Parents’ and mental health workers’ perceptions of the therapeutic needs and experiences of services for Dutch children adopted from Romania

While it is established that international adoptive families are over-represented in mental health care, little is known about their experiences of mental health services. Catharina Rijk, René Hoksbergen and Jan ter Laak describe the experiences of eleven adoptive families and 12 mental health workers involved with severely deprived Romanian children adopted from institutions. Parents and mental health workers were interviewed. Reasons for applying for help, diagnoses, treatment method and evaluation are discussed. Most parents reported difficulties in finding appropriate care and had consulted several therapists before arriving at the current mental health service. Diagnoses often included cognitive delays, autistic symptoms and attachment difficulties. Different treatment methods were applied, in both outpatient and residential settings. Parents were more positive about the treatment outcome than were the mental health workers, the latter often having to consult colleagues about appropriate treatment. While the workers agreed that knowledge about adoption and the effects of deprivation are essential for suitable treatment, most of them felt that they lacked expertise for such work.

The need for help
Several international studies report an over-representation of families with internationally adopted children in the use of mental health services (Johnson, 1999; Ryan, 2003; Judge, 2004; Castle et al., 2006), a pattern that prevails after correcting for differences in experienced problems between adopted and non-adopted children (Warren, 1992; Miller et al., 2000). This is especially the case when children have experienced long periods of deprivation in their early childhood. Possible consequences of early-life deprivation include cognitive delays, behavioural problems such as quasi-autistic symptoms, and symptoms of trauma and Attention Deficit Hyperactivity Disorder (ADHD) (Rutter et al., 2001; Hoksbergen and co-workers of the Romania project, 2002). In their recent study of Romanian adopted children in the UK, Castle and colleagues conclude that approximately one-third of the children adopted after the age of six months need special education and mental health services for a long period of time and that early deprivation and its consequences are the most important reason for this (Castle et al., 2006).

However, other reasons for the over-representation of adoptive families in mental health services have been suggested. For example, the higher socioeconomic status of adoptive parents could lead to more requests and better service responses (Ingersoll, 1997; Brand and Brinich, 1999). There is likely to be greater insecurity among adoptive parents.
(Ingersoll, 1997) and access to services might be easier given the pre-adoption preparation period when parents are in regular contact with professionals (Miller et al, 2000). Whatever the reasons, the fact remains that adoptive families in general and families of deprived adopted children in particular feel a higher need for mental health services.

Available care
In addition to regular mental health services for children and adolescents, some adoption-specific services are available, especially in countries where substantial numbers of Romanian children have been adopted, such as the USA, UK and the Netherlands.

Adoption-specific care is often directed at the parent–child attachment, taking the form of parent support groups, individual therapy for the child and/or parent, family therapy and residential care (Frank and Hochman, 1991). In the Netherlands, several types of services are available for adoptive families of internationally adopted children, although, with the exception of specific courses and adoptive parent groups, these are rarely exclusive to them. Video home training, a therapeutic technique incorporating video recordings of daily life, is often used for adoptive families (Polderman, 2004). However, appropriate care for adoptive families immediately after placement of a severely deprived child from a less economically developed country is not available and the effects of early-life deprivation produce an additional challenge to the attachment and identity formation problems common to all adoptions (Hoksbergen and co-workers of the Romania project, 2002).

Despite the challenges for adoptive families posed by adopting severely deprived children, little is known about their experiences, especially in relation to mental health services. This study explores these experiences, gathering the opinions of participants about the process, the help available, the results achieved and the need for information on specific issues raised by adoption.

A qualitative design was used as it allows more in-depth discussion of these topics. Using case descriptions of eleven Romanian children, we charted the problems with which parents sought help, the services they used and how they identified sources of support (eg referred by others or through a search of their own). The process of therapy is also described, along with diagnoses and treatment methods. We also discuss the perceptions of parents and mental health workers on the effectiveness of the services provided, including aspects that parents and mental health workers view as essential for effectiveness.

Method

Participants and procedure
This research is part of a longitudinal study of a group of 80 Romanian adoptees, as described by Hoksbergen et al (2004). For the current third stage of the study, children with multiple and severe behavioural problems were selected for scrutiny, based on their test scores in earlier stages. Twenty-nine children had a clinical score on the Child Behaviour Checklist (CBCL) (Achenbach and Edelbrock, 1983), indicating that professional support was advised. Eighteen children additionally scored in the clinical range of at least one of three other instruments designed to identify the presence of symptoms of autism, ADHD and Post Traumatic Stress Disorder (PTSD).

This group of 18 children showing multiple behavioural problems was selected for participation in this third stage. The parents of all 18 children were interviewed but for the analysis of experiences of mental health care, the group was narrowed down to eleven. This was because only eleven were receiving professional help at the time of the study, although 18 had received it in the past. Of the seven children not selected, three no longer needed extra support; the parents of the other four felt that the support they received from the school for special education was sufficient.

The eleven children selected for study did not differ significantly from the other 69 children in the longitudinal study with regard to age at arrival in their adoptive family or the length of time they had been there. During the interviews with parents,
permission was requested to contact the professionals they had consulted; where several professionals had been involved parents were asked to select the person they felt had worked with the child most and been most effective in dealing with problems. Except for the parents of one child, who felt that caregivers at two institutions had played an important role in the treatment of their child and that both should be interviewed, all parents were able to name at least one mental health worker. Thus, 12 mental health workers were approached, all of whom agreed to participate in the study. Interviews with parents and mental health workers lasted about an hour.

The nature of the services provided differed, but all mental health workers interviewed had worked with the child and/or the family on several occasions. Three children were in residential care, the other eight lived with their parents. Ten of the mental health workers were part of the regular mental health care system in the Netherlands and the costs of any therapy were covered by health insurance. Two therapists were independent but were officially registered mental health workers. Parents were able to apply for a special personal budget for services for their children, through which independent care was partially funded.

**Interviews**

Parents and mental health workers were interviewed using a list of topics to be discussed. Questions were open ended and elaboration, discussion and the use of examples were encouraged. In the interview with parents, many subjects concerning the functioning of the child were examined but this article focuses on questions regarding service use. Table 1 provides an overview of the topics discussed with parents and mental health workers.

**Analyses**

All interviews were recorded, transcribed and analysed using the method described by Strauss and Corbin (1990). The text of the interview was divided into fragments, each containing information about one subject. These fragments were labelled using one or two words by two independent observers, who showed a high level of agreement. Discrepancies were then discussed and adjusted. The labels formed a classification system that could be applied to all interviews and used to answer the research questions.

**Results**

An overview of the interviews about the eleven children is given in Table 2. First, general details about the children is presented: their age at time of study and at time of adoption, and whether they were receiving special education. The average age of the children was eleven years; their average age at adoption was three years and three months. Ten children attended a school for children with special education needs and one was in a school for regular education. As

<table>
<thead>
<tr>
<th>Mental health workers</th>
<th>Parents (treatment related)</th>
</tr>
</thead>
<tbody>
<tr>
<td>– General data about mental health worker and institution</td>
<td>– Reason for seeking professional help</td>
</tr>
<tr>
<td>– Reason why the family applied for help</td>
<td>– Pathway to current services</td>
</tr>
<tr>
<td>– Diagnosis</td>
<td>– Earlier experiences with professional help</td>
</tr>
<tr>
<td>– Role of adoption and deprivation in current problems</td>
<td>– Treatment method</td>
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<tr>
<td>– Treatment plan and method</td>
<td>– Effectiveness of treatment</td>
</tr>
<tr>
<td>– Status treatment process</td>
<td>– Contact with mental health worker</td>
</tr>
<tr>
<td>– Effectiveness of treatment</td>
<td></td>
</tr>
<tr>
<td>– Need for information about adoption and deprivation and need for consulting colleagues</td>
<td></td>
</tr>
<tr>
<td>– Expectations for the future</td>
<td></td>
</tr>
<tr>
<td>Child characteristics</td>
<td>Reasons for consulting professional</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>1. Female</td>
<td>- aggression - self-harm - compulsions - problems in contact with other children - communication problems - extreme need for attention - lack of conscience</td>
</tr>
<tr>
<td>Age: 10.9</td>
<td></td>
</tr>
<tr>
<td>Age at adoption: 2.4</td>
<td></td>
</tr>
<tr>
<td>Special education: Yes</td>
<td></td>
</tr>
<tr>
<td>2. Female</td>
<td>- aggression - communication problems - cognitive problems - self-harm - testing boundaries</td>
</tr>
<tr>
<td>Age: 9.10</td>
<td></td>
</tr>
<tr>
<td>Age at adoption: 2.8</td>
<td></td>
</tr>
<tr>
<td>Special education: Yes</td>
<td></td>
</tr>
<tr>
<td>3. Male</td>
<td>- aggression - lack of conscience - autistic behaviour - testing boundaries - inappropriate sexual behaviour</td>
</tr>
<tr>
<td>Age: 12.9</td>
<td></td>
</tr>
<tr>
<td>Age at adoption: 6.7</td>
<td></td>
</tr>
<tr>
<td>Special education: Yes</td>
<td></td>
</tr>
<tr>
<td>4. Male</td>
<td>- aggression - tics</td>
</tr>
<tr>
<td>Age: 10.3</td>
<td></td>
</tr>
<tr>
<td>Age at adoption: 3.1</td>
<td></td>
</tr>
<tr>
<td>Special education: Yes</td>
<td></td>
</tr>
<tr>
<td>5. Male</td>
<td>- problems in social behaviour - fears (abandonment, new situations)</td>
</tr>
<tr>
<td>Age: 8.6</td>
<td></td>
</tr>
<tr>
<td>Age at adoption: 2.3</td>
<td></td>
</tr>
<tr>
<td>Special education: No</td>
<td></td>
</tr>
</tbody>
</table>

¹: Anthroposophical principles refer to a holistic approach to health and well-being, emphasizing the interconnection between the individual and their environment, often involving dietary adjustments, homeopathy, and lifestyle modifications. The principles are deeply rooted in the work of Rudolf Steiner.  
²: Video Home Training is a form of non-directive therapy that uses a structured environment to help children develop appropriate social and emotional skills.  

Table 2: Overview of diagnosis, treatment method and effectiveness according to parents and mental health workers for the 11 children.
<table>
<thead>
<tr>
<th>Child characteristics</th>
<th>Reasons for consulting professional</th>
<th>Diagnoses</th>
<th>Treatment method</th>
<th>Effectiveness of care according to parents</th>
<th>Effectiveness of care according to mental health worker</th>
<th>Treatment Finished</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: 12.3</td>
<td>Age at adoption: 2.5</td>
<td>Special education: Yes</td>
<td>– problems in social contacts – aggression – inappropriate sexual behaviour</td>
<td>– PDD-NOS – severe cognitive delays</td>
<td>– guiding parents – co-ordination: approach child at home and at school → consequent</td>
<td>–</td>
<td>No</td>
</tr>
<tr>
<td>7. Male</td>
<td>– aggression – testing boundaries in classroom – needs to be in control – demands much attention</td>
<td>– attachment difficulties – fears – severe attention problems</td>
<td>play therapy (learning awareness of own emotions and behaviours, and how to control them)</td>
<td>+ – (progress during drug therapy, but no change in other situations)</td>
<td>No</td>
<td>Therapy will not be concluded in the foreseeable future</td>
<td></td>
</tr>
<tr>
<td>Age: 12.9</td>
<td>Age at adoption: 0.7</td>
<td>Special education: Yes</td>
<td>– problems in contact and communication</td>
<td>– attachment difficulties – cognitive delays</td>
<td>– holding therapy (working with family and guiding parents)</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>8. Male</td>
<td>– aggression – testing boundaries in classroom – needs to be in control – demands much attention</td>
<td>– attachment difficulties – fears – severe attention problems</td>
<td>play therapy (learning awareness of own emotions and behaviours, and how to control them)</td>
<td>+ – (progress during drug therapy, but no change in other situations)</td>
<td>No</td>
<td>Therapy will not be concluded in the foreseeable future</td>
<td></td>
</tr>
<tr>
<td>Age: 10.11</td>
<td>Age at adoption: 3.2</td>
<td>Special education: Yes</td>
<td>– problems in contact and communication</td>
<td>– attachment difficulties – cognitive delays</td>
<td>– holding therapy (working with family and guiding parents)</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>9. Male</td>
<td>– aggression – testing boundaries in classroom – needs to be in control – demands much attention</td>
<td>– attachment difficulties – fears – severe attention problems</td>
<td>play therapy (learning awareness of own emotions and behaviours, and how to control them)</td>
<td>+ – (progress during drug therapy, but no change in other situations)</td>
<td>No</td>
<td>Therapy will not be concluded in the foreseeable future</td>
<td></td>
</tr>
<tr>
<td>Age: 11.1</td>
<td>Age at adoption: 4.3</td>
<td>Special education: Yes</td>
<td>– problems in contact and communication</td>
<td>– attachment difficulties – cognitive delays</td>
<td>– holding therapy (working with family and guiding parents)</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>10. Male</td>
<td>– low cognitive level – delay in emotional development – problems in social interaction – inappropriate sexual behaviour</td>
<td>– severe cognitive delays – attachment difficulties</td>
<td>– guiding parents both practical guidance (eg school placement) and advice (helping parents accept the situation)</td>
<td>+ –</td>
<td>No</td>
<td>Mental health worker foresees placement in residential care in near future and wishes for</td>
<td></td>
</tr>
<tr>
<td>Child characteristics</td>
<td>Reasons for consulting professional</td>
<td>Diagnoses</td>
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</tr>
<tr>
<td>11. Male</td>
<td>- aggression</td>
<td>- attachment problems</td>
<td>- guidance for parents: +</td>
<td>+ (set goals were partially reached)</td>
<td>No</td>
<td>Therapy will gradually be concluded</td>
<td></td>
</tr>
<tr>
<td>Age: 8.2</td>
<td>- fits of anger</td>
<td>- self-harm</td>
<td>- advice about parental approach</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at adoption: 1.8</td>
<td>- problems in social interaction</td>
<td>- symptoms of PDD-NOS</td>
<td>- alternative therapy: homeopathic medication (relaxing)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PDD-NOS = Pervasive Developmental Disorder – Not Otherwise Specified

1 Based on the teachings of Rudolph Steiner. Much emphasis is placed on the creative development of the child, and specific therapy forms such as eutony are used.

2 Video home training is a therapeutic technique for which video recordings of daily life are used. Parents review the recorded material with their therapist and receive advice about how to handle the problems that occur.

Most parents indicated that they had been referred to the current services by former mental health workers. Two parents and two current services on advice from their child's school (both schools for special education). They had not been able to engage new services because they thought the efforts involved in starting a new treatment process was often not rewarded with effective therapy.

When asked to explain previous failed treatments, parents often mentioned a lack of knowledge among mental health workers about adoption-specific problems and, in particular, the effects of deprivation about the effects of early-life deprivation led to the families being passed around mental health workers without successful treatment. In some cases, this lack of knowledge about the effects of early-life deprivation led to the families being passed around mental health workers without successful treatment. In some cases, this lack of knowledge about the effects of early-life deprivation led to the families being passed around mental health workers without successful treatment.
Reasons for finding professional help
When we asked parents why they sought counselling, the following difficulties were mentioned most frequently: problems in social interaction, aggression and symptoms of conduct disorder. When the mental health workers were asked the same question, as can be seen in Table 2, the problems they identified were similar: aggression, difficulties in interaction and communication and conduct disorder.

There were no large discrepancies between the perceptions of the two groups. Exceptions were self-harm and inappropriate sexual behaviour. Initially, these were not mentioned by the parents as reasons for finding professional help, but emerged when parents were asked to list all of the behaviour problems that their child displayed.

The mental health workers of four children clearly stated that they felt that the burden on the family was too high:

The burden of bringing up this child is really becoming too much for these parents. But they find this really hard to accept. I try to help them with that as well, not just with their care for the child.

Three of them wondered whether the child would be able to continue living at home or would be better placed in residential care.

Mental health workers’ thoughts on diagnosis
Some mental health workers had access to an official diagnosis of the child made in the institutions where they worked. Others formed their own opinions by making an inventory of the different behavioural problems that the child displayed. Nine children were diagnosed with Reactive Attachment Disorder (RAD), four with Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS), two showed symptoms of PDD-NOS, five were diagnosed as ‘mentally retarded’ and one other child was diagnosed with cognitive delays. As can be seen in Table 2, some children received multiple diagnoses. A combination of severe cognitive delays and (symptoms of) PDD-NOS and attachment difficulties occurred frequently. Some mental health workers mentioned problems with diagnosis owing to lack of knowledge about the child’s genetic background and early-life experiences:

And we thought about Foetal Alcohol Syndrome, because he shows some of the signs. But without any information about his background, it is really hard to say something about that. You can’t be sure.

Perceived causes of problems
All mental health workers agreed that the period of deprivation that the children had experienced in their country of origin before they were adopted was of great importance. Both physical and affective deprivation were seen as factors that contributed to current problems. Physical neglect was regarded as a possible cause of developmental delays, while affective neglect might well be the source of attachment difficulties and problems in social interaction:

And I heard from her parents about the circumstances there. They must have been very damaging to her, even physically, in the development of her brain, not to mention the forming of conscience and the possibilities for attachment.

Aggression and a delayed development of conscience were (partially) blamed on the ‘survivor’ behaviour that may result from severe deprivation. In order to survive, the child had learned to take as much as she or he could and not to care about others:

He was almost six when he was adopted. That clearly shows in his behaviour. . . He is a fighter, a survivor.

Hereditary problems and alcohol and drug misuse by the mother during pregnancy were also mentioned as suspected causes, but not enough background information about the children was available to confirm this.

Treatment methods
Different treatment methods were applied. Three children were in a residential setting, receiving guidance in
small living groups. When asked about the nature of this guidance, mental health workers cited that the children needed a structured approach in which the daily routine was clearly set. The children required considerable individual attention and time had to be invested in explaining things and making visual aids. The professionals also stressed the importance of an affectively neutral approach to the children. Emotions like anger or sadness shown by the mental health worker confused the children and hindered the development of positive behaviour.

For six families, one of the mental health workers’ tasks was to guide the parents. This often included advice on how to deal with parenting difficulties. The workers also emphasised the importance of a structured, consequent approach to the child and, occasionally, helping parents accept the current situation and the fact that their child might not be able to continue living with them. Practical help was also offered, for instance with school placement and in co-ordinating the efforts of those engaged in helping the child.

The mental health workers who guided the parents usually had limited contact with the child. The exception was in two families where professionals worked directly with the whole family, using video home training or holding therapy, an intensive physical method applied to form a bond between child and parents. Two other mental health workers worked mainly with the child, using play therapy and social skills training. Play therapy was employed to make the children aware of their emotions and their behaviours, and to enhance control of these. In three cases, the mental health worker was also (partially) responsible for the child’s medication, in most cases a neuroleptic drug.

**Perceived effectiveness of treatment**

Parents and mental health workers indicated whether they thought the help had been successful. In general, parents were more positive about the achievements made than were the professionals. Ten of the eleven children’s parents saw a positive development:

_They work really hard to change that behaviour and we do see a positive change . . . one step at a time . . ._

_It is really nice that we have finally found someone who listens to us, who is cooperative in finding solutions to improve the daily functioning of our family._

In contrast to the positive opinion of the parents, only one of the mental health workers felt that the treatment had been fully successful:

_It is amazing how much some children change through therapy. They are finally able to realise that these parents are going to stay and take care of them, even when they behave badly. They can become a child again and lose the feeling of having to care for themselves all the time._

Six others saw some improvement but not all the therapy goals were achieved. Four others saw little or no change in the child’s behavioural problems. One mental health worker explicitly said that he was not satisfied with what he had achieved:

_Although I know the parents are satisfied with the care they are receiving here, I am actually not. I wish I could do much more for them. They have had such a long and ineffective history of professional care before they came here. I would really wish a good and effective adoption aftercare for them, and for all parents struggling with these problems._

**The future**

For the three children in residential settings, the mental health workers expected them to stay there until adulthood and probably need some form of help for the rest of their lives. For three children currently living in families, the mental health workers doubted whether this was sustainable because the pressure on the family was so high and some form of residential care might well prove necessary in the future:

_The family is able to take the burden right now but puberty may change this. I doubt whether they will be able to maintain the_
current situation, or whether residential care may prove to be unavoidable.

For three children, mental health workers indicated that help was likely to be necessary for a long time because treatment goals had not been achieved and serious issues remained:

*We see a clear positive change, but we still have a long road ahead of us and new issues are surfacing.*

For two boys (see Table 2, nos. 5 & 11), the mental health workers expected to complete the therapy soon. For another boy (see Table 2, no. 9), therapy was concluded without referral to other services although professionals remained available if needed.

**Knowledge about adoption-specific problems**

All mental health workers agreed that knowledge about the specific problems of adopted children, especially deprived adopted children, was a necessary condition for effective therapy. Adopted children in general may face issues in the development of their identity and in coping with abandonment (Brodzinsky and Schechter, 1990). Early life deprivation may in addition cause developmental delays and behavioural problems (Rutter *et al.*, 2001; Judge, 2004):

*The unique situation of these children, and of these families, requires knowledge about adoption and about the effects that prolonged deprivation may have on a child.*

Three of the mental health workers interviewed indicated that they had considerable experience in working with adopted children, whereas the other nine had little or no relevant experience. Most of them felt that, at the start of the treatment, they had insufficient knowledge about the specific problems presented by adopted children from severely deprived backgrounds. They had to search for information about adopted children and the effects of deprivation on treatment, whereupon the majority found that consultation with colleagues was the most fruitful source.

Knowledge about the consequences of deprivation was seen as important for both parents and mental health workers and the need for adoption information to be available in all children’s agencies was expressed. The mental health workers also indicated that they should be able to contact adoption experts during therapy as specific questions arose.

**Conclusion**

A qualitative design was chosen to study the experiences of eleven families with severely deprived Romanian adopted children (mean age 11; at adoption 3.3; 2 females, 9 males) and 12 mental health workers. All parents needed professional help. The design enabled us to explore both the experiences and opinions of the parents and mental health workers.

The parents cited different reasons for requesting professional support, but aggression, symptoms of autism (problems in social interaction, among others) and symptoms of conduct disorder were most frequently cited. Previous reports indicate that these problems often occur among deprived internationally adopted children and place a great burden on the parents (Rijk *et al.*, 2006). The high need for help with these difficulties reflects this burden. Hence, professionals should be alert when parents of internationally adopted children report such problems and parents should receive support immediately in order to prevent deterioration.

There was strong agreement between parents and mental health workers about the reason for treatment, indicating that the former were able to communicate successfully the problems they were experiencing. Parents and mental health workers also tended to speak the same language because they discussed the problems together during treatment. In addition to the difficulties named by parents, mental health workers also identified self-harm and inappropriate sexual behaviour, problems that parents did not raise initially although they did acknowledge them in the general part of their interview but not as a reason why...
they sought help. Parents may be more prone to mention the problems they experience on a daily basis.

The most frequently occurring diagnoses were attachment difficulties, PDD-NOS and cognitive delays. This was to be expected, based on earlier research on deprived Romanian adopted children, as it is known that a period of severe deprivation may lead to cognitive delays, attachment difficulties and quasi-autistic symptoms (Fisher et al., 1997; O’Connor, 1999; Rutter et al., 1999; Rutter et al., 2001). It is also notable that attachment difficulties were often not mentioned by the parents as a reason for seeking help. Possibly, they focused more on problematic behaviour and so did not think of attachment difficulties as an underlying cause. The high frequency of attachment problems may also be due to the fact that this term is often applied as a general diagnosis encompassing diverse difficulties. It tends to be one of the first things mentioned when adopted children display challenging behaviour.

When mental health workers were asked about the cause of the children’s difficulties, the adverse effects of deprivation were clearly stated. All felt that the period of deprivation in Romania had played a significant part in the current problems. Other possible causes they named were hereditary factors and drugs and alcohol misuse by the mother during pregnancy, the latter possibly leading to Foetal Alcohol Syndrome (Stromland, 1996). Often, little is known about the children’s genetic background and early life experiences, which makes a proper diagnosis and anamnesis more difficult. It is important for institutions and adoption agencies in the country of origin to collect as much information as possible about the child as a means of helping later treatment.

For most families, the road to finding appropriate support services was a long one. Almost all had already seen two or more other mental health workers and parents reported finding it difficult to access services that suited their child and family, a delay that harms the development of the child. Adoptive parents need easy access to available and appropriate services, so that therapeutic help can be started as soon as possible.

The eleven children received different kinds of treatment. Three were in residential care and mental health workers suspected that this would be necessary for three others in the future. Such care relieved the burden on the family and offered the child a very structured, predictable environment.

The advice of ensuring structure and predictability was also given to those parents seeking help with parenting. In order to function optimally, these children require a safe environment with structured daily activities and few unexpected changes. The same conditions were also found to be important in studies among the parents and teachers of these children (Rijk, Hoksbergen and ter Laak, submitted).

Therapy with the whole family was used to improve the parent–child relationship and promote attachment. Through this, mental health workers hoped to achieve behavioural modification. For one child, video home training (Polderman, 2004) was used; for another, holding therapy (Welch, 1988). In both cases, parents learned to interpret the behaviour of their child from an attachment perspective and how they could best respond to this.

Individual play therapy was applied to make the child aware of their own behaviour and emotions, and to help him or her control and modify them. Early-life deprivation may lead to (symptoms of) PTSD (Hoksbergen et al., 2003). Play therapy may be useful to reduce these problems.

In general, parents were more positive than mental health workers about the effectiveness of therapy. Parents appeared to value any positive development, even if treatment goals were not reached. It may be that earlier experiences with (ineffective) services had lowered their expectations. An earlier part of this study indicated that adoptive parents have a more positive approach towards their children’s difficulties than non-adoptive parents (Rijk et al., 2006). The mental health workers seemed more aware of the fact that the treatment did not have the
effect it was supposed to have, and that the goals established after intake were not reached. The nature and severity of the children’s behavioural problems lead to low expectations of future improvement.

For only one child was the therapy concluded successfully. The method used was holding therapy, an intensive approach in which explicit physical proximity is promoted to form a bond between parents and child. This is a controversial form of therapy that requires extensive knowledge and sensitivity on the part of the professional and can be harmful and dangerous when applied wrongly (Myeroff, Mertlich and Gross, 1999). The therapy was aimed at one specific goal (parent–child attachment) and the desired result was reached in a relatively short time. A clear and singular aim and the lack of additional (severe) problems may explain this success. For the other ten children, therapy was still in progress or the child had been referred to another agency. Most mental health workers expected that long-term treatment would be necessary and for some children help is likely to be necessary throughout their lives. Although in a few cases treatment goals were partially achieved, other issues remained. The complex and extensive nature of these children’s difficulties form a challenge for both parents and mental health workers and long-term investment is necessary (Rushton, 2003). It is important for interventions with deprived internationally adopted children with behavioural problems to undertake longitudinal follow-up studies charting their development to adulthood.

Limitations and recommendations for future research

The aim of this study was to explore the experiences of families with deprived internationally adopted children receiving professional help. Diverse treatment possibilities (residential care, guidance of parents, therapy for families and children) were used. The study provides a general picture on which future research may be based. It would be interesting, for example, to compare the effectiveness of different therapies and to assess which one is best suited for which child.

A limitation common to qualitative studies is the lack of a non-adopted group with comparable behavioural problems and a comparison group of adopted children from countries other than Romania. Since no previous research has been done on this subject, comparison was not possible.

Implications and recommendations for practice

The mental health workers agreed that adoption-specific knowledge was important for people working with adoptive families as most of them felt they lacked this at the onset of treatment. Ideally, all mental health workers should have this knowledge, but since adopted children form a relatively small group and deprived internationally adopted children an even smaller one – it is not reasonable to expect it. However, it is possible for mental health workers to have easy access to relevant information. Several of the workers and parents we interviewed suggested that adoption experts should be available for consultation. Adoptive families benefit from an approach that is adapted to their specific situation (Hart and Luckock, 2006). It is remarkable in a country as sophisticated as the Netherlands that these obviously severely deprived children are placed in their adoptive families without any structured aftercare. The severe behavioural problems of the children and the difficulties of the parents in finding suitable help identified in this article demand radical change to the system, with standard aftercare available to all adoptive families.

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