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Discuss the Importance of the Therapeutic
Relationship Across the Lifespan, but with Particular
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Discuss the Importance of the Therapeutic Relationship Across the Lifespan, but with Particular Reference to Working with Adults and Older Adults

"The meeting of two personalities is like the contact of two chemical substances: if there is a reaction, both are transformed" (C.G. Jung, 1933)

Introduction

At a fundamental level, as humans we are ultimately alone; we come into this world alone and leave it alone (Safran, 1998). Yet, paradoxically, we are intrinsically linked to others; we are born in a relationship with another, as we emerge from our mother's womb (Safran, 1998), and we develop in the context of relationships with other people (Bowlby, 1969). Indeed, from birth, our very survival depends on our hard-wired propensity for maintaining relatedness to others (Bowlby, 1969). We have evolved as social animals, existing in complex systems in which social relationships and ties are paramount and inherently linked to mental health (Sloman & Gilbert, 2000). A need to maintain relatedness to others persists not just in infancy, but throughout the lifespan (Mackie, 1981).

Throughout our existence we develop countless relationships with others; family, friends, and colleagues. However, modern Western society is associated with the frequent breakdown of stable close relationships of marriage and friendship (Feltham, 1999). Sociologists suggest that psychotherapy occupies the void left by the crumbling of these social structures (Halmos, 1965). For a multitude of reasons, it has become increasingly more common for individuals to seek and undergo therapy.

The term 'therapeutic relationship' can refer to any relationship between two individuals, longstanding or fleeting, in which some form of healing takes place (Feltham, 1999). Here, the therapeutic relationship is concerned with: *"a planned, emotionally charged, confiding interaction between a trained, socially sanctioned healer and a sufferer"* (p.50 Frank, 1985). More specifically, the focus will be on the therapeutic relationship within individual

therapy with adults and older adults. In particular, the therapeutic relationship will be examined across the modalities of psychodynamic therapy, cognitive behavioural therapy ("CBT") and interpersonal therapy. Given the vast amount of literature in relation to children and the therapeutic relationship, this will not be examined here. The term 'therapeutic relationship', has a long history and shall first be examined in more detail.

A Brief History

The notion of a therapeutic relationship or therapeutic alliance (coined by Zetel, 1956) is derived from a psychoanalytic perspective, where Freud (1913) writes of "*a well developed rapport…the first aim of treatment consists in attaching him to the treatment and to the person of the physician*" (p.121). Freud (1912) recognised the importance of the therapeutic relationship and the notion that it was not unique to psychoanalysis, calling the role of friendliness and affection as "*the vehicle of success in psychoanalysis exactly as it is in other methods of treatment*". (p.95).

By the beginning of the nineteenth century, psychotherapy sought to become a scientifically based profession, needing a theory of human change that could generate robust, refutable hypotheses (Horvarth, 2005). Thus, the idea of the therapeutic relationship became more prevalent with an attempt to define and operationalise the concept.

By the middle of the twentieth century, technological innovations permitted live recordings of therapy sessions, opening the way to an unprecedented, reliable exploration of psychotherapy processes (Horvarth, 2005). Rogers (1965) identified three core conditions of empathy, unconditional positive regard and congruence as being both essential and sufficient alone for therapeutic change. This led to the humanistic or client-centred approach. It seems possible that these conditions alone could be sufficient for clients with relatively simple problems. However in clients with more complex issues, additional

qualities may be required. Nevertheless, these conditions are clearly helpful in contributing to defining what constitutes a good therapeutic relationship, but they remain conceptually different.

In stark contrast to the Rogerian approach, the behaviourist approach, initially valued the therapist's technique over and above the relationship between the individual and the therapist (Sweet, 1984). Interestingly, there is currently wide spread use of internet based therapeutic programs, where technique is delivered in the absence of a relationship. Attrition rates in these programs seem to be fairly high, and the effect sizes of the efficacy seem to be relatively modest, indicating a possible preference for the human interaction within a therapeutic intervention (Wantland, Portillo, Holezemer, Slaughter & McGhee, 2004).

Outcome Research

A major thrust of research on the therapeutic alliance concerns its relationship to psychotherapy outcome. In the late 1970's many studies consistently indicated that, broadly speaking, different therapies produce similar amounts of therapeutic gains (Hovarth & Luborsky, 1993). In addition, in the 1980's, treatment manuals were developed so that the precise specification of treatment principles and techniques in an unambiguous fashion could aid therapist training (Safran & Muran, 2000a). However, the consistent finding is that adherence to treatment manuals does not relate to treatment outcome (Moncher & Prinz, 1991).

These facts led to the inference that it was the non-specific factors, i.e.: relational factors, which were driving the outcome and led to an examination of the relational factors per se (Catty, 2004). This interest in common factors gave rise to 'pantheoretical models' of the therapeutic relationship such as Bordin's (1976) reformulation of the concept into a

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'working alliance' to emphasise its purposive function. The main methods of Bordin's (1976) model relate to 'tasks, bonds and goals' focussing on the collaboration between the therapist and client against a common enemy of pain and self-defeating behaviour. Bordin's (1976) conceptualisation seemed for the first time, to highlight the complex, dynamic and multi-dimensional nature of the alliance (Safran & Muran, 2000a).

The measurement of the therapeutic relationship requires valid, reliable and quantifiable measures of the overall construct, and numerous measures have been developed (Kivnick & Kavka, 1999). The most widely used are the Working Alliance Inventory (WAI) (Horvarth & Greenberg, 1989) and California Psychotherapy Alliance Scale (CALPAS) (Gaston, 1991). The therapeutic relationship can be measured from three perspectives; that of the therapist, the client and an independent observer. The client's rating of the therapeutic relationship has been consistently shown as the best predictor of therapeutic outcome (Horvath, 2005).

Although different models currently vary on their opinion of the importance of the therapeutic relationship, increasing numbers of studies seem to suggest, that it is this factor, more any other, that determines the effectiveness of psychotherapy (Clarkson, 2003). Lambert (1992) estimates that the alliance contributes to up to 30% of outcome, whilst the most recent meta-analysis found a more modest association of 22% (Martin, Garske & Davis, 2000). Indeed, current Department of Health guidelines (2001a) indicate that "*the effectiveness of all types of therapy depend on the patient and the therapist forming a good working relationship*". Current models vary on their opinion of the different aspects, that contribute most to the therapeutic relationship, and these will be examined later in more detail. Currently, a closer look at the lifespan approach will be taken.

Age

In psychological terms, chronological age although often used, may be considered as somewhat meaningless, for example; the 'psychological age' of an adolescent who has experienced severe trauma may be comparable to that of an older adult. Non-chronological concepts of age such as our social, functional and biological age, all contribute to the question of how old we are (Sugarman, 1981). In conventional terms, however, the usual arbitrary cut-off point for children to become adults, is age 18 and for adults to become older adults, is age 65 (Woods, 1999). Defining individuals within their chronological age groups may be seen as an artificial but necessary measure.

Ironically, discrimination against minority oppression such as sexism and racism, have long been tackled by UK law (Hepple, 2004). In contrast, although the National Service Framework for Older People (Department of Health, 2001a), proposes the elimination of ageism as a creditable aim, it doesn't suggest how this might realistically be achieved (Hepple, 2004). Western culture is an inherently ageist society, where youth and independence are highly valued (Feltham, 1999). This may be seen (psychodynamically), as society collectively employing denial-based defences to protect against frightening existential uncertainties of ageing (Hepple, 2004). Since undertaking clinical work with older adults, I have become far more aware of the existential issues that are inevitably stirred up. Issues of loss, death, grief and dependency seem to be understandably common. By using structured and regular supervision to reflect on these feelings, one must strive to recognise the depth of these feelings, particularly in the way that they impact the therapeutic relationship.

Expectations

Previously, older age was thought to negatively predict treatment outcome. However, this view has slowly changed and the use of therapy, as with younger adults, is vital (Hyer,

Kramer & Sohnle, 2004). Generally, older adults may be advantaged in relation to adults, in utilising therapy since they show increased self-acceptance (Ryff, 1991), a more realistic ideal self and lowered expectations (Dittmann-Kohli, 1990). Their ability to utilise emotions in more integrated and complex ways (Hyer et al, 2004) than younger adults, may enhance their ability to use therapy productively. However, given the possible irrelevance of chronological age, there is probably greater within group, rather than between group variation, in comparing adults and older adults.

On one hand, Lebowitz and Niederehe (1992) propose that the stigma of mental illness is especially strong amongst some members of the current generation of older adults, as they may associate mental disorder with personal failure, spiritual deficiency or some other stereotypic view. On the other hand, this view is also often encountered in some members of the younger generations. Whenever this view of mental illness is held by an individual of any age, the therapeutic relationship seems to play a particularly important role in overcoming this belief.

In addition, Knight (1996) proposes, that today's cohort of older adults may have more inaccurate expectations about the nature of therapy and have been found less likely to label their problems as psychological, more often as medical. Thus, Hyer et al (2004) considers that older adults may require longer socialisation and more repetition at intervals to understand the idea and process of therapy. However this is also often required for adults who may come to therapy with the expectation of a 'magic cure' for their problems. In any case, a longer and repetitive socialisation process may prove beneficial, allowing for the slow and solid establishment of the therapeutic relationship. The difficulties may arise in managing to establish and maintain the therapeutic relationship whilst aiding therapeutic change within the brief session provision of today's NHS.

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Adaptations

There are a number of practical and technical considerations that are often recommended when working with older adults, such as ensuring a quiet room and sitting closer to the client (Woods, 1999). These adaptations may considerably enhance the therapeutic relationship. In actual fact, these adaptations would be necessary for an adult with limited hearing or a child with a physical or learning disability. This emphasises that a client must not be defined by their physical or mental disorder, but seen in the individual context of their circumstances. Technical adaptations include repeating concepts both verbally and visually, providing a tape-recording, and frequent summarising (Hyer et al, 2004). A weak therapeutic relationship is associated with the rigid application of technique, (Ackerman & Hilsenroth, 2001), thus emphasising the importance of the therapist adapting sessions creatively and flexibly. Once again I would argue that these adaptations may be necessary for others such as an individual with low IQ, regardless of age.

Psychodynamic therapy and adults

Classical psychoanalysis is a lengthy and intensive process involving 50-minute sessions up to five times a week (Arden, 2002). Within the NHS, there is limited but increasing provision for psychodynamic therapies offered as one session per week, for up to a year, with often considerably briefer time frames (Arden, 2002). Research conducted into the efficacy of psychodynamic therapy indicates broadly, that these approaches do benefit adults experiencing a variety of mental distress (Roth & Fonagy, 1996), particularly those with moderate depression (Hepple, 2004). Nonetheless, psychodynamic therapy is unsuitable for some adults including those with psychosis and it may even exacerbate severe depression (Arden, 2002).

The psychoanalytic roots of psychodynamic therapy were established by Freud (1856-1939) who pioneered psychotherapy by way of his analysis with adult patients. The

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therapeutic relationship in psychodynamic therapy focuses on the development of insight into repressed unconscious material from earlier life experiences and on the working through of this material in the therapeutic relationship (Hepple, 2004). Given these assumptions, the therapeutic relationship is of absolute and central importance and has been called the 'sine qua non' of effective psychodynamic therapy (Kivnick & Kavka) or the "*single most important precondition to the success of the process*" (Waterhouse & Strupp, 1984).

The therapeutic relationship in psychodynamic therapy is comprised of the real or conscious aspect of the relationship: the mutual human response of the patient and therapist to each other (Safran & Muran, 2000a), and the transference relationship. The relevance and meaning of the transference relationship has been long debated, but is taken here to mean the transferral of a relationship (often of a parent) onto the therapist. What is transferred is an unconscious element of a person's current internal world, developed from early patterns of relating, onto the present, external reality of the therapist (Leiper & Maltby, 2004).

Initially, transference was seen negatively within the therapeutic relationship as a problematic resistance, whereby patients replicated past experiences as a defence against recalling them. However, current psychodynamic thinking makes use of the transference as a tool in providing a directly accessible rich source of information about the patient's current and past interpersonal relationships (Waterhouse & Strupp, 1984).

Within psychodynamic therapy, countertransference is also used as a tool to provide information about the alliance between the individual and the therapist. Countertransference is assumed to provide a vital source of information about the client, gained by the therapist's own reactions and aroused feelings in response to the client (Leiper & Maltby,

2004). The strength of this contribution to the alliance is that it provides clues to subtle (perhaps non-verbal) aspects of the client that might otherwise lie outside the therapist's awareness. Indeed, a further assumption within the alliance of psychodynamic therapy is the use of Klein's (1946) notion of projective identification. Here, the assumption is that the client unconsciously projects unwanted or overwhelming feelings onto the therapist (Safran & Muran, 2000a). In theory, this allows the therapist to experience the disowned feelings, in the hope that they are is able to contain the projection and the client is able to recover these feelings in a detoxified form (Safran & Muran, 2000a).

The strength of these tools lie in their provision of a uniquely personal alliance that takes account of each client's individual past experiences and relationships. However, the very subjective, intuitive and almost ambiguous nature of these aspects make it difficult to evaluate in contributing to the therapeutic relationship. Therefore, rendering psychodynamic therapy as "*doomed to exclusion*" (p.292 Hinshelwood, 2002), from today's evidence based NHS.

Psychodynamic therapists may also vary considerably in the way and extent to which they use these tools within the alliance. Indeed, it may be difficult for trainee therapists to learn the psychodynamic approach, as by its very nature, it is gained through experience within individual alliances. There is also a danger for the therapist to use these concepts in disclaiming responsibility for their role in the interaction (Safran & Muran, 2000a).

In terms of the real, or non-transference aspects, as Anna Freud (1954) reminds us that "*we should leave room somewhere for the realization that the therapist and patient are also two real people…in a real personal relationship to each other*" (p.611). Indeed, if the client does not feel that the relationship is 'real' then the value of the interpretations made via the transference or countertransference, is diminished (Mackie, 1981). Bowlby (1975)

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considers that the requirement of an attachment figure persists throughout adult life, most evidently during times of uncertainty or distress. The role of a psychodynamic therapist may be seen as that of a 'temporary attachment figure' providing the patient with a 'secure base' (Mackie, 1981) or 'limited re-parenting' (Young, 1994). Mackie (1981) considers that if this attachment based need is met then the "*whole alliance is facilitated and consolidated*" (p.206). The therapeutic relationship in psychodynamic therapy is considered as a complex, dynamic entity. The numerous aspects of the therapeutic relationship may be difficult to evaluate since they are occur simultaneously at many different levels.

Psychodynamic therapy & Older Adults

Freud, (ironically at age 49), was erroneously convinced that "*near or above the fifties the elasticity of the mental process, on which the treatment depends, is as a rule lacking…Older people are no longer educable*" (p. 264, 1905). Early views of psychodynamic development considered that all important psychological development takes place in childhood and that individual personality structures are 'solidified' before the age of 20, rendering psychodynamic therapy as useless for older adults (Kivnick & Kavka, 1999).

Given the inherently developmental nature of psychodynamic therapy, current thinking however, seems to consider older adults as particularly suitable candidates; taking advantage of their "characteristic focus on the self and interior life as a unique age-related readiness for introspection, life review and reminiscence that are essential to the work of dynamic treatment" (p.111 Kivnick & Kavka, 1999). Similarly, Hildebrand (1990) considers that issues common to old age such as "*feelings of abandonment and despair, intimacy and isolation, arrogance and disdain*" are well suited to the psychodynamic model (p.250, Hildebrand, cited in Hunter, 1989). Psychodynamic therapy has broadly been found to be superior to no treatment and roughly equal in effectiveness to other types of treatment (Woods, 1999), despite the difficulties in evaluating the psychodynamic approach.

When working with older adults, it is recognised that there is a difference within the therapeutic relationship, as compared to working with adults. Genevay & Katz (1990) propose that it may be the changed nature of the transference and countertransference when the client is older than the therapist. In terms of the transference, the therapist may be seen as a child or even grandchild, rather than a parent (Knight, 1996). In terms of the countertransference, clients are more likely to be reminiscent of the therapist's parents or grandparents. Equally, however, transference spans the generations (Hepple, 2004) and a younger therapist may also be seen as having parental qualities. As with any client, whether they are a child, an adult or older adult, the therapist must strive to recognise and interpret this communication in an exploratory manner that is of benefit to the client. Although difficult, given the subjective nature of these interpretations, Knight (1996) proposes, that becoming more familiar with these unconscious feelings may be helped through self-observation, supervision and perhaps personal therapy (Knight, 1996). Woods (1999) again highlights the "*quintessentially idiosyncratic phenomenon*" (p.306), in each unique therapeutic relationship with another individual, regardless of their age as an adult or older adult.

I have observed in my work so far, with older adults with dementia, that there is often a yearning for previous attachments to parents who have died long ago, or 'parent-fixation'. In these instances, I would tentatively propose that the use of attachment based 'temporary re-parenting' may be helpful to these individuals. Although it may be difficult to work psychodynamically with individuals with severe dementia, to a certain extent, 'momentary re-parenting' can be seen to occur in validation therapy. Within validation therapy there is acknowledgement of the emotional reality of the person's experience in favour of an objective 'truth' (Feil, 1993).

Kitwood (1997) proposes a useful person-centred approach in regard to individuals with dementia. Here, an individual is not seen as 'the person with DEMENTIA', but as 'the PERSON with dementia'. I propose that similarly, this may be extended across the lifespan. Accordingly, each individual client within the therapeutic alliance is not defined by their mental distress, by physical disability or by their age, but seen as unique.

Interestingly, the termination of therapy with some older adults is often experienced as more difficult by the therapist than the older client. This may indicate the greater impact of the therapist's countertransference on the therapeutic relationship with an older adult. Or, as Knight (1996) considers, "*older clients have…had considerable experience with endings*" (p.76).

CBT & Adults:

The current Department of Health guidelines (2001b) consider CBT as efficacious, citing it as the therapy of choice for adults with many disorders from depression to deliberate self-harm (Holmes, 2002). The theoretical rationale behind CBT is that people's feelings and behaviour is largely determined by the way they perceive and structure their experiences, particularly concentrating on negative automatic thoughts (Beck, Rush, Shaw & Emery, 1979). Initially, the technical aspects of therapy were seen as the active ingredients which enable change, and the therapeutic relationship was regarded as a by-product of the actual therapeutic process (Beck, 1979). This could be potentially daunting for trainees learning to master the technical aspects of CBT.

A common criticism of CBT was that cognitive behavioural therapists pay little attention to the therapeutic relationship (Sanders & Willis, 1999). A good relationship was initially seen as necessary, but not sufficient alone for therapeutic change (Beck, et al 1979). However,

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research consistently reported that clients find the relationship with their therapist as more helpful than the techniques that were employed (Keijsers, Schaap & Hoogduin, 2000).

Currently, the therapeutic relationship is viewed more centrally and made more explicit, being more actively integrated within the therapy (Beck, Freeman et al, 1990), particularly within the newer generations of therapy that have evolved from CBT.

As in personal construct psychology where "*client and therapist work together as co-experimenters*" (Winter, 1992), in psychoanalysis, Freud (1895) referred to the patient being a 'collaborator' with the doctor. A central principle of CBT is the 'collaborative empiricism' (emphasised by Beck, et al, 1979) that innately assists the establishment and maintenance of a good therapeutic relationship. Beck, Emery & Greenberg (1985) proposes that the therapist should not play the role of the expert, rather that client and therapist should work together to set therapeutic goals. The client is the expert on their thoughts and experiences, whilst the therapist provides structure and expertise in how to solve problems (Beck, et al 1985). Thus, CBT aims to avoid 'hidden agendas'; all aspects of the therapy are openly discussed with the client. Although CBT strives to establish an equality between therapist and client, as Lowe (1999) considers, perhaps equality within therapy is impossible given "*the power embedded in the institutional role of the therapist*" (p.83). For example, clients who expect that their expressed thoughts may lead to hospitalization and ECT are unlikely to be forthcoming (Safran & Segal, 1990).

CBT has built-in features that enhance and appreciate the importance of the therapeutic relationship by continually asking for feedback and considering in detail the clients view of the problem (Beck, et al 1985). Throughout, Beck stressed the importance of showing Rogerian qualities to the client. Indeed, Persons (1989) proposes that the therapeutic relationship can be used as a 'laboratory for testing beliefs' by the therapist's use of

moment-to-moment formulation and hypothesising about the client's difficulties. Formulation allows the therapist, in conjunction with the client, to individually tailor the intervention taking into account the client's unique history, life experiences and needs.

Indeed, CBT therapists have been found to employ relationship skills at least as much as other oriented therapists and there is no evidence to suggest that they are colder or more mechanical with their clients (Keijsers, Schaap & Hoogduin, 2000). CBT therapists seem to take a middle-ground with regards to the therapeutic relationship, taking care not to overpower clients with 'too much' sincerity, particularly if they are very depressed (Beck et al, 1985).

CBT & Older adults

CBT has been a staple for older adults for many years, and is the most researched and accepted treatment especially for depression and anxiety (Abeles, 1997). Numerous meta-analyses demonstrate the effectiveness of CBT for older adults, even when combined with medication and applied to more complex cases (Hyer et al, 2004).

Ageing is associated with cognitive slowing, yet, in CBT, the performance of older adults is sufficient to most tasks (Wetherell, 2002). Indeed, contrary to prior belief, older people do continue to learn (Laidlaw, Dick-Siskin & Gallagher-Thompson 2003). Actually, perhaps because of higher attendance and lower dropout rates, older clients have been shown to respond more quickly than younger ones (Walker & Clarke, 2001).

Although older adults may be considered as ideal candidates for CBT since they often de-emphasize the past and the future and live life in the present (Woods, 1999), it may take some time for older adults to adapt to the collaborative nature of CBT which gives

responsibility to the individual for their problem, in contrast to the medical model where responsibility for being unwell is taken away from the person (Woods, 1999). However, it may be proposed that numerous adults also find it difficult to adapt to collaborative nature of many talking therapies. Again, this may be seen more as a function of the individual, rather than of their age.

Interpersonal Therapy:

The interpersonal approach uses the strengths of both CBT and the psychodynamic approaches, and combines these in a manner that appreciates the potential use and importance of the therapeutic relationship. This approach recognizes the importance of the therapeutic relationship and uses it as the central focus of treatment, regardless of the age of the client (Safran & Muran, 2000b). More specifically it views the exploration of 'ruptures' or breaches in relatedness within the therapeutic relationship, (as are inevitable within therapy) at the fundamental heart of therapeutic change. Safran (1990) proposes the use of 'interpersonal markers' where the therapist uses their own feelings (similarly to countertransference in psychodynamic therapy) to pinpoint specific client behaviours, as an ideal juncture for cognitive exploration. Traditional aspects of CBT, such as the emphasis on the collaborative approach and encouragement of continuing work between sessions, are also employed.

Ruptures can be viewed as a 'window' into understanding the client's characteristic construal patterns (Safran, 1998). The interpersonal perspective takes account of our human goal in maintaining relatedness to others throughout the lifespan (Bowlby, 1969). It considers that repeated ruptures may enact the type of vicious cycles that are thematic of the client's other relationships in the real world. However, the extent to which the therapeutic relationship generalises to other relationships in the client's life is always kept as an open question (Safran & Muran, 2000b). This allows therapists to approach clients in

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a 'non-blaming fashion' and allows the recognition that accepts the therapist's responsibility for their own contribution to the interaction (Safran & Muran, 2000b).

In addition, any rupture within the alliance must be considered to varying degrees as a contribution from both client and therapist (Safran, 1998). Indeed, regardless of model, the enormous contribution of both therapist and client characteristics separately, as well as the way that these characteristics interact, are perhaps the most crucial elements with regards to the establishment and maintenance of the therapeutic relationship (Ackerman & Hilsenroth, 2003).

Metacommunication

Usefully, Safran & Muran (2000b) propose the use of 'metacommunication'. Within metacommunication, the therapist 'invites' the client to step back from the process and examine or metacommunicate about what is currently going on between them. This also allows for the recognition of the ongoing nature of the therapeutic alliance. The relationship is not static, it is constantly changing. As Safran & Muran (2000b) propose, "*what was true about the therapeutic relationship a moment ago is not true now*", (p.239).

Metacommunication also allows the therapist to notice other important aspects that contribute to the therapeutic relationship. In infancy, non-verbal communications such as voice tone and facial expression are key. This mechanism remains into adulthood as an important portrayer of feeling in interpersonal relationships (Mackie, 1981). For example, Safran & Muran (2000b) describe a clinical vignette:

> "*The first few months of therapy went very well…the therapist found himself looking forward to the client's visits. He developed a sense that they were in tune with one another. In fact…on more than one occasion they seemed to be*

unconsciously swiveling their chairs back and forth in rhythm with one another,
as if in reflection of their mutual attunement" (p.110)

Indeed, the non-verbal aspects of both the client's and therapist's behaviour may be crucial, as a communication in providing information about the state of the alliance from moment to moment.

Conclusion:

It has been argued throughout this essay that the key importance to establishing and maintaining an effective therapeutic relationship in order to establish therapeutic change lies in the individualisation of each alliance with each client. Whether through the interpretation of the transference, countertransference and real elements of the relationship in psychodynamic therapy or the thought and activity monitoring and formulation of CBT, the therapist must tailor their approach to best suiting the client, regardless of age or disorder. I hope that I have managed to convey to some extent, as Bordin (1976) proposes, the complex, dynamic and multi-dimensional nature of the therapeutic alliance. Given the vital importance of the therapeutic process in aiding therapeutic change, I propose that trainee therapists should certainly pay the therapeutic relationship as much attention as learning how to implement specific techniques.

Waterhouse & Strupp (1984) consider, the "*conceptualization of psychotherapy as an exquisitely interpersonal endeavour*". This highlights the nature of the uniqueness of each therapeutic relationship, as well as each therapeutic interaction including non-verbal aspects (Hyer et al, 2004). This also draws attention to the concept of the therapeutic relationship as en entity which is not static, but constantly in flux and ever changing. Just as Jung (1933) likens a meeting between two people to a chemical reaction, Hyer et al (2004) describe the interactions between the therapist and the client as creating a "*synergistic chemistry*" that influences the strength and role of the relationship between them.

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Knight (1996) points out that "*psychotherapy is perhaps the only intimate relationship that is intended from the beginning to have an end*" (p.77). Although a therapeutic relationship must end "*if successful, the therapist is never lost altogether; he remains with the patient*" (p.211, Mackie,1981).

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Title:

Discuss the use of systemic and psychodynamic approaches for people with learning disability. What are the potential dilemmas and challenges faced by a clinical psychologist when using these two approaches with learning disabled people, and how can they be addressed?

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"*People with learning disabilities suffer distress no less than those without: Indeed, more so, and they are equally entitled to relief*"

(Prosser, 1999)

Learning disability is a government recommended and socially constructed term for people with an IQ below 69 (Hodges, 2003). The learning disabilities range is further divided into mild (an IQ between 55 and 69), moderate (40-55), severe (20-40) and profound (less than 20), (Hodges, 2003). An additional defining feature of learning disability includes significant impairment in adaptive functioning, which started before adulthood, with a lasting effect on development (Valuing people, Department of Health, 2001). Individuals with learning disability are a heterogeneous group of people with various degrees of intellectual impairment (Hodges, 2003). The measurement of IQ in isolation is not enough since this is subject to fluctuations for example as a result of emotional difficulties (Fredman, 2006). Consequently it may be useful when working with individuals to also take account of their overall functioning and emotional states (Hodges, 2003).

At the turn of the twentieth century Freud (1904) stated that "*a certain measure of natural intelligence and ethical development are to be required*" for talking treatment approaches. The effect of Freud's perspective was long-lasting, and historically, learning disabled individuals have had little or no access to psychotherapeutic interventions (Willner, 2005). The focus of this essay is concerned with individual rather than group interventions.

Initially the historical, social and political context in the United Kingdom will be considered, then the challenges and dilemmas of systemic therapy and psychodynamic therapy, concluding with the consideration of difficulties that are common to both approaches.

There is a distinction between a challenge, defined as "*a demanding or difficult task*" and a dilemma, defined as "*a situation in which a choice has to be made between alternatives that are both imperfect*" (Oxford English Dictionary, 2000). Clinical psychologists face huge numbers of both of these when using systemic and psychodynamic approaches with learning disabled people. It is beyond the scope of the essay to consider all aspects of these approaches and the key challenges and dilemmas are considered here.

Historical, Social & Political Context:

It is important to consider the culture and history of the group to which an individual belongs, in addition to their personal history (Hodges, 2003). Earliest records document cruelty such as infanticide, practiced on those with learning disabilities over centuries (Barnes, 1994). During the period between medieval times and the nineteenth century learning disabled individuals were classified either as 'lunatics' or 'idiots' (Andrews, 1996). Towards the end of the nineteenth century learning disabled individuals were institutionalised on a large scale as they began to be seen as a threat to society (Hodges, 2003). Although considered a short-term measure this tended to becomes a life-long incarceration to prevent reproduction, as learning disability was viewed as organic and inheritable (Baum, 2006).

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Within the twentieth century, the perception of learning disabled individuals began to change and the view of these individuals as threatening became less prevalent (Hodges, 2003). However the focus was still on deficiency rather than ability (Fredman, 2006). During the 1970's the work of Wolfensburger (1972) encouraged 'normalisation' which minimised difference and promoted the rights of individuals with learning disability (Hodges, 2003). The combination of the 1971 Education Act which stated that 'no child is ineducable', the scandal of institutionalisation mistreatments, and a 1971 White paper which encouraged increasing community care, all contributed to a large impact on services and attitudes (Hodges, 2003). Gradually the large institutions have been closed down and these individuals have moved into community care or are living with their families (Baum, 2006).

Currently, the most recent white paper 'Valuing People: A new Strategy for Learning Disability in the 21st century' (Department of Health, 2001) further emphasises the principles of rights, independence, choice and inclusion (Baum, 2006). This also encompasses changing attitudes to the provision of psychological therapies for these individuals.

Changing Philosophies of Care:

Until relatively recently, behavioural and pharmacological methods of treatments for individuals with learning disability dominated the twentieth century (Baum, 2006). In the 1960's a popular view was that all behaviour was trigged by environmental events and this shaped the nature of behavioural interventions (Hodges, 2003). During the 1980's hard-line behaviourism began to consider the needs and rights of the individual as interacting with their environment and developed as an approach (Baum, 2006).

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The development of talking treatments with people with learning disability came about in the 1980's in light of the change in the social and political climate (Baum, 2006). Cognitive-behavioural models and psychotherapeutic models have gained acceptance in psychological services (Baum & Lynggaard, 2006). Indeed Stokes and Sinason (1992) describe how cognitive and emotional intelligence are not necessarily linked. Thus it is possible for emotional intelligence to develop age appropriately whilst still being severely cognitively impaired. This valuable contribution increased the use of psychological therapies being conducted with the learning disabled population (Stokes & Sinason, 1992).

However the provision of psychological therapies still remains under-resourced and patchy throughout the UK, particularly in relation to other client groups (Baum, 2006). This is despite the fact that there are higher incidences of mental health difficulties within this population (Hodges, 2003). Indeed there are no current National Institute of Clinical Excellence or Department of Health guidelines recommending particular psychological therapies for specific mental health difficulties for learning disabled individuals. This is in contrast to every other client group that clinical psychologists work with and is related to the difficulties in conducting research within the learning disability population. This will be considered later on in this essay.

Challenges & Dilemmas of Systemic Approaches:

The concept of 'systemic' approaches have changed and evolved over time and have guided the thinking and practice of clinical psychologists (Fredman, 2006). For the purposes of this essay, the systemic approach has been considered as:

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"explor(ing) the networks of significant relationships of which each individual is a part, considering the beliefs that give meaning to people's actions and the communication patterns between people as they interact with each other and with each other's ideas"

(p.4, Kensington Consultation Centre, 2004)

Systemic therapists often work in teams with families, carers and wider system members. Additionally, systemic approaches can be used by a psychologist with one individual.

Life-Cycle Issues:

Carter and McGoldrick's (1989) "family life-cycle" theory identified a series of life-cycle transitions that families negotiate such as the birth of a child and children leaving home. Their theory considers how stressors can facilitate or hinder the process of transition (Baum, 2006). Vetere (1993) considers that the sequence of life events is often different where one member has a learning disability and life-cycle transitions often appear out of synchrony with non-learning disabled peers. This poses a challenge for a clinical psychologist of being aware and taking into account the unique circumstances of each family with a learning disabled member. Indeed, since the lifespan of individuals with learning disability now approximates to that of the general population (Grant, 1990) more and more clients may be outliving their ageing parents. Thus clinical psychologists must be aware of the prevalence of issues of grief and loss when working with this population (Baum & Lynggaard, 2006).

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Given that many learning disabled individuals live within family settings, there is a strong rationale for working with a client and their family or carers rather than the client in isolation (Roy-Chowdhury, 1992). Simultaneously clinical psychologists may be challenged by the complex network that often surrounds the client with competing ideologies about what should be offered (Petty, 2002). It may be difficult for the client to be heard amongst the network and there is potential for them to become passive recipients of what is considered best for them (Petty, 2002). In order to address this, clinical psychologists should be mindful of actively involving clients in the process of therapy as much as possible and involving the client, family, carers and referrer to regular network meetings.

Clinical issues:

Pote (2006) proposes that a key dilemma within clinical work is how to position oneself in relation to the client, the family and the wider system? Thus, aligning oneself with the learning disabled client perhaps due to concerns about how the wider system was meeting the client's needs, poses a dilemma. It may be difficult to remain aligned and work systemically while maintaining a curious and non-blaming stance towards all system members. In addressing this dilemma it may be necessary to consider the function of the alignment. Pote (2006) considers that a triangular pattern of protection between parents, the client and the wider system is common, with each trying to protect each other from distress. In order to facilitate the therapeutic process these feelings could be usefully connected in conversations with clients and their families, to the general relationship patterns that commonly develop between families and systems (Pote, 2006).

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Furthermore there is a dilemma as to how to position oneself in relation to collaborating with clients or taking an 'expert' role (Pote, 2006). Giving advice is regarded by some clinical psychologists as poor practice, yet Structural Family Therapy (Minuchin, 1974) proposes that the provision of information to families is integral. Furthermore, interactions with the wider system often require the clinical psychologist to offer an expert opinion (Pote, 2006). However, the socio-political context of discrimination towards learning disabled individuals means that there is already a power imbalance between the client and wider society. Thus there is an increased need for the therapist to address this power imbalance by collaborating with clients (Pote, 2000). Although there is recognition of some of the value of structural techniques that may be eclectically incorporated, there should be a tendency towards collaboration rather than an expert stance.

Techniques:

The view that systemic therapy is only for the verbally articulate may pose a challenge for clinical psychologists. However, there is little evidence base for this view and most learning disabled individuals have sufficient verbal ability to engage therapeutically (Fidell, 2000). Indeed, including the client in the session regardless of their ability, also empowers clients, reduces discrimination and allows us to observe the pattern of interaction that surrounds the reported problem (Fidell, 2000). An additional method of overcoming this issue is to encourage the client to talk, perhaps by establishing ground rules at the outset, for example "how will you tell us when you want the session to end?" Even when there is little verbal participation the clinical psychologist should pay close attention to their non-verbal behaviour (Fidell, 2000).

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Aspects of systemic therapy such as the need for abstract thinking and the mapping of themes or relationships across time, may be a challenging problem for the clinical psychologist (Pote, 2006). Carr (1994) proposes a method of overcoming these difficulties via the use of drawings, role-plays, symbols and life stories or pictorial accounts. By simplifying the way questions are put, the cognitive demands of the relational dialogues can be reduced (Fredman, 2006). Lynch (2004) suggests further modifications such as simplifying language, presenting information more slowly, checking for comprehension of concepts and shortening therapy sessions. Fidell (1996) describes the use of 'circular showing' as an adaptation to circular questioning, thus the ability to step outside a relationship and observe it in operation. Using genograms empowers clients as they can often give information about their family (Fidell, 2000). The need for abstract thinking may pose one of the largest challenges in the use of systemic approaches and Pote (2006) proposes that "*further critical analysis of the underlying theoretical model is warranted to develop its applicability*" (p.175)

The use of a reflecting team provides a dilemma for the clinical psychologist. Fidell (2000) proposes on the one hand that the use of a reflecting team may be limiting since it risks confusing and disempowering clients with a multiplicity of opinions, rather than a clear message. On the other hand a learning disabled client may find the experience liberating since they often hear themselves being talked about and are not supposed to listen and this may provide a novel experience (Fidell, 2000). Again this may be an issue that is considered on a case-by-case basis.

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Psychodynamic Approaches:

Psychodynamic approaches are derived from psychoanalytic psychotherapy and made up of several core aspects (Hodges, 2003). Most psychodynamic approaches consider that contact with clients' emotional experience is in the 'here and now' of the session (Simpson & Miller, 2004). The clinical psychologist closely observes the client's behaviour and speech (if any) and observes the feelings that are evoked in them, by the client (Simpson & Miller, 2004). By following these evoked feelings, or the countertransference over time, the psychologist can build up a picture of the transference or a living memory of the client's early relationships with important figures as experienced in the here and now (Simpson & Miller, 2004).

There is also a belief in the importance of the unconscious, or aspects of our functioning that we do not have direct access to, that may influence how we feel and behave (Hodges, 2003). The last aspect of the approach is that we all develop a range of defences in order to keep from developing a more conscious awareness of what our unconscious contains (Hodges, 2003). The aim of the psychodynamic approach is to enable the movement of these unconscious feelings into greater consciousness and in the process, to alleviate some of the distress associated with the unresolved feelings (Hodges, 2003).

Early Relationships:

The importance of early relationships may take on greater significance with those born with learning disabilities since there is often a disturbance in the relationship between a mother and learning disabled infant from birth (Emmanuel, 2004). After the birth, Bicknell (1983) likens parents' responses to those of grief suggesting that stages need to be gone through in

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order to make an adjustment to the child with a disability. However these feelings are rarely processed since the grief cannot even be thought about or contained (Emmanuel, 2004). Thus projections into the baby of disappointment or even disgust may occur, resulting in these children having internalised a disappointing and rejecting object and perhaps difficult patterns of attachment (Emmanuel, 2004). Korff-Sausse (1999) considers that this may be why grief reoccurs with intensity at key points in their child's life since the process of mourning is incomplete. This presents a challenge for clinical psychologists since it may be that the parents own emotional needs and unfinished mourning may need to be addressed before they can provide an adequate emotional holding space for their learning disabled child.

Furthermore, it is likely that an individual may be rejected not just within their families but also by wider society which projects feelings of inadequacy, ugliness and insecurity into the learning disabled population (Hodges, 2004). This may present an overwhelmingly enormous challenge, perhaps not just for clinical psychologists, but to society at large to overcome the negative associations and stigma attached to learning disabilities.

Transference & Countertransference:

The use of the transference and countertransference allows for working with individuals with more severe and profound learning disabilities who are less verbal. Indeed the importance of the countertransference becomes paramount when working with those who are unable to verbalise their feelings (Hodges & Sheppard, 2004). Working with the 'here and now' also addresses the difficulty of needing to think abstractly over time as encountered within systemic therapy. However there are several challenges for the clinical psychologist such as managing their own feelings that are evoked. Emmanuel (2004)

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describes her feelings of overwhelming shock and disgust after meeting with a severely learning disabled client. Lych (2004) considers *"psychotherapists are not immune to negative thoughts, feelings or attitudes…sometimes we are repulsed by a client's appearance, mannerisms or poor hygiene"* (p.401). However these feelings proved useful as it helped Emmanuel (2004) to imagine the impact of the first meeting between the client and her mother. Thus, it may be difficult to manage these unwanted feelings that are evoked within us, however their use may be invaluable. A way of managing these difficult feelings is to firstly allow ourselves to experience them. (Emmanuel, 2004). Secondly, the use of supervision and personal therapy may allow time to reflect and process these feelings, making a difference in how these complex emotional relationships can be understood (Hodges, 2003).

Alvarez and Reid (1999) consider the challenge of countertransference when working with people with autism. They propose that these individuals do not evoke the same feelings, since a core aspect of their difficulties is with a 'lack of feeling' so the psychologist must work extra hard to notice the small details that may provide clues as to how the client is feeling. Indeed *"the therapist must have a mind for two, energy for two, hope for two, imagination for two. Gradually patients may begin to get interested, not yet in us, but in our interest in them"* (p.7 Alvarez & Reid, 1999)

Defences:

Identifying defence mechanisms within the psychodynamic approach is an important aspect in helping clients to recognise unhelpful unconscious processes (Hodges, 2003). Defence mechanisms such as projection, projective identification, denial, dissociation, regression and repression can be identified both through the transference relationship and the client's

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behaviour (Hodges, 2003). In learning disability additional defences have been identified such as a 'secondary handicap' which is a process when the primary disability is exaggerated as a way of defending oneself against painful feelings of difference by consciously or unconsciously exaggerating aspects of their disability (Sinason, 1997).

Defences are employed to cope with distress and serve to protect us against uncomfortable and painful feelings (Hodges, 2003). However when defences are used over-rigidly or prevent development, they may become problematic (Hodges, 2003). The dilemma for a clinical psychologist lies in addressing an individual's defences. This may present a dilemma for any population but appears particularly important in learning disability due to the employment of additional defences. For example Emmanuel (1990) urges the need for caution since catastrophic anxiety may lie behind an individual's defences. Emmanuel (1990) advocates that the protective nature of defences should be respected and not challenged harshly. Indeed, Sinason (1999) describes how important it is to allow enough time for this work as stopping treatment early may leave a client without their defences, with their anxiety exposed and with reduced means to defend against its effects.

Dilemmas & Challenges Common to Both Approaches:

There are a number of common dilemmas and challenges that apply to both approaches. Firstly, on a very practical level clients often struggle with additional health problems and accessing services may be problematic (Pote, 2006). Indeed, it may be important to address clients' and their families' practical needs before emotional needs can be considered (Vetere, 1993).

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Ethical Difficulties:

There are particular areas of ethical concern that may be a challenge for a clinical psychologist when working with learning disabled individuals (Lynch, 2004). As applies to all client groups, a psychologist must ensure that a client gives their full and voluntary consent for treatment as well as research purposes (Lynch, 2004). It may be that individuals with learning disabilities may agree to undergo treatment without fully understanding what the treatment entails or may feel under duress from family or system members to comply (Lynch, 2004). In relation to research, Arscott et al (1998) investigated the issue of consent with 40 individuals with a range of mild to severe learning disability and found that although they appeared to understand what the study was about, had less understanding regarding the risks and benefits of research or of their right to refuse or withdraw. This is in keeping with the perception of those with learning disability as having a tendency to please others (Hodges, 2003). In relation to confidentiality, clinical psychologists must be aware of the potential for dilemma, particularly in systemic work. Clinical psychologists should be mindful of sharing information which may perpetuate a client's infantilisation or undermine their independence (Hodges, 2003). In order to avoid ethical difficulties a clinical psychologist should clarify roles and expectations as early as possible (Lynch, 2004).

Service Provision:

The client's motivation for attending therapy must be considered. This may pose a considerable challenge for both approaches if clients are not motivated to attend therapy and may raise the question of 'whose problem is it?' For example if a client is escorted by carers to sessions, there is the dilemma as to whether the problem is with the client or the wider system (Hodges, 2003). If the problem is with the wider system it places the clinical

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psychologist in an ethical dilemma as to whether or not to intervene. A way of overcoming this may be by means of careful assessment before a therapeutic intervention is undertaken. An additional solution to address this issue could be by supporting the wider system to address the issue by offering consultation and support.

Another challenge may be the change in the client whilst they are undergoing an intervention. Clients may become more able to express their feelings and perhaps more uncooperative with care staff (Hodges, 2003). This may be addressed once again by a clinical psychologist offering indirect consultation to the system.

A large challenge for clinical psychologist may be in relation to the ending of therapy, which may be difficult for the client, their family and the therapist (Pote, 2006). Underlying this challenge may be the struggles common to life-cycle issues such as difficulties in establishing independence (Pote, 2006). Ways of overcoming this challenge could be to define successful outcomes at the start of therapy and to integrate support across the life-cycle in order to prevent ongoing relationships with services being pathologised. Fredman and Dalal (1998) consider that we should empower families to help them to draw on their own resources.

Given the often slower pace of working with individuals with learning disability (Fidell, 2000) the pressure to provide short-term efficacious and cost-effective treatments provides clinical psychologists with enormous challenges. One method of addressing this challenge is to provide booster sessions as well as working indirectly giving consultation to agencies

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in the wider system (Lynch, 2004). Further difficulties of needing to gather an evidence base will be considered below.

The Challenge of Research:

One of the largest challenges for both approaches is providing the evidence that they are productive and a worthwhile use of limited resources (Hodges, 2003) particularly in the current climate of the NHS. Indeed evidence-based practice is an integral aspect of clinical governance (Hodges, 2003). However the literature reporting outcomes of psychotherapeutic interventions with individuals with learning disability is extremely limited, with a particular lack of randomised controlled trials which are considered the most superior design (Willner, 2005). There is also little evidence of process research on the specific helpful components of therapeutic packages or the optimal manner of delivering therapies (Willner, 2005). The vast majority of published material is almost entirely regarding behavioural interventions or single case studies (Hodges, 2003). Although informative about process, single cases do not allow generalisation or replication to occur (Hodges, 2003).

Outcome Studies:

A large systematic review of 98 studies looking at the effectiveness of various psychotherapies concluded that they are "moderately" effective for individuals with learning disability, however many studies were of 'poor methodological design' (Prout & Nowak-Drabik, 2003). In relation to psychodynamic approaches Beail has designed several studies (Beail 1995, Beail 1998, Beail & Warden 1996 and Beail 1998) set up to measure the effectiveness of psychodynamic approaches with adults with learning disability.

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Outcomes appear positive with problem behaviours eliminated and maintained at six-month follow up (Willner, 2005). Bichard, Sinason and Usiskin (1996) published the positive results of a three-year study considering the effectiveness of psychoanalytic psychotherapy with adults with learning disability in comparison to a matched control group. Interviews demonstrated that symptoms had 'improved or disappeared' in comparison to the control group whose symptoms had 'worsened or stayed the same'.

In relation to systemic approaches, randomised controlled trials exploring the usefulness of systemic therapy are, as yet, likely to be a distant vision (Lynggaard & Baum, 2006). This is due to the population of learning disabled individuals being small and the number of practitioners working systemically, even smaller (Lynggaard & Baum, 2006) as well as the methodological challenges considered below. There are increasing descriptive accounts of the value of systemic therapy (Lynggaard, 2006). Furthermore qualitative studies such as Arkless (2005) who evaluated families' experiences of systemic therapy, Pote (2004) who investigated therapists' accounts of systemic therapy and Baum and Walden (2006) who evaluated the effectiveness of systemic therapy within a community setting, provide some evidence of the effectiveness of systemic therapy for the learning disabled population. It may be important to consider that although there is little current outcome of process research it does not therefore follow that the approach is ineffectual (Baum & Lynggaard, 2006).

Methodological Challenges:

Methodological problems with many studies include their small samples sizes, small or absent control group and difficulties gaining meaningful outcome measures (Hodges, 2003). One way of addressing the issue of small sample sizes would be for departments to

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link up to create larger possible samples, although this presents further challenges such as ensuring equitable treatments are provided within each department (Hodges, 2003).

In relation to meaningful data-gathering, there are limited standardised assessments for people with learning disabilities, whilst others tend to require some level of verbal or reading skill (Hodges, 2003). Beail (1996) describes adapting questionnaires into interview formats as a way of overcoming this challenge, however this may interfere with any standardisation data, making interpretation and comparison of the results difficult (Hodges, 2003). Additionally there is the suggestion that people with learning difficulties have a tendency towards acquiescence thus rendering the data questionable (Fidell, 2000). However Lindsay et al (1994) conducted an experiment to investigate the consistency of learning disabled individual's reports of their feelings and emotions. It indicated that self-reports by individuals may be considered extremely reliable and valid (Lindsay et al, 1994). This investigation however, and many others, relies on learning disabled participants with some degree of verbal ability, both receptive and expressive (Hodges, 2003). This also inadvertently excludes those with limited verbal skills and the ensuing results cannot be generalised across the whole client group. Additionally interview and rating components often require the client to think retrospectively which would be affected by any organic and emotional impairments to memory or difficulty conceptualising events in the past (Hodges, 2003). This would again render the meaning of the data questionable.

Although there are numerous challenges in conducting research into this area they are not insurmountable (Hodges, 2003) and it is vital that efforts continue to gain meaningful and comparable results. Hodges (2003) proposes that rich and invaluable data can be generated from small qualitative studies in order to guide practice or future research. Additionally

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clinical audits may provide helpful feedback on services' outcomes (Davenhill, 1998). Lindsay et al (1994) encourage the use of multiple measures of the same components, whilst Kazdin (1994) proposes that outcome studies are most effective if they make measurements across several areas such as cognitive, emotional and behavioural. Other outcome measures such as repertory grid techniques can be employed or projective tests such as the 'Draw-a-Person' (DAP) test (Hodges, 2003). For the DAP test it is considered that changes in drawings can reflect changes in thinking which may infer some form of internal development (Machover, 1949)

Although they cannot be generalised, the value of single case designs, cannot be dismissed. Given that learning disability impacts individuals in very unique ways it may be appropriate that therapeutic interventions are uniquely evaluated. Additionally there is the suggestion that single case designs may provide an important role in building bridges between psychodynamic and other approaches (Hodges, 1999).

As Beail (1998) advocates, the importance of researchers working in clinical practice is paramount and it appears that practice-based evidence seems to be the best way forward for further research into the efficacy of psychological interventions and specific process components of therapy. Indeed alongside treatment efficacy and effectiveness many factors need to be taken into account such as client choice, practical arrangements, current life events and stages of the family members (Hodges, 2003).

Discuss the use of systemic and psychodynamic approaches for people with learning disability. What are the potential dilemmas and challenges faced by a clinical psychologist when using these two approaches with learning disabled people, and how can they be addressed?

Conclusion:

It is apparent that there has been a gradual move towards providing talking treatments for learning disabled individuals, and they are no longer judged as a homogenous group who are unable to benefit (Hodges, 2003). However the increased use and evaluation of different approaches is still in its infancy (Baum, 2006).

As considered throughout this essay there are numerous challenges and dilemmas present in both psychodynamic and systemic approaches. As Fidell (2000) proposes it may be that where there is a lifelong disability no one model in isolation is appropriate. The World Health Organisation (1992) point out the importance of holistic approaches to understanding individual need which look at several aspects of a person's functioning within the context of their life and relationships. There have been many suggestions for addressing the challenges and dilemmas that both approaches present for a clinical psychologist. It may be that each client undergoes an individualised assessment to help determine the necessary adaptations to maximise their strengths and minimise their deficits and identify the required modifications (Lynch, 2004).

It is important to remember that this essay has been considered from a Western cultural perspective of the notion of learning disability. The perspective have been extremely different in parts of Africa, where disabled people are regarded in high esteem as spiritual gifts and are thought to have special powers (Fidell, 2000). Additionally in the United Kingdom, the uptake of psychological services by learning disabled individuals from ethnic minorities is notoriously poor (O'Hara, 1999). The challenge of developing culturally sensitive services for those from minority ethnic backgrounds should be high on the agenda and addressed as soon as possible.

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Discuss the use of systemic and psychodynamic approaches for people with learning disability. What are the potential dilemmas and challenges faced by a clinical psychologist when using these two approaches with learning disabled people, and how can they be addressed?

When Freud (1904) considered that talking treatments were unsuitable for learning disabled individuals, he did continue to state "*I do not regard it as by any means impossible that by suitable changes in the method we may succeed in overcoming this contraindication*" (p.264). It does appear that we have come some way in overcoming this assumption, however it is clear that there is still a considerable way to go. As Sinason (2002) proposes there is a "*need for continuing professional humility and toleration of uncertainty*" (p.424).

Discuss the use of systemic and psychodynamic approaches for people with learning disability. What are the potential dilemmas and challenges faced by a clinical psychologist when using these two approaches with learning disabled people, and how can they be addressed?

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Small Scale Service Related Project

Title:

"Audit of the Availability of Psychological Therapies to Older People in Community Services"

Word Count: 4,796

Abstract:

This audit considered the availability and accessibility of psychological therapies and talking approaches to older adult service users (defined for the purpose of this audit as aged 65 years or over) in community settings in relation to the national standards. Additionally it considered the supervision and training needs of staff providing the therapies. A specifically designed questionnaire was developed as a tool to address the proposed audit questions and this was distributed to all trust staff members identified as working with older adults with mental health needs within community and day hospital settings. A response rate of 51.4% was obtained and nine disciplines were represented within the audit (occupational therapists, psychiatrists, psychologists, nursing staff, support workers, social workers, care co-ordinators and care assistants.) A range of therapies were identified as available, although the most common type (provided by 71%) was identified as therapeutic conversation, or a talking approach perceived by the mental health practitioner as beneficial to the service user's mental health. Only 18% were providing formal psychological therapy. The most striking result was that 80% of participants indicated that access to psychological therapies is unreasonably restricted by waiting lists. In relation to supervision, 22% of participants receive supervision for therapies specific to older adults, 13% receive supervision for formal therapy and 43% receive supervision for therapeutic conversations. 12 participants (17%) indicated that they are not utilising skills they possess in relation to therapy provision and 56.9% indicated that they would like to receive further training. Overall, the audit indicates that the provision of psychological therapies does not meet the requirements suggested by national standards. A number of recommendations have been suggested such as setting up a clinical governance strategy to monitor therapy provision. This includes ensuring that therapists are adequately trained, receive regular supervision and continuing professional development is programmed into their work, thus reducing waiting lists and ensuring that older adult service users are not discriminated against.

Audit of the Availability of Psychological Therapies to Older People in Community Services

Introduction:

"Older people with mental health problems deserve the kind of service we would want for our family members and ultimately for ourselves"

(p.4 Everybody's Business, 2005)

National Context:

Currently, approximately 18% of the UK population are aged 65 and over (defined for the purposes of this audit as 'older adults') and current demographic changes indicate that older age groups are growing most rapidly (Psige, 2006). Conservative estimates of mental health problems in older adults suggests a prevalence of perhaps 40% of people attending their GP, 50% of general hospital inpatients, and 60% of care home residents (Everybody's Business, 2005). Therefore the challenge of delivering *"non-discriminatory mental health services available of the basis of need, not age"* (Everybody's Business, 2005) becomes ever greater.

Best practice guidelines from the DoH state that *"psychological therapies are part of essential health care"* and recommend that *"they should be routinely considered as a treatment option when assessing mental health problems"* (p.49, Everybody's Business, 2005). Indeed, *"users of mental health services consistently place access to psychological therapies at the top of the list of their unmet needs"* (p.49, Everybody's Business, 2005). Improving the availability and accessibility of psychological therapy has therefore become a focus of government agenda (Department of Health, "DoH", 2004) and consequently a focus of local agendas.

Audit of the Availability of Psychological Therapies to Older People in Community Services

The term 'psychological therapies' covers a wide range of models. These include psychodynamic, cognitive-behavioural, arts-based and systemic approaches (p.49, Everybody's Business, 2005). These may be provided by a range of professionals within the NHS. There is now a wealth of evidence supporting the contribution of psychological therapies in the treatment of older people with mental health problems (Woods, 1999). Furthermore, "*it has been demonstrated that the person's age is not an important factor in the choice of therapy*" (p.49 Everybody's Business, 2005). In addition, the audit wished to capture the use of less formal talking approaches, defined for the purpose of the audit as 'therapeutic conversations'. The definition of this for the purpose of this audit includes "the use of a talking approach between a mental health practitioner and service user that is not a formal therapy but is intended or perceived by the mental health practitioner to be beneficial to the service user's mental health". A previous audit in adult mental health indicated that this was the most common type of therapy used.

Dementia and depression are the major mental health problems encountered amongst older people (Woods, 1999). Depression is estimated to be present in around 15% of older people and dementia affects 5% of people over 65 and 20% over 80 (p.6 Everybody's Business, 2005). Psychological therapies for the treatment of dementia have been developed over the last 35 years and include therapies specifically developed for older adults such as Reality Orientation, Reminiscence Therapy and Validation Therapy. The evidence base continues to develop in this area, (Spector, Davies, Woods & Orrell, 2000), and there are recently published guidelines (2006) by the National Institute for Clinical Excellence ("NICE") on dementia care. NICE has also recommended types of psychological treatment for a variety of other mental health disorders that include older people, such as: schizophrenia (2002), personality disorders (2003), anxiety (2004a), depression (2004b), self-harm (2004c), obsessive-compulsive disorder (2005a), and post-traumatic stress disorder (2005b). Within these guidelines, the most widely researched and recommended approach is Cognitive-Behavioural Therapy ("CBT") but other approaches are also recommended.

Everybody's business (2005) considers that "*discrimination on the basis of age and mental health, in both direct and indirect forms, presents a major risk factor to older people's well-being and needs to be challenged and eradicated*" (p.12). Discrimination in an indirect manner may be considered in the form of long waiting lists and Everybody's Business (2005) emphasises that "*access* (to psychological therapies) *should not be unreasonably restricted by waiting lists*" (p.50).

Furthermore, as part of clinical governance, the DoH recommends that all staff "*should* (be) *train*(ed)…*in relevant communication techniques and encourage a needs-based, flexible service that changes in line with people's unique needs*" (p.11, Everybody's Business, 2005). Treatment efficacy can be compromised by a therapist who provides a service without adequate training, and furthermore this can cause harm to clients (DoH, 2004). This highlights the need for and importance of auditing staff training experiences and present needs.

Moreover, all staff providing psychological therapies should be appropriately supervised for the therapies that they provide as part of clinical governance, (DoH, 2004). For the purposes of this audit, clinical supervision is defined as a working alliance between the practitioner and a suitable supervisor who is trained in the model/approach for which supervision is provided, and who has experience in circumstances for which therapy is being used. During supervision, the practitioner may have the opportunity to reflect on their interactions, receive feedback on their progress, identify areas for adjustment and agree an action plan with their supervisor.

Local Context:

The trust's annual service plan (2005/2006) stated the trust should "*identify needs for improvement of access to Psychological services*" as a principal objective. It was stated that this objective should be measured by via audit. The audit was taken on by the Older Adult Psychology Service and agreed by the Trust Clinical Audit Group in March 2006. The audit allows for the findings to be compared against national standards.

Aims of the present Audit:

The aim of this audit was to assess the availability and accessibility of psychological therapies for older people in community settings in relation to the national standards and provide recommendations for older people's psychology service provision.

Audit Questions:

The audit hopes to address the following questions:

1) What psychological therapies are available to older adult service users and in what format?
2) Which professionals provide therapies to older adults?
3) How much supervision do staff receive for their psychological work?
4) Do staff think that access to psychological therapies is unreasonably restricted by waiting lists?
5) How many staff are trained in the delivery of psychological therapies but are not utilising their skills?
6) How many staff would like further training in the delivery of psychological therapies for older adults?

Audit of the Availability of Psychological Therapies to Older People in Community Services

The findings of the audit will be compared to three standards:

Standard 1: 'Psychological therapies should be routinely considered as a treatment option when assessing mental health problems.' (Everybody's Business, 2005, p50)

Standard 2: 'Access should not be unreasonably restricted by waiting lists.' (Everybody's Business, 2005, p50)

Standard 3: 'All staff involved in psychological therapies services should have formal clinical supervision and continuing professional development programmed into their work.' (Everybody's Business, 2005, p.50)

Audit of the Availability of Psychological Therapies to Older People in Community Services

Method:

Ethical Issues:

Given that the audit is not accessing service users, after consultation with the trust Research & Development department and audit committee, this research was classified as a clinical audit and therefore ethical approval was not considered necessary.

Design:

A specifically designed questionnaire (see Appendix 1) was developed as a tool to address the proposed audit questions. After the questionnaire was initially designed, a draft was sent to some members of the adult psychology department for piloting purposes. Amendments to the questionnaire were made based on their feedback. Due to the large geographical area of the trust, one trainee distributed the questionnaire across the East of the trust, whilst another trainee was responsible for the West area. After data collection the data for both the East and West area were combined to allow for each trainee to separately analyse and write up the audit.

Participants:

Questionnaires were distributed to all trust staff identified as working with older adults within community and day hospital settings.

Audit of the Availability of Psychological Therapies to Older People in Community Services

Sampling:

In order to improve the response rate, the questionnaire was distributed by the trainees within team meetings, following an introduction to the audit, its aims and importance for the trust. It was then arranged for questionnaires to be collected, or participants were invited to return the questionnaires though the internal mail system. Participants were encouraged to return completed questionnaires via email, telephone calls and face-to-face contact, particularly with team managers.

Materials:

The developed questionnaire (Appendix 1) consisted of 25 questions in two main sections. There was a combination of yes or no responses, tick-boxes and open-ended questions. The first section of the questionnaire focused on the provision of psychological therapies. The second section focused on supervision and training needs. Additionally, staff were provided with a written information sheet about the background and aims of the study (Appendix 2) and written information regarding the definitions of therapy used within the questionnaire (Appendix 3).

Analysis:

Descriptive statistics were used to analyse responses for the majority of questions. In the case of open-ended questions, responses were analysed qualitatively.

Audit of the Availability of Psychological Therapies to Older People in Community Services

<u>**Results:**</u>

The questionnaire was sent to 140 staff identified as working with older people in the community and 72 questionnaires were returned. Thus a response rate of 51.4% was obtained.

The different professional groups that participated in the audit were as follows.

<u>Table 1.</u> **Break-down of Participants' Professional Groups:**

Profession	Frequency
Nursing	31
Social work	10
Occupational Therapy	9
Physiotherapy	7
Support Worker	4
Care Assistant	3
Psychiatry	3
Psychology	2
Care Co-ordinator	2
Unspecified	1
Total	**72**

Audit of the Availability of Psychological Therapies to Older People in Community Services

As illustrated in table 1, the majority of participants who took part in the audit were nursing staff, followed by social workers and then occupational therapists. There was less representation within the audit of medical staff from psychiatry.

Regarding the percentage of time allocated to working with older adults, a large majority of participants, 82% estimated spending between 76-100% of their post working with older adults, whilst 3% spend between 51-75%, a further 3% spend between 26-50%, 1% spend between 11-25% and 3% spend between 1-5% of their post working with older adults. 5 participants did not indicate what proportion of their post was spent with older adult clients. This did not influence how the results were interpreted.

Audit Question 1. What Psychological Therapies are available to older service users and in what formats?

Table 2: **A Breakdown of Types of Psychological Therapies Available**

Types of Psychological Therapy	Number of responses	Percentage of Responses
Formal Psychological Therapy	13	18%
Therapy Specific to Older People	40	56%
Therapeutic Conversation	51	71%
Other Therapy Provided	8	11%
No Therapy Provided	14	19%[1]

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[1] The percentages do not add up to 100% as participants had the option of selecting more than one type of therapy.

Audit of the Availability of Psychological Therapies to Older People in Community Services

Participants indicated that the majority of therapy is provided as therapeutic conversation (71%), followed by therapy specific to older people (56%). Formal psychological therapies are least available (18%). Whilst 19% of 'Other therapies' are available such as: occasional systemic therapy, counselling approaches, anxiety management, solution focused brief therapy, and resolution therapy.

Of those participants who provide therapy, the formats in which therapy is delivered varied as illustrated in Table 3:

Table 3: **The Format in which Psychological Therapies are Delivered:**

	Number of Responses	**Percentage of Responses**
Individuals	56	78%
Couples	21	29%
Groups	27	38%
Family / Carers	43	60%
Computerised Programme	4	6%
Telephone	29	40%
Internet	1	1%

Audit Question 2. Which Professionals provide therapies to Older Adults?

Table 4: **A Break-down of Which Professionals provide Which Therapies to Older Adults?**

Audit of the Availability of Psychological Therapies to Older People in Community Services

Professional Group (n=numbers in each group)	Types of Psychological Therapy Provided:			
	Formal Psychological Therapy	Therapy Specific to Older People	Therapeutic Conversations	Other Therapies
Psychiatry (n=3) **Numbers providing therapy** **% within professional group providing therapy**	1 33%	0 0%	2 66%	0 0%
Occupational Therapist (n=9)	2 22.2%	6 67%	5 56%	2 22.2%
Social Worker (n=10)	0 0%	3 33%	5 50%	0 0%
Psychologist (n=2)	2 100%	1 50%	1 50%	0 0%
Support Worker (n=4)	0 0%	3 75%	4 100%	0 0%
Nursing (n=31)	7 22.6%	21 67.7%	23 74.2%	4 12.9%
Physiotherapy (n=7)	1 14.3%	4 57.1%	6 85.7%	4 57.1%
Care co-ordinator (n=2)	0 0%	1 50%	1 50%	0 0%
Care Assistant (n=3)	0 0%	2 66%	3 100%	0 0%

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Audit of the Availability of Psychological Therapies to Older People in Community Services

Which Therapies are Provided for Which Disorders?

(See Appendix 4 for data for the therapy provisions for all mental health disorders). For the major mental health issues associated with older adults, dementia and depression, the majority of therapies provided are in the form of therapeutic conversations (71% for dementia and 75% for depression). Formal psychological therapy is provided for older adults with dementia by just 3% of staff and for depression by 6% of staff. Therapies specific to older adults are provided by 50% of staff for dementia and 42% of staff for depression.

Audit Question 3. How Much Supervision do Staff Receive for their Psychological Work?

Figure 1: **Breakdown of Supervision for Differing Therapies:**

Audit of the Availability of Psychological Therapies to Older People in Community Services
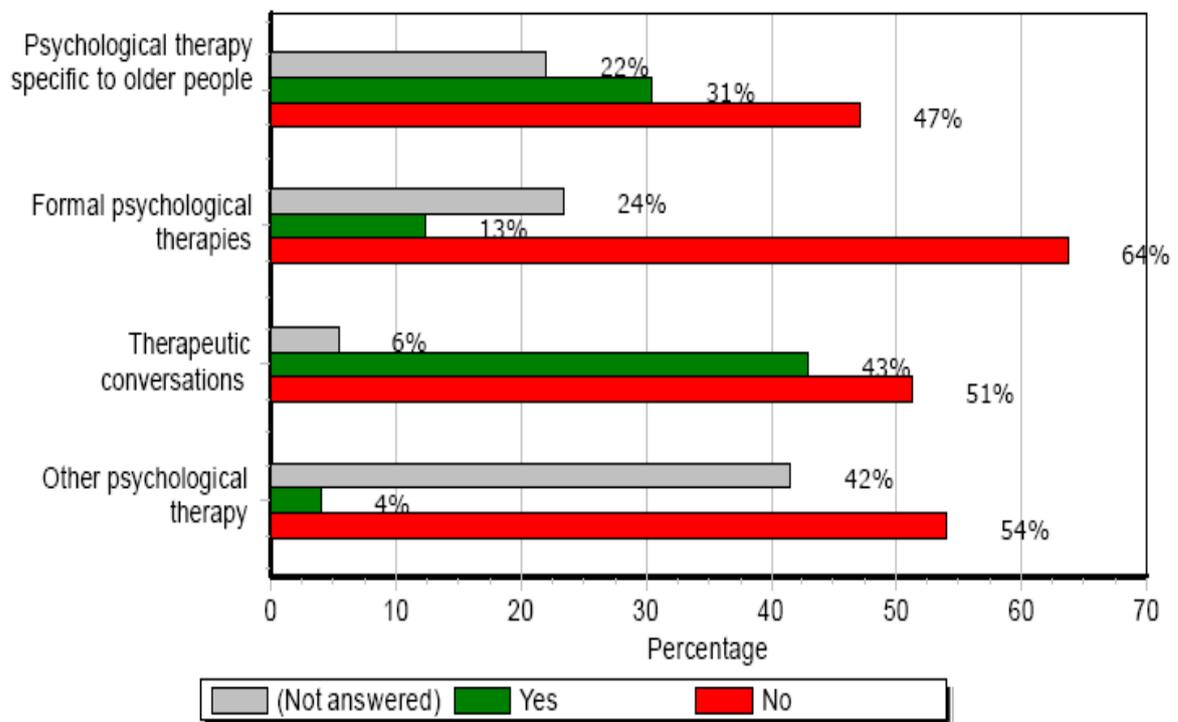
Therefore the majority of participants are receiving supervision for therapeutic conversations (43%), then psychological therapies specific to older people (22%), then formal psychological therapies (13%) and least for other therapies (4%)

Table 6: **Break-down of Supervision in Relation to Provision:**

	Number of Participants Receiving supervision	Number of Participants Providing Therapies	% of Participants Receiving Supervision
for Formal Therapy	9	13	69.2%
For Therapeutic Conversation	31	51	60.8%
For Therapy Specific to Older People	22	40	55%
For Other Therapy	3	8	37.5%

For formal therapy, 69.2% of participants are receiving supervision, for therapeutic conversation 60.8% are receiving supervision, for therapy specific to older people 55% are receiving supervision and for other therapies 37.5% are receiving supervision.

Audit Question 4. Do Staff think that access to Psychological Therapies is Unreasonably Restricted by Waiting Lists?

Audit of the Availability of Psychological Therapies to Older People in Community Services

Figure 2: **Are Psychological Therapies Unreasonably Restricted by Waiting Lists?**
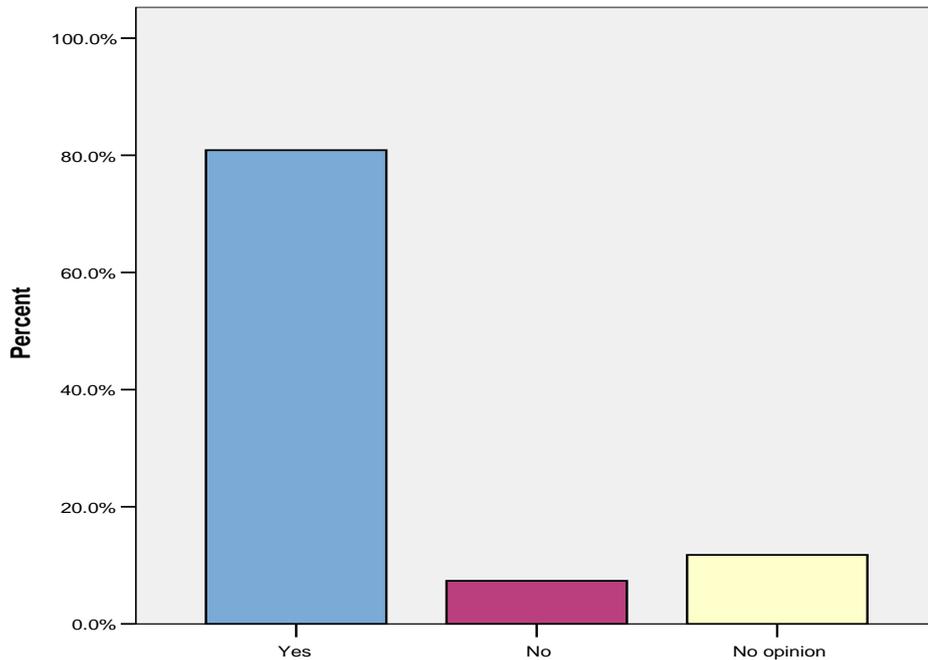
The vast majority of 80% of staff questioned felt that older adults' access to psychological therapies is unreasonably restricted by waiting lists. Indeed, when questioned why participants do not routinely consider referring older adults to psychology, 34% agreed it was at least partly due to the long waiting list and 34% of responses were at least partly due to the limited availability of psychological therapies for older people.

27 participants (37.5%) indicated that the time spent providing psychological therapies is not adequate to meet older adults' needs.

Audit Question 5. How Many Staff are trained in the delivery of psychological therapies but are not utilising their skills?

Of the 62 participants that answered this question, there are 12 participants who feel that they possess skills and qualifications that they do not have the opportunity to use.

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In the qualitative responses from individuals who felt that they did not have the opportunity to use their skills they listed the following skills:

-"Little opportunity to use MSc in systemic psychotherapy"

-"CBT approach in depth"

- "Certificate in counselling skills"

- "CBT, validation therapy, bereavement therapy"

- "systemic skills"

Participants considered that they are not utilising these skills or qualifications due to a lack of time (5 participants), lack of supervision (2 participants), lack of appropriate service users (2 participants) and lack of support or encouragement (3 participants).

In terms of the qualifications and training that staff have in relation to psychological therapies being provided the break down is as follows:

Figure 3: **Training/ Qualifications Relating to Psychological Therapies Provided:**

Audit of the Availability of Psychological Therapies to Older People in Community Services
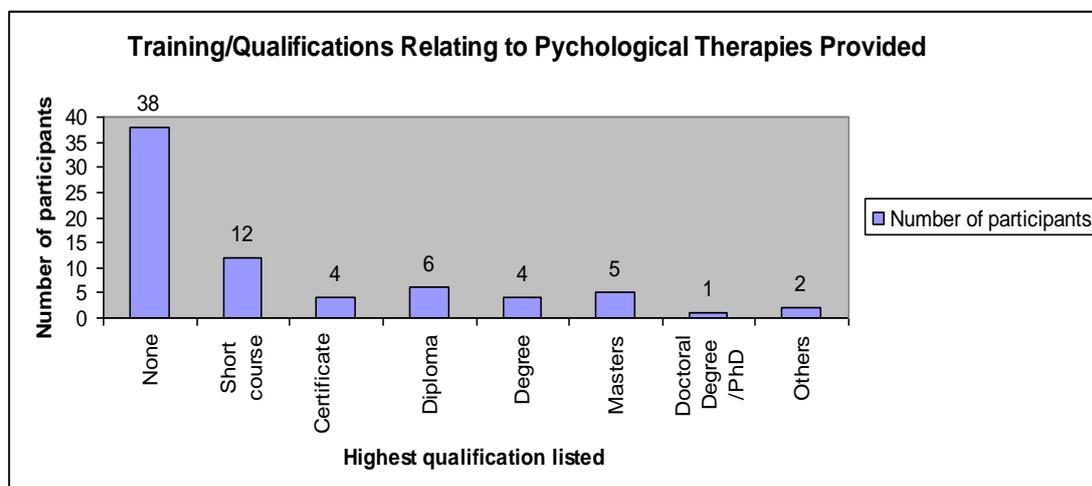
A very high number of participants (38) have no qualifications or training. While fewer numbers of participants have diplomas (6 participants), relevant degrees (4 participants), masters (5 participants), or doctoral degrees (1 participant).

Audit Question 6. How Many Staff would like to Train in the Delivery of Psychological Therapies for Older Adults?

41 (56.9%) participants indicated that they would like further training in the delivery of psychological therapies to older adults. Specifically these individuals indicated that they would like further training in the following areas:

Table 7: **A Breakdown of Participants' Training Preferences:**

	Number of Responses
In Formal Therapy	24
In Therapeutic Conversation	30
In Therapy Specific to Older People	33
In Other Therapies	4

In addition, participants had a chance to express their specific training needs. There seemed to be a unanimous feeling that "any and all" training would be appreciated. Specifically, there were requests for training for running groups with older adults, family therapy training, bereavement counselling, validation therapy, cognitive-behavioural therapy and anxiety management. There were numerous comments that training should be regular and informal.

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Further Comments:

Participants also had a chance to express their views on any matters related to the questionnaire. Comments could be considered thematically as follows:

Funding:

-"It is crucial that further funding is provided for psychological therapy for older people"

-This is a neglected area that needs more funding"

-"I am new to my post but I am already aware of the under-funding for older people"

Obstacles:

-"Waiting times need to be markedly reduced"

-"The waiting list is demotivating"

-"Easier access for referrals please"

-"Perhaps the older person will not commit to sessions often due to transport difficulties or disability"

Skills Shortage:

-"I would like to see further use of sessional therapists"

-"We need more psychologists for a good service"

Positive Experiences:

-"Psychological therapy is valuable for in-patients too"

-"My experience has shown that older people respond well to psychological therapies"

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Discussion:

Response Rate

The response rate of 51.4% was very encouraging and comparable to a similar adult audit within the trust which obtained a response rate of 45%. Nine disciplines were represented within the audit (occupational therapists, psychiatrists, psychologists, nursing staff, support workers, social workers, physiotherapy, care co-ordinators and intermediate care assistants). However there was a substantial proportion of nursing staff represented (44.9%) and far fewer psychiatrists (2.8%). Our sample seems to adequately reflect staff proportions working with older adults although psychiatrists are certainly underrepresented within the audit. Therefore any conclusion drawn from the data must be considered tentatively.

Summary of Results in relation to the Audit Questions:

In relation to the first audit question, 'What psychological therapies are available to older adult service users', at first, it appears that there is a range of psychological therapies available. Therapies are delivered in a number of formats, most frequently with individuals, families and groups and more rarely via the internet or telephone. However, looking more closely at the available therapies reveals that by far the most frequently provided therapeutic approach is the use of 'therapeutic conversation' used by 71% of participants. Only 18% of participants provide formal psychological therapies which include approaches such as CBT. The use of formal psychological therapies are those recommended by all NICE guidelines as well as in the recently published Layard Report (2006). Participants did refer to a number of other approaches used such as resolution therapy, but again these are not the types of psychological therapies recommended by NICE guidelines.

Considering the second audit question 'Which professionals provide therapies to older adults?' it appears that the therapeutic conversations are being provided by all professionals

Audit of the Availability of Psychological Therapies to Older People in Community Services

included within the audit, except psychiatrists. Formal psychological therapy is being provided by psychologists, a psychiatrist, occupational therapists, nursing staff and physiotherapists. Therapy specific to older people is being provided by all professionals included within the audit, except psychiatrists.

In relation to the third audit question 'How much supervision do staff receive for their psychological work?' it appears that not all staff are provided with formal supervision. For example, supervision ranges from 4% for other psychological therapies up to 43% for therapeutic conversations. This indicates that standard 3 'All staff involved in psychological therapies services should have formal clinical supervision programmed into their training", is not being met.

In relation to the fourth audit question 'Do staff think that access to psychological therapies is unreasonably restricted by waiting lists?' There is a majority consensus that 80% of participants consider that access *is* indeed unreasonably restricted. As a consequence this implies that standard 2 "Access should not be unreasonably restricted by waiting lists", is not being met. Of those participants who report not routinely referring older adults for psychological therapy a large number (34%) were put off by the long waiting list. There were a number of qualitative comments around the lengthy waiting list in the older adult psychology service, such as "the waiting list is demotivating", giving further evidence that standard 2 is not being met.

34% of participants consider that there is limited availability of psychological therapies for older adults and a minority 3% still consider that older adults are unlikely to benefit from psychological therapies. This may provide evidence that standard 1 'Psychological therapies should be routinely considered as a treatment option when assessing mental health problems', is not being met since if there is such limited availability, psychological

Audit of the Availability of Psychological Therapies to Older People in Community Services

therapies cannot be routinely considered. The lengthy older adult psychological therapies waiting list, may also be seen as indirect discrimination or ageism. The National Service Framework for Older People (2001) promotes that "NHS services will be provided regardless of age, on the basis of clinical need alone'' (p.16). It is clear that clinical need cannot be provided for with such a lengthy waiting list. On a positive note however, 51% of participants do routinely consider referring older adults for psychological therapy. Again however, this implies that standard 1 is not being met since 49% are not routinely considering referring older adults for psychological therapy.

The fifth audit question posed the question 'how many staff are trained in the delivery of psychological therapies but are not utilising their skills?' 17% of participants indicated that there were skills that they were not utilising. The most frequently cited reason for this was a lack of time, identified by 41.7% of these individuals, followed by a lack of support or encouragement identified by 25% of these participants. Given the demonstrated lack of availability of psychological therapies, it is crucial that those individuals who possess the necessary skills and qualifications are appropriately utilised .

In relation to the sixth audit question 'How many staff would like further training in the delivery of psychological therapies', 56.9% of participants indicated that they would. From the many qualitative comments received it seems that there is a great need and desire for further training. This may provide some evidence that staff are not receiving regular continuing professional development programmed into their work, and therefore may not be meeting standard 3. Training for psychological therapies is clearly needed.

Methodological Limitations:

Despite the therapy definitions that were provided with the audit questionnaire, it emerged that the notion of 'therapeutic conversation' is open to very different and subjective

Audit of the Availability of Psychological Therapies to Older People in Community Services

interpretations. Therefore, the high percentages of therapeutic conversations that participants indicate that they are providing may not be reflective of actual practice according to the audit's definition of therapeutic conversation. Thus the audit may not have captured an adequate picture of the types of therapies that are available to older service users.

Despite basing the questionnaire on a similar adult audit, piloting the questionnaire and adapting the questionnaire with feedback, it appeared that participants struggled to complete the questionnaire appropriately. There were very high numbers of missing data and this may have greatly affected the results.

A further limitation of the audit was that it was not able to directly assess whether individual participants were provided with adequate supervision in relation to the amount and type of therapy they provided.

Regarding individual participants' prior qualifications and training, there appeared to be few participants with high levels of training appropriate to providing psychological therapies. In addition there appear to be relatively high numbers of individuals providing psychological therapies. The audit was also limited by not being able to assess whether individual participants were appropriately qualified for the amount and types of therapy that they were providing. Worryingly it appeared that some staff may be under qualified for the types of therapy that they are providing which may be to the detriment of service users. For example it did not consider whether a short day course in CBT would be adequate for a participant to work with a service user with long-term psychosis and complex needs This audit focused on the availability and accessibility of psychological therapies and it was beyond the scope of this audit to consider the issue of either the quality or success in reducing distress of available therapies.

The audit was aimed at professionals involved in older people's mental health care. It would have been valuable to gain the perception of the availability of therapies from older adult service users since there may be a discrepancy between provision and service users' perception. For example, a recent audit conducted within the adult inpatient setting within the trust found that the therapists reported providing more therapy than the service users considered they were receiving.

Service Implications & Recommendations:

1. A waiting list initiative should be considered. For example, groups using formal psychology therapies could be set up for service users with a common mental health difficulty. Therefore, service users would be receiving the type of psychological therapy recommended by NICE and DoH guidelines such as CBT within a group setting.

2. Since the national standards for older adult psychological therapy provision are not being met, further resources for psychological therapies for older adults should be considered.

3. The audit indicates that a psychological therapies clinical governance strategy should be developed to monitor therapy provision. This includes ensuring that therapists are adequately trained, receive regular supervision and continuing professional development is programmed into their work. The trust also needs a strategy for developing psychological approaches.

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4. Additionally the clinical governance strategy should monitor that the evidence base recommended by NICE and the DoH is being considered for specific mental health difficulties. For example that a formal psychological therapy such as CBT is being provided for a service user with depression since CBT is recommended for depression in the NICE (2004) guidelines.

5. It may be useful to develop definitions of the training required for conducting different types and levels of psychological therapies.

6. Improve arrangements for staff who feel that their skills are not being unutilised to ensure that service users are receiving the benefit of available skills.

7. An additional audit should be conducted to assess the quality and effectiveness of therapies available. This could also consider whether therapists' qualifications are appropriate to the type of therapy they are providing. This audit would ideally be conducted from the perspectives of both therapists and service users.

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Appendix 1 – Audit Questionnaire

Respondent Number =

Name (optional)
Job Title:
Team:
No of hours worked per week:

0%	1-5%	6-10%	11-25%	26-50%	51-75%	76-100%

SECTION ONE. Psychological Therapy / Therapies You Provide.

1). Please indicate which type(s) of psychological therapy you provide:

(Please circle which applies)

Formal psychological   Therapeutic   Therapy specific

    therapy   conversation   to older people

Other *(Please specify)* ……………………   None – go to Q6

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2) Please indicate how you provide psychological therapies to older people by ticking all that apply:

Individuals	
Couples	
Groups	
Family/carers	
Computerised programme	
Telephone	
Internet	
Other *(specify)*	

3) What percentage of your time is used to provide the following types of psychological therapies to older adult service users?

Formal psychological therapies: ……………………………………….

Therapeutic conversations: ………………………………………..

Psychological therapies specific to older people: …………………………..

Other psychological therapy (please specify)   ………….……………….

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4) Do you spend as much time as you would *like* in providing psychological therapies to older people:

Please circle which applies:

Formal psychological therapy:

             Yes   No   Don't know   No preference

Therapeutic conversations:

             Yes   No   Don't know   No preference

Psychological therapies specific to older people:

             Yes   No   Don't know   No preference

Other psychological therapy (please specify)………………

             Yes   No   Don't know   No preference

Audit of the Availability of Psychological Therapies to Older People in Community Services

5) Please complete the following table by ticking the grids that combine the psychological therapy(s) you provide with the mental health difficulty you provide therapy for.

	Mental Health Difficulty	Dementia	Depression (inc. bipolar disorder)	Anxiety eg., generalised anxiety disorder (GAD) phobias panic attacks	Bereavement	OCD	PTSD	Psychosis	Self-harm	Personality disorder	Sexual disorders	Other functional mental health difficulties disorders (please specify) (eg. eating disorders)
Psychological Therapy Types												
Formal psychological therapy												
Therapeutic conversation												
Therapies specific to older people.												
Other (please specify) eg. Sleep hygiene, social skills, anger management training.												

Audit of the Availability of Psychological Therapies to Older People in Community Services

6) Do you believe older service users have a choice in whether or not they receive psychological therapies?
(Please circle which applies)

<div align="center">

Yes   No   Don't know

</div>

7) Do you routinely consider referring older adults for psychological therapies?
(Please circle which applies)

<div align="center">

Yes   No   Don't know

</div>

If 'no', please state why:
(Please tick all that apply)

☐   Waiting list is too long

☐   Limited availability of psychological therapies for older people

☐   Lack of awareness of how to refer

☐   I think older people are unlikely to benefit from psychological therapies

☐   Older people cannot access the services available to younger people.

☐   Other *(please specify)*………………………………………………
………………………………………………………………………..

8) Do you think access to psychological therapies for older people is 'unreasonably' restricted by waiting lists?
(Please tick which applies)

☐ Yes   ☐ No   ☐ No opinion

Audit of the Availability of Psychological Therapies to Older People in Community Services

SECTION TWO. Clinical Supervision

Definition: For the purpose of this audit, clinical supervision is defined as a working alliance between the practitioner and a suitable supervisor who is trained in the model/approach for which supervision is provided, and who has experience in the circumstances for which therapy is being used. During supervision, the practitioner may have the opportunity to reflect on their interactions, receive feedback on their progress, identify areas for adjustment, and agree an action plan with their supervisor.

9) Do you **receive** any clinical supervision for the following?

(Please circle those which apply)

Formal psychological therapies:	Yes	No
Therapeutic conversations:	Yes	No
Psychological therapies specific to older people:	Yes	No
Other psychological therapy:	Yes	No

Please specify……………………………

If 'no' to all these, go to Q13

Audit of the Availability of Psychological Therapies to Older People in Community Services

10) If 'Yes', how frequently does this supervision take place?

(Please tick which applies)

☐ Once a week

☐ Once a fortnight

☐ Once a month

☐ Other: Please specify……………………….

11) Please state, on average, how long (eg, hours/minutes)

your supervision time lasts……………………………….

12) Who do you receive supervision from and what is their job title?

Job title……………………………………

13) Do you **provide** clinical supervision to anyone for the therapies they deliver?

(Please circle which applies)

Yes   No - go to Q16

Audit of the Availability of Psychological Therapies to Older People in Community Services

14) What types of psychological therapy do you provide supervision for?

(Please tick which applies)

☐ Formal psychological therapies

☐ Therapeutic conversations

☐ Psychological therapies specific to older people

☐ Other psychological therapy

Please specify…………………

15) According to job title, please indicate how many people you provide supervision to (for psychological therapies they deliver), how often and how long it lasts:

Job Title	Number to whom you provide supervision	Frequency (eg., weekly, fortnightly etc)	Length of session (hours, minutes etc)
Occupational therapists (OT)			
OT Assistants			
Nurses			
Senior House Officers			
Psychiatrists			
Staff Grade Psychiatrist			
Specialist Registrar			
Qualified psychologists			
Assistant Psychologists			
Support workers			
Social workers			
Students (please specify)			
Other (please specify)			

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SECTION THREE. Sources of Advice or Discussion

16) If you **do not** receive clinical supervision as defined earlier, is there anyone you can go to for advice or discussion about the psychological therapies you provide?

(Please tick which applies)

☐ Yes - continue   ☐ No – go to Q20

17) Who is this person and what is their job title?

Job Title……………………………

18) If **yes**, how frequently do you consult this person?

(Please tick which applies)

☐ Once a week

☐ Once a fortnight

☐ Once a month

☐ Other (please specify)……………………….

19) Please state, on average, how long this advice/discussion lasts………………

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SECTION FOUR. Training/Qualifications.

20) Please list any training / qualifications you have undertaken that RELATE TO THE PSYCHOLOGICAL THERAPIES YOU PROVIDE, including the title of the course: eg, MSc in CBT, short course in family therapy, etc…

Course Type	Level (MSc; Diploma)	Duration of course

21) Are there any skills / qualifications (professional or otherwise) you have relating to psychological therapies that you feel you have not had the opportunity to use?

(Please circle which applies)

Yes – continue   No – go to Q23

Please list these:………………………………………………………………

Audit of the Availability of Psychological Therapies to Older People in Community Services

…………………………………………………………..

22) Why have you been unable to use these skills/qualifications?

(please tick all that apply)

Lack of time	
Lack of supervision	
Lack of appropriate service users	
Lack of support/encouragement	

Other *(please specify)*……………………………………………………………….

23) Would you like to develop additional skills/obtain further qualifications in relation to psychological therapies you provide?

(please circle all that apply)

a) Formal psychological therapies: yes   no   no preference

b) Therapeutic conversations: yes   no   no preference

c) Psychological therapies specific to older people: yes   no   no preference

d) Other   yes   no   no preference

Please specify:

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If 'yes' for any of the above, please specify what training you would like:

……………………………………………………………………………………

……………………………………………………………………………………

24) Please use the space below to provide any additional comments you have in relation to psychological therapies for older people:

……………………………………………………………………………………………

……………………………………………………………………………………………

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

Audit of the Availability of Psychological Therapies to Older People in Community Services

<u>**Appendix 2** – **Information Sheet**</u>

<u>**Audit of the Availability of Psychological Therapies to Older people in Community Service**</u>

<u>Background</u>

The Older People's Psychology Service wishes to audit the availability and accessibility of psychological therapies in community settings. We are interested to find out what therapies are available to older service users, who provides therapy, what training and supervision staff have in relation to therapy and what training they would like. We are also interested in the effect of waiting lists on staff's perception of psychological services.

Local and national guidelines highlight the need to establish provision of psychological services for older people. These include:

- National Service Framework for Mental Health.
- NICE guidance (eg., for depression and anxiety).
- The National Service Framework for Older People.
- The ever-increasing evidence base to support the application of psychological therapies to older people in conjunction with key Department of Health recommendations.

You are under no obligation to participate in this audit. However, in completing this questionnaire you are providing valuable information that will identify any short falls in the provision of psychological therapies for older people. Please return your completed form to:

Head of Psychology for Older People
Psychology Department
Internal Mail Code: 20A

Appendix 3 – Psychological Therapy Definitions Sheet

Definitions

Older People

Older people are defined as 'any person over the age of 65 years'

Psychological Therapy Definitions

There are a large variety of therapies available. For the purpose of this audit we will be focusing on *psychological* therapies, defined as follows:

i) **Formal Therapy** includes:

counselling; cognitive behavioural therapy (CBT); psychoanalytic / psychodynamic therapy; cognitive analytic therapy (CAT); interpersonal therapy (IP); systemic and / or family therapy; humanistic therapy; experiential therapy; behavioural therapy; solution focused therapy.

ii) **Therapeutic Conversations** includes: the use of a talking approach between a mental health practitioner and service user that is not a formal therapy but is intended or perceived by the *mental health practitioner* to be beneficial to the service user's mental health.

iii) **Therapies** *specifically* **for older people** includes:

Reality Orientation – for groups and/or individuals including clear signposting of locations around the ward/home, use of memory aids, and a consistent approach by all staff in interacting with the person with dementia.

Reminiscence Therapy – including the use of past memories to establish a point of interest and contact with the client.

Validation Therapy – including, 'communicating with disorientated elderly persons by validating and supporting their feelings in whatever time or location is real to them, even though this may not correspond to our 'here and now' reality.''

Resolution Therapy – staff listen carefully to the person with dementia to identify their feelings relating to making sense of the current situation, or expressing a current need.

Please refer to these therapy definitions when answering the following questions.

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Figure 1: **Breakdown of Participants' Professional Groups:**

Figure 1. Break down of Participants' Professional Groups
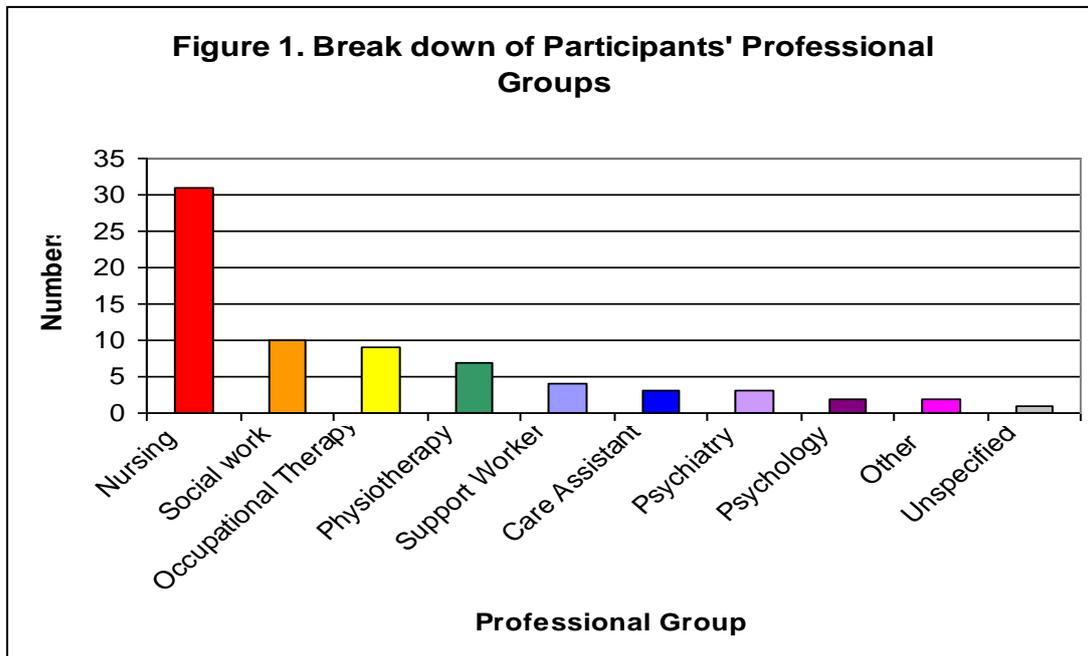
Figure 2: **Breakdown of Psychological Therapy Provision:**

Audit of the Availability of Psychological Therapies to Older People in Community Services
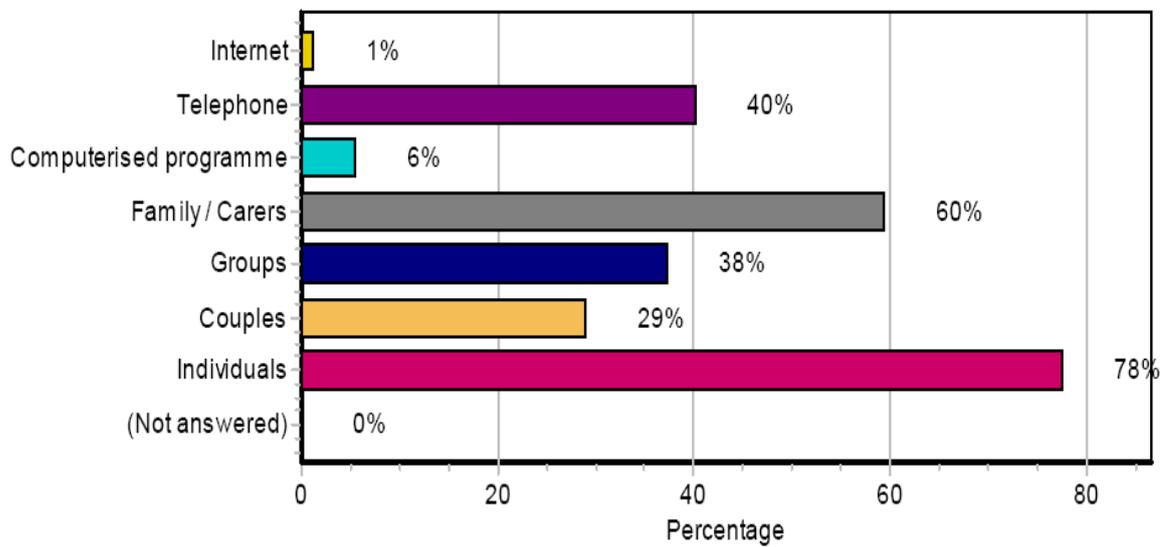
Figure 3: **Is the Amount of Therapy you Provide Adequate to Meet Needs?**
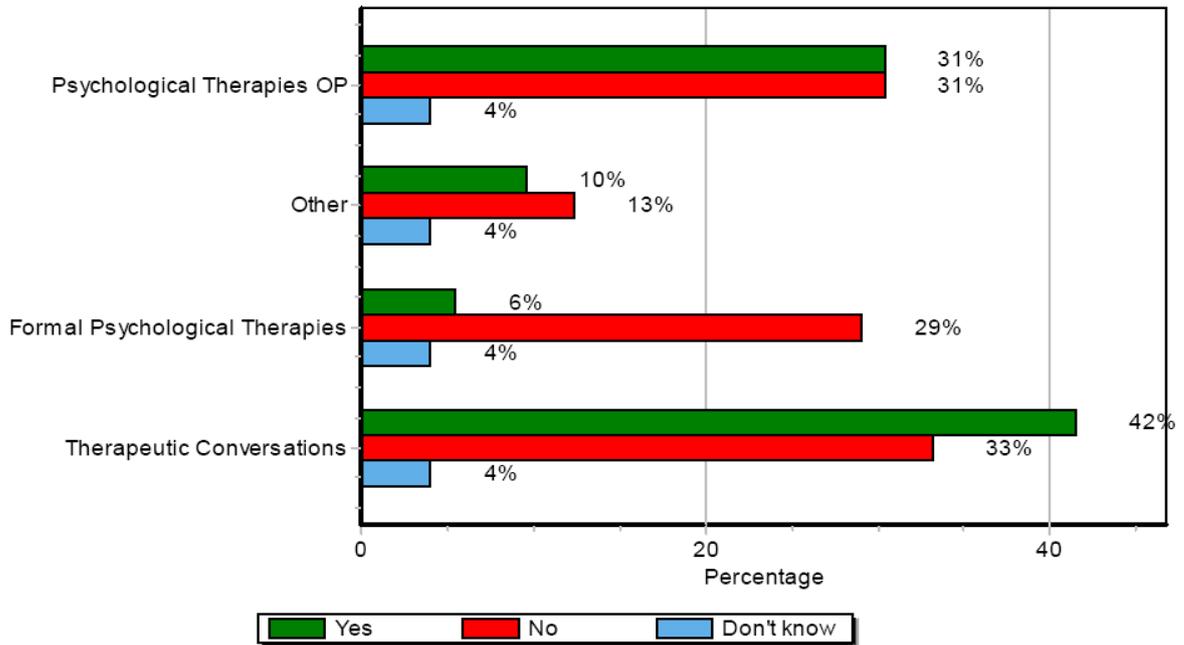
Figure 4: **Do Service Users Have A Choice In Whether Or Not They Receive Psychological Therapies:**

Audit of the Availability of Psychological Therapies to Older People in Community Services
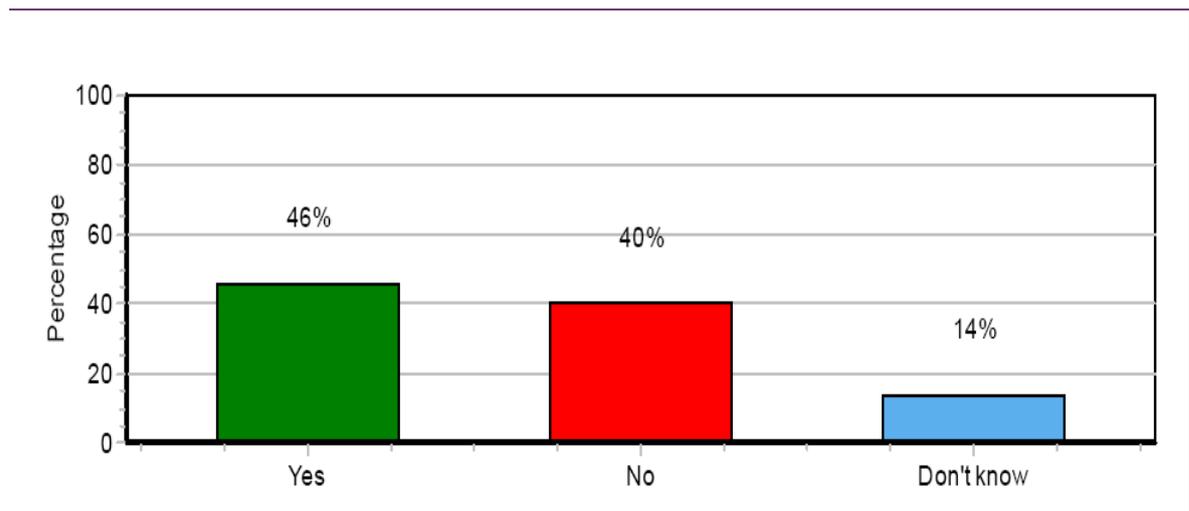
Figure 5: **Breakdown of Types of Therapy Provided for Specific Mental Health Difficulties:**

Audit of the Availability of Psychological Therapies to Older People in Community Services
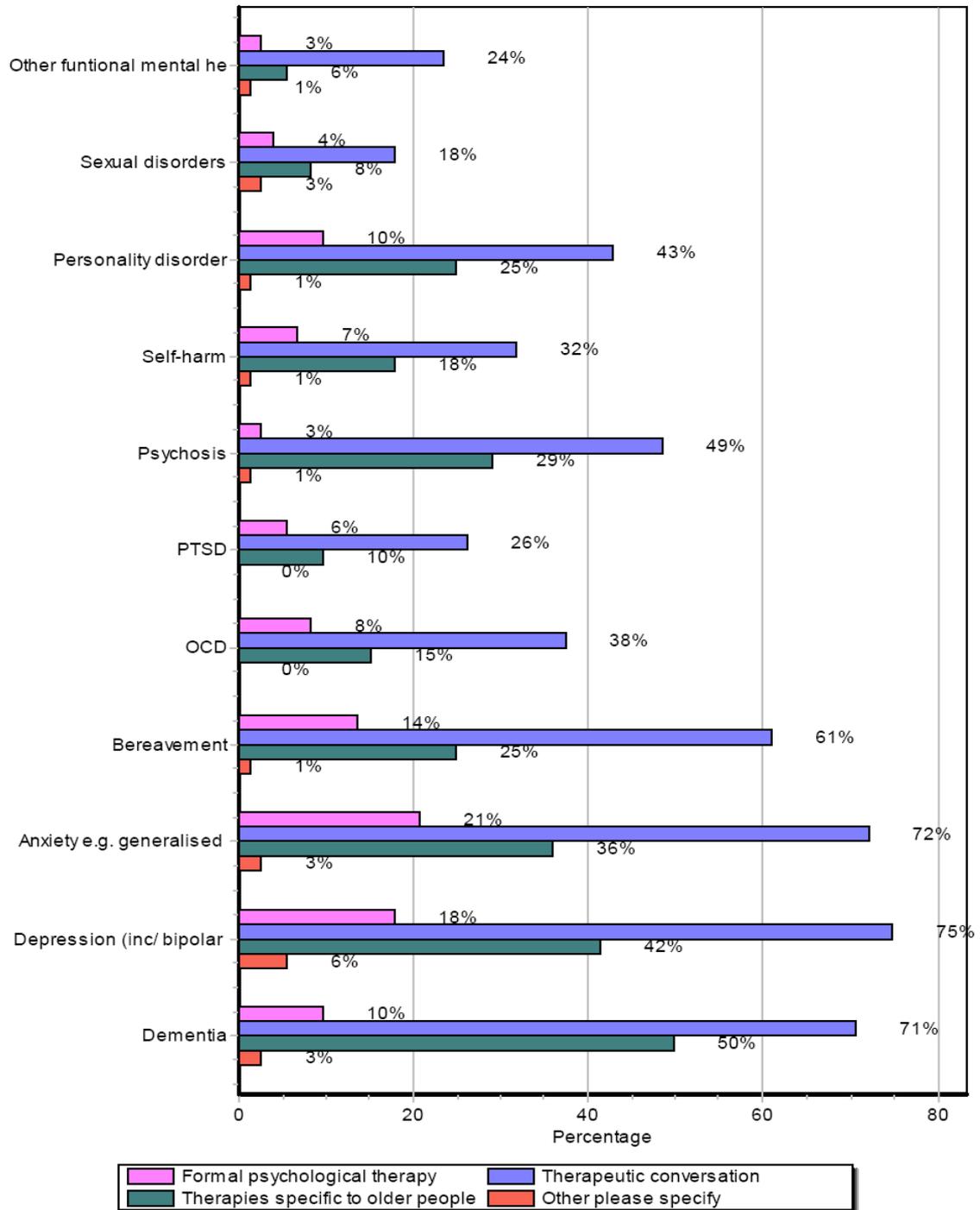
Figure 6: **Breakdown of Reasons Why Professionals DO NOT Routinely Consider Referring Older Adults for Psychological Therapies:**

Adjusted %

|	Percentage
Other	9%
Referral for older adults are not accepted by services for younger people	10%
I think older people are unlikely to benefit from psychological therapies	3%
Lack of awareness of how to refer	10%
Limited availability of psychological therapies for older people	34%
Waiting list is too long	34%
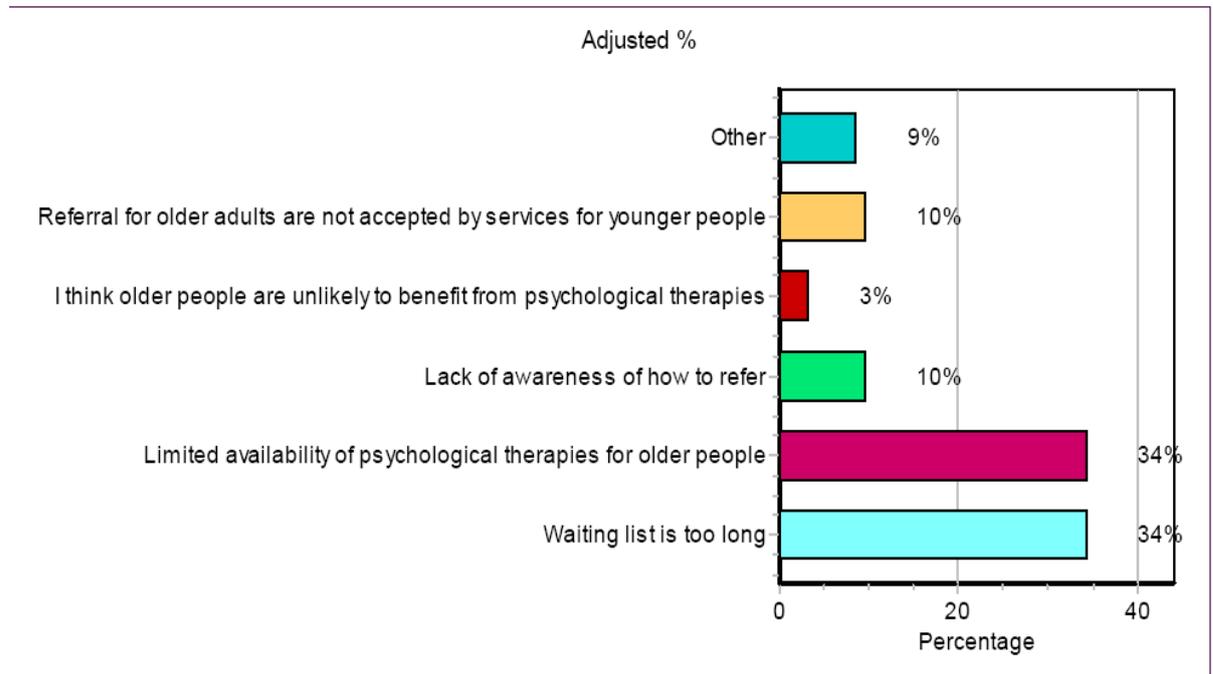
Figure 7: **Breakdown of Reasons why Professionals are not Utilising their Skills/ Qualifications:**

	Percentage
Lack of support / encouragement	25.0%
Lack of appropriate service users	16.7%
Lack of supervision	16.7%
Lack of time	41.7%

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Audit of the Availability of Psychological Therapies to Older People in Community Services

How well do Intercountry Adoptees Fare in Comparison to Domestic Adoptees and Non-adopted children?

A Review of the Literature

Word Count: 5, 034

How well do Intercountry Adoptees Fare in Comparison to Domestic Adoptees

& Non-adopted children? A Review of the Literature

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& Non-adopted children? A Review of the Literature

How well do Intercountry Adoptees Fare in Comparison to Domestic Adoptees and Non-adopted children?

A Review of the Literature

Introduction

A consistent scientific question has been about the psychological, emotional, physical and behavioural well-being of adoptees (Kim, 2002) particularly in comparison to those who were not adopted. This is an important question because of the increasing numbers of international adoptions (Bimmel et al, 2003). Many studies have focused on different outcomes of internationally adopted childrens' progress, such as developmental (Rutter, 2005), medical (Miller & Hendrie, 2000), physical (Van Ijzendoorn, Bakermans-Kranenburg & Juffer, 2007), IQ (Van Ijzendoorn, Juffer & Klein Poelhuis, 2005), language and communication (Cederbland, 1982), eating difficulties (Fisher, Ames, Chisholm & Savoie, 1997) and sleeping difficulties (Fisher et al, 1997). For the purpose of this literature review the focus will be on the mental health, behaviour and attachment of intercountry adoptees in comparison to domestic and non-adopted children. (Refer to appendix 1 for the search strategy procedure).

Although some research indicates that there is no difference in the overall adjustment of intercountry adoptees in comparison to non-adoptees (Tizard, 1991), other research indicates that internationally adopted children have a greater risk of developing serious mental health problems in comparison to their non-adopted peers (Tieman, Van der Ende & Verhuls, 2005). The research needs to be closely considered as early recognition and interventions may be of great benefit to the increasing numbers of intercountry adoptees (Tieman et al, 2005).

Definition and history of adoption

According to Van Ijzendoorn & Juffer (2006) adoption may be defined as the permanent, legal placement of an abandoned, relinquished or orphaned child within a family of relatives (kinship adoption) or within an unrelated family (non-kinship adoption). Whilst domestic adoptees are born and adopted within the same country, intercountry or internationally adopted children are adopted into a different country to which they were born (Selman, 2005). Transracial adoption describes children who are adopted by parents of a different race (Ku, 2005), thus many intercountry adoptions can also be considered transracial.

Throughout recorded history adoption has been part of human culture, such as Moses, abandoned by his mother and adopted by Pharaoh's daughter (Laurie, 2005). It is estimated that 10-40% of children in eighteenth century European cities were abandoned when their parents were unable to care for them (Boswell, 1988). Indeed adoption is a common theme throughout literature, from fairytales and myths to modern stories (Miller, 2005). The practice of adoption was very uncommon in Britain until the twentieth century (Tizard, 1991). The first Adoption Law in England and Wales was enacted in 1926 and it was feared that it would encourage immoral behaviour (Mather, 2007). At that time, there was a stigma attached to adoption and a child's adoptive status was often hidden (Tizard, 1991).

Before World War II, only 6,000 adoption orders were made annually in the UK, but after the war, the numbers peaked at almost 25,000 in 1968 (Tizard, 1991). There was then a significant fall in the number of adoptions, as a consequence of the 1968 Abortion Act and the growing trend and acceptability for single mothers to keep their children (Tizard, 1991). The same trends were seen across the rest of the Western world (Tizard, 1991).

How well do Intercountry Adoptees Fare in Comparison to Domestic Adoptees

& Non-adopted children? A Review of the Literature

History of Intercountry Adoption (ICA)

The phenomenon of ICA can be traced back to social factors such as war, poverty and political revolutions (Ku, 2005). Initially the aftermath of the second World War left large numbers of European children homeless (Van Ijzendoorn & Juffer, 2006). These children were sent by religious organisations for adoption in other European countries and the US (Tizard, 1991). From 1955 to the early 1980's most internationally adopted children came from Korea and Vietnam, particularly to the US. Again, these children were war orphans, or the mixed-race offspring of American soldiers (Bimmel et al, 2003). In the 1990's children were adopted mainly from Romania, China and Russia (Van Ijzendoorn & Juffer, 2006). As can be observed, the changes in the principal countries of origin have stemmed from crises in these countries, as well as shifting attitudes of governments and populations towards international adoption, family planning, birth control and single parenthood (Bimmel et al, 2003).

Overview of domestic and ICA statistics

What has changed over time is the numbers of internationally adopted children and source countries. Initially it began on a small scale until the late 1970's, and increased substantially over the last few decades (Bimmel, et al, 2003). The pattern of increase is difficult to ascertain since many countries, including the UK, have not collected statistics, because questions regarding adoption were not included on the national census (Tizard, 1991) until relatively recently. Currently, ICA is an increasing phenomenon estimated to involve more than 40,000 children a year moving among more than 100 countries (Van Ijzendoorn, & Juffer, 2006). The USA is the leading county of destination for international adoptees (Van Ijzendoorn & Juffer, 2006). In 2004 there were 13.5 international adoptions per 1,000 live births in Norway, 11.4 in Sweden, 10.4 in Spain and 0.46 in the United Kingdom in 2004 (Van Ijzendoorn & Juffer 2006). In 2004, the 22, 884 intercountry adoptees in the United States were mainly from China, Russia, Guatemala, South Korea and Kazakhstan (Juffer & Van Ijzendoorn, 2005. In comparison, the 15,847 inter-country

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adoptions in Europe were mainly from China, Russia, Colombia, Ukraine and Bulgaria (Juffer & Van Ijzendoorn, 2005).

International and domestic legislation

Numerous countries have changed their attitudes towards international adoptions after abuses within exporting countries such as child trafficking (Tizard, 1991). These were well-publicised within the media and led to some third world countries prohibiting ICA (Pilotti, 1986). There was a great need for internationally agreed legislation to govern and regulate this area. This came about in 1993 after The Hague Convention on the Protection of Children and Co-operation in Respect to Intercountry Adoption (Duncan, 2000). This was based on the Leysin principles formed under the auspices of the United Nations in 1960 (O'Brien, 1998). The Hague Convention was a multinational treaty aimed at protecting the rights of internationally adopted children. The main objectives included ensuring the adoption only occurs if it is in the child's best interests, to establish a system of co-operation among participating nations and to ensure regulation of intercountry adoptions which confirm to the convention's requirements (Ku, 2005). The framework set out within the convention was incorporated into UK adoption law under the Adoption (intercountry aspects) Act 1999.

Differing attitudes to ICA

Historically there has been widespread opposition to intercountry and transracial adoptions (Tizard, 1991). Opponents of transracial adoption suggest that placing children outside of their racial identity group may increase their risk for long-term psychological problems, undermine their identity development and ultimately lead to a "cultural genocide" (p. 65, Brodzinsky, Smith & Brodzinksy, 1998). Central to this is the notion that positive racial identity is at the core of healthy personal development (Brodzinsky et al, 1998). In contrast others consider that a child's need for a stable, permanent family may override the possible benefit of a racially matched family (Rushton & Minnis, 1997). Hayes (193) considers

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transracial placements as beneficial as it supports racial integration, which is what society should be striving towards. Although the Adoption and Fostering Act (2002) emphasises a preference for matching children on race, ethnicity and culture, this may not always be possible. Transracial adoption remains highly controversial and the British Association of Black Social Workers maintain opposition to all transracial placements (Brodzinsky et al, 1998).

Behaviour outcome studies

In assessing children's post-adoptive development, Bimmel et al, (2003) propose that the use of meta-analytic statistical techniques has aided the interpretation and summary of the results of large numbers of diverse studies. Bimmel et al (2003) conducted a meta-analysis of 10 studies looking at the problem behaviours of 2317 internationally adopted children in comparison with non-adopted controls. Whilst Juffer & Van Ijzendoorn (2005) conducted a meta-analysis of 64 studies to estimate the effects of ICA on behavioural problems. Their samples included over 25,281 internationally and domestically adopted cases and 80,260 non-adopted controls (Juffer & Van Ijzendoorn, 2005).

Overall, Bimmel et al (2003) consider that internationally adopted adolescents appeared to exhibit a slightly higher number of total behaviour problems than non-adopted adolescents. However, all effects were weak and Bimmel et al (2003) concluded that "*the majority of internationally adopted adolescents are well adjusted and do not show more problem behaviours than do their non-adopted peers*" (p.75 Bimmel et al, 2003). Similarly. Juffer & Van Ijzendoorn (2005) conclude that "*the rate of behaviour problems is modest, indicating that most international adoptees are well-adjusted*" (p.2510). However studies within the two meta-analyses do differ on a number of key factors:

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Gender

The studies included in the meta-analysis by Geerars, Hoksbergen & Roda (1995) and Berg-Kelly & Eriksson (1997) found significantly more behaviour problems in internationally adopted girls. Whilst Andresen (1992) found that internationally adopted boys showed significantly more behaviour problems. This is in contrast to five studies Bagley (1991), Goldney, Donald, Sawyer, Kosky, & Priest (1996), Cederbland, HööK, Irhammar & Mercke (1999), Sharma, McGue, & Benson (1998) and Rosenwald (1995) that found no more problem behaviours in internationally adopted adolescents, either boys or girls, in comparison to non-adopted peers.

Age

Most studies have found an association between increased age at adoption and adoptees' poorer mental health (Hoksbergen, 1997; Rushton & Minnis, 1997; Howe, 1998; and Cederblad et al, 1999). Since, the later the age of adoption, the increased possibility that the child will have been subjected to poor care or disruptive placements (Von Borczyskowski et al, 2006). Conversely there are other studies that indicate that that the age of the adoptee on arrival is not significantly associated with outcomes (Bimmel et al, 2003). Overall, there seems to be a consensus that it is not the age of the inter-country adoptee at adoption per se, but the quality of their pre-adoption experience that determines future outcomes.

The studies included in Bimmel et al's (2003) meta-analysis by Versluis-den Bieman & Verhulst (1995) and Bogaerts & Van Aelst (1998) report significantly more behaviour problems in the internationally adopted adolescents in comparison to their non-adopted controls. Thus Bimmel et al (2003) consider overall, that internationally adopted adolescents appeared to exhibit a slightly higher number of total behaviour problems than non-adopted adolescents. In contrast, Juffer & Van Ijzendoorn (2005) found that intercountry adoptees exhibited fewer total behaviour problems in adolescence compared to early and middle childhood.

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Externalising versus internalising behaviour problems

Juffer & Van Ijzendoorn (2005) differentiate between externalising problems (hyperactivity, aggression and delinquent behaviours) and internalising problems (anxiety, depression and withdrawal). Their findings indicate that international adoptees presented with more total externalising and internalising behaviour problems than their non-adopted peers. Bimmel et al (2003) found that when girls and boys were considered separately, only girls displayed more total behaviour problems, but that the differences between the internationally adopted and non-adopted adolescents were expressed in externalising rather than internalising behaviours. Again, the effect sizes between intercountry adoptees and non-adoptees were small.

Transracial adoptees

Considering research specifically in relation to transracial adoptees, contrary to the authors' expectation that internationally adopted transracial adolescents will present more behaviour problems, this was not the case in Bimmel et al's (2003) meta-analysis. Indeed Brodzinsky et al (1998) conclude that the overall adjustment of transracial adoptees indicates that they do not suffer negative developmental outcomes.

Mental health outcome studies

Juffer & Van Ijzendoorn's (2005) meta-analysis also included 34 studies on mental health referrals to consider if this was affected by ICA. Their findings indicate that international adoptees were over represented in mental health services (Juffer & Van Ijzendoorn, 2005). This finding was supported by Miller, Fan, Christensen, Grotevant & Van Dulman (2000), and Schechter (1960). Although intercountry adoptees are more often referred to mental health services, Juffer & Van Ijzendoorn (2005) illustrate that overall, internationally

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adopted children show better behavioural and mental health outcomes than domestic adoptees, in comparison to non-adopted children.

Tieman, et al (2005) conducted a large scale investigation of intercountry adoptees as adults and found that they were one and a half to nearly four times as likely to show increased rates of anxiety, mood and substance abuse disorders, in comparison to non-adopted adults. Furthermore, Cantor-Graae and Pedersen (2007) used a population-based cohort study and found that intercountry adoptees in Denmark had an increased relative risk of developing schizophrenia compared to native Danes. This increased risk was independent of age at onset or region of adoption.

These findings that intercountry adoptees are more susceptible to mental distress than non-adoptees, are consistent with a Swedish cohort study involving more than 11,000 intercountry adoptees (Hjerm, Lindblad & Vinnerlijung, 2002). The study demonstrated that the intercountry adoptees are at a higher risk of suicide, psychiatric illness and maladjustment. Furthermore, Von Borczyskowski, Hjern, Lindblad & Vinnerljung (2006) looked at 6,065 intercountry and 7,340 domestic adoptees and over a million non-adopted participants and found that intercountry adoptees had clearly increased risks for suicide attempts and suicide, even after adjustments for sex, age and socio-economic factors were considered. Domestic adoptees were found to have a lower risk of suicide than international adoptees but an increased risk in comparison to non-adoptees (Von Borczyskowski et al, 2006).

Again discrepancies in gender arose, as Von Borczyskowski et al, (2006) found that female intercountry adoptees were at greater risk than male intercountry adoptees. Whilst Tieman et al (2006) found that intercountry adopted males, rather than females, are more likely to meet the criteria for a mood disorder. Miller et al (2000) also found that adoptive males had less favourable outcomes compared to the general population.

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Inconsistent study outcomes: Methodological explanations

The inconsistent outcome research considered thus far may be affected by a number of different factors. In relation to the research methodology, when considering meta-analytic techniques, it must be emphasised that meta-analytic evidence is comparative and the causal nature of association between international adoption and problem behaviours has not been established (Bimmel et al, 2003). Additionally the studies selected for the meta-analysis may alter the results, for example the exclusion of Verslu is-den Bieman & Verhulst's large study in Bimmel et al's (2003) meta-analysis, significantly alters the overall results.

Tizard (1991) proposes that some studies may have come up with less positive findings as they have asked different questions (Tizard, 1991, p.749). This is confirmed by Hjern et al (2002) who consider that their study focused on very negative outcomes which could obscure the fact that most intercountry adoptees are not affected by negative outcomes.

For factors such as gender, many studies are reaching conflicting conclusions. Therefore it may be that there are greater intra-group differences than inter-groups differences. Additionally Bimmel et al (2003) propose that large scale studies should be interpreted with caution as considerable heterogeneity exists within the studies, i.e., children were adopted from several different countries and cultures, the pre-adoption placements differed and ages on arrival were different. Overall, as Miller (2005) states "*the use of disparate patient populations, diverse research questions and varied methods make the results bewilderingly difficult to synthesize*" (p.2533).

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Inconsistent study outcomes: Hypotheses on additional causal factors

Childhood versus adolescence

The age of the adoptee during the research may be a crucial factor since the analysis of the meta-analyses indicates that studies involving pre-puberty children, whether trans-racial or same racial placements, find they are developing well (Cederbland et al, 1999). In contrast it is the studies involving adolescents or mixed age samples which are less conclusive (e.g., Juffer & Van Ijzendoorn, 2005). Indeed adolescence is a tumultuous time for most and it may be that being adopted has added stressors such as bringing up a renewed fear of rejection, noticing differences and seeking a sense of identity (Deacon, 1997). Bimmel et al (2003) propose that, like most problems experienced in adolescence, intercountry adoptees who display more problems may find them diminishing or disappearing in adulthood. However, this does not explain studies such as Tieman et al (2005) who found that adult intercountry adoptees were increasingly likely to show increased rates of psychiatric disorder and substance misuse. It is clear that further research is needed in this area, particularly long-term longitudinal and follow-up studies.

'Visible' versus 'Invisible' adoption

Juffer & Van Ijzendoorn (2005) propose that intercountry adopted children fare better than domestic adoptees as many internationally adoptions are transracial and therefore 'visible'. They propose that the physical differences between parents and children are so obvious which increases the communication within families about the adoption.

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The country in which the research is conducted may influence the findings. Thus, where the research is conducted in a homogenous country like Sweden, no more than 6-7% of Swedish adolescents have a non-European physical appearance (Hjern et al, 2002). The non-Scandinavian appearance of the intercountry adoptees should be taken into consideration since this may increase their experience of discrimination, racism and identity problems (Von Borczyskowski et al, 2006). As Saetersdal & Dalen (2000) propose from considering identity formation in Norway, a homogenous country: "*intercountry adoptees are more accepting of their background than they are of their appearance.*" (p.169).

Genetic Risk?

Since some research (Juffer & Van Ijzendoorn, 2005) has found that intercountry adoptees fare better than domestic adoptees it may be hypothesised that genetic risks may be a factor. Thus, internationally adopted children are often adopted due to a lack of resources whilst domestic adoptions may involve mental health problems in the birth parents (Juffer & Van Ijzendoorn, 2005). Thus international adoptees may be at a reduced predisposed genetic risk for mental health problems in comparison to domestic adoptees.

Parental Profiles

An important factor may be due to the differences in the types of parents who adopt domestically versus those who adopt internationally. Noy-Sharav (2005) proposes that parents who adopt from abroad are often younger, more educated and have better psychological and financial resources. Levy-Shiff, Zoran and Shulman (1997) found that parents who had adopted internationally in comparison to domestically, used more problem-focused and support-seeking ways of coping. The substantially higher numbers of mental health referrals may be due to intercountry adoptees' parents having a lower threshold to seek professional help, as well as their expectations for their adoptive child as needing more help (Juffer & Van Izjendoorn, 2005). Alternatively, Tieman et al (2005)

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consider that intercountry adoptees' parents may have high expectations and put higher demands on them, leading to poorer functioning.

Why is the understanding of Attachment important?

Bowlby (1977) defined attachment as "*the propensity of human beings to make strong affectional bonds to particular others*", most notably between infants and caregivers. Bowlby hypothesized attachment as an organised behavioural system that is activated at two levels; an evolutionary level, to protect an infant from harm and a psychological level to maintain a sense of security (Hopkins, 1990). Bowlby (1977) considered that the breakdown of these bonds "*explain(s) the many forms of emotional distress and personality disturbance*" (p.201).

Barth & Berry (1991) propose that of the 8% of adoptions that break down annually, the primary reason listed is 'attachment disorder'. In order to help promote optimal attachment relationships and to prevent adoptions breaking down, an understanding of promoting secure attachment is vital. Bowlby's extensive work on attachment has led him to conclude that:

> "*what is essential for mental health is that the infant and young child experiences a warm, intimate and continuous relationship with his mother, or permanent mother substitute in which both find satisfaction and enjoyment*"

(1969 p.181, cited in Noy-Sharav, 2005).

Indeed children who are denied opportunities to form attachment relationships may withdraw from others, exhibit a general state of apathy, display medical symptoms and limited cognitive development (Spitz, 1945). Although models of attachment remain

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relatively stable across the lifespan (Collins & Read, 1994), attachment cannot be considered a fixed trait since changes in attachment patterns *do* occur (Hopkins, 1990). However the long-term sequelae of insecure and disorganised attachments are associated with increased psychopathology and problematic relationships (Fonagy, 1997)

Attachment in domestic and intercountry adoption

Noy-Sharav (2005) proposes that the quality of the parent-child relationship is the paramount factor in the development of a healthy personality. The parent-child relationship after adoption may be challenging given the child's previous experiences of relationships. Since a child's relational experiences may be so unique and subjective, it may be that there are greater intra-group rather than inter-group differences between domestic and intercountry adoptees. For example, later placed Korean-born children in the U.S fared better in comparison to the American-born adoptive sample (Kim, 2002). It was hypothesised that this was due to the Korean children living in family-run foster homes rather than orphanages.

Adoptees' perspective – factors associated with attachment

In terms of the quality of their pre-adoption experience, many internationally adopted children experience a number of disadvantageous factors that may later influence their development (Bimmel et al, 2003). Thus pre and perinatal factors such as malnutrition, inadequate medical care, exposure to alcohol or disease during pregnancy may affect the developing child (Selman, 2000). At the point of adoption many children may have experienced trauma, repeated separations, chronic malnutrition, spent time in institutions, have health problems, moved countries and experienced frustrating communication difficulties (Tizard, 1991).

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Verrier (2000) suggests that separation of the child from its birth parent leaves the child with a narcissistic "primal wound", or profound sense of loss. Indeed, Nickman, Rosenfeld, Fine, MacIntyre, Pilowsky et al (2005) propose that children adopted overseas may feel rejected not only by their birth parents but by the entire country of origin. Thus, the child's experience of abandonment by their biological parents and perhaps repeat separations may have affected their ability to attach (Noy-Sharav, 2005). It may be that that the adoptive parent, particularly for international adoptions, faces a "*more complex task in creating the primary bond*" (p.181, Noy-Sharav, 2005), (p.181).

Van Ijzendoorn & Juffer, 2006 propose that there are greater risks of exhibiting insecure attachment for internationally adopted children with backgrounds of extreme deprivation, neglect, malnutrition and abuse. There is conflicting evidence as to whether these effects are transient or permanent (Farina, Leifer & Chasnoff, 2004). O'Conner & Rutter (2000) with the English and Romanian Adoptees (ERA) Study team, compared three different aged groups of Romanian children reared in 'profoundly depriving' institutions and placed in British homes before the ages of 6 months, 6-24 months, and between 24 and 42 months, to a group of children born in the United Kingdom and placed with adoptive families before the age of 6 months. They found that the frequency of serious attachment problems increased with institutional duration. However the Romanian children placed before the age of 6 months differed little from the UK born children. 30% of the Romanian children adopted after the age of two exhibited severe attachment difficulties which suggests that institutional deprivation could be damaging but that this was not inevitable (O'Conner & Rutter, 2000).

Adoptive Parents' Perspective – factors associated with attachment

Attachment is of course a two-way process and Shapiro, Shapiro & Paret (2001) consider the parents' point of view. By the time they come to meeting their adoptive child, the parents may have been on a long psychological journey as they generally have coped with

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difficult decisions in their search for a child (Leiblum, 1997). Shapiro et al (2001) describe that initially, there may be an incongruence between the child's lack of responsiveness and the parents' joy at meeting their longed-for child. Or Nickman et al (2005) considers that adoptive parents may receive a child on short-notice that they are initially not prepared for emotionally. Furthermore, the adoptive parents may find it difficult to bond with a child who is genetically different to them and in external appearance (Noy-Sharav, 2005).

Bartel, (2005) proposes that secure attachments with adoptive families were more likely in instances where the parenting style was authoritative, the parents received strong social support, there were fewer health problems at arrival for the adopted child, and the child spent more months in the adoptive home at the time of the survey. Judge (2003) also proposes that families that are well attuned to the child's needs, have positive attitudes and coping abilities are more likely to succeed in developing strong relationships with their children.

Attachment outcome studies:

In the majority of the below studies (see Table 1) the children's attachment was measured by the Strange Situation which is a laboratory procedure designed to measure attachment relationships, (Ainsworth, Blehar, Waters & Wall, 1978). Ainsworth et al (1978) identified three groups of attachment styles on the basis of infants' responses to the Strange Situation: secure, insecure-avoidant and insecure-ambivalent. These indicate different qualities of the attachment relationship. A fourth group, disorganised attachment was later discovered (Main & Solomon, 1986).

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Table 1: The Attachment Styles of non-adopted and adopted samples – Four studies

	Study Authors	Van Ijzendoorn, Schuengel & Bakermans-Kranenburg, (1999)	Van Ijzendoorn, Goldberg, Kroonenberg & Frankel (1992)	Van den Dries et al (n prep)	O'Conner & Rutter (2000)
	Sample Type	**Non-adopted normal sample**	**Non-adopted Normal Sample**	**Intercountry & Domestically Adopted Sample**	**Intercountry Adopted Sample**
	Sample Size	Meta-analysis 80 studies	Meta-analysis 34 studies	Meta-analysis 10 studies	English & Romanian Adoptees Project -165 adoptees
Attachment style					
Secure		62%	67%	47%	45%
Insecure			33%	53%	
Insecure-avoidant		15%			13%
Insecure-ambivalent		9%			10%
Insecure-Disorganised		15%			33%

Despite the attachment assessments taking place on average, 20 months after the child's arrival in the adoptive family, it may be observed from these studies that adopted children are less secure and often exhibit more disorganised attachment than their non-adopted peers (Van Ijzendoorn & Juffer, 2006). In relation to the difference between domestically and internationally adopted children, Van den Dries et al (In prep, cited in Van Ijzendoorn & Juffer, 2006) consider that they did not significantly differ. There were significant differences in the attachment styles of early (before 12 months) adopted children and later adopted children, with later adopted children having more disorganised attachments. The

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ERA project also highlights what the DSM-IV (American Psychiatric Association, 1994) and ICD-10 (World Health Organisation, 1992) have identified as disinhibited attachment disorder or 'indiscriminate friendliness'. Here, children are overly friendly with strangers and known adults alike without discrimination as to the relationship or context (Rutter et al, 2007). It is thought of as an adaptive response in being dealt with by large numbers of caregivers such as in institutions. Indiscriminate friendliness is strongly associated with lengthy stays in institutional contexts (Rutter et al, 2007).

Interestingly Van Ijzendoorn & Juffer (2006) consider that the quality of adopted children's attachment behaviour should be compared to their own baseline, that is, to children who are still in institutional care. They considered two studies (Vorria, Papaligoura, Sarafidou, Kopakaki, Dunn et al, 2006 and Zeanah, Smyke, Koga & Carlson, 2005) and found that the children in institutional care exhibited on average, 23% secure attachment, 3% insecure-avoidant attachment, 4% insecure-ambivalent attachment and 70% disorganised attachment. Therefore, the attachment percentages of the adopted children becomes more meaningful, they show twice the percentage of secure attachments and less than half the percentage of disorganised attachments of the institutionalised children (Van Ijzendoorn & Juffer, 2006).

Limitations of attachment research

To date, studies concerned with international adoption and attachment are few (Robertson, 2005) and the ERA project excluded, further longitudinal studies evaluating attachment over time, are needed. Of note, is that the Romanian adoptees may be considered as a special case since they came from such extremely deprived conditions (Robertson, 2005). Thus the results may not be generalisable to other intercountry adoptees.

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Summary & Conclusion:

Overall, it appears that the majority of intercountry adoptees are faring well (Van Ijzendoorn & Juffer, 2006; Tizard, 1991 & Bimmel et al 2003). Those who experienced long-periods of pre-adoptive adverse circumstances may fare less well than their peers adopted at a young age (Van Ijzendoorn et Juffer, 2006). Although institutional deprivation is damaging, it is not inevitable (O'Conner & Rutter, 2000). There are some intercountry adoptees who appear to be at higher risk of psychiatric problems and risk of suicide, (Hjern et al, 2005; Von Borczyskowski et al, 2006; Cantor-Graae and Pedersen, 2007; Tieman et al). These discrepancies may be due to factors such as the research taking place in homogenous countries, where being adopted from another country has a greater impact on identity, and therefore mental health (Saetersdal, B. & Dalen, 2000). Alternatively the discrepancy may be due to methodological differences or greater intra-rather than inter-group differences. It is important that further research is conducted to clarify which individuals are at risk so that early intervention can occur.

Although intercountry adoptees are overrepresented in mental health services in comparison to domestic and non-adoptees (Juffer & Van Ijzendoorn, 2006), overall in relation to mental health, there are indications that they are faring better than domestic adoptees (Juffer & Van Ijzendoorn, 2005). It may be that intercountry adoptees are more frequently referred as their parents are more likely to seek help, rather than suffering worse mental health per se. However intercountry adoptees were found to be at greater risk of suicide than domestic adoptees, and domestic adoptees at greater risk than non-adoptees (Von Borczyskowski et al, 2006). Again the research needs to be replicated to clarify the present tentative conclusions.

In terms of attachment security it is clear that intercountry adoptees are significantly less secure than non-adopted children (O'Conner and Rutter, 2000). It is difficult to generalise about the attachment security of intercountry versus doestically adopted children, since

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there is a general consensus that the most important factor is the quality of the child's pre-adoptive experience and the post-adoptive relationship with their parent. This is of course unique to each child.

Furthermore, Haugaard, (1998) considers that adoption may be considered as a protective factor, as the comparison of adopted children with children born illegitimately, children who stayed with their biological mothers, those in institutions, and those given up for adoption and those later placed in institutions, showed that the adopted children appeared to be better adjusted and more secure (Vorria et al, 2006 & Zeanah et al, 2005). This may be a more useful comparison than with domestically or non-adopted children as it illustrates that intercountry adoptees are faring relatively well.

Since the "*fundamental argument for intercountry adoption is that it simultaneously satisfies the needs of the adopting couple and the abandoned child*" (Tizard, p.747). Intercountry adoption is likely to continue, thus the importance of understanding more about the impact on adoptees and adoptive parents, is paramount. Since there appear to be many intra rather than inter-group differences it may be useful to consider the unique circumstances of each adoption.

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<u>**Appendix I: Search Strategy Procedure**</u>

Initial ideas & broad search

The literature search process began by the author looking at key textbooks on adoption to gain background information on the topic. This enabled further information to be gained on the history of adoption, current trends, statistics and psychological difficulties associated with intercountry adoption. From this, key authors, books and papers were identified. Ideas for the focus of the literature review were discussed with the thesis supervisor.

Focus of ideas of ideas and systematic search

Electronic databases were then searched as the focus of the literature review became more established (see below). Additionally, website, citation and reference searches were also conducted (see below). This enabled the identification of relevant research since the originally identified key books and papers, were published. Through this process, gaps in the literature became more identifiable. The identification of meta-analyses such as Van Ijzendoorn & Juffer (2006) and Bimmel et al (2003) considerably aided this process.

Ensuring correct gaps in the knowledge base existed

After some time, a second systematic search (as described above) was conducted. This was to check the identified gaps were still present and to identify any recently published research. For example the paper 'Risk for Schizophrenia in intercountry adoptees, (Cantor-Graae, & Pedersen, 2007), was only very recently published and made available on-line.

Database search

Below is a list of all the databases used for the literature search:

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- PsycINFO Database

(a database of psychological literature)

- Pubmed

(provides access to citations from MedLine, a health database and other life science journals)

- National Research Register

(a register for current and recently published research in the National Health Service.)

- Cochrane Library

(database of systematic reviews of healthcare interventions)

- Scopus

(an abstract and indexing database covering health, life sciences, social sciences and psychology)

- Web of Science

Inclusion & Exclusion Criteria

A set of criteria was applied in order to evaluate the papers yielded from the searched databases.

- Include both qualitative and quantitative studies
- Exclude studies only looking at the medical or physical outcomes of adoptees
- Exclude studies that were not reported in English

Search terms

Below is a list of the search terms used:

- Adoption, adoptive, adopted
- Intercountry, international, national, domestic

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- transracial, transnational

- adoptee, adoptive parent, psychological parent, family

- difficulties, distress, problems,

- resilience, deprivation, recovery, deficit,

- outcomes, development, adjustment, impact

- attachment, disorganised, insecure, disinhibited

- behaviour

- mental health, psychopathology

- identity, adolescence

- ethnicity, racism

- cognitive functioning

- communication

- indiscriminate friendliness

- review, meta-analysis, study, longitudinal, cohort, relative risk, qualitative, quantitative

- Hague convention

- Adoption legislation

Specific searching procedure

Since a number of databases were used, each search term was entered into the databases, in turn. Combined searches were carried out using (eg: adoption and identity), using all combinations of hits that had been found for these individual searches. The Boolean operators (AND, NOT, OR) were used to improve the inclusion and exclusion of key words (eg: adoption NOT fostering). To ensure all relevant references were included, the truncation technique (putting an * at the end of the word) was used to include different forms of the each search term. Such as adolesc* to cover adolescent and adolescence.

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Website searches

Search engines on the internet such as google (www.google.com) and google scholar (www.scholar.google.com) were used. Websites such as the British Association for Adoption and Fostering (www.baaf.org.uk) were searched for general information and statistics. The office of public sector information (http://www.opsi.gov.uk/acts/acts2002/ukpga_20020038_en_1) was searched for information on the Adoption and Children's Act 2002.

Author relevant searches

The names of the most relevant authors were searched in the above databases (eg: Van Ijzendoorn, Rutter and Tizard). In addition there names were searched in search engines which led to some personal academic pages and a list of publications to be found.

References searches

Looking through the reference list of obtained papers was useful in identifying further relevant papers.

Citation searches

Web of Science identify all publications by key authors and enabled the identification of further journal articles by the same author to be accessed. This was particularly useful for example, to identify all the papers by the English and Romanian adoptees study team.

Search Output

This search elicited over 150 pieces of relevant literature. These were obtained electronically either from The University of Hertfordshire Library or via The British Library.

The articles were then grouped into themes to make the information more manageable. The themes were:

- Introduction articles
- Policy or legislation
- Outcomes
- Attachment
- Identity
- Culture
- Race

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Parental Experiences of Intercountry Adoption: An Interpretative Phenomenological Analysis Study

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Submitted in partial fulfilment of the requirements of the
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1.ABSTRACT

Intercountry[2] adoption, where children are born in one country and adopted by families in another country, has become an increasing global phenomenon (Scherman & Harré, 2004). As indicated by a review of the literature, the research in relation to intercountry adoptees provides contradictory findings in almost every area. However, since there is some evidence to suggest that a proportion of intercountry adoptees are at greater risk of developing mental health difficulties (Van Ijzendoorn & Juffer, 2006) further research, particularly in the UK, is required. As Anjudo (1988) posits, parents are their children's major reference group, and this research is therefore aimed at exploring the experience of parenting an intercountry adoptee. A qualitative approach, Interpretative Phenomenological Analysis (Smith, 1996) was chosen as the most suitable methodology. This approach aims to explore in detail how participants are making sense of their world, and the meanings that experiences hold for them. Semi-structured interviews were conducted with six participants who had accessed or were accessing support from a specialist Adoption and Fostering team. The analysis of the transcribed verbatim accounts yielded four super-ordinate themes; *'the importance of resolve and tenacity'*, *'blood versus water'*, *'weathering the storm of parenthood'* and *'the complexity of cultivating a heritage'*. The results were consistent with some of the existing theoretical, research and clinical literature. Additionally they also provided some new areas for consideration such as the emotional difficulties in negotiating the process of intercountry adoption. Additionally, areas for future research were proposed. Due to the small sample size, implications and recommendations are considered tentatively and include (1) prospective intercountry adoptive parents would benefit from the provision of pre and post-adoption supportive groups, (2) intercountry adoptive families would benefit from greater availability of multi-disciplinary specialist teams to address their needs, (3) there is a role for cultural consultants to aid both adoptive parents and professionals in their work with intercountry adoptive families. Since the number of children internationally who need new families continues to increase it is important to continue to find improved ways to support intercountry adoptive families.

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[2] The term 'intercountry' is used interchangeably with 'international' adoption throughout

Parental Experiences of Intercountry Adoption:
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2. INTRODUCTION

2.1 OVERVIEW

This section will provide an introduction to the literature and research around intercountry adoption, primarily from the adoptive parents' point of view. The focus will be on the process of intercountry adoption and the development of intercountry adoptees' identity. The aims and the research questions relating to the study will then be stated.

I have had a long-term interest in adoption, but my interest in this project was sparked by observing the intense and often emotive debates that occurred in the media in response to increasing numbers of high profile intercountry adoptions. It appeared that everyone had a strong rather than neutral opinion on the subject and I was intrigued to consider the issue further.

Intercountry adoption, where children are born in one country and adopted by families in another country, has become a global phenomenon (Scherman & Harré, 2004). Intercountry adoption is estimated to involve more than 40,000 children a year moving among more than 100 countries (Van Ijzendoorn, & Juffer, 2006). In 1998 the main receiving countries for children were the USA, France, Italy, Canada, Sweden, Switzerland and the Netherlands (Selman, 2000). The main countries of origin were Russia, China, Korea, Guatemala and Vietnam (Selman, 2000). Of those 40,000 children, the numbers of intercountry adoptees coming to England and Wales are relatively small. In 2006 there were 270 intercountry adoptions and 367 in 2005 (Mather, 2007). Whilst intercountry adoptees themselves are the subject of increasing numbers of research studies, adoptive parents appear to be less considered and are the focus of this research study.

2.2 MOTIVATION TO ADOPT

Historically a strong motivation for intercountry adopters was altruism, reaching out to a child who was in need of a family, often due to the effects of war (Westhues & Cohen, 1998). The Abortion Act of 1968, trends for single mothers to keep their children, and a marked decrease in domestically available babies, have resulted in the increase of international adoptions (Mather, 2007). Hoksbergen, Jöffer and Waardenburg (1987) note

that, in the 1980's, intercountry adoptees were often the victims of poverty rather than war. Intercountry adoption has continued to grow considerably since the early 1990's when the infamous Romanian orphanages were exposed to the world (Mather, 2007). Furthermore the internet has also fuelled awareness about the availability and needs of children from developing countries (Mather, 2007).

2.3 PSYCHOLOGICAL PARENTS

Although intercountry adoption is used by many fertile couples, a large proportion of intercountry adoptive parents are infertile (Deacon, 1997). Parents who chose to adopt in response to their infertility will have had very different experiences in comparison to those parents for whom adopting is a proactive choice. For example, the infertility may have been established after undergoing stressful, invasive and unsuccessful medical procedures (Simon & Altstein, 1991). This may leave infertile couples with the experience of "*a loss of biological continuity*" (p.77, LePere, 1987). Indeed many losses for infertile adoptive parents may exist around biological parenthood. Depending on cultural and societal attitudes there can also be experiences of shame and guilt (Triseliotis, Feast & Kyle, 2005). As Triseliotis et al (2005) found, for adoptive parents, the idea of 'family' and having children were closely associated. Thus the crisis of infertility and the subsequent desire to become adoptive parents may involve working through previous notions of what it means to be a parent in our culture (Daly, 1992).

Historically non-biological parents may have been considered more as substitute parents and viewed as inferior (Robertson, 2005). This was due to early research that proposed attachment as having a biological origin. However later research led to the overall conclusion that:

> whoever looks after a child in the early years, whether she is the blood mother, adoptive mother or foster-mother, becomes the object of the child's deepest feelings, his **psychological parent**
>
> (p.210, Robertson & Robertson, 1989)

2.4 THE ADOPTIVE PARENTS AND ADOPTED CHILD – PARALLEL EXPERIENCES

Landerholm (2001) parallels the adoptive child's experiences of loss with the infertile adoptive parents' experiences, such as being genetically unrelated from each other. As Verrier (2000) suggests, the separation of child and birth parent resulting in adoption leaves the child with a narcissistic 'primal wound', or profound sense of loss. Verrier (2000) states:

> bonding doesn't begin at birth, but is a continuum of physiological, psychological and spiritual events which begin in utero…when this natural evolution is interrupted by a postnatal separation…the resultant experience of abandonment and loss is indelibly imprinted upon the unconscious minds of these children
> (p.1, Verrier, 2000)

There are also other aspects of the child that were lost through adoption; loss of origins, possible siblings and of genealogical continuity (Noy-Sharav, 2005). Additionally there may be separations from caretakers whom they got to know, waiting for the adoption process to finalise (Trolley, 1995). Furthermore the adoptive child must negotiate losses of familiar foods, language, faces, socio-cultural interchanges as they are moved to another country and a new family (Harper, 1986). It is important to remember that intercountry adoption causes children to move from familiar surroundings where they fit in, to different surroundings where they stand out (Mather, 2007).

Indeed, Mather (2007) in considering the Western 'rescuing' of children from developing countries proposes that while adopters are often motivated by humanitarian motives, intercountry adoption can be an ethical minefield. Without insulting the intention of adoptive parents, Mather (2007) continues that it would be naïve to deny the potential exploitation of desperate parents caring for their own biological children they can't afford.

2.5 INTERCOUNTRY FAMILIES

The concept of what constitutes a family has evolved as society has developed (Deacon, 1997). Due to changing societal values about single parenthood, biracial marriage and homosexual couples (Bennett, 2003) the profile of prospective intercountry adopters has also changed. Non-traditional arrangements of single parent, gay and transracial adoptions

have become more frequent (Nickman, Rosenfeld, Fine, Macintyre, Pilowsky et al, 2005) and adoption is often a proactive choice. Indeed in the US there is a perception of an anti-homosexual bias within the domestic adoption system and a preference for gay couples to adopt internationally rather than domestically (Bennett, 2003). Additionally, open communication with birth parents is more probable (Grotevant & McRoy, 1997) and reunions with older adoptees and their birth parents are more common (Moran, 1994).

2.6 INTERCOUNTRY ADOPTIVE PARENT'S PROFILE

Typically the profiles of intercountry adoptive parents show they are more educated with better psychological and financial resources in comparison to those who adopt domestically (Noy-Sharav, 2005). Couples parenting intercountry adoptees as compared with parents of domestic adoptees have been found to report better marital adjustment and communication (Levy-Shiff et al, 1997). Again however, there may be differences in parents who adopt as an alternative to infertility and for whom adoption is a pro-active choice. Bennett (2003) considers research on lesbian adoptive families, presumably for whom adoption is a choice and found that lesbian parent-child attachments parallel heterosexual parent-child attachments. Furthermore, Fitzgerald's (1999) review concluded that

> the children of lesbian parents are developing psychologically, intellectually, behaviourally and emotionally in positive directions (p.57)

However lesbian parents did acknowledge that the family's diversity did complicate the challenges of daily life (Bennett, 2003). For a more comprehensive discussion regarding the profiles of intercountry adoptive parents see Davis (2007).

2.7 PRE-ADOPTION

After making the decision to adopt a child, potential adoptive parents are thoroughly assessed in terms of their readiness to adopt, their level of commitment to the adoption and their perceived fitness as parents (Robertson, 2005). This is achieved through a home study process, and face-to-face visits which evaluate multiple areas of family life such as finances, health, emotional stability, expectations of parenting and levels of support (Robertson, 2005).

Previously couples who may have struggled against local authorities may mistakenly have believed that adopting abroad involves less bureaucracy (Mather, 2007). However, in June 2003, the UK Adoption (Intercountry Aspects) Act 1999 was enacted, stating that any individual wishing to adopt a child abroad must undergo the same procedure as domestic adopters (Mather, 2007). Furthermore, prospective adopters are required to become experts in the adoption practices of the chosen country, making all initial enquiries and meeting all financial costs (Mather, 2007). Relatively little is known about the interountry adoption process for parents and their appears to be a lack of research in this area.

2.8 BEGINNINGS

Although prospective parents may wait a lengthy time for a child to be found, the time between when a child is found and then placed, may be short (Deacon, 1997). This may be a shock to adoptive parents who may be thrust into parenthood, unlike biological parents, where there is a nine month period to adjust (Baldo & Baldo, 2003). Initially, the psychological readiness to engage may differ between the adoptive parents and the adoptive child (Shapiro, Shapiro & Paret, 2001). For parents[3] the happiness of first meeting their longed-for child may be altered by the child's lack of emotional responsiveness to them (Shapiro et al, 2001). Parents may feel deprived of the anticipated fantasy and joyfulness of having a child (Shapiro et al, 2001). Additionally in accepting the child, the couple is also accepting the "ghosts" of the biological parents (Rosenberg, 1992). As Lindsey (2006) considers, the birth family may remain alive, consciously or unconsciously in the mind of the child, and also the adoptive parents. This union meets the needs of both the child and the parent(s) for a family and is the beginning of a meaningful psychological journey (Kirk, 1964, in Shapiro et al, 2001).

2.9 ADJUSTMENT

A review of the existing literature on how well intercountry adoptees fare in comparison to domestic adoptees and non-adopted children was undertaken by Davis (2007). The review focused on the mental health, behaviour and attachment of intercountry adoptees. It

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[3] From this point forward, 'parents' refers to the child's adoptive parents, rather than their biological parents.

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considered the available literature including a number of large-scale quantitative meta-analytic studies.

A summary of the findings of Davis' (2007) review will be provided here. Readers interested in the details of the research appraised should consult the referenced literature review. In relation to behavioural difficulties, the literature indicates that the majority of intercountry adoptees do not exhibit more difficulties than their non-adopted peers. A minority of studies indicated a modest increase in behaviour problems for intercountry adoptees, however the effect sizes were weak.

The review of literature regarding the mental health of intercountry adoptees revealed a more complex picture. The literature indicates that international adoptees are over represented in mental health services relative to the general population. Indeed studies revealed that intercountry adoptees were at increased risk for anxiety, mood and substance abuse disorders and have an increased relative risk for developing schizophrenia in comparison to non-adopted individuals. Furthermore, Davis (2007) found that two rigorous studies indicated that intercountry adoptees had significantly increased risks for suicide attempts and suicide. Indeed, female intercountry adoptees were found to have an increased risk of suicide attempts and suicide in comparison to intercountry adopted males.

Inconsistencies within the available literature were explained by a number of different factors summarized by Miller (2005) who states:

> the use of disparate patient populations, diverse research questions and varied methods make the results bewilderingly difficult to synthesize (p.2533).

Importantly, studies involving intercountry adolescent adoptees provide the most perplexing picture of their adjustment. Indeed adolescence can be a tumultuous process and it may be that being internationally adopted adds complexity, at a time when a sense of identity is being sought. Therefore identity development appears to be vital in relation to the adjustment of intercountry adoptees. There was conflicting evidence in relation to transracial adoptees, many of whom are adopted internationally. It was proposed that transracial adoptees', may experience further difficulties around identity development such

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as discrimination and racism. The literature does not provide much understanding around the identity development of intercountry adoptees (some of whom are transracial) and further research is necessary.

Overall intercountry adoptees seem to exhibit better behavioural and mental health outcomes than domestic adoptees, but not in comparison to non-adoptees. The available literature hypothesises that this may be due to the differences in typical parent profiles of those who adopt internationally versus domestically. It may be that intercountry adoptive parents seek more professional help as they have lower thresholds for seeking help and may expect their adoptees to require more help than those adopted domestically.

Attachment in intercountry adoptees was also examined since it is the quality of this parent-child relationship that appears to be the paramount factor in the development of a healthy personality (Noy-Sharav, 2005). Given intercountry adoptees' significant and early experiences of loss and disruption in early relationships with caregivers, the literature indicates that attachment difficulties may occur, but are not inevitable. Overall, Davis (2007) found evidence that it is not the age of the inter-country adoptee at adoption per se, but the quality of their pre-adoption experience that determines future outcomes.

Furthermore Van Ijzendoorn & Juffer (2006) consider that the quality of intercountry adopted children's attachment behaviour should be compared to their own baseline, that is, to children who are still in institutional care. Indeed, they found twice the proportion of secure attachments and less than half of disorganised attachments in comparison to the institutionalised children (Van Ijzendoorn & Juffer, 2006).

Overall, the literature appears to be overwhelmingly inconclusive. However, given some evidence to suggest that some intercountry adoptees are suffering from higher rates of psychiatric disorders and are at greater risk of suicide, it is important to consider areas of difficulty for intercountry adoptees. One area that seems to repeatedly indicate difficulties for intercountry adoptees, is adolescence and identity. Therefore, it appears to be of significance to investigate how intercountry adoptive parents impact their children's identity and identity development.

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2.10 ADJUSTMENT & IDENTITY

Identity development is generally viewed as beginning with children's awareness that they are separate and unique (Clarke & Justice, 2008). For example, when a red dot is put on a two-year old child's nose, they will look in the mirror and notice the dot on their face, implying that they recognise themselves (Bullock & Lutkenhaus, 1990). The process of developing an identity continues throughout childhood and becomes the focus of adolescence (Clarke & Justice, 2008). Erikson (1950) proposed a psychosocial model of identity development, the term psychosocial being derived from psychological (mind) and social (external relationships and the environment), which illustrate the important roles of both in our development and adjustment.

Erikson's model (1950) asserts that individuals experience eight crisis stages, (see **Table 1**) which significantly affects individuals' adjustment. Each stage relates to a corresponding life stage and its inherent challenges, and involves a crisis of two opposing emotional forces (Coles, 2001). For example, the first stage, *trust versus mistrust*, occurs during the first year of life when the infant relies on the dependability and quality of caregivers. Erikson (1982) proposes that if an infant is fed and cared for they will feel secure in the world and develop trust. However, if an infant is provided with a caregiver who is inconsistent, emotionally unavailable or rejecting, this may lead to mistrust, fear and a belief that the world is inconsistent and unpredictable (Erikson, 1982).

Table 1: Erikson's (1950) Psychosocial Stages of Development

Psychosocial Conflict	Equivalent Life Stage	Positive Outcomes from Crisis
Trust versus Mistrust	Infancy	Hope & drive
Autonomy versus Shame & Doubt	Early Childhood	Willpower & self-control
Initiative versus Guilt	Preschool Years	Purpose & direction
Industry versus Inferiority	Early School Years	Competence & Method
Identity versus Confusion	Adolescence	Fidelity & Devotion
Intimacy versus Isolation	Early Adulthood	Love & Affiliation

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Generativity versus Stagnation	Adulthood	Care & Production
Integrity versus Despair	Old age	Wisdom & Renunciation

The next three of Erikson's stages take place during childhood, and if resolved, involve an individual developing a greater sense of personal control, beginning to assert this control over the world and developing a sense of pride in their accomplishments (Erikson, 1982). Individuals who struggle to resolve these crises may experience a sense of self-doubt, a lack of initiative and may doubt their ability to be successful (Erikson, 1982).

Erikson (1982) proposed that the goal of adolescence was to achieve a coherent identity and to avoid role confusion, where an individual cannot see who they are and how they relate to their environment. Individuals who are encouraged to explore their independence will emerge with a strong sense of self, whilst Erikson (1982) proposes that those who remain unsure will feel insecure about themselves and the future.

Marcia (1991) hypothesised that adolescent identity development and subsequent adjustment involves two steps. Firstly, there is an upheaval where old values and choices are re-examined. This is followed by an individual committing to a certain value of their identity in an area such as politics, occupation, religion, intimate relationships, friendships and gender role. Marcia (1991) proposed that some adolescents may become overwhelmed by the task of identity development and neither explore or make commitments, resulting in social isolation or withdrawal.

Within Erikson's stage model (1950) each step builds on the successful resolution of the prior stage. For example, Erikson considered that a strong sense of personal identity (the task of adolescence) was important to developing intimate relationships, which is the task of early adulthood. Indeed, most empirical research into Erikson's work is around adolescence and identity and Marcia's (1991) research empirically supports Erikson's theory by showing that those with a poor sense of self tend to have less committed relationships and are more likely to be isolated and depressed.

During adulthood, Erikson (1982) proposes that individuals continue to build on their lives focusing on career and families. Those who fail to attain this skill are considered to feel unproductive and uninvolved in the world (Clarke & Justice, 2008). During old age, adjustment is focused on reflecting back at one's life. Erikson (1982) proposed that at this stage, if the crisis is successfully resolved, one looks back with few regrets and has a sense of integrity about accomplishments. Conversely, if unsuccessful an individual may experience many regrets and feelings of despair.

2.11 VALUE & CRITIQUE

Erikson's theory sheds light on why those who had experienced early difficulties, then also have difficulty with the subsequent crises that emerged during adulthood (Clarke & Justice, 2008). Furthermore Erikson provided a useful framework in facilitating healthy emotional adjustment and identifying key issues. Whilst Erikson's model emphasises the sequential nature of the crisis stages, the model also asserts that individuals can continue to change and develop throughout their lives, thus providing an optimistic view.

However, Erikson's (1950) model has also received criticism. For example Marcia (1980) and Waterman (1985) stated that it is difficult to objectively evaluate Erikson's theory as so many threads enter into the process of establishing an identity. Indeed, Waterman (1985) concluded that each person must create a unique synthesis of all the disparate parts.

Others have questioned how adults who rediscover themselves and develop a different understanding of their lives due to life's experiences, fit into Erikson's model (Clarke & Justice, 2008). Furthermore, many of Erikson's conclusions were based on research with male participants and thus is gender-biased

2.12 IDENTITY OVERVIEW

A central issue that underlies the debate in measuring aspects of adopted children's identity development is the lack of widely accepted, clear and consistent definitions within the research literature (Scroggs & Heitfield, 2001). For example, the available literature uses a vast array of interchangeable terms to describe different aspects of identity such as cultural, racial, ethnic, ethno-racial, heritage, ancestry, lineage and birthright. Furthermore there are

differences in what is considered to constitute a positive racial, ethnic or cultural identity and how these terms are measured. For the purposes of this introduction, overall identity will be considered, followed by different aspects of identity construed as adoptive identity, intercountry adoptive identity, cultural identity, ethnic identity and racial identity. Each area merits an introduction in its own right. However, it is beyond the scope of this introduction to consider the historical developments in each area. Thus for the purposes of this study a brief overview of each area will be considered and further relevant research will be more closely considered in the discussion section.

2.13 *PERSONAL IDENTITY*

Grotevant (1993) proposes that the answer to the question "who am I?" embodies the concept of personal identity. This psychosocial concept is associated with a complex developmental task in contemporary western society (Grotevant, 1997). Erikson, who has written most exclusively about identity and was himself an adoptee, perceived the development of a secure sense of identity as central to mental health (Noy-Sharav, 2005). Erikson's definition of identity is that it:

> Stands at the interface of individual personality, social relationships, subjective awareness and external context (p. 161, Erikson, 1968).

While Grotevant (1997) defines personal identity as concerned with:

> The interconnected issues of uniqueness and similarity… that …concerns the self, the historical and cultural contexts of the self, and change over time (p.4).

2.14 *IDENTITY DEVELOPMENT*

As stated, Erikson proposed that the foundations for identity are laid in infancy and early childhood, while the period of most acute struggle for its consolidation is in adolescence (Erikson, 1968). Grotevant (1997) proposes that identity development takes on further importance during adolescence due to the combination of physical, cognitive and social changes that take place, for example the emergence of abstract thought allows the exploration of spiritual beliefs. Adolescent identity development is the foundation for adult

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psychosocial development and interpersonal relationships (Grotevant, 1997). However identity development is not linear, it is a life-long process, and perhaps more accurately characterised as a cycle (Marcia, 1993). At each cycle, different aspects of the self may be integrated at a more mature cognitive and affective level.

2.15 THE ROLE OF SOCIAL INTERACTION IN IDENTITY DEVELOPMENT

Similarly to Erikson (1950), who considered the 'social' aspect of his psychosocial model, Mead (1967) proposed that the sense of self is an activity, a process which comes about through our engagements, relationships and connections with other people. Cooley (1902) used the term 'the looking-glass self' to highlight the extent to which our definition of ourselves relies on the feedback and evaluations we receive from others. Consequently it may be considered that the construction of identity is a temporal process mediated by the anticipated responses of significant and non-significant others (Crossley, 2000).

2.16 THE ROLE OF PARENTS & OTHERS IN IDENTITY DEVELOPMENT

Many theorists have noted that an individual's identity develops within the context of interpersonal interactions (Cooley, 1902, Mead, 1967). Indeed the search for identity is affected by an individual's social world, their parents, peers, education and surrounding society (Blewitt & Broderick, 1999). Furthermore these in turn are all affected by the cultural and historical context in which the identity formation occurs (Blewitt & Broderick, 1999). Kagan, (1999) considers the ways in which parents influence children; through direct interaction, emotional identification and family stories. Emotional identification for example may involve, a child praised for intellectual competence by parents who enjoy reading and display curiosity about the world is more likely to value intellectual pursuits than a child whose parents praise academic success but do not have interest in intellectual competence (Kagan, 1999). Furthermore the power of identification can be seen in the robust relationship between the educational level of the parents and many psychological outcomes such as frequency of aggressive behaviour, level of school achievement and attitude toward authority (Brooks-Gun, Klebanoff & Duncan, 1996).

Conversely, during adolescence individuals seek autonomy from their parents and the search for identity takes place largely within the world of peers (Blewitt & Broderick,

1999). During adolescence, individuals are usually identified with particular 'crowds' which are large, reputation based collectives of similarly stereotyped individuals (Brown, 1990). The common notion of 'peer pressure' indicates that individuals may conform despite their own judgment. However, research findings suggest that adolescents are willing members of their crowds influenced by and influencing each other (Seltzer, 1982).

2.17 CULTURAL DIFFERENCES IN IDENTITY DEVELOPMENT

Beyond the individual, the family and their friends, the even larger context of culture exerts its influence on the development of identity. A culture's values, laws, politics and customs contribute directly and indirectly to how an individual constructs a map of the world that is reciprocal and multi-directional (Blewitt & Broderick, 1999). Indeed Blewitt & Broderick (1999) note that many researchers from diverse disciplines have noted a general loss of community in Western culture, and more of a focus on individualism and material success. Furthermore Western adolescents today are:

> Careening down the information superhighway, and electronic conduits (TV, videos, computers and music) have become strong competitors to the traditional societal institutions in shaping young people's attitudes and values.
> (Carnegie Council on Adolescent Development,-1996)

Identity and our sense of self emerge differently depending on the individual's culture (Kim & Choi, 1994). For example referring to one's possessions is a marker of 'selfhood' particularly in Western children that is not universal. Whiting and Edwards (1988) found in their large cross-cultural study that children rarely claimed that toys were 'mine'. Additionally, Greenfield (1966) found that children in Senegal seemed to lack Western self-consciousness, there was no distinction between their thoughts about something and the thing itself. Indeed they proposed that children's theories of mind and the relationship between their view of themselves, may vary with cultures. Furthermore there are large inter-cultural differences of looking at the self depending on the individualistic or collectivist orientation of a culture (Van den Heuvel, 1992). Thus in their study Van den Heuvel, (1992) compared self-descriptions of Dutch, Turkish and Moroccan 11-year olds and found the Dutch children used more psychological statements and the Turkish and

Moroccan children referred more to social aspects of the self, highlighting the cultural impact of looking at different aspects of our identities.

2.18 ADOPTIVE IDENTITY

An adopted child has a more complex task in building their identity (Noy-Sharav, 2005). Even if adopted in early infancy, they have undergone a separation from birth parents and constructing their adopted identity involves two sets of parents; one actual and present, and the other more abstract in memory and imagination (Brinich, 1990).

Earlier theoretical thinking concluded that adopted individual's identity formulation is impaired due to the lack of a 'blood line' which complicates the process of identity consolidation (Noy-Sharav, 2005). Sants (1964) referred to this as 'genealogical bewilderment'. This is the distress displayed by individuals who are ignorant or confused about their origin and is common for intercountry adoptees (Hibbs, 1991). Frisk (1964) also considered that the lack of family background information prevents the development of a healthy 'genetic ego' and is replaced by a 'hereditary ghost'.

As Brodzinkski, Schechter & Henig (1992) suggested:

> adoptees have a particularly complex task in their search for self. When you live with your biological family, you have guideposts to help you along. You can see bits of your own future reflected in your parents, pieces of your own personality echoed in your brothers and sisters. There are fewer such clues for someone who is adopted (p.13).

Grotevant (1997) posits that one aspect of the identity development involves exploring choices and the other is coming to terms with the 'givens' in one's life. Being adopted is one of those 'givens' (Grotevant, 1997) that hopefully becomes integrated with overall personal identity.

Lifton (1994, in Grotevant, 1997) considers a more narrative approach to identity development and suggests:

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The adoptive child's narrative is broken when she is lifted out of her own genetic and historic family line to fix the break in the adoptive parents' narrative (p.37).

Therefore identity development involves constructing a narrative that accounts for and rationalises their adoptive status, thus leading to a sense of coherence and meaning (Grotevant, 1997). This also applies to adoptive parents reshaping their identity as adoptive rather than a biological parent (Daly, 1992).

2.19 INTERCOUNTRY ADOPTIVE IDENTITY

When additional layers are added to the basic difference of being adopted, such as race, colour, ethnicity, national and religious origin, the task of integrating these aspects of identity becomes even more complex (Grotevant, 1997)

Developmental theories on children's understanding of international adoption propose that from a young age adoptive children notice physical differences from family members and tell a basic story about coming from another country (Brodzinsky, Smith & Brodzinsky, 1992) Children in primary school can identify ways in which their birth country differs from their host country (Friedlander, Larney, Skau, Hotaling, Cutting et al, 2000). Then young adolescents have further understanding such as reasons their birth parents gave them up for adoption, and being an immigrant to their host country (Friedlander et al, 2000). Finally older adolescents are aware that their lives and standards of living may have been very different if they had remained in their country of birth (Friedlander et al, 2000).

Ideally, as Deacon (1997) proposes

When a sense of identity is achieved, the ambivalence about adoption is often resolved. The adoptee mourns the biological parents…The adoptee adopts the family (p.253).

2.20 DISCLOSURE & DISCUSSION AROUND ADOPTION

Liow (1994) proposes that the method and timing of the disclosure of the adoption is crucial. Hersov (1985, cited in Liow, 1994) suggests that if the child is told about the

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adoption too soon they may feel rejected and deserted whilst discovering too late may result in identity confusion. Indeed this issue may be compounded by intercountry adoptees' experience of being rejected not only by their birth parents but also country of origin (Altstein & Simon, 1991). Due to their physical differences from their adoptive family, transracial intercountry adoptees will invariably be told earlier rather than later and it may be that they get a 'head start' with identity development (Liow, 1994).

2.21 CULTURAL IDENTITY

Culture encompasses many layers and for the purpose of this study the definition is considered broadly, including aspects of language, customs, traditions, special events, arts, literature, food, history and sports (Scherman & Harré, 2004). Past practice urged parents to minimise their adoptive child's birth culture and assimilate their child into the dominant culture (Rowjewski, 2005). However the United Nations Convention on the Rights of the Child states that children have the need and right to maintain the culturally distinctive understandings and behaviours of their origin (Ishizawa, Kenney, Kubo & Stevens, 2006). Furthermore most professionals and adoptive parents recognise that it is important to preserve or appropriately acknowledge the culture of origin on some level in order that intercountry adoptees can accept all aspects of themselves (Trolley, Wallin & Hansen, 1995).

Scherman & Harré (2004) describe that intercountry adoptees face a challenging task in integrating two distinct cultural milieus into one cohesive identity, without risking alienation from both cultures. La Fromboise, Coleman & Gerton (1993) suggest four main approaches; *acculturation* which implies that the individual becomes competent in the majority culture but always identifies as a member of the minority culture, *assimilation* whereby an individual will discard their old cultural identity and fully accept the majority culture, *alternation* in which it is possible for the individual to adapt and alternate between two cultures; and *child choice* whereby adoptive parents allow the child to make an informed choice when they are older. Another approach is to strive toward 'biculturalism' within the family, fully integrating both the children's birth culture and the adoptive parents' culture (Friedlander et al, 2000). .

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Ku (2005) emphasises that cultural identity development is a lifelong process and highlights that the most negative potential outcome of bicultural socialisation is that the adoptee develops no strong attachment to either, becoming isolated and without a reference group.

2.22 ETHNIC IDENTITY

Ethnic identity refers to an individual's sense of membership in a group which shares a past and believes themselves to be distinct, particularly when in contact with other groups (Green, 1982, in Westhues & Cohen, 1998). In relation to intercountry adoptees it may be considered as:

> a feeling of connection with both one's cultural past and one's present adoptive heritage (p.75, Lydens, 1988 in Huh & Reid, 2000).

Cross (1987) posits a model of ethnic identity formation whereby initially there is identification with the dominant culture, the 'pre-encounter' stage. Then when children experience prejudice they enter the 'encounter stage' where they begin to be aware of their membership in their ethnic group. Subsequently they enter the 'immersion stage' where children immerse themselves in the ways of their ethnic group. Here they may become much more aware of their culture of origin and devalue the dominant culture. Then an 'internalisation stage' occurs whereby children learn to appreciate themselves and others as individuals.

2.23 RACIAL IDENTITY

Racial identity is how one thinks about oneself with respect to physical characteristics, such as skin colour, texture of hair, shape of skull, nose or cheekbones (Verma & Ashworth, 1986). The default norm governing the racial composition of families is racial homogeneity (Ishizawa, Kenney, Kubo & Stevens, 2006). Historically there has been widespread opposition to intercountry transracial adoptions (Tizard, 1991) where parents adopt a child of a different race to themselves.

Opponents of transracial adoption suggest that placing children outside of their racial identity group may increase their risk for long-term psychological problems, undermine their identity development and ultimately lead to a 'cultural genocide' (p. 65, Brodzinsky et al, 1998). Central to this is the notion that positive racial identity is at the core of healthy personal development (Brodzinsky et al, 1998). In contrast others consider that a child's need for a stable, permanent family may override the possible benefit of a racially matched family (Rushton & Minnis, 1997).

2.24 ADOPTIVE PARENTS AND IDENTITY DEVELOPMENT

Scherman & Harré (2004) propose that adoptive parents' perceptions and ethnic descriptions of their children influence the way in which children subsequently describe themselves. As Anjudo (1988) posits, parents are their children's major reference group, and most researchers concur that adoptive parents have a vital role to play in different aspects of their adoptee's identity development. Thus Gill & Jackson (1983) found that black, Asian and mixed-race adoptive children of parents who minimised the importance of race, showed little evidence of positive racial identity. Similarly children who used self-descriptive characteristics such as 'human' and 'intelligent' rather than a racial reference group, had adoptive parents who used a 'colour-blind approach', thus focusing on non-racial characteristics (McRoy & Zurcher, 1983). Kim (1978) suggests that the child needs to be cognisant of their personal, cultural and ethnic heritage in order to define themselves in society.

Parents have a difficult challenge in raising multi-cultural families (Scherman &Harré, 2004). As Tizard proposes (1991) parents hold the duel role of encouraging pride in their birth culture as well as helping their adopted child to fit into the dominant culture. In principle, acknowledgement of the child's birth culture is accepted as important, and Silverna (1997, in Scherman & Harré, 2004) found that most parents say that they intend to acknowledge the child's birth culture. Yet there appears less agreement about the right amount of attention to give to, or the best ways to acknowledge their child's heritage (Rowjewski, 2005). There is no consensus on the type and intensity of exposure needed to help an intercountry adoptee develop different aspects of their identity (Scroggs & Heitfield, 2001).

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There are differences between acknowledgement, exposure and active involvement in the child's birth culture. For example, Tessler, Garmarche & Liu (1999) propose that parents are likely to 'pick and choose' elements such as ignoring traditional values and focusing on holidays and food. Anjudo (1988) considers that it is not sufficient to passively learn about the culture or visit intermittent festivals, but instead they should actively socialise their children to their birth culture. Indeed Trolley et al (1995) proposes that the child's birth culture should be integrated into daily life activities and via contact with others of the same heritage. Furthermore Zuñiga (1991, in Scherman & Harré, 2004) proposes that parents should

> aggressively pursue and integrate with people, places and things associated with
> the child's ethno-racial group of origin (p.29).

Indeed Carstens and Julià (2000) found that the adoptive parent's involvement in the child's birth culture was one of the most important factors affecting the child's reference group identification.

2.25 OPEN VERSUS CLOSED ADOPTIONS

Societal trends have evolved from treating adoption with secrecy and shame and adult adoptees have become more verbal about their need for knowledge of their origins. Therefore adoption has moved towards greater openness and creating connections with the birth family (Grotevant, 1997). Advocates of open adoption believe that knowledge of one's past is a basic human need and denying this may result in emotional difficulties (Silber & Dorner, 1990 in Grotevant, 1997). However it is worth noting that birth records in the UK were made available to adoptees over 18 in 1975, but by 1980, only 2% had used this service (Townsend, 2003). There have been a few evaluative studies regarding the adoptive triangle (adoptee, parents and birth parents). However most are methodologically problematic (Triseliotis, Feast & Kyle, 2000 & Grotevant, 1997) and none were found to consider intercountry adoptees.

In relation to intercountry adoption, closed adoption may be enforced in numerous scenarios. For example, parents may adopt through an orphanage where the child has been

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abandoned or the biological parents may not be traced. On a practical level, distance between the adoptees' country of origin and adoptive country may mean that visits are rare. Additionally there may be difficult cultural and linguistic barriers to overcome that may prevent a reunion with birth parents (Saetersdal & Dalen, 2000). Indeed, because of this, intercountry adoption may have been deliberately chosen.

2.26 RATIONALE FOR THE PRESENT STUDY

As considered throughout this introduction, the research in relation to intercountry adoptees provides contradictory findings in almost every area. However intercountry adoption is an increasing phenomenon and there is some evidence to suggest that a proportion of intercountry adoptees are at risk of developing mental health difficulties (Van Ijzendoorn & Juffer, 2006) and indeed are at greater risk of suicide (Von Borczyskowski et al, 2006). Therefore, it appears vital to conduct further research in relation to intercountry adoptees.

There appear to be several limitations in the current literature regarding intercountry adoptees. For example, most of the research is quantitative and conducted primarily in the United States, The Netherlands and Scandinavia.

Therefore the researcher has identified a lack of research conducted in the UK that considers the experience of parents of intercountry adoptees. Interviewing the parents of intercountry adoptees allows insight into their motivation to adopt, and their pre and post adoptive experiences. Additionally, interviewing parents who have accessed psychological support allows a unique insight into the development and maintenance of difficulties and how they may best be solved. There is also a paucity of research (none UK based) that considers how parents approach their adoptees' identity development. Since identity appears to be vital in relation to the adjustment and therefore mental health of intercountry adoptees, it is crucial to research this area in more detail.

2.27 WHY THIS STUDY IS OF INTEREST TO CLINICAL PSYCHOLOGISTS?

This study itself was developed in consultation with Clinical Psychologists from the specialist Adoption, Fostering and Kinship Care Team who as busy clinicians, were enthusiastic about considering their client's experiences in depth, to an extent that is not

always possible in clinical work. More widely, it is known that parents' experiences and the stresses and joys of the adoption process will impact upon family relationships, particularly the development of attachments between adoptive parents and their children. Therefore, understanding parents' experiences in detail will help to support clinicians in their work to improve these families' mental health.

2.28 AIMS OF THE RESEARCH

The broad aim of the research is to consider parental experiences of intercountry adoption.

2.29 RESEARCH QUESTIONS

The present research study was guided by the following research questions:

- How do parents negotiate the intercountry adoption process?
- What is the experience of parenting an intercountry adoptee?
- How have parents approached the identity development of their intercountry adopted child?

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3. METHODOLOGICAL APPROACH

In the following section the rationale for using a qualitative approach will be discussed, and the approach that was chosen, Interpretative Phenomenological Analysis (IPA), will be outlined. Furthermore the researcher will consider her position in relation to the current research.

3.1 A QUALITATIVE RESEARCH APPROACH

A qualitative approach was considered the most appropriate methodology for the current study, since there is a lack of previous research into this area and an in-depth, exploratory approach might be useful to develop knowledge in the area. Secondly, the study was not aiming to make generalisations about parents' experiences, but seeking the perceptions and accounts of a specific group of parents. In contrast a quantitative approach would have been more suitable if the research questions were attempting to establish causality or correlations (Barker, Pistrang & Elliott, 2003).

3.2 INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

Interpretative Phenomenological Analysis (IPA) was developed by Smith (1996) from a broad range of theoretical influences; social cognition, phenomenology and symbolic interactionism (Smith & Osborn, 2008). IPA aims to explore in detail how participants are making sense of their personal and social world, and the main currency is the meaning that particular experiences, events and states hold for participants (Smith & Osborn, 2008). This is what Eatough and Smith (2006) call the "*lifeworld of the individual*" (p485).

IPA is phenomenological since it is concerned with an individual's personal perception as opposed to producing an objective account (Smith & Osborn, 2008). Additionally, IPA is interpretative as it emphasises research as a dynamic process, with an active role for the researcher. Thus it accepts the impossibility of gaining direct access to a participant's internal world (Willig, 2001). Access to participants' lifeworlds depends on and is complicated by the researcher's own conceptions, which are needed to make sense of the

participants' world through a process of interpretive activity (Smith & Osborn, 2008). Therefore:

> The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world (p.53, Smith & Osborn, 2008).

Thus, central to IPA is the researcher's own interpretation of meanings elicited within the analysis of each participant's interview-narrative (Jarman, Smith & Walsh, 1997).

IPA assumes a link between what people say and their emotional state (Smith & Osborn, 2008). However it is also appreciated that this link is complicated as individuals struggle to express themselves and there may be reasons why they do not self-disclose. IPA adopts a broadly realist philosophy where a participant's description is assumed to reveal something significant about their experience, thoughts and behaviour (Reid, Flowers & Larkin, 2005).

3.2.1 IPA VERSUS OTHER PHENOMENOLOGICAL APPROACHES

IPA was identified as the preferred methodology as the researcher was interested in obtaining rich, comprehensive accounts of intercountry adoptive parents' experiences that captured something of the uniqueness of each family. Furthermore IPA has also been used in previous studies exploring experiences of parenthood (see Smith, 1999; Seamark & Longs, 2004). This lends further credibility to its use in this research. Additionally since the researcher is relatively new to qualitative research, the availability of clear guidelines on the use of IPA and appropriate supervision (Smith & Osborne, 2008) were important.

In Discourse Analysis, the emphasis is on the ways in which language constructs participant's worlds. It advocates that interpretation cannot move beyond the text and language of the data (Potter, 1998). Whereas for IPA the focus is more on understanding and making sense of participant's ways of thinking and their motivations (Eatough & Smith, 2006). IPA does recognise the importance of language both influencing participants' sense-making and researchers' making sense of participants'. However, IPA takes a more realist stance, considering that it is not just about the linguistic interactions between people, but is also concerned with unravelling the relationship between what people think, say and

do (Eatough & Smith, 2006). In relation to the philosophical frameworks, the researcher felt that the light constructionist stance (Eatough & Smith, 2006) of IPA, rather than the strong constructionism of discourse analysis, fitted well with the topic under study and the researcher's position.

Grounded Theory (Glaser & Strauss, 1967) was not considered as it attempts to build a 'theoretically saturated' (Willig, 2001) account of the social processes accounting for a phenomena, rather than attempting to understand a person's experience.

3.3 RESEARCHER'S POSITION & REFLEXIVE CONSIDERATIONS

Since the researcher's own beliefs and understandings have an influential role in IPA it is important for the researcher to acknowledge pre-existing values, assumptions and beliefs (both professional and personal) that may affect the interpretation of data, and attempt to 'bracket' these to take as objective an approach as possible when trying to understand the meaning of participant's accounts (Clare, 2002).

I am a 28 year-old, female, trainee clinical psychologist. I do not have children of my own, but have a long-standing interest in infant, parental, child and adolescent mental health, having worked predominantly in this area prior to clinical training. These experiences and clinical training have informed my current theoretical position, which is to favour social constructionist, systemic and psychodynamic ideas. This position has been acknowledged by others (Elliott & Spezzano, 1997). Having completed a course in Psychoanalytic Infant Observation Studies where I observed an infant-mother dyad weekly, from the age of nine days until two years, I became interested in the impact of our earliest experiences. One area of interest for example, was around the bonding that occurs in-utero. I became interested in what happens when this continuum is broken just after childbirth, as in adoption.

I am of Middle European descent and felt greatly affected by the images of the Romanian orphanage children which were widely publicised in the media during my childhood. I have wondered what has become of these young adults, if they have overcome their early adversity and what the experience of parenting them, was like. This was stirred up more recently, having noted the emotive media coverage of debates in relation to high profile

intercountry adoption cases. Additionally, having approached the Adoption and Fostering specialist team, who were aware of an increasing number of referrals from intercountry cases, I was intrigued to consider these issues further.

Furthermore, working in a specialist child and family Refugee team has increased and challenged my interest in identity development, particularly the impact of race, ethnicity and culture. My view of identity is as a complex, variable and context influenced entity, in alignment with constructivist and social constructionist ideas.

The combination of my interest in parental mental health, identity and adoption led to the current study. I felt motivated to elucidate and understand parents' experiences of intercountry adoptees, particularly in relation to their children's identity development. It is necessary to consider that my beliefs and assumptions will have influenced the meaning that I have co-constructed with participants.

3.4 ISSUES OF QUALITY AND VALIDITY

In considering issues of quality in this study, Lincoln and Guba's (1985) guidelines on establishing 'trustworthiness' in qualitative studies was closely considered. This set of criteria corresponds to those often employed to consider quantitative studies and was found useful to orient the researcher (see **Table 2**). Additionally, further criteria compatible with the epistemology of qualitative research were considered (Spencer et al, 2003, Elliott et al, 1999, Turpin, Bailey, Beail, Scaife, Slade et al (1997) and Yardley, 2008). Key issues relevant to the study are presented in **Table 2**, grouped according to Yardley's (2008) core principles for evaluating the validity of qualitative research.

TABLE 2: CORE PRINCIPLES FOR EVALUATING THE VALIDITY OF QUALITATIVE RESEARCH (YARDLEY, 2008)

Core Principle	Steps taken in the current study to ensure the principles are met
Sensitivity to context	• Consideration of relevant literature • Formulation of a research question that addresses gaps in current understanding • Open-ended interview questions were constructed to be sensitive to the perspective of participants. • The researcher has allowed patterns and meanings to emerge that have not been specified in advance, in order to be sensitive to the data.
Commitment and rigour	The data collection was thorough - six participants were purposively sampled. The sample was homogenous since all participants are accessing or have accessed support. Additionally it included a male participant, a single parent, a parent with an additional biological child and a parent who had adopted two children. • Analysis of an interview was checked by a supervisor **Peer review** – monthly attendance at an IPA group was used to check 2-3 pages of each interview with four fellow psychologists engaged in IPA research. Additionally a wider IPA group was attended that was facilitated by an academic familiar with the methodology which ensured an in-depth engagement with the topic.
Coherence and transparency	• Efforts were made to ensure transparency of data collection, analysis and interpretation by the use of an **audit trail** (see appendix D) • Reflexivity – supervision was used to reflect on the researcher's own position and influences. • Alternative interpretations of the data were considered. • The study limitations are considered in the discussion
Impact and Importance	• Findings are illustrated with verbatim interview extracts. • It is hoped that the study may have direct practical implications, for example, for practitioners supporting parents of intercountry adoptees in the Adoption and Fostering Team.

3.4.1 RESPONDENT VALIDATION

Respondent validation is obtained by asking participants to comment on the transcription analysis (Silverman, 1993). On the one hand this is a valuable way to engage participants to

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ensure their views are not misrepresented. However as Yardley (2008) proposes it is not always appropriate since analysis may highlight differences and contradictions. Moreover, the concept of respondent validation may be considered problematic from a constructivist and social constructionist perspective since it assumes the 'truth' can be correctly identified (Angen, 2000). This issue was carefully considered and it was decided that in this instance it was not appropriate to seek out participants' feedback. If the approach of co-operative inquiry (Reason & Riley, 2008) had been chosen then it would have been appropriate to consider participants as co-researchers and involved them fully at each stage of the research.

The researcher was transparent about the purpose of the research interview as stated in the consent forms that the participant was required to sign. Additionally it was ensured that the participants had the researcher's contact details if the event that they wished to withdraw. Furthermore following the completion of the study, a summary of the results was sent to participants (see appendix F.1).

3.4.2 AUDIT TRAIL
The audit trail (see appendix D) has been provided to show evidence linking the raw data to the final results, to ensure that that the study has been carefully completed and documented (Yardley, 2008).

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4. METHOD

4.1 DESIGN

This section will detail how the present research was designed and conducted. This includes the research setting, how participants were recruited, ethical issues, how interviews were conducted, analysis and considerations of the quality of the research.

4.1.1 RESEARCH SETTING

The research was conducted within a specialist Adoption, Fostering and Kinship Care Team in a Child and Family Department within a London based mental health service. This is a multi-disciplinary team which provides a clinical service to looked after children, their carers, adoptive families and children in the care of their extended families or friends where children are experiencing emotional or behavioural problems. The team offers comprehensive assessments and then longer-term individual or family treatments the aim of which is to care for the mental health of the child or adolescent, and to alleviate the problems faced by adoptive care-givers. The team works closely with professional networks and a range of consultation, assessment and treatment packages are available. These include treatment for children in transition and post adoption work. The team also provides a range of other assessment and consultation services to Social Services Departments and offers specialist training to professionals working in the field of fostering, adoption and kinship care.

Intercountry adoption cases constitute a small proportion of the team's cases, but referrals for intercountry adoptees have been noticeably increasing over recent years.

4.2 PARTICIPANTS

4.2.1 RECRUITMENT

Participants were parents of intercountry adoptees who were currently accessing or had accessed the Adoption, Fostering and Kinship Care Team. Clinicians within the team identified twelve possible participants who were eligible to take part in the study. These

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potential participants were given written information about the study and the option to opt-in. Seven participants expressed an interest to participate and were contacted by the researcher. This enabled any queries to be addressed and to set up an interview. In the case of a parental pair, one member was interviewed since IPA does not lend itself to interviews with more than one participant from each family, as it is concerned with the meaning the phenomenon holds for that person (Smith & Osborn, 2008). One possible participant later opted out of taking part, prior to the interview had taken place. Eventually a total of six participants were interviewed.

4.2.2 INCLUSION & EXCLUSION CRITERIA

Exclusion criteria included those parents experiencing severe problems with their adoptee, including severe attachment difficulties, the significant possibility of the adoption breaking down and parents with any severe mental health difficulties. This led to one eligible participant being excluded from taking part in the study, prior to the opt-ing in process. Inclusion criteria included fluency in English in order to take part in the interview.

4.2.3 SAMPLE

The aim was to recruit a small, purposive and homogenous sample of participants as IPA is concerned with gaining an in-depth understanding of their experiences, rather than making more general claims (Smith & Osbourne, 2003).

Please refer to **Table 3** to consider the demographic information of the sample which was composed of six participants, one male and five female. Names and identifying information has been removed or modified for the purpose of protecting the participants' identities. The participants' had a wide range of religious beliefs; Atheists, practicing Jews, practicing Church of England and a 'relapsed Catholic'. Furthermore, there were wide ranging ethnicities; White British, South African, Irish, Polynesian, Polish and Chinese.

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Table 3 – Participants Demographic Information

Interviewee (age) Ethnicity	Marital status	Occupation	Partner's Occupation	Name of Child	Country of Origin	Age of child at adoption	Child's current age	Additional Information
Max (69) Polish-British	Married	Retired from running a small business	Retired teacher	Allan	Romania	3 ¾	20	Allan is currently on a gap year before beginning a school leavers training course
Felicity (58) Scottish	Married	Jewellery designer	Retired Lawyer	Alice	Columbia	6 months	15	Alice is statemented and attends a mainstream school
				Daniel	Columbia	3 months	14	
Isabel (48) Tongan	Married	Home-maker	Accountant	Leo	Tonga	17 months	7	The couple have a biological daughter, Matilda, born with the aid of IVF
Emma (51) Irish	Single	Management Consultant		Mia	Vietnam	5 months	7	
Tara (53) Scottish	Married	Home-maker	Advertising executive	Joshua Oliver	Paraguay Paraguay	Both at 7 months	16 15	
Judy (49) Australian	Married	Lecturer	Dentist	Carlos	Honduras	5 months	15	Both are statemented and receive extra support at mainstream schools
				Felipe	Guatemala	10 months	13	

4.3 ETHICAL ISSUES

The researcher sought and gained ethical approval for the study from the Local Research Ethics Committee (see Appendix A.1). Approval was also gained from the Research and Developmental department attached to the service in which the research was conducted (see Appendix A.2).

4.3.1 INFORMED CONSENT

Before participants were approached, it was important that the clinicians proposing possible participants were aware of the aims and rationale of the study. Therefore all clinicians within the team were provided with written information on the study (see Appendix A.3). In turn clinicians themselves then provided participants with similar written information. (see Appendix A.4) Furthermore this was discussed verbally with each participant before the start of the interviewing process. They were also required to sign a consent form (see Appendix A.5). Participants were assured that their decision to take part would have no bearing on the treatment they were receiving and furthermore were given the option to withdraw at any point within the study.

4.3.2 CONFIDENTIALITY

Before the interview began, the researcher explained the limits of confidentiality to the participants. Therefore, the researcher explained their obligation to take action which may involve breaking confidentiality if there was concern about a criminal disclosure or about the risk of harm to the participant or another.

In order to protect participants' identities all data was anonymised and identifying details were changed. Data was securely stored at all times. Audio recordings and paper copies of the transcripts were kept in a locked cabinet and the data that was stored on a computer was password protected. In accordance with the Data Protection Act (1998) the data will continue to be stored at the researcher's university under the guardianship of the researcher's Research Tutor. The data will be held for up to five years and then will be destroyed.

4.3.3 POTENTIAL DISTRESS TO PARTICIPANTS

Given the nature of the exclusion criteria, it was anticipated that the risk of distress to participants was minimal, particularly considering that the suitability of participants to take part in the study was considered by a clinician already involved or having had some involvement with the family.

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Nevertheless the interviews had the potential to raise some sensitive issues, and in order to minimise any possible distress, participants were informed that they were not obligated to answer questions, were free to withhold information and withdraw from the interview. In addition the researcher has had some experience of clinical interviewing and used her judgement to monitor participants' distress which could be recognised and addressed. There was also the option for the researcher to seek consent of a participant to feed back to the clinician known to the participant within the team. Furthermore after terminating the interview, some time was provided to discuss the debriefing sheet (see Appendix C.2) and all participants were provided with general information on further sources of support available (see Appendix C.3).

4.4 INTERVIEWS

Whilst it is possible to obtain data suitable for analysis such as diaries, focus groups and personal accounts, the semi-structured interview method was selected as it is considered the best way to collect data for IPA analysis (Smith & Osborn, 2008). This method of interviewing allows the researcher and participant to engage in a dialogue whereby initial questions are modified in the light of participant's responses, allowing interesting areas to be further considered (Smith & Osborn, 2008).

All of the interviews were conducted in the homes of the participants. The interviews were conducted over a four month period and lasted between 54 minutes and 67 minutes.

Interviews were guided according to the interview schedule (see Appendix C.1) which consisted of a number of open questions and follow-up probes. It was developed in consultation with the Adoption Team and research supervisors (Smith, 1996; Smith & Osborn, 2003). Many of the questions were open questions and related directly to the research questions. Therefore questions one, two, three, four, seven and eight were in relation to parents' negotiation of the intercountry process, while questions five, six, twelve, thirteen and fourteen were in relation to their child's identity, and the remaining questions were in relation to the experience of parenting their child. Revision of the schedule included the addition of prompts which aided the flow of the interview.

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After completion, the interviews were transcribed verbatim. Non-verbal behaviour was excluded and all words spoken including false starts, significant pauses, and laughs were recorded, as recommended by Smith & Osborn (2008).

4.5 REFLECTIVE DIARY

A reflective diary was kept throughout the data collection process. This was completed after each interview and allowed a space to reflect, keep track of changes that occurred over time and document any thoughts that may influence the data analysis. For example, here is an extract written after a participant interview

> She spoke about a child that she had become very attached to, but lost, as the adoption had not gone through. There was a sense of her being understandably traumatised by this experience. The way she spoke of it was full of raw, unprocessed emotion, as though it had happened more recently than it did

The experience of this participant's raw emotion during the interview may have been lost when reading the transcribed interview. Therefore the reflective diary was useful to remind the researcher of these important experiences.

4.6 DATA ANALYSIS

The interview data was analysed using IPA. Analysis followed the procedure outlined in Smith & Osborn (2003) and Smith & Osborn (2008). In summary, analysis involved the development of a systematic, rigorous and comprehensive account of the themes within the data (Clare, 2002). Or as Smith (1996) proposes, IPA is:

> an attempt to unravel the meanings contained in…accounts through the process of interpretative engagement with the texts and transcripts (p.189).

Such engagement is facilitated by a series of steps that allows the researcher to identify themes and integrate them into meaningful clusters, first within and then across cases (Willig, 2001).

4.6.1 ANALYTIC PROCEDURE

(See Appendix D for the whole analytic procedure as it was applied to an interview 1).

1. The transcript was read numerous times for the researcher to familiarise herself with the account (Smith & Osborn, 2008). Throughout the whole transcript the left-hand margin was then used to annotate anything interesting or significant about what the interviewee had said. These annotations were summaries, associations, comments on language or preliminary interpretations.

2. The right hand margin was then used to document emerging theme titles. Thus initial notes were transformed into concise phrases, aiming to capture the essential meaning and context of the participant's experiences.

3. Subsequently, the next stage involved listing all the emerging themes chronologically.

4. The next stage involved consideration of the themes in relation to each other and identifying any connections between them. These 'clusters' of themes were then given labels which capture the essence of meaning in the text. Furthermore care was taken to ensure that the link with the text remained clear. The 'clusters' were presented in a summary table showing the themes with quotations that illustrate them. Some of the themes generated thus far will be excluded, i.e. the themes that are not well-represented within the text. The themes included in the summary table capture something of the quality of the participant's experience of the phenomena under investigation and represent the superordinate themes.

5. After the analysis of the first interview was completed, this was used to help orient the subsequent analysis of the remaining interviews (Appendix D.4). Thus, it was used to discern repeating patterns also to acknowledge difference and uniqueness between the participant accounts.

6. Finally, after all interviews were analysed, the themes from each account were listed (see Appendix E.1). These in turn were clustered (see Appendix E.2) and used to

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construct a final table of superordinate themes (see Appendix E.3). The themes are not selected purely due to reoccurrence but due to the richness of the data. The analysis continues into the writing up stage as themes are elaborated upon and put in the context of relevant literature.

4.7 WRITING UP

The aim of writing up an IPA study is to transform the identified themes into a narrative account, with verbatim extracts from the participant accounts to support the analysis. It is important to differentiate between the researcher's interpretation and what participants state.

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5. RESULTS

In this section the results of the Interpretative Phenomenological Analysis of six in-depth interviews with parents of intercountry adoptees are presented. The four super-ordinate themes and constituent sub-themes that emerged from the analysis are summarised in **Table 4**. In the remainder of the chapter these themes are explored and illustrated with verbatim extracts from the interview transcripts.[4] Discussion of the themes will focus on convergences and divergences, recognising ways in which the participants' accounts are similar but also different.

Table 4. - Main Themes and constituent Sub-themes

The importance of resolve & tenacity	Blood versus water	Weathering the storm of parenthood	The complexity of cultivating a heritage
• A traumatic process • Determination in overcoming obstacles	• Biology versus chemistry • The inevitable visibility of difference	• Managing the impact of early experiences • Life turned upside down • Adjustment over time	• Biculturalism versus Assimilation • Ambivalence • Importance of shared experiences

5.1 THE IMPORTANCE OF RESOLVE AND TENACITY

The theme that emerged in relation to negotiating the intercountry adoption process was *the importance of resolve and tenacity*. The participants suggested that it is these qualities that are necessary to help them persevere in fulfilling their hope of becoming a family. This theme can be considered to span a lengthy time period, often a number of years from the decision to adopt a child from another country, the adoption itself, and the post-adoption processes. In the UK this often included re-adopting the child under UK legislation. The

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[4] All identifying information has been removed or altered to ensure the anonymity of participants. The researcher has made some minor changes, such as repeated words or 'um's' have been removed for readability. Any missing material that is not considered pertinent to the participant's extract is indicated with ellipses (…). The researcher has used [square brackets] to insert material for reasons of readability.

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theme was comprised of two sub-themes: *a traumatic process* and *determination in overcoming obstacles*.

5.1.1 A TRAUMATIC PROCESS

It is imperative to consider that prior to the adoption process most participants had attempted other (unsuccessful) methods to become a family:

> …having gone through many IVF procedures…we…worked for years before that to have our own (Max)

Indeed, the traumatic impact of multiple IVF treatments is alluded to:

> I'd had quite a bad experience with fertility…I'd been really ill and, in fact, to tell you the truth, I'm not sure I was fully ok (Judy)

Not being "ok" may allude to the realisation of infertility, which could hold meanings including the inability to experience pregnancy, the dissolution of dreams and the lack of genetic ties. Being really ill may allude to physical illness which is understandable given the invasive nature of fertility treatments, but perhaps also to emotional ill-health.

There appeared to be an expectation from local support services that the crisis of infertility results in a need to mourn. As this participant experienced:

> I had IVF treatment before that and then they make you wait two years after that, because they think you're in mourning…meantime, you think hang on a minute, I'm getting older (Felicity)

Felicity seemed to characterise her experience less as one of needing to mourn, but more in pragmatic terms in relation to her increasing age and on-going desire to become a mother. One can speculate that Felicity may not have experienced a conscious need to mourn. However, the quote conveys that Felicity experienced the period of mourning as unnecessary and being imposed upon her.

Since all of the participants then went on to decide to adopt, it can be assumed that their resolve aided them in working through the crisis of infertility. There was in a sense, a kind of 'double trauma' for the participants; both coming to terms with the crisis of infertility and the adoption process itself:

…it was an extremely long, drawn out, painful, harrowing, difficult process (Emma)

Similarly:

Researcher: What was the experience like of going through the adoption?

Horrendous (Felicity)

Horrific in many ways (Max)

It was a nightmare (Judy)

It was ridiculously difficult (Felicity)

It was all kind of terrifying really (Tara)

From Emma's response there was a sense of the process as invasive, "painful", and the word "harrowing" captures a disturbing quality to the experience. There was something about Judy's response, "a nightmare", as capturing the essence of the whole process, the sense of seeming powerless and out of control. Tara's response connects to the experience as a nightmare as she experienced it as frightening. Indeed the oppressive nature of the process is aptly portrayed by Felicity:

…the day we did the adoption…felt a bit like getting out of jail… you feel like superwoman (Felicity)

Additionally, the participants often had to contend with the context of poverty and sorrow within the countries where the adoption took place:

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…it was difficult for me and my wife to hide our tears. We went to many orphanages…where babies and toddlers were crammed into small rooms like sardines and there was no one there to give them a normal life and they were ill and they were crying and they were under-nourished, and that was a painful thing to go through every time (Max)

Max and his wife were moved to tears, seeming distressed and perhaps feeling helpless in the face of vast numbers of children in need. There is something so poignant about the vivid description of the children as "sardines" implying how squashed they must have been as though piled on top of each other.

Furthermore the process appeared to be a rollercoaster of emotions for the majority of the participants. In several accounts, chances for adoption often fell through:

…were told that this particular child had Hepatitis B and might or might not live a long time (Max)

In the extreme:

…we heard that the child had died (Felicity)

I was initially…assigned a different child and that adoption fell through…when I realised I would have to give the child back…only then was I really aware of…how awful it was going to be to lose her (Emma)

At each disappointment, participants' hopes of parenthood had appeared to be nearing, but were then dashed. Emma spoke of the excruciating experience of spending six weeks with a child, whom she was then unable to adopt. It appears that Emma had only realised the depth of her attachment to the child in the context of losing her, and there is a sense that she may have felt guilty about this. As she spoke of this experience the sense of unprocessed trauma was palpable in her affect and fragmented use of language.

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*5.1.2 D*ETERMINATION IN OVERCOMING OBSTACLES

This participant aptly portrayed what she believed is necessary to successfully adopt a child:

> …as long as you persist…determination will get you through. If you ever give up, you'll lose them (Felicity)

Felicity's use of language is suggestive of a struggle, where there is a possibility of winning or losing and there is a sense that a great feat has to be overcome. There is a sense of the struggle lasting infinitely "if you ever give up", as though it takes forever to accomplish. All participants managed to persevere, battling on to find a child to adopt, with great dedication, despite the difficulties and set backs:

> [We] spent in total…five or six months out there…we went to a total of about 23 towns and villages…very many institutions, maternity wards, orphanages (Max)

Rather than a struggle, there was a sense that this participant was on a great search, almost like a treasure hunt, going to an extraordinary number of places to find their child. Participants who arranged the adoption themselves encountered a great many challenges along the way. This participant was told by the judge:

> I'll do the adoption when you speak to me in Spanish! (Felicity)

This forced Felicity to immerse herself culturally and linguistically in her child's country of origin. There was a sense of participants learning the ropes as the process progressed, rather than knowing what to do in advance. Many participants struggled with the bureaucratic procedures necessary for the adoption to take place, for example needing to gain the authority of their children's biological parents:

> [We]did not expect the red tape, the bureaucratic process to be as involved and difficult as it turned out to be (Max)

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…we were told that Carlos' birth mother was from a rural place…where you travelled two days to get a signature (Judy)

The analysis revealed a difference between participants who went to the child's country of origin to organise the adoption themselves and those who used an agency to help with the process. Agencies were experienced as efficient in processing paperwork:

…It was fine, quick and all done and dusted (Tara)

It is of interest that despite the practicalities being eased, this did not minimise the emotional trauma of the process (eg, Tara described it as "terrifying"). The uncertainty seemed intolerable for those who depended on agencies for news of their child:

For God's sake, there's this child, who' supposedly…you're going to adopt and it takes ages…[we were] going slightly mad…going crazy (Judy)

Thus, being actively involved in finding their child, appeared to be helpful, providing a sense of purpose and giving participants an element of control:

[It] was quite nice to have things to do and feel like you were being quite active (Isabel)

Once the participants became parents, completing the adoption in their child's country of origin, the importance of resolve and tenacity continued as they often encountered further obstacles when they returned to the UK:

…you think God it's still not over…he wasn't legally ours (Isabel)

…there's no support offered for the horror of the process that you go through here…[it] became very complicated…I had to go to the High Court (Emma)

Often participants were required to undergo assessment by their local social services. This participant reveals the ominous opening words of their social worker:

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…don't think this is a foregone conclusion…he's black you're white, he shouldn't be with you (Tara)

This social worker was referring to the UK's 'same race' adoption policy. In this instance the social worker's words could be interpreted as threatening, as it creates a feeling of instability that there is a possibility of the adoption being disallowed. Emma contrasts intercountry adoption in the UK with the process in the United States:

African-American children are routinely adopted by white families in America in a way that's completely considered inappropriate here (Emma).

For all the participants, their resolve and tenacity eventually paid off, and their dream of a family became a reality. Although the whole process was often lengthy, the time between the participants being alerted to the possibility of a child and the adoption was relatively short. Participants touchingly struggled to find the words to describe this part of their experience:

I'll never forget it…it was wonderful, fantastic, it was really amazing (Tara)

…we had a celebration…the final day was very, very nice (Isabel)

It was lovely, yes a fantastic sensation…it was just a fantastic thrill (Max)

5.2 BLOOD VERSUS WATER

In adoptive families the bonds are of course, not biological. 'Blood is thicker than water' is an English proverb indicating that the bonds of family are stronger than the bonds between unrelated kin. The theme of 'blood versus water' reoccurred in a number of different ways, across participant accounts. The theme comprised two sub-themes; *biology versus chemistry* and the *inevitable visibility of difference*.

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One participant spoke about the lengthy and intrusive assessment process the couple underwent prior to the adoption process. She compared the experience of having biological rather than adoptive children:

> whereas if you have children of your own naturally, no one takes a blind bit of notice as long as they are fed and watered (Felicity)

Felicity implies that it is something about being an adoptive parent that means one has to prove oneself in contrast to a biological parent. Amongst the participants, Isabel provided a unique insight as she was the mother of one biological child, Matilda, conceived through IVF and Leo, who was adopted. The family's ethnicity also permitted a unique cultural perspective:

> Leo's birth family have a very distant link, blood link [to the adoptive mother's family]…the UK didn't recognise it as a family link…but in Tonga that's still a strong link…there's something very strong culturally about the, the blood....The Chinese are very blood oriented, for them *blood is thicker that water*. [My mother-in-law – of Chinese ethnicity] found it so difficult to accept Leo into the family (Isabel)

Thus, for some families, the meaning of blood is yet more important. Here Isabel suggests that culturally, any connection in lineage, no matter how distant, is still considered important and meaningful. Indeed the meaning of 'blood' is so important in the Chinese culture that it influenced how an adopted child was received into the extended family.

5.2.1. BIOLOGY VERSUS CHEMISTRY

Some participants used emotive language suggestive of an instantaneous chemical reaction to describe the first encounter with their child. Despite not having a biological link, they experienced an immediate 'chemical rush' that seemed to create a feeling of being bonded with their child, similar to 'falling in love at first sight':

> …we really did feel quite, instantly bonded with him (Judy)

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…my wife and I just fell in love with him there and then…there was immediate chemistry (Max)

Similarly:

I just fell instantly in love with him (Tara)

In contrast, others had a very different experience feeling much more distant from their child:

…it was like meeting a stranger (Isabel)

I wasn't expecting it to be a kind of immediate, I knew that we weren't going to sort of feel this astonishing attachment immediately…we looked at one another and we thought…who's this? (Emma)

The use of the language "stranger" conveys that Isabel appeared to not have felt an immediate connection to her child. It sounded as though Emma had even prepared herself for this possibility since her experience of meeting her child appeared clouded by the trauma of the lost child:

…it was complicated by the fact that this was October and in July the previous child had been taken away and so I wasn't really over that (Emma)

This perhaps conveys the deep pain that Emma experienced in losing that child. Emma conveys that she constructs this experience as something to get over, but perhaps rather it is something that will becomes less painful over time.

Some participants spoke of their encounters with their child's biological parents, often the mother:

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…here she was [the biological mother] in a western hotel with westerners, who had her baby…I didn't feel threatened…I was just delighted that we could say to him we did meet her (Judy)

This mother talks about herself as a westerner from the point of view of the biological mother, as though identified with her, empathising with how difficult the situation must have been. For other participants, long after the meetings, the biological parents were still present in their minds:

Alice would have heard her mother's lovely singing voice when she was in the womb (Felicity)

For the majority of the participants, the adoption was a closed one, severing their child's ties with biological relatives:

…you take her away, and the parents or the orphanage or whoever never sees the child again and you never see them again (Emma)

There was such a sense of finality to the way Emma spoke about this. This may be due to the closed adoption being imposed on Emma since it was the cultural norm for Vietnam. For others, they had left the possibility for future connection, open:

They can both trace their mothers if and when they want to (Tara)

For Isabel, the adoption remains an open one as they make visits to Tonga:

…he [the biological father] came over to say hello to Leo and we took some pictures and I told Leo who he was (Isabel)

This raised complex and somewhat ambivalent feelings for Isabel:

Leo started calling him 'daddy' which is a really kind of, intimate word. I would have been upset if he called his birth mother 'mummy' but we couldn't find her (Isabel)

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One may speculate that these upsetting and difficult feelings are hard to tolerate, and it may be that Isabel feels a sense of both sadness and relief in not being able to contact her son's birth mother.

All participants spoke of their children's awareness of their adoptive status, very early on:

> from the moment they could speak they knew they were adopted (Tara)

> it seemed necessarily inevitable and right to talk about it from the beginning (Emma)

> as soon as possible…we told him that there was another 'tummy-mummy' (Max)

The analysis revealed that participants felt a sense of urgency that their children were told of their adoptive status, as early as possible. There is almost the feeling that the participants felt burdened by having this knowledge as though worried about how their children may react and felt purged by sharing it.

One participant reveals that her child expressed his feelings about his adoptive status, seeming to indicate a yearning for a biological connection:

> I think that he did feel…unhappy that he didn't come from my tummy so he used to crawl into my clothes…when he was smaller…you know inside…then he would stay under there (Isabel)

This seemed to illustrate Leo's magical or perhaps wishful thinking, hoping to make himself biologically connected to his mother.

5.2.2. THE INEVITABLE VISIBILITY OF DIFFERENCE

The title of this sub-theme refers to the inevitability of physical differences between the adoptive parent and child.

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> …its always been obvious to everybody when we are together that we are not biologically [related] (Emma)

For some participants, like Emma the differences between them and their children were immediately obvious, particularly if they did not share the same skin colour. For another participant, minimising the impact of the physical differences was something that they were particularly cognisant of during their search for a child:

> …were looking for a child that was healthy and that would look like us…with Mediterranean features (Max)

This couple seemed to have clear criteria when they searched for a child. One can speculate whether their desire for physical similarity was to benefit the child's identity development or for the sake of appearances, or both.

The inevitable visibility of difference acted as a constant reminder of biological separateness. It appeared to bring an aspect of parents' private selves into the public domain:

> its always right there. Anybody will make that assumption about how we're constituted and I think that makes it more…inexorably part of the relationship…it does change how you think about yourself as well, how you see the world because of that, *inevitable visibility* (Emma)

The language that Emma uses could indicate feeling quite removed, as though mirroring the biological separateness. There is an irrevocable permanency to their physical differences which cannot be changed. It suggests that she feels quite judged by others to the extent that it has changed her view of herself and the world.

Tara felt the need to justify herself to others in light of the physical differences between her and her children:

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in the beginning I was always explaining that they were my adoptive children. In hindsight I didn't really need to do that at all (Tara)

It was almost as if Tara did not feel entitled to motherhood, and over time she has managed to grow into this role. The analysis also revealed some advantage to the physical differences between one participants and her daughter:

It gives Mia a useful space to be able to say 'is that my mother? 'No, of course not' (Emma)

Amongst the participants, Judy provided a unique insight into the impact of physical differences as one of her sons resembles his parents skin colour more than the other:

Felipe is aware of the way he's perceived as a black boy…it is a conversation in the family…we can't underestimate how he feels, because he does stand out and he'll say things like 'it's not fair, there are three white people in our family and me (Judy)

The family appear to be sensitive to this issue, probably because a negative family narrative around the sons' identification with different racial groups exists. There is a sense of injustice -"its not fair" - and perhaps a feeling that he does not belong and is the odd one out. His mother has observed Felipe's desire to connect to his racial group:

two of Sam's friends are black, that's good, isn't it? (Judy)

The family took a trip to New York that appeared to have a big impact:

They both remarked the whole time on how many black people there were and Felipe said how many people looked like him…we went to this basketball thing and [both sons] remarked there was only one white person in about ten teams, they absolutely loved it (Judy)

There was a sense of Felipe feeling identified with the New Yorkers, on the basis of their skin colour which is in contrast to being the odd one out within his family. The difference in racial identification between the sons has hugely impacted their identity:

> Felipe very much sees himself, he aligns with the kind of rude boy, black rude boy…whereas Carlos has a much more middle class identity…Carlos sees himself much more, slightly grungy, slightly, you know going to rock concerts (Judy)

When considering the proverb 'blood is thicker than water' in the case of adoptive families it may be more appropriate to consider Aldous Huxley's (1920) interpretation:

> Blood, as all men know, than water's thicker, but water's wider, thank the Lord, than blood

Thus although the bonds of adoptive families are not biological, they may be equally valuable in a different way, "wider" rather than "thicker".

5.3 WEATHERING THE STORM OF PARENTHOOD

All participants talked about the experience of parenting their child and the metaphor of 'weathering a storm' emerged from the analysis in relation to this. Being in the middle of a storm can be a frightening and unpredictable experience, although the expectation is that all storms will pass, despite some taking longer than others. There was variation between participants who were experiencing different difficulties, due to the varying ages of the children. For some there was a sense that the storm had been weathered as their adoptees were older and had adjusted. They spoke about difficulties in hindsight. For other parents there was a sense that they were in 'the eye of the storm', experiencing current or recent difficulties.

5.3.1 MANAGING THE IMPACT OF EARLY EXPERIENCES

The analysis revealed that all participants discussed the impact of their child's early experiences:

> It's clear with both of them that their early beginnings have had a major effect on their relationships and the way they behave and their life (Judy)

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Judy seemed to make sense of her son's experiences very much in the context of the impact of their early life events. Some participants described that they experienced quite immediate difficulties following the adoption. Again, participants tended to make sense of these difficulties by linking it to their child's early experiences:

> …when he came from his birth parent's family, both of them had very little food and so…when the plate was empty…he'd start crying, so we'd give him some more but at first he used to overeat…he ate so much that he threw up (Isabel)

> I remember a period of nappy changing because although the orphanage staff told us that he was toilet trained… he, wasn't…He would not allow us to wash him… he was very scared of water. Rumour has it that they were hosed down with cold water even in winter…he would run round to our bedroom…every couple of hours or so in the middle of the night…he needed to reassure himself that we hadn't bust off anywhere (Max)

> …for the first few months Carlos did smile wanly at anyone and go to anyone (Judy)

Here, participants give examples of very different issues; in relation to food, toileting behaviour, indiscriminate friendliness, fear of abandonment and of water. For each of these there is a sense that these behaviours were adaptive for the children in relation to their pre-adoptive lives. For example, eating as much food as is available would be adaptive when food was scarce. However, these behaviours were rendered less useful in their post-adoptive lives and over-time would become less frequent.

For other participants there was a sense that they almost idealised their children, minimising any early difficulties:

> I never had that with mine, they really slotted into things perfectly…there was never any problem (Tara)

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There is the sense that Tara was so elated with parenthood that perhaps any difficulties were minimised, or perhaps even forgotten over time.

In contrast, for others a sense of sadness for their child's difficulties, endured:

> …very late walking…she's delayed although I spent a lot of time waiting for her to catch up in the hope that she would…I thought she'll get there, yeah, and she didn't (Emma)

> …unlike Allan, she's not bad at school…language has never been his forte…he's not academic by nature (Max)

For these participants, their children's difficulties appear to be incongruous with what their hopes and expectations of their children had been. Perhaps one task of parenthood, whether adoptive or biological, can be considered as reconciling the differences between one's hopes and the reality of the experience. This may be more difficult in relation to adoptive parenthood.

For many of the children difficulties were associated with separation or change:

> …saying goodbye and separating were a huge problem for him for a long time…until the age of about 13 (Max)

> …she had to go to school at 4½…she failed to cope (Emma)

> He just, used to cling to me, just me…I had to get a childminder…just to give me a break (Isabel)

The language that Isabel uses, implies a significant aversion to separation on behalf of her son and may indicate a desire for Isabel herself to escape the painfulness of the situation. Similarly, Emma describes her daughter's failure to cope which may be an attempt to remove Emma herself from the painfulness of the experience. In the context of adoptive children's abandonment by their birth parents, this difficulty negotiating separation is

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logical, and one could speculate this to be an evolutionary tactic to ensure survival. In relation to attachment theory, the children may have lost several 'secure bases', hence the difficulties with separating.

Later on, their children's difficulties had often been labelled after seeking professional advice:

> [Carlos has] got dyscalculia, with a bit of dyspraxia…Felipe in contrast has a language delay…academically they both struggle in their different ways (Judy)

> …she's got very bad back teeth…and this sort-of-lazy right side, but it really manifests itself in this…CAPD [Central Auditory Processing Disorder] (Felicity)

Felicity continued to explain that this is a complex difficulty where auditory information cannot be processed ordinarily. One may speculate that these difficulties are the direct result of these children's early experiences of deprivation. Deprivation may not just occur in relation to their physical needs. The following participants, who had adopted two children, compared and contrasted their children's different early experiences in relation to their unmet emotional needs:

> Daniel is quite bright…he's got no problems…he had constant love all the time, whereas Alice obviously had this awful start (Felicity)

> I now realise the difference between the two starts that they had (Tara)

Interestingly, both of the negative starts refer to the lack of available attachment figures for the children. So those that were considered to have a 'better' start did so due to having had a single care-giver until they were adopted.

The adoptees also had to contend with other losses. Participants referred to the contrasting landscapes and lifestyles between their children's country of origin and the UK:

…it was open and hot…he was just running round like with the chickens with just a nappy on and when we came back…it was really cold and gloomy…he would just stand by the door to go outside (Isabel)

Daniel gets quite depressed…[particularly] in Winter (Felicity)

It appeared that the adoptees experienced a sense of yearning for their land of origin both directly after the adoption and a considerable time later.

For some participants, their child's difficulty was in relation to their sibling relationships:

…they really did clash…he was very physical…whereas she is completely opposite…Matilda hated him so much and she mentioned several times, cant we send him back? (Isabel)

Carlos does take it out on Felipe quite a bit and will be quite vicious with him (Judy)

For non-adoptive siblings, there is always period of preparation for the birth of a new baby, whilst adoptive siblings may have to adapt instantaneously to a new sibling, who may also be quite close in age to themselves. Biological sibling relationships can ordinarily be challenging, without the complexity of relating to an adopted sibling.

5.3.2. LIFE TURNED UPSIDE DOWN

This sub-theme describes participants 'in the eye' of the storm. Some participants experienced a dramatic and sudden change in their child:

Once Joshua hit puberty…it was like a switch was turned…*our life was suddenly turned upside down* and this child was almost alien to us and it looked like he might be kicked out of school and it had a knock-on effect on Oliver…he was not concentrating…consequences meant nothing to him (Tara)

For Tara there is a sense of Joshua's difficulties coming out of the blue in an unexpected and drastic way.

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For other participants, the severe difficulties emerged immediately after the adoption. Here Isabel describes that their difficulties reached a crisis point:

> …the initial year or two was very, very stressful…I did seek help…I was just desperate for anything… (Isabel)

Isabel portrays a sense of powerlessness in managing the situation which created a sense of desperation in her.

For other participants, their children's difficulties emerged later on. Some experienced extreme difficulties with peer relationships:

> Daniel doesn't find friends easily. He was bullied at his junior school. I had a very sad child (Felicity)

> …her social skills are crap…[Mia's] not good at boundaries, she doesn't understand that you can't force people to be your friend (Emma)

> For a long time he was a loner (Max)

It seemed unbearable and perhaps too painful for Max to consider his son in this way as he later seems to contradict this:

> …making friends was never a problem for him (Max)

For all of these participants there was a sense of their frustration with their children's difficulty in developing positive peer relationships. This frustration may have come from their inability to exert influence on this aspect of their children's lives.

Tara's son exhibited extreme behaviour, spiralling increasingly out of control and indulging in serious risk taking, as though he was creating an external reality to mirror his internal confusion:

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Suddenly Joshua is at the stage where he is wondering 'Who am I'? and 'What's my identity?' and he is very confused….he was getting into trouble with the police, going out at night…we feared for his life…caused all sorts of havoc…playing on train tracks…once had a call he was in A & E, he was so drunk…mugged another time at knife point (Tara)

Tara described the impact this had on the family as 'terrifying'. Initially there was a sense of self-blame:

…we must have done something wrong (Tara)

In contrast, Felicity didn't blame herself but was baffled by her son's depressed behaviour:

I just couldn't work it out…I didn't have a clue (Felicity)

This sense of helplessness and uncertainty was also shared by Emma in relation once again to her daughter's peer relationships:

I hadn't a clue what to do (Emma)

But later on in her interview Tara described making sense of the ordeal very much in relation to Joshua's experience of being adopted and experiencing a crisis of identity:

…[its] all harking back to this separation from his birth mother…you know it is all the rejection…what he was doing was testing us to the absolute limit to see would we give him up like his biological mother did? (Tara)

There was a belief that his behaviour was completely influenced by the adoption itself, rather than an extreme bout of teenage rebellion.

5.3.3. ADJUSTMENT OVER TIME

For the majority of the participants, there was a sense that difficulties had certainly improved over time:

> it was just a question of time and coaxing him, slowly… a long time…he would not touch vegetables…he eats everything now… he's very self-confident. We had to teach him early on to look people in the eye when he speaks because he would look down…he's got a girlfriend…it's the other way around now…he doesn't need us (Max)

> he wouldn't go to anybody…only me…[now] he's very sociable…he gets on with anybody…Once he knew that there's always enough food in the cupboard…his eating is normal now… (Isabel)

> He remained at school…he is a very bright boy, instead of achieving his potential…hopefully he'll pass his GCSE's just about scrape through (Tara)

Their children's adjustment seemed to evoke a number of ambivalent feelings for the participants. For Max, not being needed seemed to relay a sense of both sadness and pride. Similarly, for Isabel being needed so continuously by her son seemed to be both indicative of a strong bond and a heavy burden. There is a sense of relief that "he now gets on with anybody". For Tara there is a sense of simultaneous disappointment and hopefulness. There is recognition of how far he has come and, although he may not achieve his potential, there is hope that he will at least continue it on to the next academic stage.

Specifically, participants talked about their children's relationship developments with others over time:

> …he did have to learn to negotiate and not to lash out and not to bite (Judy)

> now he's very sociable with his friends and popular, although he doesn't relate to adults as well (Judy)

Additionally, sibling relationships had seemed to have improved:

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they squabble nicely (Felicity)

they still obviously bicker a bit and tease each other a bit, but I don't think its any different from a normal sibling relationship…they can play really nicely together (Isabel)

Some of the participants' sense-making in relation to their children's difficulties had also changed over time. Previously, Tara had blamed herself for her son's difficulties, but later in the interview she states:

we must never blame ourselves, we learn from stuff (Tara)

Furthermore, time appeared to have served a valuable function in providing insight for participants:

I think I can say now it's really lovely…you know…five or so years away from when he arrived. Its really worked out well for us and we're so happy to have him in the family (Isabel)

Isabel's hindsight after the difficulties may illustrate how tumultuous the experience of being in the eye of the storm actually was.

There was a palpable sense of pride when the participants talked about how far their adoptees have come:

He made a speech off the cuff. That's very typical of him…we're really extremely proud of him and he's given us extreme joy and happiness (Max)

5.4 THE COMPLEXITY OF CULTIVATING A HERITAGE

Cultivating their child's heritage (used in this sense as an umbrella term for cultural, ethnic and racial identity) proved to be extremely complex experience for the participants. Cultivating a heritage was impacted by both the child and parent(s). It also appeared to be

affected by the age of the adoptee. For example, some adolescent adoptees took less interest in their heritage than younger adoptees.

 A person's name could be considered to encompass something fundamental to their heritage and identity. Indeed, dependant on the age of the child at adoption, it may be a bewildering experience to have a change of name. Several of the participants did change their child's name, but often retained something of their original name:

> Allan is his new name yes as we thought that his original name Alin would not really work so well in Britain…we searched for something beginning with A (Max)

> Her Vietnamese name is her middle name (Emma)

> He's had several names, because his birth mother named him…his birth father renamed him…they changed his name…but its such a difficult name to pronounce that we named him Leo which was his second name (Isabel)

> we felt in this country he'd be [teased with his original name]…Joshua was my father's name (Tara)

For one participant, her child remained nameless, identity-less until she was adopted:

> [her biological mother] hadn't registered her name, because she felt that her new mother would want to give her, her name (Felicity)

For another participant there was an active decision to keep both of their children's names:

> we felt for both of them, we felt very strongly, [their names] were the one thing that they were given by their mothers…there was no way we would change it (Judy)

For this family there was a sense that they wanted to respect and honour the only decision that the birth mothers had made.

5.4.1. AMBIVALENCE

From the participants' perspective adoptees appeared to experience a great deal of ambivalent feelings, particularly in relation to their heritage. Interestingly, these often emerged in relation to sport where adoptees had to choose between countries:

> I'm sure he sees himself as completely British. But when there was the world cup…in 2004/5, England against Romania, surrounded by our two Romanian friends…he was egging the Romanian side on…he feels completely integrated here…as far as he's concerned there's no culture, he was in an institution, locked up (Max)

> When the world cup was on a couple of years ago…England and Paraguay were playing and I remember the boys saying we're not sure who we want to support here…they felt more English than Paraguayan...(Tara)

Both Max and Tara seemed quite sure that their children viewed themselves as British or English, but this was contradicted by their children wanting to support the team from their country of origin. Max denies that his son feels any cultural connection to Romania, due to his negative experiences there. However it is clear that in the presence of other Romanians, he does feel a connection to his birth country.

For Felicity, there had been early efforts to create a connection to Columbian heritage:

> ….I just gave up trying to teach the Spanish. Although we used to take them to Columbian school every Saturday till they were about 8…I don't think I could sustain this school…I thought I've done my bit, I've tried (Felicity)

Creating a connection appeared to be unsustainable. There was a sense that it was something that Felicity perhaps resented, feeling as though she had to "do her bit".

In relation to visiting their children's birth countries, there appeared to be a great deal of ambivalence, both from the participants and their children:

> …we talk about it quite a lot…we'd need to prepare them…we just can never quite find the best time to go (Judy)

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…we haven't been back there yet. But he's never expressed any desire, although we've offered it to him, to go to Romania…he said 'yes I'd love to', but that [opportunity] never came (Max)

…in the last eighteen months Joshua doesn't want to know anything about Paraguay, he won't talk about it…it's a new thing…we were probably going to go next year…been saying things like, well you can go, I'm not, it's too hot, I don't want to go there (Tara)

For the participants, the thought of going back to their children's birth countries appeared to raise difficult feelings. For Allan, (Max's son) it seems that the thought is palatable, but the reality of returning is not. Whilst for Joshua, (Tara's son) the very idea is unthinkable. Understandably visiting a birth country is a huge undertaking and being ready to do this must be a very personal choice. Indeed, one of the youngest in the sample had already visited her birth country and found it to be a very positive experience:

I wasn't sure she was quite old enough to take it in, but actually it was very good for her. She had an absolutely wonderful time…it made her identity seem concrete…going there…seeing people, but also being accepted, being welcomed (Emma)

It could be speculated that visiting her birth country had an additional impact for Mia (Emma's daughter) in comparison to Joshua and Allan, since there is more visible physical difference for Mia. Isabel had also taken Leo to his birth country and found it a positive experience:

we'll always keep going back [to Tonga]…we've taken him back to Tonga once since the adoption (Isabel)

This family were unique in that Leo shared his ethnicity with his adoptive mother, providing a greater impetus to return to visit extended family who remained in Tonga.

5.4.2. BICULTURALISM VERSUS ASSIMILATION

There was a great deal of variety in the way participants helped to cultivate their children's heritage. There appeared to be two ends to the spectrum of behaviour; biculturalism at one end and assimilation at the other. Two of the participants identified at the extremes of the spectrum, whilst the majority of participants identified at various points between the two extremes. All participants did attempt to forge some kind of connection to their child's birth country.

Some parents very actively sought these connections by exposing them to the food:

> we make a lot of [Tongan] food (Isabel)

> …the only connection that I've managed to create for Mia with Vietnam is probably through food…partly because she loves food so she likes to eat Vietnamese food (Emma)

Exposing their children to the tastes and smells of their origins provides both physical and symbolic nurturing of their heritage. It is both a sense-indulging and tangible way to connect with their country of origin. Additionally, using food can provide creative and varied opportunities to engage children.

Participants also talked about exposing their children to festivities celebrated in their country of origin:

> we celebrate New Year (Emma)

> we go to this place where the dragon comes into the restaurant and he was you know, initially extremely frightened, but he loves that culture (Isabel)

These festivals involve rituals that may aid the transmission of their children's heritage as the adoptees become more familiar with them, over time. There was also the sense that participants took every opportunity to expose their children to other individuals from their birth countries:

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…we knew Romania generally speaking does not have a good image…so we made a point of having friends from Romania, who were living in London…[One Romanian young man] has since become, like a second adopted son…so that he has a positive image of his country and countrymen (Max)

Alice has got a Columbian…Godmother

…and I have Tongan friends here…(Isabel)

Max's family went to extreme lengths to actively foster ties with Romanians. The fact that one relationship developed so much, illustrates how much effort was put into fostering these ties. In choosing a Columbian to be Godmother to her daughter, Felicity ensured that Alice will have a permanent relationship with someone from her country of origin.

Other participants seemed less involved in exposing their children to their heritage and more involved in assimilating them to the majority culture:

Researcher: Do you do anything to celebrate Paraguayan culture? No I don't actually (Tara)

However, despite no active exposure to her son's birth culture, Tara did place an importance of a linguistic exposure to her children's country of origin, retaining some connection:

We specifically chose the school they are going to because it is one of the few…that teaches Spanish (Tara)

So it appears that there is variation in what is important to different participants, in relation to cultivating their children's heritage. To the other extreme these participants under-exposed their children to the host culture:

we always had Columbian au-pair girls…[they spoke to Alice and Daniel only in Spanish] so in fact, when they got to school, they didn't speak anything much (Felicity)

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Perhaps Felicity had been so concerned about retaining Columbian ties for her children, that she gave less thought to exposing them to the culture and language that they were surrounded by. Or perhaps there was the hope that they would acquire English more easily than they did. This demonstrates the delicate challenge that intercountry adoptive parents face, in balancing both pride in the birth culture and fitting into the dominant host culture.

Linguistic ties also seemed important for other participants:

…both of them do Spanish at school (Judy)

…we talk about learning Vietnamese (Emma)

…initially we hired a nanny who was fluent in both English and Romanian to make sure we did not have a cut-off…we thought it would be too drastic to sever him from his…he didn't speak but that doesn't mean he didn't understand (Max)

Max demonstrated a thoughtful approach in giving consideration to his son's early experiences. He was extraordinarily empathic to how disorienting the experience may have been of switching completely from one language to the other. Perhaps a factor in his consideration was due to his son being the oldest at the time he was adopted (in relation to the other participants) and therefore having greater exposure to the language of his birth country.

Some participants described the use of resources:

I had lots of books about Honduras and stories from both countries, I remember…Carlos saying…because the prince in it is described as having cinnamon-coloured skin and jet-black hair and that aptly describes Felipe (Judy)

We read up from books (Max)

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Judy seemed to use stories to help her children identify with their birth country and racial heritage. For Max the use of books was more in relation to gaining specific factual advice about a range of difficulties that the family experienced due to Allan's early experiences in the Romanian orphanages, thus providing perhaps practical tips and some level of reassurance.

For participants nearer to the bicultural end of the spectrum, further links with the children's birth country was established:

> …got a few things from both countries…towels…a few cushions…we do look in the paper to see if there is anything about Honduras and Guatemala…Carlos spends a lot of time, as soon as he comes in, he goes on the computer to see how the Honduran football team are doing…sadly they don't do desperately well ever (Judy)

This family appear to be fostering connections with their children's birth country on many different levels and the impact of this can be observed by Carlos' enthusiasm toward his country's football team. The description of Carlos looking 'as soon as he comes in' suggests that it is something ever-present in his mind, that he feels passionate about. Establishing connections with their birth country also presents some additional challenges for participants:

> …they both watched…a gang series…[they were] shocked…the poverty, the violence, the absolutely appalling living conditions (Judy)

By participants encouraging connections, there seems no option for their children's birth countries to be idealised: children gain exposure to both positive and real aspects of their heritage. In the extract above, Judy describes her children's 'shock' at hearing about the context of poverty and violence of South America which may have been a very sobering and perhaps unexpected experience.

The participant who was in the unusual position of sharing her son's ethnicity provides an account of bicultural competence:

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he's got every opportunity to take from both cultures…he's very curious. He does ask lots of questions…he loves that culture... (Isabel)

5.4.3. *IMPORTANCE OF SHARED EXPERIENCES*

A theme that re-occurred for all of the participants was the importance of shared experiences. The connecting to other adoptive families, often from the same countries of origin appeared to be a huge source of support, particularly in the early days following the adoption:

> ...huge network of parents who adopted from Paraguay…we used to meet…every month, it was lovely…we had to give it up when…we all lived in different parts of the country and they all went to school and it wasn't that easy to meet up (Tara)

> …we belonged to a club, an association of people who had adopted from abroad…went to all of their meetings…got a lot of help from them…another adoptive friend of us, told us…he opened our eyes….we were warned to give them, him very light foods (Max)

> There's a yearly reunion, so we go [of parents who adopted from Vietnam]…but not nearly often enough (Emma)

Here Max indicates how essential the groups are, providing vital advice about which food to give his newly adopted son. Tara indicates how, as well as coming together, there is also a separation of the groups. It seemed that as life continued it became increasingly harder to connect. Perhaps as the adoptee becomes more integrated there is also less of a need for support. Although Emma indicates that she would welcome more frequent meetings. Additionally, as their children grow older as Judy indicates, they exert influence over how they spend their time:

> When they were younger, we all used to meet up and, not really now, I mean we still know the other kids, but you know, when they, the children are 16-ish they don't want to do these things (Judy)

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Some participants spoke of their children's relationships with others with shared experiences:

one of his little friends…was adopted (Tara)

Mia really likes meeting other Vietnamese little girls (Emma)

Some participants talked about the helpfulness of professional support they received:

…we started talking about what we were experiencing…and they were nodding, saying yes, this is typical, and suddenly we thought wow, these people know what we are talking about and it was a huge breakthrough (Tara)

[They] really put me onto a really good thing, is that Matilda and I used to go out every Saturday on our own because I think she really felt that I wasn't giving her any attention because Leo did really take all of my attention (Isabel)

Tara exudes an enormous sense of relief in describing her experience of sharing her difficulties. The fact that the professionals recognised and normalised their difficult experiences seemed invaluable to this family. Additionally, Isabel gives an example of very practical advice provided to aid the family.

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The results have been considered within the structure of four superordinate themes identified from the analysis of the interviews with six participants. In the following section the results will be discussed in relation to the existing literature.

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6. DISCUSSION

6.1 OVERVIEW

In this section the following original research questions will be addressed:

- How do parents negotiate the intercountry adoption process?
- What is the experience of parenting an intercountry adoptee?
- How have parents approached the identity development of their intercountry adopted child?

The questions will be discussed in light of the main findings that emerged from the analysis of the six semi-structured research interviews, and in the context of existing theory and research literature. Additionally clinical implications and recommendations for future research will be outlined. Furthermore, methodological strengths and limitations, and personal reflections will also be considered.

6.2 HOW DO PARENTS NEGOTIATE THE INTERCOUNTRY ADOPTION PROCESS?

The theme that emerged in relation to this first research question was '*the importance of resolve and tenacity*' in order to negotiate the intercountry adoption process. The sub-theme '*a traumatic process*' seemed to capture something significant about the quality of the adoption experience for participants. What was so striking about the participants' accounts of their experiences, was the extreme level of dedication and determination needed to tolerate the "horrendous" "nightmare"[5] that appeared to encompass the process for so many of these participants. This finding makes a contribution to the existing literature since there appears to be a lack of specific research in relation to the difficulty of negotiating the intercounty adoption process.

Indeed Gulland (2008) warns prospective adopters that "*intercountry adoption is not for the faint-hearted*" (p.2), implying the necessity of resourcefulness. Given the typical profile of intercountry adoptive parents as younger, more educated and having better psychological and financial resources (Noy-Sharav, 2005) it is more likely that those who successfully

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[5] These are participants' own words.

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adopt internationally have increased resources to provide considerable determination and resilience to pursue the process (Barratt, 2006).

This traumatic process that adoptive parents undergo on the journey to parenthood may mirror (for differing reasons), the traumatic experiences that their children have undergone prior to their adoption. Four of the six participants interviewed described their involuntary childlessness, providing evidence to support the view that a large proportion of intercountry adoptive parents are infertile (Deacon, 1997). A further participant explained her status as a single parent and adoption being her chosen means of entering into parenthood. The remaining participant had one child achieved through IVF but, being unable to use this method again, chose intercountry adoption.

The Adoptive Family Life-Cycle (Scott & Lindsey, 2003) proposes that prior to adoption, prospective parents' tasks include coping with feelings of inadequacy, letting go of dreams of being a birth parent and mourning these losses. The need to mourn is supported within the literature Miall, (1987), Van Tuyll (1994), Daly (1992) and Trolley (1995). Indeed, Miall (1987) proposes that psychological adjustment to infertility is the crucial variable in explaining the success or failure of adoption. Yet in this study one participant described that a period of mourning was very much imposed upon her. It may be argued that for this participant a more unconscious need for mourning was occurring. However it may be important to take into account individual reactions to experiences of involuntary childlessness.

Barratt (2006) suggests that following the decision to adopt, the process of being investigated as prospective parents is an invasive procedure, perhaps emotionally reminiscent of infertility treatment. Furthermore, the experiences that several parents shared of losing potential adoptable children, might mirror the repeated failed infertility attempts where hopes are repeatedly raised and dashed (Tollemache, 2006). For Emma the trauma of losing a potential child appeared to be so significant it interfered with her interaction with the child that she was able to adopt. It can be hypothesised that Emma may have been experiencing some symptoms of post-traumatic stress. It is important to consider that Emma was left alone to deal with these complex feelings and did not receive any professional support at this time.

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There is also minimal literature in relation to negotiating the experience of bearing witness to distressing contexts of poverty and sorrow whilst visiting their children's countries of origin. In this study there was a sense that the participants were un-prepared for the situations they found themselves in. Van Tuyll (1994) in a paper discussing compulsory preparation classes for prospective international adopters in the Netherlands, dedicates some time to depicting the living conditions of potential adoptive children, to prepare parents. This seems vital to better equip prospective adopters for what they may face in their children's birth countries.

6.2.1 DOMESTIC VERSUS INTERCOUNTRY ADOPTION

A second theme that emerged captured something of the reason why participants required such resolve and tenacity, that is, a '*determination in overcoming obstacles*'. As Barratt (2006) proposes, *all* prospective adopters require considerable determination and resilience to pursue their application. However, what appeared to require additional resources for intercountry adopters were the further layers of complexity in the process such as geographical distance, language barriers, negotiating different systems, bureaucracy and respecting local cultural practices. Furthermore after successfully negotiating this aspect, adopters then had to also deal with the UK system, which in some instances proved as problematic as the adoption itself. These experiences may dispel the myth that many of these participants held, namely that it is easier to adopt a baby from abroad, than domestically (Gulland, 2008).

On a practical level, the experiences particularly in relation to bureaucracy, seemed to be less stressful for those participants who were aided by an adoption agency. However agency input also appeared to provide additional emotional stress since participants felt they had even less control over the process. Therefore, there seem to be different advantages and disadvantages to negotiating the process alone or in conjunction with an adoption agency.

Participants seemed to experience difficulties in relation to local authorities, particularly in relation to transracial adoptions. A number of participants experienced great resistance by

the local authorities due to their 'same race' policy. Indeed there is no conclusive empirical evidence for the assumption that children are better off being raised within a racially matched environment (Scherman & Harré, 2004). In a UK based study Rushton (2007) confirms that traditional psychological measures have revealed no significant difference in placement stability or other outcomes for transracial placements. However this assumption still prevails within the UK, as Goldstein (1999) points out, particularly in relation to black children with white parents. One must consider the historical socio-political context to understand this, for example, these placements may be considered as "*emblematic of wider historical and political injustices such as slavery*" (p67, Brodzinsky et al, 1998). What is interesting, however, is that despite similar historical and political struggles, transracial adoption is much more common in the USA. Indeed, in 1994 the Multiethnic Placement Act was passed, forcing all agencies not to delay an adoptive placement on the basis of race (Bausch & Serpe, 1997). Therefore in the US there appears to have been a successful negotiation of progressing their view of transracial adoption in a manner that is respectful and acknowledging of historical racial injustices. Indeed, when a child is waiting for a family, a matched race placement is preferable. However, when families of the same race and ethnicity cannot be found, a balance should be struck between holding out for a same race family and finding a nurturing but racially dissimilar family environment.

Liow (1994) suggests that the debate around transracial intercountry adoptees extends well beyond the debate of the 1970's which centred around whether black children should be placed with white parents. Like some of the children of the participants in this study, for many children adoption is an issue of life or death and not just a risk of problematic racial or cultural identification (Liow, 1994). Indeed, one participant stated that the physical differences between her and her child provide a useful space to consider the impact of being adopted. Juffer & Van Ijzendoorn (2005) confirm this, positing that where the physical differences between parents and racially dissimilar children are obvious, this may increase the communication within families about the adoption and aids identity development.

In relation to the participants in this study who exhibited high levels of resolve and tenacity, this adds evidence to the personality profile of intercountry adopters. It supports the finding of Levy-Shiff et al (1997) who found that intercountry adoptive parents in comparison to

domestic adopters, were more problem-focused, used more support-seeking ways of coping and viewed parenting as a challenge (Levy-Shiff et al, 1997).

6.3 WHAT IS THE EXPERIENCE LIKE OF PARENTING AN INTERCOUNTRY ADOPTEE?

The metaphor of '*weathering the storm of parenthood*' emerged from the analysis in relation to this second research question. This was of course reflective of the clinical sample that had been chosen, and participants' reflected on overcoming stormy times. There was a sense of stages that participants went through, managing difficulties, being in the midst of difficulties (the eye of the storm) and then picking up the pieces and adjusting over time. Indeed there are a number of models that contextualise adoptees behaviour in relation to stages. One such model is Ward (1980) which postulates four stages, (1) the honeymoon stage, (2) hostility and grief in adapting to the new family, (3) resignation, where the family is accepted and (4) acceptance of the adoption.

What was striking about these participants' experiences of parenthood was the severity of the 'storms' that they had experienced or were in the process of enduring. One may only speculate that in comparison to domestic adoptees, intercountry adoptees face more changes in the pre to post adoption period, which may in turn present more challenges for their adjustment. Furthermore, depending on their pre-adoption circumstances, intercountry adoptees may have faced greater levels of adversity such as negative in-utero experiences, maltreatment and deprivation (Robertson, 2005). Moreover research on brain development confirms that early psychological care and stimulation are critical to neurodevelopment and thus the capacity for language, cognition, exploration and the capacity to modulate feelings (Shapiro & Applegate, 2000, Perry, Pollard, Blakely, Baker & Vigilante, 1995)

6.3.1 MANAGING THE IMPACT OF ADOPTEES' EARLY EXPERIENCES

Participants spoke of a range of difficulties that their adoptees experienced. These included eating problems, toileting behaviour, sleeping difficulties, separation issues, indiscriminate friendliness or disinhibited attachment and relationship difficulties including sibling rivalry, physical and academic delays. This is consistent with the wider picture of intercountry adoptees depicted in the research literature. These difficulties have been widely considered

in the research literature in terms of outcomes (Juffer & Van Ijzendoorn, 2006 for a recent overview) and mentioned in the literature review (Davis, 2007).

Participants spoke of some of the losses that their children had negotiated. In addition to the losses that domestic adoptees experience, intercountry adoptees' losses may encompass disorienting aspects such as landscapes and lifestyles. One participant spoke poignantly of her son standing by the door on a cold and gloomy English day, being used to a warm, outdoor lifestyle, in a way reminiscent of a dislocated refugee. Indeed Papadopoulos (1997) uses the term 'nostalgic disorientation' to encapsulate the losses that refugees negotiate, but may also be considered in the context of intercountry adoptees.

For participants who were still experiencing the legacy of their children's early experiences there were many emotions evoked such as a sense of sadness and perhaps disappointment. Indeed there was a feeling that the hopes and expectations that participants had had, differed in some ways to the reality of parenthood that they were experiencing. For example, in one family where intellect was highly valued, the participant expressed sadness at their son not being academic. As Barratt (2006) concluded, expectation of educational achievement may be common and parents may not understand the level of impairment that comes from early deprivation or feel blamed by the educational system. Furthermore, from a psychoanalytic perspective Tollemache (2006) suggests that reconciling the gap between expectation and reality of adoptive parenthood is a complex process, particularly since our hopes may not always be experienced consciously. Indeed, some participants demonstrated idealisation in describing the early days with their children. It may be that they were overwhelmed at the joy of becoming parents, but perhaps may also defend against more difficult feelings evoked during this time.

Many participants spoke of their children's difficulties with separation or change. As Deacon (1997) posits any separation holds meaning as there is always a fear of abandonment and rejection as experienced by the child in relation to their birth parents. Furthermore, Verrier (2000) proposes that there is often no permission for adoptees to mourn the loss of their biological parents, which may contribute to unresolved grief and difficulties throughout life. Moreover, intercountry adoptees may have little experience in dealing with the beginnings and endings inherent in everyday life (Shapiro et al, 2001).

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Participants in the study emphasised the role of time in helping their adoptees build a sense of trust and better negotiate separation. This is consistent with the research literature (Shapiro et al, 2001).

6.3.2 IN THE EYE OF THE STORM

Despite the focus on intercountry adoptees, it is important to consider that adolescence is a tumultuous time for many families (Deacon, 1997). Indeed, referral levels of adopted children to clinical settings increase at age eleven, peak at fifteen and then steadily decline (Hajal & Rosenberg, 1991). For some of the participants the difficulties for which they sought help occurred just after the adoption process. However for the majority of the participants difficulties occurred within their children's teenage years. Indeed, Brooks, Allen & Barth (2000) found that the proportion of parents who felt close to their child hit a low of 59% during 13-18 and then increased to 80% after the age of 18. Tollemache (2006) suggests that it may be particularly difficult for adoptive parents to express their unhappiness due to a fear that their children may be removed. Thus it is positive that these participants were able to seek help in difficult times. One may speculate that there are other parents experiencing similar difficulties who feel unable to seek support.

What was striking was the similarity between the feelings evoked throughout the adoption process, and those evoked in relation to their children's difficulties; the feelings of helplessness, frustration and lack of control that these parents spoke of. In the extreme, one participant's son had engaged in extremely serious life-threatening behaviour. Deacon (1997) suggests that this kind of behaviour may be to challenge parents in order to find out whether the feared abandonment will come to fruition. Additionally, as Friendlander (1999) posits during adolescence intercountry adoptees have to begin to understand that their experience of the world would have been considerably different in their birth countries. They may have spoken a different language, perhaps been impoverished and may not even have survived (Friedlander, 1999). As adolescents begin to make more sense of the adoption, intercountry adoptees may also be plagued by a kind of 'survivor's guilt' and may feel that they have abandoned siblings and family in the context of poverty and deprivation (Noy-Sharav, 2005). In light of the other demands of adolescence, these are incredibly

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complex feelings to contend with, and one may speculate that adoptees' behaviour may be an attempt to make sense of these emotions.

Participants seemed to make sense of their children's difficulties by relating their behaviour to their early experiences. It is difficult to know how much of the adoptees difficulties may be attributed to their intercountry adoption status, early experiences, their temperament or adolescence alone. It appears that a combination of all of these factors is most likely.

6.3.3 THE CALM AFTER THE STORM

As with the majority of the adoptees in this study, the research seems to consider that, overall, the majority of intercountry adoptees are faring well (Van Ijzendoorn & Juffer, 2006; Tizard, 1991 & Bimmel et al 2003). From the perspective of the participants earlier difficulties seemed to have improved in all accounts. This attests to the resilience of these children, the dedication of their parents and the utility of professional support. Although difficulties had improved, they still remained to some degree or another. Nevertheless, there was a sense that participants and their families were now managing these difficulties better and were more in control. Indeed, particularly for participants whose children were older there was perhaps a sense of sadness at being needed less than previously. Moreover, throughout all of the accounts, there was a palpable sense of pride, pleasure and happiness when reflecting on their families.

This is consistent with Talbot's (1998) findings, where for the vast majority of participants, the adoption had a positive impact on the family and despite the difficulties 97% said they never thought of relinquishing their children. Shapiro et al (2001) consider that parents realise that children have bought a special fulfilment into their lives and may take satisfaction from knowing that they gave their children a qualitatively different life experience.

6.4 HOW HAVE PARENTS APPROACHED THE IDENTITY DEVELOPMENT OF THEIR INTERCOUNTRY ADOPTED CHILD?

The theme '*The complexity of cultivating a heritage*' emerged from the analysis in relation to this third research question. 'Heritage' was used as an umbrella term to consider different

facets of identity including cultural, racial and ethnic identity. Again, as suggested previously, often the distinction between racial, cultural and ethnic identity is often unclear (Bennett, 2003). Identity cultivation is already a demanding developmental task required in contemporary Western society (Grotevant, 1997). What the participants conveyed was the further complexity of the identity development process, which was both enriched and complicated by the added layers of difference. Thus, they felt that their children had to negotiate their identities as adoptees, from a different country and being of a different race, colour, national, ethnic and religious origin to their parents (Grotevant, 1997). Indeed Vonk, Simms & Nackerud (1999) propose that international adoptees have problems establishing their identities because they:

> struggle to integrate an identity that includes acceptance of their own physical appearance, their birth heritage, and the heritage of their upbringing (p.500).

It is of consequence that the participants had adoptees at differing ages, so parents were often at different stages in aiding their child's identity development. There were different challenges facing the participant whose child was seven, where the pertinent issue was forging links with the birth country, compared to another participant whose son was twenty, (where there were challenges in relation to balancing family and peer influences).

6.4.1 THE NAMED PART OF ONE'S SELF

An individual's name may be considered key to their identity (Deacon, 1997). Furthermore, as Trolley (1995) proposes, as an intercountry adoptee even the familiarity of being addressed by your name may be lost as a new name may be substituted. The majority of participants discussed the adaptations that were made to their children's names. Participants often incorporated a link to their child's past by using their original name as a middle name or finding a name beginning with the same letter as their original name. This was also found in Scherman & Harré's (2004) study with New Zealand parents of intercountry adoptees, who had often kept part of their children's original names. Indeed, only one participant in this study kept their children's entire names after they were adopted, showing clear acknowledgement and respect for the child's past (Scherman & Harré, 2004).

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6.4.2 SPLIT SELVES

The sub-theme of '*ambivalence*' arose from the analysis and can be considered key in capturing something of the difficultly for intercountry adoptees of cultivating their heritage.

All participants had visited their child's country of origin prior to their child's adoption. This is recommended by Carstens & Julià (2000) who found that this visit is crucial in forging a connection between the parents and their children's culture of origin. Indeed, one participant had been required to stay in her child's country until she had learned the language. The judge in this adoption was determined that this participant would not forget her child's connection to the country.

Two participants had re-visited their child's country of origin after adoption and this had been a positive experience for all members of the family. However, the remainder of the participants expressed ambivalence about returning to their child's country of origin. Although the idea of going back seemed to appeal in theory, it felt more difficult for them to execute in practice. This ambivalence seemed to be expressed both by the parents and their children and may represent the complex emotions that returning may stir up for families. Interestingly, the families who had already made return journeys had younger children. It was the adolescent adoptees and their parents who seemed to express most ambivalence about returning. Since identity formation is a task that takes on particular significance during adolescence (Wilkinson, 1995) it may be hypothesised that for adolescents already struggling to consolidate their identity, a visit to their country of origin may compound the difficulties that they already face. Perhaps when international adoptees are given the opportunity to visit their country of birth it presents a dilemma of loyalty between their birth parents and adoptive parents.

Difficulties with loyalty between the birth and adoptive parents may occur for all adoptees. However, what participants' spoke of as an additional issue for their children was a conflict of loyalty between the culture of their birth country and host country. Two of the participants spoke of this poignantly, observing their children watching these two sporting teams against each other and feeling unsure about which team to support. It may be hypothesised that as Ku (2005) considers, reconciling this dilemma is a lifelong process and not something that can be achieved overnight.

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6.4.3 PARENTAL INFLUENCE

As Scherman & Harré (2004) propose, the way in which adoptive parents' perceive and describe their children influences the way in which children subsequently describe themselves. Thus the models of cultural socialisation that appeared at the extremes of the spectrum for participants appeared to be bi-culturalism or assimilation (La Framboise et al, 1993). The majority of participants were positioned between the extremes of the spectrum.

There was great variation in the way that participants exposed their children to their heritages. For some participants exposure was achieved through food, festivities, learning the language, the use of resources such as books and exposure to other individuals from their child's birth country. For other participants there were further steps such as exposing their children to relevant television programmes, surrounding them with artefacts and actively searching out current news articles in relation to their birth countries. For one participant there was an attempt to expose their children to their language of origin which came at the cost of being under-exposed to their current language. This example seemed to demonstrate the very delicate balance that the challenge of heritage exposure, provides for parents.

It is noteworthy that in this study all participants attempted to foster some level of connection between their children and their birth country. For some participants early efforts to expose their children culturally, had tailed off or were minimal. It could be concluded that the children of these participants were essentially assimilated to the host culture. However it seems important to recognise that participants had acknowledged their children's birth culture. For other participants their attempts had gone beyond minimal and were very active and engaging connections to their children's birth country.

Zuñiga (1991) recommends aggressively pursuing activities, places and people associated with their child's origins. However, it is also important to consider that parents' attempts at cultural socialisation do no occur in a vacuum and whether their children embrace or resist their parents attempts at forging connections may have a great deal of influence on the process.

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Indeed Scroggs & Heitfield's (2001) noticed that there was a great deal of variation in parents' efforts to introduce their children to their heritage. On the one hand it may be that adoptive parents' efforts vary, but on the other hand it may be that despite parents' active involvement, it may be adoptees themselves who reject their parents' identity promotion attempts, as they yearn to blend in with the host culture (Huh & Reid, 2000, Cross, 1998 & Tizard, 1991). Indeed, Friedlander et al (2000) suggests that ethnic identification seems to be important for some intercountry adoptees and not others.

To address this issue further, it is important to consider the attempts of the participants in this study at cultivating their children's heritage, in the context of other studies. Four quantitative studies from non-UK samples will be considered to make sense of the activities of the participants in this study.

Scherman & Harré, (2004) interviewed intercountry adoptive parents in New Zealand. They found that almost half of the families engage regularly in formal cultural activities such as events and structured classes and more frequently informally, through social gatherings and socialising with people from their child's birth country. Thus most families in this study went beyond acknowledging their child's birth culture and are actively involved in it. The children were identified both as having some birth-culture identity and also wanting to fit into the dominant culture, which fits in with the idea of adopted children wanting to blend in.

A US based study (Scroggs & Heitfield, 2001) concluded that all parents believed that it is important for their children to be raised with:

> connections to, and pride and respect for, the cultures and people of the countries in which their children were born (p.25)

Parents expressed the greatest interest in having their children interact with members of their birth country as well as exposing their children to art, history and rituals of from their origins.

In another USA-based study, Friedlander et al (2000) interviewed families who had adopted a racially different child from another country. They found that there was little evidence of identity confusion for the children. Furthermore, the psychosocial adjustment of the children was better when their parents acknowledged the physical differences between them, but emphasised their psychological similarities. Consistent with the other studies, these parents were actively promoting their children's cultural identification. They concluded that a major hurdle for these children appeared to be their sense of being different, and that this is the major challenge for cohesive identity development.

Finally, Huh & Reid (2000) found that parental encouragement and co-participation seemed critical to the cultural identification process. Indeed they found that children's interest in their birth cultures varies over time, particularly in adolescence, where it typically decreases. Indeed, Roejewski (2005) proposes that recognition of different aspects of the intercountry adoptive child's identity is dynamic and changes over time as the child's interest and understanding changes.

Studies with adult transracial adoptees provide a unique insight into this debate due to their direct experience (Scroggs & Heitfield, 2001). These adult intercountry adoptees advised that parents should:

> do more to help their children form connections to, and an appreciation and respect for, the culture and people of the ethnic or racial community to which the children were born (p.6, Scroggs & Heitfield, 2001).

Thus it can be tentatively concluded that identity development is dependent on both parents' exposure to their child's heritage, the child's willingness to connect with their origins and to take into account that these factors appear to fluctuate over a life-time.

6.4.4 SHARING EXPERIENCES

Trolley (1995) proposes that a positive aspect in relation to international adoption is the development *"of extremely special friendships"* (p.263) with other parents of children adopted abroad. Indeed, a sub-theme that emerged repeatedly during the analysis was the *'Importance of shared experiences'* for both the parents and children. The pattern that

seemed to occur for all of the participants was to rely more heavily on this support, whether through organised groups, internet forums or individual friendships, in the earlier days of the intercountry experience. Then gradually, as a normality was established the groups seem to dissipate. It was notable how valued participants' experienced these supportive relationships to be. Indeed, for one participant these relationships were key in providing invaluable advice about his son's post-orphanage nutritional needs.

Despite all participants having current or had past access to the Adoption and Fostering team, this experience was not referred to directly within the interview schedule. Some participants did allude to this experience. One participant in particular shared her enormous sense of relief and expressed feeling supported by professionals who were able to normalise her experiences in a non-blaming way. Indeed, Barth & Miller (2000) consider that the quality of support that parents receive from adoption services is vital in helping parents better understand their child and difficulties surrounding adoption. Furthermore, for children, these services may aid their understanding of what it means to grow up as an adoptee.

6.5 BLOOD VERSUS WATER

A further theme '*blood versus water*' emerged from the analysis of participants' accounts. This was a powerful theme that applied across all of the research questions. It captures something of the 'adoption triangle' the link between the adoptive child, the adoptive parents and the biological parents which is always a central issue (Van Tuyll, 1994). Miall (1987) conceptualises the blood tie as:

> indissoluble and of mystical nature that transcends legal or other kinship arrangements (p.35)

Furthermore, Schneider (1968) posits that a blood relationship can never be severed whatever its legal position, and this appears to be the key difference between biological and adoptive parenthood. Miall (1987) also considers that in a society that values biological kinship ties, the lack of a blood tie between a mother and her child may be stigmatising. For example one of the participants spoke of her early days of being an adoptive parent and feeling the need to disclose her children's adoptive status to everyone. However in

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exploring the inadvertent stigmatisation of adoptive parenthood, Miall's (1987) found that most adoptive parents considered their friends and family as viewing adoptive parenthood as basically the same as biological parenthood. Trolley (1995) posits *"what is most essential, a bond of the flesh or of the heart?"* It is very clear from these participants that a bond of the heart, presides.

There may be cultural differences in the manner in which blood ties are considered, which may affect intercountry adoptees more than domestically adopted children. For example, one participant spoke of how difficult it was for her mother-in-law of Chinese heritage to accept her adopted son due to the beliefs about the importance of blood ties. O'Brien (1997) elaborates further on this issue that although adoption in China is widespread, in some parts, adoptive parents must adopt a child with the same surname. Thus, Waltner (1990) quotes from Ming law *"he who adopts a child of a different surname, causes chaos in the lineage"* (p.7). Surnames represent blood family lines which are often seen as sacrosanct (O'Brien, 1997).

As well as considering issues related to biology, participants also spoke of chemistry. The way the participants spoke of first meeting their children was strikingly dichotomous. On the one hand some participants spoke of instantaneous chemical reactions reminiscent of love at first sight. Indeed Shapiro et al (2001) confirm that *"many parents talk of falling in love at the first sight of their child"*. Yet they also point out that it may often take a long time for parents to feel that their love is returned from their children. Perhaps for other participants who described their initial meeting more like meeting a stranger, they may be more identified with the children's view of them as strangers, rather than the new view of themselves, as parents.

The participants frequently had contact with their child's birth parents, often the mother to legalise the adoption. Interestingly, this was often discussed by participants in a very factual way. For most of the participants, although the adoption was a closed one, there was a sense of the biological parents remaining in mind. For one participant who was in contact with her child's birth father, there were extremely complex feelings stirred up in relation to this. As Sykes (2001) found, in a study considering adoptive families in continuing contact with

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birth families, adopters expressed many conflicting emotions about this contact, for example issues around ownership, fear, anger and blame.

6.5.1 THE INEVITABLE VISIBILITY OF DIFFERENCE

LePere (1987) proposes that an aspect of infertility that parents struggle with is a loss of the tangible evidence of their physical continuity. By tangible, this implies biological children who resemble their parents. A theme that reoccurred concerned the inevitability of the physical differences between participants and their children.

Similar to the difficulty in discerning the outcomes of research on cultural and ethnic identity, there are conflicting outcomes about intercountry adoptees racial identity, Feigelman & Silverman's (1983), Tizard, (1991), Simon & Altstein (1992), Westhues & Cohen (1994). Kim (1977) in an early study found that Korean children adopted by white parents tended to be very concerned about their physical appearance and tend to reject their racial background. Additionally, Feigelman & Silverman (1983) found that twenty-six percent of Korean adoptees in the US were sometimes uncomfortable about their appearance. Whilst Tizard (1991) proposes that, however adoptees regard their ethnic or cultural identity, they *must* come to terms with their appearance.

It appears that the place where the research is conducted, the ethno-racial mix of these communities, the attitude of adoptive parents and availability of others of the same race impacts the racial identity development of intercountry adoptees living there. Therefore, Friedlander et al (2000) propose that transracially intercountry adopted children who live in predominantly white communities and have little exposure to minority cultures, are understandably confused about race. It appears that homogenous countries such as Norway may be experienced differently by transracial adoptees than more multiracial settings. Thus, Saetersdal & Dalen (2000) found that Norwegian-Vietnamese adoptees described their relief when they visited multiracial settings such as London, feeling as thought they 'disappeared' in the street. Interestingly, one participant spoke of a similar experience for her son who enjoyed a visit to New York, where he noted many people being of a similar racial background. This appeared to provide this adoptee with a sense of pride and

belonging which was in contrast to looking different to his family where he felt like the odd one out.

Interestingly, Scroggs & Heitfield (2001) found that for parents whose children's appearance made clear their racial origin, they attached even greater importance to exposing their child to their birth-culture. Therefore parents felt that they should provide them with a stronger sense of their heritage to prepare them for questions and possible prejudice.

Moreover, the importance of intercountry adoptees' racial identity becomes more pronounced at adolescence when they may need to cope with bias, discrimination and possibly racial insults (Triseliotis, 1993). Fortunately, in this study, according to the participants whose children were racially dissimilar to themselves they had not thus far, experienced incidents involving racism. Again, this may be due to the research being conducted in a relatively racially heterogeneous community and perhaps, parents may not be aware of their children's experiences of racism.

6.6 IN CONCLUSION

The number of children available for domestic adoption in the UK is declining (Mather, 2007) whilst the number of children internationally who need new families continues to increase. Consequently while it appears inevitable that intercountry adoption will continue, it is essential to ensure it continues in a regulated manner. Intercountry adoption raises some complex ethical issues, and it is difficult to balance the needs of the child, birth parents and adoptive parents (Van Ijzendoorn & Juffer, 2006). Ultimately in a perfect world without conflict and huge inequalities in living conditions, intercountry adoption would not exist (Mather, 2007). Indeed, Mather (2007) considers that leaving the country of one's birth is a risky and disempowering process, given free choice, few would attempt and furthermore this decision is not made by the child concerned. Finally, Mather (2007) concludes that

> While the change is often from poverty to relative wealth, wealth alone cannot guarantee a better life (p.479)

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Efforts should continue to be made to ensure that children, where possible, remain in their own families and countries, for example, by structurally enhancing the life chances of economically disadvantaged families. However, this may not be possible in all instances. For example in the near future the AIDS pandemic will enormously increase the number of orphans in Africa, which means that intercountry adoption is likely to be an important means of improving life outcomes for children who can no longer be cared for by kinship networks (Roby & Shaw, 2006). Van Ijzendoorn & Juffer (2006) consider, intercountry adoption is an impressive intervention leading to astounding 'catch-up' and propose that it is therefore justifiable on ethical grounds. Indeed adoption can be considered a protective factor, as different participants considered the fate of their children had they not been adopted:

> All these little…bare foot kids would come and try to get money…I was thinking gosh, Joshua, if you stayed you would possibly be one of those little children…This family had adopted a girl from Thailand, she was 9 and a prostitute…he said if we hadn't adopted her she would be dead by now (Tara)

> I don't think that they really would have had such a good prognosis in terms of health and survival (Judy)

As Altstein, Coster, First-Hartling, Ford, Glasoe et al (1994) propose, in relation to intercountry adoptees, each person's experience is unique and each adoptee has a different history, therefore each family must decide how to help the child connect with their origins and heritage (Shapiro et al, 2001).

6.7 SIGNIFICANCE OF THE FINDINGS – IMPLICATIONS FOR CLINICAL PRACTICE

In considering parental experiences of intercountry adoption, the study appeared to achieve its aims. The results were consistent with some of the existing theoretical, research and clinical literature such as the difficulties in cultivating intercountry adoptees' heritage and the complexities of managing the impact of intercountry adoptees' early experiences. The results also provided some new areas for consideration and contribution, the implications of which will be considered below. It is important to acknowledge that the research findings

were based on a small sample size of participant accounts, and implications are therefore considered tentatively.

Since intercountry adoption for these participants was described as such a traumatic experience, it appeared that as prospective adopters they were under equipped to deal with what they faced along their journeys to parenthood. Therefore, as Van Tuyll (1994) discusses, greater availability of preparation classes for prospective intercountry adoptive parents would better prepare them for what lies ahead. This could provide prospective parents with:

- Information about the bureaucratic, assessment, legal and financial implications of intercountry adoption
- Information about using an adoption agency or undertaking an independent adoption
- Help parents to become aware of their feelings about adopting and their hopes for parenthood, including possible grief in relation to the loss of biological continuity
- To consider the issue of the 'adoption triangle', themselves, the birth parents and the adoptive child, as always playing a central role, including the effect of early separation
- The background and living conditions of the potential adoptive child in various countries of origin
- The importance of fostering a connection to their child's heritage and origins
- Awareness of the background and history of the adoptee, that could potentially influence the child's development

Additionally, bringing together a small group of prospective adopters would provide an intervention in itself since as the participants in this study proposed, the utility of shared experiences was vital in their negotiation of the whole process. A kind of preparatory group such as the structure suggested by Van Tuyll (1994) may help to strengthen prospective parents' resolve and tenacity in approaching and negotiating the process. By being more informed about what to expect, it is hypothesised that other parents would experience the process as less traumatic than the participants from this study.

Given that participants had differing experiences depending on their use of an agency or undertaking the adoption themselves, this has implications for the way that participants

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could be supported to negotiate the process. Therefore, participants who used an agency appeared to have less difficulty negotiating the bureaucratic aspects of the process, but seemed to find the emotional experience even more demanding as they felt powerless in influencing the adoption. Thus, prospective parents using an agency may need further emotional support during the process. Those participants who negotiated the adoption alone, seemed to find that the continuous demands of the process were helpful for their emotional well-being. Thus, prospective parents negotiating the process alone, may need further support in negotiating the practicalities of the process.

Additionally, a post-adoption group for new parents could prove extremely useful. This would ensure that the social support of the group could continue in a more formal way. This would give parents an opportunity to come to terms with their rapid change in status from an individual or couple, to a parent, and to consider both the pleasure and difficulties in adjusting. Learning about the impact of their children's adverse experiences in theory, is very different to watching the difficulties unfold in practice, as occurred for the majority of the participants in this study. Additionally like these participants, other parents may be undergoing stressful procedures in relation to the UK adoption of their children, in which a group could provide a useful forum for support.

Given the complexity for parents of cultivating their children's heritage, the use of cultural consultants could potentially help parents with the delicate balance of both fostering connection with and pride in their child's country of origin and fitting into the dominant culture. The use of cultural consultants could provide families with specialist knowledge in relation to their specific situation. For example, one participant demonstrated the importance of blood ties in the Chinese culture. Furthermore a cultural consultant could provide specialist advice to professionals involved in working with intercountry adoptive families. Cultural consultants could also provide the tools to aid families when they are considering a visit to their child's birth country, since, as these participants' demonstrated, this may raise a number of complex feelings.

From the research it is clear that the needs of intercountry adoptees are complex. Ideally, intercountry adoptive families would also have better access to multi-disciplinary specialist teams, or more post-adoption support to address their children's different needs. For

example paediatricians to monitor children's physical development, dieticians to provide advice on nutrition and eating difficulties, clinical psychologists to provide strategies and support with behavioural difficulties, adjustment difficulties and relationship struggles, such as peer and sibling relationships, educational psychologists to provide assessment and advice with school and learning difficulties and social workers to provide advice in relation to post-adoptive assessment and adjustment.

Lastly, although the research was considering the point of view of parents of intercountry adoptees, what was communicated were the ambivalent and complex feelings raised for intercountry adoptees themselves in negotiating their identity, particularly during adolescence. Therefore a group for intercountry adopted adolescents could be considered as therapeutic to normalise and share their common experiences.

6.8 WHY THIS STUDY IS OF INTEREST TO CLINICAL PSYCHOLOGISTS?

This study was established in response to a need identified by a Clinical Psychologist within the specialist Adoption team, examining in depth the client's experiences and feelings. As stated, the study appeared to achieve its aim of examining the experience of intercountry adoptive parents and has considered in detail how the often traumatic process impacted significantly on family relationships and their associated mental health. This study can shed light on the issues faced by intercountry adoptive families and helps to provide a greater understanding of clinically relevant issues for working with these families.

6.9 FURTHER RESEARCH

This study has also illuminated a number of additional areas and questions for future research. These include:

- Since the majority of this sample had experienced fertility difficulties and sought adoption as an alternative it would be interesting to consider a sample who had chosen to adopt. Specifically, what themes would emerge that would be different and similar to the current sample.

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- If an extended period of time had been available it would have been fascinating to follow the same participants over a longer period, thus using a longitudinal rather than cross-sectional design. This would have been particularly interesting in relation to the development of their child's identity.

- Since all of these parents were successful in adopting, it would be interesting to further consider individuals who did not successfully adopt. Specifically, to examine what prevented them from completing the process and how further support may have helped.

- Interviewing both parents, individually would allow a comparison of those aspects of their experiences which were similar or divergent. This would highlight the meaning that individual participants ascribe to their experiences as the same experiences could be considered from two points of view.

- Due to the increase in same sex parental couples, it could be relevant to consider how these couples negotiate their parental roles together.

- It may be useful to compare intercountry adoptive families' experiences of open versus closed adoptions. This may help shed light on the impact of open adoption on adoptees and their parents.

6.10 *METHODOLOGICAL STRENGTHS & LIMITATIONS*

The use of IPA in this study has been the source of a number of limitations and strengths. Overall, using IPA allowed the researcher to adequately address the research questions, providing a great deal of rich and interesting material. For a newcomer to qualitative approaches, as Willig (2001) proposes, IPA provides clear and systematic guidelines for researchers which, with supervision, may be followed with relative ease. The explicit nature of the approach was considered a real strength.

IPA is not intended to analyse large data sets (Jarman, Walsh & Smith, 1997) and the small sample size may be seen as a limitation of the study, as it is not clear to what extent the

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findings can be generalised to other parents of intercountry adoptees. The researcher however, saw the smaller sample also as a strength, since it allowed participants' insightful accounts of their experiences to be considered in great detail. As Collins & Nicholson (2002) suggest, the subtle inflections of meaning may be lost in the analytical process of coding large swathes of transcribed data.

The sample was obtained through a single organisation which may have impacted the type of participants interviewed, for example these parents appeared highly motivated to seek support for their children's difficulties. The sample is further limited due to a selection bias, since participants were selected by therapists working with the participants. Families choosing not to participate may have provided interesting alternative perspectives. However, since half of the possible sample size was interviewed it appears that the participants were not an un-representative sub-sample of possible participants. Additionally, the impact of the exclusion criteria is hypothesised to be relatively minimal as this affected the inclusion of only one potential participant. Furthermore, it was noticeable that apart from one participant, the sample constituted of parents who had sought adoption as an alternative to infertility. On the one hand this may have skewed the emergent themes, whilst on the other reflects the nature of this particular clinical sample. This dilemma highlights the importance of conducting further research in this area.

A further limitation to the findings may be the number of heterogeneous factors within the sample, such as the broad age range of the children , mixed countries of origin, transracial and same-race adoptees, and adoptees being at different ages at adoption. Nevertheless, IPA requires a homogeneous element, which in this study was met by all participants accessing or having accessed the Adoption and Fostering team for support. The heterogeneous factors can also be considered as allowing the interesting comparison of experiences which were similar and those which were divergent, for participants.

IPA focuses on perceptions, and aims to give an understanding about how participants perceive and experience the world from their perspective (Willig, 2001). Thus IPA describes and documents the lived experience but it does not attempt to explain the cause or origin of the phenomena. Thus it is limited since using an IPA approach implies that conclusions regarding causality cannot be established

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Although a collaborative stance was adopted throughout the study, respondent validation (Silverman, 1993) was not used, which could be considered a limitation of the study. It would be interesting to conduct further research, perhaps working alongside participants as co-researchers from the start of the process which would help to address any difficulties relating to power imbalance.

Despite the study's limitations, the results clearly demonstrate that the findings fit well in relation to existing literature which adds further support to IPA as a valid and useful methodology.

6.11 PERSONAL REFLECTIONS ON CONDUCTING THE STUDY

The overall experience of conducting this study made me feel extremely privileged to bear witness to such moving stories about becoming a family. Participants' generosity in sharing their deeply personal experiences was extraordinary, for example, (although not used in the research process) one participant also shared their written diary from the time that they were going through the adoption process. Indeed at times it felt challenging to retain a balance between working through the interview schedule and getting distracted by fascinating stories that participants had to share. Moreover throughout the interview process I learnt to negotiate the intricate skill of working through the interview schedule. In the earlier interviews, the schedule was used more chronologically, whilst toward the later interviews, I was more able to be flexible, following the schedule as questions seemed more pertinent to the participant.

Participants' expectations about involvement in the research at the time of giving consent may not have matched the actual experience of being interviewed. Despite my prior clinical experience and effort to establishing rapport (although not apparent), participants may have felt inhibited Moreover, in relation to social desirability, participants may not have wanted to express their true experiences for a fear of being judged. For example it would be difficult to admit that as an adoptive parent, at challenging times, one had had thoughts of relinquishing their child. Furthermore, participants may (not consciously) have used the interviews as a chance to create a new and preferred narrative about the experience of

parenting an intercountry adoptee, rather than focussing on the more personal or negative aspects of the experiences.

I found that the experience of conducting the interviews challenged my dual identity as a clinician and a researcher. Thus at times I noticed that I wished to slip into my role as a clinician to perhaps normalise participants' experiences and it felt difficult to refrain from this. However, the process of conducting the research has also enriched my role as a clinician, for example by helping me to further consider clients' use of language perhaps more closely than previously.

In considering the impact of my position and beliefs on the research, what I noticed was that when the participants expressed views that went against my own assumptions and values it felt important to consider how these would be included in the analysis and this was negotiated through the use of the reflective diary and supervision. Throughout the course of the research I considered that the aim was not to remain objective per se, but to consider the role and impact of my part which is implicitly linked with the findings.

In relation to the analysis, I found it invaluable to use the first analysed interview to orient myself to subsequent interviews. Using IPA in this way helped to discern both the similarities and the uniqueness of each interview. I felt that having one interview that anchored the others, helped to separate each interview. It is hypothesised that when analysing the interviews without one to contextualise the others, it may have been more difficult to hold on to the uniqueness of each interview, since it is challenging to put aside one's previous thoughts and reactions to the material as they are bound to influence the analysis.

6.12 CONCLUSIONS

The primary aim of the study was to develop an account of what parents' experiences of intercountry adoption, are like, with secondary objectives to explore the experience of the process, parenting and the child's identity development. The use of a qualitative methodology, IPA, facilitated participants' meaningful accounts which fully addressed the objectives. In summary, there are three key concluding points:

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1. Negotiating the intercountry adoptive experience appears to be a traumatic process, requiring a great deal of resolve and tenacity

2. Parenting an intercountry adoptee is both a challenging and rewarding experience. The use of support from those with shared experiences is imperative

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3. Cultivating connections to their child's country of origin, individuals of similar ethnicity and balancing pride in the host culture, is a demanding task.

On the basis of the study, several clinical implications were tentatively generated:

1. Prospective intercountry adoptive parents would benefit from the provision of pre and post-adoption supportive groups.

2. Intercountry adoptive families would benefit from greater availability of multi-disciplinary specialist teams to address their needs.

3. There is a role for cultural consultants to aid both adoptive parents and professionals in their work with intercountry adoptive families.

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8. APPENDICES

APPENDIX A: ETHICAL ISSUES
A.1 Local Research Ethics Committee Approval
A.2 Local Research and Development Department Approval
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A.5 Consent Form

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F.1 Summary of the Study & Thank you Letter to Participants

Parental Experiences of Intercountry Adoption:
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NHS

Camden & Islington Community Local Research Ethics Committee
Room 3/14
Third Floor, West Wing
St Pancras Hospital
4 St Pancras Way
London
NW1 0PE

Telephone: 020 7530 3799
Facsimile: 020 7530 3931

20 September 2007

Ms Marielle Davis
24 Malcolm Court
Malcolm Crescent
London
NW4 4PJ

Dear Ms Davis

Full title of study:	**Parental Experiences of Intercountry Adoption: An IPA Study**
REC reference number:	**07/H0722/62**

Thank you for your letter of 20 September 2007, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

An advisory committee to London Strategic Health Authority

CAM411

Parental Experiences of Intercountry Adoption:
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Document	Version	Date
Application		02 August 2007
Investigator CV	C.I. - Marielle Davis	02 August 2007
Investigator CV	Supervisor's CV - Pieter Nel	
Investigator CV	Supervisor's CV - Paul Jefferis	
Protocol	Version 1	02 August 2007
Covering Letter		02 August 2007
Compensation Arrangements	U.M. Association Ltd. (University of Hertfordshire)	31 July 2007
Interview Schedules/Topic Guides	Version 1	01 August 2007
GP/Consultant Information Sheets	Version 1 - Letter to Therapists	01 August 2007
Participant Information Sheet	Version 2	18 September 2007
Participant Consent Form	Version 2	18 September 2007
Response to Request for Further Information	E-mail from C.I.	20 September 2007
Further Sources of Advice and Support	Version 1	01 August 2007
Debriefing Sheet	Version 1	01 August 2007
Local letter of support (part indemnifier)	Dr Daniel Herron, Tavistock and Portman NHS Foundation Trust	01 August 2007

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from http://www.rdforum.nhs.uk/rdform.htm.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Feedback on the application process

Now that you have completed the application process you are invited to give your view of the service you received from the National Research Ethics Service. If you wish to make your views known please use the feedback form available on the NRES website at:

https://www.nresform.org.uk/AppForm/Modules/Feedback/EthicalReview.aspx

We value your views and comments and will use them to inform the operational process and further improve our service.

An advisory committee to London Strategic Health Authority

07/H0722/62	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely
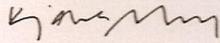
Ms Stephanie Ellis
Chair

Email: katherine.ouseley@camdenpct.nhs.uk

Enclosures: *Standard approval conditions*

Copy to: *Dr Nicholas Wood*
Doctorate in Clinical Psychology Training Course
University of Hertfordshire
College Lane
Hatfield
Hertfordshire
AL10 9AB

R&D office for NHS care organisation at lead site – Dr Daniel Herron,
R&D Manager, Tavistock and Portman NHS Foundation Trust

An advisory committee to London Strategic Health Authority

Parental Experiences of Intercountry Adoption:
An Interpretative Phenomenological Analysis Study

The Tavistock and Portman **NHS**
NHS Foundation Trust

Dr Daniel J. Herron
Research and Development Manager
Research and Development Directorate
Tavistock Centre
120 Belsize Lane
London NW3 5BA

Wednesday 1st August 2007

Dear Marielle Davis,

Re: **Parental experiences of intercountry adoption: an IPA study.**

I am happy to confirm that your research protocol and proposal have been peer reviewed and formally accepted by the Research and Development Directorate on behalf of the Tavistock and Portman NHS Foundation Trust. As a part of this, your research will be sponsored and indemnified by the Trust and registered with the Department of Health National Research Register.

Best of Luck with your research.

Dr Daniel J. Herron
Research and Development Manager
Research and Development Directorate
Tavistock and Portman NHS Foundation Trust

Parental Experiences of Intercountry Adoption:
An Interpretative Phenomenological Analysis Study

UH

Doctor of Clinical Psychology Training Course
University of Hertfordshire
Hatfield
Hertfordshire
AL10 9AB

Dear Sir/Madam,

My name is Marielle Davis and I am currently undertaking my Doctoral training in Clinical Psychology, at the University of Hertfordshire. I am undertaking this 'Major Research Project' as part of my training, and as such I am looking for parents who have adopted a child from another country, to take part in my qualitative study focussing on attachment and identity development.

With this letter you will find a research information sheet. I would be grateful if you could read this as it explains the study. If, after reading the information sheet you can think of any suitable potential participants to take part, I would be grateful if you could be in touch via post, email or telephone. Fluency in English would be a necessary prerequisite. Parents would not be considered suitable if they are experiencing extreme difficulties with their adoptee such as severe attachment difficulties, the possibility of the placement breaking down and any mental health difficulties. Since you know the families I would like to leave it to your clinical discretion if you feel they would be suitable to take part in the research.

The research involves the participant taking part in a face-to-face interview for around an hour. The interview can take place either in their home or at the Tavistock at a mutually convenient time. Questions will be around their reasons for intercountry adoption, how their hopes and expectations prior to the adoption compared to the actual experience, what has been good, what has been more challenging and issues around their child's identity. If they agree to take part, the participants will keep one of the consent forms and I will keep the other for my records. When the interview has been completed it will be transcribed and anonymised, so any identifying information will be changed.

If you have any questions at any stage, please feel free to contact me:
Email: m.2.davis@herts.ac.uk   Telephone: 07973 386 264
Postal address: as above

Thank you for your time.
Yours Sincerely,

Marielle Davis
Trainee Clinical Psychologist

Parental Experiences of Intercountry Adoption:
An Interpretative Phenomenological Analysis Study

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Marielle Davis
Title of project: Parental Experiences
of Intercountry Adoption:
An IPA Study.
Version 2. 18.09.07

INFORMATION SHEET FOR PARTICIPANTS:

Introduction
You are being invited to take part in a doctoral research study which is considering parents' experiences of intercountry adoption. Before you decide whether you would like to take part, please take the time to read the following information which I have written to help you understand why the research is being carried out and what it will involve.

The researchers
The study is being carried out by Marielle Davis, Trainee Clinical Psychologist, as part of a Doctoral qualification in Clinical Psychology. The study is supervised by Dr Pieter Nel, Clinical Psychologist, and Dr Paul Jefferis, Consultant Clinical Psychologist.

What is the purpose of the study?
This research is considering the experience of parents who have adopted children from another country. It is particularly focusing on the development of the parent-child relationship and the development of your child's identity. This is an important area of investigation, as it can help clinical psychologists to better understand the unique experience of parenting an intercountry adoptee.

What is involved?
If you decide to participate, you will be asked to take part in a face-to-face interview that will last about an hour. You will be asked about your experiences in relation to your child's adoption and your development as a family. The researcher will tape the interview and then type it up.

Who is taking part?
This study will include parents of children adopted from another country who are accessing the Adoption, Fostering and Kinship Care Team at the Tavistock Clinic. This study aims to recruit between six and eight parents in total.

Do I have to take part?
No. If you do not want to take part, or you change your mind *at any time* during your participation in this study, you do not need to give a reason. Participation is entirely voluntary and you can withdraw at any time. If you decide not to take part, this will not in any way affect the service that you receive from the team at the Tavistock Clinic.

What do I have to do?
If after reading this information sheet you would like to take part in the research, you will be given this sheet to keep and will be asked to sign two consent forms. You will keep one copy of the signed consent form and the researchers will keep another copy. You will then be invited to attend an interview at a mutually convenient time. The location of the interview is up to you, it can take place within your own home or at the Tavistock clinic.

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Parental Experiences of Intercountry Adoption:
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Marielle Davis
Title of Project: Parental Experiences
Of Intercountry Adoption:
An IPA study.
Version 2. 18.09.07

Will taking part be confidential?
Yes. If you do decide to take part, the notes of your interview will be made anonymous. This means that any identifying details will be removed or changed. Interviews that have been typed up will be confidential to the researchers and kept at a secure location which will only be accessible by the researchers. To further ensure confidentiality, consent forms will be kept separately from the interview tapes and typed up interviews will also be kept separate. The overall findings of the project may be published in a research paper, but no individuals will be identifiable.

Anything else I should know about confidentiality?
As a trainee clinical psychologist conducting the research, if there were any concerns raised about the safety of the child I would be obliged to pass this information on and possibly take action. If this were to occur I would discuss this with you in the first instance. If I were concerned about an immediate and serious risk I would be obliged to take action immediately which would involve breaking confidentiality. These are the same conditions that apply when working with any clinician within the Trust.

What are the benefits of taking part?
Taking part in this study may not benefit you personally. It may provide a useful and interesting time to reflect on your experiences. It is hoped that this research will help to develop an understanding into the experience of parenting a child adopted from another country, which should be of assistance to professionals and organisations providing services for families with adopted children. If you would like to receive the results of this study, please fill in your contact details in the attached sheet.

What if I have questions or concerns?
If you have any further questions about the research, please feel free to contact the researcher via email, telephone or post, details of which are below. In the event that participating in this research has caused you distress in some way, please do not hesitate to contact the researcher, or the clinician working with you at the Tavistock clinic, who will be able to advise you on where they may be able to access further help.

Who has reviewed this study?
This study was reviewed by University of Hertfordshire Research ethics committee and the Camden and Islington Community Local Research Ethics Committee, and has been approved as an ethically sound and suitable project to be conducted within in the NHS.

Thank you for taking time to read this.

Contact details of the researcher:
Marielle Davis
Email address: m.2.davis@herts.ac.uk
Telephone number: 01707 286 322
Postal address: Doctor of Clinical Psychology Training Course
                      University of Hertfordshire
                      Hatfield
                      Hertfordshire
                      AL10 9AB

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An IPA study
Version 2. 18.09.07
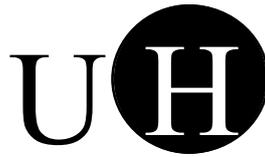
CONSENT FORM

Title of Project: **Parental Experiences of Intercountry Adoption: An IPA Study**.

Researcher: Marielle Davis, Trainee Clinical Psychologist

Please initial box

1) I confirm that I have read and understand the information sheet dated 18.09.07 for the above study. I have had the opportunity to consider the information and if needed ask questions that were satisfactorily answered.

☐

2) I understand that participation is voluntary and that I am free to withdraw at any time, without giving any reason, without healthcare or legal rights being affected.

☐

3) I understand that if I agree to take part in the above study, the interview will be tape-recorded.

☐

4) I agree to take part in the above study

☐

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

……………………………….. ……………….. …………………………………
Name of person taking
consent
(if different from researcher)   Date   Signature

……………………………….. ……………….. …………………………………
Name of researcher   Date   Signature

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COMPARISON OF THE CRITERIA FOR JUDGING THE QUALITY OF QUANTITATIVE VERSUS QUALITATIVE RESEARCH (ADAPTED FROM LINCOLN & GUBA, 1985)

Conventional Terms	Terms more compatible with qualitative research	
Internal validity	Credibility	Refers to the believability of the findings from the perspective of the participants.
Generalisability	Transferability	Refers to the degree to which findings can be transferred to other contexts or settings.

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1.	Why did you decide to adopt a child from another country?
2.	What led you to country X?
3.	What was the experience like of going through the adoption?
4.	The first time you met your child, what was that experience like?
5.	Did you keep the name that your child was given at birth?
6.	How did you go about getting acquainted with your child's heritage?
7.	What were your feelings, hopes and expectations before the adoption went through?
8.	How did this compare to the actual experience
9.	When you were first together as a family, what was exciting/ good?
10.	What were some of the more difficult challenges you faced? What was hardest?
11.	How was it adjusting?
12.	
13.	How did you discuss adoption with your child? When?
14.	Is your child's birth culture remembered/ honoured/ celebrated?
15.	Have you been or do you plan on going to your child's birth country?

Prior to interview-
Going through consent forms, information sheet, addressing any concerns and building rapport

Prompts
-Could you tell me more about that?
-Say a little more?
-What do you mean by that?

Following the interview:
Thanking participants, time for debriefing, addressing any questions or concerns and checking contact details.
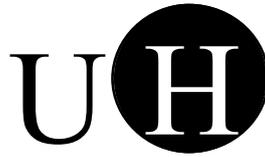
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U(H)

Thank you very much for making this study possible!

This study is investigating parents' experience of intercountry adoption. There is not much research looking at the experience from the point of view of the parents. Since there are increasing numbers of parents who are adopting from other countries it is important to understand what the experience is like.

This study is interested in what has gone well and what have some of the more challenging issues been in relation to adopting a child from another country. In relation to those things that have been more difficult, it is important for us to think about these and how we can help people experiencing similar difficulties.

It is hoped that this research will lead to a better understanding of the psychological factors associated with adopting a child from a different county, thinking particularly about how you as parents help to develop your child's identity which includes culture, ethnicity and religious beliefs and how the relationship has developed between you.

If you have any further queries or questions do not hesitate to be in contact via the details on the information sheet.
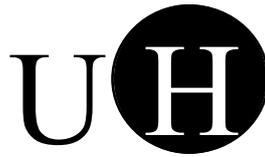
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Further Sources of Advice & Support:

Contact details of the researcher:
Marielle Davis
Postal address: Doctor of Clinical Psychology Training Course
                         University of Hertfordshire
                         Hatfield
                         Hertfordshire
                         AL10 9AB
Email address: **m.2.davis@herts.ac.uk**   Telephone number: 01707 286 322

Contact details of your therapist:
Telephone number: 0207 435 7111
Postal Address: The Adoption, Fostering & Kinship Care Team
                         The Tavistock Clinic
                         120 Belsize Lane
                         London
                         NW3 5BA

Charitable Mental Health Organisations:

- **MIND**

UK mental health charity. Website contains over 100 online information fact sheets and booklets.
www.mind.org.uk
Information Line: 0845 766 0163

- **SAMARITANS**

Available 24 hours per day to provide confidential emotional support for people experiencing distress.
www.samaritans.org 08457 90 90 90

Specific Information about Adoption:

- **British Association for Adoption & Fostering (BAAF)**

A useful source of information for families who adopt and foster children.
www.baaf.org.uk 0207 421 2670

NHS Organisations:

- **NHS Direct**

24 hour nurse led confidential helpline providing advice or information.
www.nhsdirect.nhs.uk 0845 46 47

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Introductions to the interview

Italicised type = researcher
Non-italicised type = participant

23 24 25 26 27	-element of luck -meeting those one-step ahead of the same experience	What led us to Romania specifically was a chance meeting with a couple who had started the process in *(um-huh)* umm…2000…1989 *(um-huh)*…sorry in early 1990 soon after the fall of the er of the dictatorship *(um-huh)*.	-Luck -Importance of those with shared experience -Political context
28 29		*Ok. And um tell me your son's name I haven't asked*	
30		Allan[6]	
31		*Allan*	
32		Yup	
33 34		*so how old was Allan at the time that he was adopted?*	
35	3¾ when adopted	Three and three quarters	
36		*Three and three quarters ok.*	
37		Yes. Three and three quarter years	
38 39		*And what was the experience like of going through the adoption?*	
40	instantaneous ness of response -emotive word -horror, frightening	Horrific.	Adoptive process as horrific
41		*Horrific?*	

[6] All names and identifying information has been altered

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42	-different aspects of the process as equally difficult	Horrific in many ways, yeah.	
43		*What was horrific about it?*	
44 45 46 47 48 49 50 51	-prior lack of regulation -children to be 'chosen' or handed out on a piece of paper	Well many things. We were doing the process at the time when people were free to choose children *(uh-huh)* babies. *(right)* and before you were furnished with a chit with a specific name. (*ok*) So we were lucky (*ok*) and we went round a lot of places. However many if not most of the children and babies that we saw were ill (*right*) and saw…	-unregulated process -luck -bearing witness to painful reality
52		*So you actually went over to Romania?*	
53 54 55		*Yes. Right and so was the experience of being in Romania itself horrific or The whole experience?*	
56 57 58	-matter of fact tone ie: need to be detached to bear the painfulness of the situation -seriousness of illnesses	No I would say that it was basically seeing so many babies that were ill virtually from birth either with AIDS or hepatitis B.	-detached from painful reality
59		*Right. That must have been very difficult.*	
60		Yes	
61 62 63 64		*So give…give me a little bit of an idea of….so initially you looked into adopting very briefly here…then you met this other couple and then what* (but) *led you to Romania?*	
65 66 67 68 69 70	-looked into different host countries -victim of unregulation -financial commitment	Well, there were other stages we were also considering adopting from Central America (*right*) it was either Nicaragua or Guatemala, I cant remember, er Guatemala I think. *(um-huh)* But there unfortunately (*right*) the lawyer took the money up-front and disappeared…so we	-long journey to parenthood -unregulated process

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71 72		didn't pursue that avenue.	
73		*So that was a rogue lawyer experience*	
74	-commitment to process – an obstacle, rather than giving up	Yah, yeah	
75 76		*Ok so you met this couple, and then did you go through an agency over to Romania?*	
77 78	-going it alone -alone, but sense that there were helpful others	No we did it completely on our own…on our own speaking	-isolation
79 80		*Um. Did you keep Allan's name that he had when…*	
81 82 83	-name changed after adoption	No. No Allan is is his new name yes as we thought that his original name Alin would not really work so well in Britain.	-assimilation into the majority culture
84		*So it was quite a similar name?*	
85 86	-conscious effort to find a new name linking to past eg: same initial	Yes. We searched for something beginning with A. yes.	-retained a connection to origins
87 88 89 90		*Ok. so what were your feelings and your hopes, and your expectations before the adoption went through perhaps after you visited Romania?*	
91 92 93 94 95	-hopes minimal – prepared by previous disappointments? -practical rather than emotional	Umm hopes and expectations….I don't think I ever had any hopes and expectations. But lets put it this way I did not expect the red tape, the er beucocratic process to be as involved er and as difficult as it turned out to be.	-practical obstacles

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	difficulties		
96 97		*And and what was that like? Why was it so difficult?*	
98 99	-need to point finger for difficulties?	But a lot of it er. A lot of the blame can be put at the er door step of the home office	
100		*Right*	
101 102	-barrier to be overcome	Which was really a big barrier to, er, to progress	-obstacles to be overcome
103 104 105 106		*Ok. So tell...tell me a little bit more about what it was like...in terms of...you were here, presumably you went over to Romania perhaps more than once?*	
107 108 109	-Dedication and commitment	Yes out of er, out of, from five visits I could say that we spent in total, five or six months out there	-dedicating time
110		*Goodness, So a long time...*	
111 112 113 114	-time frame	Yes a long time and this was spread between May 1990, sorry March 1990 to May slash June of the following year (*ok*) and in that time…	
115 116		*So that was a long period of time there in a relatively short period of time actually*	
117 118	-privileged position to be able to do this	Yes. And in that time I was able to combine work with er looking for a child	
119		*Right*	
120 121 122 123 124 125	-separation as a couple -sense of searching	And sometimes when I couldn't go, my wife would go. We weren't always there at the same time together (*ok*). All in all we went to a total of about 23 er towns and villages (*goodness*) and very many institutions (*right*) maternity wards, orphanage and some...	-separation & sacrifices -dedication
126 127		*And what were your experiences like in those 23 different places?*	

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128 129 130	-hospitality versus resentment?	Yes, well they each place was different. In some we were welcomed and in others we weren't.	
131 132		*Right. And what were you looking for when you moved between places?*	
133 134 135 136 137 138 139 140 141 142 143	-very specific criteria -healthy child -looks like them -hiding adoption to strangers? -toddler, not a baby -health as paramount	What were we looking for? Well we were looking for a child um that was er healthy and that would um er look like us, you know, with Mediterranean features and um we met one or two other people who had bad experiences in the sense that they took babies not realising that the babies were infact quite ill until they brought them back to England. (*right*) So that was one of the reasons we were looking for a toddler rather than a baby of less than 12 months.	-paramount importance of health & appearance of adoptee
144 145		*So you had very specific ideas about what you…*	
146 147		Yes we had er an idea about the age and the health of the child, yes	
148 149 150 151		*And how did you go about knowing whether the child was healthy, apart from how they looked, did you take anyone medical with you…?*	
152 153 154 160 161 162	-invasive checking of potential children	Yes of course, yes, fortunately we met a scientist who worked in a lab in Bucharest (*right*) so we could always take urine and blood samples. (*right*) and Unfortunately er in one or two cases we found out that the child was ill with hepatitis.	-luck -lost potential children
163 164 165 166		*It sounds like a real rollercoaster as perhaps you got your hopes up when you met a particular child and then if the tests came back and they weren't well enough and…*	
167 168 169 170	-'correct' & incorrect, seems very black and white?	Correct and in one case we took the um sample back to London (*right*) and were told that this particular child had hepatitis B. (*right*) and might or might not live a long time (*gosh*) and	-lost potential children -context of sorrow

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171 172	-'particular child' sounds emotionally distant -seriousness & contagiousness illnesses	in any case the er the um illness was contagious.	
173 174		*Goodness, so a real rollercoaster of a year it sounds like…*	
175		Yes	
176 177		*So tell me about the story of…presumably was it the 23 orphanage where you met Allan?*	
178 179 180 181 182 183 184 185 186 187 188 189 190 191 192	-babies to be 'shown' -un-emotional almost cut-off tone -low expectations – in good health and able to walk as the exception rather than the rule	Errr yes. I think it was at the er one of the very last ones that we went to where we met him. Yes, one of the very last ones, yes, yes. We met him in er we went to the orphanage in October 1990 and at the time we er we weren't actually shown prospective babies or toddlers for adoption *(um-huh)* but we went back in er February or was in March, I cant remember, of the following year, and the doctor in charge er said um "yes I can er I can show you um two little boys" and um they were um, we were surprised that they were still available, so to speak as they were really um healthy, and er you know they looked ok etc, and they could walk, many children couldn't walk at that age.	-un-regulated process -low expectations
193		*And Allan was one of those two?*	
194		Allan was one of those two, correct, yes.	
195 196		*And do you remember sort-of the first time you met him? What was that like?*	
197		Well…	
198	Emotional reaction	*You smile, that's a big smile.*	
199 200 201 202	-vivid memory of details – flash bulb memory -idealised?	Well, yes he came into the doctor's um office on the ground floor of the orphanage with another little boy and um immediately they were, they were good friends, the other boy	-flash bulb memory

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203 204 205 206 207 208 209 210 211 212 213 214	-emergent personality -element of fate, meant to be together	may have been more intelligent in the sense that we bought toys for two or three children and the other boy was better at um handling the toys and crayons, etc. but he stuck to himself to a corner and made no attempt to be with us. Whereas Allan, um, you could see already then was quite an extrovert and a er happy child, you know, and he, he more or less, you know jumped on our knees and played and my wife played with him, it was, in a way one could say that he chose us as much as we chose him.	-value sociability -nature vs. nurture -fate
215 216		*So it sounds like a very vivid* (yes) *moment when he jumped on your lap.*	
217 218 219 220	-felt like love at first sight -instantaneous reaction	Yes, er, yes, um, we er, I just, um my wife and I just fell in love with him there and then (*um-huh*) and we thought that we would like to be able take him.	-chemical process of bonding
221		*And what was the process*?	
223 224 225 226 227 228 229 230 231 232 233 234 235 236 237	-backdrop, political regulation -getting to know the Romanian bureaucratic aspects -financial costs	Then the process was that, we had to go back, by that the the rules were tightening up, and we had to go back to the capital, to Bucharest to get a chit (*right*) allowing us to take a specific child or children with the names on (*ok*). So um, we went back, um er and the legal process started (*um-huh*), if I can remember rightly in April, a month or two later. And that was quite quick because the um, the social worker into the orphanage helped us to find a solicitor (*right*), and the solicitor worked quite fast, albeit, not cheaply. Then the medical tests were done in that period between our acquaintance with the little boy and er, the start of the legal process	-political context -learning the ropes -chance introductions -financial commitment -medical testing
238		*So you knew, quite early on…*	
239		That he was healthy, yes.	
240 241		*And during the time that the legal process was going on did you go back and see Allan?*	
242 243	-getting to know each	Yes, we er, I er I made an effort to go back and be with him and play with and at one stage he	-bonding -connecting vs.

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244 245	other -painful for both	followed me out, but of course he couldn't go out yet.	separating
246		*What was that like?*	
247 248 249	-enjoyment of child -emerging personality	Yes, it was wonderful, we could tell that he was a very intelligent child and quick witted etc. he was…	-nature vs. nurture

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-luck	…cont
-importance of those with shared experience	-pragmatically cutting off from painful
-political context	emotions
-adoptive process as horrific	-justification for adoption
-unregulated process	-contrast to own infertility
-luck	-looking for happiness in the context of sorrow
-bearing witness to painful reality	-shock:
-detached from painful reality	emotive
-long journey to parenthood	painful
-unregulated process	overwhelming
-isolation	-sense of helplessness and powerlessness
-assimilation into the majority culture	-dedication to becoming a family
-retained a connection to origins	-long emotional and painful journey following
-practical obstacles	another arduous journey
-obstacles to be overcome	-positive aspects of the adoption process
-dedicating time	-culture, intellect and hospitality held in high
-separation & sacrifices	esteem
-dedication	-political context
-paramount importance of health & appearance	-creation of friendships based on shared
of adoptee	experiences
-luck	-dedication – separation as a couple
-lost potential children	-adoption in context of stressful life events
-lost potential children	-split gender roles, wife as preparing the nest
-context of sorrow	-novelties
-un-regulated process	-future fantasies and hopes for son
-low expectations	-chemistry vs biology
-flash bulb memory	-connecting
-value sociability	-realisation of family dream
-nature vs. nurture	-hopes vs reality of parenthood
-fate	-developmental delay
-chemical process of bonding	-time-consuming
-political context	-split gender roles
-learning the ropes	-connecting with others – need for dialogue
-chance introductions	-past, in present, in mind
-financial commitment	-connecting vs. separating
-medical testing	-legacy of the orphanage
-bonding	-novelty
-connecting vs. separating	-autonomy
-nature vs. nurture	-symbolic closing door on old life and opening
-Fate	door on new life
-connecting, bonding	-luck
-lost children	-importance of shared experiences
-ill-fate	-sense-making

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-legacy of the orphanage	…cont
-legacy of the orphanage	-learning from others with shared experiences
-sense making	-age appropriate way of disclosing adoption
-adjusting over time	-inevitable visibility of physical differences
-Maslow's hierarchy of needs	-actively seeking those of a similar ethnicity
-separating vs connecting	-connection to culture & birth parents
-anxious-insecure attachment	-anxiety about future connection to birth family
-importance of shared experience	-disappointment in lack of linguistic interest
-adjustment over time	-desire to assimilate linguistically
-luck	-ambivalence toward heritage
-assimilation to foods	-impact of culture on identity
-adjustment over time	-transmission of cultural ambivalence
-fully adjusted	-cultural ambivalence
-shared experiences and the importance of social support	-bi-cultural vs. assimilation
-connecting vs separating	-difference between the theory and practice of returning to the birth country
-social support and other resources	-struggles
-luck	-Importance of support
-physical lag	-adjusting over time
-developmental lag	-scarcity versus plentifulness
-assimilating culturally	-separation vs. connecting
-socialisation of school versus survival in the orphanage	-nature vs nurture
-connecting vs. separating	-adjustment over time
-relationships with peers vs. authority and rules	-connecting
-appreciation of family dream	-well adjusted
-separating vs connecting	-parental vs child conflict
-nature vs nurture	-hopes vs reality
-insecure-anxious attachment	-pride vs disappointment
-legacy of the orphanage	-hopes vs reality
-long-term decade of adjustment to separating	-negative connotations of culture
-contrast with separation in the present	-cosmopolitan, intellectual family culture
-importance of relationships with those with shared experiences	-trans-generational culture
-connecting and separating	-transmission of culture
-sense-making	-Making sense of son's experience
-tolerating separation	-transmission of religion
-disappointment	-parental vs peer influences
-hopes vs. reality	-emerging sense of agency
-lag due to early deprivation	-palpable pride
-disappointment vs. pride	-palpable happiness
-hopes vs. reality	
-nature vs. nurture	
-luck	

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Determination to overcome obstacles	
Context of sorrow	difficult to hide our tears…with children packed like sardines 10.319[7]/ many if not most were ill 2.49/ either with AIDS or Hepatitis B 2.57/ babies crammed, ill and undernourished 10.320
Adoptive process as horrific	Horrific in many ways 2.42
Dedication	Spent a total or 5 or 6 months out there 4.108/ went to 23 towns and villages 5.123
Obstacles to overcome	Didn't expect the bureaucratic process to be as difficult 4.94/ home office a big barrier 4.101/ rules were tightening up 7.224/ we were moving homes 12.386
Unregulated process	people were free to choose children 2.45/ the lawyer took the money up front and disappeared 3.70/ solicitor worked fast albeit not cheaply 8.223/ social worker helped us to find a solicitor 7.231
Long journey to parenthood	Many IVF procedures, we worked for years to have our own 11.332
Positive aspects	Many things…discovered a new country…very hospitable & met their families 11.358
Realisation of family dream	Couldn't wait, it was just a fantastic thrill 13.417/ just thrilled 18.538
Luck vs. Fate	Fortunately met a scientist 5.152/ had contacts…managed to locate the father 9.284/ 9.280 / 14.467 Could say that he chose us as much as we chose him 7.213
Witnessing and nurturing of post-traumatic growth	
Chemistry	Wife and I just fell in love with him 7.217/ immediate chemistry 13.413
Importance of relationships with those with shared experiences	Friend who adopted told us 14.468/ belonged to a club of people 17.546/ needed moral support 19.630/ warned me only to give him light foods 16.522/ warned me not to do his mistake 21.737/ still in touch with some 12.371
Making sense of the orphanage legacy	That's why he didn't speak 13.428/ scared of water 15.482/ orphanage series of doors 14.470/ hosed down with cold water 15.487/ part of his repressed memory 25.883/ summer camps helped 26.914
Adjustment over time	Matter of time 15.492/ until 14 saying goodbye was a big problem 19.608/ long time wouldn't touch fruit and vegetables or fruit 16.528/ now its normal like everyone else 16.544
Well-adjusted	He's got a girlfriend, he's very popular 19.617/ now its normal…like everyone else 16.544/ other way round 19.617
Insecure-anxious attachment	Needed to reassure himself that we weren't going 15.495/separating and saying goodbye were a

[7] Supporting quotes followed by the page and line number where they may be found

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	problem 19.608/ run round to our bedroom 15.503
Socialisation	Teaching him to speak 13.428/ no conversation 14.425/ too wild 17.565/ had to teach him to look people in the eye 26.929/ sufficiently integrated at 18.571
Disappointment vs pride	School wouldn't have him 17.559/ Unlike him she's not bad at school 20.680/ language has never been his forte 23.814/ He's not academic 21.717/ can give him a mike he'll take it 26.930/ got natural business instinct 27.972
Transmission of cultural ambivalence	
Impact of culture on identity	I'm carrying a lot of luggage culturally…mixed identity 24.844/ sees himself as British, but egging on Romania in the world cup 24.855/not had a need to visit…no desire 25.879
Cosmopolitan, intellectual family culture	Doctors and uni lecturers 11.350/ open house, no week without guests 29.1022/ cosmopolitan 28.1000/ began to copy us 29.1029/ religious practice, until a year ago 29.1045/ bar-mitzvah 30.1055
Assimilation into the majority culture	Feels completely integrated in Britain 25.868/ there was no culture he was in an institution 28.994 / can count up to 20, never been interested 23.821
Actively seeking out cultural and ethnic ties	I'd like you to meet him (to Romanian)…like a son 22.782/ belonged to a club of people 17.547
Name change	Allan is his new name…his original name wouldn't work 3. 81

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Interview 1 Themes	Themes in other interviews which were similar[8]
Determination in overcoming obstacles	-Determination with get you through (2) -Negotiating bureaucratic complexities (3) -Arduous process (6)
Witnessing and nurturing of post traumatic growth	-Long-term impact of early experiences (2) -Adjustment over time (3) -Joy of parenthood (5) -Lasting impact of early experiences (6)
Transmission of cultural ambivalence	-Un-sustainable exposure to country of origin (2) -Desire to create a connection with the country of origin (4)
	Themes in other interviews which were divergent
	-Incongruence between the anticipation and reality of parenthood (2)
	-Blood versus water (3)
	-Bi-culturalism (3)
	-Traumatised self (4)
	-In the eye of the struggle (4)
	-Inevitable visibility of difference (4)
	-No desire for biological continuity (4)
	-Intolerable uncertainty (5)
	-Our life turned upside down (5)
	-Assimilation (5)
	-Visibility of differences (6)

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[8] The bracketed numbers indicate which interviews the themes are from

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Interview 1 Themes:
Determination to overcome obstacles
Witnessing and nurturing of post-traumatic growth
Transmission of cultural ambivalence

Interview 2 Themes:
Determination will get you through
Incongruence between the anticipation and reality of parenthood
Long Term impact of early experiences
Unsustainable exposure to country of origin

Interview 3 Themes:
Blood vs. water
Bi-culturalism
Negotiating bureaucratic complexities
Adjustment over time

Interview 4 Themes:
Traumatised Self
In the eye of the struggle
Inevitable visibility of differences
No desire for biological continuity
Desire to create a connection with the country of origin

Interview 5 Themes:
Intolerable Uncertainty
Joy of Parenthood
Our life turned upside down
Assimilation

Interview 6 Themes:
Honouring heritage
Arduous Process
Lasting impact of early experiences
Visibility of Differences

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Determination will get you through
Determination to overcome obstacles
Negotiating bureaucratic complexities
Traumatised self
Intolerable uncertainty
Arduous process
Witnessing and nurturing of post-traumatic growth
Long-term impact of early experiences
Adjustment over time
In the eye of the struggle
Our life turned upside down
Lasting impact of early experiences
Incongruence between the anticipation and reality of parenthood
Transmission of cultural ambivalence
Unsustainable exposure to country of origin
Bi-culturalism
Desire to create a connection with the country of origin
Assimilation
Honouring heritage
Blood vs. water
No desire for biological continuity
Inevitable visibility of differences
Visibility of difference

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The importance of resolve & tenacity	Blood versus water	Weathering the storm of parenthood	The complexity of cultivating a heritage
• A traumatic process • Determination in overcoming obstacles	• Biology versus chemistry • The inevitable visibility of difference	• Managing the impact of early experiences • Life turned upside down • Adjustment over time	• Biculturalism versus Assimilation • Ambivalence • Importance of shared experiences

Parental Experiences of Intercountry Adoption:
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UH

Doctor of Clinical Psychology Training Course
University of Hertfordshire
Hatfield
Hertfordshire
AL10 9AB

Dear Participant[9],

Re: Research Study ~ Parental Experiences of Intercountry Adoption

You will recall that you took part in a research study about your experiences of being an adoptive parent of a child from another country. Thank you again for you time and interest in this research and sharing your remarkable story with me.

I have now completed the study and wanted to feedback to you the main themes identified in the overall study. Although I will not be incorporate any changes to the final draft of my thesis, I will be able to make changes when writing up the paper for publication and I welcome your feedback (details are provided below). It is important to say that not all participants were represented within each theme.

The first identified theme was '*the importance of resolve and tenacity*'. This theme was specifically in relation to negotiating the intercountry adoption process. What was so striking about the different accounts was the extreme levels of dedication and determination needed to manage the adoption process. There appeared to be infinite numbers of obstacles to be overcome, sometimes both in your child's country of origin and then also on your return to the UK. This seemed to be an important finding as there is a lack of literature on the negotiation of the intercountry adoption process.

The second identified theme was '*blood versus water*'. This theme appeared to capture something of the links between you, your children and their biological parents. It considered aspects such as the physical differences between you and your children and the process of bonding with your child.

The third identified theme was '*weathering the storm of parenthood*'. This theme was in relation to parenting your child and emerged as a metaphor 'weathering the storm'. Within this theme there was most variation between participants, who were at different stages due

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[9] This letter is due to be finalised in consultation with the Adoption, Fostering & Kinship Care Team

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to the variation in ages of their children. What emerged most strongly within this theme, was parents' perseverance and dedication in managing the impact of their child's early experiences and how difficulties adjusted over time.

The fourth and last identified theme was *'the complexity of cultivating a heritage'*. What came across throughout the accounts, was the difficultly of balancing the demands of both encouraging pride in your child's birth culture as well as helping them to fit into the dominant culture. It is noteworthy that all families made efforts to foster connections between their child and their birth culture.

Although the sample size was small and generalisations to other intercountry adoptive parents cannot be made, some conclusions were tentatively proposed. These were:

- Negotiating the intercountry adoptive experience appears to be a difficult process, requiring a great deal of resolve and tenacity

- Parenting an intercountry adoptee is both a challenging and rewarding experience. The use of support from those with shared experiences is imperative

.

- Cultivating connections to their child's country of origin, individuals of similar ethnicity and balancing pride in the host culture, is a demanding task.

If you would like to contact me, I would welcome an email (marielledavis@hotmail.com) or a letter (to the address at the top of this letter).

Thank you once again for taking part in my research and making this study possible.

Yours sincerely,

Marielle Davis
Trainee Clinical Psychologist

Parental Experiences of Intercountry Adoption:
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PARENTAL EXPERIENCES OF INTERCOUNTRY ADOPTION: AN INTERPRETIVE PHENOMENOLOGICAL ANALYSIS STUDY

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Summary

Intercountry adoption is an increasing phenomenon and this article explores parents' experiences of intercountry adoption. A qualitative methodological approach, Interpretive Phenomenological Analysis was used to analyse the semi-structured interview accounts of six participants. Participants constituted a clinical sample and were accessing or had accessed a specialist Adoption and Fostering team. The following four themes emerged, '*the importance of resolve and tenacity*' in relation to negotiating the process, '*blood versus water*' in relation to the adoptive triangle (the adoptive parents, biological parents and the child), '*weathering the storm of parenthood*' and '*the complexity of cultivating a heritage*'. The findings are considered in light of the existing literature and due to the small sample size, clinical implications are tentatively proposed.

Introduction

Intercountry or international adoption is estimated to involve more than 40,000 children a year moving among more than 100 countries (Van Ijzendoorn, & Juffer, 2006). Of those the numbers of intercountry adoptees coming to England and Wales are relatively small. In 2005 there were 367 intercountry adoptions (Mather, 2007). Whilst intercountry adoptees themselves are the subject of increasing numbers of research studies, adoptive parents appear to be less considered and are the population considered in this research.

Historical context

The phenomenon of intercountry adoption can be traced back to social factors such as war, poverty and political revolutions (Ku, 2005). Additionally, the Abortion Act of 1968, trends for single mothers to keep their children, and a marked decrease in domestically available babies, have resulted in the increase of international adoptions (Mather, 2007). Intercountry adoption has continued to grow considerably since the early 1990's when the infamous Romanian orphanages were exposed to the world (Mather, 2007).

Attitudes toward intercountry adoption

Historically, there has been widespread opposition to intercountry adoption, which is also often transracial adoption. Opponents of transracial intercountry adoption suggest that placing children outside of their racial identity group may increase their risk for long-term psychological problems, undermine their identity development and ultimately lead to a "cultural genocide" (p. 65, Brodzinsky, Smith & Brodzinksy, 1998). In contrast, others argue that the physical differences between intercountry adoptees and their parents are so obvious, leading to better communication and associated mental health (Noy-Sharav, 2005).

Numerous countries also changed their attitude towards international adoptions after child trafficking abuses (Tizard, 1991). These were well-publicised within the media and internationally agreed legislation was only established in 1993 after The Hague Convention on the Protection of Children and Co-operation in Respect to Intercountry Adoption, occurred.

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Intercountry adoptive parents

There appear to be differences between those parents who adopt domestically versus those who adopt internationally. Additionally there are differences between those parents who chose to adopt in response to infertility in comparison to those for whom adoption is a pro-active choice. Noy-Sharav (2005) proposes that parents who adopt from abroad are often younger, more educated and have better psychological and financial resources.

After deciding to adopt a child, potential parents are thoroughly assessed in terms of their readiness to adopt, their level of commitment and their perceived fitness as parents (Robertson, 2005).

Adjustment

The literature around the mental health, behaviour difficulties and adjustment of intercountry adoptees is inconclusive. Most reviews looking at inter-country pre-pubescent adoptees consider that they develop well and do not differ in their adjustment from non-adopted children (Cederbland., Höök, Irhammar, & Mercke, 1999). However, other studies on the adjustment of inter-country post-pubescent adoptees have produced less conclusive results (Bimmel, Van Ijzendoorn, & Bakermans-Kranenburg, 2003). For example, international adoptees are over represented in mental health services and were at increased risk for developing mental health difficulties, Tieman, Van der Ende, & Verhulst, (2005), Cantor-Graae & Pedersen (2007. Furthermore, Von Borczyskowski, Hjern, Lindblad & Vinnerljung (2006) and Hjerm, Lindblad & Vinnerlijung, (2002) found that intercountry adoptees had significantly increased risks for committing suicide.

Identity overview

Erikson (1950) proposed a psychosocial model of identity development, demonstrating the impact of our identity development on our subsequent adjustment. The model consists is a 'psychosocial model' to impact the dual role of psychological and social factors in adjustment. Similarly, Mead (1967) proposed that the sense of self is an activity, a process which comes about through our engagements, relationships and connections with other people. Cooley (1902) used the term 'the looking-glass self' to highlight the extent to

which our definition of ourselves relies on the feedback and evaluations we receive from others. Consequently it may be considered that the construction of identity is a temporal process mediated by the anticipated responses of significant and non-significant others (Crossley, 2000).

A central issue that underlies the debate in measuring aspects of adopted children's identity development is the lack of widely accepted, clear and consistent definitions that pervades the research literature (Scroggs & Heitfield, 2001). Erikson (1968) perceived the development of a secure sense of identity as central to mental health and period of most acute struggle for its consolidation occurs in adolescence. It is interesting that some intercountry adolescent adoptees exhibit higher numbers of problematic behaviours and adjustment difficulties around the time when one becomes more preoccupied with establishing a sense of self (Bimmel et al, 2003).

Frisk (1964) proposes that the formation of identity in adoptees may be impaired as the lack of family background information prevents the development of a 'genetic ego'. Furthermore, when additional layers are added to the basic difference of being adopted, such as race, colour, ethnicity, national and religious origin, the task of integrating these aspects of identity becomes even more complex (Grotevant, 1997).

Adoptive parents and identity development

In the past, there was widespread practice of minimising the adopted child's heritage and encouraging assimilation (Rojewski, 2005). Currently, most adoptive parents and professionals embrace the notion of connection to the intercountry adoptees' heritage.

Scherman & Harré (2004) propose that adoptive parents influence the way in which children subsequently describe themselves. As Anjudo (1988) posits, parents are their children's major reference group, and most researchers concur that adoptive parents have a vital role to play in different aspects of their adoptee's identity development. However, parents have a difficult challenge in raising multi-cultural families (Scherman &Harré, 2004). As Tizard proposes (1991) parents hold the duel role of encouraging pride in their birth culture as well as helping their adopted child to fit into the dominant culture.

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In principle, although most parents say that they intend to acknowledge the child's heritage (Silverna, 1997), there is less agreement about the right amount of attention to give to, or the best ways to acknowledge their child's heritage (Rowjewski, 2005).

Rational for the present study

The research in relation to intercountry adoptees seems to provide a number of contradictory findings. Since, intercountry adoption is an increasing phenomenon and there is some evidence to suggest an association with an increased riak of developing mental health difficulties (Van Ijzendoorn & Juffer, 2006) it appears vital to conduct further research in relation to intercountry adoptees.

In relation to the current literature regarding intercountry adoptees, most of the research is conducted primarily in the United States, The Netherlands and Scandinavia. Therefore there is a paucity of UK-based research that considers parental experiences. Interviewing parents who have accessed psychological support allows a unique insight into the development and maintenance of difficulties and how identity development is approached. Since identity appears to be vital in relation to the adjustment and therefore mental health of intercountry adoptees, it is crucial to research this area in more detail.

Aims of the research

The broad aims of the research are to consider parental experiences of intercountry adoption.

Research Questions

The present research study was guided by the following research questions:

- How do parents negotiate the intercountry adoption process?
- What is the experience of parenting an intercountry adoptee?
- How have parents approached the identity development of their intercountry adopted child?

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Method

Interpretative Phenomenological Analysis

A qualitative approach was considered the most appropriate methodology for the current study. There is a lack of previous UK-based research into parents' experiences of intercountry adoption, thus a qualitative, in-depth, exploratory approach was chosen to develop knowledge in the area. The study was not aiming to make generalisations about parents' experiences, but seeking rich and comprehensive accounts of a specific group.

Interpretative Phenomenological Analysis (IPA) was developed by Smith (1996). IPA aims to explore in detail how participants are making sense of their world, and the main currency is the meaning that particular experiences, events and states hold for participants (Smith & Osborn, 2008).

Design

Participants

The research was conducted within a specialist Adoption, Fostering and Kinship Care Team in a Child and Family Department within a mental health service. Participants were parents of intercountry adoptees who were currently accessing or had accessed this team. The researcher sought and gained ethical approval for the study from the Local Research Ethics Committee.

Exclusion criteria included those parents experiencing severe problems with their adoptee, including severe attachment difficulties, the significant possibility of the adoption breaking down and parents with any severe mental health difficulties. Inclusion criteria included fluency in English in order to take part in the interview.

Sample

Please refer to **Table 1** to consider the sample of six participants.

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Table 1: Participant Demographic Information

Interviewee (age)	Marital status	Occupation	Partner's Occupation	Name of Child	Country of Origin	Age of child at adoption	Child's current age	Additional Information
Max (69) Polish-British	Married	Retired from running a small business	Retired teacher	Allan	Romania	3 ¾	20	Allan is currently on a gap year before beginning a school leavers training course
Felicity (58) Scottish	Married	Jewellery designer	Retired Lawyer	Alice	Columbia	6 months	15	Alice is statemented and attends a mainstream school
				Daniel	Columbia	3 months	14	
Isabel (48) Tongan	Married	Home-maker	Accountant	Leo	Tonga	17 months	7	The couple have a biological daughter, Matilda, born with the aid of IVF
Emma (51) Irish	Single	Management Consultant		Mia	Vietnam	5 months	7	
Tara (53) Scottish	Married	Home-maker	Advertising executive	Joshua Oliver	Paraguay Paraguay	Both at 7 months	16 15	
Judy (49) Australian	Married	Lecturer	Dentist	Carlos	Honduras	5 months	15	Both are statemented and receive extra support at mainstream schools
				Felipe	Guatemala	10 months	13	

Interviews

The semi-structured interview method was selected as it is considered the best way to collect data for IPA analysis (Smith & Osborn, 2008). The interviews were conducted over a four month period and lasted between 54 minutes and 67 minutes. After completion, the

interviews were transcribed verbatim and analysed according to the procedure outlined in Smith & Osborn (2008).

The aim of writing up an IPA study is to transform the identified themes into a narrative account, with verbatim extracts from the participant accounts to support the analysis

Results

The four super-ordinate themes and constituent sub-themes that emerged from the analysis are summarised in **Table 2**. These themes are explored and illustrated with verbatim extracts from the interview transcripts. The researcher has made some minor changes for readability and non-pertinent material is indicated with ellipses (…).

Table 2: Main Themes and constituent Sub-themes

The importance of resolve & tenacity	Blood versus water	Weathering the storm of parenthood	The complexity of cultivating a heritage
• A traumatic process • Determination in overcoming obstacles	• Biology versus chemistry • The inevitable visibility of difference	• Managing the impact of early experiences • Life turned upside down • Adjustment over time	• Biculturalism versus Assimilation • Ambivalence • Importance of shared experiences

The importance of resolve and tenacity

The theme that emerged in relation to negotiating the intercountry adoption process was *the importance of resolve and tenacity*.

A traumatic process

It is imperative to consider that prior to the adoption process most participants had attempted other (unsuccessful) methods to become a family. There was in a sense, a kind of 'double trauma' for the participants; both coming to terms with the crisis of infertility and the adoption process itself:

> …it was an extremely long, drawn out, painful, harrowing, difficult process (Emma)

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Similarly:

> Researcher: What was the experience like of going through the adoption?

> Horrific in many ways (Max)

> It was a nightmare (Judy)

From Emma's response there was a sense of the process as invasive, "painful", and the word "harrowing" captures a disturbing quality to the experience. There was something about Judy's response, "a nightmare", as capturing the essence of the whole process, the sense of seeming powerless and out of control. Furthermore the process appeared to be a rollercoaster of emotions for the majority of the participants. In several accounts:

> I was initially…assigned a different child and that adoption fell through (Emma)

At each disappointment, participants' hopes of parenthood had appeared to be nearing, but were then dashed. As Emma spoke of this experience the sense of unprocessed trauma was palpable in her affect and fragmented use of language.

Participants conveyed considerable *determination in overcoming obstacles* to adopt their children:

> [We] spent in total…five or six months out there…we went to a total of about 23 towns (Max)

Many participants struggled with the bureaucratic procedures necessary for the adoption to take place:

> …we were told that Carlos' birth mother was from a rural place…where you travelled two days to get a signature (Judy)

Once the participants became parents, completing the adoption in their child's country of origin, they often encountered further obstacles when they returned to the UK:

> …there's no support offered for the horror of the process that you go through here…I had to go to the High Court (Emma)

Often participants were required to undergo assessment by their local social services. This participant reveals the ominous opening words of their social worker referring to the UK's 'same race' adoption policy:

> …don't think this is a foregone conclusion…he's black you're white, he shouldn't be with you (Tara)

For all the participants, their resolve and tenacity eventually paid off, and their dream of a family became a reality.

Blood versus water

In relation to the sub-theme, *'biology versus chemistry'* some participants used emotive language suggestive of 'falling in love at first sight' to describe the first encounter with their child.

> …my wife and I just fell in love with him there and then…there was immediate chemistry (Max)

In contrast, others had a very different experience feeling much more distant from their child:

> …it was like meeting a stranger (Isabel)

The use of the language "stranger" conveys that Isabel appeared to not have felt an immediate connection to her child.

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For the majority of the participants, the adoption was a closed one, severing their child's ties with biological relatives:

> …you take her away, and the parents or the orphanage or whoever never sees the child again (Emma)

For others, they had left the possibility for future connection, open:

> They can both trace their mothers if and when they want to (Tara)

In relation to the sub-theme, '*the inevitability of difference*' this refers to the physical difference between the adoptive parent and child:

> …its always been obvious to everybody when we are together that we are not biologically [related] (Emma)

For some participants, differences between them and their children were immediately obvious, particularly if they did not share the same skin colour. The inevitable visibility of difference acted as a constant reminder of biological separateness. It appeared to bring an aspect of parents' private selves into the public domain. Indeed Tara felt the need to justify herself to others in light of the physical differences between her and her children:

> in the beginning I was always explaining that they were my adoptive children. In hindsight I didn't really need to do that at all (Tara)

It was almost as if Tara did not feel entitled to motherhood, and over time she has managed to grow into this role. The analysis also revealed some advantage to the physical differences between the adoptive parents and their child:

> It gives Mia a useful space to be able to say 'is that my mother? 'No, of course not' (Emma)

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Weathering the storm of parenthood

The metaphor of 'weathering a storm' emerged from the analysis in relation to parenting their children. The analysis revealed that all participants discussed the impact of their child's early experiences:

> …he…had very little food and so…when the plate was empty…he'd start crying, so we'd give him some more…he used to overeat…he ate so much that he threw up (Isabel)

> I remember a period of nappy changing because although the orphanage staff told us that he was toilet trained… he, wasn't…he would not allow us to wash him… he was very scared of water (Max)

There is a sense that these behaviours were adaptive for the children in relation to their pre-adoptive lives. However, these behaviours were rendered less useful in their post-adoptive lives.

In contrast, for others a sense of sadness for their child's difficulties, endured:

> …very late walking…she's delayed although I spent a lot of time waiting for her to catch up in the hope that she would…(Emma)

The sub-theme *'life turned upside down'* describes participants 'in the eye' of the storm. Some participants experienced a dramatic and sudden change in their child:

> this child was almost alien to us and it looked like he might be kicked out of school …he was not concentrating…consequences meant nothing (Tara)

For Tara there is a sense of Joshua's difficulties coming out of the blue in an unexpected way. For other participants, the severe difficulties emerged immediately after the adoption. Here Isabel describes that their difficulties reached a crisis point:

…the initial year or two was very, very stressful…I did seek help…I was just
desperate for anything… (Isabel)

Isabel portrays a sense of powerlessness in managing the situation. For other parents, their
children's difficulties emerged later on for example with peers:

Daniel doesn't find friends easily. He was bullied at his junior school. I had a very
sad child (Felicity)

…her social skills are crap…[Mia's] not good at boundaries, she doesn't understand
that you can't force people to be your friend (Emma)

For all of these participants there was a sense of their frustration with their children's
difficulty in developing positive peer relationships. This frustration perhaps came from
their inability to exert influence on this aspect of their children's lives.

For the majority of the participants, there was a sense that difficulties had certainly
improved over time indicated by the sub-theme *'adjustment over time'*:

it was just a question of time and coaxing him…he would not touch vegetables …he
eats everything now… he's very self-confident…has a girlfriend…it's the other way
around now…he doesn't need us (Max)

he wouldn't go to anybody…only me…[now] he's very sociable…he gets on with
anybody…Once he knew that there's always enough food in the cupboard…his
eating is normal now… (Isabel)

Their children's adjustment seemed to evoke a number of ambivalent feelings for the
participants. For Max and Isabel many feelings were evoked at no longer being needed.
Furthermore, time appeared to have served a valuable function in providing insight for
participants:

I think I can say now it's really lovely…you know…five years away from when he
arrived. Its really worked out well for us (Isabel)

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The complexity of cultivating a heritage

Cultivating their child's heritage (used in this sense as an umbrella term for cultural, ethnic and racial identity) proved to be extremely complex experience for the participants. From the participants' perspective adoptees appeared to experience many ambivalent feelings, particularly in relation to their heritage. Interestingly, these often emerged in relation to sport:

> he sees himself as completely British. But when there was the world cup…in 2004/5, England against Romania, surrounded by our two Romanian friends…he was egging the Romanian side on (Max)

Max seemed quite sure that his son viewed himself as British but this was contradicted by his wanting to support the Romanian team from their country of origin. Perhaps in the presence of other Romanians, he does feel a connection to his birth country.

For Felicity, there had been early efforts to create a connection to Columbian heritage:

> …we used to take them to Columbian school every Saturday…I could[n't] sustain this school…I thought I've done my bit, I've tried (Felicity)

Creating a connection appeared to be unsustainable. There was a sense that it was something that Felicity perhaps resented, feeling as though she had to "do her bit".

Bi-culturalism versus assimilation

All participants did attempt to forge some kind of connection to their child's birth country.

Some parents very actively sought these connections by exposing them to the food:

> we make a lot of [Tongan] food (Isabel)

> …the connection that I've managed to create…is…through food…partly because she loves food so she likes to eat Vietnamese food (Emma)

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Exposing their children to the tastes and smells of their origins is both a sense-indulging and tangible way to connect with their country of origin. Participants also talked about exposing their children to festivities celebrated in their country of origin:

> we go to this place where the dragon comes into the restaurant and he was you know, initially extremely frightened, but he loves that culture (Isabel)

There was also the sense that participants took every opportunity to expose their children to other individuals from their birth countries:

> Alice has got a Columbian…Godmother

There was variation in what is important to different parents, in relation to cultivating their children's heritage. To the other extreme these participants under-exposed their children to the host culture:

> we always had Columbian au-pair girls…[they spoke to Alice and Daniel only in Spanish] so in fact, when they got to school, they didn't speak anything much (Felicity)

Perhaps Felicity had been so concerned about retaining Columbian ties for her children, that she gave less thought to exposing them to the culture and language that they were surrounded by

What seemed vital for participants *'the importance of shared experiences'*. The connecting to other adoptive families, often from the same countries of origin appeared to be a huge source of support, particularly in the early days following the adoption:

> ...huge network of parents who adopted from Paraguay…we used to meet…every month, it was lovely…we had to give it up when…we all lived in different parts of the country and they all went to school and it wasn't that easy to meet up (Tara)

Some parents spoke of their children's relationships with others with shared experiences:

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Mia really likes meeting other Vietnamese little girls (Emma)

Finally, participants talked about the helpfulness of professional support they received:

…we started talking about what we were experiencing…and they were nodding, saying yes, this is typical, and suddenly we thought wow, these people know what we are talking about (Tara)

Discussion

To summarise the main findings of the study, there are three concluding points:
:

4. Negotiating the intercountry adoptive experience appears to be a traumatic process, requiring a great deal of resolve and tenacity

5. Parenting an intercountry adoptee is both a challenging and rewarding experience. The use of support from those with shared experiences is imperative

.

6. Cultivating connections to their child's country of origin, individuals of similar ethnicity and balancing pride in the host culture, is a demanding task.

The findings will be considered in relation to the research questions.

1. How do parents negotiate the intercountry adoption process?

The theme '*the importance of resolve and tenacity*' emerged in relation to this research question. Although Gulland (2008) warns prospective adopters that "*intercountry adoption is not for the faint-hearted*" (p.2), implying the necessity of resourcefulness. There appears to be a lack of specific research in relation to the difficulty of negotiating the intercounty adoption process and this finding makes a contribution to the existing literature.

As Barratt (2006) proposes, *all* prospective adopters require considerable determination and resilience to pursue their application. However, what appeared to require additional

resources for intercountry adopters were the further layers of complexity in the process such as geographical distance, language barriers, bureaucracy and respecting local cultural practices. Furthermore after successfully negotiating this aspect, adopters also had to deal with the UK system, which in some instances proved as problematic as the adoption itself.

2. What is the experience like of parenting an intercountry adoptee?

The metaphor of '*weathering the storm of parenthood*' emerged from the analysis in relation to this second research question. This was of course reflective of the clinical sample that had been chosen, and participants' reflected on overcoming stormy times. There was a sense of stages that participants went through, managing difficulties, being in the midst of difficulties (the eye of the storm) and then picking up the pieces and adjusting over time. Indeed there are a number of models that contextualise adoptees behaviour in relation to stages. One such model is posited by Ward (1980) which postulates four stages, 1. the honeymoon stage, 2. hostility and grief in adapting to the new family, 3. resignation, where the family is accepted and 4. acceptance of the adoption.

What was striking about these participants' experiences of parenthood was the severity of the 'storms' that they had experienced or were in the process of enduring. One may only speculate that in comparison to domestic adoptees, intercountry adoptees face more changes in the pre to post adoption period, which may in turn present more challenges for their adjustment.

With the majority of intercountry adoptees, as in this study, the research seems to consider that, overall they are faring well (Van Ijzendoorn & Juffer, 2006; Tizard, 1991 & Bimmel et al 2003). From the perspective of the participants earlier difficulties seemed to have improved in all accounts. This attests to the resilience of these children, the dedication of their parents and the utility of professional support. Although difficulties had improved, they still remained to some degree or another. Nevertheless, there was a sense that participants and their families were now managing these difficulties better and were more in control.

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3. How have parents approached the identity development of their intercountry adopted child?

What the participants conveyed was the further complexity of the identity development process, which was both enriched and complicated by the added layers of difference. Thus, they felt that their children had to negotiate their identities as adoptees, from a different country and being of a different race, colour, national, ethnic and religious origin to their parents (Grotevant, 1997).

Difficulties with loyalty between the birth and adoptive parents may occur for all adoptees. However, what participants' spoke of as an additional issue for their children was a conflict of loyalty between the culture of their birth country and host country.

The models of cultural socialisation that appeared at the extremes of the spectrum for participants appeared to be bi-culturalism or assimilation (La Framboise, Coleman & Gerton, 1993). The majority of participants were positioned between the extremes of the spectrum. There was great variation in the way that participants exposed their children to their birth culture. For some participants this was achieved through exposure to food, festivities and other individuals from the birth country, learning the language and the use of resources such as books. For other participants there were further steps such as exposing their children to relevant television programmes, surrounding them with artefacts and actively searching out current news articles in relation to their birth countries. It is noteworthy that in this study all participants attempted to foster some level of connection between their children and their birth country.

Zuñiga (1991) recommends aggressively pursuing activities, places and people associated with their child's origins. However, it is also important to consider that parents' attempts at cultural socialisation do no occur in a vacuum and whether their children embrace or resist their parents attempts at forging connections may have a great deal of influence on the process.

Blood versus water

A further theme '*blood versus water*' emerged from the analysis of participants' accounts. This was a powerful theme that applied across all of the research questions. It captures something of the 'adoption triangle' the link between the adoptive child, the adoptive parents and the biological parents which is always a central issue (Van Tuyll, 1994). Participants spoke of the first meetings with their children. For some participants this was experienced similarly to the instantaneous chemical reaction of falling in love. Whilst other participants experienced their children, like strangers. Indeed Shapiro et al (2001) confirm that "*many parents talk of falling in love at the first sight of their child*".

The participants frequently had contact with their child's birth parents, often the mother to legalise the adoption. Interestingly, this was often discussed by participants in a very factual way. For most of the participants, although the adoption was a closed one, there was a sense of the biological parents remaining in mind. For one participant who was in contact with her child's birth father, there were extremely complex feelings stirred up in relation to this. As Sykes (2001) found, in a study considering adoptive families in continuing contact with birth families, adopters expressed many conflicting emotions about this contact, for example issues around ownership, fear, anger and blame.

One aspect that emerged from the analysis was in relation to the physical differences between the participants and their children. LePere (1987) proposes that an aspect of infertility that parents struggle with is a loss of the tangible evidence of their physical continuity. By tangible, this implies biological children who resemble their parents.

In conclusion

Ultimately in a perfect world without conflict and inequalities in living conditions, intercountry adoption would not exist (Mather, 2008). However it seems inevitable that intercountry adoption will continue and it is essential for intercountry adoption to continue in a regulated manner. Intercountry adoption raises some complex ethical issues, and it is difficult to balance the needs of the child, birth parents and adoptive parents (Van Ijzendoorn & Juffer, 2006). Furthermore, above all, it must not be forgotten that:

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> While the change is often from poverty to relative wealth, wealth alone cannot
> guarantee a better life.
>
> (Mather, p.479)

As Altstein, Coster, First-Hartling, Ford, Glasoe et al (1994) propose, in relation to intercountry adoptees, each person's experience is unique and each adoptee has a different history, therefore each family must decide how to help the child connect with their origins and heritage (Shapiro, Shapiro & Paret, 2001).

Clinical implications

It is important to acknowledge that the research findings were based on a small sample size of participant accounts, and implications are therefore considered tentatively. Several clinical implications were generated:

4. Prospective intercountry adoptive parents would benefit from the provision of pre and post-adoption supportive groups.

5. Intercountry adoptive families would benefit from greater availability of multi-disciplinary specialist teams to address their needs.

6. There is a role for cultural consultants to aid both adoptive parents and professionals in their work with intercountry adoptive families.

Strengths and Limitations

Overall, using IPA allowed the researcher to adequately address the research questions, providing a great deal of rich and interesting material. The smaller sample was seen as a strength, since it allowed participants' insightful accounts of their experiences to be considered in great detail.

The sample was obtained through a single organisation which may have impacted the type of participants interviewed who may not be reflective of typical intercountry adoptive parents. Although a collaborative stance was adopted throughout the study, respondent validation (Silverman, 1993) was not used, which could be considered a limitation of the

study. It would be interesting to conduct further research conduct further research, perhaps working alongside participants as co-researchers from the start of the process which would help to address any difficulties relating to power imbalance.

Despite the study's limitations, the results clearly demonstrate that the findings fit well in relation to existing literature which adds further support to IPA as a valid and useful methodology

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