Post-Traumatic Adoption

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If you work with troubled children very often, you will end up working with families who have adopted. The conditions that create a child available for adoption are often very difficult on the child. Whether the child is abused, abandoned, or put up for adoption at birth or afterward, each of these situations can result in psychological problems for the child and challenges for the adoptive family.

In my career I have worked with many adoptions--before, during, and after the adoption has occurred. Because of the nature of my work, most of the adoptions have been of the difficult variety. I have not worked frequently with the typical adoptive situations in which there are children who need a home and a family fully prepared to provide one. The overall statistics provided by adoption agencies indicate the vast majority of adoptions succeed, at least by the definition that the adoption does not disrupt. In the State of Oregon, for example, which prides itself on its success with adoptions, figures are thrown out that over nine out of every ten adoptions are successful. What a successful adoption is may be a matter of contention, but let's accept that most adoptions do not disrupt.

I work with the hard-to-place, and the exceedingly hard-to-place children. Many of these adoptions are the ones in the one out of ten group that do disrupt. In fact, in the first five years of my adoption work with children, who were adopted coming out of our residential treatment program, a full 64% of the adoptions of our children disrupted when placed by the State adoption program. In response to this serious problem, we developed a new way to approach adoptions that we called the Adoption Courtship Model. This model was initially printed in the book Handbook for Treatment of Attachment-Trauma Problems in Children (James, 1994). It can be found in another article on the Adoption Courtship Model.

I want to stress that good programs are similar to good interventions, they must be designed around the particular needs or issues in the situation. The model that will be described is a program designed for very difficult children. There are components that might not work as well, or perhaps work at all, in the average adoption. As adoption agencies face the task of finding homes for the challenging children in the system of care, I believe that our experience may be of use in many of these situations.

As we implemented this model, we began to have successful adoptions for the first time. This was back in the 1980s. It would be years later before I was to face another major problem for both the child and the family related to the aftermath of disrupted adoptions. After developing the adoption courtship model, over the next ten years were spent working to place children coming out of our program into homes that were fully informed, prepared and ready to take on the challenges that came along with each child.

After initial resistance to handing over some of the control of the process, the state adoption agency allowed us to follow our process due to the severity of the past problems with our children. With this new approach, we experienced immediate success and had no disruptions for the first five years. We continue to this day to find success with a model that was based on the family and the child mutually progressing through three levels of commitment: from committing to spending time together, to a commitment to developing a relationship, and, finally, to a commitment to a relationship for life. We found that when children felt a real choice in the matter, as well as taking the process one step at a time, our success rates with the most difficult children went from 36% success to 84% long-term success with the same population of children.

In the early 1990s, I began to see a different type of problem with adopted children and their families. By this time, our program had developed some specialization in treating attachment problems in children. Over the next decade we began to have children come to us who had divergent pasts, but who also had a recognizable dynamic occurring between themselves and their families. These children came from pasts that included: drug-affected children who were adopted very young, only to present problematic symptoms years later, foreign-born adoptions, and all varieties of serious abuse and neglect resulting in the child pushing the families away with all their might.

We were able to develop some methods to deal with the attachment problems the children displayed. These methods can be found in my book Raising Children Who Refuse To Be Raised (Ziegler, 2000). However, as we became more skilled at working with attachment disorders, another problem began to arise when it came to children coming into our program from adoptive families. Put briefly, the better the child became, the more stress we observed in the families. At first this surprised us, but over the next five years, the names changed but the dynamic was frequently the same.

The overarching fact we observed was that, regardless of the progress of the child with the attachment disorder who came into the program from a previous adoption, the child invariably did not return to the adoptive family. At times the family called a halt

to the relationship and disrupted the adoption; and at other times the family remained fiercely loyal to the adoption, but not to the child who returned to their home. As I mentioned earlier, some of these children improved considerably in treatment, and yet it seemed that the more they improved, the more stress was observed among the family members. Along with this dynamic came considerable tension and sometimes conflict between the family and treatment staff within and outside of our agency. I watched this dynamic occur over and over until the pattern began to make some sense to me.

I now believe this dynamic to be what I call *Post-Traumatic Adoption*. This PTA is a very different than the Parent Teacher Association most parents belong to, and it is not fun for anyone--the family, the child, or people trying to help both. Basically, what Post-Traumatic Adoption entails is that the family members have exhausted their resources while the child was in the home and the results were seldom what they wanted, and often times were damaging to family members. The combination of giving their all resulting in continual failure became the traumatic experience for family members in relation to both the child and the adoption itself. The subsequent steps usually were: continual fruitless efforts searching for help, convincing the adoptive agency such as the state to assist with the cost of treatment, and a very exhausted family coming to our program for help with their child.

Our program does considerable work with posttraumatic stress disorder. This problem initially was associated with soldiers in combat and adults who were the unlucky victims of life-changing traumas such as rape, car accidents, and other terrible events. However, it was later recognized that children who had been through serious child abuse and neglect had the same symptoms as adults following serious trauma. In the mid-1980s Dr. Michael Reaves, a psychiatrist, and I identified that not only were abused children every bit as seriously affected as soldiers with combat PTSD, the children appeared even more deeply affected by the trauma they had lived through.

Although I had experience with both adults and children with PTSD, this problem was something individuals experienced and I never connected it to a common experience with a group of people, such as a family. I did not make this connection, that is, until later years when I began to see the same dynamic in the traumatized adoptive family as in the traumatized child.

I need to explain that the term Post-traumatic Adoption may sound like a mental health diagnosis, but it is not. It is more of a description of the dynamic following an exceedingly difficult adoption where the family members individually and even collectively exhibit symptoms that are remarkably similar to posttraumatic stress

disorder. I am using a similar term because I believe it is a useful association and has some similar implications for treatment.

The Diagnostic and Statistical Manual (DSM) is useful in this discussion as a reference for the types of symptoms associated with PTSD. Before discussing the similarities, it is important to say that post-traumatic adoption is not about fault nor blame. The victim of trauma is not held responsible for the negative impact on his or her thoughts and emotions. In the same way, the symptoms of trauma exhibited by family members in a post-traumatic adoption are not the responsibility of the family, instead the problem lies in the trauma they have experienced. If this was a question of blame, we would need to look at whether the placement was appropriate in the first place, whether sufficient information about the child and the child's past was available to insure a reasoned decision about the adoption, or we would need to look at the perpetrators of the violence, abuse and neglect in the child's past that led to being adopted in the first place. But the discussion of post-traumatic adoption is not concerned with fault or blame. Much like any other symptoms stemming from trauma, it is not the victim's (in this case the family's) fault, despite internal guilt or responsibility the victim may feel.

Similarities Between PTA and PTSD

The DSM defines a variety of clinical criteria that are helpful in considering this paradigm of symptoms associated with trauma within an adoption. PTSD has six general criteria and 19 sub-criteria within the six areas. Each of the criteria will be briefly addressed to see if they relate to difficulties experienced by the family in an adoption.

The diagnosis of posttraumatic stress disorder is always experienced by an individual. PTSD is an intensely internal experience. To consider PTA, we need to view the trauma as experienced by a family unit, although it is possible that just one member of the family would be affected. This is not to say that everyone in the family has a qualitatively similar experience of the difficult events in the adoption. All family members have their own internal experience of the adoption, with some family members being more traumatized than others. I will mention that from my experience the family member, who typically pays the greatest price from an adoption that has gone bad, is the mother. This makes perfect sense in that mothers are, more often than not, the glue that holds family units together. Accordingly, when the family begins to come apart, the mother often feels the most pain, responsibility, guilt, and other forms of distress. To complicate matters, the adopted child often targets the mother.

[When this was written the latest version of the DSM was DSM IV, but now it is the DSM 5]

The first DSM criteria is that the traumatized party (in this case the family) experiences or is confronted with events that are serious, a threat to the integrity and well-being of others, and experiences fear and helplessness. There is little doubt that this criteria roughly describes the comments I have heard from family members in an adoption where nothing is going quite right.

The second criteria requires at least one of five events: recurrent and intrusive distressing thoughts and images of the trauma, distressing dreams, feeling as though the trauma has not ended, intense psychological distress related to cues of the trauma, and physiological reactivity when exposed to events that resemble aspects of the trauma. Again, these descriptions are quite close to how families often respond following months or years of effort to make an adoption work; and they feel like the harder they work, the farther from their goal they find themselves.

The third criteria includes an avoidance and numbing of general responsiveness involving three or more of the following symptoms: efforts to avoid thoughts and feelings of the trauma, avoidance of activities or people that arouse traumatic feelings, inability to remember aspects of the events associated with the trauma, feelings of detachment or estrangement from others, restriction of affect such as the ability to keep loving others, and a sense of a foreshortened future of the marriage or the family unit. The serious PTA cases include all or most of these factors. Parents, particularly the mother, associate helpless feelings with having the child in the home, and often have little interest in repeating past problems by allowing the adopted child to return to the family's environment.

Parents almost always remain strongly committed to the adopted child after the child leaves the home, yet they cannot bring themselves to expose members of the family to continuing difficulties associated with the adoption. This leaves the parents in a quandary: how to fulfill their commitment to the adopted child, while also fulfilling their commitment to every other member of the family? I find that one of the only ways parents can resolve this dilemma is by fiercely advocating for the child, while they attempt to insure the child is not returned any time soon to the family, if at all.

The fourth criteria involves increased arousal of two or more of the following: difficulty sleeping, irritability or anger, difficulty concentrating, hypervigilance, and they startle easily. One of the battlegrounds of difficult adoptions is during the evening and nighttime hours. It seems that when the adoptive child often has difficulty is when the family can least afford the consequences. In this case the consequences of behavioral problems late into the night and even nighttime mischief by the child are an increase in hypervigilance leading to sleep difficulties, and general exhaustion occurs when quality

sleep is absent for extended periods. The result of this dynamic is usually irritability, trouble concentrating on other aspects of life (such as work), and other heightened stress responses.

The last two criteria are essentially givens, the duration of the difficulties has lasted more than one month, and the problems associated with the adoption difficulties are causing significant distress in the functioning of the family and/or the parents and other family members. In a PTA, both of these will be true.

The above criteria from the Diagnostic and Statistical Manual is used as a means to show that significant trauma and resulting symptoms can follow from an adoption that is very difficult on a family. These criteria are not appropriately used to say the family has PTSD, because this is an individual diagnosis and not a disorder experienced collectively by a group of individuals. In this discussion, I am borrowing these criteria to outline a different way to look at the stress and the struggle that the family is going through--and to help explain how the resulting dynamic may affect social service professionals who are trying to help the family.

Over the years, in my experience, I believe the conceptualization of Post-traumatic Adoption has shown some validity. Families with PTA often present to our program when the adopted child has been removed from the family to a psychiatric hospital, foster home, or residential program of some kind. Sometimes the change is agreeable to the child and fewer serious behaviors occur, which can further stress the adoptive family. In cases of serious attachment disorders, such as child adopted from Russian or Romanian orphanages, the reduced requirement of intimacy can calm some of the child's serious behaviors, or may change the way the behaviors are exhibited. Care providers outside the family who are unaware of the dynamics of these children may incorrectly believe either that the child is fine and the family is the problem, or they may believe they have given the child what he has needed all along and now the child is much improved. Both of these conclusions are probably erroneous. These families are not child abusers, and in fact, they will often put up with abuse from the child until they have no other recourse but to have the child removed, often for the safety of other family members or pets. Just because a child is not exhibiting serious behaviors in one setting, especially where there may be little required intimacy such as that associated with a permanent family placement, does not mean the behaviors will not come roaring back when the environment signals that closeness is once again required of the child.

We must take one further step in considering the plight of the family. Families open their lives to a child who they are often less familiar with than they need to be. Too often families are not told about all the important details of the child's past--including

abuse or serious neglect. At times this detailed background information is not available and at other times it is withheld to not jeopardize the adoption. The family gives and gives for years, spends all their emotional and financial resources trying to make the adoption work, only to feel the internal guilt when they have the child temporarily leave their home for professional help. At this point, the child often initially improves and the family must try to explain that this may very well be temporary, while the family agonizes with what to do next.

In the above paragraph, I have tried to show the most important step of effectively working with a family experiencing PTA. If you, as a helping professional, cannot show the family that you truly understand their experience and their dilemma, they cannot trust nor effectively work with you. When the family does not have the assurance that you understand their situation, the results are various degrees of anguish for the family, sometimes the child, and often the professionals trying to be of help.

PTA families that have not received the assurances they need, to trust the understanding and expertise of the therapist or other helping professionals, can appear resistant, controlling, hostile, unworkable, negative, demanding, manipulative and lacking in concern for the child. However, each of these impressions held by the helping professional is a misunderstanding of the experience of the family. As I was formulating this paradigm of the post-traumatic adoption, I described the general premise to several families in this situation, and every family said something similar to, "Yes, that is exactly what we are going through." There is no better feeling for a client than to hear that your therapist understands the deepest aspects of what you are going through. In the case of families dealing with PTA, it is not a matter of making them feel better, it is a matter of make it or break it regarding the recovery of the family and any remaining hope for the adoption. If this level of trust from the family is not obtained, the result is a state of limbo for everyone. The child will likely not be going home, the parents find themselves in the terrible place of wanting help for their child while they must stress that the child is not really getting better, adoption agencies often are paying the cost of expensive out-of-home care, and the helping professional attempting to work with the family is so perplexed she goes home and wonders what can be done about the situation.

Navigating the Fire Swamp of Healing

A number of years ago, a Rob Reiner movie came out called The Princess Bride. In this fairy tale, the hero had to take the heroine on a treacherous journey through the darkest and most foreboding place one would ever imagine--the dreaded fire swamp. I like to use this analogy for any very difficult journey that is necessary for the healing process,

and it fits nicely with the healing of post-traumatic adoption. An essential point of this discussion is the PTA family will need to go through the healing process, it is not just about the adopted child getting professional help. The starting place in helping the family is to have them understand the family must go through a healing--whether they have the child returned to the family or not. In fact, it is not unusual to find that the family has been more damaged than the adopted child by the problems in the adoption. The child often has the self-protection of an attachment problem; the same wall that prevents emotionally bonding with the family also tends to protect the child from further trauma. As is true with PTSD, the trauma of PTA that is untreated does not often improve over time. I have observed marriages break up, other children in the family step into the problem child role when the adopted child leaves the family, and many families find the adoption has taken the wind out of their sails in all aspects of family functioning.

The trip through the fire swamp involves both knowing the route and also what hazards to avoid. Although I am not a believer that typical human beings need a professional therapist to get by in the world, trauma is a different sort of beast. As I said before, research has shown that untreated trauma usually does not go away, and can actually intensify over time. The traumatized individual cannot always trust personal instincts and an internal compass for the journey of healing. It is wise to get a trauma guide, at least to acquire a road map, if not for support throughout the journey.

The hazards to avoid on the journey of healing from post-traumatic adoption are potentially many. The blame game is the first road-block. It is not helpful to look for who is at fault for the problems the adoption has brought the family. Finding fault does not make a situation better. The fault finder often becomes more upset when blame is placed because, once determined, there was no reason to have gone through the blame game in the first place. Blaming the child frequently occurs, but few adults within themselves will allow blame to go to a child who was abused, neglected and/or abandoned. Parents who put the most energy into blaming the child are likely the parents who are trying unsuccessfully to convince themselves that fault belongs not with themselves, but with the child. Parents who blame themselves take on an internal psychological weight that they will carry a very long time. Extra weight is not helpful on any journey. For those who must find blame, it can often be shared by all family members, the biological parents who initially did not provide the child what he or she needed in the early years, and potentially the adoption agency and the adoption process itself. However, blame never solved a problem, but it does take a great deal of energy away from the journey toward finding solutions.

Another hazard to avoid involves the lasting effects of grief and loss. It is often the case that a family must grieve the loss of the dream they had of successfully adopting a child, who would accept the love of the parents and learn to reciprocate. In a PTA, this has not happened and the fact is that it will likely not happen in the way the parents initially hoped it would. Therefore, they must say good-bye to the image they had of a successful adoption if there is any chance for the adoption to succeed. It is very difficult to let go of our dreams, but this step is not unlike what most successful marriages must go through--the difference between what we dreamed our partner would be like and/or the marriage would become, compared to what actually happened. Adults who hold onto an image of an ideal relationship will most likely go from one partner to another looking for "Mr. or Ms. Right," rather than creating the right relationship with the person you commit to. After we let go of an image of what we want, we have a better chance of developing a working situation with what we have.

We are not yet done with hazards along the healing journey. One of the most typical effects of post-traumatic adoption is the inability of the adoptive parent to trust professionals trying to help. This often comes out as a lack of trust that the professional really knows the problem and how serious it is. This often results in the tragic dance of on the surface the parent asking for help, but appearing not to accept it. Another way this comes out is an apparent resistance to believing either the child can improve, or in the face of data indicating real improvement, not being willing to accept it. Although frustrating for the helping professional, it is even more stressful for the adoptive parent who desperately wants to see the child improve, but, due to the trauma of the adoption, cannot come to believe it is real improvement. The end result of this dynamic is that the child continues to reside away from the family in some form of substitute care, while the professionals try to reunify the family, and the family resists reunification. This is a roadblock that will stop any further progress on the journey to healing for the family.

What Can be Done with PTA

Can this complex dynamic be avoided or worked through? I believe it can, and here is how. Preventing a problem is always preferable to trying to get out of a pit after you fall into it. If adoptive families know that the dynamic described above will lead to a dead-end, they are much more likely to avoid going very far down this road. The best prevention is to get as much information on the child as possible to make an informed decision on adoption. The second step is to be prepared for the worst and hope for the best. The third step is to have the resources on your team to face the difficult times that nearly all adoptions, and for that matter all families, will have. And when all other attempts to prevent an adoption trauma are tried and have failed, get the child out-of-

home intensive treatment the child needs before the family has exhausted all personal resilience and family resources and is exhibiting signs of serious burn-out.

Once the post-traumatic adoption has happened, the first step of the healing journey is to want to heal. This is generally not a problem for families who have struggled unsuccessfully with a difficult adoption. These families want things to improve. However, what will bring improvement is often unclear to the adoptive parents, although their instincts say that keeping the adopted child away from the family is an important element. In the short run this may be true, but if the adoption has any chance of success, keeping the child away is part of the problem and not part of the solution.

The second step after the adoptive child leaves the family for some intensive treatment is for the parents to take a step back and see the landscape of where they have been and where they wish to go. This may seem obvious, but it is often true that traumatized individuals focus on going from day-to-day rather than looking with a long-range perspective. This long-range view not only requires reexamination of the adoption decision and what has actually happened to date, but it also requires the parents to consider where they want their family to be a year, two, or more down the road. Without this perspective of having long-range goals, the family will be unlikely to reach them. Trauma produces a very short-term focus, which is one of the insidious aspects of trauma. The individual, or in this case the family, thinks about surviving right now, not a year from now. But without a plan, the family cannot develop a road map to reach the destination they desire.

The next step to healing is to get the right type of help. The right help is not a function of a professional degree or completion of a special certification program to work with adoptive families (something that has been put together in my state). Perhaps the most important ingredient of the right person is someone who comes highly recommended, someone you can trust, and the most important credential--experience with helping traumatized individuals and families. Once this person is found, it will be important for everyone to move forward together with the realization that there are many hazards along the way. Every family will be unique, every family will need to have their own individual long-term goals. Sometimes the family will want to invest much more effort into making the adoption work, while other families will need help to verbalize that they cannot go any further with the adoption. However, although the specifics of the healing journey must be individualized, this chapter can be a general road map, and one that both the helping professional and the family can discuss and use to help plot a direction.

A Message to Helping Professionals

There is no substitute for supportive, knowledgeable help for the family that has experienced a PTA. Similar to other trauma survivors, the adoptive parents will not always be the easiest of clients to work with. Traumatized children often have considerable stored-up anger that may only come out once they feel safe with you. You are rewarded for your efforts with being the target of the rage that rightfully belongs to the child's abuser(s). This dynamic is true for adults with PTSD from wartime experience, serious accidents, assaults, and other causes of trauma. Just when trust is beginning to develop, the adult lashes out at the person helping them. Unless you are ready for this, it can be very disconcerting when it happens. Traumatized adoptive parents can take the helping professional by surprise even more than other trauma survivors. They often appear not only normal, but very successful, conscientious, and loving parents. Most adoptive families have a great deal to give, and have made the altruistic decision to share their lives with an adoptive child, oftentimes a child with a problematic past. These are good people, very good people. You may find yourself believing these very good parents sitting in front of you are on board with the plan and trusting your help, only to run into what appears to be "resistance," as less and less progress toward reunification begins to occur.

I recommend that the question of reunification be raised at the first meeting you have with the family, and this topic be a frequent discussion point along the way. I also recommend that some of the hazards and pitfalls described earlier in the chapter be on the table and discussed before, during, and after they appear in the process. Your ability to let the adoptive parents know that you have an understanding of their family's and their own internal experience with the adopted child, can go a long way to establishing trust. But even after you have established respect and trust, the hard work of healing is still ahead.

I will not go into great detail in this chapter on the specific steps of trauma treatment, this can be found in chapter 8, but I will briefly mention some important steps. For trauma to heal, some level of "re-exposure" to the trauma must occur as the stressful reaction is altered. With PTA the re-exposure includes contact between the parents and the adopted child, and then the more important re-exposure--the child being in the home with the parents and any siblings. As with other traumas, this step must be taken carefully because, if the ground work has not been laid, the results could reinforce the trauma rather than counteract it, and the trauma is magnified. The parents must have new skills to work with some of the child's old behaviors. Regardless of the success of treatment for the adopted child out of the home, the child must do some testing when returned to see if the parents will be able to handle the difficult issues. As you can imagine, unless the parents are prepared to face some of the old behaviors, the PTA symptom of re-experiencing the earlier trauma will kick in. When this occurs, the

parent will believe nothing is different and can quickly feel hopeless. However, if the parents have learned the skills that have worked with the child in the out-of-home setting, and implement these approaches when the child tests, the child is reassured and the parents have begun the process of feeling successful with the child. This positive dynamic will need to be repeated over and over to overcome the legacy of past traumatic failure of the adoption.

At any point in this process that the adoptive parents begin to hedge on having the child returning to the family home, even for visits, the issue of eventual return of the child should be discussed. If the parents indicate they have considered disrupting the adoption, the odds are they have done more than just considered it. If they indicate they are 50/50 regarding disruption, the odds are they are closer to disruption than they are saying just to see how this possibility will be received. If they say they are fairly sure they want to end the adoption, take this at face value and look closely at the consequences for everyone of a disruption. It is important not to try to talk a family out of disrupting an adoption. To give the adoption a chance, it is actually more helpful to spell out the details of a disruption, and families that are not sure will more likely want to put more effort into the reunification process.

The dynamic that is most troublesome is when parents indicate that they have lost none of their commitment to the adoption, but they do not see that it is feasible for the child to return to their home anytime soon, if at all. The parents want to advocate for the child and not leave the child "adrift" in the world, but do not plan on parenting the child in their home. This is nearly always a losing proposition for the child, for the funding source paying for out-of-home care, for the helping professional, and for the adoptive parents as well. This is one of the scenarios in which no one can win. There are many reasons why this roadblock must be avoided. The child will not have the chance to grow up in his or her family regardless of the improvement make, the funding source must fight with the parents to avoid paying out-of-home costs indefinitely, the helping professional working toward reunification is thwarted by the parents at each stage in the process, and the adoptive parents have all their internal guilt enhanced by pushing away the child and even by the help that is being offered to them. The way to avoid this trap is to work toward the goal of either giving the adoption another chance with the child in the home or disrupting the adoption. To not go in either direction is to not go in a healing direction. There is nothing easy about making this decision or helping adoptive parents make such a wrenching decision--but taking the non-decision direction (status quo) will not be the easy way or the best way in the long-run.

A final note to the helping professional. Remember that there are no bad guys in adoptions. The child is confused and is in no position to determine what she needs, although she usually has a lot of demands. The family wouldn't have adopted the child unless they felt they had a lot to give a deserving child, and the adoption agency likely did the best they could with the information they had. You certainly are not the bad guy because your only agenda is to be of help. At times, the adoptive child is pathologized based on the testing that all children must do to insure they are safe--so they can turn their attention to being a child learning about the world. At other times the adoptive parents are pathologized because they are "resistant" to reunification, or want the child to be considered dangerous or mentally ill. This happens when parents are not sure they can trust that progress has been made, and that the initial trauma, that tore apart the family the first time, can be prevented from happening again.

Remember to avoid labels and avoid blame. Remember, as in all trauma therapy, if you do a good job there will be times you will be rewarded with the wrath of your client, who desperately need to express their rage related to the trauma they have gone through. The fact that it is directed at you means that they trust that you care enough and are capable of accepting their most intimate feelings--their pain. Just like a serious medical diagnosis, trauma may require some painful interventions that may be as painful as surgery before the road to true healing can begin to give the patient hope for eventual success.