The Parent-Toddler Group Adoption Project
A feasibility study of an online group

Report two

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Executive summary

Introduction
The early years of a child’s life lay the foundations for their later development, wellbeing and mental health. Adopted children can have some of the most traumatising starts in life. Research tells us that infants and toddlers who have been abused or neglected exhibit a range of serious cognitive, emotional and behavioural difficulties (Shonkoff et al, 2012). Research also indicates that these difficulties can remain without early intervention; however, very few therapeutic services exist to support adoptive families with toddlers or very young children. The Adoption Parent-Toddler Group was developed to fill this gap and was subsequently adapted for online delivery in response to the coronavirus pandemic. This study explores the feasibility of delivering the group online and includes preliminary findings on clinical outcomes.

The model
The Adoption Parent-Toddler Group is based on the Parent-Toddler Group model, an approach to working with parents and toddlers in groups first developed by Anna Freud in the 1950s. Parent-Toddler Groups are therapeutic play groups informed by psychoanalytic, child development, attachment and trauma-informed theory, which aim to support the key developmental tasks of toddlerhood. The adaptations made for online delivery included the incorporation of ‘Watch Me Play!’ (Wakelyn & Katz, 2020), a structured therapeutic tool to support parents to observe their children playing. Sessions were also shorter than the face-to-face model, and the families were invited to additional individual introductory sessions prior to the group commencing.

Methods
Three families (five adults and four children) took part in group between November 2020 and March 2021. The evaluation followed a mixed method design, combining qualitative interview data with parents and clinicians and preliminary clinical outcome measures, collected pre- and post-treatment.

Findings
The parents were highly positive about the group and perceived the intervention to be beneficial to them, valuing elements such as the peer and therapeutic support, and the ‘Watch Me Play!’ tool. They reported positive aspects of being online, for example not needing to travel and feeling more at ease in their home environment. Negative aspects of online delivery included difficulties with angling the screens of phones and computer equipment to include children playing, the absence of one-to-one discussions, and children not being able to play together in-person. The therapist reported that online delivery of the group enhanced parental involvement but reduced opportunities for observing and participating in child-led creative play. Additional preliminary outcome data indicated positive changes in child development and parental warmth, and parents felt they had achieved the goals they set themselves for the group.

Discussion and next steps
While there were many positive findings from the study, it is not recommended that the Adoption Parent-Toddler Group is delivered online routinely, given the model’s founding in psychoanalytic observation which is made difficult by working online with this age group. The small number of participants means that findings should be considered with caution and further research is needed.
Introduction

The importance of the early years

Pregnancy and the early years are a critical time in child development during which the foundations for long-term health and happiness are put in place (Bellis et al., 2015). Early experiences, along with genetic influences, impact on a child’s brain development, which is happening at a rapid pace. One million neural connections are formed every second in the first year of life and during the early years, these connections are pruned to be more efficient, shaping how we understand ourselves and the environment around us (Harvard Centre for the Developing Child, 2022).

Brain development is influenced by the care children receive in the early years. Sensitive, loving and attuned care reinforces important cognitive, social and emotional skills that help children thrive into adulthood (Robinson et al., 2017). This understanding of the importance of the early years provides a compelling rationale for focusing on early intervention to help children get the best possible start in life, mitigate health inequalities and promote positive health outcomes throughout the life span (Hughes et al., 2017).

Vulnerability in the early years

The early years is a time of vulnerability as well as opportunity. While most parents and carers are able to provide the love and protection that their children need, some are not, and babies and young children suffer harm as a result. This can lead to profound negative effects on child development (Palacios et al., 2019).

Babies and young children are disproportionately vulnerable to maltreatment compared to older children, due to their dependency on and time spent with their caregivers, and their innate physical vulnerabilities (Austin et al., 2020). Children under the age of one are the age group most likely to be killed by another person (Office of National Statistics, 2021).

The negative impact of abuse and neglect on key aspects of children’s growth and development has been documented extensively (Shonkoff et al, 2012). Exposure to maltreatment increases the lifetime risk for many psychopathological difficulties such as depression, anxiety disorders, post-traumatic stress disorder, substance use disorders, suicide, internalising and externalising symptoms, and physical health problems such as increased risk of cardiovascular disease (Cicchetti & Doyle, 2016; Hughes et al., 2017; Howe, 2005, Kavanaugh et al., 2017). Children who have experienced maltreatment are also more at risk of developing insecure or disorganised attachment patterns which are associated with socio-emotional development difficulties (Cyr et al., 2010; Howe, 2005).
Adoption in England

Children are adopted when they are not able to live with their birth parents. Most children who require adoptive families have experienced abuse or neglect, with 66% of children in care for this reason and this number steadily rising year on year (Department for Education, 2021). In 2021, 19% of children in care (Department for Education, 2021a) and 33% of children with a child protection plan were under five years old (NSPCC, 2021).

In England, the majority of children who are adopted are first placed into the care of the local authority. Achieving permanence in a child’s placement is considered a priority in the UK, leading to a focus on adoption. In the year ending March 2021, 2870 children were adopted from care. This was an 18% decrease from the year before, which may be explained by the impact of the coronavirus pandemic on court proceedings. In the reporting year of 2021, the average age of a child at the time of adoption was three years and three months.

The Department for Education reported that 73% of children were adopted by heterosexual couples, 11% were adopted by same sex male couples and 6% by same sex female couples. A further 11% of children were adopted by a single person (Department of Education, 2021a). White children were less likely to be looked after (74%) and more likely to be adopted (83%) compared with their share of the population of all under-18 year olds (79%). Black children were more likely to be looked after (7%) and less likely to be adopted (2%) compared with their share of the under-18 year old population (5%). Asian children were less likely to be looked after (4%) and less likely to be adopted (1%) compared with their share of the under-18 year old population (10%) (Department for Education, 2021b).

Common difficulties for adoptive children and their families

Adoption has the potential to mitigate the negative impact of early adversity in childhood via the nurturing caregiving environment offered by adoptive parents (Van de Voort et al., 2014). For some children, however, the effects of maltreatment can be lifelong (Hughes et al., 2017; Shonkoff et al., 2012) and research shows that adoption is not able to attenuate the impact of all previous adverse experiences. Many adopted children demonstrate social, emotional and behavioural problems (Rushton & Dance, 2002; Selwyn et al., 2014) as a result of their experience of abuse or neglect, the loss associated with removal from their birth family, and often multiple moves between foster homes (Schofield & Beek, 2006).

Becoming a parent is an important transition that can change a person’s psychological wellbeing, social network relationships, and quality of relationships with partners. (Cowan & Cowan, 2000; Doss et al., 2009; Simpson et al., 2003). Adoptive parents face additional challenges as well; in most cases, they have experienced infertility (Cohen et al., 1993; Daniluk & Hurtig–Mitchell, 2003) and have become parents later in life (Ceballo et al., 2004).
A recent survey of over 2,638 adoptive parents in the UK reported that 70% of parents felt that it was a continual struggle to get help and support for their child’s needs (Adoption, 2019). When asked what would make the most significant positive difference to their family, 52% of parents responded ‘easier access to ongoing therapeutic support for my child/children’. The need for support was recognised by the government when they set up the adoption support fund (ASF) in 2015 and it has supported over 36,000 children so far. A recent longitudinal evaluation of the ASF reported that 84% of respondents had found the support accessed from the fund to be beneficial for themselves, and 81% felt the support had been beneficial for their children. Despite this positive feedback for the ASF, the survey reported continued high rates of difficulties which indicate a need for ongoing support (Gieve et al., 2019).

While early intervention is encouraged, external professional support is often delayed in adoption cases to allow for a settling in period. Though this time together as a family is important, the challenging experience of the adoption process and the subsequent adjustments to family life can mean that support and advice are crucial at these early stages. In particular, the use of group interventions have been recommend for adoptive families as they provide both professional and peer support. As adoptive families often become experts by experience, being able to share their own knowledge with others who have been through similar challenges can be valuable.

Interventions to support adoptive families in the early years

The evidence base on supporting adoptive families specifically in the early years is in its early stages of development, and therefore we focus here on emerging evidence from Anna Freud’s Parent-Toddler Group model.
The Adoption Parent-Toddler Group

The Adoption Parent-Toddler Group is based on the Parent-Toddler Group model, an approach to working with parents and toddlers in groups first developed by Anna Freud in the 1950s. Parent-Toddler Groups are therapeutic play groups informed by psychoanalytic, child development, attachment and trauma-informed theory, which aim to support the key developmental tasks of toddlerhood. These include the toddler’s developing independence, sense of self and ability to manage strong feelings, and the parent’s and toddler’s capacity to tolerate separation while retaining a positive relationship. The main vehicle for change is the parent-child relationship. The group aims to strengthen the parent-child relationship through facilitating child creative play, verbalising the toddlers’ feelings, managing aggression and setting limits, exploring parent-toddler closeness and feeding back observations (Zaphiriou Woods & Pretorius, 2016). Typically, a Parent-Toddler Group is co-delivered by a therapist with clinical training in psychoanalysis and child development and another clinician or assistant. Groups take place weekly for 90 minutes and families with children aged one to three attend for up to two years.

A qualitative study of the Parent-Toddler Group reported that parents found the group to be a safe place where they were able to share their worries and anxieties, helping them to feel less alone (Barros, Kitson, & Midgley, 2008). Furthermore, the parents reported a better understanding of their child by engaging with their perspective. Another study looked at quantitative data collected from 12 mothers who attended a Parent-Toddler Group. The results reported an increase in their self-reported reflective functioning, which is indicative of increased mentalizing (Rivera et al., 2013).

The model was trialled with adoptive parents in 2019 with minor adaptations. The Adoption Parent-Toddler Group operated as a closed group and ran for six months, due to the nature of the ASF funding. A small-scale pilot study was conducted to evaluate the adaptation of the Parent-Toddler Group model to work with adoptive families (Crasnow et al., 2020). The findings showed high rates of acceptability and feasibility and parents reported satisfaction with the intervention. They also reported that their participation in the group has positively impacted their understanding of their child’s thoughts and feelings. Preliminary outcome data of this small group of families indicated positive changes in child development and parental mental health and parenting stress across the intervention.

Online therapy

Adult therapy has been delivered online since around the 1990s through video, emails, chat rooms and self-help packages (Chester & Glass, 2006). Research on the remote delivery of therapy has increased along with its practice, and evidence is showing that when compared with face-to-face therapy, online psychotherapy has similar effects (Bastastini, et al, 2020; Bitencourt Machado, et al, 2016).

There is little evidence on the effectiveness of delivering online therapy for parents and carers and young children, in dyads or group settings. This is likely to be because until recently this model has not been attempted very often, given the complexity of working with young children online. However, during the pandemic, online platforms were sometimes the only way to reach young children and their families. Guidance by organisations working therapeutically with young children during the pandemic set out considerations for working online (Anna Freud Centre, 2020; The Association of Child Psychotherapists, 2020). These included:

• ensuring therapists’ competence with technology;
• considering if and how risk can be managed;
• ensuring regular clinical supervision;
• considering whether the therapeutic relationship had already been established face to face,
• and the impact of the change to online therapy;
• ensuring the family has a private and safe space to be in;
• and what to do in the event of technological difficulties.

When working with young children online, the following techniques were suggested: using slow, clear speech; positioning the phone or device at the same level as the child; creating time for play in all sessions; and being able to explain the situation in an age-appropriate way.
Adapting the Adoption Parent-Toddler Group for online delivery

In order to continue the delivery of the Adoption Parent-Toddler Group in a safe way during the coronavirus pandemic, the model was adapted to be delivered online. Learning from the pilot study was also incorporated into this iteration of the model.

The aims of the online adaptation remained the same as the original model, namely to strengthen the parent-child relationship by facilitating child-led creative play, verbalising the toddlers’ feelings, managing aggression and setting limits, exploring parent-toddler closeness and feeding back observations. Unlike the face-to-face model, the online adaptation included the use of ‘Watch Me Play!’ (Wakelyn & Katz, 2020), a structured therapeutic tool to support parents to observe their children playing outside therapeutic sessions. This tool was introduced to the online model as facilitators were unsure whether the largely free play structure of the in-person groups would translate to the online setting. It was felt that ‘Watch Me Play!’ would help retain the focus on child-led creative play in the absence of the real-world shared play setting.

The group was delivered using the Microsoft Teams platform. The online sessions were 75 minutes long, 15 minutes shorter than the face-to-face Adoption Parent-Toddler Group model. A total of 14 75-minute group sessions were planned for the online group, fewer than in the face-to-face model. The families were also offered four individual introductory sessions with one clinician, rather than one session in the face-to-face model. These introductory sessions aimed to increase engagement with the intervention and enable parents to practise using the ‘Watch Me Play!’ tool before the group sessions began.

Responding to recommendations from the pilot for closer working with other professionals around the family, the online model included an invitation to the family’s social worker to attend the first individual session with the parents and clinicians.

The structure of the group remained the same as the face-to-face model, with the exception of the inclusion of the “Watch Me Play!” tool. It comprised a welcome song for the children, followed by a group discussion about families’ experiences over the past week. During the discussion, clinicians would aim to bring the children into conversations and talk with them and their parents about their play, their experiences and their interaction with the group. There was group snack time at the same time each week, as included in the original model, followed by ‘free play’ during which parents and clinicians could observe the children and discuss any ‘live’ examples of play. Clinicians would then facilitate a group discussion of parents’ experiences of ‘Watch Me Play!’ and consider with the group each family’s specific needs. Group discussions also provided opportunities for families to offer each other advice and discuss similar experiences. The group sessions were co-facilitated by two female therapists.
Methods

Aims
This report aims to explore the feasibility and acceptability of delivering the Adoption Parent-Toddler Group online. The research questions were as follows:

1. Feasibility and acceptability:
   - What were the adoptive parents’ experiences of the online intervention?
   - What were the clinician’s experiences of delivering the intervention online?

2. Preliminary clinical outcomes:
   - Was the online Parent-Toddler Group effective in improving clinical outcomes for adoptive families?

Recruitment
Families were recruited via their local authority adoption social worker in an urban inner-city area. Anna Freud Centre therapists liaised with the social work team manager and referrals were made by the team.

Participation
Three families (five adults and four children) took part in the intervention between November 2020 and March 2021. The families attended all of the planned individual and group sessions, with the exception of one family who missed one group session. Two were families who had adopted single children and one family had adopted twins. Four of the parents were White British and one was from another White background. The families included two same sex (male) relationships and one heterosexual relationship (only one partner, a woman, attended the group). Two of the families had adopted within the previous year, and the other family had adopted over two years prior after adopting another child. Four of the five parents who took part in the Adoption Parent-Toddler Group completed the interviews, representing all three families. The group was funded via a portion of the parents’ annual ASF allowance.
Logic model: Adoption Parent-Toddler Group

1. TARGET: Who is the intervention for?

Adoptive parents and their toddlers aged 10 months to 3.5 years.

2. INTERVENTION: What is the intervention?

- A weekly, online play group for parents and toddlers, based on the Anna Freud psychoanalytic Parent-Toddler group
- Online adaptations include:
  - inclusion of Watch Me Play! tool
  - introductory individual sessions to increase engagement and learn about the tool.
- Group themes cover:
  - child-led creative play
  - exploring parent-toddler closeness and independence
  - verbalising child’s thoughts and feelings
  - sensitive behaviour management
  - sharing experiences and creating connections between families.
- Four individual hour-long sessions then 14 weekly group 75-minute sessions.
- Facilitated by a psychoanalytic child psychotherapist and a clinical psychologist.

3. CHANGE MECHANISMS: How and why does the intervention work?

- Observing, practicing and learning about child-led creative play and sensitive behaviour management.
- Observing and practicing the process of understanding parental and child behaviour within the context of mental states and putting them into words.
- Practicing finding the balance between self-focus/care and attending to the world through a toddler's eyes.
- Strengthening social networks through peer-to-peer support and connecting to parents in similar situations.
- Experiencing containment through the group experience.
- Experience of positive reinforcement and confidence building.
- Provision of safe space allowing open and confidential communication.
- Observing an attuned and respectful relationship, modelled through the group leaders' relationship.

4. OUTCOMES: What difference will it make?

**Toddler outcomes:**
- Toddler development outcomes. Improved physical, social, emotional and behavioural development of toddler (measured by ASQ-3 and ASQ:SE).

**Parent outcomes:**
- Parent-identified goals. Progress towards concrete goals set jointly with therapist at start of intervention (measured by Goal Based Outcomes).
- Parental mental health. (Reduced parental distress and mental health symptoms measured by CORE-34).
- Social support. Increased perceived social support (measured by Multidimensional Scale of Perceived Social Support).
- Parental engagement. Good attendance in group (measured by DNA and cancellation rates).

**Relationship outcomes:**
- Parent-toddler relationship. Improved quality of parent-toddler interaction (measured by Maternal Objects Relations Scale).

5. MODERATORS: What factors will influence the change process?

- **Parental engagement:** willingness of parents to practise Watch Me Play!, attend sessions consistently, participate in activities and share their experiences during sessions.
- **Fidelity to intervention model/group facilitators’ skills:** how closely group leaders keep to the intervention model through high-quality specialist training and supervision, capacity of group facilitators to engage parents and children remotely and to facilitate all parents to participate.
- **Implementation issues:** training of group facilitators including time for preparation and debrief; adequate functioning of technology; and parents' access to adequate play and computer equipment.
Evaluation design and procedure

The online Adoption Parent-Toddler Group ran from December 2020 and March 2021. The evaluation followed a mixed method design, combining qualitative and quantitative data collection. Families who agreed to take part in the group completed the pre-intervention outcome measures (T1) in the individual introductory sessions or outside the sessions prior to the group commencing. The post-intervention outcomes measures were completed following the end of the group (T2). The clinicians and the adoptive parents were then invited to take part in an interview with a member of the evaluation team which took approximately half an hour each. The interviews were recorded and transcribed.

Outcome measures

The measures used to assess the impact of the intervention on the children were: Ages and Stages Questionnaires, third edition (ASQ-3) and Ages and Stages Questionnaires: Social-Emotional (ASQ:SE).

The measures used to assess the impact of the intervention on parents were: Clinical Outcomes in Routine Evaluation -34 (CORE-34); Mother Object Relations Scales (MORS); Goal Based Outcomes (GBOs); and Multidimensional Scale for Perceived Social Support (MSPSS). For more details, see Appendix A.

Qualitative feedback

Qualitative data was collected using semi-structured interviews with the adoptive parents who attended the group. The interviews took place in April and May 2021 and were completed by video call using Microsoft Teams. An interview was also conducted in August 2021 with one of group’s facilitators. The interview focused on their experiences of facilitating the group, any changes they saw in the parents and their views of delivering the intervention online. It was only possible to interview one of the two clinicians who facilitated the group, due to the second facilitator leaving employment at the Anna Freud Centre.

Data analysis

The transcribed qualitative data from the interviews were analysed using thematic analysis (Braun & Clarke, 2012). Following familiarisation with the data, initial codes were generated based on information and coded using the software analysis tool NVivo.

Ethical approval

As a routine service evaluation, this project did not require NHS ethical approval. However, ethical considerations were embedded in all aspects of the project. Written consent was sought from all the families and clinicians that took part, and they were made aware of the aims of the study, benefits and risks of taking part, consent and withdrawal processes, data storage and confidentiality processes.
Findings
What were the adoptive parents’ experiences of the online Adoption Parent-Toddler Group?

Interviews were carried out with four adoptive parents one month after attending the group online. Four themes and five sub-themes emerged (Figure 1).

Figure 1: themes emerging from interviews with adoptive parents who attended the online Adoption Parent Toddler Group.
Uncertain expectations

Three parents spoke about joining the group with the expectation that they would receive help with parenting their child, something they felt they urgently needed in any form available.

“Even someone like with a top hat and a magic sort of wand came saying I can help you, I would have said ye I will take whatever you can give me!”

Other than being provided with help, parents weren’t sure what to expect from the group. Several families expected the sessions to provide answers to specific questions or challenges, or to provide “adoption hacks”. The parents spoke about the process of realising that participating in the group instead meant engaging in their own learning journey over time. They spoke about being surprised by the richness of the support they received.

“I also thought that their, their sort of interference was going to be more hands on. ‘Do this, don’t do that.’ And it took me a while to understand that it’s like therapy. You do the learning, you do the talking and they’re there to sort of facilitate.”

One parent said that they would have preferred more information about the group’s therapeutic model at the start in order to manage their expectations.

“We had our individual goals to get out of it, but what [I wanted to know] the point of the group is. Maybe a little bit more on that at the start or sort of going into it would have been useful to manage expectations.”
Being online

The parents spoke about positive and negative aspects of meeting online. The parents all indicated a preference for a face-to-face group due to a range of practical and communication challenges, including how to best position the camera for the group to see the participant, child and room, but away from the reach of the children; feeling distant from the group and unable to join in discussions in a natural way; the session feeling overly long in the online format; and the lack of opportunity for more impromptu one-to-one discussion.

“Person to person would have helped tremendously. Not that the group didn’t hold me... they did, you know... they really did. But yeah, it was just that online factor was tricky and sometimes just made me feel like ugh do I really want to do it? But, um, I’m glad that I persisted because it was, you know, a phenomenal support.”

Particular difficulties were raised by one participant who had a hearing impairment which were mitigated to some degree by intervention from the therapists to ensure other participants muted themselves when not speaking.

“Particularly with Teams or Zoom, if someone is talking it mutes other people’s microphones but see, other families had children who were chatting, [and] it would choose those over the people who were talking. So I found that was I was probably having to concentrate an awful lot to watch what people are saying so I could sort of partly lip read, which meant that I wasn’t probably playing with the kids as much as I could have done.”

It was also difficult for the children to interact and build relationships with one another online.

“Certainly, our kids would have interacted I think to a deeper level with other children had they been together.”

The parents also felt there were benefits to holding the group online, in particular in relation to how accessible in practical terms it was. This removed any concerns about travelling to the group or arriving on time, facilitated both parents in each couple attending all the sessions and enabled families to attend the group even if a child was unwell or “kicking off”.

There was also a theme in the interviews about safety relating to holding the groups online. Parents could join the group from their living room and in turn see others in their home environments, which was felt to foster intimacy. In some ways, being online felt less intense and pressured, enabling parents to speak more freely about difficult subjects, and in turn making more meaningful connections and deepening understanding.

“Well I personally felt more at ease from day one because I was at home. So I wonder to what extent it wasn’t easier to open up.”

They also felt this was true for their children. Children were felt to be more secure and relaxed in their home environments, with access to their own toys and snacks. Online sessions also prevented disruption to routines:

“The fact that we’re doing it from home meant we could slot it into our routine quite easily. [Child] did not have his routine disrupted in any way.”
Learning about child-led play

The parents felt they learned about their child during the group through the therapists’ facilitation and the ‘Watch Me Play!’ tool. One parent described how ‘Watch Me Play!’ had equipped them with the knowledge to be comfortable with simply being present and interested in their child’s play, rather than feeling obliged to act as an “entertainer”, allowing them to relax and enjoy play sessions more. Another spoke about learning to avoid “power struggles” with their child, and in turn gaining the confidence to support children with challenging behaviours.

Another parent described how ‘Watch Me Play!’ is now a part of their routine:

“We sort of embedded it in just the way we play with the children and in terms of observing, having a bit of time where we just observe what they’re doing and talk about it rather than trying to lead. So it was really, really helpful.”

Parents also highlighted the value of learning by observing the other parents and how that process helped them to understand their own interactions with their children. Additionally, sharing their own experiences felt beneficial for the parents. One parent described being able to share their insights with the other parents as “nourishing” and “therapeutic”.

The group made the parents feel more confident. The parents spoke about having high expectations of themselves as parents, feeling responsible for getting “it right all the time”. Both the observation techniques taught in the group and the therapeutic support provided by the therapists were found to be affirming and to build the confidence and self-esteem of the parents:

“I think it’s empowered me to not beat myself up... when I sense that we’re not connecting as intimately or as closely as I’d like or maybe [child] would like, just go in for five minutes of, of the Watch Me Play! you know and that’s okay, if they get five minutes a day, that’s okay, that’s vastly more than a lot of kids get.”
Feeling connected and supported

The final theme to emerge from the interviews with parents was the development of a support network. The parents spoke of the strong connection they made with the other parents in the group, feeling at ease together and feeling able to confide about intimate parts of their lives with people they had only known for a short time. A key driver for this was that the parents were “going through very similar things”. One of the parents described the difference between sharing with this group compared to their other support networks:

“We’ve developed a really lovely new pair of friends just based on hanging out in the playground every day. But I think it’s just also nice to have to get to have a set of people going through adoption as well, because it’s really just a little bit different... We’re doing the same things, we’re facing the same battles.”

The group was felt to be a safe space where they didn’t feel it was necessary to “put a brave face on”, and they felt about to share without judgement.

“There was a similar level of openness amongst us all and quite a high level of willingness to share – both the good and the not so good. There was no judgement, there was no negativity, just lots of, well, just positive sharing really.”

The parents were positive about the way the group was facilitated. They felt the less structured approach to the sessions enabled the group to be responsive to live issues, describing the group as relaxed, balanced and fluid. The parents found the therapists to be warm and accepting:

“They were just so welcoming, and so sort of loving, and kind of warm and just [laughs] totally accepting of the fact that I was you know, just like, in a mess, and that was a support to me, um, and just made me feel normal again at the end of it, so that stands out to me.”
What were the professionals experiences of the online Adoption Parent-Toddler Group?

It was only possible to interview one of the clinicians who facilitated the group. The key themes from that interview are reported here, focusing on the impact of online delivery.

The therapist reflected on how delivering the intervention online brought a particular focus on the parents. The online format provided a unique space for the parents to connect with each other that was less possible in face-to-face groups. The toddlers were often off-screen playing, meaning that the parents were left physically facing each other in an intimate space, with attention focused on them.

“They’re just sitting looking at each other. It’s sort of a forced kind of intimacy that [...] I think they liked [...]”

The therapist also reflected on changes to the content of what the parents spoke about, compared to the face-to-face groups. In face-to-face groups, discussions about family life often elicits responses based on practical elements of parenting or their children’s behaviour, whereas this group reflected more on their own feelings and emotions. They were able to build close relationships and were supportive of each other.

“I think that compared to the usual Parent-Toddler model, there was much more space for parents to connect emotionally about the things that they are experiencing, and they were much quicker [than face-to-face groups] to tell each other how hard things were.”

The therapist reflected on whether providing safety and containment for the parents in this way may in turn impact on parents’ own capacity to provide this for their children. They also considered how this sense of safety could be replicated in the face-to-face setting, by the therapists being more explicit with parents about the group being for them as individuals, as well as being about their relationship with their child.

The ‘Watch Me Play!’ tool was provided to the parents to use outside the group sessions, to support them to observe their child playing. The therapist described how they had planned to also use 20 minutes of the group to discuss how parents had used the tool at home. However, they found that group discussion was rich and free-flowing, and did not require the ‘hook’ of the tool to generate discussion. The therapist described how ‘Watch Me Play!’ felt like another adult-focused task and reflected that as facilitators, they found they preferred to focus on the children’s live play when the opportunity arose.

The therapist reflected on the implication of the online format for the toddlers. A key part of the Parent-Toddler Group model is the therapist being able to observe the child alongside the parent, to enable a better understanding of the child through verbalising their possible feelings and wishes and through modelling other desired behaviours. This was more difficult in the online group:

“I guess the things that I missed doing was crouching down next to a child and watching what they were doing with a toy and hopefully having their parent or other parents there too, and sort of being curious about it and starting to think with parents about that”
There were missed opportunities for reflection and learning in response to children’s behaviour, for example when the session ends.

“They switch the computer off, whereas you know in the live group saying goodbye is a really big thing and when the toddler starts to struggle with it, that’s when we as therapists would start to really understand and be able to help parents with their children.”

The therapist also reflected that the physical separation meant they felt less able to be alongside the parent in response to their child’s behaviours. For example, the therapist spoke about a one-to-one appointment with a family online at the beginning of the group, and there was a sense of guilt at not being able to be in the room supporting the parent and toddler throughout the conversation. The physical separation between the therapist and family meant that it was more difficult for the therapist to develop a relationship with the child, which seemed to be experienced as a loss.

“I still don’t like working with children online at all. In fact [this group] made me dislike working with children online because it’s just I think it would be so much nicer being with them.”

In addition to the more limited contact between the child and therapist, the children were also less able to interact with each other. The therapist described how this impacted on the model because some of the ways in which parents are supported to better understand their children is through these child-to-child interactions, including conflictual ones.

“What we didn’t have was any aggression or there wasn’t an opportunity for it. So that’s very counter to the model.”

However, the therapist did witness positive interactions between the children despite the difficulties that being online presented, including children going to fetch similar books, or noticing when other children were missing from the group. Even in this limited form, the therapist felt that this interaction between children was affirming for the parents, who often have concerns about their children’s social development.

The therapist felt able to build an effective working relationship with the second therapist, who they had not previously worked with. The therapist also felt that the online format made it easier for the two therapists to vocalise a mentalizing stance. Being close together on a screen, rather than dispersed in a room, meant that the therapists could “think aloud” with one another, and model this reflective stance to the parents. Being online also facilitated the attendance of the families’ social workers at their individual meetings, and the ease of attendance (without having to allocate time to travel) was felt to have increased the social workers’ engagement with the group.
Preliminary outcomes

The sample size for this study was small and not all those participating completed the outcome measures at both timepoints. Therefore, statistical analysis was deemed inappropriate and descriptive information is provided.

The Ages and Stages Questionnaire-3 (ASQ-3) and Ages and Stages Questionnaire: Social-emotional (ASQ:SE) are parent-completed questionnaires that are designed to identify potential developmental delay in children. Four parents completed the ASQ:3 at T1 and T2. The scores indicated generally positive trends, with fewer children in the clinical range post-intervention, see Table 1.

Table 1: group outcomes for the ASQ

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Children in clinical range pre-intervention</th>
<th>Children in clinical range post-intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Gross motor</td>
<td>50% (two out of four who completed the measure)</td>
<td>None</td>
</tr>
<tr>
<td>Fine motor</td>
<td>75% (three out of four who completed the measure)</td>
<td>25% (one out of four who completed the measure)</td>
</tr>
<tr>
<td>Problem solving</td>
<td>25% (one out of four who completed the measure)</td>
<td>None</td>
</tr>
<tr>
<td>Personal-social</td>
<td>50% (two out of four who completed the measure)</td>
<td>25% (one out of four who completed the measure)</td>
</tr>
</tbody>
</table>
Four out of five parents completed the ASQ:SE questionnaire at T1 and T2. All scores indicated clinically significant problems for their children both before and after the intervention.

The CORE-34 measures commonly experienced symptoms for anxiety and depressions in adults. Four out of five parents completed the CORE-34 at both timepoints. None reported scores above the clinical cut off indicating parental mental health difficulties in T1 or T2.

The Multidimensional Scale of Perceived Social Support (MSPSS) is a questionnaire used to identify an individual’s perceived level of social support with family, friends and significant others. Four parents completed the MSPSS at T1 and T2. Two reported the maximum score of 7 for the perceived support from their significant other, family and friends at both T1 and T2. One parent scored a 6.5 at both timepoints. Only one parent showed a change in perceived support, with their score increasing from 5.5 pre-intervention to 5.8 post-intervention.

Goals Based Outcomes (GBOs) is a tool used to understand progress towards a client’s goal in clinical work. Three parents completed the GBOs. All parents found that they had nearly completely reached the three goals they initially set, with scores of 8 and 9 (out of 10).

The Mother Object Relations Scales (MORS) questionnaire assesses a parent’s representation of their child. Four parents completed the MORS at T1 and T2. The MORS warmth subscale showed a general positive trend which indicates improved parental warmth from pre-intervention (M = 24.3, SD = 2.3) to post-intervention (M = 27.5, SD = 2.2). For the MORS invasion subscale, with higher scores representing more invasion, one parent showed no change (T1 and T2 = 15), two parents showed a decrease in scores (T1 = 14 and T2 = 12, and T1 = 9 and T2 = 7) and one parent showed an increase in scores (T1 = 7 and T2 = 13).
Discussion

In order to continue delivering the Adoption Parent-Toddler Group in a safe way during the coronavirus pandemic, the model was adapted to be delivered online. The Adoption Parent-Toddler Group is itself a nascent model. The findings from this small-scale study are discussed in relation to the use of the Parent-Toddler Group with adoptive families and its suitability for online delivery. The findings are also considered in relation to the learning from the pilot study of the face-to-face Adoption Parent-Toddler Group (Crasnow et al., 2020). It must be emphasised that this is a small-scale study and it is not possible to generalise the findings beyond this group.

The Adoption Parent-Toddler Group model was able to be delivered online with fidelity to some parts of the model, and indeed some aspects were enhanced by online delivery. The group remained based in psychoanalytic practice and change mechanisms included in the logic model continued to be employed, including modeling behaviour, giving space for free flowing discussion and play, observing and discussing children’s behaviour, and supporting parents to find balance between their own needs and those of the child. Parents valued the supportive and thoughtful facilitation of the group by the therapists and spoke about how the group boosted their confidence in their parenting, which echoes the learning from the pilot study. Peer support also remained a key element to the success of the group as with the pilot study, with parents valuing the development of relationships with other parents going through a similar life experience. The parents felt they had achieved the goals they set themselves for the group (as measured by the GBOs).

The online format of the group seemed to enhance parental involvement. Unlike in the face-to-face settings, without the opportunity for therapists and group members to play directly together with the children or to move around the room, the parents found themselves more at the centre of the group. It was clear that the parents valued the space given to them as individuals as well as parents. It seemed that the intimacy of being in front of a screen enabled some parents to more quickly share about their feelings and personal experiences. It is interesting to consider the concept put forward by the therapist of a “forced intimacy”. Did the parents feel more able to share because they were in their own homes and protected in some way by the screen; or conversely did they feel obliged to share because they became more of a focus in the group? It is possible also that this willingness to share intimate feelings may have been influenced by the experience of living through a pandemic, during which many people felt isolated and were eager for interaction with others.

Online delivery made it easier for the families’ social workers to attend the individual introductory sessions, strengthening the team around the family. The pilot study recommended modifications to the model to improve closer working with other professionals, and the online structure of this group facilitated that.

The parents were initially unsure of what expect from the group, mirroring findings from the pilot study. However, unlike the parents in the pilot study, they seemed to develop a clearer understanding of the aims and methods of the group as it progressed. This could be for several reasons. It is possible that the therapists built on learning from the pilot to improve parents’ understanding of the group at an earlier stage, or that the greater focus on parents during the sessions was a supportive factor. The use of the ‘Watch Me Play!’ tool may have supported parents with their learning journey, as it was highly valued by the parents and appeared to support learning and increase parental confidence.

Another recommendation from the pilot study was to provide more of a structure to the sessions, as parents reported feeling unsettled by the free-play structure of the group. The parents in this study spoke about enjoying the free-flowing nature of the group. It is possible that online sessions are by nature more contained than face-to-face sessions, even when children are engaging in free play in both types of session.

As noted, a key component of the Parent-Toddler Group model is the psychoanalytic observation of children in free play. The findings from this study suggest that while the therapists found innovative ways to bring the child into the room (through the ‘Watch Me Play!’ tool and through the sensitive and thoughtful facilitation of the group and individual sessions) this is a more difficult to replicate in an online group with toddlers. Therapists were less able to observe and respond to children in play and
interacting with one another through the screen, and it was also more difficult to observe and respond to interactions between parents and children. For example, in face-to-face sessions, supporting parents and children with the process of saying goodbye and leaving the building and toys at the end of session is a key aspect of the therapeutic approach. The therapists are able to observe the children’s and parents’ behaviours and model responses, and this opportunity was not present in the online group.

While some of the practicalities of holding the group online were celebrated, there were difficulties in relation to preferred camera angles and poor internet connection that should be considered in any future online groups. Particular attention should be given to ensuring that online groups are accessible to people with hearing impairments and other types of disability.

The children’s experience of the group was captured through the parents’ and therapist’s perspectives. The parents felt that there were benefits for the children in being able to be at home during the group, for example maintaining routines and being in a safe space, which are particularly important for children who have experienced previous trauma and loss. In the face-to-face pilot study, the parents spoke about the children’s relationships with each other as a major area of development and success for the family (Crasnow, et al, 2020). This was difficult to re-enact online, and was again experienced as a loss for the children by the parents.

Unfortunately, the limited quantitative data from this study means it is difficult to make generalisations from the dataset. What is notable is that the parents felt they had good social support networks in place before as well as after the Adoption Parent-Toddler group. A recent survey of 3,500 adoptive families reported a mixed picture of social support networks for adoptive families (Adoption, 2019). It found that the majority of adoptive parents agreed that their family and wider community were supportive and understanding of their child’s needs and that they were able to call on their support networks for help. However, 70% of respondents also agreed that the difficulties faced by their adopted child or children had placed a strain on their families and wider relationships.

The parents who took part in this group did not present with mental health difficulties before or after the intervention. It is likely that future groups will include parents with mental health difficulties, given the particular stresses that adoption can bring, and this should continue to be considered in the model’s development.

All children presented with clinically significant socio-emotional developmental issues prior to the intervention although other areas of children’s development did improve. Further research is needed to explore the reasons behind this, and the online and relatively short-term nature of the intervention should be considered as a possible influencing factor. Finally, there appeared to be an increase in parental warmth for adoptive parents who attended the Adoption Parent-Toddler Group, but the findings for invasive parenting were mixed. Again, it is difficult to ascertain the reasons for this finding, and further research is needed.
Limitations of the study

This is a developing evidence base and, to date, the research on the impact of the Adoption Parent-Toddler Group is with small samples. This study includes data from four parents and one facilitator. The evidence base can be strengthened with continued efforts to evaluate future Adoption Parent-Toddler Groups, with a particular focus on increased sample size, the completion of routine outcome measures relating to the logic model, and capturing qualitative data from both facilitators immediately after the group has ended.

Next steps

While there were many positive findings from this study, it is not recommended that the Adoption Parent-Toddler Group is delivered online routinely, given the model’s founding in psychoanalytic observation which is made difficult by the online setting with this age group. Where it is necessary to deliver the group online, the findings from this study should be taken into account, particularly in terms of ensuring diverse needs are considered in relation to the use of digital platforms, to what extent child-parent observation can form part of the model, and efforts to improve outcome data collection.
References


Appendix A: Outcome measures

Child development

The Ages and Stages Questionnaires, third edition (ASQ-3): The ASQ-3 is a parent-completed, child monitoring system that is designed to identify potential developmental delay in children aged between one month and 5.5 years in five domains: communicative, gross motor, fine motor, problem solving and personal-social. The domain scores range from 0 to 60 and clinical cut-off points vary depending on the age of the child, with higher scores indicating better mastering of the skills of each category.

The Ages and Stages Questionnaires: Social-Emotional (ASQ:SE): The ASQ:SE is an adaption of the ASQ, with a focus on social-emotional behaviours. It was developed to be used alone or in conjunction with the ASQ, and it focuses on infants’ and young children’s social and emotional development (Squires et al., 2009). The score ranges vary between the different age-specific versions (e.g. the 2-month version has a score range of 0-240, the 36-month version has a score range of 0-525 etc.) and so do the cut-off points. For all versions, lower scores indicate better socio-emotional development.

Parent measures

Clinical Outcomes in Routine Evaluation -34 (CORE-34): The CORE-34 measures commonly experienced symptoms for anxiety and depressions and associated aspects of life and social functioning. Scores range from 0-40 with a clinical cut-off point at 10, above which scores are considered to be in the clinical range.

Mother Object Relations Scales (MORS): The MORS questionnaire assesses a parent’s representation of their child. It comprises of two scales: a ‘warmth’ scale and an ‘invasion’ scale, both ranging 0-35. For the ‘warmth’ scale, lower scores indicate more risk, with scores below 10 representing a high concern, 10-15 representing moderate concern and above 15 representing low concern. For the ‘invasion’ scale, higher scores indicate more risk, with scores above 16 indicating high concern, 12-16 indicating moderate concern and below 12 indicating low concern.

Goal Based Outcomes (GBOs): GBOs is a tool used to understand progress towards a client’s goal in clinical work. The measure allows a client to compare how far they feel they have moved towards reaching a goal that they set for themselves at the beginning of an intervention. Parents and carers are asked to rate how much they felt that they had reached their goals on a scale from 1 to 10 where 1 indicates that the goal was not met at all and 10 indicates that the goal was fully met.

Multidimensional Scale for Perceived Social Support (MSPSS): MSPSS is a questionnaire used to identify an individual’s perceived level of social support with family, friends and significant others. Each of these three subscales have a score range from 1-28, whereas the total score ranges between 1-84, with lower scores indicating less perceived social support.
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