DOCTORAL THESIS

Knowing Me, Knowing You

Exploring the role of parental sensitivity and mentalization in relationships where adoptive children display aggression and violence and evaluating the impact of a parenting program to support these families.

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Knowing Me, Knowing You:

Exploring the role of parental sensitivity and mentalization in relationships where adoptive children display aggression and violence and evaluating the impact of a parenting program to support these families.

by

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Abstract

Adoptive families often report aggressive behaviour and violence exhibited by some of the children. Using a mixed method methodology, this thesis focuses on a promising novel group parenting intervention for adoptive families who experience violence and aggression from their children and uses theories of Attachment, Parental Sensitivity and Mentalizing to explore the data.

Participants were 35 adults with 53 adoptive children aged 4-12 years old referred to the program by adoption support services. The first two studies examined quantitative changes in parental sensitivity, parental reflective functioning, parental stress, parent child relationship and child behaviours both around the intervention and in the longer term. These are then followed by three qualitative studies: The third study used a single case study design to examine the process of change for one participant. The fourth study used Reflexive Thematic Analysis to explore participant's experience of the intervention. The final study used Interpretive Phenomenological Analysis to explore the experience of adoptive fathers whose children display aggression and violence.

Findings showed a significant improvement in parental sensitivity and reflective functioning and a significant reduction in parental stress after the intervention. The quality of the parent-child relationship was also significantly improved, however the findings around child behaviours were more mixed with some improvements not reaching statistical significance. Qualitative findings showed positive change attributed to the intervention, illustrated the process of change for one participant, showed the positive experience of intervention participants plus brought deeper understanding to the under researched area of adoptive fatherhood where children display aggression and violence.

Collectively the findings build on previous understanding of the relationship between parental sensitivity, parental reflective functioning, parental stress and displays of child behaviours while also filling gaps of knowledge around the experiences of this population group plus interventions to support them. These findings have important implications for adoptive families and professionals working with them, especially where there is display of violence and aggression from the children.

List of Publications

Barrow, V., Grey, B., & Essau, C. A. (2022). “I am not exaggerating, literally a monster … a Jekyll and Hyde type thing”: Understanding the lived experience of adoptive fathers whose children display violence and aggression. *Human Systems: Therapy, Culture and Attachments, 3*(1), 300-50.

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Introduction

Aggression and violence are some of the most frequently cited issues by adoptive families seeking support. Over the last few years surveys of adoptive parents show that between 57% and 65% have experience violence and aggression from their children in the previous 12 months (Adoption UK, 2022, 2023). Certain levels of human aggression are necessary for survival and functioning in society but too much or too little can be detrimental (Waltes, 2016). The development of non-normative aggression can have many causes, and roots of maladaptive aggression are often in early experience of maltreatment, adversity, trauma plus environment as well as other parental factors (Jaffe et al., 2012; Latimer et al., 2012; Tuvblad & Baker, 2011). While these factors can contribute to the development of aggression and violence studies show that parental sensitivity can moderate and help regulate extreme fear or anger responses in young children (Braungart-Rieker & Hill-Soderlund, 2010).

Adopted children often have complex histories, with abuse, neglect and frequent moves in their history and will have adapted to survive their early care giving environment (Landa & Duschinsky, 2013), and while they will also adapt to their new care giving environment some of the old patterns will remain. Attachment theory and the theory of mentalizing bring insights to the landscape of aggression and violence in adoptive families, and studies have found that responsive, child-centred parenting mitigates the risks caused by early adversity (Kriebel & Wentzerl, 2011). These theories will be explored in more depth in the following chapters.

This current thesis explores both qualitative and quantitative data around a group parenting course specifically designed for adoptive parents whose children display

aggression and violence. Both the study and the course are grounded in attachment theory and theories around parental sensitivity and mentalizing.

Attachment was initially developed in the work of John Bowlby and seeks to explain the affective bond between infant and caregiver that provided safety and support for the child's development (Bowlby, 1973 & 1988). Bowlby's early work was built on by Mary Ainsworth, who differentiated the differences in individuals' attachment defining them as insecure-avoidant – A, Balanced – B and insecure-ambivalent/resistant-C (Ainsworth et al., 1978). Then two of students of Ainsworth went on to expand on her categories and develop further categories and assessment methods that to cover the lifespan and a range of differing human functioning. These models have become known as the ABC+D model (Main & Solomon, 1986) (also known as the Berkeley model, Baldoni et al., 2018) and the Dynamic Maturational Model (Crittenden, 2016; Holmes & Farnfield, 2014).

Coming out of the development of attachment theory there are several key concepts that are critical to this current thesis. Parental sensitivity was first developed as a concept by Ainsworth (Ainsworth, et al., 1974), though originally called 'maternal sensitivity', put simply it refers to the parent's ability to read and appropriately respond to their children's signals in a timely manner. This sensitivity, or how parents act with their child was found to be linked, though weakly, to the transmission of attachment (van IJzendoorn, 2005). Another factor considered to be part of how attachment is transmitted is the parents mental construct around the child, how they think about their child especially around danger and comfort (Crittenden, 2016; Grienenberger, Kelly, & Slade; 2005; Slade, 2005). Researchers started to examine how parents thought and felt about their child and the attachment signals that they were displaying (Grey & Farnfield, 2017b), and so the theory of mentalizing was

developed in the work of Peter Fonagy and colleagues. Simply put mentalizing is the ability to understand oneself as a having a weave of thoughts, feelings, motivations, and desires that drive our behaviour and that others also have their own separate and different complex weave (Fonagy et al., 2018). Beneficial mentalizing is seen as being essential to successfully navigate social interactions (Fonagy & Target, 1998) and parental mentalizing impacts, and is influential in the development of attachment security (Fonagy et al., 2016; Meins, 1999, 2013; Meins et al., 2012; Slade et al., 2005). A key part of parental mentalizing is parental reflective functioning and this is seen as the mentalizing being made explicit and overt (Slade, 2005) and parental reflective functioning is the parent's ability to reflect on and consider their child's mental states and internal world (Slade et al., 2005).

Research around adoptive families is often lacking in rigour. Some of the most popular interventions would seem to have little or no research basis and others that have been researched lack control groups or longitudinal data (Selwyn, 2017b). There is also a paucity of research into interventions that impact CPV amongst adoptive families and to date there appears to be no quantitative studies into the effectiveness of Non-violent resistance (NVR: the most popular intervention for CPV) amongst this population group. This current study around an intervention specifically designed for this population group aims to address some of the gaps within research and issues around methodology and rigour.

Another area that research seems to have neglected is that of adoptive fatherhood, with the majority of research focussing on the mother-child relationship which at times leaves these fathers invisible (Siegel, 2014; George and Solomon, 2008), thus ignoring an essential part of many family systems and losing the voice of these fathers. With this in mind this thesis includes a specific qualitative study into the

experience of adoptive fathers which particularly highlights when circumstances cause a self-defence response from the fathers that not only blocks the experience of pain within the father-child relationship but also blocks experience of pleasure, this kind of response has come to be known as blocked care (Baylin & Hughes, 2016). Blocked care, particularly in adoptive fathers, is little researched and became an area of special interest to the researcher after observing the phenomenon multiple times within clinical practice.

This study aims to add to knowledge and literature around adoption, child to parent violence and aggression, parental reflective functioning, parental sensitivity and adoptive fatherhood using different aspects of the data collected around the Knowing Me, Knowing You program which was especially developed for adoptive parents. First, quantitative data is used to explore whether the intervention has been able to impact participants' reflective functioning, parental sensitivity, parental stress levels as well as their construct around their relationship with their child and the child's behaviours. Then a qualitative approach is taken to further understand any changes seen, the experience of participants on the course, and to explore the experience of adoptive fathers whose children display aggressive and violent behaviour.

Assessing change in sensitivity and mentalizing in adoptive parents.

While there is a range of literature and studies exploring changes in parental reflective functioning, and parental sensitivity, for babies and toddlers there would appear little or no literature looking in to changes in parental sensitivity brought by interventions aimed at school age children and above. One of the measures of parental sensitivity is the Meaning of the Child Interview (MotC: Grey & Farnfield, 2017a) a method of analysing parenting interviews such as the Parental Development Interview used within this study. The Meaning of the Child interview

(MotC), in the 10 years since its' original validation Study (Grey, 2014; Grey & Farnfield, 2017a) has been used in research, clinical and forensic practice and once as a part of an intervention itself (Smith et al., 2018), the only time it has been used as a measure around an intervention is this study author's own Master of Science thesis (Barrow, 2019, although other studies are in progress). There are also gaps in literature around group interventions that impact reflective functioning of adopters. While there are interventions for families experiencing aggression and violence, these are not explicitly designed for adoptive families, while this current study is centred on a novel intervention designed specifically for this group.

As already stated, many of these families struggle with their child's aggression and violence, so research into interventions that may help, plus research that deepens the understanding of these families is essential.

As can be seen this current study contributes and fills in some missing pieces to several key areas including parental sensitivity and parental reflective functioning amongst adopters, plus interventions that help where aggression and violence is being shown by adoptive children, it also adds to understanding about the complexities of these adoptive parents' experience, particularly the under researched area of adoptive fatherhood.

Epistemology, Ontology and Reflexivity

This is a mixed methods study which combines an ontologically realist stance with an epistemologically critical realist position where, as Lakoff (1987) puts it:

> 'Scientific realism,... assumes that "the world is the way it is," while acknowledging that there can be more than one scientifically correct way of

> understanding reality in terms of conceptual schemes with different objects and categories of objects' (Lakoff, 1987, p. 265)

Personally, I believe that our understanding of reality is shaped by our own context and experience, and use of language both reflects and informs our understanding, plus that any intervention and research should be concerned both with the person and their context.

As such different methodologies are utilized in the 5 studies that make up this thesis with a view of finding different ways of understanding that build knowledge around the area of investigation.

My own interest in the area came from my personal experience as a mother to adopted children, who came at older age and at times displayed aggression and violence. This personal experience combined with years of training and practice as a play therapist and then psychotherapist plus discovering this to be an under researched area led me to the development of the Knowing Me, Knowing You program and the research questions below.

Research Questions

The aim of this thesis is to explore and answer the following questions:

- Can a parenting group for adoptive parents whose children display aggression and violence improve parental mentalization and caregiving, reduce stress and positively impact the parent-child relationship and child behaviour?
- What can be learned from studying the group about the role of parental sensitivity and mentalizing in the experience of parenting an adoptive child who displays aggression and violence?

Methodology

This thesis uses data around the Knowing Me, Knowing You program to address the research questions through 5 different studies employing varying qualitative and quantitative methodologies, 2 quantitative studies measuring change; a case study looking at the process of change in a specific participant; a reflexive thematic analysis explores the participants experience of the group intervention; and finally an Interpretive Phenomenological Analysis looks at adoptive fathers' experience of their child's aggression and violence.

More details of individual methodology are given at the beginning of each study.

Measures used within this study include:

- The Parent Development Interview (PDI; Aber et al., 1985) a 38 question semi-structured interview.
- The Meaning of the Child Coding of the PDI (MotC; Grey, 2014) which measures parental sensitivity through exploring parental narratives and scripts.
- The Parental Reflective Functioning scale (PDI-RF; Slade et al, 2004) coding for the PDI that measures the parents reflective functioning.
- The Parental Stress Scale (PSS; Berry& Jones, 1995).
- The Carer Questionnaire (also known as The Thinking about your child questionnaire) (CQ: Gurney-Smith 2017) which measures areas including the parents' confidence and levels of reward within the parent child relationship.

- The Brief Assessment Checklist for children (BAC-C: Tarren-Sweeney, 2013) a behavioural measure specially designed for children who have been through trauma.
- The Goodman Strength and Difficulty Questionnaire (SDQ; Goodman, 2001) a widely used questionnaire that measured behavioural, emotional, peer and hyperactivity difficulties plus pro social behaviour.

Findings

This study found that, as hypothesised, both the parental sensitivity as measured by the MotC coding and the Parental Reflective Functioning as measured by the PDI-RF coding were significantly increased by the intervention as compared to the SAU control group. Stress levels in the parents also significantly decreased. The Carer Questionnaire total score, plus Parental Skills and Understanding, Parent Child Relationship and Child Responsiveness to care also significantly increased, however Placement Stability did not.

Results from the child behaviour scores were more mixed with a significant reduction in behaviours as measure by the BAC-C but not in majority of aspects measured by the SDQ.

Longitudinal results were limited by extreme small scale of the study but on in-depth examination there were strong signs that the benefits of the course increased over time.

Qualitative results were able to explore the changes in reflective functioning and language a single participant showed and were able to attribute this to the

intervention rather than other non-therapeutic reasons, plus explore her process of change.

The Thematic Analysis of course participant's feedback identified 4 superordinate themes. 'Change' highlighted their gradual change and recognition that it starts with them, 'Journeying Together' highlighted the importance of peer support and how they valued a facilitator with lived experience, 'Feelings and Emotions' showed their journey through both their own and their child's emotions to a more hopeful place and 'Reflection' accentuated how important they felt the process of thinking and reflecting were to their growing understanding and confidence.

The study into the experience of adoptive fathers also identified four superordinate themes 'The problem is in the child', showing where they located problems in their family, 'Confusion and comparison' revealing their sense of helplessness and longing for things to be different, 'The mixed Blessing of Feeling Like a Father' showing the dichotomy of both anger and fondness for their children and 'Looking Back' revealing their reflection on their own and their children's history.

Thesis Layout

Part 1 of this thesis comprises of the first six chapters which contain a more in-depth literature review and exploration of the key subjects and theories that are needed to further understand the research.

Chapter 1 starts with an exploration of adoption, its history and current landscape, including current characteristics of children placed for adoption in the UK today and the parents who they are placed with. It also includes background of the selection and matching process, then moving into outcomes for adopted children and specific issues around support.

Then in chapter 2 we move on to an exploration of human aggression, its adaptive nature and the effects that aggression and violence have on both the individual and society. The contribution that nature, nurture and environment have on the development of non-normative aggression and violence as well as gender expressions are explored. The specific nature of violence and aggression displayed towards their parents is then looked at with reference to Patterson's Coercion Cycle (Patterson, 1982), as well as the contribution of attachment theory to understanding aggression and violence displayed by children, thus linking into the adoption community.

Chapter 3 explores Attachment Theory in depth, looking at the history and development of the theory and the two main different models ABC+D (Main & Solomon, 1968) (now also known as the Berkeley Model of Attachment) and the Dynamic Maturational Model (Holmes & Farnfield, 2014). This chapter also looks at the idea of parental sensitivity and the contribution that this has to attachment security, then lookis at the gaps in understanding around the intergenerational transmission of attachment.

Chapter 4 looks at the work of Peter Fonagy and the development of the Theory of Mentalizing (Fonagy et al., 2018). It explores how mentalizing develops and the importance of beneficial mentalizing to safely negotiation of life's challenges. This is linked in to both psychoanalytic and attachment theory and the importance of parental mentalizing for the development of healthy attachments. This chapter then goes on to explore Epistemic Trust and its importance for learning. Finally, this chapter looks at parenting stress and the interplay between high levels of parenting stress and levels of externalizing behaviours in children.

Chapter 5 reviews various group-based parenting programs that exists, the efficacy and cost effectiveness of group-based programs. It then goes on to look at the different programs that are designed to help where there is child to parent violence and aggression, those that are designed to aid mentalization and reflective functioning plus those that are designed particularly with adoptive parents in mind, identifying where there are gaps in research and specific interventions.

Chapter 6 details the development and theoretical basis of the Knowing Me, Knowing You program, the program that this research is centred around. It details the subjects and method of delivery plus course aims of the 9-week program.

Part 2 of this thesis contains a brief introduction followed by 5 different chapters, each containing a study using data collected around the Knowing Me, Knowing You Program.

Chapter 7 is a quantitative study into the effectiveness of the KMKY program. Pre- and post-intervention data from each of the interview coding systems and the self-report questionnaires are examined with the use of repeated measures ANOVA to compare the intervention group with the service as usual control group.

Chapter 8 is in two parts, a quantitative study into the small number of participants who returned follow up questionnaires at 6-9 months post intervention (the statistics are examined by using a repeated measure ANOVA), then each family's data is explored using an adapted N=1 case study approach.

Chapter 9 is a mixed methods single case study of an individual participant of the KMKY program. Using both qualitative and quantitative data it looks at what has changed, how it has changed and why the change may have come about. The first part of this study looks purely at the interview transcripts to examine the change in

language and the second part uses a methodology based on Hermeneutic single-case efficacy design as outlined by Robert Elliott (2002).

Chapter 10 contains a reflexive thematic analysis of feedback from course participants with the aim of exploring their experience of the KMKY course, what they valued and their experience of any change it brought.

Chapter 11 is an Interpretive Phenomenological Analysis of the pre-intervention transcripts of 6 adoptive fathers, it aims to explore the experience of these fathers whose children display violence and aggression towards them.

Part 1

Chapter 1: Adoption

Adoption: The History

Adoption involves the permanent removal of parental rights from birth parents and transferring of these rights to new adoptive parents who are often completely unrelated to the birth family (Adoption and children Act 2002). However, more than a legal act, adoption results in significant and lifelong impact on the child, birth families and adoptive families. Even when in the best interest of the child, grief is an integral part: the child loses not just their birth parents, possible siblings, but biological family history; birth parents lose their child and the ability to impact and see that child grow up; it also brings complexity to adoptive families who may grieve the loss of early days with their child, the effect that the early history has on the child and also loss occurring through infertility (Neil, 2013; Thomas, 2013).

Adoption has been in existence since ancient times with major Biblical characters such as Moses, Esther and Samual brought up outside their biological families. Adoption has been long used as a solution to social problems in societies where extra-marital sexual relations were frowned on and there was no social or financial support for single mothers, it was seen as a way to enable a new start for both the mother and child while providing children for those who were infertile. This was historically perceived as beneficial to all parities impacted by adoption (Keating, 2009).

While adoption is now seen as just one of the possible solutions for children who are not able to live with birth parents, its history is contentious and ethical debates are

still regularly ignited with strong feelings on all sides (Ward et al., 2022). Adoption history is strewn with scandals such as the forced adoption of babies from un-wed mothers in Ireland (McNamara, 2021). Babies and children were removed by the thousands from parents opposing the regimes in Spain in the 1940's (Richards, 2005) and Argentina in the 1970's (Lazzara, 2013) then to be placed with parents sympathetic to the ruling regime. During the second world war children were removed from Polish parents to be placed with Aryan families (Nicholas, 2005). In some countries adoption was a used as a weapon to crush dissention, while in others to eradicate culture or practices seen as 'other' such as happened to Aboriginal and dual heritage families in Australia (Human Rights and Equal Opportunities Commission, 1997).

Traditionally adoption was surrounded in secrecy with adopted children given new birth certificates and little or no information given on birth history. It was believed that this would give both the child and birth parents a fresh start (Keating, 2009) and little was understood about the trauma and consequences of this policy for all parts of the adoption triad (Kenny et al., 2012; Triseliotis, 1973), but thankfully there is now growing awareness for the need for transparency in modern day adoption.

Public discourse around adoption has been impacted by historical practices and at times this unfortunately overlooks the reasons behind the majority of children entering the care system today, child maltreatment, neglect and abuse (Ward & Brown, 2016).

Adoption: landscape today

As of 2023 official figures from the Department for Education stated that that numbers of children within the care system in England were at an all-time high of

83,840 this being a 2% increase on the previous year and a 23% increase since 2013 (Department for Education, 2023). The number of children adopted from care in the same year was 2,960, considerably less that when adoptions peaked in 2015 at 5,360. Reasons considered to have brought about this large decrease include the extensive court backlogs brought on by the Covid-19 pandemic and court rulings in 2013 that asserted that adoption orders were only to be used where there was no other viable alternative such as placing with relatives or family friends (Department for Education, 2023). The average time it took for a child to be adopted after entering the care system was 2 years and 5 months an increase from previous years, though on average they are within their adoptive placement for 10 months of this leaving a wait time of 1 year 7 months to placement. The average age at time of adoption order was 3 years 5 months. Children also left the care system permanently by being places on a Special Guardianship Order (SGO), often with birth relatives or family friend, but also 9% were with their former foster carers. In 2023, 3,840 children were placed on this kind of order with their average age being 6 years and 2 months (Department for Education, 2023). While historically families with children placed under SGO's rather than full adoption orders have been supported to a lesser degree, all children under SGO's who were previously in the care system now have a right to post placement support in line with their adopted peers.

Adopted child characteristics.

The majority of children adopted in the UK come from the care system, figures from 2017 show that around 71% of adopted children suffered abuse and/or neglect before entering the care system, approximately 35% have experienced abandonment or rejection and 20% sexual abuse (Selwyn, 2017a). These figures do not include the neglect or abuse suffered in utero with around 25% diagnosed or

suspected to have foetal alcohol spectrum disorder (Adoption UK, 2020) and unknown numbers drug affected or who have experience domestic abuse and violence in utero.

It is now widely known that adverse early and in utero experiences can significantly impact normative child development. Research suggests that up to 70% of birth mothers of children in care in the UK and US misused drugs and/or alcohol during pregnancy (ASPE 2011, Selwyn et al., 2010). Extensive research into the effects of alcohol exposure in utero show that the child can be sustain permanent damage to cognitive functioning, physical development and alcohol can cause small birth weight and still birth (Dejong et al., 2019). The effects of drug use are lesser researched, perhaps due to issues around mothers using multiple substances at once including alcohol, however a longitudinal Norwegian study (Nygaard et al., 2015) into babies born to drug abusing mothers showed that behavioural challenges and cognitive deficits persisted right into adulthood.

In addition to substance and alcohol use, other prebirth factors are relevant. Research shows that maternal exposure to stress and domestic abuse also impacts neurodevelopment, and children born to these mothers have higher risk of ADHD and conduct/behavioural problems (Talge et al., 2007; Glover 2011). Parental mental health or aggression issues also can cause genetic vulnerability for the child, especially when interacting with experiences of poor parenting or harsh parenting environment whether within the birth home or adoptive home (Lipscomb et al., 2014; Myllyaho et al., 2019).

Many adopted young children have suffered multiple forms of abuse prior to entering the care system (Sturgess & Selwyn, 2007) including physical abuse, neglect,

witnessing domestic violence (Selwyn, 2017b), experiencing family rejection (Rushton & Dance, 2003) and though less prevalent, research shows 14-23% have been sexually abused (Dance & Rushton, 2005; Sturgess & Selwyn, 2007, Selwyn et al., 2010). In addition, the children may have experienced multiple carers within birth families and placement moves once in foster care (Selwyn et al., 2006; Ward et al., 2012; Ward & Skuse, 2001). Research in the US context revealed that multiple foster placements correlated with subsequent development of mental health issues even once additional factors were controlled for (Newton et al., 2000; Rubin et al., 2007), highlighting the importance of stability for the developing child.

During early childhood the child develops and adapts to the caregiving environment they find themselves in (Landa & Duschinsky, 2013), particularly to the care afforded by the primary caregiver. Abuse and neglect effects the attachment process to the child's primary caregiver and how they respond to dangerous environments. Impacting attachment relationships, maltreatment is known to effect a wide range of areas of the developing child such as intellect, emotional regulation and social development again having lifelong negative impact to some children (Brown & Ward, 2012; Cicchetti, 2013; McCrory et al., 2010, 2011, 2012). The contribution that Attachment Theory brings to understanding issues for adopted children will be explored more fully in later chapters.

Children within the care system also have a disproportionate level of physical complaints when compared to their non- care experienced peers. Common issues were vision problems, enuresis, and asthma with higher rates of autism, ADHD and speech and language delay (Green et al., 2016; Meltzer et al., 2003).

Adoptive parent characteristics

In the year up to 31st March 2021 89% of children adopted were adopted by couples with 16% being same sex couples and 73% heterosexual couples, the remaining 11% were adopted by single adopters (Department for Education, 2021). At any one time there are approximately 2000 -3000 children waiting to be adopted, but the majority of these are often older, sibling groups or categorised as hard to place (Home for Good, 2023).

Selwyn (2017b) states that in the UK adoptive parents are generally older than first time birth parents and often have some personal link with adoption or are connected through their profession such as social work, teaching or psychology. As baby adoption is no longer the norm in the UK parents need to have an awareness and openness to what is needed to support a child who has had adverse early experience and while infertility is still a major motivator a substantial number of adoptive parents are more altruistically or religiously motivated (Selwyn, 2017b) with some larger families actively choosing to adopt children with disabilities (Good, 2016). Adopters from the LGTBQ+ communities often choose adoption first rather than initially pursuing fertility treatment (Mellish et al., 2013).

Assessment of Prospective Adoptive Parents

“The best possible care involves giving children security, stability and love through their childhood and beyond.” (Department for Education, 2012, pg. 5)

In 2012 the government published its plan to tackle the long delays in placing children in adoptive homes (Department for Education, 2012). The rigorous assessment system for prospective adopters was now divided into two stages, each with their own timescales. The clock now started ticking the moment an agency

received a formal expression of interest from potential adopters. During stage 1 the agency has 2 months to collect statutory checks, medical checks, references and exhaustive chronologies of both life events and all jobs (paid or voluntary) that the potential adopters have had, this stage can be extended to 6 months if deemed necessary. Presuming all references and checks are positive the potential adopters can then move on to stage 2. Stage 2 should be completed within 4 months and involves in depth interviews with the applicants, their close family and friends and their support network. The applicants are also required to attend an adoption preparation course. The information is then collected together in the Prospective Adopters Report (PAR), this includes the recommendation of suitability from the assessing social worker. Once completed the PAR is presented to the agency Adoption panel, a panel that is made up of professionals including social workers and a medical expert, but also people with lived experience of adoption and fostering. The panel's recommendation then goes to the agency decision maker for consideration and a final decision.

Once approved, the prospective adopters enter a matching process where they and their social worker will be given details of specific children, and children's social workers are given the prospective adopters information. If the team around the child and the prospective adopters agree that the match is suitable, the case then goes to a matching panel. If approved a plan for gradual introductions and placement is formed.

While a rigorous process, the faster timescales that became law as part of the Children and Families Act 2014 (Department for Education, 2014b) are not without controversy with them being given as a factor in cases such as that of a disabled child placed for adoption with an unsuitable and dangerous carer and then having to

be removed once again by the court (Schraer, 2015). In this case the prospective adopter was found to have serious health and mental health issues that had failed to be picked up in the assessment process.

While the assessment process is rigorous, and the prospective adopter's motivation to adopt is explored as well as their thoughts and feelings about their own childhood, there is no psychological assessment as part of the process and the social workers, while trained in assessment may not have any training in psychological assessment and therefore cases, such as already mentioned, can be missed. Despite this it is stated that the majority of adoptions are successful with disruption or adoption breakdown estimated at between 3% and 9% (Adoption UK, 2024; First4Adoption, 2024). However, it is only once the adoption order has been granted that a disruption is classed as 'adoption breakdown' and there seems to be no figures about how many placements disrupt before the adoption order is granted.

Adoption outcomes

Australian comparisons of adopted adults compared to those who grew up in care (Ward et al., 2022) found that these adopted adults did significantly better in life outcomes such as education, employment and training. In Sweden, Hjern and colleagues (2019) research had similar findings with adopted adults showing higher educational achievement and income, lower levels of disabilities and criminality than their peers who grew up in the care system, however mental health and substance use were more similar with only slightly better outcomes for the adopted cohort. Earlier studies showed evidence of similar challenges with behavioural and emotional difficulties between adopted children and those in foster care (Biehal et al., 2010).

Research shows that children who are adopted have more feelings of security and are better integrated into their substitute family, they have also been provided with greater levels of stability than those who remain in the care system (Biehal et al., 2010; Thomas, 2013). However, the extent that these figures allow for the possibility that children with more challenging behaviours remain in long term foster care rather than being placed for adoption is unknown. The permanence afforded by adoption is important for the child's developing sense of identity. When comparing adoption and long-term fostering de Rosnay and colleagues (2015) state

"…while it is clear that early adoption engenders a deep sense of belonging and acceptance, which contributes profoundly to healthy identity formation, it is not clear that long-term fostering reliably engenders these same feelings." (de Rosnay et al., 2015, p.2).

Family integration and differentiation

Many tasks that adoptive families face are the same as birth families, but at each stage of the family's, and child's, development adoption brings different challenges and issues to that of biological families. Adoptive parents will have been through a process to come to the decision to adopt, often through the experience of infertility, which is not only a loss, but some would say a trauma that can cause significant psychological distress (Farnfield, 2019; Jaffe & Diamond, 2011; Klock, 1993).

Transition to parenthood has been considered a normative crisis (Brodzinsky & Pinderhughes, 2002), but for adoptive parents there are more challenges than for a couple becoming biological parents, for instance they have had to be evaluated and receive the approval from the relevant agency (Brodzinsky, 1987; Brodzinsky & Pinderhughes, 2002). In addition, while biological parents have a fairly specific time

of waiting for the child to arrive (pregnancy) adoptive parents can experience an extended assessment period plus a possible wait of years from point of approval to child arriving. Not only this, there still remains a social stigma around adoption that is experienced by both adoptive parents and their children, where adoption can be views as second best or a back-up plan for parenthood (Grigoropoulos, 2022).

One of the initial tasks for an adoptive family is integration (Brodzinsky & Pinderhughes, 2002), not just the family system but the child itself must modify patterns of relating and relationship, though this happens when a birth child arrives in a family there are again perhaps more challenges for the adoptive family as children are often older when placed, have many previous experiences and are statistically more likely to have addition needs and disabilities. To be fully psychologically integrated there needs to be shared sense of affiliation and reciprocity within the dyadic relationship (Neil, 2012).

Just as there are differences between birth families and adoptive families in initial integration, throughout life the adopted young person and their family will need to adjust and integrate the additional meaning that adoption brings to them. Adoptive identity has many dimensions, and the adoptee has to fathom out what it means to them to be adopted and part of the adoptee community (Colaner, 2014; Grotevant, 1997; Grotevant et al., 2000). Lack of information around their birth history and biological family may well complicate their identity formation process and bring extra challenges that their nonadoptive peers do not face (Conlaner, 2014).

As the child grows, develops, and progresses through different psycho-social stages the adoptee is also faced with issues such as resolving loss and grief, dealing with

adoption stigma and considerations around possibilities of birth family search and contact (Brodzinsky et al., 1993).

Post Adoption Support

In the UK the responsibility to provide support for the adoptive child or family rests with the placing agency until 3 years post adoption order, it then transfers to the agency most local to where the family lives regardless of where the child originated. US figures show that while approximately 10% of the general population accessed mental health support during childhood, these figures are 46% for domestic adoptions from the foster care system and 35% for intercountry adoptees (Vandivere et al., 2010). While these figures do not seem to be available in the UK, in England the time that adoptive families are most likely to approach services for support is when the child reaches early adolescence with adoption disruptions peeking at the age of 14 years (Selwyn et al., 2015).

The support offered by adoption authorities in England ranges from general courses available to all adopters such as basic attachment training, internet safety and navigating birth family contact, social meetups, and activity days for adoptive family to more intense specialist therapeutic help. Some adopters are given financial help in the form of an adoption allowance, but this is generally for harder to place children such as those with disabilities or in sibling groups, or where the adopters are in financial hardship. Foster carers who adopt their foster children are also entitled to an allowance in line with their fostering allowance for 2 years, after that it is down to assessment and discretion of the local authority (Selwyn, 2017b).

Adoptive parents are clear in what they want from post adoption support, they want a service that responds in a timely way with experienced professionals who have the

specialist knowledge around adoption and early trauma; they want empathetic professionals who are not blaming of the adoptive parents or children, but willing to listen and respond in a compassionate way (Selwyn, 2017b). Historical experience of dismissive services leads to parents not approaching services or waiting until they reach crisis before reaching out, however more recently messages have changed from professionals and adopters are more often told that they are highly likely to need services at one point or other (Selwyn, 2017b). Evidence from research shows that perceptions of being judged; lack of social worker knowledge; poorly conducted assessment; lack of services, qualified therapeutic professionals and financial support have all proved to be barriers to families accessing the support they need (McKay & Ross 2011; Livingstone- Smith 2010; Selwyn et al., 2015).

Historically, parents found adoption support across the UK to be patchy and hard to access, in response to this the government piloted a new type of support fund across 10 local authorities in England, and due to the success of this pilot they introduced the Adoption Support Fund (ASF) in May 2015. The ASF is currently only available in England and not in the devolved nations (King et al., 2017). Once introduced the government found that demand far exceeded predictions in the initial year and in October 2016 a fair access limit of funding was introduced at £5000 per child per financial year, if further funding was required a match funding approach was taken where the local authority would share the cost with the ASF. To date, the ASF is still a centrally administered fund guaranteed until March 2025 but access to it is dependent on assessment of need that is conducted by the local authority with responsibility for post adoption support. Early evaluations of the ASF found that 85% of families were able to access support that they had not been able to before the ASF existed, and that significantly more families were receiving support plus the

support available had expanded with new providers coming into the marketplace (King et al., 2017). In the year 2017/2018 an extra fund of £2500 per child became available for occasions where specialist assessment was needed. Since the ASF began in 2015, approximately 50,000 families have received support costing the Department for Education nearly £200 million (Adoption UK, 2023).

Each year, the national adoption support charity Adoption UK undertakes a survey of adoptive families entitled ‘The Adoption Barometer’. This survey has shown that, despite the existence of the ASF and many recent changes to legislation, many families feel they have to battle to get the support they need plus there is still a lack of awareness of adoption issues amongst many professionals particularly those in education and healthcare (Adoption UK, 2023).

In 2022 1,665 established adoptive families responded to the Adoption Barometer Survey, of these families 25% said they were mainly doing well, 45% were facing some challenges but managing and 31% were facing sever challenges or at crisis point.

The families surveyed in 2022 accessed a range of different types of support; 45% had accessed Therapeutic Parenting Support, 35 % Theraplay – an attachment and play based therapy, 22 % Creative Therapies, 20 % Non-violent resistance training for parents, 19 % Dyadic Developmental Psychotherapy, 15% Sensory integration/attachment therapy and 12 % psychotherapy. Smaller amounts accessed Eye-movement de-sensitization and reprocessing (EMDR), Filial therapy and multi-systemic therapy.

Aggression and violence is an often sighted issue when adopters approach support services. The Adoption Barometer 2023 (Adoption UK, 2023) showed that 57% of

families surveyed in the previous year had experienced violence or aggression from their children, this is lower than previous years in 2022 it was 65% (Adoption UK, 2022) and in 2021 coping with aggression and violence was one of the most pressing issues for adoptive families surveyed along with accessing appropriate support and educational issues (Adoption UK, 2021).

Aggression and violence displayed by children to their parents or carers is explored in more depth in subsequent chapters.

Educational Support for adopted Children.

Government data suggests that compared to their non adopted peers, adopted children are underachieving academically. Figures including those who are adopted and those under special guardianship orders show that just 41% are meeting expected standards (writing, reading and maths) compared to 65% of non-care experienced children and 37% classed as 'looked after' (within the care system). Figures at GCSE level are also disparaging with just 16.9% of adopted children achieving grade 5 or above in Maths and English compared to 40.1% of non-care experienced young people. However, the figure of 16.9% is still considerably better than 7.2% of looked after children (DfE, 2020a, 2020b).

As already mentioned, adoptive parents frequently report lack of understanding and knowledge from wider professionals including education (Adoption UK, 2018; Hamblin, 2018; Selwyn, Wijedasa and Meakings,2015) and that it appears that the presumption that the provision of a loving home is enough to ameliorate the child's history leads to their early experiences and needs being overlooked (Adoption UK, 2014; Golding, 2010). Despite this, the needs of adopted children in education settings are becoming more recognised (Gore Langton, 2017) and in the last decade

those who are adopted and under special guardianship orders are entitle to extra funding in school entitled Pupil Premium Plus (Department for Education, 2014) which amounts to £2300 per year paid directly to the school, but this is dependent on parents declaring their child's eligibility. The aim is to put in extra support to raise attainment of eligible children. Pupil Premium Plus is not ringfenced to individual children, but schools must publish their strategy for its usage. The remit of the Virtual School has also been extended to cover adopted children with the requirement for a Designated Teacher with responsibility for adopted children within education settings (Department for Education, 2018a, 2018b). In recent years there has also been a push for schools and teachers to understand more about attachment and the effects of early trauma with development of training such as that for Attachment Aware Schools (Dingwall & Sebba, 2018). This program recognises that many children with adverse early experiences are not in a state of readiness to learn and that an understanding of some of the reasons and meaning behind behaviours that are exhibited in schools would give skills and confidence to staff in their practice. Particularly primary schools where the program was implemented saw increase in academic achievement and decrease in problematic behaviour exhibited by vulnerable children (Dingwall & Sebba, 2018).

In summary

Adoption has a long, and at times contentious history, it is not simply a one-time event and engenders strong feelings and ethical debates. Its impacts are multifaceted and is shown to affect family relationships, identity, education, and mental health. While outcomes for adopted children are often much better than for those who remain in the care system, research evidences the need for robust support for the family, the adopted person in life and within educational settings.

Chapter 2: Aggression and Child-to-Parent violence.

In terms of survival, aggression is a necessary behaviour both for humans and other species, in fact humankind is one of the most aggressive species (Georgiev et al, 2013). Too little aggression can mean a lack of protection, but too much is detrimental both personally, and for society (Waltes, 2016).

In particular for children and adolescents, high levels of aggression and violence are shown to be an antecedent to negative life outcomes and mental health problems for both the victim and the perpetrator (Tremblay et al, 2004).

Definition and typology of aggression

A useful definition of aggression comes from the area of social psychology, that aggressive behaviour is observable and has the intention of harming a person that has no wish to be harmed and is motivated to avert it (Allen & Anderson, 2017). This definition of aggression emphasises the observable and intentional nature and therefore precludes the inclusion of a person's thoughts and affect, though these are both linked to, and can be a forerunner of, aggressive behaviour. It also emphasises the intentional nature therefore precluding accidental harm (Allen & Anderson, 2017). Within the array of behaviours that can be described as aggressive there is a wide range, from the relatively minor such as name calling to acts of extreme violence that can result in injury or death (Allen & Anderson, 2017). This definition may be considerably different to that given by the general population who may well ascribe destructive acts towards objects and property as being part of aggression.

Aggressive behaviour can be physical, relational (social aggression) or verbal in expression (Bushman & Huesmann, 2010) and further categorised into various forms, proactive (Instrumental) versus reactive (hostile) (Bushman & Anderson,

2001) and covert versus overt (Krahe, 2013) amongst others. Reactive aggression is usually a response to a threat, whether actual or perceived (Waltes et al., 2016), while proactive aggression is premeditated and has been linked to the wish to gain dominance plus has also been found to be highly associated with callous-unemotional traits (Kempes et al., 2005; Thornton et al., 2013). Aggressive behaviour is not only detrimental to the target but also the instigator, and studies have shown that while both proactive and reactive aggression predict future adult substance use, proactive aggression is notably predictive of adult antisocial behaviour and psychopathic traits, whereas reactive aggression is linked to anxiety and mood disorders (Fite et al, 2009).

Relational aggression behaviour is harmful to others and relationships, and includes behaviour such as gossip, social exclusion or spreading of lies about a person. Being also either proactive or reactive, it is a form of aggression that is more chiefly displayed by girls (Crapanzano et al., 2010; Marsee et al., 2014).

Overt aggression is often seen as being more physical in nature while covert tends not to be physically but more in the form of rule breaking, vandalism, spreading rumours and defiance, though some may not see this directly as aggression but rather as anti-social behaviour, and some aspects do not fit into the aforementioned definition of aggression (Burt & Donnellan, 2009). Studies highlight the possibility that covert and overt aggression have a different developmental pathway, with covert being related to impulsivity whereas overt aggression is more related to affect regulation (Burt & Donnellan, 2008; DeMarte, 2008).

Direct versus indirect aggression are also classifications with direct happening with the victim present and indirect the victim is absent (Buss, 1961; Krahe, 2013; DeWall

et al., 2012). Verbal bullying would be seen as direct, whereas sending derogatory messages indirect.

A further interesting categorisation is that of displaced aggression, where the perpetrator may have been triggered by an event, or aggression from another subject, but for some reason feels or is powerless to react, then in another situations directs the aggression at an innocent party (Bushman & Huesmann, 2010). This can also become triggered displaced aggression where a minor mistake by an otherwise innocent party triggers them into becoming a target (Miller, Pedersen, Earleywine, & Pollock, 2003). For example, a parent experiences an aggressive outburst from their boss at work then goes home and yells at a child for knocking over a glass of water.

While dichotomous categories can be useful within research and theory, there is a growing recognition of the complexity and overlap between different types of aggression and are perhaps an oversimplification of a pertinent area of research (Allen & Anderson, 2017).

Violence

Within social psychology violence is not considered as separate from aggression, but rather as a subset. Violence is at the highest end of the range of aggressive behaviour where the intent or goal is physical harm (Anderson & Bushman, 2002; Bushman & Huesmann, 2010; Huesmann & Taylor, 2006). The key to this definition is not the harm actually caused but the intent or goal. While the majority of what is considered to be violence is of a physical nature, developments within the field also bring into consideration other subsets of aggression that are now classified as violent, such as emotional violence where the subject's wellbeing are significantly harmed (Allen & Anderson, 2017).

Aetiology of aggression

Understanding the roots of non-normative aggressive behaviour is complex, normally overt physical aggression peaks in toddlerhood, around 2-4 years old, and then decreases (Stranger et al., 1997; Tremblay, 2003; Tremblay, Vitaro, & Cote, 2018). The increase in aggression in early childhood is linked to many developmental aspects, such as increased mobility (WHO; 2006), frustration of goals (Tomasello et al, 2005; Young & Keenan, 2022; Liu et al., 2022), conflict with parents/caregivers (Biringen et al., 1995; Hoskins, 2014) and fear and anger reactivity (Braungart-Rieker & Hill-Soderlund, 2010). Fear and anger reactivity are key constituents of infant distress and serve as developmental protective factors with fear promoting proximity to care giver, while anger appears when goals are frustrated and encourages further pursuit of goals (Braungart-Rieker & Hill-Soderlund, 2010). Maternal sensitivity has been shown to moderate and regulate over reactivity of fear and anger (Braungart-Rieker & Hill-Soderlund, 2010). Parental sensitivity will be explored later in this thesis. Whereas normatively aggression peaks in toddlerhood, covert behaviours such as rule-breaking are relatively rarely shown in early childhood but peak during adolescence (Stanger et al, 1997; Tremblay, 2010). Eddie Gallagher, the developer of a specific program for families with violent and aggressive children points out that children do not need to learn to be violent, they are naturally violent, but they do need to learn not to be violent (Gallagher, 2014).

Nature, Environment and Nurture

A key question of research into aggression is how much humans are influenced by genetics and nature, and how much by environment and nurture. Twin and adoption studies have endeavoured to answer these questions.

Heritability would appear to have different levels between types of behaviour, for physical aggression early studied showed genetic influence accounting for up to 65% of variation, whereas with rule-breaking genetics account for up to 48% of variation (Burt, 2009: Tackett et al., 2005). Though other studies estimate heritability for physically aggressive behaviour slightly lower at 50% (Tuvblad and Baker, 2011). Heritability levels also seem to be lower in the pre-school age, peaking during adolescence (Waltes, 2015), and that genetic influences increase with age while environmental influences factors decrease (Tuvblad & Baker, 2011).

Environmental factors are known to be significant predictors of development of violence and aggression, with adversity, maltreatment, parental mental health, prenatal factors and socio-economic status amongst others (Tuvblad and Baker, 2011; Latimer et al., 2012; Jaffe et al., 2012). In some twin studies, where the twins did not share the same environment, results showed that the contribution of environmental factors are as significant of that of genes. With the results of studies being highly variable, there does not seem to be clear answers other than that individual differences in aggression are influenced by genetic, shared and non-shared environmental factors and further to these, epigenetic changes due to environment are also considered to be a factor in the transmission and development of aggression (Waltes et al., 2016).

Interestingly it would appear that there are differences in the developmental pattern of proactive and reactive aggression, with stability across childhood of proactive 85% explained by genetics whereas only 48% explained genetically in reactive aggression (Tuvbald et al., 2009).

Attachment theory also brings in an interesting perspective on the development of aggression and violence, in that substantial evidence suggest a strong link between disorganised attachment and the development of externalising and aggressive behaviours (van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999), and that the links between attachment insecurity and externalising behaviour increased with age (Fearon et al., 2010). These links will be explored further in later chapters.

Gender expressions of violence

The largest predictor of aggression and violence is a person's gender (Fields, 2019) and differences in gender expression of violence is thought to be an evolutionary feature that optimises differing survival strategies for each gender (Georgiev, 2013). While some studies that used self-report measures have shown higher heritability in boys than girls (Baker et al., 2008; Wang et al., 2013), interestingly, meta-analysis of twin studies found that there is little of no difference in the aetiology of aggression between males and females. However, it is not known if there are differences in moderators for different genders and if this may explain increased prevalence in males (Tuvald & Baker,2011).

What is known is that there is a gender preference in the types of aggression shown, and while verbal aggression prevalence is similar in males and females, males use significantly more physical aggression while females use significantly more indirect aggression (Bjorkqvist, 2018).

What is also clear is that society holds different scripts and constructs around aggression and gender that may well affect the development of aggression. Gender differentiated parenting and expectations around aggression are subjects of both social role theory and gender schema theory (Bem, 1981; Eagly et al., 2000). Even

today there is still a division of gender roles within most societies (Endendijk et al., 2017) which may lead to stereotypical ideas and scripts of what is accepted behaviour for males versus females. It would appear that there is little considered of this within research into problematic aggression from children and young people, and that perhaps what a parent sees as acceptable from a male child would be seen as unacceptable from a female child. Access to support services is usually reliant on parent report of behaviour and given societal scripts may be different depending on gender of child, or even from family to family there is highlighted a weakness in understanding of what may constitute unacceptable aggression and violence from children and young people.

Child to parent Violence

What has come to be known as Child-to-Parent Violence (CPV) or Adolescent-to-Parent Violence (APV) was first recognised in the late 1970's by Harbin and Madden (1979), they then termed it as 'battered parent syndrome'.

Until just a few years ago CPV and APV were hardly talked about, this was perhaps for a number of reasons, including parental shame and lack of recognition by professionals and parent blaming. There can be an oversimplification of factors involved in the development of violent and aggressive behaviours in young people where either the parents, genetics or early environment are held totally to blame not paying consideration to the complex weave of factors that affects a developing child (Gallagher, 2014). In recent years the growing number of cases has highlighted this specific form of familial issue (Holt, 2016). Research and understanding of this area are in their relative infancy with much of it coming from within the Spanish context (Seijo., et al, 2020). Estimates of CPV and APV are from 3% to 27% (Gallagher, 2008; Holt, 2012*a*). Understanding of the issues are not helped by varying definitions

of APV and CPV, also sometimes called ‘mother abuse’ (though as implied by the name possibly ignoring dynamics with the father), but one that is regularly applied is that of Paterson and colleagues:

“Behaviour considered to be violent if others in the family feel threatened, intimidated or controlled by it and if they believe that they must adjust their own behaviour to accommodate threats or anticipation of violence” (Paterson et al., 2002, p. 92)

In late November 2023 the UK government instigated an open consultation to agree a definition of child to parent abuse which encompasses child to parent violence and aggression (Gov.uk, 2023). This was in recognition that just as children can be harmed by adults also adults can be harmed by children. The attempt to agree a definition was part of their plan for tackling domestic abuse. Key aims of this 10-week consultation were to establish common language and support professionals and parents to identify this kind of abuse. Even the use of the word abuse in this consultation could be problematic as it places the blame for the behaviour on the child, and as is explored here the factors that contribute to a child displaying, aggression, violence and abuse are complex and is often bidirectional and can be a result of trauma, overly permissive parenting or disability. The consultation did make the point that the boundary between normal boundary testing and what is abuse is not clear, however it asked if ‘abuse’ should be defined as a single event as in the definition of domestic abuse or if it need only apply to a pattern of behaviour. This consultation only closed on 7th of February 2024 and at time of writing the results had not been published.

Early studies into APV and CPV that relied on Judicial samples, which by definition probably included the more extreme end of externalising behaviours, seemed to

show a gender difference in the instigator of the violence with girls considerably outnumbered by boys (Armstrong et al., 2018) though this was not the case in community studies where there was little or no gender difference (Loinaz et al., 2020). Over time, rather than looking at incidence and gender differences in types of violence shown, research has begun to focus on factors that lead to the development of CPV and APV such as family characteristics and parenting styles (Seijo et al, 2020; Simmonse et al, 2018). However, as already mentioned, access to support services usually relies on parent report and research also regularly relies on parent report measures, and this in itself could be problematic due to lack of triangulation of measures or use of observational measures. Also previously mentioned, there may be psychological barriers to parents seeking help and this result in them downplaying incidents, or alternatively some parents may feel overwhelmed by behaviours that are close to normative and therefore exaggerate situation to elicit support.

CPV and APV are particularly marked out by a change in the normal power dynamics between parent and child and the coercive nature of the child or adolescent's behaviour. Understanding of the causes is growing and though mechanisms are unclear, Patterson's coercion theory (1982) helps to explain how these patterns of behaviour may have come into being.

Patterson Coercion Cycle

Patterson (1982) Suggested that harsh and negative parenting practices can create a positive feedback loop where parents and children engage in increasingly coercive strategies creating an environment where challenging and aggressive behaviours thrive. When a child is disobedient or displays an unwanted behaviour, the parent becomes angry and reacts with hostility and punishment, the child may then react to this with increasingly disruptive behaviour and the parent becomes even more angry

and so coercion escalates on both sides. This coercive cycle or pattern of interrelating is known to impact both behaviour and a child's social development (Waller et al., 2010). Coercive parenting tends to make use of harsh punishment, threat, and rejection to manage a child's behaviour, the emphasis is on controlling the behaviour rather than supporting the child to regulate (Prinzie et al., 2009). Over time, as this cycle continues, the interactions between parent and child become increasingly negative and hostile. The cycle only stops when parent or child gives in and the other wins. If the child 'wins' then they are more likely to become aggressive next time there is a conflict, and if the parent 'wins' the cycle is reinforced. Either situation will lead on to further escalation and over time the child may become increasingly aggressive and violent in their behaviour and the parent becomes increasingly harsh and rejecting, thus the relationship breaks down. Patterson (1982) believed that this cycle starts very early on when the child is a baby and the child's temperament can be a contributing factor as well as the parent's authoritarian approach. These parents often struggle with their own emotional regulation and may interpret the child's negative emotions as being from negative intent. Coercive patterns of parent-child relating are known to be related to a child's later display of conduct problems (Smith et al., 2014).

In keeping with Coercion theory child to parent violence is often bi-directional in nature and therefore a relational phenomenon, though not always readily acknowledged by parents (Ibab & Jaureguizar, 2011). Links have also been established between exposure to other forms of interpersonal violence and development of violent behaviour in children and adolescents, particularly CPV and APV (Cottrell and Monk, 2004; Hunter et al., 2010). Not only authoritarian parenting, but neglectful or overly permissive styles of parenting are also linked to the

development of emotional and somatic symptoms and externalising behaviour (Lamborn et al., 1991; Galleagher, 2008; Kotch et al., 2008; Contreras and Cano, 2014; Ibabe, 2015; Suárez-Relinque et al., 2019). Levels of affection shown to children and young people and the quality of their attachment relationships with their parents also make a contribution, with those not receiving appropriate affection more likely to develop maladaptively and engage in CPV or APV (Gámez-Guadix et al., 2012; Cortina and Martín, 2020). Conversely, Supportive parenting where nurture and emotional warmth is shown has been established as a protective factor against the display of violence and aggression by children and young people (Jiménez-García et al., 2019; Suárez-Relinque et al., 2019; Cortina and Martín, 2020).

As mentioned, within normative development, children's display of violence peaks at around 2 to 4 years, and when supported properly these toddlers begin to be able to moderate their urges and use other skills, such as language, to express their needs and wishes. Difficulties in early attachment relationships are strongly associated with display of aggression (Tremblay, 2000). In addition to factors already mentioned, abuse and maltreatment in childhood is also associated with aggressive behaviours, some studies have focused on attachment development and how adverse experience and maltreatment can cause a child to not trust in the adults and become self-reliant and behave in a way to control their environment (Zeanah, 2009; Corriveau et al., 2009), others look at evidence within the biology of stress response and reward processing that can cause difficulty in processing and identifying emotions (McCrory et al., 2012; Jaffe and Christian, 2014).

Fonagy (2004, 2012) argues that children learn to inhibit and control aggressive and impulsive urges through the parent being able to respond sensitively and in an attuned fashion, this process is called mentalizing, and the child's capacity to

mentalize is dependent on the parent's. When there is a failure in mentalizing there is often a lack of ability to inhibit violent and aggressive urges. Mentalizing and parental sensitivity will be dealt with in more depth in subsequent chapters.

The Dynamic Maturational Model of Attachment (DMM)

The DMM proposes attachment organisation as being around the danger that a child faces and strategies developed as self-protective ways to limit threat and danger and maximise survival to adulthood (Crittenden, 2008; Crittenden and Landini, 2011). Therefore, attachment behaviour and strategies are adaptive to the situation a child finds themselves in. Crittenden attributes coercive strategies displayed by children, including violence and aggression, to inconsistent parenting. The parent is unpredictable to the child, at times present and nurturing and at others distant and disengaged or even frightening, or perhaps the parent is misleading and deceiving as well as unpredictable. The child using a coercive or 'C' Strategy (also known as ambivalent) often oscillates between exaggerated displays of vulnerability and exaggerated displays of anger and aggression to keep the parent more engaged and therefore making them more predictable (Crittenden, 2008; Crittenden and Landini, 2011). Some children may have had care givers who were predictably unavailable or predictably reacted badly to the child's displays of negative affect, this can lead to a child attempting to suppress negative affect and when this fails sudden outburst of violent behaviour with seemingly little triggers can be displayed, this would fall within the avoidant or A strategies in the DMM (Crittenden, 2008; Crittenden and Landini, 2011).

Child-to- Parent violence in the adoption world

Dealing with challenging behaviours, aggression and violence is one of the most commonly cited need for support by adoptive parents here in the UK (Adoption UK,

2019; Elias, 2019) and previously, adoptive status itself has been presumed to be a risk that can affect a child's development (van der Vegt et al., 2009). In addition, the behavioural adjustment of adoptees has been found to be considerable different to the normative population (Dalen & Rygvold, 2006; Dhavale, Bhagat, & Thakkar, 2005; Hawk & McCall, 2010). Meta-analysis of control studies showed both higher internalizing and higher externalizing behaviour in adoptees (Juffer & van IJzendoorn, 2005).

When exploring Adolescent-to-parent Violence in adoptive Families Selwyn and Meaking (2016) found that children whose adoptions had disrupted were 3 times older on average at time of entering care than the normal of the time (14 months). They linked this to the likelihood of higher level of exposure to maltreatment plus repeated moves in foster care, therefore having no consistent person supporting with their management of affect. Thus increasing the chances of the child having experienced a negative environment with possible high rates of aggression or inter personal violence displayed by the adults around them.

Cumulative effects of multiple adverse experiences are believed to affect behaviour and psychopathology (Stilo et al., 2017; Cicchetti & Rogosch, 1996), and given this, and the aforementioned factors of heritability and early environment, it doesn't bode well for adoptees and a higher prevalence for CPV and APV may well be expected amongst this population. However, Roskam & Stievenart (2014) found that there was a common pathway to maladjustment amongst adopted and non-adopted adolescence, and that it was not the adopted status, per say, or even just the pre-adoptive experiences that predicted maladjustment. The young person's characteristics and the nature of the adopting family interplayed with early risk to be predictive of behaviours and maladjustment in line with cumulative effect theory.

Supportive parenting was found to be a protective factor, though adopted adolescence were more likely that their non adopted peers to display externalising behaviours, and in contrast to the non-adopted control there was a high co-morbidity for both internalizing and externalizing behaviours. These findings were in keeping with earlier studies looking at the early history of adoptees, which found that child-centred responsive parenting mitigated the harmful effects of these risks (Kriebel & Wentzerl, 2011).

In their exploratory study Thorley and Coats (2017) highlighted the impact that CPV had on parents' mental and emotional health, relationships as well as employment and finances. This is not exclusively a problem for adopters, but the majority of respondents in the study were either adoptive parents or those with special guardianship.

While not a rigorous or scientifically sound study due to the methods of data collection and lack of peer review (acknowledged by the authors) this exploratory study highlights the need for more research in this area. And called for early intervention via knowledge and training for these families. This paper also highlighted the effect on siblings and lack of support, belief or trust from family and friends, plus struggles with reporting and response from social services. Many respondents reported isolation from their support network, highlighting the need for support. Reluctance to approach services would seem to be a problem both in adoptive families and birth families struggling with CPV and APV, this may be for a wide range of reasons, such as shame, lack of acknowledgement of the situation and fear of consequences both for self and the child (Downey, 1997; Edenborough et al., 2008; Concordia Gabinete, 2018; Selwyn & Meakings, 2016). It is suggested that professionals may also struggle in their response, as APV and CPV are contrary

to the normal mindset where the child is the victim (Selwyn & Meakings, 2016), though considering coercion theory and the interpersonal dynamic that has allowed violence and aggression to thrive the actual reality may be that the child is both the victim and perpetrator.

In the government funded ‘Beyond the Adoption Order: challenges, interventions and adoption disruption research report’ Selwyn and colleagues (2014) proposed that their findings around anxiety and depression in adoptive parents who either were living with or had lived with CPV potentially showed the ongoing effects of this living situation and impact on society as a whole, however no information was known about the adoptive parents’ mental health prior to adoption, or other factors that could be impacting their mental health and therefore this correlation cannot be presumed to be causational.

While studying parenting representations, and states of mind, Steele and colleagues (2003, 2008) found higher levels of hostility and anger amongst adoptive parents where the child was placed later than infancy. These parents reported more challenging behaviour and aggression from their children and needed far more support with parenting. Again, what is not clear is the parents’ expectations from the parenting experience, their journey into adoption and their representation and attachment strategies pre parenthood, so the increased hostility and anger cannot be presumed to be because of the child they are parenting, and it is possible that some of the child’s behaviours may be in response to the adoptive parenting environment.

Selwyn & Meakings (2016) highlight poor response from services and that parents are often reported they were made to feel like failures when they approach services for help with their child’s aggressive behaviour. They also highlight that many

adoptive parents within their research report seemed to be suffering from symptoms consistent with secondary trauma. This study highlights that the young people concerned have multiple risk factors consistent with the development of aggression and violence and that simply changing the environment has not worked to mitigate the risks. This study made use of questionnaires and parental interviews to explore the data, what was not looked at was the parents' own mindset and attachment strategies, or reports from the young people concerned to see how they had experienced being parenting and as such does not look either the dyadic relationship or the family system in which the aggression and violence has grown. The problem would seem to be located within the young person rather than the relationship, this is perhaps in response to the poor support and response from professional services.

APV and CPV within adoptive families is perhaps even more complex than within birth families as you have the genetic, relational, and environmental contribution from the birth family plus possible multiple foster placements with relational and environmental contributions, as well as the environmental and relational contribution from the adoptive family. For professionals this is a complex map to navigate and yet it would seem that a response that does not either place all the blame on the adoptive parent or alternatively all on the child and their early experiences may not exist.

In summary

A level of aggression is normative and necessary within society and can be physical, verbal, relational and either covert or overt. Aggression can be both proactive and reactive and high levels are associated with negative life outcomes. Violence is a subset of aggression. Nature, nurture and environment are all found to impact the likely display of violence and aggression with genes and environment having a

similar level of impact. There are gender differences in expression of aggression with males more likely to use physical aggression.

Child on Parent Violence (CPV) is a previously ignored and under researched area that is now coming to recognition, it has lacked definition and currently the UK government are seeking to redress this with public consultation. Within the adoption world, CPV is one of the most frequently cited reasons for seeking support, and the early history of the children plus their genetic history brings added complexity to supporting this group of families and children.

Chapter 3: Attachment, Parental sensitivity, Transmission gap.

Attachment Theory

Attachment has been described as the affective bond or relationship between an infant and their primary caregiver and can be seen as an evolutionary concept that maximises chances of survival by activating a range of behaviours in the infant or child when under threat, ill or feeling alienation and separation (Bowlby, 1973 & 1988). More recently, understanding of the brain has shown the importance of early attachment relationships to the development and organization of brain structures that underpin the complex abilities that are needed to successfully navigate adult life (Fonagy & Target, 2005). Attachment theory has not just been limited to explanation of dynamics within parent-child relationships and is now understood to be able to describe and understand adults' ability to negotiate all close relationships (Fonagy et al, 2014). Since its early days, based on the post second world war work of John Bowlby, Attachment theory has become an increasingly popular way to understand human development behaviour, relationships and emotions (Holmes and Farnfield, 2014).

Bowlby's new theory was developed in response to his behavioural observation of infants who had been separated from their mothers. Findings showed that they broadly fell into 4 categories; Infants who were hostile to the appearance of their mother, Infants who became excessively demanding and often had violent meltdowns, infants who seemed to cheerfully go to any adult carer – not showing preference to the mother and infants who became silent and withdrawn (Bowlby, 1953). In collaboration with Mary Ainsworth and James Robertson, research into the emerging field continued with children separated due to hospitalisations and in domestic settings both in the USA and Uganda. Of particular interest was the child's

reaction to separation and reunion resulting in the development of a laboratory assessment known as the Strange Situation Procedure (SSP) (Ainsworth & Bowlby, 1991; Ainsworth et al., 1978). Repeated administrations of the SSP gave rise to researchers categorising attachment into 3 discrete categories (A, B and C) that overlapped with Bowlby's original 4 observational categories, and thus the SSP became a foundation on which future research into Attachment was built (Holmes and Farnfield, 2014). In the ABC model, B represented Children who were securely attached while A and C were insecurely attached. The avoidant 'A' child inhibiting attachment signals in order to maintain caregiver proximity and reduce the possibility of rejection and ambivalent 'C' child exaggerating attachment signals in order to elicit a more predictable response from their care giver respectively.

Over time a new generation of researchers gained prominence and in particular two women Patricia Crittenden and Mary Main, who had been Ainsworth's research students, would expand on the then understanding and later diverge in their explanations. On examination of the SSP videoed procedures it was found that some mother-child dyads could not be categorised using the ABC categories earlier defined, this lead Mary Main and her collaborator Mary Solomon to define a category where the child was disorganised-disorientated, and this became known as the 'D' category and thereby developing the ABC + D model of Attachment (now also known as the Berkeley model of attachment) that is widely used. The researchers observed that some of the children within this category had suffered maltreatment and this progressed to becoming an explanation for the behaviour (Main & Solomon, 1986). It was at this point that Crittenden and Main's explanations diverged. Main had focused on proximity seeking behaviour believing that was the goal of the attachment system, whereas Crittenden rather felt that attachment was all about keeping a caregiver

available (Landa & Duschinsky, 2013). This subtle difference in the understanding of function of the behaviour led to Crittenden not seeing these uncategorised dyads as the child having disorganised behaviours and strategies, but that they had an organised response to the situation that simply did not fit within the existing categorisations and beliefs about caregiver proximity. Though still firmly rooted in Bowlby and Ainsworth's early work she developed a differing model called the Dynamic Maturational Model of Attachment and Adaptation (DMM) (Crittenden, 2016; Holmes and Farnfield, 2014).

The ABC+D model of Attachment has historically been possibly the most accepted model worldwide, it has a rigorous research base with approximately 30,000 studies in existence (Cassidy & Shaver, 2016) compared to around 500 DMM studies (Crittenden et al., 2021c). Despite this acceptance some view it as limited in its clinical applications as other than giving a classification its ability to explain complexity of behaviours seen within the non-normative population is limited, as shown by the disproportionately high number of maltreating adults that have been categorised as secure in ABC+D assessments (Crittenden et al., 2021a). Thus, the ABC + D model is left deficient in providing professionals direction for work. In recent years there has also been a move within the ABC+D community to the acknowledgement that 'D' is not attachment pattern per se, but a category in which to put cases that do not fit A, B or C, and that the idea of disorganisation has been misused in potentially harmful ways (Granqvist et al., 2017). Crittenden's DMM, while still using some of the same constructs as ABC+D in addition to differing constructs perhaps gives more potential to understanding of this complexity and how to work with individuals in need of help and intervention. Interestingly, meta-analysis shows that only 45-55% of infants and 55-60% of adults can be classified as having secure

attachment within normative population, this suggests that within society there are adults and children with insecure attachments that function in a normative way (Cassibba et al., 2013).

Dynamic-Maturational Model of Attachment and Adaptation (DMM)

This current study uses the framework for the DMM for multiple reasons, the DMM appears to be less simplistic in explanations containing more possible categorisations and a focus on the function of the behaviour rather than a superficial attribution of the behaviour. This focus on function and the flexibility within the model to see how attachment patterns could change and function in different relationship and at different life stages perhaps provides more possible pieces of the puzzle to understanding the complexity of human relationships than the ABC+D (Berkeley) model is able to provide. This focus on function within a relationship or situation where many factors influence behaviour is more understanding of the family system as a whole and perhaps is less blaming of parents and caregivers, which we do at our peril as warned by Dallos (2019). Given these considerations and it's flexibility, this current study is rooted in the theoretical model of the DMM (while still paying attention to literature and research using the ABC+D model) and with this view the DMM is here explored in more detail.

Bowlby's later work focused on the mother as a 'Secure Base' and that the drive behind attachment behaviours was to achieve as sense of safety and security (Bowlby 1988, Bowlby 1969), for Crittenden there is a differing emphasis finding most interest in human behaviour and survival when endangered, that strategies grow up that maximise the chances of an infant reaching reproductive maturity when endangered (Crittenden, 2002). Within Crittenden's definition of attachment there are 3 aspects that hold equal importance

1 a unique, enduring, and affectively charged relationship (e.g., with one's mother, with one's spouse);

2 a strategy for protecting oneself (of which there are three basic strategies, Types, A, B, and C as identified by Ainsworth, and many sub strategies, as described by the DMM);

3 The pattern of information processing that underlies the strategies.

(Crittenden, 2016, pg. 10)

Bowlby (1980) had also utilised the idea of information processing within early Attachment theory and had used the term 'internal working model' to convey the concept of mental representations of processed information around attachment figures. For Crittenden the 'internal working model' seemed too fixed and not representative of the complexity of information and many (and at times conflicting) mental representations that a person can have around their caregivers, so she replaced this with term 'Dispositional Representations' (DR's) that had previously been used by Damasio (1994). In DMM theory, DR's are contextual and cause a person to act in a particular way within that situation while expecting a certain outcome (Farnfield & Stokowy, 2014). DR's lie dormant within physiology until triggered. Within a person there are multiple DR's that were gained through genetics, environment, and experience and multiple can be triggered at once (Damasio, 2000). The key to functioning successfully is the ability to organise these at times conflicting DR's in a way that promotes behaviour that facilitates safety.

Bowlby (1980) proposed that at times information that might activate a painful experience can be automatically kept out of awareness, he labelled this 'defensive exclusion', recognising that the brain transforms information received through

sensory experience at times by omission or distortion. The insecure attachment categories employ more distortion while within secure attachment there is relatively little. For Crittenden the key distortions or omissions that are of interest are cognition and affect, with the A strategies relying more on cognitive information to the neglect of affective information and C strategies relying more heavily on affective information while omitting or neglecting the cognitive (Crittenden, 2016).

The DMM is underpinned by the idea that strategies available to a person increase with age, hence ‘Maturational’ being within the title, and these available strategies are grouped into age/developmental stages (Farnfield & Stokowy, 2014).

- Infancy
- Pre-school
- School age
- Adolescence
- Adulthood

In total there are 22 categorisations (Farnfield & Stokowy, 2014), for the purpose of this study it is not necessary to go into detail of each of these stages and the strategies available, however information on some other ideas from the DMM are necessary for understanding the theoretical framework of the study.

Crittenden theorised that unresolved loss and trauma can cause a normally stable strategy to suddenly disintegrate or disrupt and uses the metaphor of a land mine suddenly exploding, this disruption may only be temporary (Crittenden and Landini, 2011), the building evidence base agreeing with this assertion (Farnfield et al., 2010; Crittenden et al., 2021b; Crittenden et al., 2021c; Dallos & Smart, 2011). Through examining multiple Adult Attachment Interviews she also identified modifiers that can

induce more long-term breakdowns of self-protective strategies, such as depression. People using the higher ‘A’ strategies deny affective information and supress their own negative affect. This can result in sudden intrusions of that negative affect, these can be sudden and explosive leading to inexplicable and at times violent behaviour and Crittenden entitled these ‘Intrusions of forbidden negative affect’ (INA’s). Crittenden also paid attention to non-verbal behaviours that may be somatic symptoms such as coughing, sighing, and jiggling concluding that these are symptoms of conflict within the speaker around the subject being spoken about. While the DMM recognises the effect of trauma and these other modifiers on a person’s strategies, it also recognises the ability for a person to reorganise and over time gain a more secure attachment strategy (Farnfield & Stokowy, 2014).

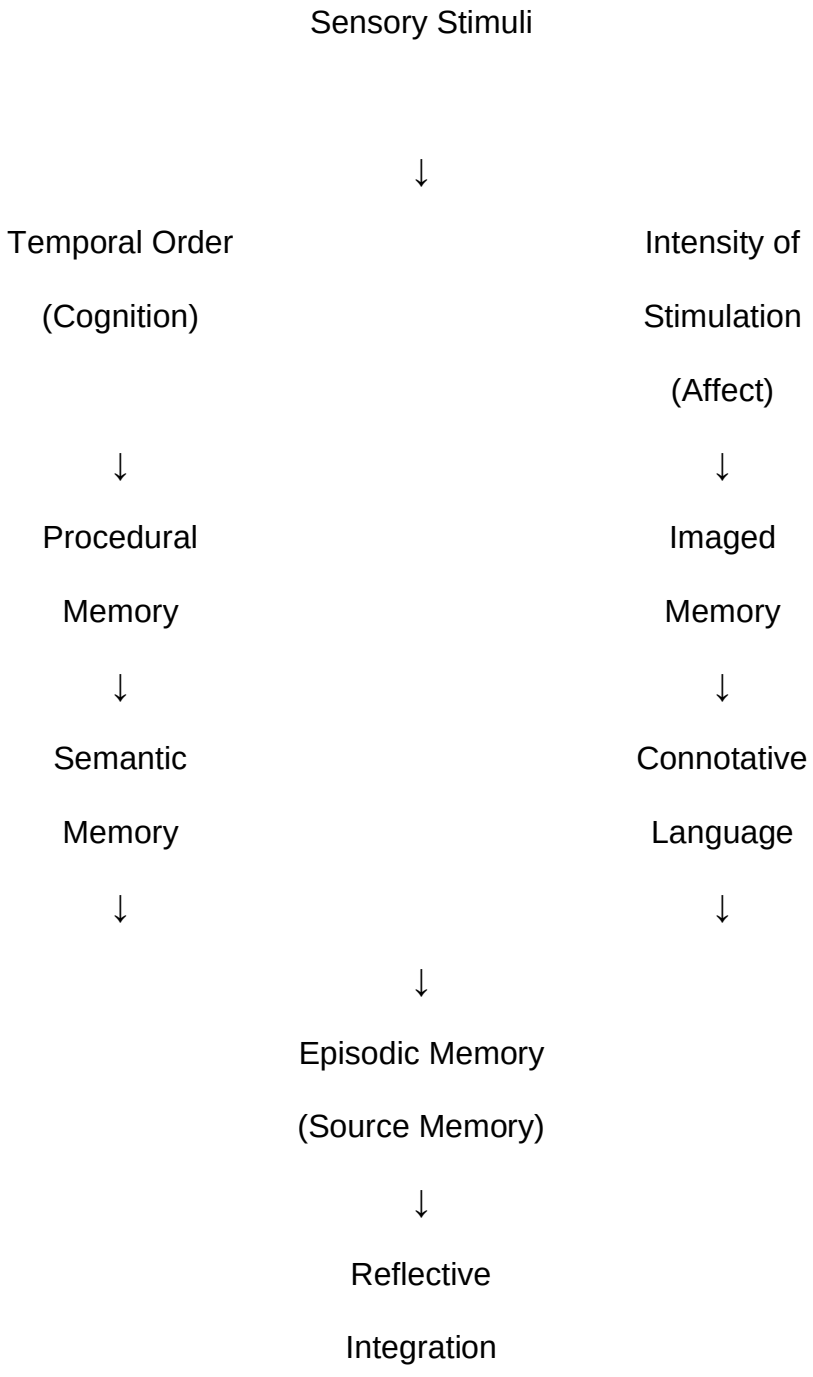
Memory Systems.

Crittenden holds that the past is our only reference point and that when in danger we need to reference the past in order to find a working solution for the situation we find ourselves in (Crittenden, 2002). Bowlby (1980) had already combined Tulving’s (1979) work on memory systems and information processing with his attachment theory, Crittenden then went on to expand on this work within the DMM, becoming a central characteristic. Crittenden’s theory utilised a framework of 6 memory systems that were implicit or explicit and cognitive or affective, linking to the cognitive or affective biases of the A and C attachment styles. These systems were also linked to differing stages of maturation. Procedural and Imaged memory, both being implicit develop in infancy pre language acquisition (Landa & Duschinsky, 2013; Farnfield & Stokowy, 2014). She later added the somatic memory systems of Physiological arousal and Body Talk, however they were developed subsequently to the DMM assessment procedures and do not relate directly to the DMM’s central distinction of

attachment patterns organised by their relationship to cognition and affect (Crittenden, 2016). Their integration into assessment of attachment patterns is a work in progress so won't be focussed on within this thesis.

Figure 1

Crittenden's organisation of memory systems (Farnfield & Stokowy, 2014, P. 62)



(Working Memory)

Procedural memory gives us the knowledge of how to do things, this cognitively based memory system allows us to take automatic actions. For infants this is the system that helps them predict probable responses of their caregiver based on previous experience.

Imaged memory contains all the sensory inputs from previous experiences, particularly those that cause a strong affective experience such as times of danger. This memory system is affective, or emotional rather than cognitive and holds memories of things such as distressing incidents, raised voices or painful experiences (Farnfield & Stokowy, 2014).

Semantic memory and connotative language both being explicit and starting to develop as language develops at around 2 years of age.

Semantic memory is cognitively driven and is the verbalisation of procedural memory and serves as predictive, or descriptive of sequential events, and Crittenden believed this was key in the child's understanding of caregivers' availability (Landa & Duschinsky, 2013; Farnfield & Stokowy, 2014).

Connotative language being the verbalisation of imaged memory is affectively driven and can function to up or down regulate both the speaker and listener, plus communicate feelings.

Episodic memory using both cognitive and affective information is also explicit. This is perhaps what most people think of as memory, it is the story we tell around a

certain situation and is far more detailed than the abstract of semantic memory. This starts to develop from around 3 years old (Farnfield & Stokowy, 2014). Crittenden stated that episodic memory is “biased to reflect experiences that recall strong, unresolved feelings” (Crittenden, 1997, p. 79).

Working memory is an example of reflective integration, it is the process of gathering and analysing the information that is available from the other memory system that can then inform the creation of new DR’s. This process is much slower than the use of the other memory systems and does not function well when the person is under stress or very aroused, as shown by phenomenon like stage fright (Farnfield & Stokowy, 2014).

While perhaps not as widely accepted as the ABC+D model of attachment, the DMM holds strengths in that there are assessments available for every developmental stage and with its wider range of strategies, it perhaps gives a more nuanced understanding of the relationships of children who have experienced significant danger, and their parents, and therefore to clinical interventions that may help a particular person who presents within a clinical setting.

Parental sensitivity

Parental sensitivity, or what was initially called ‘maternal sensitivity’ has been a key concept of attachment theory since its early days. The construct was originally created by Mary Ainsworth over 60 years ago (Grossmann et al., 2013) and both Ainsworth, (1973 & 1979) and Bowlby, (1980) felt that it was a principal predictor in infant attachment patterns. Ainsworth’s ideas around maternal sensitivity initially came through her time in Uganda observing mother and baby dyads where she observed babies using their mothers as a secure base for exploration (Grossmann et

al., 2013). The concept of sensitivity is a complex one, it is the ability of a parent not just to read and accurately interpret a child's signals but then to react contingently and meet the child's needs. It is a dyadic process of communication between a parent and child and is not just about the parent's ability to read signals but about the child's ability to signal in a way that the parent can read and respond. The ability to read and respond are not always connected as a parent may read signals correctly but for any number of reasons does not respond appropriately or in a timely fashion (Claussen & Crittenden, 2000). It was Mary Ainsworth who first developed a measure of sensitivity after her years of observation both in naturalistic settings and in her Strange Situation Procedure, finding that it had a strong predictive capacity for later developing attachments difficulties (Ainsworth et al., 1979). Ainsworth's 9-point Sensitivity-Insensitivity to Infant Signals and Communications scale measures a range of traits in the mother in differing situations, and could be conducted within the laboratory or a naturalistic setting (Mesman & Emmen, 2013), later on Crittenden would develop her own DMM measure of sensitivity plus the babies responsiveness based on Ainsworth's scale called the CARE-Index (Mesman & Emmen, 2013).

In addition to supporting the development of attachment relationships sensitivity is believed to be crucial to both cognitive and social-emotional development throughout childhood (Bernier, Carlson, & Whipple, 2010; Feldman & Masalha, 2010; Mesman, van IJzendoorn, & Bakermans-Kranenburg, 2012). The contingent response of the parent helps to develop a sense of agency in the child and provide a model of possible relationships to come, what Bowlby would term 'internal working models' and Crittenden would term 'Dispositional Representations' (a term taken from Damasio, 1994). Shoenmaker and colleagues (2015) longitudinal study found that adoptees who experience higher maternal sensitivity in infancy were more securely

attached in infancy and representations of attachment were also more secure in early adulthood, and in their meta-analysis Zeegars and colleagues (2017) also found a persistent significant relationship between parental sensitivity and attachment security.

When children are born, they are not able to recognise or regulate their own emotional states, they experience them sensationally, it is the sensitive parent's ability to appropriately mirror the affect to the child that helps the child develop understanding of self and self-regulation (Gergely & Watson, 1996).

Sensitivity is also not to be confused with warmth and affection, as it is perfectly possible for a parent to be affectionate with a child while not reading signals correctly and therefore become intrusive (Seifer & Schiller,1995). Sensitivity in itself is hard to measure as it is a dyadic process that is not just around the parent's behaviours but the dynamic way they interact with their child as the needs and signals of the child change and develop. There are few validated measures that successfully assess this concept, but those that do include the DMM CARE-Index, a videoed interactional procedure that codes both the parent's and infant or toddler's behaviours over a couple of minutes (Crittenden, 2007), and The Meaning of the Child coding of the Parental Development Interview (Grey & Farnfield, 2017) that uses a transcribed semi-structured interview to examine the parents constructs around their child and assess sensitivity through the parent's ability to give credible meaning to the child's signals rather than a direct observation of parent and child. This procedure is one of the core measures within this current study and will be described more fully in subsequent chapters.

The Transmission Gap?

The intergenerational transmission of attachment has long been a subject of interests within the field of attachment with Van Ijzendoorn and Colleagues (1995) introducing the term with reference to the Adult Attachment Interview. Fonagy & Target (2005) felt that understanding this was key to understanding inheritance of both personality disorders and issues with mental health. In recent times interest and understanding of neuroscience has increased and given that, it is now generally accepted that early attachment is significant in brain organization and development (Fonagy & Target, 2005), understanding how attachment is transmitted between generations has become of great interest. While Parental sensitivity has been established as a factor in this transmission there remains a gap in understanding and explanation of how attachment is transmitted (van IJzendoorn, & Bakermans-Kranenburg, 2019). A persistent link has been found between adult's representations and state of mind concerning their own attachment and their own child's security of attachment (Grey, 2014; Fonagy, Seele and Steele, 1991a). The adult's state of mind regarding their own childhood had in fact been part of the early development of the Adult Attachment Interview where Mary Main and colleagues noticed the link between parents who were highly idealising around their own childhood, seldom reporting negative experience and then highly avoidant dyads observed in the Strange Situation procedure (Duschinsky, 2020).

While Crittenden agrees that security in adulthood predicts security in children, and that insecurity predicts insecurity, she would postulate that transmission of attachment is far more complex as a child's attachment pattern is organised around the danger that their particular parent's caregiving exhibits (Crittenden Partridge & Claussen 1001, Crittenden, 2008). Grey (2014) postulates that early understanding

of the transmission of attachment missed out aspects of the dyadic nature of relationship and that the child itself brings a contribution to the relationship, not to mention external factors that may well be affecting the mother's ability to care. Even the term 'transmission gap' could be problematic due to is the implicit one-way nature and the lack of consideration of threat within the environment. Fonagy and Target (2005) put forward that perhaps a missing piece to the puzzle of understanding the transgenerational transmission of attachment may be the parent's reflexive processes such as reflective functioning and ability to mentalize for the child and this has now been found, like parental sensitivity to be part of the picture to understand both transmission and changes in attachment styles between generations (Zeegers et al, 2017). However, even considering these, there is still not a complete picture. Van Ijzendoorn & Bakermans-Kranenburg (2019) put forward that other interesting areas that may bring a fuller picture of how exactly attachment patterns are transmitted include; how a parent repairs mismatches, sets limits, supports autonomy or parents protectively, but for now the full picture remains elusive.

In summary

Attachment theory was originally proposed by John Bowlby with the aim of understanding the importance of early relationships and human development. Early relationship is now understood to be important for the ability to negotiate adult relationships. Early research by Bowlby then Ainsworth gave rise to 3 categorizations of infant relationships; A= avoidant, B=Balanced and C=Ambivalent. Later the category of D=disorganized/disorientated was added to explain cases that didn't fit into the initial 3 categories. Later researchers, Main and Crittenden, diverged in their explanations giving rise to two separate models of attachment,

ABC+D (Berkeley) and the Dynamic Maturational Model (DMM). This study is rooted in the Dynamic Maturational Model of Attachment and Adaptation primarily because of its level of nuance in understanding endangered relationships.

Parental sensitivity is the ability of the parent to read and accurately interpret the child's signals then respond appropriately and in a timely manner, it is a key predictor of an infant's attachment patterns and is supportive of appropriate development in a number of areas. While parental sensitivity is important for the transmission of attachment, there is still a gap of understanding in the complex area as to how attachment is transmitted from generation to generation. This is sometimes referred to as 'The transmission gap' and other factors such as the parent's reflexive processes also contribute to the picture though it is still not fully understood.

Chapter 4: Mentalizing, The Meaning of the Child, Epistemic Trust and Parental Stress

Mentalizing

The ability for a child to experience themself as a person with separate mind that has inner workings and is separate from external reality is not automatic or innate, it is through interpersonal experience, particularly early attachment relationships, that we begin to learn to understand our self and the workings of our own mind (Fonagy et al., 2018). Mentalization, as we now understand, it is rooted in the work of Peter Fonagy and colleagues who, when working with clients who had the diagnosis of Borderline Personality Disorder (BPD) proposed that difficulties with empathy, relationships, identity and affect were caused by an avoidance and inability to process their own and others mental states (Duschinsky & Foster, 2021).

Fonagy took a developmental perspective and believed that the development and evolution of this understanding of self is dependent on interaction with other minds who are non-threatening and reflective and that aversive experiences during childhood such as (and not limited to) trauma and abuse would cause the development of these abilities to be inhibited (Duschinsky & Foster, 2021). This has now been evidenced through multiple studies (Terrada et al., 2021; Wagner-Skacel et al., 2022).

The theory of mentalization combines both psychoanalytic and attachment theories and sees early relationships as key to development, but not as Bowlby (1980) suggested, simply as a template to compare or model later relationships on, but that these relational experiences influence the later ability to process social environments and relationships and interpret both one's own and others mental states (Fonagy, 2018).

Mentalization is both cognitive and affective (Fonagy, et al. 2018), and affect regulation is precursor to mentalization. Mentalization is also both intrapersonal and interpersonal. A simple understanding of the concept of mentalization is a person's ability to understand both themselves and other as beings who have a complex weave of thoughts, feelings and motivations behind any behaviour they exhibit. The self-understanding, once gained, can also be communicated to others. The ability to mentalize for self and others is key to all social relationships and situations as it aids us in predicting, or anticipating what actions may be taken by another person (Fonagy & Target, 1998) and hence integral to human survival. Human beings are meaning making animals, and the meaning that we attribute to our internal states not only impacts on self-regulation but self-concept and esteem. This meaning also aids in communication and collaboration with others, enabling depth of relationship and cooperation (Fonagy et al., 2018).

Initial understandings of Mentalization were unclear and so Fonagy and Luyten (2009) proposed 4 polarities within the construct of mentalization; 'automatic versus controlled, cognitive versus affective, internal versus external-based, and self versus other focused.' (Fonagy & Lutyen, 2009. Pg. 1358). Automatic mentalizing takes limited cognitive work and happens quickly, while controlled is more measured, deliberate and conscious. Beneficial mentalizing requires integration of both cognitive and affective information and should not exclude either of these sources of information and finally the focus of mentalizing can be on oneself and the person's own experience or that of others and focus on exterior features such as facial expressions of others or on judgments about the person's own internal mind or that of others. In clinical work, Fonagy and Colleagues (Bateman, & Fonagy, 2016) consider that ability to use all types of mentalizing at each end of the polarities highly

important and that clinicians should consider if a patient is stuck in any one type of mentalizing and unable to use another.

‘Mentalizing is optimal when the dimensions – for example, emotion and cognition, or representation of self and other – are in balance and nonmentalizing modes are inactive’ (Bateman, & Fonagy, 2016. p.viii)

It is perfectly possible for mentalization to be completely absent, in essence blocked where a person is not considering their own or others experience in the framework of thoughts and feelings, and there are times in life where this is necessary for functioning, essentially it is necessary to move in and out of mentalizing states (Duschinsky & Foster, 2021), this not mentalizing is very different to nonmentalization. The antithesis of mentalization is nonmentalization, in that it is the incorrect or skewed attribution of thoughts feeling and motivations. Fonagy and colleagues (2018) identified 3 specific areas of nonmentalizing: Psychic equivalence, Pretend mode and Teleological mode.

Psychic equivalence is where the person’s current experience and their inner mental reality is mistaken for external reality. When in this mode a person cannot consider there may be another perspective other than their own, they are concrete and inflexible in their thought and stance, they take whatever they feel or sense in the moment to be reality with no regard to the probability or improbability of it, or ability to take into account other’s perspectives to adjust errors or limitations in their own perspective. In this mode a person relies exclusively on internally generated information.

Pretend mode serves to cause separation or an uncoupling from outer reality, it is as if the mental world is disconnected from real experience and serves to protect the

person from the pain of reality. It is talking about mental states using a borrowed or imported external perspective around how it is perceived people should think and feel rather than what is internally true. In this mode a person relies on externally generated information without referencing the internal world.

Telelogical mode demands concrete evidence to believe a concept. Behaviours are only understood from what is seen rather than from the underlying thoughts, feelings and motivations. This mode is mechanical in explanation inferred from what is observed without a reference to relational issues.

Though over simplified, a parent's own attachment mental representation and experience is linked to the transmission of attachment, however a parent's ability to reflect on the child's personal mental experience is seen as key to developmental outcomes and secure attachment (Slade, 2005).

Fonagy and colleagues (2018) consider that inconsistent and inadequate parenting cause vulnerability within the child and a later psychological susceptibility if the child experiences further adverse experience. Ability in mentalization can be a buffer to the effects of these adverse experiences but as Fonagy states.

'However, brutalization in the context of attachment relationships, generates intense shame. This if coupled with a history of neglect and a consequent weakness in mentalization, becomes a likely trigger for violence against the self or others, because of the intensity of the humiliation experienced when the trauma cannot be processed and attenuated via mentalization.' (Fonagy et al., 2018, pg. 12).

Essentially, adverse experiences can be processed through mentalization as it enables the person to create a distance from the intensity of experiences and negative meanings associated to reflect rather than simply react.

Parental Mentalizing and Reflective functioning

Along with parental sensitivity, parental mentalizing is considered influential in the prediction of secure attachment relationships in infancy and childhood (Fonagy et al., 2016; Meins, 1999, 2013; Meins et al., 2012; Slade et al., 2005). Meta-analysis has confirmed significant correlation between the constructs of parental mentalizing and attachment security (Zeegars et al., 2017). It is thought that it promotes secure attachment due to the child experiencing their parent recognizing their affective state through parental consideration of the child's thoughts and feelings (Fonagy & Target, 1997). Low parental mentalizing is distinguished by either indifference or no awareness, or perhaps misinterpretation of the child's internal world (Fonagy et al., 2016; Slade, 2005; Meins et al., 2001, 2012).

Initially assessment of parental mentalizing had been through interview procedures looking for explicit verbalisation showing awareness of the child's internal states and reflexivity (Zeegars et al., 2017). More recently a growing awareness of other aspects of implicit mentalization or parental embodied mentalization (Shai & Belsky, 2016) has led to new areas of research (Zeegars et al., 2017).

Zeegars and colleagues (2017) report that there are 3 key concepts and measurements within parental mentalizing; parental mind-mindedness (Meins, 1997), parental insightfulness (Oppenheim & Koren-Karie, 2002), and parental reflective functioning (Slade et al., 2005).

Parental Mind-Mindedness

Conceptualised by Meins (1997), in an attempt to measure parental mentalization, refers to the ability of a parent to see their child as individually operating with their own mind. In infancy it is displayed by the appropriate attunement or non attunement

when speaking about their child's internal states (Meins et al., 2003) and then later measured through the parents' ability to talk about their child's emotional and mental stated and characteristics. Meins and colleagues (2001) used 5 specific indexes to measure mind-mindedness: encouragement of autonomy, and maternal responsiveness to direction of gaze, object focused action, and imitation as well as appropriate commenting and interpretation of the child's internal states.

Parental Insightfulness

Parental Insightfulness (Oppenheim, & Koren-Karie, 2002, 2013) is the capacity of a parent to 'see things from the child's point of view' (Oppenheim, & Koren-Karie, 2013, p. 551). To assess this Oppenheim and Koren-Karie (2013) used constructs from the Adult Attachment Interview (AAI: George et al., 1984), focusing on speech and thought organisation, plus learning from the Ainsworth and colleagues (1971, 1974) work on maternal sensitivity. To assess this parent and child dyads would be filmed in 3 different situations then parents watched back each one and talk about what they thought their child was thinking and feeling, they were further asked to talk about their child and the relationship between them. The parents' discourse was transcribed and then coded in a similar manner to the AAI (Zeegars et al., 2017).

Parental Reflective functioning

Followed on from Reflective Function (RF) that was first defined and measured by Peter Fonagy and colleagues (1998). Originally a scale to measure RF was developed to be used with the transcribed Adult Attachment Interview (AAI: George et al 1984), however this related to the adult's ability to reflect on their own childhood and though related to ability to reflect on their child's inner world, this was not actually measured. To measure this specific parental reflective functioning, the scale was adapted to be used with the Parent Development Interview (PDI: Aber et al,

1985), it is this scale that is used in part of this current study and is described further within the methodology.

Slade (2005) saw reflective functioning as the process of mentalizing being made explicit and overt. Specifically, Parental Reflective functioning is the parent's ability, or lack of, to hold in mind what may be their infants state of mind then reflect on this. Once the child's mental state is reflected on it enables the parent to react in a contingent and sensitive way, as already mentioned in the section on parental sensitivity. To be able to be reflective about the child's internal world, the parent needs to both be able to use their imagination to understand what might be going on while maintaining an understanding of reality at the same time (Slade et al, 2005).

The Meaning of the Child Coding

As already mentioned, this current study uses the Reflective Functioning coding of the Parent Development Interview (PDI-RF) which measures parental reflective functioning. However, this study also uses the Meaning of the Child coding of the Parent Development Interview (MotC). The MotC is of particular interest to this study as, though measuring similar concepts to the PDI-RF it goes further and uses multiple markers to understand the meaning that the child has to the parent, by making apparent the various scripts that the parent has around their child and further explores the parent's style of parenting (Grey, 2014). The MotC is grounded in the DMM model of attachment, and as with much of the DMM goes further than wishing to simply categorise the parent it aims to identify strengths and weaknesses in the parents construct around the child, and the relationship, and therefore the level or risk to that child's development within the relationship. In revealing the weaknesses and scripts that the parent has there is also opportunity to devise interventions that would be most beneficial to both the relationship and to the child. The MotC was

validated against Crittenden's measure of parental sensitivity CARE-Index (Crittenden, 2007) as well as the PDI-RF and as such is validated to measure both parental sensitivity and parental reflective functioning, and the developer would argue that it also measures the style of parenting such as, unresponsive or controlling, shown by the parent with limited sensitivity.

This is particularly of interest when assessing adoptive families due to the level of nuance in representations and scripts that the MotC can bring to light in the complex world of adoptive families, thus enabling interventions to be directed where most needed.

The MotC and its coding are further described in chapter 7.

Epistemic Trust

Trust is essential in many aspects of life not least in psychological professionals as their ability to help their client involves an element of the client trusting in the professional (Gorman & Sandefur, 2011). Extending their work on mentalization Fonagy and colleagues took on the idea of 'epistemic vigilance' from Sperber and colleagues (2010). Epistemic vigilance is an automatic stance that human beings have, and is self-protective, we cannot trust every piece of information we are given, and it is necessary for survival to be able to weigh the trustworthiness of information. Not everything others teach us is true or in our best interests (Fonagy & Allison, 2018). Duschinsky and Foster state 'For Fonagy and Colleagues, 'epistemic vigilance' often appears to mean a state in which information from others is not felt to have bearing or resonance' (Duschinsky & Foster, 2021 p. 179). Epistemic vigilance is self-protective but children who have had a highly endangered early experience and have not experiences safety in the adults around them are prone to epistemic

hypervigilance where they no longer trust any information they receive from the adults around them, or easily learn from experiences (Fonagy & Allison, 2014). The opposite of epistemic vigilance is epistemic trust, Fonagy and Allison describe it as ‘an individual’s willingness to consider new knowledge from another person as trustworthy, generalizable, and relevant to the self.’ (Fonagy & Allison, 2014 p. 373). Epistemic trust enables us to learn from those who we judge as trustworthy, and then helps us to integrate that into our experience adjusting our thoughts and actions accordingly (Duschinsky & Foster, 2021). As we have already seen, positive attachment experience and beneficial parental mentalizing helps to develop the child’s own mentalizing capacities, but Fonagy and colleagues do not think it ends there, these experiences also help to develop epistemic trust and therefore attachment is key to transmission of beneficial knowledge down through generations (Fonagy & Allison, 2014).

Within attachment relationships ostensive cues such as marked mirroring (a parent using exaggerated sing song voice or facial expressions when communicating with their young baby) help to build secure attachments as the baby experiences themselves as being seen and understood by the parent, but it also encourages the development of epistemic trust (Fonagy and Allison, 2014). Thus, it can be seen that a child who does not have these positive and attuned early experiences will not develop the same level of epistemic trust and therefore will remain more vigilant. This is very relevant to the world of adoption as many of the children placed for adoption will not have had enough of these positive early experiences and therefore are less likely to trust in the adults around them. Research into Mentalization Based Treatment (MBT) can bring hope in this context as the mentalizing stance of the therapists helps to repair the lost mentalizing experience in the client (Sharp et al.,

2018), the adoptive parent taking this stance can help to develop their own child's mentalizing and development of epistemic trust.

Parenting Stress

It has long been known that parenting is not an easy task and at times the parent can become stressed with the task at hand. Parenting stress is conceptualised as a mismatch between a parent's preconceptions and perceptions of what parenting is, and the reality of the demands of parenting their particular child, as a negative reaction psychologically to their responsibility as a parent (Abidin, 1995; Bornstein, 2013; Deater-Deckard,1998). The daily tasks of a parent can be stressful and at times all parents may become tired, confused, frustrated and stressed even when parenting an 'easy' child (Barroso et al., 2018; Crnic & Greenberg, 1990). Researchers have found significant relationships between parenting stress and the exhibition of behavioural problems by children (Benzies et al, 2004), autism and child developmental delay (Hayes and Watson, 2013), plus mood disorder problems (Theule et al., 2013). While it is difficult to ascertain the directionality, the relationship between both externalizing and internalizing child behaviours and parenting stress has been highlighted within research (Davis & Carter, 2008; Dubois-Comtoise et al., 2013; Rodrigues, 2011; Tharner et al., 2012), while other researchers suggest bi-directionality between child behaviours and parental stress (Neece et al., 2012; Williford et al., 2007; Woodman et al., 2015).

Levels of parenting stress are of psychological importance as it is understood that it can impact the parents' capacity to care for the child in a responsive way and therefore can impact the psychological development of the child (Abidin 1990; Greenley et al. 2006; Webster-Stratton 1990).

Within adoption research it is known that adoptees display higher levels of internalizing and externalizing behaviours than their nonadopted peers (Juffer & van Ijzendoorn, 2005) and are disproportionately represented in clinical settings (Juffer & van Ijzendoorn, 2005; Miller et al., 2000; Warren, 1992; Wierzbicki, 1993). Nadeem and colleagues (2017) studied child behaviours and parenting stress in families who adopted from foster care, their study found that there was both a reduction in externalising behaviours and parental stress in the first year post adoption, but then parenting stress plateaued for those who had adopted children over the age of 4 while it increased for those who adopted younger aged children until there was no significant difference between the two groups. When studying parental stress early in adoptive placement, Canzi and colleagues (2017) found that both the behavioural and emotion difficulties plus child's age at placement were predictors of parent's stress, but that the quality of couple relationship was a protective factor. Research has evidenced that parenting stress is positively related to a parent's construct around their child's emotional and behavioural difficulties (Goldberg & Smith 2014; Judge 2003; Mainemer et al., 1998; McGlone et al., 2002; Miller et al., 2009; Rijk et al. 2006; Viana & Welsh 2010), and thus parenting stress may well be linked to the parents reflective and mentalizing capacities discussed earlier in this chapter, in fact recent research by Santelices and Cortes (2022) explored the links between mentalization, parental stress and mother-child interactions finding that the ability for the mother to be encouraging was predicted by their emotional mentalization and parental distress while their ability to teach was influenced by cognitive mentalizing and the mothers construct around the child being 'difficult', highlighting the intertwining of parental stress, mentalizing and the parenting task.

In summary

Mentalizing is the ability to understand oneself and the complex weave of thoughts, feelings, motivation and desires that underly any action, but not just this, it is also the ability to understand that others are separate beings who also have their own different complex weave. The theory of Mentalization as early developed by Peter Fonagy and colleagues combines both attachment and psychoanalytic theory. The development of mentalizing abilities is within early relationships and beneficial mentalizing is essential for successful navigation of adult life. Many mental health diagnoses such as Borderline Personality Disorder (BPD) are significant in the lack of beneficial mentalizing capacity. Parental mentalizing and reflective function are important for the development of secure attachment relationships.

The Meaning of the Child coding of the PDI (MotC) measures parental sensitivity, mentalization and reflective functioning as well as being able to identify risk to development within the parent- child relationship and different styles of non-sensitive parenting.

Epistemic vigilance is a natural human state, we need be able to process the information we receive to judge it is trustworthy or not. Epistemic trust is the opposite, it enables us to take on information from trusted others and our experiences and integrate this information into our way of being. Children who have experienced trauma, abuse and loss in their early years are more likely to remain in a state of vigilance and not developed epistemic trust, therefore find it hard to learn from the adults around them and their experiences.

Parental Stress is caused when there is a mismatch between a parent's preconceptions and the actual demands of parenting. It is significantly linked to

differing disorders and behaviours displayed by children. There is a bidirectionality between parental stress and child's challenging behaviours.

Chapter 5: Group based Parenting Programmes and Interventions

Chapter 2 explored the roots of aggression and the contribution of environment and parenting practices on the development of aggression in children and young people, then in chapter 3 and 4 the parental- child relationships were further explored in the context of parental sensitivity, parental reflective functioning, and attachment theory. These chapters showed how parenting practices are predictors for childhood outcomes. Given this, it would seem logical that parenting programs would be an important first step in impacting issues displayed by children.

Adopted children, fostered children and those who have lived through early neglect and traumatic experiences show a higher incidence of externalising and aggressive behaviour (Brown, Waters, & Shelton, 2017; Juffer & van IJzendoorn, 2005) that can continue into adulthood (Dekker et al., 2017). Carers report finding these behaviours highly stressful (Harris-Waller, 2016) and at times this can lead the carer either to becoming overly punitive or to withdraw from the relationship thus, once again, leaving the child with the possibility of their attachment needs not being met. The regulation of arousal may be problematic for both parent and child (Crittenden, 2016; Howe, 2011). Often professionals focus on the child with attempts to modify behaviour, but Crittenden (2016) suggests a different perspective, that changing the environment that the child experiences would reduce anxiety and more extreme behaviours the child developed as survival strategies (Canzi et al., 2019), thus further suggesting that parenting programs may have efficacy in alleviating issues within this particular population group.

Parenting programs have been long promoted by governments as a cost-effective intervention for a range of family and childhood issues (Stevens, 2014). Investigating in the Swedish context, Nystrand and colleagues (2019) used a randomised control

trial to explore the longitudinal cost effectiveness of 5 parenting programs versus a control group. Using disability-adjusted life-years (DALY's) and cost of delivery to calculate benefits they found that almost all the interventions were cost effective at reducing externalising behaviours compared to the control group.

Efficacy of parenting programs

The drive towards evidence-based practice has increased research into efficacy of parenting programs, not just their clinical efficacy but as already mentioned the cost effectiveness. Research studies and meta-analysis of randomised control studies come to the conclusion that group parenting interventions significantly reduce the display of problematic behaviours and conduct problems, encourage effective discipline and positive parenting strategies, and improve both child and parental emotional and mental health. In fact the more sever the emotional and conduct problems were the more benefit was gained from parenting programs (Barlow et al., 2012, 2016; Dretzke et al., 2009; Furlong & McGilloway, 2015; Kaminski et al., 2008; Leijeten et al, 2018; Nowak & Heinrichs, 2008). However, some of the meta-analyses were limited in their findings due to lack of data around control groups, follow up measuring and information around mediators such as socio-economic groups. The heavy reliance on parent report measures could also be problematic as they showed more significant change than observational measures (Kaminski et al., 2008; Nowak and Heinrichs, 2008). Interestingly within these research studies, some of the strongest predictors of reduction in problematic behaviours were factors that showed improvements in the parent-child relationship (Kaminski et al., 2008). Studying the long-term efficacy of parenting programs, Gray and colleagues (2018) found that there were significant improvements in parental well-being, parenting style and behavioural problems 12 months after the completion of evidence-based

parenting programs, showing the sustained effectiveness of these types of programs.

While meta-analysis has suggested that parenting programs are effective in improving outcomes, and generally cost effective, Furlong and McGilloway (2015) point out that sometimes results shown in studies are hard to replicate, particularly in the context of disadvantage. Using a qualitative method study embedded in a larger randomised control trial they pointed to the importance of carefully considering the individual make up of each group and attention being paid to parental preparedness to engage in the group and change process, thus highlighting the importance of screening processes. This suggests that a drive to cost-effective and group-based interventions could lose sight of the fact that it is unique individuals existing within their own unique family groups, each struggling with different types and levels of stresses that could potentially affect the impact of a group intervention.

Interventions for families experiencing Child to Parent Violence (CPV) and Adolescent to Parent Violence (APV)

There are a range of interventions that have been developed in recent years to help families struggling with CPV and APV. A brief outline for the 3 best known interventions is included below.

Non-Violent Resistance (NVR) (Jakob, 2018)

NVR is probably the best-known intervention for CPV and APV and with is growth in usage there is an increasing evidence base being produced. It is delivered as a 10-week course for parents and does not require active participation from the young person, after the course the facilitator can act as a coach to individual families.

Developed by psychologist Haim Omer, the NVR program is a systemic approach that has its roots in the non-violent resistance movements within politics. Instead of trying to develop insight in the child or young person displaying violence or aggression, the program aims to empower the parent and bring restoration to the parent- child relationship that has often become eroded over time. A key concept within NVR is that of 'parental presence' in the child of young person's life, the developers of the intervention found that relationships between parent and child had often begun to disintegrate due to the challenges within the family, and that when faced with a violent child, parents often become overly accommodating as well as show increasing withdrawal from interaction with their child. NVR utilises the expansion of the families support network, as well as techniques called 'sit-ins' and 'announcements' as well as 'campaigns of concern' with a view to raising the parental presence in the life of the young person and bring moderation to behaviours by the parent resisting those behaviours. Key to NVR is creating transparency, violence often thrives when hidden, and supporting parents and carers to share with their social network about what is going on in the family reduces the power and secrecy dynamic (Omer & Lebowitz, 2016). It also requires a commitment from the parents to be non-violent in their responses and take unconditional acts or reconciliation after a rupture in the relationship.

Parents and carers are supported to resist behaviours by documentation and sharing information with their support network. This is not about doing something in the heat of the moment or in a violent, shaming, or threatening way, but once and incident is over the carers document what has happened and share with a few of their supporters who then contact the child. This contact is not giving the child a 'telling off' but make them aware that they know what has happened and they wish to

support the family to help things get better (Omer & Lebowitz, 2016). NVR also utilises aspects of restorative justice to help the child make amends for some of the behaviours.

Peter Jakob describes it as a “Systemic intervention for violent and destructive behaviour in young people. Parents, carers, siblings, members of the wider family and community, and professionals are brought into the intervention, forming a proactive support network.” (Jakob, 2018, pg. 25-26)

Since its inception NVR has been expanded for use in other areas such as schools, as well as for a range of other conditions and situations where young people display aggression and violence. NVR has shown itself to be effective with young people with anxiety disorders and OCD (Lebowitz, 2013; Lebowitz et al., 2014) with foster families (van Holen et al., 2015) and for parents who have adult children living at home and displaying controlling behaviours while not working or studying (Lebowitz et al., 2012).

In their analysis of existing publications around NVR Omer and Lebowitz (2016) found that key principles within NVR had allowed it to be used across different cultures and setting to great success and noted that even with basic training in NVR family therapists have been able to integrate it successfully into their practice whatever their key modality (Wilson & Smith, 2014). Perhaps the most powerful effect of the NVR program is restoring the parent’s sense of agency in a situation where they are totally focused on the child’s adverse behaviours with little or no sense of their part in escalation or ability to stabilise their child (Omer & Lebowitz, 2014).

Independent research into NVR found it to be a useful intervention. Within a small-scale pilot program in the UK, parents reported finding the de-escalation strategies and encouragement to show unconditional love particularly useful, and there was a significant difference between pre and post parental scores on the Goodman Strengths and Difficulties questionnaire (SDQ), though this study did not make use of a control group (Newman et al., 2014).

Contrary to other finding a recent randomised control study of young people with severe tyrannical behaviour did not show any significant difference in improvements of parental stress as measured by the Parenting Stress Index/Short Form and young people's behaviour using the Goodman SDQ (Fongaro et al., 2023).

The Who's in Charge program (Gallagher, 2014)

This 9-week parenting program, developed by Australian psychologist and social worker Eddie Gallagher, aims to help the parents understand the complex weave of issues that may be contributing to their child's behaviour, reduce shame and blame, and changing parental attitude.

The development of the course was based on Gallagher's years of work with families struggling with violence and aggression from their children and his exploration of the limited literature, interventions and theoretical explanations of the phenomena. It would appear that there is not one key theoretical stance underpinning the course development but aspects theories that have had influence include Social Learning Theory (Mihalic and Elliott, 1997), Attachment Theory (Kesner et al.,1997), Conflict Theory (Hoffman and Edwards, 2004), Stress Theory (McKenry, et al., 1995), Differential Association Theory (Agnew, and Huguley, 1989), Social Control Theory

(Agnew, and Huguley, 1989), and Nested Ecological Theory (Cottrell and Monk, 2004).

Loosely divided into four sections, the first focuses on the reduction of isolation and guilt while supporting them to be firm in their desire to maintain boundaries and not accept violence from their children. The aim is to support the parent/carer in attitudinal change towards their child and the situation they find themselves in.

The second section aims to educate the parent with some concrete ideas that will assist in behaviour change for the young person. There is a focus on the use of consequences to modify behaviour. The third section explores both parental and the child's anger, then looks at assertiveness and self-care.

The final part is a ninth follow up sessions after approximately 2 months that is used to consolidate knowledge and assess group efficacy.

Gallagher lists the overall group aims as

- Reduce parents' feelings of isolation.
- Challenge parents' feelings of guilt.
- Loosen deterministic thinking about causes (e.g. "he can't help it because he has A.D.H.D. or he saw his father be violent") – it is **always** multi-causal
- Create belief in possibility of change.
- Clarify boundaries of what is acceptable and unacceptable behaviour.
- Examine strategies for creating meaningful and practical consequences for unacceptable behaviour.
- Reinforce progress and provide emotional support while parents attempt to become more assertive.
- Explore anger, both children's and parent's.

- Encourage assertiveness.
- Encourage self-care.
- Reduce parents' feelings of depression and powerlessness by the end of the course.
- Reduce the amount of violence and abusive behaviour in a majority of the families.

(Gallagher, 2014, pg. 8)

According to Gallagher (2014) although it is against the program's philosophy to state that parental behavioural change brings child behavioural change, this is in fact the experience of many of the parents attending, and that reductions in guilt, parental stress and depression are also reported. Gallagher also points out that it is highly important that the professionals working with families do not ascribe all the fault to the parents, but equally that deterministic ideas around early environment or genetic factors are not held. He believes the importance is to see the complexity in the situation where not one single factor has led to the dynamics developing.

There would appear currently to be no peer reviewed research into this program, and therefore its effectiveness is unknown.

Break4Change (Ginn, 2009)

The Break 4 change 10-week program was developed by a multidisciplinary team in Brighton and Hove to support an increasing number of families where APV was an issue. The program is based on Non-Violent Resistance theory (NVR) and restorative justice and integrates the work of Eddie Gallagher who developed the Who's in Charge program. This program works with both the parent and young people (aged 11-17), in contrast to NVR and Who's in Charge, but only on the

condition that both engage willingly. Like the other programs it aims to reduce shame and stigma, empower the parents, and bring clarity to boundaries. Parents are supported to challenge their mindset around the violence and stop making excuses for the behaviour and this helps to remove the powerlessness that many parents in these situations feel.

During the program parents and the young people are in two separate groups that run in parallel. These sessions support both groups to work through the type of relationship they want with their parent/child and ways to relate with one another and share their thoughts and feelings. The parent group enables the parents to reassess the dynamics that have developed within the family and their parenting style as well as the effects on the whole family of the violent and aggressive behaviour. The young people's groups are designed to be both educational and therapeutic and use creative means to work with the participants and help build insight and awareness as well as develop empathy.

Dialogue between the parents and child is supported by a film process where views are expressed separately from the presence of the other party.

Aims of the program are listed as

- create belief in the possibility of change and stop or substantially reduce the abuse.
- help young people learn to manage their frustration in a non-abusive manner.
- enable better listening, communication skills and sense of responsibility to enable more mutually respectful behaviour in young people.

- clarify boundaries of what is acceptable and unacceptable behaviour.
- increase parents' sense of well-being and reduce their isolation.
- assist parents to hold the young person accountable for his/her violence while maintaining the relationship.
- examine strategies for creating meaningful and practical consequences for unacceptable behaviour.
- enhance parents' skills in listening, communicating, conflict avoidance, resolution and negotiation.
- reinforce progress and provide a forum for emotional support while parents attempt to become more assertive parents.

(Break4Change Partnerships, 2015, pg. 12)

The developers of Break4 Change state that any facilitator of the course must understand the cycle of change based on Di Clemente & Prochaska (1982) model of change, that to bring any behavioural change into being a person has to go through several stages, pre-contemplation, contemplation, decision, action, maintenance then at times relapse. The program is about collaborating in a way that respects the participants autonomy, and professionals need to guard against being prescriptive.

Though widely adopted, as with the 'Who's in Charge' program, currently there does not appear to be research or evaluation of the effectiveness of the program.

Interventions that aid reflective functioning.

Arietta Slade was one of the early developers of the concept of parental reflective functioning (PDI-RF) and she believed that success in promoting change to parenting and the parent child relationship depended on facilitating improvements in

parental reflective functioning (Slade, 2007). She theorised that success in earlier work in attachment interventions and parent-child psychotherapy were largely resultant from changes in parental reflective functioning even though this had not been a specific focus of the treatment (Slade, 2007). This hypothesis led to development of programs that specifically aimed to impact PDI-RF, Parents First (Goyette-Ewing et al., 2003) and Minding the Baby (Slade et al., 2005).

For Slade (2007) there are several key aspects to aiding and improving PDI-RF; Firstly, to help development of a '*reflective stance'* (Slade, 2007, pg. 644)– this is by aiding the parent to move from seeing their child in terms of the physical 'behaviour' but rather in terms of having an internal experience that might be motivating behaviour. This is done by the facilitator/therapist '*modelling reflectiveness'* (Slade, 2007, pg. 650) both around what is happening for the child as well as the parent, then *'facilitating wondering'* (Slade, 2007, pg. 650) and encouraging curiosity in the parent around the child's experience. Another key component is '*Eliciting Affect as a Means to Mentalization'* (Slade, 2007, pg. 646), it is in these highly experiential moments that the ability to reflect and mentalize moves from the theoretical to the practical as the parent experiences being helped to regulate their own intense feelings (Pine, 1985).

Secondly Slade advocated *'Holding the parent in mind'* (Slade, 2007, pg. 647) – many parents themselves may not have experienced being heard and understood in their own childhood or in adult life and the therapist starting with parent's own experience and hearing their 'cry' initiates a situation where the parent can hear their own child's cry (Fraiberg, 1980).

Thirdly it is essential to work at '*A level the parent can manage'* (Slade, 2007, pg. 648). Overloading a parent who may be already struggling is of no benefit and many parents may not be able to handle the complexity of their child's internal world, so starting at a relatively non-threatening level and then gently leading forward is very important.

Finally, Slade (2007) believes that reflective parenting programs are an '*Explicitly psychoanalytic approach'* in line with the shifts away from interpretation as the key facilitator of change but utilising interpretative thinking as the therapist identifies and makes assumptions about the parents' capacity and what arises in the parent child relationship, thus through this helps the parents understand a tolerate the child's internal states.

Aiming to integrate ideas around mentalization and PDI-RF, **Parents First** (Goyette-Ewing et al., 2003) is a group-based program delivered over 12 weeks aimed to be preventative with lower risk parents of children aged from birth to pre-school. **Minding the Baby** (Slade et al, 2005), is also preventative but working with higher risk mothers from the third trimester of pregnancy. This home visitor based program also linked in to other local services within the mothers communities. Programs were also developed for specific populations such as inpatients with substance abuse issues (Pajulo et al.,2006), **The Mother and Toddler Program** (MTP; Suchman et al 2008, 2010a, b) for use with substance abusing mothers, and **New Beginnings** (Bardon et al., 2008) a group-based intervention for mothers in prison.

The Attachment and Biobehavioural Catch-up (ABC) (Dozier, Dozier and Manni, 2002) that was delivered within the carers home over 10 sessions using video

feedback found that foster carers (as well as at-risk parents) could be coached into more sensitive parenting (Bernard, et al., 2012; Dozier, et al., 2005).

Cooper and Redfern's Reflective Parenting Model (Cooper and Redfern, 2016) has been developed into a group-based parenting program by the Anna Freud centre, that uses mentalization-based psycho-education to specifically promote the parents ability to mentalize for the self and the child, and is entitled **The Reflective Parenting Program**. This has further been developed into the **Reflective Fostering Program** (RFP: Redfern et al., 2018). Pilot evaluation of the RFP showed significant improvements in areas such as foster carers stress as well as the child's behaviours (Midgely et al., 2019).

Group Based Interventions for adopters.

While there are a number of group-based parenting programmes for adoptive families, there would appear to be very little evidence for the effectiveness of these programmes. Selwyn (2017b) suggests that some of the reasons there may be little rigorous research into interventions may be lack of funding for research and the implementations difficulties for randomised control studies within social care settings.

Non-violent resistance - As one of the most researched interventions for CPV, NVR has been adapted and used with adoptive and fostering families (Samuel, Holdaway., & Vella., 2022), but studies found no reduction in violence amongst fostering families (Van Holen., et al. 2016). To date there would appear to be no quantitative research specifically into NVR with adoptive families though an Interpretive Phenomenological Analysis of interviews with adoptive mothers who have undergone NVR therapy showed that some found it an effective intervention.

The Great Behaviour Breakdown (Post, 2016) also proves to be popular with adoptive parents. Based on the book of the same name by Clinical Social worker and adult adoptee Bryan Post aims to help the parents understand the roots of behaviours and improve the parent child relationship. He bases some of the course on the work of Bruce Perry (2009) and Dan Siegel (1999) The course is usually presented of 3 full days consecutively. There is currently no research evidence into this intervention.

Adoption changes. Based on the 'Fostering Changes' program is a 12-week course combining social learning theory and attachment approaches. The aims of this course are; help build positive relationships between carer and child, appropriate limit setting and encouragement of positive behaviour. This program is focused on problematic behaviours rather than mental health issues and studies into the fostering version found some reduction in problematic behaviours and improvements in carer reported relational quality but no improvement in pro-social behaviour, emotional problems, and hyperactivity (Warman et al., 2006: Brinksman, et al., 2012; Luke, et al., 2014).

The 'AdOpt' program (Harold, et al., 2017) is an adaptation from the US based **KEEP** programme and is aimed at parents of children between 3 and 8 years old. Delivered by 2 trained facilitators, one of whom is usually an adoptive parent, it is run for 16 weeks, and each session is of around 1.5 hours. As with Adoption Changes it was designed with Attachment and Social Learning theory at the forefront and intended to be used within the first couple of years of placement. This was intended as a pre-emptive programme for the families of children likely to display complex challenges. The evaluation study used pre-intervention and post-intervention self-report measures including child measures, the Goodman Strength and Difficulties

Questionnaire (SDQ: Goodman, 2001) Assessment Checklist for Children Plus (ACC+; Tarren-Sweeney, 2007) Assessment Checklist for Children - Short Form (ACC-SF, Tarren-Sweeney, 2007) and parent measures Parenting Sense of Competence (PSOC, Jones and Prinz, 2005) which examining the self-efficacy of the parent, The Parenting Style and Parent–Child Relations (Iowa Youth and Families Project(IYFP) – Parental Monitoring and Discipline Subscale, Conger et al, 1992) and Time Spent with Child: Parent-Child Affiliation Style (Harold et al., 2007). Data was collected for 101 children, though there was approximately a 10% drop out resulting in between 81 and 90 full sets of data for each questionnaire returned. Findings from the evaluation (Harold, et al., 2017) were similar to those of the fostering changes program around the child's problems with improvements in conduct but not pro-social, hyperactivity and emotional problems. Parents self-report did show improvements in their sense of competency and parental monitory with larger effect size than that of the child measures showing that even where child behaviour showed no improvement the response and attitude of the parents did. There was no longitudinal follow up for this study and also no control group in this evaluation.

Over recent years the focus on Mentalization and reflective functioning has led to group-based programs that specifically aim to aid reflective functioning such as the Nurturing Attachments Program (Staines, Golding, & Selwyn, 2019) and the afore mentioned Reflective Fostering Program.

Nurturing Attachments Program (Staines, Golding, & Selwyn, 2019) Possibly one of the most popular and frequently commissioned group programs for adopters it is delivered over 18 sessions. It is informed by the Dyadic Developmental Psychotherapy (Hughes, Golding and Hudson., 2018) and educates the parents on

the PACE (Playfulness, Acceptance, Curiosity and Empathy) attitude of parenting. Though this intervention is poorly researched (Crossar, 2014; Lewis et al., 2022) and it appears that studies to date into the efficacy of Nurturing Attachments do not include any control groups the Department for Education has categorised it as a 'research based' intervention (Department for Education, 2016). While it appears that parental reflective functioning improved across the time points (as measured by the self-report PDI-RFQ), the children's challenging behaviour increased (Staines, Golding, & Selwyn, 2019).

The Family Minds Program (Bammens, Adkins, & Badger, 2015) was originally piloted in Texas with both adoptive and fostering parents. This short-term group-based intervention of just 9 hours across 3 sessions aims to promote the parents' curiosity and introduce them and educate them on the theory of mentalizing and reflective functioning, plus give enhance skills through experiential exercises. A randomized control trial, this time with just foster parents showed that a short-term group intervention may well increase the parents RF (Measured through the use of 5-minute speech samples), sensitivity and emotional regulation, also decreasing parenting stress while it appears that it may also decrease some internalizing behaviours exhibited by the children (Adkins et al., 2021).

Circle of Security (Cassidy et al, 2011) Delivered through a mix of group sessions and individual home-based sessions this intervention is based on a mixture of attachment theory and object relations theory. The aim is to help the parent recognise their child's signals and then respond appropriately; it also aims to help the parent understand how their response affects their child. Using a mixture of psychoeducation and video feedback the hope is that the intervention will help increase attachment security while also increasing the parent's ability to self-reflect

and regulate in stressful situations and when triggered emotionally. Though there are few studies the results are promising and show a significant decrease in attachment insecurity and disorganisation (Cassidy et al., 2011; Powell, Cooper & Hoffman, 2013; Powell et al., 2009).

The Incredible Years Parenting Programme (adapted for adoptive parents) (Henderson & Sargent, 2005). This adaptation of the very well-established Incredible Years Program is delivered in a group setting over 12 weekly sessions and aimed at parents of children ages 3-9 years old. The original program focused on 4 areas; play, praise, reward and effective limit setting and the adapted model amended the material to include information on telling the child about adoption, function of play for traumatised children, regression and adapting strategies for praise that don't lead to challenging behaviour. Part of the aim of the program is to provide the parent with a toolkit of strategies, but also to provide peer support. Though there are 3 evaluations of the adoption program, none have used control groups and while parenting stress levels fell it was not to a statistically significant level (Henderson & Sargent, 2005; Menting et al., 2013; Selwyn, 2017b).

As laid out above there are a range of parenting programs that are designed for parents of children who display aggression and violence, or designed to aid reflective function, or specifically designed for adoptive families, some have more evidence base than others. However, there would appear that there are none that are specifically designed for adoptive families where children display aggression and violence that are also designed to enhance the parents reflective functioning.

It also appears that the research basis for many of these programs, even those that are widely used, is very limited. What studies there are often lack control groups and

are heavily reliant on parent report measures, with virtually none using measurements from the perspective of professionals around the child, such as teachers or social workers. Those that do measure the reflective functioning generally also use parent self-report measures with the exception of one that used 5 -minute speech samples. These studies may well have been more robust had they used measure from other perspective or independently coded interviews, plus the inclusion of control groups for comparison.

In summary

Parenting programs have been evidenced to be both effective and cost effective at improving parenting strategies, improving parent- child relationships and parental wellbeing plus reducing problematic behaviours.

Interventions for families experiencing aggression and violence from their children include Non-Violent Resistance developed by Haim Omer, which is relatively well researched. The Who's in Charge program developed by Australian psychologist Eddie Gallagher and Break4Change program that was developed by a multidisciplinary team in Brighton, neither of which appear to have any research into their efficacy.

There are a range of interventions to aid parental reflective functioning, and these often have a good research base and are based on the work of Arietta Slade. These interventions include The Reflective Parenting Program and The Reflective Fostering Program that were developed at the Anna Freud Centre and have been also used with groups of adoptive parents.

There is also a wide range of parenting group programs specifically for adoptive parents and these range from those that are very behaviourally focused such as The

Incredible Years to those that are more mentalization based such as Nurturing Attachments, though research into the effectiveness of these intervention is limited, and what exists often relies heavily on parent self-report measures also often lacking control groups.

Chapter 6: Development of Knowing Me, Knowing You Adoption Parenting Program

To bring added insight to the development of the KMKY program a reflexivity statement has been placed at the start of this chapter

Reflexivity Statement

At time of writing this I am one week away from my 53rd birthday, I am a parent to 8 children, 6 of whom are adopted, so the subject matter in this thesis is very close to my heart.

My journey through this PhD somewhat mirrors my journey through adoption parenting. At the start of both the PhD and adoption I was excited, hopeful and somewhat naïve as to what was to come.

Most of my children joined our family at older age, ranging from 2.5 years to 10 years at time of placement and several of them displayed aggression and violence. My husband and I went on a journey from traditional parenting to more psychologically informed and reflective therapeutic parenting. I started to train in the area of adoption and trauma, not at first to work professionally, but to gain more insight into how best to parent our children and help them journey through the trauma and loss they had experienced. I then started to support other adoptive parents in a peer support capacity as I realized some of the learning journey we had been on could help others, I then went on to qualify in a number of psychotherapeutic areas and perhaps more by accident the areas of childhood aggression and violence became an area of my therapeutic expertise.

What I observed in my clinical practice was families were struggling with increasing aggression and violence from their children as they got older, whereas we had a

different experience as a family, that as the children settled, began to feel safe and understood, their aggression decreased. This triggered my journey into the world of the Dynamic Maturational Model of Attachment and a more in-depth understanding of the literature around childhood aggression and violence.

The intervention that this study is based around was born out of our years of experience as a family, my years of experience as a therapist and my search for literature and understanding that might just bring to light another piece of the puzzle.

As already stated, this subject area is close to my hear and I live it in every aspect of my life, home, research and work. With this in mind it has been hard at times to separate out my personal view from that of literature and research, I have had to be constantly aware of confirmation bias throughout my research, and while I have worked hard at this I am not under any illusion that this work is totally free of it, and also recognise that my personal experience will also bring to light additional beneficial areas in the research that perhaps would have been missed if explored by a researcher with different life experience. I am after all, and inside researcher.

At times I have felt that this would be never ending and questioned the value of it, just as at times in our adoption parenting journey we have questioned if we were really helping our children to grow, heal and blossom into the people they could be rather that being defined by their trauma and behaviours that resulted from it. Hindsight is a wonderful thing! Just as we see each of our children enter adulthood and thrive and achieve in their own individual way, and recognize the amazing journey we have been on with them plus the incredible resilience each of them has shown, now near the end of this process I can recognize the journey and growth I have been on through struggling, and pushing through at times despite the odds.

Birth of a new program

In late 2017 the researcher was approached by the post adoption support team for a local authority with the view to developing a new group-based intervention for adoptive families who were struggling with challenging and violent behaviour from their children and young people. At the time the team felt there were no appropriate group-based programs that specifically met the needs of this population, there also seemed to be a dearth of therapist available to work with each family individually. Costs for individual work would also have been prohibitive as many of the families were needing to access multiple interventions and assessments through the Adoption Support Fund meaning that the fair access limit would be quickly exceeded.

There was a general feeling within the adoption support team that the Non-violent Resistance program (NVR) in its then current form was not sensitive to the trauma that many young people had suffered prior to placement and other approaches were more behavioural focused and did not take into account the emotional struggles of both parent and child. The researcher had been working with a wide range of families that the team supported, and they were interested in her integrative approach that took aspects from several different therapeutic and theoretical stances including attachment theory, NVR, Dyadic Development Psychotherapy, Sensory Attachment theory and Mentalization as well as understanding of neurodevelopment. The resulting program was named the ‘Knowing me, Knowing you Adoption Parenting Course’.

The title ‘Knowing Me, Knowing You’ was chosen as exercises within the course started with parents reflecting on their own experience, thoughts, feelings and responses based on the premiss that understanding and ability to reflect on and

mentalize for the self is an important precursor to the ability to understand a child's internal world, plus the evidence from Suchman et al, (2010a) that self-reflection rather than reflection on the child was the best predictor of sensitivity in responsiveness to the child. The course design aimed to balance psychoeducation with enhancement of reflective capacity.

Key concepts and considerations in the development of the KMKY program included some of those put forward by Slade (2007). In aiding the development of parental reflective function (PDI-RF) during the course the facilitator needed to retain an empathetic stance where they held each parent in mind and provided an open and understanding listening space to enable each participant to be heard in a way that they perhaps had not felt they had been before. Throughout the course there were specific exercises and examples that aimed to develop the reflective stance through wondering, allowing the sharing of stories that would elicit affect and enable reflectiveness to be modelled. Slade (2007) also advocated working at a level that the parent can manage, for some parents working through their child's inner world may be overwhelming and too painful to start with, with this in mind the KMKY program uses a mixture of psycho-education using scientific based evidence mixed in with affectively ladened reflective aspects to provide breaks for the parents from the internal exploration of themselves and what their child may be experiencing. The psychoeducational aspects were aimed to help with the cognitive understanding of what the families were experiencing while helping the parents regulate and understand both theirs and the child's affective experience.

The design of the KMKY program drew on both evidence-based practice as documented in Chapter 5, but also on practice-based evidence from the course developer's years in clinical practice. One example of this practice-based evidence

was the selection of certain aspects of NVR theory and the omission of others such as ‘sit-ins’ that seemed to increase shame and escalate behaviours in adopted children. In his seminal work ‘The Reflective Practitioner’ Donald Schon (1984) argues the importance of this kind of practice-based learning and the insights that can only come from the practitioner’s experience.

KMKY Course Delivery

Initially the course was intended to be over 10 group sessions of 4 hours weekly, but after the pilot program this was adapted to 9 group sessions with an initial individual session in the participant’s home that included the administration of the PDI. This adaptation was included as it had becoming clear that some participants on the pilot program were not ready to attend and benefit from the course and had only attended due to feelings that they were required to do so, thus making group working challenging, and at times distressing for other group members. One of the aims of the course developer was to provide a safe space for participants to share and explore, while giving and receiving peer support. Research evidences that peer support helps to reduce carer stress, facilitates information sharing and can even help to avoid adoption disruption (Bryan et al., 2010).

All participants were referred to the course by their post adoption support social worker due to them reporting regular aggression and/or violence from their children. The initial one-to-one session was intended to help the participant familiarise themselves with the facilitator, giving an opportunity for them to ask any questions and thereby reduce anxiety around attending the course, but it was also part of a course readiness assessment. Subsequent to the pilot program each participant underwent the Parent Development Interview (PDI: Aber et al., 1985) which was then coded using the Meaning of the Child coding (Grey & Farnfield, 2017) thus

helping the facilitator to understand more about the family situation and the current struggles while assessing course readiness. At time of course development, the inclusion of measures of parental mentalizing such as the MotC was novel, and brought in considerable insight to the parent's mind sets, reflexive processes and understanding of their child, enabling facilitators to emphasise areas that were of particular issue to the participants. This inclusion was also able to evidence the efficacy of the program and any changes that it brought, and help to bring understanding to process of change around parental sensitivity and reflective functioning. The PDI MotC process in itself encourages and aids reflection and early course participants cited how important this pre-program process had been as it started them thinking about their child in a different way and prepared them for what the course may entail, then the post program interview helped them reflect on and consolidate learning.

Participants were also asked to fill in several questionnaires around their stress, construct of the relationship with their child and child behavioural measures. It was in this initial visit that the participants were asked if they wanted their data to become part of the current study, a place on the course was not dependent on research consent.

KMKY Course Aims and Goals

- Develop parent's ability to self-reflect.
- Develop parent's ability to mentalize for their child.
- Develop parent's ability to respond sensitively and appropriately to their child.
- Improve parents understanding of attachment and trauma and how both their own history and their child's history can impact interactions.
- Help parents to be more aware and proactive in their self-care and well-being.

- Improve parent's understanding of escalation and provide them with de-escalation skills including being able to pause and reflect rather than simply react.
- Improve parent-child communication, understanding and empathy.
- As parental sensitivity increases, reduce the need for the children to display challenging and destructive behaviours.
- Provide parents with tangible tools to use every day, and in a crisis, that enable them to maintain boundaries while giving high levels of nurture.
- Facilitate peer support and information exchange between participants in each cohort.

KMKY program content and theoretical basis

The program was designed to be led by two facilitators, and that one of these should have lived experience of adoption or fostering and children with challenging behaviour. Throughout the program and group and individual exercises the course leaders model a mentalizing stance, so that the participants can experience being understood, mentalized for and empathised with. This experience is thought to help establish epistemic trust (Fonagy & Allison, 2014) which can then enable learning and change.

Week 1

After introductions of the facilitators and participants the first task of the group is to work together to develop a set of group guidelines. This exercise is lead and facilitated by course facilitators, but all participants are encouraged to take part and contribute. Group working is always complex and dynamic resulting in many differing interactions (Kozlowski &Ilgen, 2006) and ground rules help to regulate the complex interactions (Pina e Cunha, Rego & Simpson, 2022).

The Starting Point exercise – Many of the adopters experiencing aggression and violence from their child reported to the researcher that they felt frightened for what the future may hold for themselves and their child, also that they felt angry that they found themselves in this situation. This exercise encourages them to write down and explore what they are feeling angry and/or frightened about. Labelling feelings and naming emotions is understood to assist the processing, understanding and management of these emotions (Leiberman et al., 2007). This exercise was placed at the start of the program as being emotionally regulated is known to be important for readiness to learn and take on new concepts (Graziano, 2007). The course facilitators lead discussions and model mentalizing for the participants while showing empathy for their experience. This exercise is followed by introduction to breathing techniques that aid regulation then filling out a sheet with family goals that they hope for and look forward to.

Introduction to self-care and self-compassion – The participants are introduced to the ideas of importance of self-care and self-compassion while caring for their adopted children. Self-care can be described as “practice of activities that individuals initiate and perform on their own behalf in the interest of maintaining life, health, continuing personal development, and well-being” (Artinian et al., 2002, pg. 162). Theorists postulate that self-care can help improve physical health (Lee & Miller, 2013; Miller et al., 2017), reduce stress (Grise-Owens et al, 2018; Lu & Wykle, 2017) and may help alleviate vicarious trauma (Adams, Boscarino, & Figley, 2006; Dunkley & Whelan, 2006; Newell & MacNeil, 2010). Self-compassion is described as “being open to and moved by one’s own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding, non-judgmental attitude toward one’s inadequacies and failures, and recognizing that one’s own experience is part

of the common human experience" (Neff, 2003, pg. 87). Self-compassion is important when parenting children with challenging behaviour as research suggests that it is a mediator in parenting stress (Stenz, Breitmeyer & Jansen, 2023). This was included in the first session as was seen as critical to the participants ability to gain the maximum from experiencing the program. Many other courses touch on aspects of self-care, however it is usually towards the end of the course and almost an add on. Self-care and self-compassion are woven in and talked about throughout the KMKY program.

Shared Lunch and time to build peer relationships.

Introduction to types of escalation – Omer (2001) puts forward that there are 2 distinctive types of escalation that happens when children have severe challenging behaviours in the home; Reciprocal (also known as symmetrical) escalation where violence and aggression begets more violence and aggression with both parent and child becoming more and more aggressive, and complimentary aggression where the parent acquiesces to the child's demands and this leads to the child becoming more demanding and more aggressive in the demands. The participants are introduced to the idea that how we habitually deal with conflict is often dependent on our experiences of conflict as a child and young adult. The participants are then introduced to the ideas of frightening and frightened parental behaviour and how that impacts the child. These forms of behaviour have been linked to attachment disorganisation as described by Mary Main (Abrams & Hesse, 2006). The participants then work in small groups to talk through incidents from their own experience and explore what kind of escalation may have been going on and how else the incident could have been dealt with.

Press the pause button – The participants are introduced to the idea of using simple tools, such as pausing for a few seconds and taking a couple of breaths before reacting to the child.

Homework- The homework for the week is to take a small amount of time for themselves or give themselves a small treat that encourages self-care and reflection.

Week 2

Check in - and reflection on how the last week has been.

Review – quick recap of types of escalation, frightening and frightened parental behaviour plus opportunity for participants to share anything they have noticed at home in context of this learning.

Bryan Posts Stress Model – Introduction to the work of Bryan Post, The Great Behaviour Breakdown (Post, 2016). In Post (2016) Stress model he puts forward 3 principles that help when dealing with children who have challenging behaviour; that all behaviours come from a state of stress; that there are only two primary emotions, love and fear, with many of what we would see as negative emotions such as jealousy, anger, hurt and anxiety being rooted in fear, his third principle is that children with these behaviours are not consciously choosing to behave in a challenging way but that the behaviours are driven by their unconscious. Participants are then asked to think of a conflict situation with their child and think about what their own behaviour was, what may have been their fear underneath their own behaviour, what triggered the behaviour at the time and what in their past might have led them to react in this way. Once they have explored the situation from their perspective, they are asked to do the same process for their child and explore what may have been affecting their child's behaviours. This exercise encourages the

parent to separate out mentalizing for self and mentalizing for the child, both of which are needed for good mentalizing (Suchman et al., 2010b).

Dysregulation (Perry, 2009; Perry, et al., 1995; Perry, & Szalavitz, 2017; Seigel, 1999) – When faced with stress we can become either hyper-aroused or hypo-aroused. Hyper-arousal can result in shouting, running, hitting and hyper vigilance amongst other things and Hypo-arousal can result in shutdown, defiance, numbness and zoning out. There is then an introduction to Fight, Flight and Freeze, the parasympathetic and sympathetic nervous systems. The participants are then encouraged to explore what happens to them when they are very stressed and if they tend to become hyper-aroused or hypo-aroused. They are then encouraged to think about how their child reacts to stress.

Shared Lunch and time to build peer relationships.

Personal Space Exercise – Each participant is asked to make a personal space on the floor with a piece of yarn. The course facilitators then help them explore what it feels like to have someone invading your personal space and how your body reacts. This exercise aims to help the participants become aware of how our bodies react to potential threat, and how it is generally automatic and not cognitively thought through, this is then linked back to ideas around dysregulation.

Sensory Regulation (Bhreathnach, 2017) – Interventions to aid sensory regulation are in the top 6 interventions funded by the Adoption Support Fund (Adoption UK, 2022). Essentially, trauma is initially experienced on a somatosensory level and can affect a child's ability to regulate (Joseph et al., 2021). Aggression and violence are signs of dysregulation and can be signs of problems with sensory modulation (May-Benson & Koomar, 2010). This area is usually neglected within parenting programs

and the course developer's clinical experience led her to believe that it was important to be included within the KMKY program.

The participants are introduced to the idea of sensory regulation and that food, motor activities and environments can promote regulation and dysregulation. They are asked to think about and explore what sensory experiences they find regulation followed by thinking about what may be regulating or dysregulating for their child.

Week 3

Check in - and reflection on how the last week has been, each participant is asked to share what things help them to relax.

Resource Bank – The participants are encouraged to share ideas, information, and websites that they find helpful.

Dysregulation review and Window of Tolerance introduction (Siegel, 1999)– review information from last week and introduction to the idea that dysregulation is when you can no longer tolerate the stress, and that behaviour is an attempt to bring ourselves back into regulation. The 'Window of Tolerance' (Siegel, 1999) is the range of arousal that is best for a person to be able to function normatively, in this state emotions are not overwhelming and can be experienced and integrated without distress. Siegel (1999) puts forward that childhood trauma and stress reduces a person's window of tolerance. Once out of a person's window of tolerance they either become hyper-aroused or hypo- aroused. The participants are asked to consider 5 things that help them to stay in their window of tolerance followed by 5 things that would help their child. This builds on the previous weeks learning and understanding of sensory regulation.

Memory – Sharing of early memories, then exploration of how most of our memory is unconscious and this is linked back to Bryan Posts principle that children who display challenging behaviours are acting out of an unconscious place.

Shared Lunch and time to build peer relationships.

Mindfulness and counselling – A person independent of the course shares personal experience and benefits of mindfulness and personal counselling when caring for traumatized children.

Parental Presence (Omer, 2004) – Omer (2004) postulated that often when a child is aggressive or violent that can cause the parent to withdraw both physically and emotionally from the child as a protective measure, and that this is the opposite of what the child needs. Bryan Post (2016) also proposes that parent should concentrate on giving the child more positive attention and that this will reduce the child's need to act in a challenging way. Participants are asked to think about a plan to spend more positive time connecting with their child.

Borrowing Regulation and Connection before Correction (Golding, 2008, 2013; Hughes, 2009; Perry, 2020) – Before a parent can correct a child or talk to them about an incident, the child needs to be calm enough and feel safe enough for the conversation to take place. The parent needs to connect with the child and help them to regulate, and only after that they can explore the incident that has happened. The participants are asked to talk about this in their small groups then come up with a plan for when there are incidents in the home. Course facilitators within each group model listening and reflecting skills while mentalizing and empathising with how difficult it can be to put these principles into practice.

Week 4

Check in - and reflection on how the last week has been, any situations that they have been able to react differently compared to their previous reactions, how have their children been reacting to any change in response.

NVR Baskets exercise – an exercise to help the parents prioritise the unwanted behaviours. The participants are given a sheet with 3 baskets of different sizes drawn on it. They are encouraged to write a list of behaviours they find challenging or unwanted. The majority of the behaviours are put in the largest basket to be left/ignored for now. A few behaviours that will be dealt with in the future or negotiated over are put in the middle basket then just one or two behaviours are put in the smallest basket. The behaviours in the smallest basket are the ones that the parent is going to actively work to diminish.

Negative and Positive Feedback loops (Post, 2016) – We are all conditioned both negatively and positively. The participants are asked to reflect and consider where they may be engaged in a negative feedback loop with their child, then to think about how to change this and what it may be like to change their own behaviour.

Blocked Trust and Blocked Care (Baylin & Hughes, 2016) – Blocked Trust is when children have experienced neglect, abuse and inconsistent care, their brains become primed for survival, and they are unable to trust adults around them. They are blocking the fear and pain that they receive when connected to others, but at the same time they are blocking the joy and comfort that can be found in relationships. This can lead them to reject affection and constantly be hypervigilant. These children need consistency and playful interactions to help them begin to trust the adults

around them. The video of Edward Tronick's Still Face Experiment (1978; UMass, 2022) is shown.

Shared Lunch and time to build peer relationships.

Blocked care (Baylin & Hughes, 2016) is described as happening when a parent or carer is not regularly getting the responses they expect from the child, the relationship is not reciprocal. This can cause the carer to suppress their openness and reflective capacity as a defensive response. Baylin and Hughes propose there are 5 caregiving domains; **The approach system** that helps us to be open to and seeking connection; **The reward system** that enables caregiving and relationships to be rewarding and pleasurable; **The child reading system** – similar to mentalizing – enables us to make sense of behaviours and reflect on thoughts, feelings and motivations; **The meaning making system** – linked to our own personal history it helps us create narratives of life, when calm and regulated the narratives are more likely to be positive; **The executive system** integrates the other four systems and enables us to reflect and adapt.

Oxytocin and dopamine are both part of the approach and reward system but in stressful circumstances these neurochemicals are suppressed, and relationships are less rewarding (Hughes & Baylin, 2012). When stressed we also become less empathetic so narratives and child reading are more likely to have negative attribution, these can all combine in blocked care. When a parent is in blocked care, they are more likely to be harsh and critical, feel overwhelmed and exhausted, blaming and overly punitive.

Self-care and Self-compassion as explored in week 1 are referred back to as ways of helping avoid or assist with blocked care. Mindfulness, counselling, and journalling are also explored in the group setting as ways of handling blocked care.

This is often a very emotive session for the parent on the course, and ample time is given for the participants to share from their own experiences and be supported by the course facilitators and the group.

Week 5

Check in - and reflection on how the last week has been.

Breaking the Taboo (Taken from NVR theory. Coogan & Lauster, 2014; Omer, 2004) – Patterns of behaviour can build up in families where the children effectively forbid the parent from actions, such as entering their room or sharing with friends and relatives what is going on in the family. Violence and aggression often thrive in secrecy. The participants are encouraged to explore what it would be like to break some of the taboos and share with people in their wider network what is going on day to day in their family. The participants are supported to explore what are the barriers to breaking the taboos.

Recruiting support (Taken from NVR theory. Coogan & Lauster, 2014; Omer, 2004) - Participants are encouraged to think creatively about recruiting to their support network or utilizing their current support network.

Two hands of parenting (Golding, 2013, 2017) – one hand represents the nurture and affection that a child needs while the other hand represents the necessary structure, discipline and boundaries. This is linked into an idea from NVR theory called ‘Acts of resistance’ where a parent maintains a boundary that they have not previously felt confident enough to maintain.

Shared Lunch and time to build peer relationships.

Acts of reconciliation and Restorative Justice (Braithwaite, 2007; Coogan & Lauster, 2014; Omer, 2004). Acts of reconciliation are spontaneous and not deserved or earned, but simply the parent giving a treat or affirming the child because of their love for the child, this helps to build relationship and help the child to trust in the parent's unconditional love. Restorative justice (Braithwaite, 2007) encourages dialogue and relationship between the victim and perpetrator. An example of this would be the child helping to mend or repair something that they had broken while becoming aggressive or violent, the key is that it is not done in a punitive way but a restorative way. The participants are supported to explore the feelings and barriers to them taking acts of reconciliation or to encouraging and helping the child in restorative actions.

Revisiting Parental Presence from week 3. The participants are supported to write down a plan for increasing parental presence.

Week 6

Check in - and reflection on how the last week has been, sharing any successes and way in which they have been able to increase parental presence.

Sympathy vs Empathy – understanding the difference between sympathy and empathy is important for therapeutic caring. Sympathy is a feeling of pity towards another person and may well be an unwanted feeling (Post et al., 2014; Sinclair et al, 2016) whereas empathy is the ability to accurately understand feelings of another person, to attune to them and acknowledge them (Post et al., 2014; Sinclair et al, 2016). The animation of Brene Brown talking about sympathy and empathy is shown

to participants (The RSA, 2013). Beliefs that can help with empathy are explored and discussed.

Shame vs Guilt – While both strong feelings with an internal aspect, shame involves a belief that nothing is changeable and it is the trait of the actual person that is wrong and worthless, guilt however involves the belief that it is the action that is wrong and therefore changeable and a person can decide to behave differently (Tilghman-Osborne et al., 2008). Children who experience developmental trauma and do not experience themselves as being unconditionally loved can experience extreme shame, that it is because they are 'bad' that they are not loved (Golding, 2015). These children then may protect themselves against the feelings of shame by displaying a range of behaviours such as blaming others, lying, minimizing the effects of what they have done and flying into a rage. Golding and Hughes (2012) call this the 'Shield of Shame'. Normal behaviour management techniques can increase feelings of shame. Ideas of regulation and connection from week 3 are linked in through group discussion around guilt and shame.

Shared Lunch and time to build peer relationships.

The second half of week 6 is around challenging scripts about children's behaviours that the participants may have from their own childhood and early adulthood.

Changing scripts Attention seeking vs Attention/attachment needing some child display behaviour that can be seen as naughty or attention seeking (Rees, 2011; Lyons et al., 2020), and traditional parenting would tell you to ignore the attention seeking child but many traumatised children are functioning emotionally much younger age and instead of being attention seeking they are seeking the early experiences they lacked to help them feel safe.

Changing scripts expressed need vs hidden need Often children who have experienced trauma and adversity behave in a way that does not seem to make sense to the adults around them, but on some level it makes sense to them in the context of their early experiences, if the adult is able to name the need or feeling that is underneath the behaviour it can help the child to feel supported and then calm (Lyons et al., 2020)

Week 7

Simple tools to help.

Flyby statements (Post, 2016) Short statements naming a feeling or noticing what is happening. These are not questions but similar to Siegel's Name it to Tame it (DLCPE, 2014). Once used you quickly move on to avoid to high arousal.

Shine the light of consciousness (Post, 2016) Similar to flyby statements but more in depth. Parents using reflection and their imagination to name what may be going on for the child, naming the feelings underneath the behaviour. Post (2016) describes this as a bit like dragging a trigger up from the unconscious primitive parts of the brain to the conscious thinking part of the brain where it can be examined and explored. Avoid questioning as this places demands and increases stress and therefore the likelihood of dysregulation and subsequent behaviours.

Time in vs Time out for the last few decades, as an alternative to physical discipline 'time out' or the use of the 'naughty step' has been advocated, but more recently this has been criticised as it uses isolation as punishment rather than helping a child to regulate. Time in helps the child to connect with the parent and to regulate as well as sharing feelings (Holden et al., 2022). In studies parents have found the technique useful and effective (Holden et al., 2022).

Reflect, Relate, Regulate (Post, 2016). First stop and reflect on your own feelings, takes some breaths to regulate yourself. Second, relate to your child telling them how you are feeling and wondering (but not questioning) how they are feeling. Thirdly, regulate together.

Regulate, Relate, Reason (Perry, 2019). First help the child to regulate and become calmer, secondly connect, relate and attune with the child. Thirdly once all is calm, reflect and reason exploring what has happened.

Shared Lunch and time to build peer relationships.

Exploration of specific behaviours; Lying and aggression – group working around these behaviours. Exploring participants emotional experience when their children tell lies or become aggressive. Using theory and ideas from the course to understand what may be driving the behaviours and what would be an alternative way to respond.

Week 8 & 9

Weeks 8 and 9 are review weeks, with the mornings spent going through the learning from the first 7 week. As with previous weeks they start with a check in and reflection time. Afternoons are spent workshopping specific behaviours suggested by the group, sharing what is going well and what are the struggles, practising mentalizing for themselves and their children in specific situations.

In Summary

Originally designed to run over 10 weeks, then adapted to 9 weeks this course was specifically designed for adoptive parents who reported high levels of aggression and violence from their children. It is a mentalization based and psychoeducational program that tries to integrate current theory on attachment, childhood trauma and

therapeutic parenting. It is novel in its integration of the PDI MotC to help facilitators understand the reflective capacity and mental processes of the participants around their relationship with their child plus the child's behaviours. It is designed to be delivered by two facilitators, one of whom should have direct personal experience of parenting adoptive or fostered children.

Part 2: The Studies

The Studies: Introduction

Part 2 of this thesis takes the form of 5 studies using the data gathered around the Knowing Me, Knowing You program.

The first study takes a quantitative approach to examine any changes in parental reflective functioning, parental sensitivity, the constructs that the parent has around their relationship with their child, parental stress as well as child behaviour measures. Within this study a quasi-experimental design is used to examine changes in the intervention group in comparison to a service as usual control group.

The second study looks at the results of the small subgroup that returned questionnaires at the 6-9 month period after completing the intervention. Part 1 of this study looks at the statistics and graphs to examine the trends in results and part 2 takes a multiple individual (or N=1) case study approach to examine what is happening in the individual cases.

The third study is a case study of one particular participant whose positive results were similar to the general trend. Again, this study is split into 2 parts, part 1 being an examination of changes in language used around her daughter and part 2 uses part of the structure and principles of Hermeneutic Single Case Efficacy Design to examine evidence of for the intervention brining the change plus this individual's process of change.

The fourth study is a reflexive thematic analysis looking at the experience of course participants through the use of their feedback, both from interviews and anonymous feedback forms.

The fifth and final study uses Interpretive Phenomenological Analysis to take an in depth look at the little studied area of adoptive fatherhood, with the view of gaining understanding of the experience of these fathers who are experiencing aggression and violence from their children (A version of this has been published as Barrow, V., Grey, B., & Essau, C. A. (2023). “I am not exaggerating, literally a monster … a Jekyll and Hyde type thing”: Understanding the lived experience of adoptive fathers whose children display violence and aggression. *Human Systems: Therapy, Culture and Attachments, 3*(1), 300-50.).

Ethical Considerations

Throughout these 5 studies ethical considerations were held constantly in mind.

- Informed consent was supported through the use of consent forms, participant information sheets and debrief sheets.
- All participation was voluntary and non-participation did not affect the service they were being provided with.
- Anonymity was maintained through the use of numerical codes for each participant in the quantitative studies and pseudonyms in the qualitative studies.
- Confidentiality was maintained through the use of secure data storage and removal of identifying information.
- The participants were informed of their right to remove their consent at any times, however they were informed that if their data had already been part of published work they may not be able to have it removed.
- Potential for harm was limited by each participant having the support of a named post adoption support worker throughout the intervention and research process.

Chapter 7: Study 1, Examining the impact of the Knowing Me, Knowing You Program

As already explained in previous chapters, the Knowing Me, Knowing You program is a group-based course for adoptive parents whose children display aggression and violence. The causes of non-normative aggression and violence displayed by children are many and complex and include genetic, environmental, trauma and relational factors (Jaffe et al., 2012; Latimer et al., 2012; Tuvblad & Baker, 2011). This study comes from the perspective of attachment theory and adheres to the theory that sensitive and responsive parenting mitigates the risks and need for children to display aggression and violence (Braungart-Rieker & Hill-Soderlund, 2010; Kriebel & Wentzerl, 2011).

This quantitative study uses a range of measures, including self-report questionnaires and coded semi-structures interviews, to explore any change to parental sensitivity, parental reflective functioning, feelings, and construct of the parents around their child, parental stress, as well as any changes in the child's display of behaviour. It aims to use this data to answer the research questions.

- Can a parenting group for adoptive parents whose children display aggression and violence improve parental mentalization and caregiving, reduce stress and positively impact the parent-child relationship and child behaviour?
- What can be learned from studying the group about the role of parental sensitivity and mentalizing in the experience of parenting an adoptive child who displays aggression and violence?

Objectives

The current quantitative study evaluates the effects of the 9 week Knowing me, Knowing you program on parental sensitivity measured by the MotC coding, Parental Reflective Functioning measured by the PDI-RF, Children's behaviours as measured by the Goodman SDQ and BAC-C, parental stress as measured by Parental Stress Scale and the Parents' feelings around their care giving and children as measure by the Carer Questionnaire, when compared to a Service as Usual (SAU) control group who were wait listed for the intervention. It was hypothesised that in comparison to the SAU group: -

1. The intervention would significantly increase the levels of parental sensitivity as measured by the Meaning of the Child coding of the Parent Development Interview.
2. The intervention would significantly increase the levels of Parental Reflective Functioning as measure by the Parental Reflective Functioning Scale coding of the Parent Development Interview.

Secondary outcomes were hypothesised as that in comparison to the SAU group: -

A The intervention would significantly decrease parental stress as measured by the Parental Stress Scale.

B The intervention would significantly improve the parent's perceptions of the parent-child relationship as measured by the total score and subsections of the Carer's Questionnaire.

C That levels of difficult behaviours as measured by the Brief Assessment Checklist for Children (BAC-C) and by the Goodman Strength and Difficulties Questionnaire (SDQ) would decrease and pro-social behaviours as measured by the SDQ would increase.

Method

Design

This effectiveness study uses a quasi-experimental design comparing a mentalizing based, and psychoeducational program for adoptive parents whose children display aggression and violence (KMKY) against service as usual (SAU) used in a post adoption support service. Non-random assignment was applied with families being allocated to the intervention by their social workers and the service as usual group were waitlisted for the KMKY program.

Power calculations were not made before the commencement of the study for a variety of reasons, this is a small-scale early stage study from a convenience group in a limited population and is also an innovational study (Bacchetti et al., 2011).

Participants

Potential participants in the KMKY program were referred by post adoption support teams due to the parent's report of aggression and violence being displayed by their children. All parents attending the KMKY program were given the opportunity to take part in the study, receiving the intervention was not dependent on agreeing to the study, consequently within any cohort there were some who were part of the study and some who were not. The only exclusion criteria were if the family has ongoing safeguarding involvement. Participants could choose between simply filling out the parent report questionnaires or to additionally undertake the semi-structured interviews.

The intervention group was made up of 24 adults (18 undertaking interviews) representing 38 children, and control group 11 (8 Undertaking interviews) adults representing 15 children.

Pre–intervention questionnaires were completed at an initial home visit and post intervention questionnaires were completed in the 2 weeks after the intervention was finished, then participants in the intervention group were asked to completed questionnaires 6-9 months later. Of the original 35 adults only 5 returned the longitudinal questionnaires 6-9 months on, representing 8 children. Reasons for poor return rate at this stage will be discussed later in this study.

Demographic characteristics of parents and children are given in Table 1.

While age was given for all children for whom questionnaires were completed, only adults undertaking interviews (n = 26) were asked their age, with one interviewee in the intervention group choosing not to disclose age. One parent in the intervention group failed to complete any questionnaires so their children are not represented in the data (n=3).

The average age for adults in the intervention group was 45.53 years (SD = 3.45) with adults in Service as Usual group (SAU) being older and showing a significant difference ($p<.001$). SAU adult average age was 53.88 years (SD =4.46). The difference in mean child age between intervention and SAU groups were also significant ($p<.001$), with children in the SAU (mean = 11.40, SD = 2.12) compared to those in the intervention group being younger (mean = 7.52 years, SD = 2.12).

Table 1

Demographic information for parents and children at baseline, stratified by study group.

Baseline Characteristics		KMKY		SAU	
	n		n		p
Adults					
Age, M (SD)	17	43.53 (3.45)	8	53.88 (4.64)	P<.001
Male (%)	6	25	5	45.5	
Female (%)	18	75	6	54.5	
Children					
Age, M (SD)	35	7.52 (2.12)	15	11.40 (1.30)	P<.001
Male (%)	18	51.4	13	86.7	
Female (%)	17	48.6	2	13.3	

Procedures

Those referred to the KMKY program were initially met in their own home by the course's primary facilitator. The visits' purpose was to familiarise the participant with the facilitator, screen for course readiness and administer the PDI interview (Later coded with both PDI-RF and MotC coding) and questionnaires. Initial cohorts of the course were given the option of undertaking the interview, but later it was added for

all participants as part of the screening process. At this stage, the participant was asked if they would consent to their data being used for research purposes.

The initial visit including interview and questionnaire administration (giving pre-intervention data) was followed by the 9-week Knowing Me, Knowing You program delivered over a 4 hour daytime session with a lunch break for parent networking. Those who had consented to the research were then invited back for the post-intervention interview and completion of questionnaires. Participants were approached once more via secure email at 6-9 months post intervention with the request to fill out questionnaires once again.

Ethics

Full ethical approval was given by the University of Roehampton Ethics committee reference PSYC 20/374. As the researcher was also working with the participants careful consideration was given to any pressure to take part that the participants felt, and as such the invitation to participate was only given once with no follow up request for those who did not volunteer. It was made clear both in written from and verbally that inclusion in the program was not dependent on participation in research. Participants were also informed that the interview process could touch on subjects that may cause distress and the participant could stop the interview at any time, they were also signposted to appropriate support. Throughout the process each participant had the support of a named post adoption support social worker. Informed consent was supported using a participants information sheet, consent document and participants debriefing sheet. At this point participants could choose for just their questionnaire, or a combination of interview and questionnaires to be included in the research. Participation in the course did not depend on consent to research and only data from those who consented was used in this study.

Assessment Procedures and Measures

While originally designed as assessment procedures, the Parent Development Interview, Meaning of the Child coding and Reflective Functioning Scale described below are being used as quantitative measures for the purpose of this study.

The Parent Development Interview (PDI; Aber et al., 1985)

The Parent Development Interview is used to elicit the parent's representation of their relationship with their child, the child itself and view of themselves as a parent. The parent is asked a wide range of questions including what gives them the most joy, guilt, happiness and anger in being a parent. The interview also explores the parents own experience of being parented and their childhood relationships with their parents.

The PDI is a semi-structured interview with 38 questions plus follow up questions, that takes approximately 45-60 minutes to administer.

The interviews were transcribed verbatim and then coded with the Meaning of the Child Coding system (MotC; Grey, 2014) as well as the Parental Reflective Functioning Scale (PDI-RF; Slade et al, 2004).

The Meaning of the Child Coding of the PDI (MotC; Grey, 2014)

The Meaning of the Child coding for the Parent Development Interview (PDI; Aber et al., 1985) was developed in an attempt to make visible the scripts or narratives that a parent has around their child and the relationship with their child (Grey, 2014). It is grounded in the theory that human beings are meaning making animals and that children have a psychological meaning to their parents. For example, in their studies of child deaths from abuse Reder, Duncan & Gray (1993 &1999) argued that parental scripts had given negative meaning to the child and relationship, and that

this distortion was key to the fatal abuse. The creator of the MotC coding aimed to develop a validated method for assessing this meaning and therefore the risk level to the healthy development of the child within that particular relationship. As previously mentioned in the chapter that addresses attachment theory the meaning that a person ascribes to a past event can be transformed and distorted, in such a way that is protective of the person but may actually be endangering to a child (Crittenden, 2009; Farnfield et al., 2010). Grey (2014) in agreement with Crittenden (2006) puts forward in his doctoral thesis that 'Problems in parenting occur because information from and about the child is distorted by the adult's pattern of information processing, leading to either action that is self-protective for the adult but not for the child, or failed attempts to protect the child because the parent is paying attention to information that is or was relevant only to their safety not their child's' (pg. 17). More recently he has also argued that the parents' caregiving pattern may be shaped by past and present adversity within the environment, that what is protective in one environment may not be in another and in fact may create more risk (Grey, 2023).

To link the representation of a child to the parenting of that child the MotC was validated against Crittenden's CARE-Index (Crittenden, 2007) that measured parental sensitivity through observation of the dyadic relationship between parent and child in a videoed free play interaction (Grey & Farnfield, 2017). The MotC, as a tool, is useful within child protection, research and for informing therapeutic interventions and can also discriminate between normative and risk samples. The MotC was chosen for this study due to its ability to offer a window into the nature or the parent-child relationship through its analysis of parental discourse, plus it's focus on endangered relationships and use of Crittenden's DMM it has particular value in

understanding the relationships where there is aggression and violence, the focus of this current study.

The MotC is coded through and manualised system and allocates different categories for the parent-child relationship: High Risk, Intervention, Adequate and Sensitive. For the purpose of analysis, in this current study each category and borderline between categories was allocated a numerical value ranging from 1=High risk to 7=Sensitive as was done in Grey & Farnfield's validation study (2017). All interviews were coded by the researcher who is a certified reliable coder, then for the sake of validity and reliability a sample of just under 20% were sent to be second coded by other certified reliable coders. Inter coder reliability was calculated as excellent, r=.908.

The Parental Reflective Functioning scale (PDI-RF; Slade et al, 2004) coding for the PDI

The Parental Reflective Functioning Scale (PDI-RF: Slade et al.,2004) is a way to measure and code the reflective function of a parent. Parental reflective functioning capacity is strongly related to their ability to mentalize, that is understand themselves as having a complex inner world of thoughts, feeling and desires and these motivate them, also that their child also has their own separate complex inner world. The PDI-RF built on the work of Fonagy and colleagues (1998) who developed a manual for coding the Adult Attachment Interview (AAI; George et al., 1996). Certain questions that actively demand reflective functioning are scored by a manualised system, then an overall score is given for the pattern that is shown over the full transcript. Scored on an 11-point scale from -1 to 9 with higher scores relating to higher reflective functioning. A normative score is of 5, where the parent has been able to show clear evidence of their reflective and mentalizing capacity. The PDI-RF is the most used

and validated measure of parental reflective functioning and mentalization and therefore is used within this study of an intervention that aims to increase both parental reflective functioning and mentalization.

As with the MotC coding, all interviews were coded by the researcher who is a certified reliable coder. Approximately 15% of the scripts were sent to be coded by other reliable coders completely separately from the MotC coding in contrast to Grey (2014) where scripts were all coded for MotC and PDI-RF by the same coder, thus extra rigour was added to the process of this particular study. Inter coder reliability was calculated as excellent r=.913.

The Parental Stress Scale (PSS; Berry& Jones, 1995)

The Parental Stress Scale was developed an alternative and much shorter questionnaire to the 101 item Parenting Stress Index (Abidin, 2012). This measure was used in the current study as parental stress can be related to poorer child behaviour, poorer quality of the parent- child relationship (Essler et al, 2021) and lower levels of parental sensitivity (Pereira et al, 2012).

The PSS considers both the stressful, negative aspects as well as the positive aspects of parenting using an 18 question, 5-point Likert scale ranging from strongly disagree (1) to strongly agree (5).

Within the current Study the PSS had a good internal consistency α=.87.

The Carer's Questionnaire (also known as The Thinking about your child questionnaire) (CQ: Gurney-Smith 2017)

The CQ was used to measure the confidence, stability and level of reported reward the parent experiences with their child. It has been used to shown change in Dyadic Developmental Psychology (DDP: Golding, 2008) informed interventions such as

Fostering Attachments (now Nurturing Attachments (Golding, 2008); and Foundations for Attachment (Golding and Hughes, 2017).

A 11-question 10-point numerical scale rating agreement with statements ranging from not at all (1) to Very (10). The Questionnaire generates a total score but also has 4 subsections. Parental Skills and Understanding (PSU) is made up of 4 questions, Parent Child Relationship (PCR) and Child Responsiveness to Care (CRC) each have 3 questions while Placement Stability (St) is single item. Some versions also contain one non scoring question.

Within the current study the questionnaire full score showed excellent internal consistency α=.91, while PSU and PCR had good internal consistency α=.89 and α=.81 respectively and CRC had acceptable internal consistency α=.73.

The Brief Assessment Checklist for children (BAC-C: Tarren-Sweeney, 2013)

With similarities to the SDQ, the BAC-C was designed to be more focused on behaviours displayed by a child struggling within attachment relationships or one who had experienced childhood trauma. It was derived from the 120 item Assessment Checklist for Children (ACC; Tarren-Sweeney, 2007). In Australian studies it was found to have high accuracy in predicting difficulties relating to trauma and attachment (Tarren-Sweeney, 2019). Scores over 7 implies referral to services needed.

This parent/carer report questionnaire consists of 20 question, 3-point Lickert-type scale and within the current study the BAC-C showed a good internal consistency α=.83

The Goodman Strength and Difficulty Questionnaire (SDQ; Goodman, 2001)

The parent report SDQ is a brief questionnaire that screens for both negative and positive behaviours. The SDQ is a widely accepted and validated assessment questionnaire, though focused on parent's perspective of behaviours, the hope is that as parental sensitivity changes, then the children will begin to display less of the challenges seen previously. The SDQ is a commonly used tool in both research and clinical settings both within the UK and internationally (Fongaro, 2023).

25 questions are scored on a 3-point Likert-type scale, 0 (not true), 1 (somewhat true), 2 (certainly true). It measures 5 key areas each containing 5 items, Pro-social behaviours, Emotional Distress, Conduct/behavioural issues, Peer problems and Hyperactivity. The SDQ total difficulties score is made up by totalling the 4 difficulties sub-scales (Behavioural, Emotional, Hyperactivity, and Peer)

Within the current study the SDQ total difficulties had an acceptable Cronbach's Alpha of .78, the hyperactivity had a good internal consistency α= .86, acceptable values were also found for Pro Social α=.75, Conduct/behavioural difficulties α=.74, and Peer Difficulties α=.76, while the Emotional difficulties sub-scale was questionable at α=.67

Data analysis

A repeated measures (factorial) ANOVA test was used to examine differences between pre- intervention and post-intervention measures comparing the intervention group and the SAU group. The standardised effect sizes were presented us partial ETA^2. Significance level was set as $p< 0.05$ as is the generally accepted level to negate the risk of type 1 and type 2 errors in a study of this size. Normality

checks were carried out on the residuals which were approximately normally distributed.

Advice from statistical experts was sought around the use of ANOVA to make multiple comparisons. The measures used often measured very different concepts and it was deemed that putting in corrections due to the repeated measures would not add to robustness of the findings.

Results

Interview Based Measures

Effect of intervention on parental sensitivity as measured by the Meaning of the Child coding (MotC)

Time had a main effect on parental sensitivity (F (1, 24) = 9.297, p = .006, η^2 = .279) showing a significant effect with large effect size. There was also an interaction between the experimental condition (intervention vs. SAU control) and time (pre vs. post) (F (1, 24) = 13.542, p = .001, η^2 = .361) also showing large effect size.

Table 2 shows the Means and Standard Deviations of parental sensitivity by conditions.

Table 2

Descriptive Statistics of Parental Sensitivity Measured by the MotC Coding.

		n	*M*	*SD*
Pre MotC	Intervention	18	3.61	1.38
	SAU Control	8	4.50	1.85
	Total	26	3.89	1.56
Post MotC	Intervention	18	4.94	1.59

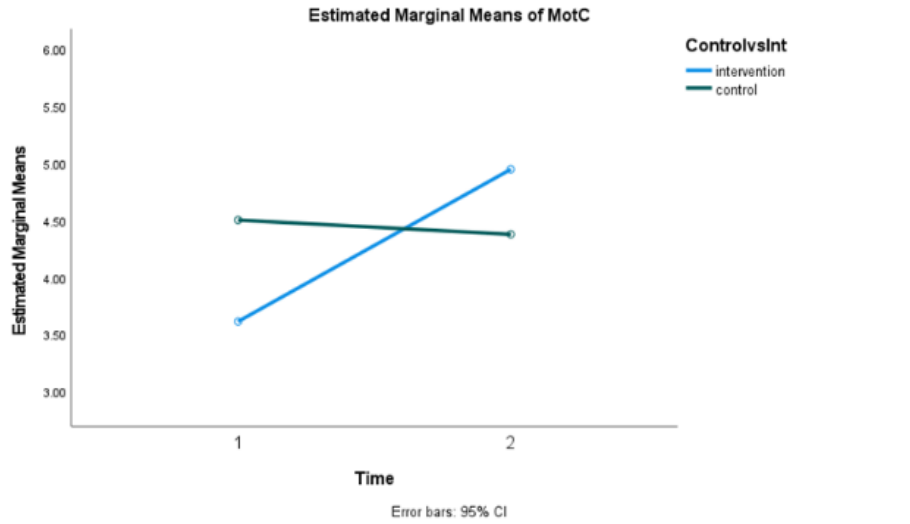
SAU Control	8	4.38	1.85
Total	26	4.77	1.66

Pairwise comparisons revealed that there were no significant differences between the intervention and SAU control group at the MotC pre-test (p = .185) also at the MotC post-test (p = .430). Exploring the interaction further, pairwise comparisons revealed that the intervention group showed a significantly higher parental sensitivity post-test vs. pre-test (p <.001) while the SAU control group did not show any significant change post-test vs pre-test (p = .708), (though their results were trending in the reverse direction).

Figure 2 shows the trends along with the interaction effect.

Figure 2

Mean in Parental Sensitivity Scores in 2 Groups Before and After Intervention



The results show that the intervention significantly increased parental sensitivity as measured by the MotC coding, in line with the original hypothesis, while those in the SAU control group showed no significant change.

Effect of the intervention on Parental Reflective Functioning Scale (PDI-RF)

There was no main effect of time on Parental Reflective Functioning (F (1, 24) =.182, p =.674, η^2 = .008). However, there was an interaction between the experimental condition (intervention vs. SAU control) and time (pre vs. post) (F (1, 24) = 20.799, p < 0.001, η^2 = .464) showing large effect size, meaning that the intervention had a significant effect on PDI-RF in comparison to the SAU group.

Table 3 shows the Means and Standard Deviations of the conditions.

Table 3

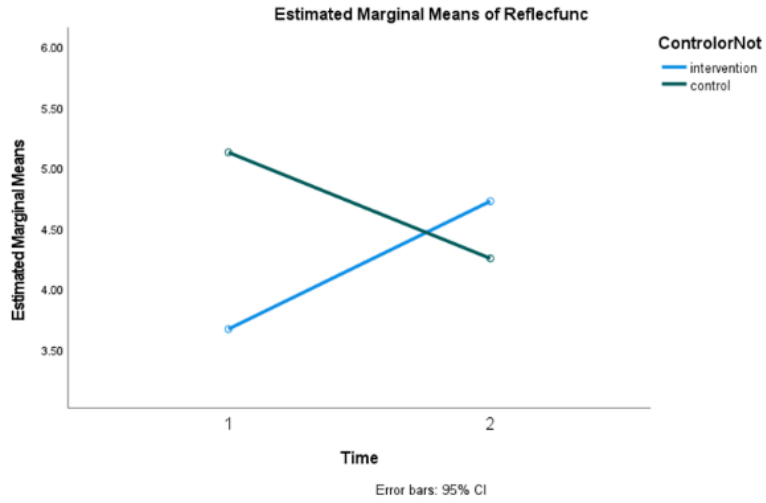
Descriptive statistics for conditions for Parental Reflective Functioning measured by PDI-RF

		n	*M*	*SD*
Pre RF	Intervention	18	3.67	.91
	SAU Control	8	5.13	1.25
	Total	26	4.12	1.21
Post RF	Intervention	18	4.72	1.13
	SAU Control	8	4.25	1.58
	Total	26	4.58	1.27

Pairwise comparisons revealed that the intervention group had a significantly lower Parental Reflective Functioning score at pre-test that the SAU control group (p =.003). However, the difference between the experimental groups was not significant (and trending in the reverse direction) in the post scores (p = .39). Figure 3 shows these trends, along with the interaction effect.

Figure 3

Mean in Parental Reflective Functioning in 2 Groups Before and After Intervention



Exploring the interaction further, pairwise comparisons revealed that the intervention group showed a significantly higher PDI-RF at post-test vs. pre-test (p < .001), while the SAU control group showed a significantly lower PDI-RF at post-test vs. pre-test (p < .020).

Overall, these results were as hypothesized and show that the intervention significantly increased the PDI-RF of participant, while those in the SAU control group showed a decrease in PDI-RF.

Parent Self Report Measures

Parental Stress Scale

There was no main effect of time on Parental Stress to the criteria of p< 0.5, though it was approaching this level (F (1, 31) = 3.502, p = .071, η^2 =.102) with medium effect size. Similarly, the interaction between the experimental condition (intervention vs. SAU control) and time (pre vs. post) (F (1, 31) = 3.221, p = 0.082, η^2 = .094) had medium effect size but was not significant to the p<.05 level, but again approaching this level.

Table 4 shows the Mean and Standard Deviations for the conditions.

Table 4

Descriptive statistics for conditions for Parental Stress Scale.

		n	*M*	*SD*
Pre P Stress	Intervention	23	53.30	8.93
	SAU Control	10	53.00	8.86
	Total	33	53.21	8.77
Post P Stress	Intervention	23	48.52	9.69
	SAU Control	10	52.90	8.95
	Total	33	49.85	9.55

Hsu (1996) reports that it can be a mistake to not pursue further comparisons, even if initially the null hypothesis has not been rejected, with this in mind pairwise comparisons were explored.

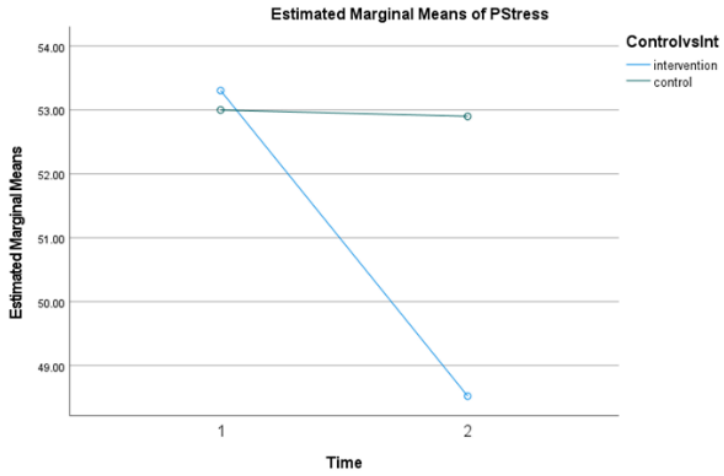
Pairwise comparisons revealed there were no significant differences between the intervention and SAU control groups at pre-test p =.929, or post-test p =.232.

Exploring the interaction further, pairwise comparisons revealed that the intervention group showed a significantly lower parental stress score at post-test vs. pre-test (p = .002) while the SAU control group showed no significant difference at post-test vs. pre-test (p = .964).

Figure 4 shows the trends and interaction effect.

Figure 4

Mean in Parental Stress in in 2 Groups Before and After Intervention



Overall, the results show that despite the absence of significant main effect, intervention significantly decreased the level of parental stress felt as measures by the Parental Stress Scale when compared to pre-test scores.

Carer Questionnaire

Table 5

Descriptive statistics for conditions for Carer Questionnaire total and subscales.

		n	*M*	*SD*
Pre CQ total	Intervention	35	71.66	14.82
	SAU Control	15	73.47	13.01
	Total	50	72.20	14.19
Post CQ total	Intervention	35	81.94	12.09
	SAU Control	15	71.13	12.08
	Total	50	78.70	12.97
Pre CQ PSU	Intervention	35	25.49	6.81
	SAU Control	15	28.07	3.37
	Total	50	26.26	6.07
Post CQ PSU	Intervention	35	30.66	4.42
	SAU Control	15	27.93	3.22
	Total	50	29.84	4.25
Pre CQ PCR	Intervention	35	20.46	4.88
	SAU Control	15	20.13	5.10
	Total	50	20.36	4.89
Post CQ PCR	Intervention	35	22.83	3.85
	SAU Control	15	18.69	4.03
	Total	50	21.64	4.28

Pre CQ CRC	Intervention	35	17.83	4.93
	SAU Control	15	17.27	5.12
	Total	50	17.66	4.94
Post CQ CRC	Intervention	35	20.20	4.25
	SAU Control	15	16.733	4.334
	Total	50	19.16	4.52
Pre CQ Stab	Intervention	35	7.89	1.49
	SAU Control	15	8.00	1.65
	Total	50	7.92	1.52
Post CQ Stab	Intervention	35	8.26	1.69
	SAU Control	15	7.60	1.68
	Total	50	8.06	1.70

CQ Total Score

Time showed a main effect on the total score of the CQ (F (1, 48) = 5.882, p =.019, η^2 = .109) with medium effect size. There was also an interaction between the experimental condition (intervention vs. SAU control) and time (pre vs. post) (F (1, 48) = 14.812, p < .001, η^2 = .236) with large effect size.

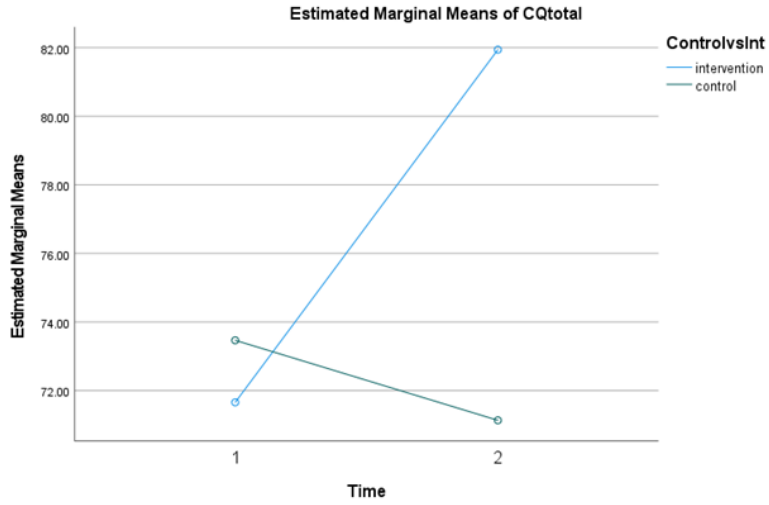
Pairwise comparisons revealed that there was no significant difference between the score of intervention vs SAU control group at pre-test (p = .684), However there was a significant difference between experimental groups at post-test (p = .006).

Exploring the interaction further, pairwise comparisons revealed that the intervention group reported a significantly higher CQ total score at post-test vs. pre-test ($p < .001$) while the SAU control group score reduced but this was not of a significant nature ($p = .399$).

Figure 5 shows the trends and interactions.

Figure 5

Mean in Carer Questionnaire Total Score in 2 Groups Before and After Intervention



Overall, the results show that the intervention significantly increased the participants total CQ score while those in the SAU control group showed a reduced score.

The subcategories of the CQ were also analysed using an ANOVA test.

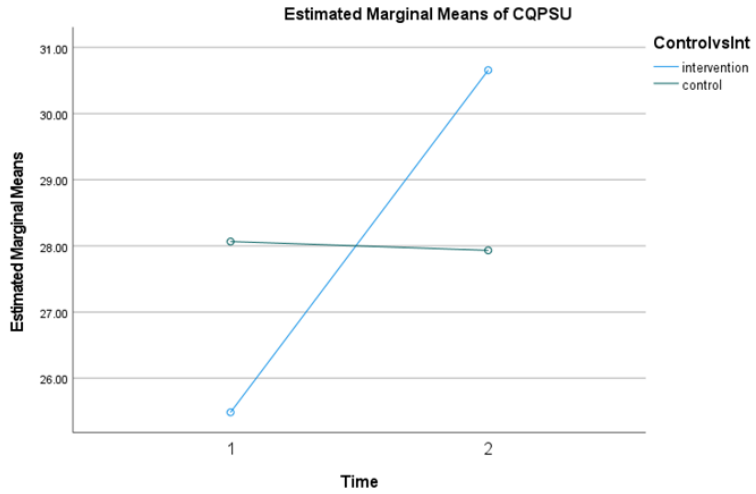
Carer Questionnaire Parental Skills and Understanding (PSU)

Time showed a main effect on Parental Skills and Understanding (F (1, 48) = 13.657, p <. 001, η^2 = .222) with large effect size and there was also an interaction between experimental condition and time (F (1, 48) = 15.141, $p < .001$, η^2 = .240) also with large effect size.

Pairwise comparisons revealed no significant difference between intervention and SAU control groups at pre-test (p = .171), however there was a significant difference between intervention and SAU control at post-test (p = .037). Exploring the interaction further revealed that reported PSU was significantly higher for the intervention group pre-test vs. post-test (p < .001) while there was no significant difference for the SAU control group (p = .907). Trends and interactions are shown in figure 6.

Figure 6

Mean in Parental Skills and Understanding Score in 2 Groups Before and After Intervention



Thus, it can be concluded that the intervention had a significant effect on the self-reported levels of Parental Skills and Understanding as measured by the Carer's Questionnaire.

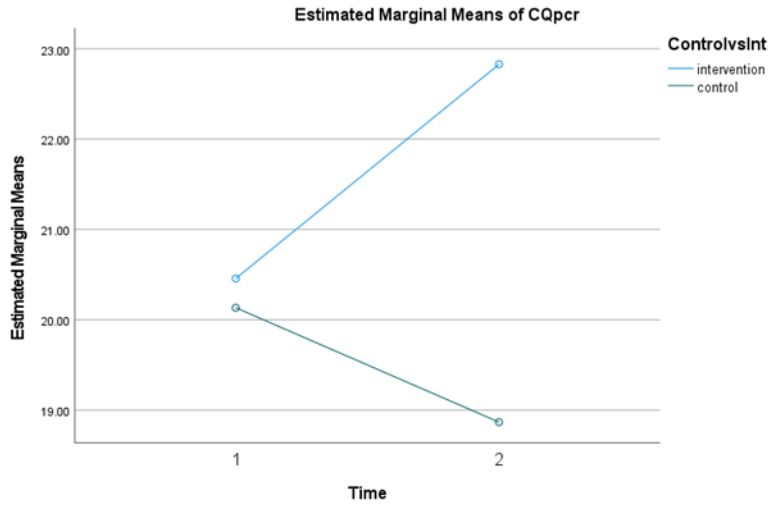
Carer Questionnaire Parent Child Relationship

There was no main effect of time on Parent Child Relationship (F (1, 48) = 1.003, p = .322, η^2 = .020). However, there was an interaction between the experimental condition and time (F (1, 48) = 10.880, p = .002, η^2 = .185) with large effect size.

Pairwise comparisons revealed no significant difference between intervention and SAU control groups at pre-test (p = .833) however there was significant difference at post-test (p = .002). The intervention group reported a significant rise in score pre-test vs. post-test (p < .001) and the SAU control group reported no significant change (p = .176) though again figure 7 shows there was movement in a reverse direction.

Figure 7

Mean in Parental Child Relationship in 2 Groups Before and After Intervention



Again, it can be concluded from these results that the intervention had a significant effect on the self-reported levels of Parent – Child Relationship as measured by the Carer's Questionnaire

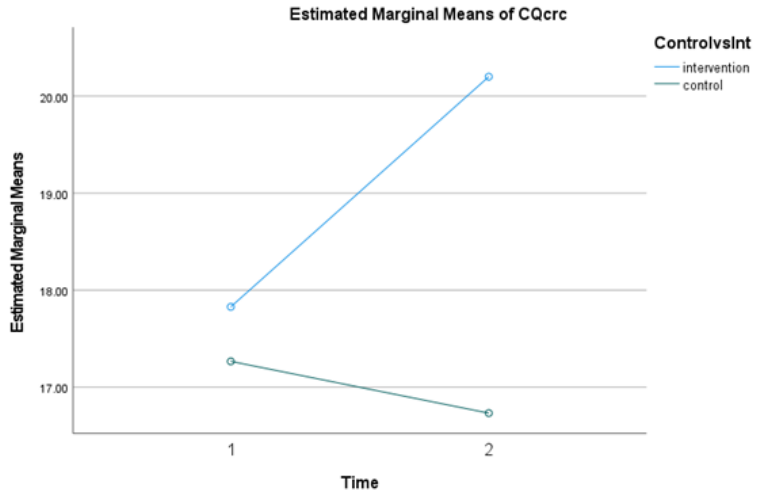
Carer Questionnaire Child Responsiveness to Care

There was no main effect of time on the reported score of Child's Responsiveness to Care (F (1, 48) = 2.027, p = .161, η^2 = .041) however, once again there was a significant interaction between the experimental condition and time (F (1, 48) = 5.063, p = .029, η^2 = .095) with medium effect size.

Pairwise comparisons revealed no significant difference between intervention and SAU control groups at pre-test (p = .717) and a significant difference post-test (p = .011). Exploring further revealed the intervention group reported a significant difference pre-test vs. post-test (p = .002) whereas the SAU control group reported no significant change (p = .624).

Figure 8

Mean in Child Responsiveness to Care in 2 Groups Before and After Intervention



Once again, it can be concluded that the intervention had a significant effect on the parent reported Child's Responsiveness to care as measured by the Carer's Questionnaire.

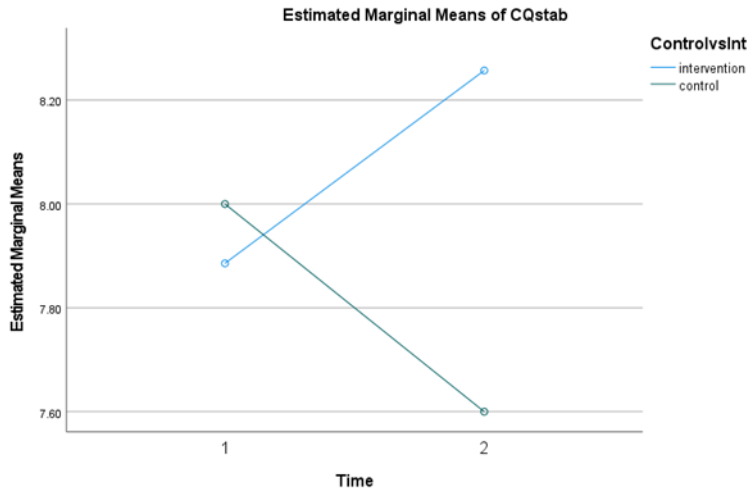
Carer Questionnaire Placement Stability

There was no main effect of time on Placement Stability (F (1, 48) = .003, p = .956, η^2= .000) also no interaction between experimental conditions and time (F (1, 48) = 2.276, p = .138, η^2 = .045). Pairwise comparisons revealed that there was no significant difference between intervention and SAU control groups at pre-test (p = .811) or post-test (p = .212), also that there was no significant change in post-test vs pre-test scores (p = .191). While there was no significant change, examination of

Figure 9 shows that for the intervention group stability was moving in the desired direction while stability of SAU control group moved in a negative direction

Figure 9

Mean in Placement Stability in 2 Groups Before and After Intervention



Therefore, despite the significant effect on total score and other subcategories, it cannot be concluded that the intervention effected placement stability.

Parent Report Measures of Child Behaviours

Brief Assessment Checklist for Children

Table 6

Descriptive statistics for conditions for Brief Assessment Checklist for Children

		n	*M*	*SD*
Pre	Intervention	34	17.85	7.52
	SAU Control	13	17.15	7.63
	Total	47	17.66	7.48

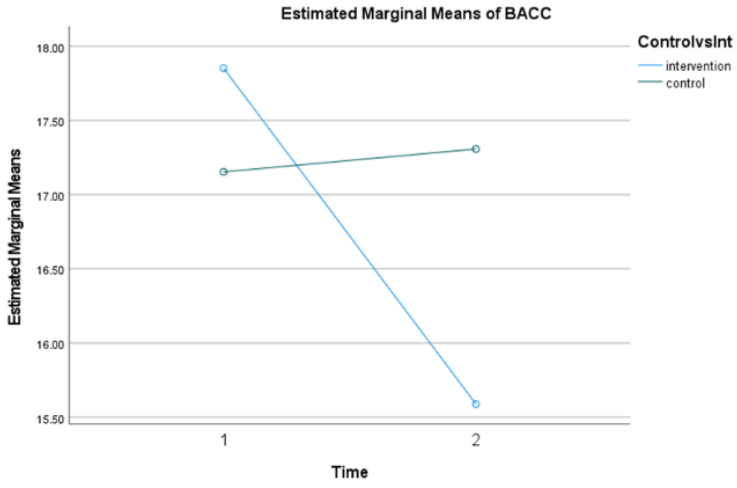
Post	Intervention	34	15.59	6.97
	SAU Control	13	17.31	7.74
	Total	47	16.06	7.15

There was no main effect of time on behaviours reported using the BAC-C (F (1, 45) = 1.955, p = .169, η^2 = .042) there was also no interaction between the experimental condition and times (F (1, 45) = 2.567, p = .116, η^2 = .054)

Pairwise comparisons showed there were no significant differences between the intervention and SAU control group at pre-test (p = .778) or at post-test (p = .467). Exploring further pairwise comparisons revealed that the intervention group reported significantly lower levels of problematic behaviour as measured by the BAC-C pre-test vs. post-test (p = .007), The SAU control group showed no significant change (p = .905).

Figure 10

Mean in BAC-C Child Behaviours in 2 Groups Before and After Intervention



Although there was no main effect, the pairwise comparisons show that the reported post -test scores for the intervention group were significantly different to the pre-test scores and therefore we can conclude that the intervention had a significant effect.

Goodman Strength and Difficulties Questionnaire (SDQ).

Table 7

Descriptive statistics for conditions for Goodman Strength and Difficulties total difficulties score and subscales.

		n	*M*	*SD*
Pre SDQ Total	Intervention	33	19.33	7.85
	SAU Control	13	21.08	8.34
	Total	46	19.83	7.93
Post SDQ Total	Intervention	33	18.15	7.43
	SAU Control	13	20.08	7.79
	Total	46	18.70	7.50
Pre SDQ Em	Intervention	33	4.49	2.51
	SAU Control	13	4.31	2.66
	Total	46	4.44	2.26
Post SDQ Em	Intervention	33	4.39	2.25
	SAU Control	13	3.62	2.02
	Total	46	4.17	2.19

Pre SDQ Beh	Intervention	33	5.03	2.48
	SAU Control	13	5.15	2.38
	Total	46	5.07	2.43
Post SDQ Beh	Intervention	33	4.79	2.45
	SAU Control	13	5.31	2.10
	Total	46	4.94	2.34
Pre SDQ Hyp	Intervention	33	6.91	3.17
	SAU Control	13	8.00	2.48
	Total	46	7.22	3.00
Post SDQ Hyp	Intervention	33	6.39	2.99
	SAU Control	13	7.23	2.77
	Total	46	6.63	2.92
Pre SDQ peer	Intervention	33	2.91	2.45
	SAU Control	13	3.62	2.66
	Total	46	3.11	2.51
Post SDQ Peer	Intervention	33	2.58	2.59
	SAU Control	13	3.92	2.63
	Total	46	2.96	2.64
Pre SDQ Pro So	Intervention	33	6.27	2.19

	SAU Control	13	6.69	2.50
	Total	46	6.39	2.27
Post SDQ Pro So	Intervention	33	6.70	2.08
	SAU Control	13	6.15	2.38
	Total	46	6.54	2.16

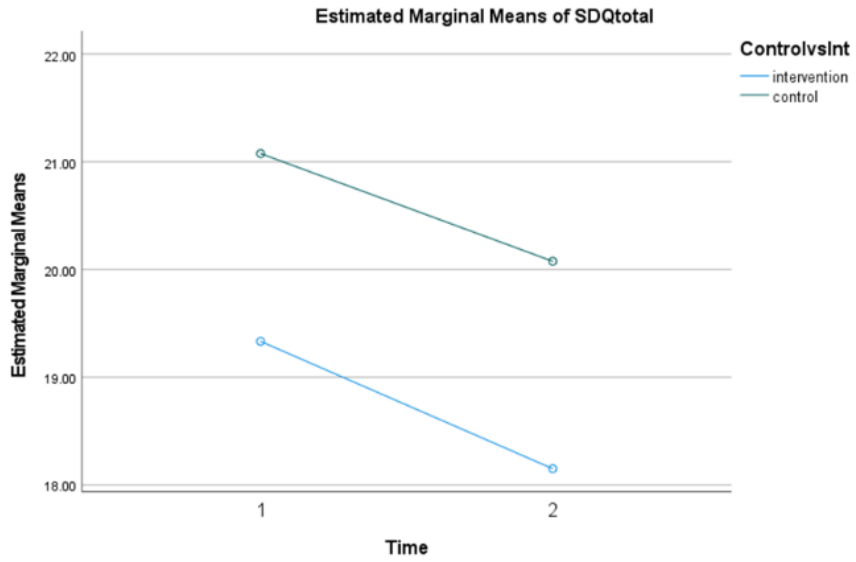
Strengths and Difficulties Questionnaire total difficulties score

There was no main effect of time on the SDQ total difficulties score (F (1, 44) = 2.886, p = .096, η^2 = .062) at the $p < .05$ though it was approaching significance, there was also no interaction between the experimental condition and time (F (1, 44) = .020, p = .888, η^2 = .000). Pairwise comparisons also revealed no significant differences between intervention group and SAU control group pre-test (p= .508) or post-test (p = .439) Further exploration of pairwise comparisons showed no significant difference between pre and post test scores for the intervention group, though once again it was approaching significance (p = .090) and no difference between the SAU control group pre and post test scores (p = .363).

Although there was no significant interaction or difference recorded and therefore, we cannot say that the intervention had an effect on the SDQ total stress score, the relative closeness to significance levels seems to indicate that the scores for the intervention group were progressing in the desired direction.

Figure 11

Mean in Strengths and Difficulties Questionnaire Total Difficulties Score in 2 Groups Before and After Intervention

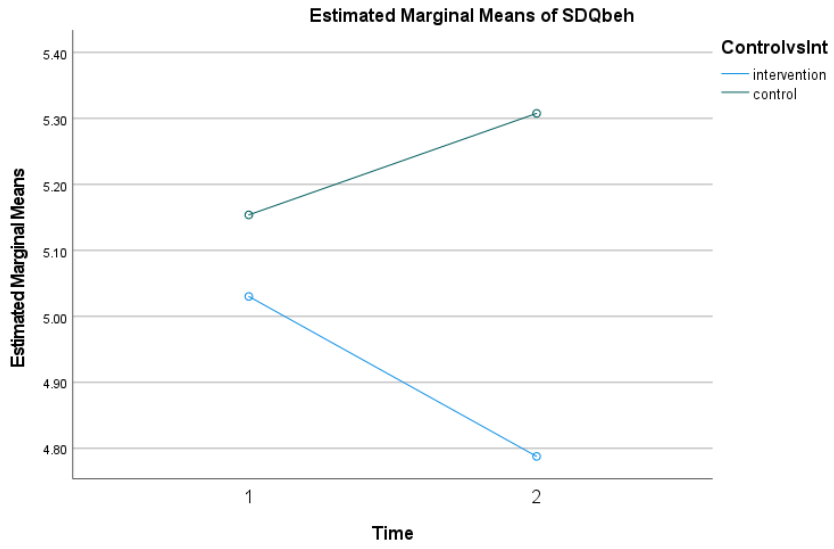


Strengths and Difficulties Questionnaire Behavioural difficulties score

There was no main effect of time on the SDQ Behavioural difficulties score (F (1, 44) = .030, p = .864, η^2 = .001) or on the interaction between time and the experimental condition (F (1, 44) = .598, p = .443, η^2 = .013). There was no significant difference between the intervention and SAU control groups either at pre-test (p = .803) or at post-test (p = .504), there was also no significant difference between pre and post-test for the intervention group (p = .387) or the SAU control group (p = .725).

Figure 12

Mean in Strengths and Difficulties Questionnaire Behavioural Difficulties Score in 2 Groups Before and After Intervention

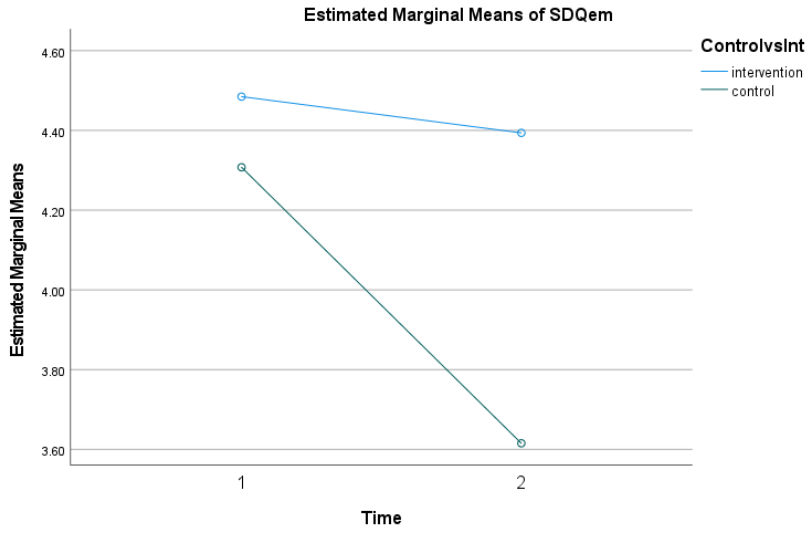


Strength and Difficulties Questionnaire Emotional Difficulties Score.

There was no main effect of time on the SDQ Emotional difficulties score (F (1, 44) = 1.578, p = .216, η^2 = .035) or on the interaction between time and the experimental condition (F (1, 44) = .931, p = .340, η^2 = .021). There was no significant difference between the intervention and SAU control groups either at pre-test (p = .833) or post-test (p = .283), there was also no significant difference between pre and post-test for the intervention group (p = .785) or SAU control group (p = .197).

Figure 13

Mean in Strengths and Difficulties Questionnaire Emotional Difficulties Score in 2 Groups Before and After Intervention



Strength and Difficulties Questionnaire Hyperactivity Difficulties Score.

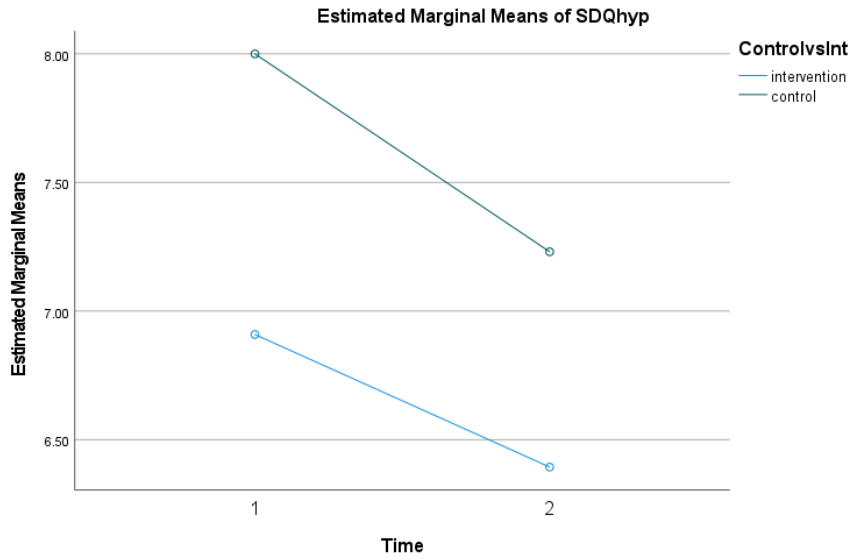
Time showed a main effect on the SDQ Hyperactivity difficulties score (F (1, 44) = 7.159, p = .010, η^2 = .140) with large effect size. However, there was no significant interaction between time and the experimental condition (F (1, 44) =.280, p = .599, η^2 = .006).

Pairwise comparisons showed there was no significant difference between the intervention group and SAU control group at pre-test (p = .272) or post-test (p = .388).

Exploring the interaction further, pairwise comparisons revealed that the intervention group reported a significantly lower level of hyperactivity at post-test vs pre-test (p = .05). For the SAU control group there was not a significant decrease in reported score post-test vs pre-test (p = 0.65) though this too was approaching statistical significance.

Figure 14

Mean in Strengths and Difficulties Questionnaire Hyperactivity Difficulties Score in 2 Groups Before and After Intervention



From these results it can be concluded that time had a significant effect on the hyperactivity score.

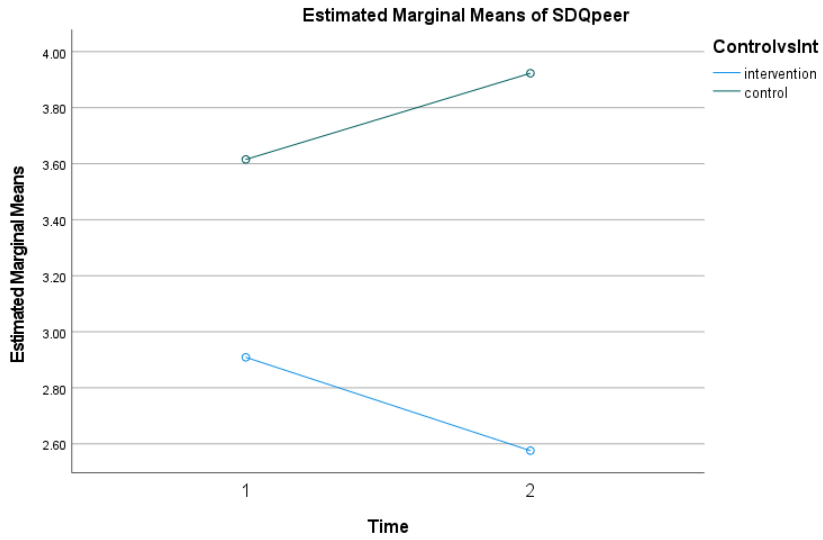
Strength and Difficulties Questionnaire Peer Difficulties Score

There was no main effect of time on the SDQ Peer difficulties score (F (1, 44) = .003, p = .957, η^2 = .000) or on the interaction between time and the experimental condition (F (1, 44) = 1.871, p = .178, η^2 = .041).

There was no significant difference between the intervention and control groups either at pre-test (p = .395) or post-test (p = .120), there was also no significant difference between pre and post-test for the intervention group (p = .188) or SAU control group (p = .442).

Figure 15

Mean in Strengths and Difficulties Questionnaire Peer Difficulties Score in 2 Groups Before and After Intervention



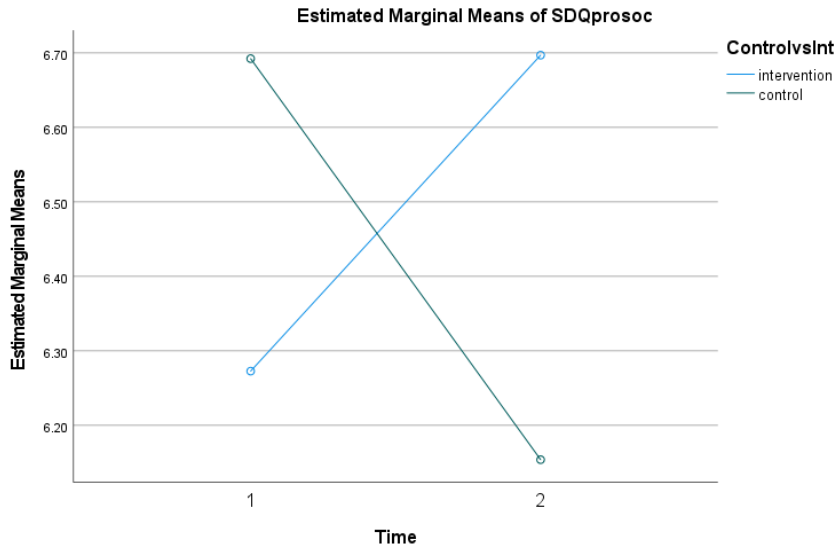
Strength and Difficulties Questionnaire Pro Social Behaviour

There was no main effect of time on the SDQ Pro Social Behaviour (F (1, 44) = .073, p=.788, η^2 = .002). However, there was an interaction between the experimental condition and time (F (1, 44) = 5.189, p = .028, η^2 = .105) with medium effect size.

Pairwise comparisons revealed that there was not significant difference between the intervention and SAU control group at pre-test (p = .577) or post-test (p = .448). Exploring the interaction further, pairwise comparisons revealed that the intervention group showed a post-test vs pre-test difference that was approaching statistical significance (p = .066) whereas the SAU control group did not (p = .140). This would imply that the effect of the parents attending the intervention may well have increased the levels of pro-social behaviour their children displayed, while we can see from the interaction chart that the pro-social behaviour of young people in the control group decreased.

Figure 16

Mean in Strengths and Difficulties Questionnaire Pro Social Behavioural Score in 2 Groups Before and After Intervention



Correlation between Meaning of the Child Coding Score, Parental Reflective Functioning Score and Parental Stress Scale Score.

The Meaning of the Child coding was originally validated by comparison with a number of procedures, including the Parental Reflective Functioning Scale, it would therefore be expected that the PDI-RF and MotC in this study would also correlate. Using all data points in this study (pre and post intervention) the MotC and PDI-RF did indeed show a strong positive correlation $r = .812$, $p < .01$.

As already mentioned in earlier chapters of this thesis, levels of felt parenting stress are also intertwined with the parents' ability to mentalize (Santelices and Cortes, 2022), so it would be expected that there would be an inverse correlation between both the MotC and parenting stress, and PDI-RF and parenting stress. When using all data points in this study it was found that the MotC and PSS had a negative

correlation r = -.359, p <. 01 and the PDI-RF also had a negative correlation r = -.234, p < .05.

Discussion of Results

At the start of this study, it was hypothesized that the mentalization based 'Knowing Me, Knowing, You' program would significantly increase the levels of parental sensitivity as measured by the MotC, and this hypothesis was upheld by the results from this study. Parental Sensitivity and Mentalization are explored in more depth in the earlier chapters of this thesis but the results are in keeping with earlier theorising and studies that postulate, and evidence, that parental mentalizing is key to development of parental sensitivity and that parents with superior mentalizing capacity tend towards a more sensitive approach to their child (Fonagy et al., 1991b; Koren-Karie & Oppenheim, 2018; Koren-Karie et al., 2002; Slade et al., 2005a; Slade, 2005). While not fully understood, both parental sensitivity and mentalization are linked to the development of attachment security, particularly in infants (Camoirano, 2017; McMahon & Bernier, 2017; Zeegers, Colonnesi, Stams, & Meins, 2017). This study did not use any measures to assess the attachment patterns or security of the children of participants, but if, as it seems the results would show, parental sensitivity is increased by the intervention, then it is suggestive of the possibility that the children's attachment security may also improve over time.

It was also hypothesized that the intervention would significantly increase the PDI-RF of course participants in comparison to the SAU group. This too was found, in fact while the PDI-RF of the participants significantly increased, for those in the SAU group PDI-RF decreased. These results are similar to those found by Sleed, Baradon and Fonagy (2013) who used a randomised control trial to study the effects on reflective function of an intervention with incarcerated mothers. While the PDI-RF

score significantly increased for those undergoing the intervention, it significantly decreased for those in the control group.

In their 2016 evaluation of the Nurturing Attachments Program, Julie Selwyn and colleagues found that the intervention significantly improved the reflective functioning of the participants, however there was no control group, and the reflective functioning was measured by self-report questionnaire rather than through interview and coding process. To date there does not appear to be other evaluations including control groups of a group parenting program for adoptive parents that specifically aim to impact parental sensitivity and reflective functioning, and therefore the findings here are of particular interest. However, The Reflective Fostering Program as developed by the Anna Freud centre has shown promising results and a large, randomized control study is currently underway (Midgley et al, 2021).

Thus, both primary hypotheses 1 and 2 were found in this study.

One of the secondary outcomes was hypothesized to be that the intervention would significantly decrease parental stress as measured by the Parental Stress Scale and within this study the parental stress was found to have significantly decreased as compared to pre- test scores for the intervention group. This paired with the significantly increased in parental sensitivity and PDI-RF would seem to be in line with the findings of Decarli and colleagues (2023). Their study into parental reflective functioning and cortisol reactivity during conflict with adolescent children, found that higher levels of PDI-RF was a predictor of lower parenting stress. Dolberg and colleagues (2022) also found that PDI-RF was a moderator between a baby's prematurity and parental stress. The relationships between parental stress, parental sensitivity and reflective functioning are complex as is their relationship to child

outcomes, but higher levels of parental stress are related to mental health issues in parents such as anxiety and depression and this in turn can affect the parental practices and responsiveness to the child's needs and signals (Bayer et al., 2006).

The Carer's Questionnaire measured the parents' perception of different aspects of their relationship with their child. It was hypothesised that the intervention would have a significant effect on the scores both in the total score and the subsections. This was held up for the total score, as well as for Parental Skills and Understanding, Parent Child Relationship and Child Responsiveness to Care, but not for the Placement Stability which was a single item subsection.

The Parental Skills and Understanding links into the parents' feelings of competence around the parenting task, in their Spanish study of foster carers and children Molano and colleagues (2023) found that levels of felt competence were inversely related to levels of parenting stress, and that the level of felt competence was also inversely related to psychological problems in the child. This would seem to link with the results from this study that show a decrease in felt stress and an increase in parental skills and understanding. Both Parent Child Relationship and Child Responsiveness to Care subsections are around the believed quality of the parent-child relationship. The reflective ability of the parent and their parental sensitivity are core components to attachment theory and are core to good quality parent- child relationships (Rostad & Whitaker, 2016). Resulting from their study into parent child relationship quality and reflective functioning Rostad and Whitaker (2016) proposed that this was a key area that interventions should target.

Given the significant results in the other categories, it is interesting that the intervention did not significantly impact perceived placement stability, though

examination of figure 9 shows that it is progressing in the desired direction, while the stability of the SAU group is decreasing. This lack of statistical significance may be due to a number of reasons, including the small scale of the study, the fact that it is a single item category or that perceptions of placement stability is not directly related to other factors such as reflective functioning and feelings of competence. In her master's thesis, Silvia Mandujano (2016) found that one of the most significant factors leading to instability in placement and breakdown was the young person's behaviour and as we see from the results shown above, despite significant improvements in other areas and in behaviours as measured by the BAC-C, the challenging behaviours within this study group as measured by the SDQ did not significantly improve. However, strong parenting skills have been found to be a protective factor against placement breakdown (Rock et al., 2015), so perhaps feelings of stability will grow over time with the improvement in skills and understanding.

The final secondary hypothesis was that levels of difficult behaviours as measured by the Brief Assessment Checklist for Children (BAC-C) and by the Goodman Strength and Difficulties Questionnaire (SDQ) would decrease and pro-social behaviours as measured by the SDQ would increase. Statistical analysis of behaviours as measured by the BAC-C showed no main effect, however the pairwise comparisons did show that the intervention significantly lowered the behaviour score pre-test vs post-test. However, when examining the SDQ, there was no significant difference in total difficulties, behavioural, emotional or peer difficulties. There was a significant reduction in hyperactivity score for the intervention group, though the SAU was also approaching significance suggesting time may be a factor. Changes in the SDQ pro-social scale were approaching significance. These findings were similar to

those of the study into NVR, where Fongaro and colleagues (2023) also did not find any improvements in SDQ scores. It is interesting that the BAC-C shows change where the SDQ does not, this is possibly due to their design differences. The SDQ was developed as a measure for the population as a whole whereas the BAC-C was developed specifically for the looked after child and those who are in kinship or adoptive placements (Terren-Sweeney, 2013). The creator had identified that existing measures such as the SDQ did not pay particular attention to measure adequately certain behaviours and attachment-related difficulties that were prevalent in this particular population. The KMKY intervention was designed specifically for parents of adopted children, as well as attempting to aid the mentalizing capacity of the parents the psychoeducational aspects of the course had a strong focus on attachment and trauma and how to therapeutically parent traumatized children. With this in mind it seems to make sense that impact on behaviours is more likely to be shown by the BAC-C, that was designed for use with traumatized children, rather than the SDQ that was designed for the general population.

Taken all together, the secondary outcomes of reducing parental stress and improving the perception of the parent-child relationship were founded, while the outcome of reducing behavioural issues was only partially founded.

These measures did not consider the longitudinal effects of the intervention, all graphs of effects showed that for the intervention group each measure was progressing in the desired direction. The KMKY course is only a 9-week intervention and while significant movement is shown in all parental measures, it is perhaps too short a time scale to expect that the changes in the parents would be significantly impacting the children and therefore their behaviours.

Conclusion

This small-scale study into a novel intervention that includes both mentalzing and psychoeducational aspects shows lots of promise and brings hope for parents and professionals dealing with adopted children showing child to parent violence and aggression. The key findings are that the' Knowing Me, Knowing You' course program is shown to significantly improve parents reflective functioning as measured by the PDI-RF and parental sensitivity as measured by the MotC, and thus that it helps to increase the participants mentalzing capacity. Importantly it is also shown to significantly reduce parental stress, plus it has also shown that improvements can be brought to the parents construct around their relationship with their child, improving sense of competence and quality of relationship. There is also some evidence that the intervention directly impacts the behaviours shown by the children, however this is limited and may be due to the limited timescales involved in this study.

Future Studies would benefit from larger sample size and a longitudinal design to explore if change is maintained or even improved over time.

Strengths and Limitations

This study of pre and post intervention measures around the KMKY program holds great strength in the number and range of measures used to explore changes the participants showed over the time period of the KMKY program, the use of interview protocols that were then separately coded rather than just self-report measures is relatively unusual and also adds to the strength of the data.

At point of writing, it appears this is the only study of adoptive parents experiencing aggression and violence from their children that contains a control group while specifically looking at the parental sensitivity and reflective function of these parents.

There also appears to be no studies to date measuring changes in parental sensitivity using the MotC coding around a group parenting intervention. It adds weight to the growing area of group interventions that aid mentalization and parental reflective functioning.

Majority of studies into changes in reflective functioning make use of the self-report Parental Reflective Functioning Questionnaire (PDI-RFQ; Luyten, Mayes, Nijssens, & Fonagy, 2017), rather than interviews however, Adkins and colleagues (2022) also made use of five-minute speech samples, in addition to the PDI-RFQ in their study of the Family Minds intervention for foster carers.

This study is also novel in that it is around a recently developed mentalizing intervention that was specifically designed for adoptive parents experiencing aggression and violence from their children. Most programs in this area such as NVR and Break for Change, are not designed with the adopted population in mind, though some have been adapted for this use.

It is limited by its size and the lack of longitudinal information, plus it is noted that the researcher was the course developer and also was either the primary or secondary facilitator on all the courses including in this study, the replicability using other facilitators is unknown.

Chapter 8: Exploring the Longitudinal Effects of the Knowing Me, Knowing You Program.

The study contained within chapter 7 is an in-depth exploration of the effects that the KMKY program had on a wide range of measures. As mentioned in the discussion section these measures are only around the time of the intervention itself and do not explore the longitudinal effects that the intervention may have. The full study was originally designed to take this into account and as part of that design the questionnaires were supposed to be repeated 6-9 months after the intervention concluded. All parents who underwent the intervention and had consented to the research were approached via secure email 6-9 months after the intervention to once again complete the questionnaires. Interviews were not repeated.

Unfortunately, there was a very poor response to this request with just 5 (representing 8 children) out of 23 parents returning the questionnaires. This may be for several reasons, for the majority of parents the time period fell during the Covid-19 pandemic with many of them juggling homeschooling their children during multiple lockdowns and their work commitments, it is worth noting that these families were already living in multi-stressed circumstances and hence had been referred to the intervention. A further learning point for the researcher was that the questionnaires were paper based and required filling in and sending back, had they been on a web-based format such as Qualtrics they may have been more accessible for families to complete.

Out of the 5 adult who did respond, 4 of them where within cohort 1. Cohort 1 took place during 2018. Out of that cohort 5 adults who had consented to research completed the course and the pre and post measures, 4 of these also completed the 6-9 months on questionnaires, with one adult failing to respond. For all further

cohorts the return date for the follow up questionnaires fell from December 2019 onwards. Only one of these adults returned the follow up questionnaires at the 6-9 month point. The spring 2020 cohort had started face to face but then proceeded to online and all further cohorts attended the course online.

The service as usual (SAU) control group in the first study had been wait listed for the intervention, and by the 6-9 month period some were undergoing the intervention, therefore the SAU group were not approached to complete the longitudinal questionnaires.

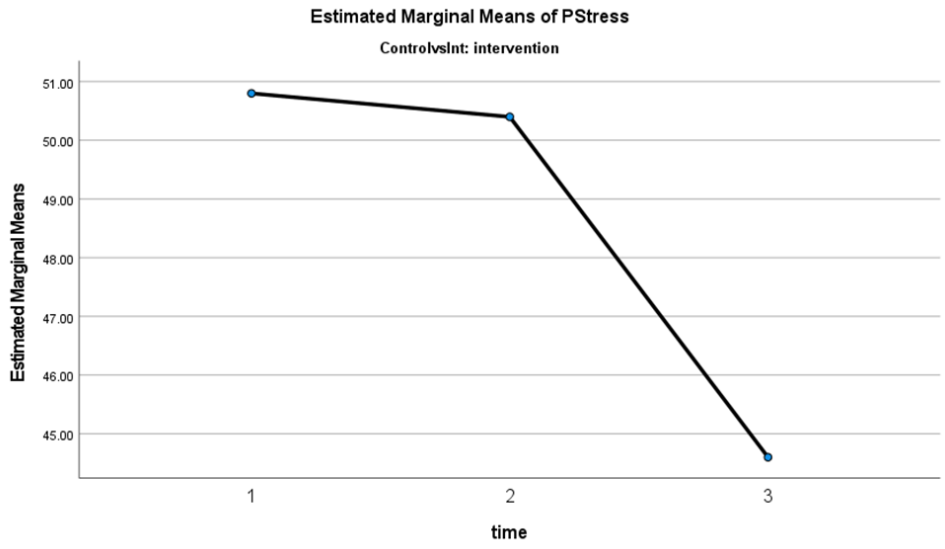
With such few respondents the data from statistical analysis of the questionnaires is limited, and therefore this study is split into two sections. Part 1 looks at the statistical analysis across 3 time points for each measure to see if any hypothesis around longitudinal effects can be formed, and Part 2 takes the form of multiple case study informed by the single case study (n = 1) approach to look in detail at each respondent and consider how the measurements for each participant changed over time.

McLeod (2010) bemoans the decline of the use of single case study approach in favour of randomised control studies to answering efficacy questions in counselling and psychotherapy, and points to the value of this type of research. While single case study requires the examination of trends across multiple time points, in this study there are just 3 time points, however there are multiple measures that can be examined. Due to the complexity of information and multiple measurements within part 2 graphs for each participant were not drawn as this would render the information unintelligible.

Part 1: Statistical Analysis of Parent Self- Report measures
Parental Stress Scale

Figure 17

Changes Parental Stress Scale Over Time, n=5



Note. Time point 1= pre-intervention, 2=post-intervention and 3 = 6-9 month post-intervention follow-up.

There was no significant main effect of time on the parental stress of this subgroup (F (2, 8) = 1.698, p = .243, η^2 = .298).

For the participants as a whole, statistical analysis showed that the intervention significantly lowered parental stress score at post-test vs. pre-test (p =.002). The above graph shows that for this subgroup of 5 parents, there was only a small difference between their mean score at pre-intervention and post-intervention, but then there appears to be a much larger difference between point post-intervention and follow-up showing a further reduction in parental stress, though this was not at a significant level, perhaps due to the small sample size. The difference between pre-intervention and follow-up was approaching significance (p = .08) suggesting the

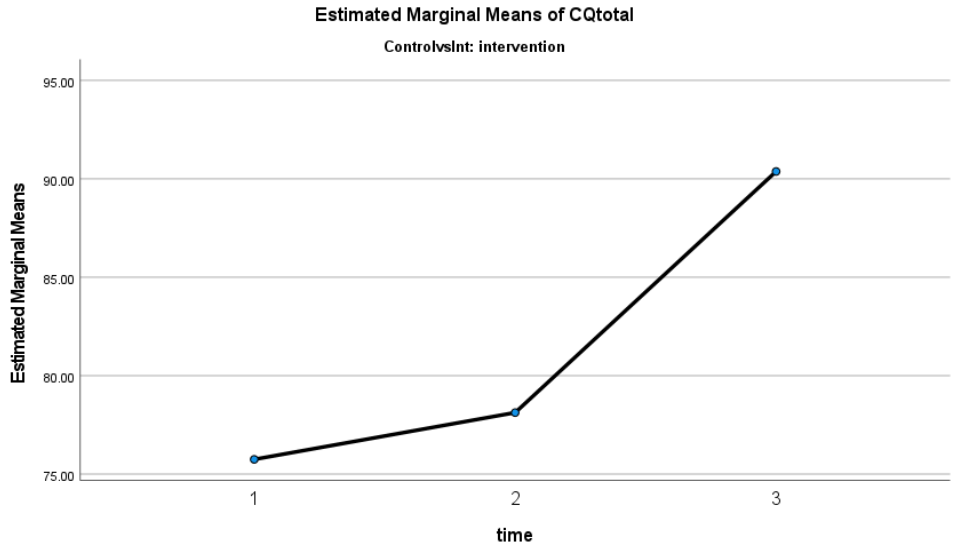
possibility that the level of parental stress felt by parents who engage in the intervention may in fact continue to decrease in the time period after the intervention.

Carer Questionnaire

Carer Questionnaire Total score

Figure 18

Changes in Carer Questionnaire Total Score Over Time, N = 8.



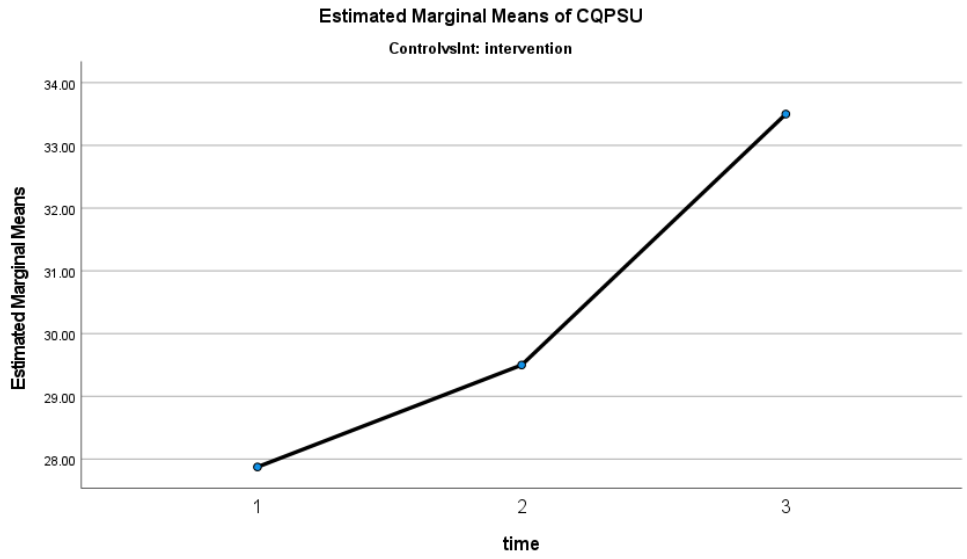
Note. Time point 1= pre-intervention, 2=post-intervention and 3 = 6-9 month post-intervention follow-up.

Time showed a significant effect (F (2, 14) = 7.766, p = .005, η^2 = .526) with large effect size. The difference between pre-intervention and post-intervention was not significant (p = .563) however the difference between pre-intervention and follow-up and post-intervention and follow-up were both significant (p =.003 & p =.032). Showing that for this subgroup, after small gains post intervention, there were considerable gains in the carer's questionnaire total score during the 6-9 months after the intervention.

Carer Questionnaire Parental Skills and Understanding Score

Figure 19

Changes in Carer Questionnaire Parental Skills and Understanding Score Over Time, N=8.



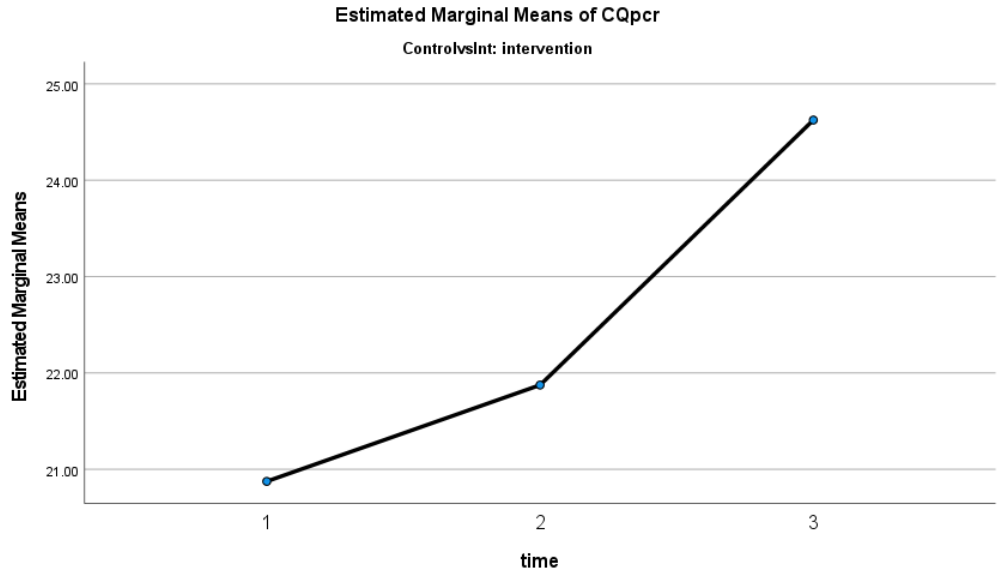
Note. Time point 1= pre-intervention, 2=post-intervention and 3 = 6-9 month post-intervention follow-up.

Time did have a significant effect on parental skills and understanding (F (2, 14) = 11.458, p = .001, η^2 =. 621) with large effect size. The difference between pre-intervention and post-intervention was not significant (p =.250), however the difference between post-intervention and follow-up was (p =.025), and also between pre-intervention and follow-up (p <.001). Again, suggesting that the time after the intervention was completed was significant for continued improvements in the parents' feelings of competence in their skills and understanding.

Carer Questionnaire Parent Child Relationship Score

Figure 20

Changes in Carer Questionnaire Parent Child Relationship Score Over Time, N=8



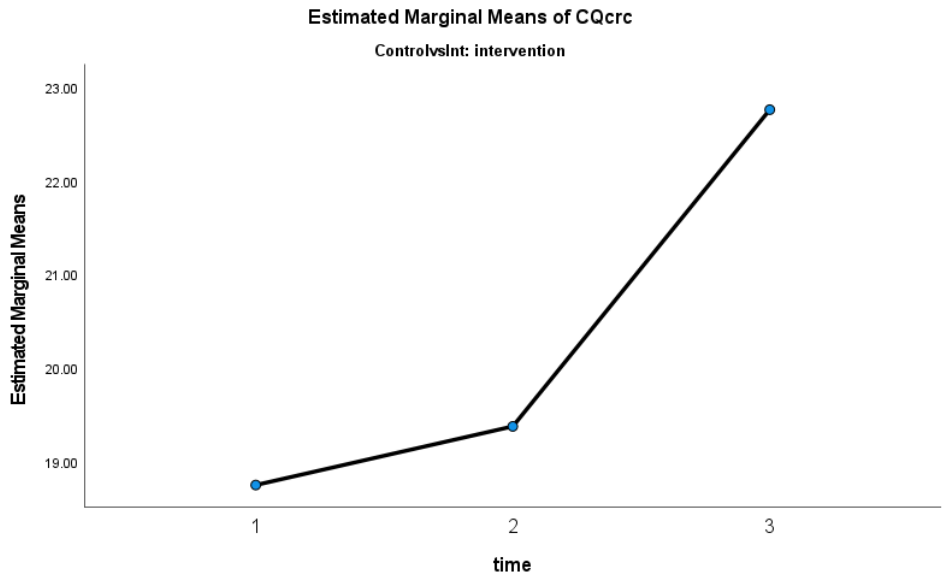
Note. Time point 1= pre-intervention, 2=post-intervention and 3 = 6-9 month post-intervention follow-up.

Time showed a significant effect (F (2, 14) = 4.817, p = .026, η^2 =.408) with large effect size. The difference between pre-intervention and post-intervention was not significant (p = .441) nor was the difference between post intervention and follow-up (p = .066) though this was approaching significance, the difference between pre-intervention and follow-up was significant (p = .021). Showing the continued improvements between post-intervention and the longitudinal follow-up.

Carer Questionnaire Child Responsiveness to Care Score

Figure 21

Changes in Carer Questionnaire Child Responsiveness to Care Score Over Time, N=8.



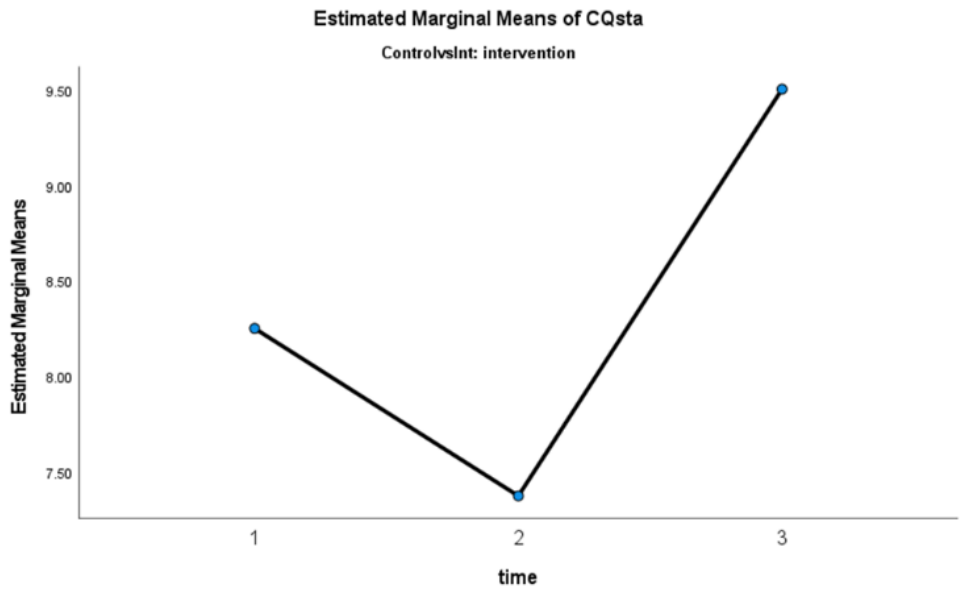
Note. Time point 1= pre-intervention, 2=post-intervention and 3 = 6-9 month post-intervention follow-up.

Time showed a significant effect (F (2, 14) = 4.097, pc=.040, η^2 =.396) with large effect size. The difference between pre-intervention and post-intervention, plus between post-intervention and follow-up were not statistically significant (p =.716, p =.067). However, the difference between pre-intervention and follow-up was significant (p = .017). Showing continuing improvements after intervention was completed.

Carer Questionnaire Placement Stability Score

Figure 22

Changes in Carer Questionnaire Placement Stability Score Over Time, N=8.



Note. Time point 1= pre-intervention, 2=post-intervention and 3 = 6-9 month post-intervention follow-up.

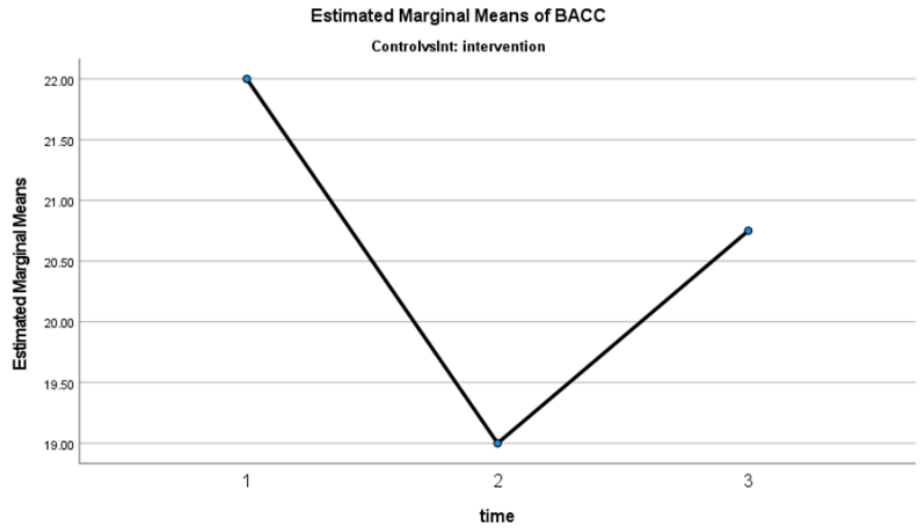
Time showed an effect that was approaching and very close to significance (F (2, 14) = 3.712, p = .051, η^2 =.347) with large effect size. None of the differences between pre-intervention and post-intervention (p =.195), post-intervention and follow-up (p =.081) and pre-intervention and follow-up (p =.83) were significant, though it can be seen that the differences between point post-intervention and follow-up and pre-intervention and follow-up were approaching significance. Examination of the graph showed that stability actually worsened for this subgroup at post-test vs pre-test, then improving after intervention to a point that was higher than the pre-test level by the 6-9 month period.

Parent Report Behavioural Measures

Brief Assessment Checklist for Children

Figure 23

Changes in Brief Assessment Checklist for Children Over Time, N=8.



Note. Time point 1= pre-intervention, 2=post-intervention and 3 = 6-9 month post-intervention follow-up.

Time did not show a significant effect, although it was approaching significance (F (2, 14) = 3.651, p = .053, η^2= .343). While the difference between pre-intervention and post-intervention was only approaching significance (p = .068) the difference between post-intervention and follow-up was significant (p =.026) but going in the opposite direction to desired outcomes, the overall change between pre-intervention and follow-up was not significant (p =.329). The above graph shows that while the levels of behaviour reported at the point straight after the intervention and between pre-intervention and follow-up had reduced, for this subgroup it shows and increase in levels between post-intervention and follow-up. Showing that after initial

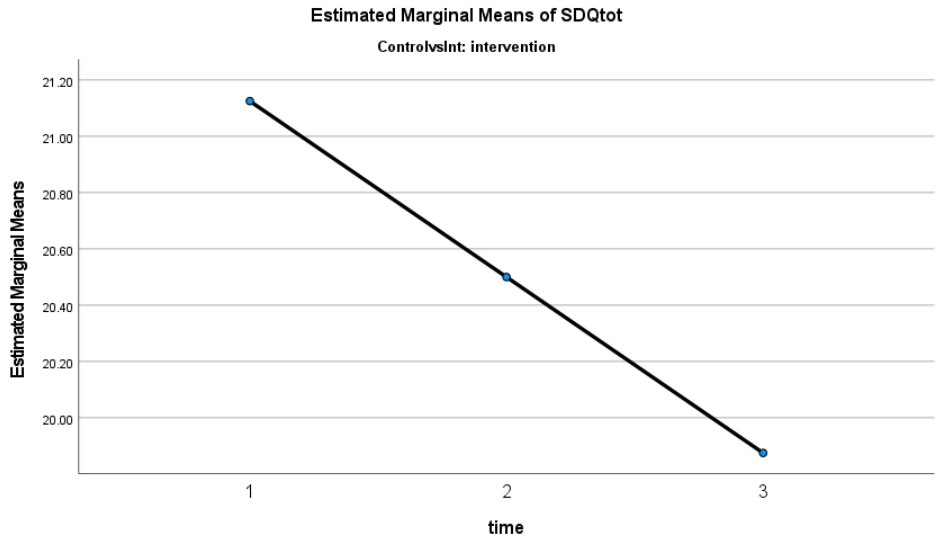
improvements there was a certain level of regression over the following months, however, even after this time there was overall improvements.

Strength and Difficulties questionnaire

Strength and Difficulties Total Difficulties Score

Figure 24

Change in Strength and Difficulties Total Difficulties Score Over Time, N= 8.



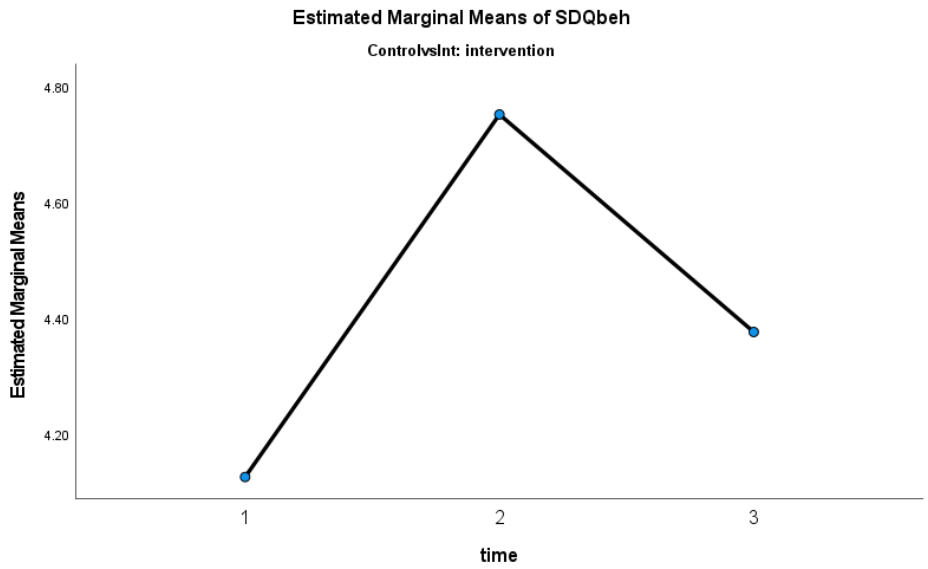
Note. Time point 1= pre-intervention, 2=post-intervention and 3 = 6-9 month post-intervention follow-up.

There was no significant effect of time (F (2, 14) = .295, p = .749, η^2 = .040), there was also no significant difference between pre-intervention and post-intervention (p = .644), post-intervention and follow-up (p = .710) and pre-intervention and follow-up (p = . 535). While the graph appears to show that there is a reduction in score, it cannot be presumed that this is due to the intervention.

Strength and Difficulties Behavioural Difficulties Score

Figure 25

Changes in Strength and Difficulties Behavioural Difficulties Score Over Time, N=8.



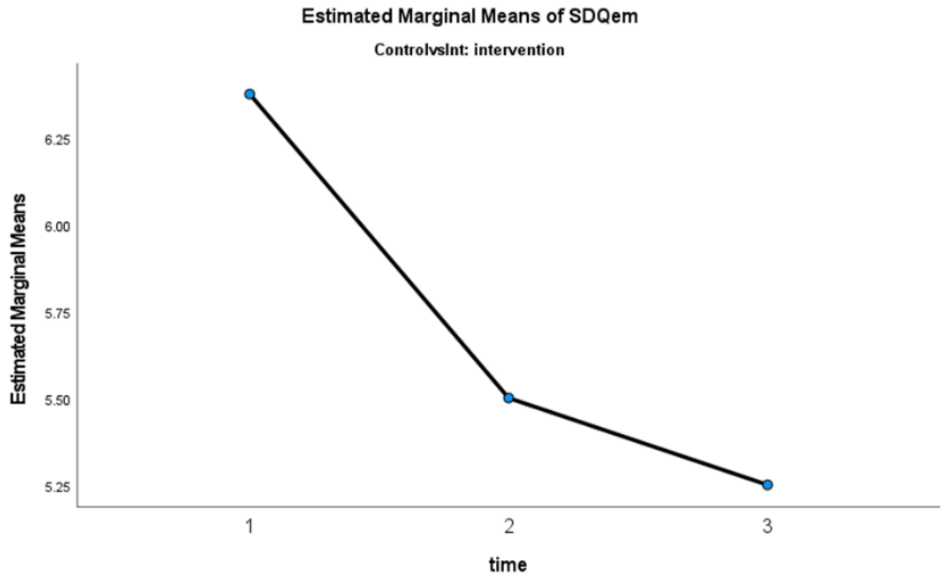
Note. Time point 1= pre-intervention, 2=post-intervention and 3 = 6-9 month post-intervention follow-up.

There was no significant effect of time (F (2, 14) = .289, p = .754, η^2 = .040), there was also no significant difference between pre-intervention and post-intervention (p = .503), post-intervention and follow-up (p = .634) and pre-intervention and follow-up (p = . 775). Examination of the graph shows that the behavioural issues of this subgroup actually increased post-test vs pre-test, then in the following time period improved, but not to the original level.

Strength and Difficulties Emotional Difficulties Score

Figure 26

Changes in Strength and Difficulties Emotional Difficulties Score Over Time, N=8.



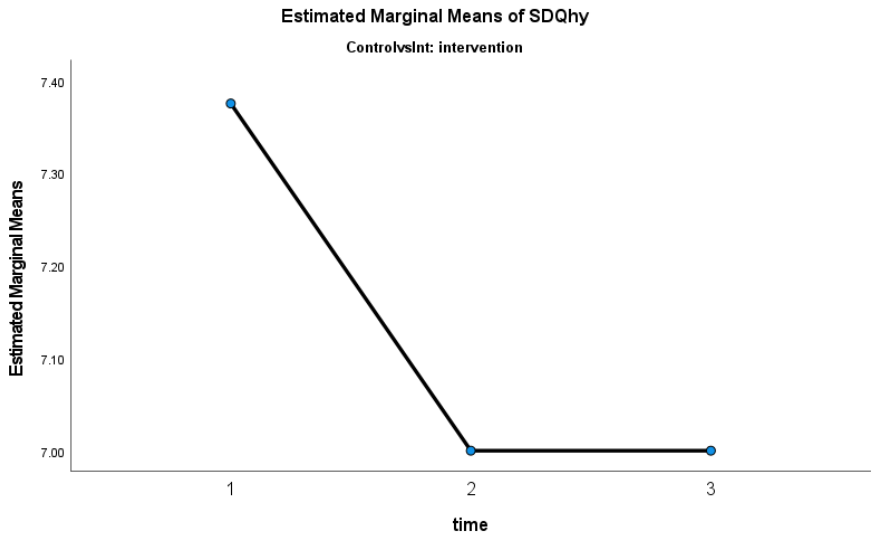
Note. Time point 1= pre-intervention, 2=post-intervention and 3 = 6-9 month post-intervention follow-up.

There was no significant effect of time (F (2, 14) = 1.601, p = .237, η^2 = .168), and though the graph would suggest a progression in the desired direction, there were also no significant changes between any of the time points. Pre-intervention and post-intervention (p = .111), post-intervention and follow-up (p = .732), pre-intervention and follow-up (p = .185).

Strength and Difficulties Hyperactivity Difficulties Score

Figure 27

Changes in Strength and Difficulties Hyperactivity Difficulties Score Over Time, N= 8.



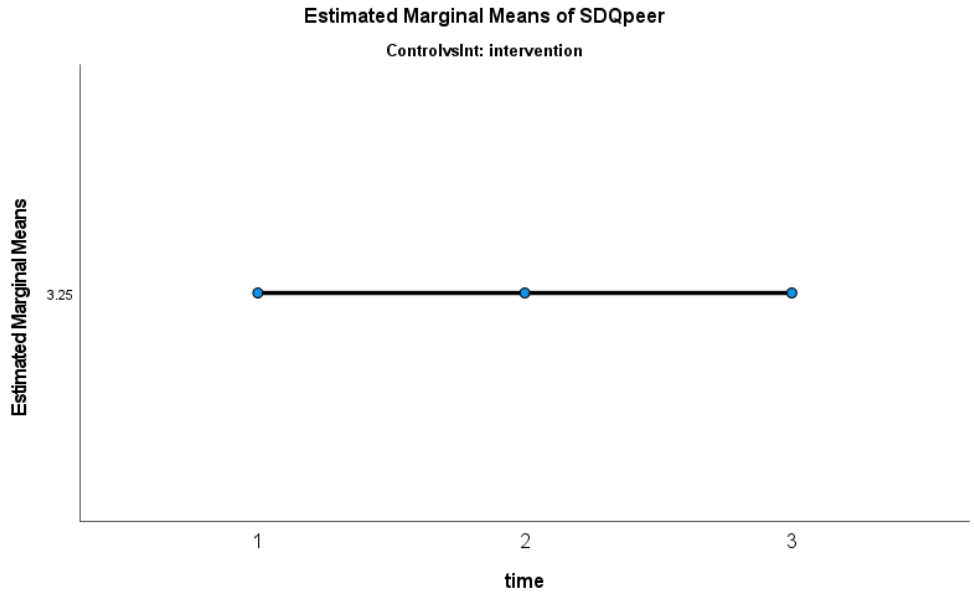
Note. Time point 1= pre-intervention, 2=post-intervention and 3 = 6-9 month post-intervention follow-up.

There was no significant effect of time (F (2, 14) = .188, p = .831, η^2 = .026), there were also no significant changes between any of the time points. Pre-intervention and post-intervention (p = .476), post-intervention and follow-up (p = 1), pre-intervention and follow-up (p = .654).

Strength and Difficulties Peer Difficulties Score

Figure 28

Changes in Strength and Difficulties Peer Difficulties Score Over Time, N = 8.



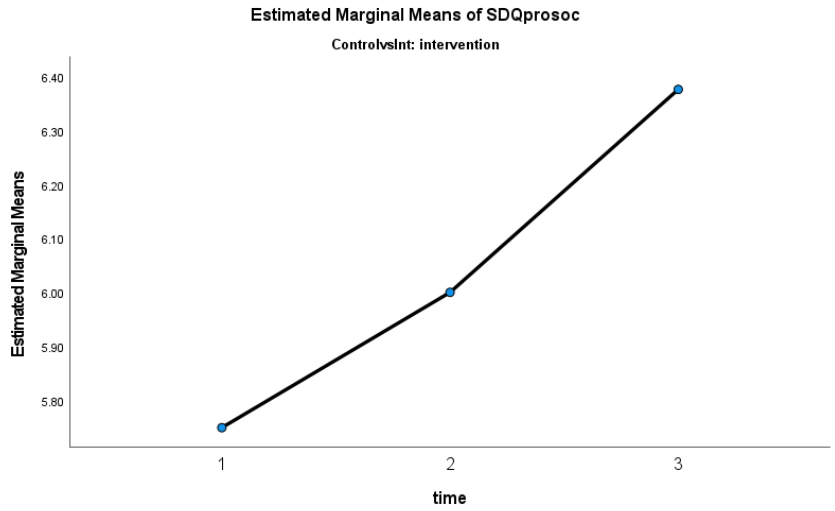
Note. Time point 1= pre-intervention, 2=post-intervention and 3 = 6-9 month post-intervention follow-up.

As can be seen by the graph, there was no change whatsoever in the peer difficulties experienced by this subgroup. (F (2, 14) = 0, p = 1, η^2 = 0).

Strengths and Difficulties Pro Social Behaviour Score

Figure 29

Changes in Strength and Difficulties Pro Social Behaviour Score Over Time, N= 8.



Note. Time point 1= pre-intervention, 2=post-intervention and 3 = 6-9 month post-intervention follow-up.

There was no significant effect of time (F (2, 14) = 1.317, p = .299, η^2 = .158), there were also no significant changes between any of the time points. Pre-intervention and post-intervention (p = .589), post-intervention and follow-up (p = .285), pre-intervention and follow-up (p = .140), though examination of the graph would imply they were moving in the desired direction, i.e. the pro social score was increasing.

Discussion of longitudinal results

As previously stated, this subgroup of the whole study is very small, and therefore the results may not be indicative of the group as a whole.

In this subset, we see that the parental stress levels continued to fall in the period after the intervention, and these findings are very similar to those of studies into The Incredible Years Program that saw parental stress falling in the months following the

intervention, though not to the level of statistical significance (Henderson & Sargent, 2005; Menting et al., 2013).

When it comes to the Carer Questionnaire, positive change is seen between post-intervention and follow-up in all the measures, reaching statistical significance for the total score and parental skills and understanding score, with it approaching significance in parent child relationship, child responsiveness to care, and placement stability. Apart from placement stability that showed a negative change between pre-intervention and post-intervention, all subcategories showed small positive change at this stage, then a much larger change between post-intervention and the follow-up questionnaires, suggesting that the time after the intervention when the parent is integrating the learning brings more improvements to the relationship, and the parents mental construct around the child. Similarly, Wassall (2011) in her doctoral thesis found that the parent's sense of competence had improved both after the Nurturing Attachments intervention and again 8 months after. The findings around stability reduction post intervention were contrary to what was expected (though in the post intervention this improved to higher than original level) and could be due to the measure being only a single question measure, however, further study into perceptions of stability of placement would be useful.

As stated, it would seem that the time period post intervention consolidates learning and continues to support improvements both in felt stress levels and constructs around the child. However, what is not known is the contribution of other factors post course, such as the participants gaining support from ongoing peer contact, or the reduction in shame and the pressure that brings to parenting.

Within this small subgroup of the original study none of the behavioural measurements showed statistically significant change in the behavioural measurements between pre-intervention and follow-up, despite this, on examination of the graphs all except the SDQ Behavioural and Peer subscales showed movement in the desired direction. The SDQ Behavioural subscale showed an increase in behavioural problems initially then a reduction, but not to the original level and the Peer subscale remained static throughout. This was contrary to what was hypothesised and hoped for. Studies into interventions, specifically adopted children and/or children displaying aggression and violence of this populations group have varying results when it comes to child behavioural measures with some showing improvements and others showing no difference when compared to control groups. The Family Minds course adapted for foster carers also found no significant change in children behavioural scores post intervention, however there was a significant difference 6 months post intervention in the SDQ total score (Adkins, 2022). There is a dearth of longitudinal evidence for either of these groups, with seemingly none specifically for adopted children displaying aggression and violence. It would therefore be of great interest and further understanding of this specific group if future studies included both a control group and longitudinal data and were much larger in size.

Part 2: Examination of individual cases.

Anne and Ella

This 40-year-old female in a marriage relationship was an adoptive parent to a single female child, Ella aged 5. Anne attended the course on her own, but due to finding it to be helpful her husband attended in a later cohort. Ella had been placed at the age of 22 months after periods of time with birth parents and in foster care. Age wise

Anne was younger than average for the intervention group and just outside 1 standard deviation (*M* = 43.53, *SD* = 3.45), Ella was also younger than average and outside of 1 standard deviation (*M* = 7.52, *SD* = 2.12).

Anne was part of the pilot group, when participation in the interviews were not compulsory and she elected to engage in them and to be part of the research. Initially her interview was coded as scoring both a 3 on the MotC and a 3 on the PDI-RF. Post intervention she had moved to a 6 on the MotC and a 5 on the PDI-RF showing gains in her parental sensitivity and reflective functioning.

As can be seen by table 8 below, Anne's parental stress score pre intervention was very close to the average for the whole intervention group (*M* = 53.30, *SD* = 8.93), post intervention she shows a 3 point decrease in stress level, but this is above the group average (*M* = 48.52, *SD* = 9.69), it then decreases 1 further point at the 6-9 month point, at this stage she can only be compared to the subgroup of 5 parents that returned questionnaires, despite the further reduction her parental stress remains considerably higher than the mean of this subgroup (*M* = 44.60, *SD* = 9.56).

Table 8

Parental Stress Scale for Anne at all time points

	Pre	Post	6-9 months post
Parental Stress	54	51	50

Anne's Carer Questionnaire **-** With the total score, and subsections, of the Carer Questionnaire a rising score indicates an improvement.

When it comes to Anne's Carer Questionnaire total score, pre-intervention she is already scoring considerably higher than average (*M* = 71.66, *SD* = 14.82) and gains 2 points immediately post intervention to 80 which is just under average at this point (*M* = 81.94, *SD* = 14.82), over time she loses 1 point leaving her just 1 point improvement on the original total score and considerably below the average for the subgroup at this stage (*M* = 90.38, *SD* = 8.38).

For Parental Skills and Understanding her pre and post scores of 26 and 31 respectively are both close to average for the group (*M* = 25.49, *SD* = 6.81; *M* = 30.66, SD = 4.42), over time she loses one of the points gained, but is still close to the post intervention average, however she is lower than the subgroup average at this time point (*M* = 33.50, *SD* = 2.39)

Parent Child relationship shows a loss over the intervention time, her pre-intervention score of 23 is above the average (*M* = 20.46, *SD* = 4.88), she then loses 2 points and is lower than average (*M* = 22.83, *SD* = 3.85), regaining one point she is also lower than the subgroup average (*M* = 24.63, *SD* = 3.38) but within 1 standard deviation.

Child Responsiveness to Care remains stable throughout at a score of 20, this is above average at the start (*M* = 17.83, *SD* =4.93) average post intervention (*M* = 20.20, *SD* = 4.25), and lower than average of the subgroup at the 6–9-month period (*M* = 22.75, *SD* = 3.41).

We see a steady decrees in the Stability score of 1 point between each time point, she starts at above average (*M* = 7.89, *SD* = 1.49), post intervention is approximately average (*M* = 8.26, *SD* = 1.69) but is lower than average of the subgroup at 6-9 months (*M* = 9.50, *SD* = 1.07)

It is interesting that as the parental skills and understanding have increased, the placement stability seems to have decreased, it is possible that as Anne has become more aware of her child's difficulties and how to handle them, she has also become more aware of potential issues in the future and therefore feels the placement is less secure.

Ella's Strengths and Difficulties Questionnaire - Improvements in the SDQ are shown by reduction in score in SDQ total difficulties, and the Emotional difficulties, behavioural difficulties, Hyperactive difficulties and Peer difficulties. An improvement in the Pro-Social subscale is indicated by an increase.

The Strengths and Difficulties total difficulties score sees a steady reduction through the time points, 23, 22 and 19 respectively with the largest gain being between the post intervention and the 6–9-month period. Ella's score at the start is above average for the group (*M* = 19.33, *SD* = 7.85) remaining above average at post intervention (*M* = 18.15, *SD* = 7.43), but at 6-9 month very close to average of the subgroup (*M* = 19.88, *SD* = 2.75).

The emotional subscale also sees a steady reduction, 1 point between each time point. The average of the intervention group as a whole sees little change in score in this subscale pre and post intervention (*M* = 4.49, *SD* = 2.51; *M* = 4.39, *SD* = 2.25). At 7 and 6 Ella's score is higher than average for pre and post intervention, but at 5 is just below average of the subgroup at 6-9 months (*M* = 5.25, *SD* = 1.83).

Ella's behavioural subscale moves in an opposite way to the emotional scale with level of difficulties increasing (4, 5 & 6), rising by one point between each time points. She starts off lower than average (*M* = 5.03, *SD* =2.48) rising to slightly above average at post intervention (*M* = 4.79, *SD* =2.44) and being higher than

average of the subgroup at 6-9 months (*M* = 4.38, *SD* = 1.85). Looking at this movement it is possible that as the Anne's behaviours and responses to Ella have change, the child's challenges are presenting in a different way, however it was not expected that behavioural issues would increase.

The Hyperactivity subscale is where we see dramatic change, and this would appear to be driving the reduction in total difficulties. Ella starts by scoring the maximum of 10 considerably above the average (*M* = 6.91, *SD* =3.17), she remains at 10 post intervention (*M* = 6.39, *SD* = 2.99) but then drops 4 points at 6-9 months (subgroup *M* = 7.00, *SD* =2 .27), this is a large drop in a 10-point scale. Symptoms of hyperactivity, hypervigilance and inattention are common to children with ADHD diagnosis, but also to those with PTSD diagnosis and experiences of trauma (Miodus, Allwood, & Amoh, 2021). It is possible that the reduction in hyperactivity exhibited by this young girl is due to increased security, and Anne being more able to read her signals and respond sensitively, though it is also possible that due to the girl's young age some of the decrease was her gaining in maturity.

Ella's peer subscale remained relatively stable with a drop of 1 point post intervention, then it raises 1 point to the original levels at 6-9 months, 2, 1 & 2 respectively. Pre intervention = 2.91, *SD* = 2.45, post-intervention *M* = 2.58, *SD* = 2.59, subgroup 6-9 months *M* = 3.25, *SD* = 2.25.

As with peer difficulties, pro-social behaviour remained relatively static, and constantly lower than average 6, 7 & 6 respectively (*M* = 6.27, *SD* = 2.20; *M* = 6.70, *SD* = 2.08; Subgroup *M* = 6.38, *SD* = 2.39).

Ella's behaviours as measured by the BAC-C were far higher than average pre-intervention, scoring 25 (*M* = 17.85, *SD* = 7.52), and though far lower at post-

intervention, scoring 17, she was still above average (*M* = 15.59, *SD* =6.97). In the time period after the intervention an increase in behavioural issues is seen reaching a score of 21, but it is still lower than the starting level and only slightly above the average for the subgroup (*M* = 20.75, *SD* = 4.65).

Table 9

Results for Carer Questionnaire, Strengths and Difficulties Questionnaire and Brief Assessment Checklist for Children at all time points. Anne and Ella.

	pre	Post	6-9 months post
CQ PSU	26	31	30
CQ PCR	23	21	22
CQ CRC	20	20	20
CQ St	9	8	7
CQ Total	78	80	79
SDQ Em	7	6	5
SDQ Beh	4	5	6
SDQ Hyp	10	10	6
SDQ Peer	2	1	2

SDQ Total Difficulties	23	22	19
SDQ pro so	6	7	6
BAC-C	25	17	21

It appears that there have been clear benefits from the intervention in Anne's parental sensitivity and reflective functioning, plus in her parental skills and understanding, there is also a reduction in her parental stress. For Ella the results are more mixed, but there is an overall reduction in behavioural issues and a particularly dramatic reduction in hyperactivity, and for this area it seems that the time period post intervention was when the most change happened. This suggests the possibility that true effects of the intervention may not be seen until several months after completion.

Jane and Mark

This 44-year-old female was single parenting her older birth daughter and 12-year-old adopted son, Mark. Jane was very close to the average age of the intervention group (M = 43.53, SD = 3.45), but as these groups were generally aimed at parents of children aged 4-12, Mark was the one of the oldest children (M = 7.52, SD = 2.12). At 3 years old Mark was placed with Jane and her then husband, but the marriage relationship broke down just a few years after Mark was placed, and his adoptive father now had minimal involvement. Jane was also part of the pilot group where

interviews were optional, but she too consented to the interviews. Pre-intervention she scored a 4 on the PDI-RF and 5 on the MotC, post intervention she was assessed as still being a 4 on the PDI-RF but had moved to a 6 on the MotC coding. She was one of the most sensitive and reflective parents' pre-intervention.

Table 10 shows Jane's parental stress scores. Jane's pre intervention score of 39 was considerably lower than average (*M* = 53.30, *SD* = 8.93), post intervention she shows a 8 point decrease in stress level to 31, well below the group average (*M* = 48.52, *SD* = 9.69), it then stabilized and remained at 31 for the 6-9 month point, still considerably lower than average for the subgroup (*M* = 44.60, *SD* = 9.56).

Table 10

Parental Stress Scale Sores for Jane at all time points.

	Pre	Post	6-9 months post
Parental Stress	39	31	31

For the CQ total score, pre intervention Jane already scored considerably higher than average (*M* = 71.66, *SD* = 14.82) at 77, and she gained 10 points immediately post intervention to 87, again above average at this point (*M* = 81.94, *SD* = 14.82). Over time she gains a further 5 points to 92, just above average for this subgroup (*M* = 90.38, *SD* = 8.38).

For the Parental Skills and Understanding subscale, Jane's pre-intervention score of 30 and post intervention score of 34 are again above average for the group (*M* =

25.49, *SD* = 6.81; *M* = 30.66, *SD* = 4.42), her 6-9 month score remains the same and is close average at this time point (subgroup *M* = 33.50, *SD* = 2.39).

Jane's Parent Child relationship showed a stead gain from 18 pre-intervention which is below the average (*M* = 20.46, *SD* = 4.88), rising 4 points to 22 at post intervention (*M* = 22.83, *SD* = 3.85), rising a further 3 points at the 6-9 month point to 25, just above the subgroup average (*M* = 24.63, *SD* = 3.38).

Child Responsiveness to Care also showed steady gains through the time points and is constantly above average, pre-intervention 19 (*M* = 17.83, *SD* = 4.93), post intervention 21 (*M* = 20.20, *SD* = 4.25), and 23 at the 6–9-month period (subgroup *M* = 22.75, *SD* = 3.41).

Stability remains a constant score of 10 and is above average at all timepoints (Pre intervention *M* = 7.89, *SD* = 1.49; post intervention *M* = 8.26, *SD* = 1. 69; subgroup 6-9 months *M* = 9.50, *SD* = 1.07)

Jane seems to have already felt quite competent at handling her son's challenges even before the intervention with a high score for parental skills and understanding, her levels of stress were also relatively low. The course would appear to have impacted this and raised her levels of skills and understanding while lowering her stress. It is interesting that her PDI-RF and MotC were also high compared to the group, and this may have been a reason for these higher scores' pre-intervention.

Mark's Strengths and Difficulties total difficulties score sees a considerable reduction in score at each time point, 30, 26 and 18 respectively with the largest improvement being between the post intervention and the 6–9-month period. Mark's total difficulties score of 30 at the start was well above average for the group (*M* = 19.33, *SD* = 7.85), and at 26 remaining well above average at post intervention (*M* = 18.15,

SD = 7.43), but at 6-9 months the score of 18 is below average of the subgroup (*M* = 19.88, *SD* = 2.75).

Mark's emotional subscale also sees a considerable reduction, 3 points between pre and post intervention then a further 2 points at 6-9 months, 9, 6 & 4 respectively. The average of the intervention group as a whole saw little change in score in this subscale pre and post intervention (*M* = 4.49, *SD* = 2.51; *M* = 4.39, *SD* = 2.25) and this child's score of 4 was lower than the average of the subgroup at 6-9 months (*M* = 5.25, *SD* = 1.83).

The behavioural subscale moves by the same number of points as the emotional difficulties subscale scoring 7, 4 and 2 respectively. Mark again starts off scoring higher than average (*M* = 5.03, *SD* = 2.48), descending to just lower than average at post intervention (*M* = 4.79, *SD* = 2.44) and being considerably lower than average of the subgroup at 6-9 months (*M* = 4.38, *SD* = 1.85).

The Hyperactivity subscale also shows a different pattern of change, starting at 5, there is an increase of one point to 6 at post intervention but then a 2-point reduction to 4 at 6-9months. For this subscale Mark started lower than average at pre-intervention (*M* = 6.91, SD=3.17), and despite the increase he remained slightly lower than average at post intervention (*M* = 6.39, *SD* = 2.99) but then dropped 2 points at 6-9 months, to well below the subgroup average (*M* = 7.00, *SD* = 2.27).

The peer subscale remained relatively stable with increase of 1 point from 9 to 10 at post intervention then a drop of 2 points to 8 at 6-9 months. His score for difficulties in this area remained well above average at all timepoints (Pre-intervention *M* = 2.91, *SD* = 2.45, post-intervention *M* = 2.58, *SD* = 2.59, subgroup 6-9 months *M* = 3.25, *SD* = 2.25).

Pro-social behaviour remained static, scoring 5 at each time point, this was constantly lower than average (*M* = 6.27, *SD* = 2.20; *M* = 6.70, *SD* = 2.08; Subgroup *M* = 6.38, *SD* = 2.39).

The reduction in all the difficulties scales combined together to show the dramatic change in the SDQ total difficulties score. When compared to the statistics of the group as a whole which do not show statistically significant change in the SDQ measures, the figures are suggestive that this young man's behaviour was dramatically impacted by changes his mother made due to attending the course.

It is also interesting that for both this and the previous case there seems to be little impact on peer difficulties and the pro-social behaviour sub-scales.

Mark's behaviours, as measured by the BAC-C, started off with a high score of 29. As with Ella in the previous case this was far higher than average pre-intervention (*M* = 17.85, *SD* = 7.52) and though his post intervention was far lower at 22 post-intervention, he was still above average (*M* = 15.59, *SD* = 6.97). In the time period after the intervention his score increased to 24, though this was lower than his starting point it was still above the average for the subgroup (*M* = 20.75, *SD* = 4.65).

Both the SDQ and the BAC-C showed improvements in Mark's difficulties, but to different levels with the SDQ showing a far larger change than was captured by the BAC-C, perhaps due to the different behaviours that each instrument measures.

Taken together it appeared that there were positive outcomes for both Jane and Mark in all areas apart from Mark's pro-social behaviours. Time wise it appears that the period between post-intervention and 6-9 months was driving much of the change in the SDQ difficulties measures and as with the first case, suggests that this period may be critical for the integration of learning and impact on child functioning.

Table 11

Results for Carer Questionnaire, Strengths and Difficulties Questionnaire and Brief Assessment Checklist for Children at all time points. Jane and Mark.

Mark	pre	Post	6-9 months post
CQ PSU	30	34	34
CQ PCR	18	22	25
CQ CRC	19	21	23
CQ St	10	10	10
CQ Total	77	87	92
SDQ Em	9	6	4
SDQ Beh	7	4	2
SDQ Hyp	5	6	4
SDQ Peer	9	10	8
SDQ Total Stress	30	26	18
SDQ pro so	5	5	5

BAC-C	29	22	24

Louise and Alex

Louise also attended the pilot program; she chose not to engage with the interview and did not disclose her age or how old her son Alex was at placement. Alex was 6 years old at commencement of the intervention. Louise was a single adopter, and Alex her only child. During the time of the intervention Alex went on to a reduced timetable at school as he was displaying challenging behaviour and not managing in full time school. Due to not engaging in the interview process, there is no data on Louise's parental reflective functioning or parental sensitivity as measured by the MotC, and therefore only data from questionnaires was examined.

Table 12 shows Louise's parental stress scores. Her pre intervention score of 52 was just under the group average (M = 53.30, SD = 8.91), post intervention she shows a 1 point decrease in stress level to 51, above the group average (M = 48.52, SD = 9.69), it then raised by 4 points over the next time period to 55, higher than her starting score and considerably higher than average for the subgroup (M = 44.60, SD = 9.56).

Table 12

Parental Stress Scale Sores for Louise at all time points.

	Pre	Post	7 moths post
Parental Stress	52	51	55

The following figures show that Louise's scores showed little improvement with only Parental Skills and Understanding, stability and the total Carer's questionnaire showing any improvement, all of Alex's behavioural scores showed increasing problems.

For the CQ total score Louise's pre intervention score of 74 was higher than average (*M* = 71.66, *SD* = 14.82) and she gained 7 points immediately post intervention to 81, an average at this point (*M* = 81.94, *SD* = 14.82). Over time she loses 3 points to 78, which is below average for this subgroup (*M* = 90.38, *SD* = 8.38).

For the Parental Skills and Understanding subscale, Louise's pre-intervention score of 30 is above average and post intervention score remaining at 30 is average for the group (*M* = 25.49, *SD* = 6.81; *M* = 30.66, *SD* = 4.42), her 6-9 month score of 33 shows a small gain and remains close average at this time point (subgroup M=33.50, SD= 2.39).

Louise's Parent Child relationship showed a small gain from 20 pre-intervention, which is approximately average (*M* = 20.46, *SD* = 4.88), rising 2 points to 22 at post intervention (*M* = 22.83, *SD* = 3.85), then falling 3 points at the 6-9 month point to 19, just below her starting point and below average for the subgroup (*M* = 24.63, *SD* = 3.38).

Child Responsiveness to Care also showed a similar pattern of gain then loss, pre-intervention 16 (*M* = 17.83, *SD* = 4.93), post intervention 20 (*M* = 20.20, *SD* = 4.25), and 17 at the 6–9-month period (subgroup *M* = 22.75, *SD* = 3.41), this was slightly higher than her starting point but more than 1 standard deviation lower than average for the subgroup at the final time point.

Stability showed a small gain of 1 point, from 8 to 9, across the intervention time then remained there at the 6-9 month point (Pre-intervention *M* = 7.89, *SD* = 1.49; post intervention *M* = 8.26, *SD* = 1.69; subgroup 6-9 months *M* = 9.50, *SD* = 1.07).

Similar to Jane, Louise seems to have felt quite competent at handling her son's challenges before the intervention with a high score for parental skills and understanding, but conversely to Jane her scores for parental stress are higher, starting close to the average group score but over time increasing and being well above the average score. The course would appear to have and raised her levels of skills and understanding and possibly slightly increased the child's responsiveness to care and stability.

Alex's total difficulties score saw an increase at each time point, 18, 19 and 22 respectively with the largest increase being between the post intervention and the 6–9-month period. Alex's total difficulties score of 18 at the start was just below average for the group (*M* = 19.33, *SD* = 7.85), and at 19 was just above average at post intervention (*M* = 18.15, *SD* = 7.43), but at 6-9 months the score of 22 was further above the subgroup average (*M* = 19.88, *SD* = 2.75).

Alex's emotional subscale also sees a 1-point increase between pre, and post intervention then stabilized at 6-9 months, 4, 5 & 5 respectively. At all these points he was close to average showing that he did not have more struggles in this are than the majority of the group (*M* = 4.49, *SD* = 2.51; *M* = 4.39, *SD* = 2.25; Subgroup *M* = 5.25, *SD* = 1.83).

The behavioural subscale initially saw a 2-point reduction from 5 to 3, but then a large 4-point increase between the post intervention and 6-9 month points. Alex's started off scoring higher than average (*M* = 5.03, *SD* = 2.48), descending to lower

than average at post intervention (*M* = 4.79, *SD* = 2.44) but then being considerably higher than average of the subgroup at 6-9 months (*M* = 4.38, *SD* = 1.85).

The Hyperactivity subscale also shows a similar pattern of change as the emotional subscale moving from 4 to 5 post intervention then it remained at 5 for the 6–9-month time point. For this subscale Alex started lower than average at pre-intervention (*M* = 6.91, *SD* = 3.17), and despite the increase he remained slightly lower than average at post intervention (*M* = 6.40, *SD* = 2.99) and was below the subgroup average at 6-9 months (*M* = 7.00, *SD* = 2.27).

The peer subscale remained relatively stable with increase of 1 point from 5 to 6 at post intervention then a drop of 1 point back to 5 at 6-9 months. His score for difficulties in this area remained well above average at all timepoints (Pre intervention *M* = 2.91, *SD* = 2.45, post-intervention *M* = 2.58, *SD* = 2.59, subgroup 6-9 months *M* = 3.25, *SD* = 2.25).

Pro-social behaviour did show a 2-point improvement from 3 to 5 post intervention but then a single point was lost by 6-9 months, this was constantly lower than average (*M* = 6.27, *SD* = 2.20; *M* = 6.70, *SD* = 2.08; Subgroup *M* = 6.38, *SD* = 2.39).

Alex's behaviours, as measured by the BAC-C, started off with a lower than average score of 16 initial showing a decrease to 15 but then an increase of 3 points to 18, pre intervention and post intervention his scores were lower than average for the full group (*M* = 17.85, *SD* = 7.52; *M* = 15.59, *SD* = 6.97), and although the score increase he was lower the average for the subgroup (*M* = 20.75, *SD* = 4.65) at 6-9 months, the mean scores of this subgroup were consistently higher than those of the group as a whole at each time point (Subgroup pre-intervention *M* = 22.00, *SD* = 5.16, Post-intervention *M* = 19.00, *SD* = 5.78, 6-9 months *M* = 20.75, SD = 4.65).

Both the SDQ and the BAC-C showed an increase in difficulties in Alex behaviour, and though Louise seems to feel she has a relatively high level of skills and understanding she is clearly struggling with his behaviours. Challenging behaviours and parental stress have been found to be bidirectional in nature (Neece, Green, & Baker 2012) and the increase in both Louise's stress and Alex's behaviour measure would seem to be in line with this. However, despite the rise in felt stress and behaviours, Alex's placement stability actually improves as does Louise's skills and understanding. We are not aware of all the factors that are impacting this family, and the lack of full-time school placement could be part of the picture of increasing challenges.

Table 13

Results for Carer Questionnaire, Strengths and Difficulties Questionnaire and Brief Assessment Checklist for Children at all time points. Louise and Alex

	pre	Post	6-9 months post
CQ PSU	30	30	33
CQ PCR	20	22	19
CQ CRC	16	20	17
CQ St	8	9	9
CQ Total	74	81	78

SDQ Em	4	5	5
SDQ Beh	5	3	7
SDQ Hyp	4	5	5
SDQ Peer	5	6	5
SDQ Total Stress	18	19	22
SDQ pro so	3	5	4
BAC-C	16	15	18

Brenda, Jasmin, Connor, and Elisha

As with Anne, Jane and Louise, Brenda had attended the pilot program. She was a single mother to her 3 children Jasmin aged 10, Connor aged 7 and Elisha aged 6. She did not disclose her age, but the children who were full siblings were placed at the same time aged 4 years 7 months, 2 years 2 months and 1 years old. Brenda had not adopted as a single parent, but the marriage had broken down less than 2 years after placement. The divorce had recently been finalised and there was a lot of parental conflict. It was particularly the behaviours of the older 2 children that had brought her on the course. Being part of the pilot program, engagement in the interviews was optional and as with Louise, Brenda chose not to engage with that

part of the study and therefore there is no information about her PDI-RF or sensitivity as scored by the MotC.

Table 14

Parental Stress Scale Sores for Brenda at all time points.

	Pre	Post	6-9 months
Parental Stress	58	56	48

Brenda's situation seemed to be one of the most challenging in the group, single parenting 3 adopted children, Jasmin seemed to be managing in mainstream school, Connor was in a special school and Elisha was in a mainstream infant school with the support of an Education Health and Care plan (EHCP).

Her pre intervention Parental Stress Scale score of 58 was quite a way above the group average (*M* = 53.30, *SD* = 8.93), post intervention she shows a 2 point decrease in stress level to 56, even further above the group average (*M* = 48.52, *SD* = 9.69), it then reduced by 8 points over the next time period to 48, 10 points lower than her starting score but still higher than average for the subgroup (*M* = 44.60, *SD* = 9.55).

Brenda filled out a Carer Questionnaire, The SDQ and BAC-C for all 3 children at each of the time points.

Brenda and Jasmin

For the CQ total score for Jasmin, Brenda's score of 69 was lower than average (*M* = 71.66, *SD* = 14.82) losing 15 points immediately post intervention to 54, nearly 2 standard deviations below the average (*M* = 81.94, *SD* = 14.82). Between the post

intervention and 6–9-month time point the score gained a massive 34 points to just below average for this subgroup (*M* = 90.378, *SD* = 8.38).

For the Parental Skills and Understanding subscale, the pre-intervention score of 27 is above average and post intervention score of 25 below average for the group (*M* = 25.49, *SD* = 6.81; *M* = 30.66, *SD* = 4.42), her 6–9-month score of 36 shows a large gain of 11 points and is now above average at this time point (subgroup *M* = 33.50, *SD* = 2.39).

Brenda's Parent Child relationship with Jasmin again showed a loss from 17 pre-intervention, which is lower than average (*M* = 20.46, *SD* = 4.88), a well below average of 13 post intervention (*M* = 22.83, *SD* = 3.85), then jumping 9 points at the 6-9 month point to 22, 5 points above pre-intervention but still below average for the subgroup (*M* = 24.63, *SD* = 3.38).

Jasmin's score for Child Responsiveness to Care also showed a similar pattern of loss then gain, pre-intervention 18 (*M* = 17.83, *SD* = 4.93), post intervention 12 (*M* = 20.20, *SD* = 4.25), and 20 at the 6–9-month period (subgroup *M* = 22.75, *SD* = 3.41), this was still slightly lower than average for the subgroup but points higher than her starting point.

Again, stability showed a similar pattern of loss then gain 7, 4 and 10 respectively (Pre intervention *M* = 7.89, SD=1.49; post intervention *M* = 8.26, *SD* = 1.69; subgroup 6-9 months *M* = 9.50, *SD* = 1.07).

It seems at the post intervention time point Brenda was having particular difficulties in her relationship with Jasmin, but by the 6–9-month time period there are meaningful improvements across the board.

Jasmin's total difficulties score saw a large increase from 19 to 26 at post intervention, then losing 5 points to 21 between the post intervention and the 6–9-month period, ending 2 points above the starting point. Jasmin's total difficulties score of 19 at the start was just below average for the group (*M* = 19.33, *SD* = 7.85), and at 26 was considerably above average at post intervention (*M* = 18.15, *SD* = 7.43), despite the decrease seen at 6-9 months the score of 21 was still above the subgroup average (*M* = 19.88, *SD* = 2.75).

Jasmin's emotional subscale also sees a 1-point increase between pre and post intervention then a 3-point decreases at 6-9 months, 6, 7 & 4 respectively, ending up 2 points lower than at the start. Pre and post intervention she scored above average, but at 6-9 months she was below average for the subgroup (*M* = 4.49, *SD* = 2.51; *M* = 4.39, *SD* = 2.25; Subgroup *M* = 5.25, *SD* = 1.83).

The behavioural subscale initially saw a dramatic 5-point increase from 3 to 8, but then a large 4-point decrease between the post intervention and 6-9 month point to 5, remaining 2 points higher than at the start. Jasmin started off scoring lower than average (*M* = 5.03, *SD* = 2.48), increasing to much higher than average at post intervention (*M* = 4.79, *SD* = 2.44) but then being close to average of the subgroup at 6-9 months (*M* = 4.38, *SD* = 1.85).

The Hyperactivity subscale also shows a steady increase across the three time points, 6, 7, & 9 respectively. For this subscale Jasmin started lower than average at pre-intervention (*M* = 6.91, *SD* = 3.17), and despite the increase he remained close average at post intervention (*M* = 6.39, *SD* = 2.99), then jumping to above the subgroup average at 6-9 months (*M* = 7.00, *SD* = 2.27).

The peer subscale remained relatively stable remaining at the same score of 4 pre and post intervention then a drop of 1 point back to 3 at 6-9 months. Her score for difficulties in this area was above average at pre and post intervention, but then just lower than average (Pre intervention *M* = 2.91, *SD* = 2.45, post-intervention *M* = 2.58, *SD* = 2.59, subgroup 6-9 months *M* = 3.25, *SD* = 2.25).

Pro-social behaviour showed a steady improvement from 7 to 8 post intervention gaining another point to 9 at 6-9 months, in this area she was consistently above average showing that one of her strengths was her high level of pro social behaviour even when she was struggling in other areas (*M* = 6.27, *SD* = 2.20; *M* = 6.70, *SD* = 2.08; Subgroup *M* = 6.38, *SD* = 2.39).

Jasmin's behaviours, as measured by the BAC-C, scored consistently higher than average, starting at 25, rising to 28 and then remaining at that level (*M* = 17.85, *SD* = 7.52; *M* = 15.59, *SD* = 6.97; subgroup *M* = 20.75, *SD* = 4.65). It looks like the rise in Jasmin's score at 6-9 month point 28 is partly driving the high mean of the group at this point.

Throughout the child specific measures, apart from pro social behaviours Jasmin's scores are showing a complimentary pattern to those of Brenda, as her behaviour level increases, Brendas sense of competency and understanding decreases as does the score she gives to the quality of relationship and Jasmin's responsiveness to care, then as things improve for Brenda so do the behavioural scores and vice versa. Again, this seems to point to how close the links of a parent's stress and positive feelings about the relationship are to a child's behaviours. Due to lack of information, we do not know what has trigged the seeming crisis in Jasmin and

Brenda's relationship and behaviours displayed, but the improvement in scores at 6-9 months would imply that things had settled considerably by that point.

Brenda and Jasmin's case has further complexities as there are 2 other adopted children in the home who also have their own struggles, but as we see in the following analysis, they do not follow the same pattern.

Table 15

Results for Carer Questionnaire, Strengths and Difficulties Questionnaire and Brief Assessment Checklist for Children at all time points. Brenda and Jasmin

	pre	Post	6-9 months
CQ PSU	27	25	36
CQPCR	17	13	22
CQ CRC	18	12	20
CQ St	7	4	10
CQ Total	69	54	88
SDQ Em	6	7	4
SDQ Beh	3	8	5
SDQ Hyp	6	7	9
SDQ Peer	4	4	3
SDQ Total Stress	19	26	21

SDQ pro so	7	8	9
BAC-C	25	28	28

Brenda and Connor

The forms Brenda filled out around her relationship with Connor tell a different story. The Carer Questionnaire total, and all subscales apart from stability show an improvement at each time point with the largest gains being made between the post intervention and 6-9 month time point.

Brenda's Carer Questionnaire total score for Connor was 63, 68, & 91 respectively, moving from well below the group mean at pre-intervention and post-intervention to slightly above at follow-up (*M* =71.66, *SD* = 14.82; *M* = 81.94, *SD* = 14.82; subgroup *M* = 90.38, *SD* = 8.38). Parental Skills and Understanding increased throughout from 25, to 26 and then 30 respectively (*M* = 25.49, *SD* = 6.81; *M* = 30.66, *SD* = 4.42; subgroup *M* = 33.50, *SD* = 2.39). Parent Child Relationship also started below average at pre-intervention, 17, moving to around average at post-intervention,22 and above average at follow up, 26 (*M* = 20.46, *SD* = 4.88; *M* = 22.83, *SD* = 3.85; subgroup *M* = 24.63, *SD* = 3.38). Child Responsiveness to Care showed a similar pattern of increase at 14, 17 and 25 respectively (*M* = 17.83, *SD* = 4.93; *M* = 20.20, *SD* = 4.25; subgroup *M* = 22.75, *SD* = 3.41). For each of these subscales, the starting point scores that Brenda gave for her relationship with Connor are low, but

as time goes on this rise to close to or above the average. His scores for stability are more dramatic, starting off at 7 it dramatically drops to 3 then rises to the maximum of 10 (Pre intervention *M* = 7.89, *SD* = 1.49; post intervention *M* = 8.26, *SD* = 1.69; subgroup 6-9 months *M* = 9.50, *SD* = 1.07).

Connor's Behavioural scores showed a more mixed pattern. Starting at 20 his SDQ total score dropped, to 18 post intervention then moved back to the starting point of 20, keeping generally a higher-than-average score (*M* = 19.33, *SD* = 7.85; *M* = 18.15, *SD* = 7.43; subgroup *M* = 19.88, S*D* = 2.75)

Connor's emotional subscale is relatively static, first lowering by 1 point from 4 to 3 then remaining there, all these scores showing he had less difficulties in this area than average (*M* = 4.49, *SD* = 2.51; *M* = 4.39, *SD* = 2.25; Subgroup *M* = 5.25, *SD* = 1.83).

His Behavioural subscale at first shows and increase of 2 points from 4 to 6, but then a 1-point reduction to 5, above his pre intervention level, starting below average, but then remaining above average at post intervention and 6-9 months (*M* = 5.03, *SD* =2 .481; *M* = 4.79, *SD* = 2.44; subgroup *M* = 4.38, *SD* = 1.85).

Connor's Hyperactivity difficulties subscale of 8, 7 and 10 respectively was consistently above average and despite showing an initial decrease, it increased to a maximum score at 6-9 months (*M* = 6.91, *SD* = 3.17; *M* = 6.39, *SD* = 2.99; subgroup *M* = 7.00, *SD* = 2.27)

The peer subscale showed a decrease in difficulties initially from 4 to 2 points and then remained at 2 (Pre intervention *M* = 2.91, *SD* = 2.45, post-intervention *M* = 2.58, *SD* = 2.59, subgroup 6-9 months *M* = 3.25, *SD* = 2.25).

Pro-social behaviour was also relatively static (7, 6 & 6) and remained close to average throughout (*M* = 6.27, *SD* = 2.20; *M* = 6.70, *SD* = 2.08; Subgroup *M* = 6.38, *SD* = 2.39).

Connors's behaviours, as measured by the BAC-C, despite losing 6 points from 23 to 17 between pre and post intervention, showed more difficulties than average (*M* = 17.85, *SD* = 7.52; *M* = 15.59, *SD* = 6.97). However, remaining at 17 at 6-9 months he was below average for the subgroup (*M* = 20.75, *SD* = 4.65).

Connor's SDQ does not show any particular improvement across the time points, however, the more attachment behaviour focused BAC-C does show a considerable improvement and coupled together with CQ that Brenda filled out for her relationship with Connor, it would seem that they had gained considerable benefit from the intervention. However, as we have seen form Brenda and Jasmin's questionnaires, there are considerable issues going on elsewhere in the family. The only clue from these questionnaires that something else may be at play in the family system is the sudden drop in the Carer Questionnaire placement stability from 7 to 3 at the post intervention time point, but then it rises again at 6-9 months to a maximum score of 10.

Table 16

Results for Carer Questionnaire, Strengths and Difficulties Questionnaire and Brief Assessment Checklist for Children at all time points. Brenda and Connor

	pre	Post	6-9 months
CQ PSU	25	26	30

CQPCR	17	22	26
CQ CRC	14	17	25
CQ St	7	3	10
CQ Total	63	68	91
SDQ Em	4	3	3
SDQ Beh	4	6	5
SDQ Hyp	8	7	10
SDQ Peer	4	2	2
SDQ Total Stress	20	18	20
SDQ pro so	7	6	7
BAC-C	23	17	17

Brenda and Elisha

The Carer Questionnaire that Brenda filled out for her relationship with Elisha showed considerable improvements throughout. Carer Questionnaire total score starting at 73, then rising to 93, & 97 respectively (*M* = 71.66, *SD* = 14.82; *M* = 81.94, *SD* = 14.82; subgroup *M* = 90.38, *SD* = 8.38). Parental Skills and Understanding

started at 27, rising to 34 and then 36 respectively (*M* = 25.49, *SD* = 6.81; *M* = 30.66, *SD* = 4.42; subgroup *M* = 33.50, *SD* = 2.39). Parent Child Relationship started at 21 pre-intervention, rose to 26 post-intervention and remained at 26 at the 6-9 months follow-up (*M* = 20.46, *SD* = 4.88; *M* = 22.83, *SD* = 3.85; subgroup *M* = 24.63, *SD* = 3.38). Child Responsiveness to care started at 18 pre-intervention, rising considerably to 26 at post-intervention, then losing one point to 25 at follow-up (*M* = 17.83, *SD* = 4.93; *M* = 20.20, *SD* = 4.25; subgroup *M* = 22.75, *SD* =3.41). Stability scored 7, 7 and 10 respectively (*M* = 7.89, *SD* = 1.49; *M* = 8.26, *SD* =1 .686; subgroup 6-9 months *M* = 9.50, *SD* = 1.07).

Elisha's Behavioural scores also showed a more mixed pattern. Her SDQ total difficulties started at 19, reduced to 14 then raised again to 17 (*M* = 19.33, *SD* = 7.85; *M* = 18.15, SD = 7.43; subgroup *M* = 19.88, *SD* = 2.75)

Similarly, her emotional subscale showed a reduction then increase back to original level 5, 3 & 5 (*M* = 4.49, *SD* = 2.51; *M* = 4.39, *SD* = 2.25; Subgroup *M* = 5.25, *SD* = 1.83).

The behavioural subscale was stable throughout with a score of 3 at all-time points, again displaying less difficulties than average (*M* = 5.03, *SD* = 2.48; *M* = 4.79, *SD* = 2.44; subgroup *M* = 4.38, *SD* = 1.85).

The Hyperactivity subscale at first showed a decrease across from 10 to 7, then a slight increase to 8 respectively. For this subscale Elisha started higher than average at pre-intervention (*M* = 6.91, *SD* = 3.17), and despite the decrease she remained slightly above average at post intervention and 6-9 months (*M* = 6.39, *SD* = 2.99; *M* = 7.00, *SD* = 2.27)

Elisha's Peer subscale remained static at 1 across all 3 timepoints, showing she had little or no struggles with peer relationships (Pre intervention *M* = 2.91, *SD* = 2.45, post-intervention *M* = 2.58, *SD* = 2.59, subgroup 6-9 months *M* = 3.25, *SD* = 2.25).

As with her elder sister, Elisha showed a steady improvement in her pro social behaviours, 5, 6 & 7 (*M* = 6.27, *SD* = 2.20; *M* = 6.70, *SD* = 2.08; Subgroup *M* = 6.38, *SD* = 2.39).

Elisha's behavioural difficulties as measure by the BAC-C, showed a 4-point decrease from pre to post intervention 13 & 9 respectively then a gain of 4 points back to pre-intervention levels by the 6–9-month time point. At all times her score was considerably lower, and therefore showing less difficulties than average (*M* = 17.85, *SD* = 7.52; *M* = 15.59, *SD* = 6.97; Subgroup *M* = 20.75, *SD* = 4.65).

The information shown in these questionnaires imply that there are relatively few struggles in the relationship between Brenda and Elisha and that Brenda find her to be a rewarding child to care for.

Table 17

Results for Carer Questionnaire, Strengths and Difficulties Questionnaire and Brief Assessment Checklist for Children at all time points. Brenda and Elisha

	pre	Post	6-9 month
CQ PSU	27	34	36
CQ PCR	21	26	26
CQ CRC	18	26	25

CQ St	7	7	10
CQ Total	73	93	97
SDQ Em	5	3	5
SDQ Beh	3	3	3
SDQ Hyp	10	7	8
SDQ Peer	1	1	1
SDQ Total Stress	19	14	17
SDQ pro so	5	6	7
BAC-C	13	9	13

The questionnaires from Brenda about her family show a complex picture of a family where the parent was particularly struggling with one of her children at the point when the intervention came to an end. Overall, it could be seen as a case of improvement, the parental stress and all the Carer Questionnaire showed improvements. The behavioural scores for each of the children show a more mixed story. It would seem clear that there was a particular crisis in relationship with

Jasmin post intervention, there are only small clues to this in the other questionnaires such as the suddenly very low score in Connor's placement stability.

Perhaps an explanation of the experience of this family and in particular the relationship between Brenda and Jasmin, is that of Blocked Care (Hughes and Baylin, 2012, 2016). Psychologists Dan Hughes and Jonathan Baylin first expounded the idea of Blocked Care, this is when the parent or carer becomes defensive and ridged in their thinking in the face of caring for a child where relationship is nonreciprocal and unrewarding. Blocked care can be short term or long term and could affect all relationships or just one. At the post intervention stage, Jasmin's behaviours had become more challenging, we don't know what had triggered this, but it seems that Brenda then found her more challenging to care for and the relationship less rewarding, and therefore may have become rejecting of her which in turn would impact behaviours. What we can see is just as there had been a dramatic deterioration between time points 1 and 2, there had been an almost equally dramatic improvement between time points 2 and 3 showing that the situation had not been particularly long term. Huges and Baylin (2012, 2016) propose that some of the ways to avoid blocked care or help moving out of blocked care is by the use of self-reflection and self-care/compassion as well as activation of our brains executive system and that one way to do this is through psychoeducation. Key components to the KMKY intervention are reflection, selfcare and self-compassion as well as psychoeducation, perhaps these combined helped the relationship between Brenda and Jasmin move on from whatever crisis there was to a better footing in the post intervention to 6-9-month time period.

Lizzie, Bandon and Theo

Brandon and Theo were placed with Lizzie and her wife when they were approximately 3 and 5, at the time they came on the KMKY course the boys had been part of the family for 3 years. Both Lizzie and her wife attended the course together and they were in the cohort that attended the first half face to face in early part of 2020, but then the course had to go to virtual means to be completed. Lizzie consented to research; her wife chose not to be part of the research. Lizzie engaged in both interviews and was the only parent to respond to the longitudinal questionnaire request during the pandemic. Lizzie proved to be one of the most reflective and sensitive parents attending the course, scoring a 5 on the PDI-RF and a 6 on the MotC both pre and post intervention.

Lizzie's parental stress scores showed and interesting pattern, starting at 51, (M = 53.30, SD = 8.93), post-intervention she shows a 8 point increase in stress level to 63, well above the group average (M=48.52, SD=9.69), but then a large drop of 24 points to 39 which was below the subgroup average at 6-9 months (M=44.60, SD=9.56). The point of returning the post intervention questionnaires was right in the middle of the first pandemic lockdown, both Lizzie and her wife were front line medical workers who remained working throughout the pandemic, so levels of stress were likely to be impacted by these circumstances as confirmed by several studies from around the world (Calvano, et al., 2021; Johnson, et al., 2021; Whaley & Pfefferbaum, 2023). When returning the 6-9 month questionnaires she reflected on how different she felt their home situation was to when she returned the post intervention questionnaires, and this is perhaps a partial explanation of the results.

Table 18

Parental Stress Scale Sores for Lizzie at all time points.

	Pre	Post	6 months post
Parental Stress	51	63	39

Lizzie and Brandon

The Carer's Questionnaire that Lizzie filled out for her relationship with Brandon showed improvements throughout by the 6–9-month time point, however, post intervention had been a different picture with only parental skills and understanding showing improvement, the rest were either static or had slightly decreased. Most gain was between post intervention and 6-9 months. Carer Questionnaire total score was 80, 80, 97 respectively (*M* = 71.66, *SD* = 14.82; *M* = 81.94, *SD* = 14.82; subgroup *M* = 90.38, *SD* = 8.38). Parental Skills and Understanding showed steady increase and remained above average at 27, 29 & 34 respectively (*M* = 25.49, *SD* = 6.81; *M* = 30.66, *SD* = 4.42; subgroup *M* = 33.50, *SD* = 2.39). Parent Child Relationship started at 24, losing 1 point to 23 post-intervention, then climbing to 28 at follow-up (*M* = 20.46, *SD* = 4.88; *M* = 22.83, *SD* = 3.85; subgroup *M* = 24.63, *SD* = 3.38). Child Responsiveness to care similarly showed a loss of a point from 20 pre-intervention to 19 post-intervention, then climbing to 25 at follow-up (*M* = 17.83, *SD* = 4.93; *M* = 20.20, *SD* = 4.25; subgroup *M* = 22.75, *SD* = 3.41). Stability remained relatively stable at 9, 9, & 10 respectively (*M* = 7.89, *SD* = 1.49; *M* = 8.26, *SD* = 1.69; subgroup 6-9 months *M* = 9.50, *SD* = 1.07). At the pre intervention starting point all scores were around or above the average and by 6-9 months follow-up they were

considerably above average for the subgroup. Thus, following the pattern of large improvements seen in parental stress in that time period.

Brandon's total difficulties score saw a decrease in difficulties at each time point, 20, 19, & 17 respectively. Brandon's total difficulties score of 20 at the start was just above average for the group (*M* = 19.33, *SD* = 7.85), and at 19 was just above average at post intervention (*M* = 18.15, *SD* = 7.43), but at 6-9 months the score of 17 was below the subgroup average (*M* = 19.88, *SD* = 2.75).

Brandon's emotional subscale also sees a 1-point decrease between each time point, 10, 9 & 8 respectively. At pre and post intervention he was above the whole group average and despite improvements at 6-9 months he remained above the subgroup average (*M* = 4.49, *SD* = 2.51; *M* = 4.39, *SD* = 2.25; Subgroup *M* = 5.25, *SD* = 1.83).

The behavioural subscale was stable at 3 at the first two time points, then decreased to a 2 at 6-9 months. Throughout he displayed fewer behavioural difficulties than average (*M* = 5.03, *SD* = 2.48; *M* = 4.79, *SD* = 2.44; subgroup *M* = 4.38, *SD* = 1.85).

The Hyperactivity subscale was relatively stable, initially decreasing from 6 to 5 then remaining at that level. As with behaviour, he was displaying less than average difficulties in this area (*M* = 6.91, *SD* = 3.17; *M* = 6.39, *SD* = 2.99; subgroup *M* = 7.00, *SD* =2.27).

The peer subscale remained relatively stable with increase of 1 point from 1 to 2 at post intervention then remaining there at 6-9 months. His score for difficulties in this area remained consistently below average at all timepoints (Pre-intervention *M* = 2.91, *SD* = 2.45, post-intervention *M* = 2.58, *SD* = 2.59, subgroup 6-9 months *M* = 3.25, *SD* = 2.25).

Pro-social behaviour showed a different pattern, with an initial 2 points loss from 4 to 2 then a single point gain to 3 at 6-9 months, this was constantly lower than average (*M* = 6.27, *SD* = 2.20; *M* = 6.70, *SD* = 2.08; Subgroup *M* = 6.38, *SD* = 2.39).

Brandon's behaviours as measured by the BAC-C saw little change, initially gaining 1 point from 22 to 23 then remaining at that level this was above average throughout (*M* = 17.85, *SD* = 7.52; *M* = 15.59, *SD* = 6.97; subgroup *M* = 20.75, *SD* = 4.65).

Table 19

Results for Carer Questionnaire, Strengths and Difficulties Questionnaire and Brief Assessment Checklist for Children at all time points. Lizzie and Brandon.

	pre	Post	6-9 months
CQ PSU	27	29	34
CQ PCR	24	23	28
CQ CRC	20	19	25
CQ St	9	9	10
CQ Total	80	80	97
SDQ Em	10	9	8
SDQ Beh	3	3	2
SDQ Hyp	6	5	5

SDQ Peer	1	2	2
SDQ Total Stress	20	19	17
SDQ pro so	4	2	3
BAC-C	22	23	23

Lizzie and Theo

The Carer's Questionnaire that Lizzie filled out for her relationship with Theo showed improvements throughout by the 6–9-month time point, however, this time none showed improvements post intervention and all except stability showed a decreased score before rising to a higher point at 6-9 months. Carer Questionnaire total score 92, 82, 101 respectively and despite the decrease at post intervention time point they remained above average (*M* = 71.66, *SD* = 14.82; *M* = 81.94, *SD* = 14.82; subgroup *M* = 90.38, *SD* = 8.38). Parental Skills and Understanding, 31, 27, 35 respectively started above average, dipped below then jumped to well above average (*M* = 25.49, *SD* = 6.81; *M* = 30.66, *SD* = 4.42; subgroup *M* = 33.50, *SD* = 2.39). Parent Child Relationship, 27, 26, & 29 were above average throughout (*M* = 20.46, *SD* = 4.88; *M* = 22.83, *SD* = 3.85; subgroup *M* = 24.63, *SD* = 3.38). Child Responsiveness to care, 25, 20 & 27 started above average, dropped to average and then jumped to well above (*M* = 17.83, *SD* = 4.93; *M* = 20.20, *SD* = 4.25; subgroup *M* = 22.75, S*D* = 3.41). Stability 9, 9, & 10 (*M* = 7.89, *SD* = 1.49; *M* = 8.26, *SD* = 1.69; subgroup 6-9

months *M* = 9.50, *SD* = 1.07) was consistently higher, and despite struggles in other areas did not drop.

Theo's total difficulties score remained the same at the first two timepoints but then increased by 5 point by follow up, 20, 20, & 25 respectively. Theo's total difficulties score of 20 at the start was just above average for the group (*M* = 19.33, *SD* = 7.85), and from then on was above average (*M* = 18.15, *SD* = 7.43; subgroup *M* = 19.88, *SD* = 2.75).

Theo's emotional subscale showed a 1-point decrease between pre and post intervention but then jumped by 3 points 6, 5 & 8 respectively. At all time points he showed more difficulties in this area than average (*M* = 4.49, *SD* = 2.51; *M* = 4.39, *SD* = 2.25; Subgroup *M* = 5.25, *SD* = 1.83).

The behavioural subscale initially showed a 2-point rise, then a single point decrees 4, 6 & 5 (*M* = 5.03, *SD* = 2.48; *M* = 4.79, *SD* = 2.44; subgroup M = 4.38, SD = 1.85).

The Hyperactivity subscale was relatively stable, initially decreasing from a maximum score of 10 to 9 then remaining at that level, showing that throughout he had considerable difficulties in this area. (*M* = 6.91, *SD* = 3.17; *M* = 6.39, *SD* = 2.99; subgroup *M* = 7.00, *SD* = 2.27).

Initially the Peer scale score of 0 shows that he had no difficulties in this area, but at the final time point it raises to a score of 3, this still not being a high score (Pre-intervention *M* = 2.91, *SD* = 2.45, post-intervention *M* = 2.58, *SD* = 2.59, subgroup 6-9 months *M* = 3.25, *SD* = 2.25). It is interesting that as his struggles with emotional difficulties increased, so had his peer difficulties, perhaps more overt display of emotional struggles had effected his peer interactions, however, time point 1 was pre intervention and before the first Covid-19 lockdown, point 2 was during first lockdown

when peer interaction was severely limited and time point 3 was at a time when more children were back in school and therefore peer interactions would have been markedly more complex than earlier in the pandemic.

Theo's pro social behaviours were consistently high, at 9, 9 then the maximum score of 10 (*M* = 6.27, *SD* = 2.20; *M* = 6.70, *SD* = 2.08; Subgroup *M* = 6.38, *SD* = 2.39).

Theo's behaviours as measured by the BAC-C showed some small change, initially decreasing by 2 points from 23 to 21 then regaining a single point to 22, this was above average throughout (*M* = 17.85, *SD* = 7.52; *M* = 15.59, *SD* = 6.97; subgroup *M* = 20.75, *SD* = 4.65)

The pattern of scores that Lizzie gave in Theo's Carer questionnaires have similarities to those of Brenda and Jasmin, however there is not the increase in behavioural difficulties in Theo's scores that were seen in Jasmin's scores, so the crisis does not seem to have been caused by, or have significant impact on his behaviour, in fact behaviours as measured by the BAC-C have reduced slightly over this time. Theo does show an increase in behavioural difficulties at the 3rd time point, but at this point it would seem that Lizzie is feeling very competent as a parent and finds him rewarding to care for, and there is a very large decrease in parental stress.

Table 20

Results for Carer Questionnaire, Strengths and Difficulties Questionnaire and Brief Assessment Checklist for Children at all time points. Lizzie and Theo

	pre	Post	6-9 months
CQ PSU	31	27	35

CQ PCR	27	26	29
CQ CRC	25	20	27
CQ St	9	9	10
CQ Total	92	82	101
SDQ Em	6	5	8
SDQ Beh	4	6	5
SDQ Hyp	10	9	9
SDQ Peer	0	0	3
SDQ Total Stress	20	20	25
SDQ pro so	9	9	10
BAC-C	23	21	22

Looking at Lizzie, Brandon and Theo together there is a picture of a sensitive mother caring for 2 boys with challenges through a pandemic, while perhaps integrating learning from the course. It appears there was a crisis in stress levels at post

intervention time point which was in the middle of the first England lockdown, and though Theo's scores for the Carer Questionnaire are perhaps suggestive of some of this crisis and it is suggestive of him being less rewarding to care for around the second time point, Brandon's are not. It is possible that her strengths in reflective functioning and sensitivity actively buffered the effects of the increased stress she and the family were under due to the pandemic, PDI-RF has been found to in difficult situation in other studies (Nijssen et al, 2018. Dolberg etl al, 2022). While the scoring of PDI-RF and MotC do not show change, they are already high showing that she is both able to reflect and respond sensitively. Another study into micro changes in her sensitivity and reflective functioning may well give a fuller picture of any gains in this area through the intervention.

Conclusions

This small-scale longitudinal study has interesting implications for further research, from looking at the statistical analysis it would seem that the benefits of parents attending the Knowing Me, Knowing You program go beyond any initial gains seen at the post-intervention time point. Parental Stress levels continue to fall, and all subcategories of the Carer Questionnaire showed positive gains in the time period between the intervention finishing and the follow up questionnaires being completed. However, as already mentioned, the contribution of other factors in the post intervention phase is unknown. It could be that the increase in peer support, reduction of shame around family dynamics, and increased perceptions of professional support amongst other things may have impacted improvements rather than the course in itself.

From examination of graphs all other measures around the children's behaviours, apart from the Strengths and Difficulties Behavioural difficulties and Peer difficulties

showed improvements at the 6-9 month time period compared to the starting point. Due to the small numbers of participants involved, no generalizable conclusions can be made from these other than to say it is implying possibilities for the long term benefits of attending the program and implies that further study at a larger scale would be beneficial.

The individual case examination shows that the time period between the intervention ending and follow up questionnaires was one of considerable positive change for all but one family, Louise and Alex, for whom most scores got worse except for Louise's positive feelings around her skills and understanding. Brenda's case study was of particular interest, as being able to examine the different scores for her and each of her children revealed how overall stress can decrease even when struggling with one particular child. It also showed how important the time period after the intervention was for settling some of the struggles she was having with her eldest daughter and coming to a point where despite challenges she felt her relationship with her daughter was much improved. The case of Lizzie, Brandon and Theo was also interesting due to the measurements falling during the Covid-19 pandemic when families were particularly under stress. These individual case studies show that both the research community and professionals working with families would benefit from further in-depth case studies of adoptive families experiencing child to parent violence and aggression.

This study has mainly focused on positive findings, however there were some finding that were counter intuitive. Particularly interesting were the SDQ peer problem scale that seemed to have not really been impacted, plus the CQ placement stability that got worse through the period of the intervention. What this study does show is some of the complexity around adoptive families, feelings of stress and perceptions of

relationship especially when more than one child is involved. A simplistic understanding would be that engaging in a program such as KMKY would improve relationships between the parent and all their adoptive children, plus the parents understanding of behaviour, however as the case of Brenda and her 3 children show it is perfectly possible for the situation to improve and a parent to feel more competent with one child while feeling at a loss with another.

Strengths and Limitations of Study

This longitudinal study into the effects of the Knowing Me, Knowing You program holds strengths in the detail and quantity about each of the cases.

Limitations of the study include its small size due to poor return of the 6-9 month questionnaires plus lack of control group to make comparisons against. The multiple single case studies hold strength in the number of measures around each participant, however they are only across 3 time points.

Chapter 9: Single case Study of a Participant in the Knowing Me, Knowing You Program

Introduction

This thesis seeks to explore the role that parental sensitivity, mentalization and understanding of the child plays in adoptive parents whose children display aggression and violence, and further it seeks to explore if these relationships can be positively influenced by a parenting group intervention, namely the Knowing Me, Knowing You program.

Chapter 7 compared the intervention and service as usual groups and showed the significant probability that improvements in parental sensitivity and reflective functioning shown within the intervention group were brought by the KMKY program. That chapter also demonstrated that other parent focus measures plus some of the child focus measures showed improvement. In chapter 8, despite being a very small-scale study, also showed that there was evidence that suggested that these measures continued to show improvements in the 6-9 month time period after the intervention was completed, and that this warranted more study. While quantitative data is useful in being able to tell if an intervention has worked or not, at times it can be a blunt instrument as it is not able to explore the nuance of the information such as causal processes as well as the personal experiences of intervention participants (Elliott, 2002; Thirsk & Clark 2017).

The KMKY program brings together multiple different theories and aims to impact cognitive, affective, and behavioural functioning, and is by nature complex intervention, and though psychological, it meets the criteria for a complex intervention as set down by the Medical Research Council (2008). Qualitative research is recommended as a means to help evaluate and understand such

complex interventions (Thirsk & Clark, 2017) so that the intervention, its mechanisms and participants' experiences can be understood. Much of qualitative research focuses on the participants' experiences, and this is addressed within this thesis in chapter 11 where Interpretive Phenomenological Analysis is used to explore the experience of adoptive fathers who are experiencing aggression and violence from their children, and in chapter 10 where Thematic Analysis is used to explore participants experience of the KMKY program, plus how they experienced any change brought by the program. What neither of these studies address in detail is what has actually changed and why, in light of the theoretical basis, this may be, hence the current study that uses a more hermeneutical approach in exploration.

The researcher for this current study was aware of holding multiple interpretations of the data and to be able to gain a more comprehensive understanding of the data generated in the study it was deemed that it would be particularly interesting to explore a single participants narrative around the intervention and any change it may bring.

Hermeneutical research has been present in psychology, social work, health and education for a number of years (McAffrey, Raffin-Bouchal, & Moules, 2012; Moules, McAffrey, Morck, & Jardine, 2011). Palmer, (1969, p. 13) describes it as "a process of bringing to understanding" and as with other qualitative methodologies it involves the researcher interpreting the data, the difference is that instead of exploring the person's experience of a phenomenon it uses the person's reports to understand the phenomenon itself, in this case the transformational capacity of the KMKY program.

Within this case study comparisons are made between the pre-intervention and post-intervention transcripts and 3 research questions are asked of the text.

- What kind of changes in the nature of a parent's sensitivity and mentalizing are being picked up in the MotC and RF coding of the PDI?
- How real is this change for the participant?
- How is the change related to the KMKY group program?

Methodology

Part 1 of this study addresses the first question in an illustrative case study to show the qualitative evidence behind the reflective function and sensitivity scoring, Part 2 seeks to answer the second and third questions by using the structure of Hermeneutic Single Case Experimental Design.

In 2002, Rober Elliot (2002) outlined a new approach to studying single cases entitles 'Hermeneutic Single Case Efficacy Design' (HSCED) proposing that this interpretive approach would help with evaluation of treatment and its causality particularly of psychotherapeutic interventions. Using mixed methods, he stated he wanted to 'create a network of evidence that first identifies demonstrations of causal links between therapy process and outcome, and then evaluates plausible nontherapy explanations for apparent change in therapy' (Elliot, 2002 p 1). The three key questions that his methodology seeks to answer are.

1. Has there actually been change within the client?
2. Is the intervention responsible for the change?
3. What is it within or without the intervention are catalyst to the change?

To undertake HSCED as proposed by Elliot there needs to be a comprehensive case record including data on background of the case, intervention process and outcomes, plus various measures used to include quantitative and qualitative such

as interviews. Due to the specific measures that were used in this study being different from those suggested by Elliot, plus the lack of multiple perspectives or a team resource, this study is not strictly an HSCED study but uses some of the key aspects to examine the same questions, which are in line with the research questions for this current study.

Participant

Chapter 7 established the positive change trend in reflective functioning and sensitivity of the intervention group as a whole and as we wished to know how positive change occurs. For this case study a single participant who displayed positive quantitative change in the Meaning of the Child (MotC) and Parental Reflective Functioning (PDI-RF) coding of her pre and post interviews was selected. A more in-depth explanations of these coding methods can be found in chapter 7. This participant was selected from those who showed positive change as her transcripts had already been second coded by another reliable coder. All names in this study have been changed for the purpose of anonymity.

Data Analysis

Initially the transcripts were read and coded by the researcher in line with both the PDI-RF and PDI-MotC coding protocols, they were then sent off for blind second coding by certified reliable coders who had no awareness of the case in question. The pre-intervention and post-intervention transcripts were second coded separately by different coders who were blind to the background and to the other transcript, thus limiting the likelihood of identifying change where there is none. Each transcript was ascribed a numerical score. The PDI -RF ranges from -1 to 9 with 5 being normative reflective functioning and 9 being exceptional. The MotC scoring ranges from 1 to 7,

with 1 showing there is high risk of developmental problems in the relationship to 7 being an extremely responsive and sensitive parents.

Pre and post intervention scores for the PDI-RF, MotC, Parental Stress Scale and the Carer questionnaire can be found in table 21.

Within the PDI-RF assessment process there are two different types of questions, ‘demand’ questions that explicitly call upon the interviewee to use their reflective capacities and permit questions that allow, but not necessarily require, reflection. Once the coding had been examined the discourse was focused on to explore any changes. Due to the large amounts of data held within the transcript, for the purpose of this particular study, some of the questions assigned as ‘demand’ within the PDI-RF were chosen for deeper analysis with reference both to the coding markers within the PDI -RF and the MotC constructs and hermeneutic research philosophy. For the purpose of this study the participant was allocated the name ‘Lesley’ and the particular focus was on her relationship with her younger child ‘Emily’.

The first part of this study looks any change in the language Lesley uses when talking about Emily, the second uses aspects of Hermeneutic single-case efficacy design as outlined by Robert Elliott (2002) to explore Lesley’s self-reports of the benefit of the intervention. These will be looked at in conjunction with her self-report scoring for Carer’s Questionnaire around her relationship with Emily and the self-report Parental Stress Scale.

Data Collection

Interviews were conducted face to face by the researcher. The semi-structured interview consisted of the Parent Development Interview (PDI: Aber et al., 1985) pre

intervention and then a specially adapted version of the PDI post course completion. The interview was transcribed verbatim and then further checked for accuracy.

Ethics

Full ethical approval was gained from the University of Roehampton. Informed consent for data to be used for research purposes was supported by the use of a consent form, participant information and participant de-brief forms (Sample forms can be found in the appendices). Data protection procedures were followed, with names and personal details changed to maintain anonymity.

Results and Discussion

Lesley was a 43-year-old female, mother of 2 adopted children at the time of the intervention. Lesley and her marriage partner had both been referred to the Knowing Me, Knowing You program due to their reports of aggression and violence from both their adopted daughters aged 8 and 7 at the commencement, they found their younger daughter, Emily's behaviour particularly challenging. The girls were full siblings born 18 months apart and placed for adoption separately at the relatively young ages of 4.5 months and 8 months. Lesley and Peter had been through multiple failed infertility treatments before deciding on the adoption rout to build their family.

Both Lesley and Peter attended the first few sessions of the course, though sat separately and seemed to be struggling in their relationship. After a few sessions other professionals raised some safeguarding issues around Peter, an investigation was initiated, and although the was no further action he disengaged from all professional support. To the surprise of the course facilitators, and others in the social work team, Lesley wished to continue attending the course, citing how helpful

she felt the material was plus how she appreciated the peer support from others on the course, she had struck up a particular friendship with one of the other mothers attending who also had 2 girls of similar ages.

Although the child focused questionnaires showed no improvements in the children's behaviour across the report time points, the coding for Lesley's PDI show reasonable gains in both her Parental Reflective functioning as shown by the PDI-RF coding and her parental sensitivity as shown by the PDI-MotC coding.

Table 21

Pre and Post intervention scores for PDI-RF, MotC, Parental Stress Scale (PSS) and Carer Questionnaire (CQ) for Lesley.

Measure	Pre-Intervention	Post-Intervention
PDI-RF	3	5
MotC	1	4
PSS	55	64
CQ Parental Skills and Understanding	14	28
CQ Parent Child Relationship	20	16
CQ Child Responsiveness to Care	22	16
CQ Stability	7	7
CQ Total Score	63	67

Part 1

The scoring for the PDI-RF and MotC both showed positive change for Lesley, to help understand what change there is, sections of the pre-intervention interview were compared with corresponding sections with the post-intervention interview. Within

each interview Lesley was asked to describe a time when she and Emily really ‘clicked’ and then what her feelings were at the time and what she thought her child’s feelings were. This was followed by her being asked to describe a time when she and Emily really weren’t ‘clicking’ and once again she was asked to talk about her feelings at the time, followed by Emily’s. When comparing these sections, the first thing that becomes apparent is the change of frequency of language around thoughts, feelings and desires. The extracts for how Emily was feeling are used here to illustrate the findings. When asked pre-intervention ‘What do you think she was feeling?’ Lesley replied,

> “Umm, like she wants to, like she wants to control what I am doing and where I am, so, I, or Peter, she would rather do it to daddy, if he was there, umm, but in his absence sometimes she will try it with me, lesser with me to be honest, but if we are both in the house, she will try it with whoever is around, someone has to come running.”

In this excerpt we see that there is very little thought or feeling state language, simply ‘She wants to control’ and then later ‘would rather do it to daddy’ and both of these occasions Lesley is ascribing negative intent to Emily, there is no nuance or understanding of why her daughter may be feeling like this. She seems fixed in her idea of what is going on in her daughters mind, and there is no acknowledgement of the opacity of others mental states, that we can never totally know what is going on inside another person’s mind. Within the PDI-RF method of analysis this would be noted as questionable or low reflective functioning, scoring a 3 (out of a possible 9, where under 5 is below average). Here it looks like Lesley has the ability to talk about feeling states but on very simplistic terms, and that she seems unwilling to look beyond her first judgement.

The incident described before this excerpt is one of Emily refusing to go to bed. In this passage, Lesley describes Emily as “keep shouting and hollering and basically shouting insults at you” and then talks about “we are in that loop again of just here we go again!”. She distances her daughter’s actions by using ‘you’ rather than ‘me’. There is a hopelessness in the language that Lesley uses, and it is as if she feels like there is nothing she can do about it, she appears to be the victim of her child’s behaviours. At times her discourse suggests that Lesley feels that it is her child that is in control of situations rather than her as the parent, and here this is shown through Lesley’s language but also her explicit statement that Emily wants to be in ‘control’. Lesley is also placing the blame with Emily, it seems she believes it is Emily’s fault and that she has little control, that Emily is causing all the problems. There are also aspects of this section that show Lesley’s high level of feelings of parental helplessness which would imply a certain amount of emotional withdrawal from the relationship as she feels herself helpless to change or influence the situation. Lesley is feeling controlled by Emily’s behaviour and therefore believes that this is Emily’s intent, the distinction between thought and behaviour is blurred for Lesley and she believes that her perspective is the full truth of the situation (a state known in the literature as Psychic Equivalence, see Chapter 4).

These same questions were asked in the post intervention interview. This time, when asked to describe a time when she and Emily weren’t clicking, Lesley recounts an occasion where Emily couldn’t decide what clothes to wear, and Lesley is trying to support her with her decision making. It seems to Lesley that whatever she suggests Emily rejects, and this leaves Lesley stating, ‘I was kind of I think confused umm, frustrated, yeah, those kind of emotions really.’ After which the interviewer asked her what she thought Emily was feeling

Lesley

> “Probably similar, you know stressed out, frustrated, umm, like, overwhelmed, umm, yeah just like, just like it is too much for her, umm… yeah. I like, I don’t know whether she is wishing I would solve the problem or just, she seems like she is wishing I would solve the problem and getting frustrated that you are not, but actually if you start ‘solving the problem’, that seems to make it worse. So, actually I don’t think she does want you to solve the problem, it is just the way of, behaviour that she is stuck in, for those few minutes. Umm, yeah.”

On first examination, there are far more instances of thought and feeling state language. Lesley starts by likening Emily’s feelings to hers, but then she goes further and starts to explore why that may be, she states that she doesn’t know what Emily really wants and that her wishes may be different to what they appear to be. She also recognizes that this may be a habitual pattern for Emily. The language contains more nuance, not just stating what the feelings are at face value. She is less blaming of Emily and not jumping to a conclusion but searching for what may be going, she is more flexible and questioning her own thought process, however she does create some distance in her language by changing the use of ‘I’ to ‘you’.

Within the PDI-RF paradigm there are a number of indicators of moderate or higher level reflective functioning that are particularly looked for, these fall into four categories: the speaker shows awareness of the nature of mental states; the speaker is explicit in effort to tease out what the mental states underneath the behaviour may be; the speaker shows recognition of developmental features of mental states; the speaker shows awareness of mental states of the interviewer

(Fonagy et al., 1998). Within each of these four categories there are several subcategories.

The above excerpt could be coded under a number of the categories, Lesley is showing an awareness of mental states and that she recognizes she has limited insight into what is actually going on for Emily, she is actively trying to work out what is going on, there is also a freshness about her thinking, and she recognizes that there may be conflicting thoughts and feelings for Emily, despite the use of some distancing language she was scored at 5, which is normative mentalizing.

Within the MotC paradigm, this excerpt could be coded in a number of ways. In contrast to the pre-intervention excerpt Lesley is showing a capacity to mentalize for her child, and though at the start she says she thinks that Emily is feeling the same, which could be her projecting her own mental state on Emily, she continues to explore it and her judgments seem to be more credible and therefore her mentalizing seems more appropriate. However, there are still elements of this section that betray a sense of the child still being in control, showing though there is an improvement, there is still a way to go.

The next comparison is drawn between Lesley's responses to the question 'What gives you the most pain in being a parent?' Before this question she was asked 'What gives you the most joy in being a parent'. Pre-intervention Lesley had replied that 'just happy times that other families enjoy' and 'seeing them doing well' gave her joy, these were quite cliched and generalized and it drew a focus to the fact that she probably did not feel they were like other families.

"Interviewer: What gives you the most pain or difficulty in being a parent?

> Lesley: Probably the two, opposites of those things so umm, the meltdowns, the, the aggression, the insults (crying) all of that, the stuff that flies around when they are angry umm, yeah."

As we can see here, Lesley finds this very difficult to talk about it and is becoming emotionally overwhelmed, similar to the previous section, in this pre-intervention excerpt she uses very little feeling state language and also uses distancing language 'the, aggression, the insults'. She shows no ability to put into words how it makes her feel, she seems helpless and hopeless. She is overwhelmed by the affect caused by thinking about the situation and is stuck and unable to explore. Sharp and colleagues (2018) point out how difficult it is for a caregiver to mentalized for another when their own 'internal resources are low' (Sharp, et al., 2018, p. 4), it would seem that Lesley's resources are very low at this stage and the emotional overwhelm may be a signifier of depression.

Within the MotC paradigm she is showing her sadness and her hopelessness, and once again she is losing the sense of being an active parent to her child, it appears she feels unable to do anything about the situation. In the MotC coding system, this is known as "Abdicating Parental Responsibility/ Helpless" (Grey, 2019 p 110), an important marker as this kind of thinking facilitates the parent's withdrawal from the relationship with the child and active parenting, protecting the parent from self-blame for failures by perceiving the situation as irredeemable or hopeless.

Her post intervention script talks about similar aspects of life but in a very different way, and this time she is not overwhelmed by her feelings around her answer:

> "When the children are aggressive because I am not, yeah I don't like conflict, I don't like aggression I don't like, shouting, and yeah, so yeah, I don't like,

> and I don't like actually having attention drawn to myself so actually it's difficult for me and when the children are out in public and the children go off the rails and they are shouting the awful things that they shout, that I find difficult cause I just want to be hidden away because you like, just, so uncomfortable, if you are an introvert, to have all the eyes somewhere on you, and you know, there is nothing you can do about it except just tolerate it and grin and bear it, yeah."

This time at the start Lesley's language is not distanced in the same way it was previously and she owns her own feelings around her children's behaviour. Instead of simply being overwhelmed she has understood her feelings and why she finds it so uncomfortable she has worked hard to think through what her mental state is and how it is affected by the children's behaviour and that it is particularly her dislike of being the object of attention that makes what the children are doing so very difficult. Within the construct of mentalizing there are different polarities; self vs other; internal vs external; cognitive vs affective; automatic vs controlled, and that beneficial mentalizing is where each of these are in balance. In the pre-transcript expert about pain in parenting it seems that Lesley is stuck in the affective, in fact overwhelmed by this and unable to process anything else, it is also more automatic rather than controlled. In the post intervention excerpt she is no longer overwhelmed by affect but is able to use her cognition to tease out how she was feeling and put it into words, she is more in control and no longer operating purely automatically, she is able to step back and observe her mental states rather than being caught up in them. For this excerpt she was given the score of 5, which equates to normal mentalizing even though there is a bit of generalization and distancing when she states 'if you are an introvert'.

Within the MotC coding she shows appropriate mentalizing for herself however, towards then end when she talks about ‘just tolerate it and grin and bear it’ there are still elements of hopelessness or abdication of her parental responsibility once again. Similar to the first passage, there is improvement, however she still finds thinking about these occurrences and what they mean to her difficult.

The final comparison between the pre and post-intervention interviews is where Lesley is asked to think about a time when she was apart from her children. Interestingly in both interviews she talks about going on a spa day. Pre-intervention, when asked how she felt while away from the children she replied,

> “Umm, good, good, relaxed, umm, relaxed but I am always thinking about them and what they are doing.”

As with the other pre-intervention excerpts, she is fairly telegraphic in her answer and though gives some feeling states she does not go into details. When asked how she thought the children were feeling she responds,

> “Umm, that particular day I think it was a Saturday so I think, it was quite a novelty so I think I can’t remember what they did now but I think they did things that made it seem like a sort of a one of kind of a day, as opposed to any old Saturday. Umm, so yeah I think they were probably wondering what I was doing as well, but I think we think of each other when they are not there, typically on a Sunday when I am at work, you know they will do stuff and sometimes will go “oh we went to the Christmas fayre” and “we brought you this”, and I will have done the same sort of thing at work, “I saw this, I want to show you this”, and “look what I have got, this picture of this”, so I think yeah.”

She starts off talking about the details of the day rather than the feelings, and when she gets to talking about their feelings, she states they were probably wondering about what she was doing, but then adds a generalization “I think we think of each other when they are not there”. Here she and her children are lumped together, there is no separateness of thought or experience. This is the only part that is about feeling or thought states and she quickly moves away and into direct speech which also serves to distance and inhibit reflection, her mentalizing is very limited. Within the MoC coding, the using telegraphic speech is part of a pattern that shows withdrawal from the relationship, Lesley is not deliberately being obstructive she simply can’t explore these aspects of the relationship as she lacks the reflective capacity.

Post intervention Lesley is asked if she thought about the girls while she was away from them. She replies,

> “ I did think about them, and I noticed that once it had got to, even though I could have stayed until tea time or later, once it got to the time that they were out of school, that is when I felt like I need to head off soon, even though I knew that Pete was picking them up and I think, were my mum and dad there that day? No I don’t think they were I think it was just, but I felt a sort of a, a responsibility to get back home. Yeah.”

As with the other post intervention excerpts, here she goes into more detail, it is not just that she simply thought about the girls, but she is noticing her own process and that even though she knew the girls were safe and looked after she felt pulled back to them. This shows her growing self-awareness and self-knowledge, she is no

longer taking things at face value but teasing out more of the complexities. Again, here she has moved more towards normative mentalizing.

When asked what it may have been like for the girls with her being away, she replies,

> "I think on that particular day I was conscious that they probably weren't having much fun after school, because I knew that Pete would be trying to work so, without me there, to entertain them more, I felt like they might be getting frustrated. I don't think they were as it turned out, I think they just were happy watching TV for a couple of hours but yeah I was kind of, worried that, I don't know that someone might get upset or something might go wrong, or, that something had happened at school that day, so I didn't want to get home too late near bed time or anything like that, so, yeah."

She continues thinking about her process and what she was aware of, then starts to relate that to the girls. Pre-intervention her response was very factual, but this time she was more aware of what may have been going on for the girls, but also recognizes that the reality was different from her concerns and that there are differing perspectives on any situation. These passages once again show Lesley's increasing ability to talk about and explore both her and her daughters' mental states, though there is tangible anxiety and fear about what may have been going on at home and she links this to her feeling the urge to return.

As well as levels of risk, the MotC system of analysis distinguishes between 3 patterns of caregiving named for how the child might experience them. These are Sensitive, Unresponsive and Controlling. The non-sensitive patterns can be seen as protecting the parent in some way from the threat or pain involved in caring for their

child. The unresponsive parent finds their child threatening or experiences the negative feelings their child has as threatening, and due to this psychologically withdraws from the relationship with the child. The controlling parent has a clear connection to their child, but it is a negative one and the child needs to submit to the parent's view and expectations of the relationship, these parents are often intrusive in their interactions with the child and try to control the narrative with the interviewer. Within these excerpts of Lesley's interviews, she shows both unresponsiveness to her child in her parental helplessness and at times she is controlling of where she locates the blame for the problems. When it comes to the post intervention interview there is more indicators of sensitivity with evidence of mentalizing for herself or for Emily. Interviews are coded as a whole, and both were coded as being unresponsive despite the evidence of some controlling aspects. Her pre-intervention interview showed the relationship to be in crisis from Lesley's perspective while the post-intervention interview showed her to be moving from this position of crisis to one of managing, albeit with issues that needed some level of support. Throughout the transcript there is an appearance of newly learnt skills, and that Lesley is doing this new thought in a very deliberate way, it is very cognitive, and she is having to work hard at it, however, it is very different to what is seen throughout the pre-intervention transcript.

For the PDI-RF these excerpts show that Lesley has moved from simply being able to use some thought and feeling state language to being able to, at times, tease out greater understanding of mental states for both herself and her child, and this increase of use in mental state language and attempts to understand was seen throughout most of the post intervention transcript, with her pre-intervention total score being a 3, showing questionable reflective functioning to a 5 showing average

or ordinary reflective functioning. Within both constructs Lesley has shown an improvement in her capacity to reflect and mentalize both for herself and her child.

Fonagy & Luyten (2009) suggest that mentalizing is not likely to be successful if it is excessively influenced by automatic, highly emotional, or very self-focused aspects. Pre-intervention Lesley jumps to answers and attributions, such as Emily is 'trying' to control, plus she bursts into tears several times through the transcript and tends to see herself as the victim of her children or situations. By the time she undertakes her post intervention interview, she is more cognitive in her exploration also more regulated talking about difficult things plus shows growing awareness of, and interest in, what may be going on for her daughter. The second MotC coder for Lesley's post intervention interview commented on some of her knowledge being very cognitive, fairly new to her and perhaps a bit borrowed. The KMKY program aims to model mentalizing throughout, provide opportunities for participants to practice their mentalizing as well as being psychoeducational. Mentalizing is learnt within secure attachment relationships, and within mentalization based therapy there is an aim to help repair lost experiences by the therapist's use of a mentalizing stance towards the clients (Sharp et al, 2018). It is hard from these interviews to tell exactly what aspect of the program may have influenced the changes seen, but possibly due to her cognitive nature it is a combination of the psychoeducation and scenario practice, and the course facilitators mentalizing stance that is helping Lesley apply her learning to her thinking around her children.

Part 2

The first question that needs answer is whether there are clear links between the intervention and outcomes, and if so, what is the direct evidence or indirect evidence.

The examination of the change in scoring for both the PDI-RF and the MotC are evidence of change, plus the examination of excerpts of the pre and post-intervention interview transcripts also show clear evidence of change in the amount and type of mentalizing based language that Lesley is able to use. Further to this there were pre-intervention and post- intervention questionnaires that Lesley completed about her levels of parenting stress and the relationship she had with Emily. These questionnaires show a different picture, her scoring for the Parental Stress Scale actually increased by 9 points (see table 21) which showed that she felt more stress in her parenting role post intervention than before the intervention. The Carer's Questionnaire total score showed an increase of 4 points which implied and improvement in the relationship, but on further examination of the subscales this change is driven by Parental Skills and Understanding that saw the score double from 14 to 28, Stability of placement remained steady at 7, however both Parent Child Relationship and Child Responsiveness to Care showed a reduction in score or worsening. This adds complexity into the picture, while there is evidence of positive change, there is also evidence of regression.

Elliot (2002) states that there should be at least two different and separate bit of data that support the link between the intervention and any change for further analysis to proceed, and he states that one of these should be the client's own attribution of change to the therapy. Within the post intervention interview there is a section that asks the participant to talk about the intervention and any effects that it may have had. When asked how the intervention has affected Lesley and her relationship with her children she responded,

> "I think, I'm, a lot more aware of the fact that their behaviour is very rarely a choice that they are making, and I think before, before I started the course I

> was, probably interrogating their behaviour in my own head thinking what, you know why, is she doing this, why, as if it was a conscious thing and now I get a lot more that it isn't a conscious thing and that they can't give me a reason for why they are doing it and even if we sat down the day later and we tried to talk about it, they can't give me the reason I have to figure that out."

Here she is clearly attribution her new awareness to the course. Later, she is asked about further if it has changed the relationship she responds,

> "I think some of the things we have been doing, over the last few months, has made me feel closer to them, and especially closer to Emily, who I felt like sometimes, sometimes I felt like she wanted to keep me at arm's length."

She goes on to state that "Oh I think it has had a good effect on them (the children)" and when asked how she feels about this she replies "Positive, really positive."

These excerpts show that Lesley is directly attributing to the KMKY program positive change to both her thinking and her relationship with the children.

Taking the combination of quantitative change in the MotC and PDI-RF scoring, the transcripts evidence of change in language used and Lesley's attribution of change to the intervention gives enough evidence to conclude that in line with question 1 of Elliot's 3 questions, there has been positive change, and that there is evidence that this change was brought about by the intervention itself. However, Elliot (2002) does state that there should be a "good-faith effort to find nontherapy processes that could account for an observed or reported client change" (Elliot, 2002, p 7). And in the following section we explore possibilities of other factors that may have effected change using 7 out of the 8 different factors that Elliott puts forward.

Trivial or Negative Change

While the interview ratings would seem to be positively changed, and they are of more than a single point, the questionnaire show a mixed picture. As already mentioned, the Parental Stress Scale has shown a sizeable negative change, this is interesting as previous findings have shown that increased reflective functioning and mentalizing is related to reduced parenting stress (Santelices and Cortes, 2022). Parenting Skills and Understanding has dramatically increased by 14 points, however the Parent Child Relationship and Child Responsiveness to care saw negative change and thus the statistical picture of change is very mixed.

The qualitative picture while seeing change in the language used, and Lesley ascribing the change to the intervention, also gives a slightly mixed picture. Elliot (2002) recommends being aware of ambivalent or qualified language that may discredit some of the reported change, Language such as ‘I think’, ‘I guess’, ‘Maybe’. Here in Lesley’s transcript we see several incidents of this kind of language “I think before, before I started the course I was, probably interrogating their behaviour”, then again when asked if it has affected the relationship “yeah I think probably it has”, then later “I think there is lots of things that I have probably started putting into practice or actually just an awareness that seems to be forming.” Despite this ambivalent language she does not attribute any negative effects of the intervention.

Conclusion. While on the one hand there are signs of positive change in the MotC and PDI-RF and use of language plus Parental Skills and Understanding, there are also signs of negative change and ambivalent language around the change that Lesley attributes to the intervention, and thus a mixed picture of change is emerging.

Relational Artifacts

In any therapy or therapeutic intervention, it is necessary to build a therapeutic relationship with the client, and due to this relationship improvements may be partly caused by the dynamic between the professional and client. Due to the therapeutic journey they have been on the client may wish to please the professional. Mcleod (2013) encourages researchers to consider that clients respond to questionnaires and interviews within a context, and that pre and post intervention are completely different contexts. The 'hello goodbye effect' suggests that at the pre therapy point a client will accentuate their issues to show their need for support or intervention, and then the possibility that the therapeutic process itself can cause a client to view questions differently, and therefore respond in a different manner, even if feelings are the same as before. The client may well feel gratitude to the professional and wish to please with attribution of change. Elliot (2002) also points out that it is better that a separate researcher rather than therapist or course facilitator undertakes the interviews as this reduces the clients drive to please the person they have built a relationship with. Unfortunately, this was not possible, so all interviews were administrated by one of the course facilitators. To interrogate the possibility of these relational issues being a factor in reported positive change signs of elaboration and discrimination as proposed by Bohart and Boyd (1997) should be looked for.

When asked for the effect on the relationship, Lesley could have simply answered that there was a good affect, but instead she talks about her learning "I'm, a lot more aware of the fact that their behaviour is very rarely a choice." She goes on to elaborate around this and her responsibility in supporting the children to figure it out. Later on, she starts off with very qualified language using a lot of 'I think' and 'probably' but then also proceeds to elaborate about how she previously felt about

her relationship with Emily and how it is changing. Her answers are in depth, giving examples of situations and differentiating what she previously felt and how she now views the situation and her resources moving forward.

Conclusion. Despite the use of qualified language and possibilities that she wanted to please the interviewer, Lesley goes into detail about what has changed, comparing it with her experiences and thoughts prior to the intervention and this makes it unlikely that the reported change is down to relational artifacts.

Expectancy Artifacts

'Cultural or personal expectations ("scripts") or wishful thinking may give rise to apparent client change.' (Elliot, 2002, p. 12). Here Elliot proposes that because there is a personal or cultural expectation that therapy will help, a person may have persuaded themselves of change that does not really exist, and therefore ascribe psychological change where there is simply a change in mood or self-evaluation. The best way of testing this is to look at the language used around the experience and that if the change is driven by expectation, then scripted or cliched phrases and language would be used, plus descriptions may be vague and distanced. Reports of change that contain unusual content, seem reflective, contain detailed descriptions or are idiosyncratic are less likely to be expectation driven and therefore more credible (Elliot, 2002). Within Lesley's transcript there appears to be no cliched talk about the benefits of the intervention, though at times aspects of her descriptions of what she has learnt are cliched eg 'Don't sweat the small stuff' plus there are some excerpts that are a little vague and distanced 'I think there is lots of things that I have probably started putting in to practice', 'Just an awareness that seems to be forming', but mixed in with these are other excerpts that are idiosyncratic and unexpected such as when she talks about her fear for the future ' I had that fear of the future

massively more than I do now' and when she mentioned that she previously felt that Emily had wanted to keep her at arm's length. These could not be seen as being prompted and expected through the interview process. She is also reflective about the process and how she herself has been deliberately working at change.

Conclusion. While there is some evidence of vague and distanced language, there is no use of 'scripts' around therapy or therapeutic interventions and Lesley's descriptions of what has changed in her relationship with her children seem personal, detailed and credible.

Self-Correction Processes: Self-Help and Self-Generated Return to Baseline Functioning

It is possible that alongside any therapy or therapeutic intervention the client has engaged in self- help strategies that have in fact driven the change rather than the intervention itself. Elliott (2002) encourages examination of the client's narrative to see if there are clues to this kind of process going on. For true HSCED the Change Interview (Elliott, Slatick, & Urman, 2001) needs to be used, this was not used in this current study, so therefore the questions asked perhaps did not support Lesley to talk about and self-help strategies or self-generated change, however, there is no evidence within her post intervention transcript that she had engaged in any other self-help outside of the course. This is in comparison to other course participants who mentioned about books they had been reading or other support they were seeking out.

Elliott (2002) also encourages the examination of time factors such as duration of problems, as change could possibly be cause by the return to baseline and that the presenting problem was simply a temporary issue. In Lesley's case we do not have

data about how long the family had been struggling with the children's aggression and violence, however, the process of getting post adoption support and being referred to interventions plus application for funding is not a quick one. To get to the stage of being referred to the course there would usually have been at least a year's involvement with support services, plus Lesley also reported having problems with Emily's behaviours from very early on, so it is reasonable to presume that this was not a short-term problem that would have self-corrected in times.

Conclusion. The lack of report of self-help or self-generated change and the likelihood of the longevity of problems that this family had points to the change being caused by the intervention rather than self-help or self-correction.

Extratherapy Events

As already mentioned, this case study differs from Elliott's HSCED and the Change Interview (Elliott, Slatick, & Urman, 2001) was not used, so direct questioning about what had helped to bring change was not included in the interview. However, Lesley was asked what change she thought the intervention had brought. Elliott (2002) points out that events such as changes in relationships, crises, house moves, physical illnesses or medical treatments can all impact psychological functioning both for the positive and negative. Not much background is known for Lesley and her family, but during the time of the intervention there were no known significant changes in the family situation, other than perhaps a worsening of the marriage relationship and that her husband stopped attending the course. It would be reasonable to think that a worsening relationship would actually have negative effects on the measurements rather than positive effects, so the positive changes in measurements of the MotC and PDI-RF, plus Parental Skills and Understanding are unlikely to have been influenced by this, however the reduction in the Child

Responsiveness to Care and Parent Child Relationship and increase in the Parental Stress Scale may well have been influenced by worsening couple relations. The only factor that may have been supportive to change was the peer support that Lesley found within the group and the one strong friendship she made.

Conclusion. It is unlikely that extratherapy events had any positive impact on the positive change seen, however, they could have influenced the negative change seen in the PSS, CRC and PCR.

Psychobiological Causes

Many clients engaging in therapy or therapeutic interventions may be on medical treatment for anxiety or depression, they may also be receiving treatment for hormonal imbalances or attempting to help themselves with herbal remedies. They may also been in recovery from illness or surgery. These factors are hard to quantify, but Elliott encourages them to be considered as possible vehicles or change. It is unknown if Lesley was on any medication or receiving support from medical professionals, as none was disclosed. There was also no information about any psychobiological factors such as starting medication for depression etc that would influence change.

Conclusion. There is no evidence either for or against psychobiological causes for change.

Reactive Effects of Research

Being part of research, itself can have an effect, this effect also known as the ‘observer’s paradox (Labov, 1972). Simply stated, the fact of consenting to research and being interviewed and recorded can bring change both negative and positive. It is very hard to quantify any change that is brought by being part of research, but

clues can be found within the interview itself. In Lesley's case, there was no reference either positive or negative to the interview process or being part of the research, so no conclusions as to the effects of the research can be drawn.

Summary and Conclusions

Though this study is not a true HSCED, aspects of the analysis has been applied to it. Within HSCED there needs to be at least two direct forms of evidence to be able to conclude that the intervention was responsible for change, and here we have seen that there is both quantitative changes seen in the coding of the MotC and PDI-RF, plus change in the frequency and nuance in mentalizing language used as well as attribution by Lesley to the course brining change. Thus, there is adequate evidence for the change being driven by the intervention.

Negative evidence for change is from exploring nontherapeutic explanations for change, and as long as no single or combination of nontherapeutic factors can explain all the change then it can be again presumed that the therapeutic intervention brought change. As we have seen, the evidence is mixed with some quantitative measures showing negative change and some limited possibility that expectancy and relational artifacts could be at play, these do not give indication that these influences could bring the change seen without the intervention.

Taken together this leads to the conclusion that there was positive change for Lesley, and it was brought about mainly through the intervention, however this does not tell us much more than the intervention can be effective.

To understand further the role that the Knowing Me, Knowing You program took in helping to bring change, the transcripts were further explored to try and understand Lesley's specific change process.

It seems that the program has helped Lesley to be in a state where she is ready to take on new ideas and explore thoughts and feelings. Lesley states that “I’m a lot more aware of the fact that their behaviour is very rarely a choice”. She has taken in some of the psychoeducational aspects of the course, and recognized as she changed her behaviour it “has made me feel closer to them”. This would appear to have made her more confident in her parenting and that now “has made home life easier”. She has become aware of her own mental processes and previous “catastrophizing” and has learnt to let go of some of these ideas plus she has learnt to be less reactionary and more regulated and reasoned, she appears then more able to attend to and understand the mental processes of her children.

This process appears to be a positive feedback loop where each piece of change or learning has impacted the next and helped to improve different aspects of the family life and their relational functioning.

Further detailed study into individuals process of change may benefit and aid possible adaptations to this course and other similar courses and therefore maximize the opportunities for participants to engage in the process of change.

Strengths and Limitations

This study has made use of a rich data set to conduct an in-depth study of one of the KMKY program participants. It holds strength in its detail and the understanding of change that can be brought. This study is limited by its only partial use of HSCED as put forward by Elliot (2002), the study was conducted post hoc and did not use the recommended ‘Change Interview’ (Elliot, 2002) it also came from the single perspective of the researcher and therefore did not benefit from the team judicial

approach. Future research into the KMKY program would benefit from the use of recommended measure for HSCED.

Chapter 10: Exploring the experience of Knowing Me, Knowing You course participants.

Introduction

The Knowing Me, Knowing You (KMKY) program is both mentalizing based and a psychoeducation course developed to meet the needs of adoptive parents who are experiencing violence and aggression from their children. Grounded in attachment theory, mentalizing and reflective functioning theory plus non-violent resistance theory and current thinking around therapeutic parenting, this 9-week group-based program aims to impact parental reflective functioning, mentalizing and sensitivity and thus the parental environment in order to reduce displays of aggression and violence from the adopted children.

This current qualitative study does not go into theory in detail, but instead examines the course feedback to explore the participants experience and understand any change that the course has brought in parental behaviour, processing and thinking.

Change and its mechanisms has long been the study of psychologists both within the areas of behavioural change and psychological change. As with any psychological or psychoeducational intervention the course that this current study is around aims to support change, both for the attendees and their children and hence the family system. Change itself is challenging and difficult, and the process often includes complications and relapses as habitual patterns are gradually disrupted and changed (Orbell & Verplanken, 2020).

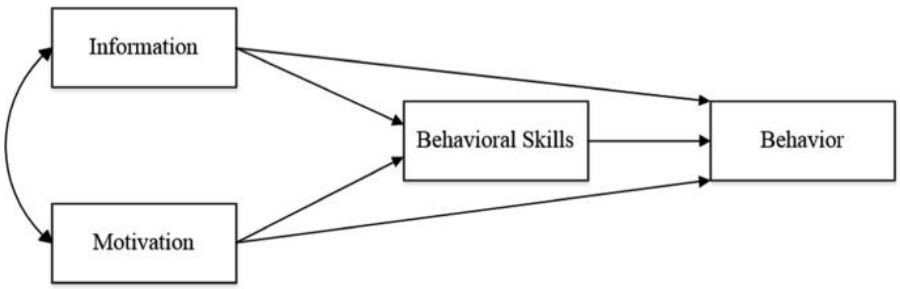
Within behaviour change research there are a number of predominant theories, the transtheoretical model, developed by Prochaska and DiClemente (1982) while studying smoking cessation, proposes that there are 6 differing stages in the change

process; Precontemplation – where there is no intention to change; Contemplation – where the individual sees benefits to change and but also the disadvantages and spends time weighing these up; Preparation- where the individual plans and begins to take steps towards the change; Action – the individual is actively taking steps towards the change and is having some success; Maintenance – where active behaviour continues in an amount that prevents relapse and regression; Termination – where the individual is now comfortable with their new ways of being and no longer has to actively work against temptation. As with many process models, the theorists do not propose this is strictly linear and relapse and regression can cause a person to revisit an earlier stage.

Fisher and Fisher (1992) explored literature on behavioural change specific to AIDS-risk behaviour. They theorised that there were 3 key factors impacting behavioural change; Information about behaviour – including conscious and automatic thoughts; Motivation – including personal and social motivation for behavioural change; Behavioural skills – influenced by both information and motivation. These 3 factors influence any change in behaviour.

Figure 30

The information–motivation–behavioural skills model (Fisher & Fisher, 1992)



Michie, van Stralen and West (2011) aiming to assist professionals delivering interventions as well as policy makers set forth the Behaviour Change Wheel. Core components to their theory of change were the persons motivation, capability, and opportunity to change. Capability, both physical and psychological includes both knowledge and skills, opportunity includes environmental factors while motivation includes energy, thoughts and feelings. Any intervention aiming to bring change would need to impact these areas as shown in their COM-B model (see figure x).

Figure 31

The Behaviour Change Wheel (Michie, van Stralen & West, 2011, p. 9)

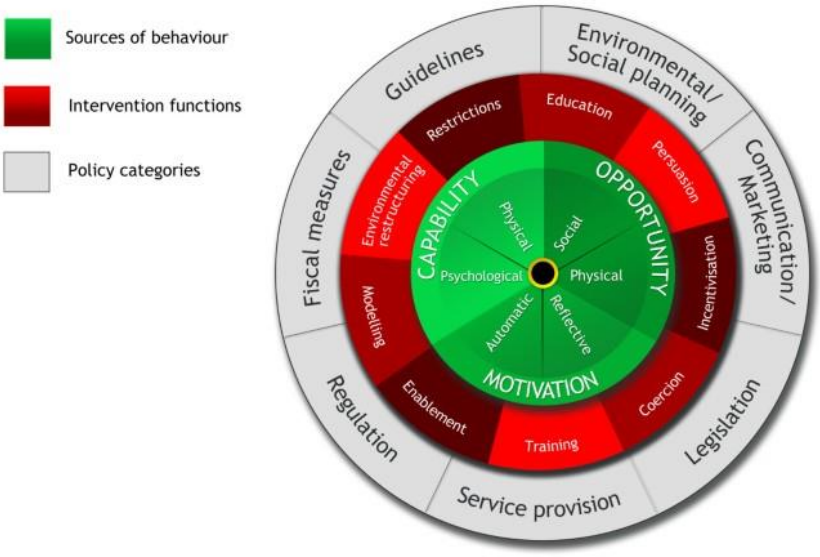
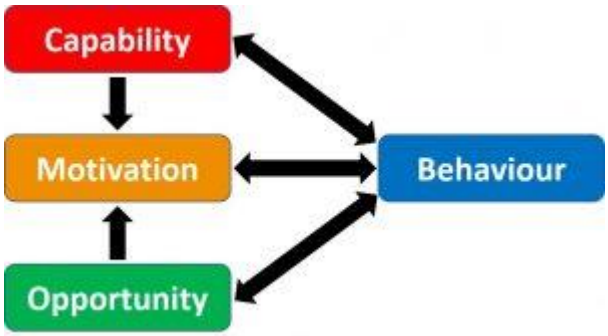


Figure 32

COM-B model



For all three of these models' information and motivation are key to behavioural change.

Moving on to theories around psychological change rather than behavioural change, ideas become more complex and as yet there are still gaps in understanding (Young, 2022a). Some studies amongst children have shown that cognitive restructuring and processing are key mechanisms for psychological change in children (Kangaslampi and Peltonen, 2019; Lemmens et al., 2016). Young (2022b) states that areas such as cognition and schemas should not be considered in isolation as they are part of executive functioning. Young later goes on to suggest that autonomic nervous system changes and hypothalamic–pituitary–adrenal axis (HPA) processes should be considered, and that change should be approached from an understanding of biopsychosocial factors (Young, 2022a).

Emotional processing and affect, such as hope or hopelessness, are also variously proposed as mechanisms of change and emphasise the mix of cognitive and affective information that is involved in self-regulation (Gallagher et al., 2020; Higginson & Mansell, 2008; Tsvieli et al., 2020, 2021). Social constructs and the importance of therapeutic relationships are also seen as important mechanisms of

psychological change (Tyrer & Masterson, 2019). In their work with borderline personality disorder, Fonagy and Bateman (2006) emphasise the importance of therapeutic alliance and activation of the attachment system, as well as the experience of being held in mind and mentalized for as key to change in mentalizing.

Study Rational

It would appear that the majority of studies that centre around psychological interventions focus on the effectiveness of the intervention while there is a relative dearth of exploration of the participants experience (Appiah, et al., 2021). Exploring the participants experience can provide additional understanding of the change process of participants and any therapeutic effects. This exploration can also aid the researcher to capture some of the motivations and mechanisms underpinning any changes (Kerkelä et al., 2015; Mitchell et al., 2018). Investigation into thoughts and feelings about a course or intervention plus any change that has occurred is also of interest for future delivery and development. With this in mind, looking at the participants feedback this study aims to further understand any benefits of the KMKY program. Reflexive thematic analysis was used to facilitate exploration of the rich dataset provided by the post intervention transcripts plus written feedback forms.

The research question considered in this study is:-

What are the course participants' experiences of the Knowing me, Knowing you program and of any change that it brings?

Methodology

Study Design and Rational

As with the previous studies in this thesis, this study makes use of a segment of data from the larger investigational data set around the Knowing Me, Knowing You program (KMKY).

In order to identify the aspects of KMKY that course participants really valued, qualitative analysis drawing upon Braun and Clarke's (2006; 2022) approach to reflexive thematic analysis was applied to the final section of post intervention interviews and feedback forms. This current thematic analysis has an experiential focus to help understand the participants internal experience of being part of the program and thus brining an additional perspective to the previous studies that focused on the quantitative evidence then the attachment and reflective functioning focused aspects. Throughout the analysis theory of change and mentalizing remained partners in making sense of the participants comments and dialogue while not diminishing the inductive experiential primary focus of the analysis.

As far as is possible this study uses an inductive process, with a 'bottom up' approach where the data held within the transcripts was driving the generated codes and themes, though it is recognised that the researcher was also the course developer and therefore not unbiased. Epistemologically this study comes from a critical realist approach where the language is assumed to reflect reality but also partake in the construction of the speaker's reality, which at times could potentially cause tension between the more realist approach of the attachment assessments used within this thesis, however this current Thematic Analysis study does not seek to externally assess change but rather understand the participants perspective in a more inductive way.

Participants

Transcripts of the feedback section of the interview for the 18 course participants who consented to the data being used for research purposes, plus 17 anonymous feedback forms were analysed. Ages of interviewees ranged from 38 to 50 years old, 5 of the participants were male, and 13 females. Within this group there were 2 heterosexual couples who attended the course at the same time and a further heterosexual couple who attended on separate cohorts. As the feedback forms were unnamed, the age and gender details are unknown.

Data Collection

Interviews were conducted face to face where possible, however during the COVID-19 pandemic interviews were conducted virtually. All interviews were conducted by the researcher. The semi-structured interview consisted of the Parent Development Interview (PDI: Aber et al., 1985) that had been adapted for use post course completion. The interview was transcribed verbatim and then further checked for accuracy. For the purpose of this study the final 4 interview questions around the participants thoughts and feelings about the course were used.

Feedback forms were collected for all in person cohorts of the course, with those who consented to research placing their forms in a separate area to those who had not. Names were not asked for on feedback forms to enable participants to freely give their opinions.

The following questions were asked on feedback forms.

- What did you find helpful?
- What did you find unhelpful?

- Any other comments about the training?

The following questions were asked during the interview.

- Recently we have been working through a course about how early trauma affects children and how parenting a traumatized child can affect you, as well as looking at different parenting strategies.

  Can you tell me a little bit about how this has affected you and your relationship with your child?

- Is there anything that you feel you have learnt or changed since doing this course?

- How do you feel about that?

- What affect do you think that you doing this course has had on your child?

Data Analysis

Thematic analysis is both accessible and adaptive to different subjects and epistemologies. Braun and Clarke's (2006; 2022) approach involve 6 distinctive stages; transcript familiarisation, initial code generation, identification of themes, review of the themes, naming of themes and write up. For the purpose of this study NVivo Software was used to facilitate generation of codes and then themes. Initially one transcript was explored in depth with codes generated and sorted, then the process was repeated with each transcript in turn, then the feedback forms, with additional codes generated as identified. The codes were then sorted into superordinate and subordinate themes. This process of sorting was repeated several times.

35 separate pieces of qualitative data were analysed, this included the relevant excerpts from 18 post intervention interviews (see above) and 17 anonymous handwritten feedback forms.

Ethics

Full ethical approval was gained from the University of Roehampton. Data protection procedures were followed, with names and personal details changed to maintain anonymity.

Informed consent for data to be used in research purposes had been gained with the aid of research participants information sheet, research participant debrief document, and a consent form. The interview participants have been given pseudonyms to protect their anonymity, while quotations from feedback forms are simply labelled ‘anonymous’.

Analysis and Discussion

Four superordinate themes were identified each with 3 or 4 sub themes. The themes were not chosen due to frequency or coverage but to the perceived weight and importance within the transcript. Themes and subthemes can be seen in Table 22.

Table 22

Table of themes

Superordinate Themes

The Journey of Change	**Journeying Together**	**Feelings and Emotions**	**Reflection**
Subordinate themes			
It starts with me:	Opportunity to talk.	Being open with feelings	Think and Reflect.
Gradual change process	Similar situation	Different emotional atmosphere	Growing understanding
Doing it differently, thinking differently	Lived experience of facilitator	Feeling hopeful	Growing confidence
Positive change			

The Journey of Change

It is perhaps unsurprising that the exploration of participants experiences of an intervention that aims to bring change would result in a major theme being that of the journey of change itself. Looking at the transtheoretical model of change, by the time participants have started to attend the course they would have already begun this journey and moved through both precontemplation and contemplation to preparation, and possibly action stages. As a motivation to change there must be some hope for a different future in contrast to their present experience.

It starts with me: 'it is all about changing me and not about changing him.'

Throughout the course there is an emphasis on understanding of the self before trying to understand the child, and that change also needs to start with the self. Participants seem to have understood this and integrated it into their thinking but realise that change is not instantaneous or easy.

Lizzie

"I have learnt a lot about why I react the way I do umm.. and that it is not great, but it is okay (laughs) and I guess it is still a work in progress."

Eddie

"I wouldn't say it has all be easy though, some of it has been challenging and yeah it is a lot."

Anonymous

"Needs to come with a bit of a health warning as to how reflective you have to be!"

Bethany encapsulates what this new way of thinking has meant for her and the realisation that how she is deeply impacts her family, the thinking has also motivated decisions to make changes in life. She acknowledges the transactional process that go on within the family.

> “I think it has made me umm, much more aware of how much, the way I am, impacts them, umm, and Ian (husband) as well, so the way that we respond, has a massive impact on them. Umm, and that if we are in a good place, and able to manage, what is happening in our day and ready for them in their day then umm, they going to achieve much more in that, umm, one thing it has made me do is realize I was working too much, so I have stopped one job and I am now only working 20 hours a week, so I have more time and I am not so exhausted and I think that has had a big impact because I am able to be more in control of who I am and what I need, umm… and I think the whole thing of looking after me, or us, first, has been the thing that I think I have probably been aware of that I can’t look after them, if I am not looking after myself, and if I am exhausted then I can’t look after them properly and do the things I need to do and be ready for whatever is coming”

Bethany here talks about the importance of self-care, Benzies and Colleagues (2023) when studying prevention focused parenting education noted that self-care without guilt was a positive driver for change within the parents’ relationship to themselves as a parent.

When asked if there is anything that she had learnt or changed Nadine again centres on thoughts around self and the transactional process.

> "Trying to regulate ourselves I think, umm.. and knowing it is important to try and find time to regulate yourself as in, trying to, trying to breath, and, and, know that whatever I am feeling is transmitting straight to her, so, just trying to make everything a lot calmer first so that she is calmer."

Jackie is very clear in her thought process around benefits of attending the program, though she attended the program to reduce aggression and violence displayed by her son, she recognizes it is her that needs to change first.

> "So, I think that umm, the effect on him, is going to be the effect on me. So, umm, the, the more that I can umm, step back and help him umm, just understand the growing up process almost you know, these things have to be learnt there, not, there not umm, they are not inherited, no I don't know what the right word is, inherent, inherent, umm, there umm, but, umm, I think as an adult you have to learn it yourself first …….So, the thing that I want to say is actually it is all about changing me and not about changing him."

Interestingly, Suchman et al., (2010b) in their study of reflective functioning with drug using mothers found that it was self-mentalization rather than child-mentalization that was associated with appropriate maternal behaviour and therefore concluded that improving this area was important to improving parent-child relationships. This would suggest that the participants realizations around their self may well be assisting with any change in relationship and children's reactions.

Gradual change process: 'It's good, we are still not there yet'

This subtheme links in with the last and Lizzies statement about it being a 'work in progress'. Eddie also described it as being 'a work in progress' and went on to talk about his difficulties at times of stress and challenge.

> “but I personally still struggle to deal with.. the situation umm….. I find it very difficult to engage those thoughts at those times.”

Others acknowledged that they were more at the start of a process than at an end,

> Richard
>
> “It’s good, we are still not there yet, and we know it is going to take, it is not like flicking a switch and that is it, it is all fixed, and you know it’s going to take, years, you know……. I think not being lulled into the false sense of security because things are going okay, you know recognizing that this is going to take a long time.”
>
> Charlotte
>
> “I’ve tried to take on board what you have said, and I think it’s, I think you are always going to grow in, everything grows.”

but even at an early stage the children were benefitting from small changes.

> Lesley
>
> “Oh I think it has had a good effect on them, I think, I think I mean whilst, by no means have I been able to put everything into practice, I think there is lots of things that I have probably started putting into practice or actually just an awareness that seems to be forming.”
>
> Richard
>
> “I think you can already see some positives, and I think again, even though Anne has her, ‘it’s all a disaster, it’s all hard,’ when she is being a bit more

rational, she acknowledges we are heading in the right direction, the blow ups are happening less frequently."

Simon

"It has taken some, it has been quite hard to get my head around, sort of get it to lodge, is the thing to do and I must admit it has been, taken a bit longer than I thought to try and sort of lodge it but I think with the reading that we have done and the some of the resources that we have gone through, I think it is kind of sinking in now."

For Simon the factors that go into behavioural change as theorized by Fisher and Fisher (1992) seem particularly relevant, he has the motivation and more information and now is beginning to change his behaviour, this could also link in to the transtheoretical model of behaviour change (Prochaska and DiClemente, 1982) where he is in the action stage, already having some success but it is hard work and he is not yet in the maintenance stage.

Simon

"I think I have definitely learnt the strategies, I still need a lot of work on implementing them, cause it is quite hard to go away from the default especially when you are under stress, the default is the shouting all the, saying stop, this isn't me trying to be the authoritarian doesn't always work, and I think I need to get better, at doing that under stress, when the stress levels start to rise or like I say take yourself out and calm down before you then go back in."

He is having to work hard to disrupt the former habitual patterns of functioning.

Doing it differently, thinking differently: ‘I am coming from completely a different mindset.’

Within this subtheme there are two aspects, doing things differently to how their parents would have done it, and they themselves would have previously, plus changes in thinking.

Jackie wants to do things differently and better than her parents.

> “Hopefully I can get it better than my parents did and no doubt Justin when he comes to have his own children will get it better than me and it will continue because everyone wants to do better than their own parents.”

Jane recognized her new approach did not escalate situations in the same was as her past approach.

> “I am able to sort of let that go as well and not try and correct him or punish him or consequences immediately for that, which is what I think I was doing before which I think would just escalate things.”

Maria is also moving away from the traditional parenting approach or reward and punishment that she took in the past.

> “It is just the approach to any given situation as we discussed, we don’t always get it right but it is approaching, we have approached stuff through the feelings and we have used some of the techniques…….it just gives you something else rather than just shouting and like I say, I do feel like I do have that permission, I don’t have to, take away an iPad or you know, I don’t have to put in, you know I don’t have to throw out loads of punishments.”

Both Nina and Simon talked about their changes in thinking and how this leads to different reactions plus parenting in a way that is different to traditional parenting.

Nina

"it made me think in different ways, made me really think about, pressing the pause button and not responding immediately but really standing still and thinking about what I should do, regulate myself and think about how they would feel, before I respond or react, so I think that is really."

Simon

"I think it has been useful, definitely given me ways to think, to think differently about Amanda, about, I think about how I approach, and how we come up against some of the behaviours and how they might, what where they might come from and how best to try and, address them and meet them rather than, yeah cause I think beforehand we were quite, you know traditional trying to meet them head on which doesn't work which, so it is the thinking of better ways to approach it."

For Vanessa her changed thinking and mindset around behaviours has changed her emotional reaction to incidents.

"think it is the reminder that… they are doing these things for a fear, coming from a fear response.. so… knowing that… so when (incident happened) my first thought wasn't oh you naughty boy why, have you done that? It was he is scared about something and then when you get time to reflect you realise well actually… first day back at school he has not seen me all day, we have gone and done something outside then we have come back here, and I have gone straight into the kitchen… and he is scared I have forgotten him… It makes

more sense, so it means that the emotional responses that I have to it… are different… because I am coming from completely a different mindset."

Here Vanessa is concentrating on her cognitive process around what may be her son's affective process, she recognizes that her cognition also affects her emotions then her behaviour. As talked about in the introduction the mixture of cognitive and affective information has helped her to regulate.

Positive Change: 'Our bond is definitely getting stronger.'

The changes in thinking and parental behaviour have brought about positive change to the quality of relationship that these parents perceive they have with their children. For Anne and Laura, it meant a stronger relationship with their children.

Anne

"I think the relationships got stronger, …. I am doing more for myself, I am taking more time out so I think that helps because I feel less tired.. I don't, flare, I don't feel myself flare quite so much as I was going to, so I think my patience has increased. So, generally overall I think it has all benefitted towards, towards the relationship."

Laura

"particularly with Annabel it feels stronger than it was.. umm.. I think Todd and I already had quite a solid….. umm.. connection but I think Annabel and I… our bond is definitely getting stronger."

Both Jane and Maria felt the changes had resulted in a calmer household.

Jane

> “It has probably helped him to be a bit calmer and to understand his emotions a bit better because I am naming them more for him and I think things are just calmer here so, yeah, I think it has had a positive impact.”

Maria believes that it is not just her that is recognizing positive changes, but her children are also noticing.

> Maria
>
> “I think, they, I think they have responded to, the different techniques that I have used so, and they have recognized, they have recognized that I am not so shouty, umm and I think they genuinely recognize that we are trying our best umm, and so I think it has had an effect on their behaviour definitely. Umm, they definitely, it is definitely a calmer house, generally.”

Jane recognizes that she already had quite a lot of theoretical knowledge, but the course gave her more confidence in the outworking of this and it has brought them closer together.

> “I think it has had a really positive impact on my relationship with Mark, because it’s, although I knew some of the techniques in theory about PACE and Bryan Post, umm, it’s really cemented for me umm, how to deal with Mark’s anxiety and how to see it thought his eyes a little bit better umm, and that’s only that’s just been a positive all the way through. I feel more confident in what I am doing and that it is right for us. Umm, and that’s just meant that I think we have got closer because I think he feels that I understand him a bit better.”

Lesley also was feeling closer to her girls.

> "I think probably it has, I think it's, I think some of the things we have been doing, over the last few months, has made me feel closer to them, and especially closer to Emily, who I felt like sometimes, sometimes I felt like she wanted to keep me at arm's length."

In their research into prevention-focused parenting education programs Benzies and colleagues (2023) noted changes in both the parents' relationship with themselves as parents but also their relationship with their children. They found that the changes in relationship with their children was particularly facilitated by increasing their understanding of the child's perspective, improvements in communication and changes in their parenting behaviours. These quotes within this last sub theme it would seem that this study also upholds these findings.

Journeying together

Meeting with people who have a similar experience, especially those who share a stigmatized or negative experience can help improve well-being and reduce feelings of isolation (Kearns et al., 2017; Bradshaw and Muldoon, 2020) and peer support is well documented within the areas of mental health and addiction (o'Hagan, 2011; Tracey & Wallace, 2016). Dennis (2003) describes peer support as "*the provision of emotional, appraisal, and informational assistance by a created social network member who possesses experiential knowledge of a specific behaviour or stressor and similar characteristics as the target population."* Within this study strong themes of both being in a group with others who have similar experiences and with a facilitator who also has lived experience of adoption were prevalent.

Opportunities to talk: ‘Shared experience with the group.’

Talking through situation with people who had similar experiences was seen as a key part of the group. The course was deliberately designed to have multiple times in every session for the participants to talk as a group and share thoughts, feelings, and experiences. It seemed like the shared experience enabled people to be open about their situation. When asked what was particularly helpful on the feedback form, multiple responses mentioned the opportunity to talk, for some this seemed to be almost more important than the course materials.

> Anonymous
>
> “Although a lot of the material has been covered in previous courses it really helped to have the opportunity to talk through our situation and share strategies.”

For some they wanted this to be ongoing after the completion of the course

> Anonymous
>
> “Very useful to go over different strategies and time to practice/reflect on them over the week and discuss the next session. Would be good to this have ongoing support.”

Adoptive parents attending the course often talked about the loneliness and isolation of their situation. Literature has highlighted the value of peer support in a range of situations to reduce loneliness and isolation (Lai et al., 2020; Theurer et al., 2021; Zeng & McNamara, 2021) and here the feedback forms show how positive participants found being able to talk with peers.

> Anonymous

> “Shared experience with the group and talking over situations with parents in the same place as us was extremely helpful.”

Similar situation: ‘New friends made.’

Closely linked to the previous subtheme, this theme of ‘similar situation’ builds on the perceived benefits of meeting with others who are on a similar journey and probably understand what the participants are going through. Adoptive parents who are struggling with aggression and violence from their children reported often receiving a poor response from support services and being made to feel that they had failed as parents (Selwyn & Meakings, 2016), and that these factors act as barriers to seeking support. Here we see the participants find acceptance and strength in being in a room full of others with similar experiences.

Jackie

> “to be in a room of other people that umm, all having the same problem and nobody is saying oh that’s because you are the worst mum ever and you know you feel that anyway, you don’t need anybody else to tell you that, that’s the way you feel regardless umm, even though you know you are doing your best, you still feel like the worst mum ever, but you are just in a room of people that all feel that way anyway, they are all the worst mum’s ever and they are not, none of us are.”

Nadine

> “I think that was amazingly good, that and the fact that the others in the group because we were all living it and nobody else gets it, nobody, none of your friends get it, even people that you are really close to don’t, don’t see the

> constant grind of it all, so they don't see the, flares because you stop it happening when your people are there so it was nice to just be able to go”

Within this subtheme there are hints at the loneliness and isolation that some of the parents feel, and as we see from Nadine’s comments here some feel that they have to hide the situation they are in from the family and friends for fear of them not understanding. This anonymous comment from the feedback forms puts it more explicitly.

> Anonymous
>
> “Honesty amongst everyone which has helped the not alone feeling and hints and tips they give from real life experience.”

Other comments from feedback forms echoed the importance of being with people in similar situations.

Anonymous answers to the question “What did you find helpful?”

> “Meeting people in similar situations – new friendships made.”
>
> “Sharing experiences with other parents going through the same difficulties.”
>
> “Coping strategies, networking with other parents in similar situations and have a better understanding of the possible reasons behind the child’s behaviours.”

Lived experience of facilitator: ‘training from someone who has lived it!’

The final subtheme of ‘Journeying together’ centres on the participants experience of having training facilitated by a professional who was also an adoptive parent. This is a key component of the KMKY course, that at least one of the course facilitators should have experience either as an adoptive parent or as a foster carer.

Jackie

> “It has been enlightening to not only, you know, go on other courses and you see other adopters and sometimes you see adopters that have got it worse than you and sometimes you see adopters that think they have got it better than you but they have only been in it for 3 months, but what you never see is a trainer that gets it, umm, that has been there and done that, so that has been quite refreshing to have a trainer that actually kind of gets it and has been there and has done it and got the t-shirt quite literally!”

For Eddie it didn’t seem to matter that the experience was not exactly the same, it was that the facilitator had actually lived it.

Eddie

> “I mean obviously it has been beneficial overall because of those bits of information that we are getting that we hadn’t thought about before, all of the real-world experience that you have had and passed on.. to us, for situations that you have been in, whether they have been similar to us or not..”

And later on it seems that the facilitator being further on in the journey also brought hope.

> “Just to say thank you for the insight that you (the course facilitator) have brought to this course and the real-world experience that obviously being in your situation you’ve been there and been through a lot of the battles that Vanessa and I are maybe just starting to go through, but to know that someone’s.. come out the other end.”

Comments on the feedback forms also echoed these sentiments.

> “(The course facilitator) having lived through the problems we are living through was very helpful.”
>
> “Loved being with a trainer/tutor who has lived the life as well as knows the theory.”
>
> “Great to have training from someone who has lived it!”

It seems that the lived experience of the trainer helped the participants to take on board the theory and ideas from the course, it seemed to add validation.

> Nadine
>
> “It is has helped hugely because you gave us practical things to do, umm, a lot of things that you read or people that you talk to and you have got lived experience too.”

As already mentioned in the introduction, for therapy or therapeutic interventions to work it is important to establish a therapeutic alliance or relationship. Fonagy and Bateman (2006) also emphasized the importance of activating the attachment system within their therapeutic work, and later went on to develop the theory of epistemic trust. Sperber and colleagues (2010) put forward the idea that human beings all have automatic epistemic vigilance as it is necessary for human survival to filter information and not believe everything to be true or trustworthy. From these ideas Fonagy and Allison (2014) developed the ideas of epistemic trust, that it is necessary that this trust is established for a person to be open to new ideas and internalize new knowledge. This idea of epistemic trust is very important in the area of attachment theory and trauma as many children who have been through adverse experience struggle to trust the adults around them and therefore trust the information they are receiving, both affectively and cognitively. While relevant to the

field of attachment studies and mental health it would seem that this is also applicable to these course participants, perhaps the lived experience of the course facilitators helped to build this epistemic trust and therefore they were more open to the ideas, cognitive, affective and reflective learning.

Feelings and Emotions

Mentalizing is both affective and cognitive, it is the ability to understand oneself as having a multiplex of internal thoughts, feelings and motivations and added to this that others also have their own differing weave of these (Fonagy, et al. 2018). Just as the theme of Journey of Change was unsurprising, perhaps also themes around feelings and emotions could be predicted when the intervention was specifically designed to impact and enhance mentalizing capacity!

Being more open with feelings: 'it is okay no matter what you feel.'

While many post adoption courses focus on what the child may be feeling, the KMKY program starts with the parent, encouraging them to be open with themselves and others about what they are feeling, and this in turn creates and atmosphere where the child's feelings can also be talked about.

Anne

> "Being more open about my feelings, whether that be with Ella, with Richard, with you know just being more open about how I feel, and what is going on, and letting Ella know that it is okay no matter what you feel, it's not, it's not, you can't feel it, we have just all got to learn to deal with it in different ways and even more of the repair than I did before if I do something like shout or something."

For Vanessa, expressing feelings and exploring them has made her feel stronger.

> "So, I think we are much stronger than we were before, we have put in a few little tweaks here and there of.. narrating our inner world, or making sure we use a lot more… I'm wondering but taking it a little step further than we were before.. umm…. Going into the feelings… so it has been really helpful, really helpful."

Labelling feelings and emotions is known to calm both the emotions plus calm the amygdala response to difficult situations (Lieberman et al, 2007; Torre & Lieberman, 2018). Vanessa's feeling of being stronger is perhaps because, using this technique, both she and her children are being overwhelmed less easily.

Being open with feelings has made a dramatic difference for Jane and her son Mark.

> "I think it's, with the confrontation, when you get into situations where you are in a confrontation situation with Mark …I am really taking a step back now, and doing the whole umm, yeah just saying to him "Gosh, you are angry" you know not "Why are you angry?" like I used to be like "What's gone wrong, and why are you doing that? Why don't you just.. you know." It has just given me a different approach and more confidence in that approach to just empathize with him and it just de-escalates the confrontation, I haven't had any physical aggression from him at all, I get verbal but that is as far as it goes now."

Different emotional atmosphere: 'things have been really quite cool, between us all!'

This subtheme is very closely related to the earlier one of positive change, as we saw both Jane and Maria felt their household was a lot calmer. John also saw changes in his household.

> John

> “It has definitely, seen an improvement, the way the girls are generally I think they are more relaxed…. I would say since we have been doing the course, it’s, things have been really quite cool, between us all!”

Bethany and Vanessa feel that their more consistent approach has had an effect on their children’s sense of security.

Bethany

> “I think it’s, meant that they have not been living in this sort of erratic, spiky life that they have been having to live in because they don't know what response they are going to get.”

Vanessa

> “I think they feel more secure, I think we are putting in a lot more umm… boundaries, that is not to say we are becoming stricter, but I think we are.. becoming better at… saying where our limit is and not just letting them…. not run away with things but I think we were in a bit of a no, no, no.. yes, kind of mentality and I think we are becoming more no, we have said no, that’s, that is it. It is my job to set the rules it is your job to have the feelings about it, you know, you can feel what you feel but… it is a no.. Umm.. and I think they feel safer with that approach.”

For Maria there has been a change in stress levels due to their changing approach resulting in feeling more relaxed.

Maria

> “I think it’s, we have been a lot more relaxed, I think that the children, well I know that the children have noticed some of the changes because they have

commented on it, so I think in the main life is much happier I really do, umm, I think, having some of the techniques and actually felt like I have been given permission that I don't have to discipline over everything umm, it is just taken away some of that stress, umm, so, yeah, other than the odd blip, I think things are much better."

More positive emotional atmosphere is known to be beneficial to children, particularly in their teen years. In their study of parent- adolescent communication and adolescent psychosocial functioning, Kapetanovic & Skoog (2020) found that parenting strategies had more beneficial effect when the family's emotional atmosphere or climate was positive, also that this positive atmosphere facilitated more open emotional communication from the young people, showing that relational situation was a protective factor.

Feeling hopeful: 'I think I had that fear of the future massively more than I do now.'

The positive changes that participants were beginning to see, being more open and aware of both theirs and their children's feelings plus changes in the emotional atmosphere of the family seemed to combine into this last subtheme of the feeling and emotions section. The participants were cautiously hopeful for the future.

Jackie

"I feel positive about it, umm, obviously time will tell. Umm, but it's umm, it's actually, it has been enlightening …… hopefully you know give us another 6 months, will really be reaping the benefits umm, yeah, looking forward to it."

Maria

> “Oh, I feel, I honestly feel lighter for it if that makes sense, I just feel like it is a bit of a weight taken off, a bit of a pressure taken off umm, yeah, I do, I feel much lighter.”

Vanessa who attended the course with her partner Eddie felt that what they had learnt and gained from the program had potential to be life changing.

> “Thankful, grateful, happy…. (laughs) like… they are going to be life changing, they are going to change all of our lives and.. you know it already has, it has already started… Ed’s had 4 nights of.. decent bedtime.. umm.. you know it is all…. Coming, coming together.”

Lesley voiced that her fear for what the future may bring had diminished.

> “Positive, really positive, I feel, like it’s, yeah I feel like it is okay not to bother with a lot of things that previously I was thinking oh I should do something about this, what if, what if, I think I had that fear of the future massively more than I do now.”

Reflection

The final theme, similar to the last theme links in with mentalization. As mentioned in an earlier chapter Zeegars and colleagues (2017) report that there are 3 key concepts and measurements within parental mentalizing; parental mind-mindedness (Meins, 1997), parental insightfulness (Oppenheim & Koren-Karie, 2002), and parental reflective functioning (Slade et al., 2005). Throughout the course the participants spent time thinking and reflecting about themselves, their behaviours as well as about their children. This shows through in their feedback responses.

Think and reflect: ‘a chance to step back a bit and look.’

This sub theme is closely linked to the earlier on of ‘Doing it differently, thinking differently’, we saw that both Vanessa and Simon were taking more time to think and reflect, and this enabled them to react differently to how they would have in the past. One of the ideas within the course was to ‘press the pause button’ to take a moment in any situation to think and reflect rather than simply react, this idea seemed to hit home with the participants.

Jackie

“I, certainly hit the pause button a lot more frequently, umm, and umm, that’s kind of my go to for everything at the moment, hit the pause button… give myself a moment to think.”

Nina

“I think I am standing still more and thinking and regulating myself, in that moment.”

This thinking and reflecting meant that John then reacted in a different way to in the past.

“Yeah just, just taking, just umm, reflecting and taking time out, where as before, it was you know, one of the kids would be playing up rather than just stamping all over it and jumping all over it saying don’t do that sort of stuff, … it is actually made us.. take time out a little bit, and think about, let them have the blow out really, rather than stop the blow out right there and then, let them have the blow out and then say right, take stock of it, calm down a little bit and then use the methods to talk to them, …that’s the most important thing, just don’t jump to it straight away and then approach it in a different way, it is just

so much easier because then, we are not stressed then…., makes you take stock of it a little bit, makes you, think a bit more, and ask the questions and then it works."

Laura uses the time to reflect and try and think of things from her child's perspective rather than just her own and this has improved the relationship with her child.

Laura

"I suppose in terms of managing his behaviour, kind of, trying to reflect and think of things more from his perspective….

okay.. can you tell me a little bit about how you think this might have affected your relationship with David?

Umm.. I think it has improved it, umm…given me a chance to step back a bit and look."

Taking time to reflect on what had changed within her relationship seems to have echoed what Laura had learnt during the program. Within their work on systemic therapy and attachment narratives, Dallos and Vetere (2022) note the importance of reflection as part of the consolidation process at the end of therapy.

Growing Understanding and awareness: 'An awareness that seems to be forming.'

Linking back to the theme of gradual change process, participants talked about their growing awareness as they applied the ideas and approaches from the program to everyday life. Lesley seems to believe that the growing awareness and understanding is impacting how she feels about the children, how she reacts to them and that seems to have made things easier in the home.

Lesley

> “I think, I’m, a lot more aware of the fact that their behaviour is very rarely a choice that they are making, and I think before, before I started the course I was, probably interrogating their behaviour in my own head thinking what, you know ‘Why is she doing this, why?’ as if it was a conscious thing and now I get a lot more that it isn’t a conscious thing and that they can’t give me a reason for why they are doing it and even if we sat down the day later and we tried to talk about it, they can’t give me the reason … and actually a lot of the time the root cause of things is going to be just their trauma… actually just an awareness that seems to be forming, my ability to let things go, just let, just, not sweat the small stuff more. That… that has made home life easier…and the awareness of the girls umm, what is going on in their heads has changed yeah, which has helped us all I think.”

Sereana reflected that the growing understanding helped her make sense of past experiences of parenting her children.

> “Yeah, it is good, it kind of does make you understand more about umm, what we were doing before, why it hadn’t worked, umm, I wish we had, had it earlier because I think, a lot of the stuff that we tried, we should have never bothered to try, because it was never going to work.”

Lizzie

> “I am grateful that we were able to learn so much really and I guess it is more understanding and I do feel that I feel, I feel a bit stronger most of the time umm.. and that I have more understanding of them, more insight into them and their behaviours”.

Eddie considered that his increased understanding would help them more forward.

> “Understanding about their early life trauma as well, how.. their behaviours fit in with.. with observations from professionals umm.. it should help me deal with the tough times a bit better.”

For Anne it was not just her growing understanding, but she felt that the change in the way they were dealing with Ella’s struggling times was changing Ella’s own understanding.

> “So actually, by letting her work through it to the end, I think it is making her a little bit more aware of perhaps how she was feeling in the first place.”

Growing confidence: ‘a different approach and more confidence.’

Within the subtheme of ‘positive change’, we saw that the course had already helped Jane to feel more confident, this was a sentiment that was repeated again and again by participants.

Anne

> “(I) feel more confident in what I am doing, I don’t worry quite so much. I’m certainly a lot more honest with other people about what our life is actually like, whether they believe it or not, rather than trying to pretend that life is, is rosy.”

Bethany

> “I think it has made me, it’s given me confidence, it has made me realize that we can do it and that we have to do it together.”

Bethany goes on to reason that the changes in the way they are parenting and responding to the children is giving her children more confidence in her as a safe parent.

> “I think it’s, given them more confidence in me, I think that, particularly with Jake, where he has seen me not, react, and wobble and be afraid of him, so much then, that gives him more confidence in me being his parent because I am a bit more a safe base for him than someone that is going to fall apart every time he takes, feels like there is that control.”

Benzies and colleagues (2023) saw that as parents gained in confidence in their ability to parent their children, there was a change of attitude about their role and a belief that things could improve, and that they could improve their skills. They also found that confidence was a key component to change in a number of areas as well as the parents reflective functioning.

Conclusion

This study using reflexive thematic analysis of course feedback is an in-depth exploration of participants experience of the Knowing Me, Knowing You program. The aim was to explore the possible benefits of the course and how the participants experienced both the course and any change that the course facilitated.

It seems from the themes generated that the participants had a positive experience of the course and benefits within their family, thought they were under no illusion that it was an easy process with both the course content being emotive and change having to be constantly worked on. The theme of ‘Journey of change’ showed they saw this as a gradual change with successes and regressions. Participants recognised that if dynamics were to change in their families it needed to start with

them and acknowledged that as well as noticing improvements that their hard work brought, at times their children were noticing this too. They also acknowledged the challenge of changing ingrained patterns, but that this resulted in closer and improved relationships.

One of the key findings of this study is around the area of Epistemic Trust and the second theme of ‘Journeying Together’ really highlighted this. This theme showed that participants particularly appreciated the peer support aspects of the course, commenting on the benefits of having space to spend time and talk with other parents in similar situations without feeling a need to put hide their issues. These parents also really appreciated the experience and highlighted that wanted new friendships were added to their social network. Of particular note was that having a facilitator who not only had professional knowledge but also had lived experience of being an adoptive parent was seen as unusual and highly beneficial and plus this seemingly helped to build trust in the theory and techniques that were talked about. This is an area that future interventions would do well to consider. Men are often underrepresented within adoption research, adoption intervention plus professions that support adoptive parents, further support of adoptive fathers could be the inclusion of an adoptive father as co-facilitator of courses such as the KMKY program.

The third theme of ‘Feelings and Emotions’ showed that as the participants began to be more exploratory and open with their own feelings, they were able to support their children to exploring their feelings, and they found that approaching behaviours from a feeling’s perspective, plus understanding what may be driving behaviour, actively deescalated situations and reduced the need for punitive methods. They reported positive changes in relationships and emotional atmosphere of the family, and that

they had new hope that their situation was not as negative as they had previously thought.

The final theme of ‘Reflection’ showed that participants felt taking time to think and reflect rather than simply reacting brought new understanding and insight and a gain in confidence in their ability to parent their child. This seems to replicate the findings of other studies that showed that reflective functioning is an important component of responsive parenting.

Findings from this study support those of earlier studies the use and benefits of peer support groups and facilitators with lived experience in reducing loneliness and isolation (Kearns et al., 2017; Bradshaw and Muldoon, 2020), plus raises interesting questions about lived experience being used to support epistemic trust. This study also highlights the positive effects of attending the course itself for this particular group of adoptive parents.

Strengths and Limitations

This study holds strengths in the depth and richness of data that has been explored by the flexible approach of reflexive thematic analysis. It gives important insight into the process of change and experience of adoptive parents attending a group-based intervention address in childhood violence and aggression. However, this study is limited in that feedback was only received from participants who completed the course and consented to data being used for research, therefore the experience of participants who did not finish the course or consent to research are not captured within the study, their experience may have been very different, and this could have contributed to not finishing the course. The interviews were also conducted by one of

the course facilitators and this may have limited participants' feelings of freedom to give more negative feedback.

Chapter 11: An Interpretive Phenomenological Analysis of Adoptive Fathers

(N.B. A version of this study has been published in the Journal of Human Systems: Therapy, culture and Attachments entitled '"I am not exaggerating, literally a monster … a Jekyll and Hyde type thing": Understanding the lived experience of adoptive fathers whose children display violence and aggression' by Victoria Barrow, Ben Grey and Cecilia Essau.)

Introduction

Caregiving and parenting research, particularly regarding adoptive parenting, has focussed primarily on mother-child relationships, leaving the role of father in adoption largely invisible and often forgotten (Siegel, 2014; George and Solomon, 2008). Most children, whether adoptive, step, birth or foster children live within a family, a complex system of different individuals, behavioural exchanges and habitual patterns of interaction between members. It is within this complex context that both desirable and problematic behaviours occur (Johnson and Ray 2016). Infant and child behaviour is adaptive to caregiving environments, with each child organising their own protective attachment response to maximise the nurture they receive from the complex network of social relationships in which they are situated (Crittenden and Dallos 2009). A number of studies have identified social, cognitive, and emotional outcomes of father-child relationships (Cabrera 2020, Lewis & Lamb 2003, Pleck 2012). While the role that fathers take within child rearing may have changed as societal norms changed across the years, interestingly, as far back as 1964, when looking at separation distress, Shaffer and Emmerson noted that while 80% of babies saw their mother as their principal attachment figure, this was reduced to 50% by the age of 18 months, though as Grey (2014) points out this was before the development and understanding of different attachment patterns theory. Crittenden

and Dallos (2009) call for the understanding of the whole system of attachment relationships again emphasising that behaviour is adaptive to situation.

Currently, few UK adoptions are infants or voluntary relinquishment; most adopted children emerge from the care system having experienced abuse, trauma, loss and multiple placements. Their behaviour will have developed in response to this early experience, but once placed within adoptive families, the child will begin to adapt to the new caregiving environment and relationships existing therein (Crittenden, 2015). The neglect of fathers in research into the relationships of adopted children, is a neglect of the context in which all the adopted child's relationships are formed.

Reflective functioning

Reflective functioning (RF) is the ability to reflect on and think about your own internal world, thoughts, and feelings, also to consider the internal world of others understanding that it is separate from your own (Fonagy et al. 1991b). Reflective functioning in parents is understood to be salient to successfully navigating the challenges of parenting (Benbassat & Priel, 2015). High RF allows self-awareness while accepting that others are psychologically distinct, it is both cognitive and imaginative, enabling regulation and understanding experience of both self and others (Slade, 2005). Evidence shows that children of parents willing to explore and talk about both their and their child's emotions are better able to understand their own and other's minds (Liable & Thompson, 2002; Ruffman et al, 2002). Parental RF also has a role in mediating parenting stress (Nijssens et al, 2018).

Adopted children often display problematic externalising behaviour and regulatory problems (Elias, 2019). A link has been found between regulatory problems, externalising behaviours, anxiety disorders and low parental RF (Camoirano, 2017;

Zeegers et al. 2018;). Further to this, higher RF among parents increases sensitivity towards a child's emotional needs and ability to help children cope with their feelings without overwhelm (Walker, 2008; Zeegers et al. 2018).

Fonagy et al. (1991b) linked a child's attachment security with fathers' RF. Buttitta et al (2019) identified father's reflective functioning (RF) as central to emotional regulation of their children. They found direct association between father's RF and social emotive supportive behaviours, which also moderated links between autonomy supportive behaviours and low income. Some studies found fathers reflective functioning scores were lower than mothers (Esbjorn et al., 2013) also empathy and 'theory of mind' ratings appear to be lower in men (Eisenberg & Lennon, 1983). Nevertheless, adopter's RF was found to be higher than in general population (Leon et al, 2018).

Aggression and Caregiving

The presence of aggression during childhood, and its management, is related to problems within the individual and relationships, causing long-term consequences (Estevez et al, 2014; Reef, et al., 2011). Studies suggest the mix of genetic make-up, and environment, impact the propensity to aggressive behaviour (Simons et al, 2011). The developing child's environment is largely impacted by parent-child relationships and the parenting style, with positive relationships a buffer against adversity (Hazel et al 2014). Linking attachment to aggression and violence, Savage (2014) found a persistent correlation with attachment insecurity and aggression. Roskam and Stievenart (2014) found that the pathways to maladjusted behaviour was the same in both adopted and non-adopted adolescents. However, increased levels of externalising behaviour were displayed by adopted children, which links

back to the higher prevalence in externalising behaviours among adopted young people mentioned above.

Kawabatta et al (2011) found both positive and negative parenting behaviours are linked to aggression from children. Specifically, father's psychologically controlling parenting was related to increased levels of aggression and that positive parenting was related to lower levels. Grey and Farnfield suggest that controlling parents see the child's separateness as a threat, something that can become particularly acute in adoptive parent-child relationships because of the child's biological relation to birth parents that are often considered to be dangerous (Farnfield, 2019; Grey & Farnfield, 2017a). These parents may attempt control their child to neutralise the potential for the child to hurt them and may feel they are protecting the child from the consequences of their own behaviour. Crittenden (2007) links controlling caregiving with either overly-compliant or 'difficult' babies, as the child must either fight the parent or internalise the parents' control (Grey & Farnfield, 2017a).

Glover et al. (2010) found little or no difference between adoptive and biological parents' self-reported warmth and negativity towards the child dependent on the child's adoptive or non-adoptive status, or their gender. However, they found significant correlation between the parent's negativity and appearance of child's externalising behaviour. These combined findings highlight the impact of parental environment on the adopted child's display of externalising and or aggressive behaviour, that it is not just caused by the child's pre-adoptive experience and trauma.

Research Questions

There is a paucity of literature focusing on adoptive fathers' relationships, and the research on the caregiving of fathers generally, tends to take a quantitative approach that excludes exploration of systemic complexity in family relationships, as well as the interpersonal meaning that fathers have given to their experiences. As a result, we wanted to understand the experience of adoptive fathers, particularly those whose children display aggression and violence within the framework of attachment and reflective functioning. Specifically, we asked:

1) How do adoptive fathers understand their relationship with their adoptive child in the context of violence and aggression?
2) What sense do these fathers make of their child's aggression and violence?
3) What implications for the family system are there of the way in which the adoptive fathers experience their relationship with their adoptive child?

Methodology

Study design and methodology

This study utilises data taken from a larger ongoing investigation into parental sensitivity and Reflective Functioning changes around an intervention specifically designed for adopters with children who exhibit aggression and violence.

This study uses a qualitative, attachment-informed, interpretive phenomenological analysis (IPA: Smith et al., 2009) to explore the lived experience of adoptive fathers of these children, and its interpersonal implications. (This study used IPA as described by Smith and Colleagues (2009) rather than the more recent version proposed by Smith, Flowers and Larking, 2021). 6 fathers were interviewed using the Parent Development Interview (PDI: Aber et al., 1985) that was developed to help

understand the parent's representation of child, the parent-child relationship, and their own experience of being parented. The discourse within the interview transcripts was analysed using the frameworks of both the Parent Development Interview Reflective Functioning Scale (PDI-RF: Slade et al., 2005) and the Meaning of the Child analysis (MotC: Grey and Farnfield, 2017a, 2017b) followed by Interpretive Phenomenological Analysis.

The Reflective Functioning (RF) scale was developed by Fonagy and colleagues (1998) for adults talking about their own childhood relationships but did not take into account relationships with children, it was then later adapted by Slade et al. (2005) for the PDI. Originally used with mothers, the PDI-RF changed the focus to the parental understanding of the child and the parent-child relationship, giving attention to how and whether the parent constructs the child as a separate experiencing self.

The Meaning of the Child (MotC: Grey & Farnfield, 2017a, 2017b) uses attachment theory-informed discourse analysis to understand the psychological meaning a child has to their parent, and its implications for the parent-child relationship. It is suggested that the adult's need protection and comfort, and their perceptions of danger in their current context, transforms the meaning given to their relationships with their children and parenting. That is, their own past experiences of relational danger inform what is attended to in the present, and what is disregarded, transforming the experience of the present moment to facilitate self-protection action (Crittenden & Landini, 2011) This self-protective transformation of meaning by the parent shapes their parenting and the parent-child relationship itself, especially when the parent feels threatened (Grey et al., 2021). The MotC analysis of these fathers' parental discourse highlights the relational and self-protective context of the fathers'

experience of their child, and suggests how it may influence how the father interprets the child and his or her experience.

Once analysed using the PDI-RF and MotC, Interpretive Phenomenological Analysis (IPA: Smith et al. 2009) explored the father's subjective experience. Early analysis included familiarisation with transcript through a process or reading and re-reading followed by notating the transcript multiple times; notations and interpretations were collected and sorted into themes, then sorted into subordinate and superordinate themes. This was repeated with each transcript, before comparison and the creation of subordinate themes for the whole sample. Within this study this process was supported by the use of NVivo software.

Smith et al. (2009) suggest that qualitative analysis is a 'double hermeneutic' process: the participant attempting to make sense of their world while the researcher attempts to make sense of the participants' process of interpretation. In using an attachment-informed IPA, this study is not trying to replace the participants' interpretation with an external theory-driven one. Rather, as Rizq and Tagart (2010) suggest, when using IPA alongside the mentalizing and adult attachment analysis, the attachment-theory informed analysis offers a third or 'triple' hermeneutic, from which to make sense of the participants' experience, drawing out possible relational and self-protective aspects of the meaning-making studied. The interview context is itself a social encounter rather than offering direct access to participants' experience, and the inclusion of attachment analysis as a 'third voice' gives this explicit attention in the analytic process. The attachment analysis was therefore brought into the overall IPA at the stage of critical engagement with the text of each interview, and the drawing together themes for each transcript and the group as a whole.

Participants

Interview transcripts from the first 6 fathers interviewed and giving research consent were used. Ages ranged for 39 to 50, all were married and had up to 3 adopted children. Children's ages at time of interview ranged from 6 to 10 years and placement age ranged from 4.5 months to 3 years. All but 2 children were female. The focus on six fathers allows for comparison across the group without losing the ideographic focus that is central to IPA, a particular threat given the complexity of the analytic process employed.

Ethics

Full ethical approval was gained from the University of Roehampton. Data protection procedures were followed, with names and personal details changed to maintain anonymity.

Peer review

Each interview was analysed with PDI-RF and MotC by the first author, a certified reliable coder, then a selection of transcripts were sent to reliable coders blind to the study to incorporate perspectives not influenced by the concerns of the study or the relationships developed within it. Analysis from these coders was incorporated into the findings in keeping with the study's qualitative methodology. The overall analysis was considered by all authors of the study and integrated into the final presentation.

Analysis and discussion

Analysis of transcripts identified 4 superordinate themes each with several subordinate themes, which are outlined in Table 23 below. The superordinate themes were: The problem is in the child; confusion and comparisons; the mixed blessing of feeling like a father; looking back.

Table 23

Table of Themes

Superordinate Themes			
The problem is in the child: 'Whatever you say doesn't seem to make a difference'	**Confusion and comparisons: 'I just don't get it'**	**The mixed blessing of feeling like a father: I don't think I was ever as angry before I had children**	**Looking Back: 'it's the nature/nurture thing'**
Subordinate themes			
My child is unreasonable	I just don't understand	Feeling angry and frustrated	They had a difficult early start
Child as persecutor	Compared to normal	Genuine fondness and joy in having their fathering role validated	Trauma and echoes from own childhood

Jekyll and Hyde flip	Trying to be different from own parents

Theme 1 - The problem is in the child: 'Whatever you say doesn't seem to make a difference'.

Throughout the transcripts most of the participants located the problem was firmly within the child.

My child is unreasonable: 'Are we going to be doing this forever?'

Participants had multiple examples of children's behaviour they considered unreasonable, often seeming at pains to communicate just how alien their child's behaviour was to them:

John

"she was unbelievable, as soon as we come in through the door and she would… you know, we would say 'We have got to go in babes, it's late, we are going to go upstairs, brush your teeth, we are all going to go to bed' and she just kicked off, no reason at all, and started to do these stupid (noises) all that sort of stuff and we were just trying to get her to brush her teeth and get her clothes on."

Then later on

"so for example they would be playing on the side of the table here and if they are doing like arts and crafts stuff we have got like a matt that we put out and

> umm she knows that and she knows that if she if going to play that sort of stuff then it all needs to be protected……..(she) can be quite selfish at times and as long as she is doing what she wants she will just go ahead and do it"

Simon

> "We have been through this, explained this, we have said this is what is going to happen, I have asked you not to do that, you are still doing it ... are we going to get beyond this, or are we going to be doing this forever?"

'Meltdowns' were experienced as almost incomprehensible in their frame of reference, with no identifiable triggers. Simon seems desperate, feeling they're caught in a loop with no sign of change.

Richard

> "It's just the, we have the meltdowns, and sometimes there is no, couldn't tell you what her trigger… general sort of, disobedience, you know, even though we will warn and say, right you know another 2 minutes in the bath and you're set a timer, so in two minutes it goes de,de,de, and then we would get, 'can I have another minute', 'no problem', and then you to get out, you get the meltdowns and not triggers, and just the, I say, unwillingness to do the, (sighs) very, very basic requests, it is not like it is something difficult."

> "Despite warning, warning, warning, warning, World War 3 when we take it away"

Interestingly, although Richard says he doesn't understand, he does look to himself occasionally and wonders about his actions, if there is something else he could have

done, failing to find a helpful answer as to what could be done differently to help his daughter. However, Richard experiences his daughter is mechanically, 'from the outside' without an internal perspective, motivation or rationality; '*triggers*', *'meltdowns*', *'unwillingness to do'*, and '*World War 3'* refer to her observed behaviour, without him being able to see a self, with human feelings, thoughts and logic behind her difficult behaviour. Her behaviour is therefore experienced as an impersonal explosion against which he has no protection, rather than human interaction with someone he loves and with whom he is in relationship.

Callum

"Whatever you say doesn't seem to make any difference, all the distracting things you can think of."

Ben

"The transitional thing when she flips it's really nasty, umm, [pause], and I think that's the time where you know I think I could probably think, I want nothing to do with you now, I am, not getting involved here, but she's still screams, and shouts, and I would say that's probably the worst."

"So even if it is something like, dad can I take this toy in the car and you say no to her, that can be enough just to spark an emotion from her, and how bad it gets depends on how much she wants that toy or that object of that thing."

Participants experienced these incidents as unreasonable and incomprehensible, experiencing little sense of personal agency, it almost just happens to them. Whilst this protected them to some extent from a sense of shame arising from these relationship ruptures, this offered no room to see themselves as parents, in the

sense of offering nurture, protection or containment. In these moments of threat, they do not experience themselves as relating to a person.

Child as persecutor: 'She is playing games with us'

The lack of agency these fathers experienced went further in that they frequently saw themselves as victims of their children:

John

"I can't help but feel like she is playing games with us, or something."

"I just feel like you know she gets in in her mind that she doesn't want to do something she literally stands her ground and kicks off about it, and it could be the most simplest thing."

"The girls bickering and they just, it just, they just go on, its like a, its like Japanese water torture, it never stops."

Richard

"I will walk into the room and just get growled at, for, just literally, just get, growled at!"

"It's difficult to cope with and difficult to deal with because well, what was the trigger I have done? I don't, I've not consciously done anything wrong, but you know all of a sudden, 'Daddy, don't like you!"

Again, though seemingly feeling the victim of his child, Richard is searching, wondering if there is something that he has done to trigger his child, but fails once again in finding answers. He talks as if he is trying to placate a tyrant, trying to work out whether he is doing the right or wrong thing, trying to fathom the impersonal rules he has to follow, rather than feeling as able to help or manage his child as a parent.

Simon

“I think it’s the obsessing, the obsessing over the minutest of things, sort of which means we have to, we’ve got ourselves into sort of a set of, life pattern, pattern of life I guess which means that we can’t be spontaneous, or we can’t be, we have to manage our time quite, we seem to be putting ourselves through torture!”

Callum

“He abuses tablets, so we are deliberately trying to be like, he will get in the corner of something and start smacking the screen.”

“Interviewer: What do you like the least about A?

Client: Umm.. being attacked by him or him attacking other people. Err…that is particularly dangerous, or even attacking the car, windows, something like that…probably one when we were in the car park and he is on the car roof, kicking the window in, there are other people around and it is dangerous, so, umm that sort of thing”

“Like I said before if he is trying to hit you or attack you and he just won’t give up.”

Ben

“Her shriek, her screaming… when she is in a bad mood, it’s just not pleasant to be around and that’s at times when you just think, ‘Do you know what? I just can’t cope with this, I am just going to take a step away’, but they just keep pushing, pushing.”

Images of torture and violence are woven throughout several transcripts, also the use of violent language. Noticeably with Ben, his daughter shifts from being a 'she' to an impersonal 'they' who just keeps 'pushing, pushing'. Participants seemed to experience desperation and feel trapped by a violent unknowable threat they must accommodate rather than feeling in a relationship with someone they have an influence over. Seeing their child as an impersonal, alien aggressor helped these fathers organise to meet the threat, minimising the pain of being hurt by someone they love. At the same time, it robbed them of being a parent to a child who is 'theirs', whom they can influence and contain by virtue of their relationship with her/him.

'Jekyll and Hyde' flip

At times, participants found their children highly unpredictable and frightening, and used strong language to convey this. They wanted others to understand how hard, perhaps impossible, a job parenting their children is:

John

> "It can be from one minute she can be the most loving, beautiful little angelic thing and then just turn into this monster where she is literally, I and not exaggerating, literally a monster, you think it's like a Jekyll and Hyde type thing, it's unbelievable goes from one thing to the next."

Then about his other daughter

> "She can be a difficult kid too, she is like marmite!"

Some fathers felt misunderstood, they saw something different to the rest of the world but wanted others to know and validate their experience.

John

"A lot of people almost don't see and believe there is this, this other side, they kind of see this wonderful, loving child, and, and , she genuinely is, you know, loving and affectionate like the cuddles and stuff, then the devil is a bit too far, but you, there is just this other side where it is disobedient, meltdown, etc, etc."

The fathers were at pains to articulate two different sides to their children.

John

"Volatile would be a step too (sigh) it, it's a step too harsh but it…, it's, something like that I am trying to think of a more suitable word, the, we are fine, she has snapped, I don't know, what I had done wrong, so is that volatility?"

Harry

"It is normally when she's going to bed… a couple of nights ago, I was sat on the bed next to her, and then, as she was falling asleep, she woke up again and just started kicking me for no reason, and trying to bite me and scratching me."

Callum

"Very energetic, enthusiastic, umm, but flips very quickly from one thing to another (pause) flips very quickly in mood, from this is amazing, to this is, you know, worst thing ever (laughs)."

By splitting the child into 2 opposite, 'Jekyll and Hyde' selves these fathers can find part of their child to love: '*beautiful little angelic thing'*, this '*wonderful, loving child*', projecting the difficult aspects of the relationship on to the '*devil*'. However, in both aspects of this split they have lost the experience being a parent to a child in whom they are in relationship (note for example, the distance in language in John's '*beautiful, little angelic thing'* and Callum's '*this is amazing'* to describe a person). They do not know which child they will face and experience the changes as '*for no reason*', without any sense of their own influence.

Theme 2 - Confusion and comparisons: 'I just don't get it'

By the same token, this meant that the fathers experienced their child as unknowable and outside their control, leaving them helpless in their role as an adoptive parent.

'I just don't understand!'

A sense of confusion permeated the scripts. Some participants particularly stressed their lack of understanding or ability to fit their child's behaviour with their expectations of normal development, or reasonable responses to their own behaviour.

John

"And it's that, it's the fact that she can lose her temper over the most, smallest, trivial things and I'll, I don't know, I just don't get it (laughs), I just don't understand!"

"We didn't know where it has come from it was just bizarre because we had, had such a nice evening."

> “I don’t know, I just, I just don’t get it. I don’t understand! I could understand if… I was really abusive or something like that, and you get that return back.”

Simon

> “Things that they might not like but are you know pretty low level will induce tears and crying and that or shouting and shouting and screaming which I think other, of the same, 6 years olds wouldn’t be doing.”

This confusion led to feelings of disempowerment.

John

> “I don’t know how to deal with it. You know, I wish I was a crystal ball, and I could just see well this is why she is acting like this.”

Richard

> “It’s just helplessness and frustration.”

Compared to a normal family: ‘the simpler thing is to have your own birth children’

The theme of wanting a ‘normal family’ with a ‘normal child’ suggested the participants did not experience their family or child as ‘normal’. Normality seemed something they desired and regretted they did not have.

Richard

> “It obviously looks like a normal family unit, it’s not the hold on your both kind of ginger and your blonde child and you know, she’s really short and both really tall, and it, we look like as sort of a, regular family unit, some people are like ooh, I never would have thought that, and well good.”

Richard became emotionally overwhelmed, crying when mentioning his child looking quite like him and his partner. The repeated ‘it’ adds to his sense of a chasm between that appearance, and his actual experience of family life as anything but ‘*normal*’ or ‘*regular*’.

Callum also articulated the perceived difference to having a birth child and how he feels you can’t parent in a normal way:

> “Well, I guess the simpler thing is to have, your own birth children.”
>
> “If you reacted normally, or as a parent would normally with a child doing that sort of thing, just up the stakes even more and then he would try and turn the pram over or whatever.”

The final ‘or whatever’ emphasises the futility of trying to make sense of, or predict, what his child might do.

Sharing his fellow participants desire for normal family life, **Ben** talked with warmth about good times that he felt were ‘normal’:

> “Just feels like a normal household for once, you think yeah that’s quite pleasant.”
>
> “Seeing them actually play together when we are able to have shopping days, when we go to the shops as a family, or go to the movies when you feel like a normal family there, they are good days and things that make me feel happy I suppose.”

However, even these accounts are tinged with doubt, with qualifying statements like ‘*for once’*, ‘*they are good days’*, and ‘*I suppose*’ emphasising the rarity and showing

his underlying experience of disappointment and loss of the normal family life he had hoped for.

All participants within this IPA study did not have birth children, coming to adoption through infertility, often multiple failed attempts. Infertility is frequently compared to both trauma and loss (Jaffe & Diamond 2011) at times leading to considerable psychological distress (Klock, 1993), as well as confusion about caring for a child who is not genetically your own (Farnfield, 2019). These fathers seem to be not only dealing with challenges of adoptive parenting but possibly unresolved loss of not being able to have biological children.

Theme 3 - The mixed blessing of feeling like a father: 'I don't think I was ever as angry before I had children'

Feeling angry and frustrated: 'I don't like how cross it has made me'

Despite the need to impersonalise the child and push difficulties outside the parent-child relationship, ruptures in their relationship with their children still felt personal to these fathers. Feelings of frustration appeared often, and some participants talked about anger, whilst others shied away, seemingly shamed by it, with their anger apparent in the language and imagery they used.

Simon

> "I don't think I was ever angry ever as, before I had children, now I am about 25% cross all the time (laughs, pause). I don't like how cross it has made me and how cross it makes me about tiny things."

For Simon, parenting has evoked emotions that he was not aware of having before being a parent. He has nowhere to go with his anger and is simply left regretting it.

Richard acknowledged getting angry is not helpful, but struggled to regulate himself in the face of extreme behaviour:

> "All I wanted to do was shout 'enough, stop it!' you know, don't, we don't hit mummy, we don't throw things at mummy, that's not nice."

Callum

> "He can be fine one minute and the next minute umm, you know throwing something across the room, he's quite happily destroy, destroy his toys, things, clothes anything umm, as well as anybody else err, which in a way I suppose (laughs) shows he is not particularly discriminatory."

Callum's sense of the child being outside the realm of human relating is tinged with pain and anger; he destroys '*happily*' and is not '*discriminatory*'. It is not just that his child is outside the range of someone who can be 'seen' and mentalised for, Callum's own pain of not being seen or regarded by his child is apparent in his language.

Ben wished to emphasise that his anger did not originate in him but was created by his children's behaviour. This helps him create distance from his angry feelings and avoid seeing them as interpersonal, which would increase the sense of pain and rejection in his relationships with his daughters:

Ben

> "It's normally triggered by them, so they're normally in a bad mood anyway, and there normally screaming and shouting at us and then we are reacting to that. I don't think there has ever been a time where I have come home in a bad mood and I have just shouted at the girls because I am in a bad mood,

> umm, if that was the case, I would understand that they would just be sad and you know, would be very upset but normally, it is always triggered by the way they behave that creates that, environment."

Ben's anger becomes an '*environment*' created by the girls' behaviour, rather than something that is happening between them in their relationship. Ben protects himself from the pain of experiencing the conflict as a ruptured relationship, but as we have seen loses a sense of himself as a person and parent in the process.

In contrast, **Harry** managed to keep alive a sense of himself as a parent in a relationship with his daughter but pays a heavy cost in terms of self-blame and disappointment.

> "I feel disappointed with me, because I am the adult, and I feel sorry for [child] that I have, got angry with her over, stupid things."

What cannot be projected outwards in anger, is taken onto the self, illustrating the dilemma that drives the way in which the fathers' experienced their children as an impersonal source of violence and aggression; the alternative may be unbearable and make it difficult for them to function as fathers.

Genuine fondness and joy in having their fathering role validated: 'when we are having a nice Daddy-Daughter time, I love it'

At the same time, this residual sense of being a father, although challenged by the sense of the child being something 'other' than a child, also made way for experiences of being rewarded by their children. Several participants spoke of warm moments and seemed to especially to appreciate when their children showed them physical affection.

John

"And she just give you everything, she gives you 100% love, without a shadow of a doubt, she will just come in and she's straight over to you and she will just cuddle you straight away"

Richard

"When we are having a nice Daddy, Daughter time I love it… she will just be nice and in the mornings, cuddle up in bed and it's just, it's, it's bliss, it is really, really, really, nice, when and just seeing her happy and enjoying the things she likes to do, its just that, that, that's nice"

Harry

"Any point during the day, she'll come up and give you a cuddle and say 'my lovely daddy' and, hug you, and hold you or if we have gone out somewhere, all she wants to do is hold your hand and walk along and chat and, umm, happens all the time."

There are explicit links here between receiving affection and feeling a '*lovely daddy'*, this illustrates the importance of these experiences not just as being nice, but of affirming their fatherhood. For some this was found was in seeing the children achieve:

John

"When the girls achieve something, off their own back. I love that! If they come home from school with a certificate because they did this and they did that, that's brilliant, because you think yeah you have really earnt that,"

Simon

> “I think seeing the boys do well, I think yeah both of them have learnt to swim without any sort of floats on, both of them have learnt to ride a bike without any stabilizers.”

Callum

> “Seeing them being able to do things themselves; when he is riding off on his bike for the first time or whatever, painting or [pause] able to climb higher than he could the last time, something like that.”

Ben

> “I think it is just seeing things they are good at, things that they enjoy doing.”

For some fathers, slightly more concrete and externally focussed activities were easier to experience as a confirmation and acknowledgement of their fathering role, and affirmation of the sense of normality they had expected from being a father.

Theme 4 - Looking back: ‘it’s the nature/nurture thing’

Although much of the discussion was caught up with the pain of the present, many of the participants were still able to make relevant connections with the past.

A difficult early start: ‘A lovely kid that’s just been dealt a wrong deal’

Participants found it difficult talking about their child’s early history, sadness was evident as well as some awareness of its effects.

John

> “I think she is just such a lovely kid that’s just been dealt a wrong deal personally”

> "I think she carries, the not knowing of, I think for her, the not knowing who her family is even though she has seen them in the books and the pictures and stuff."

Harry

> "The first 6 months, where she lived with her birth parents [pause]. I think that is possibly, the worst part of her life."

Callum

> "The effects of drug, possibly quite likely alcohol, outside of that, who knows what he might have heard or outside of that in the first few months, getting umm…not having….all the time, you know the birth mother, did have him in hospital so you know….left by himself in a ward I guess"

Whilst the children's past experiences of abuse and trauma explained the difficulties they faced and helping fathers like John to see their child as a 'lovely kid' who was 'dealt a wrong deal', the questions in Callum's mind, and John's sense of what his daughter does not know, also reflect fear that these children bring danger with them with so much of their early history and its effects unknown. This may contribute to the sense of otherness that seemed to characterise their experience of the children.

Trauma and echoes of own childhood

All but one of the participants described their own childhood experiences in negative terms and experienced situations that were either traumatic or even abusive, with absent or unavailable fathers a common theme, as well as controlling behaviour.

John described his father as being *"pretty absent all the time."* He then explained that his father had a secret other family:

> “See betrayal might be a tough word, probably not the right word because I don’t really know the ins or out’s. What dad did, what he did but, umm, I felt like, I felt like he betrayed my mum.”

Richard

> “Dad actually has a very short temper, very short temper, that doesn’t help by the fact he, probably still drinks too much…, but it is one of those ones I can always remember and think, the association between alcohol and anger… I just never drunk because I had that connection of, alcohol, violence, all the rows I remember with my mum and dad you know, my dad was always drunk.”

Simon

> “My dad used to work a lot of shift work, so I definitely remember him not being, it was an odd kind of, him not being around a lot, umm, but, not yeah, because he was asleep while we were awake… I would use absent but not absent because he wasn’t physically there.”

Callum talked about his parents being controlling, always putting him down, telling off for things that weren’t his fault:

> “Say you were walking along and an adult barges into you by mistake or whatever they would tell you off (laughs) that kind of thing, it would always be something you have done wrong.”

Ben also had a father who worked nights and really clashed with him:

> “I was running a bath and I think he had worked nights or something ‘cause he was a police force, umm, so I was running a bath (laughs), but the water

> wasn't flowing out as fast as he liked, and he said, 'are you running that bath properly?' and I said, 'Yeah of course I am', knowing that he wanted me to get the taps running faster, but I was like 'No! That's how it is' and he flipped at me and stormed in there."

In keeping with Farnfield's (2019) study that found 58% of potential adopters had unresolved loss or trauma and negative childhood experience, it was clear in these powerful and evocative stories that past trauma was very much alive for these fathers, with the strong feelings expressed containing strong echoes of their experiences of being controlled or ignored by their adopted children. For example, compare Callum's sense of always being in the wrong with his many descriptions above of having no influence in his relationship with his child, and Ben's talk of how his father '*flipped*' and '*stormed*' and his children's volatility and the aggressive response they '*trigger*' in him.

Trying to be different from own parents: 'I … actively didn't want it to be like that'

These fathers want to be different and better than their parents, what Dallos (2019) calls 'corrective intentions' to offer their children a different experience from their own.

While **Simon** understands why his father was unavailable, he wants to be different.

> "I think the being more available is important, and again, understand, I definitely understand the reasons behind it, but I think that's something I think I try and do more, and I think I do, and I definitely do, do more. Umm, time with the boys."

Richard reflected explicitly on the influence that his father's alcoholism and violence had on him:

> "The big thing is too much of my own, it's the nature/nurture thing and how much has my father's parenting effected the way I parent, and I don't think I am better than him, or a long way, but it is still probably, impacting me."

While wanting to be different from his father he recognised that in some ways he was still like him, particularly in his unemotionality, and while comfortable for him and self-protective it may not be best for his children:

> "I am quite, still quite unemotional, which, I, like, 'cause that is what I am used to but I can see how that might be a, sort of not fit with, or probably better for me, may help the boys more if I was a bit more emotionally attuned to them. Yeah, what they are thinking."

Harry was the only participant not reporting any major issues within childhood, but despite this reflected there may be some things he would like to do differently.

> "I like to think I am quite reasonable as a parent, I look back at what my parents did and, and, not saying they did a terrible job… but I try and, make sure that, I am avoiding the things that annoyed me as a child without compromising the child's safety if you see what I mean."

Callum reported having had to think through parenting styles, not wanting to be like his parents:

> "For the adoption stuff you have to go through and think about…. parenting styles, and because they were so authoritarian and the rest of it, I didn't want that, actively didn't want it to be like that."

The difficulty with such intentions is that parents experience shame when things don't turn out as they intended (Grey et al. 2021); this may be driving the parent's difficulties in placing themselves relationally in their conflict with their children; their descriptions of being helpless bystanders may be less painful than experiencing themselves as not living up to being the kind of father they intended to be. At the same time, these fathers showed a greater willingness to think about the ways in which their past may still be impacting them that might have been thought likely, given how threatened they evidently felt in their role. Despite their confusion and lack of a sense of being able to influence their situation, these fathers were actively thinking things through and trying to adapt.

Conclusion

This study explored the experience of 6 fathers in depth, and so by the same token did not research the perspective of others in the family, although the MotC analysis considered the participants' experience systemically. Our aim was to explore the perspective of fathers of adopted children who displayed violence and aggression specifically looking at how they understood their relationship with their child, made sense of the problems in the family.

Most of these fathers found their children's behaviour illogical and at times incomprehensible, struggling to understand where the behaviour came from or to reflect on what may be going on for the child. Terms such as 'Jekyll and Hyde' showed the extent to which fathers experienced their child's difficulties as suddenly coming from the outside, leaving them bystanders to their children's difficulties, rather than parents involved supporting them with their difficult emotions. Incomprehension led to feelings of anger, frustration, and helplessness.

These fathers had also experienced difficulties and trauma in their own childhoods, which has likely impacted upon how they mentalise their relationships (Fonagy et al., 1991b), but also added to their sense of failure and shame, at not being able to create a the more positive family life they had intended. The fathers' frustrated dreams of 'normality' suggested a sense of shame, that may have been driving their experience of their children as 'other' and beyond parenting (Grey et. al. 2021). Further research could consider whether societal expectations around adoption may contribute to these parents' sense of blame when things don't work out, and the relational consequences of this that were evident in our study. We also wonder what contribution societal discourses of maleness and fatherhood may be making to the sense of failure experienced by the fathers in the study.

In addition, Farnfield (2019) found many prospective adopters carried unresolved loss and showed marked 'disorientation', a chronic relational confusion which he suggested may reflect profound confusion around nurturing the genes of strangers in their non-biologically related children. As Grey et al, (2021) note, the experience of the child as not reflecting anything about yourself powerfully challenges the caregiving system, in a way that is particularly problematic for adoptive parents. Having this powerfully brought home in relational ruptures, these parents experienced an '*assault on the caregiving system'* resulting in '*caregiving helplessness'*, a collapse in the parents ability to experience themselves as effective in nurturing and protecting their child (George & Solomon, 2008, p. 848).

This offers a way of understanding what Hughes and Baylin (2012) termed 'blocked care', sometimes known as 'compassion fatigue' or 'carer burnout': a state that parents may experience when their capacity to cope has been exhausted. We wonder as a result whether, instead of simply focussing on explaining the child's

trauma in ways that emphasise the child's 'otherness', helping professionals should look at ways in which the fathers' own experience, including their experiences of trauma, could become more visible, recognising its impact on the child. Paradoxically, if done sensitively, it may help fathers in this state feel more involved – more of a parent to the child than a helpless observer. Certainly, we found the fathers in the study much more willing and active in considering these issues (see 3.4.3 above), than might have been apparent from their helplessness when thinking about the child's behaviour in isolation. This was also the experience of Mckenzie et al. (2021) in their evaluation of a multi-family intervention with parents of autistic children, where comparable problems of feeling their child as 'other', and blamed for their problems were also evident. Far from blaming fathers, such an approach takes seriously their role and influence, supporting them in such a way that affirms both their own and their child's experience in challenging circumstances.

Final Conclusion

Throughout this thesis I have explored and reiterated the importance of parental sensitivity, mentalization, parental reflective functioning and a thorough understanding of attachment theory to explain and understand the phenomena of child to parent violence in adoptive families, as well as how to help and support these families. Amongst other things, this thesis set out to explore changes in parental reflective functioning and parental sensitivity around a group-based intervention for these adoptive parents.

The findings from the first statistical study appear to show the utility of the Knowing Me, Knowing You program in its effectiveness at brining significant positive changes to both these constructs when compared to the SAU control group. Therefore, the primary hypotheses of this study have been confirmed and contributes to a developing area of research of reflective functioning. Additionally, this study provides novel findings concerning parental sensitivity. However, the course has only ever been delivered by a team including the course developer who is also the researcher and therefore the apparent positive in parental reflective functioning and sensitivity could be the result of the course developers clinical practice rather than the program itself. Further studies would benefit from the use of other trained facilitators to assess the replicability of the program.

The second study that includes both statistics and case study methodology, though limited by small number, gives evidence to suggest that positive effects of the program may go on beyond the initial intervention time and showed that for 4 out of 5 cases examined there appeared to be continuing improvement in the 6-9 month time period after the intervention had been completed.

The individual case study of Lesley and her daughter Emily looked in more focus at the evidence for change and the process of change for one particular participant who showed positive change. This study showed the changes in the language she used around her daughter and seems to imply an increased ability to explore her own thoughts and feelings as well as those of her daughter. It highlighted that her process of change seemed to start with her becoming more aware of what may be driving her daughter's behaviour and this in turn led her to changing her own behaviour and that over time she became more regulated and less reactionary plus more aware of her own processes, this improved the relationship and made things easier at home. This study adds to understanding of how an intervention effects change to reflective functioning and parental sensitivity; it also adds to literature that uses hermeneutical approaches to case studies. Plus, it sheds light on the process of change for this particular participant.

Reflexive thematic analysis of course feedback highlighted the journey of change for participants and how important the peer support aspects and lived experience of course facilitator was to this journey and their being open to change. This adding to understanding around the role of epistemic trust, not just within attachment relationships but within adult learning opportunities. As with the case study of Lesley and Emily it highlighted the journey of becoming more understanding and open with both their own and their children's feelings, time to stop, think and reflect appeared to be key to changes in family dynamics.

The final study into the lived experience of adoptive fathers was unusual in its focus on adoptive fatherhood and highlighted how these fathers struggled with their children's behaviours often seeing them as illogical and incomprehensible. It showed their struggle with feeling of agency in their situation and highlighted that several

carried their own difficulties and trauma from childhood into their parenting experience. Though there was fondness and pride in their children's achievements they struggled with feelings of 'otherness' and that their family experience was not a normal one. The experience of adoptive fathers is much neglected and the IPA study of six fathers brings new insight to their particular struggles and joys, highlighting their struggles to make sense of their child's behaviours and how their own experiences of being parented impacts their parenting emphasizing their sense of otherness around their families. This also brought up important questions about how professionals can support these fathers and enable them to have more of a sense of agency in their relationships with their children. Within the study as a whole, the majority of participants were adoptive mothers, and this was also reflected in the attendance of the groups as a whole. These fathers play and important role in their children's lives and services may benefit from ways in which to engage fathers more frequently in therapeutic interventions.

This thesis also builds on previous understanding of the relationship between parental stress, parental reflective functioning and parental sensitivity plus adds further validation of the Meaning of the Child coding system due to its replication of validation study results showing a close correlation to parental reflective functioning.

This study can only be seen as a preliminary validation of the Knowing Me, Knowing You program due to small numbers and replicability not being tested, however, as well as the findings around parental reflective functioning, sensitivity and stress, they showed the program appears to improve the Parents Skills and Understanding, Parent Child Relationship and the Child's Responsiveness to Care, as hypothesized, so once again fills gaps of knowledge around interventions that can impact these areas for this specific group.

While findings around child behaviours are more mixed, with unexpected results being that behaviours as measures by the Goodman SDQ showed little or no improvement. However, these results are similar to other studies that found little change over the time of the intervention, the longitudinal data brings in to focus the period of time after the intervention was completed where it seemed that improvements grew and continued. This study did not include any measurements of attachment and therefore it is not known if the program may be improving the attachment relationship rather than just looking at child behaviour. More research is needed both into how the program may impact the attachment relationship and to more fully understand the long-term benefits of attending the program.

From the evidence within both the quantitative and qualitative aspects of this study, it would seem that the has been a been a paradigm shift in the parents thinking. Reflective Functioning and parental sensitivity improved as did the parents understanding of what may be driving the child's behaviour. The reflexive thematic analysis highlighted participants thoughts that change needed to start with them, not the child. In addition the case study of Lesley showed that gaining understanding of what may be driving Emily's behaviour enabled her to respond more appropriately. This raises the question of how change in the children is measured, whether a purely behavioural focused measure would capture the benefits of the course as while the behaviour itself may not have changed, the parents construct around it and their feelings of stress relating to it has.

As shown above this thesis adds novel information to a number of areas having gaps or limited literature, plus adds to literature in other growing areas. This thesis shows that KMKY program is a novel, innovative and effective intervention for these adoptive parents who are struggling with aggression and violence from their children.

This thesis has also show the MotC, along with the more commonly used PDI-RF, offers a valuable and sensitive framework for assessing individual change in parenting constructs.

Implications for Future Studies

Within this thesis I have highlighted a number of areas that need further research

- The longitudinal benefits of attending the KMKY program, particularly impacts on children's behaviours, but also using some form of measure of the child's attachment to the parent to examine any observable changes in the relationship.
- Further detailed research into different individuals process of change on this or similar programs to inform and improve interventions particularly for this group of families.
- Ways in which adoptive fathers can be helped to integrate their childhood experiences into their understanding of their adopted children, and that both their experience and their child's experience can be validated.
- Further research into epistemic trust and the use of peer support and peer facilitators particularly for adoptive families experiencing challenging behaviour from their children.

Appendix 1

Ethical Approval Details

The research for this project was submitted for ethics consideration under the reference PSYC 20/374 in the School of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 1st February 2021

Appendix 2 -Participant Forms and Information Sheets

Research Participants Information Sheet

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Research into the Knowing Me, Knowing You Adoption Parenting Group.

The Knowing Me, Knowing You program has been developed as an intervention for adoptive families who are experiencing aggression and violence from their children.

This research is looking into the benefit of this group intervention. Specifically, it is looking at the potential for the group to increase parental sensitivity, decreases stress felt by the parents and some of the behaviours that are displayed by the child. It also looks at any improvements in the parent child relationship.

Data is being collected using self-reported questionnaires, and a semi structured interview and some families who are willing will also have a video assessment of the dynamics within the parent-child relationship called the Marschak Interaction Method.

The interview and questionnaires are about your thoughts and feelings about your child and their struggles. They cover areas such as how much you feel you understand your child, your child's behaviours and levels of stress within the family. There are no right, or wrong answers and all questionnaires are tick box or ask for a number score, they do not require written answers.

These measures will be done 2-4 weeks before the commencement of the course group sessions and again straight afterwards (questionnaire are handed out on last session and interview will be 2-4 weeks later). Families who are willing will be also offered the opportunity to do these measure 6-9 months after completion of the group.

The interviews and the MIM (for those who are participating in this procedure) will be completed during a visit your home by the course facilitator. During the restrictions due to the Covid pandemic interviews and questionnaires will be completed by remote means, and the MIM will not take place.

A transcription service will be used to transcribe the audio recordings of the interview.

All data will be pseudonymised, this means that all participants will be allocated a number and information that links participants to the number will be kept separately from the data. Identifying details in interview transcripts will be removed.

Videos of the Marschak Interaction Method will be kept separate from other identifying data. These are stored on an encrypted and password protected device, only Tory Barrow and other reliable coders will have access to these videos.

The data is being collected and collated by Tory Barrow, who is also the course facilitator.

On occasion, interview transcripts will be assessed by another reliable coder, but all identifying information will be removed before this assessment takes place. They will not have access to details that can link the participant number to their name or other details

Audio recordings will be destroyed once they have been transcribed and coded, results will only remain in coded alpha numerical form. Videos will be kept for 10 years on an encrypted device and will only be viewed by the researcher and another reliable coder.

This study has been approved as ethical in line with Hampshire County Council/Adopt South Policies.

What is involved in the study?

On I will meet with you and undertake the semi structured interview, I will then leave a set of 4 questionnaires for you to fill out and bring to the first week of the course. This will be repeated after the completion of the course. During the Covid Pandemic restrictions the course is being delivered remotely and interviews will also be delivered remotely. Questionnaires will be sent and returned through and encrypted email service.

You may also be asked if you, and your child are willing to undergo a play-based observation called the Marschak Interaction Method (MIM).

What are the risks involved in this study?

Parenting is an emotive subject; the interview and questionnaire may highlight areas that you are struggling with and cause some mild emotional distress. Please do let us know if you find the interview distressing, it can be stopped at any time and Tory will be available to support you with any distress at time of the interview and can

signpost you to further support services. Your allocated social worker can also provide you with support around issues that are raised.

Confidentiality will be maintained as far as possible. Specific details will only be disclosed to relevant authorities if there is a risk of harm to you or anyone mentioned in line with current safeguarding regulations. You will always be informed if this information is going to be shared.

All data is kept securely in line with current data processing laws.

What are the benefits for taking part in this study?

Taking part in this study gives the opportunity for any data collected from you to impact research and policy on supporting adoptive families. This study will continue over the next 3 year period and once completed you can access the results by contacting barrowv@roehampton.co.uk

What are your rights as a participant?

Taking part in the study is voluntary. You may choose not to take part or subsequently cease participation at any time.

Will I receive any payment or monetary benefits?

You will receive no payment for your participation. The data will not be used by any member of the project team for commercial purposes. Therefore, you should not expect any royalties or payments from the research project in the future.

How long will Data be stored for?

Consent forms will be stored for 6 years. All research data will be stored for 10 years after the study is finished. All data including videos and pseudonymised transcripts will be stored on an encrypted and password protected device.

For more information or to express concern please contact

Tory Barrow

barrowv@roehampton.ac.uk

07501773776

Or your post adoption support social worker.

Or

Director of Studies contact details:

Prof Cecilia Essau

Department of Psychology

Head of Department contact details:

Dr Yannis Fronimos

Head of Psychology Department

Roehampton University	University of Roehampton,
Whitelands College	London
Holybourne Ave	SW15 5SL
London, SW15 4JD	yannis.fronimos@roehampton.ac.uk
Email c.essau@roehampton.ac.uk	Whitelands College
Telephone 020 83923647	Tel: +44 (0) 20 8392 3627

Research Participants Information Sheet For Indirectly Collected or Re-used Data

RESEARCH PARTICIPANT INFORMATION SHEET FOR INDIRECTLY COLLECTED OR RE-USED PERSONAL DATA

You have previously provided personal data to the University of Roehampton to be included in a research project entitled MSc Study into the Knowing Me, Knowing You Adoption Program.

We are writing to you because the University intends to use the data you originally provided for a new project. Information about the new research project and contact details for the research team are included below

Title of Research Project: Will a Parenting group program improve parental sensitivity in adoptive families?

The data from the questionnaires and the interview you previously provided will be used in this new study. All data has been pseudonymised and no identifying details will be used in the research. Transcripts from interviews and data from questionnaires will be kept on an encrypted device for 10 years after the study concludes.

Investigator Contact Details: Victoria (Tory) Barrow

Department of Psychology

University of Roehampton

Whitelands College

Holybourne Avenue

London SW15 4JD

barrowv@roehampton.ac.uk

07501 773776

Privacy Notice:

You have the right to opt-out of your personal data being processed as part of this research project, which you can do by contacting Tory Barrow. If you do withdraw, your data may not be erased but will only be used in an anonymised form as part of an aggregated dataset.

More information about how your personal data will be used can be found in the University's Data Privacy Notice for Research Participants. and its Data Protection Policy

Research Participants Consent Form

Department of Psychology

University of Roehampton

Whitelands College

Holybourne Avenue

London SW15 4JD

www.roehampton.ac.uk

Research project title: Will a Parenting group program improve parental sensitivity in adoptive families?

Research investigator: Tory (Victoria) Barrow

Tory Barrow is both the Research investigator and course facilitator.

Research Participants name:

The interview will take approximately 1 hour. There will also be 4 self-reported questionnaires. Some participants may also be asked to undergo a play-based assessment with their child that will be videoed. You have the right to stop the interview, play based assessment or withdraw from the research at any time.

The interviews and the play-based assessment (for those who are participating in this procedure) will be completed during a visit your home by the course facilitator. During the restrictions due to the Covid pandemic interviews and questionnaires will be completed by remote means, and the play-based assessment will not take place.

Thank you for agreeing to be part of the above research project.

Ethical procedures for academic research undertaken from UK institutions require that interviewees explicitly agree to being interviewed and how the information contained in their interview will be used. This consent form is necessary for us to ensure that you understand the purpose of your involvement and that you agree to the conditions of your participation. Would you therefore read the accompanying information sheet and then sign this form to certify that you approve the following:

- the interview will be audio recorded, and a transcript will be produced
- A transcription service will be used to transcribe the audio recordings of the interview.
-
- All data will be pseudonymised, this means that all participants will be allocated a number and information that links participants to the number will be kept separately from the data. Identifying details in interview transcripts will be removed.
- Videos of the Marschak Interaction Method will be kept separate from other identifying data. These are stored on an encrypted and password protected device, only Tory Barrow and other reliable coders will have access to these videos.
- the transcript of the interview will be pseudonymised then analysed by Tory Barrow as research investigator. The pseudonymised transcript may then be blind analysed by an additional researcher.
- access to the interview transcript will be limited to Tory Barrow and academic colleagues and researchers with whom she might collaborate as part of the research process
- Access to the video recording of play-based assessment will be limited to Tory Barrow and academic colleagues and researchers with whom she might collaborate as part of the research process.
- any summary interview content, or direct quotations from the interview, that are made available through academic publication or other academic outlets will be anonymized so that you cannot be identified, and care will be taken to ensure that other information in the interview that could identify yourself is not revealed

- the actual recording will be destroyed
- any variation of the conditions above will only occur with your further explicit approval
- Attendance on the KMKY program is not dependant on consent for your data to be used for research purposes.
- Details of the content of the interview, videoed play based assessment and questionnaires will be kept confidential and not be shared with your supervising social worker or Local Authority unless there is concern of serious harm to the participant or another person, or you give explicit consent for the contents to be shared.
- General findings from the research will be shared with the Local Authority, but no individual will be identifiable from what is shared.

Quotation Agreement

I also understand that my words may be quoted directly with all identifying features removed or anonymised. With regards to being quoted

I agree to be quoted directly if my name is not published and a made-up name (pseudonym) is used.

I agree that the researchers may publish documents that contain anonymised quotations by me.

All or part of the content of your interview may be used;

- In academic papers, policy papers or news articles
- On other feedback events
- In an archive of the project as noted above

By signing this form I agree that;

1. I am voluntarily taking part in this project. I understand that I don't have to take part, and I can stop the interview at any time;
2. I consent to my child taking part in the videoed play-based assessment. I understand the I, or my child do not have to take part and can stop the assessment at any time.
3. I have explained to my child the purpose of the play-based assessment.
4. The transcribed interview or extracts from it may be used as described above;
5. I have read the Information sheet;
6. I don't expect to receive any benefit or payment for my participation;
7. I can request a copy of the transcript of my interview and may make edits I feel necessary to ensure the effectiveness of any agreement made about confidentiality;
8. Details of individual coding and scoring for the interviews, videoed assessment and questionnaires will not be available to me.
9. I have been able to ask any questions I might have, and I understand that I am free to contact the researcher with any questions I may have in the future.

Consent Statement

I agree to take part in this research and am aware that I am free to withdraw at any point without giving a reason by contacting Tory Barrow. I understand

that if I do withdraw, my data may not be erased but will only be used in an anonymised form as part of an aggregated dataset. I understand that the personal data collected from me during the course of the project will be used for the purposes outlined above in the public interest.

By signing this form you are confirming that you have been informed about and understand the University's Data Privacy Notice for Research Participants.

The privacy notice sets out how your child's personal data will be used as part of the research project. By signing this form, you are confirming that you have explained the content of the Data Privacy Notice for Research Participants to your child.

The information you have provided will be treated in confidence by the researcher and your identity will be protected in the publication of any findings. The purpose of the research may change over time, and your data may be re-used for research projects by the University in the future. If this is the case, you will normally be provided with additional information about the new project.

Printed Name

_____ _____

Participants Signature Date

_____ _____

Researchers Signature Date

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator (or if the researcher is a student you can also contact the Director of Studies.) However, if you would like to contact an independent party please contact the Head of Department/ Director of School.

Research Investigator - Tory Barrow

barrowv@roehampton.ac.uk

07501773776

Director of Studies contact details:

Prof Cecilia Essau

Department of Psychology

Roehampton University

Whitelands College

Holybourne Ave

Head of Department contact details:

Dr Yannis Fronimos

Head of Psychology Department

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Tel: +44 (0) 20 8392 3627

Should the Head of Department change over the lifecycle of the research project the new Head of Department will become the independent contact. Contact details for the new Head of Department can be obtained from the investigator

Participant Debriefing Form

University of Roehampton London

Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue

Participant Number: _____

PARTICIPANT DEBRIEFING FORM

Title of Research Project: Will a Parenting group program improve parental sensitivity in adoptive families?

Thank you for taking part in this study which is to examine how the 'Knowing me, Knowing You Adoption Program' benefits families with adoptive children who display violence and aggression.

All data gathered during this study will be held securely and pseudonymously. If you wish to withdraw from the study, contact us with your participant number (above) and information will be deleted from our files. Please be aware, however, that data in summary form may already have been used for publication at the time of request. You will not be negatively affected in any way if you later decide you do not want your responses to be used. However, if you do decide that you want to withdraw from the study then you will need to let your teacher know who can contact the investigator.

If you feel that taking part in this study has upset you in any way, or brought up any issues, then please talk to a member your post adoption support social worker or the course facilitator. You also have researcher contact details.

If you wish to discuss any aspect of this study further, then please do not hesitate to get in contact. Do you have questions at present?

Thank you again for your time.

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator, or the director of studies. However, if you would like to contact an independent party please contact the Head of Department.

Investigator contact details:
Tory Barrow
barrowv@roehampton.ac.uk
Tel: 07501773776

Director of Studies
Prof Cecilia Essau
Department of Psychology
Roehampton University
Whitelands College
Holybourne Ave
London, SW15 4JD
Email c.essau@roehampton.ac.uk
Telephone 020 83923647

Head of Department contact details:
Dr Yannis Fronimos
Head of Psychology Department
University of Roehampton,
London
SW15 5SL
yannis.fronimos@roehampton.ac.uk
Whitelands College
Tel: +44 (0) 20 8392 3627

Wait List Information Sheet

Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
London SW15 4JD

www.roehampton.ac.uk

Research into the Knowing Me, Knowing You Adoption Parenting Group.

The Knowing Me, Knowing You program has been developed as an intervention for adoptive families who are experiencing aggression and violence from their children.

This research is looking into the benefit of this group intervention. Specifically, it is looking at the potential for the group to increase parental sensitivity, decreases

stress felt by the parents and some of the behaviours that are displayed by the child. It also looks at any improvements in the parent child relationship.

You are on the waiting list for the program and have agreed to be part of the research while you wait. You will be allocated a place on the next course.

Data is being collected using self-reported questionnaires, and a semi structured interview.

The interviews will be completed during a visit your home by the course facilitator. During the restrictions due to the Covid pandemic interviews and questionnaires will be completed by remote means.

The interview and questionnaires are about your thoughts and feelings about your child and their struggles. They cover areas such as how much you feel you understand your child, your child's behaviours and levels of stress within the family. There are no right, or wrong answers and all questionnaires are tick box or ask for a number score, they do not require written answers.

A transcription service will be used to transcribe the audio recordings of the interview.

These measures will be repeated approximately 10 weeks after they are initially done.

All data will be pseudonymised, this means that all participants will be allocated a number and information that links participants to the number will be kept separately from the data. Identifying details in interview transcripts will be removed.

The data is being collected and collated by Tory Barrow, who is also the course facilitator.

On occasion, interview transcripts will be assessed by another reliable coder, but all identifying information will be removed before this assessment takes place. They will not have access to details that can link the participant number to their name or other details

Audio recordings will be destroyed once they have been transcribed and coded, results will only remain in coded alpha numerical form.

This study has been approved as ethical in line with Hampshire County Council/Adopt South Policies.

What is involved in the study?

On I will meet with you and undertake the semi structured interview, I will then leave a set of 4 questionnaires for you to fill out and email to me. This will be repeated when we meet again in 10 weeks.

During any restrictions due to the Covid pandemic the interviews will be done virtually and questionnaires emailed.

What are the risks involved in this study?

Parenting is an emotive subject; the interview and questionnaire may highlight areas that you are struggling with and cause some mild emotional distress. Please do let us know if you find the interview distressing, it can be stopped at any time and Tory will be available to support you with any distress at time of the interview and can signpost you to further support services. Your allocated social worker can also provide you with support around issues that are raised.

Confidentiality will be maintained as far as possible. Specific details will only be disclosed to relevant authorities if there is a risk of harm to you or anyone mentioned in line with current safeguarding regulations. You will always be informed if this information is going to be shared.

All data is kept securely in line with current data processing laws.

What are the benefits for taking part in this study?

Taking part in this study gives the opportunity for any data collected from you to impact research and policy on supporting adoptive families. This study will continue over the next 3 year period and once completed you can access the results by contacting barrowv@roehampton.ac.uk

What are your rights as a participant?

Taking part in the study is voluntary. You may choose not to take part or subsequently cease participation at any time.

Will I receive any payment or monetary benefits?

You will receive no payment for your participation. The data will not be used by any member of the project team for commercial purposes. Therefore, you should not expect any royalties or payments from the research project in the future.

How long will Data be stored for?

Consent forms will be stored for 6 years. All research data will be stored for 10 years after the study is finished. All data including pseudonymised transcripts will be stored on an encrypted and password protected device.

For more information or to express concern please contact

Tory Barrow

barrowv@roehampton.ac.uk

07501773776

Or your post adoption support social worker.

Or

Director of Studies contact details:

Prof Cecilia Essau

Department of Psychology

Roehampton University

Whitelands College

Holybourne Ave

London, SW15 4JD

Email c.essau@roehampton.ac.uk

Telephone 020 83923647

Head of Department contact details:

Dr Yannis Fronimos

Head of Psychology Department

University of Roehampton,

London

SW15 5SL

yannis.fronimos@roehampton.ac.uk

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Tel: +44 (0) 20 8392 3627

Wait List Research Consent Form

Department of Psychology

University of Roehampton

Whitelands College

Holybourne Avenue

London SW15 4JD

www.roehampton.ac.uk

Research project title: Will a Parenting group program improve parental sensitivity in adoptive families?

Research investigator: Tory (Victoria) Barrow

Tory Barrow is both the Research investigator and course facilitator.

Research Participants name:

The interview will take approximately 1 hour. There will also be 4 self-reported questionnaires. You have the right to stop the interview or withdraw from the research at any time.

The interviews will be completed during a visit your home by the course facilitator. During the restrictions due to the Covid pandemic interviews and questionnaires will be completed by remote means.

Thank you for agreeing to be part of the above research project. You have agreed to this while on the waiting list for the Knowing Me, Knowing You Adoption Parenting Program, you will be offered a place next time the program is being run.

Ethical procedures for academic research undertaken from UK institutions require that interviewees explicitly agree to being interviewed and how the information contained in their interview will be used. This consent form is necessary for us to ensure that you understand the purpose of your involvement and that you agree to the conditions of your participation. Would you therefore read the accompanying information sheet and then sign this form to certify that you approve the following:

- the interview will be audio recorded, and a transcript will be produced
- All data will be pseudonymised, this means that all participants will be allocated a number and information that links participants to the number will be kept separately from the data. Identifying details in interview transcripts will be removed.
- A transcription service will be used to transcribe the audio recordings of the interview.
- the transcript of the interview will be pseudonymised then analysed by Tory Barrow as research investigator. The pseudonymised transcript may then be blind analysed by an additional researcher.
- access to the interview transcript will be limited to Tory Barrow and academic colleagues and researchers with whom she might collaborate as part of the research process
- any summary interview content, or direct quotations from the interview, that are made available through academic publication or other academic outlets will be anonymized so that you cannot be identified, and care will be taken to ensure that other information in the interview that could identify yourself is not revealed
- the actual recording will be destroyed
- any variation of the conditions above will only occur with your further explicit approval
- Attendance on the KMKY program is not dependant on consent for your data to be used for research purposes.
- Details of the content of the interview, and questionnaires will be kept confidential and not be shared with your supervising social worker or Local Authority unless there is concern of serious harm to the participant or another person, or you give explicit consent for the contents to be shared.
- General findings from the research will be shared with the Local Authority, but no individual will be identifiable from what is shared.

Quotation Agreement

I also understand that my words may be quoted directly with all identifying features removed or anonymised. With regards to being quoted

I agree to be quoted directly if my name is not published and a made-up name(pseudonym) is used.

I agree that the researchers may publish documents that contain anonymised quotations by me.

All or part of the content of your interview may be used;

- In academic papers, policy papers or news articles
- On other feedback events
- In an archive of the project as noted above

By signing this form I agree that;

10. I am voluntarily taking part in this project. I understand that I don't have to take part, and I can stop the interview at any time;
11. The transcribed interview or extracts from it may be used as described above;
12. I have read the Information sheet;
13. I don't expect to receive any benefit or payment for my participation;
14. I can request a copy of the transcript of my interview and may make edits I feel necessary to ensure the effectiveness of any agreement made about confidentiality;
15. Details of individual coding and scoring for the interviews and questionnaires will not be available to me.
16. I have been able to ask any questions I might have, and I understand that I am free to contact the researcher with any questions I may have in the future.

Consent Statement

I agree to take part in this research and am aware that I am free to withdraw at any point without giving a reason by contacting Tory Barrow. I understand that if I do withdraw, my data may not be erased but will only be used in an anonymised form as part of an aggregated dataset. I understand that the personal data collected from me during the course of the project will be used for the purposes outlined above in the public interest.

By signing this form you are confirming that you have been informed about and understand the University's Data Privacy Notice for Research Participants.

The privacy notice sets out how your child's personal data will be used as part of the research project. By signing this form, you are confirming that you have explained the content of the Data Privacy Notice for Research Participants to your child.

By signing this form you are confirming that you have been informed about and understand the University's Data Privacy Notice for Research Participants.

The information you have provided will be treated in confidence by the researcher and your identity will be protected in the publication of any findings. The purpose of the research may change over time, and your data may be re-used for research projects by the University in the future. If this is the case, you will normally be provided with additional information about the new project.

Printed Name

_____ _____

Participants Signature Date

_____ _____

Researchers Signature Date

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator (or if the researcher is a student you can also contact the Director of Studies.) However, if you would like to contact an independent party please contact the Head of Department/ Director of School.

Research Investigator - Tory Barrow

barrowv@roehampton.ac.uk

07501773776

Director of Studies contact details:

Prof Cecilia Essau

Department of Psychology

Roehampton University

Whitelands College

Holybourne Ave

London, SW15 4JD

Email c.essau@roehampton.ac.uk

Telephone 020 83923647

Head of Department contact details:

Dr Yannis Fronimos

Head of Psychology Department

University of Roehampton,

London

SW15 5SL

yannis.fronimos@roehampton.ac.uk

Whitelands College

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Should the Head of Department change over the lifecycle of the research project the new Head of Department will become the independent contact. Contact details for the new Head of Department can be obtained from the investigator.

Appendix 3 – Participant Questionnaires

Carer Questionnaire

Carer Questionnaire

Childs ID……Date of Birth……Date Completed……

How much do you feel you understand your child's difficulties?

Not at all 1 2 3 4 5 6 7 8 9 10 Very

How much do you think your child's difficulties relate to their early experiences?

Not at all 1 2 3 4 5 6 7 8 9 10 Very

How much do you understand why your child behaves as they do?

Not at all 1 2 3 4 5 6 7 8 9 10 Very

How confident are you that you can manage the challenges that your child has?

Not at all 1 2 3 4 5 6 7 8 9 10 Very

How skilled do you feel in managing the specific challenges your child presents?

Not at all 1 2 3 4 5 6 7 8 9 10 Very

How good do you feel your relationship is with your child?

Not at all 1 2 3 4 5 6 7 8 9 10 Very

How easily can you and your child communicate with one another?

Not at all 1 2 3 4 5 6 7 8 9 10 Very

How responsive do you feel you child is to your attempts to help them?

Not at all 1 2 3 4 5 6 7 8 9 10 Very

How difficult is your child to care for?

Not at all 10 9 8 7 6 5 4 3 2 1 Very

How difficult is it to build a relationship with your child?

Not at all 10 9 8 7 6 5 4 3 2 1 Very

How rewarding do you find your child?

Not at all 1 2 3 4 5 6 7 8 9 10 Very

How secure do you feel the placement/family situation is at the moment?

Not at all 1 2 3 4 5 6 7 8 9 10 Very

PSU PCR CRC St

Goodman Strength and Difficulties questionnaire

Strength and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviours over the last six months.

Child's ID……Child's Date of Birth

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings			
Restless, overactive, cannot stay still for long			
Often complains of headaches, stomach-aches or sickness			
Shares readily with other children (treats, toys, pencils etc.)			
Often has temper tantrums or hot tempers			
Rather solitary, tends to play alone			
Generally obedient, usually does what adults request			
Many worries, often seems worried			
Helpful if someone is hurt, upset or feeling ill			
Constantly fidgeting or squirming			
Has at least one good friend			
Often fights with other children or bullies them			
Often unhappy, down-hearted of tearful			
Generally liked by other children			
Easily distracted, concentration wanders			
Nervous or clingy in new situations, easily loses confidence			
Kind to younger children			
Often lies or cheats			
Picked on or bullies by other children			
Often volunteers to help others (parents, teachers, other children)			
Thinks things out before acting			
Steals from home, school or elsewhere			
Gets on better with adults that with other children			
Many fears, easily scared			
Sees tasks through to the end, good attention span			

Parents ID……Date……

Brief Assessment Checklist for Children

Brief Assessment Checklist for Children (ages 4 to 11)

Child's ID ..... Boy / Girl
Child's age .....
Your relationship to this child ..... (e.g. mother, father, aunt, foster mother, grandfather)

Here are some statements that describe children's behaviour and feelings. For each statement, please circle the number that best describes your child in the **last 4 to 6 months**.

 circle **0** if the statement is **not true** for your child in the last 4 to 6 months.
 circle **1** if the statement is **partly true** for your child in the last 4 to 6 months.
 circle **2** if the statement is **mostly true** for your child in the last 4 to 6 months.

1.	**0**	**1**	**2**	Can't concentrate, short attention span
2.	**0**	**1**	**2**	Craves affection
3.	**0**	**1**	**2**	Eats too much
4.	**0**	**1**	**2**	Fears you will reject her/him
5.	**0**	**1**	**2**	Hides feelings
6.	**0**	**1**	**2**	Is convinced that friends will reject her/him
7.	**0**	**1**	**2**	Lacks guilt or empathy
8.	**0**	**1**	**2**	Prefers to be with adults, rather than children
9.	**0**	**1**	**2**	Relates to strangers 'as if they were family'
10.	**0**	**1**	**2**	Seems insecure
11.	**0**	**1**	**2**	Startles easily ('jumpy')
12.	**0**	**1**	**2**	Suspicious
13.	**0**	**1**	**2**	Too dramatic (false emotions)
14.	**0**	**1**	**2**	Too friendly with strangers
15.	**0**	**1**	**2**	Too jealous
16.	**0**	**1**	**2**	Treats you as though you were the child and she/he was the parent
17.	**0**	**1**	**2**	Uncaring (shows little concern for others)
18.	**0**	**1**	**2**	Distressed or troubled by traumatic memories
19.	**0**	**1**	**2**	Does not show pain if physically hurt
20.	**0**	**1**	**2**	Sexual behaviour not appropriate for her/his age

U.K. English version www.childpsych.org.uk

Parental Stress Scale

Parental Stress Scale
Participant ID……..

The following statements describe feelings and perceptions about the experience of being a parent. Think of each of the items in terms of how your relationship with your child or children typically is. Please indicate the degree to which you agree or disagree with the following items by placing the appropriate number in the space provided.

1 = Strongly disagree 2 = Disagree 3 = Undecided 4 = Agree 5 = Strongly agree

1	I am happy in my role as a parent.	
2	There is little or nothing I wouldn't do for my child(ren) if it was necessary.	
3	Caring for my child(ren) sometimes takes more time and energy than I have to give.	
4	I sometimes worry whether I am doing enough for my child(ren).	
5	I feel close to my child(ren).	
6	I enjoy spending time with my child(ren).	
7	My child(ren) is an important source of affection for me.	
8	. Having child(ren) gives me a more certain and optimistic view for the future.	
9	The major source of stress in my life is my child(ren).	
10	Having child(ren) leaves little time and flexibility in my life.	
11	Having child(ren) has been a financial burden.	

12	. It is difficult to balance different responsibilities because of my child(ren).	
13	The behaviour of my child(ren) is often embarrassing or stressful to me.	
14	. If I had it to do over again, I might decide not to have child(ren).	
15	I feel overwhelmed by the responsibility of being a parent.	
16	Having child(ren) has meant having too few choices and too little control over my life.	
17	I am satisfied as a parent.	
18	I find my child(ren) enjoyable.	

Appendix 4 – Parent Development Interview Protocol

PDI (The Meaning of the Child)

Explanatory Note

The Parent Development Interview (Aber et al., 1985 - 2003[1]) was adapted by Professor Arietta Slade and her colleagues for use the Reflective Functioning scale and was initially used in the research validating the Meaning of the Child. However, experience of both the use of the Meaning of the child and also of working with parents in the family court system, have resulted in the need for some changes to the PDI. Questions in black derive from the original PDI, those in red (or faded text) have been modified or added for the purposes of the Meaning of the Child.

View of the Child.

[Today we're going to be talking about you and your child. We'll begin by talking about your child and your relationship, and then a little about your own experience as a child.]

Let's just start off by your telling me a little bit about your family – who lives in your family? How many children do you have? What are their ages? (Here you want to know how many children, ages, including those living outside the home, parents, other adults living in home. If atypical rearing situation get some of the detail of that just to create a context for understanding the interview.)

How old was your child when they were placed with you?

1. I'd like to begin by getting a sense of the kind of person your child is… so, could you describe him/her for me?
2. And, what about you, what kind of person are you? What is it important for us to know about you?
3. OK, now let's return to your child…In an average week, what would you describe as his/her favorite things to do, his/her favorite times?
4. And the times or things he has most trouble with?
5. What do you like most about your child?
6. What do you like least about your child?

[1] Aber, J., A. Slade, B. Berger, I. Bresgi & M. Kaplan, (1985 - 2003) *The Parent Development Interview: Interview Protocol,* Unpublished manuscript: Barnard College, Columbia University, New York.

7. When you are with [child] and look at [child] is there anyone s/he reminds you of? How does that make you feel?

View of the Relationship

1. I'd like you to choose 3 words or phrases that you feel reflect the relationship between you and (your child). (Pause while they list adjectives.) Now let's go back over each of the words or phrases you choose. Does an incident or memory come to mind with respect to _____? (Go through and get a specific memory for each adjective.)

2. Describe a time in the last week when you and (your child) really "clicked". (Probe if necessary: Can you tell me more about the incident? How did you feel? How do you think (your child) felt?)

3. Now, describe a time in the last week when you and (your child) really weren't "clicking". (Probe if necessary: Can you tell me more about the incident? How did you feel? How do you think (your child) felt?)

4. How do you think your relationship with your child is affecting his/her development or personality?

C. Affective Experience of Parenting

1. Now, we're going to talk about your feelings about being a parent. How would you describe yourself as a parent? [If necessary probe: Can you give me an example of this?]

2. What gives you the most joy in being a parent?

3. What gives you the most pain or difficulty in being a parent?

4. When you worry about (your child), what do you find yourself worrying most about?

5. How has having your child changed you?

6. Tell me about a time in the last week or two when you felt really angry as a parent. (Probe, if necessary: Can you tell me a little bit more about the situation? How did you handle your angry feelings?)

6a. What kind of effect do these feelings have on your child?

7. Tell me about a time recently when you felt really guilty as a parent. (Probe, if necessary: Can you tell me a little bit more about the situation? How did you handle your guilty feelings?)

7a. What kind of effect do these feelings have on your child?

8. Tell me about a time in the last week or two when you felt you really needed someone to take care of *you*. (Probe, if necessary: Can you tell me a little bit more about the situation? How did you handle your needy feelings?)

8a. What kind of effect do these feelings have on (your child?)

9. When your child is upset, what does he/she do? Can you tell me about a recent time when s/he was upset? How does that make you feel? What do you do?

10. Does (your child) ever feel rejected?

D. Parent's Family History:

[Where a full AAI has already been given, skip questions 1 - 3]

Now I'd like to ask you a few questions about your own parents, and about how your childhood experiences might have affected your feelings about parenting….

1. Could you just tell me something about your childhood family; who you grew up with, what your childhood relationship with your parents was like, that kind of thing?

2. I'd like you to choose 3 words or phrases that describe your childhood relationship with your mother, from as early as you can remember….Now let's go back over each adjective. Does an incident or memory come to mind with respect to?

3. Now can you choose 3 words or phrases that describe your childhood relationship with your father? (Pause while they list adjectives.) Now let's go back over each adjective. Does an incident or memory come to mind with respect to _____?

4. How do you want to be like and unlike your mother as a parent?

5. How about your father?

6. Do you think there are any ways in which you ***are*** like your mother? .. father?

Co-Parenting and Family Relationships

I would just like to ask a few questions about [your child's] relationships with the rest of your family and with others important in her/his life:

1. Can you tell me a bit about [your child's] relationship with your partner? Could you describe a recent time that illustrates this [*adapt to parent's answer*]?

2. Most parents have times where they disagree about parenting. Can you tell me a time when you and (partner) didn't see eye to eye about [child]?

3. Can you tell me how do you think [your child] fits into the household? How does s/he get on with her brothers and sisters? When was the last time you were all together as a family? Can you tell me a bit more about that? [*Probe if necessary*]*:* How did you feel?

4. How does [your child] get on with your relatives? Can you tell me about the last time s/he met [choose a relative from those mentioned]?

5. How does [your child] respond to people she doesn't know? Have you got a recent example of this?

6. [*Where the child's parents are not living together*] How does [your child] get on with her/his [*non resident*] mother/father? How does that make you feel? When was the last time s/he can any contact with him/her? How did that go?

Separation/Loss

1. Now, I'd like you to think of a time you and your child weren't together, when you were separated. Can you describe it to me? ***(Probe: What kind of effect did it have on the child? What kind of effect did it have on you?)*** **NOTE*:*** Probe for a *recent* separation [within the last year].

2. Is there anyone very important to you who (your child) doesn't know but who you wish he/she was close to, or could have been close to if things had turned out differently?

3. Do you think there are experiences in your child's life that you feel have been a setback for him?

Integrative Questions

1. Your child is _____ already, and you're an experienced parent. If you had the experience to do all over again, what would you change? What wouldn't you change?

2. We have spent some time looking at what it is like to be a parent, your experiences of being parented, and your relationship with [child]. Is there anything you would like to add that will help us understand you now as a parent, or feel we should know about your relationship with [child]?

Appendix 5 - Adapted PDI Post Intervention

Adapted interview for after Knowing me, Knowing you course.

This interview is quite similar to the one we did a few months ago. Some of the questions will be the same and some will be different. Please don't worry about what you answered last time we did this, just talk about the first thing that comes to mind.

1. First of all can you remind me of who lives in your house, You, your partner, the children and their names and ages, things like that?

8. Tell us about the time s/he came to live with you? How did it feel for you? How do you think c. was feeling? How has c. changed?

9. OK, now let's return to your child…In an average week, what would you describe as his/her favorite things to do, his/her favorite times?

10. And the times or things he has most trouble with?

11. What do you like most about your child?

12. What do you like least about your child?

A. View of the Relationship

5. I'd like you to choose 3 words or phrases that you feel reflect the relationship between you and (your child) at this moment in time. (Pause while they list adjectives.) Now let's go back over each of the words or phrases you choose. Does an incident or memory come to mind with respect to _____? (Go through and get a specific memory for each adjective.)

6. Describe a time in the last week when you and (your child) really “clicked”. (Probe if necessary: Can you tell me more about the incident? How did you feel? How do you think (your child) felt?)

7. Now, describe a time in the last week when you and (your child) really weren’t “clicking”. (Probe if necessary: Can you tell me more about the incident? How did you feel? How do you think (your child) felt?)

4.a Can you t tell me about c.’s schooling/nursery? How is s/he doing? How does it affect her/him? How do you feel when s/he is at school? Can you tell me about a recent time where s/he struggled with something about school *(this can be adapted to query for an episode for problems already raised by speaker)*

C. Affective Experience of Parenting

1. Now, we’re going to talk about your feelings about being c.’s parent. How would you describe yourself as a parent? [If necessary probe: Can you give me an example of this?]

11. What gives you the most joy in being c.’s parent?

12. What gives you the most pain or difficulty in being c.’s parent?

13. Tell me about a time in the last week or two when you felt really angry with (your child).

5a. What kind of effect do these feelings have on your child?

14. Tell me about a time in the last week or two when (your child) was really angry with you? (Probe, if necessary: Can you tell me a little bit more about the situation? How did you handle it? How did it make you feel?) What do you think may have been the trigger for the anger?

7a. What kind of effect do these feelings have on (your child?)

9a. When you are feeling ill, what do you? How do you take care of yourself?

9b) Tell me about a recent time when you were ill and how you took care of yourself.

What kind of effect does this have on your child? \

9 c When you are feeling distressed/upset what do you do?

9d Tell me about a recent time when you were distressed/upset. What effect did this have on your child?

10) When your child is upset, how do you respond? Can you tell me about a recent time when s/he was upset? How does that make you feel? What do you do?

11a.When your child is feeling **ill**, how do you respond?

11**b.**Can you give me an example of a time your child was ill and how you responded?

12**a**.If your child gets **hurt** or injured, how do you respond?

12**b**.Can you give me an example of a time when your child was hurt or injured and how you responded?

13**a.**When your child needs **comfort** how do you respond?

13**b.** Can you give me a recent example of a time when your child needed comfort and how you responded?

D. Child's birth family:

Now I'd like to ask you a few questions about your child's birth family, and what impact you think they might have on your parenting of c.

7. Could you just tell me something about [your child's] birth family, who is in it, and what precipitated her/him coming to live with you?

8. How do you feel when you think about C's early history?

E. Co-Parenting, Family and Social Relationships

I would just like to ask a few questions about [your child's] relationships in *this* family, and in [your child's] current daily life:

7. Can you tell me a bit about [your child's] relationship with your partner? Could you describe a recent time that illustrates this (adapt to answer)?

8. Are there any other professionals that [your child] meets? Tell me about [your child's] relationship with her/him? What happened the last time they met?

F. Separation/Loss

4. Now, I'd like you to think of a time you and your child weren't together, when you were separated. Can you describe it to me? ***(Probe: What kind of effect did it have on the child? What kind of effect did it have on you?)*** **NOTE*:*** Probe for a *recent* separation [within the last year].

G. Integrative Questions

3. Recently we have been working through a course about how early trauma affects children and how parenting a traumatized child can affect you, as well as looking at different parenting strategies.

Can you tell me a little bit about how this has affected you and your relationship with your child? Is there anything that you feel you have learnt or changed since doing this course? How do you feel about that? What effect do you think that you doing this course has had on your child?

4. We have spent some time looking at [your child} and your relationship with her/him, is there anything else you think we should know about her/him, or her/his relationships that would help us understand [your child] and what it is like looking after her/him? Is there anything else you'd like to add?

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