

Portfolio Volume 1:
Major Research Project

**The experiences of
Birth Relatives who
engage in person-
centred counselling
following the loss of
their children to
compulsory
adoption or foster
care**

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Hertfordshire in partial fulfilment
of the requirements of the degree
of Doctor of Clinical Psychology

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Abstract

This study was concerned with exploring the meaning birth relatives gave their experiences of counselling following the removal of their children from their care. An exploratory research question was formulated and addressed using a qualitative approach. The involvement of a service user as expert supervisor added an important element and certain validity to the design, analysis and findings. Interviews took place with five birth mothers who had received counselling from one birth relatives counselling service. Three master themes were constructed from the data: *From feeling alone, judged and let down to feeling part of a special relationship*; *“The healing process”*; and *“My children are my world”*.

Chapter 1: Introduction

Overview

Lost in society that we cannot trust
longing for forgiveness is a must.

Extract from 'Storms and Effects' by Clarissa Stevens¹

Birth relatives have never been asked about their experiences of counselling after having their children removed from their care. In this chapter I will build an argument for the necessity of the present study situating it in its historical, cultural and political context. I will pay attention to the power of language to shape the experiences of the powerless. I will outline my personal connections to the topic, both near and far, and the epistemological and ontological influences at play. I will consider the social construction of 'motherhood' and how this may have influenced the research and literature relating to 'birth mothers'. I will then explore what has been written about the impact of child removal on birth relatives and the current UK policy context. After discussing what the literature says about the characteristics of birth relatives I will look at what has been written about the provision of support services for this 'vulnerable' group. Finally, I will present a systematic literature review of published research concerning support services available to birth relatives following the loss of a child to adoption. Through evaluating what limited literature there is, I will find that no conclusions about what therapeutic support birth relatives find helpful can be drawn with any certainty and that the voices of birth relatives have not been heard.

¹ The complete poem 'Storms and Effects' by Clarissa Stevens is reproduced in Appendix A. It was created using the words of a birth mothers group following their participation in a 'tree of life' workshop (Ncube, 2006)

A note on language

“Language is very powerful. Language does not just describe reality. Language creates the reality it describes.” Desmond Tutu (cited in Moyes, 2007)

As a researcher and aspiring clinician, I hold a responsibility to use language with care and thoughtful consideration. Language has the power to bring about change in how people think. Words can carry numerous meanings depending on who is speaking, to whom and to what purpose (Burr, 2003).

Separating children from their birth families is one of the most serious interventions society can undertake (Angel, 1999 cited in Angel, 2015). The language of adoption is therefore sensitive and has the potential to offend, disempower or even cause pain to people for whom family separation and adoption are lived experiences. I have tried to use ‘inclusive’ adoption language wherever possible throughout this research (Andrews, 1996). In doing so I also acknowledge that the language of adoption changes and evolves over time and strong arguments exist for both what has been termed ‘positive adoption language’ (Irwin-Johnston, 2004) and ‘honest adoption language’ (Origins Canada, 2003).

‘Birth relative’

The term birth relative will be used throughout the research where possible, to refer to people who have experienced the loss of children they are biologically related to into the care system and/or by adoption (e.g. parents, grandparents, siblings and other relatives).

I do this acknowledging the position of some parents and advocates for birth mothers that the term “birth mother” denies the existence of any post-birth bond (Cuthbert, Murphy & Quartly, 2009; Wilson-Buterbaugh, 2013); that the terms “birth mother” and “birth parent” were not invented by birth mothers themselves (Origins Canada, 2003); and that alternative terminology exists (e.g. ‘first mother’, ‘natural family’, ‘non-resident mother’).

‘Relinquishment’ vs ‘Removal’

The term ‘relinquishment’ is used frequently in adoption literature to describe the act of ‘giving up’ a child for adoption. The ‘relinquishment continuum’ is an idea that comes from Baden and O’Leary Wiley (2007) who acknowledge the reality of overlap between voluntary and involuntary child relinquishment. To reflect the fact that ‘relinquish’ implies choice, which many birth mothers say they did not have, even in so-called ‘voluntary’ adoptions (Harris, 2004), I have chosen to use the term ‘removal’ where possible in this study. This will be discussed in greater detail later.

Personal and Epistemological Position

Personal Connections to topic

Following the disappointment of a previous research project becoming untenable, I came to this topic of investigation motivated to work quickly and determined to see the project through to fruition. The phenomena under investigation was, in the beginning, of secondary concern to that of finding a project that was viable within the timeframe and constraints of the Doctorate course. This project fulfilled these requirements as a follow-on project connected to existing research and utilising existing connections with

an external organisation ready to support the recruitment of participants and even the dissemination of findings.

However, during the initial discussions with my new research supervisor I began to notice many personal connections with the topic and links to both my professional and personal experiences. I had experience working with children in the care system as an Assistant Psychologist prior to training. I noticed that my experience was working with children who were also experiencing emotional or behavioural difficulties and their foster carers and social workers. I became curious as to why I had previously paid little attention to the experiences of 'birth relatives' except in the case histories of the young people I was working with. I also noticed how in my experience of working with this group of looked-after children, birth relatives were usually only described in terms of abuse or neglect, and the impact they had had on their children. I started to become more curious about the experiences of this group of birth parents in their own right; instead of in relation to the children who had been removed from their care. I also started to acknowledge some of my assumptions about this group and to notice the dominant discourses available to me in this role of 'unfit parents', 'domestic abuse' and the 'inflictors of damage' to the children. I had chosen to work again with looked-after children on my third-year specialist placement and these assumptions, conflicts and ethical dilemmas were increasingly present in my mind and in my work.

Personally, I had very limited knowledge and experience of the adoption circle². Using White's description of 'experiences near' and 'experiences distant' (White, 2007) I

² The term adoption circle will be used to describe what might have previously been referred to as the 'adoption triad'. An 'adoption triad' or 'adoption triangle' is a triangle which symbolizes three of the many

reflected on how near or far I have come to adoption circles in my life so far. I noticed that personal connections were either to friends I knew who had been adopted themselves or who had come to the decision in adulthood to become adoptive parents. To my knowledge I had no personal connections to any birth relatives. I started to think in terms of a 'hidden population' (Broadhurst *et al.*, 2015a) and became curious as to why this might be.

I had also recently become a mother for the first time. I was acutely aware of the incredible challenges that accompany parenthood, as well as the experience of feeling my parenting was constantly being judged and commented on by others. The thought of someone removing my son from my care felt difficult to comprehend and thankfully far from my, in many ways privileged, experience. In this sense it could be argued that I was occupying a position between two poles of 'insider' and 'outsider' researcher (Olson, 1977). I noticed a conflict between recognising the overwhelming impact of becoming a parent and starting to understand the challenges this brings; with the idea of someone neglecting or 'doing harm' to their own child. Once again, I noticed the assumptions my previous experience had brought with it: that birth relatives of adopted children are only neglectful or abusive. I realised what was missing in my understanding were the stories of the birth parents, the histories and challenges that impacted their daily lives, and the things that got in the way of their ability to be fully

parties involved in an adoption: adoptee, adoptive parents and birth parents. The triad or triangle appears to demonstrate an equal distance or separation between the three members. More recently campaigners affected by adoption have argued that the so-called equality shared by members of the triad does not represent their experience (Wilson-Buterbaugh, 2013). Also, that the three-sided shape does not represent the many other individuals or organisations involved in every adoption, for example grandparents or other family members; social services, agencies, governments, and wider society. 'Adoption circle' is a term used by Feast (1992) that is becoming more commonly used (e.g. Irwin-Johnston, 2004). I have chosen to use the term adoption circle as I believe it not only encompasses the wider scope of 'birth relatives' whose experiences are the focus of this study, but also allows for the differing levels of power and control of various parties involved.

connected to the needs of their children. Through this process of self-reflexivity I started to see how my own experiences, values and beliefs were already influencing my approach to this field of study.

A final connection to the topic came through a personal interest in the Arts and a family connection to The Foundling Museum³ in London. The Foundling Museum explores the history of the Foundling Hospital, the UK's first children's charity and home for 'abandoned' children. Over many visits to the museum I had increased my appreciation of the social contexts surrounding 'child abandonment' and the long history of parents, more specifically mothers, finding themselves in situations that led to them being unable to care for their children. I had often explored with humility the museum's collection of objects left by birth mothers with their children as a means of identification. Described as 'fragments of maternal hope' (Howell, 2014) these 'tokens' had always represented to me the lost stories of the birth relatives and the circumstances that led them to 'give up' their babies in this way. Engaging with this topic of research linked these lost stories in my mind to the potential stories of contemporary birth relatives and their experiences of child removal.

Epistemological Position

I am influenced by the realisation that my previous understanding of 'birth relatives' was socially and culturally situated within the context of working with looked-after children who were experiencing emotional and/or behavioural difficulties. In investigating the subjective experiences of birth relatives accessing counselling, I wish

³ See <https://foundlingmuseum.org.uk>

to take a critical stance towards this previously 'taken-for-granted' knowledge (Gergen, 1985). Linking my work with today's looked-after children and the children cared for at the Foundling Hospital in the 18th century, I am also keenly aware of the historical and cultural specificity of my knowledge.

Social constructionism as described by Burr (2003) is an approach to the study of humans which has at its foundation the key assumptions of a critical stance towards 'taken-for-granted' knowledge and the historical and cultural specificity of understanding (among others). By using a social constructionist frame I can maintain a critical eye on these powerful influences over me and in the lives of those who are part of adoption circles.

I became aware of the privileged and powerful position I embody as a researcher and of the overwhelmingly powerless position occupied by birth relatives. As such I was also influenced by the principles of emancipatory research (Evans & Fisher 1999) to enhance the power of service users. Very early in the research process a birth relative with experience of counselling following the loss of her children to adoption was recruited and joined the project's supervisory team. This will be discussed further later.

Historical and Cultural Context

The phenomenon of birth relatives becoming separated from their children extends throughout history. Usually accompanied by stories of hardship, sacrifice, illegitimacy, war, poverty, family breakdown, or abuse. It is well documented in history, literature and culture, examples including the story of Moses (Exodus, 2:1-10), Dickens's Oliver

Twist (1838) and more recently the film Juno (2007) and the Tracey Beaker or Hetty Feather Stories by Jacqueline Wilson (1991 and 2010 respectively). As well as powerful 'happily ever after' narratives, loss and pain are common themes present in stories of adoption: the loss of the birth family for the child, the loss of the child for the birth relative, and (possibly) the loss of a view of themselves as capable of creating new life for the adoptive parents (Brinich, 1990).

In the 1950s and 1960s articles published on the psychology of birth relatives focussed solely on the birth mother and were based on psychoanalytic theory (e.g. Cattell, 1954 and Deutsch, 1945 cited in Carr, 2007). At that time birth mothers were reportedly unmarried women experiencing unplanned pregnancies at a time when mothers and infants born out of wedlock were subject to significant social stigma and 'illegitimacy'. For most birth mothers their pregnancy and the removal of their children were never discussed once the child had been removed. There was a belief in society that birth mothers should 'put the event behind them', forget about the child and move on with their lives (Carr, 2007). Mothers were encouraged to 'act as though nothing unusual has happened' (Scourfield *et al.*, 1991). It is often noted that prior to the 1980s birth relatives were the most neglected members of the adoption circle (Logan, 1996; Baden & O'Leary Wiley, 2007; Carr, 2007); and birth parents whose children had been removed involuntarily remained strikingly absent until very recently (Mason & Selman, 1997; Shaw *et al.*, 2014). Logan (1996) suggests this neglect was also due to the misconception that the birth relative experience ends when a child is removed.

Attitudes towards adoption, and toward 'illegitimacy' have evolved over time. In some cases, adoption came to be viewed as a 'violent... political act of aggression' (Shawyer,

1979 cited in Logan, 1996). Feminist writers have charted the development of attitudes towards birth mothers from 'fallen women' to be saved, to 'sexual delinquents' to be controlled, to 'neurotic girls' to be cured (Kunzel, 1993; Solinger, 1992 cited in Wegar, 1997).

Since the 1980s the findings of research with birth relatives have varied considerably. Freundlich (2007) situated this variation in terms of social and cultural values related to the practice of adoption across the English speaking (Western) world (specifically the UK, USA and Australia). Research involving birth parents in the USA, where voluntary 'relinquishment' is more common, is described as more comprehensive than research with birth relatives whose parental rights are terminated involuntarily, a practice more common in the UK. She identifies two conflicting themes present in the literature on outcomes for birth mothers specifically that adoption is either: 1. a traumatic experience with lifelong negative consequences or 2. beneficial to both the birth mother and the adopted child in the long term. Research in the USA tended to emphasise the risks involved in becoming an 'unwed mother' (Wegar, 1997) and highlight the positive social benefits of adoption (Curtis, 1990). However, others have argued that there is a bias against adoption in the research literature and that this amounts to a 'suppression' of the 'success story' of adoption (Bartholet, 1993 cited in Cuthbert *et al.*, 2009). This could be viewed as further evidence of the influence of cultural or personal values in adoption research and practice.

The link between these contrasting research findings and the location in which the research is situated can be understood further by considering the relevant social, cultural and historical contexts. Australian research happens in the context of

understandable shame at the history of adoption practices and the “stolen generation” of Aboriginal children (Cuthbert *et al.*, 2009). Research in the USA that highlights the risks associated with unmarried parenting, does so in the context of a powerful pro-life, anti-abortion lobby (Staggenborg, 1991); stringent welfare system; limited access to contraception; and possibly more socially acceptable attitudes towards adoption as an alternative to parenting for unmarried birth mothers from a particular demographic; namely White single mothers from higher socioeconomic and educational groups (Baden & O’Leary Wiley, 2007). In a USA study, mothers typically said they placed their child for adoption because they ‘did not feel ready to parent’, only a minority felt ‘forced’ to relinquish (McRoy *et al.*, 2001 cited in Neil, 2013). It has also been argued that an overly positive view of the adoption process has been promoted by adoption agencies and facilitators in an effort to meet the needs of removed children and find adoptive families (Smith & Sherwen, 1988 cited in Henderson *et al.*, 2007).

Another important factor in the history of birth relatives is what Baden and O’Leary Wiley describe as the ‘relinquishment continuum’ (2007, p429). Research with birth relatives often distinguishes between voluntary and involuntary ‘relinquishment’. The former being more prevalent in the USA, and the latter in the UK and Australia (Baden & O’Leary-Wiley, 2007; Neil, 2000). In reality this is a false dichotomy and as Baden and O’Leary Wiley (2007) attest, the distinction should be considered more of a continuum. They point to research that has found birth parents can feel coerced into signing adoption orders ‘voluntarily’ (De Simone, 1996; Carolan *et al.*, 2010; Logan, 1996; Freundlich, 2007). Nowadays in the UK, adoptions of voluntarily ‘relinquished’ children are rare and tend to happen only in very complex circumstances (Neil, 2000).

What research and academic literature concerning birth relatives there is, is hugely varied in terms of scope and focus. Baden and O'Leary Wiley (2007) see this variation as a lack of integration between professional and academic disciplines involved with birth relatives in various Western countries. Freundlich (2007) goes even further to say that variation in research and clinical practice reflects the social values and professional concerns relating to the practice of adoption. Others have explained the lack of professional and academic consideration of the lives and situations of birth relatives as a consequence of the stigma of having children removed from your care (Slettebø, 2013). As late as 1996 authors were lamenting the dearth of knowledge about the experiences of birth relatives, specifically birth mothers (Logan, 1996). Logan compares this absence to the substantial body of literature on stillbirth and perinatal bereavement (e.g. Rando, 1986) and suggests that it is related to the idea that birth mothers are "deemed to have wronged, need to be punished and therefore are not worthy of attention" (p.610).

It has also been argued that the notion of the 'best interests of the child' (Goldstein *et al.*, 1996) has gained influence internationally and has deeply affected how members of the adoption circle are viewed. Broadhurst and Mason (2017) warn how this notion can lead to an exclusive focus of the interests of the child at the expense of the parents. Carolan *et al.* (2010) note that whilst children are rightly viewed as the most vulnerable members of society, mothers are not 'allowed' to be seen as vulnerable. Through a feminist lens they note that birth mothers' histories of complex trauma and oppression are minimised and that women are held up to higher standards and greater expectations than birth fathers (Carolan *et al.*, 2010).

The Social Construction of Motherhood

“Adoption is not about unwanted babies – it is about unwanted mothers”

Exiled Mothers, N.D.

Motherhood and the role of mother have been socially and historically constructed by the middle and upper classes (Hays, 1996 cited in Carolan *et al.*, 2010). The expectations of mothering are therefore based on a predominantly white, middle-class, Eurocentric model (Carolan *et al.*, 2010). Both birth mothers and adoptive mothers have been depicted as ‘deviant’ in the clinical adoption literature, for failing to conform to these expectations and other dominant definitions of true ‘womanhood’ and ‘good mothering’ (Wegar, 1997). Birth mothers writing about their experiences report being told “some people don’t deserve children” or being called “a disgrace to womanhood” (Post-adoption Centre, 2000). This bias has even been found in the attitudes of mental health professionals towards women who had relinquished their children (Baran *et al.*, 1977 cited in Logan, 1996).

Medina and Magnuson (2009) sum up the implications of the social construction of motherhood for counsellors, noting that the majority of both counsellors and counselling clients may be mothers (Muller, 1990 cited in Medina & Magnuson, 2009). They describe how historically, if women were not mothers or potential mothers, they were ‘nothing’, and find that society defines mothers in terms of what they ‘do’ rather than by what they ‘feel or think’ (Medina & Magnuson, 2009, p.91). By this definition mothers whose children have been removed and for whom they no longer have caring responsibilities would no longer be considered mothers. Conversely, some contexts

deem that by relinquishing their babies, unwed mothers were again 'worthy' of being wives and mothers in the future (Wegar, 1997).

Medina and Magnuson (2009) also sum up the 'intensive mothering ideology' (Hays, 1996 cited in Medina & Magnuson, 2009) which contributes to a belief held by society that "women who cannot afford to devote their time and attention to mothering should not have children" (p.92). The effects of this ideology on birth mothers is evident in a paper by Kielty (2008) who describes how the situation of 'non-resident' mothers conflicts with powerful cultural norms and leads to significant social isolation and stigma. She also describes the influence of an internalised "ever-available totally nurturing mother" which can fuel strong feelings of guilt for mothers who don't feel they can live up to this ideal (Keilty, 2008, p.375). The influence of the women's movement on attitudes towards single-mothers is reported to have helped reduced the stigma or 'illegitimacy' of unwed motherhood (Wegar, 1997). However, it has been argued that for women whose children are removed by the court, the stigma of illegitimacy has been replaced by the stigma of 'bad parenting' (Neil, 2013).

A feminist perspective of the psychological reaction to child removal outlined by Logan (1996) stresses the importance of understanding how for women caring, nurturing and motherhood are few of the only socially acceptable goals available. Failure to live up to these expectations may compound feelings of powerlessness and low self-esteem (Logan, 1996). Weinreb and Murphy (1988) stress the need to understand how sociocultural views of birth mothers may impact and interact with the mother's own grief, shame and anger. Coupled with this, it has been argued there is no socially accepted role for the adopted child in the birth mother or birth relative's life (Fravel *et*

al., 2000) and so birth mothers can struggle to talk about the children they have lost with others.

It should also be noted that 'mothering' is viewed differently in non-Eurocentric cultures and that other forms of mothering exist, for example step-mothering. Cuthbert *et al.* (2009) note how mothering other people's children is far more common in non-white communities and "cultures where family is understood as an inclusive, and not as an exclusive, concept; and mothering is a function, rather than an identity" (p.407).

The impact of child removal

"Adoption is like death. When a child is adopted, it is like a death you've got to grieve (and get on with it...)"
(Post-Adoption Centre, 2000)

Prior to the research of the last 30 years birth mothers in particular were assumed to be unaffected by child removal and expected to have 'put it all behind them' (Logan, 1996; Harris, 2004). It was considered that in particular, 'confidential' adoptions allowed for a birth mother to mourn the loss in a "normal" way and move on with her life (Kraft *et al.*, 1985).

Complex grief; guilt, loss and shame

Important research has started to look at the impact of child removal on birth relatives, particularly the impact on birth mothers (Aloi, 2009; Brodzinsky, 1990; Brodzinsky & Smith, 2014; Charlton *et al.*, 1998; Deykin, *et al.*, 1984; Fravel *et al.*, 2000; Henney *et al.*, 2007; Howe *et al.* 1992; Logan, 1996; Neil, 2013; Winkler & Van Keppel, 1984). Findings suggest birth mothers experience a complex grief reaction, including anger, loss, guilt and low self-esteem (Henderson *et al.*, 2007; Neil *et al.*, 2010). Neil (2013) highlights

that adoption can be both the cause and consequence of distress to birth parents. *Still Screaming* (Charlton *et al.*, 1998) powerfully portrays the persistent feelings of guilt, loss and shame in the lives of birth mothers. Doka's (1989) notion of 'disenfranchised grief' is used frequently to understand the grieving process required of birth relatives (Aloi, 2009; Broadhurst & Mason, 2013; Brodinsky & Livingston Smith, 2013; Robinson, 2002; Schofield *et al.*, 2011). However, as multiple authors point out, and as has been discussed previously, much of the early research focused on the impact on mothers who had 'voluntarily relinquished' their child for adoption (Cossar & Neil, 2010; Broadhurst & Mason, 2017). Whilst it is possible to see similarities in the experiences of birth mothers at either end of the 'relinquishment continuum', researchers have found the process of having a child removed by the courts to be distinctive (Cossar & Neil, 2010).

Removal by court order

The termination of parental rights via a court order has been likened to the "death penalty" due to its finality and gravity (Hewett, 1983 cited in Baden & O'Leary Wiley, 2007). In 1997 Mason and Selman declared that the "voice of the non-relinquishing parents has not been heard" (p. 22) in research. However, several studies have addressed this silence since then with most if not all highlighting long term psychological distress, 'unease', mental illness, ongoing anger and guilt, shame, and grief (Baum & Burn, 2007; Broadhurst & Mason, 2013; Fravel *et al.*, 2000; Henderson *et al.*, 2007; Logan, 1996; Memarnia *et al.*, 2015; Neil, 2006; Neil, 2013). The loss of a child through court order sets this group of birth relatives apart and separates them from communal experience or cultural ritual to process, and grieve their losses (Broadhurst & Mason, 2017). Considering a social model of psychological distress, Neil (2013) links how birth parents' experiences of trauma, powerlessness and isolation from social

support could lead to psychological difficulties such as anxiety, depression, hearing voices and self-harm.

Harwin *et al.* (2014) name the fact that parents involved in family court proceedings tend to be viewed as a homogenous group in the available published research which describes their experience as 'alienating, difficult to understand, intimidating and deeply stressful' (Hunt, 2010 cited in Harwin *et al.*, 2014). Henderson *et al.* (2007) also describe birth relative distress caused by the adoption procedure itself, as do Cossar and Neil (2010) who state that as well as adjusting to the loss of the child, birth parents are also expected to cope with the effects of the process. The adversarial and disempowering nature of court proceedings for birth parents is widely acknowledged (Broadhurst & Mason, 2017; Cossar & Neil, 2010).

Broadhurst and Mason (2017) highlight the 'collateral consequences' of court-ordered child removal. As well as mourning the loss of the child, they report how birth parents also experience social and legal stigmatisation, possible sanctions on other family relationships (if children have been placed with kinship carers), and reduced welfare support (Broadhurst & Mason, 2017). Carolan *et al.* (2010) describe how women become 'invisible' as they become childless mothers. As laws and policies are adjusted to consider the needs of the child as paramount, time-scales for birth parents to demonstrate change are shortened (Broadhurst & Mason, 2017). This may, as a consequence, cut short birth parents rehabilitation efforts as treatment services and other forms of support are removed at the same time as the child.

Stigma

Social stigmatisation is also well documented across the literature as effecting birth mothers and other relatives at both ends of the 'relinquishment continuum' (Kietly, 2008; see also Broadhurst & Mason, 2017; De Simone, 1996; Carolan *et al.*, 2010; Neil, 2013; Pengilley, 2003; Salveron, Lewig & Arney 2009; Schofield *et al.*, 2011; Slettebø, 2013; Wegar, 1997; Zamostny *et al.*, 2003). As discussed, it has been noted that when children are removed by court order, the stigma of 'illegitimacy' is replaced by the stigma of failure at parenting (Neil, 2013).

Other Birth Relatives

The impact of child removal on birth fathers and other birth relatives is even less well studied. Neil *et al.* (2010) identify three significant studies with birth fathers (Deykin *et al.*, 1988; Cicchini, 1993; and Clapton, 1997) that suggest that many birth fathers also experience long term negative effects of child removal. They also point to research with birth grandparents (Tingle, 1994; 1995 cited in Neil *et al.*, 2010) indicating that losing a grandchild to adoption can also be a painful experience. Neil (2006) interviewed birth parents and grandparents and found that being a grandparent was more likely to result in 'positive acceptance' of the adoption.

The literature consistently reports that children as well as birth relatives, will suffer in the long-term unless the impact of child removal is addressed. It would seem that a variety of birth relatives may benefit from support services that recognise the impact of child removal and take account of their mental distress.

Current UK Context

The current study took place in England, UK. The 2002 Adoption and Children Act is the most influential reform in Adoption Law in England and Wales in recent years. It sought to recognise changes in adoption practices that had taken place since the 1980s, and in particular the increased use of adoption for older children in care (Ball, 2005 cited in Cossar & Neil, 2010). Since 2002 there has also been cross-party support for adoption as the preferred permanency option for infants and young children (Broadhurst & Mason, 2017). The Adoption and Children Act 2002 put the welfare of the child at the forefront of decision making when considering an adoption order. It also increased birth relatives' rights to support services when their children are adopted. It specifies that birth relatives should have access to a range of support services both before and after adoption (Department of Health, 2001). This guidance has however been interpreted and implemented in many different ways and it is unclear to what extent it has translated into meaningful support and services for birth relatives.

The number of looked after children in England, that is the number of children removed from their birth families and taken into the care of the local authority, has steadily increased over the last nine years (ONS, 2017). This was also following the death of Peter Connelly (often referred to as Baby P), which led to a huge increase in the number of children being taken into care in England. The U.K. government had strong responses to both the Peter Connelly case and the Victoria Climbié case previously (Laming 2003, 2009). These developments and reports were so influential in shaping the culture of child protection in the UK, making services much more risk adverse and inclined to defensive practice (Community Care, 2005). Broadhurst *et al.* (2015a) report that the number of infants removed at birth has also increased during this time, which they take

as evidence of both this policy shift towards fast removal from harm, and reduced community support services for struggling families. On the 31st March 2017 there were 72,670 looked after children in England. The number of looked after children who were then adopted increased between 2011 and 2015 from 3,100 to a peak of 5,360. In 2016 the number of adoptions fell for the first time since 2011, by 12% and in 2017 the number of looked after children who were adopted fell again, by 8% to 4,350.

Adoption is a key welfare policy in the UK where it is believed to offer “unique stability and care within a new family which lasts long beyond childhood” (Department for Education, 2016). However, adoption is one of the most controversial areas of social policy. The use of non-consensual adoption across the UK has sparked disagreements between judiciary and government, criticism from many birth parents whose children have been adopted against their wishes, and questions within the social work profession itself about the ethics of this increasingly politicised area of practice (Featherstone, Gupta and Mills, 2016). Following a ruling in the Supreme Court where it was said that adoption should remain a “last resort”, the number of adoptions has fallen in recent years and the number of adopters being recruited is declining (Stevenson, 2017).

The important work of Karen Broadhurst and her colleagues in England has shone a light on the prevalence of repeat appearances of women in the family court. They identified that over a 7-year period (2007–2014) more than 43,000 women appeared as respondents in family court proceedings in England (Broadhurst *et al.*, 2015a); and that the probability of recurrence was 24%. They cite this as evidence of the importance of building an evidence base and professional expertise such that this population of

parents can benefit from effective mental health intervention, which addresses the complex psycho-social consequences of child removal (Zamostny *et al.*, 2003 cited in Broadhurst & Mason, 2017).

Who are birth relatives?

'Deficient'

Birth parents have been described as “unmotivated clients” (Koch, 1987, p.89), as a “marginalised and vulnerable group” (Cossar & Neil, 2010), and as being from deprived socio-economic backgrounds (Broadhurst & Mason, 2013; Neil *et al.*, 2010). The literature speaks in terms of the deficits of birth relatives, described as “dysfunctional” and “with multiple problems” (Koch, 1987), or as having high levels of “social and psychological difficulties” and “complex needs” (Selleck, 2007; Cossar & Neil, 2010). Parents whose children are removed are described in literature from the UK as marked by economic and psychological deprivation, and affected by problems of mental ill health, substance abuse, or learning disabilities (Neil, 2000). It is also acknowledged that parents who come to the attention of the family court have typically experienced childhoods of great adversity themselves (Broadhurst & Mason, 2017; Logan, 1996; Neil, 2013). Broadhurst and Mason (2013) found mental health difficulties to be present in 80% of the parents in their pilot study looking at repeat removals.

'Difficult to engage'

Literature written from the perspective of therapists or counsellors highlights difficulties in engaging this group in therapeutic work and explains this in terms of the birth relatives' 'deficiencies'. Birth relatives are often described as 'hard to reach' or 'difficult to engage'. Selleck (2007) found uptake of services amongst birth relatives to

be very low and suggested birth relatives might be distrustful of services, having experienced the removal of their child against their will. They may also be isolated in terms of their family and community support networks. This may have contributed to why their child was removed in the first place, but it also contributes to their ability to cope with the aftermath of the loss (O'Neill, 2003 cited in Cossar & Neil, 2010; see also Broadhurst & Mason, 2017; Neil, 2013).

Birth Mothers

It is likely that whilst birth mothers may have some shared life experiences or characteristics, their needs may be very different in terms of intellectual disabilities, mental health diagnoses, substance misuse or experience of domestic violence (Broadhurst & Mason, 2013).

Adolescents

Much of the theoretical and research literature from the USA focuses on adolescent birth mothers (Deykin, Campbell, & Patti, 1984; Kraft *et al.*, 1985) and speaks in terms of their deficits of cognitive and emotional development (Kraft *et al.*, 1985) or poorer outcomes for those who 'choose to parent' (Freundlich, 2007). Harwin *et al.* (2014) shone a light on the findings of Broadhurst *et al.* (2014) concerning the young age of birth mothers involved in recurrent family court proceedings. Fifty percent of all mothers caught up in recurrent care proceedings were aged 24 or under at the time of the first appearance (Harwin *et al.*, 2014; Broadhurst *et al.*, 2014). By default, this also means that fifty percent of recurrent care proceedings involved mothers over the age of 25. When discussing the experiences of a group of 11 birth mothers who had in their

terms 'recovered their parenting capacity' following recurrent care proceedings, Broadhurst and Mason (2014) note that all 11 had first become mothers as teenagers.

Brodzinsky (1990) comments on the lack of research attention to the possible impact of adolescent mother's cognitive development on their decision making and ability to evaluate their circumstances. Clearly, while this is only relevant in situations where the power to make decisions regarding the future is granted to the birth mother, however it is still an interesting line of enquiry.

Disadvantaged

Deykin *et al.* (1984) found that the majority of birth mothers explained their decision to relinquish their child to adoption due to family resistance to the pregnancy, lack of finances, or pressure from their social worker. Logan (1996) reported that almost all the birth mothers she interviewed had difficult relationships with their own mothers.

When considering birth mothers subject to successive removals of children, Broadhurst and Mason (2013) found that multiple problems of homelessness, mental health and mental capacity, undermined help-seeking. They note that often it is not until a further pregnancy that they once again came to the attention of support services.

With Intellectual Disabilities

In 2007, Baum and Burns noted that a growing number of women with intellectual disabilities were becoming mothers and were at increased risk of having their children removed (Booth & Booth, 1994; Tarleton *et al.*, 2006 cited in Baum & Burns, 2007).

These women are less likely to recover their parenting capacity and have their children

returned to their care according to Broadhurst and Mason (2014), although it should be noted they only had a small sample size.

Care Leavers

Findings from the Wales Adoption Study (Anthony *et al.*, 2016) showed that more than a quarter (27%) of birth mothers (and a fifth (19%) of birth fathers) with children placed for adoption were themselves care leavers (Roberts *et al.*, 2017a). According to Roberts *et al.* (2017a), care leaver birth mothers were reportedly more likely than their non-care leaver counterparts to be diagnosed with mental health problems and were less likely to appeal the adoption plan.

Traumatised

Carolan *et al.* (2010) report that women with trauma in their own childhoods, who go on to become the victims of adult partner violence, are more likely to be at risk of becoming perpetrators of neglect or abuse of their children, especially if protective factors such as family or community support and financial resources are lacking (Levendosky & Graham-Bermann, 2001 cited in Carolan *et al.*, 2010). The impact of intergenerational complex trauma on the ability to parent is also highlighted by Carolan *et al.* (2010). They note that women with histories of complex trauma are at higher risk of becoming known to children's services and being accused of neglect. These mothers are described as 'disorganised and chaotic' or 'isolated, emotionally distant, and depressed' (Erickson and Egeland, 2002 cited in Carolan *et al.*, 2010).

Having worked closely with birth mothers Carolan *et al.* (2010) powerfully note that these women care deeply about their children and (in the case of removal) often want to

be better parents. They conclude that “the obstacles on the pathway to change are often insurmountable, leaving these women suffering, silenced, and ultimately childless mothers” (p.183).

Other Birth Relatives

The needs of grandparents and birth fathers are just as great as those of birth mothers, but are likely to be overlooked (Neil *et al.*, 2010). As Broadhurst and Mason (2017) highlight, the broader family networks where children are removed are also multiply bereaved. When the family court is involved, grandparents can be called upon to become alternative long-term carers for their grandchildren, or family members can be called to give evidence in court (Broadhurst & Mason, 2017). The research of Cossar and Neil (2010) attends to the fact that birth relatives who have not played a central part in the adoption process may not become aware of the existence of support services at all, they note that this may particularly apply to non-parenting fathers, siblings and extended family members. Broadhurst and Mason (2013) found that they are equally overlooked post-proceedings. It is clear that further work is required to even begin to understand the impact of child removal on wider family networks.

The literature acknowledges the neglect of birth fathers in research (Clapton, 2002) but continues to ignore wider family members, particularly siblings (Hipple & Haflich, 1993). Pavlovic and Mullender (1999 cited in Harris, 2004) describe the lengths birth siblings will go to in order to find brother and sisters separated by adoption and so it is clear that adoption impacts siblings too.

Support services for birth relatives (in England and Wales)

It is now usual in England for some form of contact between birth relatives and adopted children to be included in the adoption plan (Neil, 2002). Parent-child contact is considered important because of its effects on children's psychological identity and well-being (Salveron *et al.*, 2009). Neil (2013) found almost a third of birth relatives they surveyed had some form of face-to-face contact with the adoptive parents and child after adoption (although the nature of their sample means this may be an over representation). Therefore, support services for birth relatives are important not only for the welfare of the parent, but also for the well-being of their children (Cossar & Neil, 2010).

There is very little published work on practice responses to birth parents following child removal (Broadhurst & Mason, 2017; Cossar & Neil, 2010). It has been noted that child protection services do not address the birth relative's own victimisation or socio-economic disadvantages (Broadhurst & Mason, 2013). In 2010 Elsbeth Neil and her colleagues published the findings of their research study, *Helping Birth Families*, into the practice of supporting the birth relatives of adopted children (Neil *et al.*, 2010). They set out to explore issues relating to the implementation of the Adoption and Children Act 2002 in England and Wales, specifically relating to the provision of support services for birth relatives. By surveying adoption services providers, interviewing birth relatives, and performing an economic analysis, they made a number of discoveries.

Neil *et al.* (2010) separated the types of support available to birth relatives into five categories: emotional support, advice/information, help with contact, advocacy and liaison, and group support. However, in a lot of the literature the services described

overlap these categories. None more so than 'intermediary' services where the focus is helping birth relatives and adopted people seek information, trace and make contact with each other if this is something they both want. Literature describing intermediary support for birth relatives includes descriptions of counselling and groupwork with a focus on the emotional impact of searching and/or reunion with lost (mostly adult) children (e.g. Clapton, 2006; Feast & Smith, 1995, Harris & Whyte, 1999). Neil *et al.* (2010) found that despite evidence of high levels of mental distress, only a minority of birth relatives had received specialist mental health services. Those who did access generic mental health 'talking therapies' reported that adoption issues were not addressed and therefore they had not found the intervention helpful. These findings are also backed up in a study of the therapeutic experience of birth parents in the USA (Sass & Henderson, 2002).

Cossar and Neil (2010) report on the initial mapping study of the wider 'Helping Birth Families' project. They found that whilst agencies in England and Wales were good at providing or commissioning independent support services, they were less successful at monitoring the quality of these services or how successful they were at engaging with birth relatives. Neil *et al.* (2010) report support services across England to be highly variable and take-up is inconsistent. They report that Voluntary Adoption Agencies (VAAs) provided three main types of services to birth relatives: counselling or support to 'historical' birth relatives whose children had been adopted via their agency; intermediary services to birth parents seeking contact with their adopted child; and assisting contemporary birth parents with post-adoption contact (e.g. letterbox contact). Additionally, they found some Adoption Support Agencies (ASAs) also provided access to telephone helplines or drop-in services as well as the support

outlined above. Considering the amount of resource and effort put into the Cossar and Neil (2010) survey, they were disappointed by their response rate and felt this could reflect an ongoing lack of priority in this field of practice.

As we have seen there is much discussion of the difficulties in engaging birth relatives in post child removal support. Both Neil *et al.* (2010) and Broadhurst and Mason (2017) comment on how services positioned 'at arm's length' to statutory providers may be best placed to offer support to birth relatives. This finding was echoed in the work of Jackson (2000). Evidence suggests that outreach approaches may be most successful at ensuring support services are taken up (Selleck, 2007). Broadhurst and Mason (2013) recommend a 'pro-active multi-agency approach'.

The literature that is available clearly points to the idea that birth mothers and other relatives benefit from timely and empathic counselling from adoption-competent therapists (Brodzinsky & Smith, 2014).

In 2012 a small group of practitioners in the UK had begun to meet to think about the problem of the successive removal of infants in care proceedings and how best to support families for whom this was a reality (Shaw *et al.*, 2014). Since then a number of 'grassroots' initiatives working with this client group have emerged across England. Shaw *et al.* (2014) argued that "the challenge [was] to move from a proliferation of 'grassroots' initiatives to a national strategy and much more research [was] required" to evidence what helps birth relatives in recurrent proceedings (p.1286). Evaluations of the 'Pause' project and the Tavistock's Family Drug and Alcohol Court (two of these 'grassroots' initiatives) by the department for education were published in 2017.

Findings suggest that both projects had a positive impact in the lives of the birth relatives they engaged (McCracken *et al.*, 2017; Roberts *et al.*, 2017b). Findings from the first academic-led investigation of two of these initiatives was published in 2017 and is reviewed below (Cox *et al.*, 2017).

The experience of therapeutic support following the loss of a child to adoption

In Neil's 2006 study of 'Contact After Adoption' she found very few of the birth relatives she interviewed had received any support to deal with their feelings about the removal of their children. The literature highlights many barriers that may exist for birth relatives trying to access support post-adoption. Scourfield *et al.* (1991) encountered health and age barriers as well as ongoing secrecy and shame surrounding child removal, meaning some women could not access support for fear of family members finding out about a historical adoption. Neil found that birth parents with strong feelings of unworthiness and guilt may also be passive and find it very hard to 'make the first move' towards getting support (2006, p.19). She also found that birth relatives could feel angry and in this case were more likely to be distrustful of others, particularly in a professional capacity; and therefore, counselling or therapy may be resisted by those for whom anger serves as a defence against potentially overwhelming feelings of loss or despair (Neil, 2006).

Early therapeutic work with birth parents formulated an intense need to be 'reparented' within a therapeutic relationship (Fraiberg, Adelson, & Shapiro, 1975; Koch, 1987). In her work with 'Karen', a birth mother, Koch (1987) describes her treatment approach as being consistent and able to meet Karen's concrete needs. She

also found verbalisation in their therapeutic relationship to be 'peripheral' and the most important mode of interaction was to just "be with" (p.94).

"To expect Karen to seek help with parenting skills and verbalize her problems is analogous to asking an infant to ask to be fed instead of acting as if it is hungry."

Koch, 1987, p.95.

Both individual counselling and group support were found to be useful ways to diminish birth relatives' sense of failure and isolation (e.g. Charlton *et al.*, 1998; Post-Adoption Centre, 2000). Logan (1996) reported that birth mothers had been able to gain a different perspective through counselling and particularly through talking to other birth mothers. In their powerfully poignant paper, a small group of mothers whose children had been removed, highlight the social isolation common among mothers in a similar position (Post-Adoption Centre, 2000). They describe how having a birth mother as co-facilitator of their support group can help mothers share their stories, without fear of being judged, which often they have not told anyone. This was also the experience of the mothers attending the group described in Scourfield *et al.* (1991).

Some helpful factors to creating change were identified by Broadhurst and Mason (2014): 'intrinsic maternal characteristics'; 'marked resilience in the face of hugely difficult life experiences'; 'motivation to engage in professional help'; 'commitment and sense of enduring connection to their children'; 'desire to parent a subsequent infant'. Broadhurst and Mason (2014) also describe certain 'turning points' they identified in the experiences of 11 mothers who they considered 'rehabilitated' following recurrent care proceedings, in that they now had parental responsibility for a child resident in their care. These include: exiting an abusive relationship and/or forming a relationship

with a new partner who offered support and stability; the mother's capacity to make sense of life events and develop strategies of coping; newfound mental strength and maturity; access to psychological therapies and an ability to make use of that support; how experiences were processed; access to "consistent professional, skilled help that nurtured the women's sense of resolve and self-regulation was vital" (p.1575); and the quality of the professional-service user relationship was reported as 'transformative'.

Prior to the current legislation, Logan (1996) found that the majority of women they interviewed had been given no opportunity for counselling until they requested it themselves. Many of these birth mothers described gaining a different perspective having met with a counsellor and particularly with other birth mothers. Henderson *et al.* (2007) reported that 41% of their sample of birth relatives had received therapy 'at least once'; and that therapy was received from professionals in various fields (e.g. psychologists, social workers, counsellors, psychiatrists). As yet there is no evidence of 'what works' in terms of support for birth relatives. Broadhurst and Mason (2013) cite anecdotal evidence that many women manage to successfully turn their lives around and go on to parent children; but note that the details of what led to their recovery is unavailable. They point out that little is known about how women who have had more than one child removed deal with their experiences or go on to conceptualise their identity in regard to their 'lost' children (Broadhurst & Mason, 2013).

It is clear that there is an urgent need for more evidence of what birth relatives find helpful and to hear the voices of birth relatives themselves regarding their experiences of support following child removal.

Chapter 2: Systematic Literature Review

As outlined by Siddaway, Wood and Hedges (in press) the following research question was formulated as a starting point for systematically reviewing the existing literature relating to birth relatives accessing counselling: *What does the existing literature say about birth relatives' experiences of counselling following the loss of a child to adoption?*

After extensive searching of multiple databases (see table 5 in Appendix B), I was unable to identify a single published peer reviewed research study focusing on birth relatives' experiences of counselling. Therefore, the scope of the systematic literature review was widened to encompass more forms of support for birth relatives (e.g. group work, other forms of therapy) and also literature which described interventions with birth relatives but did not focus on the birth relatives' experience. The research question was updated to: *What does the existing literature say about support services available to birth relatives following the loss of a child to adoption?*

As discussed, the terminology of adoption and child removal is culturally and historically situated and has evolved over time. Search terms were added to as I became more familiar with the terminology used across historical and geographical contexts (see table 6 in Appendix B). I added keywords I consistently found in related articles. Literature from outside the UK was included due to the sparsity of research in the field. No date limit was set as I wished to gather all relevant literature on the topic.

Three large databases were searched as detailed in table 5 (Appendix B); Scopus, Social Care Institute for Excellence (SCIE) and the EBSCO Discovery Service for the Tavistock and Portman Library (searching CINAHL, PsycARTICLES, SocINDEX, PsycINFO, MEDLINE, and PEParchive). A flow diagram detailing the literature search process is produced in figure 1 (Appendix B).

Determining inclusion and exclusion criteria was a complex process due to the huge amount of variation in what is published regarding Birth Relatives (discussed previously). The final inclusion/exclusion criteria are detailed in table 7 (Appendix B). The decision was made to include articles describing or evaluating group interventions and other forms of support for birth relatives. However, where the focus of intervention was reunification or improved parenting skills (e.g. Salveron *et al.*, 2009) and/or the intervention involved working with birth relatives and their children together, the decision was taken to exclude these studies as it was felt that these types of interventions were too different to the phenomena under investigation here.

The literature search also identified a number of papers describing or evaluating 'Intermediary' services for birth relatives. Although intermediary services as described in the literature often included an element of counselling or group work (e.g. Clapton, 2006; Feast & Smith, 1995; Harris & Whyte, 1999) it was decided to exclude these papers from this review as the focus of the support is on establishing contact and/or reunification with lost relatives and not on the feelings and emotions directly or indirectly involved related to the removal of children.

Overview of Papers

After extensive searching and researching in multiple databases, 13 unique articles were selected to be included in the systematic review. Of these, 6 were from the UK (Cox *et al.*, 2017; Harris, 2004, 2005; Jackson, 2000; Lewis-Brooke 2017; Scourfield, 1991); 4 from the USA (Claridge, 2014; Frame, Conley & Berrisk, 2006; Hess & Williams, 1982; Koch, 1987); 2 from Australia (Battle, Bendit, & Gray, 2014; Robinson, 2002) and 1 from Norway (Slettebø, 2013). Only 5 of the 13 included some form of evaluation of birth relative support services (Cox *et al.*, 2017; Frame *et al.*, 2006; Harris, 2004, 2005, Slettebø, 2013), the remaining papers being detailed descriptions of clinical practice with Birth Relatives as a client group. The papers that attempted evaluations of support services utilised either a mixed-methods (Cox *et al.*, 2017) or grounded theory (Frame *et al.*, 2006; Harris, 2004, 2005) research methodology. Two papers described action research methodologies, one as a service development tool (Lewis-Brooke *et al.*, 2017) and one a service evaluation (Slettebø, 2013). The selected papers represent published literature over a period of 35 years (1982 – 2017).

The identified literature covered a variety of models of support. Most (n=7) described or evaluated some form of group intervention (Battle *et al.*, 2014; Frame *et al.*, 2006; Hess & Williams, 1982; Jackson, 2000; Robinson, 2002; Scourfield, 1991; Slettebø, 2013). One article detailed a couple therapy approach (Claridge, 2014) and there was one single case study of therapeutic work with a birth mother described as 're-parenting' (Koch, 1987). The two articles from Harris (2004, 2005) attempted to evaluate a post-adoption support service which included specific services for birth relatives (among other services for adoptive parents and adopted children). These two

articles utilised the same research data but focused on different findings. The second paper took a closer look at the data gathered from Black and Minority Ethnic birth relative service users (n=5) (Harris, 2005). Cox *et al.*, (2017) evaluated two services working to reduce recurrent care proceedings with no fixed intervention model.

Quality of papers

The 13 papers included in the systematic review varied in quality tremendously. Quality evaluation was conducted using research quality tools for qualitative and mixed methods Elliot, Fisher and Rennie (1999) (see tables 8 and 9 in Appendix C) and Long (2005).

Very few of the papers identify an explicit scientific context or purpose (Cox *et al.*, 2017; Harris, 2004; 2005; Lewis-Brooke *et al.*, 2017; Slettebø, 2013). Only one paper references ethical approval being sought and granted (Slettebø, 2013).

Five of the papers come from the peer-reviewed journal Adoption and Fostering (Sage Publishing). Whilst these papers are peer reviewed and can be viewed as important contributions to practice development, they do not meet quality criteria as robust evidence of best practice.

Six of the 13 papers describe their data analysis methodology (Battle *et al.*, 2014; Cox *et al.*, 2017; Harris, 2004; 2005; Lewis-Brooke *et al.*, 2017; Slettebø, 2013), but vary in terms of how adequate the description is and the amount of evidence provided to

support the analysis (see table 9 in Appendix C). None of the papers made explicit the researcher's position, assumptions or possible biases.

Participants

The five papers which include an element of evaluation and involved collecting data from birth relatives represent a total participant population of 159. That is across the UK, Norway and the USA. Even adding the number of birth relatives mentioned in the remaining studies, where no experiences, views or data were collected, the 'participant' number is only raised by a handful. An accurate figure is impossible to deduce as it is not always clear how many birth relatives were involved in the interventions. For example, some studies refer to birth 'families' or 'parents' without indicating more specific numbers (Battle *et al.*, 2014; Hess & Williams, 1982) and some do not refer to numbers of service users or participants at all (Claridge, 2014; Robinson, 2002).

Generally, the ethnicity of participants is not reported on with a few notable exceptions. Harris (2005) takes a closer look at the experience of post-adoption support of a small group of black birth relatives who were part of a larger evaluation study (Harris, 2004); and although Hess and Williams (1982) make no attempt to discuss the implications, it is noted that all the individuals participating in their court mandated group program were black. Jackson (2000) notes that all the mothers who attended her support group in the UK were white. The omission of participant and demographic data means that it is not possible to fully situate or contextualise these findings.

Synthesis of findings

The variation in focus, methodology and outcome of all the papers, coupled with their limited or varying quality, makes it incredibly difficult to draw any conclusions across the literature. However, the papers do represent some interesting findings and innovations in support service for birth relatives. And it is possible to identify some similarities and differences in approach, theoretical understandings and themes of the work with this client group.

The Importance of Context

As described before, the historical, political, social and cultural context of working with birth relatives is hugely influential to the research carried out and the interventions or support that is offered. The papers for review span the UK (England), Norway, Australia and the USA. Some papers acknowledge the influence of these contexts on the work (Battle *et al.*, 2014; Cox *et al.*, 2017; Frame *et al.*, 2006; Harris, 2004; 2005; Hess & Williams, 1982; Jackson, 2000; Lewis-Brooke *et al.*, 2017; Robinson, 2002; Slettebø, 2013) and some do not (Claridge, 2014; Koch, 1987; Scourfield *et al.*, 1991).

Harris (2004) describes the policy context in the UK and a 'government drive to modernise' adoption practices. Cox *et al.* (2017) and Lewis-Brooke *et al.* (2017) comment on the upward trend in care applications in England. Cox *et al.* (2017) note that for some this is viewed as evidence of the child protection system prioritising the child's needs over that of the birth parents, and for others it shows that the system is dominated by risk assessment and ignores signs of safety within a family. Lewis Brooke *et al.* (2017) also reference the parents' needs as secondary and suggest that the focus is

on 'poor parenting' rather than issues such as poverty, which is often influential. Battle *et al.* (2014) describe child protection and assessment of risk as the main policy focus in Australia; however, family reunification is the primary goal and so the support services for birth relatives are offered with this in mind. This is not the case elsewhere in the world. In the USA, Claridge (2014) reports that "adoption is increasingly socially acceptable" (p.112) and is viewed as a preferred alternative to parenting for birth parents.

Claridge (2014) supports Baden and O'Leary Wiley's (2007) 'relinquishment continuum', and states that although her couple treatment approach is focused on birth parents who have voluntarily relinquished their child for adoption, many of the strategies may also apply to work with birth parents whose children have been removed by court order. Cox *et al.* (2017) draw attention to the fact that most research with birth relatives, up to now, has focussed on the experience of relinquishment rather than removal. Jackson (2000) found that the needs of birth mothers whose children had been compulsorily removed were experienced as 'very different' to those of mothers who had relinquished.

Clear differences can be seen in the work being described in the UK and USA contexts. The relevance of the 'relinquishment continuum' is evidenced as child removal practices tend to be at either end of this spectrum in each of these settings.

Rationale for support work with birth relatives

Multiple papers, across international contexts, cite the fact that birth relatives often continue to have contact with their children after they have been removed, and can find this painful, as the rationale for offering support to this client group (Battle *et al.*, 2014, Australia; Claridge, 2014, USA; Slettebø, 2013, Norway). Battle *et al.* (2014) also note that birth relatives invariably continue to have parenting relationships if not with their own children, with step-children and children in their extended family. Given the complexity and scale of birth parents emotional needs, and the implications for any children they may care for, Battle *et al.* (2014) conclude that service provision for birth parents is critical.

Cox *et al.* (2017) use the data available concerning recurrent care proceedings in England as evidence that support work with birth mothers is warranted. Lewis-Brooke *et al.* (2017) also cite this important research. Frame *et al.* (2006) cite birth parents' 'deep emotional and practical needs' (p.517). Harris (2004) and Claridge (2014) point to the fact that adoption has life-long implications to justify providing support services to birth relatives. For Scourfield *et al.* (1991) it was anecdotal evidence of a mother finding a similar service helpful in London, that prompted them to set up a birth mother support group in Yorkshire.

Hess and Williams (1982) acknowledge the 'in-between parent' role birth parents experience when their children are removed from their care into foster care and assert that support is required if this new role is to be adopted successfully. Slettebø (2013)

point to the raft of research that shows that services offered to parents are unsatisfactory and that birth parents needs may not be met.

The literature therefore cites continuing relationships and parental roles with children, both their own and other peoples; the prevalence of recurrent care proceedings and the lifelong impact of child removal as reasons to intervene with this client group. It also points to the fact that existing services are unsatisfactory and adds clear rationale for more research into this area.

Impact: Trauma, Loss, Grief, Shame and Stigma

All the papers for review make some reference to trauma, loss, grief, shame and stigma as central experiences of birth relatives. Sadness was mentioned by a number of papers. For example, Battle *et al.* (2014) report on 'client grief' as one theme that emerged from their 'group dialogue'. Also, a mother writing about her experience of the group provided by Scourfield *et al.* (1991) comments on the 'depth of sadness' shared by the members of the group.

Many papers discuss the grief experienced by birth relatives as 'complicated grief' (Battle *et al.*, 2014; Robinson, 2002), make reference to Kubler-Ross' (2003) stages of grief model (Battle *et al.*, 2014; Frame *et al.*, 2006; Lewis-Brooke *et al.*, 2017), or use Doka's (1989) 'disenfranchised grief' model (Robinson, 2002). Claridge (2014) notes that holidays and birthdays might be particularly difficult times for birth mothers, as does Jackson (2000). She also points to research that shows that mothers who felt

coerced to relinquish their child demonstrate higher levels of unresolved grief (Claridge, 2014). In line with this, one of the main themes identified by Jackson (2000) was a yearning to be remembered and frequent thoughts about the children. Robinson (2002) views the grief experienced by birth relatives as a 'healthy response' to the adoption.

Battle *et al.* (2014) describe the importance of differentiating shame from guilt with this client group. Guilt was another of the shared experiences commented on by the mothers writing in Scourfield *et al.* (1991). Shame is also discussed by Harris (2005) particularly regarding the experience of black birth relatives working with white professionals, when white professionals were involved in deciding that their children should be adopted. Harris (2004) finds that therapy services had a positive effect on reducing shame and stigma amongst service users.

The impact of social stigma is a theme present across the papers for review (Battle *et al.*, 2014; Claridge, 2014; Frame *et al.*, 2006; Harris, 2004, 2005; Jackson, 2000; Robinson, 2002; Slettebø, 2013). Hess and Williams (1982) and Scourfield *et al.* (1991) do not reference stigma explicitly but report that their service users discussed feeling uncomfortable talking with family and friends about the trauma of having a child removed.

Taken together the literature highlights many factors that might impact birth relatives following the removal of their children to the care system. There appears to be consensus across the papers reviewed that child removal is life changing and the effects

can be life-long. This suggests multiple reasons for seeking and possibly benefiting from support services.

A Client-led/Collaborative Approach

Slettebø (2013) highlights the social trend towards more accountability in public services and sees it as part of a shift away from viewing people as passive beneficiaries of services to “emphasise the capacity of service users to be creative and reflexive and active agents in shaping their lives” (p.580). The client-centred nature of working with birth relatives is made explicit across some papers across international contexts (Claridge, 2014; Cox *et al.*, 2017; Lewis-Brooke *et al.*, 2017), but is notable by its absence in others (Frame *et al.*, 2006; Hess & Williams, 1982).

Viewing birth relative clients as the ‘experts’ of their situations is key in many of the papers for review (Claridge, 2014; Harris, 2004; Lewis-Brooke *et al.*, 2017; Slettebø, 2013). Empowerment of this user group was also central in multiple papers (Claridge, 2014; Cox *et al.*, 2017; Frame *et al.*, 2006; Harris, 2004; Jackson, 2000; Lewis-Brooke *et al.*, 2017; Robinson, 2002; Slettebø, 2013). Cox *et al.* (2017) go as far as to say that the personal empowerment of both clients and practitioners has a vital part to play in shaping sustainable strengths-based interventions with this client group. Jackson (2000) recruited a birth mother volunteer to co-facilitate a group intervention, valuing the personal experiences and awareness of issues that such a volunteer could bring. Women’s voices were central to informing the design of the practice intervention described by Lewis-Brooke *et al.* (2017) and it could be argued that the support group

described in Scourfield *et al.* (1991) would not have happened were it not for the birth mothers themselves who 'encouraged' it.

Collaboration was also key in many studies. In devising their program of support for birth parents Battle *et al.* (2014) describe a collaborative process where they incorporate feedback from parents as they refined the program. Claridge (2014) describes the role of the therapist in her model of couple therapy as one of 'collaborator' (p.126). In Cox *et al.*'s (2017) evaluation of birth relative support services 'collaborative working and collective ownership of goals' were key (p.5).

The finding that working with this client group is mutually beneficial is evident across some of the literature. Frame *et al.* (2006) acknowledge that as much benefit is derived from interventions initiated by peer group members as by group facilitators. Slettebø (2013) reports that social workers discovered not previously apparent resources in the parents they worked with. Lewis-Brooke *et al.* (2017) viewed the birth mothers to be as likely to help each other as they were to be helped by the practitioners working with them.

Collaboration and empowerment appear to be culturally and contextually situated and is far more prevalent in the UK and Europe than elsewhere currently. It would seem from the literature that ideas exist amongst practitioners that birth relatives as a client group may particularly benefit from this type of approach to intervention.

The Therapeutic Relationship

The centrality of the relationship between clients and practitioners was one of the strongest themes running across the papers for review. Particularly the qualitative interview data reported by Cox *et al.* (2017) strongly highlighted this aspect. The service users surveyed by Harris (2004) also highly valued the quality of their relationship with staff. Koch (1987) uses Loewald's theory that the parent-child relationship can serve as a model for the therapeutic relationship, to understand her work with parents of children in foster care (Loewald, 1980 cited in Koch, 1987).

Difficulty engaging birth relatives in support services is a common experience across the papers (Battle *et al.*, 2014; Harris, 2005; Hess & Williams, 1982; Jackson, 2000; Koch, 1987). Harris (2005) identifies a number of possible barriers to black people taking up post-adoption services, which include lack of knowledge about what support is available, racist attitudes of staff, the social stigma of losing children to adoption, and the support services themselves being inappropriate for this client group. However, Lewis-Brooke *et al.* (2017) discuss how birth relatives do take up services when offered the 'right services by the right agencies' and report that they did not find the women they worked with hard to engage.

Trust is identified across the papers for review as something that practitioners are required to work hard to build with birth relatives as a client group (Battle *et al.*, 2014; Cox *et al.*, 2017; Harris, 2005; Lewis-Brooke, 2017). The papers vary on how they describe building or gaining this trust from service users; some report group facilitators/therapists taking a neutral stance (Battle *et al.*, 2014;) and the importance of

being seen to be separate, or 'at arm's length' from child protection or statutory children's services (Battle *et al.*, 2014; Jackson, 2000). Other papers highlight the central importance of being reliable and consistent (Cox *et al.*, 2014; Koch, 1987). Harris (2005) draws our attention to research evidence that it may be harder for (white) professionals to develop trusting relationships with black birth relatives (Charlton *et al.*, 1998 cited in Harris, 2005).

Battle *et al.* (2014) report anecdotally that the parents attending their group benefitted from improved relationships outside of the 'community of support' that the group offered them and reported that their relationships with child protection services, their children and other family members were enhanced. This finding is echoed in the findings of Frame *et al.* (2006) that parents had made changes in choices of 'romantic relationships'. Cox *et al.* (2017) tentatively conclude that the services they evaluated had been able to "*foster relationships that 'worked'*" (p. 15, original emphasis).

Battle *et al.* (2014) acknowledge that whilst working with birth relatives can be very rewarding, it is not without its challenges. They name trying to balance the needs of birth parents with those of their children as a particular area of difficulty (p.336). In this regard they advocate the importance of professional self-care and quality supervision in supporting those undertaking this work. They highlight their work as facilitators in exploring and monitoring their own prejudices and judgements about this client group and advocate reflective practice for practitioners (Battle *et al.*, 2014).

The existing literature therefore seems to place the therapeutic relationship as central to any intervention with birth relatives. Links are made across the papers reviewed between building good working relationships between practitioners and service users and improved relationships elsewhere in the birth relatives' lives.

Theoretical influences

The reviewed papers draw on a number of theoretical influences and some similarities and differences can be identified. Battle *et al.* (2014) describe the importance of using a trauma-informed practice approach. This stems from their experience of parents attending their support group reporting not only the trauma they experience at having their children removed from their care, but also other, multiple, traumas they have experienced as children and adults themselves. They frame this as 'complex trauma' as described by Shapiro (2010, cited in Battle *et al.*, 2014) and use the three stages model (stabilisation and safety; processing trauma memories; and integration with family and normal life) for working with complex trauma to inform the content of the support group. Jackson (2000) and Robinson (2002) also understand certain reactions of birth mothers in terms of a trauma response.

Systemic (Cecchin, 1987) and psychodynamic (Fraiberg *et al.*, 1980) theories are present in the literature as an influence, particularly informing group work with birth relatives (Battle *et al.*, 2014) but also a model of couple therapy (Claridge, 2014) and Koch's (1987) work with one birth mother. Attachment theory (Bowlby, 1958) is fundamental in the model described by Claridge (2014); is reference and 'measured' by Cox *et al.* (2017); and features in the work described by Battle *et al.* (2014) and Koch (1987). Also

drawing on attachment theory, Lewis-Brooke *et al.* (2017) use the idea of a 'secure-base' as the starting point for their intervention model. Claridge (2014) is also heavily influenced by the emotionally focused therapy model (EFT; Johnson, 2004 cited in Claridge, 2014).

Literature on group processes (Yalom, 1995) can also be seen to have influenced this work (Battle *et al.*, 2014) particularly the importance of a "non-judgemental environment, client participation, leader's stance of acceptance, and relevant content" (Battle *et al.*, 2014, p.331). Other principles of group work are also highlighted, for example, Harris (2004) report that engaging in groupwork with other birth relatives and "knowing that there are other people in a similar situation" (p.57) had the effect of reducing shame and stigma among group members. Frame *et al.* (2006) also found the peer support element of group work to be effective in helping birth parents make positive changes in their lives. For Slettebø (2013) peer support was 'most important' to their service users.

The development of 'alternative stories' in a narrative sense is a feature of the groupwork described by Battle *et al.* (2014). They also report using other Narrative therapy ideas, namely outsider witnessing (White, 1995 cited in Battle *et al.*, 2014) and a 'community building narrative exercise' (Denborough, 2008 cited in Battle *et al.*, 2014). The post-adoption counselling model proposed by Robinson (2002) is also based on a narrative approach.

A stages model of grief counselling is described by Robinson (2002) with the final stage being 'preparation for reunion'. Similarly, Frame *et al.* (2006) reference Maslow's hierarchy of needs (1943). However, the use of a 'stages of change' model with birth relatives as a client is critiqued by Frame *et al.* (2006) because of what they see as the variety and complexity of issues they face.

Interventions across the papers are described as 'strengths-based' (Cox *et al.*, 2017; Frame *et al.*, 2006), 'dialogue-based' (Slettebø, 2013) or values-led (Battle *et al.*, 2014; Jackson, 2000; Robinson, 2002). Although not always referenced as such, three of the papers describe work with birth relatives that could be described as 'assertive outreach' (Cox *et al.*, 2017; Koch, 1987; Lewis-Brooke *et al.*, 2017).

It should also be noted that Scourfield *et al.* (1991) make no reference to theoretical influences at all. This is perhaps due to the nature of the paper using the words of the birth mothers themselves to describe their experiences.

Across the papers the theoretical influences are incredibly wide ranging. It could be argued that this amounts to a lack of consensus on, or evidence for, any therapeutic approach considered most suitable and/or effective with this client group. More evidence for what works, and why, is called for.

Summary/Conclusion

In summary, comparing and synthesising the findings of the papers selected in the review has presented a significant challenge. The papers are extremely diverse in terms of quality, the phenomena under investigation and the methods used. A high proportion of the papers reviewed are purely descriptive and offer no form of 'investigation' at all.

Similarities and differences in approach, theoretical understandings and themes of the work with this client group have been identified. These include the importance of context; a shared rationale for working with this client group; the prevalence of trauma, loss, grief, shame and stigma; the valuing of client-led and/or collaborative approaches; the importance of the therapeutic relationship; and wide-ranging theoretical influences.

All the papers describe some form of support work with birth relatives. However, as is evident across the literature, birth relatives do not represent a homogenous group and can vary according to where they identify on the 'relinquishment continuum' or what stage of the 'adoption' process they may be in (pre-removal, early post-removal, long-term post removal). The evaluations of these support services are either anecdotal or represent very small participant numbers, often both.

The interventions identified include: peer support, individual or couple counselling, educational, supportive or empowering group practices or assertive outreach. There is a small amount of evidence that some of these interventions may be effective. However, no systematic evaluations have been published and the sample sizes are so small no

conclusions about what therapeutic support birth relatives find helpful can be drawn with any certainty. Coupled with this, and as evident throughout history, the voices of birth relatives have not been heard in relation to their experiences of therapeutic interventions designed to meet their needs.

Rationale for present study

Over a period of 35 years, across the UK, Europe and North America, data concerning only 159 birth relatives have appeared in academic, peer reviewed research. The voices of birth relatives accessing support have simply not been heard and no evidence for what is likely to be helpful to this group of service users has been presented. Not only is there a need to raise the voices of birth relatives in the published research literature but also to hear directly from them about what the experience as helpful, or not, when they engage with services following the loss of their children to the care system.

In order to address this “conspiracy of silence” (Winker *et al.*, 1988, p.48 cited in Claridge, 2014) the present study seeks to explore the following research questions:

1st Tier Research Question:

- What are the experiences of birth relatives who engage in person-centred counselling following the loss of a child or children to compulsory adoption or foster care?

Second tier questions:

- How do they describe their experiences of what is helpful or hindering about counselling?

- How do they experience themselves as changing or staying the same over the course of counselling and how do they make sense of these developments?
- What difficulties do they experience in the counselling process?

Chapter 3: Methodology

Overview

This study was concerned with exploring the meaning birth relatives gave their experiences of counselling following the removal of their children from their care. This chapter will consider the exploratory nature of the research question and discuss how this lent itself to a qualitative approach and the design, data collection and analysis using interpretative phenomenological analysis (IPA). The involvement of a service user as expert supervisor will be referred to throughout and ethical considerations explored. Details of the sample, data collection and analysis will be given as well as an attempt to assess the quality of this research.

Choosing A Qualitative Approach

As discovered by reviewing the existing literature regarding birth relatives' experiences of counselling, the voices of birth relatives have not been heard. To address this absence, a qualitative research approach that privileged the subjective experiences of these individuals was sought. It was also important to choose a research method that could empower the research participants, treat them with respect and listen to their stories (Faulkner, 2012).

The voices of service users, gathered by qualitative means, have been identified by Cox *et al.* (2017) as advancing up the 'hierarchies of evidence' (Featherstone *et al.*, 2014, p15 cited in Cox *et al.*, 2017) used by commissioners to establish what services should be funded. Broadhurst and Mason (2014) also endorse using birth mothers' own self-report data when investigating the factors or processes involved in helping birth mothers involved in recurrent care proceedings change.

The research question is concerned with experiences of psychotherapeutic counselling. There is relatively little known about how change occurs in psychotherapy or other mental health interventions despite a substantial amount of psychological theory about what brings about change in general (Elliot, 2011). Elliot (2011) argues that this makes qualitative, discovery-orientated methods especially appropriate when investigating such phenomena.

As stated in the introduction, this study is influenced by social constructionism. However, the nature of the research question lends itself to a more phenomenological approach. Thus, the study now seeks to answer the research question taking a pluralistic approach and adopting a phenomenologist stance (Willig, 2013). The study aims to get as close as possible to birth relatives' lived experiences of counselling and to explore the detail and meaning-making within these experiences. It seeks to go beyond descriptive phenomenology and place participants accounts in their broader social, cultural and theoretical contexts (Harper, 2012). Interpretative Phenomenological Analysis (IPA, Smith, Flowers and Larkin, 2009) was therefore chosen as the most appropriate methodology.

Idiography and hermeneutic phenomenology are key concepts in IPA (Larkin & Thompson, 2012). In an idiographic analysis the focus is going deep into the particular which requires a thorough and systematic approach. Phenomenology is the philosophical study of 'being', that is of existence and experience (Larkin & Thompson, 2012). IPA acknowledges that particular experiences happen in context, and in relation to others. In this way researchers cannot access experience directly, but through a

process of intersubjective meaning-making. In this sense IPA involves a 'double hermeneutic' (Smith & Osborn, 2004), the researcher making sense of the participant, who is making sense of a phenomenon. It is therefore important that researchers are able to reflect upon their own experiences and assumptions. IPA is thus a hermeneutic phenomenology and acknowledges the role of the researcher in making sense of a phenomenon (Smith *et al.*, 2009).

IPA has been criticised (e.g. Pringle *et al.*, 2011) for including manualised steps, which can be seen as a benefit, but might also be restrictive. It has been accused of not acknowledging the role of the researcher in the interpretation, which Smith *et al.* (2009) have addressed by bringing forth the double hermeneutic more and acknowledging the co-construction of meaning. This can be further addressed by adopting a social constructionist approach to the research with is the aim of this study. In adopting this stance, I also seek to address a further critique of IPA regarding its focus on internal lived experiences which may obscure the wider context.

Service User Involvement

As well as listening to and communicating the actual words of the research participants, it was felt that the research needed to go further to achieve a shift in the balance of power with this often disadvantaged and stigmatised group. As the Research Governance Framework for Health and Social Care (Department of Health, 2009) states: '[r]elevant service users and carers or their representative groups should be involved wherever possible in the design, conduct, analysis and reporting of research' (2009, p. 8). Faulkner (2012) advocates engaging services users in the research process, analysing and interpreting the voices of their peers and ensuring the findings get back

to the communities from which they come. To this end an 'expert by experience' who had experienced counselling following the loss of her children to adoption (although not connected to the adoption agency providing the counselling in this study) was recruited to join the supervisory team. They were consulted at all stages of the study from design, through recruitment and analysis, to write-up.

This was a novel and challenging undertaking in the context of this doctoral research project. Great care and thought was put in to recruiting the right person acknowledging the potentially alienating language and systems of academic research. A service user was found who had already begun a journey from user of services, to peer supporter, to trainer of trainers and activist. On meeting with her for the first time it was felt that she had much more to offer than just 'consultation' and so the decision was made to include her in the supervisory team as another research supervisor. This also served to redistribute power more evenly amongst the research team.

As stated, including a service user in this way was not without its challenges. The systems in place for paying of expenses and access to university facilities (e.g. relevant computer programmes) were complex and perhaps only partially successfully navigated. At times communication between all parties slowed and it was difficult to manage the expectations of all involved. However, the impact of engaging in this process can be seen in the appreciative language used throughout the study. I also believe it adds credibility to the research findings. It may be that a shift in the balance of power was only partially achieved, the clinical research supervisors taking more responsibility for feedback in general. However, working in this way has proved very rewarding for all involved.

Design of the study

Change Process Research (CPR) was proposed by Greenberg (1989, cited in Elliot, 2012) to attempt to explain both how and why change occurs in psychotherapy. In line with Greenberg's (1986) and Elliot's (2011) understanding of CPR, a cross-sectional, qualitative research design was used. This consisted of in-depth, one-to-one interviews with birth relatives who have experienced person-centred psychotherapeutic counselling following the loss of their child or children to adoption or long-term foster care. The study sought to examine how people made sense of this experience and as such utilised an hermeneutic phenomenological approach and IPA design (Smith, *et al.*, 2009).

Research measures

Researcher-devised Demographic Questionnaire

A questionnaire encompassing basic demographic details; details of the number of children the birth relative has had taken into care/adopted; the amount of time that has elapsed since their first child was removed; and whether they currently have any children living at home with them, was created by the researcher (see appendix D[8]), in consultation with the supervisory team.

Semi-structured interview

A semi-structured interview schedule was created with the aim of facilitating comfortable interaction with the participants and eliciting detailed accounts of their experiences (Smith *et al.*, 2009). Questions from Elliot's 'Change Interview' (2008) were incorporated to obtain participants' understandings of what, if anything, had changed

since they had counselling and how those changes had come about, including factors that have interfered with change (Elliot, 2011). Feedback was sought from the supervisory team, including the research supervisor with lived-experience expertise. Allam *et al.* (2004, cited in Faulkner, 2012) found that involving service users and carers in the design of relevant questions in qualitative research ensured the questions were grounded in genuine experience and were therefore more meaningful. Following consultation with the supervisory team changes were made regarding the language used and some questions were simplified e.g. using the counsellor name instead of referring generically to the service (see appendix D[8]).

Recruitment of participants

The study was committed to “exploring, describing, interpreting and situating the means by which [the] participants make sense of their experiences” (Smith *et al.*, 2009, p.40) and therefore required rich and detailed personal accounts of the experience of counselling following the loss of a child/children to adoption.

A purposive sampling strategy was employed. Birth relatives who had engaged with the birth relative counselling service (BRCS) provided by one adoption agency were invited to participate in the study. The BRCS was one of the therapy services offered by a large adoption agency in South East England who also provide an adoption placement service; a developmental trauma and attachment therapy service; and a training and conference service. The counsellors employed by the BRCS have a variety of experience and training. They describe utilising both person-centred and psychotherapeutic therapy models.

The rationale for only using one such service to recruit from related to the findings of the literature review, that what is offered as 'birth relative counselling' can be very diverse. In order to create a homogenous group, as required by IPA (Smith *et al.*, 2009), a single counselling service was utilised for recruitment purposes. However, as challenges with recruitment, as evidenced in the review of the literature, were anticipated, another potential BRCS was identified as a further potential recruitment pathway if needed.

Potential participants who had attended at least 10 person-centred counselling sessions over the last 12 months were identified by four birth relative counsellors employed by the BRCS. Inclusion and exclusion criteria are detailed below in table 1. As stated, it was anticipated that recruitment/engagement might be a challenge (see below). Therefore, a number of steps were taken to support recruitment. Firstly, initial contact with participants was made by the counsellors themselves with whom potential participants have an existing relationship, so as to minimise threat and maximise chance of future engagement with the researcher. As a researcher I highly valued the experiences of anyone who had had counselling through the birth relatives counselling service and therefore I did not exclude anyone who met the criteria detailed in table 1. However, care was taken to consider how ethical it was to ask someone to participate who was currently experiencing difficulties that could be considered a 'crisis' or who was currently involved in care proceedings. It was anticipated that birth relatives in either of these situations would not choose to participate at this time. Furthermore, counsellors were involved in carefully selecting who to approach for participation. It is likely that the sample was therefore biased towards those who have had a positive experience of counselling and who were deemed able and willing to fully engage with the research

process. As this study was interested in the mechanisms of change and ‘what works’, this was considered appropriate. However, this also excluded those who were more vulnerable or who were less able to engage with or benefit from counselling. This will be returned to in reflections on limitations of the study.

The study aimed to gather detailed accounts of individual experiences and therefore focused on the accounts of a small number of individuals. It was anticipated that between 5 and 7 participants would be interviewed with a maximum of 8 accounts and a minimum of 4.

Inclusion criteria:	Exclusion criteria:
<ul style="list-style-type: none"> • Clients of the BRCS • At least 10 counselling sessions over 12 months • Counselling either completed or in the late stages 	<ul style="list-style-type: none"> • Anyone in early stages of counselling • Anyone deemed emotionally or psychologically too vulnerable to partake in a research interview at this time • Anyone currently experiencing care proceedings • Anyone deemed unable to fully understand the research procedures or provide informed consent

Table 1: Participant Inclusion/Exclusion criteria

Challenges of recruitment

As seen in the review of the literature, birth relatives are well documented to be a highly scrutinised, ‘hard to reach’ group and difficulties in recruitment are common due to life circumstances (e.g. Cox *et al.*, 2017). As had been anticipated, recruitment to the current study presented some challenges. Each of the four counsellors contacted up to three birth relatives they had met with. Unless birth relatives agreed to be part of the research no identifying information was shared with the research team. Three counsellors were successful in recruiting clients to the study. A total of six names were

forwarded to the researcher to contact. Three interviews were arranged and conducted with little difficulty. The remaining three proved more challenging to arrange, both in terms of making initial contact and finalising arrangements. These three interviews were rearranged multiple times and, in the end, only two could go ahead in the time frame of the study.

Interestingly, the one participant who had been keen to contribute, however for whom finding a suitable time and venue proved impossible, was the only birth relative that was not a birth mother. Two interview times were set up with this birth grandfather; unfortunately each time they were cancelled at the last minute due to other commitments. This meant that, while the intention was to recruit birth relatives, the study was now a study of birth mothers only (this will be returned to in the discussion chapter).

The Sample

Descriptions of IPA methodology vary in terms of recommended sample sizes. A total of five birth mothers were successfully recruited to participate in the study. Smith *et al.* (2009) suggest between three and six participants is 'reasonable'. Due to the challenges of recruitment, the small pool of participants recruited from and the richness of the data obtained, as well as the time scale and scope of this study, it was agreed in discussion with the relevant BRCS and the supervisory team, to conclude recruitment after the fifth interview.

Details of the birth mothers who participated and their children are provided in table 2. To protect the anonymity of participants the information provided is limited. However,

the range of placements and contact arrangements are included as these represent interesting findings in themselves. Demographic details are reported separately below, also for reasons of participant anonymity. All participants were asked to choose their own pseudonym, and these will be used throughout.

Name	No. of children (total)	No. of children removed	Children returned to their care?	Children currently living with them?	No. of children currently in care or adopted	Time since first child was removed	Type of placements	Contact arrangements
Rebecca	5	5	No	No	5	3 years	Foster care	Monthly face to face contact
							Adopted	Yearly letterbox contact
							Living with father	Via skype at father's discretion
Isobel	1	1	No	No	1	2 years	Adopted	Yearly letterbox contact
Saffron	3	3	Yes	Yes	2	5 years	Foster care	Monthly face to face contact
							Rtnd home	n/a
Lara	7	5	Yes	Yes	3	11 years	Foster care	1 child = twice weekly 1 child = monthly
							Adopted	Yearly letter box contact
							Rtnd home	n/a
							Not removed	n/a
Elisabeth	3	3	No	No	3	14 years	Foster care	Face to face contact once a year
							Adopted	None
							Care leaver	Regular contact via text, at least 2 trips a year to visit

Table 2: Participant details

All the participants were birth mothers. They were aged between 30 and 45. All were White British. None had received an education beyond GCSE level and some had mild to moderate learning difficulties. They were all currently single in terms of marital status; however, many were in committed long term relationships and some co-habited with their partners. One birth mother was currently in full-time employment, one was looking after young children full-time, two were out of work and looking for employment, and one was unable to work. The ages of their children ranged from 2 to 19 years.

All had received a substantial amount of support from the birth relatives counselling service. The service in question highly valued a person-centred approach and flexibility in format to take account of clients "fragility and chaotic lifestyles" (Pointon, 2008, p.14). A key part of the service model was that clients are able to continue in counselling for as long as they need and are seen to be using the service. The extent of the counselling experience of the sample, that is the number of sessions either by telephone or face to face that each had received, and over what time period is detailed in table 3.

Name	Total no. of Sessions	Face to Face	Telephone	Episode/Time Period
Rebecca	30	29	1	Episode 1 over 8 months
	15	14	1	Episode 2 over 3 months
	3	3	0	Episode 3 ongoing
	48	46	2	
Isobel	12	11	0	Episode 1 over 4 months
	18	18	0	Episode 2 over 6 months
	14	12	2	Episode 3 over 4 months
	30	29	1	Episode 4 ongoing
	74	71	3	
Saffron	58	48	10	Episode 1 over 1y 4m
Lara	5	5	0	Episode 1 over 4 months
	7	7	0	Episode 2 over 3 months
	15	5	10	Episode 3 ongoing
	27	17	10	
Elisabeth	18	18	0	Episode 1 over 1 year
	6	6	0	Episode 2 over 2 months
	3	3	0	Episode 3 over 3 months
	7	7	0	Episode 4 over 2 months
	34	34	0	

Table 3: Participant counselling experience

The average number of counselling sessions the birth mothers had received was 48.2, over an average period of 27 months. Three of the mothers were still receiving counselling at the time of their interviews and the remaining two requested to be put back on the waiting list when their counsellor made contact to ask about the research study. The counselling experience of the mothers in this study therefore equates to long term therapy, both in terms of the number of sessions and duration. It is of interest that most returned for more than one episode of counselling, these findings will be returned to in the discussion.

The participants received counselling from two counsellors, one male and one female, in order to protect their anonymity both will be referred to as s/he or him/her from now on.

Ethical Considerations

As well as the ethical principles concerning all research with human participants, namely: respect, scientific integrity, social responsibility and minimisation of harm⁴ (BPS, 2010), this project also took great care to consider specific ethical issues pertinent to a potentially vulnerable population who were asked to talk about a sensitive topic. Care was taken regarding information storage, informed consent, participants' right to withdraw, confidentiality and participant well-being. However, I also found it helpful to remain mindful of Thompson and Chambers (2011) notion that viewing participants as 'vulnerable' and the topic under investigation as 'sensitive' risks disempowering service users through placing too great an emphasis on a perceived need for protection.

Informed consent was particularly important in this regard⁵, and I worked hard to facilitate participant choice as to whether to take part in the research and to continue if the topics discussed became distressing. Consent was not viewed as something that was gained or granted once, but as an ongoing process. Opportunities were provided for participants to reaffirm (or not) their consent as the in-depth interviews progressed (Thompson & Chambers, 2011).

I also ensured that participants had space at the end of the interview to debrief and ensure that any emotional distress experienced during the interview had reduced, and that participants were aware of where they could access additional emotional support if

⁴ Extensive risk assessments were carried out prior to any collection of data (see Appendix D 2, 3, and 4).

⁵ The short and more detailed information leaflet for participants, along with the consent form are reproduced in Appendix D (5 and 7).

required. All participants were able to access further support from the birth relatives counselling service if requested.⁶

Full ethical approval was granted by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority on the 18th of January 2018⁷.

Data Collection

The Interviews

Semi-structured interviews were completed with each of the five birth mothers individually. Care was taken to ensure participants would feel as comfortable as possible in order to enable them to feel at ease sharing rich and detailed accounts of their experiences. Adapting research methodology to make it as accessible as possible is advocated by Nind (2009). At times interview questions were simplified, whilst taking care to preserve meaning and intension, or repeated to enable participants with intellectual disabilities to respond as fully as possible. Interestingly, all participants, including those with intellectual disabilities, appeared to be very able to respond the interview questions and in general had a lot to say about their experiences of counselling.

Where possible the interviews took place in the same location participants received counselling. The interviews began with a 'warming the context' question (Burnham, 2005) to further facilitate comfort and orientate participants to the research context.

⁶ The debrief leaflet given to all participants following their interview is reproduced in Appendix D(6).

⁷ Ethical approval application and notification are reproduced in Appendix D and E.

Interestingly, Willig (2013) notes that the role of the researcher within a phenomenological study context “resembles that of a person-centred counsellor who listens to the client’s account of their experience empathically, with an attitude of unconditional, positive regard and without questioning the external validity of what the client is saying” (p.16). I endeavoured to adopt such a stance in every interview.

All interviews were conducted face to face with only the researcher and participant present apart from one. When I met with Lara she requested that her 16-year-old daughter accompany her and be present during the interview. The implications of this were discussed with both Lara and her daughter and issues of confidentiality and the nature of the interview were made clear. Lara and her daughter decided to proceed together. The impact of Lara’s daughter’s presence was reflected on in my reflective diary, (an extract is provided in appendix F), discussed with my supervisory team and considered within the analysis.

Each interview lasted between 50 and 70 minutes. All interviews were digitally recorded and later transcribed. Personal reflections were kept through the use of a reflective diary to support future analysis.

Data analysis

All the interviews were transcribed by the researcher and the data analysed according to IPA as set out by Smith *et al.*, (2009). IPA analysis is a process involving the immersion of the researcher in the data through reading and re-reading the interview transcripts; making initial notes that remain close to the participants explicit meaning; making more interpretative notes that include descriptive, linguistic and conceptual

comments; developing emergent themes and searching for connections across these themes; identifying patterns between themes, or abstraction, to develop super-ordinate themes; then looking for patterns across the different accounts.

In embarking on this process, I was challenged initially to find the correct balance between describing/recounting the participant descriptions and interpreting the data. I found it difficult not to fall back on my formulation skills, and in doing so move too far from the participants' words. I was supported by my supervisory team who were experienced in IPA and a peer IPA support group to stay much closer to the data and build the interpretations step by step from there. It was also important to be disciplined and remain close to the research question, constructing meaning from participant accounts within the context of their experiences of counselling, using that as a lens for all interpretation. It was as Smith *et al.* (2009) attest, a dynamic and non-linear process.

My reflective diary was also used to record my initial thoughts, feelings and reflections but also to remain aware of my own processes, perspectives and the effect the data had on me. I endeavoured to maintain my curiosity whilst making thorough notes on each transcript. In identifying and labelling emergent themes care was taken to remain as close as possible to the participant accounts whilst acknowledging the part I played as researcher in constructing meaning from the data. The original text was returned to often, to ensure the themes that were constructed were well-founded. An attempt was made to remain balanced in terms of grounding themes in the data and levels of interpretation or conceptualisation, I was again assisted by the supervisory team and fellow IPA researchers in this regard.

Allam *et al.* (2004, cited in Faulkner, 2012) provide strong justification for involving service users at the analysis stage of research, suggesting that the validation of findings are improved by working together and finding a joint meaning of the data. The researcher utilised the supervisory team, including the expert research supervisor with lived-experience, for the purposes of validity checking the codes and themes that emerged.

Summary tables of emergent themes, and superordinate themes were produced for each transcript to facilitate the cross-participant phase of analysis⁸. After consulting with the supervisory team, a set of master themes and subthemes that brought together and was felt to best reflect all the interviews was developed. These master themes provide a framework through which to understand the experiences of birth mothers who have experienced person-centred counselling from one birth relative counselling service. They will form the basis for the results section which follows.

Quality in Qualitative Research

Yardley (2000) presents some guidelines for assessing the quality of qualitative psychological research using four broad principles: sensitivity to context; commitment and rigour; transparency and coherence; impact and importance. Smith *et al.* (2009) advocate applying these principles in the case of an IPA study, therefore the strength and methodological rigour of the current study will be explored in line with these principles.

⁸ See appendix G for example transcript with analysis and audit trail of themes for the interview with Elisabeth.

Sensitivity to context

It was the acknowledgment of the influence of social, political and historical contexts, as well as my own previous experience that led me to pursue a qualitative methodology in the first place. The research question was grounded in the absence of birth relative voices in the existing literature and attention has been paid to the context of previous research in this field as well as the UK context the current study is situated in. IPA accepts that socio-cultural, political and historical influences play a significant role in personal sense-making (Smith *et al.*, 2009). Semi-structured interviews allowed for this alongside the influences of demographic and personal characteristics on participants' perspectives to be shared. Adopting the 'person-centred' stance as outlined by Willig (2013) and mentioned above also enabled participants to feel at ease and I believe led to the collection of high quality, sensitive interview data. This data was analysed and interpreted with care taken to remain grounded in verbatim extracts from transcripts.

Commitment and Rigour

As Smith *et al.* (2009) point out there is overlap in how IPA address criteria, and the 'person-centred' stance can again be seen as evidence of the significant commitment I showed to each participant. The sample of birth relatives itself was selected with rigorous attention to the research question, ensuring that participants were a reasonably homogenous group, each with substantial experience of counselling to draw upon. The analysis was conducted thoroughly and systematically staying close to the process as described by Smith *et al.* (2009). The results section that follows will demonstrate further the attention to each participant's data through the use of direct quotes from each transcript.

Transparency and Coherence

Transparency has been demonstrated through the description of the research process and inclusion of data analysis and audit trail in Appendix G. Furthermore, reflections on the researcher stance context and extracts from the research reflective diary are included to add to transparency in relations to researcher impact on the research.

Coherence is a principle aim of this write-up. A number of constructions of the findings were considered before the final version was selected, as it was seen as coherently and comprehensively accounting for the dataset.

Impact and Importance

This will be considered further in the discussion chapter of this study which highlights the importance of the insights gained from this research with birth mothers whose voices have up until now been marginalised. It is hoped that the findings of this research will be disseminated widely. The birth relative counselling service have requested that the findings are written up for a chapter of a forthcoming book they intend to publish for social workers working with birth relatives.

Summary

A qualitative research methodology was chosen acknowledging the influences of social constructionism and change process research in psychotherapy (Greenberg & Pinsof 1986). A service user was recruited to join the supervisory team and was consulted at all stages of the research process. Five birth mothers were interviewed regarding their experiences of counselling following the loss of their children to adoption or foster care. These interviews were systematically analysed using an IPA methodology through the lens of the research question: *What are the experiences of birth relatives who engage in*

psychotherapeutic counselling following the loss of a child or children to compulsory adoption or foster care?

Three master themes were constructed from the data which will be presented in the results chapter below.

Chapter 4: Results

Overview

This chapter presents the findings from my interpretative analysis of interviews with five birth mothers who had experienced counselling following the removal of their children by social services. For the remainder of this chapter I will refer to them collectively as ‘mothers’ as there is no need to distinguish them in this context.

Three master themes were constructed from the systematic analysis and interpretation of the interviews. These master themes and corresponding subordinate themes are presented in table 4 below. They will be described in detail and illustrated using verbatim extracts from the mothers’ transcripts. These results should be considered one possible account of how birth relatives experience counselling. The themes presented here attempt to highlight commonalities across the five accounts, acknowledging similarities and differences between the individual participants. They do not cover every issue raised but have been selected due to their relevance to the research question. A separate table is provided in Appendix H indicating the pervasiveness of themes across the five participants.

Master Theme	Subordinate Themes
From feeling alone, judged and let down to feeling part of a special relationship	Feeling alone, overwhelmed and stigmatised
	Finding a way to counselling
	Learning to trust my counsellor
	Experiencing my counsellor as someone special
“The Healing Process”	Feeling understood
	Acknowledging influence of trauma and/or abuse
	Facing up to what happened to my children
	Experiencing a ‘release’
	Noticing changes
“My children are my world”	Maintaining painful connection(s) to children
	Feeling like a mum vs not feeling like a mum at all

Table 4: Master and subordinate themes

From feeling alone, judged and let down to feeling part of a special relationship

This master theme attempts to describe how the birth mothers I interviewed came to feel a powerful sense of commitment and affection towards their counsellors. This is in the context of many other difficult relationships with professionals and generally, as well as overwhelming experiences of judgement, powerlessness and mistrust in their lives before counselling. Four subordinate themes are discussed, namely *feeling alone, overwhelmed and stigmatised; finding a way to counselling, learning to trust my counsellor; and experiencing my counsellor as someone special.*

Feeling alone, overwhelmed and stigmatised

Being thrown in a situation you don't understand,
it's all set out but there is no plan.

From ‘Storms and Effects’ by Clarissa Stevens⁹

⁹ Extracts from Storms and Effects are included where they relate directly to the theme or subtheme being described. Whilst these quotes do not come from the study’s data they are used to ‘warm the context’ (Burnham, 2005). They are clearly marked to ensure they remain separate from the research data.

Most of the birth mothers I spoke to described a sense of being on their own with no support and feeling that the world was against them.

Rebecca: I just like, you know what, I've been- I'm looking after these kids you know, I've been doing everything that I possibly can for them and you've just thrown every single thing in my face for me not to have them, so I was just like, well, what do I do, you know, what am I supposed to do? But I haven't really had any, help or anything since then...

There was also a sense of these mothers finding themselves in a confusing and overwhelming system, and not knowing where to turn.

Saffron: Cos you just go through it and you just don't have a clue what's going on, and it's so confusing and then you've got all your emotions on top of it, and it's just like, I don't know, it's just, pretty horrific...

Rebecca: they had all, they had all these, their rules, their rules what I should and shouldn't be doing, so obviously I was following them, but then they start bringing in about childhood trauma, so I was just like, hold on, are you like? Do you know what I mean? I just didn't know where I stood with them...

A sense of the stigma experienced by these birth mothers was also present in the transcripts both explicitly and implicitly. Some mothers mentioned feelings of shame and some expressed their feelings of relief at discovering that they were not the only people going through the same experience.

Saffron: I suppose a lot of us feel ashamed... it's just in society... it's not something you can really get rid of...

Rebecca: ...I think that's what helped me as well, knowing that I'm not the only one that's going through this, knowing that there's other people going through this as well, that helps.

Finding a way to counselling

The journey to starting counselling was easier for some of the mothers than others.

Most of the mothers described recognising a 'need' or 'want' for counselling by themselves.

Elisabeth: ...it wasn't hard. I wanted it. I wanted, I wanted to talk to counselling, cos they're the one who got me through this, they're the one who got me to move on.

In contrast, Rebecca described needing to be convinced by others to go to counselling.

Rebecca: I didn't want to talk to nobody, I didn't want to do anything, and social worker said you have counselling, it's just like 'no!' – and it's like 'it's gonna help' and I'm like – I was just like 'I've just lost everything! You're asking me to go talk to a complete – another complete stranger!' and they're just like 'we are gonna' and I'm just like 'I'm not gonna speak to a complete stranger' and my mum's just like 'try it, it might work' and I'm like 'how is it going to work?' I'm like 'I've already had me kids, you know, it's not gonna get me kids back' my mum said, 'no, but it's gonna

help you understand, get you to a point where it's gonna get you to, hopefully do more than what you're doing'. And obviously the social worker says 'yeah', you know, and obviously they put my name down. They put me in for counselling.

Where the mothers acknowledged a 'need' for themselves they were still reliant on a social worker to support their referral.

Isobel: um, I think I spoke to a social worker, they got me in the counselling.

Most of the mothers described a relatively straight forward process once they had identified their need for counselling. In contrast, Lara described a long journey to counselling which she attributed to both a lack of opportunity for counselling but also her ongoing struggles with drug addiction (not feeling ready?) and the continuing threat of social services removing subsequent children.

Researcher: so what was it that made you decide to start counselling, after those 11 years?

Lara: just relapsing all the time... b'cos... and social workers wanted to take me other four! (very tearful, crying)... (pause) sorry...

Learning to trust my counsellor

Never really knowing who to trust
Because honesty just leaves us lost,
Powerless confused and betrayed.

From 'Storms and Effects' by Clarissa Stevens

Learning to trust their counsellors was an experience shared across all the mothers. In the context of feeling repeatedly let down, judged, and even deceived by other professionals. There is a sense of the difficulty of this task in the quote above from Rebecca where she initially describes the counsellor as “*another complete stranger*”. In this next extract she lists the many nameless ‘workers’ she has encountered before who she not only felt were not on her side, but she felt deceived her and let her down when she needed them most.

Rebecca: I had like different workers as well, different social workers, different workers, you know, and then I was like, everything was ok and the social workers had no concerns and these people had no concerns, and yet I still had like, um then I didn't feel as if they wanted to come forward in the court and say there was nothing, 'we have no concerns over her', obviously you know 'she done her best' and er, obviously they said that obviously I can't keep them safe, to the best of my ability.

Similarly, Elisabeth describes the unfair way she believes she was treated in the past.

Elisabeth: at the time I think it was unfair the way I got tret [sic] from social services, because they wasn't understanding what I was going through, with everything, and the illness and the violence, everything, they just wanted my children. That's the feeling I had. Because, I was at court every single time, and I tried to fight my hardest, and they didn't have no, they didn't give me any, any chance, at all... you know. And now, I'll be honest with ya, at the time, when I was going through that, I really really hated social services.

Lara also described a similar experience to Rebecca and linked this to how long it took her to trust her counsellor.

Lara: cos before I'd had people that told me, 'oh I'm working with you' when they weren't, they were, I felt like they were working against me to get evidence to take me kids. So there's that issue to it as well, so like, the first like five or six appointments it took me to get to know him/her¹⁰ (counsellor).

Some of the mothers expressed negative feelings towards their social workers or social services in general. Given that all the mothers came to counselling via these social workers it is understandable why they may have embarked on counselling with an initial mistrust of their counsellor.

Elisabeth: I just think, oh it's just social services, they just... I hate 'em, I really do hate 'em. I just, you know, why don't social services give people more help?

The mothers also described feeling nervous about starting counselling in the first place.

Saffron: yeah um (pause) I think sometimes you know if you know you're gonna be talking about something particularly... bad, you know, then sometimes you don't want to, I don't know, you're a bit nervous about saying, I think if you know what I mean...

¹⁰ The gender of the counsellor has been disguised in order to protect confidentiality (unless stated otherwise).

When asked what helped her not to feel so nervous Saffron explained how her counsellor seemed to make talking about difficult things a bit easier.

Researcher: was there anything that helped you not to feel nervous?

Saffron: yeah cos I think, s/he, cos s/he speaks about everything not just that one thing, if you know what I mean, s/he talks about lots of different things. So it sort of, you know, part of... the conversation it's not the whole of the conversation, if you know what I mean?

Lara describes tackling the issue head on and being upfront with her counsellor about her 'trust issues'.

Lara: ...I told him/her that I've got trust issues (laughs) with professionals so please don't take offense if erm, I end up a bit snappy or whatever or thinking that you're gonna grass on me (laughs) cos that's the way I've had to live in't it...

She goes on to illustrate how much she trusts her counsellor now acknowledging that she knows he is in contact with her current social worker, but she is comfortable with this.

Lara: So... and s/he [counsellor] talks to my social worker, but s/he don't tell anything I say to her or owt like that, erm, she rings him/her, see if I've been attending and that...

For two of the three mothers who received counselling from a male counsellor, their counsellor's gender was explicitly mentioned in the context of learning to trust and feel comfortable in counselling. Again, given the context for both of these mothers of abuse and violence at the hands of men, for them building a trusting relationship with a male counsellor was especially meaningful.

Participant 4¹¹: so I were panicking because he's a man. And things happened to me when I was a kid so I panicked 'bout talking to a man. Cos all me mental health had been women so I felt a bit scared at first going t'first couple of – but then after that it were just like, I don't know, better speaking to a man. Cos it were like I were talking to me dad. Even though I couldn't, I wouldn't dare talk to my dad like that (laughs) but I know that he would keep my secrets.

Participant 2: it's nice because, I like talk about, I know he's a man but I feel, not threatened or anything, I feel relaxed.

Experiencing counsellor as someone special

Lara: S/he's a wo/man in a million!

This was possibly the strongest theme constructed from the data. Apart from one interview (Saffron) in which the relationship with the counsellor was not given much prominence, in all the others it could be described as central. In contrast to how these

¹¹ The mothers names have been removed to protect the anonymity of the counsellors.

mothers described their dealings with social services, they spoke about their counsellors with a sense of warmth and affection, and all conveyed the message that their counsellors were important people in their lives. The strength of this relationship with their counsellors was richly described, notable in its difference to other nameless 'professional' relationships and all spoke about their counsellor in an exclusively positive light.

Isobel: I thought [counsellor]'s lovely, you know cos, when I talk to him/her s/he understands and listens. And s/he was a nice person you see, and I like him/her.

Rebecca: knowing that there's someone who's there for you, even when you're in, like you're in your darkest days, you've got someone there that's actually willing to talk to you, so yeah, that helps.

Lara: no one's ever done that, owt like that for me, no one's ever really told me, you're not crap, you know, I mean, so it's just like, really I've got like loads of workers on my case like, but the only two that stand out to me is [counsellor] and my women's aid worker. So all the rest of them are like, I don't know, they're bad, and them two just stick out cos they're good.

Lara: s/he's inspired my life!

Interestingly, however, the mothers all seemed to struggle to define their relationship with their counsellors. Some compared it to a familial connection (like Participant 4 above who said it was like speaking to her 'dad'), but also spoke in terms of 'friendship'

and Isobel distinguished it in terms of other romantic relationships (“*I like him, but not that way*”).

Elisabeth: I don't know him/her and s/he don't know me from Adam, but s/he makes you feel like s/he's, you're the part of the family.

Lara: s/he's like my professional friend! (laughs)

Elisabeth later sums up the sense of affection she feels towards her counsellor and also the struggle to define their relationship. After describing being made to feel like ‘family’ above, Elisabeth goes on to point out a difference between talking to her mum or dad and talking to her counsellor, namely that her counsellor listens.

Elisabeth: s/he makes you feel like... (pause) you know when you like try to talk to you mum or your dad? And they're like 'yeah yeah yeah', [counsellor] will sit there and listen to you.

Elisabeth: yeah, er... I can't explain it. You know when I finished the counselling... you know I never thought you know, being as a family talking and everything but when I finish, I give her a cuddle, I'll see you next time, can't wait. You know what I mean? It's like er, I can't explain it!

For some it seemed that what made their counsellor ‘special’ was the fact that they treated them like ‘normal’, or like an equal. Lara describes how important it was to her that her counsellor saw her as a ‘normal mum’.

Lara: And then every time I went to see him/her, that's what s/he kept sayin' to me 'you're just a normal mum trying to juggle life' and then I started to believe that I were and that I am (tearful, crying).

Another part of what seemed to make the relationship 'special' was the welcoming, warm and homely environment that the counselling service provided.

Elisabeth: They make you feel... you're not on your own. (pause) they make you feel like, you know, you're the family, you're not, you're not just, like, 'oh, it's you, ok go on that side' they don't make you feel like that. 'Oh yeah come in! would you like a cup of tea?' you know they make you feel welcome.

In describing their counsellors as 'special' some also included examples of being made to feel special by their counsellor. In the context of the overarching master theme and the stigma experienced by the mothers elsewhere in their lives it seems feeling this way with their counsellors was novel.

Lara: just someone that likes cares enough to gi' an hour of his/her time to like take on my like troubles and make it so it's not a trouble, it's just a slight problem... (laughs)

The mothers also seemed to really appreciate the non-judgmental stance of their counsellors and acceptance of them for who they are.

Lara: S/he proper like bigs me up. Sometimes I feel like me head's massive walking out the door!

For most the knowledge that they could ask to see their counsellors again seemed to represent their sense of being held in mind and that their relationship with their counsellor continued even after counselling ended. Rebecca reported returning to counselling when she experienced new difficulties in her life. For example, she described hoping to give her counsellor an 'update' after a recent court case.

Rebecca: if s/he's got a spare slot or anything, for me, s/he'll book me in, for an update and a chat.

The impact of the way her counsellor treated her is poignantly summed up by Lara in this quote where she describes how she felt the moment she left hospital without her baby.

Lara: when you're walking off ward and you've got your bags and you haven't got no baby yeah? Then what do you want to see in front of you? Someone that's offering you a hand going 'come on, it's going to be alright' (tearful). Cos that's what s/he does for me, that's what [counsellor] did for me (crying).

Taken together the four subthemes presented here describe a journey each mother embarked on constructed from the accounts of they gave. The master theme *feeling alone, judged and let down to feeling part of a special relationship*, has contrasted the adverse experiences of 'help' offered to these mothers with the overwhelmingly positive

experiences, for almost all the mothers, of their relationships with their counsellors. It was not an easy journey for many of the mothers. This master theme has also highlighted some of the challenges they faced in getting to counselling in the first place and then in overcoming the mistrust they had come to rely on, in order to form a meaningful and helpful relationship with their counsellors. Once this trust had been established however, the mothers were able to use counselling to create positive changes in their lives as described by the next master theme: *"The healing process"*.

"The healing process"

This master theme is an in vivo quote from Rebecca's interview that was conceptualised as capturing a key experience of the mothers across the dataset. Whilst not always so apparent as such a linear process in the other mother's accounts, similarities are present, and all the mothers described comparable experiences whilst in counselling. They referred to a number of levels of change that occurred in relation to their experiences of counselling, highlighting some of the process/aspects of change that had occurred for them. These were conceptualised as the five following subthemes: *feeling understood; acknowledging the impact of trauma and/or abuse; facing up to what happened to my child/children; experiencing a 'release'; and noticing changes.*

Rebecca: ...a lot of things could get out in the open and start the healing process.

Cos way down it hurts but, the healing process starts...

Feeling understood

Many mothers mentioned feeling that, in contrast to other people in their lives, their counsellors understood them and what they had been through. As described in the

previous master theme, difficult relationships with professionals previously and societal stigmatisation following the removal of their children meant that 'feeling understood' in this context was experienced as particularly profound and meaningful.

Rebecca: s/he worked it all out... it felt like s/he could read me quite easily, s/he knew, it felt like s/he knew me from the beginning... it felt as if s/he knew exactly how I felt, and s/he understood everything that I was saying...

Elisabeth: ...S/he always knew what I wanted...

Acknowledging influence of trauma and/or abuse

All of the mothers I spoke to referred to significant experiences of trauma and/or abuse. For most this was either in their own childhoods or through more recent abusive relationships (or both). There was a sense for many that counselling had provided a space to talk about these experiences and gain new understandings of how these may have significantly impacted on the removal of their children, either directly or indirectly.

Elisabeth: it's about all my violent relationship. I felt like I was controlled, that's what s/he (counsellor) said, I was controlled, er... s/he said I was like having, bad memories, I've been having bad memories I have about the violence, and s/he said, and then s/he turned round and said 'he can't hurt you anymore' you know what I mean? I felt really... petrified? But now if I see him, I'm not bothered? You know? But um... I just... I don't really care, (laughs) but before, I did care. But now I don't.

Some mothers mentioned making connections in counselling between their own experiences of trauma and/or abuse and the challenges in parenting their children.

Rebecca: obviously I don't understand why they was bringing that up, that I was abused as a kid, because that has got nothing to d- ok fair enough it might effect a little bit, about me raising my kids but obviously I didn't see- I didn't and, you know, they didn't- there was no proper expl- explanation?

Some mothers described using counselling to think about the trauma their children may have experienced and to see things from their point of view. Acknowledging things from this perspective seems to have been an important step on the way towards making sense of what happened. The examples below are from Saffron who used counselling to make sense of allegations her son made against her.

Saffron: trying to see things from the kid's point of view as well because obviously, while I was going through that whole thing, I couldn't work out why [son] was saying it? cos me and [son] were so close?

Saffron: you can feel a bit unwanted but then when you understand it from the child, it's a bit different it's, you know, makes more sense.

Saffron seems to have become able to not take what happened so personally, able to stop interpreting things in a way that is unhelpful and gain a new way of responding. Later in the interview she describes with a sense of relief the new understanding of the situation that speaking about it at counselling has offered her:

Saffron: with the allegations it sort of... I couldn't understand why he would say that? But then... having it like explained that you know if he's in that situation, it's sort of, it's what he's got to do to survive basically, it's, it was his way of surviving the situation he was in... so... not really... you know... not his fault...

For many of the mothers, whilst they described their own history of childhood sexual abuse and/or abusive relationships; the biggest trauma they identified was that of losing multiple children to the care system.

Lara: she got took from me at hospital, I were meant to have three days with her but I didn't, I got 24 hours and I had her at home, I got took in, and I got 24 hours and then I got kicked out of hospital with my bags and they took my baby (crying). I had to hand her t'police lady (crying)...

Lara went on to speak about the impact of her children being removed on her mental health. Through talking about these traumatic experiences in counselling, and perhaps her counsellor normalising her response, she seems to have come to reject the idea that she had mental health difficulties preferring to think about what she experienced as a 'normal' reaction to the trauma of losing her children.

Lara: it's like they haven't helped me mental health through taking my kids off me, just made me worse... do you know what, it's like they say I'm depressed, but I'm only depressed because I haven't got me babbies with me... but I've seen loads of mental health people, and they hadn't been able to help me – so is it really mental

health or do you think that I've just like, I don't know, got into this like world where I just want my kids back but I can't have 'em? (tearful)

She later described how her counsellor had helped her to acknowledge the influence of her own experiences of trauma and abuse:

Lara: but then s/he just said er, from the way I've been describing my life to him/her, yeah, it's no wonder I am the way I am. So any, s/he said that, erm because I've been through so much then I'm just a normal person trying to juggle life... (sighs)

Facing up to what happened to children

The guilt tears us apart,
always reminding us of the start,
making us feel like we no longer have a heart.
From 'Storms and Effects' by Clarissa Stevens

In this subordinate theme the mothers included vivid descriptions of the devastation they felt as counselling supported them to face up to what had happened. Counselling appeared to be a space where these intense emotional experiences could be shared and acknowledged. Most included powerful references to the emotional impact of being separated from their children. Some described feeling that their lives were over, others gave vivid descriptions of the emptiness or heart ache that they felt.

Rebecca: it didn't hit me until the final goodbyes. I felt like just like sitting on the floor and roaring my eyes out, I just wanted to just drop down like a heap of potatoes and just that's it my life was over. That, that is exactly how I felt - I felt my

whole life has just disappeared, which to me it still feels like it has because obviously there's nothing there, it was all dedicated, every single moment of time I had for the kids, and now they're just gone, it's just like what do I do now?

Elisabeth: I did not want to be here. Um, I felt my life was taken away from me...

(pause) Just no point living... I cut my wrists. I did, I means that I couldn't stand it anymore.

Lara: and then all of sudden they just said no we're putting her up for adoption and 'parents signature to be declined'. (crying) So I didn't sign her away, they just took her and now I can't get back to her (crying).

Some of the mothers spoke about turning to drugs and alcohol to help them cope.

Lara: I just turned to drugs. (pause) I were like, takin' loads of drugs, (inaudible) and di'nt go out the house, only to contact, just like, never bathed never washed or owt like that, didn't get out my bed for owt.

For some coming to terms with what had happened involved recognising the circumstances surrounding the children being removed and being helped by their counsellors to see that they were not only to blame. The accepting, non-judgemental stance of the counsellors seems to have supported this process of meaning making.

Lara: Cos I suppose when you have your baby took off you, you feel like it's you yeah? But it's not all you. And it's like, I don't know, they help you see that it's not all you.

Rebecca: ...s/he's said I've not done anything wrong, it's not my fault and that, and obviously s/he can see as well that, and that, and s/he kind of like, even when I'm blaming myself.

As well as acknowledging the circumstances surrounding their children's removal, many of the mothers described getting to a place through counselling where they could take responsibility for their part in what had happened.

Lara: I know, I know that I put them at risk, I emotionally harmed them, I know that I did all that now, but back then before, I had sat down and spoke about it and it were relayed to me in a different way, that basically I thought that, I don't know, I thought they'd be alright, but it weren't alright, it weren't alright, not by far (crying) and now I'm older and wiser and I wish I could put it all back right but I can't it's just like, we have to plod on...

Saffron: Basically I couldn't get them to school. I was having a lot of anxiety as well, I don't beat my kids up or, or like you know, I know they call it neglect but it's like they've never gone without food or anything like that you know, um, (pause) but yeah, it was more my mental health, and um, just not being able to get help for it really, I think, is what...

A sense of the complexity and overwhelming nature of the circumstances the mothers were facing is best captured in the below example from Isobel. Many of the mothers were facing up to extreme situations and multi-layered circumstance.

Isobel: really upsetting, cos I didn't have no choice, cos I had to go court and all that, and my sister was there and her bloke was there, so, all the trouble they made you know, cos she (daughter) had eleven fractures in her body... [sister's partner] done it. Cos he killed himself, cos he admitted it, and my sister found out, she knew about it.

Despite the extreme nature of the situations they faced, the mothers spoke of coming to a place of acceptance of what had happened.

Isobel: I want her to have a better life and that's why she's in another family, you know, but I had to fight for her to get her back, but it was too late, so, that's what happened, and now she's happy with another family...

Elisabeth: I've pulled myself out, I've thinking about what I want in life, I've moved on, you know. You know, I said to my mum, I said, at the end of the day my kids are safe, they're ok, you know, now it's my time to move on.

In line with the 'healing process' master theme, Rebecca powerfully explained how she was helped to face up to what happened to her children and accept the emotional pain that goes with this by her counsellor (my emphasis).

Rebecca: ...where it hurts the most you get upset for and it really hurts, and obviously you tell the counsellor how much it hurts and when the pain and everything, and the emotional pain and stuff. S/he can help you heal that by talking to you and you can try and get the - s/he puts it in a way, where it doesn't hurt so much. It's coming to more of an understanding, and, s/he helps you through that emotional, emotional pain.

Experiencing a 'release'

All of the mothers referred to a sense that talking with their counsellors provided them with a means of 'getting things out' (Isobel/Saffron), 'spitting things out' (Lara) or things coming 'flooding out' (Rebecca). Some mothers described feeling things 'build up' inside of them before counselling, for Isobel it was in her 'brain' and for Lara she felt like she wanted to 'burst'.

Isobel: Cos it helps me a real big time a lot, counselling, talk about lots of things, cos it's in my brain you see, I think about everything and then it builds up, builds up, and then I've got to let it out.

Lara: so when I got him/her, it were like a release, so like all that pain and stuff that I'd been through for that 11 years, just wanted to burst, but then I started just coming to see [counsellor] just for an hour a, every week...

Elisabeth: it was lovely. It was, you know you're sitting there and you're talking to a stranger, and, you're just exploding, you know talking, talking to yourself, what I went through, to understanding my part of what I went through, you know?

For most of the mothers this experience was framed as a positive one, like Elisabeth above when he describes it as 'lovely'. However, for one mother Lara, it seems to have been a more challenging experience and the benefit was only evident a day or so later.

Lara: ... first it felt like, but when I come home I just felt like crap, but then a couple of days after counselling I felt ok.

As well as vivid descriptions of pressure building and releasing the mothers attempted to explain how they felt afterwards. For some it was feeling like a 'weight had been lifted'.

Rebecca: I found a lot of pressure, come off me, when I was talking to him/her. A lot of the pressure I was feeling when I lost the kids, when I was speaking to him/her, it felt like a weight was coming off... and all the problems and everything I was going through and the hurt and everything, was just speaking to him/her, just felt like, well the weight started coming off my shoulders.

Lara echoed this sense of weightlessness in how she spoke about feeling after counselling. It is difficult to convey in the transcript but her 'ahhhh!' in the quote below expressed a release, relief and relaxation all at once.

Lara: you know cos you just like released all your whatever it is you want to spit out at counselling, it's like you walk in, you spit it all out then you walk back out and you think 'ahhhh!' (sighs)

Others linked the 'release' with getting in touch with their emotions, so not just releasing them but 'feeling' them. For Rebecca particularly, this was an important part of the 'healing process'.

Rebecca: I was just going there just to talk, just to see – to feel because if you don't feel you're not going to heal...

Noticing changes

All the mothers had noticed changes since having counselling. For many these included practical differences like going out more (Rebecca), having a routine (Saffron), getting a job (Elisabeth) or not returning to drug or alcohol use (Isobel/Lara).

Elisabeth: they've really helped me with a lot of things, you know, my past, the violence, having my kids taken away from me, you know and now I've got myself a job and I've got myself a new partner, we've been together six years, and I'm happy.

Like Elisabeth above, many of the mothers spoke about changes in their relationships. This included two other mothers who, like Elisabeth, mentioned their new partners. For

Elisabeth it wasn't just having a boyfriend that was different, it was having a boyfriend who cared about her and treated her well that was meaningful.

Isobel: it's hard really, but now I've got, boy, my new boyfriend now... I'm much better, because I'm happy with him, he helps me a lot, and I've changed now, I don't drink, I don't smoke.

Elisabeth: How do you explain it? Being in a violent relationship and then having a nice bloke, and it's nothing to do with money but he treats me like a, he cares about me a lot, he does.

Some mothers described the changes they had noticed in their relationships with family members. For Saffron it was the new relationship she had with her daughter who had returned to her care from foster care, whereas Lara had noticed that her relationship with her dad was different since counselling.

Saffron: but yeah cos before, every little mood she'd go through I'd go through with her (daughter) sort of thing and like that would really affect my mood, now I can just be like, 'she's just having a bad day I'll just leave her to it', and we'll be fine in half an hour, you know it'll be fine.

Lara: I hadn't really seen my dad, and now, erm, he has more to do with me now... I used to speak to [counsellor] about stuff why me dad din't want nowt to do with me as well...

Another difference the mothers had noticed was in how they felt in themselves. Rebecca linked her processing of painful emotions in counselling to freeing up space for 'good feelings' to come in.

Rebecca: just like going from being really really hurt, to feeling really painful and upset and broken to like feeling, you know what, it's not my fault and then you start to have that good feeling, start come, starting coming in, it's a slow process but you feel that slow, but you do feel it.

For many this also involved a more hopeful sense of the future which was not present before counselling.

Saffron: it gave me a lot of perspective to sort of stand back and think ok, maybe I'm not... as bad, maybe there is a little bit more hope than I thought.

However, for Saffron the hope was not in the context of life's challenges being gone, but rather within the context of her ongoing sadness.

Saffron: now, I can go out, and I can say no, that it was my mental health, it's not, you know... I just think it made me realise it's not the end of my life so much, I can still have a life, but it's not, it'll never be as good obviously.

In line with this gaining of new perspectives, Rebecca described how her counsellor had done this for her (my emphasis).

Rebecca: so s/he realised how vulnerable I was. Obviously s/he's the one that helped me pick it up, so obviously the counselling is, the counselling I find very very good, because s/he's helped me pick up, s/he's helped me see what I can't see, so... yeah...

Other mothers also noticed changes in how they saw themselves:

Saffron: ...I'm more resilient now...

Lara: ...when I come out from thingy [counselling] I'm like, 'right then I'm a good person and I'm gonna do this!' (laughs)

Many mothers also spoke of a newfound belief in themselves and increased confidence post-counselling. This was particularly present in Elisabeth's transcript who seemed to describe a sense of acceptance alongside her improved self-assurance.

Elisabeth: I'm not scared anymore. I'm not scared, I ain't frightened. I'll... speak out.

A final change present in the accounts of some of the mothers was recognising changed understandings of what happened to them, their children or even of themselves. These mothers described how having a different understanding of their experiences allowed them to change how they respond. For Saffron this was related to how she felt before contact with her boys as well as a different understanding of how her boys felt about her.

Saffron: Like I've twigged now that I get, you know down when I'm about to see them and when something's about to happen so, now I think oh ok, it's not actually me being down it's just... me panicking sort of thing, ...and then like you know obviously it'll... go away, so I know now that it'll, it's sort of a temporary, little thing that I do, if you know what I mean, instead of, whereas before I would sit there and think oh I'm a really bad mum for thinking like that.

These five subthemes each represent a part of counselling experienced by the mothers related to positive changes in their lives. The master theme "*The healing process*" encompasses the challenges and complex tasks faced by the mothers in reaching a more positive future. All the mothers in this study appeared to have made very good use of the opportunities counselling provided and, as evidenced by this master theme, have been able to make significant changes in how they think, feel and relate to themselves and to others.

"My children are my world"

This master theme is an in vivo quote from Lara's interview. It attempts to capture the mothers' powerful and at times painful tussle with the notion of 'motherhood' in the absence of their children and in the context of using counselling as a space to talk about them and connect to memories of being a mum. The two subordinate themes:

maintaining painful connection(s) to children; and feeling like a mum vs not feeling like a mum at all; are made more complex due to the wide ranging and differing

circumstances the mothers found themselves in in relation to their children. For example, the number of children of the mothers' ranged from one to seven, the legal status range was from child protection orders (with children returned home) to full

adoption orders and contact with children who were adopted or in foster care ranged from twice weekly to none. What was common across all the mothers' accounts was a sense of the pain that connecting to their children in counselling brought with it and a conflicted sense of being a mum.

Lara: They're my world man, they're the reason why I can smile every day. All seven of them.

Maintaining painful connection(s) to children

All the mothers interviewed used counselling to talk about the children that had been removed from their care. Those whose children had been adopted seemed to use counselling to reflect on the lack of information available to them about where they were or what they were doing and express their sadness or frustration at this situation. Thinking about the son she has not seen since he was a baby, Elisabeth describes how hard it is to think of him now given her lack of knowledge of his life.

Elisabeth: And, like [counsellor] said, I been through a lot, and, I need to, think of my children, how they're doing. But I haven't seen [son] since he was one years old, and um I keep going to... I keep going to counsel- um social services, and asking how's [son] doing? I keep doing it. And they're not giving me any intonation [sic] he's just gone. He's just – I don't know anything. You know and, I haven't even got a photo of him.

These extracts give a sense of the unknown and ever-present questions in the mothers' minds. Elisabeth expresses her wish to know more in such a way as to convey the

feeling that she is not asking for much. The final comment at the end of this quote illustrates how Elisabeth attempts to maintain her closeness with her missing son, through his blanket.

Elisabeth: What's he look like now? How's he getting on at school and...? You know? I don't want to like, I know he's with like, adoption people now, yeah, and I don't want to wreck that. But I just want, how, how's he getting on? And, how's school? You know like a mother? It's not like I'm, you know, looking for him or whatever, I just want a nice photo of him, you know?... I've still got his blanket, the smell of him...

Other mothers also spoke about the constant questions they had in their minds regarding their children's lives now. Isobel imagined in what way recent snowy weather may have affected her daughter, which could be seen as an attempt to connect to her daughter through a common event. The second quote included here is an example of how, in the absence of actual contact, Isobel used counselling to develop and talk about her imagined relationship with her daughter, had she not been adopted, and in the future.

Isobel: I think about her all the time, what's she's doing, what's she's doing at school? Or, you know cos when it was snowed in, I think she was probably off school?

Isobel: I just wanna take her to school and, and if she's got any homework I got [boyfriend] to help me and, or, you know, something like that. I'd like to take her

out, and bath her and take her bed, and read her a story, something like that, it's just, that's what I say to [counsellor], it's in my brain, you know.

As well as imagining life with their children had circumstances been different, many of the mothers spoke about discussing future reunions with their children in counselling. Many seemed to particularly value the idea of a 'memory box' that their counsellor suggested into which they could place items and messages that they would give to their children at a future time.

Elisabeth: It's hard, cos I've, at the back of my head I have got... my three, three beautiful children (tearful) and it's really really hard to move on, but, you know, they will find me.

Rebecca: so it means when they get older, when they come find you, they'll always see, you'll have that box with all their birthday cards and everything all in there so they know you've been thinking of them, so obviously when they turn of age you can give them...

Isobel: I just love her, I've done her like um, a box, all her bits in and stuff. Her birthday, Christmas, Easter, and that's er, when she gets older I can give it to her...

For these mothers in particular, but also for all the other mothers there seemed little doubt that their children would one day return to them. As Isobel hints at in the above extract many of the mothers described anniversaries or special occasions as being particularly difficult for them, when they turned to their counsellors for support. In

Lara's case she reports turning to drugs to cope with anniversaries before she started counselling.

Lara: it were like every year, on her birthday, I'd relapse... and the same on their birthday (indicating daughter) Christmas too, I'd be relapsing.

Isobel: cos I was saying to [counsellor] you know its Mother's Day Sunday and it's going to hit me and, [counsellor said] but why don't we do something like [boyfriend] take you out or watch a film or do something, you know, to not think... you know so...

As well as thinking of their missing children often, many of the mothers described imagining their children thinking of them.

Isobel: she probably thinks 'what's my mum doing?' and – I think she's a bit young at the moment I think when she gets older, about six, then she understands more, and she'll probably say what's she's doing and stuff, same what I do with [daughter].

Saffron: it's hard to feel loved by your kids sometimes like if you know, you've not got 'em... (becomes tearful) and it's just sort of, you know picking out bits that um, so I knew that they cared.

All the mothers described using counselling as a source of support to help them navigate contact with their missing children. In the above extract from Saffron she is

describing how the counsellor helped her to 'pick out' signs that showed her children cared about her. Later in her interview she went on to describe how hard seeing her boys in contact had become and how she felt she needed her counsellor's support to understand her feelings.

Saffron: because when I go to see the boys I'm reacting to sort of, I'm getting quite upset before I go and stuff, and I'm thinking... and I keep thinking well why can't I have them back cos I'm getting to the stage where I'm feeling a lot better in myself, and you know, I need, I think I needs something to sort of... not explain to me, I know I can't have them back but you know...

The mothers also described how difficult contact can be, both letter contact and face to face contact. When describing letter contact the mothers spoke of not knowing what to write (Lara/Isobel) and also as the quote from Rebecca below illustrates, the frustration of not being in control of when they received this form of contact.

Rebecca: it's horrible, it's hard, just wake up every morning waiting for a letter for a whole month and there's nothing there. I feel as if I've been lied to, by the government it's just like, well where's my letter?

Some mothers, who had regular face to face contact with some of their children, described feeling like they no longer knew their own children, and the pain this left them with.

Lara: so you go to one contact and he's there and he's little, so then you do little stuff with him, next time you see him he's big! And you don't know what to do with him, and it's like, you feel like you don't know your own kid, it's horrible.

In contrast to the pain present in so many of the mothers' accounts of connecting to their children in counselling, both in their memories and ongoing relationships; Isobel spoke in positive terms of speaking about her daughter in counselling and using her counsellor to help her write letters to her daughter. It seems that in contrast to finding it hard to talk about her daughter elsewhere, counselling was somewhere she could talk about her freely.

Isobel: it's really hard to talk about, talk about um, anything cos, that's why I go counselling you know it helps me a lot, and, it just, dunno really it's just nice to go counselling, you know and talks lots of things you know, it's this, it's out your body you know, it's just nice, is she going swimming or, is she going dancing or, things like that you know?

Isobel: I feel happy when I come, um, counselling, you know, talk about lots of things, cos I get a letter from the parents in June, about [daughter], what she's doing and stuff, and [counsellor] helps me with it and, when s/he writes it I talk about it, and what I did in my life and what she's doing.

Feeling like a mum vs not feeling like a mum at all

Mummy is a name we grow to love,
until love cost us too much,
identity gone no one will know
in this new world who I am or where I'm from,
but when we open our eyes each day there is
always that reminder our children are gone.
From 'Storms and Effects' by Clarissa Stevens

This subordinate theme, present across all of the interviews, gives a sense of how conflicted the mothers were in terms of identifying as a mum. Isobel particularly connected to this idea through imagining what she would be doing if her daughter was still with her.

Isobel: ...if you had if you had her now, you know she'd be with me all the time, you know, and lots of things, and, I just like, I like to, if it's her birthday and, do a little party for her and get her a – and if she wants a dog then I'd get her one you know, something like that you know – and get her a phone or, she wants this, she wants that you know, that's what Mum's do.

This quite idealised idea of 'what Mum's do' as fixed and unquestionable was also present in the accounts of the other mothers. Elisabeth uses the phrase 'a Mum's a Mum' and refers to the act of birth as if to emphasise that nothing can change that.

Elisabeth: You know a Mum is a Mum, you know, if she couldn't find her child or how they're doing or whatever you know, it's going to be really hard... I'm the one that gave birth to him.

Some of the mothers seemed to hold on to the idea of not just being a mum but being a 'Good Mum'. Being a 'Good Mum' seems to be related to what they can do for their children. Elisabeth and Saffron demonstrated this by describing examples of meeting their children's needs in contact; whereas Rebecca described her actions to protect her daughter from her violent ex-partner even now she is in foster care.

Elisabeth: ...he's got hay fever, and he's sneezing and everything... and everything 'oh mum!' um, I gave him an allergy tablet.

Saffron: It's a little bit difficult, we just sort of... making a relationship now if you know what I mean, but he's said some nice things, he was just like 'oh you've been a good mum' cos I bought them... waffles! (laughs).

Rebecca: I wanted him to be, stay away from my kids as well, cos my little girl she's like 11, ok fair enough she's in foster care but I just didn't want him being... keeping her safe...

Lara, the only mother to have young children in her care currently, described her sense of being a mum in the eyes of her children, no matter what.

Lara: the mess of me in some contacts too, was unreal, but these guys didn't bat an eyelid, I was still their mum, they still loved me.

Saffron separated herself from other people who have cared for her daughter, by identifying as the 'only one' that's never left.

Saffron: [about daughter] I'm the only one that's actually still there and that's never left her...

Saffron also illustrated the conflict experienced by many of the mothers in how their sense of being a mum is different with each of their children.

Saffron: it's really difficult, it's... cos you don't feel like a mum (tearful) ... er... I suppose just doing little things that I can still... I think with [daughter] coming back, I'm able to be her Mum properly? So that makes me feel a lot better because obviously I've got... someone to, give all my affection to if you know what I mean, but um, with the boys it's a little bit more difficult because... er, with [eldest son] I feel like I'm his mum still, because he's so affectionate and he wants that relationship so much? With [youngest son] because he doesn't really remember so much it's like a new relationship there it's a bit strange? But I think we'll get there, it's just, you know... hopefully... ...it is strange because I know him and he doesn't know me (laughs) he hasn't changed very much at all so...

For many of the mothers not feeling like a mum was linked to not doing the day to day tasks of parenting like the school run or taking their children out.

Rebecca: I still think about you know times, you know what I'd be doing if the kids were there, and that you know, about school and, I still do think about that... ... everything's different, cos you're not up early in the morning taking the kids to school, getting them ready, you know, you're not doing meals, you're not, you're not

doing, ... everything's different because you haven't, I don't have to do that anymore.

As well as not doing the 'day to day' tasks of motherhood, Saffron emotionally reflects on the fact that her sons no longer call her 'Mum'.

Saffron: um... (tearful) I... oh it's hard... um... just um, you know like, obviously cos they don't call me mum and stuff anymore, that's really hard.

Across the entire dataset the mothers seemed to hold on to an idealised version of motherhood, which included the day to day tasks but also recreational activities. In this way they seemed to hold on to the positive aspects of parenting and distance themselves from any of the challenges parenting brings.

Elisabeth: I don't feel like a mum... No. I think social services have took, ripped that away from me... I don't feel like a mum, I just, you know... I have got the mum in me because I give my daughter advice, you know... but... I just don't feel like a mum. And my mum turned round and said 'you'll always be a mum', but I don't feel like a mum, you know, because I haven't got any children around me, you know... I just, I'll be honest with you, I miss being a mum, I do, you know taking them to the park or play football or, I miss it, bake cakes, you know, flour everywhere, all over her hair and, I just miss it all, I just, you know... you know, I'm bored! (laughs).

There was also a sense in the accounts that these mothers were 'missing out'. Like in Lara's quote above when she describes the changes she sees in her son each time she

sees him, and in the extract below from Saffron who notes she is not a part of her sons' 'busy' lives.

Saffron: there's not a lot that's the same. Um... I don't know, er... obviously I still love them as much, that's never going to go away, er, but it's obviously doing the day to day things, you know, that's hard not doing, cooking their dinner and stuff like that... (tearful) and obviously... I um... I miss out on a lot of things that they do and stuff so, it's quite difficult... I try to sort of keep up with them as much as I can, but, they're always doing something different, so (laughs) it's really difficult...

This master theme has tried to capture the strength and depth of feeling present in the accounts of the mothers I interviewed regarding the children who had been removed from their care. These children were in the minds of their mothers often and counselling seems to have provided an outlet for the mothers to express their thoughts and feelings about their children not possible in other areas of their lives. In connecting to these thoughts and memories the mothers are faced with questions about their identity as mothers. All the mothers seem to experience both feeling like a mum and not feeling like a mum at the same time. The conflict inherent in their position of being separated from their children however did not lessen the sense that for all the mothers I spoke to, their children are their 'world'.

Chapter 5 Discussion

Summary of findings

This study planned to find out about the experiences of birth relatives who engage in psychotherapeutic counselling following the loss of a child or children to compulsory adoption or foster care. In-depth interviews with five birth mothers accessing counselling from one service were systematically analysed using IPA. Three major themes were constructed from the data which present one understanding of these mothers' experiences. These were: *From feeling alone, judged and let down to feeling part of a special relationship*; *"The healing process"*; and *"My children are my world"*.

After briefly commenting on the significance of the participants, this chapter will discuss each master theme in relation to existing literature and research. Links will be made where appropriate to the influence of social and political context, psychological theory and the clinical implications of these findings will be highlighted.

Participants

It is not known how many birth fathers, grandparents or other relatives were initially contacted by the counselling service and asked to take part in the research interviews. An evaluation of the birth relative counselling service in question found that over 30% of referrals to the counselling service were for birth relatives other than mothers (Wright, 2017). It also found that 70% of birth fathers and 52% of other birth relatives did not take up the offer of counselling (compared to 55% of birth mothers, Wright, 2017). More than half of birth mothers and birth grandparents and almost three quarters of birth fathers who are referred to the service following the compulsory removal of their children do not take up the offer of counselling.

The birth mothers who were interviewed for this study had all received substantial support from the counselling service, over multiple episodes, with the average number of sessions being over 42. According to the service evaluation data, of those birth relatives who do take up the offer of counselling only 22% received over 25 sessions (Wright, 2017), all the participants were from this group. This means that the five birth mothers who took part in this study only represent a proportion of the birth relatives who access the counselling service. The views of the birth fathers; birth grandparents; and those who did not take up the offer of counselling, those who did not engage and those who received shorter term interventions are not represented in this study.

Instead, this study presents the perspectives of birth mothers who fall within the small group of parents who fully engaged and received a longer-term counselling intervention. It is possible that these birth mothers were approached by the counsellors as they were believed to be most likely to participate, or because they had the most positive relationships with them. It is also possible that the counsellors thought that these mothers would be best placed to comment on what was helpful about counselling. The implications of this will be returned to later.

It is also important to acknowledge that the participant accounts were constructed within a particular context, that of a research interview, initially suggested by their counsellor, and sometimes in the same room the participants experienced counselling. All participants appeared keen to talk about their experiences and it could be they were acting out of a sense of loyalty to their counsellors. I was able to build rapport with all of the participants easily and consider that I benefitted in this regard from not only their

existing positive relationships with their counsellors, but also the positive experience of talking about their lives in counselling that they all shared. It is possible that in this context it may have been harder for the mothers to talk about any negative aspects of the counselling process that they experienced. However, the Change Interview (Elliot, 2012) is designed to probe in multiple ways for negative changes or problematic aspects of therapy. It is striking how little the mothers had to say that was negative despite this probing; this could be viewed as more evidence of the mothers' loyalty to their counsellors, or the significance of the therapeutic relationship for them.

Another interesting finding from the service use data is the prevalence of the use of telephone sessions. All but one of the mothers in the study made use of telephone counselling sessions during episodes of counselling. This finding will be explored further below.

Master Theme 1: From feeling along, judged and let down, to feeling part of a special relationship

The first master theme of this study encompasses the mothers' experiences of forming a new relationship with their counsellors, and finding that relationship therapeutic. The first subordinate theme: *feeling alone, overwhelmed and stigmatised*; is in line with the findings of other research regarding the adversarial nature of the court process. The second and third subordinate themes: *finding a way to counselling* and *learning to trust my counsellor* speak to the difficulties the mothers of this study encountered on embarking on their counselling journeys. The final subordinate theme: *experiencing my counsellor as someone special*, suggests that once a trusting or helpful relationship had been

established, that experience for these mothers was profoundly therapeutic. Each subordinate theme will be discussed in more detail below.

Feeling alone, overwhelmed and stigmatised

As stated, this subordinate theme echoes repeated previous findings that birth mothers feel powerless in the process of child protection proceedings (Drumbill, 2006); and abandoned following the court process assessing their parenting capacity (Lewis-Brooke *et al.*, 2017; Logan, 1996; Broadhurst & Mason, 2017; Carolan *et al.*, 2010). Mason and Selman (1997) found that the court experience itself was traumatic for many birth parents and Charlton *et al.* (1998) reported that parents experienced the court process with a “sense of despair” (p.37). They also found that as well as losing their children, birth parents experienced a loss of self-worth and confidence (Charlton *et al.*, 1998) a finding echoed in a quote by a participant of Logan (1996): “you don’t just lose the baby” (p.622).

Broadhurst and Mason (2017) described how for this group of parents, “stigma permeates everyday social life” (p.48). Carolan *et al.* (2010) address the impact of being young, female, and powerless in a system in which caseworkers, judges and other stakeholders have social, political, and economic power over birth mothers’ lives and fates. Birth mothers have been described as bearing the stigma of a ‘spoiled identity’ (Schofield *et al.*, 2011); this led Broadhurst and Mason (2013) to question why such highly vulnerable women appeared to engender so little consideration in mainstream policy debates.

It has been widely reported that state intervention to protect children fails to respond to the needs of the birth parents and as Broadhurst and Mason (2013, p.1) argue this can lead to “much documented iatrogenic effects”. They suggest the court process itself adds another layer of trauma to the lives of birth mothers, and links this to the need for effective rehabilitative intervention.

Lack of power in an overwhelming system is referred to often in the literature regarding birth relatives experiences (e.g. Harris and Whyte, 1999). Jackson (2000) found care proceedings to be a universally negative experience that engendered feelings of powerlessness, confusion and public humiliation. Hunt (2010) reported evidence that mothers find the family court alienating, difficult to understand, intimidating and deeply stressful. All descriptions that closely resemble the experience as described by the mothers in this study and encompassed in this first subordinate theme.

The Influence of social, political and historical context

The findings of this study cannot be viewed in isolation. Issues of power and policy are closely intertwined within all the master and subordinate themes and as such will be referenced throughout this chapter. However, the impact of policy and social attitudes are particularly pertinent to this first subordinate theme and so it is worth exploring them in more depth here.

This first master theme goes some way to highlighting the impact of current UK policy regarding child protection and adoption practices on birth mothers. The variation in outcome for the children of the mothers interviewed serves as an example of what Shea (2012) refers to as “*the permanency plan game show*”. Shea (2012) uses the metaphor of

the game show to describe the dynamic that emerges when parents and children await the court's decision regarding their relational future. She details the overwhelming and powerless position of birth relatives, the lack of communication, and "either/or" emphasis of the courts (p.67). She also notes that it is a game in which everyone loses.

The subordinate theme of *feeling alone, overwhelmed and stigmatised* in the wake of the court process could be linked to the policy drive to prioritise the child's needs over the birth parents following the Baby Peter scandal (LSCB, 2009; Broadhurst & Mason, 2013). It also serves to highlight that the government stipulation that birth relatives should have access to a range of support services both before and after adoption (DoH, 2001) may be falling short. As Broadhurst *et al.* (2015a) point out, there is no statutory mandate regarding the provision of "tailored rehabilitative support" to parents following child removal (p.2256). Although birth parents are entitled to *post-adoption* support under the 2002 Adoption and Children Act, services are highly variable, take-up is inconsistent (Neil *et al.*, 2010) and there is no evidence that any support meets the complex needs of this high-risk population (Broadhurst *et al.*, 2015b). Therefore, this is clearly a group that has received significantly less attention than others in the adoption circle.

Finding my way to counselling/learning to trust my counsellor

Previous research has not focused on this aspect of starting counselling and these findings may be significant in terms of the likelihood of birth relatives engaging in the services they are offered. One message that came from the serious case review following the death of Baby Peter, was that birth parents should not be trusted, and "assumed to

be self-serving" (LSCB, 2009, p.14). Attitudes from professionals towards birth relatives like these are likely to have a huge impact on birth relatives' ability to trust professionals following any court or child protection process.

These subordinate themes can be understood in relation to the vast array of literature regarding the importance and function of a therapeutic alliance and relationship in bringing about change. Keeping the social, political and historical context of the mothers in mind, what could be conceptualised as the relational nature of recovery (Price-Robertson, Obradovic and Morgan, 2016) will be explored below.

The Therapeutic Relationship and Relationship to Help

"If poor relationships are where things emotionally go wrong then healthy relationships are where things can be put right" (Howe, 2008, p.161)

The mothers in this study described nervousness and trepidation in meeting with their counsellors in the beginning. Given these mothers previous experiences of relationships, both with professionals and in their lives generally, finding themselves as 'clients' in counselling could easily be understood as a potentially dangerous situation (Mearns & Cooper, 2005) and so nervousness and trepidation would be warranted. Reder and Fredman (1996) highlight how the beliefs about the helping process that clients bring to their relationship with their counsellors can significantly influence the therapeutic encounter. Trauma theorists (e.g. Briere, 1992; Herman, 1992 cited in Dalenberg, 2004) agree that it is unreasonable to expect a traumatized client to quickly trust a professional helper. Many of the mothers spoke of feeling betrayed by previous 'helping' professionals and it is understandable that these experiences would impact

their beliefs about their new counsellors. Mearns and Cooper (2005) go on to ask why clients might face or even choose to confront this 'danger'. They suggest that humans are so grounded in relationship, learning to define ourselves through relating from early on, that even when previous relationships have been 'damaging' the best hope for change is still seen through relating to others (Mearns & Cooper, 2005). They agree with Howe's notion above; if the 'damage' is caused through relationship, then why not 'healing' too? This is an interesting claim to consider as the findings of this study also suggest that only a small proportion of birth relatives access potentially therapeutic relationships, and only a small proportion of those that do, go on to create the kind of long-lasting, 'special' relationships with their counsellors that the mothers in this study describe and that appear to be a key requirement for change.

The exact nature of this 'special' relationship was something that the mothers seemed to struggle to define, some comparing it to 'friendship' (Lara/Elisabeth/Isobel) and some to feeling 'part of the family' (Lara/Elisabeth). The idea of a "critical friendship" with a professional came out of the qualitative interviews Cox *et al.* (2017) conducted with the practitioners in their study. This seems to fit well with what the mothers in this study described. Particularly Lara's assertion: "*s/he's like my professional friend!*".

Difficult to engage?

Reder and Fredman (1996) describe how the therapist/counsellor also brings to the therapeutic relationship their own complex beliefs about the helping process, which can significantly influence the course of treatment. As noted in the introduction, literature written from the perspective of counsellors or therapists often describes difficulties in engaging birth mothers in therapeutic work (Neil, 2006; Selleck, 2007, Cossar & Neil,

2010). It is not possible to comment on the counsellors' experiences of engaging these mothers; however, the subordinate themes *finding my way to counselling*, and *learning to trust my counsellor*, suggest that the counsellors may have had to work hard in the beginning to earn these mother's trust and engage them in a therapeutic relationship. The findings highlight the significance, for these five mothers, of learning to trust their counsellor in the beginning. This can be linked to the history of their relationships with helping professionals, but also to the beliefs about engaging birth relatives in therapy that the counsellor themselves bring (Reder & Fredman, 1996).

Hard to let go?

The findings of this study relating to the number of episodes of counselling each mother had received, and the high average total number of sessions, may potentially suggest that ending therapy presents a challenge for either the mothers or their counsellors. It has been suggested that leaving therapy is not an easy task and that termination does not truly entail the finality it signifies (Zilberstein, 2008). Thinking about the counsellors' own relationship to help and to helping (Reder & Fredman, 1996), it is possible that having seemingly worked so hard to engage these birth mothers in a meaningful and helpful relationship, the counsellors then find it much harder to end sessions and let them go. However, Zilberstein (2008) also advocates basing decisions about whether to end therapy not only on symptom reduction, or perceived progress, but also according to the client's attachment to the therapist, considering the other types of attachments in their lives and their history of previous losses. With the history of traumatic separation from their children common for all the mothers in this study, as well as other traumatic or abusive experiences, the seemingly strong attachment to their counsellors and apparent potential difficulty separating can begin to be

understood. It has been shown elsewhere that clients with histories of painful losses often have the most difficult time separating from their therapists (Golland, 1997; Hill, 2005; Levison, 1977 cited in Zilberstein, 2005).

The idea that returning to counselling or therapy after an agreed 'ending' was a sign of incomplete therapeutic work has been called into question (Zilberstein, 2008). It has been pointed out that clients return to therapy for a variety of reasons, including novel issues that arise developmentally (Malin, 1990 cited in Zilberstein, 2008). The idea that the therapeutic relationship endures after a formal therapy ending, specifically that feelings towards a therapist continue has been shown (Craigie, 2002 cited in Zilberstein, 2008) and is echoed in the findings of this study. For some of these mothers, the knowledge that they could ask to see their counsellors again seemed to represent their sense of being held in mind and that their relationship with their counsellor continued even after counselling ended. The two services described and evaluated by Cox *et al.*, (2017) had no fixed time limit to the support they offered, and so it would seem that a precedent is emerging with this client group that a flexible approach to 'ending' is important.

Bending the frame

As well as the apparent flexible approach to ending the service provided, the mothers in this study valued the warm welcome they received which included for some a 'cup of tea' (Isobel) or a 'cuddle' (Elisabeth). This relates to literature which explores how to 'warm the context' (Burnham, 2005) for therapy for people who hold a deep mistrust of professionals and an idea that came from working with people living with HIV (where

people have multiple contextual issues) termed '*bending the frame*' (Eversole, 1997). Bending the frame, according to Eversole (1997), describes a flexible approach to the therapeutic frame which addresses the complex and ever-changing circumstances of the client. This might involve, making home visits, providing telephone counselling sessions, becoming an advocate or, in the case of one of the mothers in this study, helping to write a letter to her adopted child. This idea will be returned to when the clinical implications are discussed.

Experiencing counsellor as someone special

The final subordinate theme suggests that the establishing of a trusting or helpful relationship was profoundly therapeutic for these mothers. This echoes the findings of Cox *et al.* (2017) who also identified the centrality of the relationship between clients and practitioners as one of the strongest themes in their qualitative interviews with birth mothers; and Broadhurst and Mason (2014) where the quality of the professional-service user relationship was reported as 'transformative'.

This theme encompassed the knowledge that the mothers could ask to see their counsellors again after their current sessions had ended. This was highly valued by the mothers in this study and I would suggest unusual in the current political climate. On the back of years of 'austerity' the majority of support services are stretched, underfunded and under-resourced meaning therapy becomes extremely time-limited (McGrath, Walker and Jones, 2016). Returning to an NHS service for example, would usually require a new referral and the likelihood of seeing the same practitioner is low. This idea links to those discussed above in relation to the forming of a therapeutic relationship.

As noted in the results chapter, this subordinate theme represents arguably the strongest theme constructed from the data. Here the notion of a therapeutic relationship will be taken further and explored in terms of psychodynamic ideas of attachment and 're-parenting'; the 'common factors' model of therapeutic change; and the relatively new idea that 'recovery' in terms of mental health is relational.

A secure base

In providing his patient with a secure base from which to explore and express his thoughts and feelings the therapist's role is analogous to that of a mother who provides her child with a secure base from which to explore the world. The therapist strives to be reliable, attentive, and sympathetically responsive to his patient's explorations and, so far as he can, to see and feel the world through his patient's eyes, namely to be empathic.

Bowlby (1988, p.159)

The first master theme: *from feeling alone, judged and let down to feeling part of a special relationship*; could also be understood in terms of the creation of a 'secure base' as described by Bowlby above. Broadhurst and Mason (2014) identified as 'vital' the provision of consistent professional, skilled help that "nurtured the [birth mother's] sense of resolve and self-regulation" (p.1575).

In 1975 Mahler, Pine and Bergman described the concept of "emotional refuelling" (p.69) where a mother remains a stable point or "home base" that the child returns to before going off to explore again. They observed that through the smallest of, in the case of toddlers and mothers, physical contact the child "perks up" (p.69). As Bowlby relates

the idea of a secure base to the therapeutic encounter, the findings of this study, namely the value placed in the flexible and ongoing nature of the therapeutic relationship, could be thought of in terms of such 'refuelling'. In this context, the use of telephone counselling could be viewed as an example of a 'small contact' that serves to 'perk up' the mothers and allows them to feel confident facing the world on their own again.

With the freedom to explore comes the awareness of separateness, and perhaps separation anxiety or a fear of ending, particularly in the context of a history of traumatic loss and perhaps sub-optimal attachment relationships in childhood. Mahler *et al.* (1975) found that children who had the best 'distance contact' with their mothers (by which they mean the ability to perceive, recognise, and enjoy their mothers from a distance) were able to venture farthest away from her. Relating this to the findings of this study, particularly to the subordinate themes *learning to trust my counsellor* and *experiencing my counsellor as someone special*, coupled with the service data showing that most of the mothers in the study had multiple episodes of counselling and returned to their counsellors frequently; it could be argued that 'distance contact' with their counsellors was something that these mothers struggled with and that the difficulties they encountered in learning to trust their counsellors persisted as they tried to separate from them.

The idea that we can only feel free to explore the world in the context of a secure base (Bowlby, 1988), has influenced services for birth mothers elsewhere where nurturing relationships between practitioners and the women using their services are prioritised (Lewis-Brooke *et al.*, 2017). Having a reciprocal conversation was identified by Lewis-Brooke *et al.* (2017) as a life experience that some of the birth mothers who used their

service had not previously had. Bowlby suggested that talking on its own can function as a secure base (1988). Bolsover (2008) took this hypothesis further and stated that talking, when functioning as a secure base, is therapeutic and produces change. He suggests that the therapeutic relationship, and the talking that significantly contributes to it, can be conceptualised as functioning as a secure base. This adds to the argument that the secure base and related therapeutic relationship experienced by the mothers in this study was key.

Re-parenting in the therapeutic relationship

Taking the idea of the therapist/client relationship as a potentially reparative attachment relationship a little further, Koch (1987) described a treatment approach of being “consistent, available, [able to] interpret reality and meet concrete needs” when working with a birth mother (p.93). This “way of being” was described as more important than any promotion of “self-understanding through verbal communication” (p.94), or the more traditional mechanisms of change in counselling. The fact that what she describes as a ‘favourable environment’ has not been experienced in childhood for her client, the prioritising of the provision of this new way of relating was seen as central and named as ‘*Reparenting in the therapeutic relationship*’ (Koch, 1987). A similar approach was described by Carolan *et al.* (2010) where they recognise that part of their work was to model parenting practices both within the therapeutic relationship and in the case of working with families, with the children of birth mothers. It seemed to be difficult for the mothers in this study to articulate what it was their counsellors did to facilitate their relationship. It is possible that the counsellors adopted a “way of being”

as described by Koch, which was picked up by the mothers and which facilitated the forming of a reparative attachment relationship.

The 'common factors' model of therapeutic change

The 'common factors' model of therapeutic change argues that there is a common set of factors responsible for therapeutic change across the whole spectrum of psychotherapy and counselling approaches (Rosenzweig, 1936; Frank, 1971; Jørgensen & Ren 2004).

The quality of the therapeutic relationship has been identified as one of the key 'common factors'. In fact, after what the client brings to therapy themselves, relationship factors are cited as "probably responsible for most of the gains resulting from psychotherapy interventions" (Hubble, Duncan and Miller, 1999, p.9). Assay and Lambert (1999) estimate the therapeutic relationship to account for 30% of the variance in psychotherapeutic outcomes.

The mechanisms of the therapeutic relationship that affect change have been further studied, and various variables identified as effective (Mearns & Cooper, 2005). The first of these is the familiar person-centred condition of positive regard (Faber & Lane, 2002 cited in Mearns & Cooper, 2005). Being seen as 'normal' and for some as an 'equal' was another large part of the subordinate theme *experiencing counsellor as someone special* in the findings of this study. The mothers in this study thus valued the person-centred approach of their counsellors. 'Unconditional positive regard' (Rogers, 1957) by the counsellors towards these mothers was experienced by many as novel, and profound. Attitudes considering birth mothers to have 'wronged', and are therefore not worthy of attention, have been found amongst mental health professionals (Baran *et al.*, 1977 cited in Logan, 1996). Gair (2010) found that student social workers found it hard to

empathise with the story of a birth mother forced to place her baby for adoption. This highlights just how rare it may be for these mothers to experience 'unconditional positive regard' and goes some way to explaining how intense an experience it was for them. It also echoes the findings of Broadhurst and Mason (2014) who found that the quality of the professional-service user relationship was dependent on a "reciprocal positive dynamic", and that it could be "transformative" in terms of outcomes for children and families (p.1575/6).

Recovery is relational

The recovery approach to mental health has garnered huge support amongst policy makers and service developers (Slade *et al.*, 2014) however it has been criticised for its individualism (Adeponle, Whitley, & Kirmayer, 2012). Price-Robertson *et al.* (2016) propose that recovery is, in fact, relational. They highlight the research of Schön *et al.* (2009, cited in Price-Roberston *et al.*, 2016) who found that achievements that are normally seen as personal, such as positive changes in self-perception and identity, were described as interpersonal processes. It was "through social relationships" (P.7) that participants were able to redefine their experience. This fits well with the findings of the present study and the importance of the 'special relationship' in this final subordinate theme.

Master Theme 2: "The healing process"

The master theme "*The healing process*", appears to show that the mothers interviewed have experienced a 'process' resulting in noticeable changes in their lives. Perhaps not in a linear or clear-cut way, but the experience of feeling fundamentally understood seems to have allowed the mothers to acknowledge and face up to what has happened

to them and their children, experience an emotional 'release' and start to recognise differences in their lives. This experience seems to contrast with what Littell and Girvin (2004 cited in Frame *et al.*, 2006) suggest, namely that a 'stages of change' model is not applicable to the population of birth parents involved with child welfare services because of the variety and complexity of issues they face.

The process described by the mothers in this study in many ways supports the model for adaptive grieving proposed by Brodzinsky (1990). Brodzinsky's first criterion 'safety', encompasses the need for the bereaved to be among people who understand the loss that has been experienced. In most cases this would be family and close friends, but as Brodzinsky points out, mothers whose children have been removed experience no such 'holding environment' (Brodzinsky, 1990, p.310). It could be argued that the mothers in this study found a place of safety and understanding in their counselling sessions and through their counsellor.

Feeling Understood

The first subordinate theme: *feeling understood*; can be viewed in terms of Doka's notion of 'disenfranchised grief' (1989, 2002). Prior to counselling the mothers describe experiencing shame, guilt and stigmatisation. Doka (2002) describes disenfranchised grief as occurring when someone has experienced a loss, but "those around them feel that they have no right to grieve, that their grief isn't valid" (p.160). In *feeling understood* in counselling, it may be that the mothers' grief at the loss of their children was validated for the first time. Doka (2002) also describes how an individual's own sense of shame and guilt can inhibit the acknowledgement of grief and the requesting of support. In acknowledging these experiences in counselling, it may be that the mothers

in this study not only felt understood but could then begin to experience a “*healing process*”.

Furthermore, it can be inferred from the findings of this study that many of the participants’ experienced difficulties in their own childhoods. This is in line with previous research and literature on birth mothers (Broadhurst & Mason, 2017; Logan, 1996; Neil, 2013). Kohut’s theory of self-psychology (Kohut, 1977 cited in Koch, 1987, p90) emphasises the need for a period of ‘only’ understanding when working with clients whose needs were not adequately responded to in childhood. It could be argued that this experience of having their psychological needs met, and experiences of loss validated, resulted in the notion of *feeling understood* being a key part of the counselling experience that the mothers valued greatly.

Acknowledging the influence of trauma and/or abuse and facing up to what happened to my child/children

The subordinate theme: *acknowledging the influence of trauma and/or abuse*; speaks to the common life experiences of the mothers in this study. The childhood experiences spoken about and alluded to in their interviews relate to the findings of Levendosky and Graham-Bermann, (2001) that women with trauma in their own childhoods, who go on to become the victims of partner violence, are more likely to be at risk of becoming perpetrators of neglect or abuse towards their own children (cited in Carolan *et al.*, 2010). This is in line with Fraiberg *et al.* (1975)’s metaphor of ‘ghosts in the nursery’, which explains the ways in which a mother’s past and early relationships affect her understanding of and interactions with her infant. It links to the recent evidence that a significant number of parents return to court regarding subsequent children as their

problems are repeated rather than improved (Broadhurst *et al.*, 2015a). However, this understanding fails to take account of the role of the violent partner in perpetrating neglect or abuse. This subordinate theme suggests that counselling provided a space for these mothers to acknowledge their 'ghosts' and in doing so feel able to gain insight and greater acceptance of what happened to their children (as evidenced in the subordinate theme: *facing up to what happened to my child/children*).

Domestic violence, mentioned by four of the five mothers in this study, impacts on a mother's emotional availability to connect with her child (Malone, Levendosky, Dayton and Bogat, 2010). Malone *et al.* (2010) explain that women who continue to face violence in the context of their pregnancies find it harder to reflect on their own traumatic childhoods. The mothers in this study seemed to have been able, through counselling, to develop the capacity to tolerate the difficult memories from their own past (*acknowledge trauma*) and take responsibility for how this impacted their ability to parent their own children (*face up to what happened*). Malone *et al.* (2010) go on to describe how when a mother is able to do this, it is seen as a sign of "psychological health and wellbeing" (p.438).

A social model of psychological distress

Lara's interview speaks to the social model of psychological distress as described by Neil (2013). She rejects the psychological symptomology and diagnostic labels she has been given and has come to understand her distress as a consequence of trauma, powerlessness and isolation from social support, or as she puts it "*I'm just a normal person trying to juggle life*". Logan (1996) makes a similar argument questioning data showing high levels of 'mental illness' among birth mothers and asking:

“are birth mothers any more seriously ill than other women or have they been inappropriately pathologized and constructed as mentally ill, victims of a patriarchal society which pathologizes women who fail to conform to society’s expectations?” (p.622).

Neil (2013) also highlights the relevance of a social model of psychological distress regarding birth relatives. They view the prevalence of symptoms such as sickness, confusion, disorientation, anxiety, numbness, and depression amongst birth relatives as a ‘meaningful response’ to an ‘adverse social experience’ (p193). The findings of this research seem to suggest that a social model of distress may be a helpful framework to consider when working with birth mothers. Lara and the other mothers in this study seem to describe benefitting from having their lives being placed in a wider context and making links between their experiences and what happened with their own parenting and the loss of their children. This is very different to care proceedings and involvement with social care where the focus due to risk narratives is on child protection and risk (Featherstone *et al.*, 2016).

Complex trauma

Wells (1993) argued that many of the symptoms of post-traumatic stress disorder can be applied to birth mothers. Since then, the multiple and complex traumatic experiences of birth relatives have been conceptualised as amounting to ‘complex trauma’. In line with the parents attending the support program described by Battle *et al.* (2014), the mothers in this study would meet the description of experiencing ‘complex trauma’ (Herman, 1992). Carolan *et al.* (2010) define complex trauma as “enduring, consistent,

and ongoing victimisation throughout the lifespan” (p.172), a description which fits with the experiences of at least some of the mothers in this study, if not all of them.

In reviewing the literature on removal of children by court order the experience was compared to the ‘death penalty’ (Hewett, 1983, cited in Baden & O’Leary Wiley, 2007). This sentiment was echoed in the findings of this study by the mothers expressing their devastation and heartache in response to the removal of their children. For some of the mothers in this study, they described that their ‘life was over’ as if they too had been given a death penalty. One mother, Elisabeth, even spoke of her attempt to take her own life in the wake of the devastation she felt after her children were removed.

Viewing the experiences of the mothers within the context of counselling through the lens of complex trauma increases our understanding of why these mothers made use of such long-term intervention. It also points to important clinical implications which will be discussed later.

Experiencing a ‘release’

The subordinate theme: *experiencing a ‘release’*; can be related to the idea of ‘catharsis’ in counselling (Hawkins, 1995). Catharsis is described as the giving of shape and meaning to difficult feelings, through language (Spurling, 2009). As described previously, the findings of this study show that for most of the participants, counselling provided the first opportunity for their feelings to be validated and expressed.

Another of Brodzinsky’s criterion in his model for adaptive grieving for birth mothers (1990) encompasses the ‘freedom to express feelings’ (p.311). He notes that the ability

to express grief openly is culturally determined. Psychoanalytic theory has long praised the value of expressing long-withheld feelings and emotions. This is the premise of Freud's 'talking cure' (Freud & Breuer, 1895). Being able to express their feelings about the loss of their children was key for all the mothers in this study. This is an important finding in relation to what counselling or therapy spaces are available to mothers following child removal. As Brodzinsky (1990) points out, this process of expressing feelings and having them understood 'cannot occur in a vacuum' (p,312).

Noticing changes

The subordinate theme: *noticing changes*; echoes the findings of Logan (1996) that birth mothers were able to gain a different perspective through counselling. Many of the birth mothers also reported either changes in their relationship status or noticing differences in their relationships with family members. Improved relationships are an outcome of support often reported with work with birth mothers. Koch (1987) reported better self-care and improved relationships with family and men as outcomes of her work with one birth mother. Many of the mothers in this study also described forming new relationships with romantic partners since coming to counselling. Improved relationships was also identified as a 'turning point' by Broadhurst and Mason (2014) in the lives of birth mothers they considered to be 'rehabilitated', that is they now had parental responsibility for a child in their care. It seems that the mothers in this study experienced changes in their lives in line with those experienced by other birth mothers elsewhere in the literature.

Master theme 3: “My children are my world”

The final master theme: *“my children are my world”*; relates to the participants experiences of connecting to their children in counselling and their sense of identity as a mother.

Maintaining painful connections to my children

Broadhurst and Mason (2014) identified ‘commitment and sense of enduring connection to their children’ as a helpful factor in creating change. The subordinate theme: *maintaining painful connections to my children*; describes how the mothers used counselling as a space to talk about their children, their past memories and their present anxieties about their children’s lives now. This included anxiety regarding whether their children ever thought of them, a finding also present in the accounts of the mothers in a study by Jackson (2000). The struggle to maintain connections to their children, particularly in the absence of any concrete memories or knowledge of their lives now was also common to the mothers in the Jackson (2000) study.

It’s normal to think about the children who have been removed (Baden and O’Leary Wiley, 2007). According to Fravel *et al.* (2000) counsellors can normalise a birth mother’s experience by:

“helping her understand that there will be times when the adopted child is in her heart or on her mind, and that these occasions may produce a variety of emotions. Further, they can help her create a perspective that views psychological presence as a healthy, adaptive response, and anticipate constructive thought patterns and behaviours to manage these situations” (p.431).

The mothers in this study appear to have made good use of their counsellors in regards to these tasks, as evidenced in the master theme "*The healing process*" above.

In a 'normal' grief reaction, as described by Carr (2007), in order to come to terms with a loss an individual must come to realise that the loss is permanent. This represents a complex task for the mothers in this study, none of whom believed their loss to be a permanent one. By connecting to the painful memories of their children in counselling the mothers also appeared to use counselling to navigate the very real possibility of future reunion, or for some, concurrent contact.

Feeling like a mum vs not feeling like a mum at all

The subordinate theme: *feeling like a mum vs not feeling like a mum at all*, is consistent with the findings of Slembrouck and Hall (2003) that having a child removed into the care of the state is arguably the greatest challenge to a mother's self-identity and moral character. Carolan *et al.* (2010) acknowledged the power of this identity role when they described the women they worked with as "ultimately childless mothers" (p.183). They note that without the distraction of parenting, the mothers they worked with struggled openly with self-worth and self-blame, two issues also present for the mothers of this study. It was clear from the interviews that each of the mothers in the study cared deeply for all of their children, a finding also consistent with the experience of Carolan *et al.* (2010).

The social construction of motherhood

As identified in the introduction, 'motherhood' is a particularly prominent social identity for women. Feminist writers have highlighted the pressure on women to meet

unrealistic demands of motherhood and argued that the expectations of mothering are based on a predominantly white, middle-class, Eurocentric model (Carolan *et al.*, 2010). This subordinate theme speaks to the mothers of this study's difficulty in sustaining their mother identity in the absence of their children. Keilty (2008) reported a similar finding from her interviews with birth mothers and related this to mother's carrying an internalised image of the ever-available, totally nurturing mother and their inevitable inability to achieve this ideal.

Both birth mothers and adoptive mothers have been depicted as 'deviant' in the clinical adoption literature, for failing to conform to dominant definitions of true 'womanhood' and 'good mothering' (Wegar, 1997). The mothers in this study could all be described as coming from low-income backgrounds. Most had sole responsibility for their children with little or no support. This is in the context for some of having experienced significant abuse, neglect, or trauma. Carolan *et al.* (2010) recognises mothers like these as "mothering in the margins" (p.174).

The subordinate theme *feeling like a mum vs not feeling like a mum at all*, encompasses the mothers' struggle with their 'mother' identity post child-removal. They have gone from 'mothering in the margins' to not mothering at all. Arditti and Madden-Derdrich (1993 cited in Carolan *et al.*, 2010) assert that most women do not give up the identity of mother easily and this can be seen in the accounts of the mothers of this study. In naming them 'non-resident mothers' Kielty (2008) recognises that the mother identity is not removed when the children are.

Many of the mothers spoke of the ways they still identified as mothers and took on a mothering role. For some it was with their own children during contact or at home with children who had been returned to them, for others it was through their relationships with other children. Cuthbert *et al.* (2009) point out that narrow, mainly white, middle-class, ideas of mothering fail to account for these other forms of mothering. In non-white communities mothering other people's children is far more common where mothering is viewed as a function not an identity. The social discourses available to the mothers in this study seem to have contributed to their feelings of inadequacy and failure to fulfil the mother role. In many of the accounts the role of mother seemed to be idealised perhaps to such an extent that they would always fall short. The mothers in this study referred to specific tasks of mothering, for example 'the school run' or cooking or feeding their children. It could be argued that they were conforming with a society that identifies mothers by what they do rather than by what they feel or think (Ruddick, 1994 cited in Medina & Magnuson, 2009).

It would appear that there was no construct of mothering available to these mothers which could encompass the other forms of mothering they experienced, or their feelings towards their missing children. Coupled with this, and as identified by Fravel *et al.* (2000), there is no socially approved role for a child who has been removed in the birth mother's life. Struggling with complex relationships with their children, whether real or imagined, was a feature of the accounts of all the mothers in this study and captured by the subordinate theme, *feeling like a mum vs not feeling like a mum at all*.

Complex grief and threat to identity

Henney *et al.* (2007) found that birth mother grief is a complicated and complex process which evolves over the life span. They describe how birth mothers' grief reactions varied over time and with different levels of contact; they also varied according to changing life events and as the children aged. This variance in the experience of grief speaks to the oscillation within this subordinate theme of this study and the experiences described by the mothers I interviewed. Many of the mothers in this study were dealing with different levels of grief regarding different children at the same time.

Doka's definition of disenfranchised grief (1989) also encompasses the experience of multiple losses. The mothers of this study not only describe the loss of their children but also the loss of their role as mother. As has been explored previously, the identity of a mother is most often defined by caring for children, by actions rather than feelings (Schofield *et al.*, 2011). Some of the mothers in this study described in detail how they took on a caring role, either in contact with their children or in an imagined life with their child. Echoing the findings of Schofield *et al.* (2011) the subordinate theme *feeling like a mum vs not feeling like a mum at all*, illustrates the mothers' awareness that their status and identity as parents had fundamentally changed.

A multi-storied life

Another aspect of this subordinate theme is the way in which the mothers seemed to use counselling to explore other aspects of their lives and identities. In narrative terms this function could be related to Michael White's notion of 're-authoring conversations' (White, 2007). As the first master theme conceptualises, the mothers came to counselling *feeling alone, overwhelmed and stigmatised*. In narrative terms it could be

argued that the adversarial nature of the child protection system and family court process had contributed to the 'dominant story' of these mothers' lives being one of negativity, failure and powerlessness. The master theme "*My children are my world*" captures the idea that counselling seems to have enabled the mothers to strengthen an alternative storyline of love and devotion to their missing children, allowing them to situate themselves more fully and confidently within a preferred 'mother' identity.

The mothers described using counselling to talk about aspects of their lives now, opening up space for both the mother and non-mother aspects of their identities to be 'thickened'. Some of the mothers spoke of coming to see through counselling that their lives were not over, that they could 're-author' a life moving forward without their children. This finding is in line with White and Epston (1990)'s assertion that a person's life can be multi-storied and suggests that drawing these out in counselling is important.

I have chosen to refer to the mothers of this study as 'mothers' throughout this chapter, in doing so I hope to respect this part of their identity. However, in naming them as mothers I privilege this identity over others, the 'mothers' of this study were also women, daughters, friends, some were sisters, partners, volunteers, employees and a multitude of other identities.

Clinical Invitations

There are virtually no empirically validated guidelines for practice with birth relatives (Baden and O'Leary Wiley 2007). The findings of this study invite the provision of services for this client group that address the social and systemic nature of child

removal, privilege the relational nature of recovery, empower birth relatives and create safe spaces for the processing of the emotional pain inherent in child removal. The clinical implications of each of the master themes will be discussed separately below.

From feeling alone, judged and let down to feeling part of a special relationship

The court process was universally negative and arguably traumatic for the mothers in this, study but also in the wider literature. Harwin *et al.* (2014) consider what the court could do differently and point to the potential of problem-solving courts and the experience of the Family Drug and Alcohol Court (FDAC)¹². Problem-solving courts aim to treat as well as adjudicate in the belief that without tackling the causes of the problem, prospects for a return to court are increased (Harwin *et al.*, 2014). It could be argued that with the increasing likelihood of ongoing contact or continued mothering relationships that this approach would improve outcomes for children as well as birth relatives. However, given the histories and wider contexts of birth parents the coming together of support and judgement could prove confusing in practice.

What is clear from the findings of this study is the importance of focusing on the therapeutic relationship in any work with birth relatives, especially at the start of any intervention when huge levels of distrust and fear need to be overcome. It points to a role for therapists/counsellors to begin therapeutic work with exploration of their clients' relationship to help but also "warming the context" type conversations and "talking about talking" (Burnham, 2005).

¹² See <http://www.brunel.ac.uk/fdacresearch>

This study also points to the key role of social workers in signposting and referring birth relatives to counselling or other forms of support. This tends to happen right at the point of relationship breakdown with professionals when birth relatives may be feeling at their lowest and most let down. These findings point to considering social care policy at this crucial time and mechanisms that might increase the likelihood the birth relatives take up appropriate services if they are offered.

This study also supports the idea that helping parents with the emotional pain of losing their children is not a 'quick fix' and so will take time (Broadhurst & Mason, 2017). The importance of considering how the therapeutic relationship can endure after therapy ends (Zilberstein, 2008) has been established. Helping clients with this task, especially the more vulnerable clients who have experienced earlier, devastating losses, is important. One idea could be to build in opportunities for 'refuelling' between episodes of counselling.

This also relates to the idea of 'bending the frame' (Eversole, 1997) and alternative considerations of 'endings' as discussed earlier. Counsellors/therapists should not limit themselves to traditional roles but, as necessity demands, go beyond the established boundaries. This might involve going outside of the traditional setting, offering extended sessions, longer interventions or simply sharing a cup of tea.

"The healing process"

The importance of using a trauma-informed approach with birth mothers as identified in the systematic literature review (e.g. Battle *et al.*, 2014) is supported by the findings

of this study. It validates the idea that support services for birth mothers should attend to their complex trauma histories and the systemic and intersecting effects of oppression due to low-income, poverty, and gender (Carolan *et al.*, 2010).

“My children are my world”

As Medina and Magnuson (2009) highlight, counsellors are part of society. They will have their own biases and assumptions about ‘good motherhood’. The findings of this study highlight the value mothers place in being viewed not as ‘deviant’ but with ‘unconditional positive regard’ and whose experiences are viewed in context. They pose an invitation to challenge society’s dominant script of family and motherhood and carve a space for birth mothers to be seen, heard and acknowledged for the role they will inevitably still hold in children’s lives.

Child-centred services are clearly centre stage and the importance of protecting children from harm cannot be questioned. However, it could be argued that child-centred services are not the best way to protect children from harm. Why not family-centred services? Featherstone *et al.* (2016) point out that in reality social workers usually have responsibilities to more than one family member at a time. The findings of this study, support Broadhurst and Mason’s (2013) call for an agenda focused on maternal rehabilitation. The evidence that suggests many birth mothers (and other birth relatives) continue to have contact with the children who were removed, and for some go on to parent subsequent children, indicates that supporting mothers will lead to better outcomes, not only for the children who have been removed, but also for the future of children as yet unborn. Children will suffer in the longer term if the needs of birth parents are ignored.

Strengths and limitations

This study went beyond a service evaluation of the effectiveness of a birth relative counselling service to explore the mechanisms of change in therapy and the impact counselling can have on wellbeing and on notions of identity and relationships. This study provides birth mother's own first-person accounts of their experiences of counselling beyond child removal. This is not found anywhere else in the literature and so also represents a unique contribution to the field.

Recruitment

A significant limitation of the study is the failure to recruit any birth relatives who were not birth mothers to participate. Recruitment with birth relatives is well documented to be challenging and the focus of study is the experience of one counselling service. The birth relatives accessing counselling have already shown willingness to share and reflect on their experiences and so were appropriate and available to share their knowledge and expertise with me.

Sample

The small size and convenience of the birth relative sample mean that the findings of this research cannot be statistically generalised beyond these clients. However, through what Smith *et al.* (2009) term theoretical generalisability, these findings point to important and evocative aspects for consideration for counselling offered to birth mothers in the future. The fact that all the participants are White British is also a limitation, especially given that statistics show that children of colour appear to be over-represented in the looked-after children population (DfE, 2017).

There remain birth relatives whose experiences are not present in research or literature. This study has not addressed the experiences of birth relatives other than mothers, it has not addressed the experiences of birth mothers who are not White, and it has not heard the experiences of birth mothers for whom counselling was not an option, e.g. birth mothers in prisons. Whilst clearly limitations, these omissions also represent some interesting opportunities for future research.

Method

One of the key aims of the project and an important reason for choosing a qualitative methodology was to privilege the voices of birth relatives themselves. This study has stayed close to the experiences as described by the five birth mothers who participated and as such represents an important contribution in the context of 'silence' identified with regard the experiences of birth relatives.

Due to the nature of the methodology, and in line with the epistemological position of the researcher, it should also be noted that what was expressed in the birth mothers' interviews may only represent one account co-constructed within one interview. This is particularly important to consider regarding the potential impact of one participant having her daughter present during her interview. Whilst methodologically not ideal, this was considered the most ethical response at the time, and it is also not unprecedented in the literature concerning birth relatives. Neil (2006) also included interviews in their analysis where two people were present, acknowledging the support that these participants were requesting in taking part in the study. However, these contextual factors need to be held in mind when considering the findings.

The research question added an element of temporality to the results, particularly in relation to the first and second master themes. IPA has recently been applied to more temporal data (e.g. Van Parys *et al.*, 2014; Turner, 2016) and therefore could be adapted to accommodate this data. Given that the majority of the data were focused on rich detail lived experience and meaning-making, it is considered that IPA was the most appropriate choice of analytical method for the data generated within this study in the light of the research questions asked (see Elliot, 2011).

Directions for future research

As well as more concerted effort to recruit and collaborate with birth relatives other than (as well as) birth mothers. The findings of this study point to future research with birth relatives experiencing shorter counselling interventions, or for whom counselling has not been experienced as helpful.

The existing literature highlighted the variation in orientation, intervention and theoretical underpinnings of current support services for birth relatives. Future research would do well to increase our understandings of outcomes for this population and the effectiveness of a variety of interventions and approaches, offered by a variety of services.

The importance of the therapeutic relationship, invites further exploration of what it was that facilitated this process and supported the mothers to trust their counsellors, given their experiences. What was it that allowed them to engage in this type of work?

The final master theme "*My children are my world*" could invite further theoretical exploration of the experiences of grief and fluctuations in identity that appear to be so relevant for some birth mothers.

Final reflections

I came to this project somewhat naïve to the experiences of birth relatives and the support services available to them. Through the process of searching the academic literature, working closely with those with more wisdom than myself in this important field, and most importantly speaking to the five birth mothers I met; I now consider the experiences of birth relatives an area of incredible importance and the limited attention it has received in terms of research and service development heart-breaking.

I hope that the findings of this study can be widely disseminated and help to raise the voices of this so often marginalised group. My journey to this position has been greatly enabled by my experience of having my assumptions exposed and then shattered in meeting with the mothers I interviewed, and significantly from the opportunity I had to work with my supervisor who had lived experience of counselling following the removal of her children, Clarissa. I had concerns in the beginning about involving a service user in the project in a meaningful way. Whilst it felt most meaningful to recognise the huge contribution Clarissa could make, looking back now I wonder if I could have done more to support her in the role of 'supervisor', without any formal training or experience of this kind of research before. Empowerment of birth relatives seems to be an important aspiration of those working in the field and one which at the end of this project I hold firmly in mind.

Over the life time of the project I have noticed I have, in a small way, become an advocate for the voices and experiences of the birth relatives of the looked-after children I am privileged to work with in my current clinical role. I don't think this could have happened without my meetings with Rebecca, Isobel, Saffron, Lara and Elisabeth and for that I will always be grateful.

Conclusion

The findings of this study go some way towards answering Broadhurst *et al.* (2015)'s call to build the evidence of what this population of parents find helpful in terms of mental health intervention. Whilst failing in its aim to hear the experiences of a range of birth relatives who engage in counselling, it has none-the-less raised the voices of five birth mothers with substantial experience of counselling following the loss of a child or children to adoption or foster care.

Whilst it has been noted elsewhere that birth mothers benefit from timely and empathic counselling from 'adoption-competent therapists' (Brodzinsky & Smith, 2013), this study represents new insights into the mechanisms of change within such counselling and what birth mothers themselves value within such interventions.

The distress of birth relatives related directly to the loss of a child or children to the care system is likely to be something that never goes away (Neil, 2013). This study suggests that the process of child removal is traumatic and directly impacts on birth mothers' ability to form future trusting relationships with helping professionals. This is an important finding as the experiences of these mothers also suggests that the forming of a 'special' relationship with a helping professional, or in this case counsellor, is

fundamental to their ability to process what has happened to them and move forward with their lives. Conceptualising 'recovery' as relational, this study invites alternative considerations of 'endings' in therapy. It also invites a challenge to society's dominant script of family and motherhood and advocates a space for birth mothers to be seen, heard and acknowledged for the role they will inevitably still hold in children's lives.

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Appendix A – Storms and Effects

Storms and Effects – A poem by Clarissa Stevens

Being thrown in a situation you don't understand,
it's all set out but there is no plan,
rules need to be followed policies and regulations,
timescales to be met and so filled with frustration.
Welcome to the world of child protection,
when all us mums have ever wanted was to protect them.

Feeling so sick scared and afraid so unaware,
never really knowing what we are about to face,
the scrutiny we are under makes us fear to make a move,
because fear soon turns into living proof,
when what you love so much gets taken away,
the anger builds and changes, we play the blame game,
but living in fight or flight just turns into resentment,
never really knowing who to trust
because honesty just leaves us lost,
powerless confused and betrayed.

Whether we know too little or know too much
it all gets twisted into a knot,
get told to go right then told we are wrong.
A losing battle soon as you enter the courts,
hundreds of people all around
but so alone whilst walking through the crowds
the pressure the anxiety it all builds up,
what if I say something wrong and mess up.

Thrown into a category with all the rest
always down the line of neglect,
Ill treatment, abandonment, failing to protect
all the words you live to regret,
emotionally detached is what they claim,
emotionally drained is what we scream.

Catch 22 as the wheel goes round
throwing the dart in so we can't make a sound,
depressed because we lost,
but loosing because we are depressed,
which is when paranoia kicks in
who can we trust in our hour of need
sometimes it's just the drink
maybe someone who doesn't even know our names,
to comfort us while we grieve.

The guilt tears us apart

always reminding us of the start,
making us feel like we no longer have a heart.
Frozen like ice so cold so numb
emotions either run too much or there are none,
there is no balance no cure.

Mummy is a name we grow to love,
until love cost us too much,
identity gone no one will know
in this new world who I am or where I'm from,
but when we open our eyes each day there is
always that reminder our children are gone.

Memories don't fade just
turns into photos in a frame,
times of the year we always remember
so specific it's like torture.
Christmas and birthdays are always hard,
especially when you face them alone
just sit wondering how they must of grown.

Never knowing who your creation
will become and scared as their voices are distant,
praying they remember your existence.
Lost in society that we cannot trust
longing for forgiveness is a must.

Appendix B – Details of Systematic Literature Review Search

Databases searched	
Search 1 Scopus [Title, abstract, keywords]	332 titles screened → 54 abstracts screened → 21 full texts screened → 8 papers for review
Search 2 SCIE [All fields]	306 titles screened → 60 abstracts screened → 16 full texts screened → 6 papers (duplicates removed) → 1 unique paper for review
Search 3 Discovery (including: CINAHL, PsycARTICLES, SocINDEX, PsycINFO, MEDLINE, PEParchive) [Title only for terms relating to “birth relatives”, All Fields for remaining search terms]	99 titles screened → 24 abstracts screened → 10 full text screened → 3 papers (duplicates removed) → 2 unique papers for review

Table 5: Databases searched

Terms relating to participant group (“Birth relatives”)		Terms relating to method of support (“psychotherapeutic counselling” or bereavement/grief)		Terms relating to experience of child removal (“compulsory adoption”)
“birth relati*” or “birth parent*” or birthparent* or “birth mother*” or birthmother* or “birth father*” or birthfather* or “birth famil*”	AND	intervention or psychotherapy or counsel* or “talking therap*” or support or bereavement or grief	AND	“compulsory adopt*” or “contested adopt*” or “child* remov*” or foster* or “in* care” or adopt*

Table 6: Search terms

Inclusion criteria	Exclusion criteria
Evaluation of a birth relatives support service OR Description of birth relatives experience of service/intervention OR Detailed description of intervention specifically for birth relatives Post child-removal intervention/support Peer reviewed journal article	Not birth relatives Not peer reviewed Focus is intermediary services, contact or reunification Describes experience of child-removal only Parenting intervention (where objective is reunification) Service provider level research (except detailed descriptions of specific interventions) Social work (casework only) intervention

Table 7: Inclusion/Exclusion Criteria

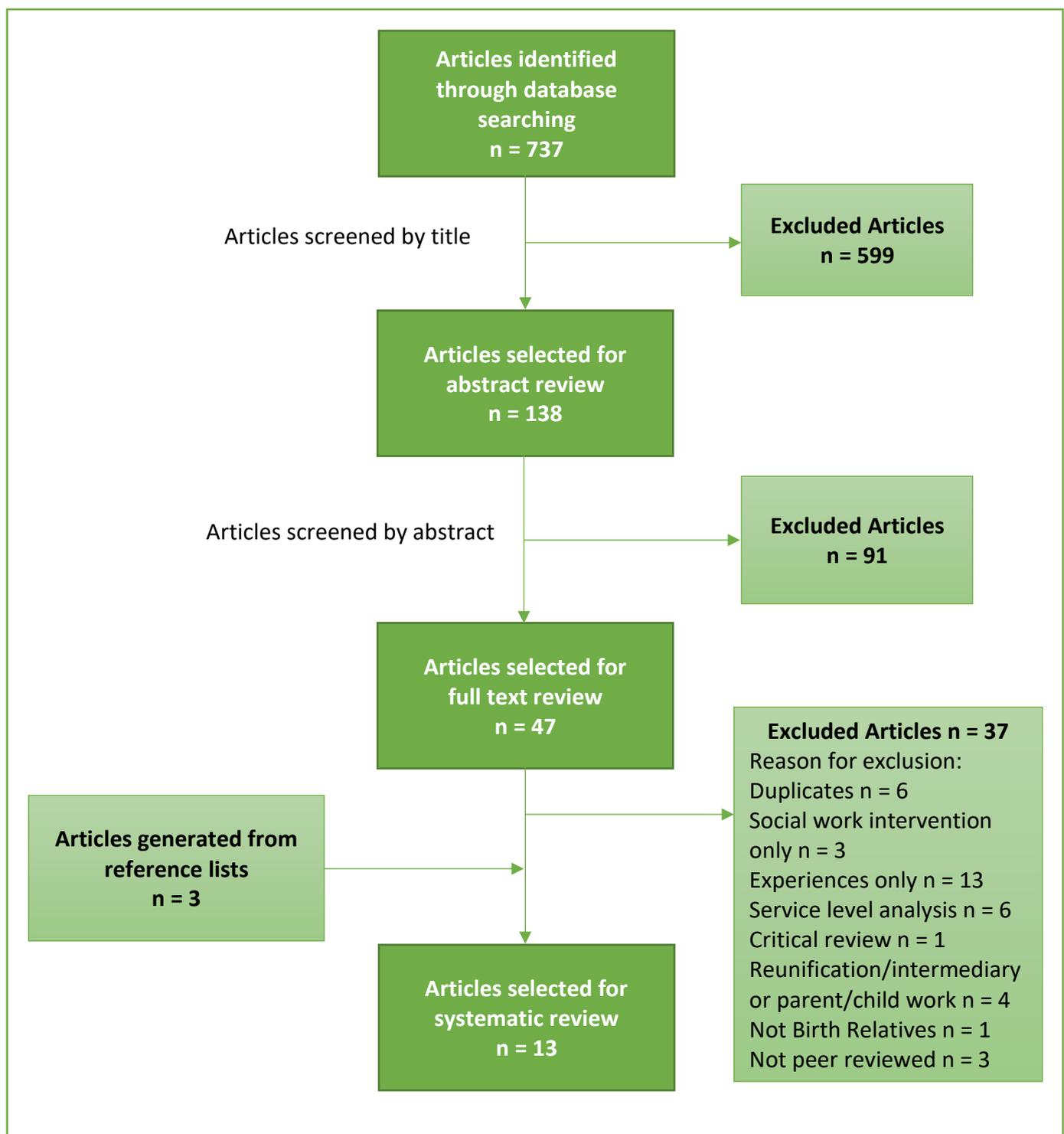


Figure 1: Flow chart of literature search

Appendix C – Systematic Literature Review Quality Tables

	Battle <i>et al.</i> 2014	Claridge 2014	Cox <i>et al.</i> 2017	Fram <i>et al.</i> 2006	Harris 2004	Harris 2005	Hess & Williams 1982	Jackson 2000	Koch 1987	Lewis-Brook <i>et al.</i> 2017	Robinson 2002	Scourfield <i>et al.</i> 1991	Slettebø 2013
Publish-ability Guidelines Shared by Both Qualitative and Quantitative Approaches (Elliot, Fischer and Rennie, 1999)													
1. Explicit scientific context and purpose	x	x	✓	x	✓	✓	x	x	x	✓	x	x	✓
2. Appropriate methods	x	n/a	✓	✓	✓	✓	x	n/a	✓	✓✓	n/a	✓	✓
3. Respect for participants	✓	n/a	✓✓	✓	✓✓	✓	✓	✓	✓	✓✓	n/a	✓	✓✓
4. Specification of methods	x	n/a	✓	✓	✓	✓	x	x	x	✓	x	x	✓
5. Appropriate discussion	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	x	x	✓
6. Clarity of presentation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
7. Contribution to knowledge	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Publish-ability Guidelines Especially Pertinent to Qualitative Research (Elliot, Fischer and Rennie, 1999)													
1. Owning one's perspective	x	x	x	✓	x	x	x	x	x	✓	x	x	x
2. Situating the sample	✓	✓	✓	✓	✓	✓	x	x	x	✓	x	x	x
3. Grounding in examples	✓	x	✓	✓	✓	✓	x	x	x	x	x	x	x

4. Providing credibility checks	x	x	x	✓	x	x	x	x	x	x	x	x	x
5. Coherence	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
6. Accomplishing general vs. specific research tasks	x	n/a	✓	✓	✓	✓	x	x	x	✓	n/a	x	✓
7. Resonating with readers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Table 8: Literature Quality Table Elliot et al., 1999

	Author, Title and Location	Participants	Research Methodology	Summary of study and key findings	Strengths and Limitations
1	Battle, C., Bendit, J., & Gray, R. (2014). Groupwork for parents whose children are in care: Challenges and opportunities. Australia.	Parents whose children are not in their care. Unclear how many.	Description of group intervention with birth parents whose children are in the care of child protection services. Recurring themes from 'group dialogue' are presented. Themes are drawn from case notes and supervision sessions.	Clinical implications and case studies illustrate the practice. The components of the current iteration of the group include the importance of using a trauma informed practice approach, the therapeutic working alliance, and group process. Narrative ideas and group exercises are described. Recurrent themes identified are: Client grief and Client shame and stigma.	Strengths: Clear rationale for the creation of a group program for parents of children who have been removed is provided with evidence from research and psychological theory. Direct quotes from parents are included. Limitations: Evaluation of group is anecdotal. No research methodology is described. There is no description of how data was analysed or themes created.
2	Claridge, A. M. (2014).	None.	Description of couple treatment approach to	A couple treatment approach is proposed and intended to be a	Strengths: Rationale for couple treatment approach is provided.

	Supporting birth parents in adoption: A couple treatment approach. USA.		supporting birth relatives. Incorporates suggestions from birth relative literature with an empirically supported therapy model: emotionally focused couple therapy.	starting point toward a comprehensive, systemic therapy approach to better serve the needs of birth parents in adoption. It does so by addressing the systemic nature of relinquishment, empowering birth parents, and creating a safe space for processing of the emotional experience of relinquishment and other attachment injuries.	Detailed description of systemic treatment approach is provided. Limitations of paper are acknowledged. Limitations: Theoretical approach, has not been validated. Provides description but no critique of existing approaches.
3	Cox, P., Barratt, C., Blumenfeld, F., Rahemtulla, Z., Taggart, D., & Turton, J. (2017). Reducing recurrent care proceedings: Initial evidence from new interventions. U.K.	82 birth relative clients (74 women and 8 men) 5 practitioners	Evaluation of two services. Mixed methods empowerment evaluation strategies. Baseline data = practitioners' assessments of individual client experience and progress. 6 self-report clinical measures (n=12). Qualitative interviews (14 clients, 5 practitioners).	This article summarises the findings of the first academic-led evaluation of two of these initiatives. Neither service is tied to a fixed intervention model or to a particular theory of change. Rather, they offer a pragmatic, client-led approach, based on one-to-one support, self-care and trust-building. Presenting evidence from a mixed-methods evaluative study, it concludes that the new services were able to foster relationships that 'worked' in reducing recurrent proceedings. Key findings include: avoided pregnancies and avoided care proceedings;	Strengths: Clear rationale for services and evaluation methods is provided. Rich description of mixed methods evaluation model, including collaborative working and collective ownership of goals. Limitations acknowledged. Findings are interpreted within the context of other studies and theory. Conclusions are justified. Limitations: Assessment data was not available for all clients across all indicators. Recruitment and retention issues (only outcome data for 5 clients). No details of ethical

				experiencing a different kind of service; clinical measures of personal change; and 5 detailed case studies.	approval being sought or granted are provided. Complicated methodology might be difficult to replicate.
4	Frame, L., Conley, A., & Berrick, J. D. (2006). "The real work is what they do together": Peer support and birth parent change. USA.	14 staff and 16 birth parents and former clients of the MCFSC group.	Grounded Theory. Focus groups, interviews and observation to understand key components of the MCFSC peer support intervention.	Description of program and findings from exploratory study are presented. Approach appears to give parents a sense of security that enables them to take risks in attempting to make changes in their parenting-related perspectives and skills. A composite case example is used to illustrate frequently used intervention methods.	Strengths: clear rationale and research question provided. Detailed description of methodology, sample, data collection and analysis. Findings are interpreted within the context of other studies and theory. Conclusions are justified. Limitations: No details of ethical approval being sought or granted are provided. Small sample size. Results are not robustly presented. Thematic data analysis is described but no themes are presented.
5	Harris, P. (2004). User views and experiences of post-adoption services: A study of a regional post-adoption agency.	66 service users (birth relatives and others)	Informed by emancipatory research; black, indigenous and critical anti-racist approaches and feminist research practice. Mixed-methods were used. The study was primarily qualitative and used purposive sampling. An analysis of initial enquiries to service; the	This paper reports on the key findings from interviews with service users (n = 41). The analysis revealed that nearly all service users had approached other people and places for help prior to contacting WMPAS, that most evaluated WMPAS services highly and that, for the majority, receiving a service	Strengths: Service user involvement in study design. Gaps in research methodology are acknowledged. Findings are interpreted within the context of other studies and theory. Conclusions are justified. Limitations: Only reports some findings from wider study. No details of ethical approval being

	U.K. (England)		collection of data on the use of the support groups; a postal survey of service users who had attended a support group; interviews with a sub-sample of 41 service users; specially designed work with an adopted child who had received a service.	had in many ways made a positive difference to their lives.	sought or granted are provided. Interview methodology and data analysis is not described. Birth relatives are only 16% of sample.
6	Harris, P. (2005). "Family is family" it does affect everybody in the family: Black birth relatives and adoption Support. U.K. (England)	5 black birth relatives who participated in interviews or a focus group of previous study.	Using data from previous study. Informed by emancipatory research; black, indigenous and critical anti-racist approaches and feminist research practice. Purposive sampling was used. Focus-group including actual and potential service users (n = ?; 3 black birth relatives). Individual interviews with service users (n = 41; 2 black birth relatives). Thematic analysis using a grounded theory approach.	Drawing on findings from larger study of service users' views and experiences of such services, (above) focuses on a small group of black birth relatives' experiences of post-adoption support, highlights some of their specific support needs, as identified by themselves, and makes concrete suggestions for ensuring that services are appropriate, accessible and welcoming to them. The article demonstrates the importance of developing non-Eurocentric, non-stigmatising, culturally appropriate and anti-oppressive services that are tailored to meeting the specific needs of this group.	Strengths: Research aims are described (not formal research question). Researcher influence is acknowledged. Direct quotes provide rich account from Birth relatives perspective. Limitations: Small sample size. No details of ethical approval being sought or granted are provided. Research methodology is unclear.

7	Hess, P., & Williams, L. B. (1982). Group orientation for parents of children in foster family care. USA.	5 families, case workers, agency.	Program development. Pilot group 'orientation' program is described. The 'responses' of the parents, case workers and agency are reported.	The authors describe the pilot phase of a program that uses a structured (6-week) group format to orient parents to their expected roles and to educate and support them in the process of deciding their children's future. Parents are reported to have found the group helpful. Continued attendance is seen as evidence of parents' interest in the group. Relationships between parents and caseworkers were felt to be improved.	Strengths: Rationale for 'orientation group' with reference to theory and research. Developmental process of group program and detailed description of intervention are included. Limitations: Attendance at the group was court ordered. Not a formal evaluation. No research question or methodology used. Small pilot study. 'Responses' are anecdotal. No implications or conclusions are drawn.
8	Jackson, J. (2000). Developing a post-adoption groupwork service for non-consenting birth mothers. U.K. (England)	Unclear. Mentions 8 service users then refers to further group 'cycles' without referencing how many attended.	Formal and informal feedback – short postal questionnaire.	Description of an informal groupwork service offered by Support After Adoption for birth mothers whose children have been in care and then adopted. Workers' and participants' evaluations of what these birth mothers gained from the group, highlight some of the learning outcomes and considers ways in which the team hopes to take this work forward. Continued attendance viewed as evidence for value of group.	Strengths: Involving a service user in setting up and running the group. Evidence of interagency working and sharing of best practice. Learning outcomes are interpreted within the context of other studies and theory. Limitations: Formal feedback (postal questionnaires) response rate was limited and results are not reported. Therefore, not a formal evaluation. No research

					methodology described. Evaluations are anecdotal.
9	Koch, P. (1987). Reparenting in the therapeutic relationship with a birth parent: a case	1 birth mother of two children in foster care	Single case study	Discusses working with a mother whose children are in foster care. A (psychodynamic) model of a parent-child relationship is proposed for therapeutic work with this client group.	Strengths: detailed description of therapeutic work with one birth mother. Intervention is drawn from theory. Limitations: No evaluation is offered. No research methodology. Small sample size by nature of single case study.
10	Lewis Brooke, S., Bell, L., Herring, R., Lehane, L., O'Farrell Pearce, S., Quinn, K., & So, T. (2017). Mothers apart: An action research project based on partnership between a local authority and a university	Birth mothers (n = 11) and staff in the development of the project.	Development of practice. Focus groups and interviews.	Reports on an action project ('Mothers Apart') involving a partnership between staff in one local authority and university researchers in London (UK). This has included both research and development of an initiative to support birth mothers whose birth children were permanently removed from their care. Reports on pilot project and intervention model.	Strengths: Clear rationale and policy context described in detail. Intervention grounded in theory and experience of working with service users. Service user collaboration valued and used effectively. Limitations: No formal evaluation. No research methodology or details of research process. States it is 'too early to evaluate' the service. Benefits reported to services users are anecdotal. Findings from interviews and focus groups used to develop intervention model but not reported on themselves (reported elsewhere).

	in London, England. U.K. (England)				
11	Robinson, E. (2002). Post-adoption grief counselling. Australia.	The Author	Personal account of experience as birth mother and counsellor/co-ordinator of support group.	Describes experiences of mothers using support services (individual and group). Grief counselling using a narrative approach.	Strengths: Explores issues for service users and relevance of grief counselling model, with reference to theory and relevant research. Limitations: No evaluation. Benefits reported are anecdotal (albeit with added legitimacy as author is herself a birth mother). No research methodology.
12	Scourfield, F. <i>et al.</i> (1991) Unfinished business - the experience of a birth mothers' group			Describes preparations for the group and a series of meetings, mainly in the words of the participants.	
13	Slettebø, T. (2011). Partnership	36 birth parents,	Action research. Descriptions and evaluations of the group	In this study, parents were provided with the opportunity to form a group together with	Strengths: Empowerment and user participation framework used. Methodology and data

	<p>with parents of children in care: A study of collective user participation in child protection services.</p> <p>Norway.</p>	<p>foster parents and social workers.</p>	<p>meetings based on field notes from participatory observation of thirty-two meetings, eight focus group sessions with parents, foster parents and social workers, and ten in-depth interviews. In addition, telephone interviews were conducted with the first twenty parents who had participated at user group meetings for their first time and six parents who attended one meeting but did not return were also interviewed.</p>	<p>social workers and foster parents. The evaluation shows that the group offered the parents both the social support they needed and a forum to voice their opinions of the services. The group was mutually beneficial; it provided the social workers with useful knowledge, which resulted in organisational development, and the birth parents described their experiences as an empowering process.</p>	<p>analysis described. Some limitations acknowledged.</p> <p>Limitations: No evidence of ethical approval being sought or granted. Dependant on social workers self-reporting organisational learning. Conclusions are not interpreted with reference to wider context.</p>
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Table 9: Literature Quality Summary Table

Appendix D – Application for ethical approval

UNIVERSITY OF HERTFORDSHIRE

FORM EC1A: APPLICATION FOR ETHICS APPROVAL OF A STUDY INVOLVING HUMAN PARTICIPANTS (Individual or Group Applications)

Please complete this form if you wish to undertake a study involving human participants.

Applicants are advised to refer to the Ethics Approval StudyNet Site and read the Guidance Notes (GN) before completing this form.

<http://www.studynet2.herts.ac.uk/ptl/common/ethics.nsf/Homepage?ReadForm>

Use of this form is mandatory [see UPR RE01, 'Studies Involving Human Participants', SS 7.1-7.3]

Approval must be sought **and granted** before any investigation involving human participants begins [UPR RE01, S 4.4 (iii)]

If you require any further guidance, please contact either hsetecda@herts.ac.uk or [ssahecca@herts.ac.uk](mailto:ssahecda@herts.ac.uk)

Abbreviations: GN = Guidance Notes UPR = University Policies and Regulations

THE STUDY

Q1 Please give the title of the proposed study

The experiences of birth relatives who engage in psychotherapeutic counselling following the loss of a child/children to compulsory adoption.

THE APPLICANT

Q2 Name of applicant/(principal) investigator (person undertaking this study)

Hannah Morgan

Student registration number/Staff number

12240415

Email address

h.morgan@herts.ac.uk

Status:

Undergraduate (Foundation)

Undergraduate (BSc, BA)

Postgraduate (taught)

Postgraduate (research)

Staff

Other

If other, please provide details here:

N/A

School/Department:

Life and Medical Sciences

If application is from a student NOT based at University of Hertfordshire, please give the name of the partner institution: N/A

Name of Programme (eg BSc (Hons) Computer Science):

Doctorate in Clinical Psychology

Module name and module code: Doctoral Thesis

Name of Supervisor: Dr Lizette Nolte

Supervisor's email: l.notle@herts.ac.uk

Name of Module Leader if applicant is undertaking a taught programme/module:

Dr Pieter Nel

Names and student/staff numbers for any additional investigators involved in this study

N/A

Is this study being conducted in collaboration with another university or institution and/or does it involve working with colleagues from another institution?

Yes

No

If yes, provide details here:

Field Supervisor Barbara Rishworth, Lead Clinical Psychologist at the Brandon Centre and Clarissa Stevens, Supervisor with lived-experience of counselling at the Brandon Centre.

The Adoption agency [REDACTED] through whom participants will be recruited

DETAILS OF THE PROPOSED STUDY

Q3 Please give a short synopsis of your proposed study, stating its aims and highlighting where these aims relate to the use of human participants (See GN 2.2.3)

Following the Adoption and Children Act 2002, birth relatives of children placed for adoption are entitled to independent support both during and after the adoption process and while there is a large body of research addressing the support services for adopted children and adoptive parents, support services for the birth relatives of adopted children have received far less research scrutiny (Sellick, 2007; Cossar and Neil, 2009).

It is now common for adopted children to have some form of contact with members of their birth family (Parker, 1999; Neil, 2000), but this can break down if birth relatives struggle to manage the resulting emotional impact (Etter, 1993; Logan 1999); thus, the mental health of birth relatives may still impact on their children, even after adoption. Evidence of what works – and what does not work – in post-adoption support is urgently needed.

Formal psychotherapeutic counselling sessions have been identified as one model of how birth relatives receive support. Described as “a chance to offload feelings, receive reassurance [...] as well as to enable shifts in thinking and perspectives” (Neil *et al.*, 2010 pg 105), birth relatives have reported high levels of satisfaction with this mode of support.

The Adoption agency [REDACTED] has been offering Birth Family Counselling services since early 2004. According to their website they recognise that adoption has lifelong implications for all involved and aim “to ensure that birth families receive the support they need in order that they can start to heal and move forward with their lives” (www.adoptionplus.co.uk/relative-counselling). They use qualified and accredited counsellors with a variety of experience and training and offer a responsive and flexible service.

In 2017 [REDACTED] conducted a retrospective evaluation of its person-centred therapeutic counselling service for birth relatives (Wright, 2017). This study identified the demographics and circumstances of birth relatives referred to the service, their take-up of counselling, and their views on the benefits of this model of adoption support. The study used a mixed methods design and found overwhelmingly positive feedback from those using the service. However, it was identified that the richness of the qualitative data was limited due to the use of questionnaires, particularly when a significant proportion of participants were identified as having learning difficulties. It was felt that the use of interviews may have allowed views to be explored in greater depth.

This study aims to explore the experiences of birth relatives who have engaged in psychotherapeutic counselling following the loss of a child/children to adoption. Its broad aims and research questions are as follows:

Aims:

- To listen to and hear the experiences of birth relatives who have engaged with psychotherapeutic counselling following the loss of a child or children to compulsory adoption.
- To investigate the difference (change?) that psychotherapeutic counselling made, if any, to these birth relatives.

- To go beyond definition and description and provide guiding explanations and practical applications for future psychological support to this population.

Research Questions:

- What difference did therapeutic involvement make?
- What ongoing challenges do birth relatives experience?
- How do birth relatives construct their identity as a person, and as a parent, post-counselling?

Q4 Please give a brief explanation of the design of the study and the methods and procedures used. You should clearly state the nature of the involvement the human participants will have in your proposed study and the extent of their commitment. Ensure you provide sufficient detail for the Committee to, particularly in relation to the human participants. Refer to any Standard Operating Procedures SOPs under which you are operating here. (See GN 2.2.4).

In line with Greenberg (1986) and Elliot (2011)'s understanding of Change Process Research (CPR) identified above, a cross-sectional, qualitative research design is proposed. It will consist of in-depth, one-to-one interviews with birth relatives who have completed psychotherapeutic counselling following the loss of their child or children to adoption. This study seeks to examine how people make sense of a major life experience and as such will utilise an hermeneutic phenomenological approach and interpretative phenomenological analysis (IPA) design (Smith, Flowers and Larkin, 2009).

A questionnaire encompassing basic demographic details; details of the number of children the birth relative has had taken into care/adopted; the amount of time that has elapsed since their last child was adopted; and whether they have any children living at home with them now, will be created by the researcher. It will also record the number of counselling sessions they received and over what time period.

A semi-structured interview schedule will be created with the aim of facilitating comfortable interaction with the participants and eliciting detailed accounts of their experiences (Smith *et al.*, 2009). Questions from Elliot's 'Change Interview' (2008) will be incorporated in order to obtain participants' understandings of what, if anything, has changed and how those changes have come about, including factors that have interfered with change (Elliot, 2011).

The interviews will be transcribed and the data analysed according to Interpretative Phenomenological Analysis (IPA) (Smith *et al.*, 2009). IPA analysis is a process involving the immersion of the researcher in the data through reading and re-reading the interview transcripts; making initial notes that remain close to the participants explicit meaning; making more interpretative notes that include descriptive, linguistic and conceptual comments; developing emergent themes and searching for connections across these themes; identifying patterns between themes, or abstraction, to develop super-ordinate themes; then looking for patterns across the different accounts.

Q5 Does the study involve the administration of substances?

Yes

No

PLEASE NOTE: If you have answered yes to this question you must ensure that the study would not be considered a clinical trial of an investigational medical product. To help you, please refer to the link below from the Medicines and Healthcare Products Regulatory Agency:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/317952/Algothrim.pdf

To help you determine whether NHS REC approval is required, you may wish to consult the Health Research Authority (HRA) decision tool: <http://www.hra-decisiontools.org.uk/ethics/>

If your study is considered a clinical trial and it is decided that ethical approval will be sought from the HRA, please stop completing this form and use Form EC1D, 'NHS Protocol Registration Request'; you should also seek guidance from Research Sponsorship.

I confirm that I have referred to the Medicines and Healthcare Products Regulatory Agency information and confirm that that my study is not considered a clinical trial of a medicinal product.

Please type your name here: Hannah Morgan

Date: 31/10/2017

Q6.1 Please give the starting date for your recruitment and data collection: January 2018

Q6.2 Please give the finishing date for you data collection: June 2018
(For meaning of 'starting date' and 'finishing date', see GN 2.2.6)

Q7 Where will the study take place?

Interviews will take place in suitable community locations where privacy can be established and that are convenient to the participant, this may be the participant's home (see risk assessment attached). If no suitable venue can be found, interviews may be conducted via Skype online.

Data collected during the study will be stored on a password protected laptop and analysed at the University of Hertfordshire.

Please refer to the Guidance Notes (GN 2.2.7) which set out clearly what permissions are required;

Please tick all the statements below which apply to this study

- I confirm that I have obtained permission to access my intended group of participants and that the agreement is attached to this application**
- I confirm that I have obtained permission to carry out my study on University premises in areas outside the Schools and that the agreement is attached to this application**
- I confirm that I have obtained permission to carry out my study at an off-campus location and that the agreement is attached to this application**
- I have yet to obtain permission but I understand that this will be necessary before I commence my study and that the original copies of the permission letters must be verified by my supervisor by the time I submit my results**
- This study involves working with minors/vulnerable participants. I/we have obtained permission from the organisation (including UH/UH Partner Institutions when appropriate) in which the study is to take place and which is responsible for the minors/vulnerable participants. The permission states the DBS requirements of the organisation for this study and confirms I/we have satisfied their DBS requirements where necessary.**
NB If your study involves minors/vulnerable participants, please refer to Q18 to ensure you comply with the University's requirement regarding Disclosure and Barring Service clearance.

Permission is not required for my study as:

N/A

HARMS, HAZARDS AND RISKS

Q8 It might be appropriate to conduct a risk assessment for the proposed study. Please use Form EC5 if the answer to any of the questions below is 'yes'.

You may also be required to complete a School specific Risk Assessment form as some Schools have indicated that their risk assessment paperwork is mandatory for any study. **Please consult your supervisor for guidance.**

If you are required to complete and submit a School specific risk assessment, please append it to your completed EC5 form. If there are no additional risks, other than the ones noted in your School specific Risk Assessment, you may state 'Included in <names of School> Risk Assessment' in the relevant sections of the EC5 form.

Will this study involve any of the following?

Invasive Procedures/administration of any substance/s? YES NO

Are there potential hazards to participant/investigator(s) YES
NO

from the proposed study? (Physical/Emotional)

Will or could aftercare and/or support be needed by participants? YES NO

IF 'YES' YOU MUST COMPLETE EC1 APPENDIX 1 AND INCLUDE IT WITH YOUR APPLICATION

Is the study being conducted off-campus (i.e. not at UH/UH Partner?) YES NO

It might be appropriate to conduct a risk assessment of the proposed location for your study (in respect of the hazards/risks affecting both the participants and/or investigators) (this might be relevant for on-campus locations as well). Please use Form EC5 and, if required, a School-specific risk assessment (See GN 2.2.8 of the Guidance Notes).

If you do not consider it necessary to make a risk assessment, please give your reasons: N/A see risk assessment form EC5 for further details

ABOUT YOUR PARTICIPANTS

Q9

Please give a brief description of the kind of people you hope/intend to have as participants, for instance, a sample of the general population, University students, people affected by a particular medical condition, children within a given age group, employees of a particular firm, people who support a particular political party, and state whether there are any upper or lower age restrictions.

This study is committed to 'exploring, describing, interpreting and situating the means by which [the] participants make sense of their experiences' (Smith *et al.*, 2009) and therefore will require rich and detailed personal accounts of the experience of counselling following the loss of a child/children to adoption.

Q10

Please state here the maximum number of participants you hope will participate in your study. Please indicate the maximum numbers of participants for *each* method of data collection.

The study aims to gather detailed accounts of individual experiences and therefore will focus on the accounts of a small number of individuals. It is anticipated that the researcher will interview between 5 and 7 participants with a maximum of 8 accounts and a minimum of 4.

Q11

By completing this form, you are indicating that you are reasonably sure that you will be successful in obtaining the number of participants which you hope/intend to recruit. Please outline here your recruitment (sampling) method and how you will advertise your study. (See GN 2.2.9).

Birth relatives who have engaged with the birth family counselling service provided by the adoption agency [REDACTED] will be invited to participate in the study. Potential participants who have attended at

least 10 counselling sessions, and at least one session in the last 12 months will be identified by four [REDACTED] counsellors. It is anticipated that recruitment/engagement might be a challenge therefore initial contact will be made by the counsellors themselves with whom potential participants have an existing relationship to minimise threat and maximise chance of future engagement with the researcher.

The researcher will provide the counsellors with a leaflet and an outline of the project detailing what is being requested of participants to enable them to seek to gain the birth relatives consent to be contacted by the researcher and be provided with more information if they are interested in participating.

CONFIDENTIALITY AND CONSENT

(For guidance on issues relating to consent, see GN 2.2.10, GN 3.1 and UPR RE01, SS 2.3 and 2.4 and the Ethics Approval StudyNet Site FAQs)

Q12 How will you obtain consent from the participants? Please explain the consent process for each method of data collection identified in Q4

- Informed consent using EC3 and EC6 (equivalent)
- Implied consent (e.g. via participant information at the start of the questionnaire/survey etc)
- Consent by proxy (for example, given by parent/guardian)

Use this space to describe how consent is to be obtained and recorded for each method of data collection. The information you give must be sufficient to enable the Committee to understand exactly what it is that prospective participants are being asked to agree to.

Verbal and written consent will be sought for each interview (please see appendix for consent form). Additionally, the consent form will explain how data will be anonymised and recorded. Informed consent is particularly important in this regard, and the researcher will need to be skilled in facilitating participant choice as to whether to take part in the research and to continue if the topics discussed become distressing. Consent will not be viewed as something that is gained or granted once but an ongoing process and opportunities will be provided for participants to reaffirm (or not) their consent as the in-depth interviews progress (Thompson and Chambers, 2011).

If you do not intend to obtain consent from participants please explain why it is considered unnecessary or impossible or otherwise inappropriate to seek consent.

N/A

Q13 If the participant is a minor (under 18 years of age) or is unable for any reason to give full consent on their own, state here whose consent will be obtained and how? (See especially GN 3.6 and 3.7)

N/A

Q14.1 Will anyone other than yourself and the participants be present with you when conducting this study?

(See GN 2.2.10)

YES

NO

If YES, please state the relationship between anyone else who is present other than the applicant and/or participants (eg health professional, parent/guardian of the participant).

N/A

Q14.2 Will the proposed study be conducted in private?

YES

NO

If 'No', what steps will be taken to ensure confidentiality of the participants' information. (See GN 2.2.10):

N/A

Q15 Are personal data of any sort (such as name, age, gender, occupation, contact details or images) to be obtained from or in respect of any participant? (See GN 2.2.11) (You will be required to adhere to the arrangements declared in this application concerning confidentiality of data and its storage. The Participant Information Sheet (Form EC6 or equivalent) must explain the arrangements clearly.)

YES

NO

If YES, give details of personal data to be gathered and indicate how it will be stored.

Demographic details such as age, gender, occupation and ethnicity will be gathered from participants. This information will be stored electronically (password protected). Hard copies will either be destroyed or stored in a locked filing cabinet at the University of Hertfordshire.

Will you be making audio-visual recordings?

YES

NO

If YES, give details of the types recording to be made and indicate how they will be stored.

Audio recordings of all interviews will be made and transcribed by the researcher. If a professional transcriber is used, s/he will sign a confidentiality agreement in accordance with University of Hertfordshire procedure. Audio recordings of interviews, electronic transcripts and all associated data/files will be anonymised by assigning each participant a unique participant code (pseudonyms). These files will be password protected and stored on a password protected laptop. If it is necessary to place any electronic information on memory sticks, to do so an encrypted memory stick will be used and the files will also be password protected. A back up will be stored on a password protected external hard drive. At the end of the study, all data will be stored at the University of Hertfordshire for up to ten years for the purpose of publication. Participants will have consented to the above.

[State what steps will be taken to prevent or regulate access to personal data/audio-visual recordings beyond the immediate investigative team, as indicated in the Participant Information Sheet.](#)

[Indicate what assurances will be given to participants about the security of, and access to, personal data/audio-visual recordings, as indicated in the Participant Information Sheet.](#)

Personal data and consent forms will be stored in a lockable cabinet at the University of Hertfordshire, which only the principle investigator and first supervisor will have access to. The audio recorded interviews and the transcriptions will be password protected and stored on a password protected laptop at the principle investigator's home, which only the principle investigator will have access to. Only the principle investigator will have access to the codes assigned to participants and the passwords to access the laptop and transcribed interviews. A transcription service may be used, in which case they will be asked to sign a confidentiality agreement. Participants' anonymity will be protected by the unique participant code (pseudonyms) assigned to them.

The content of interviews will be discussed only with members of the immediate investigative team, unless a participant discloses a matter which may pose a risk to themselves or to others. All participants will be informed prior to interviews that if a matter of serious concern related to the safety of themselves or others is disclosed during the interview, the investigating team will have a duty of care to disclose this matter.

Q18	<p>If the activity/activities involve work with children and/or vulnerable adults satisfactory Disclosure and Barring Service (DBS) clearance may be required by investigators. You are required to check with the organisation (including UH/UH Partners where appropriate) responsible for the minors/vulnerable participants whether or not they require DBS clearance.</p> <p>Any permission from the organisation confirming their approval for you to undertake the activities with the children/vulnerable group for which they are responsible should make specific reference to any DBS requirements they impose and their permission letter/email must be included with your application.</p> <p>More information is available via the DBS website - https://www.gov.uk/government/organisations/disclosure-and-barring-service</p>
Q19.1	<p>REWARDS</p> <p>Are you receiving any financial or other reward connected with this study? (See GN 2.2.14 and UPR RE01, S 2.3)</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If YES, give details here:</p> <p>N/A</p>
Q19.2	<p>Are participants going to receive any financial or other reward connected with the study? (Please note that the University does not allow participants to be given a financial inducement.) (See UPR RE01, S 2.3)</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If YES, provide details here:</p> <p>N/A</p>
Q19.3	<p>Will anybody else (including any other members of the investigative team) receive any financial or other reward connected with this study?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If YES, provide details here:</p>
	N/A
OTHER RELEVANT MATTERS	
Q20	Enter here anything else you want to say in support of your application, or which you believe may assist the Committee in reaching its decision.
	N/A

DOCUMENTS TO BE ATTACHED

Please indicate below which documents are attached to this application:

- Permission to access groups of participants from student body
- Permission to use University premises beyond areas of School
- Schools Permission from off-campus location(s) to be used to conduct this study
- Risk Assessment(s) in respect of hazards/risks affecting participants/investigator(s)
- Copy of Consent Form (See Form EC3/EC4) Copy of Form EC6 (Participant Info Sheet)
- Copy of Form EC6 (Participant Info Sheet)
- A copy of the proposed questionnaire and/or interview schedule (if appropriate for this study). For unstructured methods, please provide details of the subject areas that will be covered and any boundaries that have been agreed with your Supervisor
- Any other relevant documents, such as a debrief, meeting report. Please provide details here:

Documents Attached (in order):

1. Permission to access participants
2. EC1 Appendix 1
3. LMS Risk Assessment
4. EC5 Risk Assessment
5. Initial brief information leaflet
6. Debrief (thank you) leaflet
7. Detailed Information for Participants and Consent Form
8. Demographics Questionnaire
9. Interview Schedule

DECLARATIONS

1 DECLARATION BY APPLICANT

- 1.1 I undertake, to the best of my ability, to abide by UPR RE01, 'Studies Involving the Use of Human Participants', in carrying out the study.
- 1.2 I undertake to explain the nature of the study and all possible risks to potential participants,
- 1.3 Data relating to participants will be handled with great care. No data relating to named or identifiable participants will be passed on to others without the written consent of the

participants concerned, unless they have already consented to such sharing of data when they agreed to take part in the study.

- 1.4 All participants will be informed **(a)** that they are not obliged to take part in the study, and **(b)** that they may withdraw at any time without disadvantage or having to give a reason.

(NOTE: Where the participant is a minor or is otherwise unable, for any reason, to give full consent on their own, references here to participants being given an explanation or information, or being asked to give their consent, are to be understood as referring to the person giving consent on their behalf. (See Q 12; also GN Pt. 3, and especially 3.6 & 3.7))

Enter your name here: Hannah Morgan

Date 14/12/2017

2 GROUP APPLICATION

(If you are making this application on behalf of a group of students/staff, please complete this section as well)

I confirm that I have agreement of the other members of the group to sign this declaration on their behalf

Enter your name here: [Click here to enter text.](#)

Date [Click here to enter a date.](#)

DECLARATION BY SUPERVISOR (see GN 2.1.6)

I confirm that the proposed study has been appropriately vetted within the School in respect of its aims and methods; that I have discussed this application for Ethics Committee approval with the applicant and approve its submission; that I accept responsibility for guiding the applicant so as to ensure compliance with the terms of the protocol and with any applicable ethical code(s); and that if there are conditions of the approval, they have been met.

Enter your name here: Lizette Nolte

Date 14/12/2017

Appendix D (1) – Permission to access Participants



Hannah Morgan
Trainee Clinical Psychologist
University of Hertfordshire
Department of Psychology and Sport Sciences
Room 1F421
Health Research Building
College Lane Campus
Hatfield
AL10 9AB

19 December 2018

Dear Hannah

Re: Birth Relative Counselling Research

Following our recent meeting, I am writing to confirm that [REDACTED] are in agreement to the expansion of the research to include a qualitative element that potentially involves speaking directly to birth relatives. Our staff team will ascertain whether people wish to be involved in the research and if they do, we will arrange for you to contact them.

I have emailed the local authorities who contracted us to provide counselling support to make them aware that we are working with you to undertake this research.

Yours sincerely

[REDACTED]

Director of Services

Appendix D (2) – EC1 Appendix 1

APPENDIX 1 – INCREASED HAZARDS AND RISKS

This section is to be completed if the work you/your students plan to undertake involves the administration of substances and/or invasive procedures, whether there is a risk of physical or emotional harm, or whether aftercare and/or support might be required (please refer to Question 8 on Form EC1A/Question 7 on Form EC1B)

Name: Hannah Morgan

Title of study/activity: The experiences of Birth Relatives who engage in psychotherapeutic counselling following the loss of a child or children to compulsory adoption

Date completed: December 2017

QA1. Please give details of the procedures to be used and any harm, discomfort or distress that their use may cause to participants and/or investigator(s). (See GN 2.2.10)

Face to face interviews exploring experiences related to losing a child/children to compulsory adoption may be potentially distressing for participants.

Indicate here what precautions will be taken to avoid or minimise any adverse effects.

Every measure will be taken to ensure the risk of distress is minimised. The interviewee will be told in writing via the information sheet, and verbally prior to starting the interview that they can stop at any time during the interview process and they do not have to answer any questions which make them feel uncomfortable.

QA2. Will the study involve the administration of any substance(s)?

NO (if YES 'no' go to QA.3)

If YES, is the substance to be administered commercially manufactured for human consumption or use?

YES NO

Is the substance in pre-prepared dosage form (e.g. tablets etc)?

YES NO

If you have answered 'No' to this question you are required to explain here why the substance is being used in non-standard form and reference and include the Standard Operating Procedures (SOPs) governing the procedure/s.

Give details here of the substance(s), the dose or amount to be given, likely effects (including duration) and any potential hazards to participant(s) and/or investigator(s). You must include the recommended daily dosage (dated and referenced) and the proposed dosage for this study.

Please also indicate the maximum dose that has been administered without adverse effects.

Indicate here what precautions will be taken to avoid or minimise any adverse effects.

QA3. Are there any potential hazards to participant(s) and/or investigator(s) arising from the use of the proposed invasive procedures? (See GN 2.2.10)

YES

NO

If YES,

Indicate their nature here.

Indicate here what precautions will be taken to avoid or minimise any adverse effects.

QA4. Will or could the study cause discomfort or distress of a mental or emotional character to participants and/or investigator(s)? (See GN 2.2.11)

NO YES X

If YES,

Indicate its nature here

Face to face interviews exploring experiences related to losing a child/children to compulsory adoption may be potentially distressing for participants. Listening to these experiences may be potentially distressing for the researcher.

Indicate here what precautions will be taken to avoid or minimise such adverse effects.

Every measure will be taken to ensure the risk of distress is minimised. The interviewee will be told in writing via the information sheet, and verbally prior to starting the interview that they can stop at any time during the interview process and they do not have to answer any questions which make them feel uncomfortable.

Through my role as an experienced clinician I regularly work with people who are highly distressed and I will endeavour to conduct the interviews as sensitively as possible. If a participant becomes distressed I will remind participants of their right to decline to answer difficult questions. If need be, I may stop the interview and only continue when the participant feels comfortable. The interview can be terminated if need be. Following the interviews, I will provide participants with time to debrief and provide directions towards useful contacts for the future should they wish to talk about their experiences in more depth.

Should the content of the interview be distressing for me as the researcher I will seek supervision from either my first or second supervisors who are both experienced clinical psychologists.

QA5. Medical or other aftercare and/or support must be made available for participants and/or investigator(s) who require it where invasive procedures have been used in the study. Please detail what aftercare and/or support will be available and in what circumstances it is intended to be used. (See UPR RE01, S 2.3 (ii) and GN 2.2.12)

Details of where participants can get further support will be provided in the debrief leaflet. The Birth Relative Counselling service will also make counsellors available should the researcher feel a follow-up appointment is necessary.

The researcher has supervision, which can include processing the emotional impact of hearing the stories of the participants, through the project supervisors.

QA6.1 Please state here previous experience (and/or any relevant training) of the supervisor (or academic member of staff applying for a standard protocol) of investigations involving hazards, risks, discomfort or distress as specified. (See GN 2.2.13)

Both first and second supervisors are qualified clinical psychologists with many years experience. The first supervisor also has a wealth of experience as a qualitative researcher and research supervisor.

QA6.2 Please describe in appropriate detail what you would do should the adverse effects or events which you believe could arise from your study, and which you have mentioned in your replies to the previous questions, occur.

If a participant becomes distressed I would remind them of their right to decline to answer difficult questions. If need be, I may stop the interview and only continue when the participant feels comfortable. The interview can be terminated if need be. Following the interviews, I will provide participants with time to debrief and provide directions towards useful contacts for the future should they wish to talk about their experiences in more depth. If I am concerned for their safety I would follow safeguarding procedures as necessary, referring them in the first instance to the birth relatives counselling service. Relevant policies are referred to in the LMS risk assessment attached to this application.

Should the content of the interview be distressing for me as the researcher I will seek supervision from either my first or second supervisors who are both experienced clinical psychologists.

Appendix D (3) – LMS Risk Assessment

Ref No:	
Date:	
Review Date:	

For assistance in completing this form, please see the Guidance Notes at the end

ACTIVITY INFORMATION	
Name of Assessor/ Contact details	Name: Hannah Morgan Email address: h.morgan@herts.ac.uk Ext no:
Title of Activity	The experiences of birth relatives who engage in psychotherapeutic counselling following the loss of a child/children to compulsory adoption.
Location of Activity	Interviews will take place in suitable community locations where privacy can be established and that are convenient to the participant, this may be the participant's home. If no suitable venue can be found, interviews may be conducted via Skype online.
Description of Activity Please attach a copy of the protocol, procedure, SOP etc applicable.	Semi-structured interviews will be completed in a location of the participant's choosing. Transcription of the interviews and analysis of data will follow.
Personnel Involved	The principle investigator (Hannah Morgan) and birth relatives who have experienced counselling through the birth relative counselling service at Adoptionplus.

TYPES OF HAZARD LIKELY TO BE ENCOUNTERED		
<input type="checkbox"/> Animal Allergens <input type="checkbox"/> Biological Agents (see COSHH) <input type="checkbox"/> Chemical Compounds (see CoSHH) <input type="checkbox"/> Compressed/liquefied gases <input type="checkbox"/> Computers <input type="checkbox"/> Electricity <input type="checkbox"/> Falling Objects <input type="checkbox"/> Farm Machinery <input type="checkbox"/> Fire <input type="checkbox"/> Glassware Handling	<input type="checkbox"/> Hand Tools <input type="checkbox"/> Ionising Radiation <input type="checkbox"/> Office Equipment <input type="checkbox"/> Laboratory Equipment <input type="checkbox"/> Ladders <input type="checkbox"/> Manual Handling <input type="checkbox"/> Non-ionising Radiation <input type="checkbox"/> Hot or cold extremes <input type="checkbox"/> Repetitive Handling <input type="checkbox"/> Severe Weather	<input type="checkbox"/> Sharps <input type="checkbox"/> Slips/trips/falls <input type="checkbox"/> Stress <input type="checkbox"/> Travel <input type="checkbox"/> Vacuum systems <input type="checkbox"/> Pressure systems <input type="checkbox"/> Vehicles <input type="checkbox"/> Aggressive response, physical or verbal <input type="checkbox"/> Workshop Machinery
<p>The above is not an exhaustive list – all other hazards should be listed here.</p>		

HAZARD ASSESSMENT						
Severity of Consequences	Score	Risk Classification				
No or minor injury/ health disorder Minor Damage or Loss Insignificant Environmental Impact Group 1 Biological agents	1	Trivial (1)	Trivial (2)	Trivial (3)	Trivial (4)	Tolerable (5)
Injury or Health Disorder – resulting in absence up to 3 days Moderate Damage or Loss Moderate Environmental Impact Group 2 Biological agents	2	Trivial (2)	Trivial (4)	Tolerable (6)	Tolerable (8)	Moderate (10)
Injury or Health Disorder – resulting in absence over 3 days Substantial Damage or Loss Serious Environmental Impact Group 3 Biological agents	3	Trivial (3)	Tolerable (6)	Moderate (9)	Moderate (12)	Substantial (15)
Long Term Injury or Sickness – resulting in permanent incapacity Extensive Damage or Loss Major Long Term Environmental Impact	4	Trivial (4)	Tolerable (8)	Moderate (12)	Substantial (16)	Intolerable (20)
Death Serious Structural Damage Environmental Catastrophe Group 4 Biological agents	5	Tolerable (5)	Moderate (10)	Substantial (15)	Intolerable (20)	Intolerable (25)
Note on Risk Classification: 1-4 Trivial 5-7 Tolerable 8-12 Moderate 13-16 Substantial >20 Intolerable	→	1	2	3	4	5
	Likelihood	Almost Impossible	Unlikely – possible exposure every 1-3 years	Harm is possible	Harm is likely to occur	Harm will occur or is very likely to occur.

RISK CONTROL MEASURES
<p>Are the local code of practice and/or local rules adequate to control the risks identified?</p>
<p>Yes</p>
<p>Please list.</p>
<p>Please list all additional measures required.</p>
<p>Local Code of Practice and Local Rules applicable: University of Hertfordshire Life and Medical Sciences Health and Safety Policy (2016) Health and Care Professions Council (HCPC), 2008; BPS, 2009; Division of Clinical Psychology, 1995. UH Lone worker policy, UH Life and Medical Sciences Health and Safety Policy (2016). CPFT Lone worker policy</p> <p>Additional Measures: When the researcher makes arrangements to meet with a participant at their own home, the researcher will ask the participant regarding any potential hazards within their home environment e.g. pets. The researcher will ask the participant to minimise these potential hazards as far as possible at the time arranged for interview.</p> <p>The researcher will place the name of the participant with whom they are meeting, and the location details for where the meeting is to take place, within a sealed envelope. This will be handed to a family member of the researcher, with instructions that the envelope should remain sealed unless the researcher fails to make contact with their family member by an agreed time after the interview is scheduled to conclude (e.g. two hours after the interview is expected to conclude). Should the researcher fail to make contact with their family member within this agreed time frame, the family member will be instructed to open the envelope, and pass details of the meeting to the Police.</p> <p>The researcher will make contact via phone with their family member before and after completion of all interviews, firstly to confirm the meeting is taking place and then that the interview has been completed successfully.</p> <p>A code phrase will be agreed with the family member that can be communicated via phone should the researcher feel at risk during any part of the interview process. If this phrase is communicated, it will be agreed that the family member should make contact with the Police.</p>

ASSESSMENT OF RESIDUAL RISK			
Hazard	Likelihood Score	Severity Score	Risk Classification
Computers	3	1	3 Trivial
Aggressive response, physical or verbal	1	2	3 Trivial
Travel	2	2	4 Trivial
Stress	2	2	4 Trivial
EFFECT OF RISK CLASSIFICATION			
Risk Classification	Action		
Trivial	No further action required. Activity can begin.		
Tolerable	No additional controls required. Current controls must be maintained and monitored.		
Moderate	Reduce risks if cost effective. Implement new controls over an agreed period.		
Substantial	Activity cannot begin without major risk reduction.		
Intolerable	Activity must not begin.		

HEALTH SURVEILLANCE ISSUES	
Persons at Special Risk	None
Health Surveillance Measures (including symptoms and signs of exposure)	None
Exclusions	None

SCHOOL OF LIFE AND MEDICAL SCIENCES RISK ASSESSMENT

SIGNATURES				
	Staff/PhD student/MSc student/Undergraduate	Name (Print)	Signature	Date
Assessor	DCLinPsych Trainee	Hannah Morgan		14.12.17
Supervisor (if Assessor is a student)	Research Tutor, DCLinPsych	Lizette Nolte		14.12.17
Local Health and Safety Advisor / Laboratory Manager		John Bain		14/12/17

Appendix D (4) – EC5 Risk Assessment

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE')

FORM EC5 – STANDARD RISK ASSESSMENT FORM

Name of applicant: [Click here to enter text.](#)

Date of assessment: [Click here to enter text.](#)

Title of Study/Activity: [Click here to enter text.](#)

If you are also required to complete a School specific risk assessment, please append it to your completed EC5 before submission. Use this form to note any hazards/risks **not** already included in your School specific risk assessment. It is acceptable to state 'Included in <school> risk assessment' where appropriate on this form.

Activity Description				
1. IDENTIFY RISKS/HAZARDS	2. WHO COULD BE HARMED & HOW?	3. EVALUATE THE RISKS	4. ACTION NEEDED	
<p><u>Activities/tasks and associated hazards</u> Describe the activities involved in the study and any associated risks/ hazards, both physical and emotional, resulting from the study. Consider the risks to participants/the research team/members of the public.</p> <p>In respect of any equipment to be used read manufacturer's instructions and note any hazards that arise, particularly from incorrect use.)</p>	<p><u>Who is at risk?</u> e.g. participants, investigators, other people at the location, the owner / manager / workers at the location etc.</p>	<p><u>How could they be harmed?</u> What sort of accident could occur, e.g. trips, slips, falls, lifting equipment etc., handling chemical substances, use of invasive procedures and correct disposal of equipment etc. What type of injury is likely? Could the study cause discomfort or distress of a mental or emotional character to participants and/or investigators? What is the nature of any discomfort or distress of a mental or emotional character that you might anticipate?</p>	<p><u>Are there any precautions currently in place to prevent the hazard or minimise adverse effects?</u> Are there standard operating procedures or rules for the premises? Have there been agreed levels of supervision of the study? Will trained medical staff be present? Etc/</p> <p><u>Are there any risks that are not controlled or not adequately controlled?</u></p>	<p><u>List the action that needs to be taken to reduce/manage the risks arising from your study</u> for example, provision of medical support/aftercare, precautions to be put in place to avoid or minimise risk or adverse effects NOTE: medical or other aftercare and/or support must be made available for participants and/or investigator(s) who require it where invasive procedures have been used in the study.</p>

Distress	Participants	The exploration of experiences related to losing a child/children to compulsory adoption may be potentially distressing for participants.	Every measure will be taken to ensure the risk of distress is minimised. The interviewee will be told in writing via the information sheet, and verbally prior to	No	Through my role as an experienced clinician I regularly work with people who are highly distressed and I will endeavour to conduct the interviews as sensitively as possible. If a participant becomes distressed I will remind participants of their right to decline to answer difficult questions. If
			starting the interview that they can stop at anytime during the interview process and they do not have to answer any questions which make them feel uncomfortable.		need be, I may stop the interview and only continue when the participant feels comfortable. The interview can be terminated if need be. Following the interviews, I will provide participants with time to debrief and provide directions towards useful contacts for the future should they wish to talk about their experiences in more depth.
Disclosure	Participants	It is important to consider the procedure if a participant were to disclose something that may raise concerns about the safety or treatment of the participant or other individuals who have been discussed by the participant in reference to their experiences as a birth relative of an adopted child.	I will seek consultation with my internal and external supervisors before deciding on an appropriate course of action. Depending on the circumstances, one possibility might be to make a referral for safeguarding purposes.	No	I will seek consultation with my internal and external supervisors before deciding on an appropriate course of action. Depending on the circumstances, one possibility might be to discuss further with my contacts at Adoptionplus and follow their safeguarding procedures if necessary.

Signed by applicant: Hannah Morgan	Dated: 14/12/17
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Who will know if I take part?

- Only the research team and the Birth Relatives Counselling Service will know if you take part.
- The results and feedback to the Birth Relatives Counselling Service will be anonymous (they will not know who said what).

- If you want to take part you can either let the person who gave you this leaflet know and then Hannah will contact you in the next few days.
- Or you can contact Hannah on
07706 257 769
- If you are not interested in being interviewed you do not need to do anything. Thank you for your time in reading this leaflet and considering the study.

Meet the research team:



Hannah, Lizette, Barbara, and Clarissa

- **Hannah is the lead researcher and will interview you, should you choose to participate.**
E-mail Hannah at h.morgan@herts.ac.uk
- **Lizette is Hannah's first supervisor. She is a Clinical Psychologist and researcher and works at the University of Hertfordshire.**
E-mail Lizette at l.nolte@herts.ac.uk

- Barbara Rishworth is Hannah's second supervisor. She is a Clinical Psychologist and works at Brandon Reach; supporting young parents whose children have been removed from their care.
E-mail Barbara at barbararishworth@yahoo.co.uk
- Clarissa is Hannah's third supervisor. She has received counselling through Brandon Reach after her children were removed from her care.

If you would like to speak to Clarissa about any aspect of this research this can be arranged.

Appendix D (5) – Info Leaflet

Birth Relatives Counselling Research

Information for Participants

An invitation to participate in a research project from the University of Hertfordshire, working with the Birth Relatives Counselling Service.

University of
Hertfordshire



What is the research about?

- We want to find out about the experiences of birth relatives who have had counselling following the loss of a child or children to adoption.
- Hannah (the main researcher) wants to find out what difference counselling made, if any.
- The Counselling Service would like to know how they can improve the service they offer birth relatives in the future.

Why have I been given this leaflet?

You are being invited to take part in this research because you have experienced counselling from the Birth Relative Counselling Service.

Before you decide to take part, it is important that you understand why the research is happening and what will be asked of you.

Please take your time to read the information in this leaflet carefully. It aims to answer any questions that you may have about the research.

You can contact Hannah if you have any further questions. Her contact details are given on the back of this leaflet.

What do I have to do?

- If you decide to take part Hannah will contact you to arrange a convenient time and place to meet and talk about your experiences.
- During this meeting, Hannah will speak to you about the research and make sure that you understand the information on this leaflet. You will have the opportunity to ask any questions.
- Hannah will ask you to sign a consent form that shows that you are willing to participate.
- Hannah will then ask you some questions about your views and experiences of counselling after the loss of your child/children to adoption.
- The interview will last between 45 minutes and 1.5 hours and will be audio-recorded to allow it to be transcribed (written down) afterwards.

University of
Hertfordshire



What are the benefits of taking part?

- The interview will give you space to discuss your experiences of counselling and any issues relating to adoption and child removal.
- You may find it interesting to talk about this, although it may not benefit you directly.
- The information we get from this study will be shared with social care services to help set up new services that better support birth relatives of adopted children in the future.

What are the possible difficulties in taking part?

- The content of the interviews may be of a personal nature, and there is a possibility that you may find some things upsetting to talk about.
- Hannah will support you during the interviews if you become upset and will offer further support through providing information about resources in your community if you wish.
- You may of course withdraw from the study at any point without any consequences and without giving a reason.

Further information and contact details

If you would like any further information about the study, or you would like to know about the results of the study, please contact Hannah on:

07706 257 769

h.morgan@herts.ac.uk

Department of Clinical
Psychology University of
Hertfordshire College Lane
Campus Hatfield
AL10 9AB

Tel: 01707 286322

Thank you for your
generosity in
helping to make this
important research
possible.



Appendix D (6) – Debrief leaflet

Birth Relatives Counselling Research

***Thank
you***

University of
Hertfordshire



University of
Hertfordshire



We really appreciate you taking the time to help us.

- The aim of the study is to further understand experiences of birth relatives who have counselling following their children being taken into care.
- Your interview will be compared with others to see if there are any similar themes or patterns.
- We hope that this information will help us to understand more about the nature of the experience for birth relatives and what helps and hinders them in coping with their experience.
- The results will be written up and published in a book about supporting birth relatives after adoption.
- Information from the study will help inform future professionals and services working with Birth Relatives.

Things to remember

- You have the right to withdraw from the study at any time.
- The information we have gathered will be kept anonymous and confidential within the limits already explained to you.
- You are entitled to have a summary of the research findings. This will be made available upon your request when the study is complete.
- The process of talking may have left you feeling a range of emotions and feelings: numb, upset, relieved, listened to, frustrated or something completely different.
- Having experienced being a parent/relative whose child has been removed and/or adopted may be very distressing and difficult to process.
- You might find it helpful to make use of a number of sources of support:

Sources of Support

- Speaking with someone who you trust, such as your own friends and family.
- Talking with a professional at the Birth Relatives Counselling service:
[REDACTED]
[www.\[REDACTED\].co.uk](http://www.[REDACTED].co.uk)
- The Samaritans provide support for people who are experiencing feelings of distress or despair. National 24 hour helpline: 116 123
www.samaritans.org.uk
- MIND is a leading mental health charity in England and Wales. The Mind Info Line offers confidential help on a range of mental health issues.
0300 123 3393
www.mind.org.uk
- NHS Direct NHS Direct delivers telephone and internet information and advice about health, illness and health services, day and night, direct to the public.
111
www.nhsdirect.nhs.uk

Birth Relatives Counselling Research

Appendix D (7) **Information for Participants**

Researchers:
Hannah Morgan
Clarissa Stevens
Barbara Rishworth
Lizette Nolte

Title of Study:

The experiences of birth relatives who engage in psychotherapeutic counselling following the loss of a child/children to compulsory adoption.

Why have I been given/am I reading this information?

Before you decide whether you would like to take part in this research it is important that you understand why it is being conducted and what will be asked of you, should you decide to take part.

Please take your time to read the information below carefully. It aims to answer any questions that you may have about the research. However, if you have any further questions or if you are unclear about any information in these pages, please feel free to contact Hannah (the main researcher) - contact details are given at the end of this document.

What is the research about?

This research aims to find out about the experiences of birth relatives who have had counselling following the loss of a child or children to compulsory adoption. Hannah wants to find out what difference counselling made, if any. The Birth Relatives Counselling Service would like to know how they can improve the service they offer birth relatives in the future.

What do I have to do?

If you decide to take part you will be asked to meet with Hannah to talk about your experiences. She will contact you to arrange a convenient time and place for the meeting. During this meeting, Hannah will speak to you about the research and make sure that you understand the information on this sheet. You will have the opportunity to ask any questions. You will be asked to sign a consent form that shows that you are willing to participate. Hannah will then ask you some questions about your views and experiences of counselling after the loss of your child/children to compulsory adoption. The interview will last between 45 minutes and 1.5 hours and will be audio-recorded to allow it to be transcribed (written down) afterwards.

What are the benefits of taking part?

The information we get from this study will help us to think about ways we can support birth relatives of adopted children in the future. The interview will give you space to discuss your experiences of counselling and any issues relating to adoption and child removal. You may find it interesting to talk about this, although it may not benefit you directly. Hannah will not be able to provide support about individual concerns although she may be able to direct you to someone who can help you.

What are the possible disadvantages of taking part?

The content of the interviews may be of a personal nature, and there is a possibility that you may find some things upsetting to talk about. Hannah will support you during the interviews if you become upset and will offer further support through providing information about resources in your community if you wish. You may of course withdraw from the study at any point without any consequences and without giving a reason.

Who will know if I take part?

Only the research team at the University of Hertfordshire and the Birth Relatives Counselling Service will know if you take part. The results and feedback to the Birth Relatives Counselling Service will be anonymous (they will not know who said what).

What will happen to my data?

All data collected will be anonymised so that it cannot be connected to any person-identifying information.

The recordings of the interviews will be kept on a password protected computer. Any papers will be stored in a locked filing cabinet at the University of Hertfordshire which only Hannah and her first supervisor have access to. Following the study, the recordings will be deleted. All identifying information will be removed from transcripts to protect confidentiality. Anonymised transcripts will be viewed by the research supervisory team and examiners.

Extracts will form part of public documents, including a research thesis and published papers in peer reviewed journals and a chapter in a book. Direct quotes from your interview may, or may not, be used. All care will be taken to ensure that no one can be identified from such extracts. Your data will be stored securely for up to 5 years after which time it will be destroyed.

If Hannah has any concerns about your safety or wellbeing or that of someone else following the interview, she will have a duty of care to respond to this. In this case she would discuss this with you.

What will happen to the results of the study?

When the study is completed Hannah will write up the findings as an academic thesis that will be submitted as part of the requirements of the Doctorate in Clinical Psychology at The University of Hertfordshire. In addition, Hannah and the research team will write an article for publication in a journal and a chapter for a book about how to support Birth Relatives after adoption. A report for the birth relatives counselling service will also be produced.

These publications might use quotes from the interviews but any quotes will not identify you to ensure your privacy. If you say something during the interview that you do not want to be used, you can ask for it to be removed from the data.

What if I'm concerned about some aspect of the study?

If you have any concerns about any aspect of this study, you should ask to speak to Hannah, who will do her best to respond to any questions. If you would prefer to speak to Clarissa who has personal experience of counselling after her children were removed, that can also be arranged.

This research has been reviewed by The University of Hertfordshire, Health and Human Sciences Ethics Committee with Delegated Authority (protocol number: LMS/PGT/UH/03155)

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar; University of Hertfordshire, Hatfield, Hertfordshire, AL10 9AB.

What should I do now?

If you are interested in taking part please complete the form below (Form A) to indicate you have read this information sheet and are happy to proceed.

If you are not interested in participating any further you do not need to do anything. Thank you for your time in reading this information and considering the study.

Contact Details

Main researcher:
Hannah Morgan
Trainee Clinical Psychologist
Tel: 07808 764 718
Email: h.morgan@herts.ac.uk

Research Supervisor:
Dr. Lizette Nolte
Lecturer in Clinical Psychology
Tel: 01707 286322
Email: l.nolte@herts.ac.uk

Research Supervisor:
Dr. Barbara Rishworth
Clinical Psychologist

Research Supervisor:
Clarissa Stevens
Expert with Lived-Experience

Email: barbararishworth@yahoo.co.uk

The experiences of birth relatives who engage in psychotherapeutic counselling following the loss of a child/children to compulsory adoption.

Form A (Consent)

I agree with the following statements (please tick if you agree):

- I confirm that I have read and understood the information sheet provided.
- I understand what my participation in the project involves. I have had any questions answered to my satisfaction.
- I understand I can withdraw at any time without giving reasons and that I will not be penalised for withdrawing nor will I be questioned on why I have withdrawn.
- I understand that any information obtained will be kept confidential, unless the researcher is concerned for my safety or the safety of somebody else. When such concerns are raised these will be discussed with me.
- I agree that research data gathered for the study may be published and if this occurs precautions will be taken to protect my anonymity.
- Contact information has been provided should I wish to seek further information from the investigator at any time for purposes of clarification.

Audio recording of interviews is required. Please tick below to give consent to audio recording.

- I understand that my interview will be recorded using audio recording equipment and that this recording will be destroyed once the research study is completed.

In addition, please consider the use of your data for future studies. This choice will not prevent you from being involved in this study.

- I am happy for my data to be kept securely to be used in future studies.

Participant Name: _____

Participant _____

Signature: _____

Date: _____

Researcher Name: _____

Researcher _____

Signature: _____

Date: _____

If you would like feedback about the results of the study once completed please provide contact details below.

E-mail address: _____

Birth Relatives Counselling Research

Appendix D (8) **Questionnaire**

Researchers:
Hannah Morgan
Clarissa Stevens
Barbara Rishworth
Lizette Nolte

About you

Age range: 18-25 26-35 36-45 46-55 56-65

66-75 76-85 86-95 95+

Gender: Male Female

Ethnicity:

White

English / Welsh / Scottish / Northern
Irish / British

Irish

Gypsy or Irish Traveller

Any other White background, please
describe:

Asian / Asian British

Indian

Pakistani

Bangladeshi

Chinese

Any other Asian background, please
describe:

Mixed / Multiple ethnic groups

White and Black Caribbean

White and Black African

White and Asian

Any other Mixed / Multiple ethnic
background, please describe:

Black / African / Caribbean / Black British

African

Caribbean

Any other Black / African / Caribbean
background, please describe:

Other ethnic group

Arab

Any other ethnic group, please describe:

Education:

What is the highest degree or level of school you have completed? *If currently enrolled, highest degree received.*

- | | | | |
|---|--------------------------|--|--------------------------|
| University Higher Degree (e.g. MSc, PhD) | <input type="checkbox"/> | First degree level qualification including foundation degrees, graduate membership of a professional Institute, PGCE | <input type="checkbox"/> |
| Diploma in higher education | <input type="checkbox"/> | Teaching qualification (excluding PGCE) | <input type="checkbox"/> |
| Nursing or other medical qualification not yet mentioned | <input type="checkbox"/> | A Level | <input type="checkbox"/> |
| Welsh Baccaulaureate | <input type="checkbox"/> | AS Level | <input type="checkbox"/> |
| International Baccaulaureate | <input type="checkbox"/> | Higher Grade/Advanced Higher (Scotland) | <input type="checkbox"/> |
| GCSE/O Level | <input type="checkbox"/> | Certificate of sixth year studies (Scotland) | <input type="checkbox"/> |
| CSE | <input type="checkbox"/> | Standard/Ordinary (O) Grade / Lower (Scotland) | <input type="checkbox"/> |
| Other school (inc. school leaving exam certificate/matriculation) | <input type="checkbox"/> | None of the above | <input type="checkbox"/> |

Marital Status:

- Single Married/civil partnered/domestic partnership Divorced
Widowed Separated

Living Arrangements:

- Living alone Co-habiting Living with family (not spouse)
Other (please specify)

Employment Status:

- Employed for wages Self-employed A student A homemaker Military Retired Unable to work

- Out of work and looking for work
- Out of work but not currently looking for work

About your child/children

How many children do you have?
How many boys and how many girls?
What are their ages?
How many of your children are currently living with you?
How many of your children are currently in care or adopted?
How long ago were they taken into care or adopted?
With whom are they in care or adopted?
Do you have contact with them? If so, how often?
Are you involved with other services? If so, which services? (For example, Adult Mental Health Services)
Are your children involved with other services? If so, which services? (For example, Child and Adolescent Mental Health Services)
Preferred pseudonyms?

Birth Relatives Counselling Research

Appendix D (9) **Interview Schedule**

Researchers:
Hannah Morgan
Clarissa Stevens
Barbara Rishworth
Lizette Nolte

Title of Study:

The experiences of birth relatives who engage in psychotherapeutic counselling following the loss of a child/children to compulsory adoption.

Introduction

“The aim of this research is to get a better understanding of the experiences of people who have had counselling (with the birth relatives counselling service) after having a child or children taken into care or adopted. The interview will last up to an hour and a half and I’ll be audio recording it with a Dictaphone (show device). I’ll be asking some questions about your experiences and your perspectives. There are no right or wrong answers.”

Introductory (warming the context) questions

1. Why were you interested in taking part in this research study/interview?

Prompts:

- a. What are your hopes for this research?
- b. Is there anything really important you want to make sure we talk about today? *(write this down to refer back to at the end)*

Questions about starting Counselling

2. Can you tell me how you came to have counselling with [name of counsellor]?

Prompts:

- a. What else was going on in your life at the time?
- b. Had you ever had counselling before?
- c. What made you decide to start counselling?
- d. How easy/difficult was it to start counselling?
 - i. If it was difficult what do you think [name of counsellor] or the service could have done differently?

3. What was your experience of having your child/children removed (before/during/after)?

Follow-up questions:

- a. How did this impact on you?
- b. How did you manage this?

'Change Interview' questions

4. What was counselling like for you?

Prompts:

- a. Good things? Bad things? Surprising things?

5. What kinds of things (themes) did you talk about with your counsellor?

6. What changes, if any, have you noticed in yourself since you started counselling?

Prompts:

Have you noticed any changes to: your relationships? How you feel in yourself? How you think now about your child being removed from your care or adopted? How you think about yourself?

Follow-up questions:

- a. What do you think caused this change/these changes?
- b. How do you explain this change/these changes?
- c. Has anyone else noticed this change/these changes?

7. What personal strengths, or aspects of your life situation, helped you to make use of counselling to deal with the impact of having a child removed/adopted?

8. What things about you or your life situation made it harder for you to use counselling to deal with the impact of having a child removed/adopted?

9. What was the most helpful thing about counselling through the birth relatives counselling service?

10. What kinds of things about counselling were unhelpful, negative or disappointing for you?

Follow-up question:

- a. Was there anything that was difficult or missing from your counselling?

Life after counselling questions

11. What is life like for you now?
 - a. Do you have any ongoing challenges?

12. Can you tell me about your relationship with your child/children now?
Follow-up questions:
 - a. Do you still have contact?
 - b. What is it like for you?
 - c. What do you think it is like for them?

13. Can you tell me about your sense of being a parent now that your child is/children are in care?
Follow-up question:
 - a. In what ways do you feel different or the same as a parent?

14. Based on your experience, what advice would you give other parents in the same situation considering counselling at the birth relatives counselling service?

15. Do you have any advice for the counsellors at the counselling service?

Ending (cooling the context) questions

16. What has it been like for you to answer these questions and be part of this research today?

17. Did we talk about what you expected to/wanted to?
Prompt:
 - a. Thinking back to what you said at the beginning of the interview.

18. Is there anything else you would like to tell me about your experiences of counselling?
Follow-up question:
 - a. Anything else you think it is important for me to understand?

19. Do you have any ideas as to how the findings of this research could be shared with other birth relatives experiencing compulsory adoption?

General Prompts:

- How did you experience that?
- What sense did you make of that?
- How do you make sense of that?
- What did that mean for you?
- How did you come to understand that?
- And what did you think about that?
- What do you make of that?
- What do you think happened there?
- Can you tell me more?
- Can you give me an example of that?

Appendix E – Ethical Approval Notification



HEALTH SCIENCE ENGINEERING & TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO **Hannah Morgan**

CC Dr Lizette Nolte

FROM Dr Simon Trainis, Health, Sciences, Engineering & Technology ECDA Chair

DATE 18th January 2018

Protocol number: LMS/PGT/UH/03155

Title of study: *The experiences of birth relatives who engage in psychotherapeutic counselling following the loss of a child/children to compulsory adoption.*

Your application for ethics approval has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

This approval is valid:

From: 18/01/2018

To: 30/06/2018

Additional workers: Field Supervisor Barbara Rishworth & Clarissa Stevens, Supervisor.

Please note:

If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and your completed consent paperwork to this ECDA once your study is complete. You are also required to complete and submit an EC7 Protocol Monitoring Form if you are a member of staff. This form is available via the Ethics Approval StudyNet Site via the 'Application Forms' page
<http://www.studynet1.herts.ac.uk/ptl/common/ethics.nsf/Teaching+Documents?Openview&count=9999&restricttcategory=Application+Forms>

Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval (if you are a student) and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.

Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Students must include this Approval Notification with their submission.

Appendix F – Extracts from reflective diary

Reflective Diary – Major Research Project

23/10/17

I really want to make meaningful use of an 'expert by experience' and gain some service user input for my project but feel a bit like I'm in the dark, not knowing where to start. Where to look? What is it appropriate to ask? When is it ethical to ask? I can't pay, or should I be trying to find a way to pay someone? Is it wrong to assume a certain level of research literacy?

I'm also struggling a bit ethically with how to do this in a meaningful way. It is obviously a sensitive topic and difficult experience to have been through. Is asking someone to become a research consultant respecting their valuable contribution or patronising their position? Is avoiding it due to the 'sensitive' nature of the work doing a disservice to the resilience or strength of anyone who has been through this?

Another idea I feel I'm struggling with is thinking about mothers who choose to give up their children for adoption, voluntarily, and when they are forcibly removed. I'm wondering if these are two very separate phenomena or are they opposite ends of the same spectrum? When mothers make this choice, how much of their own free will are they exercising? Are they not pressured by societal norms and stigma? Gender issues? I find this an interesting thing to think about historically, like the foundling hospital but also situated geographically and the differences between how common or uncommon it is in USA/Ireland/UK depending on access to contraceptives or abortions... I think I'd like to look up the stats around this.

22/11/17

I'm feeling nervous and excited about possibly meeting Clarissa today. I emailed both Barbara and Clarissa yesterday to confirm but haven't heard back... I've also just emailed Barbara again. I really hope I manage to meet them both today. I'm wondering why I feel so nervous about meeting Clarissa, I think I am really invested in developing a good relationship with her that is helpful for both of us, but I suppose I am already putting a lot of pressure on us both.

I fear that I may be too patronising or assume too much and am really struggling with how to present the project to Clarissa. I hope Barbara being there and on board with the project will help.

I intend to stay open to lots of possibilities and see how today goes. Any feedback from Clarissa will be valuable.

26/11/17

Clarissa is amazing. I'm so impressed by her.

We had a very interesting meeting and discussion about the research project. Clarissa had such good ideas and I was particularly impressed by her understanding of the nuances of language in terms of power and knowledge. I felt so relieved that she was so enthusiastic

about my research. It really connected me to the purpose and potential good that could come out of it. Somehow with Clarissa's approval I feel the project is more 'legitimate'. I now feel a bit of pressure to do it justice for Clarissa. Good motivation I think.

03/03/18

Wow it's been a long time since I wrote any reflections! Lots has been happening – I got the ethics application in and approval was granted. Since then I have been working with [REDACTED] from [REDACTED] on recruitment and setting up of the interviews – this is quite a lengthy process as it involves trying to arrange to book rooms in various locations and find times to suit the individual participants. I have 6 participants and have managed to have an initial phone conversation with them all. I've been surprised by how helpful and willing all the of the people I've spoken to have been – I'm not sure why this should surprise me. Perhaps I was expecting it to feel more awkward or to have to convince people to be involved. It seems the counsellors from [REDACTED] had done a very good job of explaining the purpose of the research. And I already have the sense that the people I have spoken to feel very loyal to their counsellors and would almost do 'anything' they say!

I have now also completed my first interview – it was a great experience. I was so impressed by 'Rebecca', my participant. She spoke brilliantly and seemed very in touch with her experiences. I think I was taken a bit by surprise by how quickly and openly she spoke about some very difficult experiences for her, including childhood sexual abuse. At times during the interview I found it hard to 'stick to the script' as it were and only ask the questions on my interview schedule. I wanted to know more about the circumstances surrounding her children being removed and more about her family relationships. Sometimes it felt a bit harsh to move on to a different question after something so poignant or emotionally difficult had been said. After the interview I was left feeling incredibly impressed by 'Rebecca' for how she has managed to live her life with everything that has happened. There was one point when I think I struggled to maintain the 'interviewer's stance' when she told me that she had been told she has the 'mind of an 8 to 13-year-old'. I found it very difficult to contain my shock that a cognitive assessment outcome would be explained to someone in these terms. I am happy with the interview questions I think as it did allow for some interesting and I believe rich descriptions of experiences. At certain points 'Rebecca' became emotional, but managed this well. I feel the questions are tapping in to something important and useful for the research.

I have also transcribed this first interview – it took much longer than I expected but I enjoyed the process and feel very connected to the text. I really want to transcribe all the interviews myself as I think it will help me with the analysis.

16/03/18

Four interviews done and transcribed! I'm getting quicker at the transcribing too and am really enjoying the process and how connected I feel to the data. The second two interviews I did on the same day, I found them both incredibly moving for different reasons. 'Isobel' was so in touch with the pain she experiences when she thinks about her daughter and had such vivid ideas of what she might be thinking or feeling or doing now and what she might do in the future. I found myself reading literature around the 'psychological presence of adopted children' in their birth mothers minds. I felt such admiration for 'Katja' and couldn't help but notice what low self-esteem she had. At times I think I struggled with my role as researcher, I wanted to let her know how impressed I was

by her, I felt more able to do this as a researcher than perhaps I might have as a therapist however, I wonder looking back at the transcript if I may have been too enthusiastic and tried to make her feel better as opposed to staying close to her experience of feeling of no value.

My fourth interview involved quite a bit of organising and travel to get to, and in the event I was late. I think this did impact on the interview and the data I managed to get. 'Lara' text me in the morning to let me know she was bringing her 16-year-old daughter with her. I thought this was unusual but my priority was to make her feel comfortable so I thought it would be ok. I think had I had enough time I may have tried to some of the interview with her in the room and perhaps some without? As I was late I wanted to get started and so was focused on helping 'Lara' to feel at ease, she made it clear that that meant 'Jade' would be joining us. I think I did an ok job of setting up the boundaries and letting 'Lara' know that if there was anything she didn't feel comfortable talking about in front of 'Jade' she could let me know. It did make me wonder about their relationship, and as I got to know more about their family it seemed that 'Jade's presence was a communication in itself. It felt like it was a way of 'Lara' communicating to 'Jade' that she has 'no secrets' and will tell her anything; it seemed like 'Jade' was communicating to her mum that she was on her side; and perhaps they were both communicating to me that they didn't trust me – at least at first – mistrust of professionals was a theme that came up as the interview progressed. 'Lara's interview focused a lot of her experiences after having her children removed, unlike in other interviews I did not hear much about her early life experiences. She alluded to some things but did not mention anything specifically – I wondered if this might have something to do with 'Jade's presence. Both 'Lara' and 'Jade' became quite tearful during the interview – it was incredibly moving to witness this emotional closeness and see 'Jade' put her hand on her mum's knee to comfort her. At times it did seem like the parent/child roles had been reversed and 'Jade' was providing emotional support to 'Lara'. I couldn't not include 'Jade' in the interview, especially when asking specific questions about 'Lara's relationship with her – this might mean that opportunities to explore other avenues, e.g. 'Lara's relationships with her other children were missed. I think that what had the most impact on the data however was my lateness, I was so aware of the lack of time but also as the interview progressed increasingly aware of what rich experiences 'Lara' had to share – I felt torn between getting through the research schedule -particularly the change process questions – and using the prompts to get 'Lara' to talk in more depth about the experiences she was sharing. It felt like she had a lot more to give.

04/04/18

I got a text today from the 3rd person I interviewed asking if she could change her preferred pseudonym. I wonder what prompted this? It has left me wondering about the impact of the interviews of my participants. Has she been thinking about it ever since we met? Or has she reengaged with her counsellor and spoken about the experience with her which prompted this change of mind? Originally, she had chosen 'Mrs Peacock or something animally' quite flippantly – I didn't push her further at the time, and since I needed/wanted a first name I had chosen 'Katja' as I thought it was a similar enough match to her original name but also had a hint of 'animalliness' about it. Today she asked to be called 'Saffron', which I think is a lovely choice and I am happy to use, I am just struck that she would contact me now, and I can't help thinking that she has been worried about

this since we met, I hope not. I made sure to reply to her text acknowledging the careful thought she had put into it.

In other news my last interviewee cancelled at the last minute due to work commitments so I still need to arrange my two (hopefully) final interviews. I am concerned about one who I haven't contacted since she let me know about a family bereavement but I don't want to exclude her from participating.

Following an IPA research group meeting I have switched my focus to my intro/literature review as we were encouraged that this was best practice... I feel the pressure mounting and time running out – I feel torn between getting my intro done and delving into the interview data I already have as I was finding this a really enjoyable experience. Either way, progress is slow!

20/04/18

This afternoon I had a meeting with Barbara and Clarissa and Lizette. I felt really nervous before hand and I'm not sure why. Partly because I'm not as far ahead as I would have liked to be by now and perhaps part of me was nervous or excited about sharing the content of the interviews with others.

It was actually really lovely to introduce the team to my participants and talk about what they told me. I found it really helpful just to say some things that have been in my mind out loud. As before Clarissa was just so impressive. She spoke so well about how what my participants have said resonated with her own experiences and she was so thoughtful and attentive to my data. I am so struck by how openly and honestly she talks about her children and her experiences and the process she has been through.

It was wonderful to hear Lizette and Barbara's insights too. A couple of interesting thoughts have stayed with me, something about the relationship birth mothers have with their therapists, Clarissa spoke about the 'love' she has for Barbara, not like a family member, and not like a friend, something different and hard to put into words but something as important or powerful/meaningful. This linked to what a couple of the participants said about feeling like the counsellors were 'like friends' or speaking about them like family members.

The idea of each mother being on a journey through a grieving process, but at different times, TIME is a major factor, for some they were able to engage in counselling close to the time their children were removed, for others even though it had been 7 or 8 years they were still in a very raw place – another able to gain from counselling after 11 years but whilst STILL being IN the process i.e. still on child protection register. So not about where they are in process of child removal, its where they are in the process of grieving? Coming to terms with it? Therefore children's timescales do not match with mothers – therein lies the problem.

Feeling like a mum and not like a mum at the same time?

21/04/18

I'm finding reading research from the USA that seems to emphasise the 'benefits' of adoption (for adoptive parents mostly) is really making me angry! This says something

about my context I think working with looked after children, and the more connected I feel to the grief and trauma of the birth mothers I have met... I am noticing this anger more and more (particularly Claridge 2014).

30/04/18

I am trying to get in to the coding process. I keep noticing how as I code the transcripts my thoughts are often taken towards Stanley, either with his Dad or at Nursery and how lucky I am knowing that I will go and pick him up later, or he will be there when I get home. Connecting to the pain of some of my participants attempts to come to terms with 'life going on without' their children is really difficult.

07/05/18

Coding is hard. I was feeling really bad about reducing the rich participant accounts down to just codes and fragmenting all the logic and narrative – but then I read in the Smith book that that is how I'm meant to feel!!

I feel more happy with some codes than others. I'm worried that my codes and clustered themes are not telling the 'story' I want them to. The more detailed analysis seems to have a different feel to my gut feeling having done the interviews. But it is a process and it does feel like it is coming together.

Appendix G – IPA Audit Trail

Appendix G (1) – Example of coded transcript

Interview Number 5 “Elizabeth”

13.04.18

Key: Descriptive *Linguistic* Conceptual

Transcript has been removed to protect participant’s anonymity

Appendix G (2) – Clustered Themes ‘Elisabeth’

<p>Finding counselling helpful</p> <p>a) <u>Counselling is more than ‘a quick chat’.</u> Feeling counsellor was ‘there to help me’ ‘Counselling helped me through’ Counselling got me through. Counsellor got me to move on Counselling was motivation to keep going. Counselling helps with more than just having your kids removed. Counselling was more than I expected. Valuing space to talk about children. ‘I just told [counsellor] everything’ ‘Exploding’ with counsellor, talking about everything. I spoke about violent past Counsellor makes sense of violent relationship She said ‘he can’t hurt you anymore’. Finding relaxation exercises in counselling helpful. They (counsellors) listen Counsellor did more than just listen. Counsellor listens to everything Counsellor really listens Counsellor told me life will get better, and it did. Counselling wasn’t hard. They (counsellors) tell you which way to go Counsellor made me strong</p>	<p>Noticing changes since counselling</p> <p>a) <u>Experiencing better relationships</u> I’m happy now (different) Positive relationship with daughter (now). Having close relationship with daughter Increasing contact when on daughter’s terms Feeling close to daughter Feeling close to daughter Enjoying relationship with daughter I have a different kind of relationship now A different kind of relationship I have ‘a nice bloke’ now Feeling supported in relationship Finding closeness in other relationships? My friends miss me when I’m not here. (feeling important to others?) Having cruelty validated by others People (all mothers) ask me how I cope. Others noticing changes b) <u>Going out more, feeling part of the community</u> Noticing differences (going out more, new job) Things are different now (new job, new partner) Counselling got me out of the house. I’m going out more, socialising more. Counselling got me back in the community.</p>	<p>Recognising a ‘need’ for counselling</p> <p>a) <u>Needing someone to talk to and turning to professionals</u> I needed someone to understand how I was feeling. ‘I needed to talk to someone’ A doctor told me I need counselling. Wanting counselling. Worrying about children made me ill. Turning to health professional (doctor) b) <u>Feeling there’s ‘no point living’ (overwhelmed and on my own)</u> I didn’t care anymore (deciding to leave violent relationship) I was all over the place. ‘My mind was all over the place’ Feeling overwhelmed. Feeling overwhelmed. ‘I didn’t know if I was coming or going’. (overwhelmed) ‘I felt like I was on my own’ Feeling suicidal when children were removed. Feeling life has been taken (not just children) ‘No point living’ (without children) Experiencing others as angry. Experiencing others as angry. Feeling isolated. ‘I couldn’t talk to anyone else.’</p>
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<p>b) <u>From feeling nervous in the beginning to Feeling relaxed and understood</u> Starting counselling was hard. Trusting a stranger is difficult Taking time to trust counsellor Being initially suspicious of counsellor (on SS side?) I felt nervous at first Feeling nervous the first time. Feeling nervous at first (fearing judgement?) They (counsellors) understand Counsellor understands Counsellor 'taking in' and understanding. Having experience acknowledged. Counsellor understood me. Feeling understood Feeling understood. Counsellor understands Counsellor knew I was tense. Counsellor helped me feel relaxed.</p> <p>c) <u>Feeling grateful and positive about counselling</u> Appreciating counsellor. Feeling grateful (towards counsellor) Counselling is the best thing ever. Counselling was lovely. Counselling was lovely Nothing bad about counselling. Nothing negative about counselling Counsellor was brilliant. Counsellor is brilliant (professional?) Recommending counselling to others</p>	<p>c) <u>Feeling differently about self ('I'm not alone/I'm not a failure')</u> Being made to feel you are not on your own. (destigmatising?) Being made to feel like you are not on your own (de-shaming?) Identifying determination. I'm different now (more confident?) Feeling free? 'I'm not scared anymore' Overcoming fears in counselling Feeling like I've moved on Life goes on. Moving on. Moving on (because of counselling) 'I just want to move on' Feeling more confident since counselling I can have a laugh now. Feeling like she has 'survived'? Strong? Counsellor pulled me out of black hole. 'I've pulled myself out (of dark place?)' I have no challenges now</p> <p>d) <u>Coming to terms with child removal</u> Starting to share truth about history with others (increased confidence? Decreased shame?) Counsellor aiding understanding, shifting focus to children? Knowing my kids are safe. 'Knowing' my children will find me in the future. Increasing my understanding of what I went through. Seeing children (in foster care) once a year</p>	<p>'I just want[ed] to run away' I felt frozen, on my own (before counselling) You feel lost. You think 'why me?' You're like 'I miss my child'. c) <u>Acknowledging reasons children were removed (violence/illness)</u> Not being able to look after children because of illness. Not able to look after children because of violence. 'I was in a violent relationship' 'I was black and blue' 'I was in this black hole' (when in violent relationship) Escaping violent relationship with children. Ongoing threats from violent ex-partner</p> <p>d) <u>Experiencing shame and guilt</u> Feeling I might have made a mistake. Locking self away (shame?) Feeling like a failure Feeling I had let my kids down Feeling stigmatised because of child removal ('no one wants to listen to me')</p> <p>e) <u>Not being supported by social services</u> SS did not understand. Feeling unfairly treated by SS SS don't understand SS just want children Hating SS</p>
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<p>Request for more counselling (even though she has moved on and is happy)</p> <p>d) <u>Talking to a stranger who feels like family</u></p> <p>It was like I'd made a new friend.</p> <p>Counselling is like talking to family (even though a stranger)</p> <p>Feeling close to counsellor (special relationship?)</p> <p>Comparing counselling to seeing a family member or friend.</p> <p>Counselling is talking to a stranger.</p> <p>'I'd love to see her again'</p> <p>Like sitting with a friend</p> <p>Feeling like I'm talking to family.</p>	<p>'I've been through hell and back'</p> <p>Feeling she hasn't done anything wrong.</p> <p>I understand what other mothers think.</p> <p>Thinking about what I want from life.</p> <p>Making sense of reasons children were removed.</p>	<p>SS 'ripped that away' (chance to be a mum)</p> <p>SS are 'rotten people', 'nasty people', 'mean people'.</p> <p>SS only want children.</p> <p>SS don't listen.</p> <p>SS don't care.</p> <p>SS only want children.</p> <p>'Why don't social services give people more help?'</p> <p>SS make mothers feel 'bad'</p> <p>Blaming SS</p> <p>Feeling cruelly treated</p> <p>Feeling frustrated at limitations put on contact</p> <p>Not being in control of what happens to children</p> <p>Others in control of contact</p>
<p>Being made to feel 'part of the family'</p> <p>Feeling like counsellor is family but knowing she is not (hard to explain)</p> <p>An unusual relationship?</p> <p>Being made to feel welcome, like family.</p> <p>Counsellor looked after me.</p> <p>'They are there for you'</p> <p>Counsellor is there for you</p> <p>Appreciating informality (tea and cake)</p>	<p><u>Discarded at this stage</u></p> <p>Difficulty living with unknown.</p> <p>Generalising skills (relaxation)</p> <p>Taking what counsellor has taught forward.</p> <p>Wish to let others know they are not on their own</p> <p>Hoping for greater understanding.</p>	<p>Feeling connected to children</p> <p>a) <u>Not giving up on children</u></p> <p>Not giving up on son - 'I keep asking'</p> <p>Being kept out of adopted child's life</p> <p>Not knowing where your child is, is hard (for any mother)</p> <p>'I don't know anything, I haven't even got a photo'</p> <p>Desire for a photo.</p> <p>Desire to see what child looks like now.</p> <p>Desire for information about adopted child.</p> <p>Putting son's needs before own</p> <p>'I've still got his blanket'</p> <p>Holding on to memories</p> <p>Drive to know how child is getting on.</p> <p>Fighting for children in court</p> <p>Feeling there was no chance (in court)</p>

		<p>Having children always in mind.</p> <p>Wanting to keep children together</p> <p>Connecting to son through daughter</p> <p>Feeling her children might think she 'gave them up'</p> <p>I didn't 'give them up', they 'got took'.</p> <p>Drive to protect children.</p> <p>b) <u>Identifying as a mother vs not felling like a mother at all</u></p> <p>Identifying as a mother.</p> <p>'I'm the one who gave birth to him'</p> <p>'A mum is a mum'</p> <p>Feeling close to daughter</p> <p>I know my children are safe</p> <p>Feeling satisfied (?) with three children. (no wish for anymore)</p> <p>Feeling like a mum by meeting son's needs</p> <p>It's hard (to be a mum when your children are in care)</p> <p>Noticing her 'mothering role' in extended family</p> <p>'I don't feel like a mum'</p> <p>'I have got the mum in me'</p> <p>Not feeling like a mum.</p> <p>Not getting to do the things a mum does.</p> <p>Identifying with other mothers (whose children have been removed)</p> <p>Feeling life without children is boring.</p> <p>c) <u>Connecting to pain of separation (for both her children and herself)</u></p> <p>Having a new born baby taken away really hurts.</p>
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		<p>Connecting to pain of separation ('heart is ripped to pieces')</p> <p>Vivid memory of moment children left. (trauma?)</p> <p>Experiencing closeness and distance with children</p> <p>It's hard for my children.</p> <p>Being reminded of own children by sister's children.</p> <p>Children always in mind</p> <p>Missing my children</p> <p>Connecting to how much she misses her baby.</p> <p>'I think about them (all three children) everyday'</p> <p>My son wants to come home</p> <p>Finding it hard to explain to son why he can't come home.</p> <p>Taking pleasure in contact</p> <p>Finding contact hard</p> <p>d) <u>Preserving 'good mother' identity.</u></p> <p>Midwives told me I was a good mum.</p> <p>Feeling like a 'good mother' (compared to others)</p> <p>Seeing other ('bad') mothers with their children is horrible</p> <p>Feeling angry at other ('bad') mothers</p> <p>Protecting other people's children</p> <p>'I'm there for them no matter what' (but it's hard)</p>
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Clustered Themes

<p>Finding counselling helpful</p> <ul style="list-style-type: none"> a) Counselling is more than 'a quick chat'. b) From feeling nervous in the beginning to Feeling relaxed and understood c) Feeling grateful and positive about counselling d) Talking to a stranger who feels like family 	<p>Noticing changes since counselling</p> <ul style="list-style-type: none"> a) Experiencing better relationships b) Going out more, feeling part of the community. c) Feeling differently about self ('I'm not a failure') d) Coming to terms with child removal 	<p>Recognising a 'need' for counselling</p> <ul style="list-style-type: none"> a) Needing someone to talk to and turning to professionals b) Feeling there's 'no point living' (overwhelmed and on my own) c) Acknowledging reasons children were removed (violence/illness) d) Experiencing shame and guilt e) Not being supported by social services
<p>Feeling connected to children</p> <ul style="list-style-type: none"> a) Not giving up on children b) Identifying as a mother vs not felling like a mother at all c) Connecting to pain of separation (for both her children and herself) d) Preserving 'good mother' identity. 		

Appendix G (3) – Master Themes ('Elisabeth' shown in Purple)

<p>“My children are my world.”</p> <p>Maintaining (painful) connection(s) to children <u>Connecting to pain of separation</u> <u>Connecting to the pain of separation</u> <u>Thinking about past and hoping for the future</u> Connecting to pain of separation (for both her children and herself) <u>Life without the children is difficult</u> Keeping my children in mind <u>Marking time in terms of when the children were taken</u> <u>Working hard to keep family together</u> <u>Imagining future relationship with daughter</u> <u>My relationship with my children is special</u> <u>Taking pride in ongoing relationships with my children</u> Staying connected to daughter Feeling connected to children <u>“I still think about her all the time”</u> <u>Finding contact difficult but important</u> <u>Contact is emotional</u></p> <p>Feeling like a mum vs not feeling like a mum at all Identifying as a mother vs not feeling like a mother at all <u>Being a Mum</u> <u>Feeling like a mum (or not)</u></p>	<p>From feeling alone, Judged and let down to feeling part of a special relationship</p> <p>Feeling alone, overwhelmed and stigmatised Feeling alone but relying on others Feeling there’s ‘no point living’ (overwhelmed and on my own) <u>Feeling out of control/overwhelmed by emotions</u> <u>Feeling alone with no support</u> <u>Faceless ‘others’ with power over me</u> The “grey cloud” of social services ???????? Experiencing shame and guilt <u>The influence of social services</u> Not being supported by social services <u>Feeling ashamed</u> <u>Valuing individual space</u> <u>Feeling confused and overwhelmed by process</u> Feeling overwhelmed and powerless <u>Trying everything but feeling powerless</u> <u>Terrifying and confusing process</u></p> <p>Finding a way to counselling Finding my way to counselling <u>Coming to counselling via social services</u></p>	<p>“The healing process”</p> <p>Feeling understood <u>Feeling understood</u> <u>Valuing counsellors (non-judgmental) view of me</u> <u>Counselling is perfect</u> ...Feeling relaxed and understood</p> <p>Acknowledging influence of trauma and/or abuse Acknowledging history of trauma and loss <u>Acknowledging influence of abuse and trauma</u> <u>Thinking about life (acknowledging struggles?) before counselling</u> <u>The influence of abuse and allegations</u> Acknowledging reasons children were removed (violence/illness)</p> <p>Coming to terms with what happened to children Making sense of what happened to my children Coming to terms with child removal <u>Coming to terms with what happened to daughter</u> <u>Surviving hard times</u> <u>Taking responsibility</u> <u>Taking responsibility for ‘harming’ children</u> Connecting to the devastation (?) impact (?) of losing my children <u>The psychological consequences of losing daughter</u></p> <p>Experiencing a ‘release’</p>
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<p><u>Being a mum is important</u> <u>Some things make me feel more/less like a mum</u> Preserving 'good mother' identity. <u>Feeling unwanted/wanted</u> <u>Feeling loved unconditionally (by children)</u> <u>Putting the children first</u> Not giving up on children <u>Acknowledging ongoing responsibilities</u></p>	<p><u>Needing to talk but finding it hard</u> Recognising a 'need' for counselling <u>Needing/accepting help</u> <u>Feeling frustrated at lack of opportunity for counselling</u> <u>Being let down in the past</u> Needing someone to talk to and turning to professionals</p> <p>Taking time to trust counsellor <u>Taking time to trust counsellor (a man)</u> <u>Complications of Gender</u> From feeling nervous in the beginning to ... <u>Feeling comfortable with counsellor</u> <u>Feeling comfortable in counselling</u> <u>Valuing who the counsellor is and what he does for me</u> <u>Appreciating flexibility</u> <u>Counselling/counsellor is good</u></p> <p>Experiencing the counsellor as someone special Experiencing counsellor as someone special A normal yet special relationship (with counsellor) <u>Being made to feel 'normal' and therefore 'special'</u> <u>A different (special) kind of relationship</u> <u>Positive feelings towards counsellor</u> Talking to a stranger who feels like family <u>A friendly relationship</u> <u>Feeling grateful towards counsellor</u></p>	<p><u>Feeling a weight had been lifted</u> <u>Talking to get things 'out'</u> <u>Experiencing counselling as a 'release' (which is good and bad)</u> <u>Connecting to and accepting painful emotions</u> <u>Valuing talking</u> Valuing Talking <u>Talking helps</u> <u>Talking about anything and everything</u> <u>Talking is both nice and hard</u> <u>'Opening up' and Talking beyond adoption issues</u> Counselling is more than 'a quick chat'. <u>Emotional changes</u></p> <p>Noticing changes <u>Finding peace</u> <u>Altered perspective/changed understanding</u> <u>Seeing it from the children's point of view</u> Feeling differently about self ('I'm not a failure') <u>Rejecting MH labels</u> <u>reaching new understandings</u> <u>Noticing changes</u> <u>Learning about myself?</u> Noticing changes since counselling Noticing changes since counselling Noticing changes since counselling? Noticing impact of counselling <u>Noticing changes since counselling</u> <u>Doing things differently since counselling</u> <u>Doing things differently</u></p>
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		<p>Going out more, feeling part of the community.</p> <p><u>Changed relationships</u></p> <p><u>Changed relationships</u></p> <p>Experiencing better relationships</p>
<p><u>Discarded</u></p> <p><u>Feeling hopeful about the future</u></p> <p>Feeling helped by counselling</p> <p>Finding counselling helpful</p> <p>Acknowledging ongoing struggles? (and holding on to hope?)</p> <p><u>I need/want more counselling</u></p> <p>Feeling grateful and positive about counselling</p> <p><u>Counselling makes me happy</u></p> <p><u>The start of a healing process</u></p>	<p><u>Discarded</u></p> <p><u>Feeling validated by powerful others</u></p> <p><u>Eliciting help from others</u></p> <p><u>Relying on others when others are unreliable</u></p> <p><u>Feeling supported/helped by counselling</u></p> <p><u>Counselling is helpful</u></p> <p><u>Trying and failing</u></p> <p><u>Being 'hit' by emotion then emptiness</u></p> <p><u>Not knowing what to do/not wanting to do anything</u></p> <p><u>Noticing wider impact of losing the children</u></p>	<p><u>Discarded</u></p> <p><u>Taking or leaving the counsellors advice</u></p> <p>Understanding Counselling</p> <p><u>An unfamiliar task set by others?</u></p> <p>Valuing counselling AND wanting it to be different</p> <p><u>Praising and Acknowledging limitations of counselling</u></p> <p><u>Feeling something was missing from counselling</u></p> <p><u>Health can be a barrier</u></p> <p><u>Counselling was not what I expected</u></p>

Appendix H – Pervasiveness of themes across transcripts

Master Theme	Subordinate Themes	Rebecca	Isobel	Saffron	Lara	Elisabeth
From feeling alone, judged and let down to feeling part of a special relationship	Feeling alone, overwhelmed and stigmatised	Yes	Yes	Yes	Yes	Yes
	Finding a way to counselling	Yes		Yes	Yes	Yes
	Learning to trust counsellor	Yes	Yes	Yes	Yes	Yes
	Experiencing counsellor as someone special	Yes	Yes		Yes	Yes
“The Healing Process”	Feeling understood	Yes	Yes		Yes	Yes
	Acknowledging influence of trauma and/or abuse	Yes	Yes	Yes	Yes	Yes
	Coming to terms with what happened to children	Yes	Yes	Yes	Yes	Yes
	Experiencing a ‘release’	Yes	Yes	Yes	Yes	Yes
	Noticing changes	Yes	Yes	Yes	Yes	Yes
“My children are my world”	Maintaining painful connection(s) to children	Yes	Yes	Yes	Yes	Yes
	Feeling like a mum vs not feeling like a mum at all	Yes	Yes	Yes	Yes	Yes