Points of Breakdown in the Provision of Services to Severely Disturbed Foster and Adopted Children

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The placement of a child in an adoptive or foster home reflects the confluence of many factors. Chief among them is the fact that a new relationship is forming because a previous relationship has not been sufficient for this child. The new relationship and the previous one(s) are the critical players.

A justifiable accusation against "holding therapy" is that the child becomes the source of the problem. Proof of this comes from a review of literature published by holding therapists, such as Randolph (2001). She devotes eight pages to the office diagnosis of the child's neurological dysfunction and less than a single page to the evaluation of the parents. This highly individualistic perspective represents a curiously nonrelational view of a parent-child relational problem. In fact, it is important for any clinician providing services to these children and their caregivers to step back from the magnetic pull of the severely disturbed child and appreciate the larger relational issues that are always operative.

For example, the child is simply one level within several nested relational ecosystems (Bronfenbrenner, 1979). These levels include the larger system, which contains the adoption agency and any child protective services system that continues to be involved. State departments of social services frequently have guidelines that dictate the placement of these children. Particular agency policies may interfere with a successful placement.

Another level of the relational ecosystem includes the adoptive or foster parent. Although the majority of these individuals provide invaluable services and bring a reasonable degree of psychological health to the equation, a subset of these parents are either poorly prepared for the child's level of disturbance or have their own acute and even chronic psychiatric issues that interfere with a successful placement. Thus, the motivations to adopt a severely maltreated child need careful scrutiny during the intake.

An ancillary layer of the relational ecosystem includes the therapist or the consultant to the family. The therapist may have a narrow perspective, may not appreciate every aspect of the system, or may simply be less well-trained than is needed. Further, too many or too few mental health professionals may be involved in the child's care. These professionals may or may not interact in ways that are synergistic.

The child is at the center of these relational levels. Severely disturbed children with a history of maltreatment bring not only psychological problems to the equation but also problems with learning as well as medical and neurological issues that warrant attention. Typically, their needs are complex and can often appear to be ever-changing and even multiplying.

The remainder of this paper addresses each of these levels in turn and examines what about each level contributes to a breakdown in the adoption or fostering process.

System Level

A number of potential points of breakdown exist at the system level. Some systems have policies that are developmentally insensitive or that apply to some children but not to all. For example, many agencies and jurisdictions have policies that strongly encourage or even require that siblings be adopted together. This need to place siblings together may be applied with little regard to the fact that these siblings associate each other with prior abuse and may serve as PTSD triggers to each other (Liotti, 1999). Siblings may even contribute to the frequency that one or more of them become dissociative. Further, siblings from violent homes might even abuse each other in this new placement.

The open adoptions that characterize the placement of some severely disturbed children are a related issue. I contend that if the task is for the child to have a long-term placement with a caregiver, and the child's disturbance is rooted in an earlier relationship with the biological parent, then including these former parents and relatives in the relational equation is inappropriate. I have seen numerous situations in which only through hindsight have we appreciated the degree to which extended family members have behaved insensitively and were seen by children as threatening.

Financial considerations are also a systemic issue. Agencies and jurisdictions may lack adequate resources to support the adoptions. These are children who require ample services from the start. Multisystemic family therapy services are often needed and may not be locally available (Henggeler, et al., 1998). The availability of respite care is another issue. I have seen placements succeed in which respite care was liberally used throughout the first several years of the child's placement in an adoptive family. This may be counter to one's belief that a child must have a primary connection with the adoptive parent. However, the provision of respite care is a valuable adjunct to the adoption process because it helps to modulate the intensity of the child's developing relationship with an adoptive parent (Hazell, Tarren-Sweeney, Vimpani, Keatinge, & Callan, 2002). Therefore, if the child has learned that parental behavior leads to frustration and maltreatment, the child is more likely to adapt adequately if parental behavior is modulated through the use of respite care.

Finally, the agendas of the system and the parents may be in conflict with each other. Adoption agencies have a goal of placing children in adequate families. These agencies may use many subtle and not so subtle strategies to keep children in placements long after this placement has failed. They may lack an appreciation of the complex demands and needs of the child and may poorly prepare parents about them. Pressures can include unsupportive comments by a caseworker to a frustrated and overwhelmed adoptive parent, such as, "Please, don't let this child be rejected again."

Foster and Adoptive Parents

Adoptive parents usually deserve our support and admiration. However, the motivation to adopt may stem from unresolved loss. For example, some adoptive parents have yet to resolve a recent diagnosis of infertility. Other adoptive parents are motivated to add a child to their family either because of the loss of a child or the upcoming launching of a child from the nest. This field needs data that examine the relative success of adoptions that occur to parents who are within two years of any of the losses mentioned here versus those who are not. I would expect that the failure rate would be higher in the former group.

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The motivation for other parents is that they have functioned best as a couple when in their parental roles. This may mask an underlying marital problem. If children are used to avoid conflict in a marriage, severely disturbed children are destined to interrupt this coping strategy. Parents who have avoided conflict for years will now be forced to learn to work together. I routinely observe a temporary resolution in these situations: one parent, typically the mother, is relegated as the primary parent of the child. This resolution often adds to the ambivalence and anger between the spouses.

I know from experience that a higher than average percentage of foster parents report having had histories of being foster children. As a motivation to be helpful to a child, this is admirable as long as the historical issues that resulted in foster care have now been resolved. Regrettably, I sometimes hear from these parents that they "know what it is like to be without love." This statement indicates to me that they are likely to have difficulty knowing their own stimulus value to the child. One consequence is a problem in modulating the intensity of their affection, and the child may be quickly overwhelmed.

Adoptive parents may have the same skill deficits that occur with biological parents. For example, they may intervene insensitively and intrusively with the child. They may be excessively reactive, and their anxiety about the child's behavior may result in overly punitive behavior. They may lack the natural child management skills that characterize many parents.

Adoptive parents have explicit and implicit expectations about the success of the adoption. These expectations must be examined for appropriateness. For example, some parents may expect that the child will eventually be very well behaved, love them, and succeed in life. Adoptive parents may not appreciate that the child's gains may be very small. It is much better to have a realistic perspective early in the process than to enter into the adoption with inflated perspectives that must be ratcheted back.

Finally, foster and adoptive parents bring with them their own psychiatric issues, which may consume a significant amount of their time and energy. Adoptive parents who are being treated for depression or anxiety prior to the adoptive placement must be able to answer how they will balance child-rearing with attending to their own symptoms, getting to therapy and other appointments, and doing the relational and activity tasks that can alleviate their symptoms.

Other adoptive or foster parents have issues with unresolved trauma and maltreatment. Sexual or aggressive behavior by the adopted child may trigger their reactivity (Alexander, 1992). Other parents will have mild to moderate personality disorders that escape scrutiny by unsophisticated interviewers.

I have twice been asked by a social service agency to screen their potential foster parents. Each of them declined my services after several months because too few of the potential foster parents had satisfactory MMPIs. The generalizability of such findings is debatable, but even so, the level of psychiatric problems that some foster parents brought to the caregiving process was sobering.

Therapist Level

The adoptive parents are likely to eventually request the services of a mental health professional. It depends on the professional of their choice to appreciate that the current problems are nested within several layers of relationships. However, therapists primarily skilled in individual techniques, such as play therapy, may be only minimally useful, because their focus will be on the child and not on the contribution of the new parents or the larger system.

Individual treatment may be overwhelming to the child for several reasons. The therapy may be counter to the child's loyalty to his or her biological parents. The child may view the therapy as rejection. A language-delayed child may find the therapy frustrating. Other children may need to become more resilient to take full advantage of individual therapy.

In addition, individual therapy can be affectively intense. Consequently, the child's internal working model of adult-child relationships as punitive and frustrating becomes activated. When individual therapists are naïve about their personal need for control, or if they fail to appreciate the origins of the child's punitive and controlling behavior in the sessions, they are quite vulnerable to getting caught up in the child's internal working model (Bowlby, 1973). Thus, an individual therapy approach may actually amplify the child's behavioral problems and contribute to the child being viewed even more as the primary problem.

The child's disturbed behavior can be addressed through strategies based on attachment theory. Parent-child interaction therapy (Hembree-Kigin & McNeil, 1995) emphasizes the importance of strengthening the positive aspects of the relationship before discipline strategies are implemented. Through the use of direct coaching, parents can learn to be sensitive to their child's ability to tolerate their presence. In the process, extremely useful skills are learned and can be applied.

Matthew Speltz has developed a behavioral therapy approach for conduct disordered preschoolers that has attachment roots (Speltz, 1990). It has both an operant component as well as a skills-training component. The child's regulation of the parents' behavior during parent-child play is examined early on. The five components of the training are assessment, parent education, child-directed play with the parent, limit-setting, and parent-child communication training. The emphasis on the parent-child relationship is compelling.

The judicious and appropriate utilization of behavioral therapy skills can greatly assist adoptive parents in managing inappropriate behavior. Behavioral outbursts can almost always be reduced in both frequency and intensity through the use of creative and ever-changing behavioral strategies. However, many therapists are not as well versed in behavioral family therapy as one might expect.

A growing body of literature from infant psychiatry reflects an attachment perspective on intervention models to use with parent-child relationships characterized by insecure attachment (Cohen, et al., 1999). These authors describe a model, titled "Watching, Waiting, and Wondering," which has been empirically tested with infants but also has components that can guide work with older children. For example, parents learn to invest sensitively in their child, improve the timing of their interactions, and maintain a positive view of the child's development. Parents are also taught to reflect on their behavior.

A model of this type is very important because we do not yet have sufficient data to support one intervention over another with older

children and with teenagers who are both adopted and severely disturbed. It is possible that a model that addresses a multitude of issues at once, i.e., multisystemic therapy (Henggeler, et al., 1998), may emerge as a contender.

Seriously disturbed adopted children with child abuse and neglect histories typically must be treated by a combination of mental health providers. Sometimes this can be managed through multisystemic therapy, with some appropriate psychiatric consultation for medication. However, the child's ability to cooperate with medication usage can create another coercive parent-child cycle. Parents and children must be taught the creative techniques that are needed to get a resistant child to swallow a medication multiple times per day.

Child Level

Severely disturbed and maltreated children bring with them numerous comorbid behavioral issues that interfere with their successful placement. A recent study found significant differences between disruptive children in care and their less-disturbed counterparts. The more severely disturbed group had both more foster placements and placements of shorter duration (Garber & Delfabbro, 2002).

Other children come to their adoptive placement with cognitive impairment that may be due to neglect or secondary to prenatal exposure to alcohol. These problems interfere with the degree to which school can be an important reinforcer of appropriate behavior. Data are emerging on the effects that overwhelming trauma can have on brain function and in this way can directly contribute to problems with affect-regulation, the development of empathy, and the capacity to attach securely (Siegel,1999). Cognitive limitations only exacerbate the overall level of frustration in the parent-child equation.

Other children find therapy to be threatening. Weekly sessions become viewed as a sign that the new parent finds them wanting and hopes to be rid of them. The child may already be using the majority of his or her energy to manage this new parent-child relationship and may have very few resources to apply to an individual therapy process. I have certainly seen situations in which the adoption stabilized when individual therapy was stopped and then was started perhaps a year or two later and for a specific issue.

Summary and Recommendations

In summary, the adoption of severely disturbed children can succeed or deteriorate because of positives or negatives at a number of different levels. Clinicians must appreciate the entire range of potential breakdowns in order to serve these parents and children well. When the appropriately frustrated adoptive parents of a severely disturbed child come into your office, it is important to carefully assess the degree to which policies and services provided by the system help or interfere with the adoptive placement.

We as clinicians also need to learn to ask very difficult questions about the motivations and expectations of adoptive and foster parents. It is imperative to determine how their past history and current functioning are related to the immediate problems. Finally, if we do not have the appropriate developmental perspective, along with good parent consultation skills and a wide range of behavioral strategies, at our fingertips, we are not going to be useful to this child and family. We will have failed to demonstrate that there are alternatives to unvalidated and punitive techniques.

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