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'Adopting Minds', a mentalization-based therapy for families in a post-adoption support service: preliminary evaluation and service user experience

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Abstract

Background: Children placed for adoption are often faced with unique challenges, and are at higher risk of mental health problems compared to the general population. Yet despite some important clinical developments, there is still a lack of evidence related to effective therapeutic interventions for this population. Aims: This study reports on the preliminary evaluation of a mentalization-based family therapy service, 'Adopting Minds', offered as part of a post-adoption support service. Design: 36 adoptive families were referred to the ‘Adopting Minds’ service between September 2015 and December 2016. These parents had adopted 42 children in total. As part of a naturalistic, pre-post design, assessments on these families were carried out at baseline and at the end of therapy using a range of validated measures. Five families who had completed therapy also took part in more in-depth interviews about their experience of the service, and these interviews were analysed using an interpretative phenomenological analysis. Findings: Positive outcomes in mental health and parental self-efficacy were identified, and adoptive parents reported high levels of satisfaction with the mentalization-based family therapy service. Analysis of the semi-structured interviews revealed that the adoptive families found the ‘Adopting Minds’ service a containing space that was supportive and non-judgmental. The families felt able to express their fears and worries to a therapist who? was friendly and knowledgeable. Adoptive families also reported that the service helped them to deal with past experiences and link struggles they were facing at the time

to the child's past experiences. However, some adoptive families felt that this short-term (six session) service alone was not enough to address all the difficulties that had brought the family to seek help, and would have preferred a longer-term intervention, or therapy in combination with other types of support.

Key words

Mentalization, MBT, adopted children, adoption support, family therapy

Introduction

Children who have been placed for adoption in the UK are faced with unique challenges, often related to their disrupted relationships with their main caregivers, and the impact this can have on their development (Carnes-Holt, 2012). These children have often been exposed to precarious physical and psychological conditions (Gagnon-Oosterwaal et al., 2012), such as inadequate prenatal and perinatal care, physical or sexual abuse (Simmel, 2007), low levels of emotional support (Merz and McCall, 2010) as well as multiple changes in foster care placements (Lewis et al., 2007). It is perhaps not surprising that these children are at higher risk of mental health problems compared to the general population (Burns et al., 2004; Ford et al., 2007; Lawrence et al., 2006; Millward et al., 2006), as well as problems in school adjustment, in academic achievement and peer relationships (Pears et al., 2010); cognitive delays (Judge, 2003) and struggles in developing a secure attachment to their caregivers (Carnes-Holt, 2012; Hughes, 1999; Pace and Zavatinni, 2011; Vorria et al., 2003).

Adoptive parents can face significant challenges in developing a relationship with their child and in helping them adapt and develop to their full potential. In caring for an adopted child they may have to face their own insecurities and difficulties, triggered by the situation they are facing. For instance, because of the potential rejection by the child, they may feel confused, frustrated, sometimes leading them to blame themselves or the child (Carnes-Holt, 2012; Ryan, 2007).

Among the many ways in which adoptive parents can be helped to build strong relationships to their child, one area that has received considerable attention more recently is 'parental reflective functioning' (Slade, 2005), or 'mentalization'. This term refers to the parent's capacity to focus and understand mental states of self and their child, especially when trying to explain and predict behaviour. This process happens automatically much of the time, and helps us to regulate our emotions and to develop self-awareness, which is important for building relationships and overall adaptation (Slade, 2005; Walker, 2008). When a parent is able to mentalize, this helps them to see beyond the concrete behaviour of the child and try to imagine what may be motivating them. This capacity to mentalize can help parents to respond more sensitively to the child's behaviour and to help manage his/her feelings more effectively. Moreover, if the parent has this capacity, it will also help the child to develop it (Walker, 2008). For instance, in a securely attached mother-child dyad, the child's experiences are more likely to be mentalized, thus helping the child to develop their own capacity for reflective functioning (Slade, 2005), while poor attachment disrupts the emergence of the

mentalizing capacities (Fonagy and Luyten, 2009). Moreover, attachment and mentalizing present a bidirectional relationship: a child who lacks a reflective capacity, as is the case for many adopted children who have experienced early maltreatment and trauma, can disturb attachment relationships (Jacobsen et al., 2015).

The development of mentalization in adopted children can be facilitated by the new caregivers, but when the adoptive parents are struggling themselves, this can be a challenge. An adaptation of mentalization-based treatment for families (MBT-F), 'Adopted Minds', may be a way to address some of the problems and difficulties that adoptive parents face. MBT-F is an intervention originally developed as a trans-diagnostic intervention for use in generic child and adolescent mental health services (CAMHS) (Asen and Fonagy, 2012; Fearon et al., 2008; Keaveny et al. 2012) which works from the assumption that difficulties in mentalizing have an impact on family functioning, especially due to experiences of feeling misunderstood (Asen and Fonagy, 2012). Thus, its main goal is to improve the understanding of each family member's behaviours and feelings, by promoting their capacity to mentalize, in everyday situations and during the stressful ones. A preliminary evaluation suggested that MBT-F was associated with reductions in behavioural and emotional difficulties for children with a range of presenting problems (Keaveny et al., 2012), although this was an uncontrolled study with a relatively small sample.

Although MBT-F has been used in work with adoptive families (Muller et al., 2012), no specific adaptations of the model for work with this population have been described, and no formal evaluation of such work has yet taken place, either to explore treatment outcomes, or to gain an understanding of MBT-F from the perspective of adoptive families engaging in treatment. The 'Adopting Minds' approach recognises the particular challenges faced by adoptive families: both adopters and their adopted children coming together with no shared history; and with the possibility that both sides may also have experienced significant challenges before coming together. In the 'Adopting Minds' approach the significant relational risks both adopters and their adopted children face in working together to become a family are acknowledged, including the heightened risk of misunderstandings between adoptive parents and their children. On the one hand, adopted children, given their past histories of abuse, neglect and loss, may misread and misinterpret their adoptive parents intentions in trying to provide parenting; on the other, adoptive parents may have difficulty 'reading' the children placed with them, who may offer confusing signals about their needs or present their adoptive parents with distorted cues about what they may need. In many cases adopted children may not feel safe enough to explore the minds of their adoptive parents, so the 'Adopting Minds' approach pays close attention to how past history may be impacting on the 'here and now' and focuses on monitoring and managing arousal levels of all family members to provide a 'safe enough' experience of thinking together. Adoption may create a sense of 'unsafe uncertainty' for adoptive families (Tasker and Wood, 2016) and issues of suspicion and 'epistemic vigilance' (Fonagy and Allison, 2014) may be understandably challenging. With that in mind the 'Adopting Minds' approach offers an integration of systemic and mentalization based practice to adoptive families, with the aim of helping to build trust, improve relationships and help parents and children who have experienced trauma understand one another better.

The study aimed to offer an initial evaluation of this ‘Adopting Minds’ approach being developed to meet the particular needs of adoptive families. This initial evaluation offers an opportunity to explore the experience of the adoptive families who received the service, with a particular focus on whether the approach was suitably adapted to the specific needs of these families.

Method

This study used a mixed-methods design, and combined a naturalistic, pre-post evaluation for all families accessing the service with in-depth interviews, carried out with a sub-sample of families, and analysed qualitatively.

Setting for the Study

This study took place at Coram, a voluntary sector organisation committed to improving the lives of the UK’s most vulnerable children and young people, including those who have been fostered or adopted. An adaptation of MBT-F, the 'Adopting Minds' approach, was offered as a therapeutic intervention within Coram's post-adoption support service.

Participants

Between September 2015 and December 2016, 36 adoptive families were referred to Coram, primarily by Coram Adoption Support Social Workers and some local authority social workers. The families were initially offered a short-term (6 session) intervention. All families were invited to take part in the evaluation of the service. The 36 families included 59 parents and 42 children. Of those where demographic data was available, 81% of adults reported parenting as a couple, with both parents attending sessions in most of those cases. Of those where the data was available, the majority of parents (67%) described their ethnicity as 'white British', followed by 'white other' (24%).

Thirty adoptive households had one adopted child and six had two adopted children. No adopters reported that they had more than two adopted children. Of the 42 adopted children, the median age was nine years old and ages ranged from two to 17 years old. Data about age was available for 29 children. Half (21) of the children were aged between four and 11, six were aged between 12 and 17 years old and two children were aged three and under. Of those for whom data was available, slightly more than half (53%) were male, with 60% describing their ethnicity as 'white British', followed by 23% as 'mixed'. Of the 22 children where data was available, four (18%) were described as 'disabled'.

Data about the length of time the adopted children had been placed with their adoptive parents was available for 23 children. Two children had been placed with adopters for under one year, nine had lived with their adopters between one and four years and eight for five to ten years. Four children had lived with their adopters for over ten years.

Reasons for referral to the service were available for 22 children. Adoptive parents could select more than one reason from a list of five (relationship concerns; social and emotional concerns; behavioural such as attentional difficulties; emotional regulation; and attachment with adoptive parents). Eighteen adoptive families had been referred because their children were displaying challenging behaviour in more than one area. Social and emotional concerns and emotional regulation were the most common reason for referral. Figure 1 provides details.

[Insert Figure 1]

For the second part of the study a sub-sample of five families who had completed therapy were interviewed in more depth. Four of the five interviews included one or both parents and at least one child, with the children ranging in age from nine to seventeen. Although in most cases the therapy had involved all members of the family (i.e. parents and child/ren), and the research team offered the opportunity for all family members to be interviewed, not all family members chose to take part in the in-depth interviews. Three of the five were with the mother only (Laura, Claire and Mary), one was with the father only (Paul), and one with a father and his daughter together (John and Lucy, age 16). (All names have been changed to ensure confidentiality). The presenting problems of these five families included attachment difficulties, challenging behaviour, parent-child relationship difficulties and problems for the child in adapting to a new home.

All families in both parts of the study were seen by the same therapist, who was employed by Coram specifically to offer a service informed by MBT-F. The therapist was an experienced systemic family therapist, with specialist training in MBT-F, and extensive experience of working in fostering and adoption services. She was part of the team who had developed the 'Adopting Minds' approach.

Measures

The Brief Assessment Checklist (BAC) (Tarren-Sweeny 2013).

The BAC is a 20-item questionnaire, caregiver-report rating scale having two versions: BAC-C, for children, and BAC-A, for adolescents. Both are used for screening and monitoring clinically meaningful mental health difficulties in children and adolescents among different types of care, such as foster, residential and adoptive. For both a score of five or above has been used as a screening cut-point for children with emotional and behavioural difficulties. For the present study the appropriate version was used, depending on the age of the child, and the measure was completed by the parents at baseline and immediately after the final session.

Brief Parental Self Efficacy Scale (BPES) (Woolgar et al., 2013).

The BPSES is a five-item questionnaire measure of parental self-efficacy, used to measure the parents own perceptions of their efficacy and confidence as parents. This scale shows good internal consistency and converges well with an already established but longer measure of general parental efficacy.

Experience of Service Questionnaire (ESQ) (Attridge-Stirling, 2002).

The ESQ is a 12-item, self-report instrument that measures the experiences and perceptions of satisfaction with the service received and the environment. It is a measure very widely used in CAMHS in the UK, and it has demonstrated good inter-rater

reliability and construct validity (Brown et al., 2014). The present study used the parent/carer version, completed after the final session.

Adaptation of the Experience of Therapy Interview (Midgley et al., 2011).

The second part of the study used an adaptation of the Experience of Therapy Interview (Midgley et al., 2011). Adaptations were focused on ensuring the questions were focused on the experience of adoptive families, and could be used with parents alone, or in a joint parent/child interview setting. The semi-structured interview schedule had six areas to be explored: 'difficulties that brought the child/family to the therapy', 'the parent understanding of those difficulties', 'idea about change', 'the story of therapy', 'evaluating therapy' and 'other therapies/resources'. In line with guidance on qualitative interviewing, the interview schedule was used flexibly, to give the families the opportunity to tell their story, and to ensure that they could bring up issues that may not have been considered by the research team.

Procedure

Families were sent information about the service and the evaluation study prior to attending their first therapy session at Coram. A member of the Coram research team then met with families 30 minutes before their first session to discuss the evaluation, and seek consent to take part. It was made clear to families that they could participate in the therapy service whether they chose to take part in the research or not. Families were then asked to fill out the questionnaires prior to their first session (for the pre-evaluation) and after they finished the last session.

For the second part of the project, families who had given consent to be contacted about a follow-up interview were contacted by letter or email after therapy had ended and were given further information about the purpose of the second part of the study. In total, eight families responded; of these, one did not want to participate, and two others could not find the time to participate. For the five families who responded and agreed to participate, a date and place was set for the interview to take place, which could be at Coram or at their homes. Two of the interviews were conducted by the second author and three by post-graduate students who were part of a wider project exploring the adaptation of MBT-F in the context of post-adoption services. All had been trained in conducting semi-structured, in-depth interviews.

Data Analysis

For the first part of the project, descriptive statistics (mean and standard deviation) for the pre-measurements from the BAC and the BPSES for the whole sample were calculated. Second, the descriptive statistics for the pre/post scores from the BAC and the BPSES were calculated, but only for those families who had completed both before and after measurements. Third, a comparison between the pre and post measurements for both questionnaires was made, at a descriptive level. Finally, descriptive statistics (mean and standard deviation) for each item of the ESQ were calculated. As there are not clinical cut-offs or norms for the ESQ, an average overall score could not be interpreted.

For the second part of the study a qualitative analysis of the interviews was completed using interpretative phenomenological analysis (IPA) (Smith et al., 2009). This approach was chosen because IPA examines how people make sense of, or give

significance to, the experience of a particular life event, and emphasises that studying such phenomena requires a ‘double hermeneutic’, i.e. the research team interpreting (making sense) of the participants’ own efforts to make sense of a particular experience. In IPA sample sizes are usually fairly small, to allow for an in-depth exploration of personal experience, even if this means that findings can only be applied cautiously to other families. The focus on understanding an experience (attending the ‘Adopted Minds’ sessions), and exploring the experience of a small number of families in-depth, both fitted with the aims of this part of the study.

Each interview was transcribed by the second author and analysed separately and systematically. Transcripts were read multiple times and first impressions and exploratory comments were noted. Following this, the researcher recorded emergent themes from the interviews and a search for connections across the themes was conducted, as a way of synthetizing them. This process was supported by the first author. Emerging patterns across cases were developed using a table that recorded super-ordinate and sub-themes and connections between participants were considered. Finally, the list of the super-ordinate and sub-themes was created, supported by the extracts from the transcripts that support each domain.

Ethical considerations

Ethics permission for this project was granted by the University College London Ethics Committee (REF: 0389/009) and by Coram's own research ethics committee. All families gave informed consent to be part of the study, and any identifiable information has been disguised and names changed in order to preserve anonymity.

Results

Baseline functioning and preliminary evaluation of the 'Adopting Minds' service

At baseline BAC and BPSES data was collected from 44 and 43 adopters, respectively. The pre-therapy mean score on the BAC was 18.8, where a score of five or above is considered an indicator that further mental health assessment is needed. Among the highest-scoring items, and therefore the areas reported as most problematic, were the child ‘Craves attention' (mean 1.7), child ‘Constantly seeks excitement' (1.5) and the child is ‘Too jealous', 'Does not show affection' and 'Feels misunderstood and victimized' (all 1.3). The lowest scoring items, therefore the least problematic, were impulsive behaviour (mean 0.8) and not sharing with friends (0.9).

The pre-therapy mean score on the BPSES was 18.7. While there are no guidelines for clinical cut-off ratings, the score is out of a possible total of 25 which suggests that before receiving mentalization-based family therapy sessions parents already reported fairly high levels of parental efficacy. The highest mean-rated item on the BPSES was ‘I can make an important difference to my child’ (4.4) and the lowest mean-rated items were 'I am able to do things that will improve my child's behaviour' (3.3) and 'In most situations I know what I should do to ensure my child behaves' (3.4).

Pre and post paired BAC and BPSES data was collected from 15 and 18 adopters, respectively. Post-therapy data that was not paired has not been included in subsequent analysis.

Table 1: Paired responses from BAC and BPSES

	Pre-therapy mean score (paired)	Pre mean standard deviation	Post-therapy mean score (paired)	Post mean standard deviation
BAC (N=15)	21.7	5.56	16.5	9.58
BPSES (N=18)	18.7	3.85	20.3	3.48

The BAC mean score significantly decreased (p = 0.014) meaning that parents perceived that their children had less mental health difficulty after the intervention. The score was, however, still higher than the optimal screening cut-point, as using the BAC tool it is recommended that a child should be referred for further assessment if their BAC score is five or higher (Tarren-Sweeney, 2013). Scores decreased in all areas of the 20-item scale apart from two, which were child 'Does not show affection' and child 'Hides feelings' (mean pre and post scores for both remained the same). The biggest mean decrease was found for the item child 'Craves affection'; a decrease from 1.7 to 1.0.

The change in the BPSES mean scores was also significant (p = 0.048). This increase suggested that adoptive parents felt more effective in their parenting roles after therapy. Scores increased in all five areas of the BPSES scale. The biggest mean increase (3.3 to 3.9) was seen for the item 'I am able to do the things that will improve my child's behaviour' and the smallest mean increase reported (4.4 to 4.6) was for 'I can make an important difference to my child'.

Adopters reported high satisfaction with the service on the ESQ. All the adopters reported that: the help they received was good; their views were taken seriously; they were treated well; it was easy to talk to the people at the service; that they were listened to; and that overall the help they had received was good. Items 9 and 10 scored the lowest. Both referred to practical arrangements of the meetings, i.e. the time and location of the sessions; this related to the fact that the service was only offered in one location, and the therapist was employed on a part-time basis, so the service was only available on one day per week.

Three children completed the young person's version of the ESQ. This version asks children nine questions about their experience of therapy. Although a very small sample, all young people reported that they were either "very happy" or "happy" with the help they received from the therapist. Two young people would recommend the service to a friend, if they needed help, and one person was not sure. All young people felt listened to and treated well by the therapist. They said they could talk to the therapist easily and

felt the therapist knew how to help them. In addition the young people felt they were given enough explanation about the service and the facilities were comfortable. Finally, and importantly, all young people felt their views and worries were taken seriously.

The experience of the 'Adopting Minds' approach for families

In carrying out the IPA analysis, four super-ordinate themes were identified: 'receiving support and containment', 'a space where negative feelings are allowed, and achievements praised', 'getting help to deal with past experiences' and 'short-term support is not always enough'. Each of these themes will here be described in more detail, with extracts from the interviews to provide evidence for the themes.

Receiving support and containment

Families described how the therapeutic space acted as a supportive and containing environment. It was a place where they felt listened to, so they could talk about their anxieties, fears and worries. For instance, Laura stressed that it *"felt like it held us*", and Claire referred to the therapy as *"a sense of continuity and containment"*. Likewise, Lucy (John's 16 year old daughter) referred to the fact that she felt supported by the therapist during the sessions: *"[The therapist] was listening to everything I was saying, and taking me into consideration … I felt that I could talk to people here*". This was especially important to her as she struggled to trust the people around her.

There were several factors associated with the therapist that participants experienced as supportive, all of which spoke to the importance of the therapist's personal and professional qualities. Four of the participants (all mothers) referred to the personal qualities of the therapist as the most valued and appreciated aspect of their experience, in terms of her being friendly, warm and easy to talk to. As well as her personal qualities, some of those interviewed also commented on the therapist's professional skills and expertise: the way she formulated interventions during the sessions, and to how she talked to them. For instance, Paul found it helpful that the therapist tried to get him to question himself, making him think about what he did, why and to reconsider other options: *"…and then challenged myself about how I dealt with things, which was really useful because it helped me change my approach in dealing with the issues I had, in a good way*".

Some participants also valued and recognized the therapist's academic knowledge and expertise. They referred to their sense of her experience with children and adoptive families, and how this gave them confidence in her work with them. For instance, Mary said: *"I have found it really helpful… to talk to somebody with amazing experience in child practice*". In the same way, Claire stated: "*[The therapist] … seemed very experienced, very aware of adoption and trauma and everything… so she is fantastic"*.

Paul's experience was somewhat different to the other participants. On the one hand he felt that it was "helpful" the therapist was *"a sounding voice to speak to every time, every week about what happened and how it went*". However, overall, he did not feel that having a space to talk was enough to help him reduce his sense of isolation, and felt that he had been more supported by a group he attended with other parents who

shared similar experiences and difficulties as him: *"…so it was just knowing that I am not alone, that there is other people that are experiencing the same things*".

A space where negative feelings are allowed, and achievements praised

Alongside feeling supported, three of the participants (all mothers) spoke of the fact that the therapist did not judge them as parents. For instance, Laura found the therapist encouraging, supportive and non-judgemental, which was something she had not expected. This helped reduce her feelings of guilt and anxiety for not being a perfect mother:

> "she really wasn't hard on me; she was very encouraging" … [The therapist] never once said to me you shouldn't be doing this… you are not putting [your child] first… it was just that you know… just cut yourself some slack".

Likewise for Mary, what was important was that it was a space where more conflicted feelings were accepted, describing how what she valued was *"… just about being allowed to talk about how you feel about your child and... particularly when it is not all positive […] just makes you feel supported*". Mary described how she went to therapy feeling that she was not fulfilling the role of the 'good mother'. For her, the therapist acted as someone who reassured her and reduced her feelings of culpability: *"[The therapist] has been… just very good at reassuring me… just really helped… you know… somebody just saying to you 'you are actually not getting it wrong'".*

Similarly, Claire stated that the therapist did not criticise her but listened and encouraged her in all the positive things she was doing with her son: "*[The therapist] was fantastic at just being understanding, accepting […] So she is fantastic and really flexible, open…I just felt we weren't judged or we weren't criticized… She was just being encouraging. She was just saying: 'what you are doing is right*"". Lucy also mentioned that the way the therapist approached her made her feel as if she was an adult, which was something Lucy valued and experienced as very helpful for her. Moreover, she did not feel judged, on the contrary: *"I think the way she talked to me… she didn't talk to me like I was a little kid, she didn't make me feel like what I've done is the worst thing in the world".*

Getting help to deal with past experiences

All of the parents mentioned that their children (or themselves, in the case of one mother) had experienced difficult times during their early years which had affected their current lives. Four of the families felt that it was the sessions which helped them to acknowledge and be more conscious of these experiences, and of themselves in relation to these. Some families spoke of how their therapy helped them to be more conscious and accept their family (or their own) situation and difficulties. For instance, Mary said:

> "I have a busy life and I am quite good at, sort of just ignoring things I shouldn't ignore... and I think with [the therapist] she kind of forced me to… just recognize a lot of things as not being the norm, because I think is another thing when you have a difficult child... you start normalizing behaviour that you shouldn't really normalize..."

As it can be seen, Mary felt as if the sessions with the therapist acted as a space where she could think about the situation with her daughter and start accepting it. Equally, Laura talked about how the sessions helped her to accept and to keep in mind the condition of her daughter. This recognition made her stop feeling as if she was doing something wrong or failing as a parent, thus to avoid comparing herself with other families or parents. For Lucy (age 16), the sessions with the therapist helped her to start thinking about herself, thus realizing and understanding aspects of her behaviour:

> "I think dad's always known why I put a wall up, but it is the fact that I haven't really thought about it…. In the past I've trusted people and all of the sudden they've hurt me so... to stop trusting them then they won't hurt me like they did in the past I think… Interviewer: It sounds like [the sessions] did help to put things into perspective and understand. Lucy: Yeah, definitely."

Lucy's father, John, speaking directly to his daughter, also spoke about how the sessions helped Lucy to speak about her struggles linked to the past:

> "It also helped to give you the... confidence, courage to think a little bit more deeply and maybe assess and maybe repair all that from some of the things that have gone from the past, and to finally admit them to yourself as well. Part of dealing with it is admitting."

Some participants said how the sessions were a place where they could use theoretical frameworks – especially ideas about attachment and the impact of early trauma – to think about the impact of past experiences on their children. For instance, when speaking about her adopted son, Claire said:

> "We are conscious of what we are doing and that attachment is more present. Because, sometimes thinking "oh we are just parenting a normal child or a biological child who had not experienced trauma". And so to think and have that in our minds is, well, was really helpful […] and keeping all the things she said in mind about attachment and interaction. What he seeks, why he seeks and how early trauma may affect him"

Paul also stressed the importance of being offered information on how past experiences and trauma affect present family interactions and lead to difficulties – but felt that he'd had to go elsewhere to gain this information:

> "So we found out through adoption forums, online, and then looked it up, and my wife found a course that does it so she did a one-day workshop. I don't know if they do anything here, but they never told us about it."

Short-term support is not enough

Despite the fact that for most families the therapy was an overall helpful experience, the majority of them also felt that the service, on its own, was not enough for achieving improvements or changes regarding their difficulties or the ones their children were facing. Some families felt that it was a combination of things, including the therapy, that

influenced the positive outcomes and others questioned whether they could be sure that it was really the therapy that had helped their situation to improve.

John talked during the interview about how he felt the therapist *"certainly gave you a kick in the right direction and made you think about things in a different way"*, but felt overall that there were other factors more involved in improving things for his family. Likewise, Mary reflected on how the sessions did help her family to overcome the difficulties they were facing but that her daughter also benefitted from attending music therapy. Additionally, she stated that the sessions were mainly helpful for her as a mother, for processing her own feelings.

Laura also talked about how she felt therapy helped her but was not enough, and emphasized the need for a longer-term therapy for her daughter and her family:

> "It just helped stabilize […] it was accepted by everybody that actually six sessions with [the therapist] weren't going to solve the situation. It felt like it kept us safe over that period of time. It prevented it from getting even worse […] It helped us give us a platform for, perhaps, building on, negotiating on […] but also just helped us get through a very difficult time […] To really help [my daughter] we need to get her to the point where there is some help available either for her directly, preferably."

Paul spoke of how the changes he saw in his son were not so much because of the therapy but more about another group he attended to, that offered something different:

> "I think [my son's situation] has changed for the better, I think is not so much the therapy, it is more the adolescent-parent group that really helped. That was a 12 week course and they gave us a hand out every week and it was a different topic each week to talk about issues that adolescents go through, specifically adopted children, so that was really what impacted the relationship with my son the most."

Discussion

The aim of the project was to offer a preliminary evaluation of the effectiveness, and to explore the therapeutic experience of adoptive families who were referred to the new 'Adopting Minds' service at Coram, an adaptation of MBT-F for specific use in a post-adoption support setting. The study used a mixed-method approach, analysing quantitative pre/post data from questionnaires, as well as a qualitative analysis of semi-structured interviews using IPA (Smith et al., 2009).

The quantitative analysis of the pre-post outcome data indicated a reduction in emotional and behavioural problems in the children and increased levels of self-efficacy in adoptive parents. In particular, parents reported changes in their levels of confidence, feeling more effective in their role as parents by the end of therapy.

Findings from the ESQ and the qualitative analysis of the interviews indicated that families felt that the therapy acted as a space where they felt listened to, and where they could talk freely about fears, anxieties and conflicted feelings. Most of the families experienced the therapy as a place where past experiences, of their children or themselves, were thought about, discussed and comprehended better, thus helping them to understand their children's or their struggles in a clearer way. Feeling contained and safe enabled the parents to engage better with the therapeutic process, thus being more willing to open up and face their difficulties, as well as encouraging them to question their current parental practices. Similarly, this experience helped them to be able to talk about conflicted feeling towards their children without feeling judged.

Previous research has suggested that adoptive parents may have feelings of being judged, which was sensed as unhelpful (Howe, 1996). Services which help to address this anxiety, whilst helping adopters to speak freely, have been recognised as a key element of effective services (Henriksen, 2014; Merriman and Beail, 2009; Sheridan et al., 2010; Wimmer et al., 2010). Furthermore, the feeling of being listened and supported was of great importance to the children in the study. This finding is especially relevant as adoptive children tend to struggle trusting others and feeling safe in relationships, affecting their bonds and interactions (Pace and Zavatinni, 2010; Vorria et al., 2003).

This study also suggests that specific characteristics of a therapist may be important in getting adoptive families to acknowledge difficulties, question themselves and open up, which in turn can help them deal with their main struggles. These characteristics included the therapist's personal qualities, which previous studies have suggested may be more important to families than the model of the treatment used (Blatt et al., 1996; Sprenkle and Blow, 2004). More specifically, the qualities which were valued among the parents were friendliness, a non-judgmental approach and encouragement. This importance of the therapist being experienced as someone caring and empathic was a foundation of the person-centred approach and is found very frequently in past studies (Henriksen, 2014; Kuehl et al., 1990; Mezzina et al., 2006; Moore and Seu, 2010; Sheridan et al., 2010). It is also a key element of the 'therapist stance' in mentalization-based therapies (Keaveny et al., 2012; Midgley et al., 2017). It appears that this approach can help some parents to reduce their feelings of being 'bad parents', as well as leading to an overall high therapeutic satisfaction. For some of the parents in this study, this attitude of the therapist was a surprise, as they expected to be criticized or told what or not to do. This indicates the particular importance of addressing such anxieties in work with adoptive families, where issues of guilt and 'failure' as parents may be especially acute. Adoptive parents may experience conflicted feelings towards their children and themselves, such as frustration and guilt (Ryan, 2007; Carnes-Holt, 2012). Thus, the experience of feeling supported and not criticized in a therapeutic setting can result in a great relief and be beneficial to their sense of parental confidence and competence.

As well as the overall qualities of the therapist, this study also identified specific therapeutic skills that adoptive families found helpful, such as the way that interventions were phrased, or how questions were asked. They also spoke about the value of the therapist's 'expertise', and in particular the importance of feeling that the therapist had

both academic and personal knowledge about adoption. This aspect helped them to question themselves as to why they were acting in a certain way, to think about other possibilities of action and thought (Sundet, 2011), as well as helping them to open up and feel better able to trust others. Issues of trust have been widely reported by adolescents when engaging in therapy, as they tend to dislike being treated as children, which may be an obstacle for therapy outcomes if they feel the therapist is doing this (Freake et al., 2007). Whilst the fundamental importance of trust to the therapy relationship has been recognised in the literature for many years, more recent ideas in relation to mentalization-based therapy have suggested that overcoming 'epistemic hypervigilance' may be core to all therapies (Fonagy and Allison, 2014), and have particular significance in the context of adoptive families, where previous experiences on both sides may have led to heightened suspicions about whether adults/professionals can be trusted as sources of social learning.

However, the families also reported on limitations of the service. One participant spoke about the importance of feeling that one was 'not alone' as an adoptive parent who may be struggling, and reported that attending group sessions with parents facing similar difficulties had been more helpful. Previous studies have suggested that adopters attending group therapy, where experiences are shared, felt that interaction with other adopters provided different opportunities that individual interventions could not provide. These included social support, the developing of lasting relationships and support with challenges of parenting (Bonin, et al., 2014; MacMahon et al., 2014).

Participants referred to the importance of having information about how trauma and early adversity can affect adoptive families' present interactions. Although some interviewees felt that the therapist provided such expertise, others spoke of wanting to receive more straight-forward information, more direct and precise expert advice. The latter is something seen in past studies, where patients valued the teaching and therapist's advice (Nevas and Farber, 2001); however the literature on mentalization-based therapy speaks of the need for the therapist to take a 'not knowing' stance, and to avoid taking on an 'expert' role (Bateman and Fonagy, 2016). It may be that this study has identified a potential tension between the core MBT model, and the particular needs of some adoptive families. This is an issue that would need to be carefully considered in future developments of the 'Adopting Minds' approach.

Finally, several participants in this study felt that the short-term service offered on its own, even when valuable, was not enough for achieving major improvements or changes regarding their difficulties or the ones of their children. In some cases, the therapeutic intervention was effective in the context of a wider range of support services; but for others there was a frustration that the therapeutic support was too brief, and ended at a point where the family could have benefitted from a longer-term intervention. This finds some support from the quantitative data, which showed a significant drop in mean scores on a measure of child emotional and behaviour difficulties following therapy; but with mean scores still above the clinical cut-off point.

This raises important issues for funders and commissioners of services. The initial development of a service at Coram based on MBT-F was only able to offer a six-session

model; later this was adapted, following Adoption Support Funding being made available, to allow up to 12 sessions for some families. Nevertheless, the realities of funding (such as the cap on resources in the UK's Adoption Support Fund) means that therapeutic services may often be time-limited, even if some families identify a clear need for longer-term support. This may be especially important for families where issues of 'epistemic hypervigilance' are especially challenging to overcome, and a short-term intervention may be experienced as simply another professional who comes into their lives and then disappears.

Where short-term, time-limited interventions are the only option available, it may be important to consider the family expectations before starting therapy. The ability of the therapist to clearly present the treatment, in a way that is consistent with the client's expectations has been found to be an important element for successful therapy outcomes (Howe, 1996; Johnson and Talitman, 1997). Furthermore, it could be that families are sometimes in such need of help that they engage with an intervention without considering the information offered or asking more questions about it. Adoptive families faced with a lot of difficulties may feel overwhelmed and struggle to access appropriate services, so it would not be surprising if in their need for help they engage in a brief intervention service which may offer some help, but not be sufficient to address more complex relational difficulties.

Clinical implications

Even though these findings are initial and exploratory, they generate further ideas that can contribute to the further development of MBT-F for adoptive families. Understanding more about families' expectations and motivations for engaging in the intervention will ensure that misunderstandings could be reduced. Assessing families' needs more clearly before referring for the 'Adopting Minds' service may also reduce the risk of offering this intervention when another type of intervention may be more helpful. There are also some indications that a group-based approach could in some cases be more appropriate, either alongside or instead of 'Adopting Minds'. Likewise it may be important to have some flexibility regarding the length of the intervention, as some families may need longer-term support.

Limitations of the study

The effectiveness of the 'Adopting Minds' service would benefit from further investigation. Although a significant difference between pre and post measures was identified, the sample was small, and pre-post data was only available for approximately 40% of the families who were assessed at baseline, raising queries about how representative the sample was. A larger sample, and a higher proportion of families followed up, would further support the generalisability of this finding to the wider adopter population.

For the second part of the study, the in-depth interviews were all carried out by one researcher, although the analysis was reviewed by a second researcher. Families were approached at the end of their sessions for the qualitative analysis and so there may be a selection bias as adoptive families that put themselves forward for interview may have been those who were more engaged and had a more positive experience of the service.

Conclusion

Although the findings of this study are preliminary and exploratory, this study provides initial data to suggest that the 'Adopting Minds' approach, as an adaptation of MBT-F in the context of post-adoption support services, may be an effective approach for adoptive families presenting with a range of difficulties. This is particularly important given the lack of research into effective interventions with this particular population. Moreover, the approach was generally felt to be acceptable to families, who emphasised the importance of the personal qualities of the therapist, as well as particular elements of the therapeutic approach. However they also suggested that there needs to be greater flexibility to allow longer-term therapeutic support where indicated; and it may be that work with parents and families may benefit from being complemented by group-work, in which adoptive families can share experiences with peers, and feel less isolated with their difficulties. There may also need to be further adaptations of the 'Adopting Minds' approach, for example to consider the role of sharing expert knowledge in the context of a mentalization-based intervention. Further research would be needed to see whether such adaptations of the model are felt to be of greater help to families; whilst more systematic evaluations of outcome will be essential in order to establish whether 'Adopting Minds' can be considered an evidence-based approach to helping adoptive families.

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