Portfolio Volume 1: Major Research Project

Children and Young People’s Experiences of Dyadic Developmental Psychotherapy

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> *"Rivers know this: There is no hurry. We shall get there some day"*
>
> Winnie the Pooh

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Abstract

Aims: Dyadic Developmental Psychotherapy (DDP) is a family-based psychotherapeutic intervention designed to help children and young people with the psychological difficulties that may result from early experiences of interpersonal familial abuse, neglect, and adversity. The study aim was to understand the experience of DDP through the lens of the child, with a view to informing an understanding of any perceived changes that may have come about through the therapeutic process in relation to attachment security and increased caregiver closeness.

Method: Six children aged between 8 and 12 years old accessing ongoing DDP interventions participated. Participants were adopted or living with extended family under Special Guardianship Orders. Narrative story stem methodologies were utilised to elicit projective responses through figurine enactments, alongside additional creative visual methodologies. Data was analysed using Interpretative Phenomenological Analysis, and triangulated through a DDP therapist focus group, which was interrogated using template analysis.

Results: Two master themes and eight subthemes were identified from the data. Together these themes described a dynamic process where the qualities of the therapeutic interactions were the active ingredient, generating potential for increased caregiver closeness and connection. A cycle of interactive repair was important to maintain the process of developing trust. Most participants were able to express benefits of the therapy, depicting increased connection and closeness with caregivers.

Implications: Findings indicate that attuned emotional interactions in DDP may drive positive change, generating the relational conditions through which to blend affective states with reflective functioning, leading to increased attachment security through the active involvement of caregivers. Outcomes are likely to be moderated through therapist effects, supporting robust practitioner training with regular DDP specific supervision and development through the practicum process as relevant to ensure therapist proficiency. Play and activity-based research techniques were helpful in promoting meaningful inclusion for this group of children.

Chapter 1 Introduction

1.1 Chapter Overview

This study aims to explore children's experiences of Dyadic Developmental Psychotherapy (DDP), with the objective of developing a deeper understanding of the core components and central tenets from the perspective of the child. DDP is a family-based psychotherapeutic intervention designed to help children and young people with the psychological difficulties that may result from experiences of interpersonal familial abuse, neglect, and adversity in early childhood. DDP is one of the most frequently used interventions in the UK to support children who have entered the care system and have typically found permanence through adoption and special guardianship (Burch et al., 2022).

This chapter first positions the research and researcher, outlining the epistemological philosophy underpinning the study. To provide background in relation to the families accessing DDP, the wider context is presented in relation to adoption and special guardianship in the UK. The psychological and neurobiological outcomes of interpersonal abuse, neglect and adversity are briefly explored from a critical realist perspective. That is to say that such adversity does not cause mental illness but rather is a risk factor in a range of forms, or symptoms of distress. Theoretical underpinnings and core components of DDP are then described. Finally, this chapter provides an overview of the existing DDP evidence base.

1.2 Personal and Epistemological Position

1.2.1 Relationship to the Topic

My interest in this topic has been long-standing. As a social worker, working in the field of adoption in the late 2000's I found myself wondering how best to support the families I was working with. Over the next 10 years, I developed skills in DDP which was an approach that families generally seemed to appreciate. I witnessed the challenges of supporting children who had experienced such pain in relationships that kindness, closeness and compassion evoked fear. DDP provided a valuable framework through which to support these children and their caregivers. The theories underpinning DDP and the supervision I received, supported my compassionate stance, holding hope when those within the family system were struggling.

As a DDP therapist, I witnessed shifts in children's tolerance of closeness, with caregivers experiencing increased understanding and deeper connections with their child. Sometimes, witnessing and engaging in these relationships was challenging and I acutely experienced children's steadfast resistance. I was curious about what it might be like for the children. I knew research with children was not going to be an easy option, both in terms of ethical considerations and in terms of meaningfully engaging these potentially mistrustful children in a brief research experience. I believed I could rise to this task and figured with greater challenge comes greater reward. And off I went.

1.2.2 Positionality and Reflexivity

Positionality is multi-faceted, and identity can be complex and fluid (Day, 2012). My identity has changed over time as I have grown and developed different understandings of the world and this topic. I view the world through the lens of my identity and positionality. In line with a critical realist approach, I reflexively explored my positionality, attempting to bring my biases, assumptions, and relationship with the topic into my conscious awareness. Table 1 details the reflexive methods utilised through the stages of the study.

I am a white western, cis-gendered female. I have professional experience of adoption and special guardianship, but not personal experience. This was a fundamental difference between myself and my participants, positioning me as an outsider (Hellawell, 2006; Le Gallais, 2008), which is important to acknowledge and affords particular narratives and opportunities. My position as an experienced DDP therapist presents potential biases that were important to acknowledge and bracket as part of the process. My western privilege and education and my position as a trainee clinical psychologist may bring certain assumptions and ideas around how to conduct research and interpret data. My identity as a mother brings different meanings to research with children, my relationship with my participants, and my interpretation of their data. The reflexive process brought these perspectives into the light, not to be changed but to be acknowledged.

Table 1

Methods of Reflexivity

Method	Task
Positionality Map	I developed a Social Identity Map (Jacobson & Mustafa, 2019), which can be found in Appendix A. This was a fluid and flexible starting point to provide some visual clarity. The aim of this exercise was to consider how aspects of my identity might impact and influence the research process. This helped me to identify the aspects of my experiences and consider how this influenced the decision-making process.
Reflexivity in Research exercise	The was an exercise provided from course materials. It supported reflections on interactions between my positionality, relationship to the topic, participants and power. An excerpt can be found in Appendix B. This reflective exercise supported a reflexive process on methodological decision making. For instance, my experience of working with abused and neglected children led to a desire for the methodology to be trauma informed and collaborative, holding in mind the implications of the power adults represent for this cohort of children.
Reflexive journal	• A reflective research journal (see Appendix C for extracts) to record thoughts, decision making processes, supervisory discussions, reflective discussions with peers, and reflections from learning (lectures and reading) relevant to the research. • Reflections after interactions with participants and throughout analysis (see Appendix D for extracts). This supported greater awareness of biases and assumptions, and how my identity intersections with participants.
Consultation	Two Experts by Experience (EBE) supported the study at differing stages. EBE 1 was someone with care experience and a professional supporting children in residential care using DDP as a guiding framework. EBE 2 was a DDP Consultant. An outline of EBE involvement can be found in Table 19 in Appendix E, along with an example of notes made during an analysis discussion. EBE involvement supported the critical realist approach in providing another lens and positional perspective to decision making and analytical interpretations.

1.2.3 Epistemological Position.

Within this study, I feel morally compelled to take a critical realist position that child abuse is not merely a social construct but is a real event, which has real and long-lasting consequences on the lives of those it impacts (Pilgrim, 2017). There may be multiple perspectives, understandings, and realities for those involved in such complex relational experiences. Human understanding captures only part of reality. Critical realism provides an explanatory framework that treats the social world as real, whilst suggesting that theory, as well as human experience can help us get closer to reality (Bhaskar, 1998). Critical realism recognises the interactional forces and power that influence experience (Bhaskar, 1979), which seem so relevant to this topic. There is an external reality beyond our ideas. What happens in interpersonal experiences cannot be understood without reference to the individual but equally cannot be reduced to the individual.

Retroductivism is a logic that underpins critical realism. It involves moving from observation to postulation and the underlying structures of a phenomena (Mingers, 2003). Understanding complex interactions between humans requires stepping beyond the experience and attempting to explore deeper latent meanings (Heidegger (1977). With this interpretation I inevitably bring my own fore-understandings. Gadamer (2013) points out that it is possible to engage in a dynamic process where preconceptions can be compared, contrasted, and then modified as part of the sense making process, whilst remaining rooted in the phenomena.

The African philosophy of Ubuntu acknowledges that we exist collectively. A person is a person through other people. This study intends to make sense of the child's sense making of their DDP experience, holding the position that this is within the context of the child's relationships, past and present (Chigangaidze, 2021).

1.2.4 The Epistemological Approach to Exploring Knowledge

In a move away from traditional semi-structured interview techniques typical in western qualitative research, this study aims to enable sense making to derive the meanings an often unheard group of participants ascribe to their experiences through the co-creation of stories, doll enactment, play, and visual methods. Holding in mind the philosophical and epistemological stance of the study, a creative multi-perspectival and multi-modal approach to data collection and analysis has been applied to explore lived experience as fully as possible. This is influenced by phenomenology, the idea that a person is embedded in a world of relationships, objects and unobservable structures (Husserl et al., 2012); and hermeneutics, the theory of interpretation (Heidegger, 2010). Attention is paid to the multi-sensory and embodied experiences of the participants with the aim of capturing the 'felt sense' of the experience, which more traditional and linear forms of data collection can miss (Boden & Eatough, 2013). This necessitates a more complex design which can be helpful where there may be constraints upon the participants to verbalise, and additional modalities and perspectives can supplement this (Larkin et al., 2019). The creative methods in this study have been used as elicitation, as a way of understanding the children's meaning and sense-making. Similar methods have been reported within the literature and have been found to support participants and researchers to express and interpret some of the subtle and implicit aspects of relational experience (Boden et al., 2018).

1.3 Key Terms

1.3.1 Adoption

This study refers to a UK context where adoption was first brought into legislation in 1926 (Adoption of Children Act, 1926). Adoption is a formal process through which the parental rights and responsibilities relating to a child are legally transferred to the adoptive caregivers. Birth parents do not retain any parental rights. Adoption is permanent, except in rare circumstances. Court rulings in 2013 refocussed adoption limiting it to children for where no other care options exist (Doughty, 2013; Gupta &Lloyd-Jones, 2014). The majority

(65%) of young people enter care due to abuse and neglect, or because they were at risk of abuse and neglect, with 2% of these children becoming adopted (Office of National Statistics (ONS), 2023). The average age of adoption in the UK was 3yrs 5 months in 2023 (ONS, 2023).

1.3.2 Special Guardianship Orders (SGO)

Special Guardianship is an order made under the Children's Act (Department of Health, 1989). It is intended for children who cannot live with birth parents. Special Guardians are usually relatives but may also be friends or foster carers. SGO grants parental responsibility to the Special Guardian and is intended as a permanent alternative arrangement. Unlike adoption, SGO does not sever the legal rights of the birth parents in the entirety. The Special Guardian is able to exercise parental responsibility over the upbringing of a child. The average age of children at the point of SGO is 2 years 6 months (ONS, 2023).

1.3.3 Abuse

For the purposes of this study, the abuse we refer to is interpersonal (within the family), and may include physical, sexual, verbal, or emotional forms of abusive experience.

1.3.4. Neglect

Neglect may be physical or emotional and refers to the absence or withdrawal of safety and care from a caregiver.

1.3.5 A Note on Language

The Scottish Independent Care Review (The Promise) (2021) highlighted the importance of language on how care-experienced children feel. The language chosen in this study is considered and intentional. The intent is to avoid othering and stigmatisation. I hope that I can do this justice. I take responsibility for any mistakes. I commit to continuing to listen and learn.

This study uses the term 'care-experienced' rather than 'Looked After Children' or 'LAC', informed by TACT's 'Language that Cares' project (Ortiz, 2019). The term 'caregiver' has been used rather than 'parent' or 'SGO carer' and encompasses both adoptive parents and special guardians for the purposes of this study. Gender neutral language has been used where possible, with the intention of being inclusive while offering further anonymity to families. The terms child/children have been used to reflect the focus of this study on pre-adolescent children, aged 14 and below.

1.4 Situating the Research

1.4.1 Current UK Context of Support for Adoption and Special Guardianship

In 2015 the UK Department for Education (DfE) created the Adoption and Special Guardianship Support Fund[1] (ASGSF) designed to meet the therapeutic needs of these children, and their families. Evaluations have found that both children and their caregivers accessing the fund demonstrated high levels of mental health need in comparison to the general population (King et al., 2017; Burch et al., 2021). The formation of the ASGSF created impetus in the sector for the development of therapeutic approaches that could meet the needs of adoption and SGO families. DDP and DDP informed group programmes were among the most frequently accessed supports (Burch et al., 2022).

1.4.2 NICE Guidelines

In 2015, the National Institute for Health Care and Excellence guidelines (NICE) developed guidance in relation to interventions for children and young people with, or at risk of, developing attachment related difficulties. It covered children in the UK care system, SGO and adoption. The guidance noted that although there are various interventions

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[1] The Adoption and Special Guardianship Support Fund provides funds to local authorities and regional adoption agencies (RAA's) to pay for therapeutic support. https://www.gov.uk/guidance/adoption-support-fund-asf

currently used in the UK which may help to address attachment-related difficulties, the evidence base is limited. The guidelines note DDP to be a promising intervention, therefore suggesting a randomised controlled trial to further evaluate the therapeutic approach, alongside qualitative data on the experiences of caregivers and children involved in the therapy.

1.4.3 Outcomes of Children Who are Adopted or in Special Guardianship Care

Children in the UK who become adopted or cared for by special guardians are likely to have experienced previous abuse or neglect (ONS, 2023; Selwyn et al., 2015). Permanency through adoption or special guardianship can be an effective intervention, and many children adjust well, despite their adverse experiences (Selwyn et al., 2015; Selwyn et al., 2017; Van IJzendoorn, 2006). Complex pre- and post-adoption factors are associated with outcomes including differences in child temperament, caregiving style and sensitivity, caregiver mental health, and wider systemic and contextual factors such as school experiences and experiences of racial discrimination (Duncan et al., 2021; Luke et al., 2018). Adopted and SGO children remain more likely to experience enduring mental health challenges than non-care experienced counterparts, although estimates of this vary considerably due to variations in assessment tools in the literature (Cummings and Shelton, 2023; Duncan et al., 2021 Ford et al., 2007; Meltzer., 2003; Paine et al., 2021). Caregivers of these children may also experience challenges such as compassion fatigue (Hannah & Woolgar, 2018), with most adoptive families likely to need some additional trauma-specific support from services (Hartinger-Saunders & Troutneaud, 2015).

There is a paucity of studies focussing specifically on outcomes in SGO placements. Harwin et al., (2019) audited five English studies available at the time and found that generally children fared well in SGO placements in comparison to children in other care settings such as foster and residential care. Selwyn and Masson (2014) found that the risk of disruption (a child in an SGO placement who has become 'looked after' again) is low (5.7% over 5 years), but higher than in adoption. There are likely to be many similarities between the needs of children in adoption and special guardian arrangements as the two main forms of permanency in the UK for children who cannot live with their birth family. There are also likely to be some differences, with retention of the birth family link for SGO families being an obvious one.

A review of 52 studies (Duncan et al., 2021) examined risk and protective factors for adopted children and found that the quality of the caregiver-child relationship was an important factor in mediating the outcomes for adopted children. Family-based interventions may therefore be an effective form of post-placement support (Purrington et al., 2023).

1.4.4 Impact of Interpersonal Abuse and Neglect

Although interpersonal abuse and neglect is not the experience of all children who are adopted or on SGO's, it is helpful to briefly review the impact of such experiences to set the context for DDP as an intervention targeting the impact of such experiences. There is diversity in the developmental outcomes for children who have experienced abuse and neglect due to interacting biological, psychological, and social factors (McCrory et al., 2010; Rutter et al., 2006; Smith & Pollack, 2021). A review of studies investigating neurobiological and genetic factors associated with child abuse and adversity, suggested that an environment where caregivers are unable to scaffold young children's responses to stress may lead to an adaptation in the Hypothalamic-Pituitary-Axis[2] (HPA), as children attempt to regulate their own stress (McCrory, 2010). Such an adaptation may therefore influence a child's ability to regulate their emotions in response to stress.

Each child's responses will be unique and difficult to predict. It is important that children with early adverse experiences, such as abuse and neglect, are not considered to be 'damaged' by their experiences, and instead we see any effects as once functional adaptations to their environments (Perry et al., 1995; Wadsworth., 2015). Adaptations may be an advantage in hostile environments, but once children are moved into safer situations, they may be left with over-sensitive threat response systems (Baylin and Hughes., 2022; McCrory, 2010). This can be a barrier to engaging in caring relationships and learning environments (McCrory, 2010).

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[2] The HPA axis is a major neuroendocrine system responsible for controlling reactions to stress and physiological processes.

1.5 Theoretical Frameworks Underpinning DDP

DDP was developed from theories and research on developmental trauma, attachment, intersubjectivity and interpersonal neurobiology. This next section further explores the developmental impact of interpersonal abuse and neglect and situates DDP through these guiding principles.

1.5.1 Complex Developmental Trauma

Van der Kolk's (2005) notion of developmental trauma recognises the neurobiological impact of repeated relational traumas on the developing structures of the brain. A review by Cook et al., (2005) described 7 domains of impairment; attachment patterns, biological states and processes, affect regulations, cognitive process, dissociative states, behavioural control, and self-concept. The UK Trauma Council (2022) defines complex trauma as 'traumatic experiences involving multiple events, with interpersonal threats during childhood or adolescence'. This is a broad definition encompasses familial abuse, neglect, and violence but also community violence, racism, discrimination and war. The UK Trauma Council definition is explicit in including experiences of neglect, which is not clearly stated in other definitions of developmental trauma. It also acknowledges socio-political factors and situates relational traumas in a wider systemic context.

Complex trauma and developmental trauma are not formal diagnostic terms but are helpful concepts that recognise the importance of formulation, which considers past experiences.

1.5.2 Attachment Theory

Human infants are born entirely dependent on their caregivers for survival (Bowlby, 1969). Attachment theory is concerned with the role of the caregivers in responding sensitively to the infants' distress cues, restoring emotional regulation and a sense of safety. Attachment theory posits that the quality of the relationships will impact child development (Bowlby, 1988). When children's needs are predictably responded to, they feel safe and able to explore and develop interests (Ainsworth, 1967). For some children, their caregivers are unable to consistently respond sensitively to their needs. These children are left to rely on their own resources to manage distress and they adapt to emotionally regulate and survive. Some children may develop patterns of self-reliance, known as an avoidant pattern (Ainsworth, 1967). For others, deploying controlling patterns may be a more effective strategy, keeping the caregiver close and dependent (anxious/ambivalent pattern). For children where the caregiver may be the source of distress, or where they are unpredictable, it may be difficult to organise an effective strategy and the child is left in a state of overwhelming distress. This is known as a disorganised pattern and has been associated with symptoms of emotional and cognitive dysregulation, which can lead to difficulties in behaviour and functioning (Main & Solomon, 1990). Early insecure attachment patterns do not necessarily determine future difficulties but could be a risk factor to later behavioural difficulties and poor mental health (Brumarui & Kerns, 2010; Fearon et al., 2010). DDP focusses on regulating emotional states associated with past relational trauma to support sense making, promote the development of a more secure attachment to caregivers, and support the development of coherent narratives (Hughes et al., 2019).

There are criticisms of attachment theory. One of Bowlby's assumptions was that the mother is the most important attachment figure, which in the past has been misused to push anti-feminist, heteronormative, neoliberal agendas (Music, 2019). There is evidence that children display attachment related behaviours across cultures, using adult caregivers as a secure base (Mesman et al., 2016). These behaviours may look slightly different and caregiving practices differ (Mesman et al., 2016). Findings of cross-cultural studies highlighted the influence of socio-economic factors that may influence attachment security (Gojman et al., 2012; Valenzuela, 1997). Cross cultural studies suggest that attachment 'networks' are more applicable in collaborative indigenous cultures (Keller, 2018). Music (2019) argues that attachment theory should not be dismissed as the research linking early adversity to detrimental effects is strong.

1.5.3 Intersubjectivity

Through frame-by-frame video analysis, Meltzoff (1985) noted that infant's study, mirror and imitate the small movements in interactions with others. Trevarthen (1998) extended this idea and posited that infants are born innately primed for dyadic, emotionally responsive communication with their caregiver from birth, long before language is developed. Trevarthen (1998) and Tronick (2017) conducted experiments that show infants are acutely sensitive to small changes in the emotional state of their caregivers. Trevarthen suggested that through these preverbal conversations towards the end of the first year of life, infants begin to develop symbolic interactions and awareness of the self and others. When the rhythms of the conversation are concordant (in sync) and matched in vitality, the child and caregiver enter 'states of attunement' (Stern, 2000). Here, relational safety is experienced, intentions are shared, and joint narratives are created. For securely attached children, these concordant states happen frequently enough for them to learn they are loveable and interesting. DDP aims to replicate such intersubjective conversations in the therapeutic relationship and in the child's day-to-day care to communicate the child is important and worthy of care (Hughes et al., 2019).

1.5.4 Interpersonal Neurobiology

The field of interpersonal neurobiology (Siegel, 2012; Schore, 2021) attempts to understand the impact of abuse, trauma and neglect informed by neuroscientific understandings. It presents research showing how rich social experiences help to 'buffer' negative experiences (Tottenham, 2017). Children who have experienced frightening or non-protective caregivers may adapt neuroceptive responses to assess danger in a different way to children who have experienced consistent early care (Baylin & Hughes, 2022). Neurobiological studies on Polyvagal Theory (Porges, 2011) suggest that when children feel safe, the ventral vagal circuit in their autonomic nervous system is activated. When in this state, known as the social engagement system, they can develop social emotional skills. When a young child experiences threat, a different system is activated, the dorsal vagal circuit. This is a defence system that leads to neural alarm responses in the child's brain (Liddell et al., 2005). Repeated experiences of threat, abuse and rejection are likely to supress the social engagement system and over-activate the defence system leading to defence systems becoming more robust than social engagement systems (De Bellis, 2001; Teicher et al., 2003). Children may struggle to perceive safety in any relationships, a concept that Baylin and Hughes (2017) referred to as 'blocked trust'. Blocked trust may lead children to disengage from relationships as their nervous system responds to protect them from the anticipated pain of abuse and rejection.

Research suggests that the trusted presence of a caregiver can quieten the child's nervous system (Tottenham, 2017). Schore (2021) refers to such interactions as 'affect synchrony' and suggests they can generate increasing levels of dopamine arousal, shared emotional states of pleasure, and the urge for contact seeking. Informed by such neurobiological research, DDP focusses on creating safe relational experiences to shift the child from blocked trust and chronic defensiveness into open engagement (Baylin &Hughes, 2016).

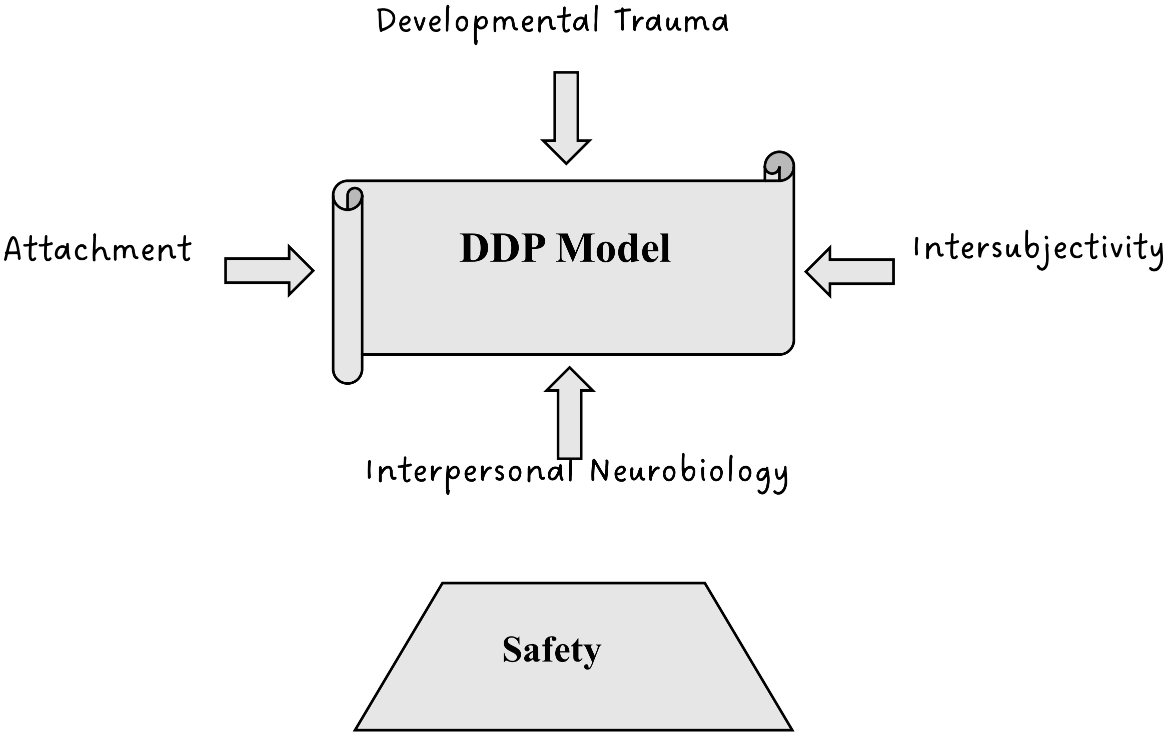
Caregivers' ability to stay open and engaged supports the child's healing and development however, sometimes they find themselves stuck in their own defensive systems. Informed by research on the neurobiology of caregiver-child interactions, Baylin and Hughes (2012) developed a model of 'Blocked Care' providing a framework to understand difficulties in the relationship within the context of neurobiological responses to threat and rejection. The message is hopeful that blocked care and blocked trust can be resolved within a DDP model with the therapist applying principles of playfulness, acceptance, curiosity and empathy in their relationship with the caregiver and child (Hughes et al., 2019).

1.6 Overview of DDP

DDP is a child-caregiver psychotherapy which seeks to address some of the common mechanisms related both to attachment insecurity and developmental trauma (Hughes, 2007). Relational safety is fundamental to the model and precedes exploration (see Figure 1). Relationships are at the heart of the work (Hughes and Golding, 2024).

Figure 1

Defining Principles of DDP



(Hughes and Golding, 2024 p.36, used with permission – see Appendix F)

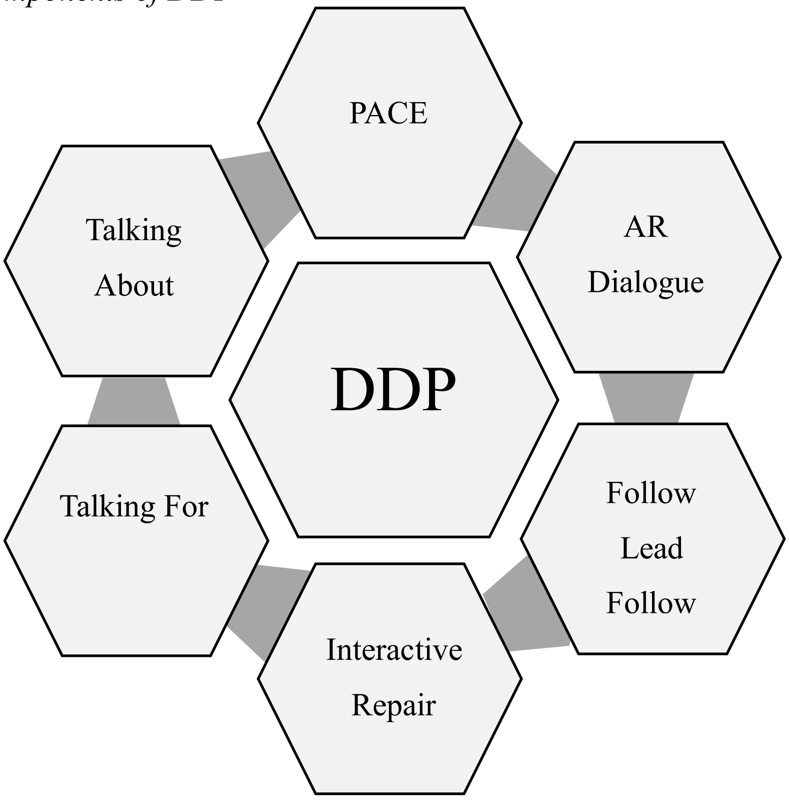
1.6.1 Components of DDP

The components of DDP are described in detail in 'Healing Relational Trauma Workbook: Dyadic Developmental Psychotherapy in Practice' (Hughes & Golding, 2024) and are summarised here for the purposes of contextualising the study. DDP therapists must be registered with a recognised governing body. They are highly trained through a robust training framework[3] and supervision practicum.

DDP is modelled on qualities of healthy relational activities with the aim of supporting and integrating emotional regulation, cognitive development, and autobiographical narratives. The DDP Framework highlights six components that are essentially the qualities of the therapeutic conversations (see Figure 2).

Figure 2

Components of DDP



(Hughes and Golding, 2024 p.147, used with permission)

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[3] For more information regarding the training framework and practicum go to https://ddpnetwork.org/professionals/

1.6.2 PACE

PACE is an acronym that denotes qualities of playful connections, acceptance, curiosity, and empathy about the child's inner world. *Playfulness* refers to the experience of relational joy and connection. It is not a contrived playfulness but rather an intention to discover liking and enjoyment in the other. It conveys a lightness in the interactions. *Acceptance* refers to an acceptance of the internal experience of the other. Emotional experiences are neither right nor wrong and are judgement free. The adult needs to stay present for child in the experience, however uncomfortable. *Curiosity* conveys a desire to deeply connect with the other, starting from a place of not knowing. Curiosity seeks to deepen understanding through story telling. Acceptance is conveyed through *empathy*. The adult allows the child's experience to be deeply felt by them, contained and gently reflected on with empathy.

1.6.3 Affective/Reflective Dialogue

Within interactions, attention is paid to both affective and reflective components. DDP intentionally aims to integrate both elements to support emotional regulation and the development of coherent autobiographical narratives. For instance, a therapist may hold and contain a child's descriptive dialogue reflecting it back with increased affect. Non-verbal communication is an important element conveying personal meaning through rhythmic prosody of voice and body language to convey safety and rich intersubjective meaning making.

1.6.4 Follow-Lead-Follow

DDP is neither directive nor non-directive, allowing for co-creation of meaning. Using PACE, the therapist might follow a theme introduced by the child, expressing curiosity and empathy to develop shared meanings, inviting the story to be actively co-created together. To support emotional regulation, the therapist will be paying close attention to the child's non-verbal signals, moving between following the child's presenting need to defend against topic in that moment, re-creating safety and then gently leading to maintain the therapeutic window of tolerance (Casswell et al., 2014).

1.6.5 Interactive Repair

DDP pays close attention to any relational ruptures. The adult takes the initiative to repair this rupture, demonstrating the importance of the relationship. It may not be that the adult has made a mistake as such, but that they recognise there has been a breach in the relationship for whatever reason. This communicates that the relationship is more important than the problem or conflict.

1.6.6. Talking For and Talking About.

Children can struggle to articulate complex thoughts and feelings, especially in relation to traumatic experiences. To assist the child, the DDP therapist may express their curiosity by 'talking for' or 'speaking about' the child in a way that invites the child into the conversation without expectation. This may provide the momentum for the child to find the words. The therapist does not take over the narrative but is tentative, inviting the child to join the conversation. It may feel safer for the child just to listen and indicate if the therapist is getting it right through a signal such as thumbs up or thumbs down. This may support children to move into deeper affective states in a way that is tolerable.

1.7 Cyclical Process of DDP

Children who have experienced relational trauma may have experienced a violation to their core sense of self and find it difficult to establish safety within subsequent relationships (Baylin & Hughes, 2016). The DDP therapist attends closely to the child's sense of safety and is likely to return again and again to re-establish safety. The therapist is sensitive to the heightened sense of threat that a child may perceive within interactions. The therapist works to join and mirror the affective tone of the child's prosody, supporting regulation through increasing and reducing prosody to establish momentum and support emotional regulation.

The therapist communicates that the child will not be trapped into exploring their trauma and the therapist may need to provide regular breaks.

It can take time for safety to be established before developing more coherent story themes with empathy, whilst keep shame low. Initially stories may be focussed on the here and now before moving towards exploring more difficult stories, when the child indicates they can tolerate it. As the stories develop without shame or fear, new meanings can be formed. The goal of DDP is to create the relational conditions through which narratives of self may be re-considered and redefined. It opens the possibility to the child to explore traumatic remembering's from their past that they may have been too fearful to consider previously, creating opportunity for fragmented memories to become coherent stories. This may be a more distant goal of DDP as the immediate intention is to establish safety and maintain intersubjective relational connections. Intersubjective interactions and storytelling may challenge previous core beliefs of feeling unlovable.

1.8 The Two Phases of Treatment.

There are two phases to DDP treatment. In the first phase, the therapist meets the caregivers without the child. During this phase the therapist works to build a therapeutic alliance with the caregiver and get to know the strengths and difficulties in the family. During these sessions carers will experience the DDP approach from the therapist and are invited to incorporate ideas from DDP into their caregiving approach. It may be decided that further sessions including the child are not necessary as shifts in caregiver behaviours and understandings may promote increased connection. If joint sessions are indicated, therapists will use their judgement to decide when best to do this.

1.9 DDP Literature and Evidence Base

The current evidence base for the effectiveness of DDP is limited but developing. The main quantitative study exploring efficacy was undertaken by Becker-Weidman (2008b).

The study explored the outcomes for one group of children who had received DDP and another group who had not. Carer questionnaires (Child Behaviour Checklist and The Randolph Attachment Disorder Questionnaire) were completed for both groups at two time periods, one year and four years after DDP. Results were positive with significant improvement on measures for the DDP group at the one-year mark, which remained at the four-year mark with scores for the control group deteriorating. There were some criticisms of the methodology of this study (Mercer, 2014) as the study did not use randomisation, and the evaluation was not blinded.

Burch et al. (2023) undertook a longitudinal study of survey data to analyse the potential effect of DDP on standardised measures of child and carer well-being outcomes Participants were 150 adoptive caregivers and special guardians who received DDP through the ASGSF. Participants were surveyed at 3 time points; before therapy, when therapy ended, and 6 months later. They found an association between the provision of DDP and improvements in children's emotional difficulties and conduct problems. They found similar associations in improvements on the carer wellbeing scale. Improvements for both children and carers were maintained at 6 months. Data was not collected in a clinical environment and control group data was not available, which reduces the confidence in attributing the improvements to DDP. The study added promising evidence and supported the continued evaluation of DDP as a potentially effective intervention.

Other studies on DDP have been based on qualitative interviews with carers and therapists after the completion of DDP interventions. Wingfield and Gurney-Smith, (2019) interviewed 12 adoptive caregivers who had taken part in at least six sessions of DDP with their children. Caregivers reported increased understandings of their child and valued new methods of caregiving with increased acceptance. All but one of the caregivers felt the intervention had been beneficial to their relationship with their child. Eight caregivers were interviewed as part of a study exploring experiences of the 'Nurturing Attachments' programme, a carer focussed family intervention informed by DDP (Hewitt et al., 2018). Carers in the study reported shifts in perspective in relation the impact of their children's attachment and trauma experiences on their behaviour.

To address the gaps in the evidence base and in response to the growth in popularity of DDP in the UK, a National Institute of Health Research funded randomised controlled trial is currently underway at the University of Glasgow[4]. This trial aims to explore whether DDP can improve the mental health of 2–12-year-olds that have been legally adopted or are in foster care, whilst its exploring cost effectiveness.

1.10 Chapter Summary

In summary, the needs of children who have experienced developmental trauma are complex. There is likely to be no 'one size fits all' intervention for this client group (Dozier 2002a; Roth & Fonagy, 2006). DDP is one intervention of several that might be helpful and is currently regularly utilised in the UK through the ASGSF. Research into DDP is lagging behind its growth in popularity as an intervention. It is imperative that we understand more about how DDP might be helpful and to whom. To examine existing knowledge of similar caregiver-child psychotherapeutic treatments for developmental trauma, a systematic review will be presented in the next chapter.

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[4] For more information on the RIGHT Trial go to: https://www.gla.ac.uk/media/Media_989385_smxx.pdf

Chapter 2 Systematic Literature Review

2. 1 Chapter Overview

A Systematic Literature Review (SLR) is more than a simple overview of the evidence (Butler, 2016). It answers a specific question and contributes to evidence-based practice and decision making within health care (Grant 2009). In line with NICE guidelines recommendations regarding interventions for children with or at risk of attachment related difficulties, this review examines the experience of caregiver-child psychotherapeutic interventions for developmental trauma. Whilst there are quantitative reviews of the efficacy of such treatment models (Fraser et al., 2013; Leenarts et al., 2013; Purrington et al., 2022; Wright 2015, 2023), less is understood about the conceptual understanding of how they are experienced.

This chapter outlines the systematic procedures and protocols pertaining to the review process. The qualifying studies are then reviewed against quality assurance guidelines before results are synthesised using a narrative synthesis approach (Popay et al., 2006). Finally, this chapter addresses limitations of the review and highlights gaps in the literature, providing a rationale for the empirical element of the study, with aims and objectives outlined.

2.2 Systematic Literature Review Aims and Objectives

This qualitative systematic review aimed to synthesise and explore current literature pertaining to experiences of caregiver-child psychotherapeutic interventions for developmental trauma with the following research question:

What does existing literature say about the experience of psychotherapeutic treatment models that focus on the dyad of the caregiver-child relationship, specifically designed to treat developmental trauma symptoms in children and young people?

The review aimed to advance the conceptual understanding of how these interventions are experienced by the clients (caregivers and children), clinicians and referrers, with a view to identifying gaps in the literature, informing the design of this study.

2.3 Method

2.3.1 Information Sources and Search Strategy

A scoping search of the literature on dyadic psychotherapeutic treatment models for developmental trauma was conducted (including but not limited to PROSPERO), revealing a paucity of SLR's exploring experience of such treatments. A thorough protocol was developed for the review guiding the search strategy, inclusion criteria and data extraction (Bettany-Saltikov, 2016), and was registered with PROSPERO[5] prior to formal engagement with the literature. Search terms and relevant databases were informed by similar review protocols (Purrington et al., 2023: Wright et al., 2023) and developed in consultation with a University of Hertfordshire Librarian, the project supervisor, and the research lead. Search terms were further developed through reading literature linked to the subject area and structured using the 'SPIDER" criteria (Methley et al., 2014) described in Table 2. Searches were performed in Scopus, APA PsycNET, PubMed, MEDLINE, CINAHL, Social Care Online and Google Scholar, as the databases most likely to contain such studies. The final search was conducted on 1st September 2023. In addition to this process, titles and abstracts of articles previously identified as relevant were examined for key terms and screened in the same way. Other search strategies that were employed included screening reference lists and citations.

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[5] Available from https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42023445041

Table 2

Overview of the Search Strategy

SPIDER Criteria:		Examples of search terms:
Sample	Children with symptoms of developmental trauma	Child OR “adopted child*” OR “looked after child*” OR “residential” OR adopt* OR foster* OR parent* OR carer* OR professional* OR therapist* OR “young people” AND “development* trauma” OR “attachment traum*” OR “attachment disorder” OR attach* OR “relation* trauma” OR “child* trauma” OR “complex trauma”
Phenomenon of **I**nterest	Dyadic psychotherapeutic interventions	“dyadic intervention*” OR “dyadic therap*”OR “dyadic developmental psychotherap*” OR “attachment intervention*” OR “attachment therap*” OR “child* parent psychotherapy*” OR “Parent-child* psychotherapy” OR “child* parent relation*” OR “family based therapy” OR “family based intervention”
Design	Qualitative data collection and analysis, mixed methods data collection.	Published articles including empirical design, case studies and discussion papers if relevant to the research question.
Evaluation	Experiences	Experience* OR view* OR role OR perception* OR opinion* OR belief* OR perspective*
Research type	Qualitative or Mixed Methods	Qualitative and mixed methods were included.

2.3.2 Study Selection

Initial searches revealed several studies within this subject area were focussed on populations of children in foster care, residential care or adopted. A decision was made to include these as search terms as a degree of relational or developmental trauma could reasonably be assumed in these populations, although the review aimed to be broader than just these populations. Studies referred to developmental trauma in various ways and full texts were screened to ensure the definition was relevant to the study topic.

Although some studies explored well evidenced (Wright et al., 2023), interventions aimed at promoting attachment security such as Circle of Security, Attachment and Bio-behavioural Catch-up and Child-Caregiver Psychotherapy, the study populations were considered to be ‘at risk’ of developmental trauma rather than specifically aimed at treating developmental trauma symptoms, and as such were not included in the review.

This study was specifically interested in psychotherapeutic treatment models focussed on the dyad of the caregiver-child relationship, to treat developmental trauma symptoms. Interventions that did not include the child, such as caregiver groups, were included only if there was a clear focus on exploring and strengthening the caregiver-child relationship. Interventions that were solely psychoeducational or training programmes were excluded. Table 3 provides a detailed overview of the review eligibility criteria.

Table 3

Overview of Eligibility Criteria

Inclusion criteria:	**Exclusion criteria:**
Studies focussing on Children under the age of 18 described in a way that fits with 'developmental trauma', or who have been adopted, fostered, or 'looked after' by their local authority.	Studies of interventions that are solely psychoeducational.
Studies focussing on the experiences of psychotherapeutic treatment models focussed on the caregiver-child dyad, aimed at treating developmental trauma. Including the clients (caregivers/children), clinicians or referrers.	Dyadic interventions that are attachment based but not specifically aimed at children who meet the criteria for developmental trauma. For example, studies aimed at vulnerable groups but participants were not selected due to developmental trauma symptoms.
Qualitative and mixed methods studies exploring first hand experiences of the interventions, including case studies.	Studies that do not evaluate or explore the experience of the interventions.
Studies published between January 2008 and September 2023.	Studies with samples over the age of 18 who are not caregivers/carers that are involved in the intervention.
Studies in the English language.	Studies of interventions focused on the child which may include the caregiver but are not aimed at supporting the caregiver/child relationship.

Following several scoping searches in Scopus with the search terms, it was decided to narrow the inclusion criteria to only include studies published in the last 15 years. Literature prior to 2008 was reviewed and found to include studies on 'attachment therapies' which is an intervention practiced primarily in the United States which included restraint practices and was deemed to be coercive and dangerous (Chaffin et al., 2006). Following a White Paper in 2007 such therapies and practices were opposed, and instead newer techniques were promoted which included attunement, sensitivity and regulation (Zeanah et al., 2011). Studies prior to 2008 were therefore less relevant to the current dyadic psychotherapeutic treatment models. Despite service and socio-political variations, an international perspective was considered valuable and all studies written in English were included. It was not feasible in the scope of this review to consider papers written in languages other than English. A decision was made not to include grey literature in the systematic review as peer reviewed literature is arguably higher quality and has been subject to peer review scrutiny. Grey literature including policy documents, guidance and personal accounts informed the broader context of this research.

A decision was made not to include quantitative studies as scoping revealed they were limited in their focus to efficacy rather than experience. Mixed methods studies were included if the qualitative element of the studies pertained to experience of the intervention. The quantitative elements of mixed methods studies did not relate to experience and is not reported in this review.

Search results from the databases were combined and duplicates removed using Covidence software. Two reviewers (the author and a course colleague) used Covidence software to screen study titles and abstracts for inclusion in the review (Cohen's Kappa 0.58). Studies that clearly did not meet the inclusion criteria were excluded (N=2426). Reviewers met together to discuss articles where it was less clear if they met the inclusion criteria to decide if a study should be included in the review. The full text of the remaining articles (N=123) were assessed for eligibility by the author. The primary study supervisor supported this decision-making process through supervision and discussion. For instance, one paper was not empirical in design but was peer reviewed and included first hand caregiver feedback. After discussion, this paper was included as it was deemed relevant to experience and added value to the literature.

2.3.3 Quality Assessment

A key stage of systematic reviews is quality appraisal of the data (Higgins et al., 2008; Noyes et al., 2018). Studies included in this review comprised of qualitative, and mixed methods research which necessitated the use of two quality assessment frameworks.

The Critical Appraisal Skills Programme (CASP) was designed for health and social care research (Long et al.,2020) and provides protocols for a variety of study designs. CASP is widely used in health-related qualitative evidence synthesis. It is endorsed by the Cochrane Qualitative and Implementation Methods Group (Long et al., 2020) and was considered appropriate for this review. CASP assessment focusses on rigour in the design, methodology, analysis of the studies, and value of the research to the field of study.

CASP does not provide criteria for mixed methods design and so the Mixed Methods Appraisal Tool (MMAT) (Pace et al., 2012; Pluye et al., 2009) was chosen due to its specific tool for mixed methods design and tested reliability (Hong et al., 2018; Pace et al., 2012).

2.3.4 Synthesis Method

It was anticipated that the included studies would represent a heterogeneity and diversity of study design. Therefore, a qualitative systematic review approach was considered appropriate to analyse the results of the review. Narrative synthesis brings together evidence in a way that tells a story about why something makes a positive difference (or not) and can be helpful in bridging the gap between research and practice (Popay et al., 2006).

Synthesis was informed by Popay et al.'s (2006) framework, and guidance from Siddaway et al., (2019), and Baumeister and Leary (1997). Table 4 outlines three of the four components of Popay et al.'s (2006) guidelines and the techniques that have been applied to this SLR. The remaining component is optional and was not deemed relevant for this review. Central and recurring concepts were identified and grouped into themes or categories. The research team supported the first author in this process through discussion of the findings and development of themes.

Table 4

Overview of Data Synthesis Method (Popay et al., 2006, pp11-22)

Component:	Aim:	Corresponding technique used:
1. Developing a preliminary synthesis	• To provide an initial description and to organise the findings.	• Tabulation: an overview of the studies with study characteristics, methodology and summary of results in tabular form (Table 5).
2. Exploring relationships within and between studies	• To move beyond description: ○ To consider relationships between the results of studies to seek to understand any effects. ○ To consider differences and similarities in implementation across the studies that provide explanation for effects.	• Concept mapping: ○ Line by line coding of results in NVivo software. ○ Development of themes across studies to develop a conceptual model that is relevant to the research question. ○ Visual representation of the relationships through development of a conceptual map (Figure 4).
3. Assessing the robustness of the synthesis	• To provide an assessment of the strength of the evidence, based on a critical appraisal of the studies included.	• Critical reflection on the quality of the studies against established appraisal tools. Considering the impact of the quality on the strength of the outcomes and providing a summary of this.

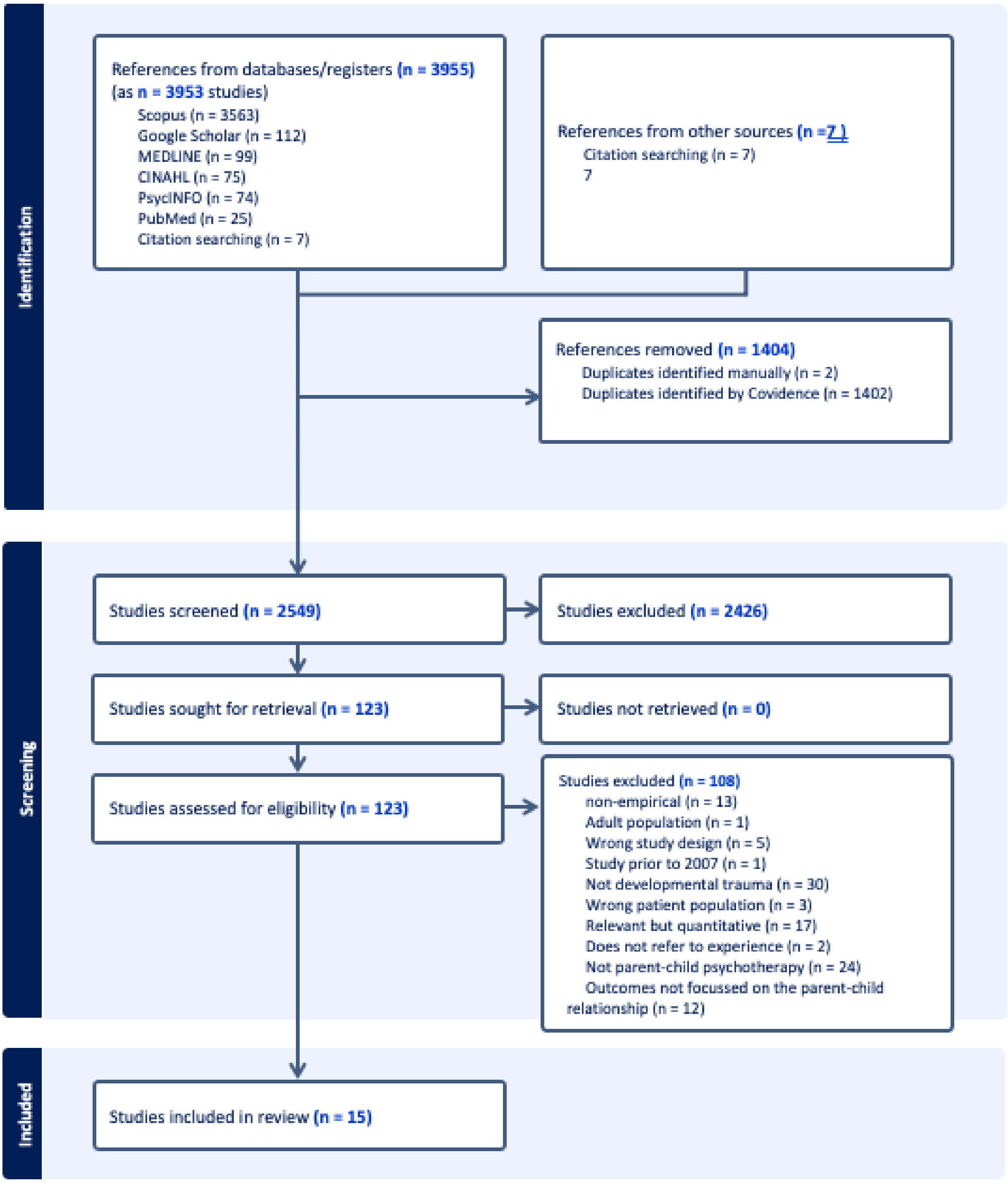
2.4 Results

2.4.1 Study Selection

Figure 3 presents a flow chart of search results and Prisma screening process (Page et al., 2021). Two studies (Hewitt et al., 2018; Selwyn, et al., 2016) used the same data set and presented the same results. In line with best practice guidance (Cochrane Information Retrieval Methods Group 2022), they were considered as one paper for the purposes of data extraction and only the most recent paper was included in the review.

Figure 3

PRISMA Flowchart of the Study Selection Process.



2.4.2 Study Characteristics

Table 5 provides an overview of the study characteristics, methodologies, a summary of the themes in relation to participants experience, and the main strengths and limitations. The sample features nine qualitative methods studies (Ashton et al., 2017; Carnes-Holt, 2012; Di-Lorenzo et al., 2023; Hewitt et al., 2018; Swan et al., 2022; Turner-Halliday et al., 2014; Whitehead et al., 2022; Wimmer et al., 2010; Wingfield & Gurney-Smith, 2019) and six mixed methods designs (Donald and Ceballos, 2020; Holmes and Silver, 2010; Laybourne et al., 2008; McCullough et al., 2016; Midgley et al., 2018; Puckering et al., 2011). Studies were conducted across a range of locations, predominantly the United Kingdom (N=9) and the United States (N=4), as well as Canada (N=1), and New Zealand (N=1). Purposive sampling was used for all studies (N=15). Qualitative data was collected through semi-structured interviews (N=9), focus groups (N=2) or both (N=2), and a questionnaire (N=1). One study (Carnes Holt, 2012) did not state how data was collected but referred to it as ‘feedback’. A range of analytical methods were deployed including Thematic Analysis (N=6), Interpretive Phenomenological Analysis (IPA) (N=4), Grounded Theory (N=1), Content Analysis (N=1) and not stated (N=3).

A range of interventions and practice models were explored in the studies with some studies reviewing group level interventions (N=10) and others reviewing individual family level interventions (N=5). Of the group level interventions N=3 involved caregivers and children together and N=7 were caregiver focussed. The underpinning theory for most of the interventions was Attachment Theory (Bowlby, 1969) (N=14), or other closely related theories of early child development (Winnicott, 1960/1965; Zaphirou-Woods et al., 2013) (N=1). Some studies explored applications of established therapeutic models including Dyadic Developmental Psychotherapy (DDP) (N= 5), Filial Therapy (N=3), Child-Caregiver Relationship Therapy (CPRT) (N=3), and Mentalisation Based Therapy (MBT) (N=1). McCullough et al. (2016) presented an integrative wrap around multi-disciplinary approach, which is neuro-sequential, and attachment focussed.

Most studies explored interventions aimed at adoptive or foster families. Puckering et al., (2011) was the only study to include birth families in a mixed sample with adoptive and foster families. Whitehead et al., (2022) was the only study to include kinship carers in a sample with foster carers. Donald and Ceballos (2020) explored experiences of residential care workers and Turner-Halliday et al.'s, (2014) paper drew from a sample of therapists and service providers to explore their experiences of DDP as part of a feasibility study. Swan et al.'s (2022) study focused on reasons for self-referral to CPRT in a cohort of adoptive parents. There were no studies that explored or considered children and young people's experiences of the interventions, although one young person was included in an interview with their caregiver in Midgley et al.'s (2018) paper exploring MBT for adoptive families.

There was a vast difference in the length of the interventions that were explored ranging from 6 sessions (Holmes & Silver, 2010; Midgley et al., 2018), to up to 5 years (McCullough et al., 2016).

Table 5

Overview of Studies Included in the Systematic Literature Review.

Author, year, country	1) Therapeutic intervention	2) Theoretical Underpinnings	3) Study Aims	4) Sample characteristics	5) Methodology	6) Summary of themes in relation to experience, views or of the intervention.	7) Strengths and limitations
Ashton et al. (2017)	**Group Level** CASA's Trauma and Attachment Group program for youth in middle childhood. A dyadic group-based intervention	Attachment theory (Bowlby, 1969, p.194),	Represents a qualitative follow up from a larger ethnographic study. Explored how TAG generated the positive changes experienced by its participants (outlined in a related quant study)	**Sample size**: Interviews with caregivers N=4, focus group interviews with facilitators N=4, informal interviews with facilitators N=2. **Population**: adoptive caregivers or foster carers who took part in the group. (3 adoptive caregivers and 1 foster carer. 3 females and one male) and group facilitators.	**Study Design**: Qualitative **Sampling Strategy**: Purposive sampling **Data collection methods**: Semi-structured interviews and focus group. **Data analysis**: Thematic Analysis.	• Participants reported experience of positive changes. Themes were identified in relation to 'Relationship as a locus for change', 'group processes' and 'psycho-education-based content'. • Relationships were viewed to be the key mechanism of change. Three key relationships – those between the caregivers, those between the caregiver and child and the caregiver and the facilitator. • Caregivers felt safe and validated within the group. It provided a sense of community.	+ meets quality assessment rigour. + clearly describes the reflexive process of analysis. + Supports effectiveness of relational interventions. +Evidences the value of including carers and promoting change through the relationship. + Demonstrates that relationship can be mechanism of change for developmental trauma. -modest sample size. -lack of inclusion of youth participants

Author, year, country	1) Therapeutic intervention	2) Theoretical Underpinnings	3) Study Aims	4) Sample characteristics	5) Methodology	6) Summary of themes in relation to experience, views or of the intervention.	7) Strengths and limitations
				Length of intervention: Not stated. **Mean age or age range of children**: Aged 5-11 years. **Location:** Canada		• Caregivers found the psychoeducation important, especially the premise of "connection before correction". • Supports the value of care givers being included in treatment • Supports the role of dyadic relational interventions in relation to promoting change in the carer-child relationship.	
Carnes-Holt (2012)	**Group Level** Child-Parent Relationship Therapy (CPRT) (Landreth and Bratton, 2006). A Filial Therapy model, grounded in the principles of child-centred play therapy (Guerney, 1969). The group is for caregivers/carers and they are encouraged to film play sessions with	Attachment theory (Bowlby, 1969, p.194), informed by Filial Therapy (Guerney, 1964)	This paper discusses CPRT and the possible adaptations that may be needed for adoptive families. It is not 'empirical' as such but has been included as it has some excerpts of feedback from	**Sample size**: Not stated. **Population:** a sample of adoptive caregivers who had participated in CPRT groups. **Length of intervention**: 10, 2-hour sessions.	**Study Design:** Qualitative **Sampling Strategy**: Purposive **Data collection methods:** Feedback to the author. It is not clear how the feedback was collected.	• The author concludes that CPRT offers an empowering treatment modality for families striving to feel connected and secure. • Quotes from feedback indicated that carers the intervention was important for family cohesion, changed their perception of how to help their traumatised children,	- The paper does not meet the quality assessment rigour but was not presented as an empirical paper. + The paper is valuable as it has a good description of the intervention and the literature. + The caregiver feedback included is not presented as formal research, but it nonetheless has some value and illustrated how the approach is valuable.

Author, year, country	1) Therapeutic intervention	2) Theoretical Underpinnings	3) Study Aims	4) Sample characteristics	5) Methodology	6) Summary of themes in relation to experience, views or of the intervention.	7) Strengths and limitations
	their children to bring to the group for supervisions and reflections.		adoptive caregivers who participant in the group.	**Mean age or age range of children:** 3-10 years **Location:** United states.	**Data analysis**: Not stated.	appreciated holding the space with other adoptive caregivers. Caregivers reported responding to their children differently with greater awareness of the impact of their trauma on their current behaviour and this was increasing feelings of closeness and connection.	+ The quotes evidence the value of a dyadic and attachment focussed intervention. -the research does not meet the standards of rigour and quality for qualitative research but has something to offer, nonetheless.
Di-Lorenzo et al. (2023)	**Group Level** Adapted from an existing caregiver toddler group model (PTG). A therapeutic playgroup for caregivers and toddlers, facilitated by psychoanalytically trained facilitators. Incorporates 'Watch me Play' a model of structured play (Wakelyn & Katz, 2020). Adoptive families	Psychoanalytic theory (Winnicott, 1960/1965; Zaphirou et al., 2013)	To explore experiences of adoptive caregivers in a new online caregiver-toddler group. With hope to contribute to wider adoption support literature.	**Sample size**: N=4 **Population:** Adoptive caregivers who took part in the intervention. **Length of intervention**: 15 structured online weekly sessions. **Mean age or age range of children**: 10	**Study Design:** Qualitative. **Sampling Strategy:** Purposive. **Data collection methods**: Semi-structured, post intervention interviews. **Data analysis:** Thematic Analysis.	• Themes inducted included 'together and apart' (described strengths and limitations of connecting with other caregivers), 'it's harder for the kids' (described that caregivers were less sure about how much their children gained from the intervention), 'Learning to be a caregiver' (described how they benefitted from the professional guidance), 'You don't need power to be in control' (described the ways caregivers felt the relationship with their children changed),	+ meets quality assessment rigour. + included same sex adoptive caregivers. + supports other evaluations of PTG which suggest it could be a positive early intervention for adoptive caregivers. + describes an online intervention which retains most of the benefits of face-to-face PTG. + meets quality criteria for rigour. -small sample size. -online intervention may have been more distant from the face-to-face PTG.

Author, year, country	1) Therapeutic intervention	2) Theoretical Underpinnings	3) Study Aims	4) Sample characteristics	5) Methodology	6) Summary of themes in relation to experience, views or of the intervention.	7) Strengths and limitations
				months to 3 years. **Location**: England		'Changing expectations, uncertain outcomes' (described the uncertain ways participants experienced the group). • Despite difficulties with the online setting, participants experienced it positively and particularly valued the supportive element of the group and the improvements in the caregiver-child relationship. • Challenges included engaging toddlers in the online setting, and participants confusion over the expectations and outcome of the group.	
Donald and Ceballos (2020)	**Group Level** Child-Parent Relationship Therapy (CPRT) (Landreth and Bratton, 2006). A Filial Therapy model, grounded in the	Attachment theory (Bowlby, 1969, p.194), informed by Filial Therapy (Guerney, 1964)	To investigate the effects of CPRT with residential care workers (RCW's) in relation to a) perceptions of	**Sample size:** N=3 **Population**: Residential Childcare Workers (RCW's)	**Study Design:** Mixed Methods **Sampling Strategy:** Purposive.	• Indications were that the treatment was effective in helping participants increase the demonstration of empathy in play sessions. • Qualitative descriptions of the relationships between	+ The paper is novel in that it addressed the experiences of residential workers. + Meets quality criteria for rigour. + Further evidence for the use of CPRT for children with attachment trauma.

Author, year, country	1) Therapeutic intervention	2) Theoretical Underpinnings	3) Study Aims	4) Sample characteristics	5) Methodology	6) Summary of themes in relation to experience, views or of the intervention.	7) Strengths and limitations
	principles of child-centred play therapy (Guerney, 1969). The group is for caregivers/carers and they are encouraged to film play sessions with their children to bring to the group for supervisions and reflections.		children’s behaviours, b) relationships with the children in focus, and c) ability to demonstrate empathy in individual play sessions.	recruited from a psychiatric residential treatment program. **Length of intervention**: 10 weeks **Mean age or age range of children:** 7-11 years **Location:** United States	**Data collection methods:** Interview **Data analysis:** Qualitative data was analysed using Thematic analysis.	RCW’s and children were positive. Behavioural challenges were ongoing within two of the three relationships explored. • Participants gained a new understanding of their Child of Focus (COF), feeling great empathy and more attuned. • RCW’s reported feeling closer to their COF despite ongoing behavioural challenges.	-small sample size -only looks at relationships in one facility.
Hewitt et al. (2018)	**Group Level** Nurturing Attachments Group Work Programme. A Dyadic Developmental Psychotherapy (DDP) informed group.	Attachment theory (Bowlby 1969, p.194), derived from Dyadic Developmental Psychotherapy (DDP) (Hughes, 2006, 2007)	This paper is the same study as the 2016 Selwyn et al., 2016 paper. Aims to explore adoptive caregivers' experiences of attending the group.	**Sample size:** N=8 **Population:** Adoptive caregivers. **Length of intervention**: 18 weeks **Mean age or age range of**	**Study design:** Qualitative. **Sampling strategy**: Purposive **Data collection methods:** Semi-structure interviews.	• Analysis revealed 5 interconnected superordinate themes which were as follows: A supportive group, A shift in perspective, ‘Turning trauma into a secure attachment’, Am I doing it right? and continuing the adoption journey. • Participants noted the importance of relationships with group	+ provides insight into the lived experiences of adoptive caregivers attending and implementing a DDP informed group-based caregiving intervention. +provides further areas of potential evaluation. -self-selecting participants who most likely had positive experiences of the group.

Author, year, country	1) Therapeutic intervention	2) Theoretical Underpinnings	3) Study Aims	4) Sample characteristics	5) Methodology	6) Summary of themes in relation to experience, views or of the intervention.	7) Strengths and limitations
				children: 2-16 years **Location:** England	**Data analysis:** Interpretative Phenomenological Analysis.	members and the group facilitators, a similar mechanism to be seen in individual DDP. 'A safe accepting and non-judgemental group atmosphere' was also seen as important. Participants reported improvements in their own ability to regulate and manage their emotions. • Outcomes reported by participants in relation to their experience of the group were consistent with outcomes reported more widely in the DDP literature.	
Holmes and Silver (2010)	**Group Level** Managing Behaviour with Attachment in mind groupwork program.	Attachment Theory (Bowlby, 1969, p.194) informed by DDP ((Hughes, 2006, 2007)	Evaluation of a group intervention that combined aspects of established caregiving groups with attachment theory, developed to	**Sample size**: 35-40 **Population**: Adoptive caregivers and foster carers **Length of intervention:** 6 weeks	**Study Design :** Mixed methods **Sampling strategy:** Purposive **Data Collection Methods:** Feedback questionnaire.	• Caregivers reported feeling more confident and learned new information. They recognised the importance of understanding the reasons for the child's behaviour as a means of changing their own behaviour and building successful relationships.	+ provides evaluation of a group that integrates other models. + good initial support for the intervention. -this was a small service level evaluation and therefore does not have the rigour of a formal research study.

Author, year, country	1) Therapeutic intervention	2) Theoretical Underpinnings	3) Study Aims	4) Sample characteristics	5) Methodology	6) Summary of themes in relation to experience, views or of the intervention.	7) Strengths and limitations
			help adoptive caregivers and foster carers to understand and manage their children's behaviour.	**Mean age or age range of children**: Not stated. **Location:** England	**Data Analysis:** Content analysis	• They felt that the course should be available for everyone. • Participants valued meeting others in similar positions. They developed empathy and felt more confident.	
Laybourne et al. (2008)	**Group Level** Fostering Attachments in Young People who are Looked After and Adopted. This later evolved into the Nurturing Attachment Programme. Informed by Dyadic Developmental Psychotherapy (DDP)	Attachment Theory (Bowlby, 1969, p.194) informed by DDP (Hughes, 2006, 2007)	The article provides a description of the implementation of the group based on the manual (Golding, 2006). It replicates the pre and post measures from a previous evaluation of the group and added qualitative methodology to explore the views and	**Sample size:** Qualitative N=6 **Population:** Foster carers who had attended the group completed the programme. **Length of intervention**: 18 weekly Session training programme **Mean age or age range of children:** Not	**Study design:** Mixed Methods. **Sampling Strategy:** purposive **Data collection methods:** 30-minute semi-structured interview. Additionally, Verbal feedback was collected during a weekly slot at the end of the session	• The verbal feedback indicated that some of the content was hard to grasp. The verbal feedback discussion each week was invaluable, enabling facilitators to go back over material. Carers regularly talked about the benefits of the group. • Qualitative findings identified themes in relation to carers increased understanding of their foster children, an increase in empathy, personal growth and development and self-reported reduction in stress.	-very small participant numbers from just one group. + this research added value to the small pool of research at the time. + The research highlighted the lack of suitable measures aimed specifically at Looked After Children.

Author, year, country	1) Therapeutic intervention	2) Theoretical Underpinnings	3) Study Aims	4) Sample characteristics	5) Methodology	6) Summary of themes in relation to experience, views or of the intervention.	7) Strengths and limitations
			perception of those involved.	stated – assumed 0-18 years. **Location:** England	**Data analysis** Thematic analysis.	• Suggest that it may be beneficial for carers to have access to the training but also caregiver-child direct interventions. • Raised the issue of difficulties when one spouse has had the training and another hasn't and so their understanding may be in a different place.	
McCullough at al. (2016)	**Family Level** Neuro-Physiological Psychotherapy (NPP). A neurodevelopmentally informed approach to therapeutic treatment for maltreated children. Companion paper to McCullough and Mathura (2019) Adopted children	Attachment Theory (Bowlby, 1969, p.194)	To evaluate the NPP model. To explore changes in behavioural, emotional and executive functioning difficulties in young people who have completed the programme.	**Sample size:** N=31 children and families. **Population:** Adoptive families who had received NPP. **Length of intervention:** Mean time in treatment = 56.36 months **Mean age or age range of children:** 9.47	**Study design:** Mixed Methods **Sampling strategy:** Purposive sampling **Data collection method:** Structured interviews exploring the families' experiences of the intervention, child presentation, relationships, education and	• Analysis of caregiver interviews provided positive results in terms of the children's engagement in education, an absence of further mental health diagnosis or involvement in the criminal justice system. • Qualitative evidence lends itself to support positive outcomes in the caregiver-child relationship and a high degree of satisfaction with the model.	+presents an integrative, wrap around model. + good sample numbers for the qualitative element. -The qualitative element of the paper has little information regarding the method of analysis. - Little information in the paper relating to the experience of caregivers or children of NPP. - no information relating to the positive impact on the intervention on the caregivers which may have been part of the positive outcomes reported in the relationship.

Author, year, country	1) Therapeutic intervention	2) Theoretical Underpinnings	3) Study Aims	4) Sample characteristics	5) Methodology	6) Summary of themes in relation to experience, views or of the intervention.	7) Strengths and limitations
				and 14.60 at retest. **Location:** England	involvement in criminal justice. **Data analysis:** The two groups were compared using Analysis of Co-Variance (ANCOVA). This was the case for both quantitative and qualitative data.		
Midgley et al. (2018)	**Family Level** Mentalisation-based therapy for adoptive families, referred to as the 'Adopting Minds' approach. This was a six-session intervention.	Attachment Theory (Bowlby, 1969, p.194), Mentalisation Theory (Bateman and Fonagy, 2009)	An initial evaluation of the Adopting Minds project.	**Sample size:** Qualitative N=5 **Population:** Adoptive families who had taken part in the intervention, including 1 child. **Length of intervention:** At least 6 weeks.	**Study Design:** Mixed methods. **Sampling Strategy:** Purposive sampling. **Data collection methods:** Interviews. **Data analysis:** Interpretive Phenomenological Analysis.	• Positive outcomes in mental health and caregiver self-efficacy were identified and adoptive caregivers reported high levels of satisfaction with the mentalisation-based therapy service. • Outcome of interviews found that caregivers found it a containing and non-judgemental space. They were able to express fears and worries. Some feedback that six sessions was not enough to address	+ explored mentalisation based therapy for adoptive families. -All families were seeing the same therapist. So difficult to attribute positive outcomes to the model or to the therapist.

Author, year, country	1) Therapeutic intervention	2) Theoretical Underpinnings	3) Study Aims	4) Sample characteristics	5) Methodology	6) Summary of themes in relation to experience, views or of the intervention.	7) Strengths and limitations
				Mean age or age range of children: Median age 9 years, ranged from 2-17 years. **Location:** England		the difficulties and would have preferred longer term intervention or therapy in combination with other types. • Themes included 'receiving support and containment'; 'a space where negative feelings are allowed, and achievements praised'; 'getting help to deal with past experiences'; and 'short term support is not always enough'.	
Puckering et al (2011)	**Group Level** Mellow Parenting programme for children with Reactive Attachment Disorder (RAD) and their caregivers/carers.	Attachment Theory (Bowlby, 1969, p.194)	To test whether an intensive intervention aimed specifically at the caregiver-child relationship can modify symptoms of RAD and improve the relationship.	**Sample size:** Qualitative N=6 (group facilitators) **Population:** Birth caregivers, foster caregivers, adoptive caregivers. And group facilitators.	**Study Design:** Mixed Methods **Sampling Strategy:** Purposive. **Data collection methods:** Focus group for facilitators.	Qualitative findings suggested there was an improvement in the mother's social networks and reduction in isolation. It concluded that the results did not justify a randomised controlled trial.	-Limited by small sample size. -Some children also had neurodevelopmental profiles which may have contributed to persistence of the problems. -may have benefitted from qualitative data from caregivers as well as facilitators to see how experience matched the quantitative data. - No information of analysis methods for qualitative data

Author, year, country	1) Therapeutic intervention	2) Theoretical Underpinnings	3) Study Aims	4) Sample characteristics	5) Methodology	6) Summary of themes in relation to experience, views or of the intervention.	7) Strengths and limitations
				Length of intervention: 1 day a week for 14 weeks. **Mean age or age range of children:** described as school aged. **Location:** Scotland	**Data analysis:** qualitative = not stated.		
Swan et al (2022)	**Group Level** Child-Parent Relationship Therapy. 2 hr weekly carer focussed group, video supervision and 7 weekly at home play/activity sessions.	Attachment theory (Bowlby, 1969, p.194), informed by Filial Therapy (Guerney, 1964)	To explore the experiences of adoptive caregivers of pre-adolescents which prompted self-referral to CPRT	**Sample size**: N=18 **Population:** Adoptive caregivers who had self-referred for CPRT post adoption. **Length of intervention**: Not relevant. **Mean age or age range of**	**Study Design:** Qualitative **Sampling Strategy:** Purposive. **Data collection methods:** 3 X focus groups. **Data analysis:** Inductive Thematic Analysis.	• 4 main themes: Adoption experiences, relationship components, caregiving considerations and child factors. • Child factors were the least responsible theme which prompted self-referral. Caregivers were seeking to reduce their stress and learn skills in relation to repair with their child. • They had a desire to increase connection and	+ Supports CPRT as an attachment-based intervention with the goal of improving caregiver-child relationships. +Themes relating to reason for self-referral parallel the clinical goals of CPRT and previously established outcomes of the intervention. -No comparison to reasons for referral to other interventions. -Data may have been different if it had been interviews rather than focus groups. -limited to one geographical location in the states.

Author, year, country	1) Therapeutic intervention	2) Theoretical Underpinnings	3) Study Aims	4) Sample characteristics	5) Methodology	6) Summary of themes in relation to experience, views or of the intervention.	7) Strengths and limitations
				children: 8-14 years. **Location:** United States.		understand their child's behaviour. • However, a sample of self-referring caregivers may be more aware of relational factors.	-acknowledged a lack of diversity in the participants in relation to same sex adopters and racial, ethnic and cultural backgrounds.
Turner Halliday et al. (2014)	**Family Level** Dyadic Developmental Psychotherapy (DDP).	Attachment Theory (Bowlby, 1969, p.194)	To establish the feasibility of a Randomised Controlled Trial (RCT) for DDP by exploring the ways DDP is operating across different UK sites and the impacts of current practice on the potential set up of an RCT	**Sample size:** N= 13 semi-structured interviews, 4 focus groups and 5 teleconferences across 8 sites. **Population:** Therapists and service managers from teams implementing both DDP and possible control interventions. **Length of intervention**: Not relevant.	**Study Design:** Qualitative **Sampling Strategy:** Purposive **Data collection methods:** Interviews, focus groups, teleconferences. **Data analysis:** Thematic analysis.	• DDP was commonly regarded to having particular congruence with the complexity of maltreatment associate problems and a common operating model of DDP was evident across sites. A single control therapy was harder to establish, however it is likely to be a non-specific context dependent intervention/s offered within mainstream Child and Adolescent Mental Health Services (CAMHS). • The nature of family change was regarded as multi-faceted, non-linear and relationship based. Assessment tools need to be carefully considered in terms of their ability to	+ The study demonstrated widespread interest, support and engagement regarding an RCT. + As maltreated children are among the most vulnerable in society, RCT evidence would be a major advance in the field. + supports the value of qualitative feasibility work. + provides insight into the experience of therapists and services. -As it is a feasibility study there is limited conclusions that can be made beyond the feasibility of an RCT

Author, year, country	1) Therapeutic intervention	2) Theoretical Underpinnings	3) Study Aims	4) Sample characteristics	5) Methodology	6) Summary of themes in relation to experience, views or of the intervention.	7) Strengths and limitations
				Mean age or age range of children: Not focussed on specific children. Assumed that children were 0-18 years . **Location:** United Kingdom		capture change that covers both individual child and family-based functioning.	
Whitehead et al (2022)	**Group Level** Fostering Changes (FC) programme. A carer focussed group. Designed to strengthen carer-child relationships and develop carers' skills in managing challenging behaviours. Underpinned by social learning, cognitive-behavioural and attachment theories.	Attachment Theory (Bowlby, 1969, p.194)	Reports Foster Carer's experiences of the long-term effectiveness of carer-focussed training intervention.	**Sample size:** N=5 **Population:** Three foster carers and two kinship carers who had completed the training 13-15 months earlier. **Length of intervention**: 12 weeks.	**Study Design:** Qualitative. **Sampling Strategy:** Purposive **Data collection methods:** Semi-structured interviews. **Data analysis:** Interpretative Phenomenological Analysis.	• Five super-ordinate themes were identified: 1) FC is perceived to be an effective training programme that provides sustained benefits; 2) foster care training is crucially important; 3) the challenges of fostering continue, irrespective of training; 4) caregiver confidence gained from training wanes over time in the face of persistent challenges; 5) foster carers require ongoing therapeutic interventions	+ explored longer term impact (13-15 months after the intervention.) -Foster carers were recruited from a single FC group. + the study was conducted by independent researchers, reducing the risk of bias. -participants perceptions were strongly shaped by a lack of ongoing support. - the lack of Māori participants in the study was a limitation.

Author, year, country	1) Therapeutic intervention	2) Theoretical Underpinnings	3) Study Aims	4) Sample characteristics	5) Methodology	6) Summary of themes in relation to experience, views or of the intervention.	7) Strengths and limitations
				Mean age or age range of children: 7-13 years. **Location:** New Zealand		and support because of their children's persistent behavioural and relational difficulties. • The findings suggest that while FC provides relevant training, carers simultaneously require ongoing clinical services. • Effects of FC endured for more than a year.	
Wimmer et al. (2010)	**Family Level** 'Attachment Therapy'. Aims to provide an emotionally corrective experience of empathetic attunement. Developmentally focussed, aimed at remediating the developmental effects of early trauma and/or deprivation. Endorsed by the Association for Treatment and Training in the	Attachment Theory (Bowlby, 1969, p.194)	To explore adoptive mothers' perceptions of therapy and its impact on family functioning.	**Sample size:** N=16 **Population:** Adoptive mothers, 3 years after therapy. **Length of intervention**: Average of 3 months **Mean age or age range of children:** 8-18 **Location:** United States	**Study Design:** Qualitative. **Sampling Strategy:** Purposive. **Data collection methods:** Semi-structured interviews. **Data analysis:** Grounded Theory.	• Attachment therapy was consistently supportive, emotionally painful and physically safe. • Therapy preserved family structure, mothers remained committed to their children, and caregiving was continuously stressful.	+ Highlighted the need for further research on the treatment of children with attachment disorders. -included the use of some more controversial techniques such as 'holding'. Attachment therapy has been described as dangerous and controlling. -The sample was limited to mothers. -Comparisons to other therapeutic modalities was beyond the scope of the study.

Author, year, country	1) Therapeutic intervention	2) Theoretical Underpinnings	3) Study Aims	4) Sample characteristics	5) Methodology	6) Summary of themes in relation to experience, views or of the intervention.	7) Strengths and limitations
	Attachment of Children (ATTACh)						
Wingfield and Gurney Smith (2019)	**Family Level** Dyadic Developmental Psychotherapy.	Attachment Theory (Bowlby, 1969, p.194)	This study aimed to understand the experience of adoptive caregivers who have completed DDP therapy	**Sample size:** N=12 Population: Adoptive caregivers. **Length of intervention**: Ranged from 8-43 sessions. **Mean age or age range of children:** Not stated – assumed to be 0-18. **Location:** England.	**Study Design:** Qualitative **Sampling Strategy:** Purposive sampling. **Data collection methods:** Semi-structured Interviews. **Data analysis:** Interpretative Phenomenological Analysis.	• Four superordinate themes were identified: (1) increased understanding, (2) 'It's a different method of caregiving generally', (3) the DDP journey and (4) 'It's a shared kind of experience you go through and come out together'. • Caregivers felt they had increased insight into their child's mind and how to better support their child. They felt DDP was a good fit to their unique situations and it appeared to promote acceptance. • The DDP journey started with caregivers feeling uncertainty and questioning the effectiveness of DDP. • Generally, caregivers became committed to the therapy once they saw change and expressed fear and sadness at ending.	+ the first direct study of caregivers' experiences of DDP. + generally supports the premise of DDP as effective and worthy of investigation. -the sample may have consisted of caregivers who had 'good' experiences. - the sample was not particularly diverse.

Author, year, country	1) Therapeutic intervention	2) Theoretical Underpinnings	3) Study Aims	4) Sample characteristics	5) Methodology	6) Summary of themes in relation to experience, views or of the intervention.	7) Strengths and limitations
						• Caregivers acknowledged the dyadic nature of DDP, feeling it helped build trust and security and supported co-regulation. • Caregivers also acknowledged the therapist's role in conveying the core DDP principles.	

2.4.3 Assessing Study Quality

Tables 6 outlines the quality assessment for the qualitative studies. The Carnes-Holt (2012) paper was presented as a discussion paper, rather than empirically collected research. Methodology was therefore not clearly defined and discussed. Although it was not presented as formal research, the caregiver feedback included was valuable in illustrating the experience of those who had attended the groups. All other qualitative studies had clear study aims or questions. Studies were able to contextualise their research within the literature relating to the intervention, relevant theory and within the wider context. Studies clearly described their methodology which was appropriate to the research design. Some studies were not clear in how they considered the relationships between the researcher and the participants (Carnes-Holt, 2012; Turner-Halliday et al., 2014; Whitehead et al., 2022; Wimmer et al., 2010). Some studies did not refer to ethical processes and considerations (Carnes-Holt, 2012; Swan et al., 2022).

Mixed methods studies generally fared well when assessed against the criteria (Table 7). Many were exploratory or pilot studies of new interventions or new adaptations. Mixed methods designs were therefore appropriate for such studies to analyse initial quantitative pre and post intervention measures, and to also capture experience of the inventions. The rationale for mixed methods was not always explicitly stated (Laybourne et al., 2008; McCullough et al., 2016; Puckering et al., 2011). For all the mixed methods studies, the qualitative accounts of the participants experiences converged with the quantitative outcomes.

There were limitations to some of the studies with low participant numbers and often focussing on one setting, reducing replicability and rigour. For instance, Donald and Ceballos (2020) investigated the effects of CPRT with three residential care workers in one care setting, however it met quality criteria and was novel in exploring CPRT in this setting, adding value to the literature. Equally, Laybourne et al., (2008) explored the Fostering Attachments group intervention within just one group with one facilitator. Again, this study met quality criteria. These limitations may reflect challenges in accessing research resources to conduct studies across a range of settings or groups. Most interventions explored could be considered innovative and developing in their evidence base. Smaller, service-based studies were therefore congruent with the research stage of the interventions.

Table 6

Outcomes of CASP Assessment of Qualitative Studies

	Was there a clear statement of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between the researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research
Ashton et al. (2017)	Yes Explored how TAG generated the positive changes experienced by it's participants (outlined in a related quant study)	Yes To illuminate the experiences and explore how changes were experienced.	Yes Provided a rationale for focus groups. Methods clearly described and justified.	Yes Recruitment strategy explained and justified.	Yes Captures the experiences of the facilitators and caregivers but not the young people (due to time constraints). Data collected through focus group and interviews.	Yes Reflexive thematic analysis is described with journaling as reflective process.	Yes. University ethics. Consideration of consent and confidentiality.	Yes Process of thematic analysis explained for both methodologies (focus group and interviews). Member checking used. They state that own role was considered through journaling and examining biases and values.	Yes Themes and subthemes described. Direct quotes to illustrate. Credibility through member checking. Findings linked to original research question and the literature.	Supports effectiveness of relational interventions. Evidences the value of including carers and promoting change through the relationship. Demonstrates that relationship can be mechanism of change for developmental trauma.
Carnes-Holt (2012)	No This is more of a discussion paper with	Yes The paper refers to the outcomes of other studies	Yes Although the research aims were not clearly stated	Can't tell Not described.	Can't tell. Not described.	Can't tell.	Can't tell Not described.	Can't tell. Not described.	No. However, this was not presented as formal	The paper as a whole is valuable as it has a good description of the intervention and

	caregiver's feedback included rather than a formal study. The feedback from caregivers in this study illustrate the points made about the experience of CPRT for adoptive families.	but the caregiver's feedback brings to life the topics of the paper.	and it is not formal research, the qualitative data included is justified to illustrate the topic.						research but used the caregiver feedback to illustrate and bring to life the discussion points in the paper.	the literature. The caregiver feedback included is not presented as formal research, but it nonetheless has some value is illustrated how the approach is valuable. The quotes evidence the value of a dyadic and attachment focussed intervention.
Di-Lorenzo et al. (2023)	Yes To explore experiences of adoptive caregivers in caregiver-toddler group. With hope to contribute to wider adoption support literature.	Yes Experience based so qualitative most appropriate.	Yes. In depth interviews appropriate.	Can't tell Only 3 participants recruited from one group so more of a pilot study.	Yes Clear rationale for interviews. Clear procedure described.	Yes Reflexive process described, paying attention to the relationship of the researcher to the organisation providing the intervention.	Yes Ethical consent from university. Ethical issues not described.	Yes. Thematic analysis described and how coding was developed.	Yes Themes and subthemes described coherently.	Limitations in from sample size of 4 just one group. Explores online provision. Has a specific focus on the early years which is novel.
Hewitt et al. (2018)	Yes Explore adoptive caregivers experience of NA group. Contextualise and understand changes.	Yes Appropriate to explore experience.	Yes Clear justification for interviews and IPA.	Yes Clear explanation of recruitment and selection.	Yes Clear about what guided the development of the interview schedule.	Yes Some reference to this and a bracketing process.	Yes University ethics approval. Discussion around ethical needs of participants.	Yes IPA process clearly described.	Yes Linked to current literature.	Yes. Supports the quantitative data and helps to make sense of it. Speaks to the value of groups for adopters.

Swan et al (2022)	Yes. Clear research question.	Yes. Exploring experience.	Yes. Methods were clearly described with a rationale.	Yes. Purposive sampling.	Yes.	Yes. Some reference to bracketing.	Can’t tell. No reference to ethics.	Yes. Lots of themes and quotes used in the results.	Yes. This is linked to other findings for CPRT.	Yes. It contributes to the literature on CPRT and it’s role in adoption support.
Turner Halliday et al. (2014)	Yes Clear research question links to goals – to explore feasibility of an RCT with clinicians qualitative views about the intervention.	Yes To illuminate the experiences of the therapist to inform how DDP is being used in the UK.	Yes Used a range of qual methods.	Yes Clear description of process with rationale. Describes a funnelling iterative approach to the recruitment.	Yes Clear description of data collection methods.	Can’t tell If it happened, it is not referred to.	Yes Ethics checked but not needed as it is professionals.	Yes Clear description of the process. Does not appear to be thematic.	Yes Clear findings but little discussion due to it being a feasibility study so focussed on conclusions.	It contributes to an understanding of what DDP is and how it was being used. Some of the paper is not relevant to our research question but some themes are relevant.
Whitehead et al (2022)	Yes Clear research question couched in the literature. Exploring FC’s perceptions of a group based on ABC	Yes As question relates to perception.	Yes Clear rationale for interview development and IPA.	Yes Clear outline of procedure.	Yes Semi-structured interviews.	Can’t tell If it happened, it was not referred to.	Yes Ethics discussed and approval sought from a university.	Yes Clear description of the IPA process.	Yes. Clear relevance to the research question.	It is a little unclear whether there is enough of a caregiver-child psychotherapeutic component or whether it is more of a training. Themes do not refer to the relationship between child and FC
Wimmer et al. (2010)	Yes. To explore mother’s experiences of Attachment Therapy.	Yes Exploring experience.	Yes Guided by the research questions.	Yes Caregivers who had participated in the therapy.	Yes Methods were explicit and justified.	Can’t tell	Yes Ethical approval with some consideration of protecting identities.	Yes	Yes	The paper is a little old. It does not feel so relevant for a UK audience. The intervention is vague and appears to

										integrate lots of models including holding therapy.
Wingfield and Gurney Smith (2019)	Yes Experiences of DDP for adoptive caregivers.	Yes Exploring experiences.	Yes Clear rationale for IPA and semi-structure interviews.	Yes Purposive sampling through DDP therapists.	Yes Clear description of how interviews were developed.	Yes Reflexivity referred to.	Yes Ethical approval sought and clear discussion in the paper.	Yes Quality and credibility discussed.	Yes Linked to research aims and literature.	Clearly supports evidence for DDP and a caregiver-child psychotherapeutic approach to treating developmental trauma.

Table 7

Outcome of MMAT Quality Assessment of Mixed Methods Studies

	Are there clear research questions?	Do the collected data allow to address the research question?	Is there an adequate rationale for using a mixed methods design to address the research question?	Are the different components of the study effectively integrated to answer the research question?	Are the outputs of the integration of qualitative and quantitative components adequately addressed?	Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?
Donald and Ceballos (2020)	Yes. To explore the effects of CPRT in residential care.	Yes. Before and after measures and semi structured interviews.	Yes. To provide a broader picture of the RCW's experience of the relationship.	Yes.	Yes. Explored together in a balanced way.	Yes. Discussed.	Yes. A full analysis of both elements.
Holmes & Silver (2010)	Yes. To evaluate the Managing behaviour with attachment in mind groups.	Yes. Before and After measures and questionnaires.	Yes. To gather both quantitative and qualitative data to evaluate the groups.	Yes. The qualitative data is discussed in the context of the quantitative results.	Yes.	Yes.	Yes. Full analysis of both elements.
Laybourne et al. (2008)	Yes. Were the initial positive findings from this programme being replicated in this group.	Yes. They replicated the quant measures from the previous study.	Can't tell. The addition of qual data adds value but this rationale is not stated	Yes.	Yes.	Yes.	Yes. Full analysis of both elements.
McCullough at al. (2016)	Yes. To evaluate the NPP model.	Yes. They look at before and after measures but also a caregiver	Can't tell, although the rationale is fairly obvious but it is not	Yes. The qualitative data help to support and make sense of the	Yes. The qualitative information clearly adds value to the quant data.	Yes. There were no divergencies.	No. Quant met the criteria but there was little analysis for the qual. No reference

		semi structured interview.	referred to explicitly in the paper.	outcomes of the quant data.			to the method of qual analysis.
Midgley et al. (2018)	Yes. An initial evaluation of the Adopting Minds project.	Yes. Appropriate pre and post measures and interview.	Yes. Interviews intended to gather more information about experience.	Yes. Both types of data compliment and are made sense of together in the discussion.	Yes. A balance in the reporting of both.	Yes.	Yes. Full analysis of both elements (quant/qual)
Puckering et al (2011)	Yes. To test the impact of the group on reducing RAD symptoms.	Yes. Appropriate before and after measure.	No. Not explicitly stated.	Yes. The qualitative interview supported the interpretation of the quant results.	Yes. A balance in reporting both.	Yes.	No. The methodology for qual was not stated.

2.5 Synthesis

After familiarisation with the selected studies, the results sections of each paper were coded line by line in Nvivo software. Discussion sections were coded, clearly marked as second order data, and used to aid sense making of the findings. Through exploration of codes, the main concepts were identified using Popay et al.'s (2006) narrative synthesis framework. The results could be conceptualised into five interrelated themes presented in Table 8, as follows:

Table 8

Main Concepts of the SLR Synthesis

Theme 1	Group processes in relation to the group interventions
Theme 2	Therapeutic alliance with the therapist or facilitator.
Theme 3	Impact on carer 3a) New understandings for caregivers of their child's feelings and behaviour 3b) Changes in the Carer
Theme 4	Positive relational change and family stability
Theme 5	Changes in the child

2.5.1 Theme 1: Group Processes

In the studies on group interventions, participants spoke about how they found the group dynamic beneficial (Ashton et al., 2017; Carnes-Holt, 2012; Di-Lorenzo et al., 2023; Donald and Ceballos, 2020; Hewitt et al., 2018; Holmes and Silver, 2010; Laybourne et al., 2008; Puckering et al., 2011; Swan et al., 2022; Whitehead et al., 2022). Carers spoke of the validation and normalisation of being with other people with similar experiences and struggles. For some, it gave them a sense of community where they felt safe to share their experiences openly and there was shared learning. One participant from the Ashton et al., (2017, p.17) study reflected on their group experience saying,

> *It takes a village. That's what that is. We all work together, and we all talk to each other and work through it.*

The 'Rebuilding Relationships' study (Puckering et al., 2011) was the only intervention that included birth mothers in a combined group with foster and adoptive mothers. The study purported that the group had a positive effect on the birth mothers' mental health, providing opportunities to reflect on early relationships, and increase social support and networking.

CASA's Trauma and Attachment Group (Ashton et al., 2017) included young people in the group. Although only the caregivers were interviewed in the study, they spoke of some of the benefits they felt their children had experienced, such as benefitting from the presence of other caring adults in the group. Conversely in the Parent and Toddler Group (Di-Lorenzo et al., 2023) which was held online, caregivers were surprised that their children formed connections with other children in the group, however some participants felt the children would have gained more benefit had the group been face to face.

The length of group interventions ranged from 6-18 weeks. For the Managing Behaviour with Attachment in Mind (MBAM) Group (Holmes and Silver, 2010) which was 6 weeks long, participants expressed a wish for it to continue, or for the sessions to be longer. One participant suggested follow-on monthly or bi-monthly sessions might be valuable. Participants in the 12 week Fostering Changes Study (Whitehead et al., 2022), echoed this sentiment wishing for a follow-up or annual get togethers. This may speak to the value of connection with others with similar experiences and the potentially isolating experience of caregiving a child with developmental trauma, as expressed by a participant in the Laybourne et al., (2018, p.71) study,

> *To hear the difficult experiences of other carers and know that you are not the only one helped me a lot.*

Three studies suggested that due to positive group dynamics, groups could offer benefits that family level clinical support could not (Di-Lorenzo et al., 2023; Laybourne et al., 2008; Whitehead et al., 2022;). However, there were indications that although group level interventions may augment treatment, they might not be able to replace direct family level interventions. One caregiver in the Di-Lorenzo study had experience of both group level and individual intervention and emphasised the value of her one-to-one sessions over her group experience. Whitehead et al., (2022) explored the long-term impact of a 12-week programme for Foster Carers and Kinship Carers called ‘Fostering Changes’, interviewing caregivers 13-15 months after the end of the intervention. All five carers interviewed in this study described their desire for further support after completing the intervention, indicating that more targeted support for their child’s behaviour or mental health was needed. They saw the group intervention as being part of the larger support system they required.

2.5.2 Theme 2: Therapeutic Alliance with the Therapist or Facilitator

In twelve papers (Ashton et al., 2017; Di-Lorenzo et al., 2023; Donald and Ceballos, 2020; Hewitt et al., 2018; Holmes and Silver, 2010; Laybourne et al., 2008; McCullough et al., 2016; Midgley et al., 2018; Turner-Halliday et al., 2014; Whitehead et al., 2022; Wimmer et al., 2010; Wingfield and Gurney-Smith, 2019), the relationship and skills of the therapist or facilitator were highlighted as an important element of the therapeutic experience. This was the case for both family level interventions and groups.

In group settings, the participants described how they experienced the facilitators as crucial for creating a safe and non-judgemental atmosphere in which group members felt contained, as described by a participant in Hewitt et al.’s (2018, p.447) exploration of the Nurturing Attachments Group programme;

> *X was a fantastic moderator . . . without appearing to do anything, but I know she was doing stuff, she . . . totally stopped there being any sense of judgement against anybody about what they were saying about the way they had reacted to their children . . . she made the atmosphere such that nobody felt judgemental.*

Facilitators in this group were explicit in fostering a non-judgemental atmosphere which seeks to keep feelings of carer shame low, allowing for exploration. Authors in Ashton et al.'s, (2017 p.16) study suggested that a thriving facilitator/caregiver relationship provided '*opportunities for healing beyond the walls of the therapeutic milieu'*.

The therapeutic stance was noted as equally important in family level interventions and families described how the therapeutic space was supporting and containing. This sentiment was expressed by the young person who was interviewed with her father in Midgley et al.'s (2018, p.28) paper on a mentalisation based approach for adoptive families:

> *[The therapist] was listening to everything I was saying, and taking me into consideration .. . I felt that I could talk to people here.*

As in the groups, a non-judgemental and accepting stance was important in building caregiver confidence as well as reducing shame. Some caregivers spoke about how the safety of this relationship reduced feelings of guilt and the need to be a perfect caregiver. It provided the opportunity for them to reflect on their own feelings and responses and engage freely in the therapeutic process. In addition to a non-judgemental stance, other attributes were appreciated such as the expertise and skill of the therapist. Caregivers in interventions informed by 'PACE' (Laybourne et al., 2008; Wingfield & Gurney-Smith, 2019), appreciated the therapist/facilitator's appropriate use of humour and playfulness. In Wingfield and Gurney-Smith's (2019, p.12) study, one participant described how his therapists' ability to make sessions playful supported his daughter to feel less guarded:

> *Tina was quite skilled at pitching it at a level that Eloise wouldn't find too threatening because, of course, if someone's defended the last thing you*

> *want to do is challenge that defendedness too early. So she was very good at making it um, including sort of playing of games and making it fun really and Eloise responded to that.*

Turney-Halliday (2014) interviewed DDP therapists who also spoke about the importance of the therapeutic alliance. They viewed their role as facilitating the relationships with the caregiver and child, deepening their interactions. They explained how they might talk out loud with the child and the caregiver about what is happening between them, providing an opportunity to reflect and problem solve in real time.

Clear expectations and communications from therapists and facilitators were considered important prior to the interventions. Adoptive caregivers in the Wingfield and Gurney-Smith (2019) paper reported some scepticism at the beginning, which dissipated as they began to see progress. Equally, adoptive caregivers in the Di-Lorenzo et al., (2023) paper exploring an online caregiver and toddler group spoke of the importance of managing their expectations through greater clarity around the intervention aims. Some families waited a long time for interventions or had experienced interventions that had failed them and may have little choice around which intervention is offered to them. This highlights some vulnerability in making decisions about what support they need. As a caregiver in the Wingfield and Gurney (2019, p.10) paper expressed,

> *We would have jumped off the Empire State Building if someone had told us it would have worked for them.*

2.5.3 Theme 3: Impact on the Carer

2.5.3.1 Subtheme 3a: New Understandings for Caregivers of their Child's Feelings and Behaviour

There was convergence across all studies relating to themes of growth in understanding for caregivers. This theme sits within the context of the first two themes which highlight the importance of a safe and accepting therapeutic milieu to create this opportunity for change. Caregivers reported increased insight into the neurodevelopmental impact of their child's trauma and early adversity, creating newfound awareness. This created a shift in how they understood their children's behaviour, with authors in Ashton et al (2017, p.17) describing this as a shift from '*my child is giving me a hard time*' to '*my child is having a hard time*'.

All the interventions were underpinned by theories of attachment and child development. These theoretical concepts were experienced as important in framing children's behaviour through a lens of early adversity. Some participants spoke about the importance of considering their child's feelings of shame. Participants began to understand that their children may have developed deep self-loathing as a result of their adversity with fear and survival instincts driving their behaviour. Participants in the Laybourne et al. (2008, p.69) study expressed the importance of thinking about early attachment experiences and children's internal working models, enabling them to recognise and understand current patterns in how their children interact and communicate,

> *I hadn't really thought about attachment much before. But now I know how important all interactions are from the point the child is born and the effect that not experiencing safety, security and comfort can have on a child.*

For participants in 7 studies (Di-Lorenzo et al., 2023; Hewitt et al., 2018; Holmes and Silver, 2010; Laybourne et al., 2008; Whitehead et al., 2022; Turner-Halliday et al., 2014; Wingfield and Gurney-Smith, 2019), the acquisition of new insights and understandings led to a greater capacity to remain present when their children expressed their emotional experiences. As a caregiver in the Midgley et al., (2018, p.31) study described,

> *We are conscious of what we are doing, and that attachment is more present. Because sometimes thinking, 'Oh, we are just parenting a normal child or a biological child who had not experienced trauma.' And so to think and have that in our minds is, well, was really helpful [...] and*

> *keeping all the things she said in mind about attachment and interaction. What he seeks, why he seeks and how early trauma may affect him.*

2.5.3.2 Theme 3b: Changes in the Carer

It seems logical that these shifts in caregiver perspective led to changes both in how they felt as carers and in how they responded to their children. Caregivers in seven studies reported improvements in their capacity to remain emotionally regulated whilst parenting their children (Di-Lorenzo et al., 2023; Hewitt et al., 2018; Holmes and Silver, 2010; Laybourne et al., 2008; Midgley et al, 2018; Puckering et al., 2011; Wingfield and Gurney-Smith, 2019). This improvement in emotional regulation may have been enabled due to a reduction of caregiver shame through the experience of the safe, non-judgemental therapeutic milieu, ameliorating their distress. Caregivers were less likely to blame themselves for the difficulties their child was experiencing. Authors in Hewitt et al. (2018), suggested that caregivers improved ability to regulate and manage their own emotions was a potential site for change, allowing caregivers to be more responsive and available for their child, therefore improving the quality of the relationship.

Six studies referred to the role of caregiver stress in parenting children with symptoms of developmental trauma (Di-Lorenzo et al., 2023; Hewitt et al., 2018; Laybourne et al., 2008; McCullough et al., 2016; Puckering et al., 2011; Winfield & Gurney-Smith, 2019; Whitehead et al., 2023). A caregiver in the Laybourne et al. (2008) study referred to how new understandings of attachment issues and support emanated from knowing others in the group were managing similar behaviours. This reduced the stress in the relationship with their children, and the personal stress of parenting a child with developmental trauma. Authors in Wingfield and Gurney-Smith (2019) suggested that a reduction in caregiver stress could allow greater opportunity for joint emotional regulation.

It is possible that the therapeutic space provided by the interventions, alongside positive changes in the carer's understanding, stress, shame and emotional regulation, allowed carers to pause and reflect on their child's behaviour and their own responses to it. Ten papers referred to caregivers' increased capacity for mentalisation or reflective functioning, with carers developing a greater understanding of themselves and their children, supporting them to navigate the complexity of their relationships with their children (Ashton et al., 2017; Di-Lorenzo et al., 2023; Donald and Ceballos, 2020; Hewitt et al., 2018; Holmes and Silver, 2010; Laybourne et al., 2008; Midgley et al., 2018; Turner-Halliday et al., 2014; Whitehead et al., 2022; Wingfield and Gurney-Smith, 2019).

Eleven studies highlighted increased skills and a greater sense of confidence in the parenting task (Di-Lorenzo et al., 2023; Donald and Ceballos, 2020; Carnes-Holt, 2012; Hewitt et al., 2018; Holmes and Silver, 2010; Laybourne et al., 2008; Puckering et al., 2011; Turner-Halliday et al., 2014; Whitehead et al., 2022; Wimmer et al., 2010; Wingfield & Gurney-Smith, 2019). These skills included attunement, empathy, curiosity, acceptance and emotional regulation. Whitehead et al. (2022) explored longer-term outcomes and found that although caregivers reported an increase in confidence after they completed the programme, some reported confidence waned or fluctuated over the next 13-15 months. This speaks to the need for ongoing support to maintain progress. Caregivers in Hewitt et al. (2018) and Laybourne et al.'s (2008) studies spoke of a new sense of hopefulness and a positive awareness that they completed the intervention with new skills and a desire to sustain the progress they had made. A carer from Hewitt et al. (2018, p.479), expressed,

> *I look forward to five years down the lines when I can actually, I can put in all of the PACE and everything now . . . it gives me hope for the future.*

Other's reported feeling more connected to their children (Donald and Ceballos, 2020; Hewitt et al., 2018; Holmes and Silver, 2010; Laybourne et al., 2008; Wingfield & Gurney-Smith, 2019). Residential workers in the Donald and Ceballos (2020) paper reported feeling more invested in their role with the child of focus, experiencing moments of connection and closeness.

2.5.4 Theme 4: Positive Relational Change and Family Stability

Study findings gave a sense that the initial impact of the interventions was on the caregivers as they gained new understandings and developed in their attitude, skills and behaviour. Indeed, many interventions were explicit in their aim of supporting therapeutic caregiving. It is then logical that relational change may follow and this was reported in 12 of the papers (Ashton et al., 2016; Carnes-Holt, 2012; Di-Lorenzo et al., 2023; Donald and Ceballos, 2020; Hewitt et al., 2018; Holmes and Silver, 2010; Laybourne et al., 2008; McCullough et al., 2016; Turner-Halliday et al., 2014; Whitehead et al., 2022; Wimmer et al., 2010; Wingfield and Gurney-Smith, 2019).

The Turner-Halliday study explored therapists experiences who referenced their hopes for therapy believing small changes make a difference in the relationship. For instance, a child feeling able to bring an emotion into the room and accept some comfort from the carer signifies little steps that represent a slight shift in the relationship. Authors in Ashton et al. (2016, p.16), posited the key mechanism for change in the intervention was the focus on the caregiver-child dyad rather than each party as individuals. As a participant in this paper expressed

> *the wounding happened in relationship and so the healing happens…in relationship.*

Participants across five studies attributed some of the changes in the relationship to experiences and interactions in between sessions, informed by the intervention (Ashton et al., 2016; Di-Lorenzo et al., 2023; Donald and Ceballos, 2020; Hewitt et al., 2018; Wingfield and Gurney-Smith, 2019). Participants in the Di-Lorenzo et al., (2023) paper attributed improvements in the caregiver-child relationship to their practice of 'Watch Me Play' between sessions. 'Watch me Play' is an observational tool which guides caregivers in a structural manner to observe their children's play (Wakelyn and Katz, 2020). This was a tool that caregivers could practice in between sessions without the need for a facilitator present and was reported to have the most significant impact on participants relationships with their children. A participant in the Di-Lorenzo (2023, p.238) study reflected on the impact of the intervention, realising that, *"the work was going on between the sessions if you will, as we internalised it and worked with the kids"*

Participants in five studies (Di-Lorenzo et al., 2023; Donald and Ceballos, 2020; Laybourne et al., 2008; Turner-Halliday et al., 2014; Whitehead et al., 2022) described how important relational changes were in strengthening the stability of the placement. In a residential setting, Donald and Ceballos (2020) suggested that systemic change could be created by increasing children's access to emotionally responsive adults and models such as CPRT could be helpful in maximising residential workers' impact on children's mental health, given the limits on their time and encroachment of other duties. Participants in the Laybourne et al. (2008, p.17) study went as far as to say that the intervention was significant in preventing family breakdown,

> *If I hadn't had the training, I feel that I would have failed the little boy I have now because the placement would have broke down. His behaviour was putting such a strain on our family and I just couldn't see a way out apart from him leaving . . . The training has changed my outlook.*

Equally a caregiver in the Wingfield and Gurney-Smith (2019, p.10) study stated,

> *The placement would have likely broken down because I don't think I could've coped with it having no understanding what was going through his head.*

2.5.5 Theme 5: Changes in the Child

Although this SLR focusses on experience and not efficacy, participants spoke qualitatively about changes they noticed in their children. This was the case not just for the interventions that included the children but also in two of the caregiver group interventions (Holmes and Silver, 2014; Laybourne et al., 2008

Participants in the Holmes and Silver (2010) group intervention felt that children had become more responsive to their attempts to help, and communication was easier. The child interviewed as part of Midgley et al.'s (2018) study was able to identify that the therapy had helped her to think more about herself, understanding new aspects of her behaviour. She described how she had started to make sense of her mistrust in the context of her relational trauma. A caregiver in the Puckering et al. (2011) study noticed that their child responded well to the facilitators and peers who modelled positive behaviour.

Participants referred to specific benefits of the interventions for their children, including improved sleep, reduced separation anxiety, educational stability, improved emotional regulation, improved relationships with siblings and friends, increased openness, reduced shame and increased trust. Participants in the Wingfield and Gurney-Smith (2019, p.9) study spoke about how they felt their children had increased insight and acceptance which enabled greater closeness and communication,

> *He knows we know that story and we know everything and we're still there and we still love him.*

Participants attributed behaviour change in the child to shifts in their understanding and parenting skills, as articulated by this participant from Laybourne et al., (2008, p.72),

> *By understanding more about his controlling behaviour and different ways I can handle this, and by my showing empathy much more often, this has actually begun to change how the little boy expresses himself and behaves . . . I really feel I am starting to build an attachment with him and he is managing to fit in much more in the family home.*

One caregiver in the Whitehead et al (2022) study explained that through the intervention she had learnt to pre-empt her child's difficult behaviour and apply new parenting skills. She felt this reduced her child's dysregulation over time. Another carer in the Laybourne et al. (2008) study identified that her increased empathy, had begun to change the way her child expressed himself. She described feeling closer to him and the home feeling more harmonious as a result. A therapist interviewed in the Turner-Halliday et al. (2014, p.10) study suggested that

> *success is when a child is open to the relationship when they have an attachment need; so they signal their needs clearly.*

Change in the child was not noticeable for all participants. This may speak to the ongoing challenges that many children with developmental trauma face. A caregiver in Hewitt et al. (2018) described cycles in their child's behaviour, with frequent changes in direction. In Donald and Ceballos's (2020) study, only one of the three residential workers was able to recognise qualitative improvements in behaviour. The possible explanation put forward for this by the authors was that the residential workers had become more attentive, noticing behaviours they didn't initially notice. They also suggested that due to the high level of needs of children in residential care, a more intensive programme may be needed to create change. Equally, the caregivers in Whitehead et al.'s (2022) study of the longer-term effectiveness of the Fostering Changes intervention all spoke of their children's ongoing relational and behavioural difficulties that remained largely unchanged. Participants in Puckering et al. (2011), also were not able to notice positive changes in the children despite there being positive evidence for the intervention in other settings. Carers in the Whitehead et al. (2022, p.145) study discussed how after completing the programme, they became more accepting of their child and had developed a greater level of patience,

> *[Some of these behaviours] are probably never going to change and [I just need to] accept that this is the kid she is.*

Puckering et al. (2011) acknowledged the complexity of the needs for the children in their study linking this to differences in the origin of their difficulties and other neurodevelopmental difficulties that could be contributing to the benefit children could receive from the intervention. Again, this highlights the need for ongoing support for many of these families rather than one-time interventions.

Behavioural change in the child may not be the main motivating factor in referral for interventions. When asked about the reasons for self-referral to a CPRT programme (Swan et al., 2022), child factors were the least responsible themes which prompted self-referral with caregivers seeking to reduce their stress and develop new skills in repairing relationships with their children.

2.6 Conclusion

The formation of the ASGSF has created impetus in the UK for the development of interventions that could meet the needs of children with developmental trauma symptoms. In line with NICE guidelines (2015) recommendations, findings may be valuable in understanding the experience of such interventions.

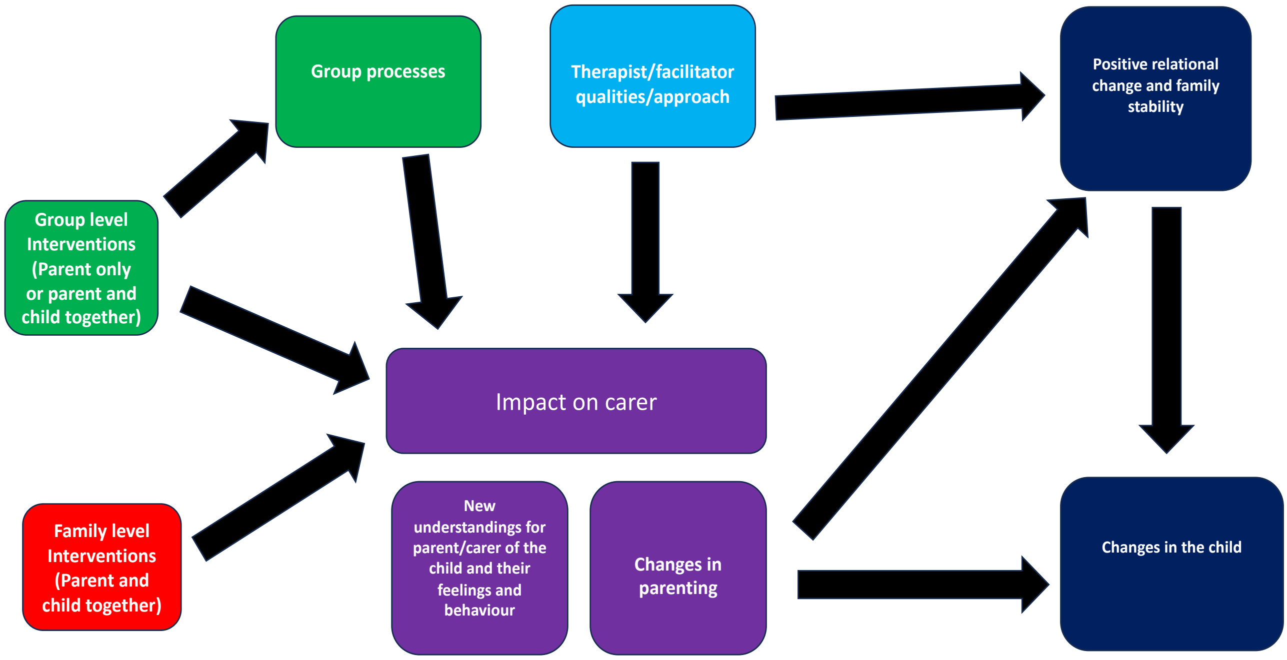
This review suggests that caregiver-child psychotherapeutic interventions for developmental trauma symptoms were overall experienced positively and provided some benefit. Group interventions were highlighted as an important part of the offer, providing opportunities for normalisation, connection and learning from others. They did not however replace family level interventions and participants provided clear rationales for needing both types of intervention.

Therapist skill and temperament were considered important in constructing a safe and non-judgemental therapeutic milieu, creating a space for change. Participants referred to the support they experienced from the therapist/facilitator and how this reduced their feelings of shame and blame, enabling them to learn and develop new understandings of their children's presentations. New understandings were underpinned by relevant developmental theories, which supported carers to understand the emotional needs driving behaviours. Caregiver's reported reductions in stress and increased emotional regulation which supported them to remain present to their children's needs, even in the tough times.

Changes in the child were more difficult to recognise. Some reported very clear benefits, but this was not the case for others. This is difficult to make sense of given the heterogeneity of the studies. Interventions varied considerably in length, approach and modality. It is also important to consider individual differences in children and carers. Given these individual differences and the complex needs of children with developmental trauma, it is unlikely that there is a 'one size fits all approach', however the papers did provide plentiful positive examples of perceived benefits of the treatments with general levels of satisfaction reportedly high. A conceptual map developed has been developed to illustrate relationships between the five themes (Figure 4).

Figure 4

Conceptual Map of SLR Results Illustrating Relationships Between Themes.



2.7 Critical Reflection of the Review Process

To the best of my knowledge, this is the first systematic review that critically examines qualitative experiences of caregiver-child psychotherapeutic treatment models for developmental trauma, thereby making a valuable contribution to the evidence base. A comprehensive search strategy was developed which facilitated access to a range of resources. Both the review protocol and the screening process were carried out in collaboration with others, reducing the risk of errors and biases. Notwithstanding this, this review is not without limitations.

It is important to remember that the review pertains to experiences only and does not include other types of evidence for these approaches that may tell a different story. It may be limiting in that it could entirely omit interventions where there is not yet qualitative literature. It therefore cannot make bold and generalised claims, nor can it comment on the value of any specific model. Furthermore, the quality assessments identified some limitations in the size and scope of the studies with most of them representing smaller service level pilot studies. The data may represent some biases due to the purposive sampling of the studies. Evidence may be derived from participants who were willing to share their experiences and may not be applicable to those who had fewer positive experiences or those who dropped out of the interventions. The findings of this review should therefore be considered with these limitations in mind.

2.8 Gaps in the Literature

The review highlights important gaps in the literature. Many studies were at a service level, or small in nature. This highlights the need for robust, high quality, qualitative studies that explore experience across settings and services that are independent of those settings and services.

The review also highlighted a limitation in the lack of studies that were retrospective, where participants could reflect on their experiences after a period of time had passed since the intervention. Only two papers considered this aspect (Whitehead et al., 2022; Wimmer et al., 2010). Given that review themes tentatively suggest that the mechanism for change may start in the carer's attitude, understanding, skills and stress levels; positive changes in the child's developmental trauma symptoms may take longer and may not be immediately apparent. Qualitative studies that explore the medium to longer impact of interventions on participants may be of value to this field of literature both to explore the longevity of any reported positive changes and to identify changes in developmental trauma symptoms that may take time to develop.

Finally, there were a lack of studies pertaining to the experience of the interventions for children and young people. Caregivers referred to their children's experiences and in one study (Midgley et al., 2018) a young person joined their caregiver’s interview, however there were no studies exploring children’s experiences directly.

Gaps in the literature highlight the need to develop research in this field through:

1) Robust, high quality qualitative studies that explore experiences of dyadic psychotherapeutic interventions for children with developmental trauma and their families in a range of settings and services,

2) Consider the long-term impact and experience of the interventions on the caregiver-child relationship and on the child’s developmental trauma symptoms,

3) Explore children and young peoples’ experience of interventions, considering their views and perspectives on what is helpful for them, how they understand the interventions, and any changes related to them.

Chapter 3. Method

3.1 Chapter Overview

This chapter first outlines the rationale, aims and objectives for the study and then goes on to describe the methods utilised to explore the research questions. In this chapter I endeavour to provide a rationale for the chosen research design, which was shaped through reflexive understandings in relation to epistemological position and ethical considerations regarding research with children with potentially traumatic histories. A detailed description of the methodology is included, followed by information regarding recruitment, data collection, and analysis. Finally, information is provided pertaining to quality appraisal in relation to the study.

3.2 Rationale for the Current Study

Children are the experts of their own experience and should be afforded the right to contribute to the development of interventions and services designed to support their mental health. This is enshrined in the Children's Act (DoH, 1989) and the UN convention of the Rights of the Child (1989, 2005, 2021). Despite the need to understand children's views, they are rarely represented in research and service evaluations (Luke et al., 2018; Sun et al., 2023).

Eliciting children's views can be complex as younger children can be less articulate and reflective than adolescents. This can be confounded by a history of familial abuse and neglect, which can impact on trust and reflective capacity (Golding et al, 2006). However, this does not justify their exclusion and evidence suggests that with appropriate methodology, both traumatised children and young children can participate meaningfully in research (Munro, 2001, Dance and Ruston, 2005, Davies and Wright, 2008; Powell et al., 2012).

Although there are published stories of children's experiences on the DDP online resources[6], these are anecdotal and to the knowledge of the author there have been no academic explorations eliciting children's views or experiences of DDP. In line with the NICE guidelines (2015) recommendations in relation to DDP, this study intends to explore DDP experiences through the lens of the child.

3.3 Aims and Objectives

Aim:
To understand the experience of DDP through the lens of the child, with a view to informing an understanding of any perceived changes that may have come about through the therapeutic process in relation to attachment security and increased caregiver closeness.

Objectives:

1. What are the perspectives of young people aged 6-14yrs old who have accessed DDP with their families?
2. How do children understand and describe their experiences of any changes that may have come about through the therapeutic process?
3. How do children experience and understand any benefits, difficulties and challenges during the therapeutic journey?
4. What can be learnt from this group of young people about the change process of DDP in the caregiver-child relationship?

Main research question:

How do children experience and make sense of the central tenets that are specific to DDP, and any change processes in relation to their caregiver?

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[6] See https://ddpnetwork.org/parents-carers/family-stories/

3.4 Design

3.4.1 Rationale for Qualitative Design

The systematic literature review highlighted the paucity of research pertaining to children and young people's experiences, views, and perspectives of dyadic psychotherapeutic interventions for developmental trauma. In line with NICE guidelines (2015), this study aimed to facilitate rich exploration of children's experiences of DDP. Qualitative inquiry can help illuminate complex concepts that are unlikely to be captured through numerical or categorical data (McEvoy and Richards, 2006; Sullivan and Sargeant, 2011). It is concerned with meaning making and the essence of experience (Pietkiewicz & Smith, 2014). As an approach, qualitative design aligns well with the critical realist epistemological stance adopted within this thesis (McEvoy and Richards, 2006). Individual realities and experiences are interpreted and filtered through my understanding of the phenomena, rather than presenting the findings as a reflection of an independent reality (Fletcher, 2016; Pietkiewicz & Smith, 2014).

3.4.2 Rationale for a Phenomenological Approach

I was curious about how participants experienced the unique properties and features of DDP and how they made sense of their moment-to-moment therapeutic experiences. Phenomenology was developed by Edward Husserl (Husserl et al., 2012) and is concerned with how people perceive and understand their experiences. Unlike other qualitative approaches, phenomenology is concerned with looking inwards at *how* people make sense of their experiences rather than looking outwards at *what* the experience is (Percy et al., 2015), and was thus fitting with the research question pertaining to the properties of children's therapy experiences. Phenomenological studies have long been used within mental health research as a way of presenting research that is reflective of lived experience (Spiegelberg., 2012; Wertz, 2005).

Phenomenological study requires a reflexive move to focus on and engage with the essence of the phenomena. Husserl (2012) argues that this first involves consciously and intentionally reflecting inwards to understand and explore our own pre-conceptions of the phenomena. This ‘bracketing’ process allows the phenomena to speak for itself, whilst acknowledging that the researcher will also have their own relationship to it. This is not to pretend that pre-existing understandings do not exist, but that bracketing allows us to suspend our own experiences to empathically enter the world of the participant (Wertz, 2005).

3.4.3 Rationale for Interpretative Phenomenological Analysis (IPA)

Underpinned by the philosophy of phenomenology, IPA is particularly interested in the experience of moments of significance, and the meaning people ascribe to these moments (Smith et al., 2021). Hermeneutics offers important theoretical insights for IPA (Heidegger, 1977; Gadamer, 2013), suggesting that the researcher enters a process of engaging with and interpreting the participant’s experience. Both the participant and the researcher engage in a sense making process in relation to the phenomena, known as a double hermeneutic (Smith and Osborn, 2003). Smith, Flowers and Larkin (2021) argue that IPA takes a centre ground where the researcher can simultaneously take the standpoint of the participants lens on the phenomena *and* question and interpret this. This corresponds with the critical realist epistemological stance that does not deny the real social world and posits that theoretical interpretation can help us identify causal mechanisms and make sense of social events (Fletcher, 2017).

The double hermeneutic approach of IPA (Larkin, Flowers and Smith, 2021) was suitable for the methodology and aims of this study, allowing the research team engaging in the data to interpret how the child makes sense of their DDP experience. IPA lends itself to data collection approaches that are flexible and open with the interviewer holding a curious and facilitative position in relation to the participants. This enabled participant’s voices to be heard, with the intention of reducing power imbalances.

3.5 Consultants and Experts by Experience

'Experts by Experience' (EBE) are people who have recent personal experience of the phenomena of study (Ahuja & Williams, 2005; Beames et al., 2021). Including EBE's in research can be of benefit to both EBE and researcher. The EBE may benefit from feeling valued and empowered (Brett et al., 2014). The researcher may benefit from gaining valuable insights about the community of interest, shaping research to be more relevant (Brett et al., 2014). EBE's can be involved at different stages of research such as consultation, analysis and dissemination (Minogue et al., 2005). One expert by experience was consulted to support analysis as they had both lived experience of the care system and professional experience in DDP practice with care experienced young people. In addition, an experienced consultant in DDP who has worked closely alongside Dan Hughes and others to develop the model in a UK context consulted on elements of the design, promoted recruitment, and supported dissemination, but was not involved in the analysis stage. A detailed overview of consultant and EBE involvement can be found in Table 19 in Appendix E. Additionally, the study benefited from a primary supervisor from an academic research background and a field supervisor who was a Clinical Psychologist and DDP Consultant.

3.6 Participants

3.6.1 Sampling

Consistent with the guidance on IPA sampling (Smith et al., 2021). This study adopted purposive sampling, with participants representing a shared experience of DDP rather than a population perspective. IPA studies aim for relatively homogenous groups where the research problem has relevance and personal significance (Pietkiewicz & Smith, 2014). This enables meaningful data collection, capturing convergence and divergence within the sample. Inclusion and exclusion criteria can be found in Table 9.

Table 9

Participant Inclusion and Exclusion Criteria

Inclusion criteria	Exclusion criteria
Children legally adopted or on SGO.	Children in UK care system (fostered or residential).
Children aged 6-14	Children who may be adversely impacted by the research process or with current safeguarding concerns (screened by therapist).
Children currently accessing ongoing DDP with a minimum of 4 sessions.	Children who have ended DDP or are within 2 sessions of a planned ending.
Therapists accredited with the DDP Network, having received specific training and supervision[7].	

The study focussed on children who had ongoing experience of DDP interventions. Children who access DDP are usually between 8 and 18 years old (Purrington et al., 2023). This is a wide age group, representing a range of developmental difference. In line with current research in DDP[8] this study focussed on pre-adolescent children. Pre-adolescence is usually defined as the ages of 6-12 (Bhana, 2010). To account for individual developmental differences and to expand the potential pool of participants, we extended the range from ages 6-14.

IPA is idiographic, allowing for in-depth, detailed analysis of each case (Pietkiewicz & Smith, 2014). Sample sizes are generally small to allow for this. Between 4 and 10 participants has been suggested as appropriate for clinical doctorate programmes in Britain (Smith et al., 2009; Turpin et al, 1997b). Such numbers grant the opportunity to study the sample in depth, whilst not risking the richness of the personal accounts (Pietkiewicz & Smith, 2014).

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[7] More information on core competencies can be found at https://ddpnetwork.org/ddpi/practitioner-certification-ddp/

[8] See the 'Relationships in Good Hands Trial' https://www.gla.ac.uk/schools/healthwellbeing/research/mentalhealth/research/projects/right/aboutthetrial/overview/

To reduce recency effects (e.g. difficulties around recall) and ensure children in the study were suitably supported, children were recruited for whom the therapy process was current. Participants needed to have accessed at least 4 sessions to ensure familiarity with the approach. Participants nearing a planned ending of therapy were excluded to avoid confusion in the data regarding endings. All children were legally adopted in the UK, or with SGO's living with extended family. Consideration was given to include children in UK local authority care; however, it was felt this might reduce the homogeneity, and posed additional complexity in relation to gaining consent from those with legal responsibility.

3.6.2 Recruitment Strategy and Challenges

Participants were recruited between May 2024 and December 2024. An outline of the process can be seen in Figure 6. The study was advertised to accredited DDP therapists and consultants in the UK. Therapists were asked to promote the study to families where children met the inclusion criteria and they felt they would not be adversely impacted by taking part.

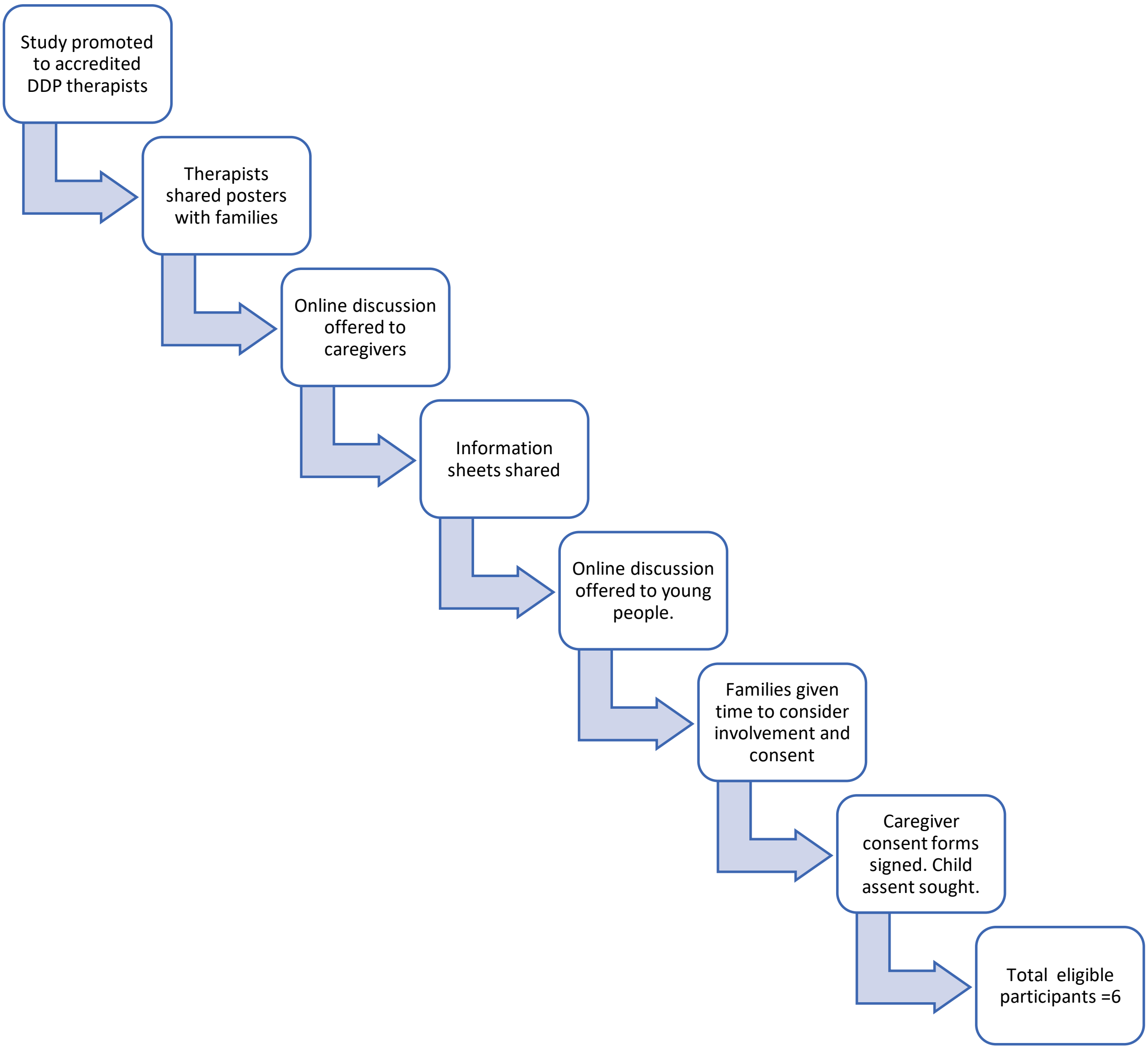
With the intention of information being accessible, three colourful engaging posters were developed aimed at therapists, caregivers, and children with information relevant to each group (See Appendix G for example). These were shared by the DDP Institute via email, website, and newsletter. Additionally, I attended team meetings at third sector organisations in the targeted geographical area to introduce myself and promote the research.

Despite a comprehensive recruitment strategy and interest from therapists, recruitment remained challenging. There were limitations in that the research was face-to-face, reducing the geographical reach of recruitment. There were incidences where therapists recommended families who did not go on to consent or who did not respond to communication. This may be reflective of the complex difficulties some adopted and SGO families experience, reducing their capacity to participate in research.

The recruitment strategy positioned DDP Therapists as 'gatekeepers' for the child participants. This was by design to protect participants through a level of screening but added a level of challenge in accessing families. The recruitment process may have unintentionally burdened therapists with a sense of responsibility for children's welfare, which has been previously documented to be a recruitment challenge (Mirick, 2014; Turner & Almack, 2017). Notwithstanding the challenges, the recruitment process provided an intermediary process whereby a trusted professional (the DDP therapist) was promoting the research and supporting the children and families who took part, reducing unwanted negative effects on participants. Eleven families expressed interest in the study and were emailed initial information. A total of 6 eligible participants consented and were interviewed. For the remaining 5 participants they declined consent citing reasons such as family instability/stress or did not respond to communication.

Figure 5

Study Recruitment Process



3.6.3 Participant Characteristics

The sample consisted of six participants aged between 8 and 12 years old with five females and one male. All were white European, which is broadly representative of the adopted population[9] Five of the children were adopted and one child was placed with relatives on an SGO. Participants were referred from three accredited, experienced DDP therapists from various backgrounds (clinical psychology, child psychotherapy, and clinical social work). Children had accessed between 4 and 60 sessions of DDP with a mean of 36.7 sessions. Adopted and SGO children may experience more complex difficulties in comparison to their non-care experienced counterparts, leading to a need for ongoing or recurring treatments (Tarren-Sweeney, 2010). This may justify the wide range in the number of sessions accessed. Participant characteristics are included in Table 10 including a brief overview of their presentation in the session.

---

[9] 83% of adopted children in England were White in 2020 https://www.ethnicity-facts-figures.service.gov.uk/health/social-care/adopted-and-looked-after-children/latest/#by-ethnicity-looked-after-and-adopted-children

Table 10

Participant Characteristics

Participant pseudonym	Age	Presentation in Interview	Number of DDP sessions
Carter	11	Playful and engaging. Some signs of anxious excitement at times (younger voice).	50 (approximately)
Lex	12	Appeared very anxious (covering self with blanket), found it difficult to engage with the format but wanted to continue. Needed lots of support from caregiver.	50 (approximately)
Asher	10	Appeared well regulated throughout. Engaged and articulate.	6
Kirby	8	Appeared keen to engage and enjoyed the play and drawing. Some signs of regression at times (younger voice) indicating some anxiety.	50 (approximately)
Scout	12	Appeared very contained and articulate. Keen to engage. More verbal responses than play.	4
Georgie	10	(Neurodiverse) Initially appeared anxious but seemed to relax. Engaged well with very long stories but struggled to engage with the more direct questions in the picture task.	60 (approximately)

Specific information regarding children’s care and trauma histories, or any current difficulties and additional was not formally sought as this was considered sensitive information and not pertinent to the study. Instead, information was sought from therapists around the typical presentations in children who access DDP. They reported that children are usually referred due to attachment related difficulties with their caregivers (assessed through psychological interview, standardised measures and observations), with both children and caregivers needing emotional support. Children typically present with signs of mistrust, fear of closeness in relationships, high levels of shame, and associated internalised and externalised behaviours. In preparatory conversations prior to the research session, caregivers were asked if there was any information they felt I needed to know to support the child's engagement in the interview (Appendix K). One caregiver offered at this point that their child had a diagnosis of Autism and Attention Deficit Hyperactivity Disorder.

3.7 Ethical Considerations

3.7.1 Ethical Approval

Ethical approval was sought from the University of Hertfordshire's Health, Science, Engineering and Technology Department (protocol number: LMS/PGT/UH/05305). A copy of this ethical approval can be found in Appendix H. Five ethical amendments were submitted and granted, relating to online recruitment material, the addition of an expert by experience, the addition of a therapist focus group for triangulation, an evaluation exercise and permission to share excerpts within the university IPA group to aide analysis.

3.7.2 Reducing the Risk of Harm

Prior to consenting, caregivers were provided information in written format outlining the aims of the research (Appendix I) and the interview schedule (Appendix J). This described how information was safely stored and how anonymity would be respected. Caregivers were offered the opportunity to talk through the research process (see Appendix K for conversation prompts). Given the age and history of the children, they were offered the opportunity for their caregiver to remain with them during the interview. Four out of six children accepted the offer of having their caregiver present to support their emotional regulation.

The most apposite ethical issue that required attention in this research was to protect children and families from risk of harm. It is a balance to protect from harm, whilst allowing children to express their views (Powell et al., 2012). Steps were taken to protect children and families from risks of harm including opportunities to debrief (See Appendix L for De-Brief sheet), and support after the interview from the DDP therapists. A protocol for managing distress was developed and shared with therapists and caregivers (Appendix M). Given the potential for histories of harm and abuse, participants were encouraged to only share what they were comfortable with in interviews and were gently guided to remain on the topic of their experience of their therapy. Families did not take the debrief offer up feeling it was not needed. It is not known if they accessed support from their DDP therapist.

Throughout the research process, the researcher utilised clinical skills to support the participants' emotional regulation and monitor any discomfort. At the beginning of each session, the researcher spent time building rapport with the child to support trust, as suggested by Crane & Broome (2017). This involved playing interactive games such as Uno, Dobble, and Marble Run. The researcher regularly checked in with the child to see how they were experiencing the research.

3.7.3 Informed Consent and Child Assent

Following consent (Appendix N), caregivers were provided with child friendly information about the project to support their discussions with their children (Appendix O). Children were offered the opportunity of a 'connect and chat' meeting online. The intention being to build relationships to aid meaningful and comfortable participation and discuss assent. Building relationships in the research process is important for supporting children to feel more at ease and less intimidated (Stirrup, 2019). Trust and rapport have been identified as important factors in meaningful engagement in research (Gallegos et al., 2023). Five of the six child participants took up this offer. The meeting was an opportunity for the child to become familiar with the researcher and ask questions and for the researcher to describe the research process to establish informed consent. The sixth participant felt comfortable to consent without the need to meet first.

It was made clear in written information and verbally, that consent and child assent could be withdrawn at any point without prejudice. It was important that assent was given without coercion. Children were not provided with any financial incentive for their participation, so as not to sway their decision. While the assent discussions with children were promising, Gallagher et al., (2010) questions whether children (or adults) can be sufficiently informed. There is a limitation therefore to the consent and assent process. It may have been difficult for children to fully comprehend what taking part in the research was going to feel like. Assent was re-checked at the beginning and at varying points of the research session. Nonetheless, children may have felt compelled to take part.

3.8 Data Collection

3.8.1 Rationale for Creative Data Collection Methods

Creative research methods are not just utilised to assist communication but also put children at ease, supporting meaningful inclusion and participation of children in research (Blaisdell et al., 2018). Such methods facilitate shifts in the power relationship as children engage with the research in the assumption that they are competent and capable participants (Barton, 2015; Lundy et al, 2011; Ponizovsky-Bergelson et al., 2019; Wall & Higgins, 2006). The research protocol was designed with the intention of being relevant to children's interests and preferred ways of communicating (Alderson, 2008), using play and activity-based techniques (Aubrey & Dahl, 2006; Davies et al., 2008; Hill et al., 2006), promoting engagement (McDonagh & Bateman, 2011). More than one method was utilised, which can help build a picture of the child's experience (Clark, 2005; Sun et al., 2023; Worrel-Davies & Marino-Francis, 2008).

Bassett et al (2008) suggest that the researcher must take steps to make the research accessible and participant feel comfortable through consideration of non-verbal language, dress and informal speech. The interviews were face-to-face and relaxed with the intention of being more conversational than interrogatory. Notwithstanding these attempts there were signs anxiety was present for some participants (see Table 10). Participants were given time to play games to support regulation. Caregivers were supportive in providing support and co-regulation.

3.8.2 Projective Narrative Story Stem Rationale

Narrative story stem methodologies (NSSM) were chosen as a way of supporting children to share their experiences without asking them directly, which could culminate in inhibition and anxiety (Woolgar, 1999). Such techniques begin with a story stem, or cue and the participant is asked to continue the story verbally and through figurine enactments. NSSM can be used to elicit projective responses that can otherwise be too sensitive for young children to communicate (Hodges & Hillman, 2000; Kelly & Bailey, 2021). Children have been shown to enjoy such tasks without too much anxiety (Hodges et al., 2003).

To explore the research question, four stems were developed which presented typical therapy scenarios or dilemmas. The stems were adapted from Hodges et al.'s, (2000) Story Stem Assessment profile (SSAP). One stem was a direct replication of a stem from the SSAP 'crying outside', adapted to a therapy setting. SSAP has been used meaningfully within cohorts of adopted children to assess attachment representations (Hillman et al., 2020). Although we were not assessing attachment representations in this study, the attachment dilemmas set up in the stems were relevant to exploring participants representations of the therapeutic relationships. The stems did not ask children directly about their experiences by replicating their therapist and family in the figurines, and instead allowed children to make representations in a displaced form by using a standard doll configuration. An outline of each stem is presented in Table 11 and a detailed protocol is in Appendix

Table 11

Story Stem Overview

Stem 1 – 'The first session' This stem sets up the child arriving at the therapy room for the first time. The child character knocks on the door and the participant is asked to show and tell what happens next. This stem was aimed to elicit feelings and memories the participant may have had at the beginning of their therapy experience. Further prompts were used if necessary to explore how the adults responded to the child if they were portrayed as struggling in this session.
Stem 2 – 'Crying Outside' In the original SSAP stem, the child is outside of the family home and is making a crying sound and the participant is asked to show and tell what happens next. In this study the child was outside the therapy room with the therapist and caregivers inside. The child is making a loud crying sound and the participant is asked to show and tell what happens next. This stem sets up an attachment dilemma. Further prompts were used if necessary to explore whether the adults were aware of the child's distress and how they responded to it.
Stem 3 – 'The Ball' In this stem, the child is in the room with the adults. The adults are wanting to talk about feelings but the child is trying not to listen and is playing with a ball. The participant is then asked what happens next. This stem sets up the adults and the children as disconnected. Further prompts were used to explore whether the adults were aware of how the child was feeling and how they responded.
Stem 4 – 'Another session' This stem is presented in the same way as Stem 1 with the child arriving at therapy, however the child has been going to therapy for a considerable time (about the same amount as the participant). This stem provides a contrast to the 'first session' stem and is designed to potentially elicit any changes. Prompts were used to explore any changes. The participant was also asked if there had been any changes in the child characters experience within their family.

3.8.3 Story Stem Administration

Participants were asked to choose figurines to represent a child, therapist, and one or two caregivers. Figurines were sourced from a variety of ethnic backgrounds. Participants were given the opportunity to name the figures and encouraged to avoid names of people they knew. The child was prompted to set out a therapy space with the use of two toy chairs, a coffee table, a sofa, a lamp, flowers and a mug (see figure 6).

Figure 6

Example of Story Stem Scene

3.8.4 Picture Task

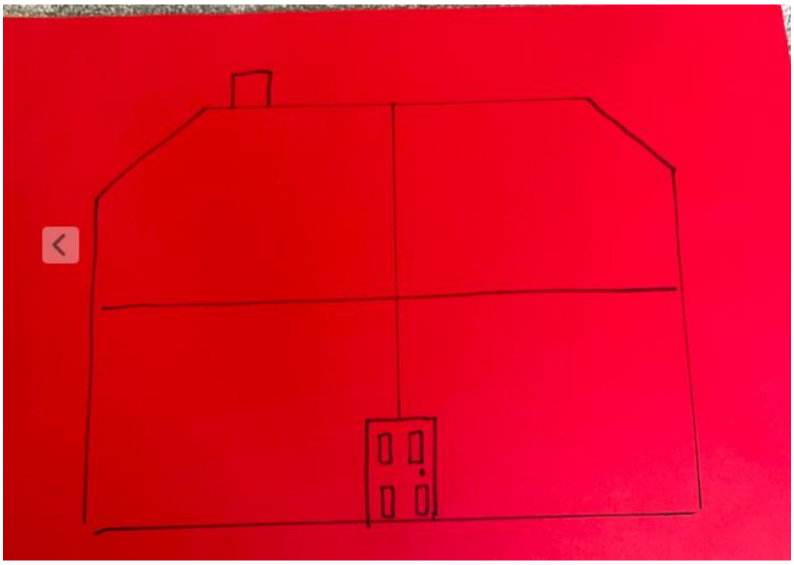
To support children in answering more direct questions and inspired by Pimlott-Wilson's (2011) paper on visual research methods, this section introduced an outline of a house on a large piece of paper (see figure 7) where children could draw or write if they chose to. To support communication and in recognition that drawing and writing can be anxiety provoking for some children (Pimlott-Wilson, 201; Young and Barrett, 2001), emotion stickers (Fane, et al., 2018) and feelings cards were on hand, reducing the pressure to talk. Four topics were suggested for each section of the house picture:

1. What children saw as the positives of their DDP sessions.
2. What children found challenging about their DDP sessions.
3. What did they wish could be different about their sessions.
4. How would they describe their experience of the sessions to a friend.

A series of prompts and follow on questions were used to facilitate discussion and, are presented in Appendix J.

Figure 7

Example of House Picture



3.9 Data Analysis

3.9.1 IPA Analysis

With informed assent from the child and consent from the caregiver, the research session was video recorded to allow the researcher to attend to the child during the interview and accurately analyse the data. Videoed sessions lasted between 35 minutes and 2.48 hours

(Mean 1.15). The differences in the range related to the need for some children to break to play games between research activities to support emotional regulation. All 6 research sessions were face-to-face due to the nature of the creative research methods.

Non-verbal enactments and communications were described and included in the analysis. This data contributed to interpretation. For instance, if the child moved figurines closer together this was noted and analysed. Tone of voice was also noted to support analysis and interpretation. This was a necessary and important part of the analysis due to the creative methodology and the request on the participants to enact stories rather than solely relying on verbal communication, increasing accessibility. The picture task was a facilitative tool rather than a separate method and was analysed in a similar way to the story stem data through transcription of the dialogue, and description of the drawing or stickers used. For instance, if a child drew something, this was stated in the transcript. Equally if they chose feelings cards this was noted.

Analysis was guided by Smith et al.'s (2022) framework and informed by Nizza et al.'s (2021) four quality indicators for IPA studies. Analysis was an iterative and inductive cycle beginning with familiarisation with the data, line by line coding, identification of patterns emphasising convergence and divergence, commonality, and nuance for each case (see Appendices Q and R for examples), and then subsequently across all the cases (see Appendix R). Table 12 details each step of the IPA analysis process.

Bracketing and reflexivity are important methodological tools, which can raise awareness and acknowledge the subjectivity of the researcher in the phenomenological enquiry (Ahern, 1999). Thoughts, feelings, and reflections were journaled after each interview and transcription. The bracketing process was practised in supervision, assumptions and biases were discussed (examples in Appendices C and D).

Table 12

IPA Analysis Process

Bracketing process during analysis Thoughts feeling and reflections were journaled after each interview, and after transcription. The bracketing process was practised in supervision through discussion of participants, my responses, and supervisor responses after reading transcripts (Appendices C and D). Assumptions and biases were discussed. A similar process took place with EBE's.
Step 1 I emersed myself in the data by watching the video recordings and making transcript corrections where necessary. This enabled me to enter each participants phenomenological world. I re-read the transcripts several times, further familiarising with the data.
Step 2 I continued reading transcripts and began making exploratory notes, actively and analytically engaging with each line of the transcript.
Step 3 I undertook a process of analysing exploratory notes to identify experiential statements (Appendix Q). These statements were grounded in the data and abstract enough to be conceptual. This is part of the hermeneutic circle in IPA.
Step 4 Experiential statements were then mapped and charted manually. Doing this manually allowed me to immerse myself physically and metaphorically in the data at this stage. I engaged in a dynamic and iterative process of moving the statements, identifying patterns(Appendix Q).
Step 5 Once clusters were developed, these were hierarchically ordered into high level themes and subthemes. Each experiential statement was numbered to provide an evidence trail linking it back to the transcript and key words and phrases used by the participant. Themes and subthemes were mapped against the brief caregiver questionnaires (see section 3.7.2 for rationale and explanation) to consider convergence and divergence.
Step 6 The process from step 1-5 was repeated for each individual case to produce Personal Experiential Themes (PET). For each case, a table of themes and subthemes was created with a written summary of the interpretation of each theme (Appendix Q).
Step 7 Individual themes and subthemes were again mapped and charted manually across cases. Particular attention was given to convergence and divergence, commonality, and nuance between PETs. Through this iterative process Group Experiential Themes (GETs) were developed (Appendix R).

3.9.2 Triangulation of the Data

3.9.2.1 Rationale for Triangulation Methods

A critical realist philosophy allows for the possibility that participant accounts may be incomplete or misguided. (Potter and Lopez, 2001). Triangulation is an important way of verifying the accuracy of qualitative research and corroborating findings (Creswell, 2008 & 2013: Golafshani, 2004; Lincoln and Guba 1985). It is typically used to increase credibility in research with child participants (Sun et al., 2023). To achieve a well-rounded and multi-layered understanding of the phenomena, data was triangulated through a caregiver questionnaire, and a focus group of DDP therapists (Yardley, 2000).

3.9.2.2 Caregiver Questionnaire

In line with Larkin et al's., (2019) ideas on multi-perspectivity, a brief caregiver questionnaire (see Appendix S) was designed to explore caregiver's perceptions of their children's experiences of therapy. In order to retain IPA's idiographic commitment to grounding the data in the phenomena, the caregiver data was used only to provide context to the child participants data. It was used in Step 5 of the IPA analysis to support and strengthen the reliability of each participants' account when developing the PETs. The data from the questionnaire was solely used to triangulate participant data as part of the IPA analysis supporting interpretation and was not analysed separately. It is therefore not reported in the results section of this study. For all participants, caregiver data broadly converged with the themes.

3.9.2.3 DDP Therapist Focus Group

DDP therapists were recruited through the DDP network. Inclusion and exclusion criteria can be found in Table 13. Therapists supporting children in the study were excluded to ensure confidentiality of participants. The focus group session was recorded and transcribed. The consent form, information sheet, demographics and protocol can be found in Appendix T.

Table 13

Therapist Focus Group Inclusion and Exclusion Criteria

Inclusion criteria	Exclusion criteria
DDP accredited therapists	Therapists who are working with children involved in the study
Therapists who have worked with at least 5 adopted or SGO children	-
Therapists who have practised DDP in the last year	-

Focus group participants had significant experience and expertise in DDP. Further details of characteristics are described in Table 14.

Table 14

Overview of focus group participant characteristics

	Ethnicity	Gender	Professional background	DDP Experience
Participant 1	White British	Female	Clinical Psychology	23 years
Participant 2	White British	Female	Clinical Psychology	10 years
Participant 3	White British	Female	Clinical Psychology	12 years
Participant 4	Indian	Female	Clinical Psychology	7 years
Participant 5	White Irish	Female	Therapeutic Social Work	2 years

The intention of the focus group was to assess divergence and convergence between the expressed experiences of participants, and a more general sense of children's views from DDP therapists. It was not designed to gather the therapists' views on children's experiences, as this would be inappropriate within the phenomenological design of the study (Yardley 2000). Recognising the need in phenomenological research for an open attitude, the researcher was open to iterative refining of the existing categories so as not to overlook any new material, whilst centralising the child participant's experiences of the phenomena as the primary source of data ensuring the hermeneutic phenomenological approach was consistent and data remained authentic (Pearlman and Michaels (2019).

Data from the focus group was analysed using template analysis as a way of charting the data and looking for commonalities and themes (Brooks et al., 2015; King, 2012) (see Appendix U for example). Template analysis is not bound to one epistemological position and can be adapted to the philosophical underpinnings of the study it is utilised within. As its roots are in experiential psychology it is considered a suitable partner to IPA (Smith, Flowers, &Larkin, 2021) (see brief communication with J. Smith in Appendix V) . Template analysis is flexible and can be adapted to meet the needs of a variety research approaches (Brooks et al., 2015). As such it is not prescriptive in relation to sampling strategies. In line with the philosophy of this study, purposive sampling was utilised. IPA-developed themes from the child participants were used as a template for developing and extending analysis (Dennis, Larkin, & Derbyshire, 2013). Findings from the focus group are discussed in the Results chapter.

3.10 Quality Assurance

In line with Smith et al.'s (2009) recommendations, I applied Yardley's (2000) four broad principles to appraise the quality of this IPA study, which are outlined below.

3.10.1 Sensitivity to Context

Design of this study was informed by the clinical and research experiences, of myself and the supervisory team in working with the target population. My experiences, theoretical understandings and current literature (discussed in more depth in the introduction) informed the need for sensitivity around the intersectional contexts for the participants. As a cohort of adopted and SGO children with unknown histories likely to include relational trauma, caution and care was needed to ensure participants experienced the research positively, meaningfully and without a risk of harm. Issues around power were considered carefully when approaching the design. There was a risk that defence mechanisms developed by participants could skew the data. For instance, a child avoidant of painful affect may struggle to share the more difficult parts of their experience of DDP when asked directly. NSSM has been utilised in research previously as a way of yielding data that bypasses these defences, encouraging increased frankness as children experience the task as non-threatening and enjoyable (Buchsbaum et al., 1992). IPA was chosen due to the immersive nature of the analytical process, further increasing sensitivity by grounding the analysis in the ideographic nature of participant experience (Smith et al., 2009).

3.10.2 Commitment and Rigour

The second principle relates to the thoroughness in the research process (Yardley, 2000). Data collection methods were chosen due to my clinical experience in NSSM, facilitating a level of commitment and competence appropriate to the study. Rigour was applied through purposive sampling and deep engagement with the data through the IPA process. The sample provided rich data in their experiences of DDP. DDP is an adaptable intervention based on the child's needs (Hughes et al., 2015). Content of sessions may vary whilst still maintaining the key principles. The participants' therapists were accredited and experienced in DDP, as were the focus group therapists, ensuring consistency and fidelity to the DDP model, thus enhancing clarity of the data.

3.10.3 Transparency and Coherence

Transparency and coherence were demonstrated through thorough triangulation, auditing and member checking, with coherence to the philosophical stance (see Table 20 in Appendix W). The study utilised triangulation in several ways, including two types of data collection (story stems and picture task), a therapist focus group, and a caregiver questionnaire as a way of corroborating the data (Denzin 2011). Investigator triangulation (Denzin 2011) was applied though sharing anonymised transcripts or excerpts with members of the research team including supervisors, EBE's and the researcher's university IPA group. This allowed space for biases to be detected and minimised. A similar process took place at the point of 'across case' theme development. This allowed for corroboration and debate through multi-layered data, providing cogency and increased confidence in the final themes.

To add to the multi-perspective approach (Larkin et al., 2019), two personal experiential theme summaries were shared with two caregivers who supported their children in the research session. This was an additional way to triangulate the data to support interpretation and has been widely used in qualitative research with children (Sun et al., 2023). The caregivers were provided the opportunity to feedback on whether they felt it reflected what they witnessed of their child in the research session (Thomas 2006). Findings were only amended where there was a very clear rationale so as not to undermine the double hermeneutical approach of the study. One of parents chose not to provide feedback and a second parent corroborated the findings and illuminated that one section of the interview had been a re-enactment of a television programme the child watched the previous night, rather than relating directly to their experience of DDP. This added interpretative information for theme development. The findings from the focus group were member checked with all 5 DDP therapists who participated. Member checking ensures that research findings are accurate and credible (Creswell, 2008).

Auditing assesses validity of the analytic steps taken (Yin, 1989). I undertook a self-audit which involved checking the paper trail to ensure the development of a coherent chain of documented information leads to the claims. Additionally, supervisors and EBE's conducted mini audits on individual transcripts, checking annotations related to the final PETs.

Reflexivity was integral to the research process at all stages based on the assumption that we are all influenced by our biases (Yardley, 2000) and is a strength of this study. This was practised through supervision, bracketing and reflexive exercises as outlined in Table 1.

3.10.4 Impact and Importance

As highlighted in the systematic literature review, the voices of children and young people in this research field are under-represented. This study not only sought the views of children but included careful design to ensure their participation was meaningful and collaborative, using creative data collection methods. With the current RIGHT trial exploring the efficacy and cost effectiveness of DDP, this qualitative research will be complimentary and may elucidate quantitative findings. The study aims to inform clinical practice and be accessible to both academic and non-academic audiences.

Chapter 4: Results

4.1 Chapter Overview

In line with a critical realist epistemology and the double hermeneutical philosophy underpinning IPA, I present these results as my interpretation of the accounts of the participants. It is important to acknowledge that my interpretations were shaped by personal and professional contexts, my experience of the participants, and through reflexive discussions and exercises.

Two group experiential themes and eight subthemes are presented (Table 15). Findings will then be described in more detail. The intention is to share my interpretative understanding whilst remaining grounded in the accounts of the participants. The recurrences of themes across accounts are identified in Table 21 in Appendix X.

To protect and respect the identity of participants, gender neutral pronouns and pseudonyms have been used. In the participant quotes, some names and pronouns of characters have been changed to protect confidentiality[10].

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[10] Direct quotes pertaining to participants are presented in italics and description of actions and non-verbal languages are in regular typeface. Where words have been omitted to improve flow and clarity of the accounts […] has been used. Pronouns have been changed to gender neutral and parent/carer terms were changed to 'caregiver' to protect confidentiality. Aside from these changes, the participants voice with their preferred terminology is retained.

Table 15

Group experiential Themes and Subthemes

Group experiential themes	Subthemes
1. ‘They’re telepathic’ – Attuned Emotional Connection	1.1 Curiosity, empathy, acceptance, and flexibility 1.2 Caregivers as co-therapists 1.3 Lightness and play 1.4 Individualised, comforting rituals and rhythms
2. Moving towards psychological safety and shared intentions.	2.1 Mistrust, misattunement and the role of interactive repair. 2.2 Differing degrees of developing trust 2.3 Increased caregiver closeness 2.4 Contemplating loss

4.2 Group Experiential Theme 1: ‘They’re telepathic’ – Attuned Emotional Connection

This first theme aims to capture the qualities within the interactions between therapists, caregivers, and children. These moments of connection were highly individualised, synchronised conversations. It was difficult for participants to verbalise these qualities and instead they tended to be projected into the interactions between characters in their stories. Participants demonstrated how the adults often noticed the child’s subtle non-verbal signals and adjusted their responses, moment to moment. Therapists were flexible in their approaches, moving into lighter or more playful moments to keep children regulated. Therapists sometimes talked for children with curiosity, to facilitate communication. Their voices (as portrayed by participants in the stories) had calm, storytelling lilts to them. The safety of the therapist was not only portrayed verbally but also non-verbally through tone of voice and gestures.

Attuned interactions were abundant within the story stems for five of the six participants. Lex struggled to engage with the story stem format and attuned interactions were not present in this element of their session. This may be for several reasons, including that Lex’s DDP therapy is delivered in an online format and so the setting of a therapy room was not familiar. Lex's caregiver remained present in their research session (at Lex's request) and there were multiple moments of attuned emotional interactions evident between them, which had a similar quality to the interactions that were reconstructed in other participant's stories.

When emotionally attuned connection was present, the children experienced the adults knowing them deeply, and their emotional needs were met without needing to verbally express them. Carter's stories suggested that they experienced the emotional connection from the therapist as that of being known so deeply that the therapist could just read their thoughts. There was a sense of unconditional positive regard from the therapist.

> Carter: *Yeah they {the therapist} always knows.*
>
> Researcher: *They always know when {Child} is hungry? What else does M know?*
>
> Carter: *Hmmm*
>
> Researcher: *Do they know other things about them?*
>
> Carter: *That they're cheeky!*
>
> Researcher: *that they're cheeky! How does the therapist know that?*
>
> Carter: *Hmmm. Cos they're telepathic.*
>
> Carter (Story 1 'First session')

Within this theme there were 4 subthemes that further describe and interpret the subtle ingredients of the interactions that seemed to create these moments of closeness.

4.2.1 Subtheme 1.1: Curiosity, Empathy, Acceptance and Flexibility

This subtheme describes in more depth the attitude and approach of the therapist and caregivers, as experienced by the participants. The theme was evident in 5 of the 6 participant accounts. In Lex's stories, such qualities were not present for the reasons discussed. Lex spoke fondly of their therapist in the picture task and there was a sense of warmth between them, however they did not describe specific interactions. This is congruent with other participants who also were not able to put words to the quality of the interactions but instead projected them through role play in the stems. Therapists were portrayed as warm, curious, empathetic, accepting, compassionate, playful, and understanding. When the child in the story was in discomfort, the therapist tended to lean into this feeling rather than problem solve or reassure. Interactions felt non-evaluative.

Participants demonstrated how the adults were curious about them by sometimes talking for and about them or making guesses and checking them back with the child. In Georgie's story when the child character was upset outside (Story 2 'crying outside), the adults first noticed this dysregulation, and then sensitively responded to co-regulate the child's affective state through nurture and play. Once the child regulated, the therapist and caregivers attended to and explored the child's experience, co-creating meaning together. To facilitate this conversation, the adults in the story assisted the child by making some guesses. The child in Georgie's story appeared to be open to and familiar with this approach.

> Georgie*: And then after they {child character} played, they talked about why {the child} was upset and then they'd already guessed.*
>
> Researcher*: oh they'd already guessed had they?*
>
> Georgie*: Yes of course they had.*
>
> Georgie (Story 2 'Crying outside')

Scout described their sessions as '*interesting and fun'*. Scout appreciated there was no pressure to talk and they could leave the talking to the adults whilst they just listened. Knowing there was no expectation to talk and that talking was a choice, seemed to alleviate Scout's anxiety. When asked what they would tell a friend about the therapy Scout said:

> *I'd tell them that umm it's a bit like, you feel quite nervous like when you go in and you like and like sometimes you don't actually need to like talk, sometimes you can just listen to what they are talking on.*
>
> Scout (Picture Task)

The experience of the therapists' deep curiosity through putting words to their feelings may be helpful in creating safety in these relationships. Children may arrive at therapy feeling anxious that they will be coerced into talking about things that are uncomfortable. Talking for and about children in this way may feel much more tolerable.

In their stories, child participants role played the therapist's flexibility. Sometimes the child took the lead and at other times, it was the therapist. There was a sense in the children's stories that sessions often moved cyclically between lightness and depth with the adults moving at a pace the child could tolerate. In Asher's story 3 'the ball', the adults were accepting that Asher did not want to talk about feelings, and they easily shifted into doing something more playful and regulating to re-establish safety.

> Asher: *And then they {adults} say 'are you ok with that?' And {child} did not know what they were talking about and said they weren't really listening. And um they {adults} say it again and explain that it's quite alright.*
>
> Researcher: *Yeah? And what if the child doesn't want to talk about feelings.*
>
> Asher*: they'd say 'I don't really feel comfortable sharing this'. And then the adults would maybe do something different and make them{child} comfortable.*
>
> Asher (Story 3 'the ball')

In Kirby's Story 2 'crying outside', they role played the caregiver and therapist's sensitive acceptance and empathy. The therapist character in Kirby's story used a rhythmic tone of voice, communicating that the child was not trapped into exploring the trauma in that moment. Children sometimes need a break and there is safety in knowing that the therapist will provide this break. The therapist communicated that the child was welcome back the following week in a way that conveyed an open and engaged attitude, without evaluation.

> Kirby: *And then. 'What's up sweetie?'*

> *'I'm too scared [*said to the caregiver*], I can't cope with it any more doing the therapy'*
>
> *They {caregiver} said 'do you wanna go in the therapy room or do you want to go back home?',*
>
> *'I wanna go back home'.*
>
> *'Ok, we''ll go back home'. And then they go home.*
>
> Researcher: *ok and what did the therapist do?*
>
> Kirby: *They said, 'Would you like to go home or stay here until the time?' and {the child} said 'I wanna go home' and {the therapist} said ' That's fine and it was nice to see you. See you next Friday'.*
>
> Kirby (Story 2 'Crying outside)

Scout expressed that they found it difficult to let the adults know when they were uncomfortable, but even after just four sessions, Scout demonstrated some developing trust that the therapist would accurately read their non-verbal signals and adjust the interaction to maintain Scout's emotional regulation.

> Scout: *umm, the therapist probably made a guess because the child was probably just sort of like fiddling uncomfortably and, I don't know, just like [....] The child probably just tells them that it is fine, everything is alright.*
>
> Researcher: *Do they continue?*
>
> Scout*: Umm. No. Umm they just probably, I don't know, probably just like play with them.*
>
> Scout (Story 3 'The ball')

In summary, the open and engaged stance of the adults was fundamental in creating trust and shared intentions. They did not coerce children into deep conversations they were not ready for. They moved skilfully between lightness and depth using curiosity and talking for and about the child to support them to tolerate conversations about their affective states. It is possible to imagine how these experiences could lead to an increased sense of agency within the therapeutic relationship. Therapists appeared to represent safety with an expectation they would be sensitive and attuned.

4.2.2 Subtheme 1.2: Caregivers as Co-therapists

Within all six participant accounts, caregivers were present and active in the therapeutic process. In story stems, it was often caregiver characters who interactively regulated the child when they appeared upset or in discomfort, either spontaneously or facilitated by the therapist.

In Kirby's Story 1, they role played the child character as upset as they didn't yet know or feel safe with the therapist. The caregiver responded with acceptance and empathy. They did not try to change the child's experience but instead supported their emotional regulation, increasing safety through proximity which enabled the child to tolerate the experience.

> *And they go outside. That's the door shut.*
>
> *And then {the caregiver} says. 'What's wrong?'.*
>
> *'I don't know if I like the person inside.'*
>
> *'If you want you can sit with me instead.'*
>
> *And {the child} says 'ok'*
>
> *And they come back and they say, 'We're back!"*
>
> *Then he'll sit there. Then they both sit there*
>
> [Kirby moves the caregiver figures closer to the child, either side on the sofa].
>
> *One there and one there."*
>
> Kirby (Story 1 'The first session')

There was a sense of closeness between the child and caregiver characters in the stories. This was also often evident in the research session itself where for some participants, caregivers were important for supporting engagement as a reassuring and co-regulating presence. This was particularly the case for Lex. In the research session they remained in close physical proximity with their caregiver, seeming to need this attuned connection to emotionally regulate and engage in the research. Although Lex struggled to put many words to their experience, their dialogue suggested their caregiver's presence in the therapy was an emotionally regulating experience. When asked to describe to a friend what it was like having your caregivers in therapy, Lex responded:

> Lex*: Calm*
>
> Researcher*: Calm. So, does it help to have {caregivers} in with you?*
>
> Lex*: Calm*
>
> Caregiver*: Yeah, do you like it?*
>
> Lex*: Calm*
>
> Researcher: *It helps you to feel calm, does it?*
>
> Lex*: Calm*
>
> Lex (picture task)

Asher was able to articulate how having a caregiver in the room was important for developing joint exploration and shared understandings:

> *Happy that they are there so you don't have to explain it all to them again at the end... Yeah. And they have more understanding of why you get upset or grumpy.*
>
> Asher (Picture Task)

This subtheme highlights the value of caregiver's active involvement in the therapy. This was not only evident within participant stories and accounts but was also observable in the research sessions. Qualities of caregiver interactions were similar to the therapist's stance, suggesting Phase 1 of the therapy had been adequately attended to. It is possible to imagine how these attuned interactions with caregivers paved the way for children to become more comfortable to turn towards them with their emotional needs. As Asher was able to articulate, open and engaged conversations that deeply explore the child's affect could become normalised. This has the potential to lead to increased closeness and greater attachment security, with relational change that transcends the therapy space.

4.2.3 Subtheme 1.3: Lightness and Play

Lightness and playfulness were key elements of the therapy expressed by all 6 participants. Participants expressed that play was what they looked forwards to most. Lightness and play provided the relational conditions that supported emotional regulation, providing the opportunity for children to engage in therapeutic dialogue. It is possible that bracketing conversations that children found more challenging in this way, may have made the process tolerable. It appeared central in facilitating connection and emotional regulation.

The child in Scout's stories was at the beginning of their therapy journey and was anxious. Despite this, Scout had developed the expectation that the adults would use play in an emotionally connecting way to help them feel less anxious.

> Scout*: They just like instead of carrying on talking about stuff {the child} doesn't feel comfortable talking about, they like helped them relax.*
>
> Researcher: *Umm humm. How did they do that?*
>
> Scout: *They played with {the child}, instead of just carrying on.*
>
> Scout (Story 3 'the ball')

Asher, again early into their DDP therapy experience, had a similar expectation. In their stories the connected playfulness enabled the child character to feel safe enough to tolerate exploratory conversations.

> Researcher: *Ok. Does the child need the adults to do anything else right now do you think?*
>
> [Asher shakes their head]
>
> Asher*: Play a game with them.*

> Researcher: *Probably play a game with {the child}. And how would that help? How would playing a game help?*
>
> Asher*: Maybe it would make them more comfortable sharing.*
>
> Asher (Story 3 'the ball')

Carter had a similar experience where playing in the sandpit enabled them to share their troubling thoughts.

> *"They play in the sandpit and they get to play with a toy bus* [points to a toy in the room] *and they fill it with sand and passengers and tip it out and there were two passengers in there but they got tipped out with everyone else. So, they had to get the bus again and they never got to where they wanted to and they pretended that that was M and B, my cousins because B gets the bus into work and he's not allowed to miss that and I was imagining that that would be terrible cos that would be terrible because then he wouldn't know lots of things."*
>
> Carter (Story 4 'another session')

Therapeutic dialogues were not problem saturated but instead were full of lightness, storytelling, and connection. Children re-created these moments frequently in their stories suggesting their importance for developing relational safety. As Carter expressed,

> *It's fun, she makes it fun and she tells a story at the end.*
>
> (Carter, picture task)

Georgie's stories showed how the therapist and child characters played a game together whilst talking about here and now experiences. The child in the stories appeared to enjoy these light connecting chats. It seemed a key element of the therapy experience as the therapist conveyed interest not just in difficulties or trauma history, but also in everyday experiences. It is possible to imagine that after an exchange such as this, the child may feel safe enough to tolerate deeper exploration into past events whilst remaining regulated and maintaining the connection with the therapist.

> Georgie: *{child character} I'll dish out the Uno cards' {the child} said putting the hot chocolate down and going to find the Uno cards that they knew were behind the sofa.*
>
> *{Therapist character} What about history? You love that remember?*
>
> *{Child} Yes. I'm very enjoying it. I'm enjoying it so much. We're learning about the Egyptians. Most of all I like learning about the cats because there is not really any ponies in it. And you know cats are my second favourite animals in the whole entire world and then sea turtles and then dolphins and then probably flying fish. They are just awesome. They are just amazing don't you think?*
>
> *{Therapist} Yes, they are very good. Yes definitely*
>
> Georgie (Story 4 'Another Story')

Scout talked about how conversations in therapy sessions started off in a light and connecting way, with the therapist gently expanding the conversation in a way that felt tolerable.

> *Well sometimes we talk about like somehow, sometimes we talk about like I don't know like 'do you like this book?[....] I don't know, I just sort of find it interesting because like, we're on one topic and then by the end of it we're on a completely different topic that somehow, we led to. That's what I find funny.*
>
> Scout (Picture task)

Playfulness and lightness were relational. It gave opportunities for adults to delight in and celebrate children, discovering strengths. It also bracketed more in-depth conversations, making them tolerable.

4.2.4 Subtheme 1.4: Individualised Comforting Rituals and Rhythm

Children projected scenarios into their stems that suggested therapy sessions were regularly punctuated with familiar, non-verbal comforting rituals and rhythms, such as games, drinks, and snacks. These synchronised rituals seemed significant in building trust and safety and were highly individualised to each child. These rituals and rhythms were not present in Kirby's stories. This could be because they do not have this experience in their therapy, or this element is less important for them. For the five remaining participants who did mention it, they emphasised the importance for them. Lex's face for instance lit up when they recalled online gaming sessions with their therapist. Some participants referred to physical surroundings of the room (familiar toys and beanbags), for some it was the importance of the therapist's welcome, settling them into the sessions with drinks and snacks and for others it was the rhythm of familiar games and shared interests. These rituals were rhythmic, predictable, soothing, and connecting.

After relational ruptures, play was used as a way of repairing and for the dyad to re-engage in joint moments of fun. In one of Carter's stories, they referred to a game that was special that appeared to re-establish safety. This seemed to be a re-enactment of Carters own experience as they offered to show the researcher how to play the game. There was a sense that this game was something they did with their therapist and caregivers that was unique to Carter's therapy experience. It was something that made them feel special.

> *... yeah, cos as a special treat they played [...] because they really like playing cushions and they take off the cushions* [the ball has become the cushion] *and play the cushion roll game. So, you roll the cushion and you keep rolling it and it's really good rolling it. [*Carter looks around the room and goes to get up*]. I can quickly show you.*
>
> Carter (Story 4 'another session')

The child in Georgie's stories was partial to a game of Uno, suggesting this was a familiar ritual in Georgie's own therapy experiences. Georgie possibly knew that the adults were allowing them to win each time, but they nonetheless seemed to enjoy the experience of winning and being celebrated by the adults. This ritual possibly provided a regular and predictable message from the adults that Georgie was worth celebrating in a way that Georgie could tolerate. It may need repeating again and again to begin to challenge their core sense of self. Georgie acted this out in the excerpt below in an interaction between the child and therapist in the story:

> Georgie: *{*child*} can we play a game? Maybe Uno flip as you know that is my favourite game of all entire time and I always win, nobody else can ever beat me.'*
>
> *{Therapist} 'yes of course. I have never done it before' D {therapist} said having a cheeky smile on their face.*
>
> *{Child} 'Of course you have, I've seen you play it 100 times, but you always let... you always loose.*
>
> Georgie (Story 4 'Another session')

The provision of food and snacks featured strongly in four participant accounts. Sometimes it was a predictable punctuation point in the session marking the beginning or ending. It appeared to be a means for the therapist to nurture the child. They often had the child's favourite biscuit, which Asher repeatedly informed me was very important. Possibly this supported participants to feel they were cared for and held in mind by their therapist, thereby meeting an attachment need. In Lex's online therapy, the caregivers provided the snacks and informed me that they did so to support Lex's regulation. The therapist in Asher's first story started the session with making everyone feel comfortable with a warm welcome, and drinks and snacks. This welcome was repeated in Asher's final story suggesting the ritualistic and predictable nature of the gesture.

> *C {therapist} comes to the door and says 'hello'. Then they come in and sit down*
>
> [Asher moved the figures to sit on the sofa and chairs]

> *Then C was offering Mummy a drink and Daddy wanted a coffee. And then C says to A {child} 'would you like a drink?'.*
>
> [Asher moved the therapist so that they were standing in front of the child character. The child character took the drink]
>
> *and they went back to room and got a snack from the snack box and they sit down on the sofas.*
>
> Asher (Story 1 'the first session')

Carter demonstrated in their story 2 'Crying Outside', how the child experienced nurture and care from the therapist when they were upset, which included a snack and drink.

> [Carter moved the therapist character to outside of the room with the child.]
> *'Would you like this?'*
> [Carter pretended to get a mini cheddar out of the packet and gestured that the therapist asked this question to the child].
>
> *'Come with me, sit down on my lovely chair'*
> [Carter showed the therapist taking the child to the chair. The child sat on the chair and the therapist stood next to them. Carter moved the caregiver figure to sit back down on the sofa opposite. Carter put the cup in the child's hand]
>
> Carter (Story 2 'Crying outside')

In the picture task, Asher said that it was the drinks and snacks which they looked forward to the most in their sessions. They also suggested that without the food and snacks, they felt hungry and irritable. Knowing that they would get this basic need met in each therapy session may have been experienced as motivating but also reassuring. This element may therefore be important for emotional regulation and especially relevant for children who have experienced previous neglect that may include unpredictable or inadequate experiences of being fed.

> Researcher: *Why do you think it's important that you have snacks and drinks?*
>
> Asher: *To feel relaxed and not feel hungry.*
>
> [Asher was looking through the feelings cards. Asher picked up the irritated and hungry feelings cards and showed them to the researcher].
>
> Asher (Picture task)

4.2.5 Group Experiential Theme 1: Summary

In summary, emotional attunement was highly individualised for participants in the study but had shared elements in relation to the stance of the adults and the use of lightness, play, and rituals through which adults could communicate the child's importance to them. The stance of the therapist in the participants accounts appeared to be purposefully intersubjective with the intention of increasing safety. This stance contrasts with more traditional therapeutic stances where the therapist may be more neutral within this relationship. Through interactions with the therapist (and caregiver) there was potential for children to experience themselves as interesting, delightful, and lovable. The adult agenda was not driving these interactions. At times the therapist joined the child's attention (on a game for instance), at other times, they gently led into deeper engagement in a way that felt tolerable and safe. The therapists' rhythmic interactions have the potential to reduce shame, enabling the child to engage in new conversations that were not possible before.

4.3 Group Experiential Theme 2: Moving Towards Psychological Safety and Shared Intentions.

Although there were examples of reciprocal attuned interactions as described in GET 1, participant's expressed hesitation and mistrust initially and it took time to establish a sense of safety and trust the intention of these interactions. This process was very individual and may be dependent on the child's early development of their sense of self, and individual differences including neurodiversity. These shifts towards an increased sense of safety suggested an enhanced capacity for relational closeness and security. This was unlikely to be a linear journey with safety needing to be re-established frequently in the process as themes of fear of rejection or abandonment emerged for participants. This suggests that within therapy there needs to be a moment-to-moment dance of making it tolerable for the child and knowing when to adjust. This theme is described in more depth in 4 subthemes.

4.3.1 Subtheme 2.1: Mistrust, Misattunement and the Role of Interactive Repair.

All 6 children were able to express their initial mistrust of the therapy and therapeutic process. Experience of psychological safety was fragile and needed to be re-established after moments of perceived threat or misattunement. It is important to acknowledge that participants were still on their therapy journey, which may have limited the possibility for reflection. However, some of them were able to reflect on their initial experiences of therapy through the first story stem exercise or in the picture task. Kirby's account suggested that a worry of theirs was whether the therapist was a safe person who would not hurt them. Although we do not know Kirby's trauma history, their reaction to the therapist may be indicative of a heightened sense of threat that can be a feature for children who have experienced adults as frightening.

> *I drew a scared face. Good and scared the first time, so I drew a scared face. They don't know you. And they don't know me, and you don't know who they are, and you don't know what they'll do.*
>
> Kirby (Picture task)

Whereas for Asher, their concerns were more in relation to whether the therapist was safe in respecting their story and confidentiality, which may suggest an alternative representation of threat.

> Asher:*…and they* {therapist}*feels safer that nothing will get out.*
>
> Researcher: *When you say nothing will get out what do you mean?"*

> Asher: *Like that {therapist character} won't tell everyone about the session.*
>
> Asher (Story 4 'Another session')

Carter was anxious because they did not know if they would like the therapist or if the therapist would like them, possibly they were concerned with rejection.

> Carter: *They're a bit nervous cos it's the first one.*
>
> Researcher: *Yes, it's the first one isn't it and they are a bit nervous. What do you think they are a bit worried about?*
>
> Carter: *That they're not going to like them.*
>
> Carter (Story 1 'First session')

Scout projected issues around trust and mistrust into their story stems and spoke to it in the picture task. They described how they were anxious at first and didn't want to speak in the sessions. Although Scout was only four sessions into their DDP experience, there was a sense of increasing comfort in the interactions.

> *Just like, when I first started, I felt quite nervous, and I didn't talk much I don't think.*
>
> Scout (Picture Task)

For some children, exploration can feel exposing, and children learn to defend strongly against this vulnerability. Lex was not able to put many words to this experience but in one of their stories the child couldn't wait for it to be over and there was a sense they felt exposed within this relationship. Lex described how the child defended against this feeling by going on their phone to avoid what they termed 'therapy talk'. Whilst sharing this story, Lex was under a blanket which at times they pulled right up over their head as if to protect themself from the memory of this exposing feeling.

> Researcher: *I wonder what {child character} needs the adults to do right now. In an ideal world, if {child} could wave a magic wand in their therapy session right now what would they change? How would they make it different?*
>
> Lex: *Time*
>
> Researcher: *Time? In what way? What do you mean?*
>
> Lex: *The time*
>
> Researcher: *The time?*
>
> Lex: *Wanting it to end faster.*
>
> Researcher: *And can {child} say anything to the adults. Do they say anything to the adults about how they are feeling?*
>
> [Lex shakes their head and stretches at the same time]
>
> Lex (Story 1 'the first session')

It was not often in participants stories or accounts that the adults were not attuned, but story stems 2 and 3 set up scenarios where the child's attachment needs were likely to be activated. For five of the six participants in story 2 'crying outside', the adults attended to the child sensitively. However, in Lex's story 2, the child was crying because they had lost a toy dog and it turned out that the therapist had hidden it. It was unclear if the therapist might be tricking the child. The adults seemed unaware of the child's distress and the child was alone and disconnected. Lex's story demonstrates that established safety can be fragile and rejection may still be anticipated.

> Lex: *the therapist put it in the lampshade*
>
> Researcher: *So, the therapist knows where it is?*
>
> Lex: *Yeah.*

> Researcher: *Well. Ok. And what happens?*
>
> Lex: *I don't know.*
>
> Researcher: *and does the therapist tell* {child} *it was there or not?*
>
> Lex: *Uh, they* {therapist} *probably gives it back to them so then they owe him money, cos, the therapist pays for postage.*
>
> Lex (Story 2 'Crying Outside')

In story 3 'the ball', the child in the stem did not want to listen to the adults. Two participants represented the adults adapting and moving into playfulness to regulate the child in that moment. For three participants, the adults remained mis-attuned, initially attempting to coax the child to join the conversation. Georgie was able to articulate the impact of this misattunement suggesting that at this early stage in their relationship, the trust was fragile.

> *It was now the second time they'd {child} been here and they'd got very used to it. D {therapist} and V {the child} were already friends, but then they had been from the start, but now they seemed like enemies now, as they were talking about something that V didn't want to talk about. They were trying to get V's attention, but it wasn't really working.*
>
> Georgie (Story 2 'the ball')

As the stories moved on, the adults moved into more attuned and regulating responses, thus repairing the relational ruptures. The therapist in Georgie's story moved into a collaborative negotiation regarding a time-limited conversation about feelings, communicating safety and agency. In Kirby's story 3, the child became quite cross with the adults for persisting in trying to get the child to talk when they wanted to play, and the child character seemed to get emotionally dysregulated. The therapist stepped in to sit next to the child character to support the regulation.

> Researcher: *Ok. And what does the therapist do? Does the therapist know that L {child} is feeling ''cross'?* [child's words]

> [Kirby nods]
>
> Researcher: *Yeah?*
>
> Kirby: *I think the therapist should be on the sofa. And then they {child} can sit next to them {therapist}.*
>
> [Kirby moved the caregiver onto the chair but moved the chair very close to the sofa. Kirby then moved the caregiver figure and their chair to be between the other caregiver and the sofa. Kirby then put the therapist on the sofa next to the child].
>
> Kirby (Story 3 'Crying Outside')

Rather than continue trying to get the child to talk about feelings, the therapist in Kirby's story was curious as to whether the child was tired and would benefit from a nap. The child and the caregivers walked out of the session all holding hands, suggesting some relational repair. This demonstrates how the safety was very fragile and the child quickly moved into a defensive stance. The therapist in the story re-established safety and emotional connection, whilst being aware of the child's tolerance levels, providing them with a break. Through these examples of interactive repair, the adults communicated that the relationship is more important than the adult agenda of exploration of affect. It demonstrates how trust can be built through the therapist giving agency to the child, articulating they will not be trapped into difficult conversations.

This subtheme highlights the difficulties for this group of children in feeling safe. Participants initially questioned the intentions of the therapist. The underlying fear was different for each child and was possibly informed by their previous experiences or early histories. For some participants it took time to trust that the therapist was not going to coerce them or trick them. Participants continued to be vigilant within these relationships and their sense of safety could quickly rupture, highlighting the need for interactive repair.

4.3.2 Subtheme 2.2: Differing Degrees of Trust

The story stems were designed to elicit changes in the participant's experiences of safety within the therapy through the introduction of a first session and a later session stem. There was a strong sense of a journey for all six participants as they moved from initial mistrust into developing shared intentions with the therapist (to varying degrees), with participants depicting child characters in the later session as more open to the therapeutic approach. Participants' stories revealed representations of connected and attuned adults, with the child experiencing increased agency and comfort. This suggests that it is the connected experience within the therapeutic relationships that creates the safety, rather than any therapeutic technique as such.

Asher described how therapy initially felt 'unusual' and 'awkward', possibly it was a different way of interacting and being with their caregivers. Initially, they felt embarrassed to share internal experiences, however they noticed that once they were able to share with their caregivers and therapist, they felt lighter and more playful. Conversations with caregivers opened that did not feel possible before. Asher's dialogue suggested that although these conversations were challenging, they were tolerable and worthwhile.

> Asher: *You do end up not feeling anxious, not feeling worried and you do feel happy and you do feel kinda like at more at ease talking about stuff instead of going home thinking 'I shouldn't have said that'. Cos now I can just say all kinds of things that I couldn't.*
>
> *[...] There is not much else I would change I can't really....*
>
> Researcher: *Would you change the hard bits? Or would you keep them in?*
>
> Asher: *I would keep them in because they are still hard but every time you do it, it gets easier and easier....and it's a good thing to do."*
>
> Asher (Picture Task)

Although Kirby expressed initial mistrust with their therapist in both the stories and the picture task, they were able to reflect on their progress.

> Researcher: *Does it stay scary? Or does that change do you think?*
>
> Kirby: *It will change.*
>
> Researcher: *It will change?*
>
> Kirby: *Once they get used to it.*
>
> Kirby (Picture Task)

It seemed they had learnt to appreciate the curious and empathetic stance of the adults. Kirby had been in therapy for quite some time, and it is possible that they had come through a period of resistance and had learnt to feel safe within such interactions. It was hard for Kirby to articulate this further but there was a sense in their account that they were able to tolerate the deep focus on them in the sessions and had learnt to enjoy being known in this way.

> Researcher*: And can you tell me a little bit more about what your sessions are like?*
>
> [pause]
>
> Kirby: *Amazing*
>
> Researche*r Amazing, what's amazing about them?*
>
> Kirby*: Umm. That there's nice questions and I love them, and I like answering them.*
>
> Kirby (picture task)

It was difficult for Carter to verbalise the journey from mistrust to developing an increased sense of psychological safety, but they could express that the child in their stories felt very differently about their therapy experiences in the later therapy session. Carter did not deny the more challenging parts of therapy (which could be assumed to be when conversations move deeper into traumatic themes), however with an increased sense of safety, the child in the stories was more able to tolerate these experiences, with their overall experience a positive one.

> Researcher: *Ok. So, when it was {child's} first day at therapy, they were quite scared weren't they?*
>
> Carter: *and now they're not, they're happy [...] Now they're happy?[...]Yes* [exclaimed loudly], *they love it!*
>
> Carter (Story 4 'Another Story)

As participants in this study had not completed their therapeutic journey, there were limitations in relation to how developed their sense of a journey was. Nonetheless, they were able to provide a sense of progress through their stories and accounts. It was difficult for them to articulate the mechanisms of any changes, but the stories indicated it was developed through the consistent open and engaged stance of the therapist. All participants were able to express in some way how their comfort in the therapy had increased. The DDP therapy had shifted from something that evoked feelings of anxiety to something they enjoyed and where they felt increasingly safe.

4.3.3 Subtheme 2.3: Increased Caregiver Closeness

Not all children were able to articulate, or maybe be aware of any impact of the therapy on them or their relational security. Asher, however, could articulate the value of their therapy. Although Asher had only had six sessions of therapy, caregiver changes through phase 1 of DDP may have influenced their narrative. Although tentative, Asher seemed to be hearing and absorbing the messages of unconditional regard from their caregivers.

> Researcher: *What do the adults do and say when you are finding it difficult? What do they say? Do they know about these feelings?*
>
> Asher: *They say, it's ok to feel embarrassed about that, it doesn't matter, we're still going to love you, and Mummy says no matter what you do we will always love you.*
>
> Researcher: *yeah. And how easy is that to believe? Is that hard to believe or easy?*
>
> Asher: *Umm sometimes both.*

Asher (Picture task)

Asher was able to elaborate that these relational changes extended into homelife with signs of increased closeness and understanding, leading to greater attachment security.

> *Yeah. And they have more understanding of why you get upset or grumpy [….] And they are better tempered now [….]And we are playing games quite a lot. It's made a big impact.*
>
> Asher (picture task)

Carter was also able to notice some relational changes with their caregivers and described how this was first modelled by the therapist. They also suggested that their caregivers were more emotionally regulated leading to increased closeness and a reduction in moments of disconnection.

> Researcher: *And are the adults different now or are they the same?*
>
> Carter: *They're calmer. But {therapist} is always calm.*
>
> Researcher: *... and has anything changed for the child in their family now that they have had lots of sessions?*
>
> Carter: *Less arguments I guess…and lots and lots and lots and lots of fun! And new games.*
>
> Carter (Story 4 'Another session')

Georgie was also able to recognise relational changes, describing a more harmonious relationship:

> *They are more happy together […] before they used to have silly arguments about who uses what toilet and who brushes what horse and how long they sit on the toilet. And which and when they go to bed and when they turn off the tv.*

Georgie (Story 4 ‘Another Session’)

This subtheme tentatively suggests change processes that transcend the therapy space with increased closeness in the child-caregiver relationship. These changes are likely enhanced through the combination of caregiver intervention sessions, and child-therapist-caregiver sessions to model and embed the DDP principles in the caregiving role.

4.3.4 Subtheme 2.4: Contemplating Loss

It makes sense that contemplating the end of the therapy could bring up feelings of loss, especially once safety has been established within the child-therapist relationship. Although endings had not yet been introduced to any of the children in the study, it is entirely possible that they were vigilant and anticipated this future loss. Four participants indirectly referred to loss in their accounts.

Although not a clear example of an anticipated ending, Carter described a moment in one of their stories when someone new answered the therapy room door instead of the usual therapist. The child character was confused and although they initially seemed to accept the therapist’s explanation, the session ended abruptly when the child got their foot stuck in a cup. This could be a projection of underlying worries about change, or endings.

> Carter:*…and {caregiver} said, “what’s wrong?”.*
>
> *She said “it was the wrong person who answered the door”*
>
> *“Oh dear!”*
>
> *and {therapist} said “that was my friend”... {therapist} said, ‘Oh that was my friend who’s come over for the week to stay on holiday she must have answered the door by accident.’*
>
> *And then {child} got up and danced and slipped on the cup and got her foot stuck in it and then sadly they had to go home to take it off.*
>
> Carter (Story 4 ‘Crying Outside)

Two participants referred to some level of loss in other ways. It is possible that painful experiences of loss rise to the surface as part of the therapeutic process and understandably they may wish to avoid these painful feelings. Lex for example created a theme of loss in their story and was able to briefly acknowledge and turn to their caregiver with their sadness.

> Lex: *they're upset because they've lost their dog. [L grins]*
> Researcher: *Ahh they can't find it. Poor {child}!*
> Lex: *{child} loves their dog [says sadly to his caregiver].*
> Lex (Story 2 'Crying outside')

For some children, themes of loss could connect with the discomfort that comes up in relation to closeness. Given the pain of previous relational losses, children may feel a need to defend themselves against the loss of the therapeutic relationship (and the caregiver relationship), creating a dilemma for them in trusting the intentions of the therapy.

4.3.5 Group Experiential Theme 2: Summary

Developing increased trust in the therapeutic process was not linear and appeared to develop through the experience of therapeutic interactions when the participants felt safe and understood, alongside cycles of rupture and relational repair. In time, the participants had an increased sense of agency, and intentions in the therapy became increasingly shared. Trust remained fragile and there were suggestions in the participants stories that fears of loss may remain close to the surface. Some children alluded to change processes in their attachment relationships, which they attributed to the therapy experience.

4.4 Triangulation Through Voices from Practice

The Focus group was analysed using template analysis as a way of charting the data and looking for commonalities and themes to triangulate the primary data from the child participants. I was open to iterative refining of the existing categories, so as not to overlook any new material, however data remained closely related to the child participants' experiences. A summary of findings from the focus group data is outlined in Table 16.

4.4.11 Template Analysis Outcome

Therapists accounts largely converged with the core sample and added depth and richness to many of the themes. The focus group data was helpful in developing the conceptualisation of the themes and increased confidence in them. The data for subthemes 2.3. 'Increased Caregiver Closeness' and 2.4 'Contemplating Loss' were drawn through to create distinct themes, informed by the outcome of the template analysis.

Table 16

Template Analysis Summary

Theme	Commonalities/Divergence and themes
Group Experiential Theme 1: Emotional Attunement: 'she's telepathic'.	The therapists third hand accounts of how children shared their experiences with them added strength to this theme. Children were able to reflect with their therapists how important this was for them, *'don't just listen to our words., look at our eyes, look at our behaviour, look at what we're doing. It's not just what we say.'* (Shared by a therapist with the young person's permission.)
Subtheme 1.1: Curiosity, Empathy, Acceptance and Flexibility	From the therapists' perspective, children experienced this feeling as a way of being interacted with that felt qualitatively different, yet was difficult for children to express verbally. Children might say things like – 'talking with you feels different to talking to other people' or 'how come you are not getting angry with me?' or 'see Mum, she knows what I am thinking!'. This was very similar to children in the core sample. Therapists talked a little more than the core sample about how children experience being talked for and about. As with the core sample, children talked about how it took the pressure off them to talk when the therapist did this for them, giving them voice and a sense of agency. One therapist described how children seem to have a strong reaction to the curiosity expressed when talking for them in this way and they 'come alive'. Therapist accounts provide greater strength to this element of curiosity.
Subtheme 1.2: Caregivers as Co-therapists	Therapists said that some children communicated how important it was their caregiver also received support. When children felt so mistrustful of the process that they could not engage, they were later able to express how it helped them to know their caregivers were getting support. This adds further depth to this theme.
Subtheme 1.3: Lightness and Play	Through their therapists, children communicated how lightness and play helped them to feel safe. Therapy felt like 'having a chat'. Again, this supported children's accounts in the core sample.
Subtheme 1.4 Individualised Comforting Rituals	Children also communicated to therapists that snacks, drinks and special games were important to the therapy. Therapists reported that some children were initially mistrustful of the drinks and the snacks,

	feeling like they might be tricked. Children learning to accept the drinks and snacks was a sign of developing trust and safety within the therapeutic relational process.
Master theme 2: Journey from Mistrust to Trust.	Children's accounts relayed via therapists verified this theme. Children tended to feel a lot of uncertainty initially around why they were there. As time went on a potential for a shared intention grew.
Subtheme 2.1: Mistrust, Misattunement and the Role of Interactive Repair	Therapists heard similar expressions from children in relation to their feelings of mistrust at the beginning of therapy. It is important to remember that some children cannot access the process at all due to the strength of their mistrust and these children will not be represented within the core data. Therapists shared that feelings of mistrust were rarely communicated at the beginning of the process but were often reflected on once there was increased safety within the relationships. Children used words such as 'weird' to describe the feeling of being interacted and attuned to in this way. Some children described feeling very exposed and it could feel torturous, or like they were being tricked. Children had a sense initially that the therapy was about someone else's agenda and not theirs. Some children also communicated initial fears that the therapeutic process could expose them as being 'bad', resulting in them being removed from their families. At later points in therapy, children could recognise that they had put up defences sometimes described like 'walls'. Therapist feedback validates the core data, adding strength and providing more detail as this was often difficult for children in the core sample to vocalise clearly.
Subtheme 2.2: Differing Degrees of Trust	As with the core sample, some children took a long time to establish any trust or psychological safety. Therapists gave examples of children communicating to them that it was not one specific thing that the therapist did that helped them feel comfortable, but it was just something they learnt over time. Rather than feeling like the therapy was driven by someone else's agenda, shared intentions developed once children felt safer with their therapist. They learnt to trust that they had power and agency in the therapeutic process. When they were able to describe this process of trust they might describe it as a metaphor, 'their therapist is guiding them to their destination' for example.
Subtheme 2.3: Increased Caregiver Closeness	Therapists said that although they could often see positive changes for children in their relationships with their caregivers, it was something that children struggled to articulate. Children said things like 'we are more coordinated now, like dancers on Strictly'.

Subtheme 2.4: Contemplating Loss	Therapists spoke about children communicating anxiety around endings. Therapy was sometimes a sanctuary, a place where they felt safe in a world that maybe didn’t understand them. It makes sense that some anxiety would arise around contemplating the ending of the therapy. This was alluded to in four of the children’s accounts and the therapists feedback adds strength to this.

Chapter 5 Discussion Chapter

5. Chapter Overview

In this final chapter I aim to synthesise the main findings and situate them in relation to existing literature in the field. First, I breakdown the research question to explore the central tenets of DDP and change processes, as experienced by the participants and interpreted through a critical realist epistemology. I then describe the strengths and limitations of the study, considering implications of the findings in relation to clinical practice and further research. Finally, I conclude with some final reflections on the project.

5.1 Summary of Findings

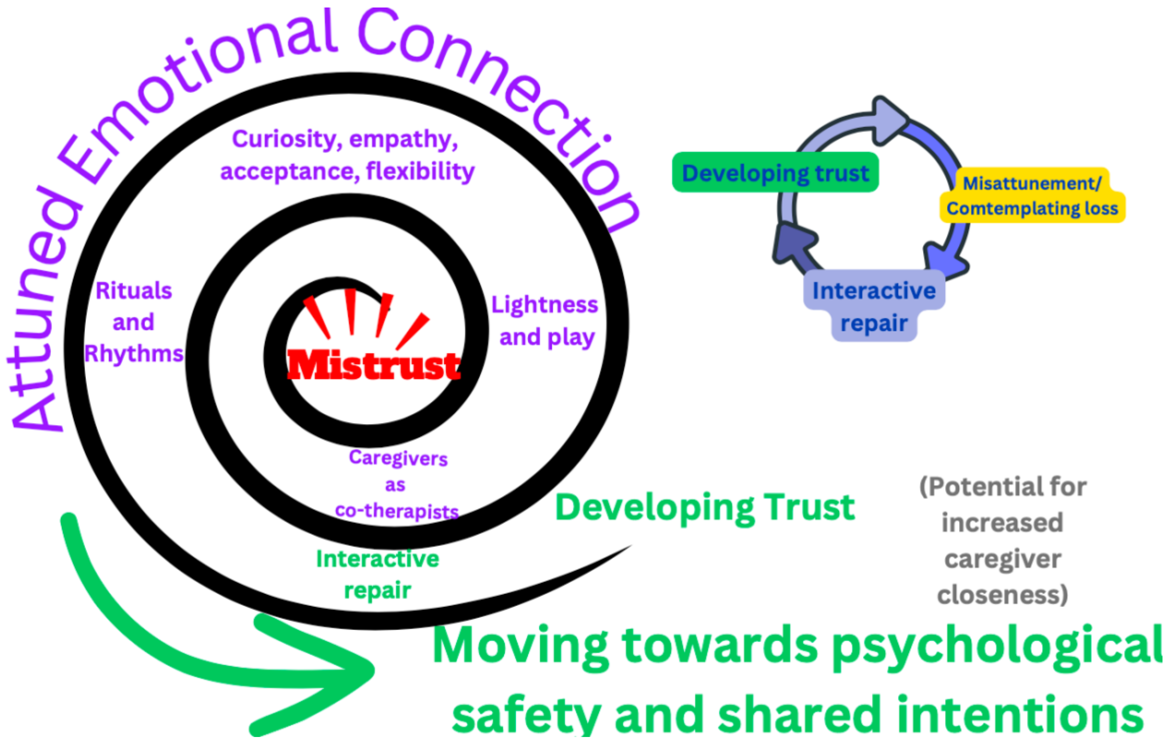
The overall aim of the study was to understand the experience of DDP through the lens of the child with a view to informing an understanding of any perceived changes that may have come about through the therapeutic process in relation to attachment security and increased caregiver closeness. The findings relate directly to the research question

How do children experience and make sense of the central tenets that are specific to DDP, and the change process in relation to their caregiver?

Together the themes described a dynamic process where the qualities of the therapeutic interactions (with therapist and caregiver as the co-therapist) were the active ingredient, generating potential for increased caregiver closeness and connection. Figure 8 aims to represent this dynamic process by visually representing the findings to aid dissemination. The process of experiencing emotionally attuned adults over the timeframe of therapeutic interactions, led to increased openness to the therapeutic relationships. The attitude of the therapist and caregivers, and the qualities of the interactions were crucial to the child learning to feel safer and develop shared intentions. An increase in trust and enriched depth within relationships may engender feelings of vulnerability. A cycle of interactive repair between therapist (and caregiver) and child seemed important to maintain the process of developing trust. At times, therapy was challenging, nonetheless most participants were able to express significant benefits of the therapy, depicting increased connection and closeness with caregivers.

Figure 8

The Dynamic Experience of DDP Intervention Through the Lens of the Child.



5.2 What Did Children See as the Central Tenets of DDP and How Did They Experience Them?

5.2.1 Central Tenet One: Emotional Attunement

Participants re-enacted and described experiences of sensitive verbal and non-verbal interactions where they felt deeply known and understood, indicative of emotional attunement. These moment to moment, individualised, interactions were conceptualised as a central tenet in the experience of the DDP intervention due to the salience and recurrence in the participant accounts. As highlighted in the Systematic Literature Review (SLR) section of this study, there is a dearth of research exploring how children may experience such interactions in caregiver-child psychotherapies. The current study therefore provides an important insight into how children understood and experienced attuned interactions with therapists and caregivers in the therapeutic space.

Attunement is a relational concept referring to the ability to recognise, understand and sensitively respond to another's emotional needs (Fonagy et al., 1991; Ostlund et al., 2017; Stern, 1985). Attunement can support a child's emotional regulation, whereas a lack of attunement can be dysregulating (Laurent et al., 2011). Self-regulation is thought to be structured through dyadic attunement in child-caregiver dyads through repeated, sensitive responding to the child's distress (Schore 2001; Tronick & Beeghly 2011). Scout provided an example of this interplay, depicting the child in their story feeling uncomfortable but unable to express this. The adults attuned to Scouts discomfort and adjusted the interaction to support emotional regulation through a connecting playful experience.

In contrast to the attuned interactions in other participant stories, the adults in Lex's stories seemed unaware of the child's discomfort. Interestingly, in the research session itself were observable repeated attuned interactions between Lex and their caregiver. Lex was feeling some discomfort in the research process but expressed a desire to continue. Lex's caregiver provided in the moment, co-regulating interactions through sensitively responding to the discomfort, offering physical proximity, playfulness, acceptance and empathy, suggesting the caregiver had been well orientated to the DDP model. The process of internalising representations of secure relationships may be complex and could provide a possible explanation for the incongruence between Lex's stories and the observable interactions in the research session. Steele et al., (2012) in their 'Adoption and Attachment representations' study learnt that although positive representations of the self and others had been internalised by children, the negative representations from earlier adversities did not assuage. It was beyond the scope of this study to draw firm conclusions about whether experiences of emotionally attuned interactions were enough to shift children's assumptions about themselves and others. However, such intersubjective interactions were experienced to an extent that seemed normalised and expected, potentially creating the conditions for new representations to be developed.

Attunement has been highlighted as an important mechanism for change within the DDP research (Hewitt et al., 2018; Turner-Halliday et al., 2014; Wingfield & Gurney-Smith, 2019), and is closely aligned to intersubjectivity, a guiding theoretical principle informing the DDP framework. The underlying goal of DDP is to increase attachment security through replicating here and now experiences of intersubjectivity in relationships with therapist and caregiver (Casswell, 2014).

5.2.2 Central Tenet Two: Attuned Curious Exploration and Mentalisation

Mentalisation describes the dynamic internal process by which we make sense of ourselves and others. According to Bateman (2022), mentalising experiences have the potential to bring about arousal patterns in interactions that replicate secure attachment relationships. Change processes in therapy may come about through the therapeutic adults making small, in the moment interpretations that can be linked to subjective reality (Fonagy & Bateman, 2006). Carter provided an example of this when the therapist could always tell when the child was hungry. For the child in Carter's story, the experience of the therapist making small interpretations such as this led to a deep feeling of being known and liked. The salience and recurrence of such interactions projected into stories indicates that this was a key element of the therapeutic experience.

Participants enacted or referred to the experience of therapists curiously talking for them or about them. Scout expressed surprise that this approach took conversations into new realms which were interesting and enjoyable. The experience of therapists reducing the pressure to speak in this way appeared to support children to articulate more vulnerable affective states in a way that was tolerable and appreciated. In one of Georgie's stories, the child was upset and the adults attuned and adjusted their interaction, reducing anxiety. Once regulated, the adults attended to and explored the child's experience, co-creating meaning. To support this communication the therapist tentatively spoke for the child, which Georgie referred to as 'guessing'. It has been argued that 'guessing' allows the possibility for the therapist to be wrong and be corrected by the child (Bateman, 2022). In the therapeutic relationship, taking a stance of 'knowing' positions the therapist as the expert whereas a position of ‘not knowing’ can lead to greater curiosity and creates a space for exploration (Anderson and Goolishian, 1988; Checchin, 1987). Bateman (2022) suggested that this less prescriptive ‘not knowing’ stance of the therapist prevents a situation where the client too easily agrees with the therapist, and instead prompts the client to appraise and explore the therapists’ statement.

The light and non-judgemental curiosity of the therapists, as described by Scout and re-enacted by Georgie, was experienced as tolerable. It led to new conversations where new meanings could be co-created and is congruent with the goals of DDP (Hughes and Golding, 2024). Feedback from caregivers in a study by Wingfield & Gurney-Smith (2019) suggested that the therapists non-judgemental and curious stance with the child may also enhance the caregiver’s curiosity in the child’s internal world. Through the curious ‘talking for and about’ approach, children may experience a process of identification with the therapists’ curiosity, becoming more curious about their own and others’ minds in the process (Fonagy and Bateman, 2006).

5.2.3 Central Tenet Three: Coregulation through Light Playful Interactions

Participants depicted relational, playful, fun and light elements of the therapeutic process, which were experienced as positive and emotionally regulating. For instance, Georgie animatedly enacted the child, therapist, and caregiver playing a card game whilst chatting about Georgie’s interests. The therapist conveyed interest in all of Georgie’s experiences and not just their difficulties or trauma history. DDP is intentional in this approach to support the child’s felt relational safety to keep children in an open and engaged state. Winnicott famously believed that therapy is form of play (1991). To Winnicott, play was not just the action of playing games, or with toys, but is an immersive therapeutic experience involving creativity and connection. Therefore, Winnicott believed that such connected playful experiences enabled clients to access parts of the self that had previously been defended against.

Some participants were able to provide insights into how these light and playful experiences supported their emotional regulation, enabling them to tolerate deeper exploration into past events, whilst maintaining connection with the therapist. Asher was articulate in being able to explain how they felt the adults in the story playing a game would help the child to feel comfortable ‘sharing’. This is in line with findings in the Wingfield & Gurney-Smith (2019) study where caregivers reported that the therapists’ playful stance was instrumental in supporting their children to be less guarded. According to Polyvagal theory (Porges, 2011), mobilisation, play and exploration are only possible when we are in our para - sympathetic nervous system and feel safe. The concept of a *window of tolerance* (Siegel, 1999) maps well onto Polyvagal theory. This is the idea that we all have optimum zones of arousal where we can experience a range of everyday emotions and stresses whilst remaining regulated, allowing us to socially engage, play and learn. Scout for instance, shared how when the child in their stories became uncomfortable with the conversation, the therapist helped the child to ‘relax’ by playing a game together. DDP posits that through such encounters traumatised children experience increased safety, allowing trust to develop thus increasing their window of tolerance (Hughes and Golding, 2024).

Within the light and playful elements, were highly individualised rituals and rhythms such as familiar games and sharing of drinks and snacks. Carter referred to a ‘cushion roll’ game, which appeared to be a ritualistic, individualised way for the therapist, child and caregiver to reconnect. This is reminiscent of Fogel’s (1993) explanation of co-regulated interactions where repeated social games such as peek-a-boo function to heighten attention and teach the child how to anticipate creativity and joy within the relationship. Hughes et al. (2019), suggest that this type of light, playful connected experience may allow children to experiment with closeness and intimacy in a way that feels less frightening than more direct forms of nurture or affection.

5.2.4 Central Tenet Four: Relational Repair

Findings indicate that although there were projected representations of developing shared reciprocal intentions in the therapy, participants remained vigilant to threats in the therapeutic relationships. Georgie described how the therapist shifted from friend to enemy instantly as the therapist became directive. This is a good example of the fragility of trust that may be a feature for children with early relational trauma and the value of the ‘follow-lead-follow’ approach in DDP. Tronick (1989) referred to intersubjective attachment relationships as inherently messy, with shifts from matched to mismatched states and back again. Tronick's *still face* paradigm, in which mothers were asked to suddenly be unresponsive to their infant, demonstrates the distress that can be experienced when relational interactions do not include reparation. Rather than pathologising the mistrust of the study participants, we can understand that they may have missed out on early dyadically regulating processes of interactive repair.

There were examples in participant's stories of interactive repair, such as Georgie's character negotiating a time limited conversation about feelings with their therapist and Kirby's character walking out of the therapy session holding hands with both of their caregivers after the child character became dysregulated. These experiences of successful reparation have the potential to establish new patterns and expectations in interactions. Tronick (2017) suggests that through such reparations, children develop positive representations of the self, and they learn they have agency within their relationships. A study by McLaughlin et al. (2014), suggested that relational ruptures are common in treatment for clients with post traumatic symptoms, and attending to such discontinuities in the therapeutic relationship throughout treatment was associated with improved outcomes.

5.2.5 Central Tenet Five: Importance of Agency in the Therapeutic Process

Exploration may feel uncomfortable for children who have developed defenses against thinking about stressful events and past traumas. In line with DDP's suggested response to this discomfort (Hughes and Golding, 2024), the therapist in Kirby's stories was skilled in providing the child with messages that they were not trapped into exploring their trauma. Focussing on creating safety through attuned dyadic interactions and moments of lightness may be helpful for supporting children to enter conversations where new meanings about themselves and their experiences can be co-created (Hughes & Gurney-Smith, 2020).

Previous writings on attachment-informed therapies have suggested it may encompass practices of adult coercion, including controversial practices such as 'holding' children (Mercer, 2014). This was not congruent with participant experiences as reported in this study. On the contrary, an important element in the trust building process was communication from the therapist that the child was not trapped, which led to deeper engagement and shared intentions. Allowing young people agency in their care can counterbalance children's difficulties with control and trust, improving stability (Hughes, et al., 2019).

5.3 How Did Children Experience the Change Process?

5.3.1 Change Process One: The Therapeutic Journey

Young people who experience early adversity in their relationships and environments may develop adaptive defensive strategies (Perry et al., 1995). Such strategies should be seen as once functional adaptations (Wadsworth, 2015) Participants projected representations of mistrust into their stories of the first session. There were variations in the manifestation of this initial mistrust with some fearing the therapist and others anxious about rejection. Tangible progress was evident in the later session story with participants projecting more positive narratives, increased comfort, and increasingly shared intentions with their therapist, most likely developed through experiencing the central tenets discussed above. This finding is in line with current research with caregivers who initially held some scepticism regarding DDP (Wingfield & Gurney-Smith, 2019). These caregivers viewed DDP as an investment which required commitment and trust, resulting in rewards of increased understanding and acceptance of their child. Asher in the current study was able to reflect a similar sentiment in a child-like way that DDP could be hard but '*it gets easier, and it is a good thing to do'*. This therapeutic process is unlikely to be linear due to the rupture and repair process and has been suggested to be more V shaped or U shaped (McLaughlin et al., 2014; Safran, et al., 2001; Stiles, et al., 2004).

The field of interpersonal neurobiology (Siegel, 2010 Siegel, 2012; Schore, 2013) may be helpful for understanding children's initial mistrust. Porges (2011) posits that when young children experience threat, their dorsal vagal circuit is activated leading to defensive nervous system responses. Children whose threat systems have been activated repeatedly develop more robust defense systems than social engagement systems (De Bellis, 2001; Teicher et al., 2003). Based on neuroscientific understandings, Baylin and Hughes (2017) developed the concept of 'Blocked Trust' as described in the introduction chapter of this study. In the picture task, Kirby drew a scared face when they thought back to the first time they met their therapist. This may be a good example of how danger was anticipated in a way that would be less likely for a child without early adversity. DDP focusses on creating safe relational experiences that soothe the nervous system and shift the child from chronic defensiveness (blocked trust) (Baylin & Hughes, 2016), into more open and engaged stances. In line with this goal, Kirby learnt to enjoy their sessions and trust the curiosity of the therapist *'there's nice questions and I love them*!'. This suggests that for Kirby, and for other participants in the study, their social engagement systems were becoming more switched on, providing the conditions for exploration, play and learning. The neuropsychological concept of the default mode network (DNM), a neural activity circuit thought to be involved the development and integration of self (Raichle, 2001), suggests that when we detect safety, this stimulates neural activity in the DNM system which may become more integrated, creating the conditions for a more integrated sense of self. DDP may therefore support the conditions for DNM activity and the possibility of developing coherent autobiographical narratives.

5.3.2 Change Process Two: Therapeutic Caregiving and Increased Closeness.

Phase 1 of DDP is intentional in 'modelling the model' with caregivers experiencing regulation, reflection and safety through the qualities and stance of the therapist (Hughes & Gurney-Smith, 2020). Caregivers in most participant's stories were portrayed as emotionally attuned and curious, suggesting they were well prepared and orientated to DDP. This was congruent with interactions observable in the research sessions itself.

Turner-Halliday et al. (2014) interviewed experienced DDP therapists as part of a scoping study. These therapists proposed that the caregiver-child relationship was key to the long-term maintenance of therapeutic changes. Caregiver-child psychotherapeutic interventions such as DDP require the therapist to not only consider their own therapeutic alliance with the child and caregiver individually, but they also need to focus on what is happening between the caregiver and child in the room. This requires a high degree of skill. The therapists in the Turney-Halliday et al. (2014) study suggested that this 'in the moment' focus presented opportunity to address past and present realities of caregiving, allowing for co-creation of new meanings.

Three children in the current study described an increase in co-regulated and playful moments in the family home which suggested that for them, this way of interacting was becoming normalised in family relationships, allowing opportunities for more joyful connection. Given the substantive work and support offered to caregivers in DDP and the positive impact of such work as outlined in the SLR chapter of this study, this number may be much higher but was outside of children's conscious awareness. Caregivers in a study by Wingfield and Gurney-Smith (2019) similarly valued shared experiences, viewing them as important in strengthening the caregiver-child relationship. They noticed improvements that transcended the therapy space. Findings are congruent with the outcome of the Systematic Literature Review which suggested that changes in the caregiver are an important component for strengthening the caregiver-child relationship. Luke et al., (2018) found that high levels of caregiver commitment could enhance efficacy in treatments aimed at preventing poor mental health for care experienced children.

5.4 Reflections on Findings

The outcome of the study suggests that the attuned relationships with the adults was the central tenet and active ingredient of DDP, over any event or technique. The implication is that such experiences drive positive changes in relation to the child's sense of self, and in relation to closeness and connection in family relationships. In line with DDP goals, the findings suggest DDP has the potential to generate the relational conditions through which to blend affective states with reflective functioning. This may create further opportunities for increased attachment security, the resolution of trauma, and for children and their families to learn to thrive. This finding is in line with a systematic review which found strong evidence for therapeutic alliance as a mediator for change in psychotherapy, suggesting it can independently drive symptom reduction, although it was unable to answer the question of *how* the alliance contributes to change (Baier et al., 2020). DDP focusses on relationships as the therapeutic vehicle and the findings of this study suggest there is a complex and individualised process at play in this alliance, with therapist (and caregiver) effects playing a strong role. This poses a challenge for empirical research exploring the mechanistic process of alliances which need to be individualised and constantly flexing to the emotional regulation needs of the child.

Participant's stories and accounts suggested that participants' journey through therapy was dynamic, non-linear, and highly individual. Initial resistance was congruent with the neurobiological impact of early complex developmental trauma and could be understood within the literature of interpersonal neurobiology. In line with the findings of the SLR, caregiver skills and understanding promoted their active role in the therapeutic process and supports the value of Phase 1 of DDP treatment. Although participants had not completed the intervention, there were positive signs that sensitive coregulating interactions with caregivers transcended the therapy space and were replicated at home, generating the conditions for increased relational security. This is consistent with literature supporting DDP as a useful treatment for adopted and special guardianship children (Purrington et al., 2023).

Special guardianship and adopted children may demonstrate more complex difficulties throughout their development than their non-care experienced counterparts and are likely to need ongoing or recurring support and treatment (Tarren-Sweeney, 2010). The findings of this study indicate that the length of appropriate DDP interventions is likely to be very individualised and difficult to predict. Long term engagement may be necessary for some children (but not all) to access the attuned relationships that create the conditions for increased attachment security and conversations that may lead to coherent autobiographical narratives. It may be helpful to view DDP as just part of the treatment children might need, providing increased safety within relational experiences and laying the foundations for healing and trauma processing.

5.5 Critical Appraisal

5.5.1 Quality Appraisal

It is important to critically evaluate quality in qualitative research to appraise rigour and trustworthiness (Lincoln and Guba, 1985). The methodology of this study has been evaluated against Tracy's (2010) *Big Tent* markers for qualitative research (Table 17) and highlighted the study's contribution as the first study exploring children's experiences of DDP. In relation to resonance, findings are based on 6 participants, further research is needed to confirm similar findings. Further strengths and limitations are considered in sections 5.5.2 and 5.5.3.

Table 17

Critical Appraisal using 'Big Tent' Criteria

Critical Appraisal of Research Using 'Big Tent' Criteria for Qualitative Research (Tracy, 2010)			
	Description of Criteria	Strengths	Limitations
Worthy Topic	The topic of research is: • Relevant • Timely • Significant • Interesting	• The growth of DDP in the UK in line with the development of the ASGSF means that the research is timely and highly relevant. • Research is significant given the research gap pertaining to children's experiences identified in the SLR and NICE guideline recommendations for DDP research. • Additional rationale was provided through the Systematic Literature Review chapter which revealed a paucity of children's perspectives in the literature. • The research has relevance to current understandings of DDP and how the main tenets and change process are defined and experienced by children. It also has wider relevance to understanding child-caregiver psychotherapies in general, as well	

		as contributing to understandings of what might be helpful interventions for care-experienced children.	
Rich Rigour	The study uses sufficient, abundant, appropriate and complex • Theoretical constructs • Date and time in the field • Sample • Contexts • Data collection and analysis process	• Although the analysis of data was presented through the lens of the researcher, reflexivity was applied and the research attempts to convey the voices of the children with experience of DDP. • Consideration and time was afforded to provide participants with as much preparation and relationship building as the timescales allowed. • Data was collected across contexts from participants who accessed DDP through three different DDP therapists with differing therapeutic groundings. • Complex and appropriate analysis (IPA) was utilised, with consistency checks through supervision and EBE discussions and was reported transparently. • A focus group of therapists and a caregiver questionnaire were included for triangulation of the data, adding depth to the themes. • In addition, results were shared with the DDP research board to	• Although the research made attempts to build relationship and rapport with participants, it is likely that this cohort of children may have developed defenses against deep exploration. Spreading the research over several sessions could have been helpful and produced greater richness in the data but was not possible in the give timescales. • Recruitment was limited by the necessity of face-to-face interviews, the reliance of therapist referral, and issues around capacity of participants in research for this population. • Purposive sampling limited access to those who had not continued with DDP and may have had differing experiences. • The sample size was relatively small (6) but still sufficient for IPA.

		reflect on the findings in relation to the goals of DDP.	
Sincerity	The study is characterised by • Self-Reflexivity • Transparency around methods and challenges.	• Self-reflexivity was utilised throughout using multiple formats supporting a multi-layered approach (See Table 1). • The voice of the researcher was present using the first person where appropriate with transparency through the presentation of reflective accounts within Appendices C and D.	• Due to DClinPsy timescales, only participants who responded within the timescales were recruited. A second attempt may have yielded a more diverse pool of participants. • The methodology and the needs of the population of focus necessitated face to face research interviews, which although preferable, arguably reduced anonymity, potentially inhibiting responses. • The need for some participants to have caregivers present for emotional regulation may also have inhibited some responses.
Credibility	The research is marked by • Thick description, concrete detail, explication of tacit knowledge and showing rather that telling. • Triangulation • Multivocality • Member reflections	• Multiple participant quotations are included in the presentation of the findings, with thick descriptions and rich narratives. • Themes were developed through the support of supervisors and EBE's presenting differing lenses. • An outsider perspective supported deep curiosity in the experience of children whilst professional experience in the field offered insights and interpretations of participant experiences.	• The research explored the experience of DDP for children who were adopted or living with special guardians. Children who are fostered or in residential placements may have different experiences of DDP. • All children were white British. Children from other groups and ethnicities may have different experiences. • Children were aged between 8-12. Children outside of these age groups, such as teenagers, may have

		• Data was triangulated in several ways representing a multi-layered approach whilst centring the participant voice. • Transparency was achieved through describing the research process with clarity and honesty. • Triangulation through a focus group and parental questionnaire strengthened the confidence in the IPA analysis and is presented clearly and transparently.	very different views and experiences of DDP.
Resonance	The research influences, affects, or moves audiences through • Aesthetic, evocative representation • Naturalistic generalisations • Transferable findings	• A significant number of quotes and descriptions were used to support connection of the reader to participant accounts. • The findings may be interesting to audiences wider than those utilising DDP and may be relevant for other child-caregiver psychotherapeutic interventions or in relation to interventions for care-experienced children. • Within the discussion, findings are explored through the research question and are linked to theory and research.	• Participants were accessing ongoing DDP and so it could be argued that they were likely to have positive experiences. • Only six participants were recruited which may impact transferability of the findings. However, data was rich and meaningful.
Significant contribution	The research provides a significant contribution • Conceptually/theoretically	• This research contributes to limited literature on DDP and is the first to focus on children's experience.	• Although the study is robust, it was small and has associated limitations that may limit broad claims. Further

	• Practically • Morally • Methodologically • Heuristically	• The research contributes more widely to the qualitative literature on child-caregiver psychotherapeutic treatments for symptoms of developmental trauma. • The discussion makes reference to recommendations for both practice and further research. • The research methodology was novel and exploratory. This research presents one way of meaningfully collecting data from a cohort that may present some vulnerability. It supports the inclusion of this group in research. • Qualitative enquiry and IPA afforded deep exploration, with a focus on the essence of the experience of the central tenets and change processes in DDP. • Creative methodology allowed for experiences to be re-enacted to elicit projective responses that can otherwise be too sensitive for children to communicate (Hodges & Hillman, 2000; Kelly & Bailey, 2021). The use of multiple data collection methods was valuable in capturing rich data and triangulating responses.	research is needed to increase confidence in the findings.

Ethical	The research considers • Procedural ethics (such as human subjects) • Situational and culturally specific ethics • Relation ethics • Exiting ethics	• Ethical Approval was granted by the University of Hertfordshire's ethics board. • Ethical considerations were adhered to throughout. • The study was designed holding in mind the needs and histories of the child participants. This led to playful, creative methods and extra focus on relationship building. • Children's assent was sought prior to the research session and checked in the research session itself. • Issues of power were considered for this cohort who may have experiences of adults abusing their power. This was considered in relation to child assent and in providing additional time for relationship building. • Findings were presented using non-gendered pronouns and pseudonyms to protect confidentiality. • Findings will be disseminated via academic journals and research conferences.	• Despite best efforts, it may have been difficult for children to fully understand the implications of their participation in the research. Children may have felt compelled to take part, possibly to please the adults around them. • There is discussion in the Method Chapter pertaining to the challenges in recruiting children with potential trauma histories both in relation to ethical recruitment and the reasons why some people chose not to take part or were not referred by their therapists.

		• The research has been shared with the DDP research board and will be presented at the DDP Worldwide conference in September 2024. • Findings will be presented to participants in an accessible child friendly visual format. • Reflexivity was utilised to inform transparent decision making and analysis with meaningful input from EBE's.
Meaningful Coherence	The study • Achieves what it purports to be about. • Uses methods and procedures that fit its stated goals. • Meaningfully interconnects literature, research questions, findings and interpretations with each other.	• Attention was given to a critical realist epistemology and IPA methodology throughout, which were coherent with the goals of exploring the essence of children's experiences of DDP. • Existing literature and theory is interconnected and addressed through the discussion section with meaningful implications discussed. • In line with IPA, purposive sampling was deployed. This was important for homogeneity of the participants, ensuring that they had recent and live experiences of DDP to draw on. • The researchers own role was reflexively examined through

	reflexive exercises, journalling and discussions with supervisors and EBE’s. These processes highlighted biases and assumptions and influenced the formation of the research question, study design and interpretation of the results.	

5.5.2 Strengths

The creative methodology and phenomenological philosophy afforded focus on the essence of children's experiences of the central tenets and change processes in DDP. The design assisted communication and put children at ease, supporting meaningful inclusion and participation. This was in line with the developmental stage of the participants (McDonagh & Bateman, 2012) thereby increasing accessibility. In line with the findings of a review by Sun et al. (2023), the use of multiple data collection methods was valuable in capturing rich data, reducing power imbalances, and encouraging children to feel comfortable.

This study supports the collaborative inclusion of young children in research who have trauma histories, if sensitively and thoughtfully designed. The methodology has the potential to generate discussion about how to meaningfully elicit views from children about their care. Barriers to engaging this group in research, including ethical approval for interviewing traumatised children, challenges in obtaining consent for children who no longer live with their birth families, and engaging children who do not trust adults in conversation, are not insurmountable. The study provides a rare opportunity to understand children's experiences and views that are rarely represented in research regarding services and interventions (Luke et al., 2018; Sun et al., 2023).

Dissemination is important to ensure that the contribution of the participants is worthwhile. This process has already commenced, and further dissemination is planned. This is outlined in Table 18.

Table 18

Dissemination Table

Completed dissemination	Future dissemination Plans	Publication plans
A presentation of research methodology has been delivered at the University of Hertfordshire Creative	Findings will be illustrated to support dissemination.	Development of the empirical section of the study into a manuscript suitable for submission to the journals (All

Research Methods Conference.		sections excluding SLR). Initial submission will be to the Clinical Child Psychology and Psychiatry Journal
A presentation of the findings have been presented at a local Camhs Looked After Child Team	These illustrations will support the development of a therapeutic story to feedback to participants. Jess Christopher will read this therapeutic story in a pre-recorded presentation to share with participants.	Development of the Systematic Literature Review into a manuscript suitable for submission to a journal.
The findings have been presented to the DDP Research Board.	Illustrations will support the development of a similar therapeutic story to be shared with a wider audience, aimed at children. This will be recorded and voiced by Dr Julie Davies (field supervisor). This will be shared with focus group participants, along with a short summary of the research. This will also be shared with the wider DDP community of therapists. It is hoped that this story may aid therapists in preparing caregivers and children for DDP.	It is hoped that a book will follow the Worldwide DDP Conference with the findings shared in chapter.

	Findings and reflections will be shared at the Worldwide DDP Conference in September 2024. This attracts many stakeholders interested in DDP, including the adoption and looked after child sector.

5.5.3 Limitations

Limitations in the purposive sampling strategy deployed in this study were highlighted, capturing only families who progressed with DDP and children who had the emotional capacity to engage in the research, and so you could argue their experience is unlikely to be negative. Going in at different timepoints or sampling differently (e.g. purposive based on clinical assessment of therapist as to how the child is progressing) may capture a broader range of experience. Findings therefore cannot state with any certainty the mechanisms of change in DDP practice, although findings elicited important insights into what children perceive to be important to their DDP therapeutic experience.

It is important to note the cultural limitations of this research. It was carried out in a western country by a white researcher. Most participants were also white. This may not be unique to DDP research and may reflect wider issues around cultural diversity in health research in general (Brown et al., 2014; Woodall et al., 2010), and in terms of adoption[11]. DDP is grounded in attachment theory, which has come under criticism for not considering cultural variabilities in child-rearing practices (Keller, 2018). DDP may therefore be experienced differently by different groups, which has been acknowledged in the latest DDP text ‘Healing Relational Trauma’ (Hughes and Golding 2024). Given the diversity within the

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[11] See https://coram-i.org.uk/asglb/data/ for up-to-date characteristics in relation to UK adoption and special guardianship.

UK population and considering the expansion of DDP in other countries around the world, it should be a priority that future research into DDP reflects this diversity.

Notwithstanding the limitations, it is anticipated that this study will aide a deeper understanding of DDP through the lens of the child and will inform the DDP research evidence base, helping to make sense of change processes that may typically be evidenced quantitatively. It has the potential to help tell the story of what DDP is and how it is relevant for this population of children, informing DDP practice and generating conversation more widely in relation to treatments for care-experienced young people.

5.6 Clinical and Research Implications:

5.6.1 Clinical Implications

Five broad implications for practice are identified:

1) Findings support the value of skilled practitioners competent in the approach who can provide consistent emotionally attuned interactions, whilst also facilitating the caregiver-child relationship. Outcomes are likely to be moderated by therapist effects (Baier et al., 2020). Findings support a robust training procedure and the supervised, skills-based practicum process that is currently utilised for DDP certification, ensuring fidelity to the model. Regular DDP specific supervision and development through the practicum process is likely to be relevant to ensure the proficiency of the therapist aligns with the skilled relational approach that is of benefit for these children. Training alone without development through regular DDP specific reflective supervision may not be sufficient to ensure the expertise needed for the approach. This may be of relevance to commissioners. It may be helpful to incorporate the findings of this study, as well as reflections on the value of projective methods of evaluation, into DDP training to reflect on the important elements of children's experience to aid therapist development.

2) The value of the active presence of the caregiver in the therapy and the importance of this relationship in the change process, reinforces the value of Phase 1 of DDP treatment. Providing adequate time and attention to this phase is likely to be critical.

Results of the SLR suggest it may be supported by other systemic support for caregivers such as DDP informed caregiver training (Golding, 2013, 2017).

3) Play, playfulness and rituals were integral to the relational process. This has resource implications, including availability of drinks and snacks, and inviting therapy spaces with access to soft furnishings such as floor mats and cushions. Emotional resources to be able to provide attuned, coregulating experiences may be equally salient. There may be implications for supervision, reflective practice, and attention to caseload planning.

4) The dynamic nature of the intervention where participants moved from mistrust towards greater psychological safety and shared intentions is a process that is likely to be very difficult to predict. For some children in the study there appeared to be positive shifts in a small space of time but for other children, they had up to 60 sessions and were likely to need more. This has implications for time limited funding.

5) There may be implications regarding online delivery of DDP given the salience of the attuned relational elements of the DDP experience. Blair et al., (2024) explored the experience of online DDP in the Covid-19 pandemic. Families reported a degree of loss in the non-verbal communication online and yet some other benefits in relation to comfort and safety. It is yet unclear whether the depth of relational attunement, that was crucial for the participants in this study is possible through video conferencing software.

5.6.2 Research Implications

The following five research implications may also be relevant to clinical practice, especially in relation to meaningful clinical evaluation.

1) The creative, play-based methodology utilised in this study could be further developed to enhance meaningful collaborative engagement of traumatised children in research and clinical evaluation. Exploration of online options may be of interest as it

could reduce time and cost implications, providing access to a wider pool of participants. This would need to be balanced with the advantages of face-to-face interactions in relation to building trust and rapport.

2) In further developing the research methodology, consideration could be afforded to the order of the story stem delivery. The first stem seemed to influence the narrative of the subsequent two stems, with participants continuing their stories of the 'first session' into subsequent stories. Re-ordering the stories may enrich the opportunity for a wider range of therapeutic experiences. For instance, placing story 1 'the first session' and story 4 'another session' together at the beginning before moving on to the remaining two stories could yield different results.

3) In parallel with the findings of this study, caregivers active support was important in supporting the engagement of the child participants in the research process. It is my opinion that without the coregulating presence of their caregiver, some participants may not have had capacity to meaningfully engage. This has implications for considering the involvement of caregivers in future research, balancing this with consideration of how this could also lead to inhibition in some cases.

4) This study focussed on the experiences of children in adoption and special guardianship placements. Children in foster care, residential placements, and other care settings may have different experiences of DDP that would be of value to explore.

5) This study took place in the UK. Participants were mostly white British. Other groups may experience DDP differently. It is important that the experience of DDP is explored in a variety of diverse cultures and settings.

5.7 Conclusion

It is important to understand children's experiences of therapeutic interventions, considering implications for their quality of life (Luke et al., 2018). In the past there has been an over-reliance on symptom reduction (Becker, 2011) and on caregiver data (Luke et al., 2018) in research pertaining to treatments for care-experienced young people. In line with the recommendations from the NICE guidelines (2015), this study focussed on understanding the experience of DDP from the perspective of the child. This is the first academic study focussing on the qualitative experiences of children undergoing DDP interventions. The rich data from the participants of this study could provide some insight regarding the mechanisms of change in DDP, which is an area of research that is less developed than research on efficacy of therapeutic interventions for care experienced young people. (Henggeler and Sheidow, 2012).

5.8 Final Reflections

I embarked on this project with the intention to elevate the voices of children within the DDP literature. This has been welcomed and supported by the DDP community who promoted recruitment and are supporting dissemination through a presentation at the Worldwide DDP Conference in September 2024. DDP therapists were engaged and enthusiastic about the project from the beginning and were open to understanding the experience through the lens of children. Their involvement and active participation enhanced this study.

I could not have predicted the nuanced and rich data that was shared by this amazing group of children. I have learnt so much about the detailed components of individualised therapeutic relationships that will influence my work as a clinical psychologist as I hold in mind their experiences. It was the children who made this study possible. I am so grateful to them for being brave enough to take the emotional risk to meet with me and take part in this study. I know this was not easy for many of them and I am thankful for their involvement.

We should not underestimate the rich and meaningful contribution to research that children can make. We should not assume that their age or trauma histories diminishes the value of their input. We should not assume it is too difficult for us, or for them. We should however be very thoughtful about how we design research that is trauma informed, collaborative, and mindful of power. I am so glad that I did my study this way and with these amazing children. I hope their efforts, their rich and meaningful words and stories, will leave a legacy. I hope that their voices will be listened to and learned from because that is what they deserve.

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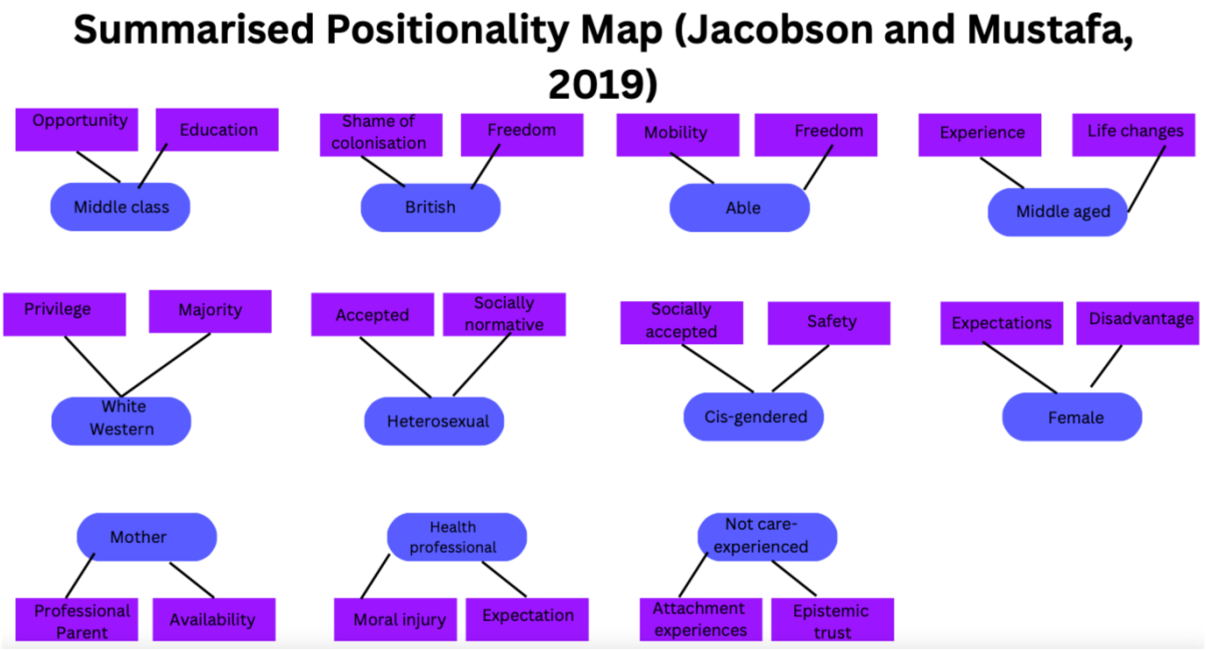
Appendices

Appendix A: Social Identity Map

Figure 9

Social Identity Map



Appendix B: Excerpt of Reflexivity in Research Exercise

Reflexivity as introspection:

- reasons for being drawn to the topic.

I have been working with this client group for a long time prior to training. I have also been practicing DDP for many years. I have asked myself what draws me specifically to both this client group and this way of working. This is something that I am still exploring. Due to my own struggles as a child and difficulties in the relationships with my own parents, I possibly feel a strong empathy, even though my experiences were very different.

DDP is a therapeutic approach where you can bring more of yourself than some other therapy. For example, it may be considered positive for the child to see that their story has an emotional effect on you. Some people are more comfortable with ‘bringing themselves’ than others. Through my development as a therapist, I have done a lot of introspection and I have found this therapeutic. I have learnt about myself and thought about my own narrative and my own story. This has allowed me to be able to put this aside in the therapeutic relationship to focus on theirs whilst holding deep empathy. I have had fantastic supervisors who have been trained in the model and have been curious about when client stories resonate with my own.

Having been a DDP therapist for several years, I have experience of the model and the process. It is a model that for me as a therapist feels aligned with my values and I hold a belief that it can be beneficial. I have had some experiences of it being valuable for families and this has been powerful. To see the connection, trust and relationships grow through the approach has been inspiring,; to witness ‘moments of meeting’ between children and their caregiver that were not possible before.

Knowing that I would need to immerse myself into the MRP, I wanted to chose something that meant something to me. I considered lots of different possibilities before landing on an exploration of DDP. It felt that this was an area of research that I felt passionate about and I am genuinely curious about the outcomes. I cannot wait to find out what children think and how they experience DDP.

I am very aware that DDP is something that I believe in and in some ways I am an ‘insider’. This comes with some biases. I have wondered if I will be more alert to the positives and the successes than other narratives. This is something to pay close attention to. My principle supervisor had no prior knowledge of DDP before supervising me and I think this is helpful in that she is an ‘outsider’. She can help me to notice my biases.

Reflexivity as discursive deconstruction:

- Which dominant discourses surround the field of your research?

There are some dominate discourse around attachment and the importance of it. There are some critiques of attachment theory, particularly in relation to much of the early research being specifically focused on mothers. There are also some critiques around whether it is more applicable to a Western model of the nuclear family. Does it apply to collectivist cultures? I think these are areas of consideration. I think a broader definition of attachment theory is more comfortable for me. The idea that children need safe and predictable carer givers for optimal emotional development. This could be many or few as long as the child’s experience is one of warmth, familiarity, protection and safety.

- What are the areas of contention surrounding your research?

Children are often not involved in research and not considered ‘reliable’ sources of information. I would like to challenge this notion with my research. I hope it will show the depth of children’s insights and that they have a valuable contribution.

There is a contention in DDP that because it is relational and encourages a depth of relationship, it could make children and families dependent on therapy. In this sense, DDP is psychotherapeutic in that it is helpful for children to be able to repeat patterns of interaction in the therapeutic relationship and receive a different response (i.e. unconditionally accepting), as a way of healing. As the caregivers are involved and there is an aim that they are co-therapist, this makes dependency less likely. There does however need to be a recognition that this process may take considerable time for some children before they are ready to move on from this therapeutic relationship. This may depend on the parental capacity of their caregiver figure and the stability of their placement.

Appendix C: Excerpts from Reflexive Journal

"14.10.22
Research methods lecture reflections…
Considering IPA as a potential analysis method appropriate to my data. IPA explores transformative experiences in depth. Mirrors therapeutic process. Do I have the expertise within my team? Can lend itself to creative design e.g. photos etc. You come up with a narrative at the end. Allows for interpretation of the meaning behind the words. Has it been done with children? – this is something to explore further. What would an interview look like?"

"November 2022
Discussion with Julie Davies re her research paper. Considering similar methodology. Value of using something similar. She used mostly cartoon drawings to look into children's experiences. One exercise was projective e.g. what might the child be thinking and feeling? and the other was more directive. Some value in doing this and allowing children to say something that they might not be able to say about themselves directly.

No sure such a reliance on drawing is right for the children in my project as some worry about being judged. Something more play based feels more comfortable - using some kind of dolls? Is this too young? Aware that children may be functioning at a much younger age. Also, with dolls they can communicate more nonverbally. Some children also do not like putting pen to paper and it may feel like school."

"February 2023
Journal club with cohort
Discussed decolonising and what it looks like in my research. Giving a voice to children goes against the patriarchy and the hierarchy. Children are oppressed. Valuing play and non-verbal communication is more valued in indigenous populations and therefore goes against decolonising."

“28.9.23

Why has recruitment been difficult?

I have had some reflective discussions in supervision and with critical friends to help me think about why recruitment was difficult.

Caregivers feeling overwhelmed with the information. Decided to reduce the amount of information I send to caregivers in the initial contact. Try and get a conversation with them early and then send the remaining information.

Gatekeepers (therapists and caregivers) being protective of children – will they be upset by the research process? Some children are very sensitive to new people and it can be unsettling. Again, I hope that this might be mitigated by early conversations so that they can meet me and (hopefully) feel reassured. Also respecting that it will absolutely be the case that the research would unsettle some children and accepting that this is a limitation. Does this mean I will be missing a section of participants? This is a limitation that can be discussed and considered in the write up.

Families had a lot of other things going on in their lives that they need to prioritise. Some families are also feeling unstable or in crisis. Would it have been helpful to have made it clearer that I have clinical skills and know how to support children? I have steered away from this as I do not want people to think I am offering a therapeutic space. But my methodology is deliberately therapeutic. What is therapeutic and what is just being thoughtful?

Children – some children are saying no. Maybe because of their mistrust? It is positive that they can make this choice. Why do some choose to say yes and some chose to say no? Again, am I getting a certain sort of participant?”

“18.11.23

The stories went well. The house picture worked less well. The child wanted to draw the rooms of the house and could not relate this to the questions. Maybe it was too abstract? The child has an ASD diagnosis and maybe took it literally. It may also be a form of avoidance – or both.”

“23.1.24

Felt a bit lost recently as I have completed my transcription and I am starting to analyse. I really feel like I don’t know what I am doing and I notice I am being a bit avoidant.”

“2.3.24

Considering the focus group analysis.

IPA didn’t feel like it fitted well as an analysis tool, as the focus group was really a way of triangulating the children’s data. I could not explore the therapists experiences as it didn’t fit with my research question. I looked at the research and read IPA the book. Looked at other papers. I decided that a mixed methodology seemed most appropriate. I will use template analysis to code the focus groups. This makes sense because it looks across cases rather than within cases. It would not be appropriate to use IPA as it is looking at individual lived experience and the focus group does not offer that. I explored the epistemology around this to consider if this fitted with the main philosophical underpinnings. I have therefore been working on the methodology section to work this up.”

Appendix D: Reflexive journal – Bracketing thoughts, feelings reflections about participants at varying stages.

(After interview reflection)

“Oops! I have been a bit avoidant of reflection lately! I think due to anxiety over not getting participants and feeling like it is not progressing!

Today, I got my first participant. I was very nervous! They were super sweet, but also nervous – slightly babyish voice was a give-away.

Anyway – think it went well. In the session, I felt keen to make them feel more comfortable and relaxed. I went nice and slowly. Although I was using curiosity, I did not want to push as I was so aware that I am a stranger, and I didn’t want to distress them. Really it would have been so much better if I could have done a few sessions so that they could get to know me and relax. I suspect this might be the case for most of the children I see.”

(After interview reflection)

“The relationship and trust was an issue in this session. The participant clammed up a couple of times and seemed to disengage. I am being much more direct than I would be in a therapy session and it is different to how I would normally work with children as I would spend much more time building a relationship first.

We played a game of Monopoly to warm the child up. They seemed quite happy to interact with me but just didn’t want to answer the questions. They said, ‘I don’t know’ and “I don’t know what to say’, or “I can’t think of anything”. The session took two hours. I checked in with them that they wanted to continue and made it clear they could stop but they said they were happy to continue. I questioned whether this was compliance as they did not seem keen to engage. I considered ending the interview myself but I didn’t want the child to think they had failed somehow. They did not appear distressed however and so I made the decision to continue. I do not know if this was the right decision. As soon as they finished, they seemed more relaxed and wanted me to stay for the rest of the game of Monopoly. I was exhausted afterwards.

.After this interview, I decided that I needed a bit more time at the beginning to help children feel comfortable. As well as connecting and chatting, I took Dobble and Uno to play first so that we could have some lighthearted fun together."

(After interview reflection)

"We played some games together and I spent longer talking through the research to make sure they understood and was giving informed consent as this interview had been arranged quite last minute. The child was amazing. Very articulate and insightful. I felt like there was some very rich data in what they were saying. This was a bit of a boost and I felt the long journey was worth it. I noticed my interest peaking when they described therapeutic interactions that were in line with the intention of DDP. I need to think about this when analysing and make sure I am not being biased in how I code this. (Discussed in supervision).

Afterwards my brother met me and we had a walk with his dog before the next appointment. It was good to connect and have time in nature in between appointments. I was feeling well regulated and not too tired."

(After interview reflection)

"I was there for a long time and their stories were very long. They seemed to struggle to start and to stop the therapy session stories. There were lots of tangents where they talked about pets and ponies. They had wanted to do the stories with no one in the room and so they didn't seem keen on being interrupted. We seemed to develop a playful way of me interrupting where we said 'pause' to pause the story and then said 'play' to resume. I wondered whether the long stories were a way of keeping me present but I also wondered if this mirrored therapy sessions where endings might be difficult."

(After transcription reflection)

"Noticing as I am listening back how young their voice goes at times. I also remember this with another participant in the interview and their carer also fed back that they regressed. I am thinking about how stressful this process might have been for them. I wonder what the function of the regressions was. Keeping themselves safe by becoming younger and therefore less likely to be rejected? This makes me feel sad that they felt they had to do this but I understand it within their histories of possible relational abuse, rejection and loss."

(Reflections during Analysis)

"Analysing the data has changed my perspective on it. It feels like the participant has gone on a journey of initially feeling mistrustful and tricked by the therapy process but learning to trust it more. I could see so much therapeutic parenting from Mum and the child was open to this – in the room not in the data as such. They were more avoidant in the stems when thinking about earlier sessions. Glad I used IPA as I can include all the data that is non-verbal. In this case, the interactions observable and the child's response to their caregiver tells me a lot about their experience. Will discuss in supervision how this might be interpreted.

I would order the stems differently now. I think doing the first session first skews the next two stems."

(Reflections during Analysis)

"Today I did the exploratory and experiential statements. Very contrasting to previous participant as the fear and shame is much lower. I reflected that this child had fewer sessions that the other 2 but yet was able to clearly identify changes within the family dynamics that were positive. This makes me think that not all children need significant DDP sessions to get to the place of safety with their therapist and caregivers. The dialogue is much less disorganised and the stories are more congruent. This has made it easier to code. I think that there is possibly still a level of people pleasing going on but not to the extent of compulsive compliance as they were able to say when I got her name wrong etc. I was curious about why they seemed so much more organised than the others. I wonder if this related to early attachment experiences. I also wonder what level of caregiver intervention there has been and whether the caregivers have had more. This difference could also be related to caregiver attachment style – maybe they have been able to engage in the DDP phase 1 really well and have built up a therapeutic alliance. So many possible variables going on the influence the success of the intervention"

(Reflections during Analysis)

"There was richer data than I had originally thought in this transcript. They managed the stems better than the picture task. I wonder whether there is a level of neurodivergence there that I am not aware of that made the picture task more difficult. I have been reflecting about how my methods might fit for neurodivergent children. The story stems seem to be more accessible than the picture task for some children. Fatigue may also be a factor though as the picture task comes second. Would it be different if I did it over 2 sessions? I am having thoughts about how the methodology could be trialed more and developed more."

(Reflections during Analysis)

"Starting to develop the group themes. I am consciously trying to bracket my understanding of the DDP framework as I can see it in the children's words. I need to stick closely to their experiences and how they are describing it rather than put it into DDP language. This is a challenge. I want to audit some of this with my supervisor who as an 'outsider' (i.e. not a DDP clinician), will hopefully notice if I am biased"

"Focus group reflections
It was difficult to just focus on what the therapists are saying about children as I am also really interested in their experience. I bracketed this to just focus on the children they were talking about. I was careful in the summary not to use quotes of words that children had used as they have not consented to take part in the study.

There were not any areas where the therapists accounts from children differed significantly to the core sample. The focus group data made me think about the conceptualisation of the themes, possibly to emphasise psychological safety within the themes. I also think it might be worth creating more codes within the trust theme to bring out inter-relational changes and what happens at the end of therapy."

Appendix E: Overview of EBE Involvement with Example

Table 19

Overview of EBE and consultant involvement

Stage	Involvement
Refinement of research topic	The DDP consultant supported the researcher in developing the research questions.
Recruitment	The DDP consultant supported recruitment for the core participants and the focus group.
Data analysis	EBE 1, a person with care experience, and also a professional with DDP skills supported audit and theme development.
Dissemination	The DDP consultant is supporting dissemination among the DDP community.

Example of EBE 1 Discussion Notes re Development of PETs

A really helpful discussion. Themes she picked up on :

- Compulsive compliance. Not wanting to do the research but continuing anyway. The research felt exposing. Therapy can feel exposing.
- Blanket as an invisibility cloak – using this as a shield or barrier. Thinking about this as a very young state of hiding – covering up eyes.
- Monopoly – also noted that it was regulating and they needed that control.
- Buying a new dog – sense of relationships being transactional – linked to loss around adoption – does the participant feel replaceable? Parents are replaceable.
- Therapy speak – the adults talking for and about them. They are quiet in the room but listening and observing. They will be soaking in the positives and learning about themself. Hearing moments of warmth from the adults and love and persistence. This is uncomfortable because it clashes with their sense of worth.
- Importance of presence of the parents – They maybe can’t let on how important this is. This is going to take them time.

- Gaming important for keeping the connection going.

The discussion adds depth to the analysis I have done so far. There were no points of significant difference in the interpretation. I will use this discussion to enhance the themes I have already made.

Appendix F: Permission to Use DDP Graphics from Norton Publishers

From: [redacted]
Date: Wednesday, 13 March 2024 at 16:35
To: Jessica Christopher [Student-LMS] [redacted]
Subject: RE: W.W. Norton - Permissions Inquiry

Dear Jessica Christopher,

Thank you for your request to use Figure 2.1, Figure 2.3, Figure 4.2, Figure 5.2 and Figure 8.1 from HEALING RELATIONAL TRAUMA WORKBOOK in your doctoral thesis, "Children's Experiences of Dyadic Developmental Psychotherapy". This letter will grant you one-time, nonexclusive rights to use the material in your thesis, and in all copies to meet university requirements, subject to the following conditions:

1. Full acknowledgment of the title, author, copyright and publisher is given as follows;

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3. You may reproduce no more than 10% of our book in your thesis.

Thank you.

Best regards,

[redacted]
Senior Permissions Manager
W.W. Norton & Company, Inc

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New York, NY 10110

From: no-reply@wwnorton.com <no-reply@wwnorton.com>
Sent: Saturday, March 9, 2024 9:16 AM
To: Permissions <Permissions@wwnorton.com>
Subject: W.W. Norton - Permissions Inquiry

You have received a permissions inquiry from the W.W. Norton WEB site.

Name: Jessica Christopher

Book Information...
Publisher: Norton
Author/Editor: Daniel A. Hughes and Kim S. Golding
ISBN: 978132403058
Title: Healing Relational Trauma Workbook: Dyadic Developmental Psychotherapy in Practice.
Copyright Line: Copyright@2024 by Daniel A. Hughes and Kim S. Golding
Page(s) on which excerpt appears: 36, 37, 52, 147, 158, 198, 326
Title of Selection: Figure 2.1 'Defining Principles, Figure 2.2 'Impact of Developmental Trauma on Development', Figure 2.3 'Components of Intersubjectivity, Figure 4.2 Components of DDP, Figure 5.2 'Three Dyadic Relationships, Figure 8.1 'Dyadic Developmental Practice Model.
Total no of Pages: 7
Total Words: 0
Total Lines: 0
Total no of Illus: 7

Your Publication...

Title: Children's Experiences of Dyadic Developmental Psychotherapy (Doctoral Thesis)

Author/Editor: Jessica Christopher

Publisher: University of Hertfordshire

Publication Date: 09/20/2024

Publication Format: University of Hertfordshire Archives

Number of Pages: 0

Amount of First Print Run: 0

Price: 0

Territory: UK

Comments: This is a request for permission to use the figures listed in my doctoral thesis. The doctoral thesis will be available to the public on the University of Hertfordshire Research Archives webpage. Submission is due 30th May, 2024

Appendix G: Example of Research Poster

EXPLORING DDP THROUGH THE LENS OF THE CHILD

PROJECT AIMS

To understand DDP through the lens of the child, with a view to informing understanding of any perceived changes that may have come about through the therapeutic process in relation to attachment security and increased parental closeness.

CALLING DDP PRACTIONERS TO HELP FIND SUITABLE FAMILIES.

We are looking for children who might be open to participating in a one off play-based research session.

PARTICIPANTS

- Children need to be adopted or on a Special Guardianship Orders
- Aged between 6 and 14 years.
- Accessing regular DDPsessions
- Therapists need to be DDP accredited or on the DDP Pracitcum and close to accreditation (beyond mid-way) witha recomendation from their supervisor

PLAYFUL, CHILD-FRIENDLY METHODOLOGY

Novel Story Stems have been designed to explore children's representations of their experiences of DDP

Children will also have the opportunity to explore various aspects of their experience of DDP through drawing a picture.

PROJECT TEAM,

Lead Researcher: Jess Christopher Trainee Clinical Psychologist, DDP Consultant.
Primary Supervisor: Dr Caroline Cresswell, Research Fellow, University of Hertfordshire.
Field Supervisor: Dr Julie Davies Clinical Psychologist and DDP Consultant.
Consultant: Dr Kim Golding, Consultant Clinical Psychologist, DDP Consultant and Trainer.

SUPPORTED BY THE DDPI RESEARCH BOARD

Dyadic Developmental Psychotherapy Institute
Certified DDP Consultant
ddpnetwork.org/ddpi
DDPI

GET IN CONTACT WITH JESS CHRISTOPHER

j.christopher@herts.ac.uk

THIS PROJECT HAS ETHICAL APPROVAL GRANTED BY THE UNIVERSITY OF HERTFORDSHIRE
PROTOCOL NUMBER: LMS/PGT/UH/05305

Appendix H: University of Hertfordshire Ethical Approval

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA ETHICS APPROVAL NOTIFICATION

TO Jessica Christopher

CC Dr Caroline Cresswell and Dr Julie Davis

FROM Dr Rebecca Knight, Health, Science, Engineering & Technology ECDA Vice Chair

DATE 22/05/2023
Protocol number: **LMS/PGT/UH/05305**

Title of study: Exploring the experience of children and young people who have participated in Dyadic Developmental Psychotherapy (DDP)

interventions with their families.

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Dr Kim Golding (CBE), Clinical Psychologist, DDP Consultant and Trainer [redacted], Expert by Experience

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: 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.

External communications: 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.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid: From: 22/05/2023 To: 31/08/2024

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Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.
Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

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.
Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. 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.

Failure to report adverse circumstance/s may be considered misconduct.

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.

Appendix I : Caregiver Information Sheet

FORM EC6: PARTICIPANT INFORMATION SHEET

1 Title of study

Exploring the experience of children and young people who have participated in Dyadic Developmental Psychotherapy (DDP) interventions with their families.

Principle Investigator

Jessica Christopher
Trainee Clinical Psychologist at the University of Hertfordshire

2 Introduction

Your child is being invited to take part in a study. Before you decide whether to provide consent in their behalf, it is important that you understand the study that is being undertaken and what their involvement will include. As the caregiver of the child, we also invite you to complete a short questionnaire to support the information your child provides in their session. Should you wish to provide consent for your child, you will also need to consent to fill in the questionnaire. Two separate consent forms are attached. One for you to consent for your child and one for your consent.

Attached with this information sheet is a detailed schedule of the research activity session that your child would participate in. Please take the time to read all of the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. It is important that you feel confident that your child would benefit from taking part and will not be unduly upset by the process.

Please do take your time to decide whether or not you wish to take part. The University's regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link:

https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs (after accessing this website, scroll down to Letter S where you will find the regulation)

Thank you for reading this.

3 What is the purpose of this study?

To understand the experience of DDP through the lens of the child, with a view to informing an understanding of any changes that may have come about through the therapeutic process in relation to attachment security and increased parental closeness.

Data for this study will be collected through a playful and engaging research session with children who have been attending DDP with their caregiver. Caregivers of the child will be requested to fill in a brief questionnaire exploring their perceptions of their child's experiences of therapy. This will be used to strengthen and support the reliability and interpretation of the data collected from the session with the child.

4 Do I have to take part?

It is completely up to you whether or not you decide to provide consent for your child take part in this study. If you do decide to consent, you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that your child has to complete it. If you consent for your child to take part, we will also need your consent to complete the brief caregiver questionnaire to support the process.

You or your child are free to withdraw at any stage without giving a reason. A decision to withdraw at any time, or a decision not to take part at all, will not affect any treatment/care that you may receive.

After the research activity sessions, you can still withdraw your information up until the end of the data collection period (April 2024).

5 Are there any age or other restrictions that may prevent my child from participating?

If your child is aged between 6 and 14 years of age they can take part in the study. In recognition of the varied development of children, we suggest that you take some time to read and consider the information you have been provided that outlines the format of the interviews and decide if it is appropriate for your child. Please only fill in the consent form if you feel that your child will engage with and benefit from the interview process.

In order for children to be able to recall their experiences of DDP therapy and to provide them with ongoing support, we ask that children have had a least 4 DDP sessions and are having regular sessions. We also ask that they are not too close to the planned ending of the sessions (within 2 sessions of the ending).

6 How long will my part in the study take?

We expect the research session with your child will take up to an hour. We will arrange a debrief phone call with you and your child within a week after the interview to provide space to process and discuss the experience. We can signpost you for further support at this point should you need it.

We expect that the caregiver questionnaire will take around 20 minutes. We will ask you to fill it in whilst your child is in their research session. If this is not appropriate due to your child's needs, we will send it to you.

We would like to contact you and your child once the investigator has done some of the analysis so that we can check with you that the themes we are drawing out fit for your child. This may be a few weeks after the interview.

Once the project is completed we would like to contact you again so that we can share a child friendly copy of the final project paper.

Interviews are planned to take place any time between April 2023 and April 2024 at a time that is convenient for your family. The project is planned to be completed by September 2024.

At some time in the future, we may contact you again about this study or another. There is no obligation to remain involved.

Should there be any significant changes to the aims or design of the study you will be informed and asked to renew your consent for your child to participate.

7 What will happen to me if I take part?

The first thing to happen is that I will share with you a personalized, child-friendly information sheet and a video for your child to view to find out about me and the project. It is important that your child understands what will be involved and is also consenting to take part. I am happy to arrange a video call with your child if that would be helpful too.

If you and your child are happy to go ahead with the research activities, I will contact you to arrange a convenient time and location for the research session.

The research sessions can either take place in your home, or at the centre where your child accesses their therapy. The choice is yours based on convenience and where you think your child will be most comfortable and able to engage.

8 What are the possible disadvantages, risks or side effects of taking part?

Although we will not be asking your child about any previous traumatic experiences, this maybe something that they talk about in their therapy sessions and so may refer to it. There is a risk that this could trigger some distress. Your child will be given the choice whether they would like you to remain in the interview with them to provide access to your support. If they prefer you not to be in the room, we ask that you remain close by so that you can be called upon should the child become upset or emotionally dysregulated. We will talk to your child before the interview and let them know that they do not have to talk about anything that makes them feel uncomfortable and if they do feel upset we can pause or stop the interview.

It is not anticipated that completing the caregiver questionnaire will risk causing you any harm, however if you do feel upset in any way, please let us know so that we can signpost you for further support.

At the interview we will arrange a time within the following week for me to call you and your child for a debrief. This can be on the phone or video call. This is an opportunity for your child to express any feelings they have about the interview or any feedback they wish to give. We can check in to make sure there have not been any adverse effects for the child from taking part. Should your child or your family need support we can signpost you at this stage.

This information has been shared with you via your therapist and they are aware of the research project. By providing consent you will also be consenting for us to make the therapist for your family aware that your child is participating in this research. This is just for support purposes, no content from the research will be shared with your therapist. This allows for you and your child to have access and receive after care from your therapist should this be necessary.

9 What are the possible benefits of taking part?

Children are rarely represented in research and evaluations. With care and appropriate research methods, children can participate meaningfully in research. So far, there has been no formal research exploring DDP from the perspectives of the children involved. This is therefore an opportunity for children to play a part in the development of DDP and shape the understanding of how DDP is experienced by children. It is hoped that by learning more about how DDP is experienced by children, this may also provide therapists and caregivers with more information to support children where DDP may be appropriate.

This research has been carefully designed with the aim that it will feel enjoyable and fun for the child participating. Of course children are all different, so it is important that you have read the outline of the interview format and feel that this is right for your child.

Please take time to carefully consider your consent. I am very happy to talk this through and discuss any questions or concerns you may have first. I am also happy to have phone calls or video calls with your child before they decide whether they would like to take part.

10 How will my taking part in this study be kept confidential?

If you agree to take part in this study, you and your child will be assigned a participant number. Any data collected such as date of birth, ethnicity, any other personal details and the caregiver questionnaire will be stored under this number on a password-protected file on the GDPR compliant University of Hertfordshire One Drive.

In the final write up of this study and in any subsequently published papers, your child may be referred to as a pseudonym that does not in any way relate to their name. Quotes from your child may be used but any details that could identify them will not be included.

Any documents, such as the consent form, that may contain personal information will be password protected and stored on the GDPR compliant UH One Drive secure OneDrive.

Usual confidentiality limits apply. Should any information come to light during the study that raises concern regarding risk of harm to you, your child or another, this will be reported through appropriate channels.

11 Audio-visual material

It is necessary to video record the research sessions so that all verbal and non-verbal data can be analysed accurately as part of the research process. This will be done using a camcorder device or the camera of a laptop and stored on the GDPR compliant UH One Drive under the child's participant number. Should this cause you or your child any concerns, please do discuss this with me prior to signing this consent form.

Video footage is for analysis purposes only and as such will only be viewed by the research team. Stills of the video, and photos of any written or art material that your child produces, may be used for presentation purposes. These images will not compromise confidentiality and images that could identify your child will not be used.

12 What will happen to the data collected within this study?

Personal Data

Personal data such as names, addresses and email addresses will be deleted on completion of the study (September 2024).

Video Data

Once the transcriptions have be made (using pseudonyms or anonymity codes), the identifiable video recordings will be destroyed.

Anonymous task data

All anonymous data which includes transcripts, anonymized stills and pictures, and caregiver questionnaires will be retained by the investigative team during the duration of the study. On completion of the study, the lead investigator (Jess Christopher) and other non-UH research team members will delete their personal copies of the anonymous task data by September 2024 (end of the assessment period). The rest of the research team (Dr Caroline Cresswell) will keep the anonymous data indefinitely, on the GDPR-compliant UH OneDrive for potential future use and in accordance with most journal's open access policies.

13 **Will the data be required for use in further studies?**

- The data collected may be re-used or subjected to further analysis as part of a future ethically-approved study; the data to be re-used will be anonymised.
- The results of the study and/or the data collected (in anonymised form) may be deposited in an open access repository.

14 **Who has reviewed this study?**

This study has been reviewed by:

- The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is **LMS/PGT/UH/05305**

15 Factors that might put others at risk

Please note that if, during the study, any medical conditions or non-medical circumstances such as unlawful activity becomes apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

16 Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with me by email: *Jess Christopher, j.christopher@herts.ac.uk*.

Alternatively, you can contact the principle supervisor, Dr Caroline Cresswell c.cresswell@herts.ac.uk

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 at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix J: Interview Schedule

MRP Interview Schedule

Exploring children's views of DDP

[The child will be asked how they want to refer to the caregiver, therapist and the therapy, for instance 'meeting with Amy' and their language will be used]

Hello. My name is Jess and I am a researcher. I work for a university. I am really interested in hearing about what children have to say about their experiences of meeting with people like [name of therapist]. I think it is important that adults understand what things are like for children. In that way, I see you as a bit of an expert. I will be speaking to some other young experts too so that us adults can learn a little more about what therapy is like for you.

It can be a little strange talking to someone new. It is not like school – there are no right and wrong answers. You don't just have to say just good things either. I am also really interested to hear about things that have been more difficult too.

I will be recording the session just so that I can make sure I don't miss or forget anything you say. The recording will be stored securely, and I will not be sharing it with anyone. When I write up my research, your name will not be included, nor anything else that could mean someone could work out who you are. What you talk to me about will therefore be confidential and protected. The only time I may need to share with other adults is if you told me something that made me really worry about your safety or the safety of someone else. Like all adults I have a responsibility to keep you safe. If this happens, we can talk it through, and I will let you know exactly what I will do with that information.

I hope that this session will be fun and relaxed for you.

Your caregiver can stay in the room if you wish, or if your prefer they can wait just outside and we can call in them anytime.

Sometimes it can be helpful to know what is going to happen.

First of all, we are going to tell some stories together. We can use the little figures to help us with these stories. I will do the first bit of the stories and then you can tell me what happens next.

After the stories we can think together a little more about what your experiences of therapy are like. We can do this by drawing or writing onto a picture. If you prefer you can tell me what you want me to write on the picture.

I hope that it will be fun but if anything feels too strange or uncomfortable, we can stop. We can change what we are doing, skip to the next bit, take a break or we can stop altogether. Any of those things are fine. It is important that you feel you have control over how this session goes as you are the VIP (Very Important Person).

I have been talking for a bit and I wanted to check in with you.
Are you ok with what we are going to do? Do you have any questions?
Remember that you can stop at this point or at any point.

If you are ready shall we begin?

Part 1 -Story Stems

Story Stem Introduction

The figures and props are introduced to the child.

Ok. So, we are going to do 3 stories. I will start the story off and after that it is your story and you show me and tell me what happens next.

For these stories with have a little boy/girl, what shall we call them?

And in these stories there is a Mum/Dad and a therapist *[the child may not be familiar with this language so the same language they use can be substituted]*

What shall we call the therapist? (guide the child to use a different name to their own therapist)

Story 1 – The first Therapy Session

So here is (child) and he/she arrives at the centre/therapy service/meeting place with their Mum/Dad. This is the first time that (child) has ever been there. It is all new. Together Mum/Dad and (child) walk into the room where (therapist) is waiting for them.

Can you show me and tell me what happens next?

Prompts:
What do they do? Do they sit down or move around?
What it is like for the child to be in the room together with the adults?
I wonder who decides what happens?
Are they talking about lots of things of just a few? I wonder what it is like for the child to talk about that?
How do the adults help?
What it is like for the child? Is it fun? Boring? Uncomfortable? Upsetting? Do you think the adults know what it is like for the child? What do they do?

When it seems the child has concluded the story the researcher checks by asking?

Did anything else happen? Did you want to show me or tell me anything else about this story?

Story 2 – Crying outside

The therapy room remains set up as it was in the last stem.

The researcher shows the child walking out of the room so that they cannot be seen by the adults.
Listen! What is that noise? [Researcher makes crying sounds]. **What is that noise? What is happening? Can you show me and tell me what happens next?**

Prompts:
If the adults don't respond in the story, ask 'do mum and (therapist) know (child) is upset?'
What it was like for the child when the adult did ....
If the adults care for the child what is that like?
What happened next?
Do you think the child wanted something different to happen instead? If yes, what did they want to happen? Could you show me and tell me?
When it seems the child has concluded the story the researcher checks by asking?

Did anything else happen? Did you want to show me or tell me anything else about this story?

Story 3 – Avoidance

The researcher now shows the child playing with a ball. **The adults are talking about feelings right now but look! (child) is very busy playing with this ball. They are trying not to listen. Can you show me and tell me what happens next?**

Prompts:
Do the adults know the child is struggling right now?
What do the adults do or say?
What does (child) needs the adults to do right now?
If the child felt able to speak, what they might say? What would they tell the grown ups?

Story 4 – Another session

For this stem the researcher sets the room back up and moved the child and caregiver out of the room.

(Child) has come to the centre/therapy room/meeting place 6 times now to see (therapist). Here they are arriving for the next session. They walk through the door and there is (therapist) again waiting for them. They are all really used to meeting now. Can you show me and tell me what happens next?

Prompts:
Is this session is different from the first session. What has changed?
What did the adults do to help this change happen?
Who decides what happens in the sessions now?
What it is like for the child? Is it fun? Boring? Uncomfortable? Upsetting? Do you think the adults know what it is like for the child? What do they do?
Does the child feel differently about their family now? If yes, how? How does the child feel about these changes.

When it seems the child has concluded the story, the researcher checks by asking?

Did anything else happen? Did you want to show me or tell me anything else about this story?

Part 2 – House picture

Wow! You did so well with the stories!

How are you doing? Would you like a break first or would you like to carry on?

If you are ready we can do the final bit.

In this part, I would like to know a bit more about what your sessions are like for you. Here is a piece of paper with a picture of a house. We are going to pretend this is the room/building you have therapy in. In the house we are going to fill in the different sections together.

In this section, feelings flash cards can be used. These will be offered if the child is struggling to name their feelings, but some space will be given for the child to name the feeling in their own words first if they can. If the child is anxious about answering the questions, they can be given the choice to put stickers in the room or just colour it in a colour. The researcher can be gently curious about their choices. The researcher can also offer to scribe for the child if they prefer.

Section 1

In this room we can draw or write about the things that you like most about your therapy sessions with Mum/Dad and (therapists name). Here you could say something about what you look forward most about going to the sessions. What things happen in the session that you enjoy or that make you feel good.

Follow on questions:
Can you tell me a bit more about what that is like?
What do the adults do and say?
Could you choose a feeling to go alongside what you are telling me? (Feelings flash cards can be used to help if the child doesn't want to say).

Section 2

I know that sessions with (therapist) and Mum/Dad might not always be easy. What is the hardest or most difficult part of coming to the sessions. We can write or draw about that in this room. *[If the child is struggling…]* **It can be hard to talk about the hard bits. Maybe you could just draw something, or colour the room in the colour of your choice. You could also just choose a feelings card or an emoji to put in that room if you like.**

Follow on questions:
Can you tell me a bit more about what that is like?
What do the adults do and say?
Could you choose a feeling to go alongside what you are telling me? (Feelings flash cards can be used to help if the child doesn't want to say).

Section 3

If you had a magic wand, what would you want to be different about your sessions with Mum/Dad and (therapist). What would the sessions look like and what would be different about them? We can write or draw about that in this room here.

Follow on questions:
Can you tell me a bit more about the thing you want to change?
What difference it would make if that thing changed?
What would the adults do and say if that changed do you think?
What would the sessions look like after you waved your magic wand?
Can you choose a feeling to go alongside it? (use feelings flash cards if the child doesn't want to say).

Section 4

If a friend of yours was going to come to have sessions at (therapy centre) like you, what would you tell them about the sessions? What do you think they would like to know about before starting? How might you describe to them what it is like? We can draw and write about that in this room here.

Follow on questions:
Could you tell me a bit more about what you mean when you say….

What things do you think they might feel if they were to come to (therapy centre)? (Feelings flash cards can be used to help if the child doesn't want to say).

Wow! Look at all the really helpful things that you have told me about your therapy sessions. Is there anything else that you wanted to let me know about your sessions with Mum/Dad and (therapist)?

It isn't always easy to talk about experiences and feelings. You did so well.

Well, we are at the end now. How are you doing?
I was wondering what bit of the session you enjoyed the most? I wonder what bits of the session where harder or less enjoyable?

Is there anything that you feel you need right now from me, or from your caregiver?

Thank you so much for taking part in our session today and sharing so much.

This might have been a different experience to things you have done before and you might feel a little strange about it afterwards. You can talk to your caregiver if you want to, and you can also talk to your therapist about it next time you have a session. You may also want to talk to me about it. I am going to call your caregiver in a few days just to check in. If you want to talk to me, we can do that on the phone, or I can arrange a video call if you prefer.

I would like to call you again in a few weeks when I am writing my report so that I can check I am getting things right. It is up to you if you would like to do this bit.

When everything is done and I have spoken to other children too, I will share with you a child-friendly version of my report. I will also send a recorded video where I talk it through. This will take me quite a while so you might I might not be able to send these too you for a few months.

I think it is important that children's views and voices are heard. When the report is finished, it will be shared with some other adults who work with children so that they can learn what it is like for children and make sessions feel ok for kids.

I have really enjoyed meeting you. Take lots of care.

Bye for now!

Appendix K: Pre-Research Discussion with the Caregiver

It will be explained to the caregiver that the purpose of the conversation will be to learn a little bit about the child, their typical behaviour, how best to interact with them and any triggers that would indicate distress. We would also like to find out about the child's developmental capacity. We will think together about the terms and the language that the child uses to refer to their therapy and therapist so that we can use these same terms.

Questions/Prompts

1. Since I have not met your child, could you tell me a little bit about them (E.g. personality, or kinds of things they like/dislike).
2. Have you got any tips for us if we are meeting [child] for the first time? (Could be a good topic to talk about, an interest e.g. sport, subjects at school, favourite games/toys).
3. You will have seen in the research activity protocol that we have shared with you that we are asking [child] to engage with some activities with us, to play some games with figures, tell stories and answer some questions, how do you imagine they will find it?

   Prompt for:
   - *What will help [child] to engage with the activities*
   - *What the researcher should avoid doing (that might make them unco-operative)*
   - *Are there any parts of this protocol or any questions that you anticipate could make [child] uncomfortable or upset?*
4. Are there any "triggers" that you are aware of i.e. things that might cause them to become distressed?

   Prompt for:
   - *Signs that researchers should look out for that might indicate [child] is becoming distressed.*
   - *The best way(s) to deal with distress (from the carers/social workers experience)*
5. What words does your child use or do you use as a family when referring to their therapy sessions?
   - *What do they call the therapist*
   - *What do they call the therapy centre.*

6. Anything else that you think would be helpful for us to know?
7. Remind them about the camera – how might the child feel about that?

Appendix L: Participant De-brief Sheet

PARTICIPANT DEBRIEF SHEET

Exploring the experience of children and young people who have participated in Dyadic Developmental Psychotherapy (DDP) interventions with their families.

Principle Investigator

Jessica Christopher
Trainee Clinical Psychologist at the University of Hertfordshire

Thank you for taking part in this study. Although we hope that taking part in this study has been a positive experience for you and your child, we understand that sometimes experiences can be more upsetting than we expect them to be.

The principle investigator will be calling you up in the next week at a time convenient for you to see how you are doing and if you or your child has any feedback from the experience of taking part in the study. The principle investigator is a trainee clinical psychologist with several years of clinical experience of working with children previously. In the debrief phone call she will be gently enquiring to explore any adverse reactions or support needs that have arisen as a result of the research.

You DDP therapist is aware of your involvement in the research process and is open to providing support within your current therapeutic package. Should you feel you need additional support, you could contact your GP for advice. Or, in a crisis you can call 111 option 2 for mental health crisis support or attend your local Emergency Department.

If you would like to discuss any aspects of the research, please get in touch with me by email: *Jess Christopher, j.christopher@herts.ac.uk*. I am happy to arrange a phone call or video call.

Alternatively, you can contact the principle supervisor, Dr Caroline Cresswell c.cresswell@herts.ac.uk

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 at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

Thank you very much for taking part in this study.

Appendix M: Protocol for Managing Distress during Research Activity

As part of children's experience of DDP they may have reflected on their experiences of relational trauma, loss or abuse. Although this research is not aimed at eliciting information regarding the child's historical experiences, it may be relevant for the child as they recall their therapy experiences. There is a potential that the child finds this upsetting or distressing. Any upset or distress of the child could also impact on the caregivers and wider family system.

Children will be carefully screened to protect children for whom this might be particularly sensitive or raw. This will be done through conversations with the caregivers and therapists on how best to approach and speak to the child and any potential triggers. See appendix 13 for the screening protocol. It is not always possible to predict when children might become distressed and so the risk cannot be eliminated altogether. This document outlines in detail the protocol in the event that a child becomes distressed during the research activity.

1) It will be clearly communicated to the child and caregiver both in the information stage and immediately prior to the research activity, that the child can withdraw or pause the interview at any stage in the process, without needing to provide justification or explanation.

2) The researcher will check in with the child at several points during the interview and be alert to potential signs of distress. This may include a change in behaviour, withdrawal, change in facial expression or increased or decreased movement. It may also include signs of dissociation such as the child staring into space. The researcher is skilled and experienced at picking up these signs. Should there be signs of distress of emotional dysregulation such as these, the child will be offered a break and reminded of their right to withdraw. The researcher will use clinical judgement to decide whether the interview should continue.

3) Caregivers are the experts on their children. The caregiver and the researcher will have a conversation prior to the interview where they discuss thoroughly the appropriateness of the research process and questions for the child (see appendix 13). The researcher will ask the caregivers for the typical signs and behaviours that might indicate that the child is becoming distressed. Caregivers will either be in the room with the child or be requested to wait just outside, if the child prefers. They know the child best and may pick up on signs of the distress or emotional dysregulation before the researcher does. Their view will be sought if the child appears distressed and they will also be reminded of their right to take a break or withdraw their child from the interview.

4) Should the child become distressed, the interview will be paused or stopped. The researcher will encourage the carer to do whatever they normally do to support their child when they are distressed. The interviewer will be guided by the caregiver as to how best to support the child are this stage. The child will be reassured that their participation was appreciated. The researcher will actively attempt to repair the relationship with the child if necessary. It may be more appropriate to do this at a later stage, again this will be guided by the caregiver and child.

5) By promoting the research, it will be made clear that therapists will be involved in post research support. It is expected that for most, the support needed will be absorbed into the support and intervention that is already being provided. Given that the children and caregivers will have an ongoing relationship with the therapist it makes sense for them to provide support and children can bring any thoughts concerns or distress into their next therapy session. It will be checked with the therapist that the next session will be within a fortnight of the research activity. Interviews will take place at a time when the therapist is available (i.e. not away on holiday). Should the child become distressed in the research activity, the researcher will contact the therapist and share with them a summary of the situation. The wording of which will be agreed in collaboration with the child and caregiver.

6) As part of the debriefing process, families will be signposted to support services. In the first instance this will be their therapist.

7) If the child has become distressed in the research activity, the researcher will offer a follow up phone call or video call within 24 hours of the research activity. This will be an opportunity to check that the child and family are managing any distress and signpost to further support. This may also be another opportunity for relational repair should this be necessary.

8) Should the child become distressed and disclose a safeguarding related concern, this will be passed on to the named safeguarding professional that will have been provided by their therapist prior to the interview.

This protocol will be shared with the therapists and the caregivers involved in the research so that all those involved are clear regarding the protocol should the child become distressed.

Appendix N: Consent Forms

FORM EC4: CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS
FOR USE WHERE THE PROPOSED PARTICIPANTS ARE MINORS, OR ARE OTHERWISE UNABLE TO GIVE INFORMED CONSENT ON THEIR OWN BEHALF

If you wish for your child to take part in this study, please complete this consent form to provide consent on their behalf.

Exploring the experience of children and young people who have participated in Dyadic Developmental Psychotherapy (DDP) interventions with their families.

Principle Investigator

Jessica Christopher, Trainee Clinical Psychologist at the University of Hertfordshire

I, the undersigned *[please give your name here, in BLOCK CAPITALS]*

………………………………………………………………………………………………

of *[please give contact details here, sufficient to enable the investigator to get in touch with you, such as a postal or email address]*

………………………………………………………………………………………………

hereby freely give approval for *[please give name of participant here, in BLOCK CAPITALS]*

....

to take part in the study entitled **Exploring the experience of children and young people who have participated in Dyadic Developmental Psychotherapy (DDP) interventions with their families.**

(UH Protocol number ……………………………….)

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of his/her involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent for him/her to participate in it.

2 I have been assured that he/she may withdraw from the study, and that I may withdraw my permission for him/her to continue to be involved in the study, at any time without disadvantage to him/her or to myself, or having to give a reason.

3 In giving my consent to participate in this study, I understand that voice, video or photo-recording will take place and I have been informed of how/whether this recording will be transmitted/displayed.

4 I have been given information about the risks of his/her suffering harm or adverse effects and I agree to complete any required health screening questionnaire in advance of the study. I have been told about the aftercare and support that will be offered to him/her in the event of this happening, and I have been assured that all such aftercare or support would be provided at no cost to him/her, or to myself.

5 I have been told how information relating to him/her (data obtained in the course of the study, and data provided by me, or by him/her, about him/herself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

7 I understand that if there is any revelation of unlawful activity or any indication of circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

8 I have been told that I may at some time in the future be contacted again in connection with this or another study.

9 I declare that I am an appropriate person to give consent on his/her behalf, and that I am aware of my responsibility for protecting his/her interests.

Signature of person giving consent

…………………………………………………………….Date…………………………

Relationship to participant

………

Signature of (principal) investigator

Date………………………..

Name of (principal) investigator

JESSICA CHRISTOPHER

FORM EC3

CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

This consent form pertains to you providing consent for the caregiver questionnaire that forms part of this study

Exploring the experience of children and young people who have participated in Dyadic Developmental Psychotherapy (DDP) interventions with their families.

Principle Investigator

Jessica Christopher, Trainee Clinical Psychologist at the University of Hertfordshire

I, the undersigned *[please give your name here, in BLOCK CAPITALS]*

……………………………………………………………………………………………………..…

of *[please give contact details here, sufficient to enable the investigator to get in touch with you, such as a postal or email address]*

…..……………………………………………………………………………………………………

hereby freely agree to take part in the study entitled **Exploring the experience of children and young people who have participated in Dyadic Developmental Psychotherapy (DDP) interventions with their families.**

(UH Protocol number …………………………………………)

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

2 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

3 It is not anticipated that there are any risks to you to completing the caregiver however, I have been told about the aftercare and support in the form of a debrief that will be offered to me and I have been assured that all such aftercare or support would be provided at no cost to myself.

4 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used, including the possibility of anonymised data being deposited in a repository with open access (freely available).

5 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

6 I have been told that I may at some time in the future be contacted again in connection with this or another study.

Signature of participant…………………………………..…Date…………………………

Signature of (principal) investigator   Date…………………………

Name of (principal) investigator

JESSICA CHRISTOPHER

Appendix O: Child Friendly Poster, Letter and Assent

HAVE YOUR SAY!

WE ARE INTERESTED IN HEARING ABOUT YOUR EXPERIENCES OF THERAPY

HELLO !

My name is Jess.

I am a researcher at the University of Hertfordshire

I think that we don't know enough about how children experience their therapy.

Could you help me to learn more about it?

WHAT WOULD TAKING PART BE LIKE?

Together we can play with toys and tell some stories

We can make a picture using pens or stickers

It won't take too long. Maybe just under an hour.

HOW I WILL HELP YOU FEEL COMFORTABLE

We could meet on a video call first.

I could come to your home or therapy room.

You can have a parent in the room with you.

You can chose to take a break or stop at any time.

WHAT NEXT?

Take some time to think about whether this is something you might like to do.

Have a chat with your family about it.

You can ask me any questions you have, or we could talk through any worries.

Monday 29th November 2022

Hi XXXX,

My name is Jess and I look like this: 

I am a researcher and I am really interested in hearing about what children have to say about their experiences of therapy. Your [caregiver] and [Therapist] wondered if you might be interested in sharing your experience of therapy.

Here is some more information about what it might be like if you wanted to share your experiences with me. It is important that you know that taking part would be your choice and it is not something you have to do if you do not want to. You don’t have to give any reason if you don’t want to and everyone will be just fine with that.

We can meet at [therapy centre] where you meet with [therapist], or we can meet at your home. You can chose where you feel most comfortable.

Meeting someone new can be difficult. Kids tell me it's easier if they know what might happen. So here are some ideas:

- We'll do some playing and story telling together!

- I might ask you what your sessions are like. What you find easy and what you find difficult.

- I have interesting fun ways to do all this, so it's not just talking

- You can have your Mum/Dad with you all the time if you like.

- It will take about an hour

- It is not like school. There aren't "right" or "wrong" answers. What you think is the most important.

- If you find something difficult, you can tell me and I'll find a way to make it easier.

- I will video record the session and this is just so that I don't miss anything. The recording will be stored on a secure computer and password protected. No one will be able to see it except from me. I will keep the video safe for a few months until I do not need it anymore and then I will delete it.

- Even if you say yes now, you can change your mind at any point. If that is in the middle of the session we can stop and I will delete any recording if this is what you want. You do not have to tell me a reason why.

- I will be talking to other children too and I will put everybody's views into a report at the end. This report will not contain any real names or any other information that could identify you.

- I will be making a fun and child-friendly version of my report which I can send to you.

- I think it is important that children's views and voices are heard. When the report it finished, it will be shared with some other adults who work with children so that they can learn what it is like for children.

- If you choose to take part I will send a video you can watch where I say hello and introduce myself so that you know who you are going to meet.

If you decide you would like to take part, you can let me know by signing your name on the form attached to this letter. You can take some time to have a think and maybe talk to your family about whether you would like to take part. You may have more questions and your caregivers know how to contact me to ask these.

Best wishes from,

Jess

Jess's research study about my experience of therapy

Please only fill this form in if you are really sure you would like to take part in the study.

My name is ……………………………………………………………………………………………
[put your full name in here]

I have read or had read to me all the information about Jess's study.

I have had time to think about it and have talked it through with my caregivers.

I would like to take part in Jess's study.

Signed ……………………………………………………………………………………………………

[This is were you can sign your name in a fancy way]

Date……………………………………………………………………………………………………….

Appendix P: Example 1 Excerpt of Transcripts with Exploratory Comments and Experiential Statements

Excerpt of Transcript for Carter with Exploratory Comments and Experiential Statements

Story 3		
Researcher: Ok so in this therapy session, she's playing the ball. She is pushing them all around room and the adults are talking about feelings right now. But look! The child is keeping herself very busy playing with this ball, and she's trying very hard not to listen to the adults talking about feelings. Can you show me and tell me what happens next?	Story stem introduction.	
Child: And then they say are you ok with that? And she did not know what they were talking about and say she wasn't really listening.	The adults check in with her when she isn't listening. They notice that she isn't listening.	The adults appear to be aware that she is trying not to listen. They are attuned to her.
Researcher: Ummhumm		
Child: And um they say it again and explain that it's quite alright.		
Researcher: So, they might. You're saying, they might sort of repeat it. And check that she's listening?	They do not get cross or annoyed, they just explain it again.	They do not get annoyed that she isn't listening they are accepting. They are patient with her.
Child: yeah,		
Researcher: and then she said, that I wasn't really listening so they talked about it again.	This is confirmed to be the case.	
[Child nods]		
Researcher: Yeah. And what if she doesn't want to talk about feelings.		

Child: She'd say I don't really feel comfortable sharing this. And then they would maybe do something different and make her comfortable.	The child is feeling safe enough to say to the adults that she is feeling uncomfortable.	The child feels safe enough to express how she feels and the adults are accepting and respectful of this, moving into doing something different to support her emotional regulation. This is what she needed from them.
Researcher: OK. And she'd be able to tell them that?	The adults respond to the child and adapt what they are doing to her needs.	
Child: Yeah		
Researcher: Ok. Does she need the adults to do anything else right now do you think?		
{Child shakes her head]		
Child: Play a game with her.	She didn't need the adults to be different in this moment.	
Researcher: Probably play a game with her. And how would that help her? How would playing a game help her.	But then she thinks that playing would help.	She hopes that the adults play with her as she recognises that this would help her to feel more comfortable with the difficult conversation. 2
Child: Maybe it would make her more comfortable sharing.		
Researcher: Umm Humm	The play would help to regulate her emotions to allow her to share how she is feeling.	
[Child nods]		
Researcher: That sounds a little bit like ummm what you were saying in the first one about how you might talk about the difficult things and then, and then play a game or talk about the week and then you go backwards and forwards a bit.		
[Child nods]		
Researcher: Yeah, okay.		


③
No Grovity
dors
mor toys
④
Helps me to be happy.
It's fun
Some nervous time
Get upset + bored
sometimes
Super-excited
Lots of fun.
①
Alis
②
Home

Example 2 Excerpt of Transcript for Lex with Exploratory Comments and Experiential Statements

Picture task Q1		
Researcher: so in each room we are going to talk about a different thing so in this we can think a bit more about what it is like for you in therapy, which I am guessing might be a little bit difficult to talk about. Are you happy to carry on? Do you want to do this bit?		
Child: yes. As long as we can carry on with the game.	I check consent. Checking in on engagement.	I check consent as I have picked up discomfort. Although they are consenting, they seem avoidant. The game helps with regulation/engagement?
Researcher: Yes, we can do both at the same time.		
Researcher: Are you sure?	They say they are still happy to carry on, even though they seem to be struggling to engage.	
Researcher: So in the first room, so you can choose which one is going to be the first room.		
Child: That one [points to a room]		
Researcher: Ok so what do you look forwards to most about your sessions with therapist?	They then engage and choose a room.	They join in. Maybe giving them permission to stop, helped them to feel they have agency and this increased engagement?
Caregiver: maybe this one [waves the stickers at child]		
Researcher: You can say something or you can make Caregiver write whatever you want to.	Caregiver is supporting	Caregiver is working hard to support them to engage.
Child: gaming		
Caregiver: which one of those [stickers] are you going to choose?	Child likes gaming in the sessions with his therapist as they do it online.	They look forward to gaming in his session. This connects them online to their therapist. They choose a smiley face sticker. This is a point of interaction and connection. The smiley face indicates this connection is a
[Child sticks a sticker on]		

Caregiver: Yay. A smiley face. What else do you look forward to when you have a session with X.	Caregiver supporting. This seems to aid engagement.	positive experience. Playing a computer game together may be a more tolerable way to connect than talking.
Child: Caregiver it is your turn [referring to the game]	They choose a smiley face. Caregiver celebrates them.	They can't tolerate the research task for long before needing to go back to playing.
Caregiver: Yeah but tell me what else you look forward to with X? Or not as the case may be.	Wanting to go back to the game. Reluctant to talk more?	
Child: I don't know		
Researcher: So what sorts of things happen in your sessions? Sometimes you do gaming but what else do you do in your sessions?	Struggling to answer the question.	I think this affectionate hair ruffle may indication from Caregiver that the talking bit is more difficult for them? Caregiver recognises that the talking part of therapy is difficult. She provides some connection. Attunement
Caregiver: talking? [ruffles L's hair]		
Researcher: talking? And what is the talking like? Is that something that you enjoy? The talking bit.	Affection from Caregiver. Caregiver says talking.	
[Child looks through the emoji stickers]	They are engaged in looking for a sticker.	
Caregiver: Yeah, let's see which emoji you pick.		
Researcher: Yep an emoji for the drawing.	Caregiver supporting engagement.	Even after 2 years of therapy talking together is hard. Maybe it feels exposing and uncomfortable.
Caregiver: Talking. Hmmm.		
[Child sticks a sticker on]	They put on a sad face. They don't like the talking.	
Caregiver: oh a slightly sad face.	They are about to say something to explain.	This seems difficult for them to articulate. Caregiver tries really hard to help interpret and help find the right words. They are able to let Caregiver know that sad is not quite right.
Child: It's not sad it's just ummm.	Maybe they can't find the words.	

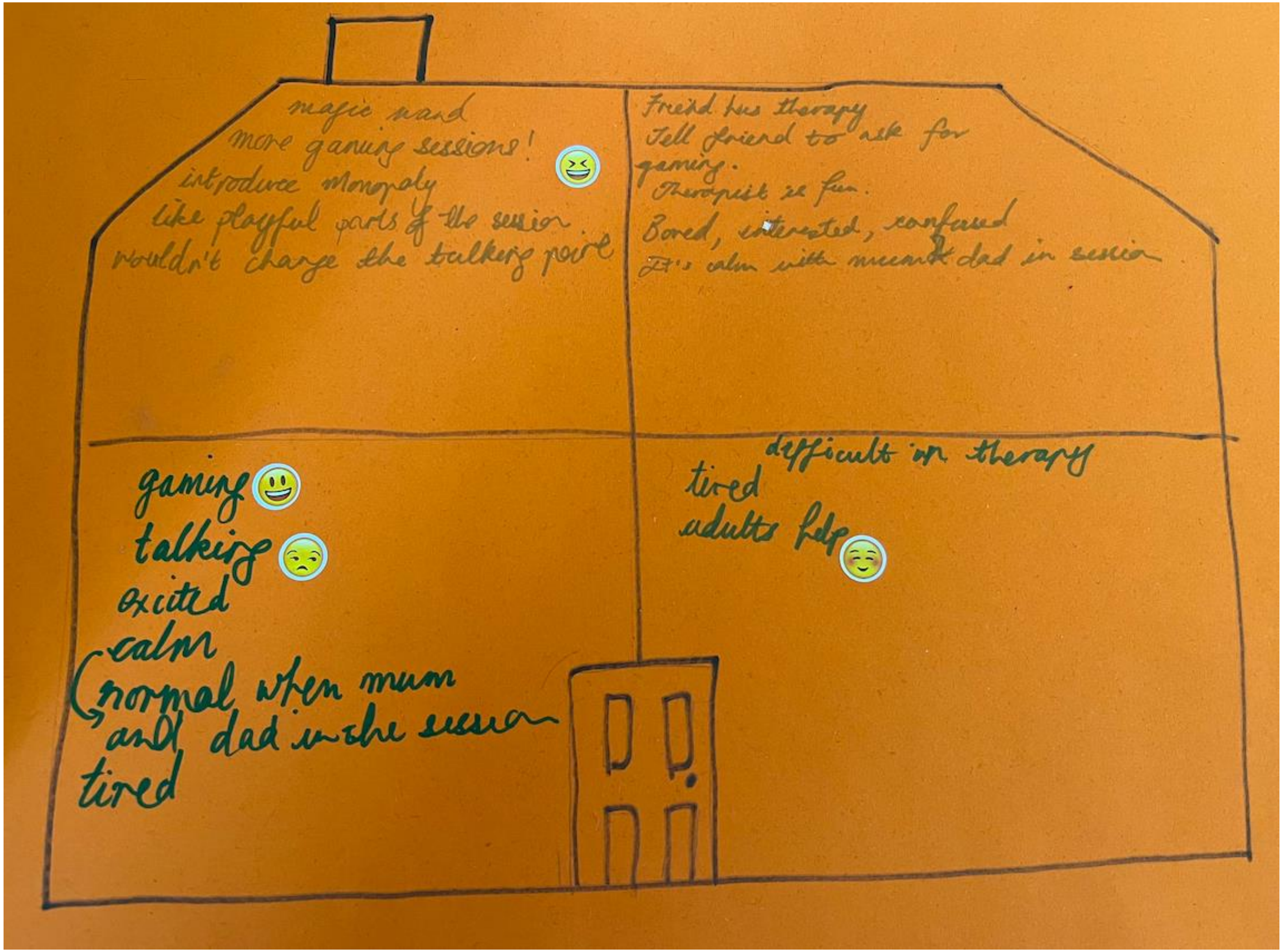
Caregiver: ummm it’s just?	Not able to find the words or doesn’t want to say.	I wonder if this difficult part of therapy is difficult to talk about. Or maybe it is difficult to find the words for the feeling.
Child: I don’t know		
Caregiver: it’s I don’t know face.		Talking in therapy brings up some difficult feelings. Maybe avoidant of bring that feeling up now.
Child: I don’t really know.	Can’t explain. Caregiver trying to re-engage him in the task.	
Researcher: So that bit is a bit less exciting than the gaming bit. Is that right?		This feels avoidant. We have only just met and safety has not been established. It makes sense that this might be difficult right now.
Child: Ok. It’s your turn. Wait Caregiver, are you going to buy Whitechapel?	Would rather play Monopoly.	I move back into playing the game to support their emotional regulation.
[We take another go around the board]		
Caregiver: So what else do you look forward to then?	We move back into playing the game.	I wonder if they are getting a bit fatigued at this point.
Researcher: What sorts of things happen in the session that you like? What are the good bits of the session other than gaming?		Is gaming with his therapist the only part of the therapy they enjoy? Caregiver is playful and affectionate in her tone.
Child: Caregiver, you go.		
Caregiver: Yeah I am going to. You have a think. Get your little brain working [said affectionately].	Avoids answering the question here.	
[Child engages with Caregiver’s turn in Monopoly]	Caregiver continues to support engagement	
Researcher: So I’ve got these cards as well. You can have a look at them, if you pass them to Caregiver. [J passes the cards]		L has a shared moment of playfulness with Caregiver. She seems important for emotional regulation.
Researcher: And you can just point at the ones you want.	I show more cards to support the communication.	

Child: I don’t think that is happy. [pointing to a card. They both laugh]		
Caregiver: Hmmm. Bored? [Shows a card]. That person does look bored. Sad. Are you excited when you have a session?	Both share in a playful moment initiated by L.	They get excited about having a session. This is confirmed by Caregiver. Could be a nervous excitement?
[Child nods. He picks the card and puts it on his picture]		
Researcher: You get excited about it?		
Caregiver: Very. Yes.	They pick an excited feelings card.	
Researcher: And what is it about the sessions that make you feel excited do you think?	Caregiver says they get very excited about his session.	They are excited about gaming with their therapist. This seems to be the most tolerable part and the only part of their therapy they feel comfortable to share with me.
Child: Sometimes it’s a gaming session.		
Researcher: Oh. And what’s it like when it’s not a gaming session?		
[Child hands Researcher the dice for her go]	They like the gaming part of the session.	Is this much harder to talk about?
Caregiver: So what if it is just a normal talky talky session?		I was not expecting this response as they seem so avoidant to talk about it and they also referred to ‘therapy talk’ in the stories. Talking is calm. Maybe they feels more neutral about this. What does calm mean? Is this a way of saying ‘everything is fine’ to avoid deeper reflection.
Child: Uhh, calm		
Caregiver: Calm.	Distracts from the question.	
Researcher: Calm?		
[L goes back to the game and Caregiver takes her turn]	They say they feel calm when it is a ‘talky talky’ session.	
Researcher: So when you have your sessions when you are not gaming do Caregiver or Caregiver come and sit in the session with you?		

Child: Yeah	They want to move back to the Monopoly game.	
Researcher: Yeah? What’s that like?		What does ‘normal’ mean? It is normal for caregivers to be in the session. What does ‘normal’ mean? They expect the caregivers to be in the room.
Child: normal		
Researcher: It feels ok?		It is normal but difficult to talk about? Are they just getting fed up with my questions?
[pause]	It is normal to have caregivers in the session.	
Researcher: Who does the talking in the session? Is it you? Is it X? Is it Caregiver or Caregiver?	Ignores question.	The adults are the ones doing the talking. This is led by the therapist. I wonder if these parts of the session are too adult led? Adult agenda?
Child: Uhmm. X (therapist) usually or Caregiver and Caregiver.		
Researcher: X or Caregiver and Caregiver. Yeah?		
Child: Yeah.	The adults are usually doing the talking.	Non-verbal sign that they don’t want to keep talking about this?
[Child is shuffling monopoly cards]		
Researcher: can you chose me a feeling or an emoji to tell me what it is like when X and caregivers are doing the talking?		They referred to therapy talk in the stories and there was an indication that they were not keen on this part of therapy.
[Child puts the monopoly cards down]	Trying to keep us playing.	
Researcher: Is that the therapy talk that you were talking about?		
[Child nods]		
Researcher: Is that what they do? Therapy talk?	This is the therapy talk.	

[Child shuffles through the feelings cards] Caregiver: Yeah? We do try and include you in it. [Child hands the cards back to Caregiver]		They struggle to articulate what it is like when they do the therapy talk. The adults include them. Are they talking for and about? Is this about avoiding a negative feeling? Not wanting to say something negative – might feel disloyal to therapist/caregivers.
Child: I can't	They try and draw him into the conversation.	
Researcher: you can't. ok.	They can't choose a feeling. Maybe they don't want to if it is negative.	
Researcher: and how do Caregiver and Caregiver include you in it? How do Caregiver, Caregiver and X include you?		The adults are curious but they don't doesn't like this. 129
Researcher: What do they do to….		
Child: they ask me questions.		
Researcher: Oooh. You don't sound too happy about that? They ask you questions. Do they ask you hard questions like I am?	They adults try to include them by asking questions. Their tone of voice tells me they are not keen on this.	They say they feel calm when the adults talk but then changes to tired. Does tired mean it is challenging to think about. Fed up? Avoidant?
[Caregiver is shuffling through the feelings cards]		
Child: Calm		Caregiver seems to be more attuned to the underlying feeling of discomfort and is supporting communication here.
Researcher: you are still calm?	They choose a calm card which doesn't seem to fit with their reluctance to talk.	
Caregiver: Are you sure you don't get like this [shows him a card and they laugh].		Caregiver is curious. Yawning seems to be a communication to stop talking? I wonder if this happens in therapy. They are always tired. Yawns – stress response. If they sleep they can't talk.
Child: I'm normal calm and tired.	Caregiver also doesn't think it fits.	
[Caregiver shows him the upset card. He shakes his head]	They add that he is calm and tired.	

Child: I’m always tired [yawns]	Caregiver wonders if they are upset but they say not. They are just tired.	I wonder if this is their way of saying that it is difficult without being negative. They can’t say if therapy is tiring for him. They may be reluctant to say something that is negative. 131
Researcher: Do therapy sessions make you tired? Do you think? Are they quite tiring?		
[Child reaches for the Monopoly cards]		
Caregiver: It’s hard work talking about yourself isn’t it?	Wondering if therapy is tiring.	
Researcher: Like now. You’ve been working hard today.		
Child: Oh no you are still stuck in Jail [referring to Monopoly].		
Researcher: Ok let’s give it another go [we resume the Monopoly game]	Avoids the question and focusses on the game.	
	I decide to move on. Playfulness and connection with Caregiver in the game.	


magic wand
more gaming sessions!
introduce Monopoly
like playful parts of the session
wouldn't change the talking part
Friend has therapy
Tell friend to ask for gaming.
Therapist is fun.
Bored, interested, confused
It's calm with mum and dad in session
gaming
talking
excited
calm
normal when mum and dad in the session
tired
difficult in therapy
tired
adults help

Appendix Q: Excerpt of Example of Personal Experiential Theme development

Attunement leading to Trust

There were lots of examples of the adults being attuned to the child in Georgie's stories. There was a sense that this was an expectation of the therapist in particular. They explained how the adults were attuned to small changes in facial expression and could accurately interpret the child's mood and responded accordingly. This attunement led to trust in the therapist and Caregiver several times in their stories they seemed to be aware that the adults were trying to help and their intentions were good.

G: Umm. Maybe D [therapist] knew that it was hard for V to talk about tricky things.
J: How do you think she knew that?
G: Because she is trained to be with children.
J: So V [child] didn't tell her. Did she just know is that what you are saying?
G: yeah
J: Yeah, ok. That's very clever. Does she know other things do you think about V?
G: Yep.
J: Without V saying?
G: Yep.
J: So what sorts of things do you think?
G: Like when they are worried or upset. Or when they are happy and excited.
J: yeah so she can tell about their mood, V's mood.
G: Yep.
J: How do you think she does that? Do you know? Any ideas?
G: By looking at their facial expressions.

In story 3 'the ball', the adults are talking about feelings and the child is playing with the ball trying not to listen. The child in Georgie's story experienced this as misattunement from the adults. They were trying to persuade the child to talk. The child had a sense that they had good intentions but was uncomfortable and was not consenting to the conversation. Georgie noted the impact of this on the relationship with the therapist.

G: And then E [caregiver] and D [therapist] were chatting about feelings and were wanting V [child] to come and join them, so [child] moved back the chairs and came to the table put the ball back, got another, got, another hot chocolate. It was now the second time [child] had been here and they'd got very used to it. D and her were already friends, but then they had been from the start, but now they seemed like enemies now, as they were talking about something that V didn't want to talk about. They were trying to get V's attention, but it wasn't really working.

But then Caregiver said 'V come over and chat with us, we'll know more once you chat to us. We are just trying to help anyway' she said.
V put down her hot chocolate and said 'I know that you are trying to help me [Caregiver] but I still don't want to talk about it.'
'We know you find it hard but you should try', [Caregiver] said, again.

V just sighed and put the ball in her hot chocolate. The hot chocolate was too chocolaty. They weren't really treating them to a big thing. [Caregiver] made a better hot chocolate anyway and this one had no creams or marshmallows on or even some syrup.
But then D spoke 'we know you are finding it dreadful hard. We don't have to talk that long, just a couple of minutes. We'd like to know how it is? And about your feelings? We know you want to avoid it but please try.'
V had to listen to D. Well, she didn't have to but she really wanted to. She didn't want to make D annoyed definitely when D was the kindest person ever. The end.

This suggests that the relationships are important for engagement in the more tricky conversations. It also speaks to the importance of moving at the child's pace and getting consent from the child to have the conversations. Without this there is an impact on the therapy. Suddenly something which seemed so important and nurturing like the hot chocolate no longer felt special. The trust in the relationships is fragile and Georgie may be sensitive to misattunement and rejection, which may lead to compliance.

Value of a Relational Approach

Having Caregiver in the room

And what do you think it's like for V [child] being in there with [caregiver] and with D [therapist] as well.
G: umm, I don't know.
J: Do you think sV would prefer to be in there with [caregiver] or without [caregiver]?
G: With [Caregiver].
J: Yeah? Why's that?
G: Because V knows [Caregiver].
J: How is that helping V. In what way does that help V? Do you think?
G: Because V is with somebody that they actually know.
J: How does that help with their feelings. What difference does it make do you think? Having someone V knows there.
G: It will probably make them feel a little bit better.

It was clear that Caregiver's presence was a supportive and important both within the stories and evident within the research session. In the research Caregiver was attuned and provided a significant amount of scaffolding to support Georgie to engage and emotionally regulate. In the stories there was a sense of the Caregiver as a co-therapist. They were present throughout and involved particularly with the games. The caregiver in the stories seemed to be less prominent during conversations between the child and therapist and this may be because at this times they are listening and witnessing these conversations.

Therapist relationship

Georgie was very clear about the significance of the relationship with the therapist in their life. The therapist wasn't just someone that they talk to about her problems, but she is someone who genuinely cares and is interested in their life. The therapist appeared to model an unconditional relationship with the child. Georgie portrayed the therapist as fun, playful, curious, empathetic, warm and compassionate.

G: When D opened the door. They came skipping out full of joy even after sitting in a meeting for over 20, no over 2 hours with no drink or food, well maybe just a tiny gingernut biscuit, but gingernut biscuits are small, well a little bit.
V came running to D.
[G shows the child and therapist holding hands]. They were practically best friends and they loved seeing each other. For V it was like the best time ever in the week. They started talking about how the day had gone.

Lightness and play

Georgie's portrayal of therapy was not problem saturated. There was lots of fun, play and light moments. These moments were important for relationship building and emotional regulation. There was a rhythm to the session of moving between play and talking. Georgie described how at the beginning of the therapy journey there was more games and play for the child in the stories. She described how the talking was introduced gradually in small increments, 5 minutes at a time at a pace that the child could tolerate. Georgie brought games into every story and it was clear that there were games they played every session which provided a familiar ritual and supported emotional regulation. Some of the games were competitive, such as Uno and some were collaborative, such as Marble run. She said that all of them decided together which games they played. In the stories, Georgie demonstrated how play supported conversation.

"I'll dish out the Uno cards" V said putting her hot chocolate down and going to find the Uno cards that she knew was behind the sofa.
[G then moves the child onto the floor where she is dishing cards out.]
"Found them" V said.
V began to deal them out doing 3 piles of 7's.
"That means that- do you know how many cards they are going to have altogether? Three times 7."
" I learnt this in class today cos we were doing our 7 times table. It's 21!"
[Therapist] "Yes it's correct! Do you like maths classes more?"
[Child]"Yes, I find it a little bit fun. Today we had to…wait… find all the 7's and colour them in and that was fun as well. I used my very special colouring pencils and was extra careful with them as well. Then I glued it in perfectly that.....Miss.....Petal… gave me 2 big golden stars. That means I might get a certificate in our whole school assembly.
[therapist] "That's wonderful, that's wonderful. What else have you been learning about. What about history? You love that remember?"
[Child] "Yes. I'm very enjoying it. I'm enjoying it so much. We're learning about the Egyptians. Most of all I like learning about the cats because there is not really any ponies in it. And you know cats are my second favourite animals in the whole entire world and then sea turtles and then dolphins and then probably flying fish. They are just awesome. They are just amazing don't you think?"
[Therapist]"Yes, they are very good. Yes definitely"
[G moves the child back to the sofa next to the therapist]
"All done. There's yours [Caregiver] and there's yours D and there's mine."

The attitude of the adults in therapy:

As well as being playful, Georgie appeared to experience the adults as engaging, curious, empathetic and accepting. There was an expectation that they would comfort them when they are upset or uncomfortable and that they are curious about what might be causing the discomfort. In story 3 'crying outside', Georgie initially denied that the child was crying, possibly they were not comfortable with this level of vulnerability. When they were supported to imagine the child was upset, the adults were attuned but also leant into the feelings rather than moving into reassurance or problem solving.

J: What if we imagine it was V and V was upset. What would the adults do?
G: Help them. Play more games.
J: How would they help them?
G: They would comfort V.
J: Uhmm humm. How would they comfort her?
G: I don't know.
J: What do you think?

G: Sort some hot chocolate and marshmallows.
J: That does sound comforting.
G: And they play more games.
J: They play more games.
G: They play Mario Kart 8 on the Switch.
J: Right
G: I love this.
J: And then how is V feeling?
G: good because V won most of the rounds.
J: So, the adults knew V was upset and they came out to them and they got them a hot chocolate to comfort them. Yeah?
G: Yeah
J: And what was that like for V. Was that what V wanted them to do? Or did V want them to do something different?
G: V didn't want them to do anything different. And then after they played, they talked about why V was upset and then they'd already guessed.
J: oh they'd already guessed had they?
G: Yes of course they had.

Nurture through food and drink

Several times in the stories, Georgie referred to the therapist nurturing the child through food and drink. This seemed to be a normal part of the therapy session. It seemed to help the child settle into the session and provided comfort.

J: I wonder what V is expecting about the session. Does V know what to expect?
G: Umm, to play games, talk, probably have a hot chocolate and snacks, of course. And Apple Juice but not cloudy.

Then the door opened and one of the helpers had brought V [child] a hot chocolate. Once they'd went said,
[Child] "how did V know I even wanted a hot chocolate? I didn't tell her."
"Maybe they heard you from something, from somewhere, when V was telling me you were coming" D [therapist] said.
V nodded and believed that D was probably correct.

The systemic impact of Therapy

There was a sense in Georgie's stories that therapy was an important part of their life at that current time. Georgie had had therapy for 2 years and was part of their routine. Georgie was able to describe how for the child in their stories, the therapy had an impact on them and their relationship with their caregiver. Georgie described themself as happier and there being less arguments and more cuddles in the relationship.

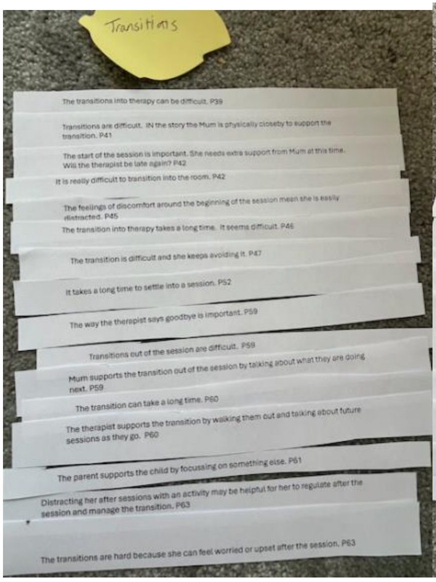
J: Ok. Do you think there is anything about going to the sessions that has changed anything at home?
G: Umm… V's more happy.
J: Right in what way? What do you think has changed?
G: Umm well V used to be more worried and upset after they met D [therapist] and now V has Patrick [the horse] and they are always really happy, most of the time.
J: Well that is a big change then isn't it?

Caregiver: Has it changed anything between V and E? At home
G: They are more happy together.
J: Can you tell me anymore about that? In what way? What can you tell me about what had changed?
G: Well before they used to have silly arguments about who uses what toilet and who brushes what horse and how long they sit on the toilet. And which and when they go to bed and when they turn off the tv.

Triangulation

The caregiveral triangulation questionnaire said that Georgie would explain their therapy experience as a place to talk about feelings and getting help about being angry. Caregiver mentioned the strong relationship with the therapist which has taken time to build. Caregiver said that Georgie could be themselves in therapy and generally experiences therapy positively. Georgie is often sad to leave a session. The caregiver said that is has taken a long time for Georgie to learn to trust the process and to engage meaningfully in therapy. The benefits have increased.

This information largely triangulates with the PETS. The relationship with the therapist came through strongly in the stems and it was clear that Georgie could bring in her interests and be herself. Georgie did not portray the child as angry at any point in the stems but this may be due to the shame she may feel around this behaviour. She did however mention that there were less arguments at home. The sadness about leaving the sessions was relevant to the stories and strengthens the transitions PET.



The transitions into therapy can be difficult. P39

Transitions are difficult. IN the story the Mum is physically closeby to support the transition. P41

The start of the session is important. She needs extra support from Mum at this time. Will the therapist be late again? P42

It is really difficult to transition into the room. P42

The feelings of discomfort around the beginning of the session mean she is easily distracted. P45

The transition into therapy takes a long time. It seems difficult. P46

The transition is difficult and she keeps avoiding it. P47

It takes a long time to settle into a session. P52

The way the therapist says goodbye is important. P59

Transitions out of the session are difficult. P59

Mum supports the transition out of the session by talking about what they are doing next. P59

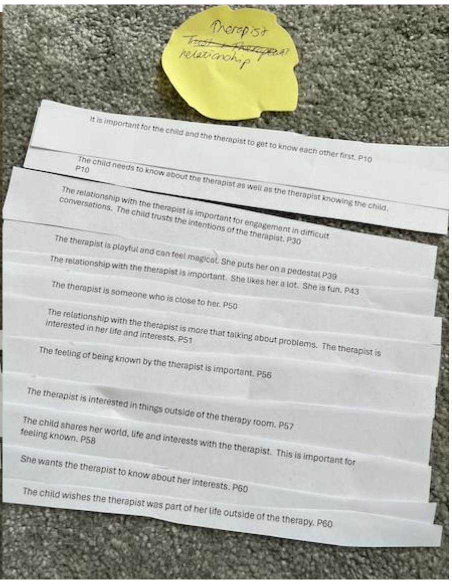
The transition can take a long time. P60

The therapist supports the transition by walking them out and talking about future sessions as they go. P60

The parent supports the child by focussing on something else. P61

Distracting her after sessions with an activity may be helpful for her to regulate after the session and manage the transition. P63

The transitions are hard because she can feel worried or upset after the session. P63



It is important for the child and the therapist to get to know each other first. P10

The child needs to know about the therapist as well as the therapist knowing the child. P10

The relationship with the therapist is important for engagement in difficult conversations. The child trusts the intentions of the therapist. P30

The therapist is playful and can feel magical. She puts her on a pedestal P39

The relationship with the therapist is important. She likes her a lot. She is fun. P43

The therapist is someone who is close to her. P50

The relationship with the therapist is more that talking about problems. The therapist is interested in her life and interests. P51

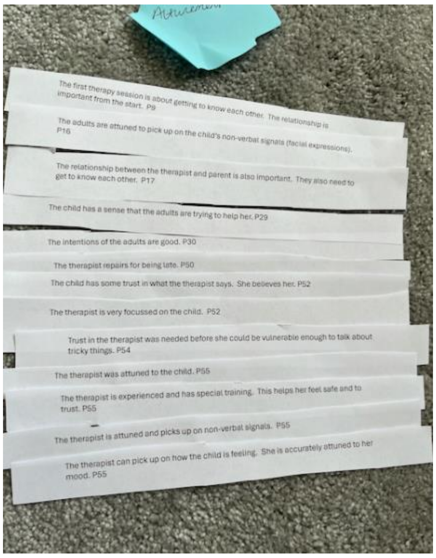
The feeling of being known by the therapist is important. P56

The therapist is interested in things outside of the therapy room. P57

The child shares her world, life and interests with the therapist. This is important for feeling known. P58

She wants the therapist to know about her interests. P60

The child wishes the therapist was part of her life outside of the therapy. P60



The first therapy session is about getting to know each other. The relationship is important from the start. P9

The adults are attuned to pick up on the child's non-verbal signals (facial expressions). P16

The relationship between the therapist and parent is also important. They also need to get to know each other. P17

The child has a sense that the adults are trying to help her. P29

The intentions of the adults are good. P30

The therapist repairs for being late. P50

The child has some trust in what the therapist says. She believes her. P52

The therapist is very focussed on the child. P52

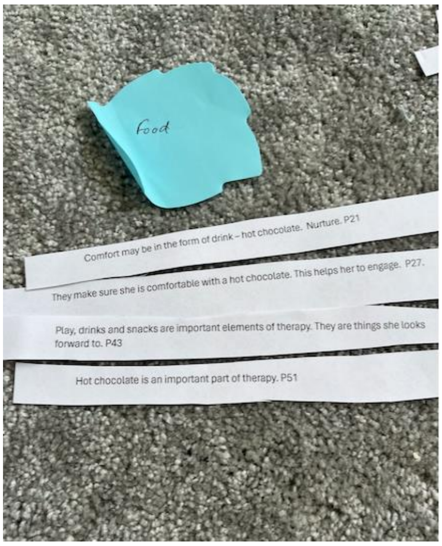
Trust in the therapist was needed before she could be vulnerable enough to talk about tricky things. P54

The therapist was attuned to the child. P55

The therapist is experienced and has special training. This helps her feel safe and to trust. P55

The therapist is attuned and picks up on non-verbal signals. P55

The therapist can pick up on how the child is feeling. She is accurately attuned to her mood. P55



Comfort may be in the form of drink – hot chocolate. Nurture. P21

They make sure she is comfortable with a hot chocolate. This helps her to engage. P27.

Play, drinks and snacks are important elements of therapy. They are things she looks forward to. P43

Hot chocolate is an important part of therapy. P51

Appendix R: Group Experiential Theme development

Summary of Personal Experiential Themes

Carter

- Safety in the room and in the relationship
- Nurture through food
- Building trust in the individualised attunement
- Mistrust, anxiety and avoidance
- Rupture, repair, resolution
- Therapy as a journey – the good out ways the bad

Lex

- The need for an invisibility blanket
- Confusion and ambivalence about the therapeutic approach
- Therapy as a journey
- Playfulness and non-verbal interactions
- Importance of caregivers involvement
- Developing trust in the therapeutic relationship

Asher

- Value of relational approach. Building trust with therapy and increased closeness with caregivers.
- Rhythms and Rituals
- New ways of being: increased openness and closeness with parents

Kirby

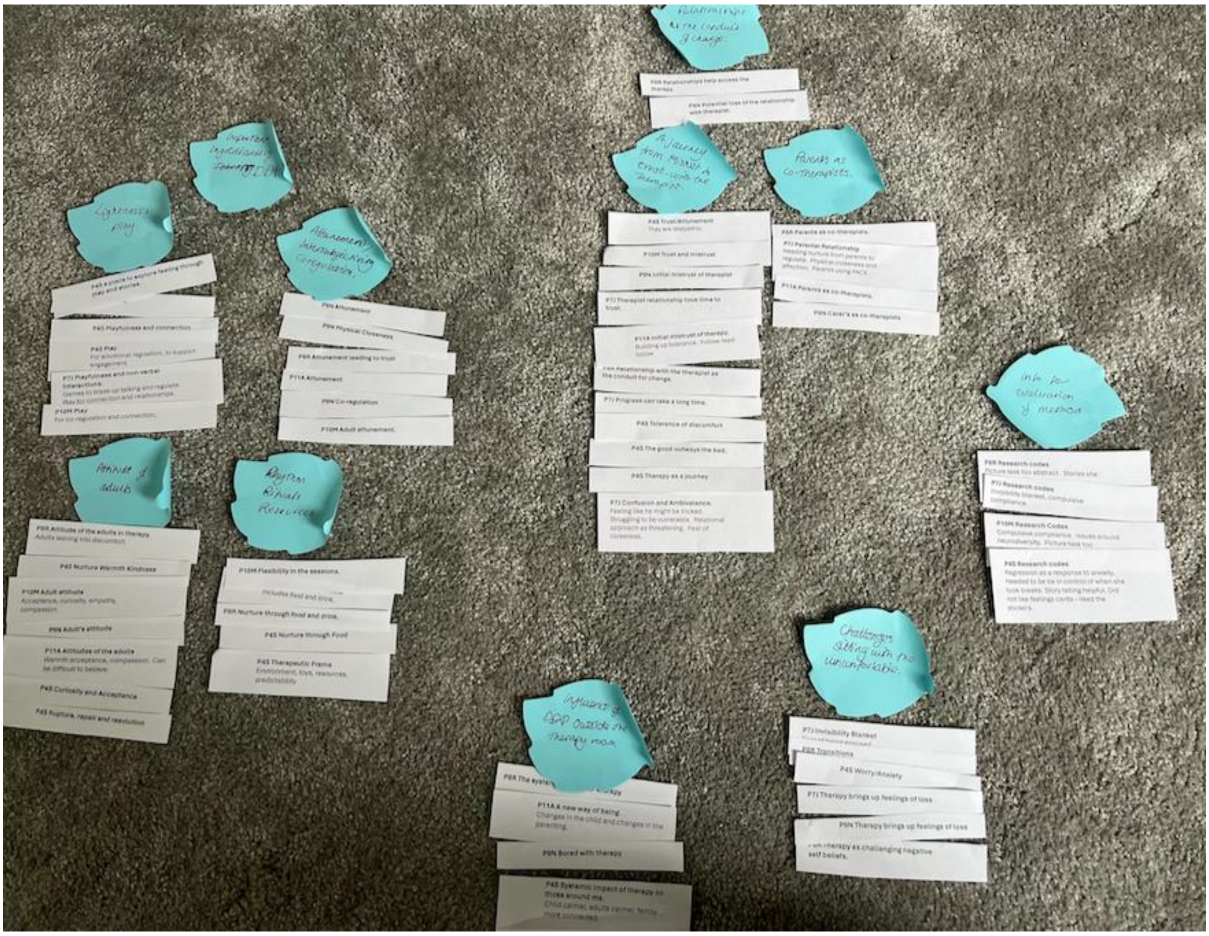
- Importance of therapeutic relationship: I love her and she helps me
- Attunement, co-regulation and acceptance with therapist and caregivers
- Contemplating loss of the therapeutic relationship

Scout

- Developing trust in the process
- Importance of relational approach
- Flexibility
- Playfulness

Georgie

- Transitions
- Attunement leading to trust
- Caregiver helps with the feelings
- Significance of the therapist relationship
- Lightness and play
- Curiosity, empathy, acceptance
- Nurture through food and drink
- Systemic impact of therapy



Group Experiential Theme 1	
Theme 1‘She’s telepathic’ – Attuned Emotional Connection	**Carter:** Attunement – ‘she is telepathic’
Subtheme 1.1: Curiosity, empathy, acceptance and flexibility	**Carter:** Curiosity, acceptance, nurture warmth and kindness. **Asher:** Relational Approach – adults remain regulated. Felt unconditional. **Kirby:** Relational Approach – curious accepting responses to child’s dysregulation. **Scout:** Flexibility – adults attuning to her and then moving into more regulating interactions. Sometimes led by therapist and sometimes by her. Liked that the adults could talk for her. **Georgie:** Attunement leading to trust – adults accepting and curious. Make good guesses.
Subtheme 1.2: Caregivers as co-therapists	**Carter:** Relational Approach – soothing presence of a caregiver figure. **Lex:** Relational Approach – caregivers important for emotional regulation.

	Asher: caregivers important for co-creating narratives. Caregivers and therapist working seamlessly together. **Kirby:** Carers curious, nurturing and accepting. Suggestion of repair process. **Scout:** Adults very present in the therapy room. **Georgie:** Mum very active in the therapy space – especially in the play. Attunement important for the more tricky conversations.
Subtheme 1.3 Lightness and Play	**Carter:** Play, playfulness and connection. **Lex:** Playfulness and non-verbal interactions – important for co-regulation. **Asher:** Ebb and flow of lightness and play with deeper conversation. **Scout**: – play for emotional regulation. **Georgie:** Experience self through play – being celebrated. Not problem saturated.
Subtheme 1.4: Individualised comforting rituals and rhythms.	**Carter:** Therapeutic frame – importance of the space, rhythm and rituals. Importance of nurture through food. **Asher:** Rhythmically moving in and out of lightness. Sessions begin with food, drink and connect and chat. Food also important for emotional regulation and safety. **Scout:** rhythm of play, talk, play. **Georgie:** Nurture through food and drink important.
Group Experiential Theme 2	
Moving towards psychological safety and shared intentions.	
Subtheme 1.1: Mistrust	**Carter:** Anxiety, worry and avoidance. **Lex:** The need for an invisibility blanket. Confusion and ambivalence about the therapeutic approach. **Archer:** Trust in therapist not immediate. Approach felt ‘unusual’. Worried about confidentiality. **Kirby:** Initially scared of therapist as she didn’t know if she was safe. **Scout:** Described anxiety and dissociation. **Georgie:** Misattunement in the stories felt disconnecting.
Subtheme 1.2: Differing degrees of developing trust	**Carter:** Rupture repair and resolution. Therapy as a journey. The good generally out ways the bad. **Lex:** Therapeutic journey – sense of increased comfort in the therapy.

	Archer: Trusted in the attunement felt she had agency. **Kirby:** Fear of therapist didn't last long. She enjoys the curious questions. Believes the therapist helps her now. **Scout:** Trust – predictability important. Helped that her caregivers knew the therapist. **Georgie**: Attunement leading to trust and challenging negative self concept. At a pace that she could tolerate.
Subtheme 1.3 Increased caregiver closeness	**Carter:** The impact on those around me – adults are calmer. Family closer. Caregivers more regulated. **Archer:** A new way of being. Increased openness with caregivers. Reduced shame. Caregivers more regulated. **Georgie:** systemic impact – less arguments and increased closeness with Mum.
Subtheme 1.4: Contemplating loss	**Carter:** Rupture repair and resolution – therapist disappearing. **Lex:** Sad story of the lost dog – metaphor for own losses? **Kirby:** Thinking about sister. Wanted to connect with therapist. **Georgie:** Difficulties with transitions.

Appendix S: Caregiver Triangulation Questionnaire

CAREGIVER TRIANGLULATION QUESTIONNAIRE

Exploring the experience of children and young people who have participated in Dyadic Developmental Psychotherapy (DDP) interventions with their families.

Principle Investigator

Jessica Christopher
Trainee Clinical Psychologist at the University of Hertfordshire

As the Caregiver of a child who is participating in this study, we ask that you complete the following brief survey exploring your perceptions of your child's experiences of DDP therapy. This will be used to strengthen and support the reliability and interpretation of the data collected with your child.

1) How do you think your child might explain their therapy experience to someone else?

2) How do you think they imagine or make sense of what the therapy is?

3) What do you think they will talk about the most when asked about their DDP experience?

4) What feelings do you think your child has about their DDP therapy sessions?

5) How might they expect the adults in the room to respond if they became upset or withdrawn?

6) What do you think your child finds the hardest about DDP therapy?

7) What do you think they feel just before they arrive at sessions?

8) What do you think they feel after the session?

9) Is there anything else you feel is relevant to tell us about your child's experience of their DDP therapy?

Many thanks for taking the time to complete this survey.

Appendix T: Therapist Focus Group Consent form, Information Sheet, Demographics and protocol

FORM EC3
CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

Exploring the experience of children and young people who have participated in Dyadic Developmental Psychotherapy (DDP) interventions with their families.

Principle Investigator
Jessica Christopher, Trainee Clinical Psychologist at the University of Hertfordshire

I, the undersigned *[please give your name here, in BLOCK CAPITALS]*

……….…

of *[please give contact details here, sufficient to enable the investigator to get in touch with you, such as a postal or email address]*

…..…….

hereby freely agree to take part in the study entitled **Exploring the experience of children and young people who have participated in Dyadic Developmental Psychotherapy (DDP) interventions with their families.**

(UH Protocol number …………………………………………)

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

2 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

3 It is not anticipated that there are any risks to you to completing the focus group, however, I have been told about the aftercare and support in the form of a debrief at no cost to myself.

4 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used, including the possibility of anonymised data being deposited in a repository with open access (freely available).

5 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

6 I have been told that I may at some time in the future be contacted again in connection with this or another study.

Signature of participant……………………………………..…Date…………………………

Signature of (principal) investigator Date…………………………

Name of (principal) investigator

JESSICA CHRISTOPHER

FORM EC6: PARTICIPANT INFORMATION SHEET

2 **Title of study**

Exploring the experience of children and young people who have participated in Dyadic Developmental Psychotherapy (DDP) interventions with their families.

Principle Investigator

Jessica Christopher
Trainee Clinical Psychologist at the University of Hertfordshire

2 Introduction

You are invited to take part in the above study. Before you decide whether to provide consent, it is important that you understand the study and what is involved. Should you wish to take part, you will need to complete the consent form that will be sent to you along with this information sheet.

Please take the time to read all of the following information carefully. Do not hesitate to ask us anything that is not clear, or for any further information you would like to help you make your decision.

Please do take your time to decide whether or not you wish to take part. The University's regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link:

https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs
(after accessing this website, scroll down to Letter S where you will find the regulation)

Thank you for reading this.

3 What is the purpose of this study?

To understand the experience of DDP through the lens of the child, with a view to informing an understanding of any changes that may have come about through the therapeutic process in relation to attachment security and increased caregiver closeness.

Data for this part of the study will be collected through a one off online therapist focus group. The aim is to elicit the perspectives of therapists on the central tenants and delivery of DDP to aid us in our understanding of how children may make sense of and conceptualise their experience of the therapy. Data from the group will be used to strengthen and support the interpretation of the data collected from the research sessions with children. Therapists who are working with children taking part in the study are not eligible to take part in the focus group in order to maintain confidentiality of the children.

4 Do I have to take part?

It is completely up to you whether or not you decide to provide consent for the focus group. If you do decide to consent, you will be given this information sheet to keep and be asked to sign a consent form. You are free to withdraw at any stage prior to the focus group without giving a reason. Verbal consent will be checked at the beginning of the focus group. You can withdraw at any point during the focus group, without providing a reason. It may not be possible to withdraw your data for reasons relating to the consistency of the data analysis.

5 Are there any restrictions that may prevent me from participating?

In order to take part, you need to be a DDP therapist accredited to the DDP institute. You need to have worked with at least five adopted children using a DDP model and be currently practicing DDP or have practiced in the last year. You need to have access to technology that will enable you to engage meaningfully and confidentially in an online session.

6 How long will my part in the study take?

We expect the focus group to take between 1 - 1.5 hours. You will be offered a debrief online meeting or phone call within a week of the group should you wish to access this. The focus group will take place at some point between October 2023 and February 2024 at a time agreeable for all participants.

We may contact you after the focus group if we need to clarify any information.

Once the project is completed we would like to contact you again so that we can share a copy of the final project paper.

The project is planned to be completed by September 2024.

At some time in the future, we may contact you again about this study or any related subsequent study There is no obligation to remain involved.

Should there be any significant changes to the aims or design of the study you will be informed and asked to renew your consent to participate.

7 What will happen to me if I take part?

If you are happy to go ahead with the focus group, I will contact you to ascertain your availability. A date and time will be arranged that will meet the availability of all those taking part.

The interview will take place using the University Online video facility such as Zoom or Microsoft Teams.

8 What are the possible disadvantages, risks or side effects of taking part?

It is not anticipated that there will be any disadvantages, risks of taking part. A debrief video call or phone call will be offered and is an opportunity to express any feelings or feedback about the focus group.

9 What are the possible benefits of taking part?

Children are rarely represented in research and evaluations. So far, there has been no formal research exploring DDP from the perspectives of the children involved. This is an opportunity to play a part in the development of DDP and shape the understanding of how DDP is experienced by children. It is hoped that by learning more about how DDP is experienced by children, this may also provide therapists and caregivers with more information to support children where DDP may be appropriate.

10 How will my taking part in this study be kept confidential?

If you agree to take part in this study, you will be assigned a participant number. Any demographic data collected and any personal details and the caregiver questionnaire will be stored under this number on a password-protected file on the GDPR compliant University of Hertfordshire One Drive.

In the final write up of this study and in any subsequently published papers, you may be referred to as a pseudonym. Quotes may be used but any details that could identify you will not be included.

Any documents, such as the consent form, that may contain personal information will be password protected and stored on the GDPR compliant UH secure OneDrive.

Usual confidentiality limits apply. If safeguarding concerns in relation to a child come to light during a focus group, it is your responsibility as a therapist to report these concerns to the child's responsible authority children's services. Should a safeguarding concern come to light regarding your fitness to practice this will be reported to the organisation you work for or the organisation(s) commissioning your DDP practice with children. It may also be reported to your professional registration body e.g. HCPC/BACP etc.

11 Audio-visual material

It is necessary to video record the focus group so that all data can be analysed accurately as part of the research process. This will be done using the record facility on the online video platform and stored on the GDPR compliant UH One Drive. Should this cause you any concerns, please do discuss this with me prior to signing this consent form.

Video footage is for analysis purposes only and as such will only be viewed by the research team.

12 What will happen to the data collected within this study?

Personal Data

Personal data such as names and email addresses will be deleted on completion of the study (September 2024).

Video Data

Once the transcriptions have be made (using pseudonyms or anonymity codes), the video recording will be converted to MP3 and stored securely using a participant identifier code. The video recordings will be destroyed.

Anonymous task data

All anonymous data will be retained by the investigative team during the duration of the study. On completion of the study, the lead investigator (Jess Christopher) and other non-UH research team members will delete their personal copies of the anonymous task data by September 2024 (end of the assessment period). The rest of the research team (Dr Caroline Cresswell) will keep the anonymous data indefinitely, on the GDPR-compliant UH OneDrive for potential future use and in accordance with most journal's open access policies.

13 Will the data be required for use in further studies?

- The data collected may be re-used or subjected to further analysis as part of a future ethically-approved study; the data to be re-used will be anonymised.
- The results of the study and/or the data collected (in anonymised form) may be deposited in an open access repository.

14 Who has reviewed this study?

This study has been reviewed by:

- The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is **LMS/PGT/UH/05305**

15 Factors that might put others at risk

Please note that if, during the study, any medical conditions or non-medical circumstances such as unlawful activity become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

16 Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with me by email: *Jess Christopher, j.christopher@herts.ac.uk*.

Alternatively, you can contact the principle supervisor, Dr Caroline Cresswell
c.cresswell@herts.ac.uk

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 at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

Exploring the experience of children and young people who have participated in Dyadic Developmental Psychotherapy (DDP) interventions with their families.

Principle Investigator

Jessica Christopher
Trainee Clinical Psychologist at the University of Hertfordshire

Demographic Form

Thank you for consenting to taking part in this study. Below are a few brief questions. This questionnaire will be stored as a password-protected file on the GDPR compliant University of Hertfordshire One Drive.

1) Please state your DDP accreditation status (e.g. accredited practitioner, consultant, trainer etc.)

2a) How many years have you been practicing DDP?

2) Please describe your profession (e.g. clinical psychologist/counselling psychologist/psychotherapist/social worker/play therapist etc).

    3a) How long have you been qualified?

3) Please describe your gender?

4) Please describe your ethnicity?

Additional Questions

It would be really helpful if you could answer a few brief questions prior to the session.

1) What are the characteristics and needs of the children you see for DDP?

    1a) What might you be looking for to decide who is suitable for DDP?

2) How is the DDP you do generally funded? E.g. Adoption Support Fund/ Local Authority/ Private/ Other.

3) What do you see as the main benefits of DDP?

4) What are the challenges of DDP and are there any barriers?

Thank you

Jess Christopher

Trainee Clinical Psychologist

Set scene
Check timings
Offer debrief
Confidentiality

RECORD!!!!!

Focus Group Questions

Have children spoken to you about what they think DDP is? How do they describe it?

How do children experience Playfulness?

How do children experience Curiosity?

How do children experience Empathy?

How do children experience Acceptance?

Have they talked to you about how they experience closeness and connection?

What do they say about what they enjoy and what they find hard?

What do they say about what helps them with the parts they find harder? Are they telling you what they need from you? And what might this be?

What do children say about what has changed for them? What is progress to them? Do they talk about changes in their family?

Appendix U: Excerpt from Focus Group Analysis Transcript

DDP Focus Group Transcript	
S M With me, they often say, stop going on about my adoption.	
Why you always talking about my adoption and which is always a message to me. But I think sometimes they think of therapy, the way I do it anyway, in the context of their early experiences, and that's normally the kids that I've been seeing for longer.	Mistrust Children can feel very avoidant when talking about adoption related issues.
So I think in the first instance they think of it a bit more like, oh, you're gonna come. And I don't know.	
People say you're gonna come and roll the ball over me and you're gonna say goodbye, or you're gonna do some art. And then you're gonna go say goodbye. And then a year down the line they go. Ohh you haven't said goodbye. Now you're gonna talk about my early experiences. Umm, so I think they conceptualise it. In my experience as exploring their early life and shift, their understanding of what the process is along the way, I think we all do, don't we?	Journey from trust to mistrust Trust may take a year to build before you can being to start thinking about exploring early life experiences.
Jessica Christopher [Student-LMS] Umm yeah, I think the children have reflected that as well. That shift from the beginning to when they've had more and how they think about it. Yeah, yeah.	
Dr. S I'm working with the family at the moment and I think some siblings and I think.	

Uh, so they they talk about it at school and they talk about getting lollies and games and things.	Lightness and play is important ‘Lollies and games’
And and uh, yeah, I think they, I think they talk about talking about the story of their name and.	Flexibility – story telling about the name. It can look like so many different thigs.
And uh, yeah, one client I'm working with talks about how the sessions are about her anger difficulties.	
It is her phrase.	
She thinks we're doing anger difficulty work, and that's not my phrase.	Trust - The therapy is a safe space to express emotion.
but I think it comes cause what she brings to the session is expressing a lot of anger, which I understand from the carer, who's with her, is not what is expressed at home like that's a safe place to express their anger.	
So she sees it as associated with thinking about her anger, I think.	
Yeah.	
Sh	
I think for me I I mine was sense of I don't think the young people I work with or children I work with, they call it therapy.	
I think when I used to do home visits, it was just that somebody would come and chat to them for a little bit and similar to S terms of maybe get some snacks at the end and they'll be some games to play with.	Lightness and play – chat Rhythms and rituals – snack and games at the end.
I think it's only as the sessions progress there’s a bit more of an understanding of what we're there for in a kind of shared intention and a kind of a an idea of what do we want to get out of this time.	Journey from mistrust to trust – it becomes a shared intention.
But I think there's a lot of uncertainty initially around ‘why I'm there’ what the purpose is who I'm there for?	Some initial mistrust about ‘why am I here?’ Whose agenda?
Who's agenda were working from?	
It feels a little bit vague to start off with until we've kind of, yeah, maybe we establish a kind of shared goal or what my role is and what they wanna get out of the sessions.	Then we establish some goals.
And yeah, what would be of benefit?	
S	
And joint intentions are so key, aren't they?	

Having complimentary intentions aren't they, and I was thinking about that this morning and that actually it's it's quite hard to have those joint intentions sometimes, particularly in the beginning when children are so averse to coming to therapy because they've been blitzed with it and just had the most hideous experiences.	Mistrust – informed by previous negative experiences.
Sh Yeah.	
S And so it's about having those joint intentions, but owning the fact that they might be different in the beginning and not actually joined.	Journey from trust to mistrust – there may not be a joint intention at the beginning.
[………]	
S But you know, I've be brought to you because I'm naughty. You're gonna basically find out how bad I am, and then you're going to take me away.	Communicating a mistrust. This is the adult's agenda. I am here because I am bad.
Jessica Christopher [Student-LMS] OK, and are they communicating that to you like verbally or like how how do we know that they're it's scary for them.	
S Well, I asked them what they think. Sort of curiously not straight away, but I might frame it as you might think this. Or when I've worked with children before, they've been really worried that I'm another person coming in, or I'm gonna think their bad. And when they've met people before, they've had to leave places. So I will be quite transparent about some concerns that other children have had, so give them a obviously permission to share, but it's normally down the line that	Therapist attitude – being open and honest. Giving children agency.

they'll say when I met you, I thought you were a social. I thought you were another social worker. That was going to take me away.	
So I think they can say it verbally depending on age and stage and our relationship or I will sort of be curious about whether other children's experience might fit with what they're feeling in the moment earlier on and they may or may not feel safe enough to acknowledge it or they may not may not feel it, but it's certainly a theme that I've experienced with the children that are adopted.	Using curiosity.
[…………]	
L	
I love the offering of food and the nurture in that, but I'm also so aware that some really struggle with it.	Offering of nurture.
And I'm always curious when they struggle with it. You know, if you say, 'would you like a wee drink?' 'No.' Would you like a wee biscuit?' 'No'. OK. Well, we'll leave them here and if you want them, and usually by the end they take them because it be safe enough now and it doesn't feel like you're tricking me and I don't have to let my guard down. Well, by taking these sweets because then it makes me feel like ohh no, she's sweetening me up for something. And it feels like I'm tricking them, so I'm always conscious of that and.	Children can be mistrustful of the nurture. Being able to accept this is a sign of increased trust.
But I do notice that's probably where my Theraplay comes in quite a bit, and that sort of playfulness and engaging them through the into the room before they even get into the room. And you know, because I'm thinking of a wee boy recently and he came in cos he was rolling on the new seats that we had got for kids to roll on in the waiting area was so lovely to see it kid rolling on them and he was like I said 'ohh you're rolling on the seats! Wow I've been really excited to see somebody on the seats	Using playfulness and humour to engage.

and he went ‘no I was not.’ Straight away my went ‘ohh. You didn't want me to see you having fun rolling on the seats?’ ‘No, I'm not talking to you today.’ ‘You’ve been told you have to come and talk to me. ‘Yes’ ‘but you're talking to me now.’ ‘No’ [Laughter] S It's delightful. [……..]	Shows the mistrust.
Dr S Yeah, it's really interesting where the young person might think I'm allied with or where my agenda is or am I assessing, am I part of the local authority, am I not, am I whatever, and I was just thinking, I think I think it's. It's interesting where the referral comes from and what my role is in the network. I think that affects it.	Initial mistrust of adult’s agenda. Who are you and who are you allied with? Assumption you are not allied with them.
So and when I've worked in within local authorities and worked from a very sort of DDP practice, DDP practice sort of perspective and I've been involved in school things on the outsides beforehand, then I that has, yeah, I can see I can, I can see my mind again person who struggled with behaviour and definitely thought I was part of the network trying to sort out his behaviour, you know and it feeling like that and maybe it feeling a bit more external and judgmental as his perceptions and it's taking a while to work with that and at the moment I'm working with the family and there I was much more independent to that but I needed to do a lot of work with the carer first of all and there's something a lot about. [………….]	Suspicion.

K (Guest)	
One of the adults that I knew as a foster child, we've tried to engage her in some DDP therapy.	
When she was maybe 8 eightish, I guess.	
And she she didn't want to engage at all.	
We worked through the foster family for her and as an adult, she just described how there's no way she was gonna let us in because she thought we were tricking her.	
And there's a real big sense of, you know, this is this is a trick.	
You're gonna trick me into.	Strong mistrust preventing accessing the therapy.
I'm not sure what she thought she was gonna be tricked into.	
I'm not sure that she knew, but there was just a sense of being tricked and and she, she was a very self-reliant young person and she just.	
Yeah. Voted with her feet.	
'I'm not going to engage with this.'	
I, however, she knew that I was in the background all through her childhood.	
So because I supported her foster family and, you know, we met, you know, we'd have chats in the corridor at where my where officers were.	
She was in the building.	
I chat with her and she always remembered those chats and when she came back as an adult, she said.	Supporting of the caregivers was important – child still experienced DDP through the caregiver work.
One of the reasons she came back to see me was because I'd always been in her life.	
Supporting somewhere around that I was a some sort of safe person.	
So actually you know, that was probably the right thing for her is not to have DDP therapy as a child and she's done a lot of work as an adult.	
So yeah.	
Sh	
Umm, it's making me think about the like you use the word Jess, the mistrust and the suspicion at the start of this kind of journey around.	
Or are you gonna be here?	
Are you gonna trick me?	Initial mistrust – are you tricking me?
Are you gonna take me away?	What is your agenda?

Are you gonna be really allied with my caregivers or my carers, that you're not gonna be able to hear my story? That, that process of even before they've met of even glanced at us. What is their perception of what this journey is gonna be about? And that. Yeah, that scepticism and how we have to work really hard.	Will you attune to me?
One of the things that I really love about DDP is the commitment that we must take to acknowledge that mistrust and to work at a kind of, you know, maybe a slower pace to prove that we can be trustworthy over time. I'm and to give that felt experience, you know, not to try and rationalize that, you know, 'we are trustworthy. We're here for you. Just believe in us.' which sometimes I can fall into But I think that's one of the things that I've noticed when I've ended with young people and children, there's a young person I'm thinking about where recently I've ended and I kind of said 'What was the turning point for you? When did you kind of starts to open up? When did you feel safe enough to open up? Tell me about that.'	Importance of therapist recognising and working with the mistrust. Relational repair.
And he said 'there wasn't one thing that you did Sh. There wasn't one strategy that you did to kind of get me to open up. It just was something that had to learn over time.' And that was the kind of I knew that here.	'Not one thing you did' – the experience of relationship over time was the change mechanism?
But that acknowledgement that it came from him to kind of say it just needed time to grow, and I needed to learn that after all my experiences have been let down by adults, that you weren't going to abandon me, that I wasn't gonna say something that you didn't approve of. And then you take that and use it against me that I needed to feel genuinely in my heart that I do, I do trust you and that you'll take what I say seriously and that you're listening to my worries and you won't. Sort of. Yeah, look down at me or judge me for that.	Developing increased trust through the experience of the relationship.
And I think that really indicated to me how this process can take time and those kind of really big protector parts that come forward for those young people who have experienced such attachment disruption and trauma in their lives and	Importance of feeling accepted.

And yeah, of course they are gonna bring that part to them in therapy where we might enact. We're another adult that could potentially let them down again, so that importance of slowing down and that mistrust really comes forward to me as you guys are kind of reflecting on your experiences as well.	

Appendix V: Communication with Jonathan Smith re Framework Analysis

From: Jessica Christopher [Student-LMS] <j.christopher@herts.ac.uk>
Sent: Saturday, February 24, 2024 12:14 PM
To: Jonathan Smith (Staff) <ja.smith@bbk.ac.uk>
Subject: Using IPA in play-based approach with children.

Hi Jonathan

I hope you don't mind me contacting you. I am a Trainee Clinical Psychologist on the Doctorate at the University of Hertfordshire. I wanted to get in contact as I am using IPA, and my data collection methods and design are a bit unusual. This was my reason for choosing IPA, as it fits my research question and has the flexibility to capture both the verbal and non-verbal responses of my participants. If you have any time to respond with any thoughts I would be very grateful.

The phenomena I am exploring is the experiences of children who have had Dyadic Developmental Psychotherapy. If you are not aware of the therapy, it is an attachment based therapeutic approach for children with developmental trauma. https://ddpnetwork.org/about-ddp/dyadic-developmental-psychotherapy/

The children in my study have all been removed from their families of origin due to issues such as abuse and neglect and are in adoptive placements, or placed with extended family members. They are aged between 8 and 13. Some of them are also neurodiverse.

I wanted to design a method where they could participant meaningfully in the research process and in a way that was trauma informed. I have used narrative story stems (Hodges & Hillman, 200; Kelly and Bailey, 2021) to elicit projective responses about their experiences to support them to be able to communicate information that might otherwise be too sensitive for them to talk about directly. I developed a novel set of story stems to explore the research question. The stems set up various dilemmas in the therapy setting using play figures, I asked the children to complete the stories using the figures to explore their representations of the therapy and their expectations of the roles the therapist and caregivers played. In addition, I also did a picture task where we explored their experiences in a more direct way. I have 6 participants and I am currently analysing the data using IPA.

I became very aware in my interviews that children were often a little guarded with me, which makes sense given their previous life experiences. So, in addition, I have also done a focus group with 5 DDP therapists. I did this because I wondered if children were talking to their therapists about their experiences in a way that they could not do so with me as an unfamiliar person. I asked the therapists to share their experiences of children sharing with them their thoughts about their therapeutic experiences.

I am currently thinking about how I can pull this together. I am thinking that I will complete the IPA process with the children's data and develop their group experiential themes. I was then thinking that I would do a separate IPA analysis for the focus group. I have been reading Palmer, Larkin, De Visser and Fadden's 2010 paper to support my thinking in how to go about this. I will then be able to compare the focus group analysis with the children's analysis exploring convergence and divergence in the themes.

I am sure you are very busy, but if you have any time to respond with any thoughts or if you are aware of anyone else who has done something similar, I would be very grateful.

Kind regards

Jess Christopher

From: Jonathan Smith (Staff) <ja.smith@bbk.ac.uk>
Date: Sunday, 25 February 2024 at 16:58
To: Jessica Christopher [Student-LMS] <j.christopher@herts.ac.uk>
Subject: RE: Using IPA in play-based approach with children.

Dear Jessica

I don't have much time to respond but I think your proposed way forward is the best thing to do. Just one caveat. I hope the therapists have not worked with the particular children. If they have their could be an issue of confidentiality where therapists say something about a child and this dyad can then be recognised in the write up. If this is the case I think you need to talk carefully with your supervisors about what to do

Best wishes

Jonathan

From: Jessica Christopher [Student-LMS] <j.christopher@herts.ac.uk>
Sent: Sunday, February 25, 2024 5:03 PM
To: Jonathan Smith (Staff) <ja.smith@bbk.ac.uk>
Subject: Re: Using IPA in play-based approach with children.

Thank you for your response Jonathan, I very appreciate it.

I made sure that the therapists in the focus group did not know the children who I interviewed for the reasons you refer too.

Many thanks!

Jess

From: Jonathan Smith (Staff) <ja.smith@bbk.ac.uk>
Date: Sunday, 25 February 2024 at 17:13
To: Jessica Christopher [Student-LMS] <j.christopher@herts.ac.uk>
Subject: RE: Using IPA in play-based approach with children.

That's great

Jonathan

Appendix W: Transparency and Rigour Process

Table 20

Transparency and Rigour Process

	Carter	Lex	Asher	Kirby	Scout	Georgie	Focus Group	Group Experiential Themes
Triangulated with caregiver questionnaire	X	X	X	X	X	X		
Audited by principle supervisor	X							X
Audited by field supervisor	X							X
Audited by EBE		X		X				X
PET's member checked by caregiver			X			X		
Findings member checked by DDP therapists							X	
Excerpts shared with IPA group		X			X			
Presented to DDP board with feedback								X
Reflective journaling and bracketing	X	X	X	X	X	X	X	X

Appendix X: Identification of Recurrent Themes

Table 21

Identification of Recurrent Themes

Group Experiential Theme	Subtheme	Carter	Lex	Asher	Kirby	Scout	Georgie	Focus group
'She's telepathic' – Attuned Emotional Connection	Curiosity, empathy, acceptance and flexibility	X		X	X	X	X	X
	Caregivers as co-therapists	X	X	X	X	X	X	X
	Lightness and play	X	X	X	X	X	X	X
	Individualised, comforting rituals and rhythms	X	X	X		X	X	X
Moving towards psychological safety and shared intentions.	Mistrust	X	X	X	X	X	X	X
	Differing degrees of developing trust	X	X	X	X	X	X	X
	Increased caregiver closeness	X		X			X	X
	Contemplating loss	X	X		X		X	X