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Case Report

Intercountry adoption, trauma and dissociation: Combining interventions to enhance integration

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ABSTRACT

Although intercountry adoption, according to systematic reviews as well as meta-analysis, is from a perspective of child protection, a successful intervention, this often comes at the cost of lengthy therapy and support. Both in studies as in clinical practice intercountry adoptees are overrepresented in mental health services worldwide (Barroso, Barbosa-Ducharne, Coelho, Costa, & Silva 2017; Palacios & Brodzinsky, 2011; Van IJzendoorn & Juffer, 2006; Rutter et al., 2009). From my clinical experience, the focus on classifying the problems and using highly standardized treatments are not enough to help intercountry adoptees and their families (Vinke, 2011, 2012). In this practice-based article, I propose to use the concept of Van der Kolk's Developmental Trauma Disorder to describe the problems intercountry adoptees face in combination with Waters' Star model (Waters, 2016; Van der Kolk et al., 2009; Gindis, 2019). Although not an official DSM-5 disorder, DTD has been embraced by many clinicians as a valid concept to approach the diversity of symptoms seen in patients coming from severe deprivational backgrounds such as intercountry adoptees. Both have proven useful in my small private practice[2]DTD and the Star model prove helpful especially when dealing with dissociative symptoms. In 2004, the ISSTD published guidelines on evaluation and treatment of dissociative symptoms in children and adolescents, yet dissociation is hardly ever mentioned in diagnostical evaluations. This strikes as odd since in daily life of adopted families, in clinical practice, in peer supervision, when discussed, dissociative behaviours seem often very present. Still they are hardly ever referred to in research, assessment or treatment in relation to intercountry adoptees. In this article, I will focus on trauma related dissociation in intercountry adoptees and present a theoretically informed, practical approach to this phenomenon with respect to intercountry adoptees that integrates insights from developmental, trauma and neurobiological research. The approach is illustrated by using some clinical case-examples.

1. Introduction

Research in general looks at intercountry adoption with ambiguity. On one hand, studies show many positive effects of adoption. There is massive catch up in growth, both physical as well as psychological, so that adoptees in due time hardly differ in functioning from their non-adopted peers. This continues into adulthood, where adoptees report a high level of satisfaction with their current life (Van IJzendoorn & Juffer, 2006; Finet et al., 2020; Greene et al., 2008; Ter Meulen, Smeets, & Juffer, 2019). On the other hand, there are many articles that show a high number of mental health problems, high referral rates and extensive use of mental health services for adoptees, throughout the life span (Behle & Pinquart, 2016; Palacios & Brodzinsky, 2011; Barroso

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[2] De Adoptiepraktijk is a small practice, with one practitioner, licensed child psychologist with a PhD in adoption. De Adoptiepraktijk specializes in assessment and treatment of adopted related mental health issues in youth and adults. Founded in 2006, 15–20 clients a week; in the period of 2016–2019 164 adopted clients were treated with an average of 20 sessions; 20% were adults, 80% were children ranging from 2 years to 18 years of age. Clinical findings in this article are based on experiences in this practice.

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2468-7499/

et al., 2017; Hjern, Lindblad & Vinnerljung, 2002; Tan & Marn, 2013). Only recently has there been a shift to a more trauma-informed and trauma-focused approach to problems presented by intercountry adoptees (Gindis, 2019).

Dutch clinical practice in post-adoption services focuses on strengthening parenting skills and attachment in adoptive families, mainly by offering preventive video based interventions soon after arrival (Juffer & Bakermans-Kranenburg, 2018). Still, after a while for a number of children problems arise and all sorts of problems may become apparent. Research mentions developmental delays, lags in physical growth, sensory processing difficulties, internalizing, externalizing, and attention problems (e.g. ADHD); delays in social skills; (quasi) autism, attachment problems, problems with speech, language, and learning deficits (Baden, Mazza, Kitchen, Harrington, & White, 2016; Tieman, van der Ende, & Verhulst, 2005; Rutter et al., 2009). In clinical practice, parents might present their worries and problems in terms like aggression, impulsivity, hoarding, sleep problems, lying, self-harm, anxiety, controlling behaviour, stealing and so on. Hence, a substantial number of intercountry adoptees are in need of more and different services at some point in their lives. Next to the interventions offered, a whole range of classifications are given to intercountry adoptees, but I have observed that none of them really covers the full range of problems they encounter, nor does any of the DSM-5 classifications provide a focus that really takes adoption or early adversity fully into account. This does in my opinion not fit with research findings on early life stress/adverse childhood experiences and (relational) trauma. Even if the latter is identified, presented symptoms hardly ever justify a DSM-5 PTSD classification. Also, pre-adoption information might be very brief or non-existing which makes classifying and treating trauma symptomatology when following DSM-5 rules difficult.

In daily life however, (relational) trauma and stress-related symptoms are often present. In my experience, these problems do need sensitive, attuned parenting, as often learned in the video interventions, but they will not diminish fully just by skilled parenting alone. In my opinion, both a more extensive assessment followed by varied interventions are needed to really address all that lies underneath the presenting problems. In this clinical-based article, I propose the use of Van der Kolk's concept of Developmental Trauma Disorder (DTD)D (Van der Kolk et al. 2009) and Water's Star model (2016) as a way to choose and plan the sequence of interventions that might be helpful for intercountry adoptees and their families.

Since this is a clinical article, I mainly use a narrative approach, guided by research findings as point of reference and clinical examples to illustrate my way of working. To get an idea of the lay of the land, I start with a short overview of the Dutch situation in intercountry adoption and mental health services provided in the Netherlands. The Star model developed by Waters (2016) is introduced, mental health issues in intercountry adoptees in general are discussed and the use of both DTD and the Star model for assessment, treatment planning and therapy in intercountry adoption is illustrated by some case examples. A discussion on future pathways and research concludes this short.

1.1. Intercountry adoption in the Netherlands

Ever since 1956, the first year the Dutch adoption law came into force, a total of over 40,000 children entered the Netherlands to be adopted. They were born in over 100 different countries. The oldest adoptees are now in their sixties, the youngest under the age of one year old. In the intervening period, intercountry adoption practice has changed. Firstly, the number of intercountry adoptions has dropped worldwide, this is attributed to various factors such as awareness of problems associated with adoption, societal criticism on adoption, political situations in birth countries and the adherence to the Hague Convention on Intercountry Adoption (Selman, 2009, 2020). This drop is reflected in the number of 145 children entering the Netherlands in 2019 to become a permanent family member compared to 20 years earlier, when the numbers where significantly higher: 1193 children were adopted in 2000 and in 2009, 682 adoptees entered the Netherlands.[3] Secondly, the profile of the adoptees has changed. Due to restrictions in adoption laws, the majority of children are under the age of six years old on entrance, in 2000 48% of the children were under the age of 1 year old on entrance[4] whereas in 2019 15% of the children belong to that category.[5] The health condition of adoptees has changed in 2019 almost all had to some extent medical, developmental or educational needs, which means that after the adoption they are in need of medical treatment and/or (intensive) therapy. These adoptions are classified as 'special needs' adoptions. Whilst in 2009, 46% of all children entering the Netherlands were classified 'healthy', in 2019 this number dropped to 5%.[6,7] (Selman, 2009, 2010, 2012, 2020; Dutch Ministry of Justice and Safety, formal statistics, 2001, 2010, 2020). This shift in practice, may lead to a higher demand of (mental) health services in the years to come.

Domestic adoptions are a big contrast to this: in domestic adoptions, a newborn infant is relinquished by the birth parent(s) and is placed after 3 months in an adoptive family[8]. This number has been around 20 each year for the past decades (Werdmuller & Bolt, 2018).[9] Adoption without parental consent is not possible. Children that cannot live with their birth parents will grow up in long-term foster care.[10]

The adoption procedure in the Netherlands is a highly regulated process with several mandatory steps and checks such as a preparation course (5 sessions) by the Foundation Adoption Services (FAS); assessment of the adopters in a home study by the Child Protection Board (CPB); leading to a formal permission to adopt by the Central Authority/Dutch Ministry of Justice and Security. Finally, the matching and placement takes place,

[3] Official statistics Dept. of Justice and Security, Dutch Government 2001, 2010, 2020: https://www.adoptie.nl/adoptie/cijfers/.

[4] Van IJzendoorn and Juffer (2006) find an almost complete catch up in attachment security for early-children adopted children, e.g. children adopted under the age of 12 months.

[5] Official statistics Dept. of Justice and Security, Dutch Government 2001, 2010, 2020: https://www.adoptie.nl/adoptie/cijfers/.

[6] Official statistics Dept. of Justice and Security, Dutch Government 2001, 2010, 2020: https://www.adoptie.nl/adoptie/cijfers/.

[7] Due to the principle of subsidiarity as honored by all countries party to the Hague Adoption Convention (33) (www.hcch.net) first kinship care is explored, then domestic adoption is considered and only when no family type care can be provided in the birthcountry, adoption can be an option. This proces takes time. After that the paperwork needed for all court procedures takes time too. Most children therefore are over the age of 1 year when entering the Netherlands.

[8] In the first 3 months the baby is placed in a neutral foster family and counselling is given to the mother so she can decide whether or not uphold her decision to relinquish. Only after one year the relinquishment is offical and the adoption can be formalised.

[9] https://www.fiom.nl//sites/default/files/landelijke-afstand-ter-adoptie-registratie.pdf.

[10] Unlike Anglo-Saxon countries the Netherlands hardly ever have the possibility for children to be adopted out of foster care or through the child protection system. Long term foster care is more common and guardianship then is either transferred to the foster parents or to the child protection services. In case of domestic adoption, unexpectedly pregnant mothers are offered services to help them decide whether or not to keep the baby and in case of relinquishment, they are allowed to help choose the adoptive family. The number of relinquishments fluctuates between 10–20 per year for the whole of the Netherlands. However, in the fifties, sixties and seventies, more children were domestically adopted, so there is a population of approximately 20,000 domestic adoptees (statistics provided by CBS and Dutch Ministry of Justice and Safety, 1956 till 2019).

mediated through one of five private adoption agencies. The process is lengthy: most cases take up to four or five years, sometimes the process even takes longer. After the actual placement, there is a medical evaluation by a pediatrician, but there is no psychological check up of the child, nor is there a specialized psychological care system in place.

Preventive interventions such as video guidance to enhance attachment are delivered by FAS and several private parties. There is no centralised or specialised mental health service focusing on adoption related issues or educational support in adoption related school problems. A small number of private organizations and clinicians are specialised in adoption and early trauma related problems and they all have full practices. Next to that adult adoptees offer coaching services based upon their personal experience. All practitioners choose their own focus, which have been mainly attachment and/or identity issues.

1.2. Core concepts

1.2.1. Developmental trauma disorder

Developmental trauma disorder has been proposed by Van der Kolk et al. to help clinicians identify symptoms and problems that occur in children and adolescents as a result of long term exposure to adverse events with a relational signature such as interpersonal violence or repeated changes of caregiver. This exposure has impacted the physical and psychological development of the child, leading to dysregulative patterns in the affective, physiological, attentional, behavioural, self and relational domains. There are post-traumatic spectrum symptoms present and there is functional impairment on several levels such as educational, familial, peer, legal and vocational (Van der Kolk et al., 2009; Ford et al., 2013; D'Andrea, Ford, Stolbach, Spinazzola, & Van der Kolk, 2012). Gindis (2019, p. 37) defines DTD in relation to intercountry adoptees as follows "Early childhood trauma is a condition caused by repetitive, pervasive, subjectively highly stressful events, mostly within the interpersonal context of the child's life that have an adverse, wide-ranging, and long-term physiological and psychological impact on the development and maturation of high psychological functions, thus compromising neurodevelopmental integration of sensory, emotional, and cognitive systems into cohesive whole of a mature socially adjusted individual." Also, Gindis (2019) adds there is an influence epi-genetic and genetic components to DTD which is very valuable although often unknown and never to be unveiled in intercountry adoptees that have little to no information on their lives prior to the adoption.

Often various states of arousal, hyper-arousal and hypo-arousal, alternate rapidly. Gindis (2019, p. 56) states that 'the rigidity of internalised traumatic consequences is astonishing.' Also, these states are not always easy to spot, especially dissociation, as a powerful survival mode against overwhelming threats or pain. I have observed this in clinical practice but this is often overlooked.

1.2.2. Star model

Waters (2016) introduces the Star model to help assess and treat especially dissociation in children. In this model, a combination of five well know psychological theories is made: attachment, neurobiology, developmental, family systems, and dissociation. She clearly distinguished 'non-pathological' dissociation from pathological dissociation, by posing both on a continuum, where the main "characteristic between nonpathological and pathological dissociation is that pathological dissociation comprises some degree of a 'structural division' within the self, causing disturbances in consciousness, memory, perception, and/or identity." (Waters, 2016, p. 5–6; ISSTD, 2004; Fisher, 2017). When exposure to traumatic events, especially of a relational nature, is prolonged, pathological dissociation may occur. It is this pathological dissociation, the instinctive neurobiological 'escape hatch' as Waters calls it, based on Porges' polyvagal theory (Porges, 2011), that is the scope of the next part of this paper. The importance of neurobiological, neurosequential informed assessment and treatment can also be found in the work of Perry (2003). He points out that the combination of genetic make up and (relational) experiences have an effect on brain and functioning of the child. Humans are meant to find ways to survive, even in the worst circumstances — they adapt to threat in their own way ranging from hyperarousal to dissociative responses and often using a combination of both. When the threat is gone, the adaptive pattern stays. Repairs can be made later in life, due to neuroplasticity but this process is often lengthy and difficult (Baylin & Hughes, 2016; Perry, 2006, 2019; Porges, 2011; Schore, 2011) (Fig. 1).

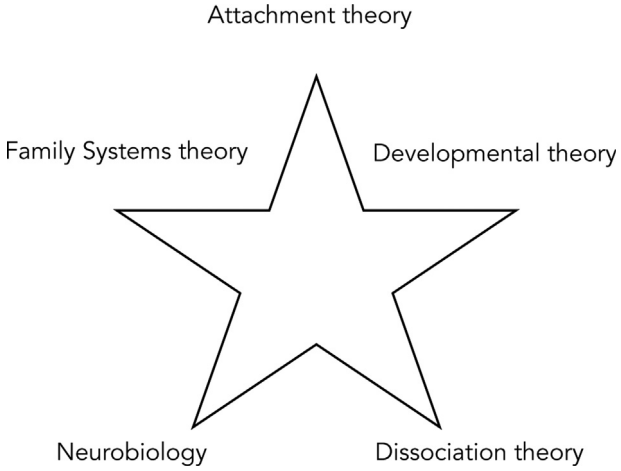

Fig. 1. Star Theoretical Model for assessing and treating childhood dissociation based on five theories (Waters, 2016, p. 4).

1.3. Mental health in intercountry adoptees

As stated above, intercountry adoptees make extensive use of mental health services and in spite of all these services provided, a significant number of adoptees still experiences life long negative effects of the past (Barroso et al., 2017; Behle & Pinquart, 2016; Dekker et al., 2017; Gindis, 2019; Hjern et al., 2002; Juffer & Van IJzendoorn, 2012; Lindblad, Hjern, & Vinnerljung, 2003; Tieman et al., 2005; Van IJzendoorn & Juffer, 2006; Verhulst, 2008).

Researchers explain these findings by a combination of adverse, often inter-relational traumatic childhood experiences that shaped the lives and brains of the adoptees prior to the adoption. Experiences such as inconsistent care, maternal stress, malnutrition, violence, abuse, neglect and maltreatment contribute to early life stress, which inhibits regular development and therefore, can be seen as responsible for the social, relational, cognitive and behavioral problems that often arise after the adoption (Swinton, 2011; Juffer & Van IJzendoorn, 2012; Gindis, 2019).

Behle and Pinquart (2016) found elevated risks for the DSM classifications of ADHD, anxiety disorders, CD/ODD, depression, substance use disorders, personality disorders, and psychoses. Attachment disorders should be added to this list: both in institutionalized children as well as in adopted children. A larger proportion of insecure attachment is found than in regular populations (Van den Dries, Juffer, Van IJzendoorn, & Bakermans-Kranenburg, 2009; Kerr, 2014).

Gindis (2019) summarizes the problems that intercountry adopted post institutionalized children[11] encounter as a threefold combination of medical issues, social and educational issues and mental health issues. In clinical practice, the medical angle is easiest recognised, diagnosed and treatment is often clear-cut. In the Netherlands, an adoption-focused medical evaluation is conducted upon arrival and if needed, treatment is started (Hogenboom, de Weerd, Tjon a Ten, Mulder, & Pelleboer, 2013; Wolfs & Pelleboer, 2017). Educational, social and behavioral issues often emerge during the years after the adoption. There is no standard psychological evaluation on entrance nor is there much anamnestic information (e.g. genetic or epigentic) to guide treatment: clinical evaluation of current symptomatology thus becomes very important. Since attachment is foundational in family formation, a preventive short video guided intervention is successfully offered to most new families, helping adopters to attune and respond sensitively to their new child(ren) (Juffer & Bakermans-Kranenburg, 2018). In the long run this is very helpful but not always sufficient for problems that arise at a later point in the adoptees life. Although I do not have exact numbers for the full adoption population in the Netherlands, in my small private practice I have seen over 150 clients since 2006, that all had various DSM classifications and although all classifications more or less might ring true, the trauma and neurobiological informed focus as proposed above, is not common. This is in my opinion one of the reasons that dysregulation and poor regulatory skills are seen but not explored further with a consequence that hard to spot features such as dissociative tendencies and pathological dissociation are often missed. Also, dissociation in intercountry adoptees has not been the focus of many research or publications. During a literature search, I could only find a few articles that were related to criminal, none relating specifically to children (Stewart, Dadson, & Fallding, 2011; Kirschner, 1992; Kirschner & Nagel, 1996). So what happens if we do look beyond the dysregulation and use a developmental trauma informed lens to take the problems that intercountry adoptees encounter into account?

2. Practice

Most children that come to my practice have had previous therapy. They bring a big file, with a number of DSM-classifications in it. On referral they fill out an adoption aware application form. For me this is a starting point — we look at previous findings and try to fill in the gaps. Since this is a tailor made approach, no standard assessment battery is used. Based on the information in the file and the indication for treatment, additional questionnaires such as the Child Behavior Checklist, Dutch parenting questionnaires, a Sensory Profile, the CRIES-13 and problem focused assessment instruments (e.g. ADHD focus or ASS focus) can be administered.[12]

Each new client starts with an average of three contacts. We start with a parent interview, then one or two parent–child sessions follow. Observations, especially tracking the body of the child, are very important in the assessment phase.

In starting therapy with adopted children that could all be diagnosed to some extent with DTD, the first step is to build a therapeutic relationship. In this relationship, I need to be predictable, attuned and nurturing for both parent and child. That is the first step, mimicking co-regulatory processes that are foundational to self-regulatory capacities in later life (Baylin & Hughes, 2016; Beeghly, Perry, & Tronick, 2016). Therapy can only make progress when both the child, parent and therapist are in a calm-active-alert state, regulated to be within the window of tolerance, working on the edges: safe but not too safe so we can actually help our clients to reorganize their experiences and change patterns that helped them survive but are no longer needed (Ogden et al., 2006; Ogden & Fisher, 2016; Porges, 2011; Porges & Dana, 2018; Perry & Dobson, 2013; Perry, 2019).

When an adequate therapeutic container forsessions is established, my first aim is to assess and if necessary work with sensory and self-regulation. In order to do this, I start with listening to the stories whilst simultaneously tracking the body. Tracking is a skill used in sensorimotor psychotherapy (Ogden et al., 2006; Ogden & Fisher, 2016). In tracking the therapist looks at present moment markers of trauma and dissociation, such as micro-movements, posture, muscle tone, breathing patterns, heart beat, orienting response, eye-contact width of the pupils. To ascertain how the experiences are held in the body. For non-somatic working psychologists it takes some practice to learn how to spot these physical signs without performing a physical exam. However, when trained it is amazing how much information just a detailed tracking of the body might give you that enables a comprehensive assessment to take place revealing the legacy of the experiences in the current day.

2.1. Case study David

David is 10 years old when he enters therapy. He is born in Colombia and adopted at age 4 together with his two older brothers. In Colombia, the boys experienced hunger, maltreatment, neglect. They were taken away from their parents by the child protective services, had four different foster families and were legally freed for adoption. At home, the parents experience is that there is a lack of reciprocity, no contact, contrasting with times he can explode and become aggressive. He is in special education where he has severe concentration problems.

He enters therapy after being diagnosed ADD by a psychiatrist. On the first session, I see an age appropriate boy that tags alongside his mum. Sits down, does not make eye-contact — eyes are moving rapidly just not meeting mine, skintone is pale, there is slow breathing, yet he is constantly fidgeting with the sleeves of his sweater.

In this case, my first aim is to help David be with me in the room. I have to find a way to engage him, to establish contact. First, I start mimicking his body. Then, I look at ways to contact him at the level where he is. The fidgeting of the hands makes me think that he needs some activity to regulate just so that we can start talking and see what we can do together. So we start throwing a ball. This is a rythmic repetitive activity that reoccurs every session thereafter and helps him be present and start talking on the topics he is sent in for. Mum, who is also present during sessions, is also part of the ball game. In time we experiment, try different balls, different speeds, keep it predictive yet playful.

This example shows in my opinion that by starting from a neurobiological informed perspective, a therapeutic container is formed, body awareness can be established by talking about what happens in the body during the throwing, the beginning of body/relational safety is formed and in due time we can move on to the other topics that need to be addressed.

[11] Gindis work focuses on post institutionalized adoptees, intercountry adopted post institutionalize children (IAPI). I choose not to use this term because sometimes children are not adopted from orphanages but directly from foster families hence IAPI is not applicable for the whole.

[12] Administration of questionnaires is a matter of shared decision making between clinician and parent, based upon previous clinical information, referral information and indication for treatment. If needed questionnaires are administered through an internet portal: http://www.embloom.nl.

2.2. Case study Emma

Emma is a 6-year-old foster child that used to live in the streets with her mother. She was taken into care after protective services found the two of them. She is a very attractive, vivid, lively child. A child that is always laughing, which seems to be a flight status because there is never a moment of rest in her: her heartbeat is high, her breath is shallow yet quick, muscles seem tense, there is a lot of movement, she seeks out active motor play activities, her eyes make contact, pupils are mostly small, her face laughs, but the eyes do not laugh, the laugh is on the outside: her eyes do not laugh as the rest of the facial muscles do. Within there seems to be a different universe.
She comes with foster mom and is all over the place. All toys need to be touched, there needs to be some rocking movement in the chair, and there is little to no possibility to 'do therapy' because she is out of her window. After a few times trying out some different approaches, we develop a little starting ritual in which she gets a drink, mom gets coffee, she sits on the couch next to mom and drinks her lemonade and we do a little meditative body-oriented story that ends with the singing bowl. At the end: how long can you hear the tone? Where does she experience the tone in her body? What happens if she puts her hand on her belly or on her chests, sends her breath there? Hence a quiet, more mindful stance is achieved where after we find something to play with and try to work at integrating traumatic events in the past. Recently, I asked her how many Emma's there are, she spontaneously answered '100'. There is still a long way to go.

In between 'throwing the ball', listening to the tone (or some other regulating or activating playful activity) psycho-education is given. Tailor made, fitting the child's developmental level. In order to do so, I use the five theories that Waters' put together in the Star theoretical model of assessing and treating childhood dissociation (2006, p. 4). Often the start is neurobiology and dissociation theory. In my practice, I then use a combination of elements from Theraplay, Dyadic Developmental Psychotherapy, Sensorimotor Psychotherapy and EMDR[13]. When there is a very fundamental disregulation (e.g. sleep problems, problems with aggression or depressive symptoms), parents and I decide this needs to be addressed separately. The child is referred to neurofeedback, a brain activity training using biofeedback. This helps the restructuring of neurobiological processes in the brain (Van der Kolk, 2014; Fisher, 2014).

Theraplay is a child–parent intervention that aims at enhancing attachment by using playful activities based on four dimensions: structure, engagement, nurture and challenge. Theraplay helps parents and children to playfully connect and build a relationship. Many small playful activities are described and they form the core of Theraplay sessions (Booth & Jernberg, 2010).

Dyadic Developmental Psychotherapy is a parent–child intervention especially designed for treatment for families with adopted or fostered children, suffering from developmental trauma. The foundation of DDP lies in attachment theory, the neurobiology of trauma, child development, caregiving and attachment and intersubjectivity. Therapist and parents use PACE-principles in the interaction with children: playfulness, acceptance, curiosity and empathy and thus help the children to develop trust and new meaning to their life stories (Hughes, 2009; Hughes & Baylin, 2012; Baylin & Hughes, 2016; Hughes, Golding, & Hudson, 2019).

Sensorimotor Psychotherapy (SP) is a body based talking therapy that is used both in the treatment of trauma as well as attachment issues. It is a bottom up approach, which means that the starting point is the body. Ogden & Minton (2000) state: "Sensorimotor Psychotherapy directly treats the effects of trauma on the body, which in turn facilitates emotional and cognitive processing."

EMDR, Eye Movement Desensitization Reprocessing, is a well researched and evidence based trauma-therapy, where the focus is on a traumatic event. During an EMDR session this event is processed by having the child focus on the trauma whilst simulaneously administereing bilateral stimulation (eye-movement, taps or auditive stimuli) (Shapiro, 2001; Gomez, 2012). In young children, sometimes stories are used for EMDR (Lovett, 1999; De Roos & Beer, 2017). When relating these interventions to the StarModel, the following figure emerges (Fig. 2).

There is no 'one size fits all' therapy for the problems adoptees present and luckily we have a number of treatment options available. Important is that all originate from the same ideas on development, attachment, trauma, neurobiology and family systems and the StarModel, when elaborated with the proposed treatment modalities, gives a good way to look at both assessment and treatment of trauma-related symptoms such as dissociation, as is illustrated by the following case study of Jade.

Jade is 8 years old when she enters therapy. She was born in China and adopted at age 2 years and 3 months. Little is known about the time before the adoption. The orphanage she was in is a good orphanage. She seems to have some memories of all the young children there. She is in special education because of a learning disability. She is insecure, needs continuous affirmation from her mother and is anxious when asked to do new things. She is small, makes little eye-contact, talks quickly, is in a general state of alert.
During the first sessions the dolls catch her attention. All dolls, all babies, have to be taken care of, some are good dolls, some are bad dolls. During the process of therapy it becomes apparent that the dolls are parts of Jade and she needs to take care of them. Thus in sessions we play with the dolls and sometimes with the doll house. Mother and I work well together, we stitch in the stories of the dolls to her life story (DDP) whilst naming what happens in her body (SP) and looking for resources (breath, movements, little sentences). Accepting what comes and empathically making space for that. Then gradually, by naming the needs of each baby (part) and nurturing them, the number of babies becomes less. They are integrated in her inner world. She can now accept the whole system and is no longer alienated from essential parts of the self. An important moment is when Jade and her family travel to China, where they visit her orphanage. After this journey Jade only brings the babies now and again and she tells me they have grown and are no longer present. After 2 years we stop therapy but we still have a therapeutic contact where we meet for two to four times a year and in these sessions we work on the things in present life she still finds hard like eye contact, or setting boundaries and deciding to go her own way. She now makes better eye-contact, seems more relaxed. She has really grown and is a lovely young woman, vulnerable because of her background and IQ but no longer as fragmented as when she came in and can really relate to both her body and her story.

2.3. Case study

When looking back on the presented three cases, the starting point always is building a relationship, making children feel

[13] http://www.theraplay.org; http://www.sensorimotor.org; http://www.ddpnetwork.org; http://www.emdria.org.

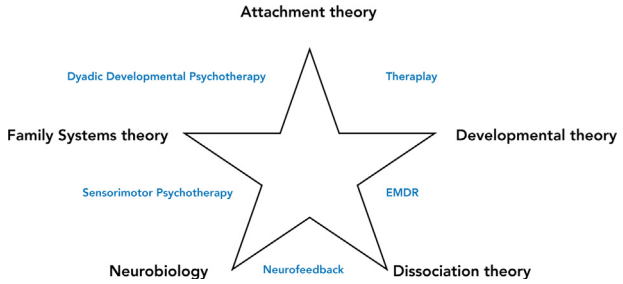

Fig. 2. Star Theoretical Model incorporating therapeutic modalities.

welcome and safe in the therapy room hence valuing the principle of organicity, where we follow and trust the process, using the present moment experience, the wisdom held within the child to be revealed and processed at the speed of the child through an attuned therapist supported by the presence of the parent. Starting with parents, as is the practice in Dyadic Developmental Psychotherapy, helps me do just that (Baylin & Hughes, 2016; Hughes, 2009; Hughes & Baylin, 2012). I always start without the child with one or more sessions, so the parents can become co-therapists, know their own attachment and trauma triggers and are able to parent with PACE: Playful, Accepting, Curious and Empathic. Psycho-education is one of the big themes in these parent-therapist sessions. Often however, parents have had video interaction guidance before they come to my practice, which really helps and makes it possible to keep this parent-therapist trajectory limited to a couple of sessions. Through the lens of Sensorimotor Psychotherapy I will then simultaneously focus on the body: what story holds the body, what do the posture, the gestures of the child tell us and how can we use this to help him or her integrate trauma and overcome attachment issues (Ogden et al., 2006; Ogden & Fisher, 2016). In this respect short interventions from both Sensorimotor Psychotherapy as well as Theraplay can be used to help explore the body, become more familiar with 'body language' and get more mindful even for young children (Booth & Jernberg, 2010; Ogden & Fisher, 2016; Mark-Goldstein & Ogden, 2013). Next to these three I often use EMDR for instance when a vivid memory pops up, or when children get disregulated during sessions: we can make the session a full protocol EMDR session or adjust our play and use EMDR/bilateral stimulation during session. The latter way of using EMDR based interventions, might help a child to stay within the window of tolerance and enhance his or her capacity of addressing the difficult issues that brought her/him in at the first place (Gomez, 2012; Parnell, 2013). Sometimes the pre-verbal trauma is addressed in a combination of EMDR and Sensorimotor therapy by writing a trauma-story along the lines Lovett (1999) proposes and processing this story by using bilateral stimulation sometimes in combination with movement. However, sometimes emotion-regulation and mood swings are really big and prevent the child to stay present or to function at school or in the family. I then refer to neurofeedback sessions, a computer assisted brain-based training, as a supportive therapeutic modality to help children regulate and be more receptive for the other therapeutic interventions (Fisher, 2014).

3. Conclusions and discussion

In intercountry adoptions, adoptees seldom have access to their full stories. However, the way experiences and trauma are held in the body give lots of starting points for assessment as well as therapeutic interventions. It does not rely on the narrative and words but through observing what is held in the body the story can be seen and the challenges each child faces in the current day can be worked with. The full life story is seldom known and may never become known. Still, relating to your life story, finding meaning to how your life evolved and finding ways to cope with the bad things that have happened are tasks every body faces and can be revealed in the way a person moves, in their posture and in the way they interact with the environment. In adoption this task is as big as it gets. Therefore adoptees often find their own styles of surviving, organize their experiences, and in doing so often need to stop being in touch with certain parts of the self, become dysregulated or even dissociated in a way that makes functioning in school and society difficult. This is a process that is not easily detected and not classifiable by using DSM-5 categories. Like Emma who is apparently active and makes contact with everybody — but is not able to sit still long enough to learn or like David who is 'dreamy' and has mood swings, who becomes lost in the inside world and cannot make contact with the outside world. For him learning and functioning is extremely difficult. Then finally Jade who is anxious and has a lot on her mind, taking care of all the little babies, in which she in the end does a wonderful job because the babies grow like she herself and are no longer a part of daily life any-more. They have integrated and she has successfully completed a lengthy therapeutic journey. Presumably for all three children, patterns have developed in a time that there was no caring, predictable adult available, helping them to make sense of the world and of themselves. Inside an invisible process started and only by looking very carefully through an attuned lens the child and the parents, this process can be named and framed. Only when parents and therapist together are curious not only for facts and stories, but also curious on why the body reacts like it does, why there is this dreamy or very active basic state, why the babies need care or why it is so hard to make eye contact, we can unravel the past and untie it from the present. Thus, helping the child to become more him or herself.

In my opinion and in my clinical practice, Waters' Star model, the concept of DTD, planning therapy on a neurosequential basis and using treatment methods based on neurobiology, attachment and trauma are needed to provide care for these children. Also, therapists need to bear in mind that for each and every adoptee an individualized treatment is needed in order to overcome the massive amount of adversity experienced prior to the adoption. Because: 'while most adoptions work well, no adoption is simple' (Douglas & Philpot, 2002) and there is never a one size fits all in therapies that address developmental trauma associated with (intercountry) adoption (Vinke, 2011; 2012).

Disclosure of interest

Dr. Anneke J.G. Vinke is the local organizer for the Sensorimotor Psychotherapy Institute in the Netherlands. The article was written on a personal note.

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