
| Types of comparison |  | |  |  |  |  |
| Types of outcome measures |  | |  |  |  |  |
| INCLUDE | | EXCLUDE | | | | |
| Reason for exclusion |  | | | | | |
| Notes: | | | | | | |

**DO NOT PROCEED IF STUDY EXCLUDED FROM REVIEW**

# Characteristics of included studies

## Methods

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Descriptions as stated in report/paper** | | **Location in text or source** *(pg & ¶/fig/table/other)* |
| **Aim of study** *(e.g. efficacy, equivalence, pragmatic)* |  | |  |
| **Design** *(e.g. parallel, crossover, non-RCT)* |  | |  |
| **Unit of allocation** *(by individuals, cluster/ groups or body parts)* |  | |  |
| **Start date** |  | |  |
| **End date** |  | |  |
| **Duration of participation** *(from recruitment to last follow-up)* |  | |  |
| **Ethical approval needed/ obtained for study** | YesNoUnclear |  |  |
| **Notes** | | | |

## Participants

|  |  |  |  |
| --- | --- | --- | --- |
|  | Description  *Include comparative information for each intervention or comparison group if available* | | Location in text or source *(pg & ¶/fig/table/other)* |
| Population description |  | |  |
| Setting *(including location and social context)* |  | |  |
| Inclusion criteria |  | |  |
| Exclusion criteria |  | |  |
| Method of recruitment of participants *(e.g. phone, mail, clinic patients)* |  | |  |
| Informed consent obtained | Yes No Unclear |  |  |
| Total no. randomised *(or total pop. at start of study for NRCTs)* |  | |  |
| Clusters *(if applicable, no., type, no. people per cluster)* |  | |  |
| Baseline imbalances |  | |  |
| Withdrawals and exclusions *(if not provided below by outcome)* |  | |  |
| Age |  | |  |
| Sex |  | |  |
| Race/Ethnicity |  | |  |
| Severity of illness |  | |  |
| Co-morbidities |  | |  |
| Other relevant sociodemographics |  | |  |
| Subgroups measure |  | |  |
| Subgroups reported |  | |  |
| Notes: | | | |

## Intervention groups

*Copy and paste table for each intervention and comparison group*

**Intervention Group 1**

|  |  |  |
| --- | --- | --- |
|  | Description as stated in report/paper | Location in text or source *(pg & ¶/fig/table/other)* |
| Group name |  |  |
| No. randomised to group *(specify whether no. people or clusters)* |  |  |
| Theoretical basis *(include key references)* |  |  |
| Description *(include sufficient detail for replication, e.g. content, dose, components)* |  |  |
| Duration of treatment period |  |  |
| Timing *(e.g. frequency, duration of each episode)* |  |  |
| Delivery *(e.g. mechanism, medium, intensity, fidelity)* |  |  |
| Providers *(e.g. no., profession, training, ethnicity etc. if relevant)* |  |  |
| Co-interventions |  |  |
| Economic information *(i.e. intervention cost, changes in other costs as result of intervention)* |  |  |
| Resource requirements *(e.g. staff numbers, cold chain, equipment)* |  |  |
| Integrity of delivery |  |  |
| Compliance |  |  |
| Notes: | | |

## Outcomes

*Copy and paste table for each outcome.*

**Outcome 1**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Description as stated in report/paper | | Location in text or source *(pg & ¶/fig/table/other)* |
| Outcome name (measure) |  | |  |
| Time points measured *(specify whether from start or end of intervention)* |  | |  |
| Time points reported |  | |  |
| Outcome definition *(with diagnostic criteria if relevant)* |  | |  |
| Person measuring/ reporting |  | |  |
| Unit of measurement *(if relevant)* |  | |  |
| Scales: upper and lower limits *(indicate whether high or low score is good)* |  | |  |
| Is outcome/tool validated? | Yes No Unclear |  |  |
| Imputation of missing data *(e.g. assumptions made for ITT analysis)* |  | |  |
| Assumed risk estimate *(e.g. baseline or population risk noted in Background)* |  | |  |
| Power *(e.g. power & sample size calculation, level of power achieved)* |  | |  |
| Notes if qualitative study: | | | |

## Other

|  |  |  |
| --- | --- | --- |
| Study funding sources*(including role of funders)* |  |  |
| Possible conflicts of interest *(for study authors)* |  |  |
| Notes: | | |

# Data and analysis

*Copy and paste the appropriate table for each outcome, including additional tables for each time point and subgroup as required.*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Description as stated in report/paper | | | | | Location in text or source *(pg & ¶/fig/table/other)* |
| Comparison |  | | | | |  |
| Outcome |  | | | | |  |
| Subgroup |  | | | | |  |
| Time point *(specify from start or end of intervention)* |  | | | | |  |
| Post-intervention or change from baseline? |  | | | | |  |
| No. participants | Intervention | | | Control | |  |
|  | | |  | |
| Results | Intervention result | SE *(or other variance, specify)* | | Control result | SE *(or other variance, specify)* |  |
|  |  | |  |  |
| Overall results | | | SE *(or other variance, specify)* | |
|  | | |  | |
| Any other results reported |  | | | | |  |
| No. missing participants |  | | |  | |  |
| Reasons missing |  | | |  | |  |
| No. participants moved from other group |  | | |  | |  |
| Reasons moved |  | | |  | |  |
| Unit of analysis *(individuals, cluster/ groups or body parts)* |  | | | | |  |
| Statistical methods used and appropriateness of these |  | | | | |  |
| Reanalysis required? *(specify)* | Yes No Unclear | |  | | |  |
| Reanalysis possible? | Yes No Unclear | |  | | |  |
| Reanalysed results |  | | | | |  |
| Notes if qualitative study: | | | | | | |

# Other information

|  |  |  |
| --- | --- | --- |
|  | **Description as stated in report/paper** | **Location in text or source** *(pg & ¶/fig/table/other)* |
| **Key conclusions of study authors** |  |  |
| **References to other relevant studies** |  |  |
| **Correspondence required for further study information** *(from whom, what and when)* |  | |
| **Notes:** | | |

# 

**Sources:**

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**Appendix F**

*Risk of bias in non-randomised studies of interventions (ROBINS-I; Stern et al., 2021)*

The Risk Of Bias In Non-randomized Studies – of Interventions (ROBINS-I) assessment tool

## Risk of bias assessment

Responses underlined in green are potential markers for low risk of bias, and responses in red are potential markers for a risk of bias. Where questions relate only to sign posts to other questions, no formatting is used.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Signalling questions** | **Description** | **Response options** | | |
| **Bias due to confounding** | | | | | |
|  | 1.1 Is there potential for confounding of the effect of intervention in this study?  **If N/PN to 1.1:** the study can be considered to be at low risk of bias due to confounding and no further signalling questions need be considered |  | Y / PY / PN / N | | |
| **If Y/PY to 1.1**: determine whether there is a need to assess time-varying confounding: |  |  | | |
| 1.2. Was the analysis based on splitting participants’ follow up time according to intervention received?  **If N/PN**, answer questions relating to baseline confounding (1.4 to 1.6)  **If Y/PY**, go to question 1.3. |  | NA / Y / PY / PN / N / NI | | |
| 1.3. Were intervention discontinuations or switches likely to be related to factors that are prognostic for the outcome?  **If N/PN**, answer questions relating to baseline confounding (1.4 to 1.6)  **If Y/PY**, answer questions relating to both baseline and time-varying confounding (1.7 and 1.8) |  | NA / Y / PY / PN / N / NI | | |
|  | **Questions relating to baseline confounding only** | | | | |
| 1.4. Did the authors use an appropriate analysis method that controlled for all the important confounding domains? |  | NA / Y / PY / PN / N / NI | | |
| 1.5. **If Y/PY to 1.4**: Were confounding domains that were controlled for measured validly and reliably by the variables available in this study? |  | NA / Y / PY / PN / N / NI | | |
| 1.6. Did the authors control for any post-intervention variables that could have been affected by the intervention? |  | NA / Y / PY / PN / N / NI | | |
|  | **Questions relating to baseline and time-varying confounding** | |  | | |
| 1.7. Did the authors use an appropriate analysis method that controlled for all the important confounding domains and for time-varying confounding? |  | NA / Y / PY / PN / N / NI | | |
| 1.8. **If Y/PY to 1.7**: Were confounding domains that were controlled for measured validly and reliably by the variables available in this study? |  | NA / Y / PY / PN / N / NI | | |
|  | **Risk of bias judgement** |  | Low / Moderate / Serious / Critical / NI | | |
|
| **Bias in selection of participants into the study** | | | | |
|  | 2.1. Was selection of participants into the study (or into the analysis) based on participant characteristics observed after the start of intervention?  **If N/PN to 2.1:** go to 2.4 |  | | Y / PY / PN / N / NI |
| 2.2. **If Y/PY to 2.1**: Were the post-intervention variables that influenced selection likely to be associated with intervention?  2.3 **If Y/PY to 2.2**: Were the post-intervention variables that influenced selection likely to be influenced by the outcome or a cause of the outcome? |  | | NA / Y / PY / PN / N / NI  NA / Y / PY / PN / N / NI |
| 2.4. Do start of follow-up and start of intervention coincide for most participants? |  | | Y / PY / PN / N / NI |
| 2.5. **If Y/PY to 2.2 and 2.3, or N/PN to 2.4**: Were adjustment techniques used that are likely to correct for the presence of selection biases? |  | | NA / Y / PY / PN / N / NI |
| **Risk of bias judgement** |  | | Low / Moderate / Serious / Critical / NI |
|
| **Bias in classification of interventions** | | | | |
|  | 3.1 Were intervention groups clearly defined? |  | | Y / PY / PN / N / NI |
| 3.2 Was the information used to define intervention groups recorded at the start of the intervention? |  | | Y / PY / PN / N / NI |
| 3.3 Could classification of intervention status have been affected by knowledge of the outcome or risk of the outcome? |  | | Y / PY / PN / N / NI |
| **Risk of bias judgement** |  | | Low / Moderate / Serious / Critical / NI |
|
| **Bias due to deviations from intended interventions** | | | | |
|  | **If your aim for this study is to assess the effect of assignment to intervention, answer questions 4.1 and 4.2** | | |  |
| 4.1. Were there deviations from the intended intervention beyond what would be expected in usual practice? |  | | Y / PY / PN / N / NI |
| 4.2. **If Y/PY to 4.1**: Were these deviations from intended intervention unbalanced between groups *and* likely to have affected the outcome? |  | | NA / Y / PY / PN / N / NI |
| **If your aim for this study is to assess the effect of starting and adhering to intervention, answer questions 4.3 to 4.6** | | |  |
| 4.3. Were important co-interventions balanced across intervention groups? |  | | Y / PY / PN / N / NI |
| 4.4. Was the intervention implemented successfully for most participants? |  | | Y / PY / PN / N / NI |
| 4.5. Did study participants adhere to the assigned intervention regimen? |  | | Y / PY / PN / N / NI |
| 4.6. **If N/PN to 4.3, 4.4 or 4.5**: Was an appropriate analysis used to estimate the effect of starting and adhering to the intervention? |  | | NA / Y / PY / PN / N / NI |
| **Risk of bias judgement** |  | | Low / Moderate / Serious / Critical / NI |
|
| **Bias due to missing data** | | | | |
|  | 5.1 Were outcome data available for all, or nearly all, participants? |  | | Y / PY / PN / N / NI |
| 5.2 Were participants excluded due to missing data on intervention status? |  | | Y / PY / PN / N / NI |
| 5.3 Were participants excluded due to missing data on other variables needed for the analysis? |  | | Y / PY / PN / N / NI |
| 5.4 **If PN/N to 5.1, or Y/PY to 5.2 or 5.3**: Are the proportion of participants and reasons for missing data similar across interventions? |  | | NA / Y / PY / PN / N / NI |
| 5.5 **If PN/N to 5.1, or Y/PY to 5.2 or 5.3**: Is there evidence that results were robust to the presence of missing data? |  | | NA / Y / PY / PN / N / NI |
| **Risk of bias judgement** |  | | Low / Moderate / Serious / Critical / NI |
|
| **Bias in measurement of outcomes** | | | | |
|  | 6.1 Could the outcome measure have been influenced by knowledge of the intervention received? |  | | Y / PY / PN / N / NI |
| 6.2 Were outcome assessors aware of the intervention received by study participants? |  | | Y / PY / PN / N / NI |
| 6.3 Were the methods of outcome assessment comparable across intervention groups? |  | | Y / PY / PN / N / NI |
| 6.4 Were any systematic errors in measurement of the outcome related to intervention received? |  | | Y / PY / PN / N / NI |
| **Risk of bias judgement** |  | | Low / Moderate / Serious / Critical / NI |
|
| **Bias in selection of the reported result** | | | | |
|  | Is the reported effect estimate likely to be selected, on the basis of the results, from... |  | |  |
| 7.1. ... multiple outcome *measurements* within the outcome domain? |  | | Y / PY / PN / N / NI |
| 7.2 ... multiple *analyses* of the intervention-outcome relationship? |  | | Y / PY / PN / N / NI |
| 7.3 ... different *subgroups*? |  | | Y / PY / PN / N / NI |
| **Risk of bias judgement** |  | | Low / Moderate / Serious / Critical / NI |
| Optional: What is the predicted direction of bias due to selection of the reported result? |  | | Favours experimental / Favours comparator / Towards null /Away from null / Unpredictable |
| **Overall bias** | | | | |
|  | **Risk of bias judgement** |  | | Low / Moderate / Serious / Critical / NI |
|



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**Appendix G**

*Critical Appraisal Skills Programme Qualitative Research Checklist (CASP, 2018)*

**CASP Checklist:** 10 questions to help you make sense of a **Qualitative** research

**How to use this appraisal tool:** Three broad issues need to be considered when appraising a qualitative study:

Are the results of the study valid? (Section A)

What are the results? (Section B)

Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is “yes”, it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a “yes”, “no” or “can’t tell” to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

**About**: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users’ guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners. For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

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|  |  |  |
| --- | --- | --- |
| **Item** | **Hints** | **Responses**  **(a) Yes**  **(b) No,**  **(c) Can’t Tell &Comments** |
| **Section A: Are the results valid?** | | |
| 1. Was there a clear statement of the aims of the research? | Consider • what was the goal of the research • why it was thought important • its relevance |  |
| 2. Is a qualitative methodology appropriate? | Consider • If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants • Is qualitative research the right methodology for addressing the research goal |  |
| 3. Was the research design appropriate to address the aims of the research? | Consider • if the researcher has justified the research design (e.g. have they discussed how they decided which method to use) |  |
| 4. Was the recruitment strategy appropriate to the aims of the research? | Consider • If the researcher has explained how the participants were selected • If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study • If there are any discussions around recruitment (e.g. why some people chose not to take part) |  |
| 5. Was the data collected in a way that addressed the research issue? | Consider • If the setting for the data collection was justified • If it is clear how data were collected (e.g. focus group, semi-structured interview etc.) • If the researcher has justified the methods chosen • If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide) • If methods were modified during the study. If so, has the researcher explained how and why • If the form of data is clear (e.g. tape recordings, video material, notes etc.) • If the researcher has discussed saturation of data |  |
| 6. Has the relationship between research and participants been adequately considered? | Consider • If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location • How the researcher responded to events during the study and whether they considered the implications of any changes in the research design |  |
| **Section B: What are the results?** | | |
| 7. Have ethical issues been taken into consideration? | Consider • If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained • If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study) • If approval has been sought from the ethics committee |  |
| 8. Was the data analysis sufficiently rigorous | Consider • If there is an in-depth description of the analysis process • If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data • Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process • If sufficient data are presented to support the findings • To what extent contradictory data are taken into account • Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation |  |
| 9. Is there a clear statement of findings? | Consider whether • If the findings are explicit • If there is adequate discussion of the evidence both for and against the researcher’s arguments • If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst) • If the findings are discussed in relation to the original research question |  |
| **Section C: Will the results help locally?** | | |
| 10. How valuable is the research? | Consider • If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant researchbased literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used |  |

**Appendix H**

*GRADE Assessment (Schünemann et al., 2021)*

Table

Description automatically generated

**Appendix I**

*GRADE-CERQual Assessment*

The GRADE-CERQual assessment table was created by the research following research and guidance on the cerqual website. <https://www.cerqual.org/what-is-the-grade-cerqual-approach2/>

|  |  |  |  |
| --- | --- | --- | --- |
| **GRADE-CERQual Domain** | **Definition** | **Footnotes** (reasons for down grading) | **Quality of evidence** |
| Methodological Limitations Component | The extent to which there are concerns about the design or conduct of the research. Typically includes appraisals of how participants and settings were selected, how data was collected and analysed, and researcher reflexivity. |  | ++++  High  +++  Moderate  ++  Low  +  Very Low |
| Relevance Component | The extent to which the body of data is applicable to the context specified in the review question. |  |
| Coherence Component | An assessment of how clear and cogent the fit is between the data from and the findings |  |
| Adequacy Component | The degree of richness and quantity of data supporting the findings |  |
| Overall |  |  |

**Section Two: Empirical Study**

**Feasibility and Acceptability of Integrating Theraplay®, Dyadic-Developmental Psychotherapy, and Eye Movement Desensitisation and Reprocessing with Adoptive Families: A Framework Analysis**

**Abstract**

**Objectives:** This study aimed to establish the feasibility and explore the retrospective acceptability of an integrative intervention for adoptive families which included Theraplay®, Dyadic-Developmental Psychotherapy, and Eye Movement Desensitisation and Reprocessing.

**Design:** Feasibility was assessed by descriptive analysis of recipient attendance patterns and post-therapy questionnaire completion rates. Acceptability was explored qualitatively utilising Framework Analysis of semi-structured interviews with intervention deliverers and recipients, with each dataset being analysed separately.

**Methods:** Purposive sampling recruited nine therapists and 14 adoptive parents from eight families. Credibility was maintained via service user/deliverer consultation, triangulation, member checking, reflexive logs, and quality appraisal checklists.

**Results:** Attendance and measure completion rates indicated the intervention is feasible. The qualitative investigation suggested the approach is predominantly acceptable for both therapists and adoptive parents. Issues detracting from acceptability for therapists included the risk of integrating models for unsuitable reasons at unsuitable times, uncertainty relating to integrating effectively, self-doubt, and feeling pressure to make the right decision when integrating. Issues for adoptive parents included the therapy being unable to ameliorate all their difficulties, aspects being hard to understand, aspects being uncomfortable and uncertain, and the therapy requiring a high level of effort.

**Conclusion:** The integration of these models was feasible and acceptable. To enhance acceptability a Delphi study contributing to the development of competency and adherence measures would be valuable for therapists. Adoptive parents would benefit from services taking steps to enhance their understanding and comfort whilst integrating these approaches. Finally, research investigating the preliminary efficacy of integrating these modalities is required.

**Practitioner Points**

* Integrative psychotherapeutic practice for adoptive families is emerging in both research and practice. This is the first study exploring the feasibility and acceptability of integrating Theraplay®, DDP, and EMDR with adoptive families.
* The integration of Theraplay®, DDP, and EMDR was deemed feasible for all intervention recipients and acceptable to all recipients and deliverers.
* Adoptive parent acceptability of integrative Theraplay®, DDP, and EMDR is mediated by the level of clarity and comfort they experience during therapy. For therapists, acceptability could be enhanced with greater guidance relating to how to integrate effectively.
* Future research evaluating the integration of Theraplay®, DDP, and EMDR should include quantitative examinations of acceptability, a Delphi study contributing to the development of competency and adherence measures, and studies of preliminary efficacy.

**Keywords:**

Adoption; Acceptability; Feasibility; Integrative; Intervention

**Feasibility and Acceptability of Integrating Theraplay®, Dyadic-Developmental Psychotherapy, and Eye Movement Desensitisation and Reprocessing with Adoptive Families: A Framework Analysis**

In England over 40,000 looked after children have entered adoptive placements since 2011 (Department for Education [DfE], 2021). Data suggests that >92% of these children entered care due to experiences of abuse or neglect, family dysfunction, family in acute stress, or absent parenting (DfE, 2021). These experiences are synonymous with the prodromal stages of attachment difficulties and developmental trauma (National Institute for Health and Care Excellence [NICE], 2015). Therefore, many of these children are at an increased risk of experiencing a wide range of attachment and trauma related symptomatology (Palacios & Brodzinsky, 2010; van den Dries et al., 2009).

Between 2015 and 2018 over 35,000 UK adoptive families accessed the Adoption Support Fund for psychotherapeutic support (DfE, 2018). NICE (2015) acknowledges that various interventions are utilised for attachment difficulties within adoptive families which may be clinically effective however, empirical evidence is scarce. Subsequently, NICE (2015) have called for additional research into therapeutic interventions for these families, specifically play therapy and Dyadic-Developmental Psychotherapy (DDP). NICE (2018) also recommends Eye Movement Desensitisation and Reprocessing (EMDR) for trauma related difficulties in children, if trauma-focused cognitive behavioural therapy (TF-CBT) has proved unsuccessful.

Evidence for Theraplay® and EMDR in general child populations is growing. For reviews see Money et al. (2020) and Rodenburg et al. (2009). Research in DDP is also emerging for children living away from birth families, see Hughes et al. (2015). Additionally, all three are beginning to feature in research and practice relating to adoptive family therapy (Stock et al., 2016). Theraplay® can positively impact communication and interpersonal difficulties for adoptive families (Weir et al., 2013), DDP can help adoptive parents develop insight towards their child(ren)’s behavioural and emotional worlds (Agbayani, 2014; Turner, 2012; Wingfield & Gurney-Smith, 2019), and EMDR can positively impact an adoptive child’s attachment, trauma, behavioural, and emotional difficulties, subjective experiences of discomfort, and validity of cognitions (Draper et al., 2021; Wesselmann et al., 2018).

The promising evidence supporting Theraplay®, DDP, and EMDR with adoptive families in clinical practice has led to the integration of these approaches. In practitioner text-books Rubin et al. (2009) present three case examples detailing integrative Theraplay® and DDP, McGuinness (2011) presents a case example promoting the integration of play therapy and EMDR, and both Rubin et al. (2010) and Lindaman and Lender (2009) discuss how Theraplay® can be combined with DDP and EMDR with adoptive families. Separately, the DDP Network published a case study documenting DDP, Theraplay®, EMDR, play therapy, and sandtray-worldplay therapy (Sun-Reid, 2012), Friend (2012) details a case example integrating DDP, Theraplay® and narrative therapy, and Aideuis (2007) reported an example of DDP, TF-CBT, and EMDR. More recently, Vaughan et al. (2016) introduced neuro-physiological psychotherapy (NPP), which integrates Theraplay® and DDP together with four other therapeutic approaches.

The more acceptable a healthcare intervention is to recipients the more likely it will produce superior clinical outcomes and treatment adherence (Fisher et al., 2006; Hommel et al., 2013). Similarly, interventions less acceptable to deliverers may not be appropriately implemented (Borrelli et al., 2005; Proctor et al., 2009). Therefore, as integrative approaches for adoptive families continue to emerge, evaluating the feasibility and acceptability of these interventions is essential (Diepeveen et al., 2013; Moore et al., 2015). Feasibility refers to the ease with which interventions can be implemented in clinical practice. Acceptability reflects the extent to which individuals delivering or receiving an intervention consider it to be appropriate (Sekhon et al., 2017). The theoretical framework of acceptability (TFA; see appendix A) presents seven constructs of acceptability. The extent to which these constructs may cluster is currently unknown. Therefore, this study selected four distinct TFA constructs: perceived effectiveness, intervention coherence, self-efficacy, and burden to determine the retrospective acceptability of an integrative intervention for both deliverers and recipients.

The current study aimed to establish the feasibility and explore the acceptability of an integrative psychological intervention for adoptive families which included elements of Theraplay®, DDP, and EMDR. Feasibility was assessed by reviewing recipient attendance patterns. Acceptability was explored utilising Framework Analysis (Ritchie et al., 2003) of semi-structured interviews with deliverers and recipients. The study aimed to address the following questions:

1. Is the integration of Theraplay®, DDP, and EMDR feasible in clinical practice?
2. In what ways is the integration of these models acceptable and/or unacceptable for deliverers and recipients across domains of:
   1. Perceived effectiveness, the extent to which the intervention is perceived to have achieved its purpose.
   2. Intervention coherence, the extent to which the deliverer/recipient understands the intervention and how it works.
   3. Self-efficacy, the deliverers/recipient’s confidence that they can perform the necessary behaviours required to participate in the intervention.
   4. Burdensomeness, the perceived amount of effort required to deliver/participate in the intervention.
3. What helps/hinders when integrating these therapeutic modalities?

**Method**

**Research Philosophy and Design**

The research assumed a critical realist ontological position as it seeks to ascertain a greater understanding of each participant’s genuine experience of acceptability, whilst acknowledging that the dataset gathered may not provide direct access to such a reality (Willig, 2008). To mediate this, an essentialist stance was taken in which the researcher recognised the information collected from each participant as an accurate reflection of their lived experience and how they have chosen to make sense of this (Dyson & Brown, 2006).

Framework analysis (FA; Ritchie & Spencer, 1994) was selected. FA upholds the importance of utilising a priori themes alongside emergent data driven concepts in constructing an analytic framework (Parkinson et al., 2016; Ward et al., 2013). Additionally, Ritchie and Spencer (1994) identified that FA can appropriately address both contextual (discovering) and evaluative (examining) research questions. This study aimed to discover the nature of each participant’s experience alongside evaluating the acceptability of these experiences, utilising the TFA as an a priori guide. Therefore, FA was deemed flexible enough to facilitate the necessary exploration into the predetermined features of acceptability whilst remaining open to additional areas of exploration which may be pertinent to each participant (Ritchie & Spencer, 1994).

To supplement the qualitative exploration of acceptability a small quantitative examination of feasibility was completed. Feasibility was assessed through descriptive analysis of adoptive parent’s attendance figures and assessment measure completion rates.

**Research Setting and Therapeutic Package**

The study was conducted within a private-sector trauma and attachment service which provides integrative psychotherapy to support adoptive, special guardianship, and foster families in three counties in the North of England covering a combined population of over 4,800,000. The service consists of two clinical psychologists, five assistant psychologists, and 14 trauma and attachment therapists. Families were referred to the service by their adoption social worker and therapy was funded via the adoption support fund.

The integrative psychotherapeutic model utilised by the service is an attachment-based, developmental, and neurosequential psychotherapeutic approach which meets the needs of the child(ren), parent(s), and adoptive family by appropriately responding to necessary demands during therapy. The integrative therapeutic package consisted of 30-hours of therapy predominantly delivered across 10 weeks. Most families received 10-hours of therapy for the family unit, 10-hours of therapy for the adoptive parents, and 10-hours of therapy for the adopted child. However, variations did occur, for example participant 15 were awarded 15 sessions of family work and 15 sessions of adoptive parent sessions, although due to financial year limitations only 10 sessions of therapy for the family unit and 11 adoptive parent sessions were accessed.

The 10-hours of therapy for the family unit involved the adoptive parent(s), their child, and their trauma and attachment therapist. These sessions aim to strengthen attachments, help families make sense of their child’s early life, and process traumatic experiences. The therapists utilise clinical judgement to integrate Theraplay®, DDP, and EMDR within this session. The 10-hours of therapy for the adoptive parents is DDP-based and involves the parents and their trauma and attachment therapist. This consists of coaching the parents in therapeutic skills, reviewing prior sessions to enhance reflective capacity, exploring problematic behaviours, problem-solving challenges, exploring how parents can look after their own emotional wellbeing, and psychoeducation around the models of Theraplay®, DDP, and EMDR.

During this therapeutic package adopted children also receive 10-hours of sensory regulation and mindfulness sessions with an assistant psychologist. However, only certain adoptive parents and none of the trauma and attachment therapists were involved in these sessions. Therefore, although the wider therapeutic package includes other therapeutic modalities, this study explores the acceptability of delivering/receiving integrative Theraplay®, DDP, and EMDR only, as it focuses on the unique experiences shared by both the adoptive parents and trauma and attachment therapists.

**Recruitment**

Purposive sampling was utilised to achieve representativeness (Teddlie & Yu, 2007). The service collated a list of potential participants according to the eligibility criteria (see Table 1).

**Table 1**

*Inclusion and Exclusion Criteria*

|  |  |
| --- | --- |
| Inclusion Criteria | Exclusion Criteria |
| Trauma and Attachment Therapists | |
| Delivered an integrative therapeutic package of Theraplay®, and/or DDP, and/or EMDR within prior six months. | Less than one year experience integrating Theraplay®, and/or DDP, and/or EMDR. |
| Had a regular caseload of 6 families a week in which integrative therapy takes place. | Do not have at least Level 1 training qualifications in at least two of the three therapeutic modalities. |
| Adoptive Parents | |
| Legal status of an adoptive parent. | Foster carers; special guardianship order carers. |
| Were contracted to receive a 30-session integrative therapeutic intervention which concluded between April 2021 and April 2022. | Adoptive families who contracted a package of therapy greater than 30 sessions in length. |
| Parents to adopted children who were exhibiting symptoms of developmental trauma and/or attachment difficulties as measured by a clinical intake interview with adoptive parents and the Marschak Interaction Method (Marschak, 1960) with adoptive parents and adoptive child. | Adoptive families considered by their trauma and attachment therapist to be experiencing acute stress and levels of difficulty which regarded it inappropriate to contact them inviting them into a research project during the time of the study. |

Recruitment was governed by the concept of informational power (Malterud et al., 2016). Malterud et al. (2016) suggest informational power is influenced by study aim, specificity, use of established theory, and quality of dialogue. Therefore, as the study’s aims were narrow, specificity was dense, dialogue was expected to be strong, and the analysis flexibly applied established theory, it was anticipated that a relatively small sample would provide sufficient informational power for this study. Subsequently, the study aimed to recruit 7-9 therapists and 7-9 adoptive parents. To operationalise the concept of informational power during recruitment, data saturation was also considered. Data saturation was applied to substantiate whether recruitment could feasibly terminate between 7-9 participants for each group, or whether further recruitment was required.

Eligible therapists were contacted by the service directors and eligible adoptive parents were contacted by their therapist. During these contacts prospective participants were provided an overview of the study and asked whether they consented to being contacted by the researcher via email. Eleven therapists and parents from ten adoptive families consented to be contacted. The researcher contacted the first nine therapists who consented to be contacted and provided participant information sheets and written consent forms, all nine therapists consented to participate within this study. The researcher completed this process again with the first nine adoptive families, two families did not respond, and therefore an additional adoptive family was contacted to engage in the study. This resulted in 14 parents from eight families consenting to participate.

Saturation for the respective datasets was deemed to be attained following interviews with nine therapists and eight adoptive families and therefore recruitment stopped. No participants withdrew once the study commenced.

**Participants**

Therapists were predominantly female (88.8%), White British (88.8%), between 37-66 years old (M=43.4), with 6-25 years’ experience as a therapist (M=13.7), and 1-16 years’ experience integrating Theraplay®, DDP, and EMDR with adoptive families (M=6.05). The average caseload was between 6-10 families per week (M=6.8), and most therapists had Level 2 training or above in Theraplay®, DDP, and EMDR (66.6%), see table 2.

The 14 adoptive parents represented 8 distinct participants. Twelve parents were interviewed in couples representing six participants and two adoptive parents were interviewed without their partners present, see table 3. The parents were aged between 28-54 years (M=44.2), the adopted children in therapy were 3-13 years (M=8.1), average length of adoption was 2-6 years (M=3.6), and average time between final therapy session and the interview ranged between 1-311 days (M=73.25). The average family therapy hour within the integrative therapeutic packages included 47% Theraplay®, 21% DDP, 17% EMDR, and 15% of time spent in other models which were most commonly whilst completing life story work. The percentage of session time spent within each modality was self-reported by the therapist, see Appendix B for session-by-session overviews and the template recording form. All participants were aware that the researcher had an interest in exploring the positives and negatives of integrative psychotherapeutic practice for adoptive families.

**Table 2**

*Therapists Demographic Information*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| P\*\* | Age Range | Highest Level of Education by Degree | Years of Experience (Integrating) | Caseload per week | Additional Therapeutic Qualifications |
| P1 | 40-50 | Undergraduate | 25-30 (4-8) | 6 | Level 2 DDP & Theraplay®,  Level 3 EMDR\* |
| P2 | 40-50 | Undergraduate | 5-10 (4-8) | 10 | Level 2 DDP & Theraplay®,  Level 3 EMDR\* |
| P3 | 60-70 | Undergraduate | 25-30 (8-12) | 6 | Level 2 DDP & Theraplay®,  Level 3 EMDR\* |
| P4 | 30-40 | Undergraduate | 5-10 (0-4) | 6 | Level 1 DDP & Theraplay® |
| P5 | 30-40 | Doctorate | 5-10 (4-8) | 7 | Level 2 DDP & Theraplay®,  Level 3 EMDR\* |
| P6 | 30-40 | Masters | 5-10 (4-8) | 9 | Level 2 DDP & Theraplay®,  Level 3 EMDR\* |
| P7 | 40-50 | Masters | 20-25 (12-16) | 6 | Level 2 DDP & Theraplay®,  Level 3 EMDR\* |
| P8 | 30-40 | Doctorate | 5-10 (4-8) | 6 | Level 1 Theraplay®,  Level 2 DDP, Level 3 EMDR |
| P9 | 40-50 | Masters | 10-15 (0-4) | 6 | Level 1 DDP & Theraplay® |

P: Participant, \*Two additional EMDR training levels with children have also been completed. \*\*To maintain anonymity the gender, ethnicity, and exact ages and years of experience of each therapist have been omitted.

**Table 3**

*Parent Demographic Information*

| P | Sex & Age Parent(s) [Child(ren)] | Years of Adoption | Ethnicity Parent(s) [Child(ren)] | Days since final session [Therapist] | Overall percentage of time in each therapeutic modality during family therapy session. |
| --- | --- | --- | --- | --- | --- |
| P10 | F41, M40, [M6] | 2 | WB, WB, [WB] | 67 Days  [P9] | Theraplay®: 40% DDP: 9%  EMDR: 0% Other Model: 51% |
| P11 | F37\*, M37, [F11\*\*, F7] | 5 | WB, WB, [WB, WB] | 17 Days  [P4] | Theraplay®: 46% DDP: 20% EMDR:0% Other Model: 34% |
| P12 | F46, M46,  [M13, M11\*\*] | 6 | WB, WB [WO, WO] | 64 Days  [P8] | Theraplay®: 27% DDP: 54%  EMDR: 19% Other Model: 0% |
| P13 | F49, M47, [F11, F6\*\*] | 3 | WO, WB [WO, WO] | 40 Days  [P2] | Theraplay®: 36% DDP: 20%  EMDR: 21% Other Model: 23% |
| P14 | F39\*, M37,  [F3, M2\*\*] | 2 | WB, WB, [WB, WB] | 311 Days  [P5] | Theraplay®: 75% DDP: 10%  EMDR: 14% Other Model: 1% |
| P15 | M54, F52, [M8] | 2 | WB, WB, [WB] | 1 Day  [P2] | Theraplay®: 55% DDP: 2%  EMDR: 36% Other Model: 7% |
| P16 | M57, F48, [F10] | 5 | WO, WO, [WB] | 1 Day  [P6] | Theraplay®: 33% DDP: 32%  EMDR: 32% Other Model: 3% |
| P17 | M37, M28, [M8\*\*, M7, M6\*\*] | 4 | WB, WB, [WB, WB, WB] | 85 Days  [P8] | Theraplay®: 63% DDP: 21%  EMDR: 31% Other Model: 3% |

F: Female, M: Male, P: Participant, WB: White British, WO: White Other, \*Parent attended therapy but did not attend the interview, \*\*Child did not attended therapy,

**Data Collection**

To assess feasibility, attendance patterns were recorded. The key feasibility indicators were the percentage of sessions attended and the percentage of outcome data completed and returned.

To explore the acceptability of the integrative therapeutic package semi-structured interviews were conducted. The researcher created separate interview schedules for the therapists and parents (see Appendix C). Both schedules were developed in line with the TFA (Sekhon et al., 2017). Service user and deliverer consultations were arranged with three therapy-experienced adoptive parents, and three trainee clinical psychologists working in children’s settings to collaboratively construct the interview schedules. Table 4 details major amendments following these consultations. Interview questions explored what led participants to receiving/delivering integrative therapy, how effective the therapy was, whether the therapy made sense, how confident they felt that they could perform the behaviours required to deliver/receive the therapy, and how burdensome the therapy was. The researcher conducted all interviews. Interviews predominately utilised a non-directive and open questioning style and when necessary, prompts were utilised to elicit more information. The interview schedules were purposefully designed to explore alternative and oppositional experiences.

Interviews took place via an online video communications platform and were audio recorded on an encrypted device for later transcription. Only the participant and the researcher were present during the interviews.Before each interview consent was rediscussed, participants were invited to ask questions, and demographic information was collected. Therapist interviews were conducted between 12.08.2021 and 06.10.2021 and were 32-61 minutes in length (M=48). Parent interviews were conducted between 28.01.2022 and 14.04.2022 and were 27-74 minutes in length (M=61). All interviews were transcribed verbatim: five by the researcher and 12 by the same hired transcriber.

**Table 4**

*Service user and service deliverer consultations*

|  |  |
| --- | --- |
| Aspect of research | Amendment |
| Service Deliverers – Trainee Clinical Psychologists | |
| Interview schedule | The opening question should be what led these participants to becoming therapists, as they may find it hard to respond to the question “what led you to integrate the models of Theraplay®, DDP, and EMDR” without providing a bit of background about why they became a therapist first, the two may be interlinked. |
| General feedback | The delivery of some questions comes across a bit robotic at present, add in some phrases such as “can you tell me a bit about…” and “I’m wondering whether you could share a bit about…” |
| Service User – Therapy experienced Adoptive Parents | |
| Participant information sheet | Replace abbreviations of therapeutic approaches throughout this document and use full names of therapies instead as it can sometimes be hard to remember what DDP and EMDR mean. |
| Interview schedule | When asking parents to discuss overall whether they feel their therapy was effective, made sense, whether they felt confident, and how burdensome it was, ask them to rate this from 0 to 10. It is easier to respond to this question with some numerical scaffolding. |
| General feedback | Where possible refer to us parents as parents and our families as families as opposed to adoptive parents and adoptive families. Unless use of the term is absolutely necessary for clarity purposes. |

**Analysis**

Framework analysis was applied in line with the guidance of Ritchie and Spencer (1994; 2002), and the worked examples of Parkinson et al. (2016) and Ward et al. (2013). Separate analysis was completed for the therapist dataset and the parent dataset. The researcher completed the familiarisation process with all transcripts to understand the range and diversity of each dataset. Immersion was obtained by listening to tapes, re-reading transcripts, and revisiting the reflective log (Ritchie et al., 2003). The researcher made familiarisation notes throughout this stage to begin the process of abstraction and conceptualisation (see Appendix D). An initial framework was constructed for both datasets which remained closely related to the interview schedules. During the indexing stage the framework was piloted on two interviews, to ascertain whether it could encompass the deductive themes emerging from the data. The framework was iteratively modified to account for categories which were not present, and the remaining interviews were then coded into the final frameworks (see Appendix E). Thematic charts were constructed from the framework to build a picture of the data (see Appendix F-M). Due to the size of the dataset, it was feasible to input direct quotes into these charts, as opposed to summaries constructed by the researcher. This ensured the charts maintained the absolute essence of each participant’s viewpoint. The charts were then utilised to inform the mapping and interpretation of the overall dataset in which the range and nature of acceptability was explored, and explanations were sought within and between participants. See Appendix N for an example of the audit process.

Nvivo (Bazeley & Jackson, 2013) was utilised to assist data analysis. Nvivo is a software package which is fully integrated with framework analysis. Nvivo enhanced the transparency of the analytic process as it provided a clear audit trail in which decisions and interpretations could be traced back to raw data (Parkinson et al., 2016).

**Reflexivity Statement**

The researcher was a 28-year-old, white British, male, trainee clinical psychologist with no personal experience of adoption. The researcher has an interest in developing integrative psychotherapies for adoptive families and in working with adoptive families to enhance the quality and safety of psychotherapeutic provision. The researcher was an ex-colleague of eight of the nine therapist participants and had no prior acquaintances with the parent participants. A reflective log was maintained throughout the research to develop insight regarding potential bias and influences over the project design and completion (see Appendix O for excerpt). It is acknowledged that the researcher’s interests and the roles and relationships shared between the researcher and participants could increase risk of bias, therefore several credibility checks were undertaken in accordance with best practice guidelines to enhance the validity of the research.

**Credibility Checks**

The interview schedule was guided by prior theory and collaboratively constructed through service user/deliverer consultat­ion. Analyst triangulation was also employed. An independent research assistant (JH) cross-analysed one therapist interview and one parent interview, as recommended by Flick (2006). JH completed the familiarisation process for both transcripts and discrepancies within initial notes were discussed. JH then cross-indexed the transcripts against the researcher’s thematic frames. Discrepancies in indexing were discussed, the final thematic frames were created, and then the remaining transcripts were indexed. JH then audited the final themes constructed following the mapping and interpretation process against two additional transcripts (Elliot et al., 1999). This quasi-consensus approach is recommended for minimising researcher bias (Barker & Pistrang, 2005). Moreover, in line with Stiles (1999) respondent credibility checks were conducted to promote testimonial validity. The transcripts, thematic results, and final manuscript were provided to all participants for member checking and feedback (Barker & Pistrang, 2005). Finally, all points on the standards for reporting qualitative research (SRQR; O’Brien et al., 2014), consolidated criteria for reporting qualitative research (COREQ; Tong et al., 2007) and critical appraisal skills programme qualitative checklist (CASP, 2018) were adhered to.

**Ethical Considerations**

Ethical approval was obtained from The University of Sheffield Ethics Committee (Registration number: 190218009, Department of Psychology Research Ethics Committee; see Appendix P). Approval was also obtained from all regional adoption agencies funding families for therapy (see Appendix Q). All participants were provided with an information sheet which detailed the study (see Appendix R), were given the chance to discuss the study with the researcher, and informed consent was obtained (see Appendix S). Consent was seen as an ongoing process and participants were reminded of their right to withdraw and timescales for withdrawal. Names have been omitted to ensure anonymity and all participants were provided with their transcript, the themes, and final manuscript to provide feedback on whether their confidentiality has been appropriately maintained. Additionally, the researcher and research supervisor addressed several ethical issues prior to study commencement, see Table 5. Finally, the University of Sheffield provided £600 for transcription costs but otherwise, this study did not receive any sources of funding or support.

**Table 5**

*Ethical Considerations*

|  |  |
| --- | --- |
| Ethical consideration | Steps taken to address ethical consideration |
| Confidentiality | Anonymity was ensured, identifiable information was removed from transcripts and was not included in the study. The limits of confidentiality were also discussed at the start of each interview with reference to safeguarding and service-related complaints. |
| Consent | Consent was obtained verbally and in writing. Consent was seen as an ongoing process and was reviewed regularly. |
| Distress | It was not anticipated that the participants or researcher would endure experiences of significant distress during the interviews, however, a list of pre-planned support options was prepared. Participants would also be guided to contact their therapist and social worker. |
| Lone working | The interviews were taking place remotely and therefore a peer ‘buddy’ system was operationalised, providing the opportunity for the researcher to reflect and feel contained following interviews, which safeguarded emotional wellbeing. |
| Research-related complaints | All participants were provided the contact details for the researcher, the research supervisor, and a clinical liaison supervisor involved in the project, and four individuals not directly involved in the project: the head of psychology at the University of Sheffield (UoS), joint chairs of the UoS’ department of ethics subcommittee, and the UoS’ department of clinical psychology research officer. |
| Right to withdraw | All participants were informed of their right to withdraw from the study, the timescales they had to consider this, and provided with several individuals they could contact if they wished to discuss withdrawing. All participants were made aware that choosing to withdraw would have no impact on their relationship with the service in terms of their career, access to the service or quality of service provision now, or in the future. |
| Safeguarding concerns | If concerns were raised relating to safeguarding the researcher planned to notify the board of directors at the service, the local authority in which the child resides, the services safeguarding lead, and follow the service’s safeguarding procedure before the end of that working day. |
| Service-related complaints | If concerns were raised regarding the practice of the service, the researcher planned to advise participants to discuss this with a member of the service’s senior leadership, the researcher would also follow the service’s complaints procedure. |
| Working with multiple stakeholders | Approval for the project was sought and obtained from the University of Sheffield, the directors of the private trauma and attachment service, and the organisational bodies funding the therapy for the families involved in the study. |

**Results**

**Attendance Patterns**

The eight families each received a package of therapy which included 10 parenting sessions and 10 family therapy sessions, participant 15 engaged in an additional parenting session resulting in the provision of a total 161 sessions. The group attended 160/161 sessions (99%). Seven families were provided 4 post-therapy questionnaires resulting in a total of 28 assessment measures. These families returned 28/28 assessment measures (100%). One family was not provided post-therapy assessment measures due to a language barrier.

**Therapist Experiences**

The interpretation process mapped the range and nature of the therapists’ experiences of acceptability (see table 6 and appendix T for alternative presentation). The key dimensions distilled from this process were categorised into four major themes which are described below, illustrated with quotes. Quotes are labelled as ‘P’ followed by a unique identifier for each participant (see table 1).

**Table 6**

*Mapping therapists’ experiences of integrating Theraplay®, DDP, and EMDR*

| **Theme/Sub-Themes** | **Frequency** |
| --- | --- |
| Successful and Precarious: I can meaningfully respond to the need in the room, and I can also integrate for unsuitable reasons at unsuitable times.  Successful: “*I’ve got lots of different ways of working available to me depending on how they present that day… it is very effective*” P8  Precarious: *“if I’m not careful I’ll end up throwing everything at them and then it just becomes a mess”* P3 | 9  7 |
| Clarity and Ambiguity: Integrating these models makes sense and it is hard to know if you’re integrating effectively.  Clarity: “*It makes complete sense to me… we’re working with complex children and so they don’t come with one issue*” P1  Ambiguity: “*when we’re mixing it… for me it’s a question of am I doing the right thing?”* P9 | 9  5 |
| Self-Assurance and Apprehension: I feel confident integrating these models and I find myself questioning my ability.  Self-Assurance: “*I think there is a variable on how the therapist is willing to take those risks*” P7  Apprehension: “*It could be that you feel I shouldn’t, I shouldn’t integrate, you know I should stick to one*” P3 | 9  7 |
| Easier and More Challenging: Freedom to integrate makes therapy easier but this freedom brings additional challenges as I feel pressure to make the right decisions.  Easier: “*Having tools to bring in when one of the therapies feels a bit stuck, makes it easier*” P6  More Challenging: “*I’d come out thinking, you know there’s a bit of EMDR and a bit of Theraplay and maybe I’ve done too little of too much*” P5 | 9  8 |

Intrinsic links between themes were identified (see appendix U). Management of flexibility was a prominent feature which contributed to the success and ease of the intervention whilst also influencing its precarious and challenging nature. Clarity and ambiguity were linked to self-assurance and apprehension with levels of knowledge, experience, and supervision appearing to mediate this association. Finally, the complementary nature of the therapies seemed to make the intervention clearer and more successful, and levels of self-assurance and apprehension were linked to the therapy feeling easier or more challenging.

***Successful and Precarious***

All therapists discussed that integrating these models made their practice more successful, as they naturally enrich the therapeutic impact of one another, see Appendix F for thematic chart.

*“…for me they [Theraplay and DDP] work really seamlessly so one really naturally feeds into the other… you can use the Theraplay games to illustrate ‘oh that’s tricky isn’t it that you have to do that’ so that would naturally lead you to a DDP conversation” P4*

*“Integrating allows you to modulate the intensity during sessions, you can make Theraplay more or less intense with DDP, or you can bring in EMDR to process a nice moment of connection” P6*

Eight therapists commented that having the freedom to integrate these models makes them more likely to meet the therapeutic needs of the family.

*“I’ve got lots of different ways of working available to me depending on how they present that day… it is very effective erm yeah I couldn’t really imagine just working with one model” P8*

*“I’ve just seen children change so much, erm and having a little bit of all three just erm at the right time… that is the best…” P2*

Six therapists discussed the risk of integrating too much during therapy or introducing modalities too soon in the therapeutic process. Five therapists highlighted the temptation to integrate models due to personal preference and two therapists noted that integrating will be ineffective if you approach it as a panacea.

*“Certain young people… their survival mechanism is to constantly be throwing out erm hooks… they will be constantly hooking you in… and if you’re not careful, if I’m not careful I’ll end up throwing everything at them and then it just becomes a mess…” P3*

*“…so what’s happened is we get a very fragmented experience of therapy where she will present as this little adult one week so its DDP and then when I try to follow the themes through to the next week she is not able to do so… when you try Theraplay she will push you to talk and when you’re talking she’s pushing you away…” P1*

*“Sometimes older children don’t like doing Theraplay so you end up doing more DDP even though they might need the Theraplay” P5*

***Clarity and Ambiguity***

Therapists reported experiencing clarity and ambiguity in equal measure, see Appendix G for thematic chart. All therapists reported understanding each modality in its discrete format and shared that the therapies naturally fit together. Six therapists reported that integrating makes sense as it is better equipped to meet the needs of the families. Therapists also reported that experience, good supervision, and support from colleagues contribute to the intervention feeling more coherent.

*“It makes complete sense to me because I think we’re working with complex children and so they don’t come with one issue” P1*

*“You cannot take full advantage of the therapy environment…if you don’t match where the child is cognitively, but crucially developmentally” P7*

*“I know when it’s not working and then I can go to supervision” P4*

Three therapists reported that certain elements are harder to integrate or make sense of, and two therapists shared ambiguity regarding how best to integrate.

*“Its hard to know when to integrate which model and which direction to take in therapy… that’s the difficulty I think, knowing how to blend it… Not having the security of erm, I went on a training course once and everybody was trained in one modality, constantly said through the training… ‘we view the problem as this’ and that feels quite reassuring to say ‘within this model we view it as this’, so you don’t have that I suppose within, within the integrative approach” P5*

*“Within Theraplay you’re not supposed to go down the memory and experiential conversations route… whereas when we’re mixing it, we are totally going against that… for me it’s a question of am I doing the right thing?” P9*

***Self-Assurance and Apprehension***

The therapists each reported differing levels of confidence relating to the individual models, see Appendix H for thematic chart. Five therapists reported feeling least confident integrating EMDR and five reported feeling most confident in utilising Theraplay®. Five therapists reported that it is important to be self-assured enough to be flexible during sessions and to be reflective and open in supervision. The importance of being attuned to the family’s needs, willingness to take risks and make mistakes, and believing in the process were also reported.

*“I think you have to [be confident enough] to make a judgement call in the moment” P6*

*“I think there is a variable on how the therapist is willing to take those risks” P7*

Six therapists reported that having good supervision and working within a supportive environment helped them to feel more self-assured. Having experience, feeling that the therapies naturally fit together, and experiences of success were also prominently reported.

*“I can see that it does work and that helps my confidence” P2*

*“I’m working in a service where permission is given to integrate and that’s really great… it definitely makes me feel more confident…” P3*

*“I think there’s the other thing around… being vulnerable in supervision and to say well actually, I don’t feel like I’m getting this, or I don’t feel I know what I’m doing and being vulnerable to, to be able to maximise your supervision…” P7*

However, five therapists reported that self-doubt associated with integrating these modalities can contribute to them feeling less confident and three therapists commented on lacking experience in certain models.

*“It could be that you feel that I shouldn’t, I shouldn’t integrate, you know I should stick to one” P3*

*“I can feel a part of my critical voice saying, “yeah but you’re not doing the model properly” and I don’t like that… I want to know I’m doing the best job I can” P9*

***Easier and More Challenging***

This theme revealed that integrating these models provided freedom which made the therapy feel easier to deliver and reduced perceived burden. However, this freedom also increased uncertainty which simultaneously intensified perceived burden, see Appendix I for thematic chart. Most therapists reported that working with integrative models makes therapy easier and thus less burdensome as the therapist can be flexible, more attuned to the family, and has more therapeutic options.

*“Having tools to bring in when one of the therapies feels a bit stuck, makes it easier” P6*

*“I can go with what’s needed and tune into where they’re at and yeah match where the young person and parent’s energy levels are or what’s needed in that moment, it makes things easier” P8*

Eight therapists reported that integrating these models places a greater strain on the therapist, seven reported a high level of uncertainty relating to whether they are doing the right thing, and three therapists reported the level of training required to feel competent, with each of these making the therapy feel more burdensome.

*“Sometimes you wonder using three interventions you’re spreading yourself thin rather than doing one quite deeply… sometimes I’d come out thinking, you know there’s a bit of EMDR and a bit of Theraplay and maybe I’ve done too little of too much” P5*

*“There’s an element probably each of the therapies would want to stand on their own… I’m very aware of how DDP doesn’t want to see you doing Theraplay in their DDP clips…” P6*

*“Theraplay pure is level 1 level 2… and you’re supervised by Theraplay supervision. DDP is the same… and then you’ve got each session analysed to the nth degree really in depth. That’s not happening here when we’re mixing the modalities because you can’t present that to DDP [institute] or to Theraplay [institute]… to mix it kind of put me back in my own basket going ‘who is going to make sure you’re good enough?’” P9*

The therapists also discussed constructs which may mediate burdensomeness. The most important aspects were having a supportive environment with good supervision, being self-confident, enjoying the work, having experience, and self-care.

*“…confidence to do things that, that erm your clinical gut and your reasoning tell you is right” P1*

*“Supervision is important, good annual leave is important, enjoying it helps, being in an environment that is supportive helps” P7*

**Parent’s Experiences**

Themes underpinning the range and nature of the parent’s experiences of acceptability are presented in table 7 and appendix T. The key dimensions distilled from the analysis were categorised into four major polarities which are described below, illustrated with quotes. Similarities between themes were also identified (see appendix U). Finding therapy useful helped the intervention to feel more impactful and worthwhile for parents. Adjustment to unfamiliar experiences seemed to mediate the extent to which parents felt clear and/or confused and comfortable and/or uncomfortable. Feeling comfortable with the therapy helped it to feel less burdensome. Finally, effective use of the parenting session seemed to influence intervention impact, clarity, and comfort.

**Table 7**

*Mapping parent’s experiences of receiving integrative Theraplay*®*, DDP, and EMDR*

| **Themes/Sub-Themes** | **Frequency** |
| --- | --- |
| Impactful and Imperfect: The integrative therapy is valuable, and it is limited as it does not solve all the difficulties you enter therapy with.  Impactful: *“There really has been amazing change for all of us”* P16  Imperfect: “*I think you can’t solve it in 10 weeks*” P17 | 8  8 |
| Clear and Confusing: The integrative approach to therapy makes sense and there are parts of it which are difficult to understand as a parent.  Clear: “*everything that happens within the sessions makes complete sense”* P12  Confusing: *“P10a: It goes against your… P10b: Your natural instincts and versions of what you should be doing”* P10 | 8  6 |
| Finding Comfort in Discomfort: It is important to find a way to feel comfortable and confident during times of discomfort and uncertainty  Finding comfort: *“It’s almost like you have to get through that awkwardness to come out the other side”* P17  In discomfort: *“you don’t know, should I say something now, should I do something now, if I do what I feel will that interfere…?”* P13 | 8  8 |
| Burdensome and Worthwhile: The therapy is a physical and emotional burden but is a burden worth bearing  Burdensome: *“I don’t think I was kind of prepared for just how hard emotionally that was”* P15  Worthwhile: “*it’s all time consuming and hard work but that was… it was worth it... the ends justified the means”* P14 | 8  6 |

***Impactful and Imperfect***

All families reported that the therapy is both effective and limited in the context of their adoption journeys, see Appendix J for thematic chart. All families reported seeing change following therapy, five families reported the parenting sessions to be particularly important, and five discussed the importance of the therapy being adaptable and child focused.

*“The parenting sessions are absolutely; we could not do without parent sessions once a week just to run through the stuff… that is a must” P11”*

*“P12a: Even in the talking bit… we can go from play to therapy, but it also can go from therapy to play where it’s like hang on we just need to do a game here. P12b: It just gives it that adaptability” P12*

*“There really has been amazing change for all of us” P16*

All families also reported that the integrative approach is by no means a panacea. Five families commented that managing the impact of their child(ren)’s early life experiences is an ongoing task for them and their family, three families shared that further therapy would be required as new difficulties have arisen following therapy, and two families discussed that therapeutic change can feel slow.

*“I think you can’t solve it in 10 weeks and that’s the reason we’re on our second round [of therapy]” P17*

*“I don’t think it failed its aims, I think… what’s come out of it, is, is, how [CHILD]’s reacted to some of that information…I just think from that therapy, erm, the, other issues have arisen that we now need to address.” P15*

***Clear and Confusing***

The theme reflects that the parents generally understood the intervention whilst also finding certain aspects challenging and confusing, see Appendix K for thematic chart. Five families reported having a better understanding of the Theraplay® aspects and three families reported that integrating these models made sense in the context of their child’s early history. Five families reported that psychoeducation and the independent parenting session helped to build their understanding whilst four families reported the importance of self-directed work outside of therapy in aiding comprehension.

*“because of [CHILD]’s trauma we knew that that had to happen that way and she was a bit resistant and therefore we knew that if we played and distracted and then went back to it that eventually she would gain trust and feel able to say something” P16*

*“the explanation parenting session before the [family] session… that was very helpful” P13*

*“…everything that happens within the session makes complete sense…” P12*

Additionally, four families reported experiences in which they were unsure how activities in therapy related to their therapeutic goals, two families reported difficulties with the therapeutic approach being contrary to their natural instincts, and two families reported feeling uncertainty about the therapeutic process due to the time it took to engage in activities they perceived to be important.

*“P10a: It goes against your… P10b: Your natural instincts and versions of what you should be doing” P10*

*“Sometimes I think oh how does this game relate to what we’re doing?” P12*

*“It felt like… we were playing games and not dealing with it” P13*

***Finding Comfort in Discomfort***

This theme reflects that the parents felt they had to become comfortable being uncomfortable with certain aspects of this therapy, see Appendix L for thematic chart. Seven families reported that the therapeutic relationship and the parenting session helped them to feel confident and three families reported to feel most confident with the games and playful aspects.

*“Knowing that we talked through it in advance in the parent session to me meant that you felt comfortable, or as comfortable as you can be in your discomfort” P11*

*“It’s almost like you have to get through that awkwardness to come out the other side” P17*

Three families reported feeling least confident exploring their child’s history, three families reported feeling uncomfortable as the therapeutic approach differed from their traditional parenting approaches, and two families reported finding the nurture aspects of Theraplay® to be uncomfortable.

*“P13a: I suppose when the talking started… P13b: We didn’t know what to do…. Sometimes you don’t because it’s just a matter of moment, you don’t know, should I say something now, should I do something now, if I do what I feel will that interfere…” P13*

*“I felt most uncomfortable as the sessions went on… our son wanted to take control… and because he would look at us wouldn’t he as if to say ‘you know I wouldn’t be doing this anywhere else…’” P10*

***Burdensome and Worthwhile***

The parents reported that the integrative therapeutic package is challenging but valuable. Positive therapeutic outcomes were reported to reduce perceived burden, see Appendix M for thematic chart.

*“this was worth… making sure we did what we needed to do” P10*

*“…it’s all time consuming and hard work but that was you know, it was worth it… The ends justified the means” P14*

*“P16a: it was hard work. But obviously hard work for [CHILD] of course. P16b: But beneficial” P16*

*“we’re willing to put that work in because we are seeing the rewards” P17*

Five families reported that the therapy was increasingly burdensome due to sessions being physically and emotionally tiring, five families reported that the logistics and time taken to attend sessions was particularly burdensome, one family reported feeling the burden of responsibility to get the most out of every session.

*“P13a: …I remember it being exhausting. P13b: It was but it’s exhausting anyway from all points of view including physical, for some reason you just feel physically exhausted” P13*

*“it makes it upsetting as a parent having to tell your child you know that their birth mother wanted, deliberately inflicted, those, those erm injuries on them, and, and I don’t think I was kind of prepared for just how hard emotionally that was” P15*

Six families reported that the therapy felt like less of a burden because of the parenting sessions and because they felt understood by their therapist and the service, and two families reported that therapy felt less of a burden because it was working.

*“…it is exhausting parenting boys that have got these issues, but I felt like that was always understood, it’s not a burden to talk about it when you feel understood” P12*

*“It didn’t feel like a burden because we were obviously getting a lot out of it” P14*

*“right down to the receptionist… who talks to us as if she’s our next door neighbour and I just think that setting of the scene just makes you feel like you belong” P17*

**Discussion**

This study explored the feasibility and acceptability of integrating Theraplay®, DDP, and EMDR with adoptive families. Recipient attendance data indicated that the integrative intervention is feasible as most sessions were attended (99%) and all post-therapy outcome measures were returned (100%). Statements from all 17 participants were consistent with the interpretation that overall, the integrative therapeutic approach is a challenging yet acceptable and appropriate therapeutic intervention. Certain experiences which detract from acceptability could be addressed with further research.

**Effectiveness**

All 17 participants reported the integrative approach to be successful in facilitating therapeutic change. Overlapping concepts woven throughout both datasets were how natural it feels to deliver/receive these approaches and how beneficial the therapy was. These experiences are corroborated in literature with Rubin et al. (2009, p.171) stating “we have found Theraplay® and DDP to be like twins separated at birth” and in studies which highlight the utility of Theraplay®, DDP, and EMDR as discrete modalities (Draper et al., 2021; Wingfield & Gurney-Smith, 2019), and within integrative formats (McCullough & Mathura, 2019; Weir et al., 2013; Wesselmann et al., 2018).

Therapists also described that relying on clinical judgement to determine when to integrate therapeutic modalities can make the therapy less effective, detracting from acceptability. Two challenges were interpreted: the risk of attempting to complete too much in therapy and the temptation to draw upon models for the therapist’s comfort as opposed to the family’s need. Each of these can contribute to therapist drift, which is conceptualised as the failure to deliver therapeutic interventions appropriately (Waller & Turner, 2016). Research exploring therapist drift suggests that increased clinician anxiety enhances the likelihood that clinicians will reduce therapeutic demands on clients (Meyer et al., 2014; Waller et al., 2012). This resonates with the experiences of therapists within this study, particularly the motivation to avoid Theraplay® with older children due to the perception that the child will not enjoy it. To safeguard against therapist drift Waller and Turner (2016) highlight the importance of the dissemination of clinical guidelines, appropriate recruitment of therapists, and the assessment of therapeutic competence, adherence, and outcomes. For current therapists integrating Theraplay®, DDP, and EMDR the routine application of outcome measures could be advised until measures of adherence and competence, and clinical guidelines are developed.

All parents shared the therapy to be limited in producing wholesale change. An appreciation for the complicated and enduring nature of the challenges experienced by adoptive families is less pronounced within intervention literature. Themes derived from the parent dataset suggest that therapeutic interventions for adoptive families may not have to accomplish substantial remission of entire difficulties to remain an impactful, useful, and meaningful element of their adoptive journeys.

**Intervention Coherence & Self-Efficacy**

All 17 participants reported that the integrative therapy made sense to them and that they felt comfortable and confident delivering and receiving it. Therapists reported that having experience, good supervision, and support from colleagues contributed to increased understanding and confidence. Parents reported that the parent only sessions, which are based on DDP principles, were important for enhancing their understanding and levels of confidence. Prior studies exploring the use of DDP with adoptive families substantiate this with parenting sessions being reported as an important feature, particularly for parental understanding (Agbayani, 2014; Turner, 2012; Wingfield & Gurney-Smith, 2019).

Five therapists expressed statements which were interpreted as representing ambiguity towards the integrative intervention and seven therapists expressed apprehension associated with integrative practice. Bennett-Levy and Beedie (2007) explored trainee therapists’ perspectives of competence, identifying that learning opportunities and awareness of therapeutic standards each contributed to enhanced experiences of competence. Similar studies have outlined the importance of knowledge of therapeutic modality (Maruniakova & Rihacek, 2018) and professional training (Lucock et al., 2006). The integration of Theraplay®, DDP, and EMDR remains an emergent area and thus lacks a clear and corroborated model, therapeutic standards, and training structures. Therefore, certain levels of ambiguity and apprehension amongst therapists are to be expected. In the absence of therapeutic standards, personal therapy (Rønnestad & Skovholt, 2003), therapeutic successes (Maruniakova & Rihacek, 2018), client feedback, and supervision (Lucock et al., 2006) have each been found to enhance therapist competence. The latter being a prominent feature which reduced therapist ambiguity and apprehension within this study.

All parents reported feeling uneasy with certain elements of the integrative intervention and six reported finding aspects hard to understand. The principles of play and therapeutic parenting which underpin Theraplay® and DDP require parents to engage in a paradigm shift away from traditional play (Booth & Jernberg, 2010) and behaviour management approaches (Elliot, 2013). In previous explorations of DDP with adoptive families, this paradigm shift has also been reported. Wingfield and Gurney-Smith (2019, p.666) reported the superordinate theme ‘It’s a different method of parenting generally’, Agbayani (2014, p.115) reported “Gave different set of parenting tools”, and Turner (2012, p.91) reported “Challenges of learning to adapt parenting approach”. This body of qualitative evidence provides context for the presence of parental confusion and discomfort identified within this integrative intervention.

**Burdensomeness**

Therapists reported that having the freedom to flexibly respond to therapeutic need contributed to feeling more attuned during therapy, which made therapy feel less burdensome. However, a consequence of enhanced freedom was increased levels of uncertainty and pressure when relying on clinician judgement to deliver effective therapy. Research examining clinical judgement has found it to have low intra- and inter-rater reliability (Bell & Mellor, 2009) and to be outperformed by statistical modelling when selecting optimum therapeutic treatment (van Bronswijk et al., 2021). Therefore, it is understandable that an overreliance on clinical judgement to govern integration would contribute to experiences of increased uncertainty and burdensomeness for therapists. However, certain levels of uncertainty may be a prerequisite for effective therapy. Mason (1993; 2019) surmises that seeking premature ‘safe-certainty’ can reduce a clinician’s propensity for curiosity, producing a negative therapeutic impact. Therefore, rather than seeking to eliminate uncertainty, therapists delivering integrative Theraplay®, DDP, and EMDR may need additional training, support, and supervision to help them remain within positions of ‘safe-uncertainty’ without experiencing this as excessively burdensome.

Parents reported the therapy to be high burden but high value. The therapeutic experience was reported to be both emotionally and physically taxing however feeling understood by the therapist, feeling as though the therapy was effective, and the service’s overall therapeutic milieu were reported as constructs which reduced perceived burdensomeness. The theory of planned behaviour (Ajzen, 1991) can provide a context to understand these experiences. Positive beliefs, experiences, and perceived usefulness of the intervention outweighed experiential burden and perceived difficulty. This maintained behavioural intent and engagement, despite high levels of effort and burden.

**Transferability**

Without a comprehensive audit of post-adoption services, it is difficult to ascertain how clinicians and services are approaching the integration of Theraplay®, DDP, and EMDR. There are likely service-to-service variations in duration, level of integration, and format of therapeutic delivery. This limits the transferability of these findings. However, the extent to which the findings were corroborated with prior research provides hope that the findings remain useful outside of the specific context explored within this study (Lewis et al., 2014; Polit & Beck, 2010).

**Trustworthiness and Limitations**

Credibility checks were employed to ensure the data was suitably collected and interpreted. The interview schedule was constructed in accordance with consultations with six service users/deliverers, analyst triangulation was completed, and member checking took place. Additionally, a reflective log was completed and revisited throughout the research. These steps maximised the credibility and confirmability that the conclusions accurately reflect the experiences studied and minimised the risk of bias. Additionally, the SRQR, COREQ, and CASP quality appraisal checklists were adhered to throughout and applied by the researcher following completion to audit study quality (see Appendix V).

However, this study is not without limitation. The specific approach to integrating Theraplay®, DDP, and EMDR within this study may not be replicated elsewhere. Therefore, each integrative provider will need to determine the extent to which these findings resonate with their routine practice. Moreover, for 15% of the integrative family therapy sessions, families were not receiving Theraplay®, DDP, or EMDR, with approaches such as life story work and dyadic art therapy also featuring. This reduces the validity of the findings as it reduces the certainty that participants were sharing experiences based on the integration on Theraplay®, DDP, and EMDR. This further highlights the need for sophisticated model configuration, competence development, and fidelity measures in this field. Additionally, the eligibility criteria which required therapists to determine whether families were unsuitable to be contacted due to levels of acute stress, increased the risk of sampling bias. This process may have contributed to the recruitment of a group of adoptive parents who had more positive experiences of integrative therapy, potentially skewing findings towards greater acceptability. Finally, the therapists were predominantly white British females >40 years old, with >10 years of therapeutic experience and >5 years of experience integrating the models of Theraplay®, DDP, and EMDR. Different issues may have arisen if a different balance of gender, ethnicity, age, and level of experience had been obtained, particularly as the interpretations within this study are consistent with the notion that therapist experience contributes to increased acceptability.

**Implications**

Quantitative investigations of acceptability and preliminary efficacy are required to corroborate these findings with statistical data and establish whether further exploration into this integrative therapeutic approach is warranted. A Delphi study, similar to Liddell et al. (2017), exploring therapeutic competencies necessary to deliver integrative Theraplay®, DDP, and EMDR is also recommended. Additionally, the development of a self-assessment skills framework, such as the Cognitive Therapy Scale Revised (Blackburn et al., 2001) and the Dyadic-Developmental Psychotherapy and Practice Rating Scale (DDP Network, 2015) is warranted. Further advancements also include dismantling studies, creation of fidelity measures, and efficacy studies of greater methodological rigour. Such research could support the reduction of therapist drift and over-reliance on clinical decision which may enhance therapist experiences of acceptability.

The implications for clinical practice are more limited. It is hoped that all practitioners engaged in the integration of Theraplay®, DDP, and EMDR for adoptive families will be able to benefit from the experiences shared and conclusions extrapolated from this study. Awareness of the factors facilitating and/or hindering experiences of acceptability can support practitioners integrating these models to be more considerate and reflective of acceptability during therapeutic engagements. For example, adoptive parents could benefit from services taking steps to enhance their understanding and comfort whilst integrating these approaches. Increased awareness and consideration of acceptability could lead to superior clinical outcomes when integrating these models (Hommel et al., 2013).

**Conclusion**

This study examined the feasibility and explored the acceptability of integrating Theraplay®, DDP, and EMDR for adoptive families. Descriptive analysis of attendance patterns indicated the intervention was feasible and findings within the qualitative investigation were consistent with the interpretation that integrating these models was generally acceptable for therapists and adoptive parents. Issues detracting from acceptability for therapists included the risk of integrating models for unsuitable reasons at unsuitable times, uncertainty relating to integrating effectively, questioning their ability, and feeling pressure to make the right decision. Issues detracting from acceptability for parents included the therapy being unable to completely ameliorate all their difficulties, aspects being hard to understand, aspects being uncomfortable, and the overall experience of therapy requiring a high level of effort and burden. Additional research is now required to investigate the preliminary efficacy of integrating Theraplay®, DDP, and EMDR for adoptive families alongside a larger scale feasibility and acceptability study. Additionally, a Delphi study contributing to the development of competency and adherence measures will be valuable for this field.

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**Appendices**

**Appendix A**

*Theoretical Framework of Acceptability (Sekhon et al., 2017)*

*Diagram, text

Description automatically generated*

**Appendix B**

*Percentage of integration throughout therapy and template recording form*

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Session Number** | | | | | | | | | | |
| **P** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **Over**  **All** |
| **10** | T:42  D:8  E:0  O:50 | T:42  D:8  E:0  O:50 | T:42  D:8  E:0  O:50 | T:42  D:8  E:0  O:50 | T:42  D:8  E:0  O:50 | T:42  D:8  E:0  O:50 | T:42  D:8  E:0  O:50 | T:42  D:8  E:0  O:50 | T:42  D:8  E:0  O:50 | T:26  D:16  E:0  O:58 | T:40  D:9  E:0  O:51 |
| **11** | T:50  D:17  E:0  O:33 | T:41  D:9  E:0  O:50 | T:50  D:60  E:0  O:0 | T:58  D:42  E:0  O:0 | T:66  D:17  E:0  O:17 | T:50  D:0  E:0  O:50 | T:16  D:0  E:0  O:84 | T:17  D:33  E:0  O:50 | T:33  D:17  E:0  O:50 | T:83  D:17  E:0  O:0 | T:46  D:20  E:0  O:34 |
| **12** | T:51  D:33  E:16  O:0 | T:18  D:66  E:16  O:0 | T:18  D:66  E:16  O:0 | T:17  D:50  E:33  O:0 | T:25  D:50  E:25  O:0 | T:26  D:66  E:8  O:0 | T:25  D:50  E:25  O:0 | T:25  D:50  E:25  O:0 | T:25  D:50  E:25  O:0 | T:26  D:66  E:8  O:0 | T:27  D:54  E:19  O:0 |
| **13** | T:17  D:50  E:0  O:33 | T:25  D:50  E:0  O:25 | T:34  D:8  E:0  O:58 | T:51  D:16  E:25  O:8 | T:34  D:16  E:25  O:25 | T:34  D:25  E:33  O:8 | T:43  D:16  E:33  O:8 | T:34  D:25  E:33  O:8 | T:42  D:0  E:33  O:25 | T:34  D:0  E:33  O:33 | T:36  D:20  E:21  O:23 |
| **14** | T:100  D:0  E:0  O:0 | T:100  D:0  E:0  O:0 | T:100  D:0  E:0  O:0 | T:76  D:8  E:16  O:0 | T:68  D:16  E:16  O:0 | T:67  D:8  E:25  O:0 | T:50  D:25  E:25  O:0 | T:67  D:8  E:25  O:0 | T:60  D:8  E:16  O:16 | T:68  D:16  E:16  O:0 | T:75  D:10  E:14  O:1 |
| **15** | T:68  D:0  E:16  O:16 | T:34  D:0  E:50  O:16 | T:42  D:8  E:50  O:0 | T:67  D:0  E:25  O:8 | T:67  D:0  E:33  O:0 | T:51  D:0  E:41  O:8 | T:59  D:3  E:33  O:5 | T:67  D:8  E:25  O:0 | T:34  D:0  E:55  O:11 | T:50  D:0  E:25  O:25 | T:55  D:2  E:36  O:7 |
| **16** | T:37  D:50  E:16  O:0 | T:25  D:58  E:16  O:0 | T:84  D:8  E:8  O:0 | T:18  D:16  E:66  O:0 | T:26  D:8  E:66  O:0 | T:18  D:16  E:50  O:16 | T:17  D:33  E:50  O:0 | T:---  D:---  E:---  O:--- | T:9  D:75  E:16  O:0 | T:51  D:25  E:8  O:16 | T:33  D:32  E:32  O:3 |
| **17** | T:67  D:16  E:16  O:0 | T:67  D:16  E:16  O:0 | T:67  D:16  E:16  O:0 | T:67  D:16  E:16  O:0 | T:67  D:16  E:16  O:0 | T:67  D:16  E:0  O:16 | T:67  D:16  E:0  O:16 | T:51  D:33  E:16  O:0 | T:51  D:33  E:16  O:0 | T:51  D:33  E:16  O:0 | T:63  D:21  E:13  O:3 |

D: DDP, E: EMDR, O: Other Model, T: Theraplay®

NB: All figures are percentages of a 60-minute session.

---: Session cancelled by family.

**Session-by-Session Recording Form**

Please provide a felt sense estimation of how much time you spent in each modality during each family therapy session.

For example:

Session

|  |  |
| --- | --- |
| Theraplay® | 35 minutes |
| DDP | 15 minutes |
| EMDR | 10 minutes |
| Other Model (Please state) | 0 minutes |
| No-Model | 0 minutes |

Session One:

|  |  |
| --- | --- |
| Theraplay® |  |
| DDP |  |
| EMDR |  |
| Other Model (Please state) |  |
| No-Model |  |

Session Two:

|  |  |
| --- | --- |
| Theraplay® |  |
| DDP |  |
| EMDR |  |
| Other Model (Please state) |  |
| No-Model |  |

Session Three:

|  |  |
| --- | --- |
| Theraplay® |  |
| DDP |  |
| EMDR |  |
| Other Model (Please state) |  |
| No-Model |  |

Session Four:

|  |  |
| --- | --- |
| Theraplay® |  |
| DDP |  |
| EMDR |  |
| Other Model (Please state) |  |
| No-Model |  |

Session Five:

|  |  |
| --- | --- |
| Theraplay® |  |
| DDP |  |
| EMDR |  |
| Other Model (Please state) |  |
| No-Model |  |

Session Six:

|  |  |
| --- | --- |
| Theraplay® |  |
| DDP |  |
| EMDR |  |
| Other Model (Please state) |  |
| No-Model |  |

Session Seven:

|  |  |
| --- | --- |
| Theraplay® |  |
| DDP |  |
| EMDR |  |
| Other Model (Please state) |  |
| No-Model |  |

Session Eight:

|  |  |
| --- | --- |
| Theraplay® |  |
| DDP |  |
| EMDR |  |
| Other Model (Please state) |  |
| No-Model |  |

Session Nine:

|  |  |
| --- | --- |
| Theraplay® |  |
| DDP |  |
| EMDR |  |
| Other Model (Please state) |  |
| No-Model |  |

Session Ten:

|  |  |
| --- | --- |
| Theraplay® |  |
| DDP |  |
| EMDR |  |
| Other Model (Please state) |  |
| No-Model |  |

**Appendix C**

*Therapist and Adoptive Parent Interview Schedules*

**Therapist Interview Schedule: Acceptability of Integrating Theraplay®, DDP, and EMDR**

**Opening Question**

* To start with I’d like to know a bit more about your therapeutic journey so far. Could you talk me through the important moments that led to you to become a therapist.
* What has led you to integrate the models of Theraplay®, DDP, and EMDR in sessions?

**We’ll start by looking at how Effective you feel the intervention is so…**

* Can you tell me about the main aims of the therapy you provide?
  + Prompt: were these aims made clear to you?
  + Prompt: how did you decide these aims? (how much input between therapy and family)?
  + Prompt: were these aims what you expected/wanted?
* Could you share a bit about the ways in which the therapy achieves these aims?
  + Prompt: Can you tell me about any changes you have recognised that you would attribute to therapy?
  + Prompt: are these changes what you expected/wanted from the therapy?
  + Prompt: has the therapy been effective in any other areas?
  + Prompt: did anything help the therapy achieve its aims?
* In what ways did the therapy fail to meet these aims?
  + Prompt: have you recognised anything that hasn’t changed that you thought would change because of therapy?
  + Prompt: has the therapy failed to achieve its purpose in any ways?
  + Prompt: did anything contribute to the therapy not meeting its aims?
* On balance, how effective do you think the therapy was for you and your family?
  + Prompt: why?

**This next section is about how well the therapy makes sense to you…**

* Can you tell me about the different aspects of the integrative therapy?
  + Prompt: and do these make sense to you?
  + Prompt: can you tell me about Theraplay®, DDP, and EMDR used individual and integrated?
  + Prompt: what sort of things did you do in session?
* Could you talk a bit about whether there are any parts of the therapy which are harder for you to make sense of?
  + Prompt: were there any parts which you did not understand?
* On balance, do you feel like you understood the intervention
  + How did it work?
  + Why it works?

**These questions will be about how confident you feel in delivering the intervention…**

* Can you tell me about the sort of things you have to do during therapy to successfully deliver the intervention?
  + Prompt: what sort of abilities were required for you to do these things?
  + Prompt: how did you feel doing these things?
* Can you tell me how able you felt delivering different aspects of the intervention? (Prompt: why?)
  + Which aspects of the therapy did you feel particularly confident about?
  + Which aspects of the therapy did you not feel particularly confident about?
* Can you tell me how confident you feel in being able to help families make gains during therapy?
  + (Prompt: why, what helps, what gets in the way?)
* On balance, how confident are you that you can perform the necessary behaviours required to deliver this integrative intervention?
  + Prompt: why?

**This final section is about how Burdensome the intervention is…**

* Can you tell me about any aspects of the therapy which required a lot of effort from you?
  + Prompt: how did you handle these?
  + Prompt: how did you experience these?
* Can you tell me about any aspects of the therapy which required very little effort from you?
  + Prompt: how did you experience these?
* Can you tell me about anything that made this therapy harder to deliver?
  + Prompt: logistics, time, preparation, planning?
* Can you tell me about anything that made this therapy easier to deliver?
  + Prompt: logistics, time, preparation, planning?
* Overall, how burdensome is it to deliver this therapy? (how burdensome)
  + Prompt: tell me more about that?

**Closing Question**:

* That is all I wanted to ask you about today, is there anything that I haven’t asked you that you would like me to know, anything else you’d like to say, or any final thoughts?

**Adoptive Parent Interview Schedule: Acceptability of Integrating Theraplay®, DDP, and EMDR**

**Opening Question**

* To start with I’m wondering whether you could tell me a bit about what led you to accessing therapy
  + Prompt: Ask about previous therapy, how this was experienced, why they have returned for more, hopes and fears they may have had when heading into this further package of therapy.
* This most recent package of therapy can you remember what it entailed was it mainly Theraplay®, Dyadic-Developmental Psychotherapy, or Eye Movement Desensitisation Reprocessing, or was it evenly balanced between the three?

**Perceived Effectiveness**

* Can you tell me a bit about what you wanted from therapy for your family?
  + Prompt: what were the main aims of the therapy?
  + Prompt: were these aims made clear to you?
  + Prompt: were these aims what you expected/wanted?
* Could you share a bit about the ways in which the therapy helped to achieve these aims?
  + Prompt: Can you tell me about any changes you have recognised that you would attribute to therapy?
  + Prompt: are these changes what you expected/wanted from the therapy?
  + Prompt: has the therapy been effective in any other areas?
  + Prompt: within the therapy, was there any specific activities or elements you completed which helped achieve these aims?
* Can you tell me about the ways in which the therapy failed to meet these aims?
  + Prompt: have you recognised anything that hasn’t changed that you thought would change because of therapy?
  + Prompt: has the therapy failed to achieve its purpose in any ways?
  + Prompt: within the therapy, was there any specific activities or elements you completed which you think did not help or were ineffective in achieve these aims?
* On balance, how effective do you feel the therapy was for you and your family? For starters on a scale from 0 being totally ineffective for you and 10 being it met all your aims and was effective, what would you say you are on that scale?
  + Prompt: why?
  + Prompt: can you tell me more?

**Intervention Coherence**

* Can you tell me about the sort of things that you did within the sessions?
  + Prompt: what did you talk about? What games did you play?
  + Prompt: what sort of things were you asked to do outside of the sessions?
    - Reading? Preparation?
* Can you tell me about whether you understood what each of these activities was for, do you know why you were asked to do these things?
  + Prompt: can you tell me more about that, what was that in service of?
  + Prompt: did your therapist help build your understanding about these activities?
    - Support? Discussions?
  + Prompt: did understanding/not understanding matter?
* Could you talk a bit about the parts of the therapy which you didn’t understand or whether there were any times you were not sure why you were doing something?
  + Prompt: did knowing/not knowing matter?
  + Prompt: how did this feel?
* On balance, from what we’ve spoken about how well you understood the therapy? From 0 (low) to 10 (high) what would you score yourself on that scale in terms of level of understanding?
  + Prompt: can you tell me more?
  + Prompt: (if needed more)

**Self-Confidence**

* Can you tell me about some of the qualities you had to bring as a parent to each session get the most out of therapy?
  + Prompt: what sort of abilities were required for you to engage in therapy?
  + Prompt: were you asked to behave in certain ways or do things in certain ways?
* Can you tell me how comfortable you felt doing these? (Prompt: why?)
* Can you tell me about any aspects of the therapy you felt particularly confident about?
* Can you tell me about any aspects of the therapy that you did not feel particularly confident about?
  + Prompt: did your self-confidence change throughout the therapy?
  + Prompt: could anything have been done that would have made you more comfortable?
  + Prompt: did the therapist help you with this?
  + Did your therapist help you with this?
* On balance, how confident were you that you could perform the necessary behaviours required to participate in the intervention, again to start please scale from 0 (low) to 10 (high)
  + Prompt: why?

**Burden**

* Can you tell me about any aspects of the therapy which required a lot of effort from you?
  + Prompt: how did you handle these?
  + Prompt: how did you experience these?
  + Prompt: did the therapist help you with these burdens?
* Can you tell me about any aspects of the therapy which required very little effort from you?
  + Prompt: how did you experience these?
  + Prompt: did the therapist help make it easier?
* Can you tell me about anything that made this therapy harder to participate in?
  + Prompt: logistics, time, travel, demands, child-care, relationships?
  + Prompt: did the therapist help you with things that made it hard?
* Can you tell me about anything that made this therapy easier to participate in?
  + Prompt: logistics, time, travel, demands, child-care, relationships?
  + Prompt: was there anything the therapist did that helped to make it easier?
* Overall, how much effort was required to participate in this therapy? (how burdensome)
  + Prompt: tell me more about that?
  + Prompt: is the effort worth it? (payoff?)

**Closing Question**:

* That is all I wanted to ask you about today, is there anything that I haven’t asked you that you would like me to know, anything else you’d like to say, or any final thoughts?

**Appendix D**

*Familiarisation Notes*

**Familiarisation for Therapist Data**

Effectiveness

1. Goals are strengthening attachment (helping children feel safe and building relationships) and processing trauma, helping child regulate, giving resources to help them cope in future, making sense of experiences, towards a happier healthier home, helping families have more insight
2. Parents bring their own goals
3. Integrating allows you to flexibly meet goals by responding to the child’s readiness to engage, it is adaptable and responsive to moment-to-moment need, responsiveness is important
4. Theraplay® first (importance of safety) once you feel safe you can then use DDP EMDR
5. Integrating can be ineffective if the child keeps themselves safe by throwing out hooks – sometimes they survive by throwing up several needs leading to over integration can be a mess – wanting to respond to everything limits utility of therapy – too much following, or too much too soon
6. Integrating would still be effective for these children but needs to be more therapist led
7. Theraplay® DDP and EMDR fit together – they compliment each other – they enhance each other
8. You can use PACE to talk about resistance in Theraplay® – Theraplay® games naturally lead to DDP conversations. You can use EMDR through Theraplay®. Theraplay® can help to regulate a child so they can access EMDR. Theraplay® presents moments where DDP comes naturally
9. Integrative therapy is effective – it works, the therapies enrich each other – it maximises therapeutic outcome as you have more tools, more likely to achieve goals
10. Knowing when to integrate is important (timing is key) – integrating DDP too early it can be negative – integrating is all about judgement – having options can make things challenging
11. Engagement can be hard getting engagement can be challenging but DDP can help with exploring this
12. Sometimes using DDP when a child is dysregulated can make it worse
13. Therapist rigidity will encounter resistance
14. It is important to be attuned to the family’s needs,
15. It is important to work with the parents as well
16. These children cannot talk intensely for an hour – needs the breaks with the Theraplay®
17. Supervision and self-reflection is important
18. The participants enjoy it
19. Presents the temptation to avoid the hard parts of therapy
20. Looking for moments
21. Willingness to take therapeutic risks?
22. Quality of training in the model is important
23. May need to get school involved and wider system
24. As a therapist you get used to the tools you use the most - something to think about
25. Important to support caregivers as well as child
26. Parents need as much support as the children
27. Videoing sessions and playing them to the parent is really important
28. I tend to always start with Theraplay®, I would start with DDP if someone needed it, It makes sense to integrate DDP into Theraplay® to name what is happening if something comes up, If from the movement into DDP big feelings come up, I would bring in EMDR in a playful manner to help the child cope with these
29. Important to have separate session with the parents
30. When a child gets stuck in Theraplay®, naming that from a DDP perspective can be really beneficial
31. When a child doesn't want to talk about anything in DDP, using Theraplay® as opposed to DDP's "light chat" perspective, can be really helpful.
32. It makes it easier for me when one therapy is at a stuck point, the others can come in

Intervention coherence

1. The individual therapies make complete sense to me as stand alone therapies
2. Integrating makes complete sense to me as children do not present with just one issue, If a child came with just attachment issues (rare) and you had indefinite sessions (rare) then it'd make sense to just do Theraplay®
3. Integrating helps you respond to moments that matter – Integrating helps to maximise your therapeutic outcomes so of course it makes sense - If a child is ready to talk, you don't think "you can come back for another package and talk about that" If you do not respond when the child brings something they may never bring it again because their attempt to share has been blocked (due to rigid models). The child cannot take full advantage of the therapy unless you meet the child with what the child needs Integrating makes sense as opposed to having the child sat in something which is too difficult for them – it makes sense to go with what the family brings
4. Integrating comes naturally – I don’t even see it as integrating anymore just as its own therapy
5. It makes sense because it works – you generally always see change if the family engages
6. Supervision is key for building trust in the integrative approach
7. Working alongside other integrative therapists is helpful
8. Integrating makes sense as they have different aims
9. Training helps
10. The therapies complement each other: It is hard for a child to do DDP without a well attached caregiver (establishing through Theraplay®): Theraplay® allows you to create space and emotional depth for DDP. Theraplay ®allows you to create space and emotional depth for DDP The integration helps children to remain in their window of tolerance, EMDR works well as it can be completed quickly and covertly during Theraplay® Being able to weave EMDR in during play is helpful. Nurture aspects of Theraplay® can support a child through difficult DDP topics. You can weave DDP and EMDR into Theraplay® EMDR work can be sandwiched by Theraplay® You do not have to integrate within the session by may have an EMDR session followed by a DDP session Integration is more Theraplay® based with DDP and EMDR coming in, Theraplay® to DDP replicates the first 5 years of life Theraplay® helps the child to feel more secure which helps them to hold some of the more challenging emotions in DDP
11. Certain aspects of integration are harder (e.g., integrating timeline work from DDP into Theraplay®)
12. I do not need to know how it works neurobiologically to be an effective integrative therapist
13. You get a felt sense for when things are working
14. I like the theory behind integrative therapeutic approaches – it makes no sense to me not to honour the biological behind the theory. I am very clear about the impact of trauma on the brain, so this intervention makes clear sense to me. It makes sense to match how the brain works to what therapy you do
15. Integrating is top down and bottom up
16. It is not a challenge to integrate these approaches
17. Having to use therapeutic judgement can be hard – there doesn’t seem to be a right way or fixed answer – it can be difficult to know when to step into each model – there may always be a sense of doubt regarding whether the right integrations have been made – how do you know you’re blending in the right way?
18. EMDR is usually the last thing people train in, so it can be harder to integrate
19. There is lots to get your head around
20. It can be hard to know whether what you’re doing is right
21. Integrating therapy introduces higher levels of uncertainty

Self-efficacy

1. The therapist is required to be flexible, willing to go off script/off plan, important to be non-judgemental and compassionate to the parents, you need to think and reflect more with integrative therapy than one model therapy, you should never stop questioning whether you’re doing it right, you have to keep up with training, you have to use supervision well, you have to be attuned, important to provide shared understanding, empathy is huge, need to be attuned to what is going on, need to respond to what you're seeing and what you're feeling, requires self-awareness, responsive to parents as well able to notice the whole picture, adaptable, self-reflective, flexible and responsive, you have to keep the other models in your mind, you have to make a judgement call, you need to assess where the parents are where the child is, confidence to operate within safe-uncertainty and take risks, model DDP, authentic and vulnerable, need to be comfortable being the attachment figure for the parents, develop relationship with parents, important to see difficult sessions as learning opportunities
2. I am confident because DDP and Theraplay® are a natural pairing, DDP and Theraplay® naturally flow
3. You need to have the confidence to do it and the confidence to review it
4. Confidence is needed to help you follow your clinical judgement and reasoning and to say when things are not working well
5. Training & Experience helps to build confidence
6. Supervision and having reflective space helps
7. Re-reading training manuals helps
8. Having a supportive environment helps – drawing on colleagues experiences
9. Being self-compassionate is important
10. Most confident using Theraplay®, more confident with Theraplay® than DDP, most confident in Theraplay® least confident in EMDR, less confident with EMDR, more confident with Theraplay®, less so EMDR I feel less confident with EMDR so I could plan that more to help me feel more confident, I’m less confident with DDP
11. I feel confident because I have seen this therapy work – believing in the approach is important
12. Confident, comfortable, and not concerned about delivering these three therapies as I have a belief that they all work well
13. I know I have support and where to go if I do not feel confident
14. Integrating helps me to feel confident - As a Therapist you can feel pressure not to integrate, but having permission to integrate has made me feel more confident and effective
15. Having experience of applying each model on its own is useful
16. Self-doubt / self-blame relating to no manual guidance?
17. Moving at a pace the family can manage can be difficult
18. There are several parts and it can be tricky
19. The concern I have is whether I am doing justice to each model?
20. Relationship with the family impacts how confident I feel integrating models
21. The environment is important: lower case load, good consistent supervision, time with parents and the family
22. The fact it makes sense gives me more confidence in delivering it
23. Integrating requires having the confidence to switch and to switch with confidence
24. Integrating with confidence takes time, practice, and good supervision
25. It takes courage and self-assurance to apply DDP and EMDR to Theraplay® as they require greater emotional capacity
26. Having good training is important
27. Integrating makes me feel more confident
28. You have to be confident enough to admit/be open to times when things are not working because it is a very challenging role

Burdensomeness

1. Therapy is difficult when attachment difficulties are present – the families we work with are never easy – the population can be challenging to engage, you get tough sessions but that is nothing to do with the models themselves, working with this cohort of people requires a lot of effort
2. I would struggle not integrating now, it can be jarring being stuck in one model, Delivering DDP by itself is harder than integrating DDP and Theraplay® now
3. Planning takes time
4. More options means more thinking – can be hard – making the decision when to integrate can sometimes be a burden – self-doubt about whether it was the right thing to do can be a burden. Knowing when to use what therapy is a lot of effort When to use what therapy? Have you gone deep enough? There is no manual to follow which is hard you have to hold a lot in your mind. Chopping and changing too frequently makes things harder
5. It is emotionally challenging
6. Having supportive colleagues helps
7. Supervision helps
8. Theraplay® is easiest
9. Integrating requires a lot of effort, experience, and skills
10. Measuring your outcomes is challenging – what made the difference?
11. It isn’t meant to be easy but I enjoy it
12. Engaging the child takes effort
13. It can be hard to get the parents on board and give hope, Getting the parents on board can help
14. Empathy comes naturally
15. You’re free to be really creative – flexibility is nice makes it easier responding to the need in the room makes it easier as a therapist, flexibility helps you to get it right for the child. Being able to respond to the need in the moment is less effort.
16. Dealing with transference is effortful
17. The integration is not the burdensome aspect
18. Playfulness not always easy if you don’t feel it
19. Single model is easier
20. The therapies go hand in hand so it is not that effortful
21. The bits you know less about require more effort, Lack of confidence makes it feel more of a burden
22. Not knowing enough? Experience helps
23. Integrating is a double edged sword between freedom and having more to think about
24. Financial burden,
25. Engaging in CPD in 3 models is
26. Having to prepare the parents for a wider range of issues
27. Risk overwhelming the parents
28. Risk of losing focus on your priorities/goals
29. Certification What’s a burden is training to be qualified practitioner in one of the models and not being allowed to integrate to get this certification because integrating is better for the child and families needs.
30. Theraplay® can be most effort
31. Good annual leave helps
32. The effort is worth it
33. It can be hard to introduce DDP early in the therapy as the parents may not have enough knowledge about this**.** Parents need coaching in DDP so moving into this unexpectedly can be challenging**.** Sometimes need to do "modified DDP" if parents don't understand it**.** You need to coach the parents in DDP

**Familiarisation for Adoptive Parent Data**

Perceived Effectiveness

1. Aim was to increase understanding, main focus more life story work. Parents provided aims and therapist helped to make these achievable, wanted child to open up more and communicate, to make child feel more relaxed, aim was to help child understand their past, aim was to help child express themselves more
2. Specific application of models: Theraplay® at the start to help connection, start and end with Theraplay® with DDP in between, any EMDR was light touch, rocking, tapping, using visual approaches helped, balancing act between talking and regulation (play), a mixture of play and talking and understanding history, play then therapy then play, tapping whilst doing talking, combination of talking and EMDR processing is really effective, therapy was structured around childs needs (bespoke), incorporating play and EMDR made it more effective, consistency and structure of sessions helped parent and child e.g., same 3 Theraplay® games before talking. We would play then talk then tap then talk
3. Parental Knowledgeable: Prior to this integrative package two packages of mainly bonding/Theraplay®, we are well aware of Theraplay® and DDP, we learnt a lot from the intervention
4. Responsive to child’s needs: It was effective because it was designed for what the child needed, the child sees it as special time between child and parent, certain activities worked really well for our child, child seems kinder, more empathy, therapy is more effective if child is regulated, child wants to engage as they enjoy it and you can be adaptable to need, if she needed to talk we would go with that, we do as much as the child can manage, child enjoyed play aspects, the therapy was a good fit for us
5. Utility of whole package: The parenting hour is really useful, parenting hour important, the regulation sessions were really helpful for understanding child and self, parent only session was important, whole package is important, claiming narrative was particularly successful, EMDR was really useful
6. Visual changes we’ve seen: Our house is calmer and we feel more relaxed - parents changing due to therapy, child is more able to verbalise their needs, helped us to improve our understanding of the child, child’s understanding of self, child seems kinder more empathy, feels like theres a stronger attachment, we have got better at knowing how to talk to our child, it met our aims and goals, no more tantrums or picking fingers, child seems happier and the changes have been maintained, helped child to understand why they’re adopted, made child more open to share feelings, child engaged so its been effective, we saw change straight away, child calmer more relaxed, child learnt how to deal with past difficult experiences, helped improve our attachments
7. I thought we'd get onto life story work sooner (too much play at the start?), It can feel like you're just playing games and not dealing with the actual problems
8. Some of the terminology was harder to understand
9. It was hard to take the Theraplay® games home as they no longer seemed to be useful
10. With the sessions being child led, it felt that they reinforced bad behaviour and made it harder to transfer learning outside of the session to the home environment
11. You shouldn't expect miracles (focus on small changes), can’t expect everything to change, the therapy is effective for what can be achieved in therapy, small steps nothing changes massively overnight, long-term process, its important to know that it’s a long term experience. You’re never going to completely heal the trauma but I can’t knock the therapy. Important to be realistic about how much can be achieved, therapy has helped so much but we still have a long way to go
12. Some activities had limited value or were less impactful
13. What maximises outcome: Completing activities at home is important, You have to be all in as a parent, Therapist is important (relationship trust, non-judgemental), connection with therapist is important
14. This is a lifestyle/wholescale approach and therapy is one part of that
15. Even the aspects of therapy the child did not like, were useful for the parents to see/understand
16. Ending is hard, we turn these kids lives upside down for 10 weeks then therapist just drops out, we would have benefitted from support outside of therapy in the year before we could return
17. We need more therapy to address child’s life story now as we didn’t get through it all, other issues have arisen from therapy

Intervention Coherence

1. I understood: Why we were doing some of the breathing games, it makes complete sense to me, it makes sense why we’d start with Theraplay® and then DDP then end in Theraplay®, it felt like I understood enough, I feel I have a good understanding of how and why the therapeutic intervention works
2. I do not understand why we did some of the games but you can sort of work it out
3. It goes against natural instinct/some bits feel unusual: Child controlling nature and therapist responding to this made the sessions feel more chaotic (parents=bystanders?), It is hard to do it (e.g., PACE) as it goes against natural instinct, Some bits can feel unusual (EMDR tapping for example)
4. Child focused: Going at the pace of the child made sense (but we did want to go faster), Always started with Theraplay® and child loved it, used drawing and pictures to support child to discuss internal world
5. The hardest bit to understand was how do we manage his responses to therapy
6. It is important to understand how and why things work, it is important to understand why you're doing it, but it is okay for some intricate bits to go over your head, Having an understanding is important, Having a deep understanding of how/why it works is and isn't important depending on your character, It is important for parents to understand the rationale for why things are happening/working
7. I understood less than I did compared to the first two packages of therapy
8. Reading: If you stop reading up about things then you lose some understanding, reading the books helped it to make sense to us, prior reading helps understanding
9. Experience: We've been doing this for a long time so it makes more sense to us, we’ve been doing the Theraplay® games and DDP/PACe for quite a while which helps out understanding, Theraplay® we had done before and we've made it part of our daily life routine so we knew it well
10. Examples of different types of Theraplay® games, Good understanding of Theraplay® demonstrated (impulse control, nurture, touch etc)
11. Having an understanding made it easier
12. Therapy/Therapist itself helped us to understand it: Understanding increases throughout therapy, Each session makes coherent sense and we naturally flow from therapy to therapy, developing out emotional understanding, regulation (flight, fight, freeze), The therapist helps to make it make sense (Trust in therapist is important), The parenting hour before the therapy helped increase understanding, Being provided with session summaries was useful bit by bit after each session (bitesized information helped), therapist is really helpful in increasing understanding. The therapist helped us to understand what and why we were doing things. The parenting session was really important in supporting our understanding of what was happening during therapy, The therapists metaphors/explanations helped to increase our understanding
13. It doesn't matter what you call the therapies because the child doesn't care
14. Some Theraplay® games it is harder to see how they relate or link or have value
15. It was effective: Blending made sense as you could see it working, Blending the therapy matched our childs needs in the moment which helped, The talking aspects were less planning but more responsive to the need in the room, The regulating Theraplay® games helped the child to tolerate therapy
16. Harder to understand the less planned aspects: Sometimes when the therapist rolled with resistance, we didn't quite understand why that was happening,

Self-Efficacy

1. The parent needs to have lots of energy, to be open minded and let go of preconceived ideas, to be open to be told when things aren't quite working, to be honest and reflective, to be playful, have to be comfortable feeling uncomfortable, have to fake it til you make it and put your own needs aside, has to make time to attend and engage and talk in the sessions, need to be a supportive team and work together, willing to analyse self and be self-critical is important, willing to talk openly, need to be willing to take on suggestions, free themselves of the burden of needing to see changes to feel like good enough parents, be prepared to pay attention and be present, plan and prepare well, think about their interactions with their child and what the best response is, commit to therapy and do the games between sessions once a week isn’t enough, has to believe in it, has to be confident enough to go with the flow, to be uncomfortable or doing things they’re not used to, to cope with uncertainty, has to empathise with what their child has been through, has to manage their own emotions, has to be comfortable enough to work as a team, needs to be comfortable enough focus on the child and put child’s needs first
2. Preparation/Experience: We felt very confident doing these things but we were prepared to do them from the outset (went looking for them), Reading and being part of community online groups helps, Having done Theraplay® and using it in everyday life for so long (experience) helped feel confident
3. Therapist: Having a good rapport with the therapist helped us to feel more confident, Sharing with therapist when I felt uncomfortable was important, Apprehension during first 2 packages but this package no worries as relationship with therapist, Therapist made us feel confident and comfortable because of her way
4. Felt most comfortable with the craft aspects of family therapy and reflective aspect of parent session
5. Therapy specific: Felt least comfortable during Theraplay® aspects due to lack of boundaries
6. Who is in charge of childs behaviour: Felt uncomfortable not knowing when to get involved as a parent or what to leave to therapist, Sometimes feel less confident relating to the uncertainty of when do you step in as a parent compared to what to leave to the therapist, Sometimes uncertainty around what can be said, or what should be said, don't want to interrupt the therapist etc
7. Goes against instinct: It can be uncomfortable going against your traditional parental instincts
8. Overall, I felt confident but the therapy challenges you which is hard

Therapy: Starting with Theraplay® made me feel more comfortable as it enhances that connection, The parenting sessions helped things to feel more comfortable, Parenting hour before therapy is important to help confidence, The parenting sessions helped us to feel more confident, Parenting hour helped to increase confidence, Preparation for sessions helped us to feel more confident (parent session)

1. Difficult nature of therapy: Some difficult interactions with children (intense nurture which is rejected) can feel difficult, Sometimes I found it hard exploring and going deeper (DDP) knowing what to say, sometimes I don't feel up for the games, Felt less confident talking about childs early life history, I felt less confident dealing with emotive topics and the empathy side of things
2. Having the structure of therapy helps to approach difficult experiences (time limited nuture e.g.,
3. I feel supremely confident I can engage in this intervention, We feel fairly confident but it is a long process, Overall we felt confident
4. Having two parents in the sessions is important helps feel more confident
5. Most confident with Theraplay® games, The games were easier, the talking was harder - empathy was hard
6. Understanding: I felt confident I could engage in this therapy because I understood it and I saw positive results, Understanding helped our confidence, Therapy helped me to understand who I was as a mother which made my confidence grow
7. Enjoying: Enjoying it helps to feel more confident
8. Responsibility: You can feel the weight of the responsibility which can make me feel less confident at times

Burdensomeness

1. Homework can make the therapy feel more burdensome, The homework can be a burden even though it is necessary/required, Some tasks between sessions can be time consuming
2. The burden made us more reactive (as opposed to proactive)
3. Experience: It felt less burdensome (or easier) because we are used to all these things now, The Theraplay® games are easy and don't feel like a burden because we've done it for a while
4. Personal circumstances (jobs) can make it more burdensome (amount of time), Other life stress such as job changes can make it feel more burdensome
5. The importance and helpfulness of therapy helped overcome the sense of burden (what you get out of the session makes it easier)
6. It is worth it
7. Emotional/Physical Exhaustion: The level of emotional exhaustion is hard after the family therapy sessions, Its tiring, you feel like you've worked hard, The therapy is exhausting in all ways, including physically, Seeing your child upset and dealing with some challenging memories is hard, It can be emotionally burdensome (digging up a lot of stuff), Theraplay® can feel like a physical effort, It can be really hard, emotionally on a parent, emotionally draining, It is exhausting and emotional, It is emotionally difficult going back into your childs past (and potentially upsetting them) but we knew we had to do that - it was worth it
8. To cope with the level of burden I remind myself why I'm doing it and it is worth it
9. Self-care is important - I exercise a lot
10. The parenting session and regulation hour are much less burdensome, preparation makes it feel less burdensome, having information in advance (parenting session), The therapist helped us with the burdens by helping us to prepare for tasks
11. Logistics: The logistics of making it to sessions can be burdensome, Logistics are burdensome - taking child out of school (timing of sessions), Your life changes for 10 weeks to accommodate the sessions, Logistics could make it harder e.g., looking after another child
12. Time: Having to catch up work hours missed can be hard, The time burden is worse than the effort needed to engage in therapy, Attending 3 hours of therapy a week is quite burdensome (logistics, driving, pick up school etc), Having to catch up work in the evenings is a burden It can feel like a lot of therapy on one day (2 hours on a day)
13. Having it funded by the ASF makes it feel like less of a burden
14. Overall burdensome is high because it is burdensome parenting boys with these early life experiences
15. When you feel understood it doesn't feel a burden
16. 10-week of 3 hours a week is enough, ready for a break afterwards
17. Doing it at the beginning of the day helps it feel less burdensome
18. Its enjoyable, it feels like it works, you have good relationships with therapists, all help
19. Its high effort and energy but its worth it, I'd definitely do it again
20. You have to give something up, but its worth it
21. Having the sessions on different days helps rather than 2 hours back-to-back
22. It can feel like all or nothing being in therapy for 10 weeks intensely then nothing until next package
23. Believing in the process helps it feel less burdensome
24. It was a lot of effort but it is worth it
25. Its all time consuming and hard work but it is worth it
26. 10 weeks is enough, we felt very drained
27. It didn't feel like a burden because we were getting a lot out of it - the ends justified the means
28. Less experience/less certain can make it more burdensome
29. Work was really accommodating, it fitted in well, didn't have to make any time up = less burdensome, School were understanding
30. Second block felt more relaxed as already had relationship with therapist
31. Having space and time to prepare for the session makes it feel less of a burden
32. it can feel like you're failing your daughter (if not getting it right), When I first started therapy I felt like a failure, I thought I was failing my daughter
33. It was hard work but beneficial
34. We did 3 and a half hours on zoom and this was too long to be online!
35. The sessions take up a big budget so we felt under pressure to make the most out of it, commit to it, put in the work! - felt burden of responsibility
36. It was heavy but so worthwhile
37. The therapist adapted things to help us understand better which made it less burdensome
38. 10 sessions is enough
39. 10 weeks of this therapy is enough in one go, I wouldn't want more,
40. It is a lot to process quite quickly, our child benefitted from having a break in one week (having time to process deep meaningful important parts of his life story)
41. We chose to have a years break between therapy

**Appendix E**

*Iterative framework utilised to organise the data in charts*

**Thematic Frame for Therapist Data**

1.0 Effectiveness? – The theme Successful and Precarious was mapped from this chart.

1.1 What does the therapy aim to do?

1.2 The therapy is effective because…

1.3 The therapy can be ineffective because…

1.4 What does integrative therapy look like?

2.0 Understanding? – The theme Clarity and Ambiguity was mapped from this chart.

2.1 It makes sense because….

2.2 It doesn’t make sense because…

2.3 What helps it to make sense

3.0 Confidence? – The theme Self-Assurance & Apprehension was mapped from this chart.

3.1 The therapist needs to be confident enough to be…

3.2 All therapists will have their own individual strengths and weaknesses

3.3 I feel confident because…

3.4 When I am less confident…

4.0 Burden? – The theme Easier and More Challenging was mapped from this chart.

4.1 All therapies with this cohort are difficult

4.2 Integrating therapies makes it easier because…

4.3 Integrating therapies makes it harder because…

4.4 Experiences that help or hinder with the burden

**Thematic Frame for Adoptive Parent Data**

1.0 Effectiveness? – The theme Impactful and Imperfect was mapped from this chart.

1.1 Aims and Focus of the Therapy

1.2 The therapy was effective because

1.3 The therapy was ineffective because

1.4 What does integrative therapy look like?

2.0 Understanding? – The theme Clear and Confusing was mapped from this chart.

2.1 The bits I understood were…

2.2 What helped it to make sense

2.3 The parts I did not understand were…

2.4 The importance of understanding

1. Confidence? – The theme Comfortable and Uncomfortable was mapped from this chart.

3.1The parent needs to be confident enough to…

* 1. We felt confident because…
  2. We felt more comfortable with…
  3. We felt less comfortable with…

4.0 Burden? – The theme Burdensome and Worthwhile was mapped from this chart.

4.1 What makes it more burdensome? (Homework, life stress)

4.2 What makes it less of a burden?

4.3 Because it was a burden…

4.4 It was hard but worth it

**Appendix F**

*Therapist Chart: Perceived Efficacy – The theme Successful and Precarious was later mapped and interpreted from this chart.*

| **P** | **How to Measure Success** | **The therapy is effective because…** | **Not effective because…** | **What integration looks like?** |
| --- | --- | --- | --- | --- |
| **1** | “two very clear goals, one is to help his child to manage the trauma and to get to the point that they can function in their daily life without being overwhelmed by that trauma and then to be able to form a good enough attachment with their care giver” Page 7  “we often say to parents therapy isn’t a magic wand, it’s not going to fix everything, its not going to leave you with the perfect child, there’s no such thing as this but actually what are the main things that are effecting your ability to function as a family” Page 9 | “Pure Theraplay would be confusing, it’s so far from her experience of life, she has no clue how to play so she would need an explanation of lots of things along the way and a lot of reflection about actually how important this is and why, how she’s missed out on this, you couldn’t avoid bringing DDP into that I don’t think because she just hasn’t got any of that underlying experience to be able to connect through play” Page 15/16  “DDP and Theraplay because to me they’re a natural pairing, they are a natural pairing that you could move in and of really responsively erm when you can feel actually for a child you’ve been exploring a really difficult thing in DDP and actually they need that playfulness that we talk about in DDP and that can be delivered through Theraplay beautifully” page 29  “for some children talking is really difficult so we need to sort of use more creative methods” page 33 | “I try to follow the themes through to the next week [client] is not able to do so because actually in that moment [client] blended into that model so [client] is resisting, when you try Theraplay [client] will push you to talk and when you’re talking [client’s] pushing you away from that… so what’s happened is we get a very fragmented experience of therapy where she will present as this little adult one week so its DDP and then when I try to follow the themes through to the next week she is not able to do so… when you try Theraplay she will push you to talk and when you’re talking she’s pushing you away… with hindsight this is a girl for whom I think a pure model would have worked better” Page 14-16  “I guess as well if I’m honest as a therapist you get used to the ones you use the most and the tool you use the least erm gets less practice so I probably you need to be mindful that you never lose a tool along the way” Page 22 | “I always see it as like a sandwich, Theraplay, DDP, Theraplay in, in, that’s the kind of model I have in my head when someone’s coming when I’m planning a session” Page 11  “So that flexibility absolutely is really important and being able to throw your precious plan out of the window in order to mee the family’s needs in the moment” Page 12  “so you know, a child is feeling really err vulnerable, they have just shared something that was really difficult for them to share, in that moment they need to feel that they’ve got the connection with their caregiver, so it might be that they just follow it up with a nurturing activity straight away” Page 29 |
| **2** | “help children feel safe within their family environment. There is a big focus on err relationship building” Page 3  “look at the trauma elements of it, so obviously talking about the past and there could be some really difficult memories, erm and so the aim of the EMDR is to, to deal with that trauma and those trauma memories “ Page 45 | “basically I’ll take the lead from them, erm, and think to myself ‘okay, is this an appropriate time to do maybe do a bit of EMDR, or you know talk about their past” Page 11  “We do EMDR through Theraplay as within the activities, so therefore it can be quite, erm, we can be more creative about how we approach that” Page 9  “some young people see play, Theraplay as being quite childish, erm so we have to be quite creative about how we engage them and I just find using PACE and being really honest and actually using erm just my communication just to be really there for them, erm and not having an agenda myself, I think that’s been really helpful” Page 9  “I’ve think I’ve just seen children change so much, erm and having a little bit of all three just erm at the right time, so I think that is the best thing” Page 12 | “it could be the young person or the child doesn’t want to [engage]” page 8  “I’ve learnt that erm having my own agenda doesn’t necessarily work the best for the child and if they’re not really with it they’re not going to be open to my suggestions” Page 11  “I think trying to do all three together, I think if you get that in your head that won’t work. I think if we do offer these three approach, but as we’ve said if we do it, if we get all three in in a session but then that’s great but we don’t go in there saying ‘okay, we have to do all three’ because again if you do... I think it wouldn’t work” Page 31 | “so first focus is Theraplay, then we go on to sort of the DDP, also EMDR, so what I do is I do them both together where possible” Page 4  “I always erm have an agenda in the back of my mind… but at the end of the day the child comes in with a totally different issue that is the most important aspect of it and so therefore I might use sort of DDP in a different way or talk about a different topic, or if the child is like really distressed and, I wouldn’t do EMDR that day because they have to be in a, in a stable place, erm so basically I’ll take the lead from them” Page 10/11  “Timing is the key” Page 12  “trying to be empowering with the parents” Page 30 |
| **3** | “I see the main aims as a rather than one aim I see it as a sort of erm foundation built upont to come to a erm sort of roof for, you know, the final crescendo at the top.” Page 4  “So I think the initial aims are around erm helping a child to regulate in order to be able to engage in therapy and then to increase their safety so that they can engage” Page 4  “The next sort of phase for me is to have them to erm process some of their trauma that they have experienced” Page 4  “The final aim is become more integrated, to integrate their trauma experience with their current erm experiences so help them make sense of how currently they’re reacting to the world” Page 4 | “I think it achieves them [the goals] by having an integrative approach means that you can be adaptable in the moment to the need in the moment” Page 5  “I think with the young people that we work with their need shift hugely in a session” Page 5  “I might see something happening and think what this child really needs right now is a sense of deep connection to these people, their care givers right in front of them, so let’s shift into something” Page 6  “By being integrative I can be flexible, I can be attuned, I can meet the needs of that child in the moment and that the child experiences being really listened to and heard, understood, taken seriously and I guess its tools in a tool box” Page 11  “so in a session you may for example be having a loose aim to help them maybe at the mid stage to sort of make sense of their, or to process their trauma but as, but in that, in that time because its activating, they then will need me to step back and take them into a space perhaps where they use things from other therapies like, like erm Theraplay which helps to regulate them and get them back into their window of tolerance cos they are not gonna be able to, erm they are not gonna be able to use say EMDR if they are way out of their window of tolerance” Page 5  “I mean if you’ve only got three tools you can only do three things whereas if you’ve got twenty tools, erm and you know how to use them you’ve just got more, erm more things at your fingertips” Page 11 | “I’ve had certain young people I’ve worked with whose, their erm survival mechanism is to constantly be throwing out erm hooks as I call them to everyone and they’re not really thought through and they will be constantly hooking you in… and if you’re not careful, if I’m not careful I’ll end up throwing everything at them and then I just becomes a mess, you know like ‘oh, okay, I need to attend to that’ and erm I attend to it by using perhaps one therapeutic approach and then that, the child then throws out another hook and I think ‘ oh no I’m going to do DDP’ and then I rush to DDP and do that and then they throw out another hook because it’s not really what it’s about” Page 8  “you said you were going to do this and actually you ended up doing that and you’re following, and its like that’s so true, I’m following” Page 9  “So you’ve also go to really attend to that child’s erm patterns of interaction… children who are quite chaotic create chaos… probably need a much more consistent approach” Page 10  “The only, the issue, one of the issues is, say with DDP, if I want to introduce it quite early on in the therapy but the parents don’t have enough, haven’t been given erm enough or any background on what I’m doing, if I just go into it because parents really do need coaching with DDP and that can be a bit tricky when I suddenly I’m going to DDP because I can see this as a good moment for it and the parents might be looking at me thinking ‘what are you doing, whats happening right now’ Page 20/21 | “I’ve got a little girl who we are doing some EMDR work with but she becomes easily dysregulated so we can just erm move into something from Theraplay, for example when she gets rocked in a blanket by her mum and dad and they sing a song to her that’s familiar, she, she then erm regulates sufficiently enough for us to go back into that other piece of work” Page 6  you have to shift goals as well as you’re going along because you can’t determine what the child’s going to bring” Page 7  “You have to like be prepared to admit to yourself I’ve made a, you know, that was not the best moment for that and find a way to kind of shift it back into a, a safer space for the child rather than stick with it and trying to keep going thinking ‘I’ve started so I’ve got to keep going’” Page 26 |
| **4** | “So the first sort of port of call is to get that really good attachment between parents or carers and the children” Page 4  “and then from that can kind of use that as a stepping stone to move towards being able to erm help the children to understand kind of what’s happened to them” Page 4 | “they [Theraplay and DDP] work, for me they work really seamlessly so one really naturally feeds into the other”  “Sometimes you can use the Theraplay games to illustrate oh that’s tricky isn’t it that you have to do that, or so that would naturally lead you to a DDP conversation without you even trying or having to bring it up into the room, it just kind of, it naturally occurs” Page 5 | “Sometimes the child can be so dysregulated by something that happens in the Theraplay that they wont, they don’t want to then, you know it sort of can lead to ‘no I’m not having this conversation with you, I want to go out, I don’t want to carry on with this session’” Page 8  “Sometimes, you can, you know, if you didn’t judge it right and you tried to bring in ‘oh eye contact was really hard then, blah blah blah’ and then they don’t want to talk, they’ve just had they were kind of enjoying that game and they might have maybe made some eye contact if you’d just carried on playing it but if you bring it in too early and start talking about, you know, birth family and drug problems or it might be just too early to bring that” Page 8/9 | “The first place is to kind of build on that attachment if there isn’t a good attachment between adoptive parents and children, or if that attachment kind of process has been disrupted in some way because of what’s happened to them in their lives” Page 2/3  “when you’re using Theraplay and a moment happens, say this child is struggling to have eye contact or erm lets just use that as an example; if a child’s struggling with ey contact you might use DDP then to say ‘oh I’m noticing that you’re really struggling to look at mum in this activity’ and then you would maybe use that as a jumping off point and then explore you know, what’s kind of happened in the past” Page 7 |
| **5** | “My aims as a therapist when working with a family is placement stability and for that family to be in a better place, for the parents to be more stable and happier” Page 4  “For me there’s kind of three, there’s three parts to this that I’m working on; one is the attachment of the child towards the parent… the second thing around being, you know, are there any internal working models or any templates or anything that’s telling this child, you know that informs a negative model that says adults are not trustworthy… and are there any traumatic experiences there” Page 6 | “It gives you the freedom to erm be attuned to what the client needs in the moment and try and address that as opposed to making the client fit within your modality of therapy if that makes sense” Page 4  “For me the two models [Theraplay and DDP] work really, really well and it allows me space to do it at a pace that works for the child”. Page 8  “You can’t do intense talking with these kids for an hour… and Theraplay allows you to do a bit of the emotional deep stuff then come away for a little bit and have a breather and also keep building that bond with the parent and then dipping into erm the emotional stuff as appropriate sometimes” Page 15  “I’ve seen the change and I have faith in the work that I do” Page 23  “You have the non-talking attachment stuff, the talking erm emotional process with DDP and the trauma processing, not necessarily having to talk about it through EMDR and that gives me three ways of working with a child using as little or as much as I need to in a session and that gives flexibility and options” Page 11  “I think it’s quite beneficia, I think it’s really beneficial and effective” Page 15 | “When I think about not reaching goals I think about the difficult of integrating in that as a practitioner you’re sat there thinking you know “do I, do I ignore this and Theraplay and keep doing Theraplay or do I stop and erm talk about this and try and deepen the affect with DDP, or actually should I tapping” and its that uncertainty of what do I do in this moment?” Page 12  “Sometimes presents a bit of a personal crisis around, do I intervene in this way in this moment erm and what is the right way to go and what isn’t the right way to go.” Page 12/13  “Maybe I’ve done too little of too much” page 27  “The difficulty with older children trying to get them to do Theraplay to be honest because sometimes they really struggle to engage with it so you end up doing more DDP even though they might need the Theraplay” Page 14  “Its that uncertainty of what do I do in this moment?” page 12  [The aim] “isn’t necessarily to bring complete resolution of trauma or to change this child because I don’t personally think you can bring, you can’t remove years of neglect and trauma from someone’s history, you can’t remove that” Page 4 | “When you’re doing Theraplay there are moments of resistance or a kid not wanting to engage and you have these kind of moments, these opportunities to come in with something like DDP, you know a talking therapy” Page 9  “sometimes, you know, I’ve gone to supervision and been like ‘oh I’ve only done DDP for five minutes in that session’ but actually that’s all that was needed or could be tolerated” Page 9  “EMDR for me works really well because of the idea of quickly processing either a memory or a trauma or feeling… you can do it very covertly within Theraplay and the kid never knows” Page 18  “I’ll often start with Theraplay and move towards DDP, integrate little bits of the EMDR” page 14 |
| **6** | “helping build the child’s regulation… the attachment… experiencing that its safe, experiencing that adults can be in control and that they can feel safe... DDP, the goal is that the child experience that its safe in the room…and they can erm be honest and sharing erm how they feel… EMDR very much the goal is around bringing down the trigger, bringing down the trauma response” Page 8/9  “more generally, like one of the big goals is for them to have fun, for it to be safe and fun and, you know, connected, reciprocal, I mean there’s that, you could talk to that side as well which is true for DDP and Theraplay” | “so the integrating is, is helpful in getting to the aim because it meets the child where they’re at” Page 10  “I think it gives you more flexibility to be in the moment and meet whatever, whatever’s coming up in the moment in terms of the need to have a conversation or the need to just have some connection and nurture or fun” Page 15  *“*All of that [goals of Theraplay] very much lines up with DDP” Page 8  “If the child’s at a point where they are not even close to being able to talk about feelings or talk about how scary it is to trust adults and all they can do is erm, is be in the moment or playing this game or having this snack, Theraplay meets them where they are at let’s them do that and you can make it more or less intense with DDP, so you can increase the kind of the like intensity and just let them feel it for a moment then step back, and naming what’s happening, erm naming the feeling in that moment or you can erm help them process this nice experience of connection with EMDR, you can do some really slow, bilateral tapping and that would help the child to kind of deepen their experience of safety and connection” Page 10/11  “You can just do Theraplay and you can just do DDP without any games and you can take breaks by just chatting, erm but I think it, I think it’s the best when you put them together” Page 12  “I think that the Theraplay is enhanced with moments of DDP reflection, so I just think integrating them does make it more effective” Page 12” | “So when I’m in a DDP conversation and the child’s starting to struggle I will go to Theraplay rather than, I think what the Practicum Supervisor that I’m working with would say is, or somebody else has said that… you could… is that you don’t learn to just live in that one model as well as you would if you only had that, if that was your only tool and you learn how to just rely on it alone” Page 12/13  “I had a case recently where it was a Theraplay case, but the child kept throwing out hooks for DDP, he kept throwing out things that were just DDP invitations in conversations and he was able to engage in them to a, to a point and then he would kind of resist them… and yet he would come back to it again and he was clearly wanting to kind of work through this but we got to a point where he agreed to do as much DDP as he could do and erm and he needed it to just be Theraplay again and I think I would say the risk was doing, continuing with DDP in the session too long because it almost kind of becomes the norm… so that’s the risk, the risk is there, it’s too much too soon for the child if you bring them all in” Page 13/14 | “I would say I see Theraplay and DDP as the core of what you always want to bring in, EMDR is the bring it in or not according to if its needed” Page 14  “You are kind of looking for moments like that when you’re doing it for where would it be helpful to kind of bring in one of the other ones which just enhances what you’re trying to do in that moment” Page 11  “bring in when one of the therapies is feeling a bit stuck, so I bring DDP into Theraplay a lot with a child that’s almost, you’ve reached a no win pass, no matter what happens they’re going to find a way to sabotage it, then the best thing you can do is just name what’s happening” Page 36  “Its been a really helpful therapy with parents as well as kids when there is something blocking” Page 7 |
| **7** | “So basically its, it’s kind of neurobiological physiotherapy is how I see Theraplay. So that’s about building up those bits in the brain that actually were the primal injury” Page 6/7  “really important that you, that you get parents on side and you also work with them” Page 8  “The DDP stuff and that’s making sense of the kind of here and now and linking that back gently back to ‘I’m wondering why that was’, and linking that back to those early, early beginnings” Page 9  “If it’s something that’s really, really traumatic that’s coming back again and again and again and we know its unprocessed then we are gonna be able to put EMDR in that and process that” Page 9/10 | “I think that if you don’t have that integrated approach, you don’t have the ability to go in and out and understand what the child needs at that point and what the parents need at that point I don’t think your outcomes are gonna be, are gonna be as good and crucially they’re not gonna generalise” Page 10  “So it’s about being able to do the that [integrate] at the right time and in line with how the brain grows” Page 10  *“*If you’re not doing an integrated approach I think your outcomes will be poorer” Page 10  “You’ve got to think about, you’ve got to respect the biology, you know, does that make sense?” Page 12  “I would say its [integrating] a gold standard of treatment” Page 11  “I can’t see a better way of working than to work in a way that combines three really solid models of therapy together. I think, you know, I think it gets the best outcomes and I think that it's a gold standard of treatment” Page 37 | “I guess those things are real inhibitors I think to, to practice. And also if you’re working in a very big organisation, and that’s like CBT, CBT< this is what we do, this is the only thing we do and we do it for ten sessions… I think there are those systemic things that are real inhibited” page 13 | “I would always start with Theraplay” page 6  “Then I would always kind of move on [from Theraplay] to kind of DDP but in-between both of them, if in Theraplay a child is being traumtised by something really, and you know that, then I would absolutely do EMDR as part of that Theraplay work” Page 16  “I think there’s something about being supervised really well and being in a culture where it’s a learning and listening culture and its full and you know, and you’re pushing and pushing and pushing to be, you know a kind of gold standard” Page 13  “there’s something also about privileging the therapist attachment history because that’s got to feed into you know…” Page 13  “But if I think that a child can’t do DDP at all then I would do EMDR” Page 17 |
| **8** | “One of my biggest aims is it help people have more insight into how they’re feeling, how they are affected by their early experiences, I think so yeah just really understanding that is a key aim” Page 3  “moving on to doing some hopefully some processing so looking at how can they be less affected by the feelings associated with their past” Page 3  “what I also do is talk to the parents and see what their aims is so we start out with that being quite clear and also there’s room for the young person to bring their aims as well” Page 3 | “I guess it helps me to have more ways of engaging with the child in terms of where they’re at, so if they come in really dysregulated I can draw on Theraplay whereas I’m probably not going to have a conversation with them while they are very dysregulated, erm or it might be they come in and they really, really need to talk about something and don’t need Theraplay” Page 6  “So for me it means I can try tuning in to what they need in that session and I’ve got a different way of meeting that, yeah rather than just having one model in my head and the child having to fit into that model, I feel like I can work more attuned with the child” Page 6/7  “I can go with what they need in the session rather than them having to fit with a particular model because I feel like I’ve got lots of different ways of working available to me depending on how they present that day” Page 9  the first thing you want to achieve any of those aims is everyone to be engaged and relaxed and able to think, so the Theraplay is really good for that, so for me it’s just such a lovely baseline therapy actually… then in terms of developing insight, erm and aims around that, DDP is fantastic because you, you can have conversations where you make links between early experiences and certain struggles, erm and EMDR is really good for processing these feelings and early trauma so actually its really good to be able to do something” Page 5/6  “The fact there’s always some change” Page 7  “Yeah I think, I think it is very effective, erm yeah I couldn’t really imagine just working with one model now” Page 9 | “I guess I’ve always, you’ve always got that kind of hope for the young person that they will process that trauma and I guess what you see is of course for lots of these children it’s still there, those kind of, that stuff is still with them for a long time” Page 7  “but yes I think what I’m realising is young people with trauma starts in life are probably going to keep needing an intervention, erm and that’s probably not because there’s anything wrong with the intervention, its probably more this is really big stuff they’re dealing with.” Page 7/8 | “I will be more aligned with what’s underneath the behaviour, that’s probably the bit I’d want to help with, erm but how I manage that is just by explaining that to parents and exploring that with them” Page 4  “So I tend to always start with Theraplay” Page 11  “Yeah so I guess I just move between them actually” Page 11 |
| **9** | “main aims are to improve the attachment relationship between the carer and the child” Page 4  “also for the, yeah for the child to feel accepted as they are” Page 4  “I think the Theraplay fills in some of the neurological attachment gaps and the physiological attachment gaps and erm sensory integration gaps” Page 4  “and DDP comes in with the emotional processing of the events” Page 4 | “its about getting to know the child and their ability to regulate and how safe they feel in that relationship and how safe they feel in that room and also their own, their own responses. I’m thinking of a girl who came to me for Theraplay and it became really clear that she really needed t be talking, we needed to bring DDP into the room, and so we had to.” Page 13/14  *“*you’ve got the neurological and physiological development answered by Theraplay and therapeutically you’ve got the DDP that bring the format of sitting with the shit that’s happened because you can’t change that.” Page 5  “The DDP aspect of the therapy means you’re making space for difficult feelings, with sitting with difficult feelings and the Theraplay means we’ve got a way of regulating and that’s been a real, that’s been something in terms of mixing those two modalities its’ been very clear, if we can bring them both in they can kind of, they go hand, they go hand in hand in a way” Page 6  “I’ve seen huge changes, particularly with really young children” Page 7.  “without one or the other it would be too much or not enough” Page 14 | “I think it could be confusing, I think, I think because children can get very distracted on the route they’re on and especially with these kids, they try and control a lot, feeling safe by controlling, I think maybe and also transitions are difficult for these kids so transition are more likely to be in control and feeling unsafe coming to the sessions and then you’ve got a, so maybe navigating that transition can be challenging for the children, erm so that’s probably a negative and again its more work to manage how to do that skilfully” Page 11  “For others it might be too confusing or erm I think it’s not gonna be right for every family or for every child” Page 13 | “it might be that I bring in Theraplay games for nuture and maybe engagement to balance with the conversations we are having” Page 16  “I think it works, both work well, erm so it’s either divided equally or there’s a flow in between the two and we dance back and forth between the two modalities a bit” Page 17 |

**Appendix G**

*Therapist Chart: Understanding – The theme Clarity and Ambiguity was later mapped and interpreted from this chart.*

| **P** | **It makes sense because…** | **It doesn’t make sense because** | **What helps it to make sense** |
| --- | --- | --- | --- |
| **1** | “Theraplay is play based attachment approach focused on four dimensions that a healthy attachment between an adult and child ideally contain.” Page 17  “With DDP we’re looking at parents being able to, it’s a dyadic therapy so it’s about parent and child really starting to hear what the other is feeling and saying” Page 19  “EMDR is about processing specific trauma memories” Page 22  “It makes complete sense to me because I think we’re working with complex children and so they don’t come with one issue.” Page 22  “you’ve got a lot of things to work on with these children I suppose in the end you, you want to get as much done in those sessions as you can at the pace that the family are able to cope with” Page 23  “Yeah that is your moment that could have been the one time that they’re prepared or ready to talk about that trauma memory and if you weren’t able to hear and to give them space and the, the model if you like to safely follow that through they may never tell anyone that again” Page 24  “I think it just kind, it feels natural to me to be honest, I don’t even think of it as blending” Page 25” |  |  |
| **2** | “Theraplay is focusses around trying to help children feel safe… filling in the gaps…help them to relinquish that control, help to erm in a playful manner to enjoy and just erm re-enact those attachment experiences” Page 3  “DDP is about making connections with what’s happening now to previously” Page 5  “EMDR aspect of that is about helping through bilateral stimulation they are helping children to remember their past and for it to be reprocessed in a different way so that they can tolerate what has happened” Page 15  “you always see, generally you always see change for children and young people” Page 18  “Because the aims are different that they work together in a erm to, to play a part in helping them feel safe, help them to talk about it and help them, you know the, the element, looking at the trauma to be sort of more manageable or tolerable for them” Page 16” |  | “I think supervision’s been the key right from the start” Page 16  “having that sort of experience built up over time” Page 17  “having support of the other therapists in the team” Page 17 |
| **3** | “you’ve got the very hands on aspect of using a child’s natural play to erm, to develop” Page 13  “You have the aspects of using erm spoken, you know speaking, so say DDP uses more speech and interaction that way  “I mean with EMDR I guess using probably much more subconscious aspects of a person’s mind”  “I don’t think I find any real challenges by integrating these approaches. I think it’s all very naturally, a natural fit. Erm it just makes perfect sense to me that your attending to the whole person, you know from the cognition all the way through to their body” Page 15/16  “I mean they’re kind of a natural, they do naturally fit together for me and it doesn’t feel clunky or difficult” Page 15”  “It makes perfect sense to me, that’s why I like it. I’m a little bit of a theory person, so I like the therapy, I like this approach because I would say it’s a big picture approach, it goes right back to the roots of human erm development what, it makes sense to me of erm why we respond and react in relationships the way we do, it gives me a foundation way of thinking” Page 12  “There’s the theory based, all of them come from the same theoretical background” Page 16 |  |  |
| **4** | “Theraplay your, your aims are to get erm a good attachment and attuned, kind of care” Page 10  “DDP is about giving a child a narrative and an understanding of what’s happened in their life”  “If you try to have those difficult, erm PACE conversations with a child who hasn’t got a good attachment with their primary care giver, erm you’re kind of, its setting them out to sea” Page 11  “Even if it’s a really deep, meaningful, emotional conversation you’re still using like the nurture aspects of Theraplay to kind of cocoon the child within that.” Page 12 | “I think the timeline stuff is difficult to make erm, erm the timeline stuff is more difficult to integrate with the Theraplay…” Page 12 | “I know when it’s not working and then I can go to supervision” Page 14 |
| **5** | “Theraplay being erm for me attachment based and about increasing erm a child connection, an emotional connection with the parent” page 16  “[DDP is about exploring] some of the more difficult vulnerable, emotional parts of their story” Page 17  “EMDR the idea is you can, for those children or those people that can’t tolerate talking about something, kids process memories really quickly” Page 10  “I understand the goals of each therapy and I understand the goals of combining all three for the family” Page 22  “I don’t think children can talk about their feelings as intensely as doing DDP for a whole hour in the way that you might want them to or an adult might be able to and Theraplay allow you space from that emotional depth of DDP, to have something a bit more lighthearted.” Page 18  “The two things [Theraplay and DDP] work really well together in that way, from erm and moving from one to the other” Page 18  “really helpful for having tools in your tool box” Page 19  “These three therapies allow me to tackle some of the trauma from different ways as I need. Erm I think it works because they are working in a way which is developmentally appropriate for children” Page 21/22  “Theoretically… if you think about the first 5 years of life, a child bonds to their parents, learns from their parents, and then in that second, third, fourth year start gaining erm, you know the mirrored, there’s attunement, there’s intersubjectivity, they start gaining emotional language from their parents so for me Theraplay leading into DDP replicates that to a degree, erm its giving the idea to give erm security an attachment to be able to grow that bond and then having had erm that relationship being increased, that security, that bond gives you, in my mind gives you some of the erm security for a child or the ability to hold some of the more difficult… parts of their story” Page 17” | Its hard to know when to integrate which model and which direction to take in therapy and its something that doesn’t have a correct answer as such which is a personal struggle for me.  “The difficulty is knowing when to step from one to the other and when to go in one intervention over another one” Page 22  “That’s the difficulty I think, knowing how to blend it and for me I blend it in a way that feels right with me as a therapist practically in the way that I work… but that the difficult bit, how to, what percentage of which do you do?” Page 22  “Not having the security of erm, I went on a training course once and everybody was trained in one modality, constantly said through the training ‘with transactional analysis we view the problem as this’ and that feels quite reassuring to say ‘within this model we view it as this’ so you don’t have that I suppose within, within the integrative approach” Page 36 | “Experience brings you a long way” Page 22  “Its taken a few years of using therapy, of using supervision rather to reflect with other colleagues to say ‘actually why am I continuing to do DDP, I should have gone to Theraplay’” Page 13  “I think it’s about being supported in using the approaches” Page 14 |
| **6** | “Theraplay is erm kind of what I was saying about left and right brain approach, the left brain neurological erm approach of helping the child’s structure but it’s a right brain therapy in terms of its about what’s happening in the room in that moment, its not about us talking about it all, its about just having moments of connection, moments of fun, experiencing safety even when adults are in charge, that type of thing” Page 15/16  “DDP is about helping, well lots of things, helping build more ability to understand each other’s perspectives, ability to have kind of attunement that the parent can… just really see what the child needs in that moment, lots of playful, acceptance, curiosity, empathy” Page 16  “EMDR is about trauma resolution, its about let’s identify what our triggers for different trauma memories or erm literal in the moment you know sense, sounds, colours, where is the trauma trigger” Page 17  “You might have a Theraplay session that is your primary one, but in the middle of the session there is a moment where the child is finding something difficult, you might do a little just DDP explanation.” Page 17  “Yes [I understand the integration of these interventions] I do think I’ve got [an understanding], yeah it comes as second nature I think.” Page 20 |  |  |
| **7** | “Theraplay is the first foundation or building block of a therapy that I would delivering, so erm as I said because you know that kind of trauma attachment injury, its physiotherapy for the brain” Page 15  “the DDP stuff is around that kind of creating experiences with parents that are in the here and now and then thinking about their, the child’s kind of trauma experiences and how that’s impacting on the here and now” Page 16  “The icing on the cake is the EMDR bit” Page 17  got to marry how the brain works to what therapy you do because it just seems that, you know, the child cannot take full advantage of the therapy environment that you are presenting if you don’t match where that child is cognitive… but crucially developmentally.” Page 18  “So, so to have a sophisticated palette of therapist in which you’re very clear what fits where, then you can achieve the right balance and get the right outcome for that child and their parents” Page 18/19  “I think because I’ve very clear about how kind of how the brain works at the point of a trauma injury, so it just makes complete and utter sense to me to” Page 18 | “the EMDR bit, so I think that’s probably most people’s last big training” Page 17 | “It makes no sense to me to do anything else because you’re not honouring that biology and you’re not honouring that development and the trauma injuries” Page 19  “I think that takes time and I think that takes a lot of practice, erm and a lot of supervision” Page 17 |
| **8** | “Theraplay, I guess I see as very much being about helping young people to develop a safe attachment, a secure attachment with their parents” Page 9  “DDP, erm I guess I feel is really about the talking, how do they make sense of early experiences, trauma experiences and how do we link them to what’s going on in our current life” Page 10  “EMDR is about doing something to move those big feelings on, doing something in the moment but being connected to early things or feelings that are about something that’s not currently happening and just finding a way to process them so they feel less difficult when they come up” Page 11  “its just like I said, go in with what they seem to be bringing, so yeah if they’re hyper aroused, need regulating we will go with some Theraplay” Page 12  “I guess just that I think they are really useful models, particularly for young people with trauma and attachment” Page 22  “If I’m doing a Theraplay activity but notice somethings happening and bring in some DDP, so we’re not just doing the Theraplay, I’m doing some of the talking and naming what’s happening and being curious about it” Page 11  “And again through that if a big feeling came up we might then do EMDR based activity so to get the child stamping, tapping, that kind of things, so actually I will bring that as well so yeah, in one situation I might bring in all three” Page 11/12”  “DDP and Theraplay I feel like I’ve got a deep sense of what’s happening and why, and why they’re helpful” Page 13” | “Maybe with EMDR I Don’t have as much kind of understanding of the process itself so bringing it in, so yeah maybe just for me personally as a therapist I maybe find that one a bit more tricky” Page 13 | “Yeah I feel really, as I now know the models I guess I just find I naturally move between them” Page 12 |
| **9** | “Theraplay working through the core dimensions of engagement, erm, err, you know challenge engagement structure and nurture using activities that allow those experience those dimensions of experience in the dyad between parent and child” Page 15  “and DDP being a talking only therapy that makes space for understanding, particularly from the parent’s perspective of the child’ experience” Page 15  “I can see the advantage of having a space for both [Theraplay and DDP]” Page 19  “It may well be that actually using Theraplay integrates physically what’s been talked about in the DDP aspect of the session” Page 17” | “with Theraplay you’re not supposed to go down the memory and experiential conversations route… whereas when we’re mixing it we are totally going against that… for me it’s a question of am I doing the right thing?” Page 17/18  “Both modalities are pure and they say don’t mix.” Page 19 |  |

**Appendix H**

*Therapist Chart: Confidence – The theme Self-Assurances and Apprehension was later mapped and interpreted from this chart.*

| **P** | **The therapist needs to be confident enough to…** | **Individual strengths and weaknesses** | **I feel confident because…** | **I feel less confident because…** |
| --- | --- | --- | --- | --- |
| **1** | “In terms of skill I think flexibility is really, really important and listening to not being dogmatic about delivering what you planned.” Page 27  “Connect with parents particularly, we need to earn their trust” Page 9  “I think in your practice you just erm, you never stop or you should never stop questioning whether you’re doing the right thing and you should never think that you’ve got the perfect, and I suppose that’s the thing about the blended approach isn’t it, I guess it challenges you to think maybe more than just sticking with more than one thing” Page 31  “Confidence to put your hands up and say um um, this isn’t gonna work, we’re gonna need, we need to change this” Page 32  “You’ve got to be confident in your end goal” Page 37 | “No, no, I mean the EMDR definitely out of the three would be the one, yeah less confident using”. Page 30 | “I suppose what happens with experience, because I’ve been a therapist a long time, is that its, you have a tool kit, that it becomes much more instinctive to dip into than maybe earlier in your career” Page 5  “DDP and Theraplay… are a natural pairing, they are a natural pairing that you could move in and out of really responsively” | “EMDR again because I don’t do it as much, I don’t instinctively move into EMDR, it tends to be something that I would plan more, partly because I probably feel I need to be erm getting my confidence up at using that model” Page 29 |
| **2** | “It is, erm, keeping up with training. I think using supervision really wisely and efficiently” Page 19  “trust in the model that does work” Page 16  “you have to be flexible in the work that you are doing, erm and you know, there might be some days where I might do more Theraplay but I might do a bit of EMDR and not do DDP, but erm there might be days when I do more DDP than EMDR” Page 31 | “I would say [I’m most confident in] Theraplay and EMDR”  “I think maybe it’s [I’m less confident about] some element of, er, maybe the DDP maybe” Page 23 | “so I can see that it does work and that helps my confidence” Page 17  “at times re-read erm training, part of training manuals that I’ve done to erm, to sort of refresh myself” Page 20  “use supervision, use colleagues experience” Page 20  “because I’ve done the training, I feel confident but that’s time that’s given us the confidence” Page 21 |  |
| **3** | “I think the ability as a therapist to do it is the ability to be able to notice, to really attune to what’s going on, so not just notice what you’re see, you have to tune in to your own responses, so my body base” Page 17  “I like to use my supervision like that to sort of explore what’s happening and how its feeling, why is this getting stuck, what do I need to do differently” Page 23  “the capacity to see the whole picture, notice everything that’s happening and being prepared to be adaptable to it” Page 17 | “I think I probably feel most confident about the Theraplay because that’s the one I’ve done the most of” Page 19  “The last thing I learnt was EMDR so I feel least confident about EMDR because I just haven’t had as much experience of it” Page 19 | “I feel more confident, so having, having tools that I’ve used and experienced and I feel more confident, and if somethings not working I’ve got something else I can try” Page 11  “so you know, I’ve, at some point just done Theraplay and nothing else, and another point just done DDP and nothing else. So I, I think that experience is needed to be able to integrate properly, erm and its really hard for me to take that away from myself” Page 18/19  “I’m working in a service where permission is given to integrate and that’s really great and it’s given, it definitely makes me feel more confident erm in my, in my abilities” Page 20 | “it could be that you feel that I shouldn’t, I shouldn’t integrate, you know I should stick to one” Page 20 |
| **4** | “I think you have to be very attuned to what’s going on in the room. Erm that’s probably the main key thing because you’ve got to know what’s going on with mum and dad or grandma and grandad or whoever, foster carer, and what’s going on with the child” Page 14  “I suppose empathy is a huge, you know, erm being able to kind of understand where everybody’s coming from and really put yourself in erm the shoes that the child or the parent are in” Page 16 | “I feel more confident with Theraplay cos I’ve been doing it longer” Page 17  “DDP is relatively new to me, I’ve only been doing it for a year, 18 months, so erm you know its erm, that is still something that I’m working on definitely and continuing to try and learn as much as I can about, but yeah not as confident with DDP for sure” | “Yeah fairly confident I think. I’ve had some good successors and families erm on the whole seem to make really good progress and are happier and more connected and more erm more of a family, and you know, they come together through therapy and its really lovely to see” Page 18/19  “But yeah supervision is there because there are definitely times when you can’t and its about looking at what went wrong and what you can do next time, so I suppose as the more experienced I get the more confident I will become” Page 15/16  “I would say I think the two naturally do fall into each other, erm its very easy to, to use the things that come up in Theraplay to illustrate things in DDP” Page 25 | “if it goes wrong you start to think “oh what am I going to do” erm “I can’t get these people on the same page or this isn’t going anywhere or this is counterproductive”… I’d be lying if I didn’t say there were occasions where I’ve thought afterwards “oh god that was an awful session” Page 15 |
| **5** | “to kind of really go near some really difficult parts of a child’s story and do that erm respectfully and do that appropriately without causing harm for want of a better word” Page 20  “You’re managing mums emotions, mums feelings, dads emotions, dads feelings, child’s feelings, my feelings, you’ve got often four people who are all having an input or impact in some way and trying to manage all of those people and then to trust mum or dad is going to be able to erm hold this kids emotions when you go in there is a really difficult thing to do” Page 21  “I think I do have to think about and reflect on my clients, I have to think about erm quite openly with erm a supervisor, what is the client bringing, what am I brining, what is erm meant to be co-creative space here” page 24 | “I found DDP one of the hardest ones to do because erm from a practical point of view as a therapist you, you know you can have fun with kids and you can do ring-a-roses and you can do row-row-row your boat, you know. I’m quite skilled at that and its quite easy but it’s a choice to be vulnerable and to be sad and to be upset” Page 20  “The part that I’m less confident in is the EMDR slightly because you don’t get many children that come and say ‘I want to do EMDR processing just on this one time that I dunno this man had a heart attack outside my house’, because kids aren’t referred in that way and children don’t necessarily process in a way that EMDR would manualise it” Page 27 | “For me, that is having good supervision and with a supervisor that works in the same modalities, erm who has done all three” Page 24  “Being trained in each approach helps and having done, I’ve done all the levels and all the approaches but haven’t don’t the practicums” Page 24  “It has taken years of work and years of reflection” Page 24  “I believe all three work well”  “I feel comfortable, I feel well trained and well prepared, erm a good supervisor behind me, erm support me in that modality” Page 28 | “It was difficult in the early days, erm because I would do 90% Theraplay and think I’m not integrating enough… DDP or whatever it might be.” Page 26  “Do I know enough? Have I integrated enough? Have I been on enough training?” Page 25  “Sometimes I wonder if I’m doing justice to each model when I’m doing it” Page 31 |
| **6** | “it will have to be flexible, I have to be responsive to what’s actually happening in the moment in the room to successfully integrate” Page 21  “I have to keep in my mind if there’s a moment of connection I’m going to try and deepen for a child who finds it really scary to connect” Page 21  “Keep in my mind if that’s not the primary one I’m doing, if I get the opportunity I’m gonna bring that in, erm so there’s a flexibility but there’s also a way of keeping it, yeah keeping it in the fore front of your mind” Page 21  “I think you have to make a judgement call in the moment, which way am I gonna go” Page 22 | “Depending on the families, certain families I might err I might feel a bit more like ‘are my skills in DDP are not ready to match their skills of defensive resistance’ for that type of thing” Page 24  “If I was suddenly to jump back into doing straight just the EMDR, erm I would probably feel a little less confident until I got those muscles going again” Page 25 | “They pretty naturally flow, one from the other now for me between Theraplay and DDP” Page 22  “You see certain families just make so much change” Page 26 | “I mean I feel, I feel confident in it, erm I feel, depends where I’m at maybe with the family and how confident I feel on discussing where there at” Page 24  “It kind of also depends on how they present, you know, if I have really blocked carer/parents who are really rigid in their views of the child’s behaviour it might be that I’m not going to be very confident about bringing DDP IN because I gonna think that they are not ready…” Page 23  “I think the thing I would like to get better at is but then I feel hesitant on this because kids like the Theraplay, but is doing DDP straight without integrating, actually without bringing in Theraplay” Page 28 |
| **7** | “I think there’s the other thing around, kind of, you know as a therapist is being vulnerable in supervision and to say well actually I don’t feel like I’m getting this, or I don’t feel like I know what I’m doing and being vulnerable to, to be able to maximise your supervision is really, you know, is really, really important” Page 17/18  “I think there is a variable on how the therapist is willing to take those risks” Page 12  “You have to be really, really authentic and, and vulnerable too I guess” Page 20  “You have to work really, really hard in maintaining and creating you as an attachment figure for them [the parents]” Page 21  “The key is to be able to, be able to just roll with your mistakes, roll with your opportunities to learn” Page 25  “You have to be open to err to tweaking and modelling ways of working” Page 27  “[you have to be able to] shut the door with work and go home” | “my best work I think is in blocked care, so with parents who are in blocked care and being able to, to be able to effect a change and for them to understand what’s going on for them and for that not to be judged or to be shamed, to just be, this is, you know to just be noticed that is makes sense” Page 22/23 | “I think there’s a variable erm how well people are trained. I think there is a variable about how well they are supervised. I think there is a variable on how the therapist is willing to take those risks and I think, you know, I’ve been doing this for a long time so if you’d spoke to me ten years ago erm I wasn’t as confident. If you’d talked to me twenty years ago I definitely wasn’t as confident” Page 12  “I think, I think you get to a point where if you’ve been doing it for a long, long, long time you acquire your own therapeutic rhythm” Page 19  “really good supervision, erm I think, I think that gets you to where, where you’ve got to be” Page 20  “I’m in an environment that enables me to do it. So, so where I work at the moment, erm I have a lower case load…” Page 22 | “So there is always things where you just, they, you know they knock, they knock that confidence…” Page 26 |
| **8** | “You should always have a vague session plan in mind” Page 14  “I Always try to be flexible because if something comes up then I just go with that, erm just kind of really honouring what they bring” Page 14 | “I think I feel really confident with Theraplay and DDP because I feel like I’ve done a lot of reading, if... feel like I’ve done training, I’ve done a lot of it, erm for a number of years” Page 16  “Probably less with the EMDR mainly because I’ve done the training more recently” Page 16 | “Having had a good consultation with the parents I do think that has been really helpful for me” Page 15  “I’ve seen lots of really positive changes, erm and particularly around I guess insight” Page 17 |  |
| **9** | “I have to plan, erm I have to be, I’m thinking of the combination of the two, erm how to work with the parents in preparation and finding a place for them in, in the integration of the model so that they feel included even as I’m holding the structure” Page 20  “I think creatively and thinking of my feet and trusting the moment, well trusting myself in the moment actually, yeah” Page 21 |  | “knowing that I’ve got enough tools in my tool kit to be able to offer what’s needed, because I have to think on my feet, I have to be able to pull the games out, I have to be able to respond to what’s happening in the moment and it might be that I do need to respond in more of a DDP or a Theraplay way in that moment” Page 21 | “I think I could feel more confident if I had done each model in its purity” Page 22  I can feel a part of my critical voice saying “yeah but you’re not doing the model properly” and I don’t like that because I don’t like to be trained poorly, I want to know I’m doing the best job I can.” Page 19 |

**Appendix I**

*Therapist Chart: Burden – The theme Easier and More Challenging was later mapped and interpreted from this chart.*

| **P** | **All therapies with this cohort are difficult** | **Integrating makes therapy easier because…** | **Integrating makes therapy hard because…** | **Experiences that help or hinder burdensomeness** |
| --- | --- | --- | --- | --- |
| **1** | “I think its effort and its experience and its skill, its all of those things and because I don’t think, it doesn’t ever become easy because the families that we work with don’t ever become easy” Page 37  “It is definitely a challenge and the minute that it’s not a challenge actually I don’t think you’re probably doing a very good job because you’ve stopped maybe thinking about it and reflecting and trying to understand, I don’t think its meant to be easy” Page 38 | “It feels very natural actually to integrate approaches” Page 4 | “I always feel like I’ve never got enough time to plan.” Page 33  “Resources wise, I think erm, I’m quite, I’d say I’m quite creative in some of the approaches I use which probably are a bit more time consuming…” Page 33  “So there’s the practical effort if you’re blending because, you know, and also because you’re sometimes responding in the moment to something that’s happened since you last saw the family, erm yeah it’s definitely effort and it’s an effort as human beings we like to know what’s happening don’t we, we like to feel in control” Page 34  “Its emotionally challenging being faced with the unexpected” Page 34  “ultimately one of the downsides of it is your measurements are much more difficult, or maybe actually you can’t say it’s the Theraplay that makes the difference or the DDP or the EMDR because you’ve done it all” Page 37 | “You can do it with very minimal resources, that actually it’s the people that are at the heart of this” Page 26  “Yeah well for me it’s about erm colleagues, it’s about coming out of a session that might have been challenging and just having five minutes to just share how it made me feel, you know sharing with somebody who has a similar role is really powerful” Page 35  “supervision as well, you know, that supervision and talking through cases that are making me feel a certain way” Page 36  “Confidence, confidence to do things that, that erm your clinical gut and your reasoning tell you is right” Page 32 |
| **2** | “Its to get a child to engage, that is the main bit and I suppose that goes for any therapist working with children and families” Page 27  “I can come away with certain sessions where I’ve thought ‘oh that was really hard’, but I think that’s more about what has actually been happening within the family or there’s family dynamics or how the child’s responded rather than the actual model itself” Page 33  “I think the more challenges or burdensome I think its more about, erm maybe just what’s happening at the time in the room rather than the model” Page 33 | “so every time I have to tweak something and there is something else that I have got in my tool of erm tool kit if you like, erm ready for the next family” Page 30  “The fact that we can be flexible… I’m glad it is flexible so that my priorities engaging the family rather than doing the activities, because if the child is not gonna engage, you know, they’re not gonna enjoy it, they’re not gonna interact with the parent and that’s what it’s all about so yeah” Page 32/33 |  |  |
| **3** | “It’s not the integration, integrative approach that’s effortful, its just the nature of the work that’s effortful and rather than, I would say on balance that the integrative approach makes it less effortful” Page 27 | “I guess the whole sort of analogy again of having more tools at your fingertips just makes it easier because you’ve just got a whole lot more choices and you don’t get stuck” Page 26  “I would say on balance the integrative approach makes it less effortful because it just feels more, erm adaptable and natural. Erm and not forcing something that isn’t the right thing because you’ve got something out, yeah” Page 27  “once you’ve got an integrative approach and you’re tuning in to what’s going on round you, you can intersect and come in at the right level for that child, so it’s not burdensome at all, its freeing” Page 27 | “The bits that take more effort, the bits that I’m less confident in or I’m less, I’ve got less erm training, or not training, less experience in. So EMDR for me takes more effort because I go back to EMDR, that thinking, thinking about what am I gonna say next or what am I gonna do next rather than just flowing” Page 22  “it all requires quite a high level of effort in terms of focus and presence. It is not a therapeutic approach where you can drift out of it for a little bit into your own head” Page 24  “[if] I’m finding myself chopping and changing too frequently between things because something about the nature of this child’s, how they get their needs met, erm their demand being, so I’ve got to strike, you know being on to that” Page 25  “I might make a shift into another modality and then, and then feel erm ‘was this the best thing to do right now’, you know maybe this is too soon because some of these therapies are much more likely to work [at certain times]” Page 25 | “if I have some cases where it feels like I’m getting stuck in certain elements of the approach, then I have regular supervision” Page 23 |
| **4** | “I think it all requires a lot of effort really. I think it’s, I wouldn’t say its burdensome but I would say it’s the nature of the job that it, there’s a burden to it and it is, you know you do, you come out of the room sometimes erm feeling the things that your families have felt and exhausted by, you know, a session because its been particularly emotional”” Page 20 | “I would say I think the two naturally do fall into each other, erm its very easy to, to use the things that come up in Theraplay to illustrate things in DDP” Page 25  “I think it’s a lot easier to do it [Theraplay and DDP] together” | “but in the back of your head you’re thinking ‘okay, when we get to DDP she probably won’t want to come as much’ and she’s not gonna enjoy it… because right now they like you but as soon as you start bringing in that stuff it becomes a real like. ‘Don’t talk about that, shut up, I don’t wanna hear that’ you know which is, you know it’s hard, its hard, its much nicer to have a child who comes and smiles and says ‘hello, can’t wait to come and play games with you’” Page 24 | “Playfulness is not always easy, being upbeat and playful and especially if you don’t feel like that” Page 21  “You can have some just gorgeous moments when you just build lovely connections with parents and that, and children, and that’s just lovely” Page 23 |
| **5** | “I don’t think any therapy is little effort to be honest, I don’t think any therapy is little effort and I think they are incredibly challenging emotionally and physically.” Page 35  [integrating is] “no more burdensome than when I’m working in a single modality for me, when I have done that, you know I think its challenging and it is hard, yes you are holding a lot of things but I wouldn’t say its more burdensome than doing any other single therapy” Page 38 | “The thing that can come quite naturally for me is being able to respond in the moment, erm and doing what feels right, both emotionally for myself and for the child” Page 34  “Freedom really to either go with more Theraplay or do the EMDR” Page 34  “What takes little effort is I can be authentic within myself and how I am working so therefore I think I am more emotionally attuned and present, whereas if I was working in a pure modality I might be changing myself to fit within, I don’t know as an example a CBT box” Page 34/35  “I don’t think children can talk about their feelings as intensely as doing DDP for a whole hour” Page 18  “Most effective way for me in my values and my philosophy and my theoretical positioning for me to respond in that way and take stock of my client and I think if I could only respond to a client in one particular modality I think I would find that harder” Page 40 | “I remember in my early days of being a therapist, just trying to get my head around Theraplay and thinking ‘oh no I should be integrating DDP and then almost telling myself off for not knowing enough or more things” Page 13  “Sometimes you wonder using three interventions you’re spreading yourself thin rather than doing one quite deeply and quite well and I can’t lie but sometimes I’d come out thinking, you know there’s a bit of EMDR and a bit of Theraplay and maybe I’ve done too little of too much” Page 27  “The difficulty is families aren’t always able to go as far as you’d like them to be able to…. There’s a part of me that wants to get, you know, parents from A to B, the tension and difficult that I feel isn’t whether I am capable of doing that, its around whether, how can I do this at a pace that parents can manage” Page 28  “[It] is an absolute mission [to get all the information across to parents] it is a lot of work” Page 29  “If a parent is struggling, my default might be to attribute that to me as not being a good enough therapist as opposed to this parent isn’t in the right place to do that piece of work at this moment” Page 30  “It’s the planning. Planning is a lot of effort” Page 32  “and it’s think the constant reflection” Page 32  “Having it all in your head [is hard]” Page 33  “when to use what therapy is the hard bit. Its knowing have I gone deep enough or haven’t I gone deep enough, erm in a particular intervention” Page 36  “The burdensome element of it is its cost my company three times the amount to train me because they send me to 3 different people. The burdensome thing is the cost, it’s the supervision, its erm you know, I want to be an expert in each of the therapies that I do which triples the CPD element of that” Page 38/39  “The difficulty with integrating is how on Earth do you measure that, its is how on earth do you track that” Page 39 | “I think having experience under my belt and working in this way I feel quite comfortable doing it” Page 26  “Once I have developed my version of integration, which might be slightly different to one of my colleagues, well it’s gonna be, once I feel comfortable doing that, delivering the therapy itself it just doesn’t feel like tonnes of effort” Page 35  “I find Theraplay incredibly easy” Page 34  “I really enjoy working the way I work and it shouldn’t be about what I enjoy it should be about how effective it is with the client and whether change occurs, I know that” page 39 |
| **6** |  | “Most of the time if you don’t overwhelm the parents, you just give them a bit of each, actually it enhances their skills, now they not only have Theraplay” Page 32  “Integrating DDP into Theraplay requires almost no effort because its not something you plan its just in that moment” Page 33  “I think it makes it easier because you have other tools to bring in when one of the therapies is feeling a bit stuck” Page 36 | “There’s an element of probably each of the therapies would want to stand on their own” Page 11  “I’m starting with practicum right now so I’m very aware of how DDP doesn’t want to see you doing Theraplay in their DDP clips and Theraplay I think is a little more, because it’s a bit more subtle, it’s a little more accepting of some DDP but, so each of the therapies would probably speak to… ‘we think it should just stand on its own’ and each one can that’s the thing” Page 10/11  “Its harder to integrate erm if depending on what you think of as the primary model, so generally I always have a primary, this is what we are working on, we are doing, sometimes it’s pretty 50/50 Theraplay and DDP but not often. Generally, you have one that is your main one. If EMDR was the main one, I think that would be the one that was harder to integrate with” Page 19  “and then I can miss it [the opportunity to integrate] sometimes and I’m like damn it, like ‘ohte that would have been really good in that moment, I should have done a bit of tapping or something’” Page 21  “Otherwise erm about integrating, erm umm I think it’s just a ‘ooh was that the right DDP interpretation in that moment or did I miss the moment where I could have brought more DDP in’ probably those just things about that I yeah would have done that just a bit differently, maybe it’s where you might look back and feel less confident than you, you know, on how you handled it…” Page 27/28  “The downside of integrating is you might overwhelm the parents, they’re trying to keep track of how to have empathy and structure and be playful but if they have too much that they’re trying to learn at once, they might find it too hard” Page 31/32  “The thing that makes it harder is where you might lose your focus of what’s your goal, you’ve got ten sessions, you can’t do everything, you cannot do everything… you’ve got to pick your priorities so I think what makes it harder is where you feel torn between competing priories” Page 34/35 | “Theraplay I guess probably is the most effort required as a therapist because you need to anticipate what games you think you’re gonna do and why, what dimension, what’s needed, how did they respond last time to that game so let me tweak it this way, that requires the most planning definitely” Page 30/31  “I’ve got lots of games that I’ve just collected over the years, so if I have a new client I might look at my life of games and and think about based on who they are, what ones do I think might work” Page 32  “On not good days it’s really frustrating where I feel like err, I feel frustrated with myself that I can’t get more done, you know I want to get it all done and you have to just remind yourself that you have to be realistic” Page 35/36 |
| **7** | “Where you’ve got a parent who is desperate to be a mum, desperate to be a dad, and the child is like “no I hate you I like daddy more” or “no I hate you you’re not my mum I don’t want you anywhere near me” and you can see the crush of that for a parent, that’s really hard, that’s really, really, really hard.” Page 29  “The level of trauma that we work with at [SERVICE] is really, really high.” Page 30  “Its hard work and you know, I always say you have one case every five years that stays with you.” Page 30  “So, its exhausting and honestly I think if you aren’t making any effort what are you doing? You know this isn’t a conversation with somebody at the bus stop, you know…” Page 32 | “We want as much bang for your buck as we can get and actually having those three therapies I think is absolutely a gold standard you know, approach.” Page 34 | “People come out and say ‘I slept for 2 hours after, you know, after therapy’ or you know ‘I just got in the car and was so tired I had to pull over’, you know its exhausting” Page 32  “I think the hardest thing… is when you’ve prepped parents for some really difficult conversations… you start to have those difficult conversations where you prep them within an inch of their lives, they know what you’re gonna say, they know what you want them to say then they come out with something completely and utterly different that’s damaging to their relationship with their child” Page 25  “If you are using a number of different modalities and that requires this kind of meta conversation in your mind right okay, so thinking about thinking, you know its constant, its absolutely constant” Page 32/33  “You know, so in their own right, Theraplay is a discrete modality, its hard work. DDP in its discrete form is difficult and EMDR equally so, you know… they all require a different set of skills targeted at a different time and I think, I think that’s hard, I think that’s really, really, really hard” Page 33  “It comes with a huge investment… it requires a huge investment into financially” Page 34 | “I think Theraplay and resistance requires a huge amount of effort” Page 28  “I think err having good supervision absolutely makes it easier” Page 34  “I also think having good annual leave really helps and just having a system that takes care of you so you can take care of erm of the families” Page 30  “I think everything requires effort, there’s stuff that I enjoy, do you know what I mean, like, like that may give me a sense but it’s not requiring effort because I’m enjoying it…” Page 31/32 |
| **8** |  | “I can go with what’s needed and tune into where the young person and parents energy levels are or what’s needed in that moment, it probably makes things easier actually” Page 20  “so like you’ve got lots of different models to draw on, I think actually you can tune in to what your client is saying or needs” Page 21 | “for me I feel quite an emotional effort or I don’t know if effort is the right word but an emotional, yeah pull or energy, a lot of energy I guess is needed” Page 18  “I’ve also got a lot of thoughts about how to respond, where is the child at, do I move the conversation forward, do we actually need to come out of it, how safe are they feeling, what are mum and dad doing, so I guess that can feel quite intense” Page 18”  “I guess you’ve got quite a lot to do in one session Page 20”  “I guess it does take quite a long time as a therapist to integrate these into your own practice and really practice the models, err so I guess it’s kind of there is a long time element” Page 22 | “being really animated and sometimes you have to be quite, almost over the top for children to really engage and I guess at the start that probably really didn’t come naturally to me” Page 19  “the EMDR is probably still needed to just understand it a bit more, erm and find different ways of bringing it in” Page 19  “Having breaks between sessions is really important just so I’ve got that kind of reboot and energy to go into the next one” Page 19  “having a session plan, having some space to actually really have that child in mind before they arrive” Page 19  “Having supervision where I explore in depth my work at times so showing videos, that kind of thing feels really helpful” Page 19/20  “The parenting consultations, that feel really natural” Page 20 |
| **9** | “Mess and tidy up, emotions are messy and they take time to tidy away and to contain… session notes and admin.” | “I don’t think we do pure DDP with some of the kids who are just too dysregulated to have it in the first place so it makes it possible and it makes it easier perhaps potentially emotionally easier.” Page 26/27 | “I suppose, you could say that by bringing Theraplay into DDP you, you detract potentially from difficult emotions, it’s probably why they say don’t do it because you’re then able to, you’re then regulating someone rather than potentially sitting with an incredibly powerful affect aspect, so maybe, maybe putting the Theraplay in there as a bit of a softener for the child” Page 26  “it can be a lot of brain work” Page 8  “Am I giving this child what they need from a DDP perspective and is this going to dysregulate them, have we got enough safety in place, questioning myself, questioning my plans, questioning if I’m getting it right I suppose, if it’s just one modality or the other it’s a lot simpler” Page 9  “Theraplay pure is level 1 level 2 level, I don’t know how many and you’re supervised by Theraplay supervision. DDP is the same you’ve got Level 1, Level 2, and you’ve got high level DDP supervision and then you’ve got each session analysed to the nth degree really in depth. That’s not happening here when we’re mixing the modalities because you can’t present that to DDP or to Theraplay, so to mix it kind of put me back in my own basket going “who is going to make sure you’re good enough” Page 9/10  “and so bring in a mixture of modalities and you’ve got more room for not good enough creeping in I think” Page 10  “slightly burdensome in that there’s the same aspect maybe that it comes down to is that I’m not following a laid-out model, I’m following two laid-out models that maybe shouldn’t be mixed but I’m mixing them so the burden is on… me because its my sessions” Page 28  “I feel slightly uncomfortable with the fact that when I’ve done my training, they’ve been so pure and I’ve always thought, I don’t think they would be very happy about what [SERVICE] are doing” Page 29 | “try and go dancing on a Monday night, try and go running as much as I can, erm try and balance my work life and err take care of myself and be kind to myself” Page 25  “speaking to.. my supervisors and hearing what you’re doing is okay, that is right, this is what we need” Page 26 |

**Appendix J**

*Parent Chart: Effective – The theme Impactful and Imperfect was later mapped and interpreted from this chart.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **P** | **Aims** | **The therapy was effective because…** | **The therapy was ineffective because** | **What does integrative therapy look like?** |
| 10 | “personally these aims for me have been to help with that life story work because (NAME-child) came to us when he was three and a half, there is a huge amount of time, like a big void if you like in his life where he has never been given any information” Page 4 | “we did something called the Claiming Narrative which is something that I hadn’t considered either and it is helpful because we saw the effect in the session how good it was” Page 8  “I would say there has been a big change in us” Page 8  “so I would say overall, I think our house is calmer because of these sessions” Page 9 | “I was going to say that its perhaps my more understanding of it but when we talked about engines, whenever we’ve done like a therapy session, I don’t think I quite understood it, I don’t think I quite understood it, I think that could have perhaps been explained better to us about what the engines meant” Page 13  “because the sessions were, were child led, there’s no pass or fail, there’s no sort of boundaries… our experience of that was really controlling behaviour so erm and it was almost like… it was, this is my session, I can do what I want, erm I’m in charge of it, I’m in control of it and anything kind of goes… and it was really hard then to try and whether we weren’t clever enough to do it or not, but it was really hard to then try and take the learning from those sessions and the things that the Theraplay was trying to give you and then apply that because it was just like that’s, ‘we're not in the session anymore so what, I’m allowed to do what I want so leave me alone’.” Page 15/16 | “we started each session with a bit of Theraplay activity I guess just as a warm up to get into the flow and to build the environment and then it was talking with (NAME-child)” Page 3  “actually was about making sure it was child led, erm and finding the right child appropriate type of tools, erm which then completely changes the way that you think about the language that you’re using or how you bring, how you approach the whole subject” Page 7 |
| 11 | “It was for (NAME- youngest child) to understand her boundaries and understand her needs, to be able to integrate those, we had a very clear set of goals starting out.” Page 4 | “I think (NAME-youngest child) sees it as special time with mummy and daddy which is always good to make connection attachment perspective” Page 6  “I think time and space, the understanding the parenting sessions that go with it” Page 6  “I think (NAME-youngest child) has, she is able to access the tools when she wants to so I think you’re bringing all the regulative tools that we’ve got in the tool box that will help her regulate” Page 7  “obviously Theraplay always helps, so the feeding activities and all the ones that help engagement and nurture, they are just good to have anyway from a parenting perspective” Page 8  “The parenting sessions are absolutely, we could not do without parent sessions once a week just to run through the stuff that’s happened so that everybody’s on the same page really when you go into therapy, that is a must,” Page 14 | “we’re not new to this so we didn’t expect magic, erm it doesn’t happen,” Page 8  “I am pleased with her overall progress, if she had progressed faster great but it’s like we said its ten weeks out of five years, so five and a half years so far, so it’s a drop in the ocean,” Page 11 | “so it was Theraplay based to start with to make sure she’s connected” Page 2  “like an ending kind of nurture Theraplay type of thing, that’s just playing nurture events with the therapy in-between.” Page 4  “I think it’s one of those things that everything has to be based on the child” Page 11 |
| 12 | “We had very specific aims on these ones, just knowing what has happened throughout lockdown, there always seems to be two triggers for [ADOPTED CHILD] towards the anger. It's even anxiety which will then go into the flights or flight response or its also linked in with self-esteem as well.” Page 3 | “We’re all working hard from lots of different angles and the therapy is one part of that” Page 2  “in those times where it just us and erm the therapist, then we talk about the whole family situation so much more you know.... So as [PARTNER] was saying, the therapist really does understand, our, our family well and it, it would be, a real struggle to start with someone new.” Page 3  “to just do the talking without the play the kid would never want to go, so you’ve got to have the Theraplay incorporated into other aspects as well” Page 20  “Erm there’s a few things of just erm outshines of kindness that have come from [ADOPTED CHILD].” Page 5 | “P2: It would be very hard to put that down to one specific therapy or anything, but, just the whole…  P1: It grows, as, as you go through the different packages as you change your parenting, that it just all and just the time, time is a factor as well isn’t it that they all interplay and things… P2: You know and the school beside this he goes to a special educational needs school who are working on all this stuff too” Page 6  “whereas is in that first session… she was trying to give us tools and we were like…  P1: We can’t use these!  P2: “So when he comes down, can you talk to him about” No! I daren’t talk to him about it. I've got half an hour where he’s below that level of regulation, I want to enjoy it with him. Not start discussing about how he last went up. P1: Yeah… We got half an hour week. There's no way we're going to jeopardise it.” Page 7  “I think we're very aware that is a long term process. 10 weeks isn't going to change anything anyway, in a way is it? It's all small steps towards achieving bigger goals,” Page 6 | “Erm so yeah there was, it always, started off with Theraplay at the beginning erm and he laps it up.” Page 10  “I think it just automatically flows or so fluently flows between them that you're not even aware of it if that makes sense, that I couldn't tell you what the different therapies are… it just works because you do just flow from the play into the right let’s talk about this and then sort of going into the more EMDR stuff that, yeah it just seems to flow.” Page 11  “P2: Even in the talking bit… we can go from play to therapy but it also can go from therapy to play where its like hang on we just need to do a game here  P1: It just gives it that adaptability” Page 21 |
| 13 | “P2: .. so the therapy was always about trying to get her just to relax, open up, express herself.  P1: Express herself.” Page 3 | “P2: Yeah but within a week (LAUGH), erm she did suddenly come out with a conversation about  P1: Her mum  P2: Her mum. It started off, she didn’t come out with it directly, she started, she came down late one night when she should have been asleep and just started saying she was worried about suicide  P1: Suicide then yeah  P2: About suicide, she wasn’t saying she wanted to do it or there was a distinct concern there but she was worried about it as a subject and why people did it and would she ever get to that situation, she was scared of what if she wanted to do that in the future and things like that.  I: Wow  P2: In a roundabout way and talking to her and actually using some of the parenting  P1: (LAUGH) using PACE  P2: You suddenly dropped on it and it came back to her birth mum” Page 11/12  “It seemed however much we did of one or the other it seemed to be a balancing act, it was managing and watching what she was doing and how she was responding.” Page 9  “P1:I think, I personally I think it was the EMDR that worked, you know  P2:And talking through her timeline and  P1:Yeah” Page 15  “P1:We’ve both changed, we, we, our reactions are different, yeah I just think we’ve transformed (LAUGH) through the sessions along with the child so.” Page 34 | “P2: It feels like it’s taken a long time to get to that point.  P2: I don’t think so this time. I might have said that for previous years  P1: Last year yeah  P2: Because it felt like we were  P2: It felt like we playing... we were playing games and not dealing with it” Page 16  “obviously through the therapy everything just goes upside down, even when it was only the Theraplay there were just upside down, they were moody, they were isn’t it during the therapy and we just felt like that, somebody is coming, will it last like that and then ten sessions gone, there it is deal with that and I’d expressed my worry to (NAME-therapist) last year, I said “well you’re leaving us after ten sessions, what are we going to do” Page 16  “I think maybe if we’d known it was gonna need, this is gonna be two/three years at least in ten session blocks, and you’re not gonna see any real shift for that period, that, I mean there was subtle shift but It was small, it was just yeah that abstract emotional stuff again and understanding and getting them to appreciate how they feel and tell us “I’m happy, I’m sad” Page 17 | “P2: Yeah it’s been a balancing act hasn’t it? Page 8  P1: Yeah so it was talking, it was EMDR because (NAME-oldest child) wouldn’t accept to be touched would end up this was a green light, red light when she would do repetitive movements, so different erm, oh god I can’t talk  P2: Alternative  P1: Alternating the two halves of the body, erm and then we had some games cos yeah, yeah  P2: Yeah it was a matter of..  P1: She needed entertainment, she didn’t like the green light, red light so.  P2: So it was, it seemed to be a balance of talking but if it seemed to be getting too tough, a distraction of a game and breaking it up, yeah something energetic to burn off any energy.  P1: Shall we say it was about half and half, half and half, half Theraplay, half therapy” Page 8/9 |
| 14 | “P: Just to see whether we could help [CHILD] feel a bit more relaxed… not… not… not you know… not be so agitated that she would you know pick at herself and that sort of stuff.” Page 3 | “P: Erm, we just saw an improvement I can’t really say why, we just did, it seemed to help her… She very rarely if ever picks her fingers now.. that doesn’t happen, she seems to have a lot less nervous energy….[pause] Erm, sh… yeah, she never tantrums” Page 3  “P: No I think, I think by the time we finished we were really, really, really happy with where she got to and actually I’d say she’s stayed at that sort of level if you like.” Page 4 | “you’re never going to erm, you know, have a, have a situation where [CHILD] is never going to worry about anything ever again, that’s just not going to happen, that just you know the nature of these things and you know and is going to live… she’s going to live with what happened forever so erm, I can’t really, I can’t really think of anything to, to, to knock it on really.” Page 5 | “P: Mainly Theraplay, you know she was fairly young at the time so, if she wanted to talk about things or if there was obviously something that was upsetting her we would sort of go with that” page 2  “there was one day where I remember her being really sad and [THERAPIST] picked up and on it and sort of sat with it as you guys would say” Page 7 |
| 15 | “P2: This, this, this second one was all about [ADOPTED CHILD] knowing his past, wasn’t it? P2: Why, why he couldn’t stop with birth parents, the reasons P1: Why he was adopted, the reasons, P2: Yeah” Page 4 | “I think its worked really well, the small chunks, the play therapy is fantastic [ADOPTED CHILD], loves play therapy…  P2: He connects well with [THERAPIST] doesn’t he…  P1: absolutely loves and I think that’s the key  P2: Yeah  P1: The key is that connection between the therapist and [ADOPTED CHILD]” Page 5  “P1: Yeah so we structured all the play therapy around the bits that we know that [ADOPTED CHILD] was struggling with, such as, regulation, sometimes we’d, if he wasn’t regulating himself, we’d do red light green light, because he’s jumping around, if he, if he needed to listen and take instructions we’d do treasure hunt” Page 8  “I think it really worked, I think he has a very clear understanding which was one of our goals about why he was adopted” Page 6  “I think the tapping has really worked as well, maybe because he asks me now to do quite a bit of tapping when we do our song on a nighttime,” Page 11 | “I think what it, its, triggered in [ADOPTED CHILD] though, is a fantasy world still where he doesn’t really want to see the negatives” Page 7  “1: Yeah, I don’t think it failed its aims, I don’t think it failed its aims, I think whats came out, what’s come out of it, is, is, how [ADOPTED CHILD]’s reacted to some of that information. So I don’t think it failed the aims, I think it hit the aims that, that we had expected you know the communication, his knowledge about, about how to, about why he was adopted, the, the knowledge about how for us, the PACE can help us erm, explore [ADOPTED CHILD]’s feelings in a maybe in a different way, erm, and I think I just think from that therapy, erm, the, other issues have arisen that we now need to address.” Page 9 | “P2: Well, it, we, we, start, we all, she always starts off with play, doesn’t she?  P1: Yeah she does yeah  P2: And then it goes into the therapy  P1: Yes  P2: And then its back to play” Page 2  “P2: I’d say its, I’d say its been two thirds, two thirds play, one third therapy  P1: One third therapy but its two different types of therapy, it’s the talking therapy whilst [PARTNER] does the tapping,” Page 2  “P2: But what we’d do is, erm, red light green light, and we’d do, tap,  P1: Tapping on our heads, yeah,  P2: Or tapping your shoulders, or tapping your knees, so, yeah,  P1: So, we’d incorporate the tapping but that would be straight after the EMDR, the tapping that, that [PARTNER] was doing as well. Erm so we’d do a bit of extra tapping as part of red light green light” Page 8 |
| 16 | “P2: Really, the aim was for her to be happy. It was all about her as an individual and how we could make changes. She’s a child so encouraging her so she can be happy, that was the goal.” Page 3 | “there really has been amazing change for all of us so its those strategies so keeping my daughter calm” Page 1  “P1: Also what we didn’t realise that when we were talking to our daughter, we were perhaps talking too much and didn’t allow her processing time and so we would reduce things to one word and chunk things to allow her to take them in and then she would get them and understand them… Also, they explained they explained kind of how her mind, a childs mind would work and the adaptations that we could make in terms of our strategies our ways of talking that would work and so on, we’ve learnt a lot of different ways of communicating with her” Page 1  “P1: Eventually we would love to be able to meet the therapist in person to shake their hand because they were absolutely marvellous, marvellous, just suited us so well“ Page 5 | “I wouldn’t say that its 100% erm but its shown huge improvements erm so yeah much closer to the overall goal really there” Page 4  “it was just hard to do it through zoom because obviously we were trying to be on the frame on the screen at the same time rather than having space in the room so that was one negative unfortunately” Page 6  “I mean don’t get me wrong we’ve still got a long way to go, this is for life we know that we expect that” Page 2 | “so it would be that [ADOPTED CHILD] would have an issue then we’d have to think what to do and so we would get her to come over and play erm take her mind off something and then we would talk about and ask her to explain something and then the therapist would say right now leave her so she’s got time to think and then we would maybe do something like the tapping and encourage that side of things with the play “ Page 2 |
| 17 | “P2: To build up his resilience really… Yeah, he was a very emotional boy and it was mainly just helping him work through his feelings and making him emotionally stronger” Page 2 | “P1: Erm so it, I, for us, I felt that and we talk about this a lot, that the important bit for us is actually the adult but, the hour we get just us, we find that more helpful. I’m not saying that the bit with [ADOPTED CHILD] doesn’t help and that does give us ideas to bring back home and we do do that, but if you were saying, if you had a gun to our head and said you could only choose one, we would absolutely hands down choose the adult only bit” Page 3  “P2: Erm you can definitely tell that his resilience has grown, he can manage his feelings a lot better” Page 3  “we see huge improvements at the same time so they’re able to articulate they’re able to work through, nothing, nothing is off the cards, if they want to bring up their past or their birth family you know, that’s fair, that fair game,” Page 4  “I think we are a different type of, of family and sort of that doesn’t make us better or worse but I think we went in with the mentality of we’re completely.. its got to be a two way street we can’t, you can’t just say that the therapist has to do x, y, and z its got to be you as well” Page 6 | “P1: Erm, no not really I think it took is a while to get used to it, particularly the child part” Page 5  “I guess when we met [THERAPIST 1] for the first time, it takes a bit of time to build that erm  P2: Relationship” Page 5  “I think you can’t solve it in 10 weeks and that’s the reason we’re on our second round and we’ve just put on for a third.” Page 7  “its that wack-a-mole as one mole goes down there’s about three come up somewhere else” Page 4 | “I think his was much more the Theraplay and then when it was with us, obviously it was a bit more DDP” Page 2 |
| 18 |  |  |  |  |

**Appendix K**

*Parent Chart: Understanding? – The theme Clear and Confusing was later mapped and interpreted from this chart.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **P** | **The bits I understood were…** | **What helped it to make sense was:** | **The bits I did not understand were:** | **The importance of understanding** |
| 10 | “P2: Yeah and we appreciate as well we can’t just jump in and do it and as we keep saying it is child led so you’re going with the pace of what’s appropriate and its perhaps just we were a bit more eager.” Page 22 | “P2: I think because 10 weeks, I guess a week between each one and we were so eager to focus on life story work and get going with it, it then did get to a point about halfway through didn’t it, we both thought we are going to run out of time, (LAUGH), to actually cover the life story.  P1: Yes so we might need to ask what the plan is because were not clear but as it turned out when we had one of the reflections session, erm the therapist said “this is what we are going to start doing “, and it was okay, alright.” Page 9 | “I think we kind of expected we would get to the life story work a bit quicker, erm so we did have a couple, the first couple of weeks of not being quite sure where it was going to go” Page 12  “erm I don’t know if it was always clear why we were doing some of the other games if I’m honest, you can kind of guess and figure it out for yourself but, but to be made clear I’m not quite sure if we always knew beforehand…I think as well, and I think part of the reason why we weren’t clear is because of the nature of our son to take control in those games so our perception, speaking on your behalf now (NAME-P1), it would be that it seemed a little bit chaotic, manic and so we were kind of looking on as bystanders rather than being in the game because he was having so much control in it” Page 19/20  “P1: I don’t think we were expecting it though. I think in reflection you can understand but I don’t think we were necessarily expecting it.” Page 21  “P1: It goes against what your… P2: Your natural instincts and version of what you would be doing with him, what you would be doing and as you say it was going so far at one point, he was really pushing us to think to ourselves well I know we shouldn’t be but at what point do we step in and say “enough” Page 31 | “P2: I think it can be important to understand how it works to err give you the real drive to be able to do it” Page 23  “P1: Yeah, I’m just thinking as well, I think if were being a bit reflective of ourselves I think you get this information at the start and you, and you absorb it and you understand it, part of the problem can be and it certainly was for us over the course of time you actually start to forget a little bit about what these things are” Page 23 |
| 11 | “I think all the Theraplay integration, like the nurture and we know, we're well versed in types of Theraplay activities that you can use to develop certain aspects” Page 16  “So I think the thing with DDP is that it is difficult, it is effort even for kids, they are not regulated if you can’t start on that journey so start out with the nurture based or the, even child based where you are just getting that regulation and connection with your kids is definitely a way to start a session and again finishing it off irrespective of how hard the session’s been they always get fed, they always get a bit of nurture and I totally appreciate why they end up with Theraplay wrapping around and so for us, we could go to Theraplay for the whole set of sessions but it wouldn’t meet the needs of what were after now because it wouldn’t address the cognitive side of things, so I think having, having the mix of both, it is the best of both worlds” Page 18/19  “when (NAME-oldest child) is older we might be able to be at the point where full sessions are dedicated to DDP but its erm, you know, I’ll probably say, even when (NAME-oldest child) is eleven her emotional age when she is unregulated is probably still about five” Page 19 | “we're like literally we’ve read the text books, she described this book, we’ve been, we’ve met him and we’ve been on his training course and that was like Brain Based Parenting” Page 17  “I just, its, we know what we’re doing and we’ve done it long enough now that we know, we know the tactics.” Page 20  “The useful part, the really useful part… especially in the parenting sessions [is] to take that step and recap on the week which it’s almost impossible to do when you’ve only got yourself and your wife to do that because you’re always in the situation so that’s really useful then that helps you just maintain balance in the sessions” Page 20 |  | “I think we would have said, we wouldn’t end up doing something that we didn’t understand the reason why.” Page 17 |
| 12 | “that was really effective just stuff on paper he really engaged with that drawing, us drawing, writing, him writing. It really felt like you were having engagement with him through this piece of paper….And really quite deep stuff as well, he was able to talk about, like show us some of the stuff was about siblings. He was able to express that he doesn't always feel lovable, like huge feelings that just because he could tick or cross rather than having to explain it, then he was more able to help us know what was going on inside. Which was really good.” Page 9/10  “…but actually everything that happens within the session makes complete sense…” Page 11  “But if [ADOPTED CHILD] enjoys it, its I guess nice for him just to have that parent time or adult time particularly which he just loves and just doing challenges that he is confident in and I guess I understand why that is good erm but yeah” Page 12 | “P1: Erm yeah, but I think as well because we have done so much reading it makes you so much more aware of everything doesn’t it anyway but I guess some people might come into it a bit colder and just go what?” Page 11 | “P2: Erm yeah probably yeah I think just sometimes I think oh how does this game relate to what we’re doing?” Page 12 | “P1: I think your understanding continually increases over time doesn’t it and actually that, that's essential that is a whole part of the therapy as well isn’t it” Page 11  “P2: But because we understand it, it makes it a lot easier” Page 11 |
| 13 | “Well the games, the Theraplay games we’ve obviously done a lot of those before, we’ve got used to those” age 21/22 | “P2: Well the games, the Theraplay games we’ve obviously done a lot of those before, we’ve got used to those. Know about the background of those” Page 21/22  “P2: Not from us, but PACE, again that’s been taught and talked about since we started the whole therapy, but even though you can read this stuff and say this stuff, understanding it and understanding how it applies, for me it’s only taken like three years to get to a point (LAUGH) where I can start to see, okay yeah  P1: And you kind of know what it’s all about  P2: To get into a pattern of doing it, it’s hard to not jumping down the normal habits” Page 22/23  “P2: Yes, and you could see there were moments when (NAME-oldest child’s) going a certain way or she stops responding to what’s been said or she’s getting fidgety, something changes and so you can see that yeah (NAME-therapist) was then turning it, she’d twist it and change what was happening, so it made sense cos you could see what was happening there on one side and then suddenly how her mood changed again as we’d shifted the focus of the sessions.” Page 24  “having an explanation at the end of each session and the explanation parenting session before the session so it’s kind of, it was before the session explained… that was explained in detail so I think yeah, that was very helpful. “ Page 28 | “Obviously we weren’t leading the EMDR, we just had to be there but it feels quite unusual doing the tapping” Page 22  “P2: I suppose there’s some stuff that it’s hard to understand or it’s a little bit over heads because were not trained in this area” Page 25  “P1: It’s a lot of information, and it’s a lot of information coming just like a bucket of cold water, shh here it is, it’s a lot to take on but yeah.” Page 25  “P2: I think that first session, that first round in particular, it felt like we were playing games without any real purpose. It was hard to understand the purposes and what the benefits were of doing that.” Page 27 | “P1: I think it’s important to have this, what is going on because otherwise why are you doing it (LAUGH), yeah its important.” Page 25  “there were times left wondering but it wasn’t a worry either  P1: Yeah, yes said that what I’d say.  P2: Yeah, you let the experts do what they’re doing and trust them to know what they’re doing (LAUGH)” Page 27 |
| 14 | “She likes to be in charge so we had to sort of lead her away from her telling us where they are or her looking on my hands for them, erm, that, that we’d always start like that so that, that was sort of consistent routine. Erm, then we would, oh goodness, we played erm, I don’t forgive me if I’m insulting you and you know all these games just let me know, but we played one called fish and chips... You’d shout, quietly or lots, to teach… get her impulse control going, they were quite effective” Page 6  “Getting that sort of attention and that eye contact and being babied because obviously we never babied her really, she, she, she was older when she came.” Page 7 |  |  | “P: Erm really useful because otherwise, let erm, I mean lets be honest some of them otherwise might look a bit weird erm but with his help we, we, excuse me, we understood you know what was going on” Page 7  “P: I think you’ve got to erm got to commit to it haven’t you and in order to commit to it you’ve got to understand what’s going on and whys, yeah plus I say its just a bit weird.” Page 7 |
| 15 | “Yeah so the play therapy we knew anyway because we had done the play therapy from the last one and that was purely play therapy linked to attachment” Page 11 | “we do play therapy, I, I do, we do play therapy with [ADOPTED CHILD] a lot. So, from the two years ago when we did the last therapy we’ve continued” Page 11  “we would always talk through exactly what we were going to do on the Thursday before we did the therapy anyway, so I knew exactly what we were, what we were going to do you know” Page 14 | “The tapping I don’t think I really understood it at first” Page 11  “P1: Oh apart from the pizza thing that was introduced…  P2: Oh yeah  P1: That was introduced by [THERAPIST] and I’m like oh why are we, why are we doing that, but I think it was because of how [ADOPTED CHILD] had reacted to something in the session so she, changed her session slightly and we’d done a different kind of Theraplay,” Page 13 | “P1: [PARTNER] would say he doesn’t care because he just, you know, just tell me what to do and I’ll do it.  P2: Yeah  P1: I have to understand it” Page 12  “P2: Yeah you’re right but I can see the, how it benefits [ADOPTED CHILD] as well, yeah, yeah” Page 16 |
| 16 | “P2: Yeah because of [ADOPTED CHILD]s trauma we knew that that had to happen that way and she was a bit resistant and therefore we knew that if we played and distracted and then went back to it, erm that eventually she would gain trust and feel able to say something and so she started to open up slowly but surely it really worked for her” Page 6 | P2: When [ADOPTED CHILD] would talk about something or refused to talk about something we would then switch to a game to get back on track and then we would ask a little bit at a time very very patiently and so that was very useful so there was no forcing her and there was nothing kind of deep but because she was initially resistant we knew that we had to give her some thinking time so that seemed to work to pose a question and then to play and to leave her to think” Page 5  “P2: With the explanation of that left and right hemisphere early on, we realised that it was important to learn that because then we could see where the gaps and delays were where there was poor development and we realised that she would be struggling with certain things because it was linked to a certain part of the brain” Page 7 |  | “P2: I think it is important, you need to understand why you’re doing what you’re doing  P1: For example with a baby thinking about their brain and knowing the different age ranges as well if there are gaps at specific times in their developing, I think its important because then you know why there are delays why things don’t necessarily work that you can then link to the therapy” Page 7” |
| 17 | “we were giving [ADOPTED CHILD] sort of grounding games to calm him down”  “I feel like I’ve got… an overview of it, because its obviously the connections in the brain and the things that they’ve missed and that’s the reason why we do it and yeah I just feel like erm obviously I’m not an expert but I know my basics and I feel like that’s what you’ve got to work with really” Page 12 | “but I think our understanding of it, we’re on a 3 year journey now and our understanding of it, things probably don’t need to be explained explicitly, everything doesn’t need.. and, and there are things that do. But then your typical games and your different type of activities that you’re doing or picking” Page 10  “P2: I did find the workbooks quite helpful though  P1: Yeah you, yeah  I: Okay  P2: On our first, on our first round we would get a workbook and it would explain what, why do we what, when we do it, erm and also” Page 11 | “Did it kind of make sense what each of those activities were for and why you were being asked to do them, over other activities?  P1: Erm, possibly not, erm, if I’m being completely honest… because we’re going straight in first to do the child bit first we all arrive together or she hasn’t got time to tell us what the games are and I guess it’s not really appropriate in the session to say we’re going this because of this.” Page 9 | “P2: Erm, I think I would prefer to know what they are for and why we’re doing them, only because you’re supposed to be a therapist at home as well that’s what [THERAPIST 2] always said to us  P1: You’re a 24-hour therapist  P2: You’re a 24/7 therapist, so to really understand the games you need to know why you’re doing them so to do them at home you need to know when, when the rights time  P1: Yeah because the context changes, yeah, I suppose, I think you do, for it to really have that  P2: Impact  P1: Impact  P2: For lasting effect” Page 9/10 |

**Appendix L**

*Parent Chart: Confidence? – The theme Finding comfort in discomfort was later mapped and interpreted from this chart.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **P** | **The parents need to be confident enough to** | **We felt confident because…** | **We felt more comfortable with…** | **We felt less comfortable with** |
| 10 | “P1: Lots of energy, lots of energy and very open minded and your kind of have to erm, you have to strip back every preconceived idea you’ve got of what to do and how to do it and I think you also need to be prepared to be told erm ‘this isn’t quite right’.  P2: And be honest as well.  P1: Yeah you need to be honest with yourself and accepting that someone is not going to interpret what you’re trying to do, this isn’t as in that’s the right way to do it or whatever, you just need to be quite reflective about erm without being sensitive.” Page 25/26 | “we’ve kind of gone into this, all of them actually on that point of we’ve been looking for the information to help put us on a better path, erm or just understand something that little bit better so that we can manage something a little bit better” Page 26  “I think we’ve been fortunate that we had a good rapport with our therapist” Page 27 | “The erm, for the sessions with erm the family sessions, the creative, the creative bits I felt more comfortable with and erm the, and for our sessions, erm I didn’t have an issue with any of the reflective work we did in our sessions, I felt they were really quite strong from my experience.” Page 27 | “P2: Yes, I think I felt most uncomfortable as the sessions went on and the games that were played and our son wanted to take control… and because he would look at us wouldn’t he as if to say “you know I wouldn’t be doing this anywhere else but I know I’m just going to go…” P1:No that’s fair, yeah that, that, not uncomfortable because of the sessions, uncomfortable with what was happening within them… Page 27/28 |
| 11 | “you have to be in it, you have to be engaged and you have to be willing to put the time in… if you don’t put the time in you can’t do it. One of the things they first said, and it’s so disparaging when you hear it the first time is that you agents of change and you get taught this as a parents, so if you wanna see a change in your child you have to change yourself to mirror that change” Page 14/15  “learning to appreciate, you fake it before you make it” Page 21  “In terms of playfulness its never been the easiest, the hardest to bring if you’re not feeling it” Page 21 | “I’m generally really happy with the idea of starting with the Theraplay just for regulation”  “Yeah, just knowing that its, in therapy its time limited, it’s always been, it’s not, you can do it at home, one of the problems that you have with nurture is with a child that’s not used to it, is how you draw boundaries at the end of it.” Page 23  “”even now I can feel, I can remember, this is a couple of years ago, I can still remember how, how it felt, how difficult it was, it almost makes me shudder, like with all, not quite disgust but that kind of level of response to how uncomfortable it made me feel at the time and my wife felt exactly the same because it was so, it was a position that (NAME-oldest child), my eldest wouldn’t allow us to venture into for fear at home but doing it in therapy in a safe space was the only way we could effectively do it” Page 23  “I think we always had, we knew, we’d already planned these eventualities, checked everything before... knowing that we talked through it in advance in the parent session to me meant that you felt comfortable, or as comfortable as you can be in your discomfort.” Page 24 |  | “I think we’ve mentioned the nurture for elements where, where that’s, it’s not that I missed it out, that was earlier on but I am aware whether that has been, not a barrier but me putting myself in a very uncomfortable position and for me and my wife… it’s probably not objectively difficult but because of all the emotional baggage that it brings with it, it feels difficult.” Page 22/23 |
| 12 | “Erm being able to analyse yourself and be self-critical is really key erm if you feel vulnerable enough by yourself I think it would be really difficult” Page 12 | “guess this time there was no apprehension going into it just because this is the third lot of sessions that there is more apprehension when you’re doing it the first time that you don’t quite know what is going to come up” Page 2  “this time round that we knew the therapist this time as well so we’ve built a relationship” Page 2  “P1: It definitely felt like it was better for having two of us.” Page 12  “we don’t come into this needing these boys to make us parents or needing affirmation from them as parents” Page 13  “P2: Maybe just, just, before you ask that I was thinking actually there’s an.. also another real benefit is that we’re really together in this. “ Page 14  “P1: Yeah she is just so enthusiastic and positive  P2: Affirming  P1: Yeah affirming that… all of those things just then feed into the atmosphere don’t they for the child and for us.” Page 16 | “I love the fun and games as much for me as for him” Page 17 | “P2: So in that, in that session you’re doing it with your son, you can dry up really quickly yourself, you know tell him, tell him four word you want to bring praise to him about and you get two and you think “oh what else can I do” Page 13  “P1: You’re not quite sure how much you’re supposed to redirect or whether you leave the therapist to the…  P2: Yeah, should I be doing something “this is starting to get out of control now eeeer”  P1: But that… that bit.. because you’re not quite sure about the power balance of like actually should I just step in and maybe draw this back or do I let it carry on and she’ll yeah…  P2: Is she actually looking for a behaviour is she looking for something you know to see where it would go? Or is she looking for something from us… so yeah…” Page 15 |
| 13 | “P2: Yeah and its maintaining it now, we seem to have started something  P1: Yeah  P2: And I think, I suppose the lingering concern might be maintaining it, keeping it going (LAUGH), using everything that we’ve been taught to try and carry on.” Page 20/21  “P2: You have to be paying attention every moment (LAUGH), you can’t let your mind wander or drift” Page 29 | “P2: Yes, well that’s where it would the parenting sessions are good as well because the therapist kind of briefs you” Page 30  “P1: Yeah and I think were also working very well as a team and when I have down moments, because you know you’ve got sometimes you’ve got a brain block or something instead of it being the other way round so yeah. All’s good.” Page 31 | “P2: Well playing the Theraplay games were quite proficient aren’t they (LAUGH), we know what we’re doing generally.” Page 31 | “then out of the the side is a question from (NAME-child), what do you think, something bad is happening whoa (LAUGH) so yeah I think being  P2: I feel, go on  P1: Being alert all the time and that’s what makes it very tense as well because it’s not only about being there physically for your child but you just need to just keep going all the time, erm practically in two plans isn’t it, one for the child and also thinking what the possible answer would be and making sure its” Page 29/30  “P2: I suppose when the talking started,  P1: We didn’t know what to do isn’t it. Sometimes you don’t because it’s just a matter of moment, you don’t know, should I say something now, should I do something now, if I do what I feel will that interfere with erm, erm with the sessions or shall I shut up, shall I say something so is that for that.” Page 32 |
| 14 | “P: Erm, commit to it and then do the games other times as well, you know once a week wasn’t enough.” Page 8 | “P: I felt like we had a grasp of what we needed to do and erm you could see the positive results.” Page 10  “P: Erm, well for instance he would send us you know things like that erm, the video, erm, various other things to read erm yeah” Page 10 | “P: Erm I think the games are easier aren’t they” Page 9 | “the, talking stuff is obviously harder that’s why you guys are the professionals and I’m not a very good… [PARTNER] found that easier, she’s a great empathiser, and talker and likes to sit with things whilst I’m much more erm solve the problem move on, which is a, a source of much frustration to my wife sometimes [laughs]” Page 9 |
| 15 | “P1: Well go with the flow” Page 16 | “P2: Ini… Initially, initially when we first started therapy it, it didn’t seem natural did it  P1: It didn’t no  P2: Like now, its just  P1: Yeah  P2: Its the norm we just come in, “Hi [THERAPIST]” and we just get… yeah” Page 16  “P1: You know and the play therapy for us, because, because I do it or we do it, not all of it, but majority of it as part of our daily family life anyway the play therapy comes naturally anyway to us, yeah so.” Page 18  “  P1: Yeah, I, I think, I think because we’d had the play therapy which was obviously new to us before and because we’d had the attachment therapy and because we’d had [THERAPIST] before, I think going into this set of therapy we were a lot more confident and this was obviously for us  P2: More important  P1: More important for [ADOPTED CHILD] so this, and, and, and I look back and I think I wouldn’t want to have done this as my first set of therapy  P2: yeah  P1: I would’ve probably said if anyone is going to do life story work, and you want him to do Theraplay and has never done Theraplay before in your whole life, have some, have a session or at least two or three sessions before you get into the, the life story work to actually master play therapy” Page 20 |  | “P1: I, I think it was a bit of an unknown for us because I, I don’t have any children and, and we’d certainly not been to child therapy before had we so I think it was a bit all unknown” Page 1  “P2: The first lot of therapy, it felt a bit awkward didn’t it?  P1: It did, yeah. I, I think, I think for new parents, I think you feel scrutinised about your parenting as to whether or not you know if [ADOPTED CHILD] does something wrong, do we tell him off do we not tell him off, do we rein him in do we not rein him in” Page 17 |
| 16 | “P1: I think we had to initially first of all kind of absorb what our daughter must have felt like when she was dropped into our family and that kind of sense of panic and not knowing what to do” Page 8  “we’ve worked hard at this and it was having to work as a team” Page 9  “we’ve had to be very patient, we’ve had to go through it step by step” Page 11 | “once [THERAPIST] got the ball rolling my confidence really grew and I started to understand right this is me as a mother and I really then learnt to understand who I am as a mother and I was less stressed so yeah” Page 8/9  “as time went on and her confidence really grew yeah we became more confident.” Page 9 |  | “P1: Yes, when I first started no, initially I felt embarrassed I felt like a failure, I felt like I was failing my daughter. Initially when I first started it was a little bit tricky” Page 9  “focussed on trauma, that was difficult, that was hard going, we didn’t want to see [ADOPTED CHILD] kind of you know go back into her background and to feel low but we knew that we had to go through that process” Page 9  “and tyring to focus on the empathy as well of how [ADOPTED CHILD] must be feeling so the empathy work was quite hard” Page 10  “P1: Yeah and I think you feel the kind of the weight of the responsibility I would say that I feel 80% of the responsibility so my confidence can really go up and down, I can be quite low sometimes and quite stressed and my mind can be a little bit all over the place” Page 11 |
| 17 | “its almost like you have to get through that awkwardness to come out the other side erm,” Page 5  “P2: You’ve got to be honest, you’ve got to… I feel like that’s… you’ve got to be open to suggestions from the therapist, erm, and you’ve got to listen, not just to the therapist but to each other and I feel like that’s our hour where we, like we chat, we chat regularly don’t we” Page 12  “P2: You’ve got to be open to different outlooks on behaviours, on why they’re difficult behaviours” Page 12  “P1: Like I said earlier, you’ve got to have the right mindset and be open, I think its key. If I’m summing it up, its just open, openness because I think if you’re open to it, to erm have a go at it and time, you’ve got to give it time” Page 12 | “P2: I feel like I’m open to trying new things and new techniques, I feel like the relationship we’ve got with our therapist has really helped that as well because, its alright to get things wrong.” Page 14/15  “P1: I think, trust is a big thing, and I think building those connections, we built it up with [THERAPIST]” Page 14  “I really struggled when we first got the boys because my, my parenting skills came from my mum and my mum wasn’t the best so it was learning techniques,” Page 14 | “P1: Mine, I don’t mind being open, he hates that in everything because his childhood was particularly challenging so I think a lot of it triggers him, but for me, I don’t, that bit I can do all day long” Page 13 | “sometimes the Theraplay bits can be quite uncomfortable erm sometimes the first time round erm we felt just a bit weird” Page 3  “P1: for me it was the, the baby activities because I understood they needed this need and they had this need and they need this development and they need this nurturing but its really hard doing it to 5, 6, 7, and now he’s 8, 8-year-old  P2: And doing it in front of someone as well” Page 13  “The only thing that I do find uncomfortable would be managing the behaviour of the child in the room at certain times because when they’re jumping around everywhere, you want to say “no you need to stop” and I think it, its letting that bit go that I struggle with, does that make sense?” Page 15 |
| 18 |  |  |  |  |

**Appendix M**

*Parent Chart: Burden – The theme Burdensome and Worthwhile was later mapped and interpreted from this chart.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **P** | **What makes it more burdensome** | **What makes it less burdensome** | **Because it was burdensome…** | **It was hard but worth it** |
| 10 | “P1: Homework is tricky. Erm so some of the readings are, and keeping up with the reading is quite tricky, erm cos there can be a lot.” Page 33  “I mean this particular one, erm our, we had job changes and other sorts of circumstances changes as well which is a big burden on us, so we found this one to be particularly hard to balance” Page 33  “Erm making, making time to, to leave work and to get to the sessions is tricky, so the practical logistics is tricky” Page 35 | “I think a lot of it has become part of the way that we just, we all live now in some respects” Page 34  “P1: Makes it easier? Erm no, the information that your getting is really important, erm and erm and this one was quite practical for us so there were a lot of, I won’t use the word practical but there were a lot of good tools for us” Page 38  “P2: I think the parenting sessions  P1: Yeah, yeah  P2: If you don’t always do the reading outside of it, I felt like I gained a lot from talking.  P1: Yeah” Page 39 | “P2:Yeah cos it’s just says, when you think about the bigger pictures throughout why he goes to wrap around care, so he’s got quite a long day as it is and then he gets homework as well you’ve got to do, so it’s then homework on top of everything else and then your day is just getting shorter so I must admit, that’s why homework for us wasn’t, was more reactive because you’re doing everything else just to get through your day, so your normal week and then squeezing that in as well, so that’s why I say I feel bad saying it because I know how important it is” Page 36  “I must admit it was nice to have a break” Page 37 | “P2: You get out what you put in, so the more effort we put in the better quality we got out of it I thought.  P1: Yeah but this was, this was worth… worth putting, making sure we did what we needed to do” Page 40 |
| 11 | “in the past the homework that goes with them has been difficult because it’s an extra time” Page 25  “the sessions themselves are exhausting. It might only be an hour but I'm unlucky that I go straight back to work, I come into work, I go straight back to work and I’m knackered for the rest of the day cos its, to be emotionally available within that level of intensity for a whole hour is exhausting.” Page 25  “There’s always the like, I think we're North Sheffield and the Therapy is South Sheffield, its extra time and logistics” Page 27  “the time burden is more keenly felt than the effort I have to put in overall to make sure the therapy works.” Page 29 | “It’s just I suppose I have to remind myself why I’m doing it, I wouldn’t be there doing it if I didn’t think a) it was worthwhile” Page 26  “The parenting sessions for us are very easy” Page 27  “and (NAME-youngest child) is, she enjoys them which if she’s enjoying herself then, and she enjoys therapy even though it’s difficult” Page 27  “Yeah, well were lucky that we, I think if I was actually paying for it I would be probably I’d have, not sure its fair to say higher expectations but I’m fully aware of how much the ASF funds… but I think for value at the moment because we don’t pay, it’s got to be up there like… I’m just very thank full for having the ASF in place” Page 30  “a lot of it comes down to the therapist like relationship” Page 31 | “I can see why it’s at 10, theoretically in my head yeah more is better but actually I don’t think if we do, we’d have summer off, we’d start with one child in September and by the time you’ve taken to count Christmas, Easter you’re back round to Adoption Support because the cut off is April the next year by the time you have done 20 sessions with all things off so actually can’t fit, particularly fit any more of them, 10 sessions each per child, by the time you’ve got everything else going on and so yes for logistics its fine and also from a, erm actually having done more. Looking back 10 is enough,” Page 14  “I am relieved when it’s over but also it’s a relief for the burden but you know it’s still ongoing.” Page 29 |  |
| 12 | “P1: Yeah having three independent hours in different places of the week it did make it harder “ Page 19  “P2: overall burdensomeness is high erm that particular package felt very high because of the covid stuff but it does require you know for some working full time that’s you know 3 hours out every week by the time you’ve got there you’ve done your two hours you’ve got back, its tiring, you feel like you’ve worked hard and then you have to jump into meeting calls straight after “ Page 18 | “P1: But I never felt like I didn’t want to go  P2: No  P1: As in it was always something I looked forward to rather than dreaded so…” Page 18  “Yes, it is exhausting parenting boys that have got these issues, but I felt like that was always understood, its not a burden to talk about it when you feels understood” Page 18  “if it is working its not going to feel like a burden is it” Page 18 | “P2: Its not that you think “oh I wish this would end” its just you know ready for a break” Page 19  “P1: But for me I missed out on meeting a friend for a coffee which I don’t’ ever get a chance to do when I’m doing therapy because I’m working the other times… it replaces that time so it is important you’re not in therapy all the time because actually you’ve got to do things sometimes for yourself at times as well.” Page 20 | “P2: I would find that I’ve got two scales on that one, so you know sort of 0/1 [scale of burdensomeness 0 low 10 high] I’d definitely do it again I’d be quite pleased to be going again, but it takes a lot of energy and effort, so 7 [scale of burdensomeness 0 low 10 high]” Page 19  “P1: See for this package lot therapy then it probably was 6/7 whereas it probably is less burdensome without the whole covid scenario going on. Erm but again would definitely do it again would recommend people to do it because it does help them it does help you” Page 20 |
| 13 | “I personally, I personally feel erm, I mean every set of sessions were exhausting from, from all points of view, erm psychologically because it puts you through a lot of work, even if it’s not about your life it’s about the life of the person you care about, you love, erm and so that hour of therapy was quite intense” Page 17/18  “P2: I suppose it’s the timing of the sessions as much as anything, how much they interfere with the normal day, whether were having to remove the kids from school to attend these sessions” Page 36  “P2: Because I remember it being exhausting.  P1: It was but it’s exhausting anyway from all points of view including physical, for some reason you just feel physically exhausted, erm its erm” Page 37  “P1: Yeah I think erm seeing them how they struggle and although you do know that you need to grieve in order to let go, it’s hard to see them going through these moments and there’s nothing we can do isn’t it  P2: See them struggling” Page 44  “P2: See I, I don’t think it’s been, well the problem isn'ts the fact that the therapy is an intense block and then almost a year off, I think it’s what we mentioned earlier of there is no check-in at any point, just to make sure there is nothing gone wrong or if there are any concerns” Page 41 | “We do it all the time anyway, we do it outside the therapy so we carry on doing, erm but” Page 44  “I think just having the information in advance, being prepared, knowing what’s coming next.” Page 46  “knowing that erm it is a stage that they need to go through, it doesn’t matter how painful is that, erm it’s like they do need to go through this in order to hear themselves here, like to try to just erm let things go and erm accept the past because they are never going to change anything, they can’t change their memories,” Page 46/47 | “P1: I wouldn’t be able to go on for a whole year every week to be fair” Page 40 | “P2: I would say it’s quite hard work, it is a lot of effort involved.  P1: It is, 8, I’d say and 8.  P2: Its tiring, wearing, physically and emotionally  P1: Can we give you decimals, 8.5 (LAUGH)  I: Yeah and so it sounds really high effort, really hard, and so is the effort worth that 8.5 or?  P1: Yeah it does, I don’t think I  P2: The way it’s gone this year it feels like it. Thinking about this year  P1: It’s already paying it isn’t it because of how quick we’ve noticed it and changes and how quick (SIGH), how quick we’ve recognised” Page 47/48 |
| 14 | “P: It wasn’t easy because obviously we’ve got [ADOPTED CHILDS SIBLING] as well to look after and he was youngish at the time so it would tend to be one of us would do some of it with [ADOPTED CHILD], or [Partner] would occasionally do it but [ADOPTED CHILD] would be around as well” Page 8  “P: There, there was a lot of effort… No doubt about it, erm lots of stuff to do in between sessions and we had two sessions a week” Page 12  “you’re digging up a lot of things as well aren’t you and you’re thinking about some of the things you haven’t done so well and when you haven’t reacted to a situation very well and we talked about all that stuff as well.” Page 12 | “P: Oh yeah all the time yeah he was always explaining what we, what we would need to do in order.. for the next section and erm that sort of stuff yeah” Page 11  “we had an option obviously to consider you know applying for more down the line if we wanted to… So yeah, I had no complaints there  I: And is that quite erm, is that quite reassuring for a parent knowing that you can revisit too, in a couple years time if needed” Page 13  “it didn’t feel like a burden because we were obviously getting a lot out of it.” Page 13 | “P: It was really good but don’t get me wrong there was a point where you know me and [PARTNER] were looking at each other thinking ‘oh god you know cant wait for this to be over’” Page 12 | “P: Erm you know and its all, its all time consuming and hard work but that was you know, its was worth it… The ends justified the means” Page 13 |
| 15 | “I’ve got full time work, [PARTNER] has full time work you know then we’re bringing [ADOPTED CHILD] out of school then we’re trying to manage and regulate him and we’re having not just one therapy session we’ve got two therapy sessions, you know.” Page 9  “P2: I think as in effort from me, the physical effort isn’t it, but not,  P1: Yeah because Theraplay can be quite physical can’t it” Page 20  “it makes it upsetting as a parent having to tell your child you know that their birth mother wanted, deliberately inflicted, those, those erm injuries on them, and, and I don’t think I was kind of prepared for just how hard emotionally that was” Page 22 | “P1: To, to be honest I don’t think it was a particular burden for us because we have a very understanding governing governor who erm let me work from home for the whole day… Does that make sense so the work gave us time off because it was 10:30 while 11:30, she let me work from home so I could monitor [ADOPTED CHILD] after the therapy if needed to, you know” Page 20  “P1: Then school were really, really good about it, erm, they were really understanding” Page 21  “[THERAPIST] had already structured over the first couple of sessions [ADOPTED CHILD]s expectations about this is what we’re going to do, so actually she kept like the first three play therapy things were exactly the same on every single one, so he knew, Page 23 | “P2: I think its enough in one go  P1: I think its enough in one go” Page 9  “P2: When we’re doing it we’ve got 3 hours a week because we’ve got the two therapy ones and then we’ve got a separate hour session with [THERAPIST], just myself and [PARTNER]  P1: Yeah  P2: So its three hours a week that’s got to be met for 10 weeks so…  P1: Yeah  P2: At, at the end of it we’re kind of “[sigh] glad that’s it” aren’t we, we really are  P1: We are but equally, I, I, yeah I…  P2: We’re having a little break now and its nice to have that little break, isn’t it?  P1: It is yeah, I wouldn’t want it more than 10 weeks, would I want it less? Mmmm, no  P2: Probably not” Page 9 |  |
| 16 | “and so, I mean it was exhausting, it was very emotional for us, it was very upsetting because you feel like you’re failing your daughter” Page 2  “sometimes in the therapy erm I would feel bad because I would feel like I’ve taken [ADOPTED CHILD] from her family that’s how I sometimes felt, I just felt bad about it” Page 10  “P2: These sessions they take up a big budget and therefore we have to make sure that we really commit and put in the work, so when you go into these things you have to deal with what they come at you with” Page 12 | “P2: The therapy work itself. Because you have to think about the strategies, when you’ve been given some information and when [ADOPTED CHILD] is explaining something, when you understand and you’re on the same page and it works well” Page 12 |  | “P2: it was hard work. But obviously hard work for [ADOPTED CHILD] of course  P1: But beneficial” Page 5  “P1: Yeah you felt the burden of responsibility with regards to making sure that you did what was required and to do it for my daughter, she was a priority so yeah it was heavy in terms of the, the content and the workload especially through zoom, but so worthwhile.” Page 12  “P2: To make sure that we can work well you know for [ADOPTED CHILD] and for her future, that we can learn, that she can learn, that if we have a problem or she has a problem that we know how to deal with it that we can be involved and we know what works well and so yes there is a heavy responsibility and burden with that but it was worthwhile” Page 13 |
| 17 | “its so intense, so much information” Page 10  “P1: So I suppose the time, I have to use my PPA time, that’s why I get the afternoon off so I’ve then got to catch that time up on a weekend as a result of coming, but you’ve got weight in the pros and cons and to me the power of coming is more important them me having to catch up 2 or 3 hours on a Saturday or a Sunday.” Page 16 | “P2: Erm, I would have to say the therapist being in charge in that, family group, I think… her taking control of this is the game we’re going to play next and just letting that be a bit more free, I feel like I’ve quite enjoyed that, because it feels like we’re just there together” Page 16  “P2: No I think its just having a really understanding therapist, because she, she’s really helped me just to trust in her a lot more” Page 17  “they never, they never make us feel like we’re hard work like… right down to the receptionist and how, I’m sure she’s like it with everybody but there’s one receptionist in particular who talks to us as if she’s our next door neighbour and I just think that setting of the scene just makes you feel like you belong” Page 18 | “We’re going to have a little bit of a break because it is intense” Page 7 | “we’re willing to put that work in because we are seeing the rewards” Page 7  “P1: Yeah I think no I think that its hard work but its worth it and you reap what you sow, you know people tend to use that in a negative way, I don’t see that as a negative phrase for me that’s a positive phrase you reap what you sow, the amount of effort you put into it you will get that out you will reap that, that will come out” Page 19 |

**Appendix N**

*Example of audit process*

**Extract from Participant 5**

*I: How confident yeah, how confident and able do you feel to deliver the three aspects and integrating them?*

*P: I feel, I feel confident weaving the three, I feel confident delivering erm all three sets of therapy on their own and as a blended approach I’m not, I don’t have a secret erm wish not to do any of them because I’m employed at [SERVICE], I don’t think ‘oh great’. I believe all three work well, erm the part that I’m less confident in is the EMDR slightly because you don’t get many children that come and say “I want to do EMDR processing just on this one time, that I dunno, this man had a heart attack outside my house", because kids aren’t referred in that way and children don’t necessarily process in a way that EMDR would manualise it, so, so EMDR for example is a little bit more of a therapeutic license, artistic license around for me integrating it. So I feel confident using it, erm sometimes, sometimes you wonder using three interventions you’re spreading yourself thin rather than doing one quite deeply and quite well and I can’t lie but sometimes I’d come out thinking, you know there’s a bit of EMDR and a bit of Theraplay and maybe I’ve done too little of too much, if that make sense. But I feel I, within my ability and within my practice I feel confident, I feel comfortable, I feel well trained and well prepared, erm a good supervisor behind me, erm support me in that modality and depending on whether you catch me on a good week or a bad week I’ll tell you whether I’m being a good therapist or a bad therapist (LAUGH)…”*

**Familiarisation Notes**

Confident, comfortable, and not concerned about delivering these three therapies as I have a belief that they all work well

I’m less confident in EMDR compared to Theraplay® and DDP

The concern I have is whether I’m doing justice to each model

Having good training is important

Good supervision is important

**Identifying a Thematic Framework**

The notes above contributed to the following features within the thematic frame:

|  |  |  |
| --- | --- | --- |
| Familiarisation note | Thought process | Framework contribution |
| Confident, comfortable, and not concerned about delivering these three therapies as I have a belief that they all work well | There is something about the belief in the models and the fact they work well together | I feel confident because… |
| I’m less confident in EMDR compared to Theraplay® and DDP | There is something about individual preferences | Individual strengths/weaknesses |
| The concern I have is whether I’m doing justice to each model | There is something about being good enough or providing the quality of care and questioning whether you have | I feel less confident because… |
| Having good training is important  Good supervision is important | There are certain sources which can boost confidence | I feel confident because… |

**Indexing**

The abstract was indexed as follows: [For those with visual difficulties, the below abstract is coded with yellow, green, grey, and blue highlights].

*P: I feel, I feel confident weaving the three, I feel confident delivering erm all three sets of therapy on their own and as a blended approach I’m not, I don’t have a secret erm wish not to do any of them because I’m employed at [SERVICE], I don’t think ‘oh great’. I believe all three work well, erm the part that I’m less confident in is the EMDR slightly because you don’t get many children that come and say “I want to do EMDR processing just on this one time, that I dunno, this man had a heart attack outside my house", because kids aren’t referred in that way and children don’t necessarily process in a way that EMDR would manualise it, so, so EMDR for example is a little bit more of a therapeutic license, artistic license around for me integrating it. So I feel confident using it, erm sometimes, sometimes you wonder using three interventions you’re spreading yourself thin rather than doing one quite deeply and quite well and I can’t lie but sometimes I’d come out thinking, you know there’s a bit of EMDR and a bit of Theraplay and maybe I’ve done too little of too much, if that make sense. But I feel I, within my ability and within my practice I feel confident, I feel comfortable, I feel well trained and well prepared, erm a good supervisor behind me, erm support me in that modality and depending on whether you catch me on a good week or a bad week I’ll tell you whether I’m being a good therapist or a bad therapist (LAUGH)*

Coding Themes:

I feel confident because Individual strengths/weaknesses I feel less confident because

Integrating makes therapy hard because…

**Charting**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **P** | The therapist needs to be confident enough | Individual strengths/ weaknesses | I feel confident because… | I feel less confident because… |
| **5** |  | “The part that I’m less confident in is the EMDR slightly because you don’t get many children that come in and say ‘I want to do EMDR processing just on this one time that I dunno this man had a heart attack outside my house’ because kids aren’t referred in that way and children don’t necessarily process in a way that EMDR would manualise it” Page 27 | “I believe all three work well” Page 27  “I feel comfortable, I feel well trained and well prepared, erm a good supervisor behind me, erm support me in that modality” Page 28 | “Sometimes you wonder using three interventions you’re spreading yourself thin rather than doing on quite deeply and quite well” Page 27  “whether you catch me on a good week or a bad week I’ll tell you whether I’m being a good therapist or a bad therapist” Page 28 |

**Mapping and Interpretation**

This took place in the wider context of all the data. Within the context of the therapist’s self-efficacy the following map was established:

|  |  |
| --- | --- |
| Level of Confidence Therapists have delivering Integrative Intervention | |
| *Confident because…*  Been doing it a long time  Therapies are a natural fit  I’ve seen successful outcomes  I have good supervision and work within a supportive environment  I’ve had all the training that is required | *Not confidence because…*  Self-doubt (Have I spread myself too thin?) Due to lack of guidance to follow  Lack of experience in certain models  Good week and bad weeks |

Key Dimensions Identified

Importance of environmental climate, training, and experience.

There is a lack of guidance and direction about how and when to best integrate effectively, which maximises the presence of self-doubt. In the face of this uncertainty the therapists are required to rely on their own clinical judgement and therefore must demonstrate courageousness, despite experiences of apprehension, to continue to deliver this integrative approach as they believe in the approach and themselves. There is self-belief and self-doubt, self-assurance and apprehension, and confident and hesitation almost in equal measure. Additionally, contending with this uncertainty can be experienced as a burdensome element of the integrative approach highlighting intrinsic links between these themes.

Self-Assurance Apprehension

Range

Self-Belief Self-Doubt**Appendix O**

Mediated by Supervision & Supportive Environment

Mediated by strength of Belief that Therapies are a Natural Fit

Mediated by Level of Experience & Past Experiences of Success

*Extract from reflective log*

**12.08.2021 – Interview with Participant 1**

I felt apprehensive ahead of this interview as I felt a pressure to ‘get it right’ although I am not really sure what that would mean or look like. I felt a bit of uncertainty regarding the semi-structured nature of the topic guide in terms of the extent to which I would explore topics brought by the participants I was not sure how much time to spend on these, how many questions to ask about certain areas, and when it felt suitable to bring attention back to the topic guide and questions in hand. In retrospect, I had no reason to be nervous. I have been applying an unrealistic level of expectation and pressure on myself when all I needed was to be human and to meet with this participant at a human level being curious about their experiences of delivering the therapy. I found it difficult to be fully present with this participant at times as I found myself glancing at my topic guide and thinking more about process-level decisions in terms of, are we going to run out of time, do I need to move things along, etc and this is something I would like to do much less in my next interview as I feel it detracted my full attention away from the participant – I am unsure how the participant would have experienced this. There were also times during the interview when themes jumped out to me and these gave me a sense of having some “aha” moments and moments of real intrigue – what is positive is that at the time of writing this (just 4 hours following the interview) I have actually forgotten what these were about, which will hopefully prevent me from searching for them in other interviews which could have a negative influence on the overall data collected. I anticipate that this feeling will come up again and it will be important for me to remain balanced, neutral, and provide all participant responses with a balanced enquiry (as opposed to choosing to follow up certain areas with an abundance of questions). I will reflect on this and consider how to manage these “aha” senses as and when they arise during interviews. This participant was very talkative and found it easy to talk at length from the questions and prompts provided. This worked well for me as it allowed me to settle into the interview and at times I felt engrossed in the participants story. It is a relief that the participant was able to talk at length about their experiences relating to the topic guide, this provides me with further confidence that the topic guide is appropriately designed following construction and piloting. The only sense I did get that may need amending was some of the wording and there was some repetition, I will look out for this if this becomes a problem and may make iterative changes to maximise the utility of the data.

**28.01.2022 – Interview with Participant 10**

I felt nervous ahead of this interview as it was the first interview I was conducting with adoptive parents. The previous 9 had been with therapists and many had been ex-colleagues which feels like a very different prospect. I also had not conducted an interview for almost 4 months. The interview went well I felt as though I had developed a good rapport with both these parents. At some points the topics the parents wished to discuss seemed too broad and went beyond the scope of this research project, this is making me consider trying to focus the remit of the interview in a better fashion. I may have to iteratively adjust the topic guide as time goes on in order to obtain a greater focus on the acceptability of receiving integrative therapy. I felt as though I had maintained a good balance between structure and fluidity, keeping within the sentiment of a semi-structured interview. The parents wanted to talk and freely discussed a wide range of experiences and a number of responses to each question from the topic guide. In this respect it was very easy to interview these participants as they were providing rich and detailed responses to each question. I felt a drive to provide a sense of therapeutic containment to these adoptive parents during times in which they discussed difficult experiences. I found this difficult to manage and I will speak with my supervisor about this to gather her experience of how to best respond to highly emotional responses to questions. I felt a need to paraphrase and feed back to the parents to demonstrate that they had been heard and to validate the difficulties they were discussing however this opened the risk of my responses to their answers then influencing their next comments. I tried to respond with “wow, thank you so much for sharing that” in an empathic tone for most of the time, however it was difficult to maintain this response when my therapeutic instincts were kicking in quite strongly.

**Appendix P**

*Ethical approval letter from University of Sheffield*

*Table

Description automatically generated with medium confidence*

**Appendix Q**

*Approval letters from Regional Adoption Agencies*

Approval letters from One Adoption South Yorkshire, One Adoption West Yorkshire, One Adoption North and Humber, and Adopt South who were funding the participants through therapy at the service.

**One Adoption South Yorkshire Approval Letter**

A picture containing graphical user interface

Description automatically generated

Dear Jack,

Thank you for sharing your proposal for your research project.

One Adoption South Yorkshire are happy to provide approval for your project to proceed.

We have allocated your project the following registration number:

* 21/22RP01 - Feasibility and Acceptability of integrating Theraplay®, DDP, and EMDR in an Independent Sector Trauma and Attachment Service for Adoptive Families

Please do not hesitate to contact me if I can be of any further assistance.

Yours sincerely,

A picture containing application

Description automatically generated

Stephanie Evans

Head of Service

OneAdoptionSouthYorkshire

**One Adoption West Yorkshire Approval Letter**

Dear Jack,

Thank you for sharing your proposal for your research project.

One Adoption West Yorkshire are happy to provide approval for your project to proceed.

We have allocated your project the following registration:

* Feasibility and Acceptability of integrating Theraplay®, DDP, and EMDR in an Independent Sector Trauma and Attachment Service for Adoptive Families

Please do not hesitate to contact me if I can be of any further assistance.

Yours sincerely,

Michelle Rawlings

Interim Head of Agency

One Adoption West Yorkshire

**One Adoption North and Humber Approval Letter**

Dear Jack,

Thank you for sharing your proposal for your research project.

I am able to confirm that from my perspective of the Teams for which I hold service manager responsibility (NYCC & York) One Adoption North and Humber, I happy to provide approval for your project to proceed. I have also liaised with Head of Service for OANH (Howard Lovelady) who agrees.

We have allocated your project the following registration:

* Feasibility and Acceptability of integrating Theraplay®, DDP, and EMDR in an Independent Sector Trauma and Attachment Service for Adoptive Families

I approve this request based on the knowledge that Jack will share his eventual findings and research paper with OANH.

Please do not hesitate to contact me if I can be of any further assistance.

Yours sincerely,

Tom Maxwell

Service Manager (NYCC & York Adoption Teams) OANH

**Adopt South Approval Letter**

*Graphical user interface, text, application, email

Description automatically generated*

**Appendix R**

*Therapist and Adoptive Parent Participant Information Sheets*

**Therapist Participant Information Sheet**

**Participant Information Sheet**

**Feasibility and Acceptability of Integrating Theraplay®, DDP, and EMDR in Therapy with Adoptive Families**

You are being invited to take part in a research project. Before you decide whether or not to participate, it is important for you to understand why the research is being completed and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

**What is the project’s purpose?**

The therapy provided at [SERVICE] Associates involves attributes of Theraplay®, Dyadic-Developmental Psychotherapy, and Eye Movement Desensitisation Reprocessing.

We are interested in understanding more about therapists’ experiences of integrating attributes of these three therapies within their family therapy sessions, with particular reference to how feasible and acceptable this experience is.

Following the completion of your therapy, we would like to find out your experiences relating to the amount of effort that was required to deliver this intervention, whether or not it was made clear to you why and how the intervention works, whether or not the intervention achieved its purpose, and how confident you felt in performing the behaviours required to deliver the intervention.

To obtain this information, we would like to interview you for between 60 to 90 minutes, following the completion of your therapeutic package.

The information provided will be written up into a piece of research and submitted towards the partial completion of the researcher’s (Jack Purrington) Doctorate in Clinical Psychologist qualification. The research will also be submitted to academic journals for publication.

**Why have I been chosen?**

You are being asked to take part as a therapist that is currently delivering therapy at Chrysalis Associates. Recruited participants will be delivering or will have recently delivered a package of therapy which integrates principles of Theraplay®, Dyadic-Developmental Psychotherapy, and Eye Movement Desensitisation Reprocessing. Adoptive parents who have accessed an integrative therapeutic package are also being recruited.

**Do I have to take part?**

You do not have to take part. It is up to you to decide whether or not you would like to take part. If you do decide to take part you will have this information sheet to keep (and will be asked to sign a consent form). Taking part is voluntary and you can withdraw from the study any time\* without any negative consequences. You do not have to give a reason. If you wish to withdraw from the research, please contact the researcher Jack Purrington.

\*Please note that there is a point at which it will not be possible for a participant’s data to be withdrawn from the research. This is once the data have been anonymised and included within a large dataset, this will commence on the 1st October 2021. Whilst you can withdraw from any on-going or future data collection, data cannot be removed from the study beyond this point.

**What will happen to me if I take part? What do I have to do?**

If you choose to take part, you should continue delivering therapy with Chrysalis Associates as normal. You will be contacted to engage in a onetime interview with the researcher, Jack Purrington. Interviews will last between 60-90 minutes. Following this interview your practical involvement in the study is over.

The interview will take place via a secure, online, video-based communication platform at a time convenient for you. The topics covered in the interview will include: how effective you felt the intervention was, how much the intervention made sense to you, how confident you felt that you could successfully deliver in the intervention, and how burdensome the intervention felt. The questioning style will be open with prompts to encourage in-depth exploration.

The information collected will contribute the providing insight into how acceptable the intervention is to deliver from a therapists perspective.

During the interview you are encouraged to speak openly and honestly about your true experience of the therapeutic intervention. You have the right to refuse to answer any interview question and to stop the interview at any point if you do not wish to continue, without any negative consequences.

Interviews will be audio recorded and then transcribed by the researcher, Jack Purrington, or hired transcribers recommended by the University of Sheffield.

The audio recordings of the interviews made during this research will be used only for analysis after they have been transcribed. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings

**What are the possible advantages and disadvantages of taking part?**

There are no reasonably foreseeable discomforts, disadvantages, or risks that need to be stated. If distress does arise during the interviews the interviewer (Jack Purrington) will assist you with contacting the most appropriate channel of support.

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will help to inform the current evidence base for therapeutic work with adoptive families. This will hopefully have a positive impact for many families accessing therapy in future.

**Will my taking part in this project be kept confidential?**

All the information that we collect about you during the course of the research will be kept strictly confidential and will only be accessible to members of the research team. **You will not be able to be identified in any reports or publications unless you have given your explicit consent for this.** If you agree to us sharing the information you provide with other researchers (e.g. by making it available in a data archive) then your personal details will not be included unless you explicitly request this.

Consent forms will be delivered by email in a password protected document. Passwords will be provided in a separate email. For the duration of the study consent forms will be stored securely on an online system.

Consent forms will be numbered, and this number will correspond with an anonymisation document which will provide each transcribed interview with a unique code. On the 1st October 2021 the anonymisation document will be deleted which will ‘delink’ your consent form and your interview, rendering all information anonymous.

When this research is written up for publication, pseudonyms will be allocated to any direct quotes you have provided which are being utilised in text.

**What is the legal basis for processing my personal data?**

According to data protection legislation, we are required to inform you that the legal basis we are applying in order to process your personal data is that ‘processing is necessary for the performance of a task carried out in the public interest (Article 6(1)(e)). Further information can be found in the University’s Privacy Notice <https://www.sheffield.ac.uk/govern/data-protection/privacy/general>.’

**What will happen to the data collected, and the results of the research project?**

Consent forms will be stored on the secure online system. The interview will be audio recorded. Following the completion of the interview, audio recordings will also be uploaded onto the secure online system provided by the University of Sheffield, recordings will then be deleted from the audio recording devices. Audio recordings will then be transcribed by the researcher (Jack Purrington) or hired transcribers recommended by the University of Sheffield. These transcriptions will also be stored on the secure online system. The only people in The University of Sheffield who will have regular access to personal information that identifies you (consent forms and audio recordings) will be the research team. A hired transcriber will have access to the audio clip, only. Finally, the transcriptions will be pseudonymised.

It is anticipated that the results of this research will be published in an academic journal. Following publication, you will be provided with information about where you can obtain a copy of the published results. You will not be identified in any report or publication.

When the study is completed, all files will be deleted from the online storage systems excluding the consent forms, raw data, and transcripts. The consent forms, raw data, and transcripts will be held for a minimum of 5 years. They will be securely disposed of after this time. Transcripts and outcome data will be placed in the University of Sheffield’s data repository: Online Research Data (ORDA), under an open license such as Creative Commons: (<https://creativecommons.org/licenses/>).

Due to the nature of this research it is very likely that other researchers may find the data collected to be useful in answering future research questions. We will ask for your explicit consent for your data to be shared in this way.

**Who is organising and funding the research?**

The research is being organised by the research team: Jack Purrington, Dr Shona Goodall, and Dr Jacqueline Lynch. The research is not being funded however The University of Sheffield is contributing a maximum of £600 for research costs such as transcribers.

**Who is the Data Controller?**

The University of Sheffield will act as the Data Controller for this study. This means that The University of Sheffield is responsible for looking after your information and using it properly.

**Who has ethically reviewed the project?**

This project has been ethically approved via the University of Sheffield’s Ethics Review Procedure, as administered by The Clinical Psychology department.

**What if something goes wrong and I wish to complain about the research?**

If concerns are raised regarding the practice of the service, the interviewer (Jack Purrington) will follow the service’s complaints procedure and support and advise you to bring this concern up with a member of the service’s senior leadership team. If concerns are raised relating to safeguarding the researcher will notify the board of directors at the service, the local authority in which you reside, the service’s safeguarding lead, and follow the service’s safeguarding procedure.

If participants wish to make a complaint about their experiences of the research project, they should contact the Principle Investigator (Jack Purrington) or the project supervisor (Dr Shona Goodall). If you feel your complaint has not been handled to your satisfaction you can contact the Head of Department (Elizabeth Milne) who will escalate the complaint through the appropriate channels.

If the complaint relates to how your personal data has been handled, you can contact The University of Sheffield Data Protection Officer [dataprotection@sheffield.ac.uk](mailto:dataprotection@sheffield.ac.uk). Further information about how to raise a complaint can be found in the University’s Privacy Notice: <https://www.sheffield.ac.uk/govern/data-protection/privacy/general>.

If you feel your complaint has not been handled to your satisfaction, they can contact the Information Commissioner’s Office.

**Contact for further information**

**Project Supervisor**

Dr Shona Goodall

[s.goodall@sheffield.ac.uk](mailto:s.goodall@sheffield.ac.uk)

Clinical Psychology Unit

The University of Sheffield

Cathedral Court,

1 Vicar Lane,

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S1 2LT.

**Principal Investigator / Lead Researcher**

Jack Purrington

[jpurrington1@sheffield.ac.uk](mailto:jpurrington1@sheffield.ac.uk)

Clinical Psychology Unit

The University of Sheffield

Cathedral Court,

1 Vicar Lane,

Sheffield,

S1 2LT.

**Clinical Liaison Supervisor**

Dr Jacqueline Lynch

[jacqueline.lynch@chrysalisassociates.org](mailto:jacqueline.lynch@chrysalisassociates.org)

Chrysalis Associates

48 Wostenholm Road,

Sheffield,

S7 1LL

**Adoptive Parent Information Sheet**

**Participant Information Sheet**

**Feasibility and Acceptability of Integrating Principles of Theraplay®, Dyadic-Developmental Psychotherapy, and Eye Movement Desensitisation Reprocessing in Therapy with Adoptive Families**

You are being invited to take part in a research project. Before you decide whether or not to participate, it is important for you to understand why the research is being completed and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

**What is the project’s purpose?**

The therapy provided at Chrysalis Associates involves attributes of Theraplay®, Dyadic-Developmental Psychotherapy, and Eye Movement Desensitisation Reprocessing.

We are interested in understanding more about parent’s experiences of having these three therapies integrated within their family therapy sessions, with particular reference to how feasible and acceptable this experience is.

Following the completion of your therapy, we would like to find out your experiences relating to the amount of effort that was required to participate in the intervention, whether or not it was made clear to you why and how the intervention works, whether or not the intervention achieved its purpose, and how confident you felt in performing the behaviours required to participate in the intervention.

To obtain this information, we would like to interview you for between 45 and 75 minutes, following the completion of your therapeutic package.

The information provided will be written up into a piece of research and submitted towards the partial completion of the researcher’s (Jack Purrington) Doctorate in Clinical Psychology qualification. The research will also be submitted to academic journals for publication.

**Why have I been chosen?**

You are being asked to take part as an parent or couple within an adoptive family that is currently accessing therapy at Chrysalis Associates. You have received a package of therapy which integrated principles of Theraplay®, Dyadic-Developmental Psychotherapy, and Eye Movement Desensitisation Reprocessing. Therapists who have delivered an integrative therapeutic package are also being recruited.

**Do I have to take part?**

You do not have to take part. It is up to you to decide whether or not you would like to take part. If you do decide to take part you will have this information sheet to keep (and will be asked to sign a consent form). Taking part is voluntary and you can withdraw from the study any time\* without any negative consequences. You do not have to give a reason. If you wish to withdraw from the research, please contact the researcher Jack Purrington.

\*Please note that there is a point at which it will not be possible for a participant’s data to be withdrawn from the research. This is once the data have been anonymised and included within a large dataset, this will commence on the 1st December 2021. Whilst you can withdraw from any on-going or future data collection, data cannot be removed from the study beyond this point.

**What will happen to me if I take part? What do I have to do?**

If you choose to take part, you should engage in your therapeutic package with Chrysalis Assocaites as normal. Following the completion of this package of therapy you will be contacted to engage in a onetime interview with the researcher, Jack Purrington. Interviews will last between 45-75 minutes. Following this interview your practical involvement in the study is over. You will also be asked for your consent for the researcher, Jack Purrington, to have access to your outcome data (results from pre-therapy and post-therapy assessment measures and questionnaires) to be utilised to help inform the study.

The interview will take place via a secure, online, video-based communication platform at a time convenient for you. The topics covered in the interview will include: attendance rates, how effective you felt the intervention was, how much the intervention made sense to you, how confident you felt that you could successfully participant in the intervention, and how burdensome the intervention felt. Questions regarding attendance will be largely closed questions requiring shorted responses, whereas the questioning style for all other topics will be open questions with prompts to encourage in-depth exploration.

Information on attendance rates will be collected to inform how feasible the intervention is, information from all other topics will contribute the providing insight into how acceptable the intervention is, and outcome data will be reviewed to help inform the interpretation of the information collected.

During the interview you are encouraged to speak openly and honestly about your true experience of the therapeutic intervention. You have the right to refuse to answer any interview question and to stop the interview at any point if you do not wish to continue, without any negative consequences.

Interviews will be audio recorded and then transcribed by the researcher, Jack Purrington, or hired transcribers recommended by the University of Sheffield.

The audio recordings of the interviews made during this research will be used only for analysis after they have been transcribed. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings

**What are the possible advantages and disadvantages of taking part?**

There are no reasonably foreseeable discomforts, disadvantages, or risks that need to be stated. If distress does arise during the interviews the interviewer (Jack Purrington) will assist you with contacting the most appropriate channel of support.

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will help to inform the current evidence base for therapeutic work with adoptive families. This will hopefully have a positive impact for many families accessing therapy in future.

**Will my taking part in this project be kept confidential?**

All the information that we collect about you during the course of the research will be kept strictly confidential and will only be accessible to members of the research team. **You will not be able to be identified in any reports or publications unless you have given your explicit consent for this.** If you agree to us sharing the information you provide with other researchers (e.g. by making it available in a data archive) then your personal details will not be included unless you explicitly request this.

Consent forms will be delivered by email in a password protected document. Passwords will be provided in a separate email. For the duration of the study consent forms will be stored securely on an online system.

Consent forms will be numbered, and this number will correspond with an anonymisation document which will provide each transcribed interview with a unique code. On the 1st December 2021 the anonymisation document will be deleted which will ‘delink’ your consent form and your interview, rendering all information anonymous.

When this research is written up for publication, pseudonyms will be allocated to any direct quotes you have provided which are being utilised in text.

**What is the legal basis for processing my personal data?**

According to data protection legislation, we are required to inform you that the legal basis we are applying in order to process your personal data is that ‘processing is necessary for the performance of a task carried out in the public interest (Article 6(1)(e)). Further information can be found in the University’s Privacy Notice <https://www.sheffield.ac.uk/govern/data-protection/privacy/general>.’

**What will happen to the data collected, and the results of the research project?**

Consent forms will be stored on the secure online system. The interview will be audio recorded. Following the completion of the interview, audio recordings will also be uploaded onto the secure online system provided by the University of Sheffield, recordings will then be deleted from the audio recording devices. Audio recordings will then be transcribed by the researcher (Jack Purrington) or hired transcribers recommended by the University of Sheffield. These transcriptions will also be stored on the secure online system. The only people in The University of Sheffield who will have regular access to personal information that identifies you (consent forms and audio recordings) will be the research team. A hired transcriber will have access to the audio clip, only. Finally, the transcriptions will be pseudonymised.

It is anticipated that the results of this research will be published in an academic journal. Following publication, you will be provided with information about where you can obtain a copy of the published results. You will not be identified in any report or publication.

When the study is completed, all files will be deleted from the online storage systems excluding the consent forms, raw data, and transcripts. The consent forms, raw data, and transcripts will be held for a minimum of 5 years. They will be securely disposed of after this time. Transcripts and outcome data will be placed in the University of Sheffield’s data repository: Online Research Data (ORDA), under an open license such as Creative Commons: (<https://creativecommons.org/licenses/>).

Due to the nature of this research it is very likely that other researchers may find the data collected to be useful in answering future research questions. We will ask for your explicit consent for your data to be shared in this way.

**Who is organising and funding the research?**

The research is being organised by the research team: Jack Purrington, Dr Shona Goodall, and Dr Jacqueline Lynch. The research is not being funded however The University of Sheffield is contributing a maximum of £600 for research costs such as transcribers.

**Who is the Data Controller?**

The University of Sheffield will act as the Data Controller for this study. This means that The University of Sheffield is responsible for looking after your information and using it properly.

**Who has ethically reviewed the project?**

This project has been ethically approved via the University of Sheffield’s Ethics Review Procedure, as administered by The Clinical Psychology department.

**What if something goes wrong and I wish to complain about the research?**

If concerns are raised regarding the practice of the service, the interviewer (Jack Purrington) will follow the service’s complaints procedure and support and advise you to bring this concern up with a member of the service’s senior leadership team. If concerns are raised relating to safeguarding the researcher will notify the board of directors at the service, the local authority in which you reside, the service’s safeguarding lead, and follow the service’s safeguarding procedure.

If participants wish to make a complaint about their experiences of the research project, they should contact the Principle Investigator (Jack Purrington) or the project supervisor (Dr Shona Goodall). If you feel your complaint has not been handled to your satisfaction you can contact the Head of Department (Elizabeth Milne) who will escalate the complaint through the appropriate channels.

If the complaint relates to how your personal data has been handled, you can contact The University of Sheffield Data Protection Officer [dataprotection@sheffield.ac.uk](mailto:dataprotection@sheffield.ac.uk). Further information about how to raise a complaint can be found in the University’s Privacy Notice: <https://www.sheffield.ac.uk/govern/data-protection/privacy/general>.

If you feel your complaint has not been handled to your satisfaction, they can contact the Information Commissioner’s Office.

**Contact for further information**

**Project Supervisor**

Dr Shona Goodall

[s.goodall@sheffield.ac.uk](mailto:s.goodall@sheffield.ac.uk)

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**Principal Investigator / Lead Researcher**

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**Clinical Liaison Supervisor**

Dr Jacqueline Lynch

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Chrysalis Associates

48 Wostenholm Road,

Sheffield,

S7 1LL

**Appendix S**

*Consent Form*

**Acceptability of Integrating Principles of Theraplay®, DDP, and EMDR in Therapy with Adoptive Families**

|  |  |  |
| --- | --- | --- |
| ***Please read each item carefully and then complete the consent form on the secure survey link provided to you.*** | **Yes** | **No** |
| **Taking Part in the Project** |  |  |
| I have read and understood the project information sheet and the project has been fully explained to me. (If you will answer No to this question please do not proceed with this consent form until you are fully aware of what your participation in the project will mean.) |  |  |
| I have been given the opportunity to ask questions about the project. |  |  |
| I agree to take part in the project. I understand that taking part in the project will include providing consent for the researcher to contact me for interview following my sessions with Chrysalis Associates. |  |  |
| I agree to take part in the project. I understand that taking part in the project will include being interviewed following the completion of my therapy with Chrysalis Associates. By ticking this box, I consent to being interviewed and for my interview to be recorded so it can be transcribed by the researcher or a hired transcriber. |  |  |
| I understand that my taking part is voluntary and that I can withdraw from the study at any time prior to the 1st December 2021, which is when the project will start being written up. After this date I understand that I will no longer be able to withdraw my information from being utilised within this study. I do not have to give any reasons for why I no longer want to take part and there will be no adverse consequences if I choose to withdraw. |  |  |
| **How my information will be used during and after the project** |  |  |
| I understand my personal details such as name, phone number, address and email address etc. will not be revealed to people outside the project. |  |  |
| I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs unless I specifically request this. |  |  |
| I understand and agree that other authorised researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form. |  |  |
| I understand and agree that other authorised researchers may use my data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form. I understand that anonymised versions of my data will be available upon request. |  |  |
| I give permission for the information that I provide to be deposited in The University of Sheffield’s data repository so it can be used for future research and learning and accessed by those who require it. |  |  |
| **So that the information you provide can be used legally by the researchers** |  |  |
| I agree to assign the copyright I hold in any materials generated as part of this project to The University of Sheffield. |  |  |

**Name of Participant [Printed]: Signature: Date:**

**Name of Researcher [Printed]: Signature: Date:**

**Project contact details:**

**Project Supervisor**

Dr Shona Goodall

[s.goodall@sheffield.ac.uk](mailto:s.goodall@sheffield.ac.uk)

Clinical Psychology Unit

The University of Sheffield

Cathedral Court,

1 Vicar Lane,

Sheffield,

S1 2LT.

**Principal Investigator /   
Lead Researcher**

Jack Purrington

[jpurrington1@sheffield.ac.uk](mailto:jpurrington1@sheffield.ac.uk)

Clinical Psychology Unit

The University of Sheffield

Cathedral Court,

1 Vicar Lane,

Sheffield,

S1 2LT.

**Clinical Liaison Supervisor**

Dr Jacqueline Lynch

[jacqueline.lynch@chrysalisassociates.org](mailto:jacqueline.lynch@chrysalisassociates.org)

Chrysalis Associates

48 Wostenholm Road,

Sheffield,

S7 1LL

**External Contact –**Should you wish to make a

complaint you can contact:

Prof. Elizabeth Milne

e.milne@sheffield.ac.uk

Clinical Psychology Unit

The University of Sheffield

Cathedral Court,

1 Vicar Lane,

Sheffield, S1 2LT

**What if I wish to complain about the way the study has been carried out?**

If you would like to make a complaint about this project, in the first instance you should contact the

lead researcher. If you do not feel satisfied that your complaint has been dealt with appropriately you can contact the lead researcher’s supervisor, If you feel that your complaint has not been handled to your satisfaction following this, you can contact. Prof Elizabeth Milne, Head of Department at [e.milne@sheffield.ac.uk](mailto:e.milne@sheffield.ac.uk) or Dr. Robert Schmidt or Dr Jilly Gibson-Miller, joint chairs of the Department Ethics Subcommittee on [jilly.gibson@sheffield.ac.uk](mailto:jilly.gibson@sheffield.ac.uk) and [robert.schmidt@sheffield.ac.uk](mailto:robert.schmidt@sheffield.ac.uk)

**Contact Information**  
This research is being conducted by Jack Purrington, Trainee Clinical Psychologist. This research will be used to write a thesis which fulfils part of their doctoral training. If you have any questions about the research, you can email the Research Officer [a.sinha@sheffield.ac.uk](mailto:a.sinha@sheffield.ac.uk)

**Appendix T**

*Alternative presentation of therapist and adoptive parent’s thematic results*

**Therapist Thematic Result**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Participant* | *Successful and Precarious* | | *Clarity and Ambiguity* | | *Self-Assurance and Apprehension* | | *Easier and More Challenging* | |
| *Successful* | *Precarious* | *Clarity* | *Ambiguity* | *Self-Assurance* | *Apprehension* | *Easier* | *More Challenging* |
| *P1* | ✔ | ✔ | ✔ |  | ✔ | ✔ | ✔ | ✔ |
| *P2* | ✔ | ✔ | ✔ |  | ✔ |  | ✔ |  |
| *P3* | ✔ | ✔ | ✔ |  | ✔ | ✔ | ✔ | ✔ |
| *P4* | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| *P5* | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| *P6* | ✔ | ✔ | ✔ |  | ✔ | ✔ | ✔ | ✔ |
| *P7* | ✔ |  | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| *P8* | ✔ |  | ✔ | ✔ | ✔ |  | ✔ | ✔ |
| *P9* | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |

**Adoptive Parent Thematic Results**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Participant* | *Impactful and Imperfect* | | *Clear and*  *Confusing* | | *Finding Comfort*  *in Discomfort* | | *Burdensome and Worthwhile* | |
| *Impactful* | *Imperfect* | *Clear* | *Confusing* | *Finding Comfort* | *In Discomfort* | *Burdensome* | *Worthwhile* |
| *P10* | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| *P11* | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |  |
| *P12* | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| *P13* | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| *P14* | ✔ | ✔ | ✔ |  | ✔ | ✔ | ✔ | ✔ |
| *P15* | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |  |
| *P16* | ✔ | ✔ | ✔ |  | ✔ | ✔ | ✔ | ✔ |
| *P17* | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |

**Appendix U**

*Diagrammatic presentation of interactions between themes in therapist and adoptive parent dataset*

**Interactions Between Themes in Therapist Dataset**

Successful & Precarious

Experiences of successful therapy (or lack of)

Management of Flexibility

Self-Belief, Courage, and Confidence (or lack of)

Self-Assurance & Apprehension

Easier &  
More Challenging

Belief that these therapies naturally fit together vs Uncertainty relating to how to fit them together

Knowledge, Experience, and Supervision (or lack of)

Clarity & Ambiguity

**Interactions Between Themes in Adoptive Parent Dataset**

Finding therapy useful (or not)

Impactful & Imperfect

Burdensome & Worthwhile

Clear &  
Confusing

Finding Comfort in Discomfort

Having an effective parenting session (or not)

Having an effective parenting session (or not)

Adjustment to ambiguity (or lack of)

Higher comfort less burden vs  
Lower comfort more burden

**Appendix V**

*Application of Quality Appraisal Checklists*

**Standards for Reporting Qualitative Researcha (O’Brien et al., 2014)**

|  |  |  |  |
| --- | --- | --- | --- |
| **No.** | **Topic** | **Item** | **Evidenced** |
|  | **Title and Abstract** | | |
| S1 | Title | Concise description of the nature and topic of the study identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interviews, focus group) is recommended | Page 94 |
| S2 | Abstract | Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions | Page 95 |
|  | **Introduction** | | |
| S3 | Problem formulation | Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement | Page 97-99 |
| S4 | Purpose or research question | Purpose of the study and specific objectives or questions | Page 99 |
|  | **Methods** | | |
| S5 | Qualitative approach and research paradigm | Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationaleb | Page 99-100 |
| S6 | Researcher characteristics and reflexivity | Researchers’ characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers’ characteristics and the research questions, approach, methods, results, and/or transferability | Page 108-109 |
| S7 | Context | Setting/site and salient contextual factors; rationaleb | Page 100-101 |
| S8 | Sampling strategy | How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationaleb | Page 102-103 |
| S9 | Ethical issues pertaining to human subjects | Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues | Page 109-111 |
| S10 | Data collection methods | Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationaleb | Page 106 |
| S11 | Data collection, instruments, and technologies | Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study | Page 106 |
| S12 | Units of study | Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results) | Page 103-104 & Table 2&3 |
| S13 | Data processing | Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/deidentification of excerpts | Page 106-108 |
| S14 | Data analysis | Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationaleb | Page 108 |
| S15 | Techniques to enhance trustworthiness | Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationaleb | Page 109 |
|  | **Results/Findings** | | |
| S16 | Synthesis and interpretation | Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory | Page 112 & 117-118 |
| S17 | Links to empirical data | Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings | Page 111-121 |
|  | **Discussion** | | |
| S18 | Integration with prior work, implications, transferability, and contribution(s) to the field | Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/ generalizability; identification of unique contribution(s) to scholarship in a discipline or field | Page 121-127 |
| S19 | Limitations | Trustworthiness and limitations of findings | Page 125-126 |
|  | **Other** | | |
| S20 | Conflicts of interest | Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed | Page 108-109 |
| S21 | Funding | Sources of funding and other support; role of funders in data collection, interpretation, and reporting | Page 110 |

aThe authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

bThe rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

**Consolidated Criteria for Reporting Qualitative Studies (Tong et al., 2007)**

|  |  |  |  |
| --- | --- | --- | --- |
| **No.** | **Item** | **Guide question/description** | **Evidenced** |
|  | **Domain 1: Research team and reflexivity** | | |
| Personal Characteristics | | | |
| 1. | Interview/facilitator | Which author/s conducted the interview or focus group? | Page 106 |
| 2. | Credentials | What were the researcher’s credentials? *E.g. PhD, MD* | Page 108-109 |
| 3. | Occupation | What was their occupation at the time of the study? | Page 108-109 |
| 4. | Gender | Was the researcher male or female? | Page 108-109 |
| 5. | Experience and training | What experience or training did the researcher have? | Page 108-109 |
| Relationships with Participants | | | |
| 6. | Relationship established | Was a relationship established prior to study commencement? | Page 108 |
| 7. | Participant knowledge of interviewer | What did the participants know about the researcher? *E.g. personal goals, reasons for doing the research* | Page 104 |
| 8. | Interviewer characteristics | What characteristics were reported about the interviewer/facilitator? *E.g. bias, assumptions, reasons and interests in the research topic* | Page 104 & 108-109 |
|  | **Domain 2: Study design** | | |
| Theoretical Framework | | | |
| 9. | Methodological orientation and theory | What methodological orientation was stated to underpin the study? *E.g., grounded theory, discourse analysis, ethnography, phenomenology, content analysis* | Page 99-100 |
| Participant selection | | | |
| 10. | Sampling | How were participants selected? *E.g. purposive, convenience, consecutive, snowball* | Page 102-103 |
| 11. | Method of approach | How were participants approaches? *E.g. face-to-face, telephone, mail, email* | Page 102-103 |
| 12. | Sample size | How many participants were in the study? | Page 103-105 |
| 13. | Non-participation | How many people refused to participate or dropped out? Reasons? | Page 103 |
| Setting | | | |
| 14. | Setting of data collection | Where was the data collected? *E.g. home, clinic, workplace* | Page 106 |
| 15. | Presence of non-participants | Was anyone else present besides the participants and researchers? | Page 106 |
| 16. | Description of sample | What are the important characteristics of the sample? *E.g. demographic data, date* | Page 104-105 |
| Data Collection | | | |
| 17. | Interview guide | Were questions, prompts, guides provided by the authors? Was it pilot tested? | Page 106 |
| 18. | Repeat interviews | Were repeat interviews carried out? If yes, how many? | N/A |
| 19. | Audio/visual recording | Did the research use audio or visual recording to collect the data? | Page 106 |
| 20. | Field notes | Were field notes or logs made during and / or after the interview or focus group? | Page 108 |
| 21. | Duration | What was the duration of the interviews or focus group? | Page 106 |
| 22. | Data saturation | Was data saturation discussed? | Page 103-104 |
| 23. | Transcripts returned | Were transcripts returned to participants for comment and/or correction? | Page 109 |
|  | **Domain 3: Analysis and findings** | | |
| Data analysis | | | |
| 24. | Number of data coders | How many data coders coded the data? | Page 107-108 |
| 25. | Description of the coding tree | Did authors provide a description of the coding tree? | Appendix E |
| 26. | Derivation of themes | Were themes identified in advance or derived from the data? | Page 100 & 107-108, & |
| 27. | Software | What software, if applicable, was used to manage the data? | Page 108 |
| 28. | Participant checking | Did participants provide feedback on the findings? | Page 109 |
| Reporting | | | |
| 29. | Quotations presented | Were participants quotations presented to illustrate the themes / findings? Was quotation identified? *E.g. participant number* | Page 111-121 |
| 30. | Data and findings consistent | Was there consistency between the data presented and the findings? | Page 111-121 |
| 31. | Clarity of major themes | Were major themes clearly presented in the findings? | Page 112 & 117-118 |
| 32. | Clarity of minor themes | Is there a description of diverse cases or discussion of minor themes? | Page 111-128 |

**Critical Appraisal Skills Program Qualitative Checklist (CASP, 2018)**

|  |  |  |
| --- | --- | --- |
| **Item** | **Response** | **Comments** |
| **Section A: Are the results valid?** | | |
| 1. Was there a clear statement of the aims of the research? | Yes | Page 99 |
| 2. Is a qualitative methodology appropriate? | Yes | Page 99-100 |
| 3. Was the research design appropriate to address the aims of the research? | Yes | Page 99-100 |
| 4. Was the recruitment strategy appropriate to the aims of the research? | Yes | Page 100-103 |
| 5. Was the data collected in a way that addressed the research issue? | Yes | Page 106 |
| 6. Has the relationship between research and participants been adequately considered? | Yes | Page 108-109 |
| **Section B: What are the results?** | | |
| 7. Have ethical issues been taken into consideration? | Yes | Page 109-110 |
| 8. Was the data analysis sufficiently rigorous | Yes | Page 107-108 |
| 9. Is there a clear statement of findings? | Yes | Page 112, 117-118, & 121-122 |
| **Section C: Will the results help locally?** | | |
| 10. How valuable is the research? | | Page 121-128 |