A qualitative exploration of how adopted children and their parents conceptualise mental health difficulties

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Abstract

Adopted children tend to have high levels of emotional, behavioural and developmental need and are more likely to present to a range of services, including Child and Adolescent Mental Health Services (CAMHS). Although research exploring adopted children's' perspectives is growing, it remains limited. Furthermore, there has been little work t0 engage adopted children in research. Our project aimed to examine adopted children's viewpoints of mental health and services alongside those of their adoptive carers. Results indicated that, although there were some similarities between carer and child perspectives, they also frequently differed. They provided different constructions of the problem but agreed that family relationships were strained. Some acknowledgement of the role of the school was offered and other external sources of support cited. Coping was considered to be complex and, while some issues were analogous to 'normal' family life, much was inherent to the adoption status.

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Introduction

The 'psychological integration' of the adopted child into their new family, which is indicated by rewarding relationships between the child and, mutual feelings of family belonging and a subjective sense of permanence, is a strong predictor of positive outcomes (Neil, 2012). Indeed UK policy promotes adoption as the best route to a stable family life for children unable to return to their birth families (Selwyn et al., 2006). However, adopted children tend to have complex behavioural, emotional and developmental needs (Marinus et al., 2006), therefore it is no surprise that they are more likely to experience a higher extent of mental health difficulties and to require more service input than their non-adopted peers (Grotevant, 1997; Hussey et al., 2012). Even though services have improved recently, a substantial proportion of these children's needs remain unrecognised and/or unmet (Boris, 2003), which can thus delay entry into the adoption system (Selwyn et al., 2006).

The broad range of these needs is often related to children's past traumatic experiences, consequently their attachment relations (Department of Education, 2013). Such experiences hence frequently underpin families' requests for help and their care pathways to services. This is often because the theory of attachment appeals to

caregivers, and despite notwithstanding the critical views of attachment theory, it can play a useful role to some extent in this context (Barth et al., 2005). The exact reasons can, however, be difficult to define at the help-seeking stage, and may relate to the child's development, social functioning, behaviours at school or home, family relationships, and their emotional well-being; often a combination of several of these factors and contexts.

Although there is considerable policy and practice recognition of these issues, evidence regarding how carers conceptualise their children's needs requiring specialist or other therapeutic input, including post-adoption services, is limited (McKay et al., 2010; Ryan and Nalavany, 2003). Some studies have indicated adoptive carers' disappointment with the response from mental health services (Howe, 2003). This can be especially problematic early in the child's placement or during sensitive transition periods, when family stress levels are high (McGlone et al., 2002; Palacios and Sánchez-Sandoval, 2006). Furthermore, we have even less knowledge on adopted children's understanding of their concerns and the help they desire, despite children having valid views on their adoption process and their experiences (see for example, Thomas, 1999). This is regardless of the increasing acknowledgement that all children, including those from vulnerable groups, should be afforded the status of experts in their own experiences, and should hold fundamental rights to contribute to their own mental health care and service

provision (Davies and Wright, 2008). The requirement for such an evidence-base among adoptive families attending mental health services was the rationale for this study.

Methods

This study aimed to address the following research questions:

a) How do adopted carers and their children conceptualise and manage their difficulties?

b) What are their perceptions of help-seeking, in particular of child mental health services?

A qualitative design was adopted to explore the views and experiences of the participants. Given the limited information on adoptive carers' experiences and the even more limited work on adopted children's perspectives, a multiple-case study design was deemed appropriate. Multiple-case study designs allow for an exploration of the similarities and differences across cases (Yin, 2003), allowing analysis within each group of participants as well as across different groups (Baxter and Jack, 2008). This allowed an exploration of similarities and differences in accounts within carers and child perspectives, as well as between them. While qualitative research is a rubric with a range of theoretical positions (O'Reilly and Kiyimba, in press), we took a social

constructionist approach allowing participants to present their versions of reality (Burr, 2003). In other words, we pay close attention to the nuances of language use, and consider the ways in which the participants construct *their own* versions of their lives and experiences (see O'Reilly and Kiyimba, in press for a general discussion; see Burr, 2003 for a full overview of this position).

Sample and Setting

The children in the sample attended a child and adolescent mental health service (CAMHS, UK). A sample of 12 participants was included, consisting of six parents and their six adopted children, with each participant representing a case within the design (Table 1). The parents and their adopted children were recruited from three consecutive adoption groups within a CAMHS team designated for vulnerable children (adopted, looked after, homeless, or in contact with the courts). The families had been in receipt of various mental health interventions, tailored to their individual needs. All children and parent were white British.

Insert **Table 1** here

Data collection and analysis

Semi-structured audio-recorded interviews were conducted to explore how participants conceptualised and managed difficulties in family life. Interviews took place in the family home to facilitate rapport (Singh and Keenan, 2010). Thematic analysis was undertaken for the identification of salient themes (Braun and Clark, 2006). This occurred through a three-level coding process (Boyatzis, 1998). Using a data-driven strategy, the manual coding framework was developed by two team members and the second order coding was collapsed into a total of 14 themes. From this framework, six themes were identified as pertinent to the research questions and developed for analysis. Ethical approval was obtained from the UK National Ethics Research Service (NRES). Informed consent was taken from all parties using an opt-in process.

Analysis

Analysis illustrated two broad issues, which were divided into six themes. First, was how adoptive family members made relevant the construction of the 'problems' encountered. The construction of the problem had four themes: 1) the child's construction; 2) the carer's construction; 3) its relevance to family life; and 4) its relevance to school life. The second issue related to how family members managed the reported problems. This issue had two themes: 5) how the family managed the problem internally; and 6) external sources of help.

Issue one: Constructing the problem

All participants identified that the family experienced difficulties, and this was sometimes linked to the adoptive status of the child. For some the problem was positioned with the adopted child, in others this was additionally or alternatively framed in a more familial context. Notably, some normative repositioning of the family difficulties took place in the sense of constructing a version of family life that could be viewed as similar to families without adopted children.

Theme one: Child's construction of the problem

Although children's versions of the problem were often different or accounted for as a less serious version than of their carers, they did provide some reports on their difficulties. The process of being adopted was one that resonated emotionally as they reflected on their pre-adoption lives.

> *"And then the day that I was really going to leave, um, the whole school; um, I said goodbye to the whole school, even the friends I had."*

(Child 3)

The process of being adopted can mean many changes, and one of the most obvious can involve a geographical move. While ostensibly a simple factor given the complexity of

adoption, it is nonetheless the human loss that resonates with children, and this child

reflected on a memory of the day when such friendship networks were forcibly left

behind *'I said goodbye to the whole school, even the friends I had'*. By implication, the

leaving behind of friends and leaving a familiar school environment was an upheaval

for the child and one that itself was emotional. Interestingly, when reflecting on the pre-

adoption point, some children reported on the relationships held with birth parents and

tended to frame this in a negative way, which is not uncommon in this group (Neil,

2012).

> "Child: *Coz my mum sucks*
>
> (Lines omitted)
>
> Interviewer: *So, you say she sucks.*
>
> Child: *Yeah, I know she does. I am not talking about the mum's that here, I am*
> *talking about the mum I used to have.*
>
> (Child 2)

There was some reluctance from the children to talk about pre-adoption experiences, but

their reports provided some sense of their recollection of the traumatic events that they

encountered before going into care. Research has indicated that the pre-adoption period

in children's lives plays a significant role in the development of emotional, behavioural

and/or attachment problems that they can experience (Howe, 2003), and it is evident here that there was residual anger when reflecting on early relationships. Despite gentle probing to unpack the notion of '*sucks*,' there was continued resistance and topic change by the child, but the repetitive use of 'sucks' indicated a negative view of the birth mother. More importantly, perhaps, was the impact that those experiences were felt to have on the child. For example, this same child described their feelings and constructed a sense of personal identity within the current context.

> *I'm more of an angry person then a nice person, I'm more of a 'no friends' than a 'friends', I'm a lonely person.*

(Child 2)

The child oriented to the construction of the problem through a self-identified persona, using a range of emotional discourses *'angry', 'lonely'* and *'no friends',* which presented an isolated child experiencing emotional and social difficulties. While the problem was not constructed in technical mental health vernacular, the orientation here presented a sense of an identity damaged by earlier relationships with the birth mother who *'sucks'.* This is consistent with the identity literature that illustrates that adoption can impact on the child's developing identity (Grotevant, 1997). This was also reflected in children's connotations of problem behaviours.

Misbehaving, like messing about at dinner, for not eating my dinner or speaking

at night till gone past nine o'clock. And then, if I was going to the park, to be

late home, I'd be grounded because I'd been told a specific time.

(Child 6)

When asked specifically about family life, children were able to articulate a range of behaviours deemed inappropriate by the carers. These were typically conceptualised using a child-discourse of terms such as *'misbehaving' 'speaking at night'* and *'not eating dinner'*, and can be categorised as behavioural misdemeanours. Such behaviours are not uncommon in children from non-adopted families, although their context and attributed meaning may take a different connotation among adoptive families.

Theme two: Carers' construction of the problem

By contrasting across the multiple-cases for similarities/differences in accounts of the problem, it was evident that the adoptive carers' construction usually reflected those of their children, but was significantly more detailed and serious. Whether by virtue of an adult vocabulary, competence or simply a greater willingness to engage with the interview, they provided a detailed conceptualisation of the difficulties.

A fundamental concern was how the child fitted in with an existing familial framework. The transition from care to an adopted environment is one that can in itself signal some challenges. Indeed, some identified the transition period as retrospectively illuminating the first signals of the existence of mental health problems.

Um, settling in was quite, um, it seemed to go quite smooth for the first bit. However, um, looking back you can see where there were issues.

(Carer 3)

He's always been quite hyperactive. Started off very keen to come to the family and then sort of once boundaries were start to put in place, got very…very challenging at times, almost unbearably challenging.

(Carer 1)

Both these carers reported how they noticed signals that the child was experiencing difficulties that were marked by the transitions from care into adopted family life. While they noticed an initial period marked by positive aspects of transition such as *'quite smooth'* and *'started off very keen'*, a clear decline in behaviour was quickly identified *'there were issues'* and *'almost unbearably challenging'*. This was something experienced by all carers in our sample, as they provided accounts of the severity of the

difficulties that the child brought with them, and were reported to develop and worsen overtime.

But as D's got a bit older and got into his teens, his stress levels are very high, he's always anxious, often depressed….. and so, we went back again because he was having suicidal ideations, lying in bed all day, not eating.

(Carer 1)

I suppose an overall escalation in physical aggression towards ourselves and his sibling who's our birth child. Some sexualised behaviours at home and school which have been ongoing, but obviously the older he gets the more inappropriate that becomes, self-injurious behaviours, quite extensive at times.

(Carer 2)

The difficulties expressed by the carers were clearly reported as more serious than their children described. For example, child 4 described himself as lonely and lacking social aspects of friendships. However, this was reconceptualised by the carer as displaying *'physical aggression', 'sexualised'* and *'self-injurious'* behaviour; i.e. far more extreme problems. Similarly carer 1 described her adopted child as *'anxious' 'depressed'* and *'suicidal',* which again are difficulties that warrant support from specialist mental health

services. While there were many of these types of reports, what is captured here is the extremity of the difficulties experienced, and thus in turn the impact on the family.

Theme three: The problem within family life

The discourses of the problems brought by the adopted child tended to be conflated with discourses of normal family life. Children and their carers depicted scenes of family relations that resonate with other families, while other issues crept into the reports that suggested that there were issues beyond typical family functioning, which again tended to be brought to the fore by the carers more than the children. Notably some children reported positive aspects of living in a family environment, which was consistent with a traditional understanding of the construction of the family. They described engaging in typical activities such as mealtimes, game playing and watching television.

> *Well, I've got my sister and I've got my mum; and then me and my sister we often just hang about, play games, me and my mum we do mainly the same and have fun.*

(Child 4)

However, most of the children offered versions of family relationships that suggested that there were inherent complexities in communication and daily functioning, both at an interpersonal and practical level, which was supported by carers' versions.

> Child: *Me and my dad hate each other, a lot.*
> Interviewer: *Why?*
> Child: *We just do.*
>
> (Child 3)

> *Um, well we had once incident that came up where he goes to school and tells stories of things that happened at home, and he came and said that daddy tried to do X, Y and Z to him. Um, we had various things where there's a lot of, a lot of lying and storytelling*
>
> (Carer 3)

While the child characterised the family relationships in emotive terms *'hate each other'*, the carer conceptualised the family difficulty more in terms of impact and behaviour. Thus, while the child provided an account of the personal relationship with the adoptive father, the mother considered the consequences for them as a family of this emotive positioning. In other words, the mother showed that the feeling the child had

about the adoptive father spilled over into school life with false accusations made. These types of accounts were common, as both adopted children and their parents tried to make sense of their familial relationships. Again the extracts below show that the child provided a characterisation of reasonably normative functioning, but the parent's conceptualisation provided a more extreme account of this.

Interviewer: *How about you and your Dad; do you guys get on?*

Child: *Yeah*.

Interviewer: *Yeah, what kind of things do you do together with him?*

Child: *Not much, because usually he's working.*

(Child 5)

The thing with E, she screams and yells and everything else, and then you get into almost you don't want to be with her. And so then what happens is, it spoils the whole day.

(Carer 5)

The complexity of family life does not simply involve the child and parents, but frequently, and in all cases within our sample, involved other children within the family. This type of relationship can be complicated by the genetic link or lack thereof between

the children, with some siblings being blood relatives of the adopted child and others being born to the adoptive parents. Sibling relations by nature tend to be characterised by a mixture of both positive emotional support and friendship, while often marked by periods of conflict and rivalry, and these periods of family life were frequently reported within the data.

Notably, all of the children described their sibling relationships in negative ways, from simplistic characterisations to more strongly negative assertions. While the children did not make causal or direct connections to their adoptive status in such reports, the descriptions of sibling relationships can be viewed to be an element of the disrupted family harmony that was being reported more generally throughout the interview process.

> Child: *Then he gets out of the house*.
>
> Interviewer: *You don't like him in the house?*
>
> Child: *He's annoying, especially at night.* [Brother]
>
> (Child 5)

> Interviewer: *And how do you get on with your siblings?*
>
> Child: *Okay, my sister kind of annoys me; and my brother.*

When directly questioned about their relationships with their siblings, adopted children characterised the relationships as problematic in some way. The most common ascription to siblings was '*annoying*', which conceptualised a state in which a mild effect was experienced by them. However, some of the children provided more extreme characterisations of relations with siblings.

Child: *Coz my sister sucks.*

Interviewer: *Coz your sister sucks? (.) Can you give me an example how she sucks*?

Child: *Yeah, she is annoying, she snitches.*

(Child 2)

Child: *I've got two brothers that are annoying. And they always hit me*.

Interviewer: *Why would they do that?*

Child: *Because we hate each other.*

(Child 3)

While again the discourse of annoyance was employed as a general description of sibling relations, both of these children reported more severe problematic relationships with their siblings. Utilising a conceptualisation that was frequently employed by child 2, he reported that his sister '*sucks*', which was an ascription afforded the birth mother. While softened to '*annoying*' with an account that could be considered a normative sibling problem, '*she snitches*', the suggestion was that the relationship with the sister is not harmonious. For child 3 this is upgraded further with a negative relationship of '*hate*' constructed. Although a discourse of hatred is not one that is necessarily one genuinely felt by the child, as it is a term not uncommon in child familial descriptions, it does illustrate the level of conflict between the two children. These types of descriptions also reflect a broader family conflict.

Interviewer: *You say your dad is strict or there are rules and things like that; did they cause conflict or anything like that?*

Child: *Between me and dad, yeah, coz…sometimes I'll leave stuff plugged in, like I'll leave my phone charger plugged in but the phone is not attached to the end, and then he'll say 'that will cause a fire…'*

(Child 1)

Notably the scene described is normative in the sense that families argue as a natural course of relationships. The nature of the offence causing the conflict is also fairly typical of family life, with the example being leaving the mobile phone charger plugged into the electric. This natural type of conflict is also oriented to by child 5 in describing a typical family morning at home.

> *Ah, probably, cos it's probably in the morning when we get shouty at each other; I hate getting up in the morning, I'm just like 'go away', 'just go like that'.*

(Child 5)

> *For example, E is very manipulative, so she'll do things she knows that wind me up.*

(Carer 5)

Interestingly, both child and carer positioned responsibility for the conflict with the child and attributed the problem as something dispositional within the child, albeit in different ways. While the child's version of conflict resonates with typical family functioning, '*hate getting up in the morning*', the carer framed the conflict more in terms of the child's personality and difficulties *'E is very manipulative'*. Thus, while in

both cases the child was positioned as responsible for the disharmonious mornings in the household, the carer's version of events placed the child as deliberately causing conflict, while the child presented a version that accounts for the morning problems that is more normative.

Theme four: School influences on the problem

As a child does not operate in a family vacuum, their mental health difficulties and problem behaviours extended beyond the family environment into other areas of life, predominantly at school and with peers. While the difficulties experienced by the children impacted on school functioning and peer relations, they were in many cases also exacerbated by them. Interestingly, children and carers offered slightly different mechanisms to these associations.

> Child: *I also like going out with friends.*
>
> Interviewer: *Yeah? Your mum was saying that you're out a lot, that they have a problem here…?*
>
> Child: *It does get to be a bit of a problem, coz they always say 'you only come here when you want something'. Part of that is true…I come here for the laptop or some food, and then I go out again.*
>
> (Child 1)

I mean this is, you know…he does this a lot with his friends, he tells the most fantastical stories and lies and you know like he wants to be in a different universe, a different reality to what he is in.

<div align="right">(Carer 1)</div>

Evidently, peer relations were constructed as something important, as illustrated by the amount of time spent with friends. The child constructed a scene of typical adolescent behaviour '*I come here for the laptop or some food*', which indicates a preference for being with peers. However, the normativity of friendship indicated by the child here was modified by the parent, who provided a more pathological view '*he tells the most fantastical stories and lies*'. This problematic view of peer relationships was echoed by most of the carers, who acknowledged that, while friendships were important, there were elements of those friendships which functioned to worsen or influence the child's behaviour, such as encouraging inappropriate behaviour '*her friends have egged her on*' (see below).

I have had incidents where her friends have egged her on to do something she shouldn't do, and that's only going to carry on and happen more.

<div align="right">(Carer 6)</div>

Notably, children with a care background can feel a sense of stigma and discrimination, which can have an effect on peer relationships (Stanley, 2007) and, while stigma was not specifically oriented to by our interviewees, negative peer relationships were talked about considerably, particularly in relation to bullying.

> *And sometimes I get called names. Like smelly sock, marshmallow, all other things.*
>
> (Child 3)

> *But then he was blaming me and it turned all the way around in the story that he was missing me at school and he was crying and people were making fun of him, and then I don't think about him when I'm at work all day.*
>
> (Carer 3)

Notably the bullying of child 3 is intrinsically tied to the problems experienced in relation to being adopted. Most adopted children do not understand how the process legally secures their family status (Neil, 2012), and issues of attachment (for some framed as 'attachment disorder') are common among them (Howe, 2003). While the child provided a simplistic version of the bullying '*I get called names*', when asked for

examples, their carer provided an account for the bullying located in the child's attachment problems. She reported that the difficulty encountered in the school was that the child missed her to a point of tears '*he was missing me at school and he was crying'*, which led to the other children *'making fun of him'*. However, bullying was not the only problem encountered in the school environment, as parents reported issues of discipline and the negative impact of inappropriate techniques from the school staff, which suggested a lack of support from the school.

> *Because they're still trying to discipline him via school disciplinary techniques, so they don't see that actually isolating him and sending him out the classroom has such negative impact on him because of the abuse and the self-esteem.*

(Carer 4)

Issue two: Managing and coping with presented problems

Given the complexity of the child's history and disrupted familial environment, carers were charged with a responsibility of managing the daily functioning of the child within and outside of the home. Both parties talked about the different ways they managed their conflicts, problems and mental health difficulties, both from within the family and through external supports. There were two key themes pertinent to managing and

coping: the fifth theme was managing internally within the family and the sixth theme referred to external sources of help.

Theme five: Managing internally (within the family)

Adopted children and their carers sought a range of coping strategies to deal with daily stressors. Again this was an issue whereby both parties provided different accounts, which reflected some of the tensions that existed within their relationships.

> Child: *And then it's going from one against one, to two against one.*
> Interviewer: *Okay. So, how would you react if they are ganging up against you?*
> Child: *I just tell them to shut up and walk out or go in my room, or go round a mate's.*
>
> (Child 1)

> *He does talk to other people, he talks to his boys brigade that he does, and he's always…you know when he's gone…when he's had therapy they've always…it has always been fed back to us that he participates well.*
>
> (Carer 1)

Here the child was describing family life and presented the case that the other members of the family collaborate against him. The picture built by the child was one of competition with the rest of the family. The coping strategy for such conflict was presented as removing himself from the situation, which to some extent is arguably a healthy way of managing it. A positive way of coping was also presented by his carer, who reported that the child does talk through the problems with friends *'he talks to his boys brigade'* and through the therapy *'he participates well'*. In contrast, it appeared more difficult to agree on adaptive responses to challenging behaviours within the family. This was an issue considered at length by both the adopted children and their carers.

> *Losing gadgets for a week. She always brings in the gadgets first, coz she knows I hate it.*
>
> (Child 2)

> *She would make me write sentences or sit on a time out.*
>
> (Child 3)

> *Sometimes she doesn't let me go out for a bit, some of...most of the times she sends me up to my room.*

There is research evidence which demonstrates that parents of children with mental health problems can struggle to discipline the extreme behaviour of their children and sometimes resort to more physical techniques (See O'Reilly, 2008). However, in these reports discipline techniques are reported as normative and general strategies. *'Losing gadgets', 'time out',* and being sent *'up to my room'* can be successful if used clearly, consistently, not punitively, and the child is aware in advance; but can be counter-productive if applied ad hoc and/or accompanied by a negative and rejecting emotive tone. Interestingly, some of the children appeared able to comprehend the purpose of these strategies. What was less clear was whether they associated them with a particular behaviour or whether they internalised their previous experience of abuse and neglect in *'I do actually deserve it'* (see below).

> *Well, I kind of understand cos it's my fault for messing about. So to be honest, I do actually deserve it.*

(Child 6)

Notably, parents offered slightly different accounts of discipline and, while reflecting the narratives of their adopted offspring, they reported taking time and effort to

understand the causes of the behaviour rather than responding immediately. This is particularly important for this group of children in the context of their past experiences.

> *If he's behaving badly, I don't address the behaviour .... I'll sit down with him and say 'what's going on with you?' you know and .....'what's worrying you?' you know, so, try to get behind the behaviour and look at what might be causing it.*

<div align="right">(Carer 1)</div>

> *If he is not managing as well, then we don't punish him for that, but what we say is 'obviously you're not managing so well at the minute, so what we are gonna do is take that responsibility away.*

<div align="right">(Carer 2)</div>

Intrinsically tied to these notions of discipline was the issue of blame and responsibility. Typically the carers' accounts were at odds with those of the children as, while there were some occasions (as pre-noted) whereby the child accepted some responsibility for their behaviour, mostly they reported feeling persecuted and blamed for all eventualities within the household. The carers contributed to this sense in the interviews by focusing on the problems within the child and holding the child responsible for the difficulties

experienced in family life. A good example of this comes from family 3, where statements could be referring to the adoption process.

Child: *My daddy thought it wasn't a good idea to have me, but he thought it was a good idea to have K and J.*

Interviewer: *Why would you say that?*

Child: *Because he never blames them too. Because he always blames me.*

Interviewer: *Right.*

Child: *And I'm always the person who gets told off as well.*

(Child 3)

There's an awful lot of destruction and breaking things, ruining things on purpose. Denying that he's done them. Um, and that only happened just a couple of weeks ago with a brand new pair of school shoes. He just ripped the whole sole off both shoes. But, again, we chatted, talked to him about it, at the time denying it, said he kicked the football and it broke. And it didn't, we know that. But just two days ago we talked about it a little bit and he said, yeah, I did; and when I asked him why he ripped them apart, he said I don't know. I don't know.

(Carer 3)

While only one example has been cited here, Carer 3 provided many examples which positioned the problem as dispositional within the child and marked the intentionality of the behaviours displayed. Thus, while the child reported a sense of persecution, of being continually blamed *'he always blames me',* and *'I'm always the person who gets told off"*, the carer presented a version that this blame was justified. Notably, the child constructed a position of opposition in his narrative as markedly being treated different from the siblings (particularly if these were not adopted), thus demarcated a sense of differentness from the rest of the family, a sense which is not uncommon for children who have been adopted (Grotevant, 1997). In contrast, the carer constructed a version of extreme behaviours, a sense of the child being out of control, behaviours that were evidently admitted by the child later on.

Theme six: External sources of help

Given the difficulties in managing family life, and the variability of success in coping and behavioural strategies, families actively sought help from a range of external sources.

> *We started a third school, and I had to have her home for three months when she*
>
> *was really distressed and in a right state, and that was just horrendous for me,*

because I had no, nobody at all giving me any help in how to deal with it, not

one person. And it was just friends of mine who kept me going basically.

<div align="right">(Carer 5)</div>

I did feel I had to get to rock bottom before I could ask for help. Cos it's almost

like you're admitting defeat and you've been interested with this child to nurture

and to bring them to the best of your ability, and you don't want to admit that

you're failing.

<div align="right">(Carer 4)</div>

Clearly these carers had a high need for support but reported that the process of asking

for help was unclear, laborious or not easily available. This is consistent with previous

research that has shown that many families had to wait for more than a year to get

support for the family or child, and that 44% felt that their needs had not been met

(Monck and Ruston, 2009). The participants described the effect of these problems as

feeling isolated and they argued that it was difficult to obtain appropriate support. For

example, carer 5 reported having *'nobody giving me any help in how to deal with it'* and

instead relying on *'friends'* to keep going. This was supported by carer 4 who argued

that she had to reach *'rock bottom'* before asking for help. This carer even admitted that

life was so difficult with the child that she contemplated handing him back to the care of Social Services.

> *So, despite all the strategies, I think at one point I was at the point of thinking*
> *I've had enough, I don't want him anymore and I did actually say to Social*
> *Services: 'look if things don't improve, that's it'. I don't want to say that and I*
> *think part of me was only saying it because I wanted to get some help.*
>
> <div align="right">(Carer 4)</div>

Of course, given the nature of this sample, eventually for all of the children CAMHS eventually became involved. In itself mental health labels can be stigmatising and viewed negatively by young people (see Moses, 2010; O'Reilly et al, 2009), which can be hindered further by their fear and uncertainty regarding what CAMHS involves prior to attendance (Bone et al., 2014). Among our families, views regarding the involvement of CAMHS varied, and mostly children resisted talking about CAMHS or therapy, while some felt that it affected their identity in negative ways.

> Interviewer: *What about the people?* [CAMHS professuals]
> Child: *They treat us like babies, just because we're stupid, don't mean they need*
> *to treat us like poos*.

Interviewer: *Why would you say you are stupid?*

Child: *Because I am. Apparently I got stupid nuts.*

Interviewer: *Who told you that?*

Child: *Me…apparently I've got special needs.*

(Child 2)

Clearly this child conveyed a negative view of CAMHS in the sense that his identity was constructed in negative ways by association with the service. The child here constructed himself as '*stupid*' referencing the label *'apparently I've got special needs'* as the evidence for the conclusion. While the label of special needs is not directly contested by the child here, it is argued that the professionals within CAMHS '*treat us like babies*' and used the construction of '*special needs*' as the account for why he is treated that way. The tone, content and nature of the account offered by the child illustrated that the view of CAMHS was a negative one, although no orientation was made to the relevance or success of the intervention offered, and the child resisted talking about specific treatment courses or outcomes. The carers were, however, much more vocal about the involvement of CAMHS, and some specifically referenced an attachment intervention that they had been involved with. Interestingly, attachment therapies can be attractive for adoptive families, as their focus is on past trauma and relationships with prior caregivers; attachment theory thus needs to be viewed through a

more critical perspective, as it is over simplistic to attribute all difficulties to early attachment (Barth et al., 2005), whilst taking advantage of the increasing body of evidence on the appropriateness and effectiveness of such interventions (Vostanis, 2014). It was perhaps, therefore, unsurprising that attachment therapy was actively sought.

> *It was J from one of those that we spoke to one of the foster parent that had been*
> *to an attachment group at CAMHS, so we again asked if he could attend that or*
> *we could attend that, and we were told at that time that there weren't enough*
> *people to run it.*

<div align="right">(Carer 1)</div>

For some children attachment-focused therapy was actually recommended by services, who considered that the child's difficulties predominantly stemmed from past experiences.

> *So, it was actually Social Services that decided to refer him to CAMHS because*
> *of his behaviour. Because they felt that his violence at going to school was part*
> *of the attachment, because he was frightened of leaving me, but also that I*
> *wouldn't pick him up at the end of the day.*

Perhaps most importantly, and in contrast to their adopted children's views, most of the carers felt that the involvement of CAMHS did lead to positive outcomes, at least to some degree.

> *It was, I wasn't on my own, you know, other women were saying the same* (at adoptive parents' attachment-focused group)*. So that was really useful, and I'm sure that was part of learning together.*

<div align="right">(Carer 5)</div>

Nonetheless, there may not be a single intervention or short-term change for some mental health problems; hence, some parents felt that the intervention was unsuccessful.

> *But at the moment I don't think it's having much difference. We had a very, very big trough at Christmas time, and it's only just plateauing out now.*

<div align="right">(Carer 4)</div>

Discussion

There is increasing acknowledgement by policy of the importance of placing available support systems in place early on in the adoption process, as research evidence has repeatedly highlighted unmet need and service gaps (Munro et al, 2013). This is in order to both enhance placement stability and child growth, and to prevent potential painful placement breakdowns. The multitude of needs for both children and carers, and the relevance to children's past experiences and current circumstances, often make in unclear whose responsibility it is to meet these needs; if so, which therapeutic framework and intervention to apply (Howe, 2003).

Such a group of families who had already attended a designated child mental health service shed some light on how they perceived the problems that initiated their help-seeking for, and the available supports they subsequently received. A number of overarching issues appear to cross-cut the emerging themes. These relate to how the problem was constructed and its different dimensions (within child, family and/or community); the extent to which these could have applied to any family or their specificity to adoption; and the similarities and differences between children's and carers' views.

The 'generic' problems that could apply to any other family included references to parental responses, discipline and setting boundaries in relation to oppositional

behaviours; family communication; peer and school relationships; and certain displacement of wider issues on the child. The latter is not uncommon from a range of settings, in terms of conceptualisation of the problem (particularly as dispositional in the child), over- or under-reporting, and explanation of underpinning reasons (Dirks et al., 2014). Factors such as a parent's own mental health may skew some of these attributions (Cornah et al., 2003), or their desire to account for issues as outside of their control, so as to not be blamed personally (see for example, O'Reilly, 2014).

A number of quotes had plausible connotations to adoption, while others made specific references. This lack of clarity, ambiguity or uncertainty merely reflect families' natural process when they seek help, indeed these feelings are often mirrored by the practitioners involved in the discussions on which is the most appropriate approach for each family and situation. Direct links were made with the child's birth parents, their move to the adoptive family, or what the child 'brought' to their new unit. Other statements appeared more indirect such as feeling different at school, being more vulnerable - for example, to bullying because of being adopted - or suffering parallel or consequential losses, like having to leave their previously stable school. Some behaviours could usually be perceived as continuous or age-specific, however, here there are also subtle inferences that unresolved issues surrounding the adoption process can resurface in teenage years.

We do recognise that this research has some limitations such as the small sample, its selection from a particular service, and the lack of information on the interventions and corroborative information from the clinicians. We acknowledge, therefore, that transferability of findings to *all* adopted children is limited by this. However, it does start to build a picture of these children's and their carers' perceptions. The key strength was the inclusion of adopted children and hearing their voices, as particularly those with mental health difficulties can be hard to recruit because of adults' concerns of inflicting distress; thus research of this nature is considerably lacking (Neil, 2012). Future studies could address these gaps by exploring families' perceptions of different agencies and treatment modalities.

Nonetheless, our findings very much reflect observations from clinical practice. Very few, if any, families are clear of the nature of the causes behind the surface (symptoms or challenging behaviours); as these can be inter-related, with the impact of past abuse and neglect, the adoption process, the young person's development, and the current environment (being parenting, family, school or peer-related) potentially playing a part. There is evidence that the threshold of help-seeking is lower for adoptive compared to other parents/carers, which may reflect their sensitivity, awareness and emotional investment (Brent et al., 2000; Ratnayake et al., 2014). The referral, assessment and

intervention process usually helps families become clearer on the differential effect of these factors, and the pace may well be different for parents and children. How do families know whether the child's behaviours are related to the adoption? Most need time to unravel their narrative, and this can be facilitated by a safe and engaging therapeutic space.

It is clear that some common questions that need to be asked for adoptive families presenting with similar concerns, is whether a universal or targeted service is appropriate at that point in time (Rao et al., 2010). Expertise in adoption, trauma and attachment problems can run through both, i.e. from post-adoption to designated child mental health or other therapeutic services (Howe, 2006; Carnes-Holt, 2012; Kerr and Kossar, 2014). Attachment-focused therapies are increasingly available, with emerging new evidence on their indications and effectiveness; however, some studies have also found them to be perceived as popular because of potentially locating blame for the child's current difficulties with the prior caregiver, thus potentially relieving adoptive and foster carers of the responsibility of addressing their own style and strategies (Barth et al, 2005). For this reason, 'here-and-now' generic problems can equally require parent training based on social learning theory, family support - including prevention of placement breakdown, and/or family therapy. These approaches are not mutually exclusive, rather complementary, but require a clear assessment and alliance with the

parents and the child, thus avoiding the temptation to either ignore the past or remain

fixated on it. Indeed, there is increasing attention on adapting generic individual, group,

parenting and family interventions for this vulnerable group (Rushton and Monck,

2009; Puckering et al, 2011; Ingley-Cook, 2013), as well as training programmes with

strong attachment focus and therapeutic elements (Allen and Vostanis, 2005). The same

dilemmas apply to schools that need to integrate children; while remaining mindful of

behaviours having different roots and explanations, hence requiring different strategies.

One should not underestimate the importance of informal supports, although these may

not be easily apparent, available or linked. Several variables will weigh on the

assessment and planning of intervention such as the child's history, age at adoption,

developmental capacity and other established risk factors (Hassey et al., 2012).

Concluding remarks

In conclusion, it is clear that formulating the nature of the presenting needs and

difficulties of adopted children, and reaching a common understanding with parents and

children is essential before determining the most appropriate agency (or agencies), as

well as the framework, objectives and level of the intervention. Naturally, these are

further constrained by their availability, which is further compromised in the current

economic climate and the loss of services, predominantly those on the interface between

statutory and specialist provision. Despite the policy rhetoric and guidelines, the reality

on the ground is very different for adoptive families.

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The authors have no conflicting interests to declare.

Table 1

Characteristics of participating families

Child number	Age at interview	Gender	Age at adoption	Years with family	Time in care pre-adoption	Number of care placements prior to adoption
1	18	Boy	6 years	12 years	18 months	More than 10
2	10	Boy	3.5 years	6 years	Not recorded	Not recorded
3	8	Boy	5 years	3 years	2.5 years	1
4	10	Boy	18 months	8 years	1 year	1
5	10	Girl	9 months	9 years	From birth	1
6	13	Girl	11 years	2 years	3 years	2