The Plant: A Perspective for Professionals

Living in Ohio offers great cities, beautiful countryside, diverse cultures, thrilling roller-coasters, Great Lake Erie and snow! This winter, we are privy to lots of snow! School cancellations seem never-ending! Parents—struggling, with challenging adoptees—are at their wits' end!

This unexpected break from the world of academics generates many phone calls to the therapist. Yesterday, in a case in which a teen adoptee is involved with an array of professionals, I received a phone call from the social worker who is in charge of case management. Her first words were of confusion about the mom and Mom's style of parenting. Apparently, the mom had been recounting an incident—to the social worker—in which her daughter, adopted at age 3, and now age 14, cut off the buds of an African Violet Mom had been nurturing for quite some time. From the social worker's perspective, Mom was being "too strict", "worrying about small issues", and overall, "Mom, really needs to learn to get a grip and change her parenting." Later in the day, a phone call from Mom revealed that she had been upset by the conversation with the case manager. She felt misunderstood and to blame for her daughter's problems.

What happened in the phone call between these two? How was there such a mismatch in the exchange?

Actually, according to the Casey Family Services White Paper, *Strengthening Families and Communities: An Approach to Post-Adoption Services*,

"Adoptive families consistently report that they face difficulties obtaining services from professionals who are sensitive to adoption issues and skilled in assisting adoptive families. The need for professional expertise with regard to adoption issues is particularly great in the fields of mental health and education. In neither of these areas do professionals routinely receive education about adoption issues.

"In other cases, therapists do not appear to understand the impact of children's pre-adoption experiences on their current intellectual and social functioning, capacity to attach and form intimate relationships, and their overall development, including the developmental effects of prenatal alcohol or drug exposure, earlier experiences of abuse or neglect, and multiple foster care or institutional placements. Adoptive parents often find that the only recommendation they receive is that their children be placed on medication—an intervention which many parents feel is not appropriate and which does not address their needs for a better understanding of their children's problems. Similarly, adoptive parents all too often find that their children's problematic behaviors are attributed to hyperactivity and treated with medication, rather than first exploring past or present experiences.

"Educators with whom adoptive parents interact also may have little understanding of or sensitivity to adoption and the issues which adoptive families face. Some adoptive parents report that educators attempt to avoid becoming involved with these issues, responding to the stresses on adoptive families with statements such as, "You made the choice and adopted him, he's your problem." In other cases, educators may simply view adoption with "rose-colored glasses." They may see adoption as having only positive outcomes and have no real understanding of children's losses or the impact of pre-adoption experiences on their current behavior and adjustment."

In order to be adoption-competent professionals, we—therapists, social workers, psychologists, psychiatrists, teachers, etc.—need to understand that the plant wasn't really the issue. The loss of the flowers that were about to beautify the home are reflective of the loss of the relationship between Mom and daughter. The relationship Mom had hoped would blossom—between herself and her daughter—has been stunted by the complex trauma the young teen brought with her from her birth home.

The behavior of severing the almost blooms was an act of anger. Anger that,

- the daughter wasn't with her birthmother,
- she had no control over the abuse she experienced,
- she wasn't with her birth siblings,
- the daughter was left without the tender care and cultivation she deserved— and which she watched Mom provide the plant—in infancy.

This adoptive mom receives this anger—this grief—because the birthmother isn't available. The system that made the decisions seems too ambiguous and large to be mad at.

Caught in grief, the two collide. Mom, caring for the home, working and attending one meeting after another with the teen's team of professionals and so on, hasn't realized that her reactions to her daughter are her grief. She needs our help to express her feelings for the loss of the daughter she expected versus the daughter she can have.

Losses are amplified for those adoptive families and made more complex because they include one or more children with mental health issues. Mental illness needs to be recognized as a major loss. When it comes to the experience of loss, the primary distinction between death and mental illness is that mental illness is not broadly and publicly recognized as a significant loss, when in fact, loss may be the primary trauma for family members during the course of mental illness.

So, we need to say to this mom, "This violet is important to you. You feel hurt that it was damaged." This statement will help Mom continue a discussion with us. This woman will explain that the flowers are just one more reminder that her daughter doesn't act in "normal" ways. Having a child who isn't on par with age-appropriate peers is heart-breaking. Mom will feel comforted that we understand—instead of blamed and criticized.

Overall, when working with adoptive families we want to keep in mind some key principles:

- The adoptive family parenting a child with mental health issues becomes traumatized. The cost of caring for a child with a history of abuse and neglect comes at great expense to each member of the adoptive family.
- The trauma of the adoptive family develops in response to efforts to integrate the adoptee into the family. The family is made unhealthy *after* the adoption; the family, in most instances, was not pathological *prior* to the placement of the child with a history of trauma.
- Models of care which center on individual treatment for the adoptee are inadequate. The successful integration of an adoptee into a family requires addressing and alleviating the trauma of all members of the adoptive family—mothers, fathers, sisters, brothers and the adoptee.

- A more *parent-centered and child-focused model of care* demonstrates dignity and respect. Parents are asked to make changes because parenting a child with mental health issues requires a distinctive set of tools. The parents are not blamed for the child's problems.
- Parents know their family best—the adoptee, the brothers and sisters, and themselves. The healing process is expedited when we listen to parents and design interventions that include their input.
- Parents are ultimately responsible for the well-being of their family. Parents want to and should be in charge in this manner. When guided to develop and implement the correct interventions, most parents can more than adequately meet their needs as well as the needs of all of their children.
- Parents set the tone for the family. A healthy, happy caregiver infects their children with their good mood. Vice versa—an angry, overwrought, tired parent transfers this distress to their children. A parent-focus provides ongoing support to parents so they can maintain as assured and optimistic an attitude as is possible. In turn, when we support parents in this manner we positively impact the entire family.
- Child-focused service means that professionals are supporting parents in their efforts to support their children. The family is the client.
- Child-focused also includes that services are extended to each member of the family as needed.