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Roma Ulasińska[1], Agnieszka Lelek[2], Agnieszka Kozik-Merino[3], Katarzyna Ślęczek[4]

BUILDING A BOND DESPITE THE TRAUMA — THE USE OF MULTI-FAMILY THERAPY (MFT) IN ADOPTIVE FAMILIES

[1]NZOZ Mental Health Centre Pro Psyche

[2]Institute of Applied Psychology JU

[3]Psychological-Pedagogical Counselling Centre in Proszowice

[4]Maltese Centre for Disabled Children and Their Families in Krakow

Attachment
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Summary

The aim of the following article is to present an original program, whose purpose is to support the upbringing competence of adopting parents with regards to raising and assisting children with emotional and anxiety disorders. A crucial issue upon which the program has been designed, are difficulties in creating bonds in adoptive families. Eight adoptive families, including 15 adults and 12 children (between the ages of 5.5–10) took part in the therapeutic project described. In preparing the project, we referred to the experience of therapists who use the Multi-Family Therapy Method in their practice. An additional element of the program was video training. Most of the participants evaluated the participation in the program positively. The parents highlighted the benefits of exchanging experiences, gaining support and eliminating feelings of guilt. Engaging children in the therapeutic process (MFT) additionally allowed for a more extensive perspective on understanding the attitude and behavior of children. Creating a safe bond in adoptive families is a difficult process, yet essential for their further functioning. For this reason, it is important for families to be able to take advantage of specialized therapeutic practices in programs geared towards providing support after the adoption process.

Introduction

The decision to adopt a child is a difficult one and a serious challenge for the family, which is often preceded by many years of attempting to give birth naturally, as well as by numerous discussions, much hesitation and many doubts, a process which, in some cases, after a long period of time, results in the decision to adopt a child. Adoption is a process that takes several months in order to prepare families for the important change in their lives. In Poland, families are carefully guided on their way to adopt a child but there are no institutional services to assist them after adoption. According to the 2018 Supreme Audit Office report, people who had used the services of adoption agencies usually rated the help of the specialists highly. 80% of respondents perceived the

psychological, pedagogical, and organizational support of the agencies as either good or very good. Most people were also satisfied with the training (57% rated them as very good and 26% as good) [1]. It should be noted, however, that the families receive support at the beginning of the adoption process, while it may take up to two or three years from registration at the agency to the moment they actually meet the child. Many parents emphasize that after such a long period, they do not remember many of the issues which arose in training. In addition, they often have no-one to talk to about current problems that may arise during childcare.

It is, thus, worth considering how assistance after adoption should look like, so that it meets the needs of both parents and children in the best possible way. According to clinical experience, in most cases, systematic therapeutic support is necessary in order for an adoptive family to function properly. In the article presented, we attempt to present the experience we acquired from working with families after adoption.

Building a bond as a challenge

It seems that the greatest problem that parents face immediately after the child arrives is establishing a bond with the child. Many parents experience a strong fear of rejection by the child, as well as feelings of anxiety about being able to love the adopted child as if he or she were their biological one. They often have very high expectations of themselves and feel pressurized to become the best caregiver they can be [2-4]. The process of building a bond may be additionally hindered by factors such as genetic defects, neurological damage (prenatal and postnatal), and trauma experienced by the child earlier in life (abuse, harassment, repeated changes of caregivers). A crucial factor that compromises the bonding process is the stigmatization that often goes along with adoption and the lack of social rituals associated with the arrival of a new family member. Rarely do adoptive parents want to share their experience of the adoption process [5]. They often prefer to hide the fact that they have adopted a child, limiting that information to the knowledge of their closest family, which means that, in consequence, they do not receive social support to the same extent as parents awaiting the birth of a biological child.

Secure attachment is the most favourable form of attachment for development. This type of bond is observed in 62% of children raised in biological families. 24% demonstrate anxious attachment and 15% disorganized attachment. These proportions vary greatly in the case of children raised in institutional care. Secure attachment is observed only in 11% of children, while 73% of cases show disorganized attachment [6].

There are two extremely different ways in which attachment disorders usually manifest in children. The first of them, which can be described as emotionally withdrawn, is characterized by a display of distance and coolness towards caregivers. Children do not seek closeness or comfort

even in situations where they experience difficult emotions, and instead, they may display a tendency to react abruptly through aggression, self-aggression, or destructive behaviour. Superficial attachment is represented by children who seem eager for closeness with a caregiver, so that they trust immediately any person. They are attached to any and every individual they come into contact with and show a tendency to shorten distances, showing feelings to strangers, and do not show signs of emotionality towards parents.

On the basis of this short description, it is possible to imagine the challenges that parents who have decided to adopt a child will face [7]. Building bonds in an adoptive family is the most important aspect, and is simultaneously a very difficult task, however, as research has shown, the effort made has the potential to bring surprisingly positive effects. A comprehensive meta-analysis of 40 studies on attachment styles in adopted children was performed by Dries et al. [6]. Based on their work, adopted children are known to have a chance to overcome difficulties and threats and to create a secure attachment, similarly to biological children. It turns out that, among adopted children and those in foster care, as many as 49% developed the most favourable type of attachment, which is secure attachment. The most positive effects are achieved in children who have been placed in the family in their first year of life. The later an adoption takes place, the greater the difficulty in establishing relationships and the smaller the chance of success. On this basis, adoption may be considered an effective instrument giving children deprived of biological parents a chance for proper emotional development. This effect is also observed in children who, in their early childhood, have experienced the trauma of growing up in a dysfunctional family and for a long time stayed in caring and nursing homes. In children who have been adopted, safe attachment has definitely increased less than a year after their adoption.

It should be emphasized that the attachment style factor of the adoptive mother was very important in this case. The expected effects were obtained only in those children whose mothers had a secure attachment style [8]. The cited study did not examine the impact of the adoptive father's attitude on the child's behaviour.

Attachment disorder therapy

The work on the process of creating bonds in adoptive families begins by helping parents to understand the notion of attachment as well as the nature of their children's emotional needs. It is also important to make parents aware that traumatized children can send misleading signals about their needs, *e.g.* they show hostility in situations in which they need support and comfort [9]. Scientific studies have shown that certain therapeutic techniques concerning attachment disorders give a greater chance of success in shaping secure attachment. Child Parent Psychotherapy (CPP), which is frequently used in such cases, aims to create bonds, to enhance communication between

the parent and the child, to increase the effectiveness of the parental intervention, as well as to teach the parent to understand the child's emotions. This is practised with children under 5 years of age. CPP sessions involving both parents and children take place either at home or in the playroom. They do not follow any rigid structure and the topics are largely determined by the parent and the developing interaction with the child [10].

Many attachment disorder therapies use video recordings of parent-child interaction. Families with parenting issues are offered Video Intervention Training (VIT), which is a form of intensive assistance based on video recordings. It emphasizes the importance of a positive approach, focusing on opportunities instead of limitations and problems. It involves the whole family, not just the troubled child. The aim of such a method is to change and develop the whole family system. For VIT therapists, parents' questions and needs, as well as their elaboration, are more important than the fact of establishing a diagnosis. A detailed analysis of the recorded material shows when the child comes out initiating contact, what the purpose of it is and the way in which the adults react to the child's behaviour [11]. As previously mentioned, video training methods are used in various therapeutic programmes. Research essentially confirms the beneficial effect of this approach on the process of sensitizing parents to the signals (also nonverbal) sent by the child and creating secure attachment [11, 12].

One of the best-known and best-described programmes using video recordings is ABC (The Attachment and Biobehavioral Catch-up (ABC)). It is an intervention dedicated to children between the age of 6 months and four years in adoptive families, as well as to those with problems of violence and abuse [13]. Children who experienced violence and relational trauma tend to display withdrawal, distance, emotional coldness, or even hostility in their behaviour. At the same time, parents are often unable to properly care for their children, and they may additionally present attitudes or behaviours that induce terror in children. On the one hand, the goal of the therapy is to create a safe space for the children so that they may be provided the chance to regain emotional balance and self-control skills, and on the other – to teach parents proper attitudes as well as to understand the children's emotions and behaviours.

Recently, a mentalizing-based therapy, which originated in Great Britain, has gained increasing popularity. This therapy focuses on the fact that while creating a relationship between parent and child, aside from building bonds, mentalizing is a key process that is based on the parent's reflection on theirs and their child's emotions. Studies show that a parent's inability to reflect on the relationship with his or her child in the event of adoption may induce the adults to feel the will to give up their role [14].

The literature describes two short-term programmes which use mentalizing ideas intended for adoptive families. The first, Adopting Minds, integrates the systems approach with

mentalization (MBT-F) [3]. Its purpose is to enhance the relationship between parents and children, in terms of trust and mutual understanding. The programme includes six family therapy sessions. Similar to the systems approach, the therapist does not act as an expert but only creates a space for the family to reflect and helps them to come to their own conclusions.

The second, the Family Minds (FM) programme [15], introduces elements of psychoeducation. Parents meet in a group three times for three hours each. The leader provides information on attachment disorders, as well as tips on how to deal with difficult situations in the family. In this form of support, the key is to encourage participants to mentalize, both during sessions and in real life. Each of these interventions, despite imperfections, positively affects the formation of a reflective attitude in parents, and thus increases the chance of developing a proper bond with the child. Research shows that the most important thing in creating secure attachment is how parents understand the child's experience as well as how they interpret the child's behaviour in the context of their own reactions [16, 17]. The parents' ability to reflect and understand both the children's as well as their own behaviour should, therefore, be the main area of therapeutic interaction.

Therapeutic project for families post adoption – our experience

The therapeutic project was organized by the Regional Centre for Social Policy of the Silesian Voivodeship (Regionalny Ośrodek Polityki Społecznej Województwa Śląskiego) and was a part of the EU project entitled "Coordination and development of adoption services." Its goal was to improve the parenting competence of adopting parents in the field of supporting, assisting and raising children with emotional and anxiety disorders. Families were invited to take part in the project by the Regional Centre for Social Policy in cooperation with adoption agencies. Most of the children participating in the project were between the ages of 5.5 and 8 years, and two children were 10 years old. One family had a biological child, who was already an adult. Most parents had post-secondary education (1 family – secondary, 1 – vocational). Most of the participants lived in medium-sized cities; 2 families in the countryside near cities. Most of the children had lived with their adopting parents for a short time, from 5 to 8 months, and only one child had lived with the new family for 1.5 years. Detailed information on the characteristics of the project participants is provided in Table 1.

Table 1. **Characteristics of the children participating in the study**

	Children	Age of adoption and history of care	Reported problems
1.	Non-biological siblings: Boy – 5.5 y.o.	Adopted at the age of 5. With a foster family for 2.5 years, before that in an emergency shelter and Crisis Intervention Center (2 years and 3 months in foster care)	FAS not diagnosed, parents were alcohol addicted Walks on toes, falls over, has a posture defect, displaced shoulder blades, hypersensitivity Mental development assessed at 3 years, according to the parents – intellectual norm Has adaptation problems, when he felt safe, he began acting out, teases his sister, pinches, kicks; keeps away from groups Peculiar utterances: *i.e.* that he hates his grandfather and that he will cut his throat Recently problems with sexuality – touches women's breasts, puts hands under skirts, acts flirtatious towards women that he doesn't know.
	Girl – 6 y.o.	Adopted at the age of 3 months Hospital	No problems were reported. Facial dysmorphic features.
2.	Only-child Boy – 6 y.o.	Adopted at the age of 3. Approximately 1 year with biological mother 2 years of emergency care	He did not speak when he was adopted; bit, kicked, screamed, stuffed himself with food until "he was in pain"; until now, when he sees food – he is unable to handle it, he uses phrases about killing ("I will burn," "I will kill"); was afraid of women. He is unable to cope in kindergarten, takes over the role of a kindergarten teacher, wants to control everything (counts, checks the time); is "verbally aggressive" to children ("I'll kill your mom"). 95% of his reactions are "no", hates opposition: wants to be the best, first, hates failures. Very intelligent, he acts out when he begins to feel bored; he can take 45 minutes to take care of what he is doing, lay out blocks and whatever is related to food (dinner for teddy bears, who he cuddles and takes care of). "Confabulates" about what he has, which means he says he has things he would like to have.
3.	Biological siblings: – Girl 6 y. 11 m. Boy, 6 y.o.	Contact with both adoptive parents for approximately a year, 3 months at home 3 biological siblings that they remember (younger sister adopted ½ year ago; two – in a foster family Father deprived of parental rights, juvenile mother; in the home of the biological parents till 4 years old Since 1 year and 3 months in a family orphanage Previously unsuccessful adoption (adoptive parents resigned after a month)	possessiveness, domination, rivalry, rules in the kindergarten; does everything carelessly, does not give away her doll. withdrawn, looks at sister to see if she will let him do anything.

4.	Girl 7 y.o.	2 years with biological mother at home 4 years in orphanage Adopted one year ago Middle child of five (from 2 fathers)	She spoke gibberish, has now made much progress. Says she knows her mother does not want her. One minute she is sweet, suddenly the devil comes out of her, she throws tantrums, likes to play the first fiddle. Seeks cuddling
5.	Girl 8 y.o	In foster family 2 years Previously in emergency care (2.5 years) Adopted 3 months ago	Beaten and tortured by mother, she remembers everything from the past very well. She quickly established a good relationship with her adoptive father but is moving away from her mom, who says: "This relationship is very strong but at the same time it is not there." She is having crying attacks for no known reason, when asked, she says, "This is the way I do." One month ago, she asked her father to buy a pacifier, which she now sleeps with.
6.	Girl 7 y.o.	Previously at grandmother and grandfather's 2 years in a foster family Adopted 4.5 months ago	Physical and mental aggression/abuse by the mother, her partner, and her partner's son. At first a perfect child, she ate everything, helped (now she grimaces); she was hungry all the time, she ate as much as her father, almost every day she experiences night terrors, gets up, screams and cries. Before going to the meeting, she asked, "Why are we going there? Maybe you'll give me back, maybe mom won't come back." There was a stage at which she wanted to be carried, she asked: "Why couldn't you have given birth to me?"
7.	Foster siblings: Boy 10 y.o. Girl 5.5 years	2 years with biological parents Emergency care In adoption for 3 years	Mistreated, did not speak until the age of 4. 1.5 years ago, he bit himself at night after seeing his adoptive father with alcohol. He destroyed his clothing, ripped clothes, cut them. Hearing disorders (does not hear in noise), asthma, allergy. Sensory integration disorders. School difficulties, fight for learning. Behaviours like a younger child.

In the preparation of the project, we consulted therapists who had experience in using the Multi-Family Therapy Method (MFT). This allows the child for an active involvement, which gives him or her a sense of control and responsibility for creating their environment. The child is not only someone who is subject to change but it also becomes an active participant and co-creator of these changes. The participation in the therapy of many families at the same time is an opportunity for them to go beyond their own perspectives and refer to the resources of the group. It permits them to feel like they are a part of a community by exchanging experience and comparing their own situations to that of other families. Families are encouraged to provide mutual support, to carry out a common analysis of the problems which emerge, and to attempt to find a solution to them. This system facilitates the understanding of one's own behaviour by facing problems of other people, promotes openness and reflection and weakens defensive attitudes. One of the premises of MFT therapy is great flexibility in the organization of meetings [18, 19].

In our project, the meetings were conducted simultaneously in 2 groups – the group of

parents and the group of children. The participants spent one-third of their time together. The formation of separate groups was the result of the need for space in which parents could raise issues that should not be discussed in the presence of children. During that time, the children took part in activities that were initially meant to be integrating meetings but in the later part of the project several important topics concerning emotions, peer relationships, and understanding of other people's behaviour were discussed. The workshops held together with the adults were interactive and a variety of techniques were used such as discussion in the plenum, small-group work, role-play, and case studies. Children's sessions included general development activities with elements of art therapy, sociotherapy, and Fairy Tale Therapy, as well as relaxation exercises. These sessions were also an opportunity to observe potential problems that occur in the children. Video training (VIT) was an additional element of the programme. It was aimed at helping to strengthen family bonds by teaching parents how to communicate efficiently with their children. As studies have shown [9, 11], it is believed to be an effective method in all families in which communication has been disturbed or has, for various reasons, failed to develop. The stages of the programme are presented in Table 2.

Table 2. **Programme of classes implemented in the project**

PROGRAMME OF PROJECT ACTIVITIES				
MEETING	TYPE OF ACTIVITIES	TIME	GOAL	METHODS
Convention I 1 day – 6 hours	JA	1.5 hours	Integration of group, introduction of families.	MFT
	PG	3 hours	Identification of family problems, learning their stories.	Group discussions, small group discussions
	CHG	. 3 hours	Integration of children's group, building an atmosphere of safety and cooperation.	Socio-therapy and art therapy techniques, mobility games
	JA	1.5 hours	Developing skills to build positive parent-child interactions through play and shared tasks.	MFT and video training communication (VIT) classes
Convention II 3 days, 6 hours each During the convention, meals and breaks between each panel were joint	JA	1.5 hours	Developing cooperation skills in families and between families who participate in the project	MFT
	PG	3 hours	Understanding the children's behaviour as manifestations of their developmental disorders and ways of testing the new relationship. Attachment style analysis	- group discussions - case studies - parental competence education (video training VIT)

	CHG	3 hours	Recognizing, naming, and experiencing own emotions, as well as responding to the feelings of other group members.	Socio-therapeutic techniques, fairy tale therapy, relaxation
	JA	1.5 hours	Comparing experiences, sharing and seeking new solutions.	MFT
Convention 3 3 days, 6 hours each During the convention, meals and breaks between each panel were joint	JA	1.5 hours	Observing the change in the relationship between parents and children. Paying attention to the strengths of children and parents.	MFT
	PG	3 hours	Rating the changes that have taken place in the families, the ability to regulate one's own and the children's emotions, methods of dealing with aggression.	- discussions - role-playing - lecture
	CHG	3 hours	Improving mutual communication with peers and understanding of their own feelings.	General developmental methods, socio-therapy, fairy tale therapy, relaxation.
	JA	1.5 hours	Summary of the group's work, strengthening the changes taking place, goodbye.	MFT
Convention IV	Individual meeting for each family	1 hour	Time was spent on summarizing the work, guidelines for further work and recommendations for (as required) individual therapy for the child or parent or family therapy.	Parents talked to therapists, watched extracts from video recordings. Time provided for children to play in a separate room with their therapists.

JA – joint activities, PG – parents' group, CHG – children's group

The therapeutic sessions implemented through the project took place in 2017 and 2018 over a period of 5 months. The project began with a one-day, eight-hour workshop. After two weeks, the families met at a three-day workshop; they worked every day for 8 hours. The next meeting was scheduled after 2.5 months and followed the same structure as the previous ones. The culmination of the therapy was a one-time individual consultation for each family.

Range of therapeutic activities

The therapeutic project began with a one-day workshop (lasting 8 hours) which had an integrating and familiarizing intent. During common sessions, the parents and the children introduced their families by preparing some artistic tasks. As the families did not know each other, this way of opening the project allowed for the breaking down of barriers and the reduction of anxiety towards other group members. The parents' group focused on the difficulties that parents experience after adoption. This promoted the identification of problems and the adaptation of the subsequent meetings to the participants' needs. During these first conversations, in front of the group, parents presented the stories of their families, talked about the children and their functioning after the child had arrived in the family and the problems that immediately arose after adoption and

which they were facing at that moment. It seems that the value of these meetings was that parents were able to share their experience with others who were in a similar situation, and that they could say what had changed after adoption and how they dealt with these difficulties.

In parallel, sociotherapeutic classes with elements of art therapy were conducted for children. During the first day, the most important thing was to ensure that children were provided a safe space in which they could express themselves and count on therapists in moments of difficulty, such as missing their parents, knee pain after a fall, or an argument with their siblings. An important element was learning the rules necessary to play together so that they could create conditions for the safe expression of feelings and conflict resolution.

Another part of the programme of that day were classes with the use of the Video Intervention Training (VIT) method. During the joint sessions, the footage was gathered in order to illustrate initiatives made by children and parents' responses to them. These recordings were used later in the project to develop the skills necessary to build positive parent-child interactions.

The second therapeutic meeting lasted 3 days (8 hours a day) and had the same structure as the previous one, *i.e.* common sessions and separate classes for parents and children. The parent sessions focused on the question: "is love alone for wounded children enough?" During these sessions, the participants talked about the children's behaviour, which was incomprehensible to parents, as their manifestations of their developmental disorders and a way to challenge the new relationship. Based on scenarios describing the mother-child relationship, the parents learned to recognize their children's attachment styles. Parents shared their feelings that accompanied the upbringing experience. They also talked about the feeling of helplessness in the context of the child's difficult behaviour and asked for specific tips on how to build a bond with a child suffering from attachment disorder. The therapists focused on the importance of shaping a correct parent-child relationship, referring to the analysis of the recordings taken during joint classes. It allowed for the parents to understand how different traumatic events experienced by their children were reflected there. Previously misunderstood reactions were renamed and reinterpreted by the parents. They could also look back on their behaviour and ways of acting with the child. The goal of the meeting was to build a secure attachment. It was helpful for parents to distinguish whether their expectations towards their children were appropriate to their stage of development and the situations they were in. Some parents did not seem to consider the fact that their children had been with them for a short period. It was also observed that adopting parents often tend to perceive normative and developmental behaviour as the pathological consequences of attachment disorders. The therapists, therefore, helped the parents to distinguish disturbed behaviours from those that were normative and age-specific. In a few cases, this also helped to relieve the parents of guilt and frustration in moments in which they felt a lack of control over the child's behaviour.

During children's sessions, through games, competitions, playing and tasks, children learned to recognize, name and experience their emotions, as well as to respond to the feelings of other participants. The introduction of relaxation exercises was an important element, due to the fact that most children found it difficult to calm down after periods of activity. At this point, it is necessary to mention that the role of time control in each session became very important. This was an especially crucial factor for the children because, in this way, they learned to postpone seeing their parents and to trust the therapists that the time of the children's session was limited and predictable. As a result, not only did the children not disturb the parents in their session but they also shared their own experiences in front of the group. Most of them coped with waiting for the break, despite the frustration associated with separation.

The goal of joint sessions for parents and children was to develop cooperation skills in the family as well as between the families participating in the project. It is to be noted that all the families in the presented project had recently adopted their children, therefore, they were at the stage of adapting, determining family roles, and creating family rules and rituals. The various tasks and exercises performed together were, therefore, aimed at experiencing one's own place in the family, expressing and understanding the needs of all members. In Multi-Family Therapy [19, 20], the session for families struggling with a similar problem is intended to be an opportunity to compare experiences, and share and search for new solutions. It was noted that families gradually began to open up to the experiences of others and often supported each other. In addition, these sessions allowed us to show the parents the importance of having fun together. Not only was it an opportunity for them to have a good time, but it also gave parents an opportunity to observe their children and get to know them better. They could observe what activities are attractive to their children, how they react to failure, how they share joy, but also how they avoid certain activities. As play forms an integral part of the child's development, parents could strengthen their parenting competence through it.

During common activities, short 5-7 minute recordings were done, which were then analysed with the parents. The analysis consisted of discussing those passages which illustrated the positive course of the parent-child interaction. Thanks to the analysis, parents could see what elements of communication enhanced it. It caused the parents to reflect upon their own role in the process. It was also an opportunity for discussions that often triggered a new narrative concerning themselves as parents as well as a new narrative concerning their children.

At the third meeting (after 2.5 months), the parents reported the changes they had observed in the children and themselves and they described their feelings. The theme of regulating one's own emotional states was also introduced. The therapists referred to the emotions experienced in childhood by the adult participants and to the family patterns of expressing feelings. Acceptance

for experiencing various emotional states helped to eliminate the feeling of guilt associated with *e.g.* anger experienced as a result of a child's bad behaviour. The subsequent sequence of the therapeutic sessions was aimed at changing the reaction to the children's behaviour. In this part of the workshop, parents received practical tips on how to use methods of replacing aggression. They participated in a psychoeducation workshop which concerned coping with stress. They were also given information about behavioural methods that can be used and those that do not work in children with attachment disorders (*e.g.* temporary isolation and token economy). The last important topic was the support that adopting parents needed.

The children's group continued to work on mutual communication with peers and on understanding their own feelings (*e.g.* "what makes me angry, sad, what am I afraid of?"). It could be observed how children who were initially shy and withdrawn suddenly became group leaders; how they learned to deal with outbursts and tears so that other children would not be afraid of them. It was also noted that those children who initially imitated others, took courage to make their own decisions without the fear of being judged.

During joint sessions, changes in the relationship between parents and children were observed. In an atmosphere of joy, but also challenges, the children could observe their parents in new roles, including when they got dressed up, engaged in new games, sat together on the floor, looked after other children and took part in role-plays. For many children, such a parental activity was a surprise, and many families discovered how many positive emotions appeared during those joint exercises. Often, pride could be seen on the children's faces after a task had been done together, and delight in other children and parents. The parents also had the opportunity to observe their children in a new external context, receive feedback from other parents, see something that they had not noticed before with their own eyes.

In this way, the children could see their parents as creative and attractive cooperation partners, while the parents saw their children as engaged and cooperating.

The last part of the project consisted of individual therapeutic meetings with parents (1 hour for each family). They were aimed at providing feedback to parents and children on how the children had functioned during activities with the peer group, and on their relationship with the adult caregivers. The first part of the meeting was also attended by the children – they could hear about themselves in the presence of their parents. Later, the therapists passed their observations and conclusions only to the parents. They related mainly to the parent-child relationship and emphasized family resources, and indicated areas for development. They answered questions about the children and mutual relationships. Selected fragments of the recordings concerning the interaction between parents and children were discussed. We also gave the parents some suggestions on further possibilities of using specialist assistance supporting children's development

and individual therapy. Some families were also interested in undertaking family therapy.

Conclusions — parents' narratives

At the end of the therapy, the participants shared their considerations. Conclusions and comments in the form of feedback concerning the changes were collected from each family after every single module and during the last individual session. In addition, the parents completed a survey after the whole course. They emphasized the importance of mutual support of people who had similar experiences and the fact that they did not feel lonely with their issues. Instead, they gained the feeling that they have the right to experience different feelings, including negative ones, when they lose their patience with the child.

— *I have gained the feeling that I am not a crazy mother when I lose my patience.*
— *In the Adoption Agency we try to make it look good – for the first time we could say what it really is like and not what it should be like. We could say that we hate and that we love.*
— *I didn't want to come here because we had been at a meeting for adoptive families and they said it was idyllic.*

Some comments concerned responsibility and the sense of agency, as well as relief from guilt, when not everything goes well. One of the mothers expressed it as such: *I can't quite influence who my child will be, in spite of the therapy; we cannot blame ourselves, we have no influence on many things; I have to try, but if it doesn't work, then so be it*. The parents also talked about getting a more realistic view of their child and experiencing the differences between their ideas, dreams, and what the child has brought. As one of the fathers jokingly said: *I have accepted that my son will not be good at technical matters; maybe my daughter will succeed?*

Another benefit pointed out by the parents was a reduction in their level of anxiety related to the child: *I am glad to hear that there are behaviours that can be considered as ordinary in these children*. Through the therapeutic meetings, the parents saw that this is not about a method or a strategy for dealing with a child, because *there is no method that would work*, but they have learned how important mutual relations are. *After what I have heard, I leave with fear and hope; I wait for them* [the children] *to open up; I can see that they have just begun to speak.*

During pre-adoption training or other meetings in groups of adoptive families, the parents had heard tips about the child's development and upbringing. However, during the meetings organised under the project on the one hand they saw their role, on the other they received help for themselves (*How to help parents – this was new*). One of the mothers said how difficult the emotions were, the feeling of loneliness and misunderstanding: *We were within the confines of our four walls with a child with his difficulties, the family commented 'what's your problem, you have*

a nice child,' we did not find any understanding. Another felt guilty when there was a problem, she felt that she was not coping as a mother, and only during therapy she saw that *the problem was in her and her child*. One of the fathers talked about the importance of relationships but also about the perception of his own participation in the formation of the so-called problem system: *I saw that not only my daughter has problems; I saw her as a child which means I need to have more patience and distance.*

Adopting parents are often particularly sensitive to whether their child's behaviour is normative and results from natural developmental processes, or it is already a symptom of a disorder. During the meetings, the parents found out that many of their children's difficult behaviours are developmental and occur in the general population. They noted that they sometimes tend to literally interpret the child's behaviour or verbal message. The statements of three different parents refer to this consideration. *After the session, I see that what they do is normal, it is something most children do. My approach has changed. I may be fooling myself, but they are just kids – and they behave like kids, these are symptoms of being a child, I do not underestimate some behaviours but I am also happy with them.* Working with VIT allowed parents to observe their children's communication initiative, thanks to which they were able to open up to the message the child wanted to communicate to them. They also began to understand that the child's behaviour may be associated with traumatic past experiences or be the consequence of breaking bonds with a significant person.

— [My daughter] […] *she told me that her mother had said she did not want her and would not come to the orphanage — and then she opened up, and a change in her was visible.*

— *We're going somewhere by car and she says that her mother used to put a knife on her. I don't try to get it out of her. We say that it is not her fault, that the child is not guilty.*

The possibility of exchanging experiences with other parents was of great emotional importance:

— Your [the parents' and the therapists'] experience is valuable. And looking at each other, it calms down. Who would understand me, if not people who have similar problems?

— Your confiding in us and sharing – it gave us a lot. We think of what will happen in the future.

The parents also got an opportunity to see changes in themselves and the child and to make their expectations about family life real. As one parent said: *I give parenthood a realistic view, I know that not everything is going well and I know that there are things which I will not be able to change.*

Despite the generally good assessment of the therapy, some dissenting opinions also came

up. Having analysed these statements and the observations of the therapists, it may be concluded that in a situation where the problem is more complex, in which the parent experiences his or her own emotional issues, when the parent has not managed to deal with his or her own traumatic experience or when the adoption of a child was to be a way of solving marital problems, the kind of help, which the families received under the project, may not be sufficient. In such cases, longer individual therapeutic work with the parent may be required.

I don't know what I should look for. It is just too much and I'm afraid of what will happen to me. [My son] *comes first, all the time for him there is only mom and it's been 1.5 years, and I don't get anything back from him, he is killing me and our marriage, I'm a bit a wreck of a human.*

Those who expected to be given a simple algorithm of behaviour also may have felt disappointed by the form of help offered: *I am worried because tomorrow everything returns to the way it was and I don't know what to do because I hear that there is no strategy.*

Recapitulation – the therapists' perspective

Adopting parents experience a difficult time in the period shortly after adoption. On the one hand, they are happy that the child has arrived in their house but on the other, they face the difficulties of carrying out specific tasks. Most of them had expected problems and have been prepared for them by the adoption agencies, however, much time usually elapses between training and adoption. Having no parenting experience, they can hardly imagine what problems they will have to deal with. Therefore, they experience different emotions that they attempt to repress and that are often so strong that it results difficult to deal with them. From this point of view, we can understand how complicated the process of creating a secure attachment in adoptive families is. Programmes such as Adopted Mind and Family Minds [3, 15] emphasize the significant role of mentalizing in adoptive families. Meanwhile, the mentalizing process is simply impossible in a situation where a person is experiencing strong stress [20], such as the one that adopting parents are subjected to as a result of new challenges and excessively high social expectations. In this case, these parents may temporarily lose their ability to take into consideration the thoughts and feelings of others. Frustration, anger, and regret they experience can lead to hostility and distance towards the environment. Therefore, it seems reasonable that in groups for parents, they have a space to share these feelings. Such a group cannot simply be a psychoeducational workshop, and the therapists must be prepared to undertake a therapeutic process. However, in further proceedings, it is recommendable to start processes of reflexivity and searching for new perspectives to understand the behaviours and attitudes of children.

The introduction of multi-family therapy to the programme for adoptive families seems to bring many benefits. First, common MFT classes certainly have an impact on strengthening bonds

within families, discovering common activities, a sense of coherence and identity of the family in the context of being a team among other families. The child actively participates in the therapy process, which is especially important for slightly older children [18]. MFT participants not only have the opportunity to exchange views but also to experience certain situations and discuss them on an ongoing basis.

When preparing the plan and the time frame of the project, we decided to have full-day meetings, because – as the experience of MFT therapists has shown [18, 21] – this context evokes situations similar to those present in everyday life. They can then be discussed on a regular basis, and group members are able to help each other by sharing their considerations and experiences. The schedule of the presented therapeutic course was an original idea, however, in our opinion, the therapy programme could have been spread over a longer period. An additional 2-3-day module would be have been useful. Nevertheless, we are of the opinion that multi-family sessions conducted at intervals of 2-3 months are beneficial to the process.

It should be mentioned here that thanks to the off-site form of training, the parents had the opportunity to distance themselves from everyday issues, focus on themselves and their relationship with the child. The entire programme included 60 hours of intensive work. Thanks to the project, families living far away from large cities were also able to benefit from assistance, because in other circumstances they are often unable to participate in professional therapy focused on their problems. Undoubtedly, the opportunity to meet other families not only during sessions, but also between them (during free time, meals, and walks) was a great advantage. This was an important element in the formation of group identity.

Thanks to the programme described above, each family enjoined some benefits, but it did not result to be sufficient assistance for all participants. In some cases, an individual parent therapy or couples therapy would be required. Some children also needed additional care, *e.g.* in the form of early development support, psychiatric care, or individual therapy.

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E-mail address: agnieszkalelek@gmail.com