Compassion Fatigue and Secondary Trauma in Adoptive Parents

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

This thesis focuses on the mental health and wellbeing of adoptive families. Part 1 reviews the research literature examining post-adoption risk and protective factors associated with adopted children's mental health and behavioural difficulties, considering parent factors, parent-child relationship factors, family factors and contextual factors.

Part 2 reports on a mixed-methods study exploring compassion fatigue and trauma symptoms in adoptive parents, who face the emotional impact of parenting a child that has experienced trauma. Survey results highlight the association of three cognitive styles, psychological inflexibility, thought suppression and rumination with trauma symptoms in adoptive parents. A further finding from the survey highlights the significance of the current emotional and behavioural difficulties, including child-to-parent violence, over the extent of the child's pre-adoptive trauma in predicting parental trauma responses. Semi-structured interviews with adoptive parents high in primary trauma highlight the emotional and traumatic impact of parenting a child that has experienced early life maltreatment. This related to both the knowledge of what their child had been through, and the current behavioural challenges that they are living with as a result of their early experiences. The knowledge of their child's past, although traumatic to live with as a parent, also allows many parents to make sense of the behaviours they face and enables them to parent with empathy, patience and compassion.

Part 3 reflects on the development and process of conducting the empirical research, including service user involvement. Recruitment challenges and issues of equality, diversity and inclusivity will be discussed, alongside reflections on the impact of the COVID-19 pandemic on the research project.

Impact Statement

The findings of the current thesis provide important implications clinically and for future research within academia. Part 1 suggests that when considering the mental health and wellbeing of adopted children, the research evidence base would benefit from longitudinal studies considering the multi-factor variables in the entire system surrounding the child, incorporating importance contextual aspects and experiences of ethnicity and discrimination. Clinically, it points to possible multi-factorial interventions to support the mental health and wellbeing of adopted children and their families.

Furthermore, the study forming part 2 of the thesis is the first known study to document and explore trauma symptoms in adoptive parents. The findings demonstrate high rates of trauma symptoms and compassion fatigue in adoptive parents, emphasising the importance of screening for trauma symptoms when working with adoptive families. The findings have further theoretical implications by highlighting the cognitive avoidant styles associated with high trauma symptomology. An important finding of part two, was the significance of current emotional and behavioural difficulties, including child-to-parent violence, over the extent of the child's pre-adoptive trauma in predicting trauma responses, which has important theoretical and clinical implications for clinicians and adoption support organisations. Clinical interventions should firstly address child-to-parent violence, and secondly focus on cognitive coping styles where trauma related to violence occurs. These findings lead to clinical interventions based on reducing avoidance and increasing psychological flexibility, such as Acceptance and Commitment Therapy.

Finally, the current study provides insight into how trauma can be measured in parents and carers. The IES-R and the ProQOL subscales were highly correlated, indicating that both could be used to measure trauma symptoms. Although the IES-R holds the advantage of being relatively shorter, the ProQOL provides further

indices to measure strengths, such as compassion satisfaction, which may hold potentially mitigating effects on compassion fatigue. Such important clinical and academic findings can be brought to focus through dissemination in scientific journals, media outlets and through direct contact with adoption support charities and services.

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Part 1: Literature Review

Mental health and behavioural difficulties in adopted children: A systematic review of post-adoption risk and protective factors

Abstract

Aim: Adopted children are at a greater risk of experiencing psychological and behavioural difficulties, with previous research highlighting the important risk and protective role of post-adoption variables. This review aimed to classify and summarise the post-adoption variables associated with adopted children's mental health or behavioural difficulties, to guide future research and interventions.

Method: Web of Science, Psychinfo, Medline and Sociological Abstracts searches for risk or protective factors associated with adopted children or adolescents' mental health identified 52 studies meeting the inclusion and exclusion criteria.

Results: Children and adolescents' mental health and behavioural outcomes were associated with the following a) parent factors, b) parent-child relationship factors, c) family factors and d) contextual factors.

Conclusions: The findings highlight the importance of focusing on the multitude of systemic factors surrounding a child following adoption. Clinical implications and direction for future research are discussed.

Introduction

Adoption, kinship care and foster care are currently the main formal and non-biological parental care arrangements in the UK when the local authority believes that a child's needs cannot be met by their parents within a reasonable timescale. Adoption is a legal order granting full parental responsibility for a child to approved adopters, whereas in kinship or foster care arrangements, the local authority continues to hold parental responsibility and the child remains 'looked after' by the local authority. Current UK policy favours achieving permanence within a permanent family setting, such as adoption (Department for Education, 2016).

The number of children that ceased to be looked after due to adoption has been continually decreasing in England. In 2018 there were 3,820 children adopted, a decrease of 13% from the previous year, despite an increase in the number of children entering care (Department for Education, 2018). There are many reasons why a child may be taken into care and subsequently adopted, with the most common reason identified as abuse or neglect, followed by 'family dysfunction', or 'absent parenting', referring mostly to unaccompanied asylum-seeking children (Department of Education, 2018).

When examining the research on adoption it should be noted that there are important distinctions in the type and process of adoption across countries. For example, within the US the majority of adoptions were to familiar adoptive parents, with 52% of children being adopted by their foster carers and only 12% of adoptions being stranger or matched adoptions (AFCARS, 2019). Whereas, in the UK, only 15% of children are adopted by previous foster carers, and 85% are stranger or matched adoptions (Selwyn et al., 2014). Furthermore, there are important distinctions between domestic and international adoptions. Although the number of international adoptions is increasing, the data on international adoption globally is limited (Selman, 2006). There are important differences across countries, for

example, most international adoptions in the United States were from China, Russia, Guatemala, and South Korea, whereas most international adoptions within Europe were from China, Russia, Colombia, Ukraine and Bulgaria (Selman, 2006). In addition, domestic and international adoptions may be transracial, with the experience of the adoptees and adoptive families varying greatly in whether or not the child is a broad racial match to the host country or family (Tuan, 2008). These important considerations highlight that there is not a central theme or pathology that follows adoption, but rather that there is great diversity in the type of adoption, and the context within which they occur. This is important to consider when evaluating the research, and when generalising the findings from research across countries but also across domestic and international adoption.

In spite of these distinctions, numerous studies have demonstrated the positive impact of adoption upon a child's physical, cognitive and psychosocial development following adversity (Palacios et al., 2011; Rutter, 1998; Segatto & Dal Ben, 2013; Van IJzendoorn & Juffer, 2006). Findings from two meta-analyses suggest that the majority of adopted children are well-adjusted (Bimmel et al., 2003; Juffer & van Ijzendoorn, 2005).

However, research into adoption has also recognised that adopted children and adolescents are at a greater risk of psychological and behavioural difficulties than their non-adopted peers. Adopted children are overrepresented in mental health services (Juffer & van Ijzendoorn, 2005), and the risk of psychiatric disorders for adoptees is estimated to be twice as high as that of their non-adopted peers (Behle & Pinquart, 2016). Specifically, in international adoptees, a large national cohort study found that although most adoptees were well adjusted, there was a significantly higher risk of suicide, psychiatric illness, and social maladjustment when compared to non-adopted peers (Hjern et al., 2002). Psychological and behavioural difficulties in adopted children and adolescents are associated with an

increased risk of adoption disruption, which in turn places adoptees at further psychological and emotional risk (Selwyn et al., 2014).

Based on these findings, further research has begun to identify risk and protective factors that predict the psychological adjustment of adopted children. Studies have focused on pre-adoptive risk factors, such as age at adoption, with some studies suggesting adoption after the age of 6 months as an indicator for increased behavioural problems (Rutter, 2007; Hawk & McCall, 2010). However, it is difficult to differentiate age at adoption with exposure to pre-adoptive adversity, with research suggesting that exposure to pre-adoptive adversities underlies the association between age at adoption and later outcomes (Tan et al., 2010). Children who are adopted have higher rates of adverse life experiences prior to being adopted, with cumulative adverse experiences being associated with internalising and externalising problems and negatively affecting psychological adjustment (Anthony et al., 2018). However, pre-adoptive factors alone do not account for the entire variability in psychological adjustment, as despite the many additional disadvantageous factors adopted children experience, many adoptees are well-adjusted (Bimmel et al., 2003; Juffer & van Ijzendoorn, 2005). Therefore, alongside pre-adoptive factors, it is important to explore the role of post-adoption factors in the adjustment of adopted children.

A psychosocial model of adoptees' difficulties that includes both pre-adoptive and post-adoption factors has been proposed as having the most support in explaining behavioural difficulties in adopted children (Peters et al., 1999). The model suggests that family and systemic processes in a child's daily life have greater significance than the effects of pre-adoptive history. Supporting studies have identified family factors such as adoptive family sense of coherence (Ji et al., 2010), and family relationships (Balenzano et al., 2018) as predictive of adoptees' psychosocial adjustment to a greater extent that pre-adoptive risk factors. Parenting factors such as parenting quality have been found to mitigate some of the effects of

pre-adoptive cumulative adversity on behavioural difficulties (Kriebel & Wentzel, 2011), and provided the basis for parenting interventions recommended in the NICE guidelines for children with attachment difficulties (NICE, 2015).

Overall, the research suggests that the psychological adjustment of adoptees is not predicted by a single risk factor, but rather as an accumulation of multiple risks (Roskam & Stievenart, 2014). Therefore, the current study aims to summarise the literature on post-adoption psychosocial risk and protective factors in the psychological adjustment of adopted children. As little can be done to amend pre-adoptive risk factors, such as the extent of adversity or age at adoption, the current study focused on post-adoption factors which provide a clear basis for potential intervention.

The specific aims of the review are:

1. To classify and summarise the post-adoption variables associated with adopted children's mental health or behavioural difficulties to guide future research and interventions.
2. To determine how mental health or behavioural difficulties are measured in adopted children.

Method

Search Strategy

The search terms used for this review were:

1. Adopt* NEAR/4 (child* OR adolescen* OR youth OR "young person" OR juvenile OR teenage*))) AND
2. "mental health" OR behavi?or* OR psychiatric* OR psychological* OR adjustment OR depressi* OR anxiet* AND
3. "risk factor*" OR resilien* OR "associated factor*" OR predict* OR correlat* OR "protective factor*" OR moderat* OR mediat* OR pathway

I consulted with clinical psychologists working within adoption services to assess the completeness of the search terms. I further consulted with a UCL librarian specialising in systematic searches within the field of psychology on the search strategy and databases to search.

Data Sources

The following electronic databases were searched: Web of Science, Psychinfo, Medline and Sociological Abstracts. The final search was from inception to October 2019.

Inclusion and Exclusion Criteria

Criteria for including and excluding studies are outlined in Table 1.

Table 1

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Adopted children or adolescents	Studies of adult populations or non-adopted children
Post-adoption psychosocial risk or protective factors	Genetic or genetic-environment adoption studies
Measure of mental health, behavioural difficulties or psychological adjustment	Studies focusing on pre-adoptive risk or protective factors
Case-control, longitudinal or cross-sectional studies	Studies not published in English
	Non-empirical or general discussion papers

Study Selection

Search results were downloaded and managed in an EndNote library, where duplicates were removed. The titles were then screened against the inclusion and exclusion criteria. Where unclear, the abstract was reviewed. Once eligibility was determined, the full text was read. Discrepancies were resolved by discussion with the research supervisor.

Data Extraction

Information from each of the eligible studies was extracted into a predesigned, structured template using an Excel database. Publication details (author, year, title, journal) were extracted. The following study characteristics were extracted: country of the study, research methods, participants information (sample size and demographic information, including age, gender, ethnicity, international or domestic adoptees), comparative group or age at follow up assessments (where applicable) and age at adoption. Further information extracted included the post-adoption predictive factor, predictor measure, outcome, outcome measure, key findings and key limitations (see Appendix A).

Quality Assessment

To determine the quality of studies in the review, each study underwent quality assessment using the Standard Quality Assessment Criteria for Evaluating Primary Research Papers from a Variety of Fields (Kmet et al., 2004). The broad nature of the quality assessment tool allowed for a range of methodologies to be assessed and to be used to both define a minimum threshold for the inclusion of studies and provide a useful quantitative score to use when synthesising information across studies. A conservative cut-off of 75% or above was used in the current review. Items contributing to the quality score included; the description of study objectives, study design, reporting of participant characteristics, outcome measures,

sample size, analytic methods and whether results and conclusions were reported in sufficient detail (Kmet et al., 2004). The 14-items were scored depending on the degree to which the specific criteria were met or reported ("yes" = 2, "partial" = 1, "no" = 0). Items not applicable to a particular study design were marked "n/a" and were excluded from the calculation of the summary score. A percentage was calculated by dividing the total sum score by the total possible score. To assess inter-rater reliability, a sub-set of 15 studies were rated by an independent researcher.

Approach to Evidence Synthesis

The findings from the studies were narratively synthesised in order to summarise the risk and protective factors for adopted children's mental health or behavioural difficulties. The narrative synthesis included categorising the risk or protective factors under common themes, exploring patterns of findings across studies, and giving consideration to the quality of studies in the interpretation of the findings. Ultimately, the purpose was to put into text format the key findings from the most robust evidence available to aid in the development of a summative model of post-adoption factors associated with adopted children's mental health and behavioural difficulties.

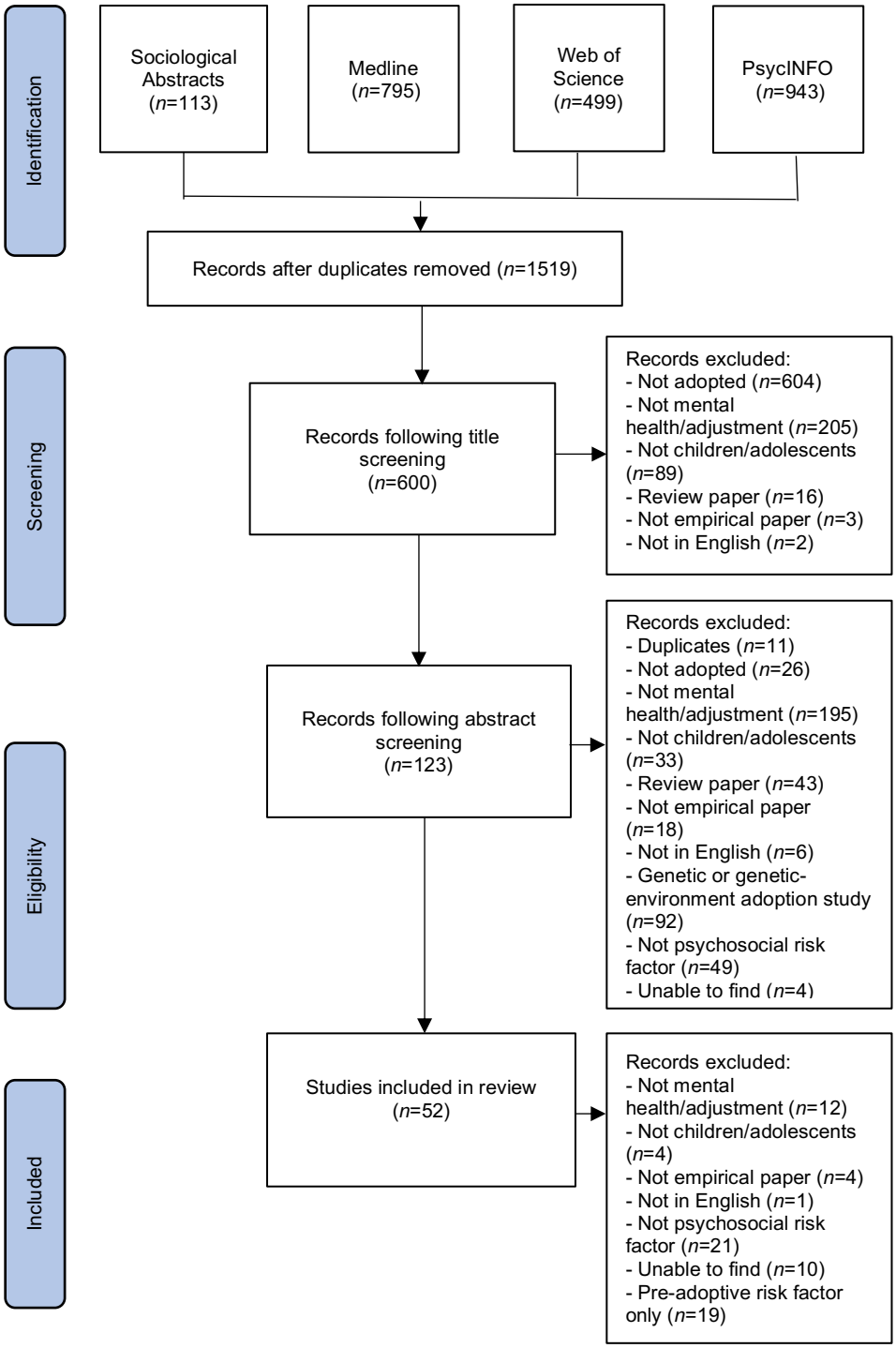
Results

Study Selection

Electronic database searches resulted in 2,350 studies across the databases, which resulted in 1,519 unique studies once duplicates were removed. From this, 600 studies were included following the title screening, and subsequently 123 studies were included from the abstract screening. After scrutinising the full texts, a total of 52 studies were included in this review. The flow diagram of study selection is outlined in Figure 1.

Figure 1

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Flow Diagram of Study Selection



Quality Assessment

Overall, the studies were of good quality, with a median score of 95% and an interquartile range of 90 to 100%. See Appendix B for quality ratings of individual studies. All studies assessed reached the threshold (75%) to be included in the review. Inter-rater reliability was high with 80% agreement rating between the two raters. As the ratings were continuous, Pearson's correlation was used to determine inter-rater reliability as acceptable (r = .56, p = .02).

Study Characteristics

The review included 29 cross-sectional studies and 23 longitudinal studies (see Appendix A). The number of participants ranged from 32 (Tarroja, 2015) to 2,089 (Harwood et al., 2013). In total 30 studies specifically focused on, or included, international adoptees. Seven studies compared adoptive families with a matched non-adopter comparison group (Audet & Le Mare, 2011; Klahr et al., 2011; Lawler et al., 2017; Nilsson et al., 2011; Priel et al., 2000; Roskam & Stievenart, 2014; Tarullo et al., 2016). The risk factors of interest to this review varied among the included studies; 23 studies looked at parent factors, 10 at parent-child relationship factors, 16 at family factors and 15 at contextual factors, with many studies looking at several risk factors from these different categories (Appendix A).

Outcome Measures

Behavioural and mental health difficulties in adopted children were measured using a variety of outcome measures. The majority of studies used a measure encompassing a broad spectrum of emotional and behavioural problems. The most common outcome measure used was the Child's Behavioural Check List (CBCL) in 26 studies, which measures both internalising and externalising problems (Audet & Le Mare, 2011; Brodzinsky, 2006; De Maat et al., 2018; Gagnon-Oosterwaal et al., 2012; Goldberg & Smith, 2013; Goldberg & Smith, 2017;

Grotevant et al., 2011; Groza & Ryan, 2002; Groza et al., 2003; Hails et al., 2019; Juffer et al., 2004; Kriebel & Wentzel, 2011; Lee, 2010; Le Mare & Audet, 2014; McGuinness et al., 2005; McGuinness & Pallansch, 2007; Neil, 2009; Priel et al., 2000; Roskam & Stievenart, 2014; Simmel, 2007; Smith-McKeever, 2004; Smith et al., 2018; Tan et al., 2012; Tarroja, 2015; Tung et al., 2018; van der Voort et al., 2014), followed by the Strengths and Difficulties Questionnaire (SDQ) used in four studies (Anthony et al., 2019; Hornfeck et al., 2019; Santos-Nunes et al., 2018; Qin et al., 2017). Other broad measures of behavioural adjustment included the Behavioural Assessment System for Children (BASC), which was used in two studies (Hein, 2017; Miller et al., 2009), The Dominic Interactive (DI), used in two studies (Gagnon-Oosterwaal et al., 2012; Smith et al., 2018), The Youth Self Report (self-report version of the CBCL) was used in a further two studies (Aramburu Alegret et al., 2020; Grotevant et al., 2011); The Behaviour Problem Index (BPI), used in one study (Ji et al., 2010) and the MacArthur Health and Behaviour Questionnaire, Parent Version (HBQ-P), used in one study (Tarullo et al., 2016).

Some studies focused on narrower subdomains of internalising and externalising behaviours, such as the Delinquent Behaviour Inventory (DBI) (Koh & Rueter, 2011), the Delinquent Behaviour Index (DBI) (Klahr et al., 2011), the Achenbach Teacher report form (van der Voort et al., 2013), diagnostic criterial for Antisocial Personality Disorder (ASPD) (Schires et al., 2020) and arrest history or substance use (Agnich et al., 2016; Tung et al., 2018).

Other studies focused on narrower symptoms scales of psychological difficulties. For example, one study included the Achenbach System of Empirically Based Assessment (ASEBA) battery from the CBCL (Balenzano et al., 2018), one utilised the Brief Symptom Inventory (Mohanty, 2015) and two studies of the same author used a combination of the State-Trait Anxiety Inventory (STAI) and Beck's Depression Inventory (BDI), Affect Balance Scale (ABS) and the Satisfaction with Life Scale (SWLS) (Yoon, 2000; Yoon, 2004). Self-esteem was measured in five

studies, using the Rosenberg Self-Esteem Scale (RSE) (Mohanty, 2015; Reppold & Hutz, 2009; Yoon, 2000), the Multidimensional Self-esteem Test (Balenzano et al., 2018) and the Self-Perception Profile for Children (SPPC) (Brodzinsky, 2006). Distress was measured in one study, using the Kessler Psychological Distress Scale (Qin et al., 2017). Emotional regulation as a psychological outcome was measured in two studies, using the Emotion Regulation Checklist (ERC) (Soares et al., 2017) and the Draw A Person-Screening Procedure for Emotional Disturbance (Tarroja, 2015).

A number of studies measured specific aspects of mental health, such as depression, post-traumatic stress disorder (PTSD), attachment disorders, attention deficit hyperactivity disorder (ADHD) and conduct disorder as the outcome. Depressive symptoms were measured using the Children's Depression Inventory (CDI) in two studies (Liskola et al., 2018; Reppold & Hutz, 2009), the Depression and Anxiety in Youth Scale (Ji et al., 2010) in one study, and the Structured Clinical Interview for the DSM–III–R Diagnosis in one further study (Schires et al., 2020). Whether a child had received a diagnosis of PTSD or an attachment related disorder was the outcome in two studies (Agnich et al., 2016; Harwood et al., 2013) and in one study for ADHD (Audet & Le Mare, 2011), whereas another used the ADHD-questionnaire to measure symptoms (De Maat et al., 2018). Conduct disorder was measured in one study using the Diagnostic Interview Schedule for Children–Child Version (DISC) (Nilsson et al., 2011).

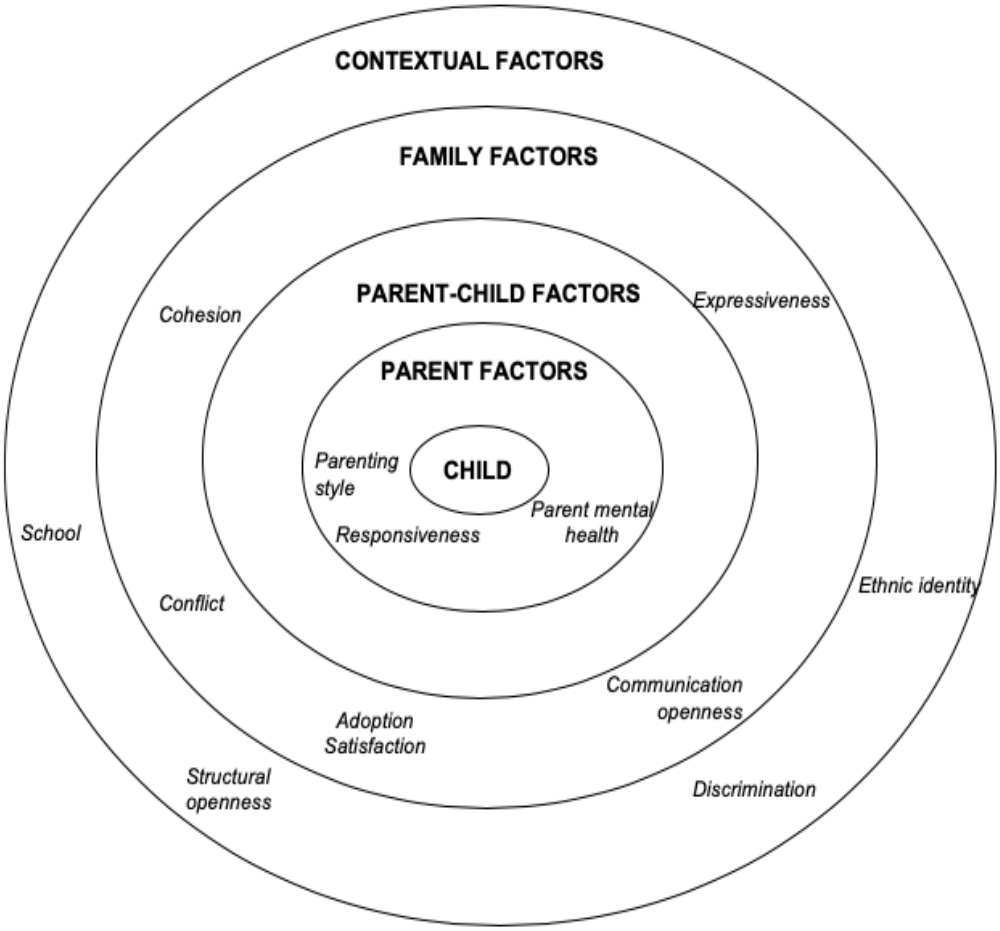
Finally, some measures focused on adaptive coping. Adaptive behaviours were measured in one study using the Vineland Adaptive Behaviour Scales (VABS) (Hein et al., 2017) and two studies using the Child Adaptive Behaviour Inventory (CABI) (Grotevant et al., 1999; Grotevant et al., 2011). Three studies utilised observational methods to measure behaviour or conflict (Klahr et al., 2011; Koh & Rueter, 2011; Lawler et al., 2017).

Narrative Synthesis

The overarching risk and protective factors associated with adopted children's mental health or behavioural difficulties were classified under common themes outlined in Figure 2; parent factors, parent-child factors, family factors and contextual factors. The narrative synthesis will describe the specific risk factors outlined under each theme.

Figure 2

Map of the Post-Adoption Variables Associated with Adopted Children's Mental Health or Behavioural Difficulties



Parent Factors

The role of adoptive parent factors was explored in 17 studies, covering parenting style, parental mental health and parental responsiveness.

Parenting style. Parenting style was the focus in the majority of studies focusing on parent factors, with 10 studies exploring the role of parenting style as a risk, or protective factor associated with adopted children's mental health or behavioural difficulties.

In a Belgian cross-sectional study comparing 40 international adoptees from a range of countries to 34 non-adopted children, both externalising and internalising behaviours were associated with low parenting support in adoptees and non-adopted children (Roskam & Stievenart, 2014). A large longitudinal study of 293 adoptive families in the USA found that negative parental affect and style were also associated with internalising and externalising behaviours (Simmel, 2007). Perhaps unsurprisingly, perceptions of negligent parenting styles were also important, in a cross-sectional non-comparative Brazilian study of 68 adoptees (Reppold & Hutz, 2009).

Permissive parenting and authoritarian parenting styles correlated with behavioural problems in a cross-sectional study from a large longitudinal cohort of 133 adoptees in the USA (Tan et al., 2012). Furthermore, regression analyses suggested that authoritarian parenting mediated the effect of non-child-related family stress on adoptees' internalising behaviours and overall behavioural problems (Tan et al., 2012). In international adoptees, authoritarian parenting was seen more in families where the child was told that they had been adopted later rather than earlier, and if they had changed their child's first name, which was associated with higher levels of depression and low self-esteem in 68 adoptees participating in a cross-sectional study (Reppold & Hutz, 2009). One longitudinal study comparing 75 Romanian adoptees with 46 non-adopted Canadian children

interestingly found that authoritarian parenting style was positively predictive of inattention and/or overactivity in adoptees with lower levels of deprivation, and negatively predictive in children with higher levels of deprivation (Audet & Le Mare, 2011). This suggests that authoritarian parenting behaviours may have a differential effect depending on the level of deprivation experienced by the child. Although unable to determine causality, it is possible that when considering children with severe deprivation, parents with an authoritarian style may be displaying sensitivity and responsiveness to their child's individual needs, understanding that they may respond better to a structured and stricter environment.

On the other hand, positive parenting, such as child-centred parenting was a positive predictor of adaptive behaviour and was found to moderate the effects of cumulative risk in the pre-adoptive environment in a cross-sectional study of 70 domestic and international adoptees within the USA (Kriebel & Wentzel, 2011). The protective role of parenting style was further supported in a cross-sectional German study of 172 domestic and international adoptees, which used structural equation modelling to demonstrate that positive parenting was linked to lower emotional and behavioural problems, again including when pre-adoption conditions were considered (Hornfeck et al., 2019). Parental warmth moderated the association between the number of adverse early experiences and internalising symptoms three years post-adoption in a Welsh longitudinal study of 374 adoptees (Anthony et al., 2019). In a further longitudinal study of 68 adoptees compared to 52 non-adopted children within the USA, higher quality parental structure and limit-setting in the early period after adoption predicted lower child regulation difficulties (Lawler et al., 2017). Furthermore, parenting was not predicted by initial child regulation, demonstrating the unique role of parenting quality (Lawler et al., 2017).

Only one longitudinal study of 74 Russian born adoptees in the USA found that behavioural outcomes showed no significant relation to parenting as reported by mothers and fathers separately (Hein et al., 2017). However, higher

discrepancies between mothers' and fathers' reports of positive parenting were associated with higher levels of behavioural difficulties and lower levels of adaptive skills, suggesting the importance of a consistency amongst caregivers (Hein et al., 2017). It is important to note that this study utilised correlational analysis and therefore cannot draw causality or determine whether discrepancies in parental report were predictive of behavioural difficulties.

Overall, the evidence reviewed is quite consistent in indicating that parenting style is a risk factor for adopted children's mental health and behavioural problems as well as an important protective factor, with the role of parenting style moderating the impact of adverse pre-adoptive experiences. However, only four out of the 10 studies utilised observation of parenting rather than self-report (Anthony et al., 2019; Audet & Le Mare, 2011; Lawler et al., 2017; Simmel et al., 2007), which is a limitation to the conclusions as reporting bias may be an important factor when assessing parenting style.

Parental mental health. The association between adoptive parent mental health and children's behavioural or mental health adjustment difficulties was explored in in seven studies (Colvert et al., 2008; Gagnon-Oosterwaal et al., 2012; Goldberg & Smith, 2013; Hails et al., 2019; Hornfeck et al., 2019; Liskola et al., 2018; Smith-McKeever, 2004). This included one study on general parental mental health (Colvert et al., 2008), and specifically parental depression in three studies (Goldberg & Smith, 2013; Hails et al., 2019; Liskola et al., 2018). Parenting stress was explored in five studies (Gagnon-Oosterwaal et al., 2012; Miller et al., 2009; Santos-Nunes et al., 2018; Smith-McKeever, 2004; Smith et al., 2018) and parent self-regulation was measured in one study (Hornfeck et al., 2019).

Only one UK cross-sectional study, as part of a longitudinal cohort of 217 domestic and Romanian adoptees examined parental mental health in general (Colvert et al., 2008). Utilising interviews, they found no evidence of an association

to either adoptees' educational attainment or self-esteem (Colvert et al., 2008). Furthermore, the outcomes of educational attainment or self-esteem do not directly relate to mental health or behavioural difficulties.

On the other hand, parental depressive symptoms were strongly associated with higher parent-reported levels of both externalising and internalising symptoms in adopted children in two large scale longitudinal studies within the USA (Goldberg & Smith, 2013; Hails et al., 2019). Interestingly, findings from a large Finnish cross-sectional study of 242 international adoptees suggested that there is a difference between the impact of maternal and paternal depression (Liskola et al., 2018). Paternal depressive symptoms were associated with the children's depressive symptoms, whereas there were no associations found between maternal depressive symptoms and any dimensions of the adoptees' depressive symptoms (Liskola et al., 2018). One longitudinal study using structural equation modelling found that exposure to adoptive fathers' depressive symptoms in infancy independently contributed to the prediction of children's internalizing symptoms at early school age, which also moderated the associations between adoptive mothers' depressive symptoms and child externalizing symptoms (Hails et al., 2019).

Parental stress was associated with internalising and externalising behavioural problems (Gagnon-Oosterwaal et al., 2012; Miller et al., 2009; Smith-McKeever, 2004), and difficulties at school in children adopted from the former Soviet Union or Eastern Europe to the USA (Miller et al., 2009). Furthermore, maternal stress was found to mediate the relationship between children's characteristics and early risk factors, such as age of adoption, and later behavioural problems in two Canadian longitudinal studies of international adoptees (Gagnon-Oosterwaal et al., 2012; Smith et al., 2018). A further Portuguese cross-sectional mediation study of 116 adoptees found that discrepancies between parents' expectations and their real experience after adoption, was associated with an increase in parental stress, resulting in a negative influence on the child's

adjustment (Santos-Nunes et al., 2018). Relational factors, such as the amount of positive time parents and children spend together and how often the parent thinks of the child when they are separated were important factors to consider alongside parenting stress within a cross-sectional study of 83 adoptees in the USA (Smith-McKeever, 2004).

Parent self-regulation was examined in one cross-sectional study, which was defined as a combination of parents' self-efficacy, perceived stress and psychological distress (Hornfeck et al., 2019). Adoptive parents' stress regulation difficulties were associated with children having more emotional and behavioural problems (Hornfeck et al., 2019).

Together, these findings highlight the important role of adoptive parental mental health as a risk factor for children's mental health or behavioural difficulties, and further suggest that parental stress, and not solely diagnosable mental health difficulties are important risk factors. Importantly, the studies on parental mental health do not include a non-adopted comparison group, making it difficult to determine whether these results are specific to adoptive families, or reflective of all types of families.

Parental responsiveness. Three longitudinal studies focused on maternal sensitivity or self-reflectiveness as a risk factor, which refers to a parent's ability to mentalise their child's state of mind and the quality with which they respond to their child's cues in a timely and appropriate manner (Priel et al., 2000; van der Voort et al., 2013; van der Voort et al., 2014). One longitudinal study conducted in Israel found that low maternal self-reflectiveness was associated with a higher rate of externalising behaviours amongst both adopted and non-adopted children (Priel et al., 2000). A further longitudinal study of 160 international adoptees, adopted by Caucasian parents in The Netherlands found that maternal sensitivity appeared to be an important predictor of delinquent behaviour, but was not found to relate to

aggression at 14 years of age (van der Voort et al., 2013). For internalising symptoms, one cross-sectional study of 160 international adoptees adopted by Dutch Caucasian families found that higher sensitive parenting in early and middle childhood predicted less inhibited behaviour in adolescence, which subsequently predicted fewer internalising problems in adolescence (van der Voort et al., 2014).

One longitudinal US study comparing 43 internationally adopted and 37 non-adopted children focused on the association between parental mental state language and children's emotional understanding, which found that parental mental state language at age 3 years predicted the emotional understanding of children at 5.5 years old in adopted children, but not for non-adopted children (Tarullo et al., 2016). Furthermore, adopted children had significantly more internalising and externalising problems, which were associated with lower levels of emotion understanding (Tarullo et al., 2016). These studies suggest the importance of adoptive parents' ability to mentalise and respond to their child as a protective factor in the development of behavioural and mental health difficulties.

Parent-Child Relationship

The parent-child relationship, which was often, though not exclusively measured through observational methods, was consistently associated with children's behavioural problems, and in particular adolescent behavioural difficulties (Groza & Ryan, 2002; Groza et al., 2003; Harwood et al., 2013; Klahr et al., 2011; Koh & Rueter, 2011; Santos-Nunes et al., 2018). One large-scale longitudinal study of 2,089 domestic and international adoptees within the USA found both direct and indirect paths between pre-adoptive adversities and mental health outcomes, with the majority of associations mediated or partially mediated by the quality of parent–child relationships (Harwood et al., 2013). The quality of parent-child relationships was measured by parental perceptions of closeness, affection and satisfaction. However, the parent-child relationship and questions on mental health diagnoses

were measured by parental report on a measure designed by the research team. A further longitudinal study of 96 Romanian adoptees in the USA consistently found the parent-child relationship, again measured by questions devised by the research team, predicted behavioural difficulties, and suggested that the parent-child relationship was also a strong resource for parents (Groza et al., 2003).

A large-scale longitudinal comparison study of 406 adoptive families and 204 non-adoptive families found that parent-child conflict consistently predicted antisocial behaviour in adopted adolescents, however this was equivalent to non-adopted peers (Klahr et al., 2011). Findings from another longitudinal study support the role of parent-child conflict (Koh & Rueter, 2011).

Although one cross-sectional study comparing 61 domestic and 230 international Romanian adoptees within the USA found that domestic and international adoptees were more similar to each other than different in terms of the role of parent-child relationship (Groza & Ryan, 2002), ethnicity was found to be an important aspect of parent-child relationship in two cross-sectional studies within the USA (Yoon, 2000; Yoon, 2004). Structural equation modelling found that a positive parent-child relationship was predictive of adoptees' wellbeing, when this included a higher collective self-esteem developed through parental support of ethnic socialisation (Yoon, 2004). Parents supporting their children's ethnic identity development and assisting with ethnic socialisation was an important aspect of a positive parent-child relationship that predicted better psychological adjustment of adoptees. These findings suggest the importance of considering ethnicity, race and contextual aspects of the parent-child relationship as a predictor of adoptees' behavioural or mental health difficulties.

Attachment was a focus of two studies examining the role of the parent-child relationship, with attachment problems being associated with ADHD symptoms more so than pre-adoptive risk factors, such as deprivation and prenatal alcohol exposure in Polish born adoptees (De Maat et al., 2018). Specifically, externalising

behaviours were associated with anxious-avoidant attachment and low parenting support (Roskam & Stievenart, 2014).

These findings from both longitudinal and cross-sectional studies demonstrate the key role of the parent-child relationship and highlight the importance of considering this in the context of ethnicity and attachment. Conclusions are from a variety of methodologically high-quality studies all within the USA; however it should be noted that one longitudinal comparison study suggests that these associations are equivalent to that in biologically related children, rather than specific to adoptive families (Klahr et al., 2011). Importantly, the studies highlight the role of the parent-child relationship as a source of support for parents.

Family Factors

Family environment: cohesion, expressiveness and conflict. Studies of the family environment focused on cohesion, expressiveness and conflict within the adoptive family system. A positive family environment was associated with children's adaptive adjustment in five studies (Ji et al., 2010; McGuinness, & Pallansch, 2007; McGuinness et al., 2005; Simmel, 2007; Tung et al., 2018), with one cross-sectional study of 379 adoptees within the USA suggesting that family coherence predicted adoptees' adjustment considerably more than pre-adoptive risk factors (Ji et al., 2010). One further longitudinal study of 83 adoptees within the USA specifically explored children's temperamental sensitivity and later family cohesion (Tung et al., 2018). Adoptees with an early reactive temperament did not exhibit greater sensitivity to maltreatment or later adoptive family cohesion, however, adoptive family cohesion demonstrated a marginally significant and protective effect on youth criminal behaviours and arrest rates (Tung et al., 2018).

When exploring the impact of family environment on pre-adoptive risk factors, one longitudinal study in the USA found that pre-adoptive risk factors declined in importance, whereas aspects of family environment as a protective

factor increased in influence over time from when the children were on average 7.7 years old to 11 years old (McGuinness, & Pallansch, 2007). A longitudinal study of children adopted from the former Soviet Union to the USA found that despite early adversities, children's development fared well within a protective family environment, characterised by cohesion, expressiveness and lower conflict (McGuinness et al., 2005). A further longitudinal study of 293 adoptees found that adoptive parents' self-reported assessment of readiness and sense of preparation for adoption was a significant predictor of behavioural outcomes, alongside family environment (Simmel, 2007). This suggests that preparation for adoption and the role of the family environment are important factors in predicting adoptees' behavioural difficulties.

Conflict and family relationships were explored in three studies (Balenzano et al., 2018; Goldberg & Smith, 2013; Tan et al., 2012). In a cross-sectional study of international adoptions from China to families within the USA, family stress correlated with children's behavioural problems (Tan et al., 2012) and parental relationship conflict was associated with greater internalising symptoms in adoptees in one longitudinal study (Goldberg & Smith, 2013). However, as a protective factor, positive family relationships mitigated the negative impact of pre-adoptive stressors on adoptees' later functioning in one cross-sectional study (Balenzano et al., 2018).

Overall, the findings are consistent in suggesting that family environment, incorporating aspects of cohesion, expressiveness and conflict, serves as a consistent and important risk and protective factor for children's behavioural and mental health difficulties. Findings suggest that family environment can serve to mitigate the impact of pre-adoption adversity on the development of behavioural or mental health difficulties. However, the longitudinal and cross-sectional studies exploring family environment do not include a non-adopted comparison group, making it unclear whether these findings are applicable to all types of families.

Communication openness. Communication openness refers to the concept of open communication within the adoptive family system, with adoptive parents being able to recognise the inherent differences associated with being an adoptive family, rather than to deny or reject such differences. Six studies focused on the role of communication openness as a protective factor (Aramburu Alegret et al., 2020; Brodzinsky, 2006; Grotevant et al., 2011; Le Mare & Audet, 2014; Soares et al., 2017; Tarroja, 2015).

Two cross-sectional studies of international adoptions in Spain and Canada found that a lower degree of communicative openness, which was associated with a history of maltreatment prior to the adoption, was significantly associated with the presence of adolescent behavioural problems (Aramburu Alegret et al., 2020; Le Mare & Audet, 2014). It further predicted emotional lability and negativity in a Portuguese cross-sectional study of 70 adoptees (Soares et al., 2017). However, findings from two studies relied on questionnaires devised by the research team, rather than validated measures (Le Mare & Audet, 2014; Soares et al., 2017). Adoption secrecy was found to predict family functioning, which predicted the subsequent adjustment of Filipino adopted children in a Filipino cross-sectional study of 32 adoptees (Tarroja, 2015). Furthermore, adoption openness was found to buffer the impact of the early adversity experienced by the adopted children (Tarroja, 2015).

When compared to structural open adoption arrangements, where contact with birth families is permitted, one US cross-sectional study of 73 adoptees found that family structural openness and communication openness were positively correlated, however, only communication openness independently predicted children's adjustment (Brodzinsky, 2006). This suggests that family process variables predict children's adjustment to a greater extent than structural variables. However, one further cross-sectional study of 190 adoptees provided inconsistent findings, suggesting that although related to contact, communicative openness did

not relate to externalising behaviours (Grotevant et al., 2011). The evidence for communicative openness is therefore inconclusive.

Adoption satisfaction. Family members' satisfaction with adoption was measured in two studies (Balenzano et al., 2018; Nilsson et al., 2011). Higher levels of adolescents' and parents' adoption satisfaction was associated with lower levels of conduct problems in a cross-sectional study of 202 adopted families within the USA (Nilsson et al., 2011). Adoptees' satisfaction with the adoption process predicted their psychological distress and wellbeing in an Italian cross-sectional study of 59 adoptees (Balenzano et al., 2018). These findings, although limited by cross-sectional designs alone, highlight the importance of family factors, including the process of adoption and satisfaction.

Contextual Factors

Ethnic identity and discrimination. Six studies explored the relationship between psychological adjustment, ethnic identity development and experiences of discrimination in internationally adopted children (Juffer et al., 2004; Lee, 2010; Schires et al., 2020; Qin et al., 2017; Yoon, 2000; Yoon, 2004). Three studies in the USA found that understandably, discrimination was associated with greater internalising problems, externalising problems, depressive symptoms and psychological distress (Lee, 2010; Schires et al., 2020; Qin et al., 2017). One large scale cross-sectional study of 1,579 international adoptees found that discrimination was greater for parents of Asian and Latin American children than Eastern European children, and that perceived discrimination was uniquely associated with greater problem behaviours for adopted children from Asia and Latin America (Lee, 2010). This finding from the USA highlights important contextual factors within international adoption, as all adoptive parents within this study identified as European American, highlighting the importance of considering inracial and

transracial adoption alongside experiences of racial discrimination. One longitudinal study of 115 children adopted to the USA from Korea found that emotional regulation styles do not moderate the association between perceived discrimination and psychological adjustment (Qin et al., 2017). One longitudinal study of 456 adoptees found discrimination to predict higher levels of depressive and externalising symptoms in children who reported less preparation for bias, the process by which parents teach their children about racial identity and prepare them to cope with experiences of discrimination (Schires et al., 2020).

The role of parenting was further explored in a cross-sectional study of 241 Korean born adoptees that found better psychological adjustment of adoptees when adoptive parents, who were mostly Caucasian (95%) supported their ethnic identity development and share ethnic socialisation experiences (Yoon, 2000). Furthermore, a positive parent-child relationship, with a greater collective self-esteem through parental support of ethnic socialisation predicted greater subjective wellbeing (Yoon, 2004). On the other hand, one longitudinal study of 176 children adopted from Sri Lanka, South Korea and Colombia to Caucasian Dutch parents found no relationship between negative reactions based on the children's physical appearance or skin colour and problematic behaviour, rather the desire to be white was associated with more behavioural problems (Juffer et al., 2004). However, this study was based on parents' reports, who were mostly white Dutch, and perhaps unable to grasp the experience of discrimination or micro aggressions experienced by their children based on their skin colour. Furthermore, it is important to consider the contextual and discriminative factors that may lead a child to develop a desire to be white, to enable change to be made to the context surrounding the child.

A curvilinear relationship was found between adoptees sense of ethnic identity and self-esteem, suggesting that a moderate level of ethnic identity was associated with positive esteem, whereas low and high levels of ethnic identity were related to low self-esteem (Mohanty, 2015). Within this study the majority of

participants were adopted from South Korea, all to white parents in the USA (Mohanty, 2015). However, this was a relatively small cross-sectional study of 100 adoptees and cannot conclude causality. Furthermore, one cross-sectional study found that exposure to culture of origin did not predict behavioural problems, further demonstrating the importance of adoptees' heritage and culture (Le Mar & Audet, 2014). It is important to note the limitation of generalising adoptees' experiences of discrimination, which will vary greatly depending on the country of adoption, and the country where they live (Lee, 2010).

These findings, although limited without a non-adopted comparison group, highlight the importance of domestic and international adoptions considering the cultural and racial context and experiences of discrimination, and particularly whether the adopted child is a broad racial match to the host country and family.

Structural openness of adoption. Three studies looked at the impact of the structural openness of adoption, referring to post-adoption contact with birth families (Agnich et al., 2016; Neil, 2009; Grotevant et al., 2011). Overall, contact was not associated with emotional or behavioural difficulties in a small UK cross-sectional study of 67 adoptees (Neil, 2009), although one large-scale cross-sectional study in the USA of 1,544 adoptees found higher rates of children in open adoptions receiving a diagnosis of "attachment disorder" (Agnich et al., 2016). However, it should be noted that the questionable diagnostic outcome of "attachment disorder" was measured as the parents' answers to "has a doctor or other health care provider ever told you that [the selected child] had an attachment disorder?" Furthermore, it is important to note that the study did not explore the mechanisms or reasons for this finding, which may be due to adoptive parents in open arrangements being more likely to identify their child's needs and access mental health services.

One cross-sectional study of 190 adoptees in the USA found that collaboration in relationships with proactive cooperation between the adoptive and birth family was key (Grotevant et al., 1999). Furthermore, satisfaction with contact appears to be an important factor when considering the impact of open adoption on children's mental wellbeing, as one longitudinal study found that higher satisfaction with contact arrangements was associated with a decline in adoptee externalising behaviours during adolescence, when compared to families with lower satisfaction (Grotevant et al., 2011). Moreover, children in open arrangements were more likely to have family relationships characterised by trust and adoptive parents' willingness to recommend adoption to others, which highlights the potential benefits of openness in adoption (Agnich et al., 2016). The findings on the role of structural openness are limited, with no longitudinal study assessing the specific role of contact on behavioural or mental health outcomes. Longitudinal data on structural openness is vital as many clinicians and adoptive parents are understandably concerned about the positive or negative impact of contact with birth families.

Schools. Parent-school relationships was a focus in one longitudinal study of 120 adoptees in the USA, which suggested that parental school involvement was negatively associated with later internalising symptoms, whereas parent-teacher conflict was positively associated with later internalising symptoms (Goldberg & Smith, 2017). These findings highlight the importance of the network around the child being taken into consideration, rather than simply child or family related factors. However, with only one study focusing on the relationship with school, these conclusions are limited.

Discussion

The aim of the current review was to expand upon previous research by identifying and classifying post-adoption variables associated with adoptees' mental

health or behavioural difficulties. The findings of the narrative synthesis support the previous research (Roskam & Stievenart, 2014), by highlighting the importance of focusing on the multitude of systemic factors surrounding the adopted child, which can be categorised into parent, parent-child relational, family and contextual factors. Overall, the findings support the psychosocial model of the development of adoptees' mental health and behavioural difficulties. The findings suggest that post-adoption factors are associated with, and often predictive of adoptees' difficulties, and that certain post-adoption factors may in fact play a greater role than pre-adoptive factors (Peters et al., 1999).

Consistent evidence was found for the role of parent factors including parenting style, parental mental health and parental responsiveness, which were all associated with children's behavioural and emotional mental health. Importantly parenting style and parental mental health were more associated with later difficulties than pre-adoptive risk. An important consideration was the quality and impact of parental relationships with the child, which predicted children's behavioural problems and also appeared to mediate the impact of pre-adoptive adversities and child outcomes. Family factors incorporated family environment, cohesion, expressiveness and conflict, which were all associated with the presence and extent of behavioural and mental health difficulties. Importantly, pre-adoptive risk factors declined in importance, whereas aspects of family environment as a protective factor increased in influence over time, highlighting the importance of research focusing on post-adoptive variables as an intervention, particularly as the age of the child increases. Communication openness within the family system predicted children's later adjustment, once again, buffering the impact of early adversity. However, communication openness was associated with the level of maltreatment, with greater maltreatment being associated with lower openness. This highlights the importance of supporting families and parents with both the

information relating to their child's pre-adoption experiences and skills in communicating such information.

A further finding of the current review was the importance of contextual factors associated with adoptees' behavioural or mental health difficulties. Structurally open adoptions, where contact with birth families is maintained, were not associated with later difficulties. However, collaboration in relationships with proactive cooperation between the adoptive and birth family accounted for variation in outcomes. Important further contextual factors included the role of parental support of racial identity, discrimination and ethnic socialisation. However, there was relatively few studies exploring such important factors. Furthermore, the research base often relied upon parent-reported experience of discrimination or ethnic identity, when the adoptive parents were often Caucasian, and perhaps limited in their experience or perception of racial discrimination. These important aspects highlight the need to study post-adoption risk factors related to adoption and minority status for both internationally adopted children and transracial adoptive families.

Limitations

The current review was confined by the limitations within the included studies. Methodologically, 29 of the studies were cross-sectional, and therefore unable to draw conclusions about the effects over the course of time. Only seven studies compared adoptive families to non-adopted families, which means that it is difficult to differentiate whether the findings are specific to adopted children.

The studies were conducted across 14 countries, with varying adoption processes and contextual factors. The 'type' of adoption is an important contextual factor, as within the USA the majority of adoptions are to familiar foster carers, whereas within the UK, the majority of adoptions are to strangers (AFCARS, 2019; Selwyn et al., 2014). With such diversity in the adoption process and experience, it

is difficult to generalise the findings across the studies included in the current review.

The review was further limited by missing information or bias in the identified studies. Burnham's social GGGRRAAACCCEEEESSS (Burnham, 1992) provide a framework to demonstrate how this missing information limits the findings of the evidence base by not accounting for difference and diversity. A total of 30 studies focused on international adoptions. Information on the countries that the children were adopted from was missing in two studies (Hornfeck et al., 2019; Lawler et al., 2017). Furthermore, over half of those studies did not describe the race or ethnicity of the adoptive parents (Aramburu Alegret et al., 2020; Audet & Le Mare, 2011; Colvert et al., 2008; Gagnon-Oosterwaal et al., 2012; Groza et al., 2003; Groza & Ryan, 2002; Harwood et al., 2013; Hein et al., 2017; Hornfeck et al., 2019; Lawler et al., 2017; Le Mare & Audet, 2014; Liskola et al., 2018; McGuinness et al., 2005; Miller et al., 2009; Qin et al., 2017; Roskam & Stievenart, 2014; Smith et al., 2018; Tan et al., 2012; Tarullo et al., 2016), which meant that it was not possible to determine whether the adopted child was a broad racial match to the adoptive family. Although some studies did document both the race of the child and parents, only one study included in the review considered the child's country of origin, the country of adoption and whether the adoption was inracial or transracial (Brodinsky, 2006). Considering the adopted child in the context of their adoption and race is vital in understanding their experiences. Transracial adoptive parents face additional challenges in supporting their child to develop a positive cultural and racial identity, and to prepare and support their child for the racial dynamics within the country of adoption (Lee et al., 2015). Within the UK and USA, the majority of adoptive parents are white (Ofsted, 2014; Quiroz, 2007). White parents are required to develop their racial awareness and cultural competence, and possibly face new challenges when considering race from this new perspective (Crolley-Simic & Vonk, 2011). One study of transracial adoption described how mothers whose racial views were considered

‘colour-blind’ often downplayed race and did not recognise their child as a member of another race (Crolley-Simic & Vonk, 2011). Parents’ ability to view their children as members of another race is vital to their development of cultural competence (Vonk, 2001). A parent who does not identify their child as of another race may be limited in their ability to acknowledge and prepare their child for experiencing racism, which adult transracial adoptees have suggested is a critical aspect of their development (McGinnis et al., 2009). The current review highlighted the importance of parental support of ethnic socialisation, which has been positively linked to children's adjustment (Yoon, 2004) and their self-esteem and sense of belongingness with parents (Mohanty et al., 2006). Further research has found that racial socialisation by white adoptive parents moderates the relationship between discrimination and stress due to experiences of racism or bias (Lee et al., 2018). These studies demonstrate the importance of exploring not only domestic and international adoptions, but also considering the adopted child within the racial context of their adoptive family and society.

Furthermore, the studies included in the review did not account for the sexuality of the parents, which is important considering that although there has been a reduction in adoptions within England and Wales, there has been an increase in same-sex couples adopting, with 12% of all adoptions being to same-sex couples in 2018 (Department of Education, 2018). Furthermore, statistics suggest that same-sex couples were more open to adopting children with behavioural difficulties and attachment difficulties, highlighting the need for research to be inclusive (New Family Social, 2016). Even so, this description excludes LGBT+ adopters not categorised as a ‘same-sex’ relationship, or single adopters, and does not consider the impact of discrimination experienced by LGBT+ adoptive families. The findings of the current review highlight the importance of contextual and systemic factors such as discrimination in the development of adoptees mental health or behavioural difficulties, making this limitation of the research significant.

Further limitations include the role of gender as findings from the current review suggest a differential impact of maternal and paternal depression on adopted children's adjustment (Hails et al., 2019; Liskola et al., 2018). Such findings perhaps highlight the need for differential support and intervention for fathers and mothers. However, findings on parental gender differences must consider the nature of parental self-report, which will undoubtedly be influenced by the social and cultural expression of depressive symptoms and parental gender roles within a given society (Sigmon et al., 2005). Furthermore, across the review generally, studies often relied upon parental report, which will inevitably inflate the relationship between the variables being studied and the outcome measures. Relying upon parents' reports of their child's difficulties, their own distress and parenting introduces risk of social desirability bias, which may impact on parental responses (Morsbach & Prinz, 2006).

It is important for the research base to consider the intersectionality of Burnham's social GGGRRAAACCCEEEESSS (Burnham, 1992) when designing, interpreting and criticising the current research. This is particularly important given the findings of the current study on the impact of ethnicity and discrimination and given the increase in adoption to non-heterosexual couples.

Future Research

This review highlights that previous research seems to focus on one or two aspects important in the development of adoptees' mental health and behavioural difficulties, with only one study included in the current review exploring three aspects of parent-child, family and contextual factors (Balenzano et al., 2018). It would be important for future research to explore the multi-factor aspects of post-adoption risk factors encompassing parent, family, relational and contextual or systemic factors surrounding the child. Such a longitudinal study would further the current review by demonstrating the relative contribution of the various factors at

different time points of an adoptee's development. The review further highlights the limitation in the evidence base to capture the impact of Burnham's social GGGRRAAACCCEEEESSS (Burnham, 1992) and diversity in adoptive families. Future research should explore diverse experiences, including the impact of discrimination. To design research with families that holds in mind intersectionality is vital to interpret and situate individual level data within a larger socio-cultural and historical context of structural inequality (Few-Demo, 2014). This would include studies being clear about their samples and reflective of the diversity of adoptive families. This will include capturing demographic information of the adopted children, adoptive parents and families and perhaps qualitatively exploring the experience of marginalised adoptive families to begin to understand any differences in experiences and processes.

Implications for Clinical Practice

These findings highlight important systemic areas for key interventions with the power to buffer the impact of early adversity. It demonstrates the importance for clinicians to hold in mind the varied systems surrounding a child when assessing and formulating possible interventions to improve the wellbeing of adopted children. However, the empirical evidence for interventions, which is limited in its findings on efficacy, often focuses on one factor, such as psychological interventions for adoptive parents (Ní Chobhthaigh & Duffy, 2019) or attachment interventions with parents or adopted children (Kerr & Cossar, 2014; Rose & O'Reilly, 2017). The current review suggests that the empirical research evidence base and interventions may be more effective when considering the multi-factor variables in the entire system surrounding the child, incorporating importance contextual aspects and experiences of ethnicity and discrimination. This would be particularly important given the complexity of the systems and society surrounding an adopted child.

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Part 2: Empirical Paper

Compassion fatigue and secondary trauma in adoptive parents

Abstract

Aims: Compassion fatigue, which encompasses secondary trauma, is recognised as one of the negative effects for professionals working with people that have experienced trauma. With symptoms of PTSD such as avoidance, hypervigilance and intrusions, the construct has been well documented in a wide range of professionals. Research has begun to explore compassion fatigue in foster carers of children that have experience childhood trauma. However, no known research has explored compassion fatigue and trauma symptoms within adoptive parents, who face the emotional impact of parenting a child with adverse early experiences. This study aimed to examine potential cognitive styles associated with compassion fatigue and secondary trauma and explore the experience of adoptive parents who display high trauma symptoms.

Method: This mixed-methods study consisted of two phases; in the first phase, 260 adoptive parents completed an online survey including self-report measures of primary and secondary trauma and a range of psychological risk factors. The second stage consisted of telephone interviews with 10 adoptive parents that reported high levels of trauma to explore their experience.

Results: Almost one fifth of adoptive parents exhibited primary trauma scores of clinical concern; with 10% reaching the threshold for a probable diagnosis of PTSD. Adoptive parents scored significantly higher than a normative sample on measures of secondary trauma, with 52.4% of the adoptive parents scoring two standard deviations or more above the norm, within the top scoring 5% of the general population. Avoidant cognitive styles predicted higher trauma symptomology and compassion fatigue in adoptive parents. The current behavioural and emotional challenges, including child-to-parent violence, predicted higher trauma scores more so than the extent of their child's past trauma. Qualitative findings suggested that how the parents experience their child's early trauma, the current parenting

demands including child-to-parent violence and the sense of stigmatisation and support all draw together to form the parents' sense of themselves.

Conclusions: The findings have clinical implications for firstly addressing child-to-parent violence and secondly for potential interventions to focus on cognitive avoidant styles where trauma related to violence occurs. A discussion of the limitations of this study and recommendations for further research are discussed.

Introduction

Adoption

In 2018 there were 3,820 children adopted from care in England (Department for Education, 2018). Outcomes for children are significantly improved once they are adopted (Performance and Innovation Unit, 2000), which has resulted in a government initiative to increase the number of looked-after children placed for adoption (Department of Health, 2001).

Children are placed in care and subsequently adopted as a result of adverse early life experiences often relating to traumatic experiences of abuse and neglect, many of which were at vulnerable stages of psychological and emotional development (Department for Education, 2018). Although not specific to the UK population, where children are predominantly adopted from care to a stranger rather than to foster carers (Selwyn et al., 2014), a large-scale series of meta-analyses, which included 101 studies from around the world, suggested that although the majority of adopted children are well-adjusted, they are at a greater risk of psychological and behavioural difficulties than their non-adopted peers (Juffer & van Ijzendoorn, 2005). Studies have since continued to demonstrate that adopted children face elevated emotional and behavioural difficulties when compared to non-adopted children (Behle & Pinquart, 2016; Dekker et al., 2017; Wretham & Woolgar, 2017). With resulting high levels of emotional, behavioural and attachment difficulties, these children need a significant amount of support from their adoptive parents to recover and make sense of their early experiences (Quinton & Rutter, 1988).

Psychological Impact on Adoptive Parents

The predominant focus within the adoption literature has been on the developmental outcomes of adoptees, with relatively few studies focusing on the

psychological outcomes and adjustment of adoptive parents who face the emotional impact of caring for a traumatised child (McKay et al., 2010).

Becoming a parent, biologically or through adoption is a major life transition, and can be associated with mental health and relational difficulties (Parfitt & Ayers, 2014; McKay et al., 2010). The transition to parenthood is a time of imbalance, with new parents adjusting to practical challenges in taking on new roles and demands, alongside interpersonal challenges to relationships (Delicate et al., 2018; Glade et al., 2005) and individual changes to self-perceptions, personal efficacy and competence and values (Antonucci & Mikus, 1988). Whilst dealing with the adjustment and daily challenges of parenthood that face all parents, adoptive parents have what has been defined as additional “adoptive strains” (Bird et al., 2002). These include more enduring or chronic conflicts and challenges specific to the experience of adoption, such as the greater vulnerability of adoptees facing mental health and behavioural difficulties (Juffer & van Ijzendoorn, 2005) and the challenges of when and how to disclose adoption (Baden et al., 2019). Furthermore, adoptive parents often become parents suddenly, which is associated with an increase in distress (Goldberg, 2010). Adoptive parents are also tasked with developing an attachment bond with their child and as a family (Goldberg et al., 2013), and face the unique fear of losing their child to birth families, who may contest the adoption order (Doughty et al., 2017; Petta et al., 2005). In addition, adoptive parents are more likely to have experienced difficulties with fertility and grieved the loss of a hoped-for birth child (Brinich, 1990; Petta et al., 2005). These combined experiences demonstrate the additional challenges adoptive parents and families are presented with.

The limited research on adoptive parents’ mental health frequently examines the initial phase of the adoption process, thus focusing on adjustment to adoption and post-adoption depression. A systematic review found that post-adoption depression is relatively common within adoptive parents, although perhaps lower

than amongst biological parents (McKay et al., 2010). When measured over time, one study found that adoptive parents maintained low, non-clinical levels of depressive symptoms and parenting stress over time, whereas adoption satisfaction increased over time (Lavner et al., 2014). In contrast, another longitudinal study found that depression scores increased significantly across three time points over three years as the child got older (McAdams et al., 2015). These conflicting findings highlight the importance of understanding the experience of adoptive parents across time, rather than focusing solely on the initial adoption period, which may be characterised by a 'honeymoon' phase (Wind et al., 2007). Within the UK population, one study suggested that adoptive parents had more symptoms of depression than the general population (Selwyn et al., 2015). A further recent UK longitudinal study suggested that depression and anxiety symptoms in adoptive parents were relatively stable across time, although symptoms related to the adoptees' internalising symptoms and parental sense of competence (Anthony et al., 2019).

Although the findings on adoptive parents' experience of depression and anxiety are mixed, findings on parental stress appear to be more consistent. Previous research has reporter higher rates of parental stress in adoptive parents when compared to a control group of biological parents (Rijk et al., 2006) or published norms (Sanchez-Sandoval & Palacios, 2012). A contributing factor to parental stress in adoptive parents may include the pressure to excel in parenting standards, with adoptive parents who perceived their anxiety to be greater than that experienced by biological parents describing an additional pressure of raising someone else's biological child (Daniluk & Hurtig-Mitchell, 2003; McKay & Ross, 2010). Furthermore, parental stress in adoptive parents may be compounded by a sense of judgement from others, with one review finding that adoptive parents often felt that mental health professionals did not recognise the extent of their parenting

challenges, which left parents feeling a sense of blame, guilt and failure (Rushton, 2003).

Although the findings on the impact on adoptive parents' mental health are inconclusive, depression in adoptive parents is associated with placements in the UK breaking down (Selwyn et al., 2014). Furthermore, parental depression and parental stress are associated with greater internalising and externalising symptoms in children (Gagnon-Oosterwaal et al., 2012; Hails et al., 2019). Therefore, it is vital to develop a greater understanding of adoptive parents' mental health and wellbeing.

Compassion Fatigue, Burnout and Secondary Trauma

Research that is predominantly focused on front-line professionals has begun to provide a useful framework for the conceptualisation of psychological distress experienced by parents and carers who are in the position of parenting children that have experience trauma. The most commonly used terms to describe the negative impact of working with people that have experienced trauma are compassion fatigue, burnout and secondary trauma (Sodeke-Gregson et al., 2013). Despite subtle differences, these concepts are often used interchangeably within the literature (Sodeke-Gregson et al., 2013).

Compassion fatigue is an over-arching term encompassing secondary trauma and burnout as underlying features (Adams et al., 2006; Stamm, 2005). Professionals suffering from compassion fatigue are thought to experience symptoms of post-traumatic stress disorder (PTSD), including relational difficulties, as well as cognitive, physical, emotional, or behavioural symptoms (Sodeke-Gregson et al., 2013). Compassion satisfaction on the other hand encompasses the positive aspects of professional quality of life for those in the caring or helping

professions, such as the pleasure derived from being able to help others (Stamm, 2010).

Burnout on the other hand is not specifically limited to those working with trauma, rather it is thought of as a reaction to the demands of one's job and environment, categorised as a state of “physical, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations” (Canfield, 2005; Pines & Aronson, 1998).

Secondary trauma is thought to be an acute reaction, with symptoms of PTSD, including the emotional response and preoccupation with the suffering of others (Figley, 1995). Figley (1995) asserted that compassion fatigue, although identical to secondary trauma, is a less stigmatising term. For both secondary trauma and compassion fatigue, the symptoms mirror those in PTSD, including intrusive thoughts, traumatic memories related to a client’s trauma, irritability or bouts of anger, difficulty sleeping and concentrating, avoidance, and hypervigilance to cues of a client’s trauma (Newell & MacNeil, 2010).

The concept of compassion fatigue and secondary trauma as a result of being exposed to harrowing traumatic experiences has been well documented in professionals working with victims of trauma (Bride, 2007; Choi, 2011). One study found that amongst social workers 55% met criteria for one, 40% met criteria for two and 5% met criteria for all three core diagnostic symptoms of PTSD (Bride, 2007). The research exploring secondary trauma in carers or parents of children that have experienced adversity is limited. A dissertation completed in the USA explored the prevalence of secondary trauma in foster carers and found that 20% of foster carers reported experiencing moderate to severe levels of secondary trauma and 12% met the criteria for a diagnosis of PTSD as a result of indirect exposure to the child’s trauma (Carew, 2016). A UK study found high levels of secondary trauma amongst

foster carers, which was predicted by compassion satisfaction, burnout and primary trauma (Bridger et al., 2020). In this study primary trauma referred to potentially traumatic experiences during fostering, with the potential to result in PTSD, for example witnessing harm to self or others (Bridger, 2020). Furthermore, a study found that 20% of foster carers scored above the clinical cut off for secondary trauma, and that intent to continue fostering was significantly associated with lower levels of secondary trauma (Hannah & Woolgar, 2018).

Cognitive Factors associated with Compassion Fatigue and Secondary Trauma

PTSD is characterised by re-experiencing symptoms, such as intrusive memories, internal or external avoidance, and hypervigilance or increased arousal and reactivity (Brewin et al., 2009). The dual representation theory of PTSD proposes that a traumatic event is represented in two memory systems; as a low-level sensation-based memory and as a contextual memory (Brewin et al., 1996; Brewin et al., 2010). The sensation-based memory system, supported by subcortical structures and areas of the brain associated with perception, contains sensory and perceptual images that are accessed involuntarily, and are interlinked with their sensory and affective characteristics (Brewin, 2001; Brewin et al., 2010). The lack of involvement of structures such as the hippocampus results in a memory that is not contextualised, but rather experienced ‘in the present’ (Brewin, 2001). The contextual memory system, associated with prefrontal areas of the brain and medial temporal lobe structures including the hippocampus, situates information in its appropriate spatial and temporal context. Both systems form normal memory processing but are thought to function abnormally in PTSD (Brewin et al., 1996; Brewin, 2001; Brewin et al., 2010). In PTSD, traumatic events are stored within the sensation-based memory system, allowing the memories to be triggered

involuntarily by internal or external triggers, resulting in hyperarousal and intrusions or flashbacks. Traumatic images and memories are understandably avoided and fail to become associated with their context, resulting in the symptoms of PTSD as a consequence of a sensation-based representation being formed, without the usual association to a corresponding contextual representation.

Avoidant coping patterns are also central to the cognitive model of PTSD, which suggests that individuals with PTSD process a traumatic event in a way that produces a sense of current threat (Ehlers & Clark, 2000). This sense of current threat is then maintained by avoidant cognitive and behavioural strategies, which are effective in reducing distress in the short-term, but increase distress in the long-term by preventing cognitive change and the contextualisation of the traumatic memory (Ehlers & Clark, 2000). Following from the dual representation theory and cognitive theory of PTSD, it is perhaps unsurprising that avoidant cognitive processes including psychological inflexibility and thought suppression have been found to predict psychological distress (Magee et al., 2012), particularly within the development and maintenance of trauma symptoms (Plumb et al., 2004).

Psychological flexibility is defined “the ability to fully contact the present moment and the thoughts and feelings it contains without needless defence and, depending upon what the situation affords, persisting or changing behaviour in the pursuit of goals and values” (Hayes et al., 2006). Thought suppression is the process of consciously and deliberately trying to avoid certain thoughts (Wegner et al., 1987). Thought suppression has a paradoxical effect in that it leads to an increased frequency of the thought intruding into conscious awareness (Rassin et al., 2000). As acceptance strategies are used over suppression strategies, an internal experience, such as a thought no longer becomes a cue for avoidance, and therefore the emotive response gradually reduces (Hayes & Wilson, 1994).

A further cognitive process relevant to how individuals respond to trauma is rumination. Rumination is defined as the repetitive, self-focused, and uncontrollable negative thinking about past experiences or negative mood (Lyubomirsky & Nolen-Hoeksema, 1993; Nolen-Hoeksema, 1991). Ruminative responses to past negative experiences are a consistent predictor of persistent and chronic PTSD (Michael et al., 2007; Murray et al., 2002; Steil & Ehlers, 2000). As well as a trigger to intrusive memories of the event, rumination is also used by individuals as a cognitive strategy to cope with intrusive memories (Michael et al., 2007).

Although similar in many ways to the presentation of PTSD, the research focusing on the cognitive processes involved specifically in secondary trauma is limited. In social workers working with trauma clients, emotion-focused and avoidant coping strategies are associated with increased levels of secondary trauma (Gil & Weinberg, 2015). Further avoidant coping mechanisms such as increased tobacco and alcohol consumption and denial were associated with increased secondary trauma in personnel working in internet crimes against children (Bourke & Craun, 2014). Specifically, within foster carers, avoidant cognitive styles of psychological inflexibility and thought suppression were associated with compassion fatigue and secondary trauma (Hannah & Woolgar, 2018).

The research into secondary trauma in parent or carer roles is developing; however there appears to be a gap in the literature surrounding secondary trauma in adoptive parents. Therefore, the current study aims to extend the current literature and understanding of primary and secondary trauma within adoptive parents. Understanding the cognitive factors associated with secondary trauma will enable parents to be identified and suitable interventions to be provided.

Aims

To our knowledge, this is the first study to examine secondary trauma in adoptive parents. The study utilised a two-phased approach. The first phase consisted of a quantitative study. Using valid and reliable measures, this study examined possible psychological risk factors associated with primary and secondary trauma to examine the contribution of three cognitive processes, psychological inflexibility, thought suppression, and rumination.

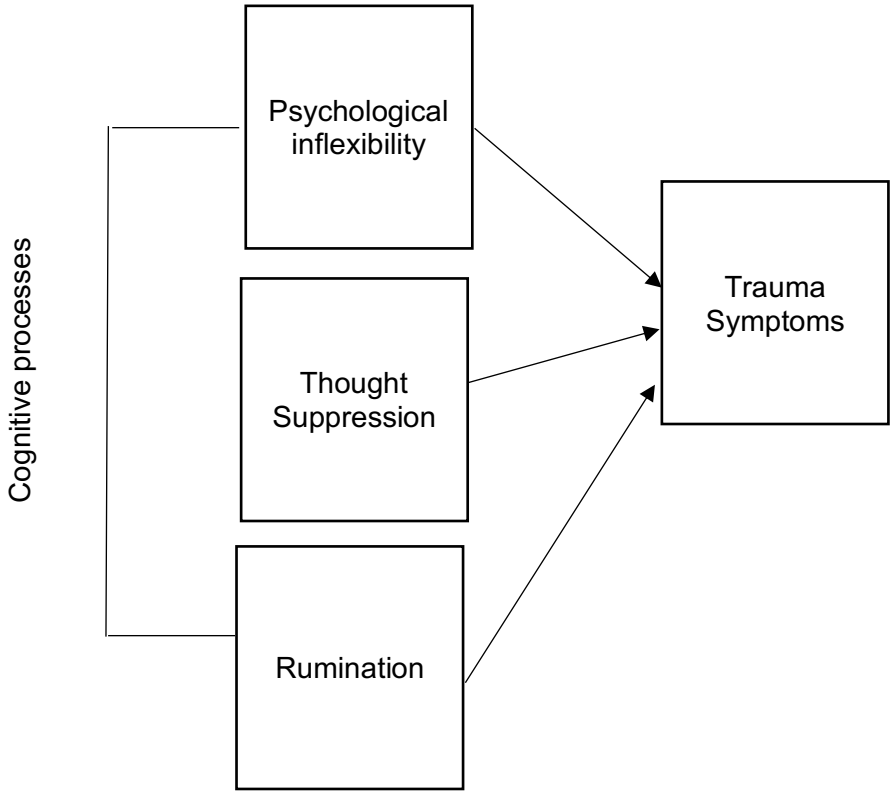
Hypotheses

1. Adoptive parents will experience clinically significant distress and trauma symptoms.
2. There will be a positive association between the measure of primary trauma and secondary trauma.
3. Cognitive processes of psychological inflexibility, thought suppression and rumination will predict primary and secondary trauma.

Figure 1 illustrates the hypotheses and constructs being explored.

Figure 1

Experimental Diagram



Due to the limited research in the area of secondary trauma within parents and carers, the second phase of this study explored the experience of parents scoring high in trauma through a qualitative study.

Method

Study Design

The current study utilised a mixed-methods design. The first phase used a cross-sectional design requiring participants to complete an online survey. A copy of the survey can be found in Appendix C. The second phase of the study consisted of interviewing a sub-sample of adoptive parents who scored high on a measure of

primary trauma in the first phase and volunteered to participate in the follow up study. The interview schedule can be found in Appendix D.

Participants

Participants were adoptive parents. Due to the complexity of the questions, the study required participants to have a good level of English.

Measures

The study consisted of a range of validated questionnaires to measure the constructs within the hypotheses. The survey included further demographic information about the parents and adopted child, and questions on the children's pre-adoptive traumatic experiences, which was summed to create a 'total pre-adoption trauma' score.

Current Challenges and Difficulties

The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) is a brief emotional and behavioural screening questionnaire for children and young people. The SDQ consists of 25 items asking parents to indicate the extent that positive and negative attributes apply to their child or adolescent. The items are scored on a 3-point Likert scale. The items are divided into five subscales of five items each: the emotional symptoms subscale, the conduct problems subscale, the hyperactivity-inattention subscale, the peer problems subscale, and the prosocial behaviour subscale. A total difficulties score can also be calculated by summing the scores on the five subscales (range 0–40). A brief extension of the SDQ includes an impact supplement that asks whether parents think that the child or adolescent has a problem, and if so, requires parents to rate their overall distress, social impairment, burden, and chronicity. The SDQ holds good reliability and validity,

which has been validated across cultures (Goodman, 2001; Muris et al., 2003; Yao et al., 2009). For this study Cronbach's Alpha indicates fair internal reliability (.68).

Child-to-parent violence refers to violence from the child towards the parent, which is intending to control, and dominate (Selwyn et al., 2014). To measure child-to-parent violence within this study, questions were developed using a published report on child-to-parent violence (Selwyn, et al., 2014), consultation with adoptive parents and literature on measuring intimate partner violence (Heise & Hossain, 2017). Parents were asked to rate how often their child displayed six violent behaviours on a 5-point Likert scale from "never" to "always", which was summed to give a total score. Parents were asked to rate their distress associated with current challenges they face as an adoptive parent and distress associated with the knowledge of their child's past traumatic experiences on a 1-5 Likert rating scale.

Parental Mental Health

The Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001) is a 9-item scale measuring depressive symptoms over the past two weeks. It is based on DSM-IV criteria and scored from 0 (not at all) to 3 (nearly every day). The PHQ-9 had been found to be valid with good psychometric properties (Kroenke et al., 2001; Löwe et al., 2004). In this study, internal reliability was high (.89).

The Generalised Anxiety Disorder-7 (GAD-7; Spitzer et al., 2006) is a 7-item measure of anxiety symptoms in the past two weeks. It is based on DMS-IV criteria and scored from 0 (not at all) to 3 (nearly every day). The GAD-7 is a reliable and valid measure of anxiety symptoms (Kertz et al., 2013; Löwe et al., 2008). For this study Cronbach's Alpha indicates good internal reliability (.92).

The Parental Stress Scale (PSS; Berry & Jones, 1995) is designed to measure the level of stress that parents experience, focusing specifically on the stress generated by the parenting role. The PSS is made up of 18 items rated on a 5-point Likert scale that describe the parent-child relationship and how each parent

feels about it. The PSS is valid and reliable (Berry & Jones, 1995). In this study, internal reliability was high (.90).

Compassion Fatigue and Compassion Satisfaction

The Professional Quality of Life (ProQOL; Stamm, 2005) questionnaire is a 30-item, 6-point Likert-type scale measuring three components: compassion satisfaction (CS), burnout (BO) and secondary trauma (STS), with each score measuring distinct theoretical concepts. This measure has good psychometric properties from a range of populations including social work and nurses (Adams et al., 2006; Potter et al., 2010). In line with the ProQOL measure, which suggests editing the phrase [helper] to reflect the population being studied, the wording of the scale was adjusted to reflect the experience of adoptive parents. For example, “I think that I might have been affected by the traumatic stress of those I [help]” was changed to ‘‘I think that I might have been affected by the traumatic stress of my adopted child(ren)’. For this study Cronbach’s Alpha indicates good internal reliability for all subtests: compassion satisfaction (.92), burnout (.78) and secondary trauma (.82).

Trauma Symptoms

PTSD symptoms were measured using the Impact of Events Scale-Revised (IES-R; Weiss & Marmar, 1997), which is a is a 22-item self-report measure that assesses subjective distress caused by stressful life events, during the last seven days. In this study, to reflect the population of adoptive parents, the parents were asked to score responses to indicate their distress in the past seven days with respect to their child's early traumatic experiences or current challenges. The IES-R is designed to measure directly, rather than secondarily experiences of trauma (Bride et al., 2007). The IES-R is one of the most commonly used self-report measures within trauma research (Joseph, 2000), with adequate internal

consistency, concurrent and discriminative validity (Beck et al., 2008). There has been no agreement about what level of distress qualifies a respondent for a diagnosis of PTSD or secondary trauma on the IES-R (Wilson & Keane, 2004). However, scores on the IES-R can be categorised as PTSD is a clinical concern, the best cut-off for a probable diagnosis of PTSD and scores high enough to suppress immune system functioning. In this study, internal reliability was high (.95).

Cognitive Styles: Psychological Inflexibility, Thought Suppression and Rumination

The Acceptance and Action Questionnaire–II (AAQ-II; Bond et al., 2011) was used to measure psychological inflexibility, with a higher score indicating greater psychological inflexibility. It consists of seven items on a 7-point Likert-type scale. “My painful experiences and memories make it difficult for me to live a life that I would value” is an example item. The AAQ-II holds good internal consistency and a one-factor structure in clinical and non-clinical participants (Bond et al., 2011; Fledderus et al., 2012) and has been validated in other languages and cultures (Flynn et al., 2016). In this study, internal reliability for this scale was high (.90).

The White Bear Suppression Inventory (WBSI; Wegner & Zanakos, 1994) is a 15-item measure on a 5-point Likert-type scale measuring a person’s tendency to suppress thoughts. An example item from the scale is “I have thoughts that I try to avoid”. This measure has been found to have good reliability and validity (Luciano et al., 2006). The internal consistency in this study was high (.94).

The Ruminative Response Scale Short Form (RRS-SF; Treynor et al., 2003) is a self-administered rumination questionnaire of 10 items describing two dimensions: brooding and reflection. For each item, each subject indicates the frequency of each event on a 4-point scale ranging from 1 (“almost never”) to 4 (“almost always”). An example item from the scale is “how often do you think about a recent situation, wishing it had gone better?”. The RRS-SF demonstrates good

psychometric properties (Parola et al., 2017). For this study Cronbach's Alpha indicates good internal reliability (.81).

Other Variables

The survey included further measures that were collected for separate research questions. This included measures of attachment and parent related factor, including the Parent Sense of Competence Scale (PSOC; Johnston & Mash, 1989), The Quality of Attachment Relationships Questionnaire (QUARQ; Briskman et al., 2012), The Revised Adult Attachment Scale (R-AAS; Collins & Read, 1996) and The Parental Reflective Functioning Questionnaire (PRFQ; Fonagy et al., 2016). Details of these measures and the reliability coefficient from the current study can be found in Appendix E. These measures were collected for different purposes and so they are not reported further in this thesis.

Interview Schedule

The interview schedule (Appendix D) was designed in collaboration with adoptive parents. The interview schedule was semi-structured to enable participants to discuss what they felt was important to their experience, and whether this related to the knowledge of their child's difficult past or whether it related to current challenges they face as an adoptive parent. Probe questions were used at the researcher's discretion throughout. Participants were asked questions on how they thought and felt about the difficult early experiences that their child may have been through before they were adopted. They were asked how it had impacted on their life, and how they coped with the challenges they face.

Procedure

Ethical approval was obtained from the UCL Research Ethics Committee (Project ID: 15201/001, Appendix F) prior to data collection.

Preliminary Stage: Consultation with Adoptive Parents

Three adoptive parents were recruited via advertisement on social media platforms to help guide the research project and advise on the best ways to help parents speak about their experiences by utilising their 'lived experience' (Appendix G). The adoptive parents provided feedback on the research materials, design, recruitment methods and measures. As a result of the consultations with adoptive parents the survey and interview schedule were edited substantially. It was edited to incorporate aspects that the parents felt were important when considering trauma responses within adoptive parents; including a measure of child-to-parent violence, social network and support system, experience of Child and Adolescent Mental Health Services and current living situation (i.e. whether a child currently lives with the adoptive family, a residential home or whether parents are parenting from a distance). Further amendments were made to the language used in the original survey. For example, when considering the impact of the child's trauma on a parent, it was felt important to incorporate the experiences of those parents who may not be fully aware of their child's history, and the impact of living with the uncertainty. All adoptive parents consulting on the project were paid £15 in Amazon vouchers for their time.

Phase 1: Survey Recruitment

Multiple methods of recruitment were utilised to address potential biases in the sample and increase responses to the survey. The survey was designed using Qualtrics and distributed to adoptive parents through gatekeepers, which included local authorities, adoption support groups, and adoption charities. The study was discussed with potential gatekeepers via telephone or email, and those who agreed to support the study were provided with a rationale for the survey, the participant information sheet and a link to the survey. Following consent from gatekeepers,

adoptive parents were sent the participant information sheet and a link to the survey via an email or through the gatekeeper's newsletter. To aid recruitment, the survey was advertised via the social media platform Twitter (Appendix H). This enabled adoption charities to 're-tweet' information about the study to their many followers and aided recruitment. To ensure only adoptive parents completed the survey, the consent form required participants to declare themselves as an adoptive parent.

Once participants clicked on the link to the survey, they were taken to the participant information sheet and consent form, which can be found at the start of the survey (Appendix C). The participant information sheet and the exit page of the survey contained information for accessing further support for any parent who may have experienced distress as a result of completing the survey. If responders had more than one adopted child, they were asked to respond in relation to their child that they felt had the greater emotional or behavioural challenges, or to complete the survey once for each child. Once the survey was completed, participants were given the opportunity to leave an email address to be entered into a prize draw to win £100 Amazon vouchers. Participants were able to remain anonymous and not enter the prize draw if they wished to.

Phase 2: Interview Recruitment

An initial pilot of the interview was carried out with one adoptive parent consulting on the project, to highlight any issues in relation to the interview structure and timing. Following completion of the survey, separately to the entry to the prize draw, participants were asked to leave their email address if they would like to be contacted regarding a follow up interview. Those who scored higher than PTSD being a clinical concern (24 or more) on the measure of primary trauma (IES-R) and consented to be contacted for the follow up were provided with an information sheet and consent form (Appendix I). If they consented, they were invited to an hour long interview via telephone. The interview focused on the impact of their child's

traumatic early experiences on their distress. The interview schedule can be found in Appendix D. Interviews were audio recorded and transcribed. All participants were given a payment of £10 in Amazon vouchers for their time.

Power

As the study explored secondary trauma within a novel population, it was not possible to estimate effect sizes based on past studies. However, a power analysis was informed by results from the literature exploring secondary trauma within foster carers (Hannah & Woolgar, 2018) and it was estimated that medium to large effect sizes were likely to result. A priori power analysis was carried out using the G*Power statistical tool, which suggested that with four predictors a minimum sample size of 72 would be required to provide an effect size of Multiple R = .30 with 80% power and an alpha level of .05.

Although there is no equivalent to the power calculation for the qualitative element to the current study, there are a number of factors that can help determine a suitable sample size. As the analysis was part of a mixed-methods design aiming to explore a novel concept in a new population, Braun and Clarke's (2013) recommendations of a sample size of 10-20 for a UK professional doctorate were considered appropriate for this study.

Data Analysis Plan

Phase 1: The Survey

The data from the survey was exported from Qualtrics into IBM SPSS Statistics 26, where it was then coded and analysed. To determine the distribution of the data, histograms were inspected and the skewness and Kurtosis statistics were tested for significance. Where assumptions of normality were not met, the non-parametic Spearman's rho correlation analysis was used, and bootstrapping, the non-parametric approach to multiple regression was run. A missing data analysis

was conducted to inform whether any corrections were required in the analyses. Correlational analysis was used to identify potential co-variates to control for in the subsequent analyses. Descriptive statistics were used to determine the levels of psychological distress and trauma within the sample. Correlational analyses were used to determine the association between the two measures of trauma on the IES-R and ProQOL. Hierarchical multiple linear regressions were used to determine whether the three cognitive styles of psychological inflexibility, thought suppression and rumination predicted primary and secondary trauma.

Phase 2: The Interviews

The qualitative data from the interviews were transcribed and entered onto the NviVo programme to analyse. The interviews were analysed using thematic analysis, employing Braun and Clarke's (2006) guidelines (see Table 1). During the familiarisation stage, the interviews were transcribed and read several times, whilst initial reflections were recorded between the research team. Interesting features of the data were systematically identified and labelled as codes throughout all of the transcripts. The codes were then organised into potential themes, which were reviewed by both supervisors and checked against the transcripts. Final themes and sub-themes were organised into a thematic map. Disclosure of the researcher's perspective and reflections from bracketing can be found in part 3 of the thesis.

Table 1

Phases of Thematic Analysis

Phase	Description of Process
1. Familiarising self with data	Data transcription, reading and re-reading the data and noting down initial ideas
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set
3. Searching for themes	Collating codes into potential themes
4. Reviewing themes	Checking if themes work in relation to the data, generate a thematic "map" of the analysis
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tell, generating clear definitions and names for each theme
6. Producing the report	Selection of extract examples, final analysis of extracts and producing report

Results

Phase 1: Quantitative Results

Missing Data Analysis

The survey was structured to limit the impact of missing data as all of the survey items were forced response, meaning that where missing data has occurred it is due to participants 'dropping out' of the survey. As this may create a bias to items presented later in the survey, a missing data analysis was conducted using published guidelines (Amsterdam Public Health, 2015). The total number of missing responses to variables ranged from 17.7% (*n* = 46 missing responses) on the SDQ to 28.1% (*n* = 73 missing responses) on the ProQOL, in line with the order in which questionnaire measures were presented in the survey (Table 2).

A missing value analysis, including *t*-tests for significant difference across demographic factors was conducted to describe the pattern of missing data, none of which were significant ($p > .05$). As the missing data was limited and random, default settings in SPSS were used in the analysis.

Table 2

Frequency of Missing Data across the Measures

Variable	*N* missing data	%
SDQ	46	17.7
PHQ-9	54	20.8
GAD-7	55	21.2
PSS	55	21.2
AAQII	65	25
WBSI	67	25.8
RRS	69	26.5
IES-R	71	27.3
ProOOL	73	28.1

Descriptive Statistics

Table 3 presents the overall frequencies of the demographic variables reported by the parents. Of the data we have, the vast majority of the respondents were female (91.0%), white British (83.5%), heterosexual (87.4%) and within a parenting couple (79.6%). Most families had one (47.2%) or two (42.1%) adopted children, with most families having no biological children within the family (84.6%). The adopted child with the most behavioural or emotional challenges that the

parents chose to refer to in the survey were mostly white British (77.0%), with almost an even proportion of males and females (male = 54.6%). Just under half of the children had a learning or physical disability (41.2%). Most children had no placements or one placement before adoption (50.0%), with 7.4% of children having five or more placements before they were adopted.

Figure 2 outlines the frequency of a range of traumatic events experienced by the children before they were adopted. Of those who reported data, the most common trauma experienced by the children, as reported by adoptive parents, was neglect (80.0%), followed by exposure to drugs and alcohol (65.8%) and domestic violence (65.4%). Over half of the respondent's children had experienced emotional abuse (54.4%), with many experiencing physical abuse (37.7%) and/or sexual abuse (16.7%). Other traumas experienced by the children included parental illness or disability (19.7%) and/or bereavement (5.7%). Twenty percent of children were removed at birth, and 15.0% of adoptive parents were uncertain as to the trauma experienced in their early life due to lack of documentation. Of those who responded, the mean total sum of pre-adoptive trauma was 3.8 and ranged from 1 to 8 (*SD* = 1.8). Over half of the children were currently being or waiting to be seen by a Child and Adolescent Mental Health Team (61.2%).

The mean age at which the children were taken into care was 1.8 years old and ranged from less than one months to 9 years old (*SD* = 1.9 years). The mean age of adoption was 3.4 years old and ranged from less than one month to 11 years old (*SD* = 2.3 years). The mean age of the child at the time of the survey was 11.4 years old and ranged from 1 year old to 27 years old (*SD* = 5.1 years).

Table 3

Demographic Information

	Variable	*N*	%
Gender of Parent	Female	233	89.6
	Male	23	8.8
	Missing	4	1.5
Age of Parent	31-40	35	13.5
	41-50	103	39.6
	51-60	101	38.8
	61+	17	6.5
	Missing	4	1.5
Ethnicity of Parent	White British	213	81.9
	White Irish	8	3.1
	Any other White background	19	7.3
	Asian or Asian British Indian	2	.8
	Black or Black British Caribbean	3	1.2
	Mixed Black Caribbean and White	2	.8
	Mixed Black African and White	1	.4
	Mixed Asian and White	3	1.2
	Any other Mixed background	2	.8
	Other ethnic group – self describe	1	.4
	Prefer not to say	1	.4
	Missing	5	1.9
Education	GCSE/O Level and equivalents	7	2.7
	A Levels and equivalents	15	5.8
	Higher education & professional/vocational equivalents	109	41.9
	Postgraduate	123	47.3
	No qualifications	1	.4
	Missing	5	1.9
Parenting Status	Single	50	19.2
	Couple	203	78.1
	Other	2	.8
	Missing	5	1.9

Parental Sexuality	Heterosexual	223	85.8
	Lesbian/Gay	17	6.5
	Bisexual	9	3.5
	Asexual	1	.4
	Prefer not to say	4	1.5
	Other	1	.4
	Missing	5	1.9
No. Adopted Children	1	120	46.2
	2	107	41.2
	3	20	7.7
	4	4	1.5
	5	2	.8
	6	1	.4
	Missing	6	2.3
No. Biological Children	0	215	82.7
	1	19	7.3
	2	10	3.8
	3	7	2.7
	4	2	.8
	6	1	.4
	Missing	6	2.3
Relation of Adopted Siblings	Only 1 adopted child	120	46.2
	Multiple adopted children, none biologically related	30	11.5
	Multiple adopted children, all biologically related	93	35.8
	Multiple adopted children, some biologically related	22	4.2
	Missing	6	2.3
Age taken into care	>1 month	57	21.9
	1-12 months (1 year old)	62	23.8
	13-24 months (2 years old)	51	19.6
	25-36 months (3 years old)	34	13.1
	37-48 months (4 years old)	19	7.3
	49-60months (5 years old)	14	5.4
	61-72 months (6 years old)	8	3.1
	73-84 months (7 years old)	3	1.2
	85 months + (8 years old +)	2	.8

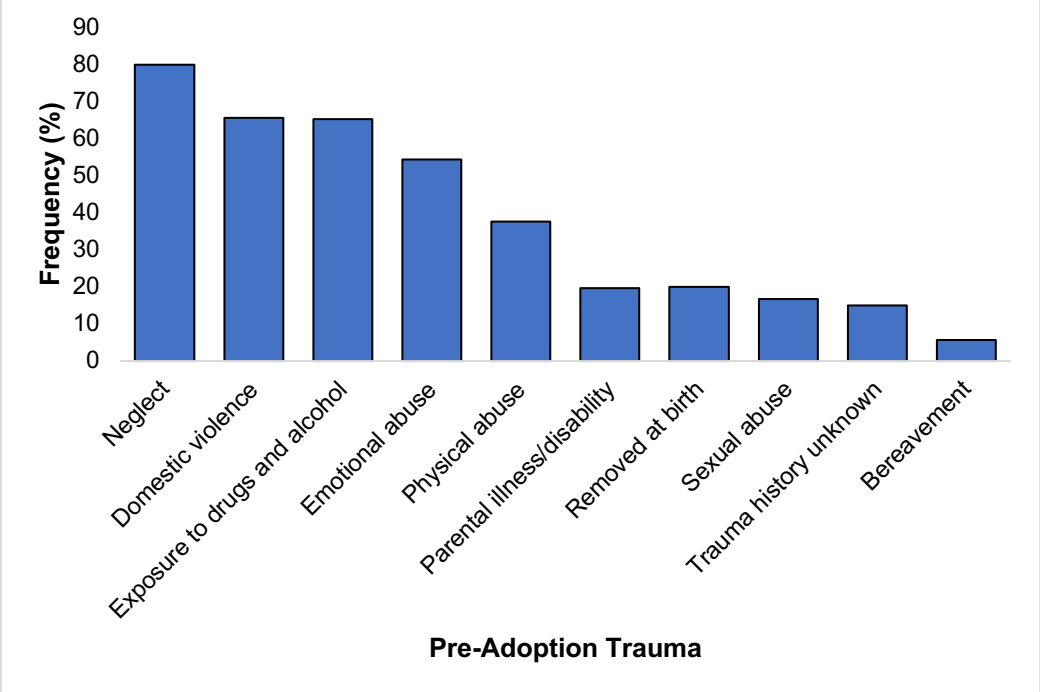
	Missing	10	3.8
Age at Adoption	>1 month	4	1.5
	1-12 months (1 year old)	38	14.6
	13-24 months (2 years old)	47	18.1
	25-36 months (3 years old)	49	18.8
	37-48 months (4 years old)	33	12.7
	49-60months (5 years old)	23	8.8
	61-72 months (6 years old)	21	8.1
	73-84 months (7 years old)	16	6.2
	85 months + (8 years old +)	14	5.4
	Missing	15	5.8
Current Age	1-5 years	19	7.3
	6-10 years	46	17.7
	11-15 years	46	17.7
	16-20 years	28	10.8
	21+	5	1.9
	Missing	116	44.5
No. of Placements	0	27	10
prior to Adoption	1	95	36.5
	2	49	18.8
	3	36	13.8
	4	18	6.9
	5	10	3.8
	8	4	1.5
	10	2	.7
	12	1	.04
	13	1	.04
	Missing	16	6.2
Gender of Child	Female	99	38.1
	Male	134	51.5
	Other	12	4.6
	Missing	15	5.8
Ethnicity of Child	White British	188	72.3
	White Irish	1	.4
	Any other White background	9	3.5
	Asian or Asian British Indian	1	.4
	Asian or Asian British Chinese	3	1.2
	Any other Asian background	2	.8

	Black or Black British Caribbean	2	.8
	Black or Black British African	3	1.2
	Mixed Black Caribbean and White	13	5
	Mixed Black African and White	2	.8
	Mixed Asian and White	1	.4
	Any other Mixed background	12	4.6
	Uncertain – lack of information	2	.8
	Missing	16	6.2
Pre-adoption Trauma	Neglect	184	80.7
	Physical abuse	86	37.7
	Sexual abuse	38	16.7
	Emotional abuse	124	54.4
	Bereavement	13	5.7
	Domestic violence	149	65.4
	Drugs and/or alcohol	150	65.8
	Voluntary/relinquished at birth	28	12.3
	Parental illness or disability	45	19.7
	Uncertain – lack of documentation of early life	33	14.5
	Removed at birth	47	20.6
	Other	14	6.1
	Total responses	228	
Physical and/or Learning Disability	Yes	94	36.2
	No	134	51.5
	Missing	32	12.3
Attempted access to Local CAMHS	Yes -child was/is seen by CAMHS	96	36.9
	Yes- child is accessing a specialist looked-after and adopted service	29	11.2
	Yes- child is currently on a waiting list	14	5.4
	Yes – unsuccessful due to CAMHS criteria	23	8.8
	No- I am unaware of local services	5	1.9
	No- I have not felt my child requires CAMHS input	60	23.1
	Missing	33	12.7
Professionals Involved	School counselling services	59	26
	Occupational therapist	93	40.9
	Speech and language therapy	82	36.1

	Educational psychologist	129	56.8
	Special educational needs co-ordinator	142	62.6
	Virtual head/virtual school	55	24.2
	Clinical psychologist/psychotherapy outside of CAMHS	97	42.7
	NHS mental health services	29	12.8
	Current social worker	84	37
	Total responses	227	

Figure 2

Pre-adoption Traumatic Experiences



Independent sample t-tests and one-way ANOVAs were conducted to determine differences in mean primary trauma, secondary trauma, burnout and compassion satisfaction scores in relation to the demographic data. The only parent demographic factor that was significant was gender; as female adoptive parents

reported significantly greater primary trauma scores (t (187) = -2.63, p = .01), secondary trauma scores (t (185) = -4.10, p < .001) and burnout (t (185)=-2.96, p < .001), than male adoptive parents. There were no significant differences between scores in terms of any of the other parental demographic factors, family factors or the adopted child's demographic factors.

Hypothesis 1: Adoptive Parents will Experience Clinically Significant Distress and Trauma Symptoms

Tests of normality and inspection of the histogram found that the IES-R scores were not normally distributed, and due to the number of participants scoring zero, the scores could not be transformed. Therefore, analyses used non-parametric tests when considering primary trauma.

To describe the number of adoptive parents experiencing clinically significant distress, Table 4 outlines the frequency of parents reporting high levels of depression, anxiety and trauma. In terms of depression, 18.5% of parents reported moderately severe or severe scores, and 17.6% of parents reported severe anxiety scores. A high percentage of parents scored above PTSD being a clinical concern (19.5%) and 10% of the participants scores reflected a probable diagnosis of PTSD. The mean total IES-R severity score was 13.1 (SD = 14.1).

Table 4

Frequency of Parents Reporting Distress

	N	**%**
PHQ-9		
Minimal/none (0-4)	56	27.2
Mild (5-9)	67	32.5
Moderate (10-14)	45	21.8
Moderately severe (15-19)	21	10.2
Severe (20-27)	17	8.3
GAD-7		
Minimal/none (0-4)	63	30.7
Mild (5-9)	70	34.1
Moderate (10-14)	36	17.6
Severe (>15)	36	17.6
IES-R		
Below cut off	152	80.4
PTSD is a clinical concern (24-32)	18	9.5
Probable diagnosis of PTSD (33-38)	8	4.2
High enough to suppress immune system's functioning (even 10 years after an impact event (39+)	11	5.8

For secondary trauma, burnout and compassion satisfaction, cut-off scores were compared to Stamm's (2010) general norms (Table 5). Independent sample *t*-tests significantly differed from the normative sample on all ProQOL subscales. Participants in the current study report higher levels of secondary trauma and burnout, and significantly lower levels of compassion satisfaction (Table 5). For secondary trauma, 52.4% of the adoptive parents scored two standard deviations or more above the norm, within the top scoring 5% of the general population. For burnout, 14.4% of the adoptive parents scored two standard deviations or more above the norm. For compassion satisfaction, no adoptive parent scored two

standard deviations or more above the norm and 7.5% of adoptive parents scored two or more standard deviations below the norm.

Table 5

Means and Standard Deviations for ProQOL Subscales

Sub-scale	**Current sample (*n*=187)**		**Norm group**		***t***	***p***	***d***
	M	*SD*	*M*	*SD*			
CS	35.0	7.7	37	7.3	-3.55	<.001	.26
BO	29.0	6.7	22	6.8	14.28	<.001	1.04
STS	27.1	7.1	13	6.3	27.16	<.001	1.99

To explore the parents' perception of what is causing their distress, Spearman's rho correlation analyses of the trauma scores with parents rating of distress caused by 'the trauma or difficulties in my child's past' and the parents rating of distress caused by 'trauma or difficulties I currently face as an adoptive parent' were conducted. Parents' rating of their distress caused by the difficulties in their child's past significantly correlated positively with primary trauma scores (r = .58, p < .001), secondary trauma (r = .55, p < .001) and burnout (r = .34, p < .001) and correlated negatively with compassion satisfaction (r = -.15, p = .04). Parents' rating of distress caused by the trauma or difficulties they currently face as an adoptive parent also significantly correlated positively with primary trauma (r = .44, p < .001), secondary trauma (r = .59, p < .001) and burnout (r = .60, p < .001) and negatively correlated with compassion satisfaction (r = -.50, p < .001). Parents perceived their distress to be associated strongly with both the difficulties in their child's past and the difficulties they currently face. Although, the association

between primary trauma and distress perceived to be caused by the difficulties they currently face as an adoptive parent was stronger.

Hypothesis 2: There will be a Positive Association between the Measure of Primary Trauma Symptoms and Secondary Trauma

To determine whether the measures of trauma were related, the correlations between the primary trauma (IES-R) and secondary trauma (ProQOL) measures were tested. The non-parametric Spearman's rho correlation was used as scores on the IES-R were not normally distributed. Table 6 outlines the correlational findings, with all measures and subscales being highly correlated to $p < .001$. The IES-R was clearly associated with the ProQOL secondary trauma sub-scale ($r = .63$, $p < .001$) and the ProQOL compassion satisfaction scale was strongly and negatively correlated to all measures of distress ($p < .001$). Table 6 also shows that measures of trauma highly correlated with measures of distress, including depression, anxiety and parental stress.

Table 6

Intercorrelations between Outcome Measures and Measures of Distress

	PHQ-9	GAD-7	PSS	ProQOL STS	ProQOL BO	ProQOL CS	IES Total	IES Intrusion	IES Avoidance	IES Hyperarousal
PHQ-9	-	.78**	.51**	.60**	.67**	-.45**	.43**	.36**	.41**	.41**
GAD-7		-	.54**	.64**	.72**	-.43**	.51**	.42**	.51**	.48**
PSS			-	.51**	.74**	-.79**	.35**	.27**	.34**	.35**
ProQOL STS				-	.68**	-.45**	.63**	.57**	.59**	.59**
ProQOL BO					-	-.67**	.47**	.41**	.43**	.43**
ProQOL CS						-	-.29**	-.21**	-.30**	-.33**
IES Total							-	.93**	.90**	.92**
IES Intrusion								-	.74**	.82**
IES Avoidance									-	.76**
IES Hyperarousal										-

**= $p < .001$

Hypothesis 3: Cognitive Processes of Psychological Inflexibility, Thought Suppression and Rumination will Predict Primary and Secondary Trauma

Co-variate analysis. To identify potential co-variates that further analyses would need to control for, all demographic factors, child factors, and measures were correlated with the outcome measures (Table 7). The Spearman's rho correlational analysis revealed significant correlations between the outcome measures with the adoptive parent's gender, current age of the child and whether the child had a learning or physical disability. Therefore, these variables were included as co-variates in all further analyses. Scores on the SDQ, total pre-adoptive trauma scores and child-to-parent violence significantly correlated but were not included as control variables as they formed part of the hypothesis testing variables.

Table 7

Bivariate Correlation Analyses

	ProQOL STS	ProQOL BO	ProQOL CS	IES Total
Parent Demographic Factors				
Gender	.29**	.22**	-.13	.19**
Age	.07	-.01	-.13	.01
Ethnicity	-.07	-.10	.03	-.01
Highest level of education	.10	.10	-.06	.06
Parenting status	.01	.02	-.03	.00
Sexuality	-.14	-.12	.09	-.08
Child Factors				
Gender	.11	.05	-.10	.13
Current Age	.13	.03	-.25**	.08

Ethnicity	.01	-.04	-.02	-.01
SDQ Total	.49**	.47**	-.34**	.33**
SDQ Emotion	.40**	.34**	-.18**	.24**
SDQ Conduct	.49**	.45**	-.45**	.34**
SDQ Hyper	.21**	.18*	-.14	.14
SDQ Peer	.24**	.31**	-.20**	.18*
SDQ Pro-Social	-.34**	-.38**	.38**	-.17*
SDQ Impact	.46**	.49**	-.32**	.28**
Physical/Learning Disability	-.15*	-.21	.09	-.12
Child to parent violence	.45**	.47**	-.34**	.40**
Adoptive Family Factors				
No. children in family	.13	.06	-.10	.09
No. biological children	-.05	-.04	-.02	-.14
Adopted children biologically related	.10	.06	-.08	.06
Child living at home	.02	.01	-.08	.046
Pre-adoptive Experience				
Age taken into care	.09	.11	-.13	.08
Age of adoption	.05	.12	-.14	.06
No. placements prior to adoption	.10	.08	.06	.15*
Total pre-adoptive trauma	.34**	.31**	-.24**	.23**
Cognitive Styles				

AAQ-II Total	.53**	.55**	-.39**	-.41**
WBSI Total	.48**	.43**	-.25**	.48**
RRS Total	.50**	.43**	-.32**	.41**

* = $p < .05$; ** = $p < .001$

Primary trauma. A series of hierarchical multiple linear regressions were conducted to examine the relationship between primary trauma response and the three cognitive coping styles, psychological inflexibility, thought suppression and rumination, after controlling for the gender of parent, the child's current age and whether they had a learning or physical health difficulty as co-variates. Bootstrapping was used for the multiple regression with the IES-R as the dependent variable, as the data did not meet the assumption of normality. As shown in Table 8, primary trauma scores were not significantly predicted by control variables alone. There was a significant increase in the models strength when cognitive coping styles were added to the model [R^2 Change = .26, F (3,130) = 16.13, p = < .001]. Table 7 demonstrates that the correlations amongst the predictor variables and the outcome measures were all highly significant ($p < .001$). However, after controlling for the other cognitive coping styles, only thought suppression made a significant and unique contribution to the model (B =.36, $p < .001$), whereas psychological flexibility (B = .15, p = .46) and rumination did not (B = .38, p = .17).

To differentiate between the impact of the child's pre-adoptive experiences and the impact of the child's current emotional or behavioural challenges in predicting parental trauma further analyses were conducted. A second hierarchical multiple linear regression was conducted to determine the contribution of the child's previous trauma to the model. As before, the model with control variables alone was not significant. When pre-adoptive trauma was added to the model alongside the

control variables, the strength of the model did not increase significantly [R^2 Change = .02, F (1,132) = 2.34, p = .13]. However, the strength of the regression model significantly increased once the cognitive coping styles were added to the model [R^2 Change = .25, F (3,129) = 15.15, p < .001]. Table 7 demonstrates that correlations amongst the predictor variables and the outcome measures were all highly significant (p < .001). Whilst thought suppression made a unique significant contribution to the model (B = .35, p < .001), psychological flexibility (B = .16, p = .47), rumination (B = .38, p = .19) and pre-adoptive trauma (B = .39, p = .47) did not. Thus, the child's past trauma did not seem to account for the relationship between coping and trauma symptoms.

A third hierarchical multiple linear regression was conducted to determine the unique contribution of the child's current difficulties and challenges to the model. As before, the model with control variables alone was not significant. When the child's current difficulties as measured by the SDQ and child-to-parent violence were added, there was a significant increase in the strength of the model [R^2 Change = .15, F (2,121) = 11.34, p < .001]. The strength of the regression model increased further once the cognitive coping styles were added to the model [R^2 Change = .19, F (3,118) = 12.49, p < .001]. Table 7 demonstrates that the correlations amongst the predictor variables and the outcome measures were all highly significant (p < .001). Thought suppression made a unique and significant contribution to the model (B = .34, p < .001), as did the child's current difficulties measured by the SDQ (B = .34), p = .04). Child-to-parent violence (B = .66, p = .09), psychological flexibility (B = .15, p = .44) and rumination did not significantly contribute unique variance to the model (B = .24, p = .35). Thus, the child's current challenging and violent behaviours were predictive of parental trauma symptoms. Independently of this, parental coping styles made a further contribution to their trauma symptoms.

Table 8

Predicting Primary Trauma from Control Variables, Cognitive Styles, Pre-Adoption Trauma and Current Challenges

	Model 1			**Model 2**			**Model 3**		
Variable	*B*	*Standard error*	*p*	*B*	*Standard error*	*p*	*B*	*Standard error*	*p*
				Regression 1					
Gender of parent	9.57	2.14	<.001	6.50	2.7	.02			
Child's current age	.19	.23	.43	.21	.19	.27			
Learning or physical health difficulty	-.92	2.30	.69	.52	2.20	.81			
Psychological flexibility				.15	.20	.46			
Thought suppression				.36	.12	<.001			
Rumination				.38	.28	.17			

F		1.91			9.34				
R^2		.04			.30				
$R^2_{Adjusted}$		.02			.27				
p		.13			<.001				
				Regression 2					
Gender of parent	9.57	2.02	<.001	9.43	.19	<.001	6.52	2.50	.01
Child's current age	.19	.23	.41	.13	.22	.56	.19	.19	.31
Learning or physical health difficulty	-.92	2.37	.70	-.10	2.48	.97	.82	2.36	.73
Pre-adoptive trauma				1.07	.62	.09	.39	.56	.47
Psychological flexibility							.16	.19	.41
Thought suppression							.35	.11	<.001

Rumination							.38	.29	.19
F		1.91			2.03			8.03	
R^2		.04			.06			.30	
$R^2_{Adjusted}$		.02			.03			.27	
p		.13			.09			<.001	
				Regression 3					
Gender of parent	9.80	2.06	<.001	7.36	2.13	<.001	5.20	2.91	.07
Child's current age	.09	.24	.70	.07	.23	.76	.12	.20	.54
Learning or physical health difficulty	.05	2.43	.99	2.68	2.49	.29	3.07	2.45	.22
Child's current difficulties				.32	.39	.11	.34	.16	.04
Child-to-parent violence				1.00	.20	.01	.66	.38	.09

Psychological flexibility			.15	.19	.44
Thought suppression			.34	.10	<.001
Rumination			.24	.26	.35
F	1.82	5.81		9.35	
R^2	.04	.19		.39	
$R^2_{Adjusted}$	.02	.16		.35	
p	.15	<.001		<.001	

Secondary trauma. A further series of hierarchical multiple linear regressions were calculated to predict secondary trauma responses based on the three cognitive coping styles, after controlling for co-variates (Table 9). Bootstrapping was not used as the scores on the ProQOL secondary trauma sub-scale were normally distributed. The model with control variables alone was significant, however, the strength of the regression model significantly increased once the cognitive coping styles were added to the model [R^2 Change = .26, F (3,129) = 18.79, $p < .001$]. Table 7 demonstrates that correlations amongst the predictor variables and the outcome measures were all highly significant ($p < .001$). Psychological inflexibility (t = 2.46, p = .02, β = .24) and thought suppression contributed unique variance to the model (t = 2.36, p = .02, β = .22), whereas rumination did not (t = 1.75, p = .08, β = .15).

A second hierarchical multiple linear regression was conducted to determine the contribution of the child's previous trauma to the model. As before, the model with control variables alone was significant, but the strength of model when including previous trauma significantly increased [R^2 Change = .04, F (1,131) = 5.80, p = .02]. The strength of the regression model significantly increased once more, when the cognitive coping styles were added to the model [R^2 Change = .24, F (3,128) = 17.74, $p < .001$]. Table 7 demonstrates that correlations amongst the predictor variables and the outcome measures were all highly significant ($p < .001$). Psychological inflexibility (t = 2.68, p = .01, β = .26) significantly contributed unique variance to the model, whereas pre-adoptive trauma (t = 1.93, p = .06, β = .14), thought suppression (t = 1.95, p = .05, β = .18), and rumination did not (t = 1.74, p = .08, β = .15). Unlike in the case of primary trauma symptoms, there was more evidence here that the child's past trauma was associated with the parent's secondary trauma, and this appeared to be partially explained by parental coping style.

A third hierarchical multiple linear regression was conducted to determine the contribution of the child's current difficulties and challenges to the model. As before, the model with control variables alone was significant. However, the model when including the child's current difficulties, measured by the SDQ and child-to-parent violence and the control variables led to a significant increase in strength [R^2 Change = .27, F (2,120) = 28.80, p <.001]. The strength of the regression model increased further once the cognitive coping styles were added to the model [R^2 Change = .17, F (3,117) = 16.75, p <.001]. Table 7 demonstrates that correlations amongst the predictor variables and the outcome measures were all highly significant (p < .001). The child's current difficulties on the SDQ (t = 4.52, p < .001, β = .32) and child-to-parent violence (t = 2.91, p < .001, β = .21) were significant unique predictor variables, alongside psychological inflexibility (t = 2.33, p = .02, β = .19) and thought suppression (t = 2.63, p = .01, β = .21). Rumination did not contribute significant unique variance to the model (t = 1.30, p = .20, β = .09). Thus, these results suggest that the child's challenging behaviour and parental coping style were significantly and independently predictive of parental secondary trauma.

Table 9

Predicting Secondary Trauma from Control Variables, Cognitive Styles, Pre-Adoption Trauma and Current Challenges

	Model 1					Model 2					Model 3				
Variable	*B*	*Standard error*	*β*	*t*	*p*	*B*	*Standard error*	*β*	*t*	*p*	*B*	*Standard error*	*β*	*t*	*p*
						Regression 1									
Gender of parent	12.36	2.87	.35	4.31	<.001	9.95	2.45	.28	4.07	<.001					
Child's current age	.15	.16	.08	.94	.35	.16	.14	.08	1.20	.23					
Learning or physical health difficulty	-4.49	1.69	-.22	-2.66	.01	-3.24	1.45	-.16	-2.23	.03					
Psychological flexibility						.29	.12	.24	2.46	.02					
Thought suppression						.16	.07	.22	2.36	.02					
Rumination						.29	.16	.15	1.75	.08					
F			7.91					14.95							

R^2			.15					.41							
$R^2_{Adjusted}$			.13					.38							
p			<.001					<.001							
								Regression 2							
Gender of parent	12.36	2.87	.35	4.31	<.001	12.21	2.82	.34	4.33	<.001	9.89	2.42	.28	4.09	<.001
Child's current age	.15	.16	.08	.94	.35	.09	.16	.05	.57	.57	.12	.14	.06	.89	.38
Learning or physical health difficulty	-4.49	1.69	-.22	-2.66	.01	-3.64	1.70	-.17	-2.14	.03	-2.64	1.47	-.13	-1.79	.08
Pre-adoptive trauma						1.13	.47	.20	2.41	.02	.79	.41	.14	1.93	.06
Psychological flexibility											.31	.12	.26	2.68	.01
Thought suppression											.13	.07	.18	1.95	.05
Rumination											.28	.16	.15	1.74	.08
F			7.91					7.60					13.61		

R^2			.15					.19					.43		
$R^2_{Adjusted}$			.13					.16					.40		
p			<.001					<.001					<.001		
								Regression 3							
Gender of parent	9.06	2.02	.38	4.49	<.001	7.64	1.69	.32	4.51	<.001	6.48	1.45	.27	4.48	<.001
Child's current age	.03	.12	.02	.22	.83	-.01	.20	-.01	-.12	.90	.01	.08	.01	.09	.93
Learning or physical health difficulty	-2.90	1.23	-.20	-2.37	.02	-1.05	1.05	-.07	-1.00	.32	-.76	.90	-.05	-.84	.40
Child's current difficulties						.30	.08	.31	3.67	<.001	.31	.07	.32	4.52	<.001
Child-to-parent violence						.54	.15	.31	3.70	<.001	.37	.13	.21	2.91	<.001
Psychological flexibility											.17	.07	.19	2.33	.02
Thought suppression											.11	.04	.21	2.63	.01

Rumination				.13	.10	.09	1.30	.20
F	7.75		18.23			22.21		
R^2	.16		.43			.60		
$R^2_{Adjusted}$	.14		.41			.58		
p	<.001		<.001				<.001	

Phase 2: Qualitative Results

Ten participants completed the qualitative interviews. All were female, with an age range of 37-64 years old. Participants had 1-4 adopted children, with only one participant having a biological child. The current ages of the adopted children ranged from five to 22 years old (median age = 14 years old). The ages at which the children were adopted ranged from four months old to six years old (median age = one year old). They all scored above PTSD being a clinical concern, rated as high enough to suppress the immune systems functioning (39+) on the IES-R, with an average score of 40.7 (*SD* = 13.9).

Four interrelated themes were generated from the thematic analysis.

Child-to-Parent Violence

Many of the parents described experiences of child-to-parent violence, which included physical violence such as *"lots of kicking, lots of punching, lots of biting, lots of hitting, lots of swearing*" (Participant 4) and intimidation "*there's a lot of body language, he will stand over me and scream down on me. A lot of verbal abuse"* (Participant 5). The injuries often left bruises and injuries with such a severity that some parents had to go to minor injuries units to seek medical help. Parents also described violence to such an extent that they had to call the police. The violence left many parents hiding their bruises and injuries from friends and families, describing a sense of shame if they told people what was happening at home: *"you feel like you're letting your son down because you're being honest to your friends and colleagues, but then you're at a stage where you can't hide it anymore"* (Participant 4). In relation to the violence, parents described finding the lack of empathy most difficult to manage: *"she will say are you bleeding, not in a worried way… that's what she wants. I said yes, just to see whether that would shock her, to show remorse but no it was the opposite, she just smiled and said can I see…"* (Participant 7).

Experiencing violence from their children understandably had a huge emotional impact on the parents: *"It broke me, it broke me completely. It went from being very scary at the start to being, oh god I've just got to let him hurt me to get it out of his system"* (Participant 4). The episodes of violence led many parents to fear their child, and in some cases, for their life: *"I remember lying in my bed and thinking 'is he going to come in here and kill me'"* (Participant 3). Connected to the violence, some parents described fears and worries for the future for their child, themselves and their family: *"I've thought we could quite easily end up as newspaper headlines. From her having killed me or her or both of us in some way, shape or form because she is angry" (*Participant 2). To manage the fears for the future, some parents described avoiding any thoughts about the future, and by attempting to remain hopeful: *"You hear about that in movies, with psychopathic children. This is all I can do for today, this week, I can't think too much in the future, rightly or wrongly I'm hoping for a medication that will take that aggression away*" (Participant 7).

When faced with such child-to-parent violence some parents felt unable to keep the child living in the family home. One participant described their experience of their child moving into a hostel: *"suddenly it hit me, I didn't feel sick and scared coming home anymore, I didn't come home thinking 'what am I going to find', for months I was living with that stress.. that was a shocking realisation"* (Participant 8). The high prevalence and severity of child-to-parent violence that the parents experienced underlies many of the subsequent themes, which are situated in the context of violence. See Table 10 for further example extracts for the sub-themes of child-to-parent violence.

Table 10

Example Extracts for the Sub-Themes under Child-to-Parent Violence.

Sub-Theme	Example Extracts
Violence	I remember I hid all the bruises until a really hot day, and I had a really bad bruise on my arm where he bit me, then others noticed and because you know this little boy is a brilliant little boy when he's regulated it was horrible saying to people 'oh [child's name] wasn't feeling too good and he bit me (Participant 4). How are we going to survive this? it was awful, she pushed me down the stairs (Participant 1).
Fear of child	But he's over six ft, so broad shouldered, a man. I'm quite small and relatively slightly built, so there's quite a big physical difference between the two of us, and he can feel quite physically intimidating. At times when he's been smashing things up that it has been quite frightening (Participant 3). I try to desperately supress any look of fear that might come onto my face when she does that, because I think that's what she looks for. She is looking to try and frighten me (Participant 2).
Fear for the future	What if this is who he is, and he will be this kind of man. I don't think he will, in my head I feel he's more likely to be the man, like the kind of little boy he was. But its 'what if this is who he is now' (Participant 3). There's the fear, the anxiety, the panic sets in about 'is this forever' (Participant 1).

Trauma Symptoms

A dominant theme that was generated related to the parents' experience of trauma. Adoptive parents are faced with parenting with the knowledge of the trauma that their child has been through, alongside the many challenging and violent behaviours in the present.

The majority of parents made reference to trauma symptoms, describing a sense of reliving the trauma that their child had experienced, summarised by Participant 3: *"it felt as though I could see it all happening again, an image would be in front of my eyes… it would be flashbacks, I'd have images of sitting there with him as a child".* The reliving and flashbacks related to imagining and wondering about the maltreatment experienced by their child before they were adopted, but also to present day trauma, which included child-to-parent violence for many parents. One parent described flashbacks to a time when their child experienced mental health difficulties and was admitted to a psychiatric hospital. In response to triggers or internal reminders of the child's past traumatic experiences, many parents described a complete avoidance of emotional responses and thoughts relating to the trauma that their adopted child had experienced, which they described as *"shutting it down… and trying not to think about it, because if I think about it, I will just get too upset"* (Participant 2). Once more, avoidance strategies were not solely related to the child's past maltreatment, but they were also utilised to manage current behavioural or emotional challenges facing the parents, which included future related worries.

The use of avoidance strategies as a way to manage the many emotional challenges facing adoptive parents extended to behavioural avoidance of activities or events that may trigger or evoke challenging behaviours in the present. For many parents, this involved avoiding situations that may result in reminders of the child-to-parent violence they had experienced *"I didn't want to see anyone; it was a proper depression because I couldn't face people or face them asking how things were"*

(Participant 4). Parents described avoiding situations that may trigger their child's past traumatic experiences, or in fact their own personal trauma history: *"I was avoiding anything that had any chance of triggering it off, really anything. To the point that I wasn't actually going anywhere that could trigger [child's name] or myself"* (Participant 5). This often meant that the parents missed out on many important events, from reunions and social contact with friends to larger celebrations, such as for their friend's milestone birthdays.

Further trauma symptoms parents described included a sense of hypervigilance to current or past threats, described as being on *"high alert"* (Participant 7). This relates to very real current threat from their child: *"She talks a lot about making me bleed, cutting me… It's about being on high alert and thinking what could go wrong here"* (Participant 7). Many parents acknowledged that this sense of hypervigilance to threat continues for many months or years after the threat or behavioural challenges from their child were no longer present: *"we probably don't have to be like that anymore because he's been so settled, but it's become a real habit and a real anxiety for us"* (Participant 4). The high threat experienced by the parents understandably leads to anxiety and fear for the violence returning.

Some participants described physical symptoms of trauma *"it was internal, or physical, sometimes it would make me physically ill, stomach problems"* (Participant 3). The many trauma symptoms described by the parents related to the knowledge of their child's past trauma, but also to a very present current threat in the form of child-to-parent violence, and further behavioural challenges as a result of their child's early experiences. See Table 11 for further example extracts for the sub-themes of trauma.

Table 11

Example Extracts for the Sub-Themes under Trauma Symptoms.

Sub-Theme	Example Extracts
Reliving and flashbacks	It was beyond thinking about it. I relived it, especially when something happened again… It was like you were not just experiencing that, but you were experiencing all of the previous times as well (Participant 3). That's another reason why my mental health and wellbeing were so difficult at that time, you're thinking about that all the time when you're looking after them, waiting for the next set of disclosures to come (Participant 10).
Avoidance of thoughts	What I do is, I shut down the part of the brain that goes shit, that's really scary, what does that mean? It's not normal. Your brain projects five years, 10 years in the future... when you can't restrain her, magnetic doors don't work… but you have to stop that (Participant 7). Well I have to shut down from it… I've ended up completely dissociating from the situation, and my automatic trigger has been the future thoughts. And what I do is avoid it, because thinking about it is just too painful, too worrying really (Participant 2).
Avoidance of emotions	I can put it in a different part of my brain now, if it was sat in the part of my brain with my feelings, I'd be a mess on the floor. You put it somewhere else, otherwise you wouldn't be able… (Participant 10).

Behavioural avoidance	While this was happening, it was mine and my friends 40th's and I ended up not going to any of it. Partly because we needed two parents with [child's name] at all times, but mainly because I couldn't face people. They would be talking about their kids and how funny they are, what great things they do. What would I talk about… 'he hit me again' (Participant 4). I ended up locking myself in the downstairs bathroom, it's my hidey hole. It's the one place they can't actually come into (Participant 5).
'High alert'	Oh god, so every morning if I haven't heard straight after drop-off that everything's ok then I'm texting to check in. But probably we don't have to be like that anymore but we do because we are so anxious (Participant 4). It's that constant being on edge that has an impact. It's taken me a long time to think about that trauma as mine. To feel as though I'm allowed to have that, because it's the boy's trauma really, that we are trying to support and work through, but at the same time it's having an impact on us. It was only a few months ago it hit me that it is traumatic for us, what we are going through (Participant 9).
Physical symptoms	I've got that initial physical well up in my chest… I suppress it I suppose to then be able to talk about it (Participant 3).

Emotional Impact

Perhaps unsurprisingly, all participants reflected on the emotional impact and exhaustion of being an adoptive parent. Understandably, almost all parents described the exhaustion of managing the emotional impact of parenting a child that has experienced a difficult early life.

The depression and anxiety, described at times by parents as feeling *"broken"* and *"soul destroyed"* (Participant 1), related to the overwhelming

cumulative challenges in parenting a child that has experienced early life trauma. Alongside the child-to-parent violence, this included feeling rejected by their child, which understandably impacted how participants felt about themselves as parents.

The depression and anxiety were often linked to a sense of loss and grief when thinking about their child's past experiences: *"I'm grieving for the loss… I do get upset for him"* (Participant 5). The sense of loss and grief related to what could have been if their child had had a different start in life, or did not have neurodevelopmental issues relating to invitro exposure to drugs and/or alcohol: *"it makes me think 'if she had just kept off the drink and drugs.. just for a few months, maybe he wouldn't have all that brain injury and damage"* (Participant 5). With this sense of loss and grief emerged a feeling of helplessness *"it makes me feel so sad, that I can't do anything to change what happened before I had her"* (Participant 2). The feelings of helplessness and thoughts of 'what could have been' led many parents to express frustration and anger at the loss their child had experienced. This was directed towards the birth family and the system for not intervening earlier and preventing their child's maltreatment and the subsequent behavioural and often violent challenges they face as a consequence of their early experiences: *"When I think about what her birth parents did… I feel anger in that the legacy for these children and what they have to manage in their daily life as a result of early life neglect and abuse, I don't think that the punishment fits the crime"* (Participant 1).

Living with the knowledge of what their child had been through prompted many parents to develop a deeper understanding of their child and the challenges they present with, which led to a greater sense of empathy and patience. Many parents described a process of reminding themselves of their child's early experiences to harness greater empathy particularly when times were difficult: "*I want to know as much as I can about their early experiences, because it helps me to make sense of what they do, and I think that there's no greater empathy than reminding myself, sometimes what the children have been through*" (Participant 6).

The empathy appeared to help the parents situate the current challenges and behaviours in the context of their past: *"I can depersonalise it a bit, to know that they are reacting more about their birth mother than me, I am just a symbol for her"* (Participant 5). Despite the challenges the adoptive parents face as a result of the legacy of their childhood trauma, some parents' empathy extended to their child's birth families. They described *"a lot of empathy"* (Participant 8), gained by developing an understanding of the birth family's circumstances and experiences, *"If things had been different for her [birth mother], she would have been ok"* (Participant 4). Linked to some adoptive parents ability to empathise and understand their child's difficulties, was their ability to draw on their own personal traumatic experience: "*If you have had a difficult lived experience… then I think you have a far better insight and skills as an adoptive parent*" (Participant 1). However, for some parents, their experience of child-to-parent violence "*woke up*" (Participant 5) their PTSD, leading to trauma symptoms. The impact of the adoptive parents' personal trauma on their experiences of parenting a child that has been maltreated appeared to be varied for each parent.

The emotional responses expressed by parents were both related to the knowledge of their child's traumatic early life experiences, and the exhausting and cumulative impact of the day to day parenting of a child that has higher emotional and behavioural needs as a result of their early experiences. Importantly, living with the knowledge of what their child had been through, although presents many challenges, it also prompts empathy, patience and a greater understanding. See Table 12 for further example extracts for the sub-themes of the emotional impact.

Table 12

Example Extracts for the Sub-Themes under Emotional Impact.

Sub-Theme	Example Extracts
Depression, sadness & anxiety	I was completely overwhelmed and depressed, definitely depressed, I went to get counselling myself, I felt soul destroyed, I absolutely understand the term soul destroyed now, because everything I was doing was being rejected and challenged and made more difficult, it was the worst time (Participant 1). I ended up on anxiety medication 18 months ago, came off it. but then my husband at that time was having problems with his chest and was referred to cardiology and actually it was anxiety because of how hard it was looking after the girls (Participant 10).
Loss & grief	if she hadn't had those experiences, she would be an entirely different child… (Participant 2). I'm in a grieving state, I do get upset for him (Participant 5).
Helplessness	So sitting back and watching a run-away train is difficult to do, even though it's a run-away train I still want to go and put my hand up (Participant 3). The moments where you feel helpless, where the ability to be able to know what you're doing is right for your child and be able to do it. For that occasion and the allegations, they are moments when all control is taken out of your hands and you are absolutely helpless (Participant 9).

Anger	All of that it really does make me really anger, because children are wholly innocent in it. So, its anger, frustration at the system, sadness for the children and then it's like, where does that go? (Participant 1). I don't trust anybody in authority anymore, especially when it comes to [child's name]. I would never take someone's first word in all of this. Whereas now I tell them because I usually know more than they do (Participant 7).
Empathy	I remind myself about what they've been through and what they've come through. Because there's a bit of compassion fatigue, it can come and go. It can be one day you have it and the next day you don't, which can be hard to deal with (Participant 6). Birth mum was a teenager, she had come from a care background as well. She had an incredibly difficult upbringing, she didn't go to school, had medical problems herself and she hadn't had the parenting she needed to make good choices when she became a parent. So, I felt really sorry for her. I just thought, if things had been different for her, she would have been ok (Participant 4).
Parents trauma history	I have PTSD from an underlying childhood thing myself. But he kind of woke that up (Participant 5). I understand it because I had traumatic experiences in my childhood and I think that is crucial to this, if you have lived it yourself… I think that is key, if you cannot put yourself in your child's shoes in any shape or form, you're going to struggle to have the empathy and actually help them (Participant 1).

Stigmatisation & Support Network

Many parents described the importance of other people's reactions, whether they were judgemental and stigmatising or supportive to them as parents, and their family.

Parents described "*a lot of judgement"* (Participant 6) from others. Relating to this was a sense of other people's lack of understanding of their child's difficulties, with most participants reporting that this can lead to a sense of isolation: *"well as a parent, because of the way she behaves, it's pretty isolating. I don't have anything to do with any of the other parents, because they don't understand the way she behaves, they don't think I parent her properly or that I don't deal with issues in the way they would expect" (*Participant 2). Many parents made reference to their *"dissolving"* network and loss of friendships since they adopted their child due to others not understanding the challenges they face as adoptive parents, or a sense of judgement regarding their parenting: "*when you adopt, you have this lovely eco map of everyone who has said they will be there to support you, but pretty much that eco map is gone. Their godparents don't turn up at any time*" (Participant 5). Furthermore, due to the judgement and lack of understanding from other people, all participants reported that being an adoptive parent had impacted on their working life in some way, reflecting that *"no employer is going to be understanding about this"* (Participant 1).

However, some parents made reference to the hugely positive impact of support from family and friends who were understanding. Alongside this, nearly all parents made reference to the importance of support from other adoptive parents: "*some of these things I would never discuss with my other friends… people just wouldn't get it unless they are adopters… I survived by talking it through"* (Participant 8). Alongside the importance of support from other adoptive parents, some parents made reference to the importance of therapeutic intervention from services. However, this was often felt to be "*like a battle*" (Participant 9) due to the

Child and Adolescent Mental Health Service criteria or funding process, which often left parents with fewer sessions or a gap in support whilst funding was sought: *"it's always one step forward a few steps back"* (Participant 2). See Table 13 for further example extracts for the sub-themes of stigmatisation and support network.

Table 13

Example Extracts for the Sub-Themes under Stigmatisation & Support Network.

Sub-Theme	Example Extracts
Judgement from others	I think they thought I was some neurotic middle-class mother, which I don't think I am, but that wasn't the problem anyway (Participant 3). And I get this thing at school so and so did that did this, the mums at school. And you think 'lucky you' my kids wouldn't do that. They don't know what my children have been through. A lot of judgement from others (Participant 6).
Others lack of understanding	Nobody seems to understand that we have to parent them differently, we can't sit them on a naughty step. A lot of people, unless they're very accepting, they can't understand (Participant 5). You can sometimes feel as though you're living in a completely different world from other parents of kids of a similar age. The things they are worried about and that you are worried about can be completely different (Participant 3).
Loss of friendships	When you first adopt, you have all your friends that you think will be there, but that all falls away (Participant 10). The friends I had before I adopted, even ones who have to write in support, well most of them dropped me like a hot potato as soon as [child's name] arrived (Participant 2).

Work	Quite a few times we were getting to bed at midnight, and I had to get up early for work in the morning and I'm thinking 'do I just call in sick?' but then you don't want anyone knowing, and then when you are at work you're very down, very snappy because people have no idea what's going on in your life and they're moaning about something completely inconsequential in your view (Participant 4).
Family & friends	My parents are brilliant. They sometimes struggle watching what's going on, but always accept it, and keep the boys understanding that they might not like their behaviours but they're still their grandparents and love them (Participant 5). In terms of family I have a tiny family anyway. My mum is about half an hour away, but she doesn't want to be a grandma. My brother has a few kids as well, but she doesn't want to be a grandma to any of them. She does at times cone and help, in inverted commas, but the fall out that it leaves, isn't worth it normally (Participant 2).
Support from other adopters	I mention that I'm connected to other adopters, some of these things I would never discuss with my other friends, I would never talk about going to my son's birth fathers funerals, people just wouldn't get it unless they are adopters… I survived by talking it through. But there's not many people you can say those things to. Because also, in terms of stress, clearly the worse things are at your home, the harder it is to connect with parents whose kids don't have issues, so it has a massive impact in terms of your time and energy (Participant 8). It all falls away so what you're left with is other adopters (Participant 10).

Therapeutic intervention	It feels like a battle when you need to access support, it feels like you're justifying why you need the support. I guess that puts some parents off accessing support (Participant 9). We do some therapy at the moment, we don't have anywhere near enough of it, it's always one step forward a few steps back, because we get such few sessions and then we have to wait for the next round of funding (Participant 2).

Sense of Self as a Parent

This theme related to parents' sense of their own abilities and conceptualisation of themselves as adoptive parents. The participants' sense of themselves as a parent was intrinsically linked to the experience of child-to-parent violence, and the shame and helplessness they often felt. The stigma, judgement or support/lack of support was central to how many adoptive parents judged their competence as a parent.

An important factor related to other people's lack of understanding of the additional challenges facing adoptive parents. The majority of parents described the additional pressures of being an adoptive parent compared to biological parents: *"As an adoptive parent, you have an underlying extra pressure to be a really, really amazing parent to give them something massive that they weren't going to get if they weren't there with you"* (Participant 2). Some parents related the additional pressures specific to being an adoptive parent to a fear that their child would reject them, with thoughts such as *"he isn't really mine, in inverted commas, is he? he's never, ever going to be mine"* (Participant 4). Some parents linked this to the unhelpful responses from other people: "*lots of people will say "well they're not really your child" (Participant 2).* Further unique pressures to adoptive parents included the regret and wish that their child had never experienced the difficulties

they faced in their early life: *"The truth is, if they had been mine from the start, I could take all the pain away. We wouldn't have this problem*" (Participant 5). This often related to current challenging behaviours, but also certain neurodevelopmental consequences of children's early experiences, such as foetal alcohol syndrome.

Many parents seemed to hold very high expectations of themselves as parents, and how they 'should' be as an adoptive parent, and how they 'should' respond in the moment when faced with behavioural challenges from their child: *"sometimes I imagine that I am writing the character of a really good mum and what they would do, rather than what I would do, try and sort of act that out. It's difficult when you're in the moment yourself"* (Participant 3). For many parents, this related to their prior expectations of the type of parent they would be: "*I thought I would be an earth mother parent, very liberal, not telling anyone off… I am far more shouty than I ever thought I would be*" (Participant 1). It also related to their expectations what being an adoptive parent would be like, and the unexpected reality "*the sort of things, oh god, I would never have dreamed that my kids would be in prison, gone to court, had mental health crisis, excluded from school, unplanned pregnancy, caused damage to home, violence. I wouldn't have thought any of this*" (Participant 8). The aforementioned factors all contributed to how parents conceptualised their abilities and competence as a parent, describing themselves as a "*rubbish*" and "*crap parent*" (Participant 1); further summarised by Participant 5: "*I end up feeling like I'm failing, if I can't get through to him then I'm obviously doing something wrong. I can't get him to understand*". In the moment, when faced with extreme behavioural challenges and violence, many parents often appeared to perceive the difficulties as a reflection of their competence as a parent, rather than as a reflection of the legacy of their child's maltreatment.

Despite the many challenges facing the adoptive parents, some parents reflected on the positive aspects and "*job satisfaction*" that raising an adopted child has bought them, which has shown them the *"real value of being an adoptive*

parent" (Participant 4). To be able to reflect on their strengths as a parent and the progress they have made as a family in spite of many current challenges was an important element to the parents' sense of self. See Table 14 for further example extracts for the sub-themes of parental sense of self.

Table 14

Example Extracts for the Sub-Themes under Sense of Self.

Sub-Theme	Example Extracts
Additional pressure of being an adoptive parent	I think a lot of parents feel like they're not doing a good enough job, but when you're an adoptive parent you feel like you need to do better, because they've already had one parent who has let them down. I think you always feel you need to be even better than a regular parent, because that bar is higher, you've got to be better than that parent who let them down, and better than any other parent (Participant 4). I always thought I was never going to let him down because he'd already had one family let him down, so if I do that I would be as bad as them (Participant 2).
Fear of rejection	She's got all that and thinks that one day they will be reunited in the family and that really rocked me because it made me think 'well what's the point', what's the point of me having all these beatings and trying really hard with him if there comes a time when he's 18 and he says see you mum, I'm going to meet her (Participant 4). Everything I was doing was being rejected and challenged and made more difficult, it was the worst time (Participant 1).

Regret… I Wish…	Regret… regret that what had happened to them, wishing things would have been different for them (Participant 8). It's quite upsetting, because I think 'I wish they hadn't gone through all of that' (Participant 6).
Expectations of self as a parent	You've got to make sure she's got a better parenting offer than she would have had than if she had stayed with her birth mum (Participant 2). As a parent you're there to keep your child safe, to protect them and either you've not been able to do that or somebody else thinks you haven't done that so they need to investigate that. You feel as though you haven't done everything you possibly could to be the parent you needed to be (Participant 9).
Parenting sense of competence	We just felt like we couldn't do anything right, everything you were trying to do wasn't having an effect, so I thought the way we were parenting mush be wrong (Participant 10). You just feel like a rubbish person because you must be doing it wrong, if you've got your child hitting you up on a daily basis, you think you must be doing it wrong (Participant 1)
Parental satisfaction	So, all of us working together and having brilliant communication has brought him into feeling very settled. If you think of being a parent as a job, there's huge job satisfaction in that (Participant 4).

Summary

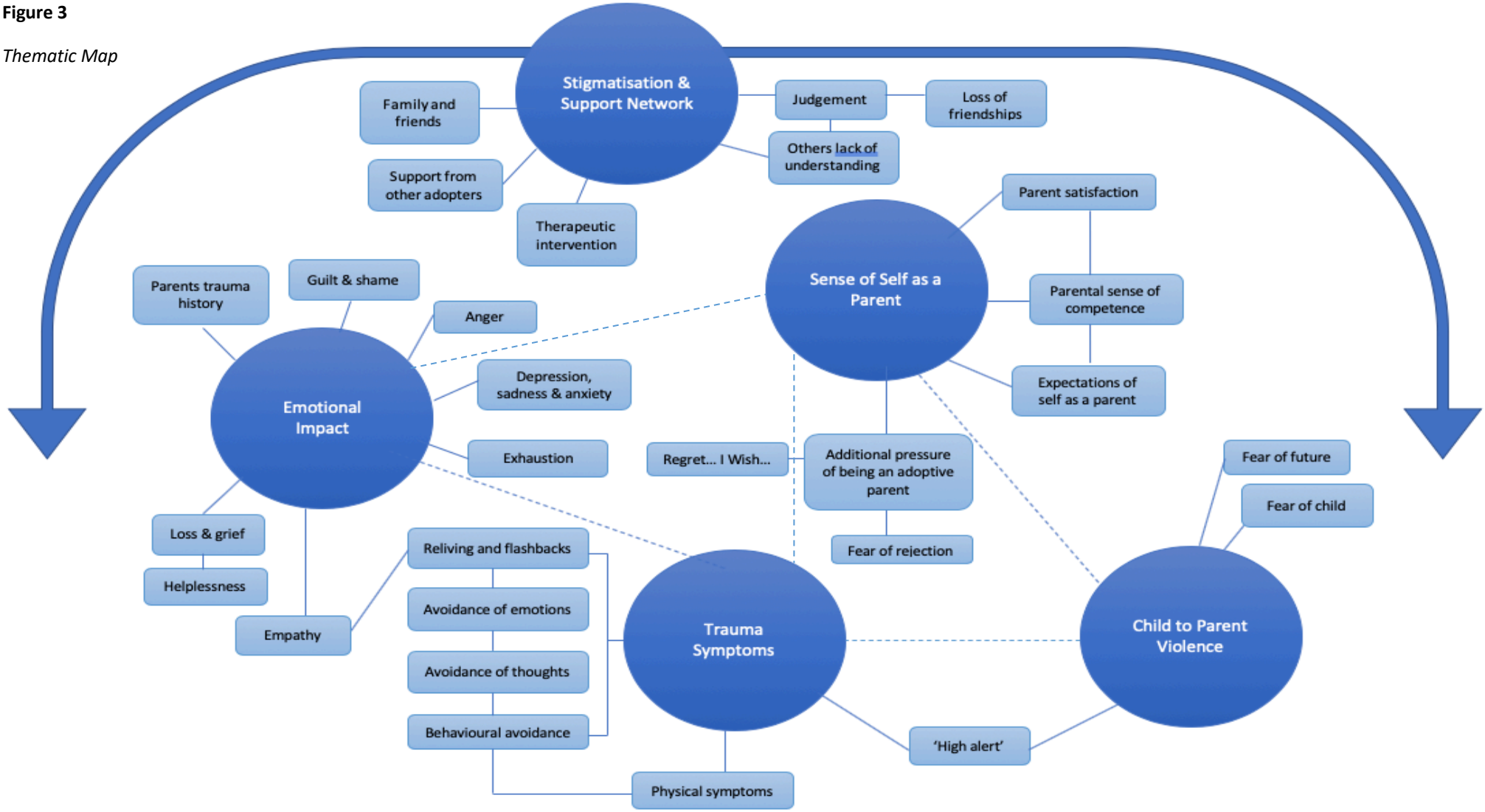
The thematic analysis outlined the emotional and traumatic impact of parenting a child that has experienced early life maltreatment. This related to both the knowledge of what their child had been through, but is predominantly driven by the current behavioural challenges that they are living with as a result of their early experiences, which includes high levels of child-to-parent violence. The knowledge of their child's past, although traumatic to live with as a parent, also allows many

parents to make sense of the challenging current behaviours they face and enables them to parent with empathy, patience and compassion. The trauma that the parents described was multifactorial, on one hand relating to the child's past and current behaviours, but also to a lack of support and a sense of isolation and judgement from others. How the parents experience their child's early trauma, the current parenting demands and the sense of stigmatisation and support all draw together to form the parents' sense of themselves. Their expectations of themselves as a parent, combined with their perception of their competence and abilities and satisfaction all form their parental sense of self. Ultimately, their own evaluation of their parenting is impacted upon, and impacts on their emotional capacity and ability to hold and manage the trauma of their child's past and the trauma they face currently.

The thematic map of the interrelated main themes and subthemes can be found in Figure 3. The thematic map demonstrates the overarching impact of stigmatisation or support in forming the parents' emotional experience as an adoptive parent. The map further highlights the overlapping connections between the emotional and traumatic experience of parenting a child that has experienced early life trauma, which is strongly influenced by experiences of child-to-parent violence. All of the above draw together to form their sense of self as a parent, relating to their sense of competence and the additional pressure and demands of being an adoptive parent.

Figure 3

Thematic Map



Discussion

Main Findings

This study aimed to investigate trauma and compassion fatigue within adoptive parents through both quantitative and qualitative methodology. The current study measured both primary trauma through the IES-R and secondary trauma using the ProQOL as previous research has found that burnout, compassion satisfaction and primary trauma predicted secondary trauma in foster carers (Bridger et al., 2020). The results from the current study found that in terms of primary trauma, 20% of parents scored as PTSD being a clinical concern. When using the more conservative diagnostic cut-off, 10% of adoptive parents in this study met the criteria for PTSD, which is higher than general population current prevalence estimates of 3% of people within England who scored positively for PTSD (McManus et al., 2009). The findings are in line with a previous study that found 12% of foster carers met the criteria for a diagnosis of PTSD as a result of indirect exposure to the child's trauma (Carew, 2016).

For secondary trauma, 52.4% of the adoptive parents scored within the top 5% of the general norms, demonstrating high levels of secondary trauma within adoptive parents. Participants in the current study reported significantly higher levels of secondary trauma and burnout, and significantly lower levels of compassion satisfaction than population norms. These findings expand on the research into secondary trauma within foster carers (Hannah & Woolgar, 2018; Bridger et al., 2020) and provide further evidence into the emotional impact of parenting a child who has experienced early life trauma. Furthermore, within adoptive families, parental mental health and wellbeing has been consistently linked to the mental health and behavioural outcomes of adopted children (Goldberg & Smith, 2013; Hails et al., 2019; Hornfeck et al., 2019). Within foster carers, high secondary trauma was associated with lower intent to continue to foster (Hannah & Woolgar, 2018). Therefore, the current findings relating to adoptive parents' trauma symptoms

is vitally significant when considering the devastating impact of adoption disruption on adoptive families and children.

The second aim of the current study was to explore the relationship between the two measure of trauma symptoms and compassion fatigue. The two measures of trauma, the IES-R measure of primary trauma and the ProQOL secondary trauma subscale were highly associated. With little conceptual certainty or consensus in the definition of compassion fatigue and secondary trauma (Najjar et al., 2009; Boyle, 2011), the findings of this study further suggest the overlap between the concepts and measures used. Although some previous researchers have outlined a preference for the term compassion fatigue (Figley, 1995), other researchers have cautioned against the use as 'it connotes a lessening of the expression of compassion' (Ledoux, 2015). There has been a suggestion that the term compassion fatigue is inevitably linked to the concept of compassion, and therefore implies that compassionate feelings and behaviours are inherently 'tiring', and that healthcare providers', or in this instance, adoptive parents' capacity for compassion is limited or reduces over time (Fernando & Consedine, 2014). Researchers would benefit from exploring the perspective of adoptive parents in their preference for each term, before taking a particular definition and applying it to this population.

The final aim of the study was to examine the contribution of cognitive styles on trauma symptomology in adoptive parents. The results suggest that the cognitive processes of psychological inflexibility, thought suppression and rumination predict higher primary and secondary trauma in adoptive parents. During the interviews, parents exhibiting high trauma symptoms described a strong avoidance of thoughts and feelings as a way to manage the current challenges and the knowledge of their child's early traumatic experiences. These findings support previous research into secondary trauma that suggests avoidance strategies and rumination contribute to the development and maintenance of secondary trauma responses (Plumb et al., 2004; Rassin et al., 2000; Michael et al., 2007). Furthermore, the findings contribute

to the research base investigating the association between cognitive styles and traumatic symptomology in carers parenting children that have experienced traumatic early life experiences (Hannah & Woolgar, 2018).

Interestingly, the results did not find rumination to independently predict trauma or compassion fatigue scores above and beyond psychological flexibility and though suppression. Rumination refers to recurrent and repetitive thoughts about the past. Worry on the other hand relates to recurrent and repetitive thoughts about potential life events, and the future (Roemer & Borkovec, 1993). Therefore, the major differences in definition is that the focus of thoughts in worry is future-orientated, whereas thoughts are past-orientated in rumination. One possible explanation of the current findings is that the concept of worry relates more strongly to the experience of secondary trauma in adoptive parents. This alternative explanation is supported by the findings in the qualitative study, where parents predominantly described future related worries. This perhaps accounts for why rumination does not predict traumatic symptomology independently of psychological inflexibility and thought suppression in adoptive parents. Alternatively, the findings may capture the overlapping concepts of rumination and avoidance. Previous research has suggested that rumination can function as a form of cognitive avoidance, in that ruminating on negative issues related to the trauma but avoiding actively thinking about the traumatic experience itself obstructs the emotional processing of the trauma (Foa & Kozak, 1986; Teasdale, 1999). There is some evidence that ruminating on “why” and “what-if” types of questions functions as a form of cognitive avoidance (Michael et al., 2005). The findings of the qualitative study further support this alternative explanation as parents described ‘what-if’ fears towards the future in light of current behavioural challenges.

An important finding of the current study was the significance of the current emotional and behavioural difficulties, including child-to-parent violence, over the child’s pre-adoptive trauma in predicting parental primary trauma responses. This

finding is important when considering the evidence that parental PTSD symptoms are positively associated with the child's PTSD symptoms after exposure to a traumatic event (Morris et al., 2012). The mental wellbeing of adoptive parents is vital to enable them to provide the significant amount of support their children need to help them recover and make sense of their early experiences (Quinton & Rutter, 1988). Furthermore, within the qualitative findings, many parents described the traumatic experience of child-to-parent violence that they were currently living through. There is surprisingly little UK research on child-to-parent violence, particularly within adoptive families (Biehal, 2012; Selwyn & Meakings, 2016). Due to this, there is a lack of consensus on the definition or measurement of child-to-parent violence, although it has been described as a wide variety of physical and psychological behaviours designed to control, coerce and dominate the parent and family members (Selwyn & Meakings, 2015). Although trauma rates in the current study are lower than estimated rates of PTSD in women exposed to domestic violence, which ranges from 31% to 84% (Jones et al., 2001), the findings remain concerning and indicate the importance of considering the large proportion of adoptive parents that are experiencing child-to-parent violence and living through current trauma. The results of the qualitative findings provide further support to the importance of measuring primary trauma, as many participants described trauma symptoms such as being on 'hyper alert', avoidance and reliving or flashbacks. In a previous study of adoptive families, child-to-parent violence was the leading cause of adoption disruptions, and adoptive parents described feeling ashamed, hopeless, and inadequate in parenting adolescents who were aggressive toward them (Selwyn & Meakings, 2015). A possible alternative explanation to the current findings, that warrants further exploration is that parents experiencing high trauma symptoms are utilising avoidant coping styles in a way to survive and manage the day to day challenges of facing current threat and traumatic violent experiences.

Limitations

There were several limitations to the current study, which should be taken into account when interpreting the results. The recruitment procedure did not allow us to calculate response rates for this study, as charities and post-adoption support organisations acted as intermediaries in the process. It is possible that the focus of the survey may have influenced the type of adoptive parent willing to respond and affected the return rate. One possibility is that those experiencing higher distress, or at the point of adoption disruption and possibly at greater risk of experiencing trauma symptoms did not feel able to take the time to complete the survey, meaning that the current results may underestimate the overall levels of trauma amongst adoptive parents. Furthermore, those parents at greater distress may not be in contact with adoption charities or support services that were utilised to advertise the study. Alternatively, the survey content may have attracted parents experiencing high levels of distress as a way to reflect and share their experiences. It is important to note that to increase responses, the survey was subsequently advertised through social media platforms. This came with certain limitations, as it would be impossible to directly ensure all respondents were in fact adoptive parents. Non-adoptive parents could theoretically click the link via social media and complete the survey for a chance to win the £100 amazon voucher prize. Although measures were taken to prevent this occurring, such as adding in a statement to the consent form (Appendix C).

Further methodological limitations include the reliance upon parental self-reported measures of trauma, distress and cognitive styles. Relying upon parents' reports of their own distress and parenting can be influenced by social desirability bias, with parents endorsing items considered to represent "good parenting" and their beliefs about parenting, regardless of their actual behaviours (Lovejoy et al., 1997; Morsbach & Prinz, 2006). Furthermore, a theme that was generated in the qualitative analysis related to stigmatisation, including a sense of judgement from

others, which may have impacted on the results of the study. Adoptive parents may have felt a fear of judgement or unwillingness to disclose the full extent of the challenges and distress they face. Furthermore, it is important to note the focus of cognitive avoidance in this study, making it likely that those parents utilising avoidance strategies may not have engaged in a study exploring trauma, or perhaps that the cognitive styles and thought suppression strategies were in use during the completion of the survey. This may have resulted in the findings underestimating the extent of trauma and the strength of the link to cognitive avoidance strategies.

Although the study utilised validated and reliable measures of cognitive styles, trauma and compassion fatigue, the measure of pre-adoptive trauma was calculated as an accumulation of traumatic experiences. Although many validated measures utilise a similar approach to capture childhood trauma, such as the Adverse Childhood Experiences Questionnaire (World Health Organization, 2018) and Childhood Trauma Questionnaire (Bernstein & Fink, 1998), they too do not capture the severity or chronicity of the trauma. Furthermore, there is a lack of consensus on the definition or measurement of child-to-parent violence, although it has been described as a wide variety of physical and psychological behaviours designed to control, coerce and dominate the parent and family members (Selwyn & Meakings, 2015).

To limit the total length of the survey shorter measures of mental health were selected, specifically the PHQ-9 and GAD-7. Although this provided a measure of depression and anxiety, it did not provide a measure of overall well-being or mental health. A longer questionnaire measure encompassing well-being, symptoms/problems and social functioning that could have been used is the Clinical Outcomes in Routine Evaluation-Outcome Measure (Barkham et al., 1998; Barkham et al., 2005). In addition, due to the scope of the thesis the findings are limited to avoidant cognitive styles, primary trauma and compassion fatigue. However, additional measures collected as part of the larger study warrant further exploration,

including attachment styles and parental self-efficacy. A systematic review of compassion fatigue and secondary trauma in professions found that attachment security was associated with lower levels of compassion fatigue, whereas an anxious attachment style was associated with higher levels of compassion fatigue (West, 2015). Furthermore, self-efficacy and poor perceived ability to manage stress relating to work are associated with higher levels of compassion fatigue (Prati et al., 2010). Further discussion is warranted to fully explore the relationship between these variables and trauma symptomology in adoptive parents.

A further limitation relates to the cross-sectional design. Although there is a clear association between cognitive factors and primary and secondary trauma, it does not determine the longitudinal trajectory of secondary trauma and compassion fatigue in adoptive parents. Furthermore, it is likely that the effects are bi-directional, in that higher secondary trauma may influence the use of cognitive avoidance strategies and vice versa.

Although there were strengths in the mixed methods utilised in the thesis to explore a new concept within a novel population, this had led to some important limitations. Due to time constraints, the qualitative findings were not cross validated with the participants. However, researchers have highlighted the limitations of participant validation, highlighting the risk that researchers 'collude' with participant accounts or risk exploiting the time and commitment of research participants (Barbour, 2001). Furthermore, qualitative research is conducted from a relativist perspective, acknowledging the existence of multiple, equally valid points of view and interpretation (Popay et al., 1998). It is important to note that utilising a mixed-methods approach meant that the constructs being quantitatively measured were formulated and in mind during the qualitative interviews and analysis. Bracketing was utilised to explore how this may have impacted on the results, which is further discussed in part 3 of the thesis.

Clinical Implications

The current study provides evidence for compassion fatigue and trauma symptomology within adoptive parents, which should provide important awareness and direction to adoption support services nationally. The impact of avoidant cognitive processes and current behavioural challenges on trauma symptomology should lead to important considerations for formal training to post-adoption support workers, adoption charities and to prospective and current adoptive parents. Furthermore, the extent of the child-to-parent violence facing many adoptive parents, and the role it holds for parents exhibiting trauma symptoms is vital information for clinicians and adoption support organisations. Clinical interventions should firstly address child-to-parent violence, and secondly focus on cognitive coping styles where trauma related to violence occurs. The findings demonstrate the importance of providing support for adoptive parents in facing current trauma rather than past trauma focused. This is particularly important for adoption support organisations to hold in mind as previous research has suggested that adoptive parents facing violence at home that resulted in adoption disruption, felt that they were not supported by services or that there was a delay in response from services (Selwyn, 2014). Alongside this, the current findings highlight the need for awareness and training to screen for trauma symptoms and provide early support for parents experiencing child-to-parent violence.

The findings provide further direction for providing supportive interventions for adoptive parents experiencing trauma symptoms. Firstly, the study has shown that both the ProQOL and IES-R are two reliable and associated measures that could be used for screening and assessing symptoms of compassion fatigue and trauma symptoms clinically within adoptive parents. Although the IES-R holds the advantage of being relatively shorter, the ProQOL provides further indices to measure strengths. Compassion satisfaction which has been shown in the current study to be negatively associated with compassion fatigue, in line with Stamm's

(2010) model, suggesting the potential alleviating effects of compassion satisfaction on compassion fatigue.

Secondly, the role of avoidant coping strategies in predicting secondary trauma suggests future interventions targeting these aspects would be beneficial. Acceptance and Commitment Therapy (ACT) (Hayes & Wilson, 1994), is a third wave Cognitive Behavioural Therapy approach that emphasises the importance of avoidance of particular internal experiences, such as thoughts, memories and feelings in the development and maintenance of distress (Hayes et al., 2012). ACT offers alternative ways of relating to unwanted internal experiences through mindfulness, acceptance techniques and by emphasising action in line with individual values (Hayes et al.,1999). ACT aims to increase psychological flexibility, with findings suggesting that as acceptance strategies are used, an internal experience no longer becomes a cue for avoidance, and therefore the emotive response gradually reduces (Hayes & Wilson, 1994). The current findings may indicate the benefit of ACT for adoptive parent support.

Implications for Future Research

As this is the first known study exploring trauma and compassion fatigue in adoptive parents, there are many avenues for future research to explore. The findings highlight high levels of trauma within adoptive parents alongside previous findings in foster carers (Hannah & Woolgar, 2018). Future research would benefit from a comparative study of trauma symptoms and compassion fatigue across different parenting roles, such as adoptive parents, biological parents, foster carers and kinship carers.

The survey enabled participants to leave comments on how they found the survey and if there were any aspects to their experience that we did not cover. The responses highlighted the importance of the research focus; *“It was a refreshing change to fill in a form that focuses on the impact of adoption on the adopter as well*

as being mindful of the child's early trauma". The responses also gave an insight into additional variables in the development and maintenance of secondary trauma in adoptive parents that warrant further exploration. In the comment section, parents suggested additional variables such as their experience of post adoption support, the adoption process, the reality of parenting versus the preparation for adoption and whether parents had traumatic experiences themselves. The exploration of attachment and parenting factors such as self-efficacy were explored in this survey, but outside the scope of the thesis and requiring further discussion. Future research would benefit from quantitatively exploring variables that emerged in the qualitative analysis, such as sense of stigmatisation and child-to-parent violence.

Due to the limitations of this study, future research would benefit from exploring the concept of secondary trauma and cognitive predictor variables across the adoption process, from the initial assessment phase and onwards. It would be important to determine at what time point predictive factors such as child-to-parent violence emerge, and at what point the adoptive parents come to rely upon avoidance cognitive processes. Furthermore, due to the findings on the role of avoidance in secondary trauma, future research would benefit from exploring the beneficial effects of an ACT intervention in a randomised control trial.

The findings of the systematic review in part 1 of the thesis consistently found that parental mental health was indicated as a risk factor for adopted children developing mental health or behavioural difficulties. Subsequently, the empirical chapter focused on adoptive parents' mental health, demonstrating high levels of trauma predominantly driven by the child's current emotional and behavioural difficulties. There is a growing consensus within the literature that parent and child factors interact with one another, contributing to children's emotional and behavioural development (Fanti et al., 2008; Neece et al., 2016; VanderValk et al., 2007). The current thesis suggests that future research would benefit from extending the literature within adoptive families (Lawler et al., 2018) by exploring the

directional relationship between adopted children's mental health and parental mental health across time.

Conclusions

This study is the first to describe rates of trauma symptoms and compassion fatigue in adoptive parents, with approximately one fifth of participants reporting trauma symptoms of clinical concern, and 10% reaching the threshold for a probable diagnosis of PTSD. Furthermore, 52.4% of the adoptive parents scored two standard deviations or more above the norm, within the top scoring 5% of the general population for secondary trauma. Adoptive parents scores on compassion fatigue were significantly higher than the population norm. Findings demonstrate that cognitive avoidant styles of psychological inflexibility, thought suppression and rumination predict trauma and compassion fatigue. Such findings lead to important clinical interventions based on reducing avoidance and increasing psychological flexibility, such as Acceptance and Commitment Therapy (ACT). Furthermore, the trauma symptomology appears to relate more to the current challenges of parenting a child that has experienced early life trauma, rather than the level of pre-adoptive trauma experienced by the child. This demonstrates the importance of screening and supporting adoptive parents facing extremely difficult current challenges in parenting, such as child-to-parent violence. Further research is required to compare trauma symptoms across different parenting roles and families, explore the longitudinal development of trauma relating to the parenting role and to determine the efficacy of interventions targeting avoidance and trauma in adoptive parents.

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Part 3: Critical Appraisal

Introduction

This critical appraisal will provide a reflection on the development and process of completing the empirical research. Firstly, I will summarise my previous personal experience and theoretical orientation to reflect on how they may have influenced the development of the study, the process of the research, and how they may have modified my conclusions. Secondly, I will reflect on my experience of service user involvement in guiding the research project. I will then reflect on the dilemmas and challenges faced with recruitment, and how this subsequently led to methodological amendments. This will include reflections on equality, diversity and inclusion throughout my research project. I will then reflect on the experience of conducting research as a trainee clinical psychologist, and finally, reflect on the unexpected impact of the COVID-19 pandemic on the research project.

Personal and Epistemological Positions

Firstly, it is essential to provide background information regarding my personal interest in the subject of this study. Since embarking on a career in clinical psychology, I have felt drawn to supporting children that have experienced trauma or difficult early experiences in life. This passion developed as I learnt about developmental psychology and attachment theory and began to see the vital importance of childhood experiences as the building block for wellbeing, mental health and how we form relationships as adults. Before beginning the clinical doctoral training, I worked in a specialist mental health service for looked-after and adopted children, where I gained direct experience witnessing the legacy of early life trauma on children, the family and the system surrounding them. I saw how parents and carers were central in the treatment of children presenting with challenging emotional and behavioural difficulties and became interested in systemic theory and

practice. Systemic theory continues to guide my professional development, and as a practice, it seeks to address difficulties not on the individual level, but by placing the individual within their context, their relationships, interactional patterns and dynamics (Dallos & Draper, 2010). I became humbled by the sheer strength of the adoptive parents that I worked with, who faced the stresses of parenthood, with the additional strains of what it means to be an adoptive parent. I vividly recall one parent, who was on the verge of adoption disruption summarising their experience to me, *'I'm broken, how can I continue to pour from an empty cup?'* This is something that has stuck with me throughout training and guided my motivation to work in a specialised fostering, adoption and kinship care team for my final clinical placement, and to develop the subject of this research project. My personal interest in the research topic helped me to stay motivated throughout the research process, drawing on the hope that the findings may have clinical implications to directly improve the support and services available to adoptive parents.

"The researcher is the instrument for analysis" (Starks & Trinidad, 2007). This quote felt pertinent throughout the entire research project, but particularly within the qualitative study. I was aware that the subjective approach to the design of the study, recruitment, data analysis and interpretation would be inevitably impacted by my assumptions, values, experiences and theoretical position. "Bracketing" is a way to increase awareness and to explore the impact of the researcher's personal and professional experiences, aiming to increase objectivity and increase the researcher's reflexive capacity (Tufford & Newman, 2012). Bracketing is not considered a one-off occurrence of outlining the researcher's preconceptions, but rather it is considered a continual process throughout conducting research (Tufford & Newman, 2012). One method of bracketing is to begin a reflexive journal before and during the research process to examine the researcher's engagement with the emerging data (Ahern, 1999). During the project conceptualisation phase I began a

reflexive journal to bring awareness to my own personal preconceptions, which I maintained throughout the process of data collection, analysis and write up. The reflexive journal has aided the write up of the entire thesis, and particularly the critical appraisal.

Having outlined my own interests and beliefs that led me to develop the topic of this thesis, and how I utilised bracketing to increase my awareness, it is worth noting that my own experiences inevitably influenced the research process, from the literature review topic selected, questionnaire measures selected for the survey, interview structure or clustering of themes during the thematic analysis (Malterud, 2001).

Service User Involvement

In the initial stages of developing the research project, I was acutely aware of my inability to truly understand and relate to the challenges facing adoptive families, as someone who is not personally an adoptive parent. Due to this, it felt vitally important to me to involve adoptive parents throughout the research process.

Service user involvement ensured that the voices of adoptive parents were heard throughout the research process, from planning through to the write up, to both shape and improve the study. As both a clinician and researcher, I value the importance of service user involvement and partnership working, therefore, throughout this process it was important for me to ensure that service user involvement did not feel tokenistic. Although this resulted in delays with a re-referral to the UCL ethics committee following amendments, it demonstrated to me the vital significance of including adoptive parents in research design and implementation.

Throughout the process of consulting with adoptive parents I was struck by my lack of direct experience and understanding of the challenges facing adoptive parents. Although as a research team, having spent many years working within looked-after and adopted children's services, it was striking to me that we did not consider vitally important aspects relating to experience of being an adoptive parent. This included measuring child-to-parent violence, which many adoptive parents face. This in turn became an important factor in predicting trauma symptomology in adoptive parents, improving the findings of the empirical paper greatly. The voices of the adoptive parents consulting on the research resounded with me particularly during the qualitative study, as I was struck by the level and frequency of child-to-parent violence experienced by the parents I interviewed.

Service user involvement was particularly important when considering the terminology used throughout the research project. Reflecting on my reflexive journal, I noted my initial personal avoidance and discomfort of using the term 'trauma' when referring to parents' experiences, as I feared causing offence to the community of adoptive parents by using a 'label'. Consultation with service users enabled me to re-evaluate this worry, identify it as my own fear, and I in turn began to see the value in naming the difficulties and very real and traumatic challenges facing adoptive parents. On reflection, I wonder if my initial discomfort and fear of causing offence played into the societal views of how to manage the emotional challenges of adoption, by avoiding the difficult conversations, which ultimately leads to the isolation of adoptive parents and families.

On reflection, it would have been beneficial to utilise the expertise of adoptive parents when interpreting the data to incorporate their unique insights and to increase the service user empowerment in the research. If I were to conduct the research again, I would consider conducting the qualitative analysis alongside an adoptive parent, to truly develop collaboration in the findings of the research project.

The consultations felt empowering to the adoptive parents, and humbling to me as a clinician, and became a vitally important aspect of the research project. I am extremely grateful for the input, passion and drive of the three adoptive parents guiding this research project.

Recruitment Challenges

The empirical research initially aimed to recruit adoptive parents through adoption charities, organisations and local authorities as gatekeepers, to ensure that all respondents were adoptive parents. In total, 30 gatekeepers were approached with an outline of the research aims and methodology, with seven responding and agreeing to support the research recruitment. The vast majority of charities did not respond to the initial email, therefore in consultation with my research supervisor, we decided to attempt to reach out to charities by telephone as a more personalised approach.

Although the responses from adoption charities were predominantly positive and supportive of the research, one charity in particular raised concerns regarding the scale and 'seriousness' of the study. They raised further concerns regarding the use of a monetary incentive, which they defined as *"a gamble – a chance to win*". The response encouraged me to reflect on the ethical use of a monetary incentive to aid recruitment. The incentive was included following consultation with adoptive parents, and in response to previous research, which has suggested that the odds of responses to electronic surveys are increased by more than a half when they use non-monetary incentives, such as Amazon vouchers or a lottery win (Edwards et al., 2009). On reflection, I initially became concerned about whether the use of a monetary incentive may have been coercive in encouraging parents to complete a survey that would directly bring up difficult thoughts and feelings about their child's traumatic experiences, and in addition, perhaps disproportionately affecting parents

with lower financial income. In response to these personal concerns, I searched the existing literature on the ethics of research utilising a monetary incentive, and found evidence that suggests the use of incentives do not induce research participants to accept higher risks (Singer & Couper, 2008). Although confident in the use of a monetary incentive, if there were no financial constraints to conducting the research, I would have preferred to reward all participants who completed the survey, rather than one parent via a prize draw.

At the point of approaching adoption charities to aid recruitment some of the challenges became clear, as due to increases in data security measures, some charities felt that it would breach GDPR guidelines for them to email parents directly regarding our study. Due to time restraints in recruitment following delays in the ethics application, we decided to explore additional recruitment options. On reflection with some adoption charities, the ethics committee, and consultation with adoptive parents advising on the research, we decided to include social media as a means to recruit participants. This came with certain limitations, as it would be impossible to directly ensure all respondents were in fact adoptive parents. Non-adoptive parents could theoretically click the link via social media and complete the survey for a chance to win the £100 amazon voucher prize. There were advantages to this decision. The consent form ensured that participants confirmed that they were in fact an adoptive parent and at this point, responses increased from five in the space of three weeks of being open to over 30 within one week of the survey being advertised on social media. However, it did present with significant limitations. The main form of recruitment was now biased to parents with access to technology, who used social media platforms and engaged with adoption charities that 'retweeted' or shared the study link. This perhaps excluded or limited the responses from parents who do not know of the support available from charities, or perhaps do not require their services. This possibly created a socio-economical discrimination within the recruitment, as it has been demonstrated that forms of social media use

correspond with social, cultural and economic aspects of social class status (Yates & Lockley, 2018). With less time constraints, I would have continued with the initial plan to utilise adoption charities as gatekeepers, and perhaps recruit through NHS specialist adoption services.

Equality, Diversity and Inclusivity

During the research project, by using the reflexive journal, it has been important to reflect on how my personal experiences and values impacted on the research process and decisions made as a research team. Issues relating to equality, diversity and inclusion are important to me personally and professionally. In line with these values, I am a Widening Access Champion on the UCL DClinPsy with the aim of increasing the diversity within training courses, and the profession of clinical psychology as a whole. Alongside this, I have developed the role of Equalities Champion in my clinical placement within a fostering, adoption and kinship care team which aims to ensure that aspects relating to equality, diversity, and inclusion are kept in the forefront of the teams thinking throughout team meetings, clinical decisions and practice. Such experiences and values have impacted on how I approached, analysed, wrote and critiqued my research thesis. In particular, this impacted on how I approached recruitment, as following discussions with the adoptive parents consulting on the research and research supervisors, I made a conscious decision to approach adoption charities specifically supporting LGBTQ+ adoptive parents. Statistics suggest that 12% of all adoptions are by same-sex couples (Department of Education, 2018). Within the current study, 6.5% of participants self-defined as gay or lesbian and 3.5% as bisexual. This suggests that the study was almost representative of the adoptive parent community in terms of sexuality. Important findings suggest that same-sex couples are more open to adopting children with behavioural difficulties and attachment difficulties, which further highlights the importance of the research evidence base being inclusive and

representative of the parents facing higher stressful demands (New Family Social, 2016).

Furthermore, the results of the systematic review in part 1 of the thesis highlights the importance of considering ethnicity and experiences of discrimination as a key factor to consider. However, a large proportion of adoptive parents completing the survey were white British (82%). This presents a significant limitation to the research project. On reflection, with more time I would have liked to target recruitment more systematically to increase inclusion and representation within the sample and to explore the impact of experiences of discrimination.

Reflections as a Trainee Clinical Psychologist

I felt that my role as a trainee clinical psychologist, with prior experience, and a desire to continue with research after qualification perhaps led to an enthusiastic, yet overly optimistic approach in what could be achieved within the timescale. Balancing clinical placement and research work, particularly the quantitative and qualitative demands of the research, alongside a large systematic review at times felt overwhelming. It felt inspiring yet challenging at times to be exploring trauma within a novel population, with little direct research with adoptive families to draw upon. My initial hope to conduct the 'perfect' research with clear results has been challenged and developed into an understanding of the value and importance of exploratory research to be used as a platform to encourage future research in an area which has been relatively neglected. Furthermore, conducting research in a novel area made including the qualitative approach feel particularly important to me.

Being on placement at a fostering, adoption and kinship care team was particularly helpful with the interviews, as I found that my clinical skills helped me to understand the difficulties and barriers that adoptive parents may face in sharing their experiences. It enabled me to develop engagement and rapport, whilst cultivating a safe space for parents to share their experiences. It further enabled me

to respond with a level of understanding and empathy, whilst considering important safeguarding principles. When faced with parents reporting high levels of extreme child-to-parent violence, I found it difficult to remain within the 'researcher' role, and noticed myself slipping into clinician and 'helper' mode. Reflecting on this with my supervisors, who reviewed the transcripts enabled me to remain within my role as a researcher, develop boundaries and keep focus upon the research aims which would hopefully ultimately support many adoptive parents.

The Impact of COVID-19

The unexpected impact of COVID-19 provided many challenges at a critical point of conducting the empirical research. The virus and subsequent lock down affected the UK in March 2020, at which point I was beginning to approach adoptive parents to take part in the interviews for the qualitative study.

With my supervisors we reflected on whether to continue with the qualitative part of the study, as exploring the experiences of adoptive parents scoring high in trauma at a time of increased global anxiety and stress would inevitably impact on the findings. At the point of interview, the lockdown brought the closure of schools, reduction or change in the provision of services to remote therapy or support and rules forbidding social contact with others outside of the household. It was clear that this would have an impact on the wellbeing of adoptive parents. Adoptive parents were suddenly expected to take on the additional role of teacher and/or therapist whilst possibly jugging the usual role of parent. This increased pressure and intensity of family life happened at a time when adoptive parents were isolated from their usual support network or self-care routines.

In addition to the strains facing all parents at this time, adoptive parents faced the additional challenge of parenting a child with attachment, behavioural or emotional difficulties attempting to manage at a time of a global pandemic, with the subject of loss being so prevalent. I wonder whether these combined factors made

the legacy of the child's trauma more pertinent and 'live' to the adoptive parents and families during the interview period.

We decided to continue with the interviews, making slight amendments to the invitation to participate in the study to acknowledge the difficulties facing families in the current climate. Throughout the interviews, many adoptive parents referenced COVID-19, reflecting how it had in fact not significantly changed their life, as routine and isolation were part of their daily lives as a family before lockdown. Some parents reflected that the closure of schools had taken away a major source of stress for their children, and how they had been shocked and impressed by how well their children had been managing the many changes and difficulties of life in lockdown. I was struck by the resilience of adoptive families at a time of global stress.

Conclusions

Throughout the research project, there were a number of challenges and limitations. However, the research has important clinical and research implications, being the first known study to document and explore trauma experiences in adoptive parents. Personally, conducting this study has been incredibly rewarding, challenging and humbling. I hope that the findings will contribute to understanding of the incredible role of being an adoptive parent, and positively influence the vital support and service provision available to adoptive families.

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Appendices

Appendix A: Extraction Table

Reference	Country	Design	Participants	Non-adoptee control	Age at adoption	Age at assessment/follow up	International adoption	Parent Factor	Parent-child Factor	Family Factor	Context Factor	Predictor measure	Outcome measure	Key Findings
Agnich et al., 2016	USA	X	1544 adoptees (712 female, 832 male).	n/a	Private adoption: 24% 1 year+ Public foster care adoption: 70% 1 year+		n/a				✓	Parent reported contact with birth family	*Mental Health:* PTSD or attachment disorder diagnosis *Delinquency:* Parent reported alcohol or drug use *Family relationships:* Parent report	Children in open foster care adoptions more likely to receive an attachment disorder diagnosis than those in closed foster care adoptions, but are also more likely to have family relationships characterised by trust and adoptive parents' willingness to recommend adoption to others.
Anthony et al., 2019	Wales	→	374 adoptees (45% female, 55% male). 93% white British. 84 adoptees at Time 1; 71 at Time 2; 62 at Time 3.	n/a	mean age 2 years (range 0–9 years)	3–5 months, 15–17 months, and 31–33 months post-placement.	n/a	✓				the warmth scale of the Iowa Family Interaction Rating Scales	Strengths and Difficulties Questionnaire	Internalising and externalising problems were significantly higher than the UK general population. The number of adverse childhood experiences was associated with internalising symptoms 3 years post-adoptive placement but this relationship was moderated by adoptive parental warmth.
Aramburu Alegret et al., 2020	Spain	X	100 adoptees (57 female, 43 male)	n/a	mean age 2.9 years old (SD=2.2)	mean age 13.9 years (SD=1.4)	🌎			✓		Adoption Communicative Scale, parent interview	Youth Self Report	A history of maltreatment prior to the adoption was associated with more closed communication between parents and children. A lower degree of communicative openness was significantly associated with the presence of all adolescent behavioural problems.

Audet, & Le Mare, 2011	Canada	→	Romanian Orphan adoptees 8 months+ institutionalised: 46 (26 female 20 male) Romanian Orphan early adoptees: 29 (15 female, 14 male)	46 non-adopted children (20 female, 26 male).	Romanian Orphan 8month+: median=18.5 months (range=8–68) Early Adopted group: median=2 months (range=0–4)	11 months, 4.5 years old, 10.5 years old, 17 years old	🌍	✓				The Home Observation for Measurement of the Environment (HOME); the composite Parent Interaction Style measured the quality of parents' interactions with their child.	Child Behaviour Checklist Attentional Problems subscale (CBCL); diagnosis of ADHD	Significantly greater inattention/overactivity in the Romanian Orphan than Canadian Born group at all ages, and greater than the Early Adopted group at ages 4.5 and 10.5. Canadian Born and Early Adopted groups did not differ. Inattention/Overactivity at 10.5 was negatively related to warmth and stimulation in the adoptive home and attachment, after accounting for duration of deprivation. Authoritarian parenting was positively predictive of inattention/overactivity in children with minimal deprivation and negatively predictive in children with extensive deprivation.
Balenzano et al., 2018	Italy	X	59 adoptees, (29 female, 30 male).	n/a	at least 5 years old	37 adolescents (aged 11–18 years) and 22 emerging adults (aged 18–24 years)	n/a		✓	✓	✓	*Attachment organisation:* Adult Attachment Interview, Attachment Interview for Childhood and Adolescence. *Adoptive Family Relationship Quality:* Family Environment Scale *Birth family contact:* Self reported frequency	Youth Self Report of the Achenbach System of Empirically Based Assessment (ASEBA) battery, The Symptom Checklist-90 Revised,Multidimensional Self-esteem Test	Results of a path-analytic model showed that attachment and family environment were significant in the prediction of adoptees' distress: attachment moderated the impact of age of first placement, type of foster care and the presence of biological children in the adoptive family, while the quality of adoptive family relationships moderated the impact of the frequency of birth-family contacts. Findings suggest attachment security and good current family relationships can mitigate the negative impact of pre-adoptive stressors on adoptees' later functioning, acting as protective factors.
Brodzinsky, 2006	USA	X	73 adoptees (35 female, 38 male).	n/a	mean age 3.8 months (SD=3.65)	mean age 11.1 years (SD=1.41).	🌍			✓	✓	*Family structural openness:* Family Structural Openness Inventory. *Communicative Openness:* Adoption Communication Openness Scale.	Self-Perception Profile for Children (SPPC), Child behaviour Checklist (CBCL)	Family structural openness and communication openness were positively correlated. Only communication openness independently predicted children's adjustment. The findings suggest that family process variables generally are more predictive of children's psychological adjustment than family structural variables.

Colvert et al., 2008	UK	X	165 adoptees (144 institutional care, 21 direct adoption); 52 within-UK adoptees	n/a	within- UK group 2.54 months (SD=1.53); Romanian institutional deprivation<6months 3.98 months (SD=1.11); Romanian institutional deprivation 6<24months 14.89 months (SD=1.11); Romanian institutional deprivation 24months+ 30.30 months (SD=4.89)	6 years old, follow up 11 years old	🌎	✓	✓	*Thoughts about divorce/negative rating of the marriage:* Dynamic Adjustment Scale questionnaire. *Change of partner:* retrospective interview *Parental Mental Health:* the Malaise Inventory, parent interview *Marriage evaluation:* parent interviews	Revised Rutter scales - mother, father and teacher report (Elander & Rutter, 1996)	Emotional difficulty was significantly more prevalent at age 11 in the Romanian group than the within-UK adoptee group. Emotional difficulties in the Romanian adoptee group were found to be significantly and strongly related to previous deprivation-specific problems (disinhibited attachment, cognitive impairment, inattention/overactivity and quasi-autism). No links were found to duration of deprivation or other deprivation-related indices, stresses/difficulties in the postadoption family environment, or educational attainment and self-esteem.
De Maat et al., 2018	The Netherlands	→	121 adoptees (48% female, 52% male).	n/a	Mean age 3 years (SD=1.6)	mean age 10.9 years (range 6.2-15.6), follow up 2 years later	🌎		✓		Global Indicationlist Attachment	The ADHD-questionnaire, Child Behaviour Checklist (CBCL)	Polish adoptees were four times more likely to have ADHD symptoms at a clinical or borderline level. Time in institutional care, early deprivation, and prenatal alcohol exposure were not associated with ADHD symptom levels. ADHD symptoms were more strongly associated with attachment problems.
Gagnon-Oosterwaal et al., 2012	Canada	→	95 adoptees (69 female, 26 male)	n/a	4-18 months	Assessment at adoption, follow up at 7 years old, mean age 7 years 4 months.	🌎	✓			Parenting Stress Index	The Dominic Interactive (DI) and the Child behaviour Checklist (CBCL).	Children's characteristics at time of adoption were significantly related to their behaviour problems at school-age, and maternal stress was found to have a mediating effect on this relationship.
Goldberg & Smith, 2017	USA	→	174 adoptees (82 female, 92 male).	n/a	37 adoptees >6 months	Time 1: 3.38 years old on average; Time 2 5.42 years old on average.	n/a			✓	Parent–Teacher Involvement Questionnaire (PTIQ)	Child Behaviour Checklist (CBCL)	Parents' school involvement was negatively related to later internalising symptoms; providing input to teachers about inclusion, and parent-teacher conflicts related to adoption, were both positively related to later internalising symptoms. Perceived acceptance by other parents was negatively related to later internalising and externalising symptoms.

Goldberg, & Smith, 2013	USA	→	120 adopted families (56 female, 64 male). 91% adoptive parent's white; 49% adoptees white.	n/a	<18 months	2–3.5 years	n/a	✓			*Parental depression:* Center for Epidemiologic Studies Depression Scale (CES-D). *Relationship conflict:* Personal Relationships Scale	The Child behaviour Checklist (CBCL)	Parental depressive symptoms were associated with higher parent-reported levels of both externalising and internalising symptoms. Parents' relationship conflict was associated with higher levels of parent- and partner-reported internalising symptoms.
Grotevant et al., 1999	USA	X	190 adoptive families, 169 birth mothers.	n/a	mean age = 4 weeks	mean age 7.8 years (range 4-12)	n/a			✓	Questions to parents	Child Adaptive behaviour Inventory (CABI)	Collaboration in relationships within the adoptive and birth family network accounted for variations in children's socioemotional outcomes.
Grotevant et al., 2011	USA	→	190 adoptees; 182 adoptees White, 7 Latino, and 1 Black	n/a	mean age=4 weeks; median=2 weeks.	mean 7.81 years, (SD=2.14); mean age= 15.73 years, (SD=2.08); mean age = 24.95 years, (SD=1.88)	n/a		✓	✓	*Contact:* interviews *Satisfaction with contact:* interview and satisfaction scale *Communicative Openness:* Adoption communicative openness (ACO).	Child Adaptive behaviour Inventory (CABI), Youth Self Report (YSR), Child behaviour Checklist (CBCL), Adult Self Report (ASR); Adult behaviour Checklist (ABCL).	externalising behaviour showed moderate stability across childhood, adolescence, and emerging adulthood. Contact and adoption communicative openness were related to each other, but not to externalising behaviours in adolescence or emerging adulthood. Controlling for the effect of Childhood externalising, adoptive families most satisfied with contact reported relative declines in externalising behaviour during adolescence compared to those in less satisfied families. Satisfaction was also indirectly associated with Emerging Adult externalising, through its effect on Adolescent externalising.
Groza & Ryan, 2002	USA	X	230 Romanian adoptees (53% female, 47% male). 61 domestic adoptees (44% female, 56% male).	n/a	Romanian adoptees mean age 20.72 months (SD25.77); Domestic adoptees mean age 26.44 months (SD=23)	Romanian adoptees mean age 72.11 months (SD=24.98); domestic adoptees mean age 71.07 months (SD=21.52)	🌍		✓		parent-child relationship scale created by research team	Child Behaviour Checklist (CBCL)	The most significant predictor of children's behaviour is a negative pre-adoptive history of abuse or institutionalization and the current parent–child relationship. The domestic and international adoptees' behaviour was more similar than it is different.

Groza et al., 2003	USA	→	96 adoptees (51% female, 49% male).	n/a	mean age 1.75 years (SD=25.2 months)	Time 1: 6 years, Time 2: 10 years	🌎		✓	Questions devised by research team: getting along, time spent together, communication, trust, respect, closeness, impact on family	Child Behaviour Checklist (CBCL)	A history of institutionalization had minimal long-term adverse effects on children's behaviour. The parent–child relationship was a strong resource for parents and was the most consistent predictors of child behaviour from both time periods. There was a strong relationship between parental negative reports with the relationship and child behaviour problems.
Hails et al., 2019	USA	→	561 adoptive families (42% female, 57% male).	n/a	Mean age 6.2 days (SD=12.54)	9 months, 18 months and 6 years old	n/a	✓		Beck-Depression Inventory (BDI)	Child Behaviour Checklist (CBCL)	Adoptive fathers' depressive symptoms during infancy contributed independent variance to the prediction of children's internalising symptoms and also moderated associations between adoptive mothers' depressive symptoms and child externalising symptoms.
Harwood et al., 2013	USA	X	2,089 adoptees: 545 international adoptees (67% female, 33% male); 763 foster adoptees (51% female, 49% male); 781 private adoptees (49% female, 51% male).	n/a	international adoptees, mean age 1.28 (SD=2); foster adoption mean age 2.02 (SD=2.81); private adoption mean age 0.75 (SD=1.97)	international adoptees mean age 8.2 years(SD=4.67),foster adoptees, mean age 10.66 years (SD=4.51); private adoptees mean age 10.51 years (SD=4.73)	🌎		✓	Latent construct with 3 indicators created by research team: (1) parental perception of close-ness of the relationship, (2) parental report of child affection, and (3) parental satisfaction with the relationship	questions on PTSD, Attachment Disorder and counseling access. Parent rating of school performance	Compared with privately adopted children, (a) children adopted from the foster care system were more likely to be identified with special health care needs, and (b) internationally adopted children showed on average poorer school performance as indexed by math and reading. Analyses yielded both direct and indirect paths between preadoption adversities and child outcomes, with the majority of associations mediated or partially mediated by quality of parent–child relationships and/or special health care needs status.
Hein et al., 2017	USA	→	74 adoptees (54.1% female, 45.9% male).	n/a	mean age 2.24 years (SD = 1.80)	mean age 5.17 years (SD = 1.66), follow up 15 months later.	🌎	✓		The Alabama Parenting Questionnaire (APQ)	Behavioural adjustment: behaviour Assessment System for Children-Parent Rating Scale (BASC-PRS) Adaptive behaviour: Vineland Adaptive behaviour Scales, Second Edition (VABS) Academic skills: Bracken School Readiness	Adoptees improved in early academic skills over time, whereas their adaptive functioning and behavioural adjustment remained stable within the normal range. Early academic skills were not related to behavioural adjustment at each time point and over time. Outcomes showed little to no relation to parenting as reported by mother and father separately, however, higher discrepancies between mothers' and fathers' reports of positive parenting were related to higher levels of behavioural symptoms and lower levels of adaptive skills at time point 2.

											Assessment, Third Edition (BSRA)	
Hornfeck et al., 2019	Germany	X	Domestic adoptees: 115 (53.5% female, 46.5% male). Intercountry adoptees: 57 (47.4% female, 52.6% male).	n/a	mean age 15.07 months (SD=20.35)	Domestic adoptees: mean age 42.33 months (SD=19.99), Intercountry adoptees: mean age 64.58 (SD=25.91)		✓		*Parents' self efficacy:* Hastings & Brown (2002) questionnaire Adoptive parents *Perceived stress:* Perceived Stress Scale *Psychological distress:* Brief Symptom Inventory *Positive parenting:* Alabama Parenting Questionnaire	Strengths & Difficulties Questionnaire	There was a relatively low amount of stress regulation problems in parents — in terms of parenting stress, self-efficacy, and mental health problems. Parents with more stress regulation difficulties and parents who scored lower on the positive parenting scale were associated with children with higher SDQ total scores, even when preplacement conditions are considered.
Ji et al., 2010	USA	X	379 adoptees (162 fename, 184 male) 69% Caucasian, 18% Latino, 7% African American, 7% other.	n/a		mean age 15.5 years (SD=1.2)	n/a		✓	Family Sense of Coherence Scale	behaviour Problem Index. Depressive Symptom Subscale of the Depression and Anxiety in Youth Scale	There was a significant impact of family sense of coherence on adoptees' psychosocial adjustment and a considerably less significant role of preadoptive risks.

Juffer et al., 2004	The Netherlands	→	176 adoptees (95 female, 81 male).	n/a	Sri Lanka adoptees mean age of 7 weeks (SD=3). Korean and Colombian adoptees mean age of 15 weeks (SD=4).	5 months, 7 years old,	🌍			✓	*Personality functioning:* The California Child Q-set (CCQ) *Racial differences:* interviews with mothers - perception of the child's experiences with negative reactions from others, peers or adults, regarding skin color, different appearance, or origin (3-point scale: none, some, or many). Asked whether or not the child had ever expressed the wish to be white	Child Behaviour Checklist (CBCL)	Resilient children showed very little behaviour problems; overcontrolling children showed pre- dominantly internalising behaviour problems; undercontrolling children showed high rates of externalising behaviour problems. Parents reported that the adopted children did not encounter many negative reactions addressing their physical appearance or skin colour, and no relation was found between negative reactions and problem behaviour. Children who parents reported expressed a wish to be white presented with more behaviour problems.
Klahr et al., 2011	USA	→	406 adoptive families (224 female, 182 male). 67% Asian-American, 21% Caucasian, 2% African-American, 2% East Indian, 3% Hispanic/Latino, 1% South or Central American Indian, 4% mixed race, and 0.1% other ethnicities.	204 non-adoptive families (55% female, 45% male). 95% caucasian origin.		10-18 years (average 14)	n/a	✓	✓		Observed coercive parenting, family interactions: Sibling Interaction and behaviour Study Rating Scales (SIBSRS): Observer rating of two 5 minute family interactions: task 1 - reach a consensus on a Rorschach inkblot, task 2 - moral dilemma. Parent-Child relationship: The Parental Environment Questionnaire (PEQ)	SIBSRS Antisocial (ANTI) scale: Observer rating of two 5 minute family interactions: task 1 - reach a consensus on a Rorschach inkblot, task 2 - moral dilemma Delinquent behaviour Index (DBI) self report	Parent-child conflict consistently predicts acting-out behaviour in adopted adolescents, and moreover, this association is equivalent to that in biologically-related adolescents.
Koh & Rueter, 2011	USA	X	617 adoptive families, 252 international adoptees (66% Asian)	n/a	mean age 4.7 months (SD=3.4)	mean age 16.14 years (SD=1.5)	n/a		✓		Multidimensional Personality Questionnaire (MPQ)	Adolescent conflict: observer ratings from the Sibling Interaction and behaviour	Findings support two conflict-mediated family processes that contributed to externalising behaviours: one initiated by parent–adolescent traits and one by adoption status. Findings also

										Rating Scales Externalising behaviour: Delinquent behaviour Inventory, symtpom count from the Diagnostic Interview for Children and Adolescents–Revised, Conners' Teacher Rating Scale and Rutter Child Scale B	underscore the salience of conflict in families and the significance of aggressive traits and negative emotionality. Adoption status did not directly add to adolescent externalising behaviours, instead, adoption status was indirectly associated with externalising problems through a conflict-mediated relationship.
Kriebel & Wentzel, 2011	USA	X	70 adoptees (35 female, 35 male). Child's ethnicity: Korean American (20), Caucasian (17), mixed parentage (11), Eastern European (7), African American (5), South American (5), Chinese (3), and Central American (2).	n/a		mean age 112.4 months (range 7.1-11.9 years).	🌎	✓	*Parenting quality:* Weinberger Parenting Inventory for Parents	Child Behaviour Checklist Attentional Problems subscale (CBCL) parent and teacher report.	Results indicated that cumulative risk (e.g., history of maltreatment) was a significant negative predictor of adaptive behaviour, whereas parenting quality (i.e., child-centered parenting) was a significant, positive predictor of adaptive behaviour. Child-centeredness moderated the effects of risk on behaviour, such that children with high risk seemed to benefit the most from child-centered parenting.
Lawler et al., 2017	USA	→	68 adoptees (41 female, 27 male).	52 non-adoptive families (26 female, 26 male).	18-36 months	Adoptees mean age of 26.13 months, (4.99). 3 months after arrival to US, 8 months later. Non-adopted children mean age 27.65 months (SD=5.71)	🌎	✓	Observational during free play task, structured play task, clean up.	Observational during free play task, structured play task, clean up.	For post-institutionalized youth, higher quality parental structure and limit-setting soon after adoption predicted reduced child regulation difficulties eight months later; however, initial child regulation did not predict later parenting. Higher quality preadoptive care for children was associated with higher scores on both sensitivity/responsiveness and structure and limit-setting among adoptive parents. Less growth stunting, indicative of less preadoptive adversity, was associated with parents' use of more effective structure and limit-setting behaviours.

Le Mare & Audet, 2014	Canada	X	80 adolescents (41 female, 39 male)	n/a	mean age 18 months (SD=16.63)	mean age 15.74 years (SD=2.25)	🌍		✓	✓	*Attachment:* Parenting Stress Index, the Inventory of Parent and Peer Attachment *Communicative openness/exposure to culture of origin:* Questionnaire devised by research team: openness about adoption and exposure to Romanian culture	Child Behaviour Checklist (CBCL)	Attachment and communicative openness were each significantly and negatively correlated with behaviour problems; exposure to culture of origin was not. Attachment and communicative openness independently predicted behaviour problems in postinstitutionalized adolescents.
Lee, 2010	USA	X	1579 adoptees (944 female, 635 male).	n/a	mean age 20.64 months (SD=28.18)	mean age 9.59 years old (SD=2.69)	🌍			✓	Frequency of inappropriate or intrusive racial comments	Child Behaviour Checklist (CBCL)	Adoptive parents with Asian and Latin American children reported more discrimination than parents with Eastern European children. Perceived discrimination was uniquely associated with greater problem behaviours for adopted children from Asia and Latin America, with the strongest association among Latin American adolescents.
Liskola et al., 2018	Finland	X	242 adoptees (125 female, 117 male)	n/a	mean age 2.74 years (SD=2.17)	mean age 10.5 years (SD=1.15)	🌍	✓			General Health Questionnaire (GHQ)	Children's Depression Inventory (CDI)	Paternal depressive symptoms were related to the total depression score and two dimensions of childrens depressive symptoms: negative mood and interpersonal problems. These associations remained significant even when adjusted for child's age and gender, age at adoption, type of placement before adoption, continent of birth and adoptive family's SES. No associations were found between maternal and any dimensions of offspring depressive symptoms.
McGuinness, & Pallansch, 2007	USA	→	105 families at Time 1 (57 female, 48 male). 57 at Time 2 (33 female, 24 male).	n/a		Time 1 mean age 7.7 years, Time 2 mean age 11 years	n/a		✓		*Family environment:* Family Environment Scale (FES)	Child Behaviour Checklist (CBCL)	Pre-adoptive risk factors declined in importance (except for birth weight) and protective factors (aspects of family environment) increased in influence over time.

McGuinness et al., 2005	USA	→	47 adopted families (27 female, 20 male).	n/a		Time 1: mean age 11, Time 2 3.5 years later	🌎		✓		*Family environment:* Family Environment Scale (FES)	Child Behaviour Checklist (CBCL)	Adopted children generally fared well developmentally with protective family environments.
Miller et al., 2009	USA	X	55 adoptees (24 female, 26 male).	n/a	mean age 21 months (SD=12)	mean age 9.25 years (SD=14 months),	🌎	✓			Parenting Stress Index	behavioural Assessment System for Children (BASC)	Behavioural and school problems were common. Parent stress was high and correlated with child externalising behaviours and inversely to child full scale IQ. Child's age at adoption related inversely to parent stress.
Mohanty, 2015	USA	X	100 adoptees (61 female, 39 male).	n/a	median age 5 months (range=1-119 months).	mean age 20.09 years (SD=3.21)	🌎			✓	revised Multigroup Ethnic Identity Measure (MEIM)	*Psychological wellbeing:*Brief Symptom Inventory (BSI) *Self-esteem: The Rosenberg Self-Esteem Scale*	The study supports a curvilinear relationship between ethnic identity and self-esteem and marginally support the curvilinearity of ethnic identity with regard to psychological distress. A moderate level of ethnic identity was associated with positive esteem, whereas low and high levels of ethnic identity were related to low self-esteem.
Neil, 2009	UK	X	62 adoptees (23 female, 39 male). 3 children of dual heritage, 59 white	n/a	mean age 22 months	mean age 8.5 years (range 5-13years)	n/a		✓	✓	parent interview, communicative openness rating scale	Child Behaviour Checklist (CBCL)	Adoptive parents involved in face-to-face contact arrangements were found to be more communicatively open than parents involved in letterbox contact. Children's emotional and behavioural development was not related to either the type of contact that they were having with their birth families or the communicative openness of their adoptive parents.
Nilsson et al., 2011	USA	X	202 adopted families (90 female, 112 male)	215 non-adoptive families (102 female, 113 male).	<12 months	16-19 years	n/a		✓		adoption satisfaction questionnaire measure	Diagnostic Interview Schedule for Children–Child Version (DISC); Monitoring the Future High School Senior Survey (MTF)	No significant differences between adopted and matched control participants on all measures of conduct disorder. Higher levels of adolescent and parent adoption satisfaction were associated with lower levels of conduct problems.

Priel et al., 2000	Israel	→	50 adoptees (21 female, 29 male). All parents and children were white; all parents Israeli. 14 international adoptees	80 non-adoptive families (36 female, 44 male).	60% adopted 0-2months, 40% adopted 2-3years old	mean age of 10.17 years (SD=1.45)	n/a	✓		Interview: researchers developed a measure Parental Self-Reflectiveness Scale (PSRP).	Child Behaviour Checklist (CBCL)	Significantly greater frequency of externalising behaviour among adopted children. A relationship was found between low maternal self-reflectiveness and a higher rate of reported externalising behaviours among adopted as well as non-adopted children.
Qin et al., 2017	USA	→	115 adoptees, (49.5% female, 50.5% male).	n/a	mean age 7.63 months (SD=4.80).	Time 1: 7- 12 years; Time 2:13-18 years. Mean age of 16.5 years (SD=2.3).	🌍		✓	*Racial/ethnic discrimination:* Study developed 9-item scale *Emotional Regulation:* Emotion Regulation Questionnaire (ERQ)	Strengths & Difficulties Questionnaire, Kessler Psychological Distress Scale	Discrimination was associated with greater internalising problems, externalising problems, and psychological distress, even after controlling for childhood levels of these adjustment problems. No significant interaction effects between discrimination and the emotion regulation profiles.
Reppold & Hutz (2009)	Brazil	X	68 adoptees (51.5% female, 48.5% males)	n/a		mean age 14.4 years (SD=0.5)	n/a	✓		Scales of Parental Responsiveness and Demandingness	Rosenberg Self-Esteem Scale (SES), Children's Depression Inventory (CDI)	The late revelation of adoption and the change of the first name are connected to higher levels of depression and low self-esteem and to increased perceptions of negligent or authoritarian parenting style. Contact with the biological family frequently mentioned among those who perceived their parents as authoritative and presented the best indicator of mood and self-esteem.

Roskam & Stievenart, 2014	Belgium	X	40 adoptees (45% female, 55% male). Adopted from Vietnam (14.9%), Brazil (8.1%), Ethiopia (6.8%), China, Colombia and Haiti (4.1% each), Belgium and Romania (2.7% each) and Cape-Verde, Guatemala, Madagascar, Thailand and Ukraine (1.4% each).	34 non-adoptive families (54.2 % female, 55.8% male).	mean age 16.12 months (SD=15.98)	Adoptee's mean age 13.15 (SD=1.88). Non-adoptees mean age 13.35 years (SD=1.93	🌎	✓	✓		*Attachment:* Experiences in Close Relationships Questionnaire — Revised *Parenting Behaviour:* EPEP scale	Child Behaviour Checklist (CBCL)	The accumulation of risk factors in the current characteristics of the adolescents and their family was significantly associated with behavioural outcomes of both adoptees and controls. Externalising behaviours were associated with anxious-avoidant attachment and low parenting support. Internalising behaviours were associated with low parent support.
Santos-Nunes et al., 2018	Portugal	X	116 adoptive families (52.2% female, 47.8% male).	n/a	mean age 2.45 years (SD=2.18)	mean age 8.25 years (SD=1.71)	n/a	✓			*Parenting Stress:* Parenting Stress Index- Short Form *Parent-child relationship:* The Parents' Evaluation of Expectations (PEE) *Parent satisfaction:* The Parental Satisfaction (PS) index,	Strengths and Difficulties Questionnaire	Parenting stress mediated the relationship between parents' evaluation of expectations and the perception of children's behavioural problems -a higher result in evaluation of expectations was associated with a lower level of parenting stress, which, in turn, was related to a perception of fewer behavioural difficulties in the children. Discrepancies between parents' expectations and the real experience, after the child's arrival, are associated with an increase in parenting stress and have a negative influence on children's adjustment. Highly stressed parents appear to be more prone to perceiving their children's behaviour as difficult.
Schires et al., 2020	USA	→	274 families of 456 adoptees (61% female, 39% male).	n/a	mean age 4.8 months (SD=4.7).	mean age of 14.9 years(SD=1.9); follow up mean age of 18.3 years (SD=2.1), follow up at 22.3 years (SD=1.8).	🌎			✓	the Race and Culture questionnaire	Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM–IV) Antisocial Personality Disorder (ASPD) Symptoms of major depressive disorder (MDD) the Structured Clinical Interview	Discrimination predicted higher levels of depressive and externalising symptoms in youth who reported less preparation for bias. In those experiencing more preparation for bias, associations were not significantly differ- ent from zero. Ethnic socialization did not moderate these associations.

										for the DSM–III–R Diagnosis	
Simmel, 2007	USA	→	293 adoptive families (49% female, 51% male). African American (11%), Asian (3%), Hispanic (29%), Caucasian (54%), and Other (3%).	n/a		Ages 2, 4, and 8 years post-adoption	n/a		✓	*Adoptive parent preparation:* self report ratings *Family environment:* Home Observation for Measurement of the Environment Short Form (HOME-SF)	Problem Behiour Index of the Child Behaviour Checklist (CBCL)	The self-reported assessment of readiness of the adoptive parents was a significant factor influencing the behavioural outcomes. Negative parental affect and style were also important, although these effects emerged primarily at the second wave.
Smith et al., 2018	Canada	→	71 adolescent adoptees (56 female, 15 male)	n/a	mean age 11.28 months (range: 4-18)	Time 1 (n=123): mean age 11.28 months (4-18months). Time 2 (n=95): mean age 7 years 4 months (4 months); Time 3 (n=71) mean age 15 years (5.6months).		✓		Parenting Stress Index (PSI), Stress Index for Parents of Adolescents (SIPA)	The Dominic Interactive at age 7 and the Dominic Interactive for Adolescents at age 15, Child Behaviour Checklist (CBCL)	A lower percentage of children reported internalising problems during adolescence than at school age while mothers reported a decrease in externalising problems over age. A few correlations were found between internalising and externalising symptoms and early risk factors. However, these links were sequentially mediated by parenting stress at school age and in adolescence.
Smith-McKeever, 2004	USA	X	83 adoptees (42 female, 39 male). 100% African American.	n/a	female adoptees: 21.8 months; male adoptees: 22.5 months	mean of 8.7 years	n/a	✓		*Parenting stress:* Parenting Stress Index (PSI) *Acknowledgement of difference:* The Acknowledgement of Difference Scale (ADS)	Child Behaviour Checklist (CBCL)	Behavioural problems were correlated with more relational factors, such as amount of enjoyable time parents and children spend together and how often the parent thinks of the child when they are separated.
Soares et al., 2017	Portugal	X	70 adoptees	n/a	mean age 3.19 years (SD=1.98)	mean age 8.96 years (SD=0.79)	n/a		✓	Questions devised by research team	Emotion Regulation Checklist (ERC).	Parents perceived their adopted children's emotion regulation as adequate. In relation to family dynamics, acknowledgment of the

												adoption specificities significantly predicted the emotional lability/negativity of the adoptees, simultaneously mediated by the emotional quality of and the parental satisfaction with the communication about adoption.
Tan et al., 2012	USA	X	133 adoptees, 100% female.	n/a	mean age 12.8 months (SD=4.1)	mena age 5.2 years (SD=0.7)		✓	✓	*Family Stress:* Social Problem Questionnaire (SPQ) *Parenting Style:* Parenting Styles and Dimensions Questionnaire (PSDQ).	Child Behaviour Checklist (CBCL)	Adoptive mothers reported relatively mild family stress, frequent authoritative parenting, and few behaviour problems in their children. Family stress, authoritarian and permissive parenting styles positively correlated with children's behavioural problems. Authoritarian parenting mediated the effect of non-child-related family stress (NCR-stress) on internalising and overall problems.
Tarroja, 2015	The Philippines	X	32 adoptees (15 female, 17 male).	n/a		mean age 12.84 (range 8-17).	n/a		✓	*Family functioning: P*eople in my Life Scale *Adoption openness:* Adoptive Parent Scale Adoptive Filiation Scale	Child Behaviour Checklist (CBCL), Draw A Person-Screening Procedure for Emotional Disturbance	Family functioning predicted the adjustment of Filipino adopted children while adoption secrecy predicted family functioning. Adopted children's perception of their family functioning and adoption openness buffer the impact of the early adversity experienced by the adopted children.

Tarullo et al., 2016	USA	→	Post institutionalised adoptees: 27 adoptees (24 female; 3 male) Internationally adopted from foster care: 26 (10 female, 16 male)	37 non-adopted children (30 female, 7 male).	Post institutionalised adoptees: mean age 12.08 months (SD=1.8); Internationally adopted from foster care: 8.08 months (SD=3.28).	3 years old, 5.5 years old.	🌍	✓		*Mental state language:* International Affective Picture System parent-child dyad *Emotional understanding:* Denham's (1986) emotion labeling and affective perspective taking tasks,	MacArthur Health and behaviour Questionnaire, Parent Version (HBQ-P)	At 5.5-year follow-up, post institutionalised children had lower levels of emotion understanding than non-adopted children. Parent mental state language at age 3 years predicted 5.5-year emotion understanding after controlling for child language ability. The association of parent mental state language and 5.5-year emotion understanding was moderated by adoption status, such that parent mental state language predicted 5.5-year emotion understanding for the internationally adopted children, but not for the non-adopted children. At 5.5 years, PI children had more internalising and externalising problems than NA children, and these behavioural problems related to lower levels of emotion understanding.

Tung et al., 2018	USA	→	83 adoptees (46.3% female, 53.7% male). 32.9% Latino/a, 26.8% Black, 18.3% Caucasian, 22% Mixed race/other.	n/a	mean age 3.92 (SD=2.2)	Assessment at 4 months to 8 years of age (average=4 years) annual follow ups for 5 years. Long-term follow-up conducted after 11–15 years			✓	*Family Cohesion:* Family Environment Scale (FES)	Child Behaviour Checklist (CBCL), arrest history, substance use	Youth with early reactive temperament did not exhibit heightened sensitivity to maltreatment nor to later adoptive family cohesion. Reactive temperament was associated with higher externalising behaviours at initial adoptive placement and escalating across childhood, controlling for age, gender, race-ethnicity, preadoption maltreatment, and adoptive family cohesion. By late adolescence/young adulthood, rates of arrest and substance use in this sample were relatively comparable to normative populations of youth, although older age of adoption predicted more substance use in late adolescence/young adulthood. Adoptive family cohesion continued to exhibit a marginally significant and protective effect on arrest history.
van der Voort et al., 2013	The Netherlands	→	160 adoptees	n/a	mean age 10.76 weeks (SD=5.53)	infancy, 7 years old, 14 years old		✓		*Effortful control:* Dutch Temperament Questionnaire *Maternal sensitivity:* Observation at 12, 18, and 30 months during structured tasks (building a tower or solving puzzles)	Achenback Teacher Report Form (TRF).	Lower effortful control, concurrent as well as 7 years earlier, predicted higher levels of delinquency in adolescence and aggression in middle childhood and in adolescence. Lower levels of effortful control in infancy predicted higher levels of maternal sensitivity in adolescence which in its turn predicted less adolescent delinquent behaviour. Maternal sensitivity also plays a role in the development of delinquent behaviour, buffering a lack of effortful control, but was not related to aggression at age 14.

van der Voort et al., 2014	The Netherlands	X	160 adoptees (85 female; 75 male).	n/a	mean age 10.76 weeks (SD=5.53)	infancy, 7 years old, 14 years old.		✓			*Maternal sensitivity:* the Egeland/Erickson 7-point sensitivity rating scales were used to rate supportive presence, intrusiveness, sensitivity and timing, and clarity of instruction during structured tasks. *Behavioural inhibition:* the Dutch Temperament Questionnaire	The Child behaviour Checklist (CBCL)	More sensitive parenting in infancy and middle childhood predicted less inhibited behaviour in adolescence, which in turn predicted fewer internalising problems in adolescence. Maternal sensitivity lowers adolescents' inhibited behaviour and decreases the risk for adolescents' internalising problem behaviour indirectly through lower levels of inhibition.
Yoon, 2000	USA	X	241 adoptees	n/a		mean age 14 (range 12-19)			✓	✓	*Collective self-esteem*: Multigroup Ethnic Identity Measure (MEIM). *Parent-child relationship:* Parent Acceptance-Rejection Questionnaire (PARQ) *Parents support of childs' ethnic background:* developed by research team	*Personal self-esteem:* Rosenberg Self-Esteem Scale (RSE). *Psychological adjustment:* items selected from the State-Trait Anxiety Inventory (STAI) and Beck's Depression Inventory (BDI), Affect Balance Scale (ABS), Satisfaction with Life Scale (SWLS)	A more positive parent-child relationship, in which the parents support their children's ethnic identity development and share ethnic socialization experiences, predicted better psychological adjustment of the adopted children.
Yoon, 2004	USA	X	241 adoptees (104 female, 137 male).	n/a		mean age 14.2 years (SD=1.51)			✓	✓	*Adoptive parental support of ethnic socialisation:* researchers developed a 4-item measure *Collective self-esteem:* Collective Self-Esteem Scale (CSE), measure of pride and shame in ethnic origin. *Parent-child*	Affect Balance Scale (ABS) and the Satisfaction with Life Scale (SWLS), the State-Trait Anxiety Inventory (STAI) and the Beck's Depression Inventory (BDI)	A more positive parent-child relationship and a greater collective self-esteem acquired through parental support of ethnic socialization each predicts a greater subjective well-being of adopted children, suggesting that a negative sense of ethnic identity represents a vulnerability to psychosocial well-being.

	relationship: Parental Acceptance-Rejection Questionnaire (PARQ), the Parent-Adolescent Communication Scale (PACS)

X = *cross-sectional design*
→= *longitudinal design*
= *Intercountry or international adoption included*

Appendix B: Study Quality Ratings

Reference	Total quality score
Agnich et al., 2016	85%
Anthony et al., 2019	95%
Aramburu Alegret et al., 2020	100%
Audet, & Le Mare, 2011	90%
Balenzano et al., 2018	90%
Brodzinsky, 2006	95%
Colvert et al., 2008	95%
De Maat et al., 2018	85%
Gagnon-Oosterwaal et al., 2012	100%
Goldberg & Smith, 2017	100%
Goldberg, & Smith, 2013	95%
Grotevant et al., 1999	85%
Grotevant et al., 2011	100%
Groza & Ryan, 2002	95%
Groza et al., 2003	85%
Hails et al., 2019	95%
Harwood et al., 2013	90%
Hein et al., 2017	85%
Hornfeck et al., 2019	95%
Ji et al., 2010	100%
Juffer et al., 2004	90%
Klahr et al., 2011	100%
Koh & Rueter, 2011	95%
Kriebel & Wentzel, 2011	100%
Lawler et al., 2017	85%
Le Mare & Audet, 2014	95%
Lee, 2010	90%
Liskola et al., 2018	100%
McGuinness, & Pallansch, 2007	95%

McGuinness et al., 2005	90%
Miller et al., 2009	90%
Mohanty, 2015	90%
Neil, 2009	85%
Nilsson et al., 2011	95%
Priel et al., 2000	90%
Qin et al., 2017	90%
Reppold & Hutz, 2009	95%
Roskam & Stievenart, 2014	100%
Santos-Nunes et al., 2018	95%
Schires et al., 2020	100%
Simmel, 2007	90%
Smith et al., 2018	100%
Smith-McKeever, 2004	100%
Soares et al., 2017	85%
Tan et al., 2012	95%
Tarroja, 2015	85%
Tarullo et al., 2016	85%
Tung et al., 2018	100%
van der Voort et al., 2013	95%
van der Voort et al., 2014	95%
Yoon, 2000	85%
Yoon, 2004	90%

Appendix C: Survey

Thank you for considering whether to take part in this research study. The study is part of a trainee clinical psychologist doctoral thesis exploring the experiences of adoptive parents. Before you decide whether to take part it is important for you to understand why the research is being done and what participation will involve.

Please take time to read the information on the following few pages carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

The study aims to explore the emotional impact of parenting, the wellbeing of adoptive parents and to understand psychological factors that could be targets for future support for parents. Whether you decide to take part or not is completely up to you. Choosing not to take part will not disadvantage you in any way.

What is the project's purpose?

We want to understand the experience of adoptive parents to better understand the emotional rewards and challenges that parenting an adopted child has on the parents, siblings and wider family. We want to understand the effect of adoption on parental wellbeing.

Recent research has begun to explore the concept of secondary trauma in professionals and foster carers of children who have experienced trauma. Secondary trauma is the emotional distress resulting from an individual hearing or experiencing aspects of the traumatic experiences of another.

The current study aims to explore the emotional wellbeing and coping strategies of adoptive parents and to explore psychological factors that could be targets for intervention. One element of this we are looking at is the occurrence of secondary trauma in adoptive families and certain risk or protective factors.

The aim of the study is to better understand the challenges facing adoptive families to improve post adoption support.

Why have I been chosen?

We are inviting all adoptive parents living in the United Kingdom to participate. The study requires a good level of English.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to give consent. You can withdraw at any time without giving a reason and without it affecting any benefits that you are entitled to.

What will happen to me if I take part?

Clicking the link to the survey will lead to a series of questionnaires that measure the impact of your child's early experiences on you, parental stress, attachment and psychological or emotional factors. Following the survey please leave an email address if you would like to be entered into the £100 Amazon voucher prize draw.

What are the possible disadvantages and risks of taking part?

The questionnaire measures will ask about the possible psychological impact of being an adoptive parent. This can be upsetting for some, and you are free to withdraw at any time.

Information on where to access support is provided below, and will be listed at the end of the survey.

If you would like further support regarding your mood or mental health, or your child's wellbeing please contact your local GP who will be able to advice on local services. Mind is a mental health charity that provide advice and support regarding mental health and will be able to provide information on local mental health support: https://www.mind.org.uk (020 8519 2122)

The charity, Adoption UK will be able to provide information on local support services and a helpline for information and practical suggestions or to point you in the direction for specialist help: https://www.adoptionuk.org (info@adoptionuk.org.uk; 01295 752240). Coram is a further adoption charity, with services in London, the East Midlands, Cambridgeshire and East Anglia: https://www.coramadoption.org.uk

What are the possible benefits of taking part?

Participants who leave an email address will be entered into a prize draw to win £100 Amazon vouchers. By participating you will be contributing to our understanding of what it is like to be an adoptive parent, which will inform future research and support for adoptive families.

What if something goes wrong?

If you wish to raise a complaint then please contact Professor Pasco Fearon (the Principal Investigator for the study) at p.fearon@ucl.ac.uk. If you feel that your complaint has not been handled to your satisfaction, you can contact the Chair of the UCL Research Ethics Committee at ethics@ucl.ac.uk. If something happens to you during or following your participation in the project that you think may be linked to taking part, please contact the research team or the Principal Investigator.

Will my taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential. You will not be able to be identified in any ensuing reports or publications. Responses will be recorded and anonymised. The data will be securely stored electronically in a password protected file. Data will be labelled with a numbered code and will be stored separately from the email address you provide to be entered into the prize draw. Your data will be stored securely and confidentially in line with privacy rights. The data will not be shared outside of the research team. The data will be stored for the duration of the study until the findings have been written up and disseminated in 2021.

Limits to confidentiality:

· Please note that assurances on confidentiality will be strictly adhered to unless evidence of wrongdoing or potential harm is uncovered. In such cases the University may be obliged to contact relevant statutory bodies/agencies.

· Please note that confidentiality will be maintained as far as it is possible, unless during our conversation I hear anything which makes me worried that someone might be in danger of harm, I might have to inform relevant agencies of this.

· Confidentiality will be respected subject to legal constraints and professional guidelines.

· Confidentiality will be respected unless there are compelling and legitimate reasons for this to be breached. If this was the case we would inform you of any decisions that might limit your confidentiality.

· Confidentiality may be limited and conditional and the researcher has a duty of care to report to the relevant authorities possible harm/danger to the participant or others.

What will happen to the results of the research project?

The results will be presented as scientific papers in peer reviewed journals, at conferences, and in a student thesis. You will not be able to be identified in any reports, publications, talks or media. Data will be stored until publication in 2021.

Local Data Protection Privacy Notice

Notice: The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice For participants in research studies: https://www.ucl.ac.uk/legal-services/privacy/ucl-general-research-participant-privacy-notice The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

The categories of personal data used will be as follows: Name (optional) Telephone number (optional) Email address (optional) The lawful basis that would be used to process your personal data will be performance of a task in the public interest.The lawful basis used to process special category personal data will be for scientific and historical research or statistical purposes. Your personal data will be processed so long as it is required for the research project.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

Who is organising and funding the research?

The research is funded by UCL department of Clinical, Health and Educational Psychology.

Contact for further information

Morvwen Duncan
morvwen.duncan.11@ucl.ac.uk
Trainee Clinical Psychologist

Professor Pasco Fearon
p.fearon@ucl.ac.uk

If you would like more information or if anything is unclear, please contact the researchers using the contact details above.

Thank you for reading this information sheet and for considering to take part in this research study.

Thank you for considering taking part in this research. If you have any questions arising from the information provided please contact Morvwen Duncan (morvwen.duncan.11@ucl.ac.uk).

Title of Study: *Risk factors associated with parental stress and wellbeing in adoptive parents*
Department: *Clinical, Educational and Health Psychology*
Name and Contact Details of the Researcher(s): *Morvwen Duncan, Morvwen.duncan.11@ucl.ac.uk*
Name and Contact Details of the Principal Researcher: *Professor Pasco Fearon, p.fearon@ucl.ac.uk*
Name and Contact Details of the UCL Data Protection Officer: *Jean-Baptiste Pingault,*
This study has been approved by the UCL Research Ethics Committee: *15201/001*

By consent to participate in the survey you consent to the following:

I confirm that I am an adoptive parent.
I confirm that I have read and understood the information sheet for the above study.
I have had the opportunity to read and consider the information sheet.
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
I agree to taking part in the above study. I understand that my contributions will be kept confidential and anonymised in any reports produced after the study.

I understand that to be entered into the £100 Amazon prize draw I will leave an email address after completing the survey.

Do you consent to participating in the survey

- ○ I consent to participate in the survey
- ○ I do not consent to participate in the survey

Appendix D: Interview Schedule

In this study we are interested in finding out how parents think and feel about the difficult early experiences that their child may have been through before they were adopted. I have some questions I'd like to ask you, but mostly I'd like to hear from you about your own personal experiences and what feels important for you. This may bring up some strong feelings for you, please take your time and let me know if it becomes too difficult.

1. Tell me about X? What are they like now? what were they like when they were first adopted?
2. Some parents may feel that knowing, or not knowing about their child's difficult early experiences has affected them as a parent, whereas others may not. Could you tell me a little bit about how that is for you?
3. Do you find yourself thinking about their early experiences? (Do you find yourself dwelling on their past?)
4. Do you think that it impacts on your life or relationships in any way?
5. How do you deal with or manage this difficult experience as a parent?
6. Stepping back, how has this whole experience changed over time, from when you first adopted X to now?

Probe questions (to use at discretion throughout)

- Can you tell me more about what that is like for you?
- Can you give me an example (of a time when child's early experiences/current challenges impacted you as a parent). Talk me through what happened and what that was like for you? When did you notice you were thinking about it? What were you feeling? What did you do in response? How did others respond?
- How did that affect you?
- What did you think about that?
- How did you feel?
- What made you feel that way?
- What did you do?
- How did you manage?
- What were other people doing?
- What did that mean for you?
- What was important about that for you?
- What makes that stand out in your memory?

Appendix E: Additional Measures used in the Survey

Construct	Questionnaire measure	Details
Attachment Relationship	The Quality of Attachment Relationships Questionnaire (QUARQ; Briskman et al., 2012)	The QUARQ is a 16-item measure of the attachment relationship between the foster carer and foster child. It is scored ranging from 0 to 64, with a higher score indicating a better quality of attachment. The measure was developed from key concepts of attachment theory, including items which measure the child's ability to show or accept affection, to trust the carer, and whether the child seeks help from their carer under stressful conditions. It also asks about the carer's understanding of the child's feelings. In this study, internal reliability was high (.94).
Parent's Attachment	The Revised Adult Attachment Scale (Collins, 1996)	The R-AAS is an 18-item, 5-point Likert scale measuring three subscales of parental attachment – close, dependent and anxiety. The close subscale measures the level of comfort the individual feels with closeness and intimacy. The depend subscale assesses if the individual feels they can depend on others to be available when needed. The anxiety subscale measures the level of anxiety the person feels about being rejected or unloved. A meta review found that the RAAS holds strong psychometric properties (Ravitz, Maunder, Hunter, Sthankiya, & Lancee, 2010). For this study Cronbach's Alpha indicates low internal reliability (.46).
Parental self-efficacy	The Parenting Sense of Competence Scale (PSOCS; Gibaud-Wallston & Wandersman, 1978)	The PSOCS is a 17-item scale designed to measure parents' satisfaction with parenting and their self-efficacy in the parenting role. It has factorial validity and internal consistency (Gilmore & Cuskelly, 2009). In this study, internal reliability was high (.83).

Reflective Functioning	The Parental Reflective Functioning Questionnaire (PRFQ; Luyten, Mayes, Mijssens & Fonagy, 2017)	The PRFQ measures parental reflective functioning, a parent's capacity to comprehend and reflect on the developing mind of their child, which is thought to be fundamental in sensitive caregiving. The measure includes 18 items rated on a 7-point Likert scale. It is divided into three subscales: Pre-Mentalizing, whether a parent is able to understand and interpret the child's mental experience accurately; Certainty about Mental States, which refers to a parent's inability to recognize that mental states are not readily apparent and Interest and Curiosity, which refers to the interest a parent has in thinking about the child's internal experience and in taking the child's perspective. Studies have demonstrated the measure to be valid and reliable (Luyten, Mayes, Mijssens & Fonagy, 2017; Pazzagli, Delvecchio, Raspa, Mazzeschi, & Luyten, 2018). For this study Cronbach's Alpha indicates good internal reliability for the Certainty about Mental States (.809) and the Interest and Curiosity (.732) subtests, but low for the Pre-Mentalizing subtest (.52).

Appendix F: Confirmation of Ethics Approval

UCL RESEARCH ETHICS COMMITTEE
OFFICE FOR THE VICE PROVOST RESEARCH

25th September 2019

Professor Pasco Fearon
Division of Psychology and Language Sciences
UCL

Cc: Morvwen Duncan

Dear Professor Fearon

Notification of Ethics Approval with Provisos
Project ID/Title: 15201/001: Risk factors associated with parental stress and secondary trauma in adoptive parents

Further to your satisfactory responses to the Committee's comments, I am pleased to confirm in my capacity as Joint Chair of the UCL Research Ethics Committee (REC) that your study has been ethically approved by the UCL REC until **25th September 2020.**

Ethical approval is subject to the following conditions:

Notification of Amendments to the Research
You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form'
http://ethics.grad.ucl.ac.uk/responsibilities.php

Adverse Event Reporting – Serious and Non-Serious
It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Joint Chairs will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Joint Chairs of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Joint Chairs will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Final Report
At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research

Office of the Vice Provost Research, 2 Taviton Street
University College London
Tel: +44 (0)20 7679 8717
Email: ethics@ucl.ac.uk
http://ethics.grad.ucl.ac.uk/

Appendix G: Advertisement for Service User Involvement

LONDON'S GLOBAL UNIVERSITY
UCL Research Department of Clinical, Educational & Health Psychology
1-19 Torrington Place
University College London
London
WC1E 7HB

Researching Together

We are seeking adoptive parents to advise us on research exploring the psychological impact of parenting a child that may have had difficult early experiences.

What the research is about:

We are in the process of developing research to understand the emotional rewards and challenges that parenting an adopted child has on the parents, siblings and wider family. The study aims to explore the emotional impact of parenting, the wellbeing of adoptive parents and to understand psychological factors that could be targets for future intervention. Ultimately, the aim is to better understand the challenges facing adoptive families to improve post adoption support.

Who are we?

This research study is being conducted by researchers at the UCL department for Clinical, Health and Educational Psychology.

How you can get involved:

We are looking to recruit 3 adoptive parents to help guide our research project and advise us on our questionnaire measures and the best ways to help parents speak about their experiences. We will invite interested parents to meet with us in person or over the phone to hear their views on the research project and materials that we are developing for the study.

Why get involved:

Your feedback will shape the research taking place, and ultimately help us to conduct research with the aim of better understanding some of the challenges facing adoptive parents. You will be paid £14 Amazon vouchers for two hours of your time.

Are you interested?

If you are interested in advising us on this study and would like more information please contact the lead researcher at: morvwen.duncan.11@ucl.ac.uk

Appendix H: Study Recruitment Advertisement

Are you an adoptive parent?

Would you like to share your experiences with us?

Chance to win £100 Amazon vouchers

What the research is about:

We want to understand the experience of adoptive parents to better understand the emotional rewards and challenges that parenting an adopted child has on the parents, siblings and wider family. Recent research has begun to explore the concept of secondary trauma in professionals and foster carers of children that have experienced trauma. Secondary trauma is the emotional distress resulting from an individual hearing or experiencing aspects of the traumatic experiences of another. The current study aims to explore the emotional impact of parenting, the wellbeing of adoptive parents and to understand psychological factors that could be targets for future support for adoptive families. One element of this we are looking at is the occurrence of secondary trauma in adoptive families and certain risk or protective factors. The aim of the study is to better understand the challenges facing adoptive families to improve post adoption support.

How you can get involved:

We are looking for adoptive parents to participate in a survey that will include a series of questionnaires that measure secondary trauma, compassion fatigue, attachment relationship and psychological factors. All responses are completely anonymous. If you take part in the survey you will have the option to be entered into a **prize draw to win £100 Amazon vouchers.**

Who we are:

Researchers at the department of Clinical, Health and Educational Psychology at UCL are conducting this study.

If you are interested in taking part in this study and would like more information, please contact the lead researcher at:
Morvwen.duncan.11@ucl.ac.uk

Or, alternatively please follow the link below, which will provide further information and access to the survey:

https://uclpsych.eu.qualtrics.com/jfe/form/SV_6L6TOjbCkJfXG2V

Appendix I: Interview Participant Information Sheet and Consent Form

Participant Information Sheet for Adoptive Parents

UCL Research Ethics Committee Approval ID Number: 15201/001

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study: Risk factors associated with parental stress and wellbeing in adoptive parents

Department: Clinical, Educational & Health Psychology

Name and Contact Details of the Researcher(s): Morvwen Duncan (morvwen.duncan.11@ucl.ac.uk)

Name and Contact Details of the Principal Researcher: Professor Pasco Fearon (p.fearon@ucl.ac.uk)

1. **Invitation Paragraph**

You are being invited to participate in a research study as part of a Trainee Clinical Psychologist DClinPsy thesis, that is exploring the experiences of adoptive parents. Before you decided it is important for you to understand why the research us being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. The study aims to explore the emotional impact of parenting, the wellbeing of adoptive parents and to understand psychological factors that could be targets for future intervention. Whether you decide to take part or not is completely up to you. Choosing not to take part will not disadvantage you in any way.

2. **What is the project's purpose?**

We want to understand the experience of adoptive parents to better understand the emotional rewards and challenges that parenting an adopted child has on the parents, siblings and wider family. We want to understand the effect of adoption on parental wellbeing.

Recent research has begun to explore the concept of secondary trauma in professionals and foster carers of children who have experienced trauma. The current study aims to

explore the emotional wellbeing and coping strategies of adoptive parents and to explore psychological factors that could be targets for intervention. The aim of the study is to better understand the challenges facing adoptive families to improve post adoption support.

3. **Why have I been chosen?**

We are inviting ten adoptive parents that responded to the survey to complete this part of the study. You have been invited to participate from your responses on the survey.

4. **Do I have to take part?**

   It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You can withdraw at any time without giving a reason and without it affecting any benefits that you are entitled to.' if you decide to withdraw you will be asked what you wish to happen to the data you have provided up that point.

5. **What will happen to me if I take part?**

A researcher will contact you at an arranged time, convenient for you. The one off telephone call will last approximately 45 minutes and will aim to explore your experience as an adoptive parent. The questions will explore the challenges and rewards of parenting for you and your family. The interview will be audio recorded to help with the analysis of the data. Before the interview a consent form will be emailed to you for you to sign and return. You can remove your data from the study up to 4 weeks after the interview.

6. **Will I be recorded and how will the recorded media be used?**

The audio recordings of the interview will be used only for analysis and will be deleted once they have been anonymously transcribed. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings.

7. **What are the possible disadvantages and risks of taking part?**

The interview will ask about your experience of parenting an adopted child, and it will include the impact, if any, that you think it may have had on your wellbeing. This can be upsetting for some, and you are free to withdraw at any time. Information on where to access support is provided below.

If you would like further support regarding your mood or mental health, or your child's wellbeing please contact your local GP who will be able to advice on local services.

Mind is a mental health charity that provide advice and support regarding mental health and will be able to provide information on local mental health support:

https://www.mind.org.uk

020 8519 2122

The charity, Adoption UK will be able to provide information on local support services and a helpline for information and practical suggestions or to point you in the direction for specialist help:

https://www.adoptionuk.org

info@adoptionuk.org.uk
01295 752240

Coram is a further adoption charity, with services in London, the East Midlands, Cambridgeshire and East Anglia:
https://www.coramadoption.org.uk

8. What are the possible benefits of taking part?

Participants will be paid £10 in Amazon vouchers for their participation. By participating you will be contributing to our understanding of what it is like to be an adoptive parent, which will inform future research and interventions to better support adoptive families.

9. What if something goes wrong?

If you wish to raise a complaint then please contact Professor Fearon (the Principal Investigator for the study) at p.fearon@ucl.ac.uk. If you feel that your complaint has not been handled to your satisfaction, you can contact the Chair of the UCL Research Ethics Committee at ethics@ucl.ac.uk. If something happens to you during or following your participation in the project that you think may be linked to taking part, please contact the research team or the Principal Investigator.

10. Will my taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential. You will not be able to be identified in any ensuing reports or publications. Responses will be recorded and transcribed. The transcription will be completely anonymised. The data will be securely stored electronically in a password protected file. Data will be labelled with a numbered code and will be stored separately from the email address you provide to be entered into the prize draw. Your data will be stored securely and confidentially in line with privacy rights. The data will not be shared outside of the research team. The data will be stored for the duration of the study until the findings have been written up and disseminated in 2021.

11. Limits to confidentiality

- Please note that assurances on confidentiality will be strictly adhered to unless evidence of wrongdoing or potential harm is uncovered. In such cases the University may be obliged to contact relevant statutory bodies/agencies.
- Please note that confidentiality will be maintained as far as it is possible, unless during our conversation I hear anything which makes me worried that someone might be in danger of harm, I might have to inform relevant agencies of this.
- Confidentiality will be respected subject to legal constraints and professional guidelines.
- Confidentiality will be respected unless there are compelling and legitimate reasons for this to be breached. If this was the case we would inform you of any decisions that might limit your confidentiality.
- Confidentiality may be limited and conditional and the researcher has a duty of care to report to the relevant authorities possible harm/danger to the participant or others.

12. What will happen to the results of the research project?

The results will be presented as scientific papers in peer reviewed journals, at conferences, and in a student thesis. You will not be able to be identified in any reports, publications, talks or media. Data will be stored until publication in 2021.

13. Local Data Protection Privacy Notice

Notice:

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice:

For participants in research studies, click here

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

The categories of personal data used will be as follows:

Name
Telephone number
Email address

The lawful basis that would be used to process your personal data will be performance of a task in the public interest. The lawful basis used to process special category personal data will be for scientific and historical research or statistical purposes. Your personal data will be processed so long as it is required for the research project.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

14. Who is organising and funding the research?

The research is funded by UCL department of Clinical, Health and Educational Psychology.

16. Contact for further information

Morvwen Duncan

morvwen.duncan.11@ucl.ac.uk, Trainee Clinical Psychologist

Professor Pasco Fearon

p.fearon@ucl.ac.uk

If you would like more information or if anything is unclear, please contact the researchers using the contact details above.

You will be given a copy of the information sheet and a signed consent form to keep. Thank you for reading this information sheet and for considering to take part in this research study.

CONSENT FORM FOR ADOPTIVE PARENTS IN RESEARCH STUDIES

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study: Risk factors associated with parental stress and wellbeing in adoptive parents
Department: Clinical, Educational and Health Psychology
Name and Contact Details of the Researcher(s): Morvwen Duncan, morvwen.duncan.11@ucl.ac.uk;

Name and Contact Details of the Principal Researcher: Professor Pasco Fearon, p.fearon@ucl.ac.uk
Name and Contact Details of the UCL Data Protection Officer: Jean-Baptiste Pingault,
This study has been approved by the UCL Research Ethics Committee: 15201/001

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking/initialling each box below I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes means that I DO NOT consent to that part of the study. I

understand that by not giving consent for any one element that I may be deemed ineligible for the study.

	Tick Box
*I confirm that I have read and understood the Information Sheet for the above study. I have had an opportunity to consider the information and what will be expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction *and would like to take part in an individual interview*	
*I understand that I will be able to withdraw my data up to *4 weeks after the interview*	
*I consent to participate in the study. I understand that my personal information including the audio recording will be used for the purposes explained to me. I understand that according to data protection legislation, 'public task' will be the lawful basis for processing.	
Use of the information for this project only *I understand that all personal information will remain confidential and that all efforts will be made to ensure I cannot be identified. I understand that my data gathered in this study will be stored anonymously and securely. It will not be possible to identify me in any publications.	
*I understand that my information may be subject to review by responsible individuals from the University research team for monitoring and audit purposes.	
*I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. I understand that if I decide to withdraw, any personal data I have provided up to that point will be deleted unless I agree otherwise.	
I understand the potential risks of participating and the support that will be available to me should I become distressed during the course of the research.	
I understand the indirect benefits of participating including contributing to our understanding of how to best support the wellbeing of adoptive families.	

I understand that the data will not be made available to any commercial organisations but is solely the responsibility of the researcher(s) undertaking this study.	
I understand that I will not benefit financially from this study or from any possible outcome it may result in in the future.	
I understand that I will be compensated for the portion of time spent in the study or fully compensated if I choose to withdraw.	
I agree that my anonymised research data may be used by others for future research. [No one will be able to identify you when this data is shared.]	
I understand that the information I have submitted will be published as a report and I wish to receive a copy of it. Yes/No	
I consent to my interview being audio recorded and understand that the recordings will be destroyed or destroyed immediately following transcription.	
I hereby confirm that I understand the inclusion criteria as detailed in the Information Sheet and explained to me by the researcher.	
I hereby confirm that: (a) I understand the exclusion criteria as detailed in the Information Sheet and explained to me by the researcher; and (b) I do not fall under the exclusion criteria.	
I have informed the researcher of any other research in which I am currently involved or have been involved in during the past 12 months.	
I am aware of who I should contact if I wish to lodge a complaint.	
I voluntarily agree to take part in this study.	
Use of information for this project and beyond I would be happy for the data I provide to be archived at UCL until 2021. I understand that other authenticated researchers will have access to my anonymised data.	

If you would like your contact details to be retained so that you can be contacted in the future by UCL researchers who would like to invite you to participate in follow up studies to this project, or in future studies of a similar nature, please tick the appropriate box below.

Yes, I would be happy to be contacted in this way	
No, I would not like to be contacted	

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature