

**Exposed, Scaffolded and Connected – Foster Carers’  
Experiences of Dyadic Developmental Psychotherapy: An  
Interpretative Phenomenological Analysis**

**Amy Murphy**

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## THESIS PORTFOLIO: CANDIDATE DECLARATION

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<b>Candidate name</b>	<b>Amy Murphy</b>
<b>Registration number</b>	<b>21026377</b>
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<b>Declaration and signature of candidate</b>
<p>I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.</p> <p>I confirm that the decision to submit this thesis is my own.</p> <p>I confirm that except where explicitly stated, the work has not been submitted for another academic award.</p> <p>I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.</p> <p>Signed: <i>Amurphy</i>      Date: 29<sup>th</sup> April 2024</p>

## **Preface**

Table illustrating breakdown of total word count:

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Thesis abstract	293
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Paper Two: Empirical Paper	7998
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## **Thesis abstract**

Paper one is a narrative literature review which explores the effectiveness of trauma-focused cognitive behavioural therapy (TF-CBT) following childhood interpersonal trauma for reducing the symptoms of post-traumatic stress disorder (PTSD) and disturbances to self-organisation (DSO) in young people. Findings suggested TF-CBT effectively reduced PTSD symptoms following interpersonal trauma, with some sustained improvements found at follow-up. Tentative support for the effectiveness of TF-CBT in reducing DSO symptoms was found, however, significant methodological flaws warrant further research.

Paper two is an empirical research paper exploring foster carers' experiences of Dyadic Developmental Psychotherapy (DDP). Ten foster carers participated in semi-structured interviews which were analysed using Interpretative Phenomenological Analysis. Four Group Experiential Themes and eleven subthemes were formed; from disbelief to clarity, scaffolded and safe, attuned and connected, and "It's worth it". Findings suggest that DDP was experienced as a worthwhile yet demanding process for foster carers', which led to a greater self-understanding and a more attuned carer-child relationship. Findings further suggest due care and attention need to be paid to ensure foster carers are providing informed consent to engage in DDP, with subsequent due attention being paid to the experience of and support for foster carers through the therapy. Future research exploring the experience and effectiveness of such support, as well as exploring the experience of kinship carers and young people within DDP, and the model's effectiveness, is needed.

Paper three is an executive summary which aims to provide an accessible overview of paper two. Two participants provided feedback on its accessibility, layout and content. This paper will be disseminated to all participants who took part in the study and can also be disseminated to foster carers' who may be curious about what DDP could entail, as well as supporting social workers and clinicians.

**Paper one: Literature Review**

**Effectiveness of Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) following childhood interpersonal trauma for Post-Traumatic Stress Disorder (PTSD) and Disturbances to Self-Organisation (DSO) symptoms in young people: A narrative review**

Word count: 8,000

(Excluding Title Page, References and Appendices)

This paper has been written in accordance with author guidelines for The Journal of Child and Adolescent Trauma (Appendix A)

## **Abstract**

Interpersonal trauma has a pervasive impact on children's development, beyond the symptoms of PTSD. Youth exposed to interpersonal trauma appear to experience disturbances to self-organisation, which incorporates emotional dysregulation, negative self-concept and/or interpersonal difficulties. Little is known about the effectiveness of trauma-focused interventions, such as TF-CBT, for improving DSO symptoms. This review therefore aimed to explore the effectiveness of TF-CBT in reducing PTSD and DSO symptoms following childhood interpersonal trauma.

Systematic searches of four databases resulted in 13 included peer-reviewed papers, which were appraised using Crowe's Critical Appraisal Tool. TF-CBT was found to be effective in reducing PTSD symptoms with sustained effects observed at 6- and 12-month follow-ups, though some young people continued to experience clinically significant PTSD symptoms. Tentative support was found regarding post-TF-CBT improvements to DSO symptoms; however, these should be considered in the context of methodological flaws. Studies were limited by small sample sizes, lack of follow-up or control group, as well as inconsistent conceptualisation and measurement of interpersonal trauma and DSO symptoms. Further research is therefore needed to address current methodological flaws.

## **Introduction**

Interpersonal trauma is defined as the intentional victimisation of a person by another individual or group (Lilly & Valdez, 2021), such as sexual, physical, or emotional abuse, or neglect. In contrast, impersonal trauma is not intentionally perpetrated towards a specific individual, such as natural disasters, injury or illness. Interpersonal trauma perpetrators can be within and outside of the family, such as parents/carers, siblings, friends, peers or strangers. Approximately half a million children in the UK are maltreated by their parent or caregiver annually (Harker et al., 2013), and interpersonal trauma perpetrated within relationships with caregivers can have an especially marked impact (Cook et al., 2005).

Experiencing interpersonal compared to impersonal trauma increases the risk of developing post-traumatic stress disorder (PTSD; Lewis et al., 2019; Alisic et al., 2014; Kisiel et al., 2014). PTSD encompasses three main symptom clusters: re-experiencing the trauma, avoiding trauma-related triggers and hyperarousal. Possibly because it occurs within a critical developmental timeframe, the impact of interpersonal trauma on children's well-being and functioning is more widespread and pervasive than impersonal trauma, beyond the symptoms of PTSD (Ford, 2015; Scheeringa & Zeanah, 2001).

Interpersonal trauma has immediate and long-term impacts on cognitive, social and psychological development and functioning (Enlow et al., 2012; D'Andrea et al., 2012). Interpersonal trauma has been linked to higher levels of emotional dysregulation (Ehring & Quack, 2010), disturbed sleep (Wamser-Nanney & Chesher, 2018), cognitive impairment (Musicaro et al., 2020; Enlow et al., 2012) and disruptions to the young person's core sense of self, self-esteem, and self-compassion (Bistricky et al., 2017; Ozdemir & Sahin, 2020; Kouvelis & Kangas, 2021), possibly due to the disruption in the critical self-identity construction period (Capella, 2017), increasing the likelihood of developing generalised negative schemas about oneself (Bistricky et al., 2017). Interpersonal trauma is further linked to more negative appraisals of and trust in others, impacting attachment relationships (Bell et al., 2019; Cias et al., 2000; Ozdemir & Sahin, 2020; Bifulco et al., 2006). Childhood interpersonal trauma therefore increases the risk of a range of

difficulties that continue into adulthood, including low mood, anxiety, substance use and suicidal ideation (Kisiel et al., 2014; Jaffee, 2017; Thornberry et al., 2010).

It is therefore argued PTSD does not encompass the complex range of difficulties faced by those who have experienced interpersonal trauma (van der Kolk, 2005; Ford, 2011; Herman, 1992). In 2018, the World Health Organization (WHO) therefore added complex-PTSD (C-PTSD) to the International Classification of Diseases, 11<sup>th</sup> Edition (ICD-11).

Alongside PTSD symptoms, C-PTSD captures three further symptom clusters relating to disturbances in self-organisation (DSO), namely difficulties with emotion regulation, self-concept and interpersonal relationships. Emotion regulation difficulties may present as heightened emotional reactivity, dissociation, outbursts or difficulties experiencing positive emotions and are considered highly prevalent among young people with PTSD (Villalta et al., 2018). Negative self-concept relates to diminished beliefs about oneself as worthless, accompanied by feelings of shame and guilt, often relating to the initial trauma, and is again highly prevalent among populations with PTSD (Saraiya & Lopez-Castro, 2016; Kip et al., 2022). Finally, interpersonal difficulties may present as difficulties in sustaining and feeling close within interpersonal relationships and are again common among populations with PTSD (Monson et al., 2010). Such DSO impairs the child's ability to function in all areas of their life, subsequently impacting development and future outcomes.

Experiencing chronic interpersonal trauma has been found to predict the likelihood of experiencing more complex trauma-related difficulties, including DSO, and therefore subsequently meeting C-PTSD criteria (Perkonigg et al., 2016; Sachser et al., 2017; Hebert & Amedee, 2020). Perhaps unsurprisingly, research has demonstrated young people exposed to interpersonal trauma experiencing complex-trauma-related difficulties have poorer outcomes following trauma-focused interventions (D'Andrea et al., 2012), possibly because experiencing DSO may impact their ability to engage with psychological support (National Institute for Health and Care Excellence; NICE, 2018).

Given the complex needs and poorer outcomes for this population, the effectiveness of trauma-focused interventions, designed to reduce PTSD symptoms, regarding their ability to improve DSO should be examined. Trauma-focused cognitive behavioural therapy (TF-CBT) is the most widely studied psychological intervention to support children and young people with trauma-related difficulties (Cohen et al., 2017) and has been found to reduce PTSD symptoms in children from preschool age to young adulthood (Cary & McMillen, 2012; McGuire et al., 2021; De Arellano et al., 2014; Morina et al., 2016). NICE (2018) subsequently recommends TF-CBT for children and young people who have experienced trauma. TF-CBT is a phased-based intervention that gradually exposes the child and their non-offending caregiver to trauma reminders to restructure their trauma narrative and cognitions that may be maintaining their distress (Cohen & Mannarino, 2015).

Initially, the therapist increases understanding of trauma-related experiences through psychoeducation and implements a range of cognitive, affective, relaxation and parenting skills. These are then drawn upon in the trauma narration and processing phase. Finally, phase three integrates and consolidates learning, through in-vivo exposure and enhancing current and future safety. After engaging in co-occurring separate sessions initially to develop individual skills and processing, conjoint youth and caregiver sessions are facilitated to allow the young person to share their trauma narrative with their caregiver. The involvement of caregivers improves outcomes for young people, possibly due to their ability to reinforce skill use and provide key social support (Deblinger et al., 1996; Brown et al., 2020).

### **Rationale for Review**

Developers of TF-CBT suggest there is sufficient evidence that adapted TF-CBT can meet the needs of those experiencing complex trauma-related difficulties, including DSO (Cohen et al., 2012). Suggested adaptations include extended skills and consolidation phases, an earlier and more consistent focus on safety, and slowing trauma exposure, with more unifying trauma themes throughout (Cohen et al., 2012). These adaptations are in line with recommendations for approaches to complex trauma-related difficulties that suggest extended sessions, and an

increased focus on safety and trust in relationships, stabilisation, trauma processing and reintegration (Ford & Cloitre 2009; NICE, 2018).

Currently, no review has explored the effectiveness of TF-CBT in reducing DSO. Given the impact of interpersonal trauma on young people's functioning and outcomes and its link with DSO symptoms, this review aims to explore the effectiveness of TF-CBT for reducing PTSD and DSO symptoms for young people who have experienced interpersonal trauma.

### **Review Question**

How effective is TF-CBT in reducing PTSD and DSO symptoms following childhood interpersonal trauma?

### **Method**

#### **Scoping searches**

Scoping searches were conducted via Google Scholar, ProQuest and Ethos between January to April 2023 to identify relevant literature and determine the feasibility of the review. A review looking at randomised control data only for all psychological interventions to support children and young people following interpersonal trauma was identified (Peters et al., 2022). The effectiveness of TF-CBT in reducing DSO symptoms however was not explored. This review was therefore deemed feasible and necessary.

#### **Search strategy**

Search terms were grouped by intervention, population, experience and phenomena of interest (see Table 1) and developed through consultation with supervisor, Staffordshire University Librarian and commonly used terms in the existing literature.

Table 1: Search Terms

Intervention		Population		Experience		Phenomena
*CBT OR "Cognitive behav*"	AND	Child* OR adolescen* OR Youth OR teen* OR young	AND	Trauma* OR abuse* OR maltreat* OR mistreat* OR neglect* OR punish* OR violence* OR Incest* OR "Sexual* abuse*" OR "Domestic* violen*" OR "Physical* violen*" OR "Physical* neglect*" OR "Physical* abuse*" or "complex trauma" or "multiple trauma*"	AND	"post trauma*" OR "post- trauma*" OR "PTSD" OR "PTSS" OR "Symptoms of stress"

Systematic searches were conducted in May 2023 using four databases: Scopus, PsychiNFO, Web of Science and Google Scholar. In line with guidance (Haddaway et al., 2015), the first 200 results from Google Scholar were screened. Reference lists and citations of the resulting papers were also screened to identify any additional suitable papers.

Inclusion and exclusion criteria are detailed in Table 2. Papers were excluded if not available in English due to lack of translation services, and if not peer-reviewed.

Table 2: Inclusion and Exclusion Criteria using PICO framework (Richardson et al., 1995)

	Inclusion	Exclusion
<b>Population</b>	<ol style="list-style-type: none"> <li>Children and young people aged 0-18 years.</li> <li>&gt;80% sample experienced multiple incidences of interpersonal trauma</li> </ol>	<ol style="list-style-type: none"> <li>Above 18 years old</li> <li>Community and collective trauma</li> <li>Single-incident trauma</li> </ol>
<b>Intervention</b>	TF-CBT	
<b>Comparison</b>	Alternative therapies, wait-list control	

<b>Outcome</b>	<ol style="list-style-type: none"> <li>1. Standardised pre- and post-intervention measures of PTSD symptoms or diagnosis</li> <li>2. Pre- and post-intervention measures of at least one DSO symptom</li> </ol>	
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In line with previous research (Peters et al., 2022; Mauritz et al., 2013), interpersonal trauma was defined in this review as trauma occurring between individuals, including emotional, physical or sexual abuse, neglect or witnessing domestic violence. Other community and collective traumas, including war, natural disasters, theft and bereavement were therefore excluded.

Given the lack of standardised measures for DSO symptoms, during screening the face validity of the studies' chosen measure was considered in supervision. If the questions in the measure were deemed to closely represent the descriptions of DSO symptoms by the WHO (2018), they were included.

### **Publication bias**

Statistically significant findings are more likely to be published than non-significant findings, resulting in publication bias (Rosenthal, 1979) and subsequently a possible overinflation of estimated treatment effects (Sun et al., 2018). Though only peer-reviewed articles were included in the review, initial scoping searches of grey literature did not identify any suitable studies. The exclusion of papers not written in English due to lack of translation services may further introduce publication bias.

### **Selection**

Identified papers were systematically screened in line with PRISMA guidance (Moher et al., 2009), see Figure 1. 3580 articles were identified, including 1194 duplicates. The remaining 2386 articles were screened by title and abstract, and subsequently, 2163 papers were excluded. 223 full-text articles were screened,

excluding a further 210 papers (see Figure 1 for reasons). 13 articles were therefore identified and included in this review.

### **Data extraction**

For each paper, the authors, year, country, aims, methodology, sample and recruitment, intervention information, findings, and strengths and limitations were extracted (see Table 3 and Appendix B).

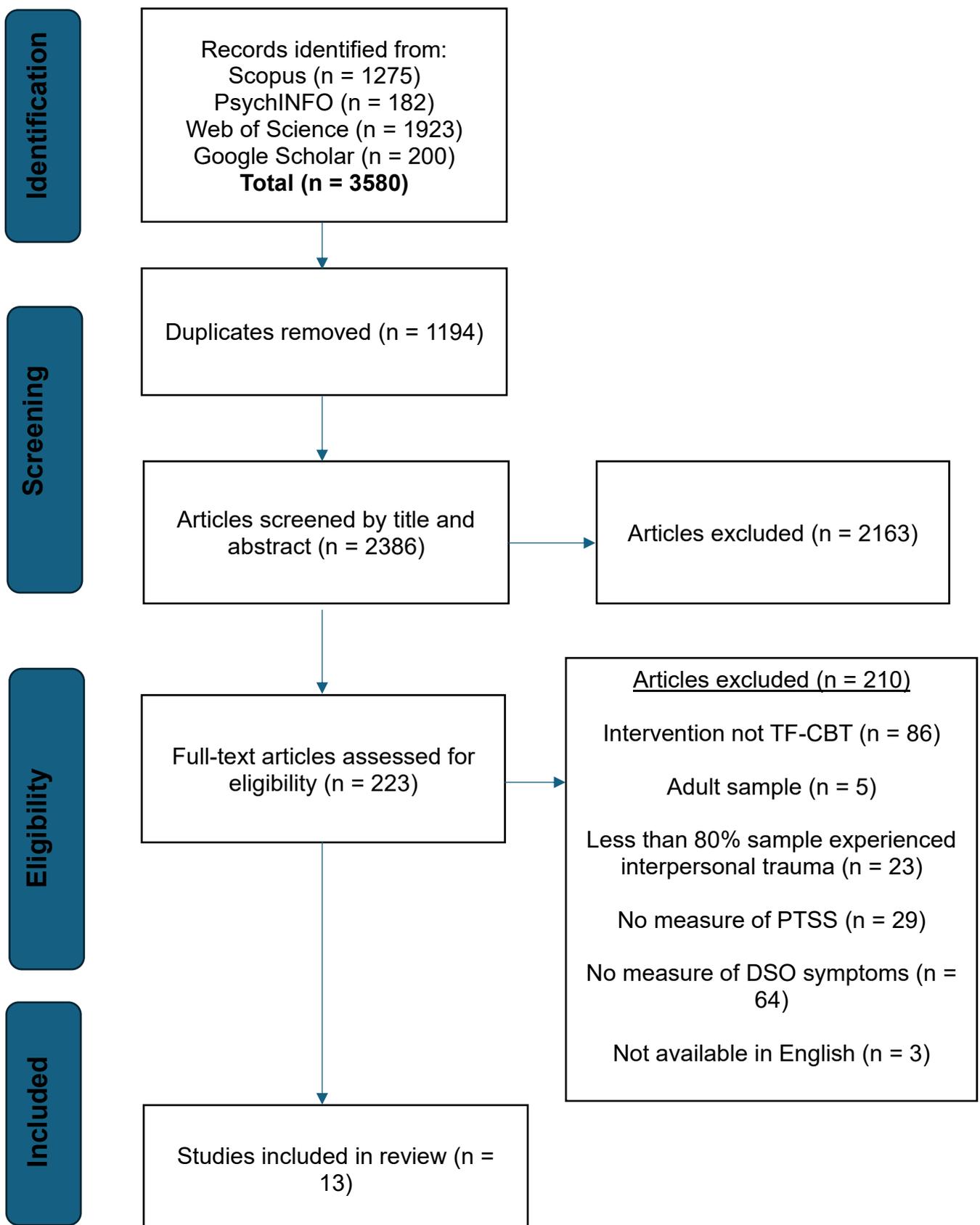
### **Quality Appraisal**

The Crowe Critical Appraisal Tool v 1.4 (CCAT; Crowe, 2013) was used to appraise the quality of each paper, due to its transferability across research designs. The CCAT User Guide v 1.4 (Crowe, 2013) was used throughout to increase reliability and validity (Crowe, 2013). The CCAT consists of 22 items across eight categories including design, sampling and ethical matters. Each item is marked as either present, absent or not applicable and subsequently total scores and percentages are then calculated, allowing for comparisons across papers. Crowe (2013) however stresses the importance of considering both total and individual category scores to ensure limitations are not overlooked. Higher scores indicate higher overall quality of the paper. See Table 3 for total CCAT scores (including percentages) and Appendix C for a categorical breakdown.

### **Synthesis**

A narrative synthesis of findings was conducted, in line with Popay et al.'s, (2006) guidance to organise, describe, interpret and summarise the narrative of the findings from this review. A meta-analysis was not deemed feasible due to the heterogeneity of study design and outcomes across papers, reducing the ability to provide a meaningful summary (Deeks et al., 2022).

Figure 1: Flow diagram demonstrating screening process following PRISMA guidelines (Moher et al., 2009)



## **Results**

13 studies conducted between 2004 and 2022 were included in this review (see Table 3 for an overview of each study and Appendix A for further information). Eight studies were conducted in the USA, two in Canada and one in Germany, Zambia and Norway. One study (Lee & Brown, 2022) is a secondary analysis of another included study's data (Ross et al., 2021). One study (Mannarino et al., 2012) is the follow-up analysis of another (Deblinger et al., 2011).

## **Design**

Studies included two randomised control trials (RCT; Cohen et al., 2004; Deblinger et al., 2011), two re-analyses of RCT data (Mannarino et al., 2012; Sachser et al., 2011), one case study (Marquez & Deblinger et al., 2020), one observational naturalistic study (Jensen et al., 2022) and seven quasi-experimental designs (Cisler et al., 2015; Deblinger et al., 2017; Hébert & Amédée, 2020; Lee & Brown, 2022; Murray et al., 2013; Ross et al., 2021; Thornback & Muller, 2015). Only two studies included follow-up data (Mannarino et al., 2012 at 6- and 12 months; Thornback & Muller, 2015 at 6 months). Cohen et al., (2004) is the only study to include an alternative therapy comparison group, which was Child-Centred Therapy.

## **Sample**

Sample sizes varied between one (Mannarino et al., 2012) and 384 (Hébert & Amédée, 2020), with a mean sample of 104. Two papers did not report mean age. Thornback and Muller (2015) reported their sample ranged between ages 7 and 12, whilst Ross et al., (2021) stated 49% of their sample was aged over 13. The mean ages in the remaining studies ranged from 7.7 (Deblinger et al., 2011) to 15.4 (Jensen et al., 2022). Cisler et al., (2015) and Marquez and Deblinger et al., (2020)'s samples were 100% female, whilst the samples in the remaining studies ranged between 50% (Murray et al., 2013) and 80.95% female (Jensen et al., 2022).

Three studies did not report information about their sample's ethnicity (Sachser et al., 2017; Hébert & Amédée, 2020; Murray et al., 2013) and a further

four studies reported participants' nationality. The remaining studies reported a range of ethnicities, with a mean of 47% of participants being Caucasian.

## **Trauma**

Whilst at least 80% of each sample in the included studies had experienced interpersonal trauma as defined in this review, four studies included other index traumas such as accidents or illness (Jensen et al., 2022; Murray et al., 2013; Sachser et al., 2017; Thornback & Muller, 2015). Sexual abuse was often the only (Deblinger et al., 2011; Deblinger et al., 2017; Hébert & Amédée, 2020; Mannarino et al., 2012; Cohen et al., 2004) or most common trauma.

Variation was found in the contextual information about traumatic experiences provided. Five studies (Cisler et al., 2015; Jensen et al., 2022; Lee & Brown, 2022; Murray et al., 2013; Ross et al., 2021) reported the mean types of trauma experienced by the sample, ranging between 1.86 and 5.65. Others (Deblinger et al., 2017; Sachser et al., 2017; Cohen et al., 2004) reported the mean number of traumatic incidents, ranging from four to 1000. Four studies identified their sample had experienced abuse over a prolonged period (Deblinger et al., 2017; Hébert & Amédée, 2020; Marquez & Deblinger, 2020; Thornback & Muller, 2015).

Some studies provided information about the relationships the abuse occurred in. Deblinger et al., (2017), Hébert and Amédée (2020) and Marquez and Deblinger (2020) detailed whether abuse had occurred within the family, with intra-familial rates ranging between 29% to 100%. Deblinger et al., (2011), Mannarino et al., (2012) and Thornback and Muller (2015) detailed whether perpetrators were adults, ranging between 42% and 80.5%.

## **Recruitment**

Sachser et al., (2017) did not provide any recruitment information, and the information provided by Deblinger et al., (2011) and Mannarino et al., (2012) was very limited. Others identified a range of recruitment strategies, including self-referrals (Thornback & Muller, 2015), volunteer outreach in local communities (Murray et al., 2013) and referrals via child protection (Deblinger et al., 2017).

**Table 3 – Table of characteristics**

<b><u>Author, date, Country</u></b>	<b><u>Aims</u></b>	<b><u>Findings</u></b>	<b><u>CCAT score /40</u></b>
<p><b>Cisler et al., (2015)</b>  <b>USA</b></p>	<p>To examine whether threat processing neurocircuitry predicts symptom reduction during TF-CBT.</p>	<p><u>PTSD</u></p> <p>Mean UCLA PTSD Index scores decreased from 36.04 (SD=17.87) pre-treatment to 18.30 (SD=16.62) post-treatment.</p> <p>100% met PTSD criteria pre-intervention, reducing to 35% post-intervention.</p> <p><u>DSO: Emotion regulation</u></p> <p>Mean DERS scores decreased from pre- to post-intervention across all subscales:</p> <p>Non-acceptance of negative emotions: 9.61(SD=7.06) pre vs 3.48(SD=5.15) post</p> <p>Difficulties engaging in goal-directed behaviour: 11.65(SD=5.75) pre vs 4.57(SD=5.54) post</p> <p>Impulse control: 8.30(SD=6.89) pre vs 3.52(SD=5.39) post</p> <p>Having limited strategies: 12.57(SD=8.98) pre vs 5.09(SD=7.30) post</p> <p>Clarity of emotions: 7.83(SD=5.35) pre vs 3.65(SD=4.99) post</p>	<p>27 68%</p>

<p><b>Deblinger et al., 2011</b></p> <p><b>USA</b></p>	<p>To examine the effects of TF-CBT with or without the trauma narrative component (TN) delivered in 8 vs 16 sessions.</p>	<p><u>PTSD</u> A significant difference between pre- and post-intervention PTSD symptoms were found across all conditions (<math>p &lt; 0.5</math>) with a large effect size, though actual effect sizes not reported.</p> <p><u>DSO: Negative self-concept</u></p> <p>A significant difference between pre- and post-intervention shame symptoms were found across all conditions (<math>p &lt; 0.5</math>) with a large effect size, though actual effect sizes not reported.</p>	<p>25 63%</p>
<p><b>Deblinger et al., (2017)</b></p> <p><b>USA</b></p>	<p>To determine if TF-CBT improved resiliency and if resilience is a moderator.</p>	<p><u>PTSD</u> Significant improvements were found from pre to post intervention for K-SADS-PTSD Re-experiencing (2.64 vs 0.94, <math>t = 13.73</math>, <math>d = 1.25</math>), K-SADS-PTSD Avoidance (3.05 vs 1.21, <math>t = 14.04</math>, <math>d = 1.30</math>) and K-SADS-PTSD hypervigilance (2.36 vs 0.76, <math>t = 11.96</math>, <math>d = 1.15</math>), <math>p &lt; .001</math>.</p> <p><u>DSO: Interpersonal difficulties.</u> Significant pre-post intervention differences were found for RSCA Sense of Relatedness (70.01 vs 74.37, <math>t = 4.03</math>, <math>d = 0.28</math>), <math>p &lt; .001</math>.</p> <p><u>DSO: Emotion Regulation</u> Significant pre-post intervention differences found for RSCA Emotion Regulation (23.16 vs 18.76, <math>t = 4.09</math>, <math>d = 0.33</math>), <math>p &lt; .001</math>.</p>	<p>26 65%</p>
<p><b>Hébert &amp; Amédée (2020)</b></p> <p><b>Canada</b></p>	<p>To differentiate PTSD profiles of child SA victims and their response to TF-CBT</p>	<p><u>PTSD</u> PTSD symptoms significantly improved from pre-treatment (62.63(SD=10.12) to posttreatment (43.97), <math>t = 7.94</math>, <math>d = .90</math>, <math>p &lt; .001</math>.</p> <p><u>DSO</u> Significant improvements found across all DSO categories.</p>	<p>30 75%</p>

		<p>Negative Self-concept: Pre-treatment= 1.17(SD=.78), post-treatment=.60(SD=.67), <math>t=6.50</math>, <math>d=0.74</math>, <math>p&lt;.001</math>.</p> <p>Emotion dysregulation: Pre-treatment=1.76(SD=.43), post-treatment =1.22(SD.82), <math>t=5.71</math>, <math>d=0.65</math>, <math>p&lt;.001</math>.</p> <p>Interpersonal difficulties: Pre-treatment=1.38(SD.67), post-treatment =.92(SD.72), <math>t=4.42</math>, <math>d=0.50</math>, <math>p&lt;.001</math>.</p>	
<p><b>Jensen et al., 2022</b></p> <p><b>Norway</b></p>	<p>To examine whether TF-CBT improves PTSD and CPTSD</p>	<p><u>PTSD</u> Significant decreases in PTSD overtime found for PTSD (estimate=-1.42, <math>p&lt;.001</math>) and C-PTSD groups (estimate=-2.09, <math>p&lt;.001</math>).</p> <p>Change was significantly greater for C-PTSD than PTSD (difference =-0.66, <math>p=.015</math>).</p> <p>All with pre-treatment PTSD diagnosis no longer met diagnostic criteria.</p> <p><u>DSO</u> C-PTSD had a significantly steeper decrease in DSO from pre- to post-treatment than PTSD (difference=-1.22, <math>p&lt;.001</math>).</p> <p>All meeting C-PTSD criteria no longer met diagnostic criteria post-treatment. 15.8% met criteria for PTSD.</p>	<p>35 88%</p>
<p><b>Lee &amp; Brown (2022)</b></p> <p><b>USA</b></p>	<p>To examine effectiveness of TF-CBT on executive functioning</p>	<p><u>PTSD</u> Significant reductions in PTSD symptoms from pre- to post-intervention found (<math>p&lt;.05</math>).</p> <p>Higher baseline PTSD scores were associated with larger negative slopes in PTSD trajectories.</p> <p><u>DSO: Emotion regulation</u></p>	<p>30 75%</p>

		Emotional control significantly improved from pre-intervention 6.10(SD2.87), to post-intervention 4.33(SD2.33), $d=.58$ , $p<.001$ for children and from pre-intervention 12.29(SD=2.99), to post-intervention SD=9.91(2.55), $d=.86$ , $p<.001$ for adolescents.	
<b>Mannarino et al., (2012)</b>	To examine the effects of TF-CBT with or without TN delivered in 8 vs 16 sessions at 6- and 12-month follow-up.	<p><u>PTSD</u> Significant improvements in PTSD symptoms maintained at 6- and 12-month follow up (<math>p&lt;.05</math>).</p> <p>K-SADS-Reexperiencing: Adjusted mean difference 1.51 (SE=0.11) post-test, 1.34(SE=0.13) at 6-month follow up and 1.11 (SE=0.13) at 12-month follow up.</p> <p>K-SADS-Avoidance: Adjusted mean difference 1.47 (SE=0.10) post-test, 1.24(SE=0.12) at 6-month follow up and 1.08 (SE=0.12) at 12-month follow up.</p> <p>K-SADS-Hypervigilance: Adjusted mean difference 1.24 (SE= 0.11) post-test, 1.14(SE=0.12) at 6-month follow up and 1.03 (SE=0.13) at 12-month follow up.</p> <p>11% continued to meet criteria for PTSD at 12-month follow-up.</p> <p>Significant 60% decrease in rate of meeting PTSD criteria at 12 months (McNemar Test, <math>p&lt;.001</math>).</p> <p><u>DSO: Negative self-concept</u> Significant improvements in shame symptoms maintained at 6- and 12-month follow up (<math>p&lt;.05</math>). Adjusted mean difference 2.56 (SE=0.25) post-test, 1.82(SE=0.29) at 6-month follow up and 1.87 (SE=0.30) at 12-month follow up.</p>	26 65%
<b>USA</b>			
<b>Follow up to Deblinger et al., (2011)</b>			

<p><b>Marquez &amp; Deblinger (2020)</b></p> <p><b>USA</b></p>	<p>To investigate the clinical value of TF-CBT for PTSD for a child whose experienced familial sex trafficking and labour exploitation.</p>	<p><u>PTSD</u> Scores reduced from within the severe PTSD range, to within doubtful PTSD range on the UCLA-PTSD-I.</p> <p><u>DSO</u> Initial scores indicated client experiencing a high level of shame. This reduced post-intervention.</p>	<p>25 63%</p>
<p><b>Murray et al., 2013</b></p> <p><b>Zambia</b></p>	<p>To evaluate the feasibility and effectiveness of TF-CBT for orphans and vulnerable children in Zambia</p>	<p><u>PTSD</u> Average post-treatment PTSD scores (27.6) were significantly lower than pre-treatment scores (67.6, <math>p&lt;.0001</math>).</p> <p><u>DSO: Negative self-concept</u> Average post-treatment shame scores (2.2) significantly lower than pre-treatment mean (8.3, <math>p&lt;.0001</math>).</p>	<p>27 68%</p>
<p><b>Ross et al., (2021)</b></p> <p><b>USA</b></p>	<p>To evaluate trauma chronicity and PTSD presentation as moderators of outcomes for TF-CBT</p>	<p><u>PTSD</u> Across groups, significant improvements in PTSD post intervention (<math>p&lt;.05</math>).</p> <p><u>DSO</u> Across groups, significant improvements for emotion regulation and negative self-concept scores (<math>p&lt;.05</math>), but not interpersonal relationships.</p> <p>Youth with acute trauma demonstrated improvements in emotion dysregulation faster than those with chronic trauma.</p>	<p>28 70%</p>

<p><b>Sachser et al., (2017)</b></p> <p><b>Germany</b></p>	<p>To determine whether CPTSD can be replicated in children and young people, and their treatment response to TF-CBT.</p>	<p><u>PTSD</u> C-PTSD group showed significant improvement following TF-CBT CAPS-CA pre, 70.57 (SD15.94) vs Post=39.61 (SD29.11), <math>T(22) = 5.37</math>, <math>d = 1.37</math>, <math>p &lt; .001</math>.</p> <p><u>DSO</u> C-PSTD group showed significant improvements across all six items of DSO, when comparing pre- and post-intervention scores. Effect sizes were medium for problems in emotion regulation (<math>d = 0.40-0.60</math>), and large for negative self-concept (<math>d = 0.87-1.16</math>) and interpersonal problems (<math>d = 0.88-1.03</math>).</p>	<p>31 78%</p>
<p><b>Thornback &amp; Muller (2015)</b></p> <p><b>Canada</b></p>	<p>To explore the relationship between emotion regulation and symptom change following TF-CBT</p>	<p><u>PTSD</u> Child-reported PTSD reduced from 10.69 (SD6.63) to 9.34(SD6.80) pre-intervention, to 7.71(SD5.33) post-treatment to 7.19 (SD6.22) at follow up.</p> <p>Parent-reported PTSD reduced from 45.31 (SD12.02) to 45.00(SD11.30) pre-intervention, to 40.00(SD11.54) post-treatment to 38.88 (SD11.80) at follow up.</p> <p><u>DSO: Emotion Regulation</u> From pre-assessment to post-treatment, emotion inhibition (<math>t = 1.77</math>, <math>p = .04</math>) and lability/negativity (<math>t = 1.69</math>, <math>p = 0.5</math>) significantly improved.</p> <p>From pre-assessment to six-month follow up, inhibition (<math>t = 1.92</math>, <math>p = .03</math>) and dysregulation (<math>t = 2.63</math>, <math>p = 0.1</math>) significantly improved.</p> <p>From pre-treatment to post-treatment, only lability/negativity significantly improved (<math>t = 2.20</math>, <math>p = .02</math>).</p> <p>From pre-treatment to six-month follow up, inhibition (<math>t = 1.48</math>, <math>p = 0.4</math>), dysregulation (<math>t = 2.37</math>, <math>p = 0.1</math>) and lability/negativity (<math>t = 1.82</math>, <math>p = 0.4</math>) significantly improved.</p> <p>Poor ER skill did not significantly improve at any time point.</p>	<p>29 73%</p>

<p><b>Cohen et al., (2004)</b></p> <p><b>USA</b></p>	<p>To examine the effects of TF-CBT and Child Centred Therapy (CCT) for PTSD and related problems.</p>	<p><u>PTSD</u> TF-CBT group had significantly lower post-intervention PTSD scores than CCT across all subscales.</p> <p>K-SADS-Reexperiencing: <math>F=10.68</math>, <math>d=0.49</math>, <math>p=.01</math>. K-SADS-Avoidance: <math>F=21.90</math>, <math>d=0.70</math>, <math>p=.001</math>. K-SADS-Hypervigilance: <math>F=7.22</math>, <math>d=0.40</math>, <math>p=.01</math>.</p> <p>21% of TF-CBT met criteria for PTSD post-intervention, compared to 46% of CCT group. This difference was significant <math>X^2(1, N=180) = 11.28.</math>, <math>p&lt;.001</math>.</p> <p><u>DSO: Negative self-concept</u> Significant improvements from pre- to post-intervention were found for both the SHAME and CAPS (<math>p&lt;.05</math>).</p> <p>TF-CBT group had significantly lower post-intervention shame scores than CCT, <math>F=9.52</math>, <math>d=0.46</math>, <math>p=.01</math>. TF-CBT group had significantly lower post-intervention CAPS self-blame for negative events <math>F=1.57</math>, <math>d=0.19</math>, <math>p=.05</math> than the CCT group.</p> <p><u>DSO: Interpersonal Difficulties</u> TF-CBT group had significantly lower post-intervention CAPS Interpersonal Trust than the CCT group.</p>	<p>27 68%</p>
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TF-CBT – Trauma-focused Cognitive behavioural Therapy; PTSD: Post-traumatic stress disorder; C-PTSD – complex post-traumatic stress disorder; DSO – Disturbances of self-organisation; DERS; Difficulties in Emotion Regulation Scale; RCSA – Resiliency Scales for Children and Adolescents; K-SADS-PTSD – Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and lifetime Version-PTSD Module; CAPS-CA – Clinical administered PTSD scale for children and adolescents; CAPS - Children’s attributions and perception scale.

## **Measures**

All studies utilised a standardised measure of PTSD symptomology or diagnosis. The Schedule for Affective Disorders and Schizophrenia for School-Age Children, Present and Lifetime Version (Kaufman et al., 1997) was most used, in five studies.

Seven papers explored the impact of TF-CBT on emotion regulation difficulties, five of which used subscales of or complete standardised measures (Cisler et al., 2015; Lee & Brown, 2022; Ross et al., 2021; Thornback & Muller, 2015; Deblinger et al., 2017), with the remaining two taking items from several measures to create a measure (Hébert & Amédée, 2020; Sachser et al., 2017). Measures explored varying aspects of emotion regulation difficulties, including emotional reactivity, ability to regulate and irritability. The Executive Functioning Index of the Behavioural Assessment System for Children 2 (Reynolds & Kamphaus, 2004) was most commonly used.

Five papers explored the impact of TF-CBT on interpersonal difficulties, three of which used subscales of or complete standardised measures (Deblinger et al., 2017; Ross et al., 2021; Cohen et al., 2004), with the remaining two taking items from several measures to construct a measure (Hébert & Amédée, 2020; Sachser et al., 2017). Measures explored varying aspects of interpersonal difficulties, including loneliness, sense of relatedness and trust.

Eight papers explored the impact of TF-CBT on negative self-concept. Five papers explored the impact on shame, all using The Shame Questionnaire (Deblinger et al., 2011; Mannarino et al., 2012; Marquez & Deblinger, 2020; Murray et al., 2013; Cohen et al., 2004). Ross et al., (2021) considered the impact on self-blame, as measured by the self-blame subscale of the Perceptions of Children Exposed to Interpersonal Violence measure (Brown, 2000). Hébert and Amédée, (2020) and Sachser et al., (2017) constructed a negative self-concept measure by extracting items from several measures.

Jensen et al., (2022) was the only study to use a standardised measure of DSO symptom frequency. The Child and Adolescent Trauma Screen 2 (Sachser et al., 2022) has been demonstrated to have good internal consistency, validity and reliability (Sachser et al., 2022). See Appendix D for further information on all measures used, including psychometric properties.

## **Intervention**

### **Facilitators**

Facilitators were predominately therapists trained in TF-CBT (Deblinger et al., 2011; Jensen et al., 2022; Mannarino et al., 2012; Ross et al., 2021; Thornback & Muller, 2015; Cohen et al., 2004). Others were doctorate-level psychology graduates (Cisler et al., 2015; Lee & Brown, 2022) or local counsellors with no professional background, trained in TF-CBT (Murray et al., 2013). Facilitator information was not provided or limited in the remaining studies.

### **Treatment fidelity**

Fidelity was not discussed in four studies (Cisler et al., 2015; Deblinger et al., 2017; Hébert & Amédée, 2020; Sachser et al., 2017) and only mentioned in the abstract of Marquez and Deblinger et al., (2020). The remaining eight studies reported that fidelity to the TF-CBT model was monitored through either or a combination of fidelity checklists, supervision or reviewing the content of audio-taped sessions. Only three studies provided information regarding how well treatment protocols were adhered to (Thornback & Muller, 2015; Cohen et al., 2004; Jensen et al., 2022), reporting high fidelity to the model.

### **Treatment**

Two studies did not state the average number of sessions completed (Cisler et al., 2015; Sachser et al., 2011). The remaining studies ranged between 7.36 (Deblinger et al., Mannarino et al., 2012) and 26.82 (Ross et al., 2021) mean sessions. In line with the TF-CBT model, all studies involved individual and conjoint sessions with carers. Murray et al., (2013) and Marquez and Deblinger (2020) detailed cultural modifications adopted to meet the needs of the local community.

## **Analysis**

All but one (Marquez & Deblinger et al., 2020) study reported descriptive statistics. Analyses of variance (Sachser et al., 2017), analyses of covariance (Cohen et al., 2004; Mannarino et al., 2012), multilevel modelling (Ross et al., 2021) and latent growth curves (Lee & Brown, 2022) were utilised. The remaining studies used either paired samples t-tests or chi-squared tests.

Only Ross et al., (2010) completed a post-hoc power analysis despite all but two studies (Deblinger et al., 2017; Hébert & Amédée, 2020) being limited by their small sample size.

## **Quality appraisal**

Quality appraisal scores for each paper are presented in Table 3 and Appendix B. Scores ranged between 25 (63%; Marquez & Deblinger, 2011; Deblinger et al., 2011) and 35 (88%; Jensen et al., 2022). Deblinger et al., (2011) did not discuss the role of shame in their introduction or discussion, despite including this as an outcome measure, provided little recruitment information and had a small sample without a power calculation, as well as ethical limitations. Similarly, Marquez & Deblinger et al., (2020) did not acknowledge significant confounding variables that are likely to have influenced the case study, nor did they acknowledge the limitations of or future directions for the study. There were also significant ethical concerns, including no information regarding how the confidentiality of the client was being maintained, such as through use of a pseudonym, despite the detail of personal information provided.

Overall, most studies lost points due to the lack of a control group or follow-up, small samples, lack of power calculation, and inconsistent reporting of results as well as significant ethical concerns.

## **Ethics**

The developers of TF-CBT were involved in six of the included studies. This conflict of interest was not declared in five of these studies (Deblinger et al., 2011;

Mannarino et al., 2012; Marquez & Deblinger, 2020; Murray et al., 2013; Cohen et al., 2004) despite stating in Deblinger et al., (2017) they receive royalties and honoraria for TF-CBT related activities. Furthermore, funding was not declared in two of their studies (Deblinger et al., 2017; Marquez & Deblinger, 2020), nor was ethical approval in a further two (Marquez & Deblinger, 2020; Murray et al., 2013).

Of the studies the developers were not involved in, ethical approval was missing from Ross et al., (2021)'s study and conflicts of interest were not declared in three studies (Lee & Brown, 2022; Ross et al., 2021; Thornback & Muller, 2015).

### **Synthesis of main findings - PTSD symptoms**

Overall, results suggest TF-CBT is effective in reducing symptoms of PTSD following interpersonal trauma. Eight papers explored and demonstrated statistically significant reductions in PTSD symptoms post-intervention,  $p < .05$  (Deblinger et al., 2011; Deblinger et al., 2017; Hébert & Amédée, 2020; Jensen et al., 2022; Murray et al., 2013; Ross et al., 2021; Sachser et al., 2017; Lee & Brown, 2022). Additionally, though statistical significance was not reported, Cisler et al., (2015) and Thornback and Muller (2015) reported a decrease in PTSD symptoms and the case study (Marquez & Deblinger, 2020) reported clinically significant change, with scores reducing from severe to within the doubtful PTSD range. Five studies reported effect sizes, ranging from small, 0.40 (Cohen et al., 2004), to large, 1.37 (Sachser et al., 2017) as based on Cohen's (1988) benchmarks. Deblinger et al., (2011) only reported that their effect size was large. It should be noted that the only study to use a control group reported lower effect sizes.

Three papers explored and reported reductions to the percentage of the sample meeting PTSD diagnosis post-intervention, ranging from 60-65% reductions (Cisler et al., 2015; Mannarino et al., 2012; Cohen et al., 2004), though Cisler et al., (2015) did not look at the statistical significance of this change. Of note, Cohen et al., (2004) reported the TF-CBT group had a significantly greater decrease in post-intervention diagnosis than the child-centred therapy control group.

## **Synthesis of main findings – DSO symptoms**

### **Emotion regulation**

All but one (Thornback & Muller, 2015) of seven studies exploring the impact of TF-CBT on emotion regulation difficulties found statistically significant improvements in all emotion regulation measures at post-intervention,  $p < .05$ . Four of these papers reported effect sizes ranging from small, 0.33 (Deblinger et al., 2017), to large, 0.86 (Lee & Brown, 2022), with a medium mean effect size of 0.57, as based on Cohen's (1988) benchmarks. Thornback & Muller (2015) found significant improvements in emotion inhibition, negativity and dysregulation from pre-treatment to 6-month follow-up ( $p < .04$ ), but no improvements in emotional regulation skills.

### **Interpersonal difficulties**

All but one (Ross et al., 2021) of five studies exploring impact of TF-CBT on interpersonal difficulties found statistically significant improvements in interpersonal difficulties post-intervention ( $p < .05$ ). Three studies reported effect sizes, ranging from small, 0.28 (Deblinger et al., 2017) to large, 1.30 (Sachser et al., 2017), with a medium mean effect size of 0.67, as based on Cohen (1988) benchmarks. It should, however, be noted that the effect size reported by Sachser et al (2017) is much higher than other papers and is based upon two items taken from two different measures, and should therefore be considered with caution. Cohen et al., (2004) found that TF-CBT leads to significantly better improvements in interpersonal trust difficulties than the child-centred therapy control group.

However, Ross et al., (2021) did not find any significant improvements to interpersonal difficulties. They did note that those only meeting criteria for PTSD, rather than C-PTSD, showed larger improvements, though this difference was not statistically significant.

### **Self-concept**

Eight papers explored the impact of TF-CBT on self-concept. All five papers that looked at shame (Deblinger et al., 2011; Mannarino et al., 2012; Marquez & Deblinger, 2020; Murray et al., 2013; Cohen et al., 2004) reported statistically significant reductions in post-intervention shame scores ( $p < .05$ ). Mannarino et al.,

(2012) found these significant reductions were sustained at 6- and 12-month follow up and Cohen et al., (2004) found the TF-CBT group had significantly lower rates of shame post-intervention than the child-centred therapy control group.

Three papers (Hébert & Amédée, 2020; Sachser et al., 2017; Ross et al., 2011) found significant improvements in self-concept ( $p < .05$ ), with effect sizes ranging from small, 0.40, to medium, 0.74, as based on Cohen (1988) benchmarks though Ross et al., (2021) did not report effect sizes. Additionally, Cohen (2004) found significant reductions in levels of self-blame following TF-CBT, which were significantly lower than the child-centred therapy control group.

### DSO overall

Jensen et al., (2022) reported changes to overall DSO symptoms. They found at baseline, those meeting criteria for C-PTSD had significantly higher rates of DSO symptoms than those meeting criteria for PTSD. They reported significant reductions in DSO post-intervention across PTSD and CPTSD groups ( $p < .001$ ) and that the C-PTSD group (estimate -2.06) had a significantly steeper decrease in DSO symptoms (estimate -0.84),  $p < .001$ . Furthermore, Jensen et al., (2022) report 100% of the C-PTSD group did not meet the C-PTSD threshold following TF-CBT, with only 15.8% of this group then meeting criteria for PTSD.

## Discussion

This review explored the effectiveness of TF-CBT in reducing PTSD and DSO symptoms following interpersonal childhood trauma. 13 studies were reviewed, appraised, and synthesised. Though all studies scored above 60% on the CCAT, variations in the quality of the papers reviewed, as well as common methodological flaws were observed. These conclusions should therefore be interpreted with such limitations in mind.

### PTSD symptoms

Overall, this review suggests TF-CBT can effectively reduce PTSD symptoms following interpersonal childhood trauma. All studies demonstrated a decrease in

PTSD symptoms post-intervention, with effect sizes ranging from small to large. Furthermore, two studies demonstrated treatment effects were sustained at 6- and 12-month follow-up. The clinical significance of these findings was further demonstrated in several studies, which found a significant decrease in the number of children meeting criteria for PTSD following the intervention. These findings are consistent with existing literature demonstrating the effectiveness of TF-CBT in reducing PTSD symptoms (Cary & McMillen, 2012; McGuire et al., 2021; De Arellano et al., 2014; Morina et al., 2016) and therefore add to the current evidence base suggesting TF-CBT can be effective for reducing PTSD symptoms following interpersonal trauma (Cohen et al., 2012). However, in all studies, some young people continued to experience clinically significant PTSD symptoms.

### **DSO symptoms**

All but one study reported significant improvements to emotion regulation post-intervention, with effect sizes from small to large, which were sustained at follow-up in one study. Whilst Thornback and Muller (2016) found significant reductions in maladaptive emotion regulation strategies, significant improvements in adaptive emotion regulation skills were not found. This contrasts with previous research demonstrating improved emotion regulation skills post-TF-CBT for children who have experienced abuse (Farnia et al., 2018). It is possible small changes in emotion regulation skills could not be detected in Thornback and Muller (2016)'s study due to the small sample limiting statistical power. These findings, therefore, suggest TF-CBT may improve aspects of emotion regulation, which has been found to be an important moderator of reductions in PTSD symptoms (Sharma-Patel & Brown, 2016).

All but one study reported significant improvements to interpersonal difficulties post-TF-CBT, again with effect sizes ranging from small to large. However, the large effect size was observed in a study that did not employ a standardised measure of interpersonal difficulties. Indeed, the study that did employ a standardised measure found no significant change in interpersonal difficulties post-intervention. This may however have been because their sample was not experiencing clinically significant levels of interpersonal difficulties pre- or post-intervention and the power to detect

smaller effect sizes was limited due to sample size. Overall, these findings are in line with existing literature suggesting interpersonal difficulties can be improved following trauma-focused therapies where interpersonal difficulties are not the focus (Swerdlow et al., 2022; Scoglio et al., 2022), including TF-CBT (Jensen et al., 2017). These findings are particularly important given research suggests interpersonal difficulties are often a motivator for engaging with trauma-focused therapies (Rosen et al., 2013) and improvements to interpersonal difficulties can improve therapeutic outcomes (Price et al., 2018).

With regards to improvements in negative self-concept, all studies exploring the impact of TF-CBT on shame demonstrated significant improvements, that were sustained at follow-up and superior to changes observed in the control group. In line with existing research (Sharma-Patel & Brown, 2016), significant improvements in self-blame were observed in one study, which has again been demonstrated to mediate reductions in PTSD symptoms (Sharma-Patel & Brown, 2016). Studies utilising an unstandardised measure found significant improvements to overall self-concept, with effect sizes ranging from medium to large. These findings are in line with existing literature suggesting TF-CBT improves young people's self-efficacy, self-compassion and negative trauma-related cognitions (Farina et al., 2018; Beaumont et al., 2016; Jensen et al., 2018) as well as caregiver's sense of shame and guilt (Mastorakos et al., 2021).

The one study exploring improvements to DSO as a whole found significant reductions in DSO following TF-CBT, as well as a 100% reduction in young people meeting criteria for C-PTSD post-intervention. This therefore evidences the clinical effectiveness of TF-CBT for improving DSO symptoms. Overall, therefore, the results of this review suggest TF-CBT shows promise in being able to effectively reduce DSO symptoms following childhood interpersonal trauma.

### **Clinical implications**

This review suggests that TF-CBT could therefore be an effective intervention for reducing PTSD, and possibly DSO symptoms, following childhood interpersonal trauma.

The mechanisms through which TF-CBT improves DSO symptoms however are currently less clear. TF-CBT explicitly aims to improve trauma-related emotion regulation skills which are then drawn upon and consolidated during the trauma processing/narration phase (Cohen et al., 2012; Cloitre et al., 2004; Sharma-Patel & Brown, 2016). For interpersonal difficulties, as well as improving the young person's relationship with their participating caregiver, TF-CBT may improve interpersonal difficulties partly by providing the young person with the experience of a safe and predictable relationship (Cohen et al., 2012), possibly challenging their inner working models of others as unsafe and unpredictable. Finally, Ehlers and Clark (2000) hypothesise that negative appraisals of the self, others and the world following trauma maintain PTSD symptoms. TF-CBT may therefore improve negative self-concept by normalising young people's and caregivers' response to trauma through psychoeducation and providing the opportunity for new learnings about themselves, others and the world during their relationship with the therapist, their improved relationship with their caregiver and the process of trauma exposure and narrative.

Future research however should aim to better understand the underlying mechanisms of change, as well as which aspects of TF-CBT are most helpful in improving DSO domains, to inform tailored interventions that meet specific needs, such as increasing modules that are found to be effective for improving interpersonal difficulties, if indicated during assessment.

Indeed, many studies reflected on the need for adaptations required to improve DSO, including increasing treatment length to 25-30 sessions, as supported by TF-CBT developers (Cohen et al., 2012; Cohen et al., 2017). However, this review found that those who experienced DSO symptoms did not require significantly more sessions than those who did not (Hébert & Amédée, 2020; Jensen et al., 2022) and improvements in both PTSD and negative self-concept were observed after only eight sessions of TF-CBT (Mannarino et al., (2012). This review, therefore, suggests that TF-CBT shows promise as a resource-effective intervention to provide improvements to DSO, with a relatively quick impact for some young people. Future research should therefore consider completing an RCT of standardised TF-CBT vs TF-CBT adapted in line with Cohen et al., (2012) recommendations to evaluate the impact of such additions.

However, whilst this review did demonstrate the effectiveness of TF-CBT, some young people continued to experience clinically significant levels of PTSD symptoms, and some DSO symptoms, post-intervention. Future research is therefore needed to understand what unmet needs may be underlying this, as well as their response to the aforementioned adaptations, to better improve outcomes for those young people whose lives continued to be affected by significant trauma-related difficulties.

This review further highlights that those experiencing DSO may experience a slower or decreased rate of change in both PTSD and DSO symptoms post-TF-CBT. These findings may be in line with NICE (2018) view that DSO symptoms may impact young people's ability to engage with trauma-focused therapies. This, therefore, highlights the importance of routine assessment of DSO symptoms in clinical practice to better inform formulation-driven intervention plans that respond to complex needs.

### **Strengths and limitations of studies**

Only two studies collected follow-up data, limiting the ability of this review to consider the long-term effectiveness of TF-CBT. The two papers that did explore this however found significant sustained effects. Similarly, all but one study did not include a control group. This limits the studies, and therefore this review's, ability to account for confounding variables, such as possible generic-therapy effects. All but two studies reported limitations regarding their small sample sizes which reduced their statistical power. Studies may not have therefore been powered sufficiently to detect subtle changes post-intervention. Future research is therefore needed to address these limitations by including larger diverse samples, control groups and follow-up periods.

A further limitation is that information provided regarding the trauma experienced varied, meaning important contextual information, such as the relationship the trauma occurred in, its chronicity and frequency, was not consistently reported. Similarly, in some studies, there was a lack of transparency regarding how

interpersonal trauma was being operationalised. This, therefore, limits the reader's ability to understand to whom the findings from this review can be generalised.

Research suggests that chronic interpersonal trauma occurring within caregiving relationships specifically has a profound impact on a child's development and attachment, above that of interpersonal trauma occurring outside of the caregiving system (Noonan & Pilkington, 2020; van der Kolk et al., 2009, D'Andrea et al., 2012), which has been associated with worsening PTSD, DSO and low mood symptoms (Lim et al., 2020; Van Dijke et al., 2013). This subpopulation of young people may therefore have different abilities to engage with, and therefore different outcomes, following TF-CBT. Future researchers should therefore aim to consistently contextualise the trauma experienced by their sample, including the nature of their relationship to the perpetrator, to allow for clearer conclusions to be drawn regarding who findings can be generalised to, and to better understand outcomes for vulnerable populations, such as those who experienced repeated trauma within their caregiving relationships.

Similarly, there is a lack of consistent information in the included studies regarding the participating caregiver, including their relationship to the child. This is important as research consistently demonstrates the influence caregivers have on children's TF-CBT outcomes (Canale et al., 2021; Yasinski et al., 2016), as well as the differing experience of and responses to TF-CBT for children in substitute care (Gusler et al., 2023; Eslinger et al., 2014; Esterer et al., 2023; Martin et al., 2023). Future research should therefore aim to contextualise participating caregivers' samples to again allow for clearer conclusions to be drawn regarding whom the findings can be generalised to.

Finally, another flaw of this review is that the developers of TF-CBT were involved in six out of 13 included studies. This should be identified as a possible source of bias, especially given the ethical concerns highlighted previously regarding lack of declarations of conflicts of interest, and funding sources.

## **Critique of review**

A clear limitation of this review is the lack of standardised measurement of DSO symptoms, with only one study using the one current standardised measure (The Child and Adolescent Trauma Screen-2; Sachser et al., 2022). Further research should therefore aim to replicate these findings, using a validated measure of DSO symptoms, such as the awaited DECRYPT trial (Allen et al., 2021) which will explore the effectiveness of TF-CBT for both PTSD and DSO symptoms for youth who have experienced multiple traumas. Future research should also consider evaluating the emerging DSO measurement tools to ensure they accurately conceptualise the psychological impact of interpersonal trauma, including as reported by young people themselves. Furthermore, future research should aim to establish norms for DSO symptoms to allow for conclusions regarding the clinical effectiveness of changes post-TF-CBT to be drawn. Taking these factors into consideration, this review can therefore only currently provide tentative support for the effectiveness of TF-CBT in improving DSO symptoms.

Despite increased trauma-related difficulties, many children who have experienced chronic interpersonal trauma do not meet the criteria for PTSD or C-PTSD (van der Kolk et al, 2009; Pynoos et al., 2008), as some forms of interpersonal trauma, such as emotional abuse, do not meet the criteria due to perceived lack of threat or actual harm (World Health Organisation, WHO; 2018), despite research demonstrating that such experiences do impact the development of young people (Ozturk & Sar, 2006). This review may therefore not capture the experience of all young people exposed to interpersonal trauma, nor consequently their response to TF-CBT. Future research should therefore consider the effectiveness of TF-CBT for youth who have experienced interpersonal traumas that are not currently encompassed within PTSD criteria.

All but one study (Murray et al., 2013) was conducted within Westernised cultures, limiting the generalisability of these findings. Samples were also predominantly females further limiting generalisability, though females have been found to be more likely to experience interpersonal trauma (Gatov et al., 2020; Fischer et al., 2016; Slotboom et al., 2020). This study is also impacted by language

bias, given only studies published in English were included due to a lack of translations resources. However, most individual studies included a wide range of ethnicities in their samples, increasing possible generalisability.

Finally, the rigour of this study was impacted as only one reviewer was involved in the selection and appraisal of articles. This risk of bias however was offset by the use of stringent inclusion criteria agreed with supervisor, and ambiguous papers were reviewed by author and supervisor against the inclusion criteria.

### **Conclusion**

This review supports the use of TF-CBT to reduce PTSD symptoms following childhood interpersonal trauma. Furthermore, TF-CBT shows promise for reducing DSO symptoms, though these findings are tentative, and further research is needed to address current methodological and conceptual flaws.

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## **Appendix**

### **Appendix A – Target Journal Guidelines**

Author guidelines for the Journal of Child and Adolescent Trauma can be accessed here: <https://link.springer.com/journal/40653/submission-guidelines>

### Appendix B – Extended Table of Characteristics

<u>Author, date, Country</u>	<u>Aims</u>	<u>Methodology</u>	<u>Sample and recruitment</u>	<u>Intervention</u>	<u>Findings</u>	<u>Strengths and limitations</u>	<u>CCAT score /40</u>
<b>Cisler et al., (2015)</b> <b>USA</b>	To examine whether threat processing neurocircuitry predicts symptom reduction during TF-CBT.	<u>Design</u> Quasi-experimental  <u>Measures</u> PTSD: UCLA-PTSD-RI  DSO: DERS  <u>Analysis</u> Descriptive statistics	<u>Recruitment</u> Through local outpatient clinics, child advocacy centres, schools, juvenile justice, churches and community organisations.  <u>N</u> 23 treatment completers  <u>Mean age</u> 13.87(SD=11.77)  <u>Sex</u> 100% female  <u>Ethnicity</u>	<u>Delivery</u> 12-week protocol of 60-90 minute weekly sessions.  <u>Facilitator</u> Post doctoral Clinical psychology fellows and a doctorate-level graduate student  <u>Treatment fidelity</u> Not provided	<u>PTSD</u>  Mean UCLA PTSD Index scores decreased from 36.04 (SD=17.87) pre-treatment to 18.30 (SD=16.62) post-treatment.  100% met PTSD criteria pre-intervention, reducing to 35% post-intervention.  <u>DSO: Emotion regulation</u> Mean DERS scores decreased	<u>Strengths</u> Approval, funding and conflict of interest statement clear.  Clear background and rationale for research.  Recruitment sources increase ecological validity.  Inclusion and exclusion criteria clearly defined.  Protocol used for intervention  Acknowledged limitations and	27 68%

		<p>39% Caucasian 52% African American 9% biracial</p> <p><u>Trauma</u> Sexual abuse, physical abuse, witnessing domestic violence</p> <p><u>Mean N of trauma types</u> 6.65</p> <p><u>Other trauma information</u> None provided</p>		<p>from pre- to post-intervention across all subscales:</p> <p>Non-acceptance of negative emotions: 9.61(SD=7.06) pre vs 3.48(SD=5.15) post</p> <p>Difficulties engaging in goal-directed behaviour: 11.65(SD=5.75) pre vs 4.57(SD=5.54) post</p> <p>Impulse control: 8.30(SD=6.89) pre vs 3.52(SD=5.39) post</p> <p>Having limited strategies: 12.57(SD=8.98) pre vs</p>	<p>conflicting existing literature.</p> <p><u>Limitations</u> No control group or follow up</p> <p>Small sample size, therefore limiting power of study and power calculation not reported.</p> <p>Limited generalisability due to sample size, all female and missing information to contextualise setting.</p> <p>No information about treatment fidelity.</p> <p>Significance of pre and post-intervention changes to outcome measures not reported.</p> <p>Psychometric properties of measures used not considered.</p>	
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					5.09(SD=7.30) post  Clarity of emotions: 7.83(SD=5.35) pre vs 3.65(SD=4.99) post		
<b>Deblinger et al., 2011 USA</b>	To examine the effects of TF-CBT with or without the trauma narrative component (TN) delivered in 8 vs 16 sessions.	<u>Design</u> RCT  <u>Measures</u> PTSD: K-SADS-PTSD  DSO: SHAME  <u>Assessment</u> Pre and post intervention  <u>Analysis</u> Descriptive statistics and paired t-tests	<u>Recruitment</u> Recruited from two sites in USA.  <u>N</u> 179  <u>Mean age</u> 7.7 (SD=2.1)  <u>Sex</u> 61% female  <u>Ethnicity</u> 65% Caucasian 14% African American 7% Hispanic 14% other  <u>Trauma</u>	<u>Delivery</u> Either 8 (7.36, SD=1.33) or 16 (13.92, SD= 3.34) sessions, either without or without TN.  <u>Facilitators</u> Psychology Graduate Therapists, clinical social work or a related field and 3 years of experience.  <u>Treatment fidelity</u>	<u>PTSD</u> A significant difference between pre and post-intervention PTSD symptoms were found across all conditions (p<0.5) with a large effect size, though actual effect sizes not reported.  <u>DSO: Negative self-concept</u>  A significant difference between pre and	<u>Strengths</u> Intervention well described  Sample flow through study clearly defined  Inclusion and exclusion defined  Consent process defined  Blind to conditions and independent rater used for outcome measures  Sample financially compensated for time  Clear data analysis plan	25 63%

			<p>Sexual abuse involving age or size differential, and utilized force, verbal threats and/or coercion.</p> <p><u>Mean N of trauma types/experiences</u> Not provided</p> <p><u>Other trauma information</u> 51% perpetrators related or unrelated adult</p>	<p>Feedback on taped sessions and independent ratings provided.</p>	<p>post-intervention shame symptoms were found across all conditions (<math>p &lt; 0.5</math>) with a large effect size, though actual effect sizes not reported.</p>	<p><u>Limitations</u> Little recruitment information</p> <p>Pre-intervention means not reported</p> <p>Individual t-test effect sizes and p sizes not reported.</p> <p>No follow up or control.</p> <p>Limited information regarding relevance of shame in introduction or discussion.</p> <p>No conflict of interest declared, but some authors involved in developing TF-CBT</p> <p>Small cell sizes therefore limiting power.</p> <p>Some overlap in conditions due to ethical reasons.</p> <p>Limited generalizability to young children.</p>	
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						No information regarding number of traumas experienced.	
<b>Deblinger et al., (2017)</b> <b>USA</b>	To determine if TF-CBT improved resiliency and if resilience is a moderator.	<u>Design</u> Quasi-experimental  <u>Measures</u> PTSD: K-SADS-PTSD  DSO: RSCA  <u>Assessment</u> Pre & post intervention  <u>Analysis</u> Descriptive statistics, paired-samples t-tests	<u>Recruitment</u> Referred by child protection, law enforcement or other child abuse professionals.  <u>N</u> 115  <u>Mean age</u> 11.65 (SD=3.03)  <u>Sex</u> 73% female  <u>Ethnicity</u> 46% Caucasian 24% Latino 18% African American 11% other  <u>Trauma</u> Sexual abuse  <u>Mean N of trauma incidents</u> 10 (SD=25)	<u>Delivery</u> Mean sessions 20 (SD=6)  <u>Facilitator</u> Not provided  <u>Treatment fidelity</u> Not provided	<u>PTSD</u> Significant improvements were found from pre to post intervention for K-SADS-PTSD Re-experiencing (2.64 vs 0.94, $t=13.73$ , $d=1.25$ ), K-SADS-PTSD Avoidance (3.05 vs 1.21, $t=14.04$ , $d=1.30$ ) and K-SADS-PTSD hypervigilance (2.36 vs 0.76, $t=11.96$ , $d=1.15$ ), $p<.001$ .  <u>DSO:</u> <u>Interpersonal difficulties.</u> Significant pre-post intervention differences were found for RSCA Sense of Relatedness	<u>Strengths</u> Clear rationale, aims and link to literature  Sample well described  Measures clearly described  Informed consent explicit  Limitations acknowledged  <u>Limitations</u> Little description of intervention, including fidelity to model and how delivered  Inclusion/exclusion not included  No control group or follow up implemented	26 65%

			<u>Other trauma information</u> Abuse occurred for an average of 348 (SD687) days for 104 children.		(70.01 vs 74.37, $t= 4.03$ , $d =0.28$ ), $p<.001$ .  <u>C-PTSD: Emotion Regulation</u> Significant pre-post intervention differences found for RSCA Emotion Regulation (23.16 vs 18.76, $t= 4.09$ , $d=0.33$ ), $p<.001$ .	Post-intervention assessments conducted 2 weeks prior to end, therefore not true post-treatment  No declaration of funding  No power calculation  Conflict of interest, though declared	
<b>Hébert &amp; Amédée (2020)</b>  <b>Canada</b>	To differentiate PTSD profiles of child SA victims and their response to TF-CBT	<u>Design</u> Quasi-experimental  <u>Measures</u> PTSD: CITES II  DSO; Items taken from; CITES II RCMAS SPPC CDI To create DSO categories.	<u>Recruitment</u> Treatment seeking youth who had disclosed sexual abuse at a Child Advocacy Centre and met inclusion criteria.  <u>N</u> 384 CPTSD subgroup – 79 their data reported in this review  <u>Mean age</u>	<u>Delivery</u> Mean of 14.54 (3.89) weekly individual.  <u>Facilitator</u> Not provided  <u>Treatment Fidelity</u> Not provided	<u>PTSD</u> PTSD symptoms significantly improved from pre-treatment (62.63(SD=10.12) to posttreatment (43.97), $t=7.94$ , $d=.90$ , $p<.001$ .  <u>DSO</u> Significant improvements found across all DSO categories.	<u>Strengths</u> Background knowledge and rationale clearly stated.  Ecological validity of the sample  Record perpetrator information to contextualise trauma  Clear data analysis plan  Procedures regarding informed consent clear.	30 75%

		<p><u>Assessment</u> Pre and post intervention</p> <p><u>Analysis</u> Descriptive statistics and pairwise t-test</p>	<p>9.56 (SD=2.11)</p> <p><u>Sex</u> 67.2% female</p> <p><u>Ethnicity</u> Not provided</p> <p><u>Trauma</u> Sexual abuse</p> <p><u>Mean N of trauma types/incidents</u> Not reported</p> <p><u>Other trauma information</u> 69% intra-familial 38% abuse lasted over 6 months</p>		<p>Negative Self-concept: Pre-treatment= 1.17(SD=.78), post-treatment .60(SD=.67), <math>t=6.50</math>, <math>d=0.74</math>, <math>p&lt;.001</math>).</p> <p>Emotion dysregulation: Pre-treatment 1.76(SD=.43), post-treatment =1.22(SD.82), <math>t=5.71</math>, <math>d=0.65</math>, <math>p&lt;.001</math>).</p> <p>Interpersonal difficulties: Pre-treatment =1.38(SD.67), post-treatment =.92(SD.72), <math>t=4.42</math>, <math>d=0.50</math>, <math>p&lt;.001</math>).</p>	<p>Possible sources of bias/confounding variables clearly acknowledged.</p> <p>Ethical approval, conflict of interest and funding clearly stated.</p> <p>Clear clinical implications and direction for future research</p> <p><u>Limitations</u> Proxy measure of DSO used therefore limiting validity, though standardised and validated measure unavailable at time of study.</p> <p>No follow up or control group.</p> <p>Possible confounding variables, such as contextual factors, though acknowledged by authors.</p>	
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						<p>Little information about how intervention provided and by who, and no information regarding treatment fidelity.</p> <p>Demographic data split by subgroups not provided, nor is flow of participants clear.</p> <p>Some inferences inconsistent with data e.g. discuss possibility of need for more sessions for CPTSD, yet no significant difference in average number of sessions for this subgroup.</p> <p>Ethnicity of sample not detailed.</p>	
<p><b>Jensen et al., 2022</b></p> <p><b>Norway</b></p>	<p>To examine whether TF-CBT improves PTSD and CPTSD</p>	<p><u>Design</u> Observational naturalistic study</p> <p><u>Measures</u></p>	<p><u>Recruitment</u> All youth referred to 23 Norwegian Child and Adolescent Mental Health Clinics screened.</p>	<p><u>Delivery</u> Weekly sessions, CPTSD average of 17.5 sessions,</p>	<p><u>PTSD</u> Pre-treatment levels of PTSS higher amongst CPTSD than PTSD</p>	<p><u>Strengths</u> Clear background and rationale</p> <p>First to use standardised measure of CPTSD and DSO</p>	<p>35 88%</p>

		<p>CATS-2 for PTSD and DSO</p> <p><u>Assessment</u> Pre-treatment, session 5, session 10, session 15 and post-treatment.</p> <p><u>Analysis</u> Descriptive statistics, t-tests and chi-square tests.</p>	<p><u>N</u> Total – 73 PTSD – 45 C-PTSD – 28</p> <p><u>Mean age</u> 15.4 (SD=1.8)</p> <p><u>Sex</u> 80.95% female</p> <p><u>Ethnicity</u> 62% Norwegian</p> <p><u>Trauma</u> 56% sexual abuse, 37% witnessing domestic violence</p> <p><u>Mean N of trauma types</u> 5.3 (SD=2.31)</p> <p><u>Other trauma information</u> None provided</p>	<p>PTSD average of 17.2 sessions.</p> <p><u>Facilitators</u> 73 Therapists trained in TF-CBT</p> <p><u>Fidelity</u> 86.4% received TF-CBT with sufficient fidelity as assessed by TF-CBT Brief Practice Fidelity Checklist</p>	<p>(difference=2.82, p=.002).</p> <p>Significant decreases in PTSS overtime found for PTSD (estimate=-1.42, p&lt;.001) and CPTSD (estimate=-2.09, p&lt;.001).</p> <p>Change was significantly greater for CPTSD than PTSD (difference =-0.66, p=.015).</p> <p>All with pre-treatment PTSD diagnosis no longer met diagnostic criteria post-treatment.</p> <p><u>DSO</u> At baseline, CPTSD had significantly higher rates of</p>	<p>symptoms, increasing validity.</p> <p>Intervention and treatment fidelity clearly discussed, utilising a standardised tool to measure.</p> <p>High external validity, due to recruitment from regular Child and Adolescent Mental Health services and diversity of trauma experience.</p> <p>Limitations, including possible sources of bias, clearly acknowledged and attempted to control for where possible.</p> <p>Funding, conflict of interest and approval clearly stated.</p> <p><u>Limitations</u> Small sample, especially at some specific time points,</p>	
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					<p>DSO than PTSD (difference=6.43, p&lt;.001).</p> <p>CPTSD had a significantly steeper decrease in DSO from pre- to post-treatment than PTSD (difference=-1.22, p&lt;.001).</p> <p>All meeting CPTSD criteria pre-intervention no longer met diagnostic criteria post-intervention. 15.8% met criteria for PTSD.</p>	<p>therefore missing data may impact results, and reduce statistical power of study.</p> <p>Naturalistic observational study therefore design limitations, including lack of control group and follow-up</p> <p>Possibility of bias, but recognised by authors, such as possibility for therapists to selectively omit less favourable results.</p> <p>Effect sizes not reported.</p> <p>As highlighted by authors, higher rate of change amongst CPTSD could be due to higher baseline scores.</p>	
<b>Lee &amp; Brown (2022)</b>	To examine effectiveness of TF-CBT on executive functioning	<u>Design</u> Quasi-experimental <u>Measures</u>	<u>Recruitment</u> Secondary analysis of Ross et al., (2021) data	<u>Delivery</u> Weekly  Treatment completers	<u>PTSD</u> Significant reductions in PTSD symptoms from pre to post	<u>Strengths</u> Clear summary of literature and rationale.	30 75%

<p><b>USA</b></p>		<p>PTSD: CPSS</p> <p>DSO: EF index of BASC-2 PRS</p> <p><u>Assessment</u> Pre, mid and post intervention</p> <p><u>Analysis</u> Descriptive statistics and latent growth curve models</p>	<p>Recruited via a community clinic</p> <p><u>N</u> Total – 278 Child – 135 Adolescent – 143</p> <p><u>Mean age</u> Child – 9.15 (SD=1.71) Adolescent – 14.97 (SD=1.65)</p> <p><u>Sex</u> Child – 58% female Adolescent – 75% female</p> <p><u>Ethnicity</u> 91% racial/ethnic minority</p> <p><u>Trauma</u> 68% sexual abuse, 43% physical abuse, 48% witnessed domestic violence</p>	<p>attended an average of 24.68(range 3 to 56) sessions for children and 21.91 (range 8 to 62) for caregivers.</p> <p><u>Facilitators</u> Doctoral level clinical and school psychology students and postdoctoral fellows, trained in TF- CBT, under supervision of clinical psychologists.</p> <p><u>Treatment fidelity</u> Weekly supervision to ensure fidelity</p>	<p>intervention found for both children and adolescents (<math>p&lt;.05</math>).</p> <p>Higher baseline PTSD scores were associated with larger negative slopes in PTSD trajectories.</p> <p><u>DSO: Emotion regulation</u> Emotional control significantly improved from pre-intervention 6.10(SD2.87), to post-intervention 4.33(SD2.33), <math>d.58</math>, <math>p&lt;.001</math> for children.</p> <p>Emotional control significantly improved from pre-intervention 12.29(SD=2.99), to post- intervention</p>	<p>Racially and ethnically diverse sample, in a community-based setting, therefore increasing generalisability.</p> <p>Exploring differential impact of TF-CBT for children and adolescents, given impact of developmental stage.</p> <p>Funding and ethical approval clearly stated.</p> <p>Possible sources of bias and confounding factors, and limitations acknowledged.</p> <p>Unexpected findings explored.</p> <p>Clear links to clinical implications and future research.</p> <p><u>Limitations</u></p>	
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			<u>Mean N of trauma types</u> Child – 1.86 (SD=0.76) Adolescent – 2.05 (SD=0.86)  <u>Other trauma information</u> None provided		SD=9.91(2.55), <i>d</i> =.86, <i>p</i> <.001 for adolescents.	No control group or follow up.  Treatment-seeking sample, therefore possible bias and limits to generalisability.  Small sample, limiting power of study.  No conflict of interest stated.  Large range of sessions delivered.  Despite stating how fidelity monitored, lack of information about treatment fidelity in study.  Effect sizes not clearly stated.	
<b>Mannarino et al., (2012)</b>  <b>USA</b>	To examine the effects of TF-CBT with or without the trauma narrative component	<u>Design</u> RCT  <u>Measures</u> PTSD: K-SADS-PTSD	<u>Recruitment</u> Recruited from two sites in USA.  <u>N</u> 92	<u>Delivery</u> Either 8 (7.36, SD=1.33) or 16 (13.92, SD= 3.34) sessions,	<u>PTSD</u> Significant improvements in PTSD symptoms maintained at 6 and 12 month follow up ( <i>p</i> <.05).	<u>Strengths</u> Ethical approval and funding clearly stated  Intervention clearly defined	26 65%

<p><b>Follow up to Deblinger et al., (2011)</b></p>	<p>(TN) delivered in 8 vs 16 sessions at 6- and 12-month follow-up.</p>	<p>DSO: SHAME</p> <p><u>Assessment</u> Pre-intervention, post-intervention, 6-month and 12-month follow up.</p> <p><u>Analysis</u> Mixed model repeated-measures analysis of covariance</p>	<p><u>Mean age</u> 7.60 (S=2.07)</p> <p><u>Sex</u> 62% female</p> <p><u>Ethnicity</u> 65% Caucasian 15% African American 6% Hispanic-American 14% other ethnic origins</p> <p><u>Trauma</u> Sexual abuse</p> <p><u>Mean N of trauma types/incidents</u> Not provided</p> <p><u>Other trauma information</u> 42% perpetrator related or unrelated adult</p>	<p>either without or without TN.</p> <p><u>Facilitators</u> Psychology Graduate Therapists, clinical social work or a related field and 3 years of experience.</p> <p><u>Treatment fidelity</u> Feedback on taped sessions and independent ratings provided.</p>	<p>K-SADS-Reexperiencing: Adjusted mean difference 1.51 (SE= 0.11) post-test, 1.34(SE=0.13) at 6 month follow up and 1.11 (SE=0.13) at 12 month follow up.</p> <p>K-SADS-Avoidance: Adjusted mean difference 1.47 (SE= 0.10) post-test, 1.24(SE=0.12) at 6 month follow up and 1.08 (SE=0.12) at 12 month follow up.</p> <p>K-SADS-Hypervigilance: Adjusted mean difference 1.24 (SE= 0.11) post-test, 1.14(SE=0.12) at 6 month follow up</p>	<p>Follow up employed</p> <p>Sample contextualised</p> <p>Participants compensated for time</p> <p>Clear links to literature, implications and directions for future study</p> <p><u>Limitations</u> States no conflict of interest, however 3 authors are creators of TF-CBT</p> <p>Small sample sizes in each cell, therefore reduced power to detect effect sizes.</p> <p>Limited recruitment information.</p> <p>Role of shame not discussed in introduction or discussion.</p>	
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					<p>and 1.03 (SE=0.13) at 12 month follow up.</p> <p>11% continued to meet criteria for PTSD at 12 month follow up.</p> <p>Significant 60% decrease in rate of meeting PTSD criteria at 12 months (McNemar Test, <math>p &lt; .001</math>).</p> <p><u>DSO: Negative self-concept</u> Significant improvements in shame symptoms maintained at 6 and 12 month follow up (<math>p &lt; .05</math>). Adjusted mean difference 2.56 (SE=0.25) post-test, 1.82(SE=0.29) at 6 month follow up and 1.87</p>	<p>Findings with regards to each outcome measure not discussed and contextualised in discussion.</p> <p>Limited consideration of bias and confounding variables.</p>	
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					(SE=0.30) at 12 month follow up.		
<b>Marquez &amp; Deblinger (2020)</b>	To investigate the clinical value of TF-CBT for PTSD for a child whose experienced familial sex trafficking and labour exploitation.	<u>Design</u> Case study  <u>Measures</u> PTSD: UCLA-PTSD-RI  DSO: SHAME  <u>Assessment</u> Pre and post intervention  <u>Analysis</u> Unclear if statistical analysis conducted	<u>Recruitment</u> Referred to community agency for treatment.  <u>N</u> 1  <u>Mean age</u> 14  <u>Sex</u> 100% female  <u>Ethnicity</u> Guatemalan  <u>Trauma</u> Sexual abuse, witnessed domestic violence, physical abuse familial sex trafficking, labour exploitation  <u>Mean N of trauma types/incidents</u>	<u>Delivery</u> 20, 90-minute weekly sessions.  <u>Facilitator</u> Therapist, no other information provided.  <u>Treatment fidelity</u> Not provided  <u>Adaptations</u> Cultural adaptations made	<u>PTSD</u> Scores reduced from within the severe PTSD range, to within doubtful PTSD range on the UCLA-PTSD-I.  <u>DSO</u> Initial scores indicated client experiencing a high level of shame. This reduced post-intervention.	<u>Strengths</u> Clear background and rationale  Novel area of research  Intervention clearly described.  Cultural adaptations made.  Client clearly described to allow inferences regarding generalisability.  Clinical value of findings considered.  <u>Limitations</u> Possible confounding factors not discussed, such as new foster home, school support, medical care.	25 63%

			<p>Not provided</p> <p><u>Other trauma information</u></p> <p>Not provided</p>			<p>Case study therefore limited generalisability.</p> <p>Ethical concerns: no information regarding funding, approval, conflict of interest, how client's confidentiality/anonymity protected.</p> <p>Pre and post intervention scores not reported, and statistically significant changes not explored.</p> <p>Limitations of study and directions for future study not explored.</p> <p>Fidelity mentioned in abstract but not in main text.</p>	
<p><b>Murray et al., 2013</b></p> <p><b>Zambia</b></p>	<p>To evaluate the feasibility and effectiveness of TF-CBT for orphans and vulnerable</p>	<p><u>Design</u></p> <p>Quasi-experimental</p> <p><u>Measures</u></p> <p>PTSD:</p>	<p><u>Recruitment</u></p> <p>Volunteer outreach workers recruited suitable families from local communities</p> <p><u>N</u></p>	<p><u>Delivery</u></p> <p>Weekly 1-2 hour sessions average across 11 weeks (8-23)</p> <p><u>Facilitator</u></p>	<p><u>PTSD</u></p> <p>Average post-treatment PTSD scores were (27.6) significantly lower than pre-</p>	<p><u>Strengths</u></p> <p>Explored feasibility, as well as effectiveness.</p> <p>Considers suitability in a diverse sample and low-resource setting.</p>	<p>27</p> <p>68%</p>

	<p>children in Zambia</p>	<p>Adapted UCLA-PTSD-RI</p> <p>DSO: SHAME</p> <p><u>Assessment</u> Pre and post treatment</p> <p><u>Analysis</u> Descriptive statistics and paired samples t-tests.</p>	<p>58</p> <p><u>Subgroups</u> Sample split into low (&lt;5) or high (&gt;5) trauma exposure</p> <p><u>Mean age</u> 12.9</p> <p><u>Sex</u> 50% female</p> <p><u>Ethnicity</u> Not provided</p> <p><u>Trauma</u> Witnessing domestic violence, physical abuse and sexual abuse most common</p> <p><u>Mean N of trauma incidents</u> 4.11</p> <p><u>Other trauma information</u> Not provided</p>	<p>18 local counsellors trained in TF-CBT, with little to no mental health background, under close weekly supervision.</p> <p><u>Treatment fidelity</u> Monitored via fidelity checklist and regular supervision.</p> <p><u>Adaptations</u> Cultural modifications agreed by local providers.</p>	<p>treatment scores (67.6, <math>p &lt; .0001</math>).</p> <p>No significant difference between males and females, or between high or low exposure groups.</p> <p><u>DSO: Negative self-concept</u> Average post-treatment shame score (2.2) significantly lower than pre-treatment mean (8.3, <math>p &lt; .0001</math>). No significant difference between males and females.</p> <p>Mean pre-treatment shame score lower (1.3) for low exposure than high exposure group</p>	<p>Clear information regarding delivery of intervention and treatment fidelity.</p> <p>Cultural adaptations considered, made and documented.</p> <p>Reasons for attrition clearly explored and contextualised.</p> <p>Findings linked to existing research.</p> <p>Limitations clearly acknowledged, with directions for future study.</p> <p><u>Limitations</u> Limited rationale for exploring shame provided.</p> <p>Ethical approval not stated.</p> <p>No conflict of interest declared, but one author</p>	
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					<p>(4.48), though not significant (p=0.23).</p> <p>Mean difference pre and post-treatment was not significantly different (p=.034) between high and low exposure groups.</p> <p>Children reporting sexual abuse had higher shame scores at both pre-treatment (15 vs 7.25, p=.004) and post-treatment (6.78 vs 1.29, p=.004).</p>	<p>involved in developing TF-CBT</p> <p>Effect sizes not reported</p> <p>Outliers not discussed</p> <p>Lack of control group.</p> <p>Convenience sampling.</p> <p>Possible bias in recruitment.</p> <p>Small sample.</p> <p>No follow up.</p> <p>No effect sizes.</p> <p>No power calculation.</p>	
<p><b>Ross et al., (2021)</b></p> <p><b>USA</b></p>	<p>To evaluate trauma chronicity and PTSD presentation as moderators</p>	<p><u>Design</u> Quasi-experimental</p> <p><u>Measures</u> PTSD:</p>	<p><u>Recruitment</u> Via a community-based clinic</p> <p><u>N</u> 176 Intention to Treat, 86</p>	<p><u>Delivery</u> 26.82 (SD=9.81) average sessions for completers, range 11-64.</p>	<p><u>PTSD</u> Across groups, significant improvements in PTSS post intervention (p&lt;.05).</p>	<p><u>Strengths</u> Clear background summary and rationale</p> <p>Inclusion and exclusion criteria stated</p>	<p>28 70%</p>

	<p>of outcomes for TF-CBT</p>	<p>KSADS-PL CPSS</p> <p>DSO: BASC-2&amp;3 PERCEIVE LPI</p> <p><u>Assessment</u> Pre, mid and post intervention</p> <p><u>Analysis</u> Descriptive statistics, multi-level modelling, t-tests</p>	<p>treatment completers</p> <p><u>Sample groups</u> Acute vs Chronic trauma PTSD vs PTSD and 2 domains of CPTD vs PTSD and 3 domains of CPTSD</p> <p><u>Mean age</u> Mean age not provided. 49% over 13 years.</p> <p><u>Sex</u> 73% female</p> <p><u>Ethnicity</u> 31% Latino 22% African American/Black 18% multiracial 9% Caucasian 19% other</p> <p><u>Trauma</u> 68% sexual abuse, 43% physical abuse,</p>	<p><u>Facilitators</u> Therapists trained to at least master levels, with training in TF-CBT</p> <p><u>Treatment fidelity</u> All therapists complete therapy logs to code components of TF-CBT and co-directors listed to audio recordings. Weekly feedback provided on treatment fidelity</p>	<p>2 and 3 CPTSD domain groups experienced significantly higher levels of PTSD at baseline than PTSD group.</p> <p>Number of sessions did not significantly differ by trauma history or PTSD presentation.</p> <p>Youth with acute trauma had a larger per-session rate of change than those with chronic trauma.</p> <p>No difference in PTSD or CPTSD symptoms at baseline between acute and chronic trauma.</p>	<p>Compensation for time awarded</p> <p>Detailed information regarding intervention, therapists and fidelity.</p> <p><u>Limitations</u> No control group</p> <p>No conflict of interest statement</p> <p>Ethical approval not stated</p> <p>Small sample therefore cannot detect small effect sizes</p> <p>P value and effect sizes not reported for pre and post outcome measures</p> <p>Measurements of convenience used for DSO, though acknowledged and no measure available at time.</p>	
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			<p>48% witnessed domestic violence</p> <p><u>Mean N of trauma types</u> 3.6</p> <p><u>Other trauma information</u> None provided</p>		<p>Chronic trauma not significantly more likely to experience CPTSD.</p> <p><u>DSO</u> Across groups, significant improvements for Emotion regulation and Negative Self-Concept scores (<math>p &lt; .05</math>), but not interpersonal relationships.</p> <p>2 and 3 CPTSD domain groups experienced significantly higher levels of emotional dysregulation, negative self-concept and interpersonal problems at baseline than PTSD group.</p>	
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					<p>Trauma history did not moderate outcomes.</p> <p>Youth with acute trauma demonstrated improvements in emotion dysregulation faster than those with chronic trauma.</p> <p>At baseline, those in the 2 and 3 domains of CPTSD groups reported worse symptoms than those with simple PTSD.</p> <p>Improvement in interpersonal relations was larger per session for those with PTSD than 2 ICD CPTSD domains.</p>	
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<p><b>Sachser et al., (2017)</b></p> <p><b>Germany</b></p>	<p>To determine whether CPTSD can be replicated in child and young people, and their treatment response to TF-CBT.</p>	<p><u>Design</u> Secondary analysis of RCT data</p> <p><u>Measures</u> PTSD: UCLA-PTSD-RI</p> <p>DSO: Items taken from: CAPS-CA CPTCI UCLA-PTSD-RI</p> <p><u>Assessment</u> Pre and post intervention</p> <p><u>Analysis</u> Descriptive statistics, dependent t-tests, analysis of variance.</p>	<p><u>Recruitment</u> Not provided.</p> <p><u>N</u> Total – 112 C-PTSD – 23<sup>1</sup>treatment completers.</p> <p><u>Mean age</u> 13.45 (SD=2.46)</p> <p><u>Sex</u> 80.6% female</p> <p><u>Ethnicity</u> Not provided</p> <p><u>Trauma</u> Paper does not breakdown trauma type, but states all experienced interpersonal trauma</p>	<p>Information taken from original study (Goldbeck et al., 2016)</p> <p><u>Delivery</u> 12 90-minute weekly sessions.</p> <p><u>Facilitator</u> 26 therapists with average of 8.3 years clinical experience trained in TF-CBT.</p> <p>Mean age 37.4 years.</p> <p><u>Treatment fidelity</u> Monitored via video-tapings of sessions</p>	<p><u>PTSD</u> CPTSD group showed significant improvement following TF-CBT (CAPS-CA pre, 70.57 (SD15.94) vs Post=39.61 (SD29.11), <math>T(22) = 5.37</math>, <math>d=1.37</math>, <math>p&lt;.001</math>.</p> <p><u>DSO</u> CPSTD group showed significant improvements across all six items of DSO, when comparing pre and post intervention scores. Effect sizes were medium for problems in</p>	<p><u>Strengths</u> Clear background and rationale for research.</p> <p>Ethical approval stated.</p> <p>Inclusion and exclusion reported.</p> <p>Effect sizes included and thorough results section.</p> <p>Limitations of study acknowledged.</p> <p>Implications and links to literature acknowledged.</p> <p>Clear future directions for research and practice stated.</p> <p><u>Limitations</u> No follow up or control</p>	<p>31 78%</p>
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<sup>1</sup> Findings relating to C-PTSD subgroup only reported as other groups did not meet threshold for 80% of the sample having experienced interpersonal trauma as defined in this review.

			<p><u>Mean N of trauma incidents</u> 6.27 (SD=3.71)</p> <p><u>Other trauma information</u> Not provided</p>	<p>compared to content checklist. Adherence to manual confirmed in 96% of evaluations.</p>	<p>emotion regulation (<math>d = 0.40-0.60</math>), and large for negative self-concept (<math>d = 0.87-1.16</math>) and interpersonal problems (<math>d = 0.88-1.03</math>).</p>	<p>Small samples used for analysis and no power calculation</p> <p>Information relating to delivery of intervention only available in original study.</p> <p>Unclear how funded.</p> <p>Validity of DSO measure unclear, though acknowledging lack of alternative at time of study.</p> <p>Interpersonal trauma not defined.</p>	
<p><b>Thornback &amp; Muller (2015)</b></p> <p><b>Canada</b></p>	<p>To explore the relationship between emotion regulation and symptom change following TF-CBT</p>	<p><u>Design</u> Quasi-experimental</p> <p><u>Measures</u> PTSD: PTSS Scale of the TSCC PTSS Scale of the TSCYC DSO: CEMS ERC</p>	<p><u>Recruitment</u> Self-referral to two agencies supporting children who'd experienced trauma</p> <p><u>N</u> Pre-assessment – 107 Pre-treatment – 78</p>	<p><u>Delivery</u> Average 17.05 sessions</p> <p><u>Facilitator</u> 34 predominantly female therapists trained in TF-CBT across 8 centres</p>	<p><u>PTSD</u> Child-reported PTS reduced from 10.69 (SD6.63) to 9.34(SD6.80) at pre-treatment, to 7.71(SD5.33) post-treatment to 7.19 (SD6.22) at follow up.</p>	<p><u>Strengths</u> Follow up implemented</p> <p>Ethical approval stated</p> <p>Inclusion of parent and child perspective</p> <p>Sample clearly described Facilitators training described</p>	<p>29 73%</p>

		<p><u>Assessment</u> Pre-assessment, pre-treatment, post-treatment, 6-month follow up</p> <p><u>Analysis</u> Descriptive statistics, paired samples t-tests.</p>	<p>Post-treatment – 58 6-month follow-up – 44</p> <p><u>Age</u> Mean age not provided. Aged between 7-12 years.</p> <p><u>Sex</u> 69.9% female.</p> <p><u>Ethnicity</u> 38.1% European Canadian 18.1% African Canadian 10.5% Latin American Canadian 5.7% South Asian Canadian 4.8% Asian Canadian 1.9% Aboriginal 21% other ethnicities</p> <p><u>Trauma</u></p>	<p><u>Treatment Fidelity</u> Adherence checklist revealed high consistency with the model</p>	<p>Parent-reported PTS reduced from 45.31 (SD12.02) to 45.00(SD11.30) at pre-treatment, to 40.00(SD11.54) post-treatment to 38.88 (SD11.80) at follow up.</p> <p><u>DSO: Emotion Regulation</u> From pre-assessment to post-treatment, emotion inhibition (<math>t=1.77</math>, <math>p=.04</math>) and lability/negativity (<math>t=1.69</math>, <math>p=0.5</math>) significantly improved.</p> <p>From pre-assessment to six-month follow up, inhibition (<math>t=1.92</math>, <math>p=.03</math>) and dysregulation</p>	<p>Rationale clearly defined</p> <p>Ethnically diverse sample</p> <p><u>Limitations</u> No control</p> <p>Pen and paper measures subject to bias</p> <p>Limitations of child-report measures</p> <p>Attrition of sample</p> <p>Conflict of interests not stated</p> <p>Small sample at follow up</p> <p>Do not report mean age</p> <p>Do not report statistical significance of changes to PTSS or CBLC scores</p>	
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			<p>75.2% sexual abuse, 11.5% physical abuse, 7.1% witnessed domestic violence, 6.3% other</p> <p><u>Mean N of trauma types</u> Mean not reported. 74.3% experienced multiple trauma types.</p> <p><u>Other trauma information</u> Perpetrator information – 92% known to child, 96.5% male, 80.5% adults</p>		<p>(<math>t=2.63</math>, <math>p=0.1</math>) significantly improved.</p> <p>From pre-treatment to post-treatment, only lability/negativity significantly improved (<math>t=2.20</math>, <math>p=.02</math>).</p> <p>From pre-treatment to six-month follow up, inhibition (<math>t=1.48</math>, <math>p=0.4</math>), dysregulation (<math>t=2.37</math>, <math>p=0.1</math>) and lability/negativity (<math>t=1.82</math>, <math>p=0.4</math>) significantly improved.</p> <p>Poor ER skill did not significantly improve at any time point.</p>	Lack of information regarding intervention	
<b>Cohen et al., (2004)</b>	To examine the effects of TF-CBT and	<u>Design</u> RCT	<u>Recruitment</u> Two sites, receiving referrals	<u>Delivery</u> 12 weekly individual	<u>PTSD</u> TF-CBT group had significantly	<u>Strengths</u> Approval, funding and methods for obtaining	27 68%

<p><b>USA</b></p>	<p>Child Centred Therapy (CCT) for PTSD and related problems.</p>	<p><u>Measures</u> PTSD: K-SADS-PL</p> <p>DSO: SHAME CAPS</p> <p><u>Assessment</u> Pre and post-intervention</p> <p><u>Analysis</u> Descriptive statistics, chi-squared tests and analysis of covariance</p>	<p>from CPS, Police, mental-health refers, child advocacy centres and self-referrals.</p> <p><u>N</u> 203</p> <p><u>Mean age</u> 10.76</p> <p><u>Sex</u> 79% female</p> <p><u>Ethnicity</u> 60% Caucasian 28% African American 12% other</p> <p><u>Trauma</u> 100% sexual abuse, 58% witnessed domestic violence, 26% physical abuse</p> <p><u>Mean N of trauma incidents</u> 4 (Range 1-1000)</p>	<p>sessions for child and carer. No joint sessions for CCT.</p> <p>TF-CBT = 10.47(2.89) CCT = 10.75 (2.44)</p> <p><u>Facilitators</u> Therapists from a range of professional and theoretical backgrounds, trained in TF-CBT and CCT, delivered both interventions.</p> <p><u>Treatment Fidelity</u> Fidelity monitored through audiotaping and</p>	<p>lower post-intervention PTSD scores than CCT across all subscales.</p> <p>K-SADS-Reexperiencing: <math>F=10.68, d=0.49, p=.01.</math></p> <p>K-SADS-Avoidance: <math>F=21.90, d=0.70, p=.001.</math></p> <p>K-SADS-Hypervigilance: <math>F=7.22, d=0.40, p=.01.</math></p> <p>21% of TF-CBT met criteria for PTSD post-intervention, compared to 46% of CCT group. This difference was significant <math>X^2(1, N=180) = 11.28., p&lt;.001.</math></p>	<p>informed consent clearly stated.</p> <p>Control group implemented.</p> <p>Therapist training clearly outlined.</p> <p>Methods for monitoring fidelity and subsequent treatment fidelity clear.</p> <p>Independent evaluators and blinding used.</p> <p>Clearly stated both interventions manualised.</p> <p><u>Limitations</u> Aims and hypothesis not clearly stated in introduction.</p> <p>Shame not listed as an outcome measure in methodology.</p> <p>No follow up.</p>	
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			<p><u>Other trauma information</u> Not provided.</p>	<p>independent rating of 25% tapes. Both treatments exceeded 95% fidelity.</p>	<p><u>DSO: Negative self-concept</u> Significant improvements from pre- to post-intervention were found across both groups for both the shame and CAPS (<math>p &lt; .05</math>).</p> <p>TF-CBT group had significantly lower post-intervention shame scores than CCT, <math>F=9.52</math>, <math>d=0.46</math>, <math>p=.01</math>. TF-CBT group had significantly lower post-intervention CAPS self-blame for negative events <math>F=1.57</math>, <math>d=0.19</math>, <math>p=.05</math> than the CCT group.</p> <p><u>C-PTSD: Interpersonal Difficulties</u></p>	<p>No sample size calculation.</p> <p>No conflict-of-interest statement, yet authors founders of TF-CBT. Resulting possibility of bias not explored.</p> <p>Limited ethnic diversity.</p> <p>As no wait-list comparison used, cannot discern general therapeutic effects.</p> <p>TF-CBT involves conjoint sessions, whereas CCT does not. Impact of this unclear.</p> <p>Sample information not split by treatment.</p>	
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					TF-CBT group had significantly lower post-intervention CAPS Interpersonal Trust than the CCT group.		
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TF-CBT – Trauma-focused Cognitive behavioural Therapy; PTSD: Post-traumatic stress disorder; C-PTSD – complex post-traumatic stress disorder; DSO – Disturbances of self-organisation; DERS; Difficulties in Emotion Regulation Scale; RCSA – Resiliency Scales for Children and Adolescents; K-SADS-PTSD – Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and lifetime Version-PTSD Module; CAPS-CA – Clinical administered PTSD scale for children and adolescents; CAPS - Children’s attributions and perception scale; CPTCI – Child posttraumatic cognitions inventory; UCLA-PTSD-RI – UCLA PTSD Reaction Index for DSM-IV; CPSS – The Child PTSD Symptom Scale; BASC – The Behaviour Assessment System 2 & 3; PERCEIVE – The Perceptions of Children Exposed to Interpersonal Violence; LPI – The Life Problems Inventory; CATS-2: Child and Adolescent Trauma Screen 2; BASC-2 PRS – The behavioral assessment for children 2, Parenting rating scale – Executive function index; CEMS: Children’s Emotion Management Scales; ERC: Emotion Regulation Checklist; PTSS Scale of the TSCC: The Trauma Symptom Checklist for Children; PTSS Scale of the TSCYC: The Trauma Symptom Checklist for Young Children; M – mean; SD – Standard Deviation

**Appendix C – C-CAT Results Table**

<b>Paper</b>	<b>Preliminaries</b>	<b>Introduction</b>	<b>Design</b>	<b>Sampling</b>	<b>Data collection</b>	<b>Ethical matters</b>	<b>Results</b>	<b>Discussion</b>	<b>Total /40</b>
<b>Cisler et al., (2015)</b>	3/5	5/5	2/5	3/5	3/5	4/5	3/5	4/5	27 (68%)
<b>Cohen et al., (2004)</b>	4/5	4/5	3/5	4/5	4/5	3/5	4/5	4/5	30 (75%)
<b>Deblinger et al., (2017)</b>	3/5	5/5	2/5	3/5	3/5	3/5	3/5	4/5	26 (65%)
<b>Deblinger et al., (2011)</b>	4/5	3/5	2/5	3/5	4/5	3/5	3/5	3/5	25 (63%)
<b>Hébert &amp; Amédée (2020)</b>	4/5	5/5	2/5	3/5	4/5	5/5	3/5	4/5	30 (75%)
<b>Jensen et al., (2022)</b>	5/5	5/5	3/5	3/5	5/5	5/5	4/5	5/5	35 (88%)
<b>Lee &amp; Brown (2022)</b>	4/5	5/5	3/5	3/5	4/5	3/5	3/5	5/5	30 (75%)
<b>Mannarino et al., (2012)</b>	3/5	4/5	3/5	3/5	4/5	3/5	3/5	3/5	26 (65%)
<b>Marquez &amp; Deblinger (2020)</b>	5/5	5/5	3/5	3/5	4/5	1/5	2/5	2/5	25 (63%)

<b>Murray et al., (2013)</b>	4/5	4/5	3/5	3/5	4/5	2/5	3/5	4/5	27 (68%)
<b>Ross et al., (2021)</b>	3/5	5/5	3/5	4/5	4/5	2/5	3/5	4/5	28 (70%)
<b>Sachser et al., (2017)</b>	4/5	5/5	2/5	3/5	3/5	4/5	5/5	5/5	31(78%)
<b>Thornback &amp; Muller (2015)</b>	4/5	5/5	3/5	3/5	4/5	3/5	3/5	4/5	29 (73%)

### Appendix D – Measures

<u>Measure and author</u>		<u>Measuring</u>	<u>Psychometric properties</u>
<b><u>PTSD/PTSS</u></b>			
Child and Adolescent Trauma Screen-2 (CATS-2)  Sachser et al., (2022)	Jensen et al., (2022)	Assess frequency of PTSD and CPTSD symptoms of the ICD-11	Good internal consistency, convergent and discriminant validity, and reliability (Sachser et al., 2022)
Children’s Impact of Traumatic Events Scale II (CITES II)  Wolfe (2002)	Hébert & Amédée (2020)	Assess severity of PTSS	Good convergent validity (Chaffin & Shultz, 2001)
Schedule for Affective Disorders and Schizophrenia for School-Age Children – Present and Lifetime version (K-SADS-PL)  Kaufman et al., (1997)	Deblinger et al., (2011)  Deblinger et al., (2017)  Mannarino et al., (2012)  Ross et al., (2021)  Cohen et al., (2004)	Assess frequency of DSM-IV PTSD symptoms	Good interrater and test-retest reliability and validity (Ambrosini, 2000)
The Child PTSD Symptom Scale (CPSS)  Foa et al., (2018)	Lee & Brown (2022)  Ross et al., (2021)	PTSD symptom severity	Excellent internal consistency, test-retest reliability and good convergent validity (Foa et al., 2001)
The Clinician-Administered PTSD Scale, Child and Adolescent Version (CAPS-CA)	Sachser et al., (2017)	Trauma exposure, and frequency and severity of PTSS as well as overall	No research regarding psychometric properties.

Nader et al., (1996)		distress and functional impairment	
The Trauma Symptom Checklist for Children (TSCC) Briere (1996)	Thornback & Muller (2015)	Assesses frequency of PTSS	Strong internal consistency, convergent and discriminant validity (Briere, 1996)
The Trauma Symptom Checklist for Young Children (TSYC) Briere (2005)	Thornback & Muller (2015)	Parent report of frequency of PTSS	Strong internal consistency, good test-retest reliability, and concurrent and discriminant validity (Briere, 2005)
UCLA PTSD Reaction Index for DSM-IV (UCLA-PTSD-RI)  Steinberg et al., (2004)	Cisler et al., (2015)  Marquez & Deblinger (2020)  Murray et al., (2013)  Sachser et al., (2017)	Assess exposure to trauma and frequency of PTSS	Good convergent validity, internal consistency, test re-test reliability (Steinberg et al., 2004)  Adapted version for use in Zambia used in Murray et al., (2013) has good reliability and concurrent validity (Murray et al., 2011)
<b><u>Disturbances of self-organisation: Negative self-concept</u></b>			
Children's Impact of Traumatic Events Scale II (CITES II)  Wolfe (2002)	Hébert & Amédée (2020)	Item relating to feelings of guilt related to the treatment event extracted e.g. "I feel like I was to blame for what happened"	Psychometric data for individual items not available.
Perceptions of Children Exposed to Interpersonal Violence (PERCEIVE) Brown (2000)	Ross et al., (2021)	Self-blame subscale extracted	No reliability and validity data available.
The Child Posttraumatic Cognitions Inventory (CPTCI) Meiser-Stedman et al., (2009)	Sachser et al., (2017)	Item "I am no good" extracted	Psychometric data for individual items not available.

The Self-Perception Profile for Children (SPPC) Harter (1985)	Hébert & Amédée (2020)	Item “Other kids are often not happy with themselves” extracted	Psychometric data for individual items not available.
The Shame Questionnaire (SHAME) Feiring & Taska (2005)	Deblinger et al., (2011)  Mannarino et al., (2012)  Marquez & Deblinger (2020)  Murray et al., (2013)  Cohen et al., (2004)	Assess shame-related feelings following child sexual abuse	Good internal consistency (Feiring & Taska, 2005)  In Zambia, demonstrated to have good internal consistency, criterion and construct validity (Michalopoulos et al., 2015)
<b><u>Disturbances of self-organisation: Interpersonal difficulties</u></b>			
Children’s Impact of Traumatic Events Scale II (CITES II)  Wolfe (2002)	Hébert & Amédée (2020)	Items reflecting feeling detached from others such as “I did not feel like playing or hanging out with other kids”	Psychometric data for individual items not available.
The Behaviour Assessment System 2 & 3 (BASC-2 and 3) Reynolds & Kamphaus (2004)	Ross et al., (2021)	Interpersonal relations scale extracted.	Good internal consistency and reliability (Karr & Garcia-Barrera, 2016)
The Children’s Attributions and Perception Scale (Mannarino et al., 1994)	Cohen et al., (2004)	Interpersonal Trust scale extracted	Psychometric data for individual scales not available.
The Children’s Depression Inventory (CDI) Kovacs (1992)	Hébert & Amédée (2020)	Items reflecting loneliness extracted such as “I feel alone all the time”	Psychometric data for individual items not available.

The Clinician-Administered PTSD Scale, Child and Adolescent Version (CAPS-CA)  Nader et al., (1996)	Sachser et al., (2017)	Item "Feeling distant or cut off from other people" in Sachser et al., (2017)	Psychometric data for individual items not available.
The Resiliency Scale for Children and Adolescents (RSCA) Prince-Embury (2007)	Deblinger et al., (2017)	Measures personal resiliency across 3 subscales: Sense of relatedness scale used.	Good internal consistency, test-retest reliability and criterion validity (Prince-Embury, 2007)
UCLA PTSD Reaction Index for DSM-IV (UCLA-PTSD-RI)  Steinberg et al., (2004)	Sachser et al., (2017)	Item "I feel alone inside and cut off from other people"	Psychometric data for individual items not available.
<b><u>Disturbances of self-organisation: Emotion regulation</u></b>			
Children's Impact of Traumatic Events Scale II (CITES II)  Wolfe (2002)	Hébert & Amédée (2020)	Items reflecting anger and irritability such as "I get upset over little things" extracted	Psychometric data for individual items not available.
Difficulty in Emotion Regulation Scale (DERS) Gratz & Roemer (2004)	Cisler et al., (2015)	Assess difficulties in emotion regulation across 5 subscales	High internal consistency, good test-retest reliability, adequate construct and predictive validity (Gratz & Roemer, 2004)
The Child Posttraumatic Cognitions Inventory (CPTCI) Meiser-Stedman et al., (2009)	Sachser et al., (2017)	Items "Anyone could hurt me"	Psychometric data for individual items not available.
The Children's Emotion Management Scales (CEM)  Suveg & Zeman (2004)	Thornback & Muller (2015)	Two subscales used: 1. Inhibition of emotional experience 2. Dysregulation	Good internal consistency, test-retest reliability and convergent validity (Suveg & Zeman, 2004)

The Emotion Regulation Checklist (ERC) Shields & Cicchetti (1997)	Thornback & Muller (2015)	Two subscales used: 1. Liability/negativity – examine mood flexibility, liability and dysregulated negative affect 2. Emotion regulation skill	Good convergent validity and internal consistency (Shields & Cicchetti, 1997)
The Executive Functioning Index for the Behavioural Assessment System for Children – 2 (EFI BASC-2) Reynolds & Kamphaus (2004)	Lee & Brown (2022) Ross et al., (2021)	Emotional control subscale extracted	Good internal consistency and reliability (Karr & Garcia-Barrera, 2016)
The Life Problems Inventory (LPI) Rathus & Miller (1995)	Ross et al., (2021)	Emotion dysregulation subscale extracted	Good internal consistency and criterion validity (Rathus et al., 2015)
The Resiliency Scale for Children and Adolescents (RSCA) Prince-Embury (2007)	Deblinger et al., (2017)	Measures personal resiliency across 3 subscales. Emotional reactivity scale used.	Good internal consistency, test-retest reliability and criterion validity (Prince-Embury, 2007)
The Revised Children’s Manifest Anxiety Scale (RCMAS) Reynolds & Richmond (1978)	Hébert & Amédée (2020)	Item “My feelings get hurt easily” extracted	Psychometric data for individual items not available.

**Paper Two: Empirical Paper**

**Exposed, Scaffolded and Connected – Foster Carers' Experiences of Dyadic  
Developmental Psychotherapy: An Interpretative Phenomenological Analysis**

Word count: 7,998

(Excluding Title Page, References and Appendices)

This paper has been written in accordance with the author guidelines for the *Psychology and Psychotherapy: Theory, Research and Practice* journal. The author guidelines are in Appendix A.

## **Abstract**

### **Objective**

Research is required to better understand the experience and effectiveness of Dyadic Developmental Psychotherapy (DDP), a promising intervention developed to meet the complex needs of developmental trauma-experienced children in substitute care. DDP is a systemic intervention, within which the child's carer plays a significant role. Given their significant role and the lack of existing research, this study aimed to explore how foster carers experience DDP.

### **Design**

A qualitative design using semi-structured interviews with ten foster carers was implemented.

### **Method**

Interviews conducted via Microsoft Teams and telephone were recorded, transcribed and analysed using Interpretative Phenomenological Analysis (IPA).

### **Results**

Four group experiential themes and eleven subthemes were formed; 'from disbelief to clarity', 'scaffolded and safe', 'attuned and connected', and "*it's worth it*". From initial confusion and disappointment, came clarity of self-understanding and a more attuned, connected attachment relationship. DDP was experienced as both fulfilling and demanding.

### **Conclusions**

Though the need to explore DDP's effectiveness remains, this study suggests foster carers experience DDP as a demanding yet worthwhile intervention. Implications for practice, especially an increased need for relational safety and carer support are explored, as well as avenues for future research.

## **Introduction**

DDP is an extensively used, (National Institute for Health and Care Excellence; NICE, 2015) promising intervention (Department for Education; DfE, 2016) to support the complex needs of children who have experienced developmental trauma. Despite having a significant role in the intervention, no research has yet explored foster carers' experience of DDP. As understanding the experience of psychological therapies can improve experiences and outcomes (Elliot, 2008), the current research aimed to better understand foster carers' experience of DDP.

The number of children looked after by their local authority has steadily increased across the UK (National Society for the Prevention of Cruelty to Children; NSPCC, 2024), to 83,840 children in March 2023 in England (DfE, 2023), 68% of which are cared for within foster placements (DfE, 2023). At least 65% of children are in care due to risks of abuse or neglect from caregivers (DfE, 2023).

Given the lack of safety and fear of harm in their early attachment relationships, many children in care have experienced developmental trauma, defined as trauma that occurs in childhood within one's own family, and often within relationships with parents (van der Kolk, 2005). Such experiences have a vital influence on the developing internal working models of the child, shaping how they view themselves, others and the wider world, which act as a blueprint for expectations and patterns in future relationships, including those with caregivers (Bowlby, 1969). The impact of developmental trauma is alarmingly pervasive (Cook et al., 2005; D'Andrea et al., 2012; McAuley & Davis, 2009), shaping key areas of the child's development such as their sense of self, attachment security, emotion regulation and cognition, which can therefore shape their adult lives. Compared to children living with birth families, children in care have higher rates of mental health difficulties (Bazalgette, Rahilly & Trevelyan, 2015; Meltzer et al., 2003) and poorer outcomes, including education, housing and employment (Gypen et al., 2017).

Parent-child psychotherapy focusing on their relationship is therefore recommended for care-experienced children experiencing attachment difficulties

(NICE, 2015). DDP, noted by NICE (2015), was developed specifically to meet the complex needs of children in substitute care who have experienced developmental trauma, in recognition of the limitations of therapies considered best practice at the time (Hughes, Golding & Hudson, 2019). Relationships are the focus, way of being and mechanism of change in DDP (Hughes, Golding & Hudson, 2015), aiming to develop attachment security between the child and their carer. Consequently, the carer becomes a safe base from which the child can experience themselves and the world (Casswell et al., 2014).

The caregiver's active presence in the therapeutic process is, therefore, a core component of DDP. After exploring their experience and understanding of the child independently with the therapist, as well as their own attachment history, the carer becomes a co-therapist in joint sessions with the child, working alongside the therapist to co-regulate the child's emotions and facilitate psychological safety (Hughes, 2017). Intersubjective experiences are another core component, which allows the child to discover a new sense of themselves through the carers' communication of their experience of the child back to them (Hughes, 2017). So too are affective-reflective dialogues, which seek to evoke and co-regulate the emotions associated with the child's early experiences and to help discover new meanings of such trauma, reducing the child's shame and forming a more coherent sense of self (Hughes, 2017). The PACE-ful way of being, from therapist and carer, which conveys playfulness, acceptance, curiosity and empathy in all interactions with the child is central to such intersubjective experiences and facilitating relational safety (Hughes, 2017).

The evidence base for DDP remains emerging (NICE, 2015). DDP-informed interventions have shown promise in increasing parental understanding of the child, parental self-efficacy and parental reflective functioning, as well as changes to the parent-child relationship (Golding, 2017; Staines, Golding & Selwyn, 2019; Downes, Kieran & Tiernan, 2019; Lewis, Stirk & Erin, 2022). To the author's knowledge, only one study (Becker-Weidman, 2006) has explored the outcomes of DDP psychotherapy, finding promising results, though methodological flaws warrant further research (Mercer, 2015) and the intervention implemented may not reflect the current delivery of DDP (DDP Institute Board, 2014). A recent systematic review

found preliminary support for the use of DDP with adoptive families (Purrington, Goodall & Lynch, 2023), though again warranted further research. A NICE-recommended (2015) randomised control trial has been found both feasible and timely (Turner-Halliday et al., 2014) and is therefore currently underway (RIGHT Trial, n.d.)

NICE (2015) further recommend qualitatively exploring the experience of DDP, to increase understanding of underlying therapeutic processes, leading to improvements in therapeutic experience and outcomes (Elliot, 2008). To date, only adoptive parents' experience of DDP psychotherapy has been explored (Wingfield & Gurney-Smith, 2018; Golding, 2023), as well as some comments on the experience of birth families in Edge of Care teams (Fletcher, McLaren & Bradley, 2023). Foster carer experiences therefore remain unknown.

## **Rationale and aim**

Whilst attachment-focused interventions may not be appropriate or feasible for shorter-term placements, many children experience longer-term foster placements, within which the foster carer aims to become their primary attachment figure.<sup>2</sup> Despite their vital role in attachment-focused interventions being recognised (Ford, 2023), and their role becoming more therapeutic in nature due to the complex needs of the children in their care and the lack of specialist services (Golding, 2004; British Psychological Society, 2009), little is known about foster carers' experience of such interventions. Fundamental contextual differences between foster and adoptive parents' relationships with the child in their care, such as permanency considerations, legal rights, placement length, contact with birth parents (Neil, Beek & Schofield, 2003; Selwyn & Quinton, 2004), as well as differences in the experience of this relationship, such as increased sense of belonging, emotional security and closeness for adoptive children and parents compared to fostering (Triseliotis, 2002;

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<sup>2</sup> Foster placements can end for many reasons. Decision-making regarding how long a child remains within a foster placement is complex and multi-faceted. Many things are factored into this decision; what is in the child's best interests, the wishes and feelings of the child (if age appropriate), the wishes and feelings of the foster carers etc. Children's social care, who often hold parental responsibility, can also decide that a foster placement is no longer meeting the child's needs for various reasons.

Selwyn & Quinton, 2004) have been found. Furthermore, it was hypothesised the complex intertwinement of the foster carers' role being both personal, as a parent, and professional, as a paid occupation (Blythe, Wilkes & Halcomb, 2014), may impact their experience of DDP, given foster carers are more open to professional scrutiny. Therefore, whilst some similarities likely remain, given the very focus of DDP is the parent-child attachment relationship (Hughes, Golding & Hudson, 2015), foster carers may experience DDP somewhat differently from adoptive parents. This paper therefore aims to better understand foster carer's experience of DDP, via Interpretative Phenomenological Analysis (IPA), which offers insights into under-researched, complex, and emotive lived experiences (Smith & Osborn, 2015).

## **Research question**

How do foster carers experience DDP?

## **Method**

### **Ethics**

Ethical approval was obtained from Staffordshire University Ethics Committee (Appendix B) and the Health Research Authority (Appendix C).<sup>3</sup> All participants provided written informed consent, which was re-confirmed verbally at the interview. Personal information was redacted from transcriptions and pseudonyms were used for anonymity. Participants were provided the option to pause, reschedule or suspend the interview should they become distressed, before being debriefed and signposted to sources of support (Appendix J). Though some participants did become distressed at points throughout the interview, all wished to continue and shared that reflecting upon their experience had been helpful overall.

### **Design**

A qualitative design was implemented, given its utility for exploring complex under-researched phenomena (Elliot, Fischer & Rennie, 1999). IPA was identified as

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<sup>3</sup> Though approval for recruitment via five NHS trusts was granted, recruitment was only conducted through the two trusts that confirmed their capacity to support the research (Appendix D).

a suitable method of analysis for this study given its focus on reflexivity and compared to methods such as thematic analysis, the idiographic focus allowed the researcher to remain faithful to the individual voices of the participants, keeping the nuances of such experiences at the fore of the analysis. Given its phenomenological roots, IPA is not concerned with providing explanatory accounts but rather seeks to understand how participants experience a phenomenon and the meaning made of such experience, as expressed in their own terms (Smith, Flowers & Larkin, 2009). The researcher then interprets and makes sense of the participants' meaning-making, known as the double hermeneutic (Smith & Osborn, 2008).

The use of IPA further allowed for comparisons to the paper exploring adoptive parents' experience of DDP (Wingfield & Gurney-Smith, 2018). Semi-structured interviews were utilised to allow participants to share their experiences in their narratives and to gather rich data. The interview guide (Appendix I) was developed with clinical and academic supervisors and informed by the interview schedule in a previous study (Wingfield & Gurney-Smith, 2018). The executive summary was sent to consenting participants and feedback on its content and accessibility were requested.

## **Recruitment**

DDP clinicians who could identify suitable foster carers were contacted via the participating NHS trusts and the DDP Network website and provided with the Study Advertisement (Appendix E) and Participant Information Sheet (Appendix F) via email. Eligible foster carers were approached by the clinician and were either given the researchers' contact details to express their interest, or they consented to be contacted by the researcher. Carers were provided with the Participant Information Sheet and offered the opportunity to ask further questions. Willing participants then completed the consent form (Appendix G) either via email or post.

## **Sampling and participants**

Purposive sampling of a homogenous group is essential within IPA, to recruit participants for which the research question is relevant and significant (Pietkiewicz &

Smith, 2014), to ensure a degree of shared lived experience (Crewsell, 2013) and to ensure findings remain contextualised within the specific sample (Robinson, 2014). IPA's idiographic commitment to understanding the depth, rather than breadth, of a phenomenon means ten is considered an optimal sample size for professional doctorates, to enable the balance between idiographic focus and credibility (Smith, Flowers & Larkin, 2021).

14 foster carers expressed an interest in participating, three did not meet inclusion criteria (Table 1) and one did not follow up on invitations to participate.

**Table 1**  
**Inclusion and Exclusion Criteria**

Inclusion criteria	Exclusion criteria
<p><u>Foster carers who:</u></p> <p>Experienced face-to-face DDP with a clinician trained to at least DDP level one.</p> <p>Have completed at least 20 DDP sessions, including some joint carer-child sessions.</p> <p>Participated in DDP within the last year.</p> <p>Are able to speak English.</p>	<p>If the participating child is over 18 years old.</p> <p>If they are biological or adoptive parents, residential care workers, or kinship carers.</p> <p>If DDP was completed in a group format.</p> <p>If have experienced DDP-informed practice, rather than DDP psychotherapy sessions.</p> <p>If experiencing significant current mental health difficulties, or if believe the study may cause significant distress.</p>

Kinship foster carers were excluded to ensure the homogeneity of the sample. It was hypothesised their experiences may differ from non-kinship foster carers due to contextual differences such as less access to support for kinship carers

(Cuddleback, 2004) and a possible difference in the perceived need for support given their existing knowledge of and relationship to the child. Furthermore, it was hypothesised that kinship carers' increased proximity to the child's trauma may affect their experience of exploring this, and their own early attachment experiences, within DDP.

Ten foster carers, three males and seven females, participated in the study. All identified as White British. One participant received DDP through social care, four through the NHS and five in the private sector. Participants' ages ranged between 38 and 69 years (average=57) and time fostering ranged between 4.5 and 24 years (average=10). Some participants fostered as a couple and experienced DDP together, though were interviewed separately. Participants had been part of DDP for between eight and 26 months so far (average=19) and all were still engaging in therapy.<sup>4</sup>

## **Procedure**

Interviews were conducted via telephone (n=1) and Microsoft Teams (n=9), recorded via a Dictaphone and Microsoft Teams, and later transcribed. A demographic questionnaire (Appendix H) was completed before the interview commenced. Interviews lasted between 45 and 101 minutes (average=83).

## **Analysis**

Smith et al's (2021) analysis guidance was observed. The researcher engaged in reflexive reading of transcripts and listened to audio recordings of interviews, to immerse themselves in the data. The following steps were completed for each transcript individually. Initial striking observations on meaning-making throughout the whole transcript were documented, in recognition of the hermeneutic circle, within which researchers move between focusing on the parts and the whole of the lived experience (Smith et al., 2009). Moving from the whole to the part, exploratory descriptive, linguistic and conceptual notes on meaning that stayed close to the participant's account were made on an electronic copy of the transcript. Experimental statements were formed, summarising interpretations made regarding

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<sup>4</sup> Limited demographic information shared to maintained confidentiality of the participants.

the participant's experiential meaning (Appendix K). Experiential statements were cut out and formed personal experiential themes clustered around meaning (PETs; Appendix L). These steps were repeated for each transcript. All PETs were written out and reviewed, noting converging, and diverging patterns to highlight connections and uniqueness of experience (Smith et al., 2021) resulting in the development of tentative group experiential themes, which evolved through reflection and supervision (GETs; Appendix M). As recommended by Smith et al., (2021) GETs were supported by at least five participants.

### **Reflexivity and Epistemology**

The researcher adopted a social constructivist-interpretivist epistemological position, given their belief in multiple realities, and that meaning is socially constructed through individuals' interactions with the world. In line with Crotty (1998), the researcher therefore viewed themselves as engaging in a process of interpreting the participant's meaning of their experience, as opposed to seeking to discover an objective truth. The researcher's influence within the interpretative process is therefore recognised, in line with the double hermeneutic. The researcher had experience of applying DDP-informed principles, though had not engaged in DDP psychotherapy, nor received DDP training. Nevertheless, the researcher held a view that DDP may offer foster carers a new and somewhat different experience. Given the researchers' epistemological position, bracketing such beliefs entirely during data collection was not deemed to be possible. To be mindful of such beliefs and ensure participants could express their experience within their own terms, open-ended questions and a reflective diary were utilised (Appendix M), and participant material was brought to academic and group IPA supervision during theme development to ensure themes remained closely linked to participants' words. To ensure trustworthiness, the analysis process was documented, including theme formation, producing a clear audit trail.

## Results

Four GETs and eleven subthemes were developed; ‘from disbelief to clarity’, ‘scaffolded and safe’, ‘attuned and connected’, and “*It’s worth it*” (see Table 2 for overview and Appendix N for a breakdown by participant).

**Table 2**  
**GETs, subthemes and number of supporting participants.**

<u>GET</u>	<u>Subtheme</u>	<u>Supporting participants</u>
<b>From disbelief to clarity</b>	<i>“What the hell is going on?”</i>	8
	<i>“It’s something you have to experience really, to understand it”</i>	9
<b>Scaffolded and safe</b>	<i>“It’s a very safe and secure relationship”</i>	9
	Guided and having a co-parent	8
<b>Attuned and connected</b>	A new insight	10
	Resourced and armed for the future	6
	A cemented relationship	9
<b>“It’s worth it”</b>	<i>“It’s been a long, sometimes arduous process”</i>	10
	Confronted and exposed	7
	<i>“It actually makes you a bit of a better person”</i>	9
	<i>“It is a big commitment, but not one that I regret at all”</i>	10

### **1. FROM DISBELIEF TO CLARITY**

All but one participant shared journeying through the process of DDP, from confusion and disappointment to clarity and advocacy, as their understanding of and faith in the model grew. The one participant who did not support this GET had prior professional knowledge of DDP, which mitigated against initial disbelief and confusion.

1a. "What the hell is going on?" (Claire, pg.41)

Most participants "*had absolutely no idea really what [DDP] would entail*" (Joanne, pg.3) beyond "*it was going to be therapeutic*" (Brad, pg.4). Despite learning more in initial sessions, DDP continued to "*sound really alien*" (Claire, pg.3). For Sue, initial sessions were "*an eye-opener on what she, on what we were going to be doing with John*" (pg.8). Sue and Brad shared a sense of apprehension regarding "*how direct it was going to be in terms of some of the questioning*" (Brad, pg.4) but held faith in the uncertainty "*that everything would be alright.*" (Sue, pg.9), possibly due to trust built with the therapist.

Most participants shared feeling bewildered once joint sessions began, as they "*didn't understand what it, what the purpose was.*" (Claire, pg.41). Sessions were therefore "*a bit of shock. Like, what? How does this work?*" (Jane, pg.33) and somewhat uncomfortable as "*I didn't really know what my role was, what I should be saying or doing*" (Molly, pg.21).

The initial time required for the therapist to build a trusting, safe relationship with the child was "*very slow...which was frustrating at times, yeah*" (Jane, pg.9), often given the "*long, long process of trying to get some support*" (Tia, pg.1). Given the unexpectedly slow and playful manner of engagement, carers tried to "*understand the value of what's happening here*" (Claire, pg.41).

In contrast to some participants' apprehension regarding DDP's directness, Jane and Frank shared frustration regarding the perceived lack of directness initially. For Jane, this was regarding the therapists' approach as "*I was more let's just get down to it. Let's just talk about what the real issues are*" (Jane, pg.10). For Frank, this related more to the child's readiness:

*"I find it really frustrating, that he's not answering questions. I understand why he isn't answering, because he's scared... but, it's still frustrating that I want him to get the best help he can get, so it's frustrating that that's the best help, and he's not, sort of grabbing it."* (Page 21).

Starting DDP, therefore, left some *“really disappointed. Because I just didn’t understand it. And I just thought, what are we doing here? What a waste of my time.”* (Claire, pg.42). The importance in the initial stage of *“putting our faith in [therapist] really”* (Frank, pg.32) and *“have[ing] a therapist that can explain it to you”* (Claire, pg.42) was highlighted, to enable participants to feel heard and reassured despite the uncertainty.

1b. *“It’s something you have to experience really, to understand it”* (Molly, pg.51)

From confusion and frustration came clarity. DDP was described as *“a learning process for me as well”* (Louise, pg.4), involving *“getting familiar”* (Louise, pg.24) with the model’s way and purpose, though DDP remained somewhat unexplainable as *“it’s something you have to experience really, to understand it.”* (Molly, pg.51).

From frustration regarding DDP’s pace, came understanding and acceptance:

*“I think just realising that a lot of that stuff just takes time, it’s not something that you can rush”* (Jane, pg.27).

For many, came clarity regarding the *“subtle”* (Jane, pg.34) simplicity of DDP, which is almost *“mind-blowing how something that seems so simple, is actually really very, very effective”* (Claire, pg.2). Faith and confidence grew, as changes within the dyadic relationship were experienced:

*“I won’t say I was sceptical before I started it, but I did wonder if it would make a difference. And I saw first-hand that it definitely did.”* (Louise, pg.70).

For those waiting for the child to be ready to progress further, faith in the model grew as *“the little things make us sort of acknowledge that there is progress”* (Tia, pg.21), however, this re-defining of progress was effortful and frustrating, in comparison to progress hoped for:

*“It’s still frustrating for me now because it’s like 14, 15 months down the line and we haven’t got anywhere. Well, we have...because he’s not under the table anymore.” (Frank, pg.17).*

Given the progress experienced, many shared becoming *“a real advocate for it”* (Brad, pg.80), as they *“could not recommend [DDP] highly enough”* (Joanne, pg.71).

## **2. SCAFFOLDED AND SAFE**

All participants referenced the importance of relational safety with the therapist, which was validating, accepting and containing, and allowed them to fully engage in the therapeutic process. This relational safety provided the scaffolding to learn new skills and navigate the journey ahead together.

### *2a. “It’s a very safe and secure relationship” (Michelle, pg.29)*

The carer-therapist relationship was experienced as *“safe and secure”* (Michelle, pg.29) and *“forgiving”* (Claire, pg.8). Carers did not *“worry what I’m going to say”* (Molly, pg.19) or *“feel as if you need to put on any extra heirs or graces”* (Claire, pg.8). Instead, the relationship provided a uniquely non-judgemental and accepting space, enabling Sue to *“talk freely”* (pg.30) and Michelle to *“say some really dangerous things without judgement....it gives you permission”* (pg.29). For Molly, the relational safety was key to its success:

*“...that’s allowed me to explore a lot of what she’s needed me to explore.... things from my past and my feelings about Ryan. And if I’d ever felt there was sort of judgement coming from or there were right or wrong answers to be giving, I don’t think the process would have worked” (pg.16)*

The stark contrast between this safety and a *“wariness to be just brutally honest about how they feel”* (Molly, pg.8) about the dyadic relationship within the

wider fostering system was noted, given the fear of scrutiny and judgement as failing what is expected of them in their professional role:

*"...there seems to be this expectation that because this is a foster child and not yours, you wouldn't have those same feelings"* (Molly, pg.9).

Instead, the therapeutic relationship allowed carers' often-complex emotional experience of the child to be *"validated that it's okay to feel like that"* (Molly, pg.10) and to be reassured *"that actually I'm doing okay"* (Louise, pg.23):

*"...it was having somebody saying - you're not failing, she's really tricky...keep persevering and you'll get there"* (Claire, pg.54).

The therapist was therefore *"someone to trust"* (Frank, pg.29), *"who had an understanding of us"* (Michelle, pg.28), from which the carers could *"have faith that she is working towards the right things for Ryan"* (Molly, pg.8).

Tia described finding *"relief"* in the carer-therapist relationship as they're *"finally the right person, for Tommy's needs, but for our needs as well"* (Tia, pg.52). The relationship then becomes the *"safety net"* (Tia, pg. 37) from which carers' can be open to new ideas and ways forward:

*"[therapist helped]...build our confidence again in that really, we are capable, we just needed a new, a new approach, and new ideas, and she could possibly offer that"* (Brad,pg.28).

## 2b. Guided and having a co-parent

Many valued the opportunity to learn through observation, as carers got to *"see how [therapist] deals with it"* (Sue,pg.30) which was *"fascinating, seeing that skill... in action every week for months...it's a good way of learning that you keep on and on"* (Joanne, pg.54 and pg.64), permitting herself to also embed the approach consistently.

At points, the therapist directly “*guides us in those sessions*” (Tia, pg.20), “*giving me sort of pointers*” (Louise, pg.4) or “*a hand signal, just to be quiet effectively and let him do what he has to do*” (Brad, pg.23). Louise noted the importance of guidance to prevent carers feeling deskilled:

*“Otherwise...I’ve sat there thinking - what do I do here... So being forewarned and hints like “why don’t you try this” really helps.” (pg.52).*

Despite modelling ways of being, the therapist was not perceived as an all-knowing expert, but as a co-parent to work alongside:

*“...you can have your input. And I think that’s what makes it feel like you are co-parenting because...although she’s the professional in the room, she’s not the boss in the room, she doesn’t make you feel like you’re inferior.” (Claire, pg.38)*

The therapist was therefore someone to “*talk it through with*” (Molly, pg.18), which was especially important given the isolation of being a single carer, and someone “*slightly objective...doesn’t get so emotionally drawn into everything... to help us to reflect, and to support us to look after him*” (Michelle, pg.68).

Some shared feeling less alone in carrying the emotional weight of the child’s experiences, as the therapist can “*share that... load and helping me with the vocabulary I need to use to support him*” (Michelle, pg.45). Nevertheless, for Claire, DDP remained a somewhat lonely experience, possibly especially as a single carer, as carers are left to manage alone outside of the therapeutic space:

*“...then you’re left with it. That’s very difficult. And I think that’s where the loneliness comes in...the therapist isn’t always there on hand 24/7. So, you are left doing a lot of the therapeutic parenting DDP style at home” (Page 28)*

### 3. ATTUNED AND CONNECTED

All participants shared gaining a new insight into the child's world, from which they became more attuned to the child's needs and developed new ways of meeting them. Consequently, a more connected and cemented relationship was experienced.

#### 3a. A new insight

All participants shared gaining "*a lot more insight*" (Claire, pg.61) into the child's view of themselves, their carer and the world, as "*we don't see it the same...not at all*" (Claire, pg.61), which was especially helpful given participants often "*only get very limited information about what's gone on*" (Joanne, pg.26). To do so, Brad shared learning to "*put your needs aside, to stand beside your child and understand, well try to understand, what they've gone through*" (pg.27).

Such insight "*enabled us to realise that his trauma is so deep and engrained*" (Brad, pg.11), providing participants with a greater "*appreciation*" (Brad, pg.82) for the impact of early trauma, enabling them to be "*very empathetic*" (Louise, pg.37). For Frank and Tia, this greater appreciation arose from observing the child "*struggle so much more than we thought he was going to*" (Tia, pg.7) to trust the therapist:

*"...you'd think oh I've been referred to a psychologist who... in your mind is...a safe person, but for Tommy no one is safe person, nowhere is a safe place"* (Tia, pg.24)

Others came to better understand and prioritise how the child sees them "*which was a great shock to me*" (Sue, pg.24) as "*...we wouldn't necessarily visibly see that ourselves, but that's how he perceives it. And so much of what we have learned is that his perception is so important.*" (Brad, pg.8).

DDP provided a "*real luxury of time and space....to really drill down into what Billy's real needs are*" (Michelle, pg.68), enabling participants to gain "*a bit more insight as to why she behaves like she does*" (Louise, pg.37). From a understanding came an ability to "*take a step back*" (Louise, pg.37) and gain clarity in "*thinking*

*about how you're going to help them*" (Joanne, pg.17), and in how to *"work in a DDP way with our other children as well"* (Brad, pg.39).

### 3b. Resourced and armed for the future

For all but one participant, DDP provided the opportunity to learn new *"skills"* (Joanne, pg.66) and *"a different way of helping"* (Jane, pg.45), in consideration of *"how we could be better for John"* (Sue, pg.66).

Brad discovered new *"tools that are better designed for that job of... standing side by side with your child"* (pg.20) meaning the family have *"more in our armoury"* (pg.39) for when they *"have to deal with new challenges"* (pg.29). Many shared the sentiment that whilst the end of therapy would not be the end of all difficulties, they would be better equipped to face the challenges ahead together.

From new tools, came new ways of being with the child. For some, this involved *"just listening"* (Joanne, pg.17) to the child's experience, rather than trying to fix it. Michelle shared feeling able to *"relax some of the things that we maybe found very difficult to, to let go"* (pg.64) whilst simultaneously *"giving us permission to talk about difficult things with him, you know, not just to keep avoiding them"* (pg.48).

### 3c. A cemented relationship

All but one participant experienced a shift in their caring relationship. The participant who did not support this subtheme shared feeling as though they were still in the initial phases of the therapy, meaning relational progress had not yet been made. Louise shared *"as a foster carer, you've got natural barriers [in your relationship] because you're not the parent"*, including a lack of an *"automatic bond"* or having *"chosen that child to be your child"* (pg.70), alongside *"barriers because of social care"* (pg.77) which subsequently creates natural barriers to connection and security, *"as foster parents, we're struggling with that on a daily basis, trying to let these children know that we're here for them"* (Michelle, pg. 32). Louise shared that:

*“...despite those barriers as a foster carer, the DDP still worked brilliantly. I actually think it’s more helpful in some ways because of those barriers.”* (Page 73)

This was possibly because DDP provided many with the opportunity for their love and commitment to the child to be understood. In therapy, carers and their child *“shared some of those really hard times”* (Brad, pg.53), they saw *“the worst of [child] and I’m still telling [child] that I’m there for you. And I’m not getting rid of you. I think that cemented it a little bit too.”* (Louise, pg.43). Carers shared being able to *“show him that we really love him, really want him, really care about him”* (Michelle, pg.60) meaning the child *“was not having to test us with that anymore”* (Michelle, pg.60). Carers experienced becoming *“a safe person, and a safe base that Tommy can always come back to”* (Tia, pg.39) which *“definitely strengthened the bond between us”* (Molly, pg.34).

Louise herself shared feeling less rejected, meaning she could *“bring my feelings more under control”* and *“repair quicker”* (pg.39), moving towards the child rather than away, in moments of rupture. For Joanne, it meant *“he can be honest with us and we can be honest about how we feel”* (pg.43) leaving the carer feeling seen and validated. Overall, the carer-child relationship became *“a lot calmer”* (Jane, pg.20).

#### **4. “IT’S WORTH IT”**

DDP came at a cost to all, mentally, physically or practically. Such costs were however experienced as worthwhile, leading to transformations of the fostering relationship, and for some of themselves as a person and parent.

4a. *“It’s been a long, sometimes arduous process”* (Louise, pg.3).

All participants experienced DDP as a surprisingly intensive commitment:

*“I didn’t know how time-consuming it would end up being, how emotional it would end up being. It’s a very exhausting process.” (Molly, page 6)*

DDP was experienced as *“a massive commitment, to go and turn up every week”* (Joanne, pg.71). Frank shared how *“we’re a year in, but I feel like there’s lots yet to come”* (pg.41), given time needed for the child to be ready to engage in the process. DDP was therefore a *“long... very slow road”* (Claire, pg.1) which can be *“useful and a good thing”* (Michelle, pg.28) given time allowed to embed new learning.

For all but one, DDP was a *“very emotional journey”* (Molly, pg.3) as learning more about the child’s early experiences left carers *“horrendously sad and angry”* (Molly, pg.30) and *“quite distress[ed]”* (Brad, pg.44). To cope, some *“put on a good face”* (Claire, pg.29) so they could convey acceptance to the child despite their discomfort, whilst others needed to *“be a little bit detached”* otherwise it would become *“too heart-breaking”* (Michelle, pg.37) to truly sit with the child’s trauma. Whilst finding new meaning in early experiences was thought to be helpful for the child, the carer is then *“left with [new knowledge of trauma], that’s very, very difficult”* (Claire, pg.27). Sessions themselves were therefore experienced as *“pretty hard work”* (Brad, pg.47) leaving carers *“exhausted”* (Tia, pg.21). The need for *“some sort of support plan”* (Claire, pg.30) was therefore acknowledged. The participant who did not support this subtheme shared feeling as though DDP was more for the child than the dyad, which perhaps altered the emotional experience of the therapy.

#### 4b. Confronted and exposed

The requirement of carers to explore their own experiences and be open to new ways of being left many exposed and confronted. Carers shared being somewhat *“naïve”* (Molly, pg.3), as the exploration of their attachment experience was something most *“didn’t expect at all”* (Claire, pg.5), leaving them feeling *“analysed”* (Louise, pg.12). This was therefore *“really intrusive, having to explain how you feel about your parenting and how you were parented”* (Claire, pg6) leaving carers feeling they are *“exposing myself a bit here”* (Louise, pg.13) and *“a little bit anxious...will I uncover something that I hadn’t realised?”* (Joanne, pg.8).

The required vulnerability was *“humbling and quite confronting...to really think so openly and honestly with somebody about how raw something can be making you feel”* (Molly, pg.4). Michelle and Louise shared how the child-centred nature of sessions at times left them feeling criticised and misunderstood, as the therapist empathises with the child’s experience over theirs, which can be *“the hardest part of going”* (Michelle, pg.20).

For some, it challenged *“fundamental beliefs”* (Michelle, pg.63) about themselves, as a person and a parent which was *“hard to accept”* (Brad, pg.33). For many, their sense of exposure decreased, as their trusting relationship with the therapist grew, and there was a belief that whilst exposure was challenging, it was necessary *“otherwise you were never going to get the most out of it”* (Claire, pg.4).

4c. *“It actually makes you a bit of a better person”* (Claire, pg.39)

From vulnerability, came greater self-understanding and a transformation to how seven participants viewed themselves as people and parents. Within DDP, *“you learn a lot about yourself”* (Brad, pg.70) which is *“enlightening”* (Louise, pg.48):

*“...its a personal revelation... thinking about how you do things, just being aware of everything we do”* (pg.79).

Some came to better understand *“how you communicate”* (Claire, pg.52), how things *“relate back to my past experiences”* (Louise, pg.12) and that *“[child] was actually triggering my own issues from the past”* (Molly, pg.5).

From self-understanding, came a transformation to ways of being as parents. Some felt more able to *“put your own needs aside”* (Brad, pg.27) to be more *“accepting”* (Molly, pg.38), *“patient”* (Jane, pg.41) and to identify *“what’s really important and to focus on that”* (Michelle, pg.61). Many fostered a new sense of compassion, meaning they were no longer *“so hard on them, [and] don’t be so hard on yourself...it’s very forgiving”* (Claire, pg.36).

For many, DDP led to a shift from “*normal parenting*” (Frank, pg.54) to “*super-parenting*” (Brad, pg.4), in recognition that “*his experiences are at the extreme end. So...we’ve had to deal with them...at the extreme end of parenting*” (Michelle, pg.64). For some, this shift was “*instinctively right*” (Michelle, pg.65), “*natural*” (Jane, pg.38) and a “*a day-to-day thing. You don’t really notice that you’re doing it*” (Claire, pg.58). For others, it was “*very challenging*” (Brad, pg.5) to go against parental instincts:

“*...it’s difficult and a big change. It’s absolutely massive. And I struggle with it*” (Frank, pg.11).

For some, came a personal transformation. Some participants shared gaining a new perspective as “*your outlook on everything is very different...to what it might have been before*” (Claire, pg.57). Changes encapsulated a shift from doing, as a “*fix-it kind of person*” (Joanne, pg.59), to an ability to simply be, becoming “*more reflective*” (Joanne, pg.7), developing “*patience*” (Jane, pg.27), and “*resilience*” (Claire, pg.37). Some noted changes within all their relationships and areas of life. There was therefore a sense that DDP “*actually makes you a bit of a better person*” (Claire, pg.39).

#### 4d. “*It is a big commitment, but not one that I regret at all*” (Joanne, pg.68)

For all, the benefits of DDP were outweighed by the costs:

“*It’s a big commitment, but not one I regret at all*” (Joanne, pg.68).

Despite not yet seeing the progress hoped for, Frank remained hopeful that “*we get there eventually*” (Frank, pg.31). The emotional toll of sessions was often “*definitely worth it*” (Claire, pg.55), as participants came to “*see the difference it’s making*” (Michelle, pg.35), and the most difficult sessions were often “*we seemed to make more headway*” (Louise, pg.3).

For some, DDP was therefore an “*honour*” (Claire, pg.58), “*a precious gift*” (Brad, pg.76) of protected time and space together and “*one of the greatest*

*privileges of my life*" (Brad, pg.51) to come alongside the child in their pain. Some shared DDP was personally and professionally fulfilling, providing the opportunity to:

*"...do something worthwhile...to actually help, to change, to develop, to help them to develop...instead of just feeling like a glorified babysitter, which, without the DDP, a lot of the time, it is"* (Joanne, pg.21).

## **Discussion**

This novel study is the first to explore foster carers' experience of DDP. Four GETs and eleven subthemes were developed; 'from disbelief to clarity', 'scaffolded and safe', 'attuned and connected', and "it's worth it". This section explores links to existing literature and theoretical frameworks, implications for practice and future research, alongside methodological strengths and weaknesses.

### **From disbelief to clarity**

Foster carers shared journeying through the process of DDP, consistent with previous research (Wingfield & Gurney-Smith, 2018). Beginning therapy was laden with confusion and disbelief for most and, given the often-significant wait for support faced by foster carers (York & Jones, 2017), such initial uncertainty resulted in frustration and disappointment. This was possibly due to a misalignment between expectations and realities of DDP, including the unexpected focus on parental experience as previously found (Fletcher et al., 2023), as well as frustration resulting from the disparity between the foster carers and child's readiness to engage in DDP. Foster carers' understanding of, belief in, and commitment to DDP grew as progress was seen.

As parental expectations and the utilisation of therapy (Shuman & Shapiro, 2002) are reportedly linked, clinicians should consider how to increase carers' understanding of the model before commencing joint dyadic sessions, as therapy preparation can improve both therapeutic processes and outcomes (Dew & Bickman, 2005). Given the value of peer support for foster carers (York & Jones, 2017), in combination with participant's reports of being the only person they knew who had

undertaken DDP and that DDP must be experienced to be understood, clinicians may wish to provide foster carers' commencing DDP with testimonies from other DDP-experienced carers, to aid understanding and confidence. These findings further highlight the importance of clinicians establishing a good working alliance with carers before commencing parent-child sessions (Hughes, 2017) to reduce the risk of relational ruptures and disengagement in the uncertainty.

### **Scaffolded and safe**

The safety of the carer-therapist relationship was a key component of all foster carers' experience of DDP, as within psychotherapy more broadly (Podolan & Gelo, 2023). In line with previous research (Wingfield & Gurney-Smith, 2018; Fletcher et al., 2023), the accepting and non-judgmental approach of the therapist allowed foster carers to feel validated and openly engage in DDP. Such communications of empathy and understanding are essential for the parent-therapist therapeutic alliance (Diamond, Diamond & Liddle, 2000) and are in line with the therapist's aim to embody the accepting way, to help both child and carer feel safe enough to express their inner world (Hughes, 2017). This was noted as especially important due to foster carers' fearing judgement as incompetent by other professionals involved, such as social workers or therapists, if they were honest about their complex emotional experience of the child, in line with the literature (Turner et al., 2023). Such fears should be held in mind during the therapy to ensure due attention is paid to the psychological safety of the carer.

In line with DDP's aims (Hughes et al., 2019), foster carers experienced their therapists' role as multifaceted. Participants learnt through observation of the therapist sitting with the complexities of supporting the child, which for many normalised difficulties faced within their dyadic relationship. Therapists were experienced as co-parents, as opposed to sitting within an expert position, which enabled carers to feel their expertise was acknowledged, in contrast to literature suggesting foster carers often feel overlooked and de-valued by professionals (Murray, Tarren-Sweeney & France, 2011; York & Jones, 2017). Such recognition of lived expertise is essential for a collaborative therapeutic alliance and thus therapeutic change (Spencer et al., 2019; Baier, Kline & Feeny, 2020). Foster carers

felt scaffolded by the therapist, who provided a safe relational foundation from which to learn new skills and ways of being, which is essential for change within DDP (Hughes et al., 2019) and family therapies generally (Diamond et al., 2000). Findings highlight the importance of a safe, collaborative therapeutic alliance that recognises the expertise of foster carers', whilst providing the support to learn new ways of being to facilitate change.

### **Attuned and connected**

Foster carers shared becoming more attuned to the child's experience, from which came new ways of being and a more connected relationship. As previously found (Wingfield & Gurney-Smith, 2018), all participants' understanding of their child's world grew, including new insights into the impact of their trauma in line with therapeutic aims (Hughes, 2011). As suggested when exploring the effectiveness of DDP-informed groups (Downes et al, 2019; Lewis, Stirk & Erin, 2022; Gibbons, Bacon & Lloyd, 2019; Staines, Golding & Selwyn, 2019), there may be an underlying increase in parental reflective functioning, increasing the carers' capacity to reflect upon the child's and their internal world (Luyten et al., 2017; Redfern et al., 2018), especially given participant reports of an increased understanding of the other children within their care that are not part of the therapy. These findings highlight the utility of DDP to improve parental understanding of their child despite, if not especially, given very little often being known of children's early years in foster care. Findings however stress the necessity for carers to feel safe and resourced within the carer-therapist relationship, to truly venture into the child's world.

Foster carers' shared stepping away from known ways of parenting, towards a PACE-ful way<sup>5</sup> by learning new skills, as previously found (Wingfield & Gurney, 2018). Carers subsequently felt better resourced and armed to face the challenges ahead and such improvements to self-efficacy have been found to improve foster

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<sup>5</sup> The PACE-ful way of being, which conveys playfulness, acceptance, curiosity and empathy in all interactions, is central within DDP to help the child who has not had secure attachment experiences learn to trust new carers in their life.

carers' relationships with the child in their care (Adams, Hassett & Lumsden, 2018). Whilst feeling instinctive and a development of existing strengths for some, this felt wholly unnatural and uncomfortable to others, as previously found (Golding, 2023).

With new-found insights and ways of relating, foster carers' experienced a shift in the caring relationship, from rejection to connection and security, becoming a safe base for the child as their love and commitment to them was acknowledged and understood. This resulted in a cementing of the dyadic relationship despite contextual barriers, leaving participants feeling more seen and able to regulate their own emotional responses, subsequently increasing their capacity to attune to and co-regulate the child's emotional experience (Hughes, 2011). Such findings therefore suggest DDP can provide a useful framework to strengthen the foster carers' attunement and attachment relationship, regardless of their prior experience, with benefits beyond the index child.

### **“It's worth it”**

All experienced DDP as a commitment of time and energy, with sessions being somewhat exhausting and uncomfortable, as previously found (Wingfield & Gurney-Smith, 2018; Fletcher et al., 2023). DDP left some feeling confronted, exposed and vulnerable, given the unexpected yet essential requirement for self-exploration in DDP, (Hughes et al., 2015) and other parenting interventions (Havinghurst et al., 2020), to increase carers' awareness of and therefore shift their patterns of relating. For many, from exposure and understanding came a transformation as a person and a parent. Given this and changes within the dyadic relationship, the costs of DDP were experienced as worthwhile, and outweighed by the benefits, as previously found (Wingfield & Gurney-Smith, 2018). For some, DDP was personally and professionally fulfilling, allowing them to fulfil their intended responsibility to the child, moving beyond meeting basic needs of food and shelter. Such fulfilment and personal reward are important to maintain foster carers' commitment and motivation, in the context of significant stressors (D'Amato & Brownlee, 2022) and lower levels of role commitment and satisfaction (Cleary et al., 2018).

Findings highlight the importance of ensuring the requirements of carers within DDP are made clear before commencing therapy, to ensure informed decisions regarding capacity and consent are made. Foster carers may however fear scrutiny if they do not consent to dyadic therapy that may be indicated for the child, due to required demands, given the increasing expectation of foster carers to engage in therapeutic parenting (NICE, 2021). Future research exploring foster carers' perceptions of the expectations of their role is therefore warranted, to ascertain the degree of alignment with the growing expectations placed upon them. Alternative psychological support, such as DDP-informed consultation, should be explored if consent is not obtained. Findings further highlight the importance of adequate attention being paid to the experience of and support for foster carers' throughout DDP by both the therapist, who may consider increasing scaffolding support within dyadic sessions or the frequency of carer-therapist check-ins if indicated, and wider social care, who may increase access to supervision and peer support, given the documented toll of the therapy and foster carers' fundamental role in its success.

### **Strengths and limitations**

This novel, NICE (2015) recommended study offers new insights into the experience of an under-researched population and therapy. National, multi-service recruitment offers broader insights into foster carers' experiences and the large sample size strengthens the credibility of findings. However, as IPA does not aim to generalise findings, these findings reflect the experience of a small, homogenous group who had broadly positive experiences of DDP, were motivated to engage in the research and had a placement duration above the national average (DfE 2023). Given the diversity of context and needs of both foster carers and care-experienced children, these findings cannot be generalised, and indeed this experience of DDP may not be accessible, to all foster carers.

Though the researcher held reservations regarding interviewing foster carers' who jointly engaged in DDP, convergence and divergence in their experience were evident, highlighting the uniquely personal experience of engaging in therapy. All

participants were White British, and although over 80% of foster carers in the UK are White British (DfE, 2023), this study therefore does not encapsulate the experience of those from other ethnic groups.

### **Future research**

Conclusions regarding foster carers' experience of the ending of DDP cannot be drawn from this paper given participants had not yet completed therapy. Given the noted significance of this ending (Wingfield & Gurney-Smith, 2018) and that participants' experience of DDP changed throughout the therapeutic process, future research may wish to employ a longitudinal qualitative design to understand the experience of endings and the underlying mechanisms of therapeutic process and change, to improve experience and outcomes.

Conclusions regarding the effectiveness of DDP cannot be drawn given the study's methodology. Findings however highlight how foster carers' experienced change within DDP, often in line with suggested mechanisms (Turner-Halliday et al., 2014), which could inform outcome measurement in future quantitative evaluations.

Further research is needed to explore kinship carers and young peoples' experience of DDP. Given children from ethnic minority backgrounds are over-represented within the care system (DfE, 2022), future research should aim to recruit more diverse populations to better understand the impact of culture on the experience of DDP.

### **Conclusion**

Foster carers experienced DDP as an evolving, demanding journey, leading to a greater understanding of themselves and the child in their care, and a more connected, resourced dyadic relationship from which to face challenges ahead. Due attention and support for the experience of foster carers within DDP must be paid and further research is needed to understand the experience and effectiveness of the model.

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## **Appendix**

### **Appendix A – Author Guidelines**

Author guidelines for the Psychology and Psychotherapy; Theory, Research and Practice Journal can be accessed here:

<https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448341/homepage/forauthors.html>

## Appendix B – Staffordshire University Ethical Approval



### INDEPENDENT PEER REVIEW APPROVAL FEEDBACK

<b>Researcher Name</b>	Amy Murphy
<b>Title of Study</b>	Foster carers' experiences of dyadic developmental psychotherapy: An Interpretative Phenomenological Analysis
<b>Status of approval:</b>	<b>Approved</b>

Thank you for your submission to the Independent Peer Review (IPR) Panel. Your application is now approved

#### **Action now required:**

You must now apply to the Integrated Research Applications System (IRAS) for approval to conduct your study. You must not commence the study without Health Research Authority (HRA) approval, and relevant site-specific approvals. Please note that the University Sponsor contact to be named on the form is Prof Nachi Chockalingam.

Please forward a copy of the letter you receive from the IRAS process to [ethics@staffs.ac.uk](mailto:ethics@staffs.ac.uk) as soon as possible after you have received approval.

Once you have received HRA approval, and participating Trusts/organisations have confirmed their capacity and capability to support your study, you can commence your research. You should be sure to do so in consultation with your supervisor.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

When your study is complete, please send an end of study report to Dr Edward Tolhurst: [e.tolhurst@staffs.ac.uk](mailto:e.tolhurst@staffs.ac.uk). A template can be found on the ethics Blackboard site.

**Comments for your consideration: None**

A handwritten signature in black ink, appearing to read 'E Tolhurst'.

**Signed:** Dr Edward Tolhurst  
University IPR coordinator

Date: 10<sup>th</sup> March 2023

## **Appendix C – NHS Health Research Authority Ethical Approval**



### **Yorkshire & The Humber - Leeds West Research Ethics Committee**

NHSBT Newcastle Blood Donor Centre  
Holland Drive  
Newcastle upon Tyne  
NE2 4NQ

**Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval**

19 October 2023

Miss Amy Murphy  
Trainee Clinical Psychologist  
Midlands Partnership NHS Foundation Trust  
Trust Headquarters,  
Corporation Street  
Stafford  
ST16 3SR

Dear Miss Murphy

**Study title:** Foster carers' experiences of dyadic developmental psychotherapy: An Interpretative Phenomenological Analysis  
**REC reference:** 23/YH/0220  
**Protocol number:** N/A  
**IRAS project ID:** 327496

The Proportionate Review Sub-committee of the Yorkshire & The Humber - Leeds West Research Ethics Committee reviewed the above application on 27 September 2023.

#### **Ethical opinion**

On behalf of the Research Ethics Committee (REC), the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

#### **Good practice principles and responsibilities**

The [UK Policy Framework for Health and Social Care Research](#) sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of [research transparency](#).

## **Appendix D – Local NHS Trust Capacity and Capability Approval**

**From:** Christopher Flanagan (RRE) MPFT <Christopher.Flanagan@mpft.nhs.uk>

**Date:** Wednesday, 29 November 2023 at 14:48

**To:** Amy Murphy (RRE) MPFT <Amy.Murphy@mpft.nhs.uk>

**Cc:** Julie Warburton (RRE) MPFT <Julie.Warburton@mpft.nhs.uk>, Chantel-Lea Grocott (RRE) MPFT <Chantel-Lea.Grocott@mpft.nhs.uk>

**Subject:** IRAS 327496 – Confirmation of Capacity and Capability at MPFT

Dear Amy,

**RE: IRAS 327496 – Confirmation of Capacity and Capability at MPFT**

**Full Study Title:** Foster carers' experiences of dyadic developmental psychotherapy

On behalf of Ruth Lambley-Burke (Head of R&I), this email confirms that **Midlands Partnership University NHS Foundation Trust** has the capacity and capability to deliver the above referenced study; please find the agreed Organisation Information Document attached as confirmation.

Please begin recruitment on this study at MPFT.

If you wish to discuss further, please do not hesitate to contact me; good luck with your study.

Many thanks,  
Chris

Chris Flanagan

**Research Support Administrator**

Branch Chair – UNISON South Staffs & Shropshire Healthcare Branch (12278)

*Pronouns: he/him #pushforpronouns*

Midlands Partnership University NHS Foundation Trust

**Telephone:** 01785 783170 (internal ext: 7128770)

Working days – Monday, Wednesday, Thursday, Friday



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Together we are making life  
better for our communities

**From:** LouiseC Alston (RLY) NSCHT <[Louise.Alston@combined.nhs.uk](mailto:Louise.Alston@combined.nhs.uk)>  
**Sent:** Friday, December 8, 2023 5:11:00 PM  
**To:** Amy Murphy (RLY) NSCHT <[Amy.Murphy@combined.nhs.uk](mailto:Amy.Murphy@combined.nhs.uk)>  
**Cc:** Research & Development <[Research@combined.nhs.uk](mailto:Research@combined.nhs.uk)>; Zoe Booth (RLY) NSCHT <[Zoe.Booth@combined.nhs.uk](mailto:Zoe.Booth@combined.nhs.uk)>; Kerri Mason (RLY) NSCHT <[Kerri.Mason@combined.nhs.uk](mailto:Kerri.Mason@combined.nhs.uk)>; Amanda Hawker (RLY) NSCHT <[Amanda.Hawker@combined.nhs.uk](mailto:Amanda.Hawker@combined.nhs.uk)>  
**Subject:** IRAS 327496 Foster carers experiences of DDP Study – Trust Authorisation of Research – North Staffordshire Combined Healthcare NHS Trust

Dear Amy

**Trust Authorisation of Research at North Staffordshire Combined Healthcare NHS Trust**

<b>Short Title:</b>	Foster carers experiences of DDP
<b>IRAS ID.:</b>	327496
<b>R&amp;D ID.:</b>	CHC0252/RS
<b>Principal Investigator:</b>	Amy Murphy

This email confirms that North Staffordshire Combined Healthcare NHS Trust has granted Trust Authorisation, and can deliver the above referenced study. Please find attached our agreed Organisation Information Document as confirmation. We agree for you to start this study once we have issued you with an NHS Letter of Access for Research.

Please take time to read the conditions of Trust Authorisation below. You will need this email as proof of Trust Authorisation.

Trust Authorisation has been granted on the basis described in the HRA approval application. The documents received and to be used at site are:

Document	Version	Date
Proposal	1.1	12/01/2023
PIS	1.2	29/09/2023
PCF	1.3	06/10/2023
Cover Letter	1.1	29/09/2023
Demographic Questionnaire	1.1	12/01/2023
Advert	1.2	29/09/2023
Participant Debrief Form	1.2	29/09/2023
Interview Schedule	1.1	12/01/2023
Risk Assessment	1.1	12/01/2023
OID	1.1	21/08/2023
HRA SoE	1.1	21/08/2023

Trust Authorisation is granted on the understanding that the study is conducted in accordance with the [UK Policy Framework for Health and Social Care Research](#), [ICH GCP](#) (where applicable), and NHS Trust policies and procedures. Trust Authorisation is only granted for the research activities which have received approval from all applicable regulatory bodies.

We wish you every success with your research.

Please contact the [R&D Office](#) should you require any further information.

## **CONDITIONS OF TRUST AUTHORISATION**

Please read the following conditions in order for your Trust Authorisation to conduct research to be valid:

- Please submit the following to the Trust's [R&D Office](#):
  - All amendments submitted to the HRA (please refer to the [HRA guidance on amendments](#))
  - Recruitment figures on a monthly basis (at end of study for non-portfolio research)
  - New researcher details (prior to them commencing on the research study) (please refer to the [HRA guidance on HR arrangements for researchers](#))
  - Changes to the status of the research study
  - A copy of reported urgent safety measures (USM), adverse events (AE) and serious adverse events (SAE) (please refer to the [HRA guidance on safety reporting](#))
  - A final report (or summary report) (please refer to the [HRA guidance and publication and dissemination of findings](#))
  - A copy of all progress reports as submitted to the regulatory body(ies) (please refer to the [HRA guidance on progress reports](#))
  - A copy of the end of study declaration as submitted to the regulatory body(ies) ([please refer to the HRA guidance on ending your study](#))
  - Details of any study publication(s)
- Please ensure to acknowledge the Trust in final reports, presentations or publications
- Please note that the Trust shares research findings internally (please contact the [R&D Office](#) for further information)
- Please ensure to complete and return in a timely manner any monitoring or audit forms sent by the R&D Office (research is subject to monitoring by the R&D Office)

Kind regards,

*Louise Alston*

Research Governance Facilitator  
North Staffordshire Combined Healthcare NHS Trust

**Please note that I am currently working from home**

**Email:** [louise.alston@combined.nhs.uk](mailto:louise.alston@combined.nhs.uk)

**R&D Generic Inbox:** [research@combined.nhs.uk](mailto:research@combined.nhs.uk)

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# Foster Carers Experiences of Dyadic Developmental Psychotherapy

## WHAT IS THE STUDY ABOUT?

The study aims to understand what it is like as a foster carer to be a part of Dyadic Developmental Psychotherapy

## WHO CAN TAKE PART?

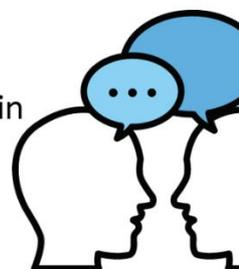
I am hoping to speak to non-kin foster carers, who have completed at least 20 sessions of DDP face-to-face in the last 12 months, including some sessions with their foster child.

## WHO AM I?

My name is Amy Murphy and I am a Trainee Clinical Psychologist studying at Staffordshire University

## WHAT WOULD BE INVOLVED?

I would like to meet you for a conversation to find out more about your experience, either in person or via Microsoft Teams/Zoom. This will last approximately an hour and will also involve you filling in a short questionnaire.



## WHAT NEXT?



If you would like to find out any further information or register your interest for the study, please contact me on my email address below, or give the person giving you this leaflet your consent for me to contact you, and the best contact number/email address to reach you on.

[m026377l@student.staffs.ac.uk](mailto:m026377l@student.staffs.ac.uk)

## Appendix F – Participant Information Sheet

### **PARTICIPANT INFORMATION SHEET (IRAS ID: 327496, Version 1.2 29.09.2023)**

#### **Study title**

Foster carers experiences of dyadic developmental psychotherapy

#### **Invitation paragraph**

We would like to invite you to participate in this research project which forms part of my Clinical Psychology Doctorate research. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

#### **What is the purpose of the study?**

The purpose of this study is to understand foster carers experiences of being involved in Dyadic Developmental Psychotherapy (DDP). This will incorporate all aspects of your experience, including things such as how your perceptions of DDP may have changed throughout the course of therapy, what it was like to be involved in DDP as a foster carer and what the emotional impact of this work may have been.

Currently, there is no research about what is like to be part of the DDP process as a foster carer, despite the growing number of foster carers supporting children with complex developmental trauma, and the growing number of foster carers engaging in DDP with the child(ren) in their care. We believe that it is important to gain a better understanding of what this may be like for you so that this can inform future research, practice and decisions about how foster carers may like to be involved in DDP, including what support may be needed.

Before you decide if you would like to take part, please read the information below and feel free to contact me if you have any further questions.

#### **Why have I been invited to take part?**

You are being invited to take part in this study because you are a non-kinship foster carer (a foster carer who was previously unknown/unrelated to their fostered child) who has experienced individual DDP face-to-face with a clinician. You have completed at least 20 sessions of DDP, at least some of which were undertaken in the last 12 months, with the child in your care being present for at least some of these sessions.

You are being asked to take part because your DDP clinician is trained to at least Level 1, you are able to speak English and are have access to the internet/a valid email address.

#### **What will happen if I take part?**

As part of this research, you will complete a short demographic questionnaire which may ask questions such as your age and how long you have been a foster carer for. You will then be asked to take part in a semi-structured interview with the researcher.

This interview aims to find out more about your personal experience of dyadic developmental psychotherapy. You may therefore be asked questions such as How have your thoughts/feelings towards DDP changed over time?

Interviews will be conducted either face-to-face or online, via Microsoft Teams or Zoom, depending upon location and preference. Interviews are expected to take approximately one hour but may take slightly longer if needed due to depth of discussion.

Your responses within the interview will be audio-recorded with your consent. If your interview is facilitated via Microsoft Teams/Zoom, this will also be video recorded, but you will have the option to turn your camera off, should you wish. The researcher will indicate the start of the recording within the interview. Your identifiable information, such as your name, will be removed and anonymised once the audio recording is transcribed.

### **Do I have to take part?**

No. Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact me if you have any questions that will help you make a decision about taking part. If you decide to take part, we will ask you to sign a consent form and return this to me. You will be given a copy of this consent form to keep.

### **What are the possible risks of taking part?**

There are no considerable risks to yourself anticipated from taking part in this project. However, some may find discussing their experiences of therapy distressing. You will be encouraged to take breaks whenever necessary during the interview, and you can decide to stop the interview at any stage. After the interview, you will be provided with a list of services that may be contacted for support, if necessary. Time will also be provided at the end of the interview to discuss any concerns you may have.

### **What are the possible benefits of taking part?**

There are no immediate, direct benefits of taking part in this research. However, some people find talking about their experiences of therapy helpful. In addition, taking part in the research will enable us to better understand what it is like for foster carers to be involved in therapy that considers developmental trauma and to consider how this can be changed/improved in the future.

### **Data handling and confidentiality**

Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR).

If you choose to take part, your information will be kept confidential, and the content of your interview will be anonymised. All personal data will remain strictly confidential and will be separated from your interview responses. Your name will not be stated within the research. Anonymised quotes from your interview may be used in the final thesis write up to illustrate key themes across data. There are some limits to confidentiality however. If what is said in the interview causes me concern that your

or someone else is at risk of significant harm, I will have to speak with my supervisor. Where possible, I will try to tell you if I have to do this.

Research data will be stored securely, password-protected, on OneDrive, as per Staffordshire University regulations. Identifiable data will only be accessed by the researcher. The researcher supervisors will only have access to non-identifiable information for supervision purposes. Anonymised data may also be accessed by the NHS Trust, Staffordshire University and regulatory agencies for auditing and monitoring purposes. Once interviews have been transcribed and sufficient immersion in the data is achieved, recordings will be immediately destroyed. Any other personal data, including consent forms and details provided to contact you with study findings (if you consent to do so), will be destroyed six to twelve months following completion of the study. All other research data will then be destroyed 10 years following the completion of the study.

### **Data protection statement**

The data controller for this project will be Staffordshire University. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the data protection law is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection and data portability. Questions, comments and requests about your personal data can also be sent to the Staffordshire University Data Protection Officer. If you wish to lodge a complaint with the Information Commissioners Office, please visit [www.ico.org.uk](http://www.ico.org.uk).

### **What if I change my mind about taking part?**

You are free to withdraw at any point of the study, without having to give a reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up until 2 weeks after your interview by contacting the researcher, after which withdrawal of your data will no longer be possible due to the analysis having already begun and being committed to the final thesis.

If you choose to withdraw from the study we will not retain any information that you have provided us as a part of this study, and it will be destroyed securely as per Staffordshire University's policy.

### **What will happen to the results of the study?**

The results of this project will be submitted as a doctoral thesis to Staffordshire University. Findings may also be published in a peer review journal, used for training purposes or presented at conferences and will therefore be publicly available. However, none of the published findings will contain any of your personal details.

Once all interviews have been conducted, the researcher will analyse the information shared in these interviews to find themes amongst the data. They will also produce an executive summary, which is a summary of the research. If you consent to do so,

the researcher can meet with you for a second time to hear your views on the themes generated, as well as your opinions of the readability of the research summary. This second meeting with the researcher is completely voluntary, and participants are therefore under no obligation to engage in this.

If you consent to do so, we will also contact you following the completion of the study to give you an overview of the findings.

**Who is organising this study?**

Staffordshire University is the project sponsor for this study.

**Who has reviewed this study?**

This study has been reviewed by Staffordshire University Ethics committee, NHS ethics committee and the Health Research Authority.

**Who should I contact for further information?**

If you have any questions or require more information about this study, please contact me using the following contact details:

Amy Murphy

Email: [m0263771@student.staffs.ac.uk](mailto:m0263771@student.staffs.ac.uk)

**What if I have further questions, or if something goes wrong?**

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the Chair of the Staffordshire University Ethics Committee for further advice and information:

Dr. Nachiappan Chockalingham,  
Staffordshire University,  
Leek Road Campus,  
32 Leek Road,  
Stoke-on-Trent,  
ST4 2RU.  
[n.chockalingham@staffs.ac.uk](mailto:n.chockalingham@staffs.ac.uk)

Dr Yvonne Melia,  
Principal Clinical Lecturer,  
Clinical Psychologist  
Staffordshire University,  
Leek Road Campus,  
32 Leek Road,  
Stoke-on-Trent,  
ST4 2RU  
[Yvonne.melia@staffs.ac.uk](mailto:Yvonne.melia@staffs.ac.uk)

**Thank you for reading this information sheet and for considering taking part in this research.**

**Appendix G – Consent Form**

**PARTICIPANT CONSENT FORM  
(IRAS ID: 327496, Version 1.3, 06/10/2023)**

**Study Title:** Foster carers experiences of dyadic developmental psychotherapy

**Researcher:** Amy Murphy

**Participant Identification Number:**

**INITIALS**

I have read and understood the information sheet Version 1.2, dated 29/09/2023.

I have been given the opportunity to ask questions, and I have had any questions answered satisfactorily.

I understand that my participation in this study is entirely voluntary and that I can withdraw my data from the project up to 2 weeks after the interview without having to give an explanation.

I understand that the interview will be audio-recorded (and video-recorded if interview is conducted remotely) but that I have the option to turn my camera off via Teams/Zoom if I wish to.

I understand that the data I provide for this research may be accessed for auditing and monitoring purposes by the NHS Trust, Staffordshire University or regulatory agencies where required. I agree for these individuals to have access to my data.

All I understand that the personal identifiable data I provide for this research will be kept securely for 6-12 months following study and then confidentially destroyed. I also understand that anonymised data will be retained securely for 10 years before being confidentially destroyed.

I hereby give consent to take part in this study

I would like to be contacted in the future regarding outcomes of the research.

I would be willing to be contacted by the researcher to partake in a second meeting to provide feedback on the data analysis and summary of the research.

\_\_\_\_\_  
Name Participant (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name Researcher (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**Appendix H – Demographic Questionnaire**

**PARTICIPANT DEMOGRAPHIC QUESTIONNAIRE  
(IRAS ID: 327496, Version 1.1, 12/01/2023)**

**Study Title:** Foster carers' experiences of dyadic developmental psychotherapy

This questionnaire aims to find out more about you, your experience of fostering and of dyadic developmental psychotherapy (DDP).

**Information about you**

Age: \_\_\_\_\_

Preferred gender: \_\_\_\_\_

Ethnicity: \_\_\_\_\_

**Information about your fostering experiences**

Are you a single carer: \_\_\_\_\_

How long have you been a foster carer for: \_\_\_\_\_

How many children have you been a part of DDP for: \_\_\_\_\_

When did you begin DDP: \_\_\_\_\_

(If appropriate) When did you finish DDP: \_\_\_\_\_

Thank you for taking the time to complete this questionnaire. Please return this completed form to Amy Murphy at [m026377l@student.staffs.ac.uk](mailto:m026377l@student.staffs.ac.uk)

**SEMI-STRUCTURED INTERVIEW SCHEDULE  
(IRAS ID: 327496 , Version 1.1, 12/01/2023)**

**Study Title:** Foster carers' experiences of dyadic developmental psychotherapy

**Introduction**

The rationale and an overview of the study will be re-explained, and consent will be re-confirmed. The participant will be given the opportunity to ask any further questions and asked if they would like to take breaks during the interview. For virtual interviews, participants will be informed they can turn their camera off, if this is their preference.

**Demographic questionnaire**

Participants will be asked to complete a short demographic questionnaire and return prior to interview.

**Interview**

- 1. How did you come to be involved in DDP?**
  - Who suggested this to you?
  - Who referred you to the therapy?
  - What, if anything, were you expecting at this stage?
  
- 2. What was your experience of beginning DDP?**
  - Can you tell me more about your initial thoughts, feelings, beliefs or expectations at this stage?
  
- 3. Often the therapist will spend some time with the carer before bringing the child into the work. Was this your experience?**
  - What was your understanding of why this happened?
  - What was this like for you? How did you feel? What were your thoughts?
  
- 4. In DDP, we often think about the carer as a co-therapist, who is very actively involved in supporting the therapy with the child. Was this your experience?**
  - Can you describe times when you experienced the therapy in this way?
  - Were there exceptions, perhaps times when you did not experience it in this way?
  - What was it like for you to take on this role, as a foster carer?
  
- 5. A key part of DDP is the relationship built with the DDP clinician. Are there words you would use to describe that relationship for you?**
  - How was this important in the therapy?
  - Did this relationship change for you over time, and if so, how?
  
- 6. What is your understanding of how DDP influenced the relationship between yourself and your child?**

- What did you notice happening in the therapy process that seemed important for this to happen?
- Outside of the therapy context, how did DDP continue to influence your relationship with the child in your care?

**7. How did you experience being part of supporting a child to make sense of their past experiences that may have led them to be in care and therapy?**

- How did this feel for you?
- Were there any times in therapy when you experienced strong emotions? Can you describe this?
- How did you cope with these feelings, during and after the session?

**8. What did you experience as helpful in DDP? What aspects of DDP did you find less helpful? Can you tell me more about any challenges you may have experienced?**

**9. How have your thoughts/feelings towards DDP changed over time?**

**10. How would you sum up your experience of DDP, in 3 words?**

- You used the word 'x', could you tell me what you mean by this?

**11. Is there anything else important about your experience of DDP as a foster carer that would be helpful to discuss?**

- Is there anything you'd like to add about anything unique to your experience as a foster parent engaging in DDP, as opposed to an adoptive or a birth parent?

**Prompts throughout**

Could you tell me more? Can you give me an example of a time when you felt like that in the therapy? What did that look like in the room? What did that mean to you? How did you make sense of that? What did you think/feel about that?

**Ending session**

The participant will be provided an opportunity to ask any further questions and discuss any issues raised throughout the interview. The participant will then be talked through the debrief form.

## Appendix J – Debrief Form



### **PARTICIPANT DEBRIEF FORM (IRAS ID: 327496 , Version 1.2, 29/09/2023)**

**Study Title:** Foster carers' experiences of dyadic developmental psychotherapy

Thank you for taking part in this study and contributing to our understanding of foster carers' experience of DDP.

#### **Can I still withdraw?**

Yes, you are still entitled to withdraw from the current research, without having to give any reason at all. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up until 2 weeks after your interview, after which withdrawal of your data will no longer be possible due to it already being committed to the final thesis. If you choose to withdraw from the study we will not retain any information that you have provided us as a part of this study, and it will be destroyed securely as per Staffordshire University's policy.

You can request your data to be withdrawn from the study by contacting Amy Murphy ([m0263771@student.staffs.ac.uk](mailto:m0263771@student.staffs.ac.uk)) within 2 weeks of your interview.

#### **Sources of support**

Though it is hoped the research has not caused you any harm or distress, discussing your experience of therapy in your role as a foster carer can evoke difficult emotions. If you find yourself feeling distressed about your experiences as a foster carer after the interview, please contact your Fostering Social Worker for direct support.

The following charities can also provide support and advice to foster carers:

- Fosterline Helpline – 0800 040 7675 (Free, 9am to 5pm Monday to Friday)
- The Fostering Network (<https://www.thefosteringnetwork.org.uk/>)

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor Dr Yvonne Melia ([yvonne.melia@staffs.ac.uk](mailto:yvonne.melia@staffs.ac.uk)) or the Chair of the Staffordshire University Ethics Committee for further advice and information: Dr Nachiappan Chockalingham ([n.chockalingham@staffs.ac.uk](mailto:n.chockalingham@staffs.ac.uk))

#### **What next?**

If you would like to receive a summary of the research findings when it is completed, please provide your email address to Amy Murphy either at the time of interview or afterwards, via the email address. If you have any further questions, please feel free to contact either Amy Murphy ([m0263771@student.staffs.ac.uk](mailto:m0263771@student.staffs.ac.uk)) or the research supervisor, Dr Yvonne Melia ([yvonne.melia@staffs.ac.uk](mailto:yvonne.melia@staffs.ac.uk)).

**Appendix K – Example of exploratory noting (right column) and experimental statements (left column) of a transcript (Example from Claire)**

<p>Sessions require a lot from carer – to attend to both therapist and child.</p> <p>Carer as an observer and therapist as a model, learning through observation.</p> <p>Sessions appear child-led, but within therapist's wider control.</p> <p>Team sport – a role and effort required of all, equally.</p> <p>Carers role being to continue to "the work" outside of sessions and at home.</p>	<p>I: And if we think about the sessions, that you're in there with Flo and *therapist*, we often think of yourself in that setting as a co-therapist who's really actively involved in therapy in the moment, was this your experience?</p> <p>C: Oh yeah, that's intense. Yeah, that is intense. Because you are, and you've got to take your cues from *therapist*. And they're not only from *therapist*, but Flo will desperately desperately try to lead. So yeah, it's interesting to watch how that sort of, gets put to sleep, but in...I mean, it gets shut down, but as far as Flo is concerned, it's not, she is leading. Yeah, it's definitely, it's like co-therapist co-parenting its definitely a team, its a team sport, isn't it? You know, you can't build all those attachments and then not continue that once you get to your own</p>	<p>Intense – hard? Pressured?</p> <p>Led by therapist – needing to work together.</p> <p>Interesting to observe – learn through observation?</p> <p>Child feels they're in control.</p> <p>Co-therapist, co-parent, team sport.</p> <p>A continuation outside of sessions inevitable?</p>
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## **Appendix L – Example of a Personal Experiential Themes Table (Michelle)**

### **1. A TRUER UNDERSTANDING**

#### **1a. A uniquely honest space to develop a truer understanding.**

**Safe space for exploration of how things truly are is a welcomed contrast to otherwise restrictive boundaries of foster care**

*“Oh, I loved it. \*laughs\* I will talk about it to anyone to listen to me \*laughs\*. And obviously, you know, within the bounds of foster caring, and we are bound a lot by confidentiality, so you know, any, any environment where you are just free to talk, and to, to explore, you know, how things really are and how you're really feeling? It is really lovely.” Page 15*

**Permission and non-judgemental space to be open and honest about how things are, which can at times feel scary and dangerous elsewhere**

*“You know, it's a very safe and secure relationship. You know, you can, you can say some really dangerous things without judgement, or you know, or fear that you're going to be judged. Yeah. I mean, you know, it's... so yeah. And, and, and it gives us permission to talk about things that are scary really, you know. There are there are some things that, you know, that, that happen that are really scary. And I think, yeah, I mean, it's just the safe and non-judgmental nature of it really, that is a really useful thing, that you know, you feel like, you know, you can really talk about how things are without it being, without being judged or, you know, or criticized, really. You know, it's a real understanding of where we are” Page 29*

#### **1b. A greater understanding of the child, and others in their care**

**A protected time and space to be honest about how things actually are, leading to an increased understanding of the child and how best to support them**

*“I think, I think what DDP to me has felt like is, it has just given us a real, a real time, a focused time every week to just sit down and really think about where we are with Billy, what his needs are, how... what his behaviour is telling us, you know, you know, all behaviours are communication and, and just trying to drill down into that, you know what, what is the way that he's behaving telling us about how he's feeling and how we're going to meet that need?” Page 67*

**Luxury of protected time and space to work together to truly understand what is going on for the child and how best to move forward**

*“But with DDP, there's a real luxury of the time and the space that it gives us just to really, really reflect and really, really drill down into what Billy's real needs are and how we can support them. So that, that's, that's been a really wonderful thing” Page 68*

**Improved understanding of other children in their care too**

*“I think that you know, that, that this therapy has been life-changing for the way that we look after Billy and, and the other children that we look after as well. You know, it's helped us to understand them a little bit more, reflect on them outside of the sessions.” Page 71*

### **1c. A truer understanding of myself as a carer and parent**

**A contrast between DDP feeling like a natural fit and a development of existing skills vs it challenging core beliefs and sense of self as a person, parent and foster carer**

*“So I think that, that's, it's just been a development of what I've, what I've always done, you know. But, but this has been a biggie. It has challenged some of those quite fundamental beliefs I've had, and so, so yeah, it's, it's, it's challenging, and it can feel a bit scary” Page 63*

### **Challenged view of self and identity as a successful parent**

*“...we're not young people and we have parented five other children and you know, so, to sort of be, and, and, you know, I suppose, have a view of ourselves as successful parents, you know, and people who are good at it, you know, so to actually, for somebody to actually say, actually, you know, you could be doing this better, it was a bit challenging.” Page 8*

### **A greater understanding of what needed to change**

*“...we knew that some of the things we were doing, were not working. So it was really good to meet somebody who actually challenged the way that we were, we were approaching things and the way that we were, we were supporting him, I suppose.” Page 6*

## **2. THE SPACE, PERMISSION AND TOOLS TO LET GO AND MOVE FORWARD**

### **2a. Letting go to move forwards**

**Learning to let go of existing rules, beliefs and approaches to allow the child to feel more safe and secure in relationship is a difficult but essential part of DDP**

*“But that was something else you see, that we wouldn't have let any of the other children done at that age, you know, so it's, it's again, having to get, get rid of some of the stuff in order to, to let the sort of the trust and the, you know, the feelings of safety and security develop. So yeah, it's, it's, I think that's a big, a big part of it has been helping us to prioritise what's really important and to focus on that” Page 61*

**DDP given support, permission and tools to let go of strongly held beliefs about how to be as a parent, to be able to meet the needs of this child now**

*“...certainly the DDP has supported us to do that and yeah, and, and to, just to focus on Billy, on the child and what, what is right for him and, and because he's, he's at the extreme end of... his experience are really at the extreme end. So, the way we've had to deal with them have been at the extreme end of parenting, you know, and so it's given us permission and support to take some of those difficult challenges and you know, those yeah, yeah, to relax some of the things that that we maybe found very difficult to, to let go.” Page 64*

### **Supported by therapist to let go of old ways of parenting to move forward as a family**

*“...but it was more of a problem for \*other foster carer\* and me. In that, you know, we were wanting our evening time and our, you know, sort of, but we've, we've sort of let that go and with support from \*therapist\*, we've, we've found a way that we can manage it as a family and you know, and it has worked, but it did mean us sort of, letting go of some of our sort of, quite hard and fast rules that we'd always had with our children.” Page 56*

### **2b. Poking the bear**

#### **Encouragement and a language to approach what previously avoided – to “poke the bear”**

*“...it's like, you know, don't poke the bear you know, just leave it and not refer to it...And I think that, that \*therapist\*, you know, was encouraging us not to do that, to you know, to, to, to revisit things and when we were calm, and sort of, to talk about them, and, and yeah, that was absolutely right. I think that that needed to, obviously that's what Billy needed, he needed to be able to talk about these difficult things, but we, it gave us a vocabulary and, and supported us to do it in a helpful way for him.” Page 8*

#### **Permission giving to address difficulties previously avoided through fear of having to manage impact alone**

*“I think, other things that have been helpful that is, just you know, giving us permission to, to talk about difficult things with him, you know, that not to just avoid them and not sort of try and exacerbate things when, when things are calm, you know?” Page 48*

#### **Relationship with therapist allows you to face the real, scary difficulties that both child and carer may otherwise avoid, head on**

*[discussing what's helpful about relationship with therapist] ” ...we don't tiptoe around things. That we confront, you know, the real, the real difficulties, and you know, that we can, we can explore those things that are, that are really scary and, you know, some of things that happened to Billy when he was a very small child are things that are, you would want to ignore or, you know, pretend didn't happen. And it's essential that we don't ignore them, or pretend they didn't happen because they did happen and they are, they are the things that are causing him all the difficulties he's having as he grows up” Page 30*

### **3. The safety and security of being understood**

#### **3a. The safety and security of being understood by the therapist**

**Feels safe, secure, understood and held in relationship with therapist, mirroring development of relationship with child.**

*\*When describing their relationship with therapist\* “trust, support, understanding. I feel they really understand our situation and, and our family dynamic. Errrm, what other words would I use to describe it? I think it feels safe. You know, it's a very safe and secure relationship.” Page 29*

**Long-term nature of DDP allows space to build a trusting and understanding relationship with therapist, that supports you as both a person and a parent.**

*“I think that because of the long period of time that DDP goes on over and the way that it's structured, you have, you have enough time to build that trust and, and that understanding, or their understanding of us, I mean, you know, and the way that we are, and the way that we, we parent.” Page 28*

#### **3b. The safety and security of being understood by the child, in the context of instability**

**Own hurt and pain recognised and validated by the child was a catalyst for growth, for child and their relationship**

*“And he actually said, you know, and he said, “sometimes I say things like that to you, Jane. And, you know, I can see how you might get really sad when someone speaks to you like that.” And that was just that, just felt like the shift, and such a move forward for him. It was amazing. I mean, you know, a real, a real light bulb moment.” Page 24*

**In the context of struggle with lacking security and stability in the fostering relationship, allow the child to see the carers' acceptance of and long-term commitment to them, exactly as they are.**

*“You know, as foster parents, we are, we're struggling with that on a daily basis, trying to let these children know that we're here for them. We're not going to give up on them, and no matter what they throw at us, we're not going to, to walk away. But you know, I think that, that, the DDP for Billy has helped him to see that, you know that, we are, we are here for him and that, you know, we know what happened to him. And we know how, we understand how difficult life is for him, and how difficult it is for him to, to, I don't know, form trusting relationships with anybody but you know. I think he now knows and understands that, that we, despite all that we're here for him. And I think that it really has helped him with that.” Page 32*

**By giving permission, skills and a safe space to explore difficult early experiences, felt able to show child their love, acceptance and commitment to them.**

*"...because he, he has found it very, very difficult over the years to feel safe and secure and protected by his carers. And so by giving us permission, and the vocabulary, and a safe space to talk about them, you know, has been really, really, really helpful for all of us you know, and, and helped... I think helped Billy to understand that, that we're not scared by what happened to him and we're not, we're not disgusted or, or put off by anything that happened to him, that we love him as the boy that he is and that we want to support him and, and, and stick with him, you know, through all these difficult times." Page 39*

**Therapy allowed carers to demonstrate their love and commitment to the child, increasing relational safety, and reducing child's need to test their relationship**

*"So I suppose, the therapy and being able to show him that we really love him, really want him, really care about him has stopped that happening because he's not having to test us with that anymore. You know? So yeah, that's, that's a big change." Page 60*

#### **4. A shared load**

**Enabled carer to feel less alone in carrying the emotional weight of the child's experiences and difficulties**

*"Yeah. I think it's, it just, it feels that I'm not trying to do it by myself. I suppose that, that's, that's a really helpful part of it. You know that sometimes, you know, you, you are, or I am met by these really big feelings, really big emotions, really, really difficult memories and, you know, and trying to hold them with him by myself can be really hard and, and knowing the right thing to say. And when we, when it's within the therapy session, there's someone else there that is sharing that, that that load and yeah, and helping me with, with the vocabulary that I need to use to to support him with it. So that, that's really helpful." Page 45*

**Therapist experienced as a consistent other to turn to if things were difficult, to help keep the understanding of the young person's needs at the heart of their care**

*"...she was always someone else, if things were difficult, that we could talk to you know, and that was, and somebody who was, absolutely putting Billy at the centre of all of it, you know, and that was really valuable and, you know, felt, we felt supported by it." Page 17*

**Therapist as an objective and slightly outside-of but invested other**

*"...having that third person who's, you know, slightly objective about it, and who's looking from the outside and doesn't get quite so emotionally drawn into everything, you know, to help us to reflect and to, to support us to look after him really." Page 68*

## **5. Worthwhile, but not without it's challenges**

### **5a. Child-centred nature of sessions left own needs dismissed at times**

#### **Child-centred nature of sessions left own needs dismissed at times**

*"...what's quite interesting is that when we go to a session with \*therapist\*, it's all about Billy. Quite rightly, Billy is the focus, and so anything sort of outside, or any, anything else that, that I suppose anything that's sort of affecting or bothering \*other foster carer\* and me, if it's not to do with Billy, then it's just not part of that conversation." Page 10*

#### **Hardest part is feeling criticised and misunderstood, despite understanding why**

*"I think it's sort of, a head and heart thing isn't it. My head understood what she was doing, and why she was doing it. But your heart is like "what, I'm not a bitch, you know, I'm a loving and caring mother to this child!" You know, and so, so that, that is hard. But, but like I say, your head is there thinking but I know why she's doing this and you know, it's, it's, it's to support him and to empathise with him, and show him that people you know, are understanding and not, not criticising his feelings or telling him that his feelings are wrong, you know, so. But, yes, I mean, it is. I mean, that that is for me, the hardest part of going there" Page 20*

#### **Own feelings/needs overlooked in prioritization of the child's**

*"And he very often will say that I'm grumpy. And, it's just his understanding of the fact that I'm distracted. You know, and that he's not the sole focus, focus. But yeah, it's, it's hard when he brings that up within a therapy session, where you, you can't, you don't feel that you can justify what he's saying or criticise what he's saying, you know, and so that, that's, that's, that's one of the most challenging things about the DDP for me, I think. Page 23*

### **5b. "If you really dwell on it too much, it can just becomes heart-breaking"**

#### **True empathy and understanding of a child's early experiences is heart-breaking and fear it may prevent them from fulfilling their role as a therapeutic parent to help the child recover.**

*"I think, I think you, I think you have to be... matter of fact about it because you know, if you, if you really dwell on it too much, it can just become so heartbreaking. And so, you know, some of the things that happened to him are just so awful, that if you, if you actually go there and put yourself in his place, it's not actually helpful. You've got to be sort, you've got to put yourself apart and be a little bit detached about it." Page 37*

## **Limits to ability to empathise with early experience, as impact of this would limit from being able to contain and support child.**

*“But you know you, if you, if you go there too much, it actually becomes, you end up going down the same spiral as him so you've got to, you've got to be bigger, stronger and wiser.” Page 38*

### **5c. Challenges of DDP in the real world**

#### **Competing demands on foster carers make it hard to maintain the intensity of the child-focussed approach outside of the therapy room**

*“I suppose, within the therapy session, our focus is solely on him, you know, and he can see that every one of the three people loving him, and supporting him and, and trying to make him feel great about himself. And then you come out into the real world, and there are two other young people that I'm also trying to support and, you know, and, and a household to run and, you know, and elderly parents living downstairs that I'm also supporting and, and suddenly, you know, he's not the sole focus.” Page 22*

#### **The transition of approach to outside therapy room is difficult at times with other demands, but important.**

*“and trying, you know, if he says something, even in a throwaway way, that is important is, is, is stopping and focusing and trying to, you know, sort of, give him time. I mean, you know, it's the middle of the night ones are the hard ones, you know, he comes in and we're all fast asleep and he says, I'm “having bad thoughts” and then it's, trying to \*laughs\* drag yourself up and you know, and be there for him.” Page 42*

### **5d. Adjusting to life after DDP**

#### **Life after DDP is somewhat scary as grown used to a consistent other**

*“But as I say, you know, \*laughs\* then we are quite dependent on her and her support. And so, you know, it just gets scary when you think actually, we're not going to have that for that much longer.” Page 28*

#### **A fear of going backwards after DDP but a hope that learning and strengthened relationship will see the family through challenges that may lie ahead**

*“And I suppose that's another thing that sort of worries me about when it finishes. You know, are we going to slip back again? You know, but that, we've, we've learned a lot and we've got a lot of skills, and our relationship has moved on so much in terms of Billy, I think feeling a lot more safe with us, you know, and understanding that you know, we are here for him. So hopefully...” Page 52*

## **Appendix M – Process of developing GETS**

**Image 1: Process of reviewing and beginning to group Personal Experiential Themes across participants**

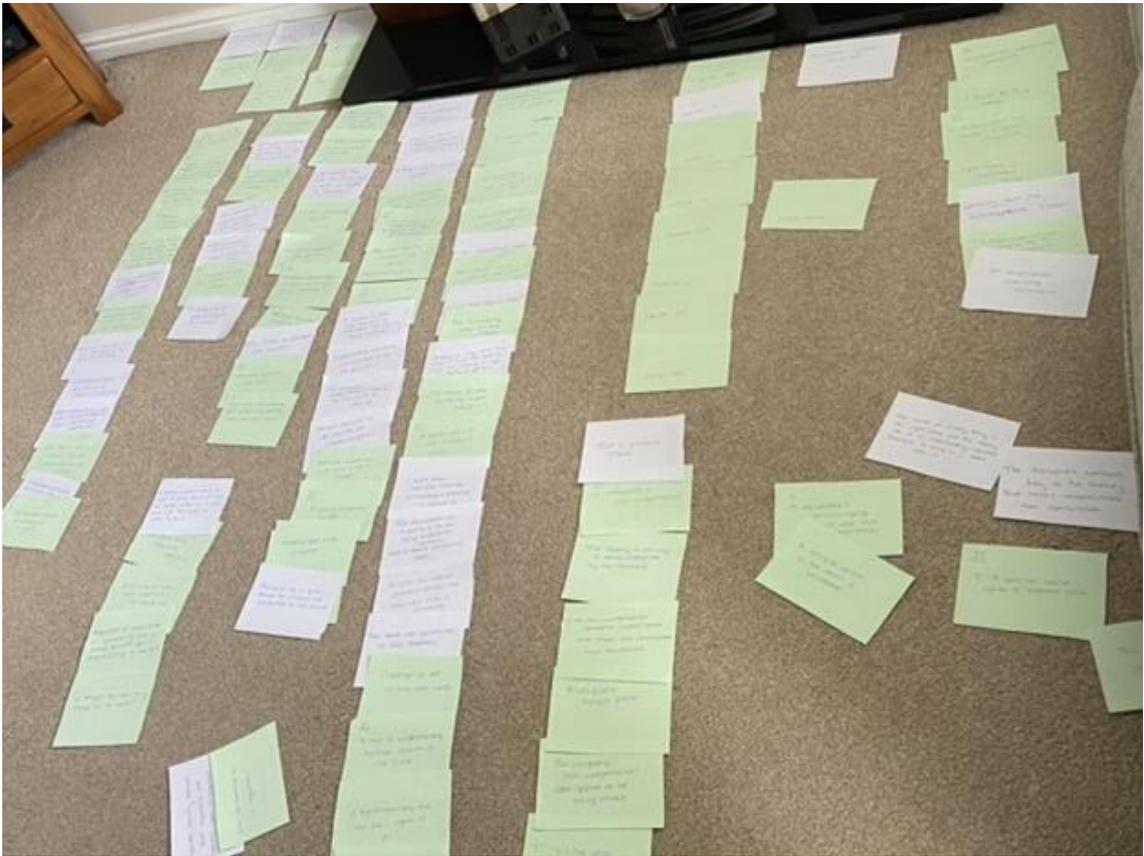


Image 2: Example of PETs grouped around convergence and divergence in meaning, for example feeling exposed & open to judgement (top group) and personal transformation (bottom group)

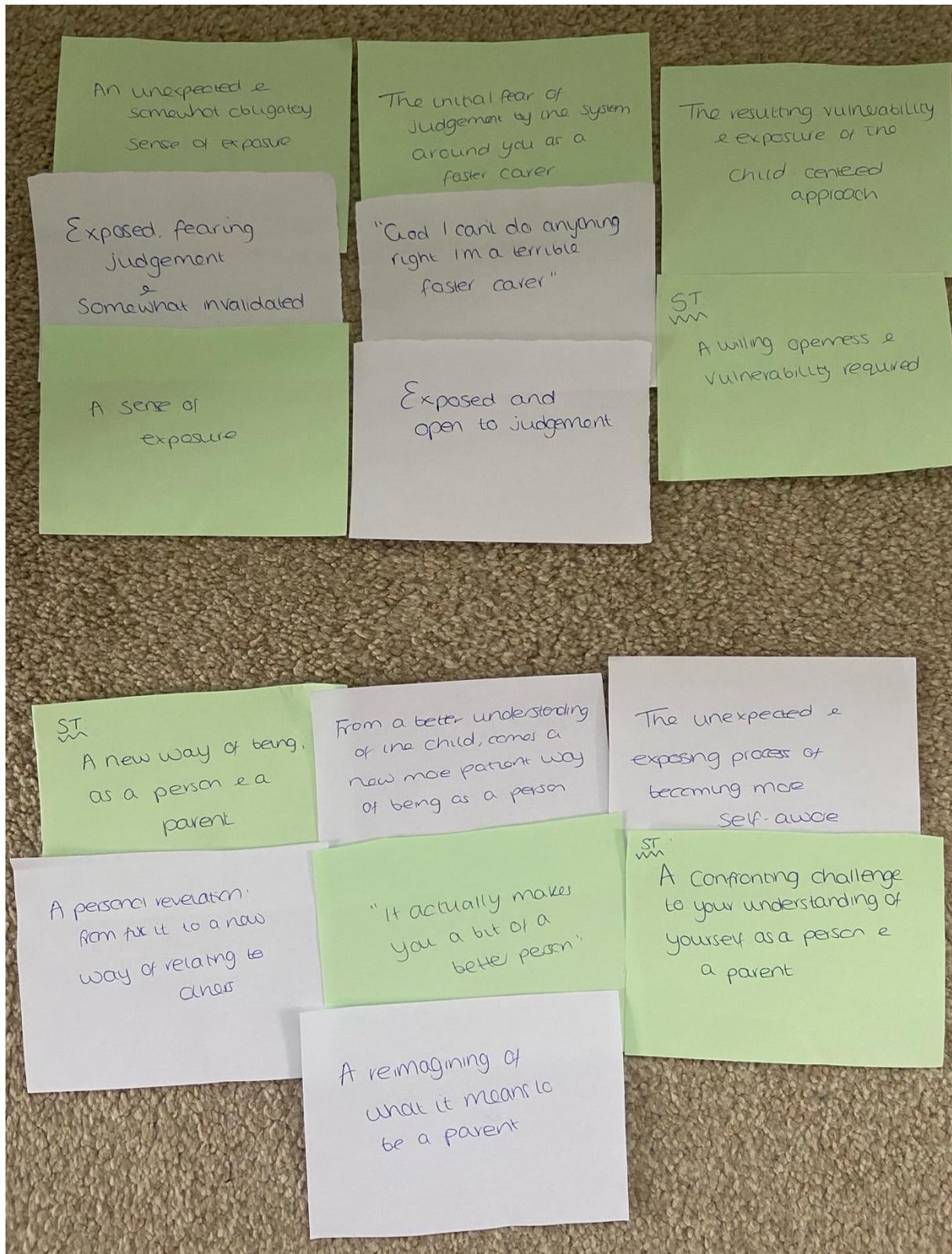
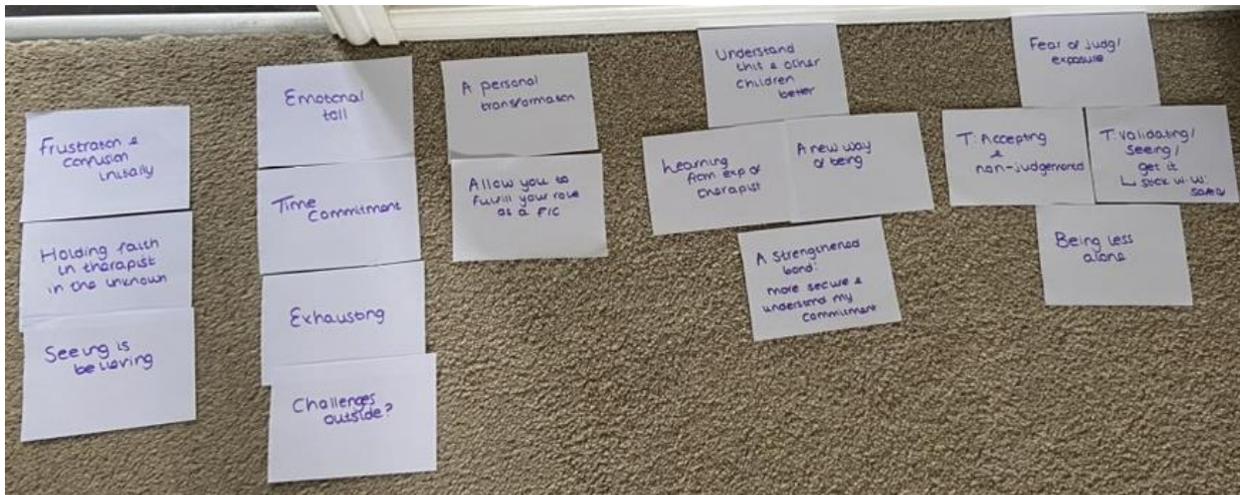


Image 3: From grouping PETS around convergence and divergence in meaning, reviewed groups of PETs to begin to form tentative GETs



Proposed original GETs were therefore;

- DDP Journey
- Costs
- Personal Journey
- Understanding and tools
- The space

Extract from reflective diary following research supervision regarding the re-organising of GETs:

Review of GET structure and naming:

- Wondered if 'costs' accurately captures the experience participants are sharing, given transcripts highlight how participants appear to be weighing up the costs of DDP against the benefits. Reviewed quotes from transcripts and wondered if relate more to a "worthwhile-ness".
- DDP Journey; wondered what this journey involves? What from and what to? Action: to review the PETS.
- Personal journey: discussed whether this needs to be a standalone GET, or if aspects are better captured within other GETs e.g. a weighing up of the challenges of the personal requirements within DDP against the benefits eg. A new understanding of self.
- Understanding and tools: action to again go back to the PETS to look at the experience of this GET. Is it the tools and understanding that's most meaningful, or the connected relationship that forms as a result?
- The space: re-consider; how does the space feel? What meaning is made of being within that space? A unique space to be honest?

Table of GETs reviewed in research supervision, with blue indicating those re-worked to be more experiential:

<b>GET and subtheme version 1</b>	<b>GET and subtheme version 2</b>
<b><u>An evolving journey</u></b>	<b><u>From disbelief to clarity</u></b>
<i>What the hell is going on?"</i>	<i>What the hell is going on?"</i>
<i>"It's something you have to experience really, to understand it"</i>	<i>"It's something you have to experience really, to understand it"</i>
<b><u>The therapist: providing the safety net from which to move forward.</u></b>	<b><u>Scaffolded and safe</u></b>
<i>"It's a very safe and secure relationship"</i>	<i>"It's a very safe and secure relationship"</i>
A guide and a co-parent	Guided and having a co-parent
<b><u>Becoming the child's safety net, from which to move forward.</u></b>	<b><u>Attuned and connected</u></b>
Understanding the child's world	A new insight
<i>"Tools that are better designed for that job"</i>	Resourced and armed for the future
Becoming the safety net	A cemented relationship
<b><u>The worthwhile costs, for the transformative benefits</u></b>	<b><u>"worth it"</u></b>
<i>"It's been a long, sometimes arduous process"</i>	<i>"It's been a long, sometimes arduous process"</i>
Confronted and exposed	Confronted and exposed
<i>"It actually makes you a bit of a better person"</i>	<i>"It actually makes you a bit of a better person"</i>
<i>"It is a big commitment, but not one that I regret at all"</i>	<i>"It is a big commitment, but not one that I regret at all"</i>

**Appendix N – Breakdown of participant support for each GET and subtheme**

	Brad	Claire	Frank	Michelle	Jane	Joanne	Louise	Molly	Sue	Tia
<b><u>From disbelief to clarity</u></b>										
<i>“What the hell is going on?”</i>	X	X	X		X	X	X	X	X	
<i>“It’s something you have to experience really, to understand it”</i>	X	X	X		X	X	X	X	X	X
<b><u>Scaffolded and safe</u></b>										
<i>“It’s a very safe and secure relationship”</i>	X	X	X	X	X		X	X	X	X
Guided and having a co-parent	X	X		X		X	X	X	X	X
<b><u>Attuned and connected</u></b>										
A new insight	X	X	X	X	X	X	X	X	X	X
Resourced and armed for the future	X	X		X	X	X			X	
A cemented relationship	X	X		X	X	X	X	X	X	X
<b><u>“It’s worth it”</u></b>										
<i>“It’s been a long, sometimes arduous process”</i>	X	X	X	X	X	X	X	X	X	X
Confronted and exposed	X	X		X		X	X	X	X	
<i>“It actually makes you a bit of a better person”</i>	X	X	X	X	X	X	X	X	X	
<i>“It is a big commitment, but not one that I regret at all”</i>	X	X	X	X	X	X	X	X	X	X

**Appendix O – Extract of the Group Experiential Theme Table**

Group Experiential Theme Subtheme	Participant	Person experiential statement Quote
<b>From disbelief to clarity</b> <i>“What the hell is going on?”</i>	Claire	<p><b>An alien concept – completely unknown, unexcepted and unclear initially.</b>  <i>“I had no, I had absolutely no idea what to expect. I'd googled it and it sounded really alien. Because you just don't know do you, and if you've never really heard of it and never experienced it, and it's like, well what? What you want on about attachment for? What's that got to do with it? So it was odd...” (Page 3)</i></p> <p><b>A completely novel and innovative way of being and therapy, that can be somewhat bewildering initially until grow to understand it.</b>  <i>“It's, for some people it might be quite revolutionary, you know. And it might appear to be quite odd, and a bit weird.” (Page 60)</i></p> <p><b>Therapists' motivations were confusing initially and somewhat frustrating.</b>  <i>“And in the beginning, I was a bit like, “why would be blowing bubbles?”. Because you just don't get it. Like “why are we blowing bubbles?” (Page 8)</i></p> <p><b>Disappointment and frustration initially as don't know why the therapist is seemingly avoiding the difficulties and just playing.</b>  <i>[When asked how they felt in the beginning of the therapy] “Disappointed, I was really disappointed. Because I just didn't understand it. And I just thought, like, what are we doing here? What a waste of my time, poking holes in paper?” (Page 42)</i></p> <p><b>The openness of therapist allows carer to be honest about confusion/frustration and to have faith that they know what they're doing.</b>  <i>“I did have to ask *therapist* a couple of times, I was like, I don't understand why you're doing that. Can you explain to me why that is something that would work? And she is quite happy to, to answer those questions. Which is perfect. You know, like that's what you want. Isn't it? You don't want them to say oh, no, it's because you don't understand. It's that openness again.” (Page 42)</i></p>
	Brad	<p><b>Stepping hopefully but blindly into the unknown, unsure what to expect in the beginning.</b></p>

		<p><i>"Well, I mean, a little bit about some of the, we knew it was going to be therapeutic. We didn't understand or I didn't understand necessarily what that what that necessarily would entail. And perhaps in some ways, how direct it was going to be in terms of of some of the questioning once the trust had been" (Page 4)</i></p>
Jane	<p><b>Confusion and frustration, as feel as though therapist isn't being as direct as hoped them to be at times.</b></p> <p><i>"I think sometimes a bit confusing. You know, because sometimes I think in my head, it's like, well, why aren't you asking that question or why aren't you asking that question? That can be frustrating." (Page 36)</i></p> <p><b>In the beginning, felt like issues were being skirted around rather than addressed directly, which felt frustrating.</b></p> <p><i>"So I felt very frustrated. Because I was like, well, why aren't we just getting down to the nitty gritty - ask the questions *laughs* and yeah, it wasn't like that." (Page 3)</i></p> <p><b>In the beginning, sessions can feel somewhat pointless and frustrating.</b></p> <p><i>"Because obviously at the beginning, you know, it's like, Oh, my God, why are we doing hang man?" (Page 33)</i></p> <p><b>In the beginning, prior to progress being made, it's hard and frustrating to sit in the slow pace, as it's hard to see how this can help.</b></p> <p><i>"Well now, thinking about it, and when I look back and look where we are now to where we were, then you can actually see how it actually helped. But that was difficult at the time, because I just wanted direct questions, and obviously the questions weren't direct." (Page 10)</i></p>	
Sue	<p><b>Reassurance was needed from therapist to calm their own anxieties about what the impact of sessions may be for the child.</b></p> <p><i>"Ermmm, I think with *therapist*'s knowledge of, of, teaching us, how to sort of, ermmm, be a, be at peace with John being at, having, having his sessions. Definitely." (Page 44)</i></p>	
Frank	<p><b>Despite cognitively understanding DDP would not be a quick fix, the reality of that is somewhat confusing and frustrating.</b></p> <p><i>"A slow process. *laughs* Which I knew, I knew it wouldn't be a quick thing. But it's confusing and frustrating to, like, just trying to get him to talk, to talk about these things cos it will make him feel better. But it's so difficult for him to, and it is difficult for him to do." (Page 46)</i></p>	

		<p><b>Given the impact of early experiences on the child, frustrating to see that they're unable yet to open up to therapist about this, perhaps especially given fight to access the support.</b></p> <p><i>"And it's so difficult to sort of like understand that he won't talk about it. If you know what I mean, because sometimes he'll sit down with us and he'll tell us loads of different things, what his old mum and dad used to do. Mum and dad used to do this, Mum and dad used to do that, and it's heartbreaking." (Page 13)</i></p>
	Joanne	<p><b>Initially unclear what DDP would involve and require.</b></p> <p><i>"Um, we had absolutely no idea really what it would entail." (Page 3)</i></p> <p><b>Starting DDP is going into the complete unknown, with the hope it'll enable them to support the young person.</b></p> <p><i>"I didn't really have any. I couldn't. I didn't really know what it was about because I never, never, never done it before. So it was basically if it could help us look after John it's got to be a good thing." (Page 5)</i></p>
	Molly	<p><b>An initial uncomfortableness and unease, as the uniqueness of DDP leaves carer feeling unsure what their role is or what is expected of them in sessions.</b></p> <p><i>"Yeah I think the first few sessions, I found quite...awkward, I suppose because I didn't really know what my...role was, what I should be saying or doing" (Page 21)</i></p> <p><b>DDP felt unclear and confusing initially, as carer unsure of their role and what is expected of them.</b></p> <p><i>"Yeah, it's, it's, it's like is somebody taking the lead here? Is that is that my... what, what am I meant to be doing here? You know, is *therapist* questioning him on things or is he just gonna do whatever he wants to do and you're watching him or I really wasn't sure what that was going to be when we first started going down." (Page 4)</i></p>
	Louise	<p><b>Support needed from therapist to guide and direct carer, otherwise can feel lost and de-skilled within sessions.</b></p> <p><i>"because I have had some sessions where I've sat there thinking " Uh oh, what do I do here? Where do I do there?" *laughs*." (Page 51)</i></p>
<b>From disbelief to clarity</b> <i>"It's something you have to</i>	Molly	<p><b>DDP needs to be lived to be understood</b></p> <p><i>"I don't think there's a way that it can be explained to people that would make it easier to understand. It's something you have to experience really, to understand it." (Page 51)</i></p>

experience really to understand it”		<p><b>Faith moving in the right direction, despite the way of moving forward seeming somewhat unclear, as can see the results in them and the child.</b>  <i>“And there are huge improvements in him, so I know somethings working.” (Page 24)</i></p>
	Louise	<p><b>Grown to understand DDP more as experienced it – have to be part of DDP to understand it.</b>  <i>“Well, I didn't know what it was about to start off with really. I did have it explained but I think until you've actually lived it, you don't know really do you, so I don't suppose it's, it's changed it in any other way than that I've got more used to it, I understand it more.” (Page 65)</i></p> <p><b>DDP a learning process for child and carer together, who come to understand what it means and involves over time together.</b>  <i>“I suppose I didn't really know what to expect. I'd been given some pointers. And we did sit down with Georgia in one of the early sessions and made out sort of a list of the things that she wanted to focus on. Things that she might be struggling with, which sort of gave us a direction to go in to start off with but no, it was it was a learning process for me as well as Georgia really going through.” (Page 4)</i></p> <p><b>Faith in DDP grown over time as come to see the benefits – see it to believe it.</b>  <i>“I've got faith in it because as I say, I saw the results with the results. You know, you cannot argue with the results, we have had a fantastic 18 months.” (page 65)</i></p> <p><b>Hard to believe in the model initially as can't understand it, however once see it in practice and the benefits of it, you have faith.</b>  <i>“I won't say I was sceptical before I started it. But I did wonder if it would make a difference. And I saw first hand that it definitely did make a difference. And hopefully it's going to continue doing that once we can get back on track. I'm hopeful.” (Page 70)</i></p>
	Joanne	<p><b>Goals became clearer overtime and encompassed the child's voice.</b>  <i>“But yeah, so yeah, the fact that there was pretty clear goals around it. Well, it wasn't clear to start with, you know, til we made that start and really kind of worked out what it was that Tom wanted from it as well. And then we're there to support what he wants and how he wants to go through it.” (Page 15)</i></p>
	Frank	<p><b>An openness and transparency from the therapist is appreciated and has helped to facilitate a sense of trust through the tricky and somewhat frustrating process.</b>  <i>“Any questions we've got, she'll answer the questions. You know, she's not hiding anything. Well, I don't feel like she's hiding anything from us or not doing what she should be doing. She explained that you know, it can be a long process.” (Page 29)</i></p>

		<p><b>A sense of needing to step back to see the progress made; progress made in child's relationship with the therapist, but not yet in the child as had hoped.</b></p> <p><i>"And it's still frustrating for me now because it's like 14, 15 months down the line and we haven't got anywhere. Well, that's not fair, we have. We've come on leaps and bounds because he's not under the table anymore." (Page 17)</i></p>
	Claire	<p><b>The journey of understanding DDP – initially seeming complex and somewhat hard to define, before a sense of simplicity.</b></p> <p><i>"Yeah, I think, I think that's what DDP is I think, you know, you have all of these different things go into it. And they're also simple. You know, when you break it down, it's really, really simple. For me, anyway at this stage, I'm sure it's not." (Page 35)</i></p> <p><b>The simplicity of DDP hard to believe or understand, given its effectiveness for children with high levels of need</b></p> <p><i>"It's just, it's mind-blowing how something that, that seems so simple, is actually really very, very effective for children who have had you know, these experiences and the traumas that that they've been through.." (Page 2)</i></p> <p><b>Trusting the process – pushing through the hard times to see the progress being made, seeing it is believing it.</b></p> <p><i>"You can feel like, like you're just wading through mud. And then all of a sudden you've just realised that you've done like four steps forward, and you haven't done any step back for a while. And then you're like, "Oh, okay. Yeah. This is good. This is good!" (Page 44)</i></p>
	Tia	<p><b>A new measure of progress – spotting signs of progress, that may be different to what expected initially.</b></p> <p><i>"But you know, little things make us sort of acknowledge that there is progress. Like yesterday, he said, would you care if I died? And then he asked *therapist*, and I thought, well, that's progress, really, because he cares what *therapist* thinks now. So just snippets of moments like that make you think oh, yes, things are moving along a little bit." (Page 21)</i></p>
	Jane	<p><b>Coming to understanding the importance and value of going at the child's pace within DDP.</b></p> <p><i>"I think just realising that, that a lot of that stuff just takes time, it's not something that you can rush and sometimes it's, it's better to go the long way round to get the information than to then to be direct. You know,</i></p>

		<p><i>because some counselling that you, that you have can be, can be just direct can't it, like Well, why did you feel like that? Whereas with DDP it's, it's not like that." (Page 27)</i></p> <p><b>After pushing through initial frustration and disappointment, come to understand DDP.</b>  <i>"Whereas now, I can see the whole point of it." (Page 33)</i></p> <p><b>In hindsight, carer can see progress made, which makes the long slow process worth it.</b>  <i>"Well now, thinking about it, and when I look back and look where we are now to where we were, then you can actually see how it actually helped. But that was difficult at the time," (Page 10)</i></p>
	Brad	<p><b>From seeing the power of DDP, becoming an advocate for others to access.</b>  <i>"Well, going forward, I would certainly say that I will be a real advocate for it. I really want people to, to give it a go. I think it should be part of the training" (Page 80)</i></p> <p><b>To be part of DDP is to become an advocate for it, as you come to see the difference it can make and believe in it.</b>  <i>"And I think, I'm not saying DDP will solve everything. I mean, I sound like a real, well I am an advocate for it. But you know, we've got to give these kids the chance, you know, and teach them and give them the ability to talk it through, and have people who understand and care and are not going to put too much pressure on them." (Page 79)</i></p>
<p><b>Scaffolded and safe</b>  <i>"It's a very safe and secure relationship"</i></p>	Molly	<p><b>Relationship with therapist feels like a truly safe and non-judgmental space, to be raw and honest about the impact of caring for the child.</b>  <i>"But I'm able to be so just honest about my feelings with her and how Ryan makes me feel, and situations that happen in the home and, and not feel at all judged by her and that's so enormous, you know I think, especially from a foster parent position." (Page 8)</i></p> <p><b>Non-judgemental, safe-space vital to allow the carer to be truly honest and open about their own experience of caring for the child.</b>  <i>"I think just the non-judgement of what we've needed to talk about a lot of the time. You know, that, knowing that it's been a safe space, and that's allowed me to explore a lot of what she's needed me to explore. The sort of things from my past and my feelings about Ryan. And you know, if, if I'd ever felt that that was sort of judgement coming from or there were right or wrong answers to be giving, I don't think the process would have, would have worked." (Page 16)</i></p>

		<p><b>A unique space to feel heard and validated.</b>  <i>"Being able to voice those feelings and feel heard, and validated that it's okay to feel like that" (Page 10)</i></p> <p><b>A supportive relationship, and a truly understanding and listening ear, which is essential.</b>  <i>"Yeah, I think it's just been really supportive. She's very.... she's such an empathic listener. And that's been absolutely vital with the DDP." (Page 15)</i></p> <p><b>The safe space especially valued as a foster carer, due to the fear of judgement and impact if truly honest about the impact the child is having on you, given this is your profession.</b>  <i>"There are there so many foster parents that I don't want to say they're not honest because I don't think that comes across right, but there's almost this wariness to just be really brutally honest about how they feel." (Page 8)</i></p> <p><b>Fear of judgement if truly open and honest about feelings towards the child, given context of possible scrutiny and cross over between personal/professional self.</b>  <i>"...although the only thing that I could potentially see people being wary of a little bit with the fostering initially is a little bit of weariness of feeling judged about how they feel about the children. But as long as you've got a practitioner that makes you feel at ease, I don't see how you could maintain those feelings." (Page 45)</i></p>
	Claire	<p><b>Therapist non-judgemental and accepting, carer able to be exactly who she is.</b>  <i>"It's definitely non judgmental. There's no judgement there. Ermm, comfortable. You know it's really comfortable, you don't feel as if you need to put on any extra heirs and graces." (Page 8)</i></p> <p><b>DDP non-judgmental and non-expert – a journey of figuring it out together</b>  <i>"Yeah, it's a bit, it's very forgiving. Because there's no right and wrong." (Page 36)</i></p> <p><b>Importance of therapist being able to validate and normalise the carer's fears and frustrations, and provide reassurance that things can change.</b>  <i>"...and it was having somebody saying, "You're not failing. You know, she's, she's tricky, She's really tricky. You know, you're not failing, keep going, keep persevering and you'll get there." (Page 54)</i></p>
	Michelle	<p><b>Safe space for exploration of how things truly are is a welcomed contrast to otherwise restrictive boundaries of foster care</b></p>

		<p><i>"Oh, I loved it. *laughs* I will talk about it to anyone to listen to me *laughs*. And obviously, you know, within the bounds of foster caring, and we are bound a lot by confidentiality, so you know, any, any environment where you are just free to talk, and to, to explore, you know, how things really are and how you're really feeling? It is really lovely." Page 15</i></p> <p><b>Permission and non-judgemental space to be open and honest about how things are, which can at times feel scary and dangerous elsewhere</b></p> <p><i>"You know, it's a very safe and secure relationship. You know, you can, you can say some really dangerous things without judgement, or you know, or fear that you're going to be judged. Yeah. I mean, you know, it's... so yeah. And, and, and it gives us permission to talk about things that are scary really, you know. There are there are some things that, you know, that, that happen that are really scary. And I think, yeah, I mean, it's just the safe and non-judgmental nature of it really, that is a really useful thing, that you know, you feel like, you know, you can really talk about how things are without it being, without being judged or, you know, or criticized, really. You know, it's a real understanding of where we are" Page 29</i></p>
	Louise	<p><b>Mutual understanding between therapist and carer has allowed carer to be more open and honest, and to be somewhat more comfortable with them.</b></p> <p><i>"I think it's good to know that she knows me quite well and mE know her quite well as well, really. I think if he can be at ease with somebody, you can open up a bit more I think. I think it's it's important in any therapy to be open and honest. And I think I am a very open and honest and out there person anyway, I don't ,I don't hide my feelings and things. But having that relationship with the therapist, is beneficial, I feel. Yeah." (Page 17)</i></p> <p><b>Trusting relationship with therapist allows carer to be open and honest, and feel somewhat safer in the uncomfortable moments.</b></p> <p><i>"But, but I've got such a good relationship with them. And they are both so lovely, that they were able to put me at ease." (Page 12)</i></p> <p><b>Trusting relationship with therapist needed to rebuild the carer's sense of esteem and competence following rejection in sessions.</b></p> <p><i>"Because I've come out of those sessions feeling absolutely defeated and deflated. And that has just reassured me that actually I'm doing okay. When I felt like oh, God, I'm rubbish at this. I'm absolutely hopeless. I'm doing this kid more damage than I'm helping. But then talking to *therapist* its like, well no, you're not. It's reassured me and it's put my mind at ease. And that they've told me I'm doing a brilliant job. So, I've needed that sometimes, especially after those sessions." (Page 23)</i></p>

Frank		<p><b>A trust in the therapist that they are competent, knowledgeable and a safe pair of hands through the confusing process of DDP. A faith in the therapist that despite feeling as though cannot see progress hoped to, that they're moving in the right direction.</b>  <i>"I think it's very good. I think she's someone to trust, very much so actually. And you know, she seems to know exactly what she's doing. And you know, we're putting our faith in her really. And I've got no reason to mistrust that at all. She's never done anything or said anything that makes us feel that we're going in the wrong direction or anything like that. So yeah."</i> (Page 32)</p> <p><b>An openness and transparency from the therapist is appreciated and has helped to facilitate a sense of trust through the tricky and somewhat frustrating process.</b>  <i>"Any questions we've got, she'll answer the questions. You know, she's not hiding anything. Well, I don't feel like she's hiding anything from us or not doing what she should be doing. She explained that you know, it can be a long process."</i> (Page 29)</p>
Brad		<p><b>Therapist came alongside carer to validate their efforts and rebuild their self-confidence.</b>  <i>"...*therapist* was always very complimentary about us and, and told, and built our confidence, again, really, that we were capable, but we just needed a new, a new approach, and new ideas and she could possibly offer that."</i> (Page 28)</p> <p><b>Therapist experienced as a valued, connected, invested other in the circle that supports the carers to support the child, facilitating a special bond.</b>  <i>"You know, and yeah, she's a, she's a very able and capable person who is not just helping him, she's helping us to help him. And that's really, a really special bond really. It's a bond. Yeah, she's, she's almost a member of the family and she's done that really quickly."</i> (Page 60)</p>
Sue		<p><b>Therapist's ability to help carer feel at ease and comfortable within an uncomfortable environment key to enabling the carer to engage.</b>  <i>"she knows how to treat people, and how to make people feel relaxed in a situation, which is, which is strange. And, ermmm, with that, it's really great that she can manage to do it. You know."</i> (Page 57)</p>
Tia		<p><b>A relief – to finally feel like you're in the right service, with the right person, to fit the needs of the family.</b>  <i>"It was just a relief. The word relief, it really is. That we're finally in the right service, with the right person, for Tommy's needs, but for our needs as well."</i> (Page 52)</p>

		<p><b>DDP feels like a safety net – that the family will have the support they feel they need to support the child through the challenges ahead, as the therapist a knowledgeable professional who truly understands.</b></p> <p><i>“But yeah, but it's just knowing for us, it's that sort of safety net in a way that we've got a professional involved who really does understand you know, where, how to support Tommy with all with all these traumas.” (Page 37)</i></p>
	Jane	<p><b>Therapist central to carer’s belief in the therapy; as saw them as a person who was knowledgeable and trustworthy, held faith that they were doing the right thing.</b></p> <p><i>“Well, I think if you didn't have trust, then it would just all be a complete waste of time. Because then, you know, my impression of the whole thing, I think would have been completely different. So my relationship with *therapist* really shaped my impression of the therapy, definitely.” (Page 40)</i></p> <p><b>A warm relationship developed with therapist, which allowed the carer to feel they could go to them for support.</b></p> <p><i>“For me, it was, it's been good. It's... *therapist* is very approachable, very friendly. And she would send me little text messages of places to go to for extra information and stuff, yeah.” (Page 6)</i></p>
<p><b>Scaffolded and safe</b> Guided and having a co-parent</p>	Joanne	<p><b>An education – learning through observation of the therapist, who models the way of being within DDP.</b></p> <p><i>“I mean, been an absolute education. It's just been completely fantastic and I've really enjoyed it. That's not really the right word, but really appreciate that. It's just for me, it's fascinating seeing that skill.” (Page 54)</i></p> <p><b>A respect for skill of the therapist, who acts as a consistent, permissive model not expert, allowing the carer to learn a new relational way of being through their relationship.</b></p> <p><i>“Yeah, I mean, it's great. I have the upmost respect. I mean, you know, to see the skill is, you know, really amazing because, and also because it's quite, there's a sort of repetitive element to it, which I find really helpful, you know, because it's like, oh, yeah, you know, it's alright, to keep going back and then do that reassuring thing, you know, like, you know. A little bit of sort of not self-mockery but self-deprecation. So that, you know, you're not like, I'm here to help down there kind of thing, you know, so that you kind of get on that level with people, you know.” (Page 60)</i></p>
	Brad	<p><b>An mutual understanding and trust between carer and therapist important, as need to have faith in them to lead, steer and direct you.</b></p>

	<p>“...and just getting a full understanding of us and also getting to know as, as people because there have been times you know, where particularly somebody like me, who's who is a talker has had to be... and I need to trust her. So she will, she might just give me a hand signal, just be quiet effectively and let him do what he has to do.” (Page 23)</p>
Louise	<p><b>Therapist a guide for how to respond when child is revealing new information about their early experiences.</b>  <i>“So she was coming out with things that I didn't know. And I was able to support, and taking on board what *therapist* was saying about you know, saying the thing about you know, “I wish I'd been there for you at that time”.” (Page 35)</i></p> <p><b>Therapist as the leader, who steers, guides and supports the carer through the process within sessions.</b>  <i>“I tend to, I always let *therapist* take the lead. If she has a strategy that she wants to go down, she will speak to me beforehand herself and say “Look, I'm gonna talk about this this time. What I want you to do is this, this and this.” (Page 50)</i></p> <p><b>Support needed from therapist to guide and direct carer, otherwise can feel lost and de-skilled within sessions.</b>  <i>“It's great. It's great. I love that. Otherwise, because I have had some sessions where I've sat there thinking “Uh oh, what do I do here? Where do I do there?” *laughs*. So yes, being forewarned and hints like “why don't you try this” really helps.” (Page 52)</i></p>
Claire	<p><b>Therapists' way of being allows carer to feel as though they are a partner in the therapy, who's input is just as valuable and welcomed, creating a sense of psychological safety.</b>  <i>“...you have to be honest, and you have to say, this doesn't work for me. I don't like this way. Or yeah, that really works, you know? That, that we'll do that again. And we *therapist*, it's fine. You can do that, you can have your input. And I think that's what makes it feel like you are co-parenting because she's not, because although she's the professional in the room, she's not the boss in the room, she doesn't make you feel like you're inferior. Yeah, she's, she's very good. Very sleek.” (Page 38)</i></p> <p><b>Carer's responsibility and burden to manage and hold the impact of sessions alone for the rest of the week.</b></p>

		<p><i>"Because once you leave, like once we leave *therapist*, *therapist* can then go home, you know, she goes in and she can do all her notes and all of this, but then I'm then left with Flo for the next seven days trying to work out what just happened in her session." (Page 22)</i></p> <p><b>Managing the emotional impact of sessions for both carer and child is an unavoidable heavy weight to carry alone, leading to isolation and loneliness.</b></p> <p><i>"And then you're left with it. That's very, very difficult. And I think that's where the loneliness comes in, is that you know, the, the therapist isn't always there on hand 24/7. So, you are left doing a lot of the therapeutic parenting or DDP style at home" (Page 28)</i></p>
	Molly	<p><b>Less alone and isolated – finally having someone to understand be alongside you in the challenges.</b></p> <p><i>"Ermm, I think it's having the time to talk through it with somebody. And especially being a single carer with... with such a tricky home makes it... it makes it so isolating." (Page 18)</i></p> <p><b>DDP offers the relational space and safety to better understand self and child, as less alone in trying to "figure it out".</b></p> <p><i>"You know, you can go, you can have incidents somewhere sometimes and you're left sort of turning things over, and not knowing what the best course of action was, or you know, wondering why somebody responded in a certain way or wondering why you feel the way you feel about it. And having somebody to discuss that with gives you the time and space to reflect in a totally different way." (Page 19)</i></p> <p><b>DDP a safety net to fall back on when things within the caring relationship are turbulent.</b></p> <p><i>"[reflecting on how it feels to have DDP in turbulent times] It's a relief to have it there." (Page 37)</i></p>
	Michelle	<p><b>Enabled carer to feel less alone in carrying the emotional weight of the child's experiences and difficulties</b></p> <p><i>"Yeah. I think it's, it just, it feels that I'm not trying to do it by myself. I suppose that, that's, that's a really helpful part of it. You know that sometimes, you know, you, you are, or I am met by these really big feelings, really big emotions, really, really difficult memories and, you know, and trying to hold them with him by myself can be really hard and, and knowing the right thing to say. And when we, when it's within the therapy session, there's someone else there that is sharing that, that that load and yeah, and helping me with, with the vocabulary that I need to use to to support him with it. So that, that's really helpful." Page 45</i></p> <p><b>Therapist as an objective and slightly outside-of but invested other</b></p>

		<p>“...having that third person who's, you know, slightly objective about it, and who's looking from the outside and doesn't get quite so emotionally drawn into everything, you know, to help us to reflect and to, to support us to look after him really.” Page 68</p>
	Sue	<p><b>Therapist as a teacher; learning from their knowledge and from witnessing their modelling.</b>  <i>“It was a pleasure basically having having chats with her and learning so much, and from how she how she deals with it” (Page 30)</i></p> <p><b>Therapists approach was not authoritarian or expert-driven, but using their knowledge and understanding to gently shape the carers approach to support the child.</b>  <i>“It wasn't really like ermmm. Sort of this is what you do. It was easing us into a, a, into how we could be better for John and bring him out of himself.” (Page 6)</i></p>
	Tia	<p><b>Therapist guides through unknown of exploring the child's early experiences, so that the right amount of exploration and support is implemented, which is reassuring.</b>  <i>“It's very different, isn't it. Very different. I mean, I've worked with lots of adults who've been distressed and it's very different, isn't it talking? Talking to a child about experiences and knowing where to gauge that and I think *therapist*s very good at that. She'll guide us in those sessions.” (Page 20)</i></p>
<p><b>Attuned and connected</b>  A new insight</p>	Claire	<p><b>Enables you to put aside your own experiences and assumptions to truly understand the child's experience, which is often completely alien to yours.</b>  <i>“And it does allow them to grow in whichever way you know, emotionally, however, but it just gives them more tools and it gives you a lot more insight as a carer or a parent, of you know, how these children see the world. Yeah, because we don't see it the same as they see it. Not at all.” (Page 61)</i></p>
	Brad	<p><b>Needing to come alongside the child, putting your own perspectives and needs aside, to truly attempt to understand them as they are.</b>  <i>“So yeah, I think to put your, to stand beside your child and understand, try to understand, what it is they've gone through” (Page 20)</i></p> <p><b>DDP enabled child to show them and take them into their world – to show how it looks, how it feels.</b>  <i>“And I think, what DDP has helped us to do, is to start to think about what those trigger points are, and also think about how he perceives the world and we're allowing him to lead us down the, down the daily path, you know?” (Page 12)</i></p>

	<p><b>The importance of coming alongside the child to understand his perspective and see into his world, to understand his behaviours and how to support.</b>  <i>"Because he talks he talks about us being grumpy and, and shouty. You know, when we, I mean, we don't, we wouldn't necessarily visibly see that ourselves, but that's how he perceives it. And so much of what we have learned is that his perception is so important. Because what it does do, is it, it informs us of, of then the behaviours."</i> (Page 8)</p> <p><b>DDP helped to understand the impact of child's early experiences on them now and how they're being maintained in their life currently.</b>  <i>"I think it's enabled us to realise that his trauma is so deep and engrained"</i> (Page 11)</p>
Sue	<p><b>Shocking and uncomfortable to learn more about aspects of the carers parenting that the child did not like in front of therapist, but enabled carer to feel they better understood the child's experience and wishes.</b>  <i>"...he did take a few things in which I didn't realise, and he expressed himself when in *therapist* on certain things that I did that he didn't like me doing in front of her, which was great because it was a shock to me because I didn't realise that."</i> (Page 24)</p> <p><b>DDP helped beyond this child; provided the skills to be able to put own perspective aside to understand other's children's worlds better, in order to meet their needs better.</b>  <i>"But yeah, DDP has given us that that that sort of extra understanding of this particular child, and probably many other children once you've, you apply it to your other kids, what has happened to them, how their trauma has, erm has affected them, and how you can help to be a secure person and a secure base to help to hold that stuff."</i> (Page 19)</p> <p><b>DDP influenced how support other children in their care.</b>  <i>"And we now, I can see that we start to, to work in a DDP way with our other children as well."</i> (Page 39)</p>
Frank	<p><b>Given the impact of early experiences on the child, frustrating to see that they're unable yet to open up to therapist about this, perhaps especially given fight to access the support.</b>  <i>"Understanding, basically, understanding what he's going to...I mean, yes, I understand what he's going through. And it's so difficult to sort of like understand that he won't talk about it"</i> (Page 12)</p>
Tia	<p><b>Shocking to learn how unsafe the child feels around new adults, in complete contrast to the carers world view, which helps them to understand the child better.</b></p>

		<p><i>"So it's, it's had to start sort of from the foundations really of not where you'd expect to start really, because you don't expect to meet somebody and think they're going to kill you in that environment. You know, you'd think oh I've been referred to a psychologist who, you know, in your mind is sort of a safe person, but for Tommy no one a safe person, nowhere is a safe place. So he started with that terror in a way of *therapist* being somebody who might hurt him. And it's taken up until a couple of months ago for him to have more of a rapport with *therapist*. To start to talk a little bit about the past." (Page 24)</i></p>
	Louise	<p><b>A greater understanding of the child's experiences and their impact on their current difficulties has allowed the carer to hold a wider understanding and view in mind, meaning they're less drawn into and less focused on individual behaviours.</b></p> <p><i>"So yeah, very empathetic, empathetic towards Georgia. And give me a little bit more insight as to why she behaviours like she does sometimes. It's helped me take a bit of a step back. Sometimes, not always *laughs* . Sometimes yeah I can take a step back and it can help me understand the behaviours." (Page 37)</i></p>
	Joanne	<p><b>Facilitated a reflective capacity that enables the carer to better understand the child's experience and support them accordingly.</b></p> <p><i>"But um, and sort of just reflecting on what's going on a bit better to understand what that young person is going through and thinking about how you're going to help help them." (Page 17)</i></p> <p><b>Allowed the carer to be more curious with the child to understand them, rather than be punitive for behaviours they don't understand.</b></p> <p><i>"It'll be like, oh, you know, if you notice the behaviour going on it's like oh, you know, not going what are you doing?! That kind of thing it's like, oh, I'm thinking because you're like this, it might be because you're sad or you know, that kind of thing." (Page 63)</i></p>
	Jane	<p><b>DDP a useful tool, to help understand the child and their experience more.</b></p> <p><i>"And I think foster carers would find it an extremely useful tool, to help understand it." (Page 43)</i></p> <p><b>DDP a new way of being with a child, based on a greater understanding and empathy for their experience, which provides you as a carer with a greater level of patience.</b></p> <p><i>"Well I think helping you just understand about emotions, and patience, and, and also just another way, it's a different way isn't it of helping that child to what you've tried before." (Page 45)</i></p>
	Michelle	<p><b>Luxury of protected time and space to work together to truly understand what is going on for the child and how best to move forward</b></p>

		<p><i>“But with DDP, there's a real luxury of the time and the space that it gives us just to really, really reflect and really, really drill down into what Billy's real needs are and how we can support them. So that, that's, that's been a really wonderful thing” Page 68</i></p> <p><b>Improved understanding of other children in their care too</b>  <i>“I think that you know, that, that this therapy has been life-changing for the way that we look after Billy and, and the other children that we look after as well. You know, it's helped us to understand them a little bit more, reflect on them outside of the sessions.” Page 71</i></p>
	Molly	<p><b>A greater understanding of how each work in isolation, and how they work together as a family moving forward.</b>  <i>“...you know, the, the process and what the importance of it is, and the fact that I've got more of understanding into me and him and why these relationships and attachments are so important now and going forward.” (Page 49)</i></p>
<p><b>Attuned and connected</b>  Resourced and armed for the future</p>	Brad	<p><b>DDP has provided an armoury for the whole family – of tools, of skills, of stronger protective relationships.</b>  <i>“...he's going to have more in his in his armoury, as we are now. We've got more in our armoury and DDP has given us more.” (Page 39)</i></p> <p><b>DDP provided new ways of being are adapted to meet this child's needs, rather than trying to change the child to fit your tools.</b>  <i>“And so, I think yeah, hopefully DDP has given us just extra tools, extra tools in the box really and new tools, tools that are better designed for that job of being, putting yourself or standing side by side with your child.” (Page 20)</i></p> <p><b>DDP-informed parenting is an ongoing, non-linear process that extends beyond the time spent in therapy, but therapy equips you with the foundation to address future challenges.</b>  <i>“...it's an ongoing process we're not, we're not there, we're not there, we've not arrived, we're not flicked a switch. It's, you know, throughout Peter's life, we are, and he, are going to have to deal with new challenges. New potential problems. You know, I guess therapy is ongoing. It's not a, it's not finished, it doesn't finish.” (Page 29)</i></p>

Joanne	<p><b>Learnt the ability to actively listen and be curious to further understand what may be going on for the child.</b>  <i>"About listening, and questioning as well, sort of, you know, how you get in there to work out what's going on?" (Page 17)</i></p> <p><b>Been able to "pick up" new skills along the way in DDP.</b>  <i>"So, yeah, it's, it's the effect on Tom, and then the second part is, you know, the knowledge and skills that we've been able to pick up from that." (page 66)</i></p>
Jane	<p><b>DDP a new way of being with a child, based on a greater understanding and empathy for their experience, which provides you as a carer with a greater level of patience.</b></p> <p><i>"Well I think helping you just understand about emotions, and patience, and, and also just another way, it's a different way isn't it of helping that child to what you've tried before." (Page 45)</i></p>
Michelle	<p><b>Permission giving to address difficulties previously avoided through fear of having to manage impact alone</b>  <i>"I think, other things that have been helpful that is, just you know, giving us permission to, to talk about difficult things with him, you know, that not to just avoid them and not sort of try and exacerbate things when, when things are calm, you know?" Page 48</i></p> <p><b>Relationship with therapist allows you to face the real, scary difficulties that both child and carer may otherwise avoid, head on</b>  <i>[discussing what's helpful about relationship with therapist] "...we don't tiptoe around things. That we confront, you know, the real, the real difficulties, and you know, that we can, we can explore those things that are, that are really scary and, you know, some of things that happened to Billy when he was a very small child are things that are, you would want to ignore or, you know, pretend didn't happen. And it's essential that we don't ignore them, or pretend they didn't happen because they did happen and they are, they are the things that are causing him all the difficulties he's having as he grows up" Page 30</i></p>
Claire	<p><b>Somewhat subtle yet consistent changes build over time to create considerable change, without it feeling like too much of an effort.</b></p>

		<p><i>"Yeah, it's a day-to-day thing. You don't really notice that you're doing it. You don't know you're doing it. You're just doing it. And that's perfect, because that's exactly what you want. It should never feel pushed or hard. You know, it must feel easy." (Page 58)</i></p>
	Sue	<p><b>DDP taught carer skills needed to meet the psychological needs of the child, as previously did not know how best to support.</b>  <i>"Ermmm, it's sort, it's, it is enabling errrr, its enabling you to learn, I mean your brain is there looking for things to learn all the time, and if it's something that's really, its, it releases feelings that you think I should have had those before but I didn't know how to get them out. " (Page 61)</i></p> <p><b>Support to learn new ways of being with the child</b>  <i>"Family members to develop healthy patterns of relating and communicating." (Page 62)</i></p>
<p><b>Attuned and connected</b>  A cemented relationship</p>	Molly	<p><b>DDP provides the opportunity for carer to reiterate their commitment and unconditional acceptance of the child, which they perceive has increased the child's sense of safety.</b>  <i>"I think the fact that you know, he's been able to talk about feelings and experiences and not be judged. You know, I'm still there constantly reassuring him and giving him empathy. And that is just reiterating to him, you know, the messages that he's had, you know, that he's not being moved, that he's safe. It's very, very slowly sinking in." (Page 40)</i></p> <p><b>Carer feels child now recognises their commitment to them, and that they are a safe base for the child.</b>  <i>"You know, he is really really struggling with attachment to birth mom and wants to be here forever and to be adopted. So he knows that this is his safe space, and that things were not as they should have been at home. He can identify with that." (Page 34)</i></p>
	Sue	<p><b>Carer feels more of an emotional connection with child following DDP, due to openness and honesty.</b>  <i>"Erm, influenced it in a way that, you know. I. before that, before that happened, I didn't really see John feeling much. Between me and other foster carer and him. There was more like feeling between his brother and family. And, and erm. You know, now I think it's like. Hes seen, he's coming out with things like I don't agree with that, I want to do itt his way." (Page 40)</i></p> <p><b>DDP enabled carer to feel their commitment and connection to the child is more secure.</b>  <i>"To secure a more permanent connection and relationship with their committed caregiver." (Page 63)</i></p>

	Louise	<p><b>DDP strengthened sense of bond with the child, that allowed for repair following ruptures.</b>  <i>“Because it gave us that good, good period where we bonded. And even when we had an argument and that bond broke, it came straight back. And that I believe, wholeheartedly that’s down to the therapy. I don’t think that would have happened if not for the therapy.” (Page 42)</i></p> <p><b>DDP a shared experience and journey for the child and carer, which fosters unconditional acceptance and a more connected, secure relationship.</b>  <i>“I think it’s just that connection between us. We’ve, we’ve made more of a connection in DDP and I think again, that is going back to that we’ve done the journey together. I’ve seen the worst of her, and I’ve loved her all the way. And I think it’s just cemented that, 100% for her now, that I’m here for her.” (Page 56)</i></p> <p><b>By feeling less rejected by the child’s behaviours that are linked to their early experiences, the carer is better able to connect with the child and repair ruptures in their relationship quicker.</b>  <i>“It’s helped me repair quicker than I have been doing over the last month or so. It’s helped me to sort of try and be normal with her although she’s not coming back as quickly to me. I’m trying to do it with her. Whereas before DDP, that would have been more difficult.” (Page 39)</i></p> <p><b>Parameters of fostering relationships (social care wider control, contact with birth family, a sense of not “choosing” and committing to that child) create natural barriers within the caring relationship.</b>  <i>“I think as a foster carer, you’ve got natural barriers there because you’re not the parents. You’re not the natural parent. So there’s not that that automatic bond that you have with the child. And again, with adoption, you’ve chosen that child to be your child. It’s just different. Although I think there are a lot of the same difficulties with adopters, I think more so with a foster carer. Because there is still isn’t that bond there that well actually, you’re my child now. The relationship is very different because no matter with a foster carer, no matter how much you try and make this child part of your family, there are barriers set by social care for foster carers, that means you cannot fully do it. And those barriers I mean, we get a lot of delegated authority now to be able to do things but a lot of those barriers and I’ve had it thrown in my face many times with Georgia.” (Page 70)</i></p>
	Joanne	<p><b>Increased a reciprocal sense of trust and honesty in the relationship.</b>  <i>“I think we’ve improved our relationship, you know, the whole sort of three of us. Yeah, I think it’s, I think it’s improved in terms of trust and honesty, that we can all be a bit more honest with each other. You know, he can be honest with us and we can be honest about how we feel about things...” (Page 43)</i></p>

	<p><b>DDP enabled carer to better communicate their commitment, love and care for the child, increasing relational closeness and security</b></p> <p><i>"I think in, during the therapy, you know, we've been able to tell him that we love him. And we really care about him and we really want the best for him and although sometimes it might not look like that's where we going with it or that's, you know, that is the that is how we feel about him. We really do love him and we want the best for him" (Page 25)</i></p>
Jane	<p><b>Safe space has facilitated a more secure base in their relationship, from which both can regulate their emotions.</b></p> <p><i>" [reflecting on changes in relationship since having safe space to explore emotions] Oh, absolutely. Definitely. Because it's a lot calmer. Definitely a lot calmer, yeah." (Page 20)</i></p> <p><b>DDP provided the permission and the support needed to truly explore the emotional experience of the relationship, which has helped both to regulate.</b></p> <p><i>"[reflecting on what has brought calmness to the relationship] Probably about being able to realise that actually, it was okay to talk about feelings, and that you could talk about feelings and then and then it was okay to do that." (Page 20)</i></p>
Brad	<p><b>Carer now an established secure base for the child to explore the world from, following increased closeness and connection.</b></p> <p><i>"But being there and being a secure base for him, where he can come back to, is really important. It's, I guess, it's allowed us to share our emotions, to feel that closeness and to, to have a really strong bond, really. Because it is, it's a very bonding experience, you know, being in that, in that place." (Page 53)</i></p> <p><b>Carer and child bonded through the shared experience of DDP, strengthening their relationship beyond that of "typical" foster relationship, to more parental.</b></p> <p><i>'I think he's, ermm, I think he treats me now like a dad really? You know, I mean, I'll still Brad, I'm not dad. He's messing around with daddy and dad and all that stuff. But I'm Brad and you know, so, but it's, it's given us a relationship really, a different relationship, because we've shared some of these really hard times and I'm still there." (Page 53)</i></p>
Claire	<p><b>Grown to understand and come alongside each other.</b></p> <p><i>"And, and that's a horrible thing to say about a child, but I just did not understand her. She didn't understand me and we were just on totally different pages. But now, we are very much on the same page. She is my proudest achievement." (Page 54)</i></p>

		<p><b>A necessary mirrored co-occurring self-development alongside the child, that provides a greater understanding of yours and their experience, enhancing relational attunement.</b>  <i>“Oh, yeah, it's not it doesn't just work for Flo. It doesn't, it isn't, isn't just helpful to her. It's helpful to us as well. I have to learn about myself and learn the tools. It just gives you a much better sense. Oh, what's the word? I know the bloody word, it's attunement! It does, it gives you that..” (Page 45)</i></p> <p><b>A mirrored strengthening of foundations for both carer and therapist, empowering them to utilise new found skills and relationship to move forward.</b>  <i>“It is empowering. You know, you feel empowered. They feel empowered. It gives them more confidence, self esteem, resilience, you know, you're, you're building on what was quite a shabby foundation, but you know, you strengthen that foundation. So you know, you've got all those, those younger tools that we know Flo didn't have when she was younger. So yeah, you are making little people. And it's that strengthening for you and your foundation too.” (Page 57)</i></p>
	Tia	<p><b>Facilitate a sense of openness and being with the child in their distress, which carer feels has helped the child to see they truly care and are committed to them.</b>  <i>“And I think he values the fact that we are open in those moments because he'll say, so you really do care about me, don't you? You do love me, don't you? You didn't want that to happen to me?” (Page 36)</i></p> <p><b>DDP helps to strengthen their relationship and provide a more secure safe base from which the child can learn and explore.</b>  <i>“I think it's that relationship isn't it, being there, being a safe person and a safe base that Tommy can always come back to, helping us all to build that trust.” (Page 39)</i></p>
	Michelle	<p><b>In the context of struggle with lacking security and stability in the fostering relationship, allow the child to see the carers' acceptance of and long-term commitment to them, exactly as they are.</b>  <i>“You know, as foster parents, we are, we're struggling with that on a daily basis, trying to let these children know that we're here for them. We're not going to give up on them, and no matter what they throw at us, we're not going to, to walk away. But you know, I think that, that, the DDP for Billy has helped him to see that, you know that, we are, we are here for him and that, you know, we know what happened to him. And we know how, we understand how difficult life is for him, and how difficult it is for him to, to, I don't know, form trusting relationships with anybody but you know. I think he now knows and understands that, that we, despite all that we're here for him. And I think that it really has helped him with that.” Page 32</i></p>

		<p><b>By giving permission, skills and a safe space to explore difficult early experiences, felt able to show child their love, acceptance and commitment to them.</b></p> <p><i>“...because he, he has found it very, very difficult over the years to feel safe and secure and protected by his carers. And so by giving us permission, and the vocabulary, and a safe space to talk about them, you know, has been really, really, really helpful for all of us you know, and, and helped... I think helped Billy to understand that, that we're not scared by what happened to him and we're not, we're not disgusted or, or put off by anything that happened to him, that we love him as the boy that he is and that we want to support him and, and, and stick with him, you know, through all these difficult times.” Page 39</i></p>
<p><b>“It’s worth it”</b>  <i>“It’s been a long, sometimes arduous process”</i></p>	Molly	<p><b>The toll of DDP on the carer comes as a shock, in terms of the time, energy and emotional investment required.</b></p> <p><i>“I didn’t know how time consuming it would end up being, how emotional it would end up being. It’s a very exhausting process.” (Page 6)</i></p> <p><b>An emotionally demanding journey.</b></p> <p><i>“So a lot of those feelings have been very, erm not necessarily negative, but I mean, some of them have been but, sad, as well, you know, difficult to deal with. So it’s been a very emotional journey so far.” (Page 3)</i></p>
	Louise	<p><b>DDP experienced as a long, laborious process at times.</b></p> <p><i>“It’s been, been a long, sometimes arduous process. We have some really tough sessions.” (Page 3)</i></p> <p><b>Challenging to feel criticised and devalued within sessions, but worth it for the impact on the relationship.</b></p> <p><i>“To be honest, I just think it’s all been helpful because I did see such fantastic results. I can’t say that there’s any of it that I don’t like, I don’t like it when I feel like I’m sat there feeling “Oh god. This is... I’ve done wrong. I’m not being validated in anywhere.” So they are difficult but I won’t say I don’t like it because I know what it is in the therapy, I know it’s important in the therapy. So yeah it’s not great but we do it, because it’s worth it. “ (Page 63)</i></p>
	Jane	<p><b>Although understand the reasoning behind the slower way of being in DDP, the pace can at times feel frustrating, as hope to progress to the core of issues quickly, in order to see progress.</b></p> <p><i>“Only the fact that it’s sloooow *laughs* and wanting that, wanting to see that instant results, you know, to be, I think that’s the difference with it, really.” (Page 30)</i></p>

	Michelle	<p><b>True empathy and understanding of a child's early experiences is heart-breaking and fear it may prevent them from fulfilling their role as a therapeutic parent to help the child recover.</b>  <i>"I think, I think you, I think you have to be... matter of fact about it because you know, if you, if you really dwell on it too much, it can just become so heartbreaking. And so, you know, some of the things that happened to him are just so awful, that if you, if you actually go there and put yourself in his place, it's not actually helpful. You've got to be sort, you've got to put yourself apart and be a little bit detached about it."</i> Page 37</p> <p><b>Limits to ability to empathise with early experience, as impact of this would limit from being able to contain and support child.</b>  <i>"But you know you, if you, if you go there too much, it actually becomes, you end up going down the same spiral as him so you've got to, you've got to be bigger, stronger and wiser."</i> Page 38</p>
	Sue	<p><b>A long journey and process, but still a sense there is more to learn and gain.</b>  <i>"But you, I mean, it's like, you know part..it's been a year, nearly a year since we've been doing this, which is quite a long time actually."</i> (Page 60)</p> <p><b>Challenging for the carer to move past their own anxieties about how uncomfortable and unsettling DDP may be, in order to support the child to engage in the process.</b>  <i>"I think the challenge is, I think the main challenge is there for, for John to, for us to sort of make sure that we had the confidence, enough confidence, to ermm, to say to John look, and believe it, to say to John that it's a really good thing.."</i> (Page 47)</p>
	Frank	<p><b>A very slow process; of getting to DDP, and then being a part of it.</b>  <i>"Yeah, a really long time. It was probably about 18 months ago when it was all sorted out and then obviously our first appointment with *therapist* was 14/15 months ago."</i> (Page 2)</p> <p><b>Initial expectation that although DDP may take a while, that the child would at least be able to engage straight away, was not met, which is frustrating.</b>  <i>"For me, I was hoping for something that'd be like a quick fix. Well, maybe not a quick fix but at least start something you know, almost straight away and start talking. He needs it but it's nothing like that."</i> (Page 3)</p> <p><b>A year in, yet lots to come – have started, but am still yet to start.</b>  <i>"To be honest, I don't know. Cos I know we're a year in, but I feel like a lots yet to come."</i> (Page 41)</p>
	Tia	<p><b>Hard to see the impact of the child's early experiences on how they see themselves and the world now.</b></p>

		<p><i>"...we talked about the same things that he talked before about but it was much, much more emotional, he was much more in contact with his emotions when he talks about it. And we both cried. You know, we're both distressed by you know, it's not just what's happened to him, it's the impact that it's had on him. It is upsetting to think that someone's treated him so badly. He was treated really cruelly and you know, it's had such a detrimental effect on him. It's, it's it is really upsetting. And obviously, you know, we love him now. I mean, he's been part of our family for *removed for anonymity* years and we really do care about him, so I can't say no, it doesn't affect me because it really really does." (Page 34)</i></p> <p><b>Sessions themselves can be difficult, given how heightened and distressed the child can become.</b> <i>"I think it's, I think it's helpful. It's not easy. I would never describe sessions as easy *laughs*" (Page 21)</i></p> <p><b>Sessions are somewhat exhausting, as trying to manage the impact on the child.</b> <i>"But yeah, I sometimes come out quite exhausted." (Page 21)</i></p>
	<p>Claire</p>	<p><b>A sense the long and slow pace of DDP required to build a trusting relationship and navigate through barriers and challenges</b> <i>"Then we've been doing it since early 2020. So yeah, it's been it's a long road, but it's a very slow road as well. You know, you have to build up all of those relationships and that trust and yeah, and you've also got to get through some of the hazards of just, you know, what's going to trigger, what's not gonna trigger, where's safe, what's not safe." (Page 1)</i></p> <p><b>Stepping into the unknown of child's early experiences is terrifying and hard to comprehend.</b> <i>"Scary. It's really scary. I know what Flo's experiences are. You know, we sort of know, you never get a full picture. They never do. And we sort of know some of the trauma that she's experienced. And you know, honestly, if I'm being absolutely honest, it scares the life out of me. Because it's not my norm. It's not something that I've experienced" (Page 26)</i></p> <p><b>Being left with the emotional impact of discussing early experiences is difficult, despite being seemingly beneficial for the child.</b> <i>"And then, you know previously when she's made disclosures, it's how that leaves you feeling. Like she's always quite relieved. But then, I don't know if she's relieved, but she's offloaded so. And then you're left with it. That's very, very difficult." (Page 27)</i></p> <p><b>A sense of needing to mask the emotional impact of early experiences on carer, in order to convey acceptance of and openness to the child's experience and emotions.</b></p>

		<p><i>"You have to put a good face on it for Flo. It's almost a little bit like wearing a mask. I don't want her to feel or to even think for one second that anything that she says, in session out of session wherever, is an issue for me. So you can't have, you've got to have that poker face, haven't you? And, and the acceptance of actually, okay, these things happens and yeah, you know, we can talk about and that's okay. We can do that." (Page 29)</i></p>
	Brad	<p><b>An intensive experience that requirements a big commitment of time and effort from carers, child and therapist, but also of funding by the local authority.</b>  <i>"Then the other thing is, we've got to find the time, funding and people to keep it going. Because I mean, that's the other thing. I don't know what the comparisons are, but it's quite intensive, you've got to put the commitment in." (Page 84)</i></p> <p><b>Exploring a child's early experiences directly is distressing.</b>  <i>"...but allow him the space to, to then reveal more if he wishes to, and to be able to be aware of... and you know, when you're in that situation, it can be quite distressing" (Page 44)</i></p>
	Joanne	<p><b>The requirement for a long-term commitment to DDP, when the mechanisms and benefits of it are initially unknown, can feel like a big, daunting ask. In time, however, can see commitment was worthwhile.</b>  <i>"Um, well, obviously, when we started, we didn't know what we're doing, what we're getting ourselves into, it was suggested and, you know, we just said well, okay, let's do it. It seemed like a lot, you know, knowing that it would go on for, you know, it would certainly be for a year. I mean, as it turns out, you know, because of the way things have gone, you know, it's been slightly less than a year. You know, it seemed like a massive commitment to go and turn up every week and do something. But, you know, it has been fantastic, and I could not recommend it highly enough." (Page 71)</i></p> <p><b>The emotional impact and mental toll of sessions can be hard to make space for with competing demands, such as work, which is challenging but perceived as somewhat inevitable.</b>  <i>"[when discussing what it's like to go straight to work from sessions] It's not always easy to be honest. You know, if it's been a bit like, you know, like those more difficult sessions, you know, by just, you just have to, like, be like, you know, on to the next thing kind of thing that's just life really, isn't it? You know, we all have to deal with difficult things and then you have to go and do something else. *laughs*, that's just life really." (Page 53)</i></p>

		<p><b>To truly listen to and understand the child's experience is both challenging and uncomfortable, as it provides an opportunity to discuss what perhaps otherwise wouldn't be discussed about the challenges in the relationship and child's world.</b></p> <p><i>"It's quite challenging and sometimes it's quite uncomfortable. You know, when you're sort of having to listen to you know, Tom's experience. And, you know, hearing him reflecting on what it was like to come to us because obviously, you know, well, that's not obvious, but it's difficult for him to say that to us. You know, what it's like to actually you know, leave his family and come and live with strangers."</i></p> <p><b>At times feeling somewhat on the spot, which is uncomfortable, but thought-provoking.</b></p> <p><i>"Ummmm, you know, uncomfortable... Because *therapist* is asking me something. Oh, God, I've got say something now. Okay. Actually, yeah, I think that. I hadn't thought that, or wasn't thinking, but now I've been asked something very specific, perhaps I do have an opinion on that." (Page 82)</i></p>
	Louise	<p><b>The emotional impact on carer of developing a greater understanding of the child's early experiences.</b></p> <p><i>"It made me think I think I came out of some of those sessions thinking again, "God what that kid went through. You know, so it sort of impacted me a bit as well emotionally." (Page 36)</i></p> <p><b>Sessions can at times be emotionally draining and gruelling.</b></p> <p><i>"As I say we've come out of them sometimes and they've been quite gruelling, and it just drain you emotionally. You do come out sometimes feeling absolutely drained." (Page 64)</i></p> <p><b>Some sessions feel really uncomfortable and taxing.</b></p> <p><i>"As I said, we've had some really difficult ones in which case I've just felt. "This is, this is awful. I just want to get out" but I haven't, I've stayed there." (Page 53)</i></p>
<b>"It's worth it"</b> Confronted and exposed	Molly	<p><b>Personal reflections and element of DDP completely unexpected, almost catching you off guard, whilst being informative.</b></p> <p><i>"And I think we did quite a few months of just me and *therapist* speaking, most weeks. Lots of, sort of in-depth discussions about how I was feeling about things that were going on with Ryan and also things about links to my past triggers and things like that. Which was really difficult and informative as well. Really helpful. And unexpected. Not something I was aware of that was happening but also aware that would be involved in the process really..." (Page 2)</i></p> <p><b>The honesty regarding the carers experience within DDP has felt confronting and somewhat exposing, as carer left feeling somewhat raw.</b></p>

		<p><i>"Yep, exactly, and my reactions to things that were happening in the home as well and how I was feeling about both Ryan and more responses to Ryan...it was ermmm, humbling and quite confronting I suppose to really think so openly about...and honestly with somebody, about how raw something can be making you feel. And you know, it's a very, it can be a very difficult home as well. So a lot of those feelings have been very, erm not necessarily negative, but I mean, some of them have been but, sad, as well, you know, difficult to deal with. So it's been a very emotional journey so far." (Page 4)</i></p>
	Louise	<p><b>Despite trusting relationship with therapist, being open and honest about past and current experiences of the carer feels somewhat exposing, as if opening self up to judgement and scrutiny.</b>  <i>"Just about exposing yourself, I suppose. I'm exposing myself a bit here and I'm opening up about problems I had when I was younger and in my life, so, yeah, it's, yeah, exposing." (Page 13)</i></p> <p><b>Personal explorations can at times leave carer feeling somewhat investigated and scrutinized, which can feel uncomfortable.</b>  <i>"A bit uncomfortable to start off with, you know, being analysed yourself. So yeah, a little bit uncomfortable to start with. But, but I've got such a good relationship with them. And they are both so lovely, that they were able to put me at ease." (Page 12)</i></p> <p><b>Given exposing nature of the therapy, and it often beginning when relationship between child and carer is difficult, an initial fear of being judged by the therapist as incompetent and to blame.</b>  <i>"And knowing that you're not going to be judged because when we first had *therapist* here and when it first started and you didn't know *therapist*, that was a fear. You know, "oh god, things are awful between me and Georgia, am I going to be judged? Is it my fault?" Because that's, that that's my fallback position anyway." (Page 19)</i></p>
	Joanne	<p><b>Initial sessions without child present an intensive unearthing of the foster carer's own experiences that may feel somewhat exposing.</b>  <i>"You know, we had to start off by *other foster carer* and I going for quite a few sessions. Six or seven. Before we started going with Tom, so that was quite, you know, intensive in a way and sort of exploring you know, our parenting styles and stuff like that. Yeah, so um it was interesting and, you know, sort of digging in a bit to like our sort of personal experiences and you know, how we were brought up and how we parented our own child and that kind of thing. So, yeah." (Page 5)</i></p> <p><b>Carer actively engaged with the therapy and working together to support the child, which can at times leave the carer feeling pressured and exposed.</b></p>

		<p><i>"...it's actually being pulled into it. Even though sometimes that's not where you want to be pulled perhaps so that you don't feel you want to say something and then something gets squeezed out of me that I might not have said others." (Page 81)</i></p>
	Claire	<p><b>Despite understanding why, self-disclosure and reflection on early experiences felt obligatory and invasive</b></p> <p><i>"And I know that its, you know, to try and build up a picture of you as a person and you as the carer and how open you are to the to the experience, and you know, how that's gonna carry on but it felt really really intrusive, having into explain how you feel about your parenting and how you were parented." (Page 3)</i></p> <p><b>An implied obligation to disclose everything about yourself is exposing and grueling</b></p> <p><i>"It was really hard. It was really...I don't, I don't know about other people, but I don't like to share everything. And it really, really felt as if you <u>had</u> to share everything. Otherwise you were never going to get the most out of it." (Page 4)</i></p> <p><b>Self-disclosure painful, awkward, uneasy.</b></p> <p><i>"Yeah, it was uncomfortable, in the beginning, really uncomfortable. Because it's almost like you're opening up little pockets of yourself that you didn't really know were there and then other things start coming out." (Page 6)</i></p>
	Michelle	<p><b>Hardest part is feeling criticised and misunderstood, despite understanding why</b></p> <p><i>"I think it's sort of, a head and heart thing isn't it. My head understood what she was doing, and why she was doing it. But your heart is like "what, I'm not a bitch, you know, I'm a loving and caring mother to this child!" You know, and so, so that, that is hard. But, but like I say, your head is there thinking but I know why she's doing this and you know, it's, it's, it's to support him and to empathise with him, and show him that people you know, are understanding and not, not criticising his feelings or telling him that his feelings are wrong, you know, so. But, yes, I mean, it is. I mean, that that is for me, the hardest part of going there" Page 20</i></p>
	Brad	<p><b>Being vulnerable and almost exposed as a carer a necessary but uncomfortable part of DDP, to allow the therapist to truly understand you as a person and carer.</b></p> <p><i>"And to be open, you know, I mean, you know, you need your therapist to know pretty much everything, really. If they ask, you know, you tell them, because that's, all of it's important." (Page 71)</i></p> <p><b>A requirement for both you and the child to be brave enough to face your own unique challenges within DDP.</b></p>

		<p>“...you both, you and your child, I think, going into the DDP have to be extremely brave.” (Page 45)</p>
<p><b>“It’s worth it”</b>  <i>“It actually makes you a better person”</i></p>	Brad	<p><b>A challenge to your existing beliefs about who and what you should be as a parent, in turn questioning your personal and professional view of self.</b>  <i>“And and I think that that certain aspects of it, we found were challenging, but I suppose they were meant to be. They were challenging our ideas of what normal parenting is.” (Page 4)</i></p> <p><b>Challenged view of self as a successful parent, which is confronting.</b>  <i>“Yeah, and I think, I think you, it's challenging because you think you what you're doing, you think you've been relatively successful.” (Page 28)</i></p> <p><b>Requires carers to re-map how they parent and recognise how this may not be helpful for this child which is challenging and hard to accept, possibly given cross over between personal and professional view of self.</b>  <i>“Well, I think you're being asked to remap yourself really, to think about the way you've done things, to analyse the way you've done things in the past. And to realise, through that analysis, and through talking, and perhaps conversing with your partner and your therapist, that you, you were getting it, you were getting it wrong. You were not dealing with it the right way in this particular instance. And that's hard work, that's hard for anybody to accept. Particularly when what you've done has worked before you know. But for this particular individual, and with these particular problems, it has... it isn't going to work, I think it probably was never going to work. And that's hard to accept, you know, and I found that hard.”</i></p> <p><b>A greater understanding of yourself, your views and your beliefs, which can be challenged during the therapy.</b>  <i>“you learn a lot about yourself.” (Page 70)</i></p>
	Michelle	<p><b>A contrast between DDP feeling like a natural fit and a development of existing skills vs it challenging core beliefs and sense of self as a person, parent and foster carer</b>  <i>“So I think that, that's, it's just been a development of what I've, what I've always done, you know. But, but this has been a biggie. It has challenged some of those quite fundamental beliefs I've had, and so, so yeah, it's, it's, it's challenging, and it can feel a bit scary” Page 63</i></p> <p><b>Challenged view of self and identity as a successful parent</b>  <i>“...we're not young people and we have parented five other children and you know, so, to sort of be, and, and, you know, I suppose, have a view of ourselves as successful parents, you know, and people who are</i></p>

	<p><i>good at it, you know, so to actually, for somebody to actually say, actually, you know, you could be doing this better, it was a bit challenging.” Page</i></p> <p><b>DDP given support, permission and tools to let go of strongly held beliefs about how to be as a parent, to be able to meet the needs of this child now</b></p> <p><i>“...certainly the DDP has supported us to do that and yeah, and, and to, just to focus on Billy, on the child and what, what is right for him and, and because he's, he's at the extreme end of... his experience are really at the extreme end. So, the way we've had to deal with them have been at the extreme end of parenting, you know, and so it's given us permission and support to take some of those difficult challenges and you know, those yeah, yeah, to relax some of the things that that we maybe found very difficult to, to let go.” Page 64</i></p>
Sue	<p><b>Therapist helped the carer to understand how their parenting needed to be adapted to meet the child's needs.</b></p> <p><i>“I mean, he was gradually getting better, but not without without *therapist* and without *therapist* actually helping us realise where we need to be.” (Page 9)</i></p> <p><b>Therapist helped carer to understand why directly addressing the child's early experiences was important to move forward, which was in somewhat contrast to their existing belief.</b></p> <p><i>“she was really easy going and helped us realise the job that needs to be done. Umm. Which we I mean. We knew John had problems, we knew about his past and that, but the thought of actually trying trying to tell him, I mean, we could never do that. We couldn't say to him right, this is what happened to you. Ummm. It would be too upsetting basically. But like you know, I I actually thought...before then that you ummm that you could just draw a line and say that all those things are horrible, forget them and step over and start life again. But it's like *therapist* said, no, that's not the way it goes.” (Page 16)</i></p>
Louise	<p><b>Despite feeling exposed, personal reflections increase understanding of self.</b></p> <p><i>“A bit revelatory in some bits. Some of it I sort of realise myself. But some of the things that I didn't relate back to my past experiences... It makes you understand a little bit more, yeah. ” (Page 12)</i></p> <p><b>Despite feeling somewhat exposed, the carer feels known and seen by the therapist, allowing them to support both the carer and child moving forward.</b></p> <p><i>“[discussing why exposure is worthwhile] Well I suppose if they understand how I feel, and how I deal with things, it helps in understanding how I'm dealing with Georgia, really.” (Page 14)</i></p>

	Molly	<p><b>Enlightening; a deeper understanding of the self and the child, and how their experiences interact, as well as how they at times are separate.</b>  <i>"I want a word like erm, not quite enlightening, but you know when something makes you understand the reasons behind things? So like it's made me understand why I feel things because of him and why he is doing things as well. How do I put that into one word? *laughs* And the ability to separate what's going on for him and what's going on for me." (Page 48)</i></p> <p><b>The greater sense of awareness in DDP has enabled carer to have a greater understanding of the relational processes and transference, meaning they feel more in aware, in control and measured in their response.</b>  <i>"But it's also, made me more... I think...I don't know if better at dealing with those situations as they come up, as well, like having an awareness that this is Ryan's stuff, not my stuff, so I'm better able to keep a lid on my wobbly feelings that are surfacing rather than that unbalanced feeling that starts coming and not knowing where it's coming from." (Page 5)</i></p> <p><b>Feeling somewhat exposed and investigated, but arriving at a greater self-awareness.</b>  <i>"I think being sort of guided by *therapist* about how some of his behaviours have been triggering for me. And digging into why that is. And not having the awareness initially that that was happening. That's been very....it's made me much more self aware." (Page 4)</i></p>
	Joanne	<p><b>A personal revelation – come to be more insightful and understand more about themselves as a person, as well as a carer, and learnt the importance of being more reflective/self-aware.</b>  <i>"Umm, on a sort of personal level because as I've said, I'm not a very reflective person. I just barge on through. It's, it's really important. It's a personal revelation of you know, thinking about how you do things, just being aware of everything we do." (Page 79)</i></p> <p><b>A realisation that usual ways of trying to “fix” situations, rather than to be in situations, was not meeting child’s needs.</b>  <i>"I tend to be rather fix-it-people, um, you know and try and make people happy, you know, by doing things and that is not, you know, particularly therapeutic it's just soothing, you know?" (Page 19)</i></p> <p><b>A shift in perspective of how to support the child in their distress – that acknowledging, accepting and empathising with their pain is enough, rather than trying to “fix” or “reassure”.</b></p>

	<p><i>“But learning, I think both of us to learn to acknowledge I understand why you feel unhappy, you know, and just let that be instead of, but everything's gonna be alright you know, kind of thing, we don't need to say that we can just say, I understand and that is enough to be helpful.” (Page 42)</i></p>
Claire	<p><b>A greater understanding and challenge to who you are as a person, personally and as a carer.</b>  <i>“It really opens your eyes as to how you are and what you do as a person. And how you communicate with other people. It really, really changes.” (Page 52)</i></p> <p><b>A transformation of perspective, understanding, priorities for the carer, that affects every area of life.</b>  <i>“Definitely, like I said how we, how we ,how we approach things now is different. And your outlook on, on <u>everything</u> is very, very different, how you interact with the people, what you do, what you what you feel is precious to you, is different to what it might have been before.” (Page 57)</i></p> <p><b>A transformative process for self as a person and in all relationships, that fosters compassion and forgiveness.</b>  <i>“It makes you a lot kinder to yourself and to others around you. More forgiving. You know it did, I think it actually it makes you a bit of a better person.” (Page 39)</i></p> <p><b>An increased understanding of and acceptance of themselves, and those around them.</b>  <i>“It allows you to feel a lot more comfort, to me it's made me feel more comfortable in my own skin. And it's, it's allowed me to be a lot more accepting of my flaws and things that I could work on. So yeah, you know, it's changed, changed a lot of things of how you know, just how you see each other and how you see yourself and others around you really. “ (Page 62)</i></p> <p><b>A mirrored strengthening of foundations for both carer and therapist, empowering them to utilise new found skills and relationship to move forward.</b>  <i>“It is empowering. You know, you feel empowered. They feel empowered. It gives them more confidence, self esteem, resilience, you know, you're, you're building on what was quite a shabby foundation, but you know, you strengthen that foundation. So you know, you've got all those, those younger tools that we know Flo didn't have when she was younger. So yeah, you are making little people. And it's that strengthening for you and your foundation too.” (Page 57)</i></p>
Frank	<p><b>Therapeutic parenting approaches within DDP feel somewhat alien to way of being in the rest of life, which is hard.</b></p>

		<p><i>“...but I don’t, I’m from more of a discipline background working in the *job removed to maintain anonymity*, I don’t think therapeutically in that sense. So I really struggle with it, with the therapeutic parenting.” (Page 4)</i></p> <p><b>An unconscious switch back to “old dad mode”, as that feels so natural and familiar. A conscious effort is therefore required to try and stay in “new dad mode”.</b></p> <p><i>“Sometimes I don’t, I fall back onto old dad mode, and I have to sort of wind myself back a little bit, and then *other foster carer* takes over, and it’s like, oh ok yes I am struggling with it.” (Page 12)</i></p> <p><b>A complete change to who carer feels they need to be as a parent – which is difficult, uncomfortable and frustrating.</b></p> <p><i>“And I’m trying to be, but it’s difficult and a big change. It’s absolutely massive. And I struggle with it. And I do try. Sometimes I get frustrated, and it’s like, I do.” (Page 11)</i></p>
	Jane	<p><b>Carer learnt a new, more patient way of being, that extends to other relationships in their life.</b></p> <p><i>“And I mean, I do use it with my grandchild. I have to say, I’m a lot more patient with their emotions.” (Page 41)</i></p> <p><b>From having a greater appreciation for the child’s experience, carer feels more measured, regulated and patient in their response.</b></p> <p><i>“Ermm, no not really. I just think I’m just to be honest, a lot more aware of how big emotions can affect children without them realising it, because obvious children cant verbalise exactly what those emotions are or how they’re feeling, so it comes out in the physical. Ermm, so I think I’m a lot more aware of that, for sure. So I think I’m a lot calmer, definitely a lot calmer, and a lot more patient.” (Page 42)</i></p>
<p><b>“It’s worth it”</b>  <i>“It’s a big commitment, but not one that I regret at all”</i></p>	Brad	<p><b>A rare, invaluable, and bonding space to be truly present as a family to work towards a future together, that should be cherished.</b></p> <p><i>“I think, to have an hour and a half in a day or a week, where you spend time with three other human beings, and you try and deal with both yours and their issues, because they are all of our issues, they belong to all of us, is a precious gift, really.” (Page 76)</i></p> <p><b>The gift of protected time and space together to move forward as a family.</b></p> <p><i>“And DDP is a precious gift. It’s given us that time. It really has and it’s made a massive difference to us.” (Page 76)</i></p> <p><b>A privilege to be part of providing the child with a new experience of themselves and the world.</b></p>

	<p><i>"And one of the I guess one of the privileges of my life was to be present when my boy discovers that he could relax because he'd never learnt, he'd never learnt." (Page 51)</i></p> <p><b>A complicated privilege to be allowed into the child's world.</b></p> <p><i>"So yeah, in that room, in that therapy room, you are in a very privileged but also very complicated place." (Page 46)</i></p>
Frank	<p><b>Long process is frustrating, yet will still be worthwhile if it supports the child in the long run.</b></p> <p><i>"But if it takes another however long it takes, as long as we can get there eventually, then you know, I suppose it was all well worth it." (Page 21)</i></p> <p><b>A long process, which will still be worthwhile if enables the child to make progress.</b></p> <p><i>"So it does take time. But, however long it takes, obviously we want it to take however long it takes to do it, as long as he's ok at the end of it." (Page 43)</i></p>
Tia	<p><b>Exhaustion and months of sessions worth it for snippets of progress</b></p> <p><i>"yeah, I sometimes come out quite exhausted. But you know, little things make us sort of acknowledge that there is progress. Like yesterday, he said, would you care if I died? And then he asked *therapist*, and I thought, well, that's progress, really, because he cares what *therapist* thinks now. So just snippets of moments like that make you think oh, yes, things are moving aalong a little bit." (Pg.21)</i></p>
Louise	<p><b>Challenging to feel criticised and devalued within sessions, but worth it for the impact on the relationship.</b></p> <p><i>"To be honest, I just think it's all been helpful because I did see such fantastic results. I can't say that there's any of it that I don't like, I don't like it when I feel like I'm sat there feeling "Oh god. This is... I've done wrong. I'm not being validated in anywhere." So they are difficult but I won't say I don't like it because I know what it is in the therapy, I know it's important in the therapy. So yeah it's not great but we do it, because it's worth it." (Page 63)</i></p>
Molly	<p><b>A toll and cost, but worth it.</b></p> <p><i>"And it's quite an emotional process, you know, going through the child's process and going through your own...issues and feelings along the way. But like I said earlier, it's like, enlightening and so worth it as well." (Page 47)</i></p>
Sue	<p><b>The challenges within DDP are a good thing, as cannot progress without it.</b></p>

		<i>"[when reflecting on the emotional toll of DDP] but it feels, it feels really good because it's definitely helping him" (Page 41)</i>
Joanne	<p><b>DDP enhanced sense of fulfilment and value as a therapeutic foster carer, as it's increased their ability to move beyond physical needs of the child to meet their psychological needs, allowing them to fulfil what they believe their role to be as a therapeutic foster carer.</b></p> <p><i>"Sort of therapeutic for us as well. Um, well to feel like we all do something worthwhile and helpful. You know, it's not just a job of feeding and clothing and, you know, taking them places and stuff like that. That you can actually help to change, well to develop, help them to develop so that that's, instead of just feeling like you're sort of a glorified babysitter, which, without DDP a lot of the time, it is." (Page 21)</i></p> <p><b>A valuable use of time, within the context of significant time pressures and demands.</b></p> <p><i>"So, yeah, that is just been really valuable for that, you know, it's really it's, I've really enjoyed it. Well, enjoyed is the wrong word. I found it very, very valuable and a very valuable use of my time." (Page 16)</i></p> <p><b>A worthwhile, big commitment.</b></p> <p><i>"So I mean, yeah. It is a big commitment. But not one that I regret at all." (Page 68)</i></p>	
Jane	<p><b>An acceptance that DDP would be a longer, slower process than expected, but a belief that it would be worth it to help the child.</b></p> <p><i>"So yeah, to be honest, I just accepted it. I mean, it was out of my control. This is how it worked. And that's enough. And that was it. There wasn't anything I could do about it. I just knew that, hopefully it would help Ria." (Page 32)</i></p>	
Claire	<p><b>Not without it's challenges, but worth it for changes for both child and carer.</b></p> <p><i>"So yeah, you know if, if anybody ever asks if it's worth it, it's worth it. It's really, really worth it. Definitely worth it." (Page 55)</i></p> <p><b>Toll, commitment and challenges outweighed by the benefits.</b></p> <p><i>"But actually it is, it's life changing. It's empowering. And like I said, you know, if you're ever offered it as a carer, or as a parent, just take it because it's worth it. It'll always be worth it." (Page 56)</i></p> <p><b>The difficulties experienced within DDP enable you as a carer to fulfil your role of as a therapeutic carer, to bear witness to and hold the child's pain to help them recover.</b></p>	

		<p><i>“There's never a negative. Yeah, all right. You asked to have those horrible conversations and, you know, they might feel a little bit eurggh. Yeah, but that's part and parcel of it. You know, that's part of, who she is, who we are, where she's coming from, what her experiences are. And actually, we should feel honoured, that she wants to share those because that means that we've done our job.” (Page 58</i></p>
	Michelle	<p><b>Hard to explore early difficult experiences, but worthwhile.</b>  <i>“<u>I</u> felt, it felt challenging. But ultimately it feels, you know, worthwhile and helpful, you know, that, it's... I suppose it's hard. It's, I mean, you know, we can see the difference it's making to him.” (Page 35)</i></p>

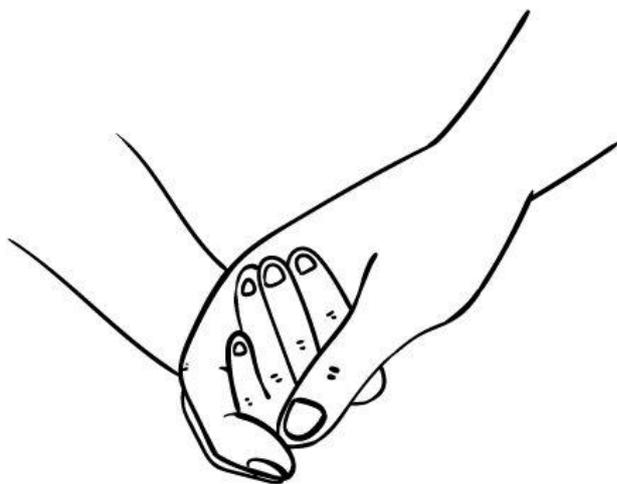
### **Paper Three: Executive Summary**

#### **Exposed, Scaffolded and Connected - Foster Carers' Experiences of Dyadic Developmental Psychotherapy: An Interpretative Phenomenological Analysis**

This summary hopes to provide a concise and accessible summary of the key findings and recommendations arising from this study.

The generous foster carers' who participated in this research are the intended target audience. Professionals working alongside foster carers may also find this a helpful insight into their experience, from which to offer support.

Thank you to two participants for sharing your contributions to the language and layout of this summary.



## **Setting the scene**

83,840 children as of March 2023 in England alone are looked after by their local authority, 68% of whom live in foster placements (Department for Education; DfE, 2023). At least 65% of these children have been placed in care due to risks of abuse or neglect from their parents or carers (DfE, 2023). Many of these children have therefore been unsafe in the key early years of their lives or harmed by the people they were told to trust the most.

Such children are at risk of developmental trauma; trauma that happens within the child's own family (van der Kolk, 2005) which affects their attachment security and forms a blueprint for how they see themselves, the world and everyone in it (Bowlby, 1969). The child's past beliefs about and ways of being within relationships are therefore repeated with other caring adults, such as foster carers. For example, if carers have previously been unsafe or threatening, the child may believe their new foster carers will be too. Such children can therefore struggle to feel safe in relationships, to manage their often-overwhelming emotions and to see themselves as lovable (Cook et al., 2005).

The National Institute for Health and Care Excellence (2015) therefore suggests we need to find ways of supporting such children to feel safe within relationships and themselves. One intervention that may help is called Dyadic Developmental Psychotherapy (DDP).

### **What is Dyadic Developmental Psychotherapy?**

DDP was designed specifically for these very children, to help build a stronger, trusting relationship between the child and their new carer. It is hoped that the carer can then become a "safe base", from which children can learn to experience themselves, the world and others in a new way (Hughes, Golding & Hudson, 2019).

### **What is required of carers in DDP?**

As their relationship with the child is central to the intervention, carers play a very crucial role in the therapy. Carers first meet with the therapist alone, to think together

about their relationship with the child and what that's like for them. As all our relationships are shaped by the relationships we've had previously, the carer will also be required to think about other relationships within their own life, including from their own childhood, to think about how that may be influencing their relationship with the child in their care.

Carers will learn a new way of being in relationships, called PACE. The PACE-ful way of being conveys playfulness, acceptance, curiosity and empathy in all interactions with the child, which over time allows them to feel safe enough to explore their difficult experiences.

By exploring what the child finds painful and often shameful, the therapist and the carer can help the child regulate the often-big emotions associated with these early memories so that they are not as painful anymore. It is hoped the child can learn that these experiences were not their fault, that they are lovable and deserving of care, and that their new carer is a safe person who can provide that.

Carers are therefore part of often weekly therapy sessions with the therapist and the child. Carers essentially become a co-therapist who works alongside the therapist to help the child come to this new understanding of themselves and others.

### **So, what is the research about?**

Well – that's a big ask of carers! Although past research has explored what being part of DDP is like for adoptive parents (Wingfield & Gurney-Smith, 2019), no research has yet explored how foster carers experience being part of DDP. That's what this study therefore aimed to explore.

### **Why is this important?**

The researchers thought that although some aspects of being part of DDP may be the same for foster and adoptive carers, there may too be some differences due to:

- Contextual differences affecting the fostering relationship, such as permanency considerations, placement length, legal rights, and contact with birth parents (Neil, Beek & Schofield, 2003; Selwyn & Quinton, 2004).

- Research suggesting differences in the experience of the caring relationship, such as an increased sense of belonging, emotional security and closeness for adoptive children and parents compared to fostering (Triseliotis, 2002; Selwyn & Quinton, 2004).
- The complexities of the foster carers' role which is both personal, as a parent, and professional, as a paid occupation, meaning foster carers' may feel more scrutinised for their role within DDP.

Understanding how foster carers experience DDP may help clinicians in the future to improve this experience and improve outcomes for both the carer and the child.

**This study therefore asks:**

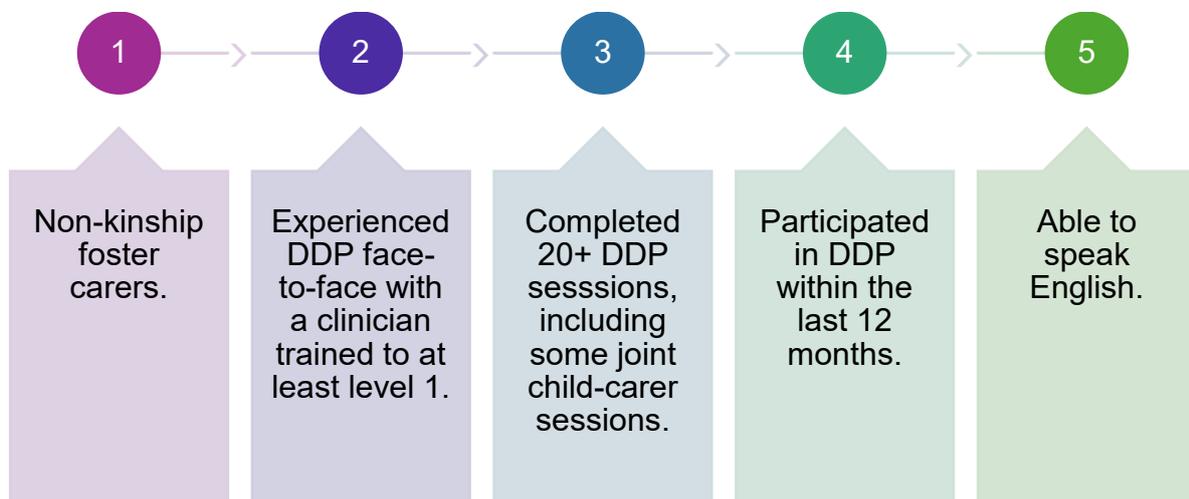
How do foster carers experience DDP?

### So, what did we do?

Firstly, full ethical approval was obtained.

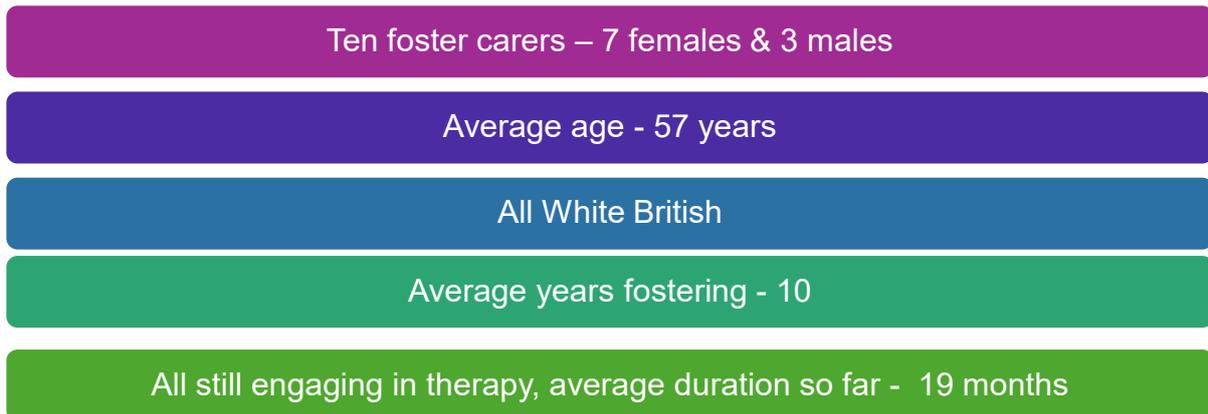
### **Next up – find the experts!**

The researchers tried to find foster carers who would be willing to take part. To do so, DDP clinicians identified through the DDP Network and some NHS Trusts were requested to ask any foster carers who may be willing and eligible to take part, according to these criteria:



Kinship foster carers, who are often family members, were not included in the study, as the researchers wondered if their experience of DDP may again differ, given their existing knowledge of the child and their relationship to the child's trauma. The researchers therefore felt this unique experience deserves due attention in future research.

### Who were the participants?



### What did they do?

Participants:

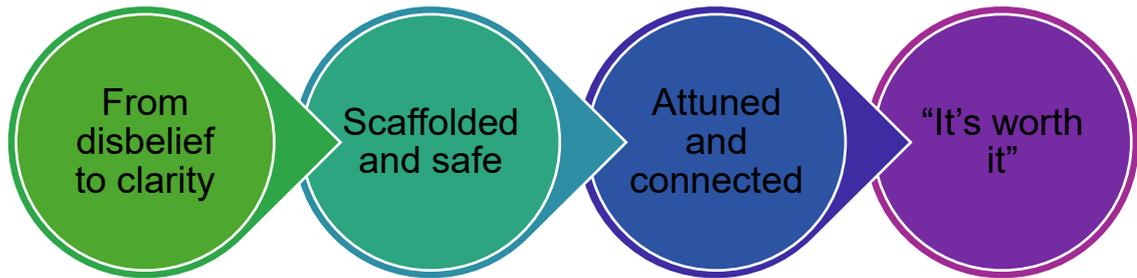


### What was next?

The researchers then transcribed the interviews and analysed the data using Interpretative Phenomenological Analysis (IPA). IPA allows the researcher to interpret what being part of DDP was like and meant to foster carers, looking for similarities and differences across the participants' stories.

## What did we find?

Four main themes, with eleven subthemes, were formed. An overview of each will be provided below, with quotes from the participants themselves, whose names have been changed to protect confidentiality.



### Theme 1: From disbelief to clarity

Participants shared journeying through the process of DDP. From initial confusion, frustration and disbelief, came clarity and understanding.

#### Subtheme 1: “What the hell is going on?”

Many participants had “*absolutely no idea what [DDP] would entail*” (Joanne). When beginning therapy, participants felt confused as they “*didn’t understand what the purpose was*” (Claire), what “*my role*” (Molly) was or “*how does this work*” (Jane). Some shared feeling apprehensive initially about how directly DDP would address the child’s trauma. Others shared wishing DDP was more direct and fast-paced, leaving them frustrated and somewhat disappointed. Overall, there was a sense of almost disbelief initially, as it was hard for participants to see how DDP could help.



## **Subtheme 2: “*It’s something you have to experience really to understand it*”**

From disbelief however came clarity, as carers grew to understand DDP through being a part of it. Once DDP made sense, it became almost “*mind-blowing how something that, that seems so simple now, is actually really very, very effective*” (Claire). Many shared then becoming “*a real advocate*” (Brad) for DDP as they felt it could help other families too.

## **Theme 2: Scaffolded and Safe**

Participants shared the importance of their relationship with the therapist.

### **Subtheme 1: “*It’s a very safe and secure relationship*”**

The accepting and non-judgemental relationship built with the therapist meant that participants felt uniquely safe and able to be honest about their experience. The importance of this in the context of sometimes feeling scrutinised as a foster carer was highlighted. Foster carers shared that the therapist was therefore “*someone to trust*” (Frank), who “*validated*” (Molly) the complexities of caring for a traumatised child and reassured them “*that I’m actually doing ok*” (Louise).



### **Subtheme 2: Guided and co-parented**

Participants shared feeling guided by the therapist. Some learnt through observation of how the therapist responded within sessions, whilst others benefited from direct coaching on how they could respond. Overall, the therapist was experienced as a “*co-parent*” (Claire), who came alongside the carer, as someone to “*talk it through with*” (Molly) and to “*share that load*” (Michelle) of carrying the emotional weight of the child’s trauma.

### Theme 3: Attuned and connected

All foster carers shared gaining a new understanding of the child's world, leading to new ways to meet their needs and overall, a more connected relationship.

#### **Subtheme 1: A new insight**

Given how little is often known of the child's early trauma, DDP provided many participants with an insight into "*how [the child] sees the world*" (Claire). Participants gained a greater understanding therefore of how the child sees themselves and others in the world, including the carer, and of what may be underlying the child's behaviour. DDP was therefore "*a real luxury of time and space to really drill into what [child] real needs are*" (Michelle). Participants shared that from being part of DDP, they understood the other children in their care better too.

#### **Subtheme 2: Resourced and armed for the future**



DDP provided all but one foster carer with new "*skills*" (Joanne) that are "*better designed for the job*" (Brad) of supporting children who've experienced developmental trauma, as opposed to traditional parenting methods. Participants therefore shared feeling better prepared to face the relational challenges ahead.

#### **Subtheme 3: A cemented relationship**

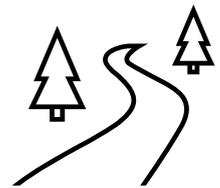
All but one participant shared a shift in the relationship with the child. Given the contextual barriers in the fostering relationship, participants shared feeling that their love for and commitment to the child was recognised through DDP, as carers saw "*the worst of the child and I'm still telling [child] that I'm there for you....I think that cemented it a little bit too*" (Louise). Many felt they became a safe base from which the child could begin to explore. Consequently, they were better able to regulate their own and the child's emotions, and repair ruptures.

## Theme 4: “It’s worth it”

DDP came at a cost to all participants. However, all participants shared that the costs were outweighed by the benefits of DDP.

### Subtheme 1: “It’s been a long, sometimes arduous process”

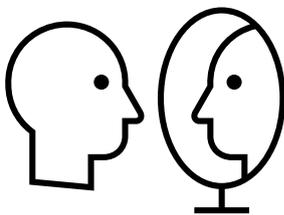
DDP was experienced as a “*time-consuming...emotional...exhausting process*” (Molly). Learning more about the child’s early trauma and the true extent of its impact left many “*horrified*” (Claire). Sitting with this trauma within sessions was difficult for participants, and some felt they needed to remain somewhat detached from the trauma, or it would be “*too heart-breaking*” (Michelle). Participants therefore recognised the need to have a “*support plan in place*” (Claire), given the emotional toll.



### Subtheme 2: Confronted and exposed

Reflecting upon the participants’ own experiences of relationships and the child felt “*really intrusive*” (Louise) for some, leaving some feeling exposed and vulnerable. Some shared feeling as though their “*fundamental beliefs*” (Michelle) about themselves as a person and a parent were challenged. This willingness to be vulnerable and open was seen as challenging, but necessary to progress by most.

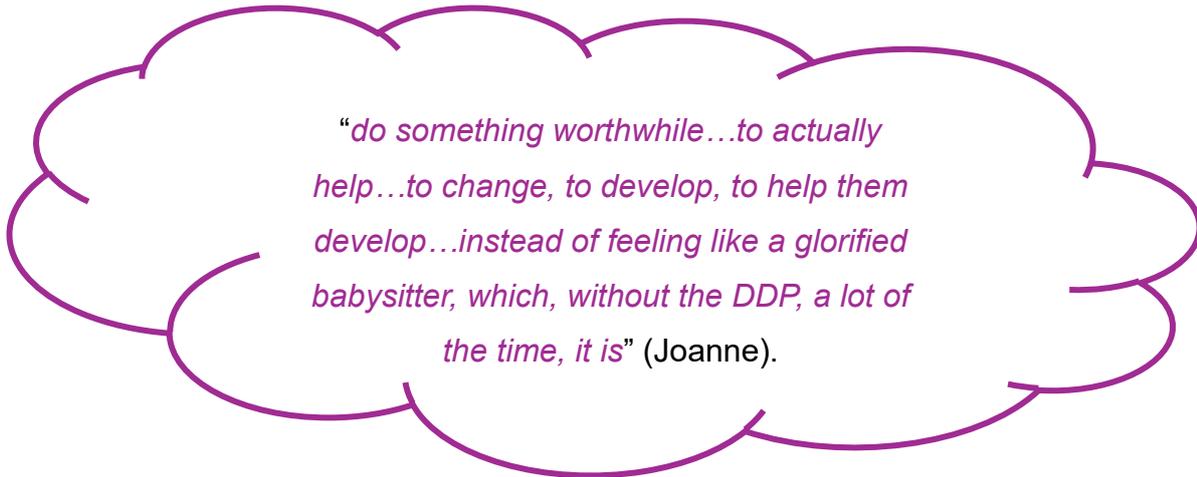
### Subtheme 3: “It actually makes you a bit of a better person”



From such vulnerability, came a greater self-understanding and a transformation of how seven participants saw themselves as people and parents. With DDP therefore came a new perspective as “*your outlook on everything is very different...to what it might have been before*” (Claire).

#### **Subtheme 4: “It is a big commitment, but not one that I regret at all”**

All participants shared that any cost or challenges within DDP were outweighed by the benefits for the family, as they came to “*see the difference it’s making*” (Michelle). DDP was therefore experienced as a “*precious gift*” (Brad), an “*honour*” (Claire) and for many was both personally and professionally fulfilling as it provided the opportunity to:



#### **So, what do these findings suggest?**

- DDP may be a **useful intervention**, even for experienced foster carers, to **increase their insight** into the child’s world and **develop attachment security**, with relational benefits **beyond those seen with the child in therapy**.
- Being part of DDP can be **personally and professionally rewarding** for foster carers.
- More effort should be made to ensure foster carers **are explicitly made aware of the requirements** within DDP, to ensure **informed consent** that considers capacity is gained. Alternative support, such as DDP-informed consultation, should be explored if the foster carer is not consenting.
- Foster carers could be provided with **testimonies** from other DDP-experienced foster carers to **help inform their decision** to partake and to

possibly help **reduce confusion and frustration** when engaging in therapy, **reducing the risk of rupture and disengagement**.

- Due attention should be paid to the **experience and therefore support needed for foster carers' engaging in DDP**, by both **DDP therapists** (such as providing more frequent check-in sessions) and **wider social care** (such as increased provision of supervision and peer support), **given the toll** acquired.
- Findings highlight the importance of a **collaborative therapeutic alliance that values the expertise of foster carers' living with the child's trauma daily**, to validate the complexities of this.

### **What are the main strengths and limitations of this study?**



This is the first study to explore foster carers' experience of DDP.



All participants had not yet completed therapy, meaning their experience of ending DDP could not be explored.

### **What would be helpful to learn more about in the future?**

- Kinship foster carers' and young peoples' experience of DDP.
- How experience and perceptions of DDP change through the therapeutic process to improve experience and outcomes.
- The experience and effectiveness of support provided to carers' during DDP, in recognition of significant requirements and the acquired toll.
- Foster carers' perceptions of the expectations of their role, to understand if these are in line with the expectations of wider social care, for example, the expectation to engage in a therapy that requires such personal exploration, like DDP.

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