Module #9: Adoptive Family Formation, Integration, and Developmental Stages

Student Packet
Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of Module</td>
<td>3</td>
</tr>
<tr>
<td>Learning Objectives</td>
<td>3</td>
</tr>
<tr>
<td>Pre-Module Assignments</td>
<td>4</td>
</tr>
<tr>
<td>Agenda</td>
<td>16</td>
</tr>
<tr>
<td>Reading List</td>
<td>17</td>
</tr>
<tr>
<td>Handouts</td>
<td>19</td>
</tr>
</tbody>
</table>
Overview of Module
This Module provides students with knowledge about the risk and protective factors shaping adoptive family adjustment, both for children and other family members, and the salient goals and intervention approaches that are important in stabilizing adoptive families experiencing adjustment challenges. It provides students with opportunities to explore their own personal biases about adoption that may impact their clinical practice with these families. The Module provides students with skills in assisting clients with clinical issues and in helping parents to understand the needs of their children and developing strategies for addressing these needs.

Learning Objectives
Students will be able to:

1. Describe at least three factors that may result in adoptive families facing greater challenges than non-adoptive families.
2. Describe four salient issues in adoption that surface again and again over time.
3. Identify three developmental tasks for adopted children and adoptive parents at different stages of the adoption family life cycle.
4. Identify four pre-adoptive risk factors influencing adoption adjustment for children and families and at least three protective factors for children and families.
5. Identify three survival behaviors underlying emotional issues in a case study and develop treatment strategies for the adopted child.
6. Describe three common dynamics in troubled adoptive families.
7. Describe four guiding principles of therapeutic post adoption services and three models of intervention that are applicable in working with adoptive families.
8. Given a case study, develop a treatment plan, including engagement techniques, goals for the adopted child/adoptive family and selection of various treatment strategies.
Module #9
Adoptive Family Formation, Integration and Developmental Stages

Pre-Module Assignments

Student Pre-Module Assignment Checklist

☑️ Read selected excerpts from *Examining Adoption Outcome Research* and jot down ideas about the research findings for class discussion.

☑️ Read selected excerpts from *Normative Development Challenges in Adoption* that focuses on the Adoptive Family Life Cycle and jot down a few reactions to the concept of the Adoptive Family Life Cycle to add to the class discussion.

☑️ Read selected excerpts from *Factors Shaping Adjustment in Adoptive Families* and develop a list of at least three “take aways” from these excerpts to contribute to class discussion.

Students’ Pre-Module Assignments

1. **Pre-Module Assignment #9.1:** Read selected excerpts (provided below) from Susan Livingston Smith’s *Examining Adoption Outcome Research*. The full article can be found in Handout #9.1 along with full citations to the research. Jot down three or four research findings that either surprised you or validated your own experiences with adopted children, youth and adults. We will discuss your thoughts in class.

**Handout #9.1. Examining Adoption Outcomes Research**

**Susan Livingstone Smith**

Adoption is a definite benefit to children who otherwise would grow up in less stable and nurturing situations; however many children come to adoption with higher risks for ongoing developmental issues. Even children adopted in early infancy who were at one time thought to come to their families as “clean slates” are seen more frequently in clinical populations. Understanding the body of research on adoption outcomes is essential for understanding families’ needs after adoption and the complexities of solutions for meeting their needs.

**Clinical Studies of Adopted Youth**

... Clinical studies found that adopted youth were more likely to be diagnosed with externalizing problems (conduct disorder, oppositional defiant disorder, and attention deficit hyperactivity disorder) rather than with internalizing disorders, such as anxiety or depression (Deutsch, Swanson, Bruell, Cantwell, Weinberg, & Baren, 1982; Weiss, 1985; Fullerton, Goodrich, & Berman, 1986; Kotsopolous, Cote,
Pentland, Chryssoula, Sheahan, & Oke, 1988; Rogeness, Hoppe, Macedo, Fischer, & Harris, 1988). Studies also found higher rates of substance abuse problems (Marshall, Marshall, & Heer, 1994) and learning problems and special education placements (Brodzinsky & Steiger, 1991) among adopted youth.

While some of the overrepresentation of adopted children and their families in clinical populations is due to a somewhat higher rate of behavioral and emotional problems, there also is evidence that adoptive families seek help more readily (Warren, 1992; Miller, Fan, Grotevant, Christensen, Coyl, & Val Dulmen, 2000). In addition, one study found that adoptive families in clinical populations are more likely to consider placement of the child as a solution to problems, even though they have greater psychosocial resources than biological clinical families (Cohen, Coyne, & Duval, 1993).

...  

**Community-based Studies of Adopted Youth**

...  

Highlighting the primary findings of a few major studies sheds light on the range of needs in adoptive families.

**The 2007 National Survey of Adoptive Parents.** This study reported usage of post-adoption services by adoptive families. For services classified as rehabilitative, mental health care for the child was the most commonly used, with 33-35 percent of private domestic and international adoptive families and 46 percent of foster care adopters reporting that they had received this service (Vandivere, Malm, & Radel, 2009).

**Search Institute Studies.** The Search Institute of Minnesota evaluated 881 teens adopted as infants (under 15 months) and compared them to 78 birth adolescents in the adoptive families. The adopted youth showed higher levels of delinquent behavior, licit drug use (alcohol/tobacco), and poorer school adjustment than birth children; however they had lower scores on withdrawal and showed greater prosocial behavior (Sharma, McGue, & Benson, 1998). Differences between adopted and non-adopted youth were greater for boys than girls. A second group of studies conducted by these researchers compared a sample of 4,682 adoptees, ages 12-18, with matched controls who were not adopted. ... The same results cited above were found again, in addition to higher rates of illicit drug use, negative emotionality, and antisocial behavior among the adopted adolescents as well as lower levels of school adjustment. The magnitude of the differences was small to moderate on all measures (Sharma, McGue, & Benson, 1996a; Sharma, McGue, & Benson, 1996b).
California Long-range Adoption Study (CLAS). This longitudinal study of adoptive families began in 1988, with data being collected at approximately 2, 4, 8, and 14 years after adoption, beginning with responses from approximately 1,200 families in the first wave with some attrition at each successive wave. . . . Overall at Wave 3, 29.9 percent of the 808 youth evaluated manifested externalizing behavior disorders (Oppositional Defiant Disorder and/or ADHD). Risk factors for manifesting these disorders included public adoption, a history of abuse or neglect, being male, presence of fetal alcohol effects, and placement in multiple foster homes. The rate of behavioral impairment among children on the total BPI scores and the five subscale scores increased over data collection periods.

Dutch Longitudinal Study. Some of the best research studies on the adjustment of internationally adopted children have been conducted in the Netherlands, where population records enable identification of adopted children. One longitudinal study with large sample sizes and a high response rate evaluated approximately 2,000 internationally adopted youth (ages 10-15) and a random sample of non-adopted youth in 1986. . . . Child Behavior Checklist scores of adopted youth at Time 2 indicated a worsening of problems since the first evaluation; nearly 29 percent of adopted boys and more than 17 percent of adopted girls were in the clinical range on their total problem scores as compared with less than 10 percent of the teens in the non-adopted sample. As young adults, 1,484 intercountry adoptees were evaluated again as well as a sample of non-adopted peers for the prevalence of psychiatric disorders as well as assessing their social functioning. . . . Overall adoptees growing up in homes of lower and middle socioeconomic status did not differ from their peers, but those from high parental socioeconomic status (2/3 of the adoptees) were 2.2 times as likely to meet the criteria for a psychiatric disorder as non-adopted individuals from the same background. On educational and professional attainment, adopted young adults were functioning at the same level as their peers in the general population (Versluis-den Bieman & Verhulst, 1995; Verhulst, 2000; Tieman, van der Ende, & Verhulst, 2005; Tieman, van der Ende, & Verhulst, 2006).

Continuum of Needs
In any discussion of adjustment in adopted children it is very important to recognize that the vast majority of them are functioning normally and that their adoptive parents are highly satisfied with their adoptions. Even among groups of adopted children coming from higher risk situations, such as institutions or those in foster care who were removed from abusive or neglectful homes, the majority are in the normal range on standardized measures of behavioral and emotional problems (Rosenthal & Groze, 1992, 1994; Howard & Smith, 2003; Howard, Smith & Ryan, 2004; Simmel, et al., 2007). As a group, children who come to adoptive families from higher-risk early environments are resilient and make rapid gains in their adoptive families; however many continue throughout childhood to struggle with ongoing challenges. Understanding these challenges and how they are manifest is a prerequisite to addressing them and maximizing children’s development to their fullest potential. Before Center for Adoption Support and Education © 2012
discussing solutions to the needs of adoptive families, this paper will explore the range of issues and challenges impacting these children and their families.

While all adopted children have differing needs, research and experience tell us that school is a primary place in which they and their families confront adjustment challenges. In a study comparing the adjustment of children living in birth and adoptive families, parents of each type of adoptee – domestic infant, from the public system or from abroad – were two to three times more likely than parents of birth children to give their sons and daughters low ratings on overall adjustment at school. However, very few parents of any type reported that children showed “poor” adjustment at home (Howard, Smith, & Ryan, 2004). Hence it is apparent that the school environment brings to the fore the behavioral or learning challenges that some adopted children face. Understanding the nature of myriad factors contributing to these adjustment issues is foundational for consideration of solutions.

2. **Pre-Module Assignment #9.2:** Read the selected excerpts (see below) from Susan Livingston Smith’s article, *Normative Development Challenges in Adoption* that focuses on the Adoptive Family Life Cycle. The full article can be found in Handout #9.2 along with full reference citations. Jot down a few reactions to the concept of the Adoptive Family Life Cycle to add to the class discussion.

**Handout #9.2: Normative Developmental Challenges in Adoption**
By Susan Livingston Smith

...  

**Developmental Tasks and the Adoptive Family Life Cycle**

Adoption scholars have identified critical developmental tasks confronting adoptive families as they work through core adoption issues at each stage of psychosocial development (Hajal & Rosenberg, 1991; Brodzinsky, Schechter, & Henig, 1992; Brodzinsky, Smith, & Brodzinsky, 1998; Schooler & Norris, 2002). These are overlaid with the usual developmental tasks of life stages for individuals and family stages. Developmental tasks for adopted children include:

- Learning one’s adoption story
- Coping with loss
- Searching for answers about one’s origin and the reasons for relinquishment
- Coping with adoption stigma
- Integrating adoption into one’s identity
- Validating affiliation with two families
- Consideration of searching for one’s birth family

Related tasks for adoptive parents include:

- Gathering information about the child’s history

Center for Adoption Support and Education © 2012
• Open discussion of adoption with the child
• Helping the child cope with loss
• Providing realistic but positive information about the adoption story
• Coping with adoption stigma
• Integrating being an adoptive parent into one’s identity
• Supporting the child’s dual family membership
• Supporting the adoptee’s search for birth family members

... 

The Adoption Life Cycle

The concept of the family life cycle was developed to describe the changes that family systems experience over time (Carter & McGoldrick, 1980), and adoption scholars have identified additional adoption-related tasks that emerge over time and interact with the more universal tasks of family life (Hajal & Rosenberg, 1991; Brodzinsky, 1998). These models incorporate a pre-adoption period which includes tasks for adoptive parents such as coping with infertility and accepting the need for social service scrutiny. These models identify the traditional individual cognitive, emotional, and social developmental processes with the related developmental tasks of adoption across the following stages: pre-adoption, infancy, toddlerhood, early childhood, middle childhood, early adolescence, late adolescence, young adulthood, middle adulthood, and later adulthood (Center for Adoption Studies, 2004).

While most adoptive families navigate these normative challenges without seeking professional help, they all can benefit from pre-adoptive preparation and post-adoption education about adoption. Also studies show that adoptive families are much more likely to seek professional help than are birth families with odds ranging from 2-5 times more likely to seek counseling (McRoy, Grotevant, & Zurcher, 1988; Howard, Smith, & Ryan, 2004; Keyes, Sharma, Elkins, Iacono, & McGue, 2008) to 4-7 times greater odds of seeking residential treatment (McRoy, et al., 1988; Landers, Forsythe, & Nickman, 1996; Elmund, Lindblad, Vinnerljung, & Hjern, 2007).

2. Pre-Module Assignment #9.3: Read the selected excerpts (see below) from Susan Livingston Smith’s article, Factors Shaping Adjustment in Adoptive Families. The full article can be found in Handout #9.4 along with full reference citations. Develop a list of at least three “take aways” from these excerpts to contribute to class discussion.

Handout #9.3: Factors Shaping Adjustment in Adoptive Families
By Susan Livingston Smith

There is a range of factors pertaining to adopted children themselves, their families, and the environments they live within that shapes their adjustment. For adopted children, their genetic histories, prenatal experiences, circumstances of birth, pre-adoption experiences and individual Center for Adoption Support and Education © 2012
characteristics such as temperament or gender contribute to their adjustment after adoptive placement. Likewise characteristics of the adoptive parents and families help to shape children’s adjustment to adoption – qualities of the emotional health of the parents and their marriage relationship, parental expectations for their children, the social support system that surrounds adoptive families, the style of discipline and communication within the family, family structure including sibling relationships, and others. And of course, the communities and society that individuals live within shape their adjustments -- the values and beliefs, the adoption service system and the adequacy of its services and preparation of families, the supportiveness of social institutions for adopted children and their families, and the services available to them.

**Risk Factors in Children**

In order to understand the nature of challenges and needs in adoptive families, it is important to review the body of knowledge on risk factors associated with adjustment in both adopted children and their families. There are also protective factors that buffer the impact of negative influences. For most children, adoption itself is a huge protective factor, bringing permanency and a nurturing environment to children who have generally been in less than adequate situations. It is necessary to understand the complexity of factors shaping adoption adjustment prior to any consideration of finding solutions to problems or challenges.

**Range of Resiliency**

While risk factors are associated with lower levels of functioning; they do not necessarily predict problems for all who experience them. Rather the presence of a risk factor increases the probability of a certain outcome. There is a broad range of outcomes among children experiencing the same risk factor. For example, in a longitudinal study of children adopted from very deprived institutional conditions in Romania, the researchers found that at age 6, children leaving institutions after the age of 2 had IQs that were on average 25 points lower than those who left by 6 months of age; however even among the late-adopted group, IQs ranged from mental retardation to superior (Rutter, O’Connor, ERA Study Team, 2004).

Also, many children may have the same condition and come from very different background situations, with some having no apparent risk factors identified. For example, while domestic infant adoptees generally have been assumed to have the fewest risk factors for developmental problems, recent studies have not always corroborated this conclusion.

... 

Primary risk factors that have been linked to developmental challenges in adopted children and research findings associated with these risk factors are summarized below.

**Prenatal Malnutrition and Low Birth Weight**

Center for Adoption Support and Education © 2012
Malnutrition in mothers during pregnancy, other maternal health conditions, and poor prenatal care can lead to problems in fetal development, premature births and low birth weight; for example, insufficient protein and iron in the mother’s diet is linked with problems in brain growth and later cognitive development.

Prenatal Exposure to Toxic Substances
Prenatal exposure to alcohol, drugs, tobacco, and other substances that have toxic effects on fetal development has increasingly become a focus of research, beginning with investigations of fetal alcohol exposure in the early 1970s.

The chronic impact of heavy alcohol consumption during pregnancy results in some of the most devastating long-term challenges, including the severe, irreversible neurological and physical abnormalities diagnosed as fetal alcohol syndrome. Low to moderate maternal drinking also poses higher risks for a range of symptoms, such as inattention and hyperactivity, learning problems, memory deficits, and mood disorders (Freundlich, 2000; Sokol, Delaney-Black, & Nordstrom, 2003).

Longitudinal studies have been conducted that get detailed histories at several points during pregnancy and follow children for many years to investigate the long-term consequences of exposure to a range of drugs, while controlling for many other variables. For example, prenatal marijuana use has been linked with increased hyperactivity, impulsivity, attention problems, learning and memory deficits, and externalizing behavior problems of children at age 10 (Goldschmidt, Day, & Richardson, 2000; Richardson, Ryan, Willford, Day, & Goldschmidt, 2002).

Older Age at Adoption
For many years, older age at placement has been identified as a risk factor for adjustment difficulties, particularly in relation to risk for adoption disruption and behavior problems (Festinger, 1986; Barth & Berry, 1988, Berry & Barth, 1989; Sharma, McGue, & Benson, 1996). Some researchers have argued that it is not age per se but experiences of adversity children placed at older ages often incur that increases their risk for problems. The body of adoption research clearly demonstrates that it is the impact of early adverse experiences prior to adoptive placement that is most clearly linked with increased risk for adjustment difficulties.
Early Deprivation, Including Institutionalization and Serious Neglect
Adequate nurture of children is the foundation of all areas of child development—physical, intellectual, social, and emotional. When children’s basic needs are not met, all areas of their development suffer, with more extreme deprivation leading to more severe and long-lasting effects. A review of 29 studies on children adopted from orphanages in Romania, Russia and China found that the most consistent predictor of ongoing problems is the length of time spent in orphanage care, with those in care a year or more having the highest risk for chronic problems (Meese, 2005).

Another problem found more frequently among children experiencing institutionalization or deprivation/neglect is sensory integration difficulties – a condition in which the brain cannot analyze, organize, and integrate sensory messages efficiently. For example, a study comparing 73 Romanian adoptees and a comparison group of American children found greater problems among the adoptees in five of six sensory-processing domains -- touch, movement-avoids, movement-seeks, vision, and audition, as well as four of five behavioral domains -- activity level, feeding, organization, and social-emotional (Cermak & Daunhauer, 1997). Children with sensory integration problems may demonstrate a range of behaviors including oversensitivity to tactile sensations such as a label rubbing their neck or defensiveness to being touched, hypersensitivity to noises, an aversion to many tastes or food textures, being distractible or whiny, clumsiness, and others (Purvis & Cross, 2007).

Experiencing Physical, Sexual, or Emotional Abuse
In addition to neglect or deprivation, many children adopted internationally and from foster care have experienced other maltreatment and trauma including physical, sexual and emotional abuse, witnessing violence, and others. The types of abuse experienced by children adopted from the child welfare system in the U.S. are not completely known. Often children are removed due to a single indicated allegation (most commonly neglect) but later other types of maltreatment they have experienced come to light. Many of the behavioral symptoms of adopted children who are seen in mental health settings stem from the effects of trauma. In fact, a high percentage of children who have externalizing behavior disorders (attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), or conduct disorder) have a trauma history. One study reported that children diagnosed with externalizing disorders had more history of experiencing trauma than those with other diagnoses. In fact, 91 percent of children diagnosed with both ADHD and ODD were assessed as having a traumatic history, primarily physical or sexual abuse (Ford, Racussin, Ellis, Daviss, Reiser, Fleischer, & Thomas, 2000).

Number of Placements Prior to Adoption
A final factor in the pre-adoption history of children that has been linked with greater risk for ongoing adjustment problems is the number of placements that children experienced prior to their adoption. Center for Adoption Support and Education © 2012
Experiencing multiple moves in care prior to adoptive placement has been linked with adoption instability and greater likelihood of adjustment problems (Festingher, 1986; Barth & Berry, 1988; Verhulst, et al., 1992; McRoy, 1999; Howard & Smith, 2003; Simmel, 2007; van der Vegt, et al., 2009).

Research studies have found that placement instability has more of a negative impact on children than the fact of placement itself. For example, one study evidenced that adopted children with a history of multiple placement moves had poorer inhibitory control abilities and more oppositional behavior than adopted children who experienced only one foster placement prior to adoption, even after controlling for pre-adoptive risk factors (Lewis, Dozier, Ackerman, & Sepulveda-Kozakowski, 2007).

Emotional Conflicts Related to Loss and Identity Issues
Over the course of their lives, adopted children and adults face the challenge of exploring the meaning of adoption and integrating this into their own identity. It is common for adopted children to struggle at times with their feelings related to being adopted, and studies have documented that emotional turmoil and difficulty related to adoption issues is associated with greater adjustment problems, including depression, lower self-worth, anxiety, and behavior problems (Smith, Howard, & Monroe, 2000; Smith & Brodzinsky, 2002; Juffer, 2006).

Protective Factors among Adopted Children
Resilience is the ability to overcome adversity and function better than might be expected. A number of protective factors – buffers that mediate the impact of stressful events – exist at a number of levels within children, families, and their environments. Of course, the absence of these factors might also be viewed conversely as a risk factor for poor adjustment. For example, whereas parental warmth and sensitivity are protective factors, the lack of these abilities can be viewed as a risk factor in adoption adjustment.

As discussed earlier, children can experience the same treatment or adversity and achieve different outcomes. Some of this difference in outcomes is due to protective factors and differential susceptibility. The body of research on risk and protective factors in child development has identified a range of factors fostering resiliency. On the individual level gender and temperament can make children more or less vulnerable to negative outcomes.

Gender
Generally, in the body of research on child development and in adoption research, being born female is a protective factor.
Child’s Temperament
Children’s temperaments, which are both genetically and environmentally shaped, can be protective and moderate their susceptibility to negative experiences.

Ability to Develop Attachments
A child’s capacity to give and receive affection or to attach is another protective factor. Attachment styles and capacities of young children are shaped through interaction with the environment. Also there is an emerging body of research indicating that there are genetic factors in children which make them more or less susceptible to inadequate caregiving and more or less responsive to positive changes in caregiving environments (Spangler, Johann, Ronai, & Zimmermann, 2009; Bakermans-Kranenburg, Van IJzendoorn, Mesman, Alink, & Juffer, 2008). Once children are placed for adoption, the development of a secure attachment is a reciprocal process between the child and caregivers. Research indicates that the child’s ability to accept nurturance and develop an attachment to the parents, particularly the mother, is significantly linked with adoption outcomes.

Family-related Protective Factors
The protective factors that contribute to positive outcomes and resiliency in adoptive families are primarily the same as in other families: 1) a stable marriage relationship with good communication; 2) a warm, cohesive pattern of family interaction; 3) an authoritative, nurturing parenting style; 4) openness in communication; and 5) good social support from outside the family. In addition, adoption experts stress the importance of realistic expectations and parental preparation for adoption as critical factors promoting resilience in their ongoing adjustment.

Realistic Expectations and Thorough Parental Preparation
Parents’ cognitive appraisal of their situation helps to shape their efforts to cope and their overall commitment to parenting. One major influence on their appraisal of their adoption is the expectations they had going into it and the congruence between their expectations and the child’s capacities. The importance of parents’ having realistic expectations for adoption is a recurring theme in the adoption literature and one that has been upheld by research (Barth & Berry, 1988; Groze, 1995; Pinderhughes, 1996; McRoy, 1999; Reilly & Platz, 2003).
One important means to achieving realistic expectations in parents and in older children placed for adoption is through thorough adoption preparation. For parents, this includes provision of accurate and up-to-date background information on the child (Barth & Berry, 1988; Nelson, 1985; Rosenthal, 1993). However, after adoption families often report not receiving enough information; for example, in a study of 259 families adopting from foster care, 58 percent reported not receiving enough information on the child and 37 percent reported the child’s problems were more serious than originally described by the agency (Reilly & Platz, 2003).

...  

**Positive Parenting Style**

In all families positive parent-child relationships promote secure attachments and contribute to positive outcomes for children. This is particularly true for children coming from high-risk situations, when parental sensitivity and responsiveness is essential to fostering a healing environment. Desirable qualities in parenting that research links with positive outcomes in children include warmth, sensitivity to children’s needs and feelings, responsiveness, positive disciplinary strategies, and active involvement (Benzies & Mychasiuk, 2008).

...  

**Communicative Openness**

In all families, family communication patterns affect child adjustment, and communication is critically important in adoptive families (Steinberg, 2001; Brodzinsky, 2006). Research on adolescents from both adoptive and non-adoptive families indicates that children from families with “consensual” communication (high in frequent, spontaneous, unconstrained conversation and high in conformity orientation or maintaining harmony) have the fewest externalizing behavior problems (Rueter & Koerner, 2008).

...  

Brodzinsky found that communicative openness in addressing adoption issues was a stronger predictor of children’s adjustment than structural openness (Brodzinsky, 2006). Adopted children experiencing more open adoption communication reported higher self-esteem and had lower parent ratings of behavior problems. Among adopted adolescents, those who perceive greater communication openness in their families report more trust for their parents, fewer feelings of alienation, and better overall family functioning (Kohler, Grotevant, & McRoy, 2002). Research on communication about adoption also indicates that parents often underestimate the difficulty their children have in talking about adoption, and the level of openness can vary between the same child and different parents as well as across different adopted children in the same family (Beckett, et al., 2008; Hawkins, et al., 2007; Wrobel, Kohler, Grotevant, & McRoy, 1998; Wrobel, Grotevant, Mendenhall, & McRoy, 2003).
Environmental Protective Factors

Family well-being is influenced not only by characteristics of children, parents, and their interactions but also by their social networks, organizations such as school and churches, and characteristics of their communities. Some environmental factors that have been identified through research that promote resilience include: 1) family involvement in the community through access to social networks and resources; 2) peer acceptance for children; 3) supportive mentors; 4) access to quality childcare and schools; and 5) access to quality health and mental health care (Benzies & Mychiasiuk, 2009).

Sufficient Informal and Formal Social Supports

... 

For families adopting a child with many challenges, social support is particularly critical. The family impact resulting from caring for an individual family member with extraordinary health or mental health problems is far-reaching – economic cost, impact on family and other relationships, restrictions on personal and social activities, stigma, psychological overload, and others. When parents are experiencing chronic parenting stress, it can lead to smaller social networks (fewer friends), reduced feelings of competence, and restriction of their interactions outside the family (Armstrong, Birnie-Lefcovitch, & Ungar, 2005).

... 

When families are unable to meet their needs for support within their informal social support system, they may seek out formal helping services. Adoptive parents may talk with their pediatrician or child’s school seeking advice, and many who are connected to a trusted adoption agency will contact them for suggestions.
Module #9  Adoptive Family Formation, Integration, and Developmental Stages

Agenda

9:00AM – 9:10AM  Welcome

9:10AM – 9:30AM  Introduction and Challenges in Adoptive Families Evidenced by Research

9:30AM – 10:45AM Normative Developmental Challenges in Adoption

10:45AM – 11:00AM Break

11:00AM – 12:15PM Factors Shaping Adoption Adjustment: Risk and Resilience

12:15PM – 1:15PM Lunch

1:15PM – 2:30PM Challenges to Adoption Stability: Understanding Child Behaviors and Coping

2:30PM – 3:15PM “Unhelpful Help” & Principles & Goals of Therapeutic Post-Adoption Services

Break will be called during this segment

3:15PM – 3:45PM Models of Intervention

3:45PM – 4:25PM Small Group Exercise: Treatment Plan with Whitman Case

4:25PM – 4:30PM Summary and Closing
Reading List

Web Based Resources


Other Resources


Center for Adoption Support and Education © 2012


Module #9: Adoptive Family Formation, Integration, and Developmental Stages

Handouts
Handout #9.1: Examining Adoption Outcome Research
By Susan Livingston Smith

Adoption is a definite benefit to children who otherwise would grow up in less stable and nurturing situations; however many children come to adoption with higher risks for ongoing developmental issues. Even children adopted in early infancy who were at one time thought to come to their families as “clean slates” are seen more frequently in clinical populations. Understanding the body of research on adoption outcomes is essential for understanding families’ needs after adoption and the complexities of solutions for meeting their needs.

Clinical Studies of Adopted Youth
The greater representation of adopted children and their families in clinical populations of those receiving mental health services – a pattern documented across many Western countries – raised questions among adoption experts about the reasons for these differences and led to increased study of adopted youth. Clinical studies found that adopted youth were more likely to be diagnosed with externalizing problems (conduct disorder, oppositional defiant disorder, and attention deficit hyperactivity disorder) rather than with internalizing disorders, such as anxiety or depression (Deutsch, Swanson, Bruell, Cantwell, Weinberg, & Baren, 1982; Weiss, 1985; Fullerton, Goodrich, & Berman, 1986; Kotsopolous, Cote, Pentland, Chryssoula, Sheahan, & Oke, 1988; Rogeness, Hoppe, Macedo, Fischer, & Harris, 1988). Studies also found higher rates of substance abuse problems (Marshall, Marshall, & Heer, 1994) and learning problems and special education placements (Brodzinsky & Steiger, 1991) among adopted youth.

While some of the overrepresentation of adopted children and their families in clinical populations is due to a somewhat higher rate of behavioral and emotional problems, there also is evidence that adoptive families seek help more readily (Warren, 1992; Miller, Fan, Grotevant, Christensen, Coyl, & Val Dulmen, 2000). In addition, one study found that adoptive families in clinical populations are more likely to consider placement of the child as a solution to problems, even though they have greater psychosocial resources than biological clinical families (Cohen, Coyne, & Duval, 1993).

As some adoption experts began to question whether adoption itself was a risk factor for children, social scientists recognized the need for studies on large, community-based samples of adopted youth and comparing representative populations of adopted and non-adopted youth.

Community-based Studies of Adopted Youth
Beginning in the 1980s, there have been more studies of large samples of adopted children and their families using standardized instruments that permit comparison to the general population as well as studies comparing substantial groups of adopted and non-adopted children. Some of these studies are longitudinal, enabling analysis of changes over the developmental course. Overall this body of research does indicate a somewhat higher risk for a range of problems among adopted youth. Also for studies Center for Adoption Support and Education © 2012
looking primarily at early-placed adoptees, differences generally are not manifested until children are school age, intensify during adolescence, and level off in young adulthood (Coon, Carey, Carley, & Fulker, 1992; Feigelman, 1997; Simmel, Barth, & Brooks, 2007). While this report will not review the entire body of outcome research on adoption, highlighting the primary findings of a few major studies sheds light on the range of needs in adoptive families.

The 2007 National Survey of Adoptive Parents reported usage of post-adoption services by adoptive families. For services classified as rehabilitative, mental health care for the child was the most commonly used, with 33-35 percent of private domestic and international adoptive families and 46 percent of foster care adopters reporting that they had received this service (Vandivere, Malm, & Radel, 2009).

**Search Institute Studies.** The Search Institute of Minnesota evaluated 881 teens adopted as infants (under 15 months) and compared them to 78 birth adolescents in the adoptive families. The adopted youth showed higher levels of delinquent behavior, licit drug use (alcohol/tobacco), and poorer school adjustment than birth children; however they had lower scores on withdrawal and showed greater prosocial behavior (Sharma, McGue, & Benson, 1998). Differences between adopted and non-adopted youth were greater for boys than girls. A second group of studies conducted by these researchers compared a sample of 4,682 adoptees, ages 12-18, with matched controls who were not adopted. (No distinction was made between relative, step-parent, and nonrelative adoptions.) The same results cited above were found again, in addition to higher rates of illicit drug use, negative emotionality, and antisocial behavior among the adopted adolescents as well as lower levels of school adjustment. The magnitude of the differences was small to moderate on all measures (Sharma, McGue, & Benson, 1996a; Sharma, McGue, & Benson, 1996b).

**California Long-range Adoption Study (CLAS).** This longitudinal study of adoptive families began in 1988, with data being collected at approximately 2, 4, 8, and 14 years after adoption, beginning with responses from approximately 1,200 families in the first wave with some attrition at each successive wave. The survey incorporated the Behavior Problem Index (BPI) utilized in the National Longitudinal Survey of Youth (NLSY). Families studied were primarily domestic adoptions (95%), included those adopting independently as well as through public and private agencies, and received most of their adopted children as infants (mean placement age=7 months). Successive analyses of this data set have focused largely on examinations of externalizing symptoms in adopted children, outcomes for children with prenatal drug exposure and those adopted from foster care, preadoptive risk factors associated with outcomes, and services usage. Overall at Wave 3, 29.9 percent of the 808 youth evaluated manifested externalizing behavior disorders (Oppositional Defiant Disorder and/or ADHD). Risk factors for manifesting these disorders included public adoption, a history of abuse or neglect, being male, presence of fetal alcohol effects, and placement in multiple foster homes. The rate of behavioral impairment among children on the total BPI scores and the five subscale scores increased over data collection periods. In comparing foster care (who were older) and non-foster care groups, differences...
between the two were pronounced at Wave 1, but much less so at Wave 3. For example, on the total BPI score, 30 percent of foster and 11 percent of non-foster groups of adoptees met the cutoff scores for clinical impairment at Wave 1, and at Wave 3 the rates were 34 percent (foster) and 27 percent (non-foster) (Simmel, Brooks, Barth, & Hinshaw, 2001; Simmel, et al., 2007).

**Dutch Longitudinal Study.** Some of the best research studies on the adjustment of internationally adopted children have been conducted in the Netherlands, where population records enable identification of adopted children. One longitudinal study with large sample sizes and a high response rate evaluated approximately 2,000 internationally adopted youth (ages 10-15) and a random sample of non-adopted youth in 1986. Approximately 1,500 adopted teens and their peers were evaluated again, at ages 14-18, and a third time as young adults (ages 24-30). Child Behavior Checklist scores of adopted youth at Time 2 indicated a worsening of problems since the first evaluation; nearly 29 percent of adopted boys and more than 17 percent of adopted girls were in the clinical range on their total problem scores as compared with less than 10 percent of the teens in the non-adopted sample. As young adults, 1,484 intercountry adoptees were evaluated again as well as a sample of non-adopted peers for the prevalence of psychiatric disorders as well as assessing their social functioning. Differences between the two groups varied by type of disorder and gender; for example, adopted men were 3.8 times as likely to have a mood disorder as nonadopted men, but there were no significant differences on this measure for women. Overall adoptees growing up in homes of lower and middle socioeconomic status did not differ from their peers, but those from high parental socioeconomic status (2/3 of the adoptees) were 2.2 times as likely to meet the criteria for a psychiatric disorder as non-adopted individuals from the same background. On educational and professional attainment, adopted young adults were functioning at the same level as their peers in the general population (Versluis-den Bieman & Verhulst, 1995; Verhulst, 2000; Tieman, van der Ende, & Verhulst, 2005; Tieman, van der Ende, & Verhulst, 2006).

In addition, U.S. Census data on children ages 5-15 reveals that the rate of disabilities (sensory, physical, mental, and self-care) among both domestically and internationally adopted children is approximately double that of the general child population. Disability rates for internationally adopted children ranged from a low of 3.7% for children from China (below the general child population rate of 5.8%) to approximately 25% for children from eastern and western European countries and Haiti (Kreider & Cohen, 2009). These classifications did not measure behavioral or psychological problems.

**Continuum of Needs**

In any discussion of adjustment in adopted children it is very important to recognize that the vast majority of them are functioning normally and that their adoptive parents are highly satisfied with their adoptions. Even among groups of adopted children coming from higher risk situations, such as institutions or those in foster care who were removed from abusive or neglectful homes, the majority are in the normal range on standardized measures of behavioral and emotional problems (Rosenthal & Groze, 1992, 1994; Howard & Smith, 2003; Howard, Smith & Ryan, 2004; Simmel, et al., 2007). As a Center for Adoption Support and Education © 2012
group, children who come to adoptive families from higher-risk early environments are resilient and make rapid gains in their adoptive families; however many continue throughout childhood to struggle with ongoing challenges. **Understanding these challenges and how they are manifest is a prerequisite to addressing them and maximizing children’s development to their fullest potential.** Before discussing solutions to the needs of adoptive families, this paper will explore the range of issues and challenges impacting these children and their families.

While all adopted children have differing needs, research and experience tell us that school is a primary place in which they and their families confront adjustment challenges. In a study comparing the adjustment of children living in birth and adoptive families, parents of each type of adoptee – domestic infant, from the public system or from abroad – were two to three times more likely than parents of birth children to give their sons and daughters low ratings on overall adjustment at school. However, very few parents of any type reported that children showed “poor” adjustment at home (Howard, Smith, & Ryan, 2004). Hence it is apparent that the school environment brings to the fore the behavioral or learning challenges that some adopted children face. Understanding the nature of myriad factors contributing to these adjustment issues is foundational for consideration of solutions.

**References**


Center for Adoption Support and Education © 2012


Handout #9.2: Normative Developmental Challenges in Adoption
By Susan Livingston Smith

Salient Issues in Adoption

Many adoption experts have identified a range of issues that surface again and again for members of the adoption triad as they address emotional aspects of adoption. Probably the most commonly cited conceptual framework of adoption issues is Silverstein and Kaplan’s (1988) seven core issues of adoption: loss, rejection, guilt & shame, grief, identity, intimacy, and mastery & control. There are emotional themes that are interwoven with other developmental issues over the course of individual and family development. These may take center stage during different developmental stages of individuals or families and then recede into the background during other periods.

Adoption is Different than Birth
Adoption is a different and more complex way to form a family than having children by birth; and, consequently, adoptive families face a range of challenges that are intrinsic to the nature of adoption. It is important to recognize that all families face challenges, some more than others, and all families bring their own strengths in coping with these challenges. Adoptive families, like families formed through birth, are all unique and fall along a continuum on a variety of dimensions of family functioning. However, the most recent census data demonstrate that as a group, adoptive families are above average socioeconomically (Kreider, 2003). According to the 2000 Census, adoptive children reside in families where parents have more education and higher incomes than the families of stepchildren or biological children, and adoptive parents are on average 5 years older than parents of biological children.

One of the first scholars to recognize the significance of “difference” among adoptive families is H. David Kirk (1964, 1981), a sociologist and adoptive parent. He stressed that the “acknowledgement of difference” between being a parent to a birth child and to an adopted child is a necessary element of coping with the additional tasks and challenges adoption brings to parenting and family life. In his view “rejection of difference” was a coping pattern which interferes with positive adjustment in adoptive families. Others have built on his work recognizing that denial of difference inhibits open communication and honest exploration of a range of adoption issues conveys to children the idea that difference is somehow deviant or bad; however overemphasizing adoption or “insistence of difference” is an extreme coping pattern linked with maladjustment (Brodzinsky, 1987; Kaye, 1990).

Adoption Is a Lifelong Process
Adoption is a process, not an event, and it has salience across the individual and family life span, with somewhat predictable points where its importance looms larger, such as during adolescence for individuals (Brodzinsky, et al., 1992). A recent study of identity in adopted adults underscored that adoption is an important factor in most adopted persons’ lives, not just as children and adolescents, but throughout adulthood. In this study adoption increased in importance to respondents during Center for Adoption Support and Education © 2012
adolescence and continued to increase during young adulthood, remaining very important to the vast majority throughout adulthood – 81 percent of Korean respondents and over 70 percent of White respondents rated their identity as an adopted person as important or very important during young adulthood (Evan B. Donaldson Adoption Institute, 2009).

**Loss & Grief**
Loss is a central aspect of adoption and a life-altering event. Children experience the loss of connectedness to birth family, genetic identity, and culture. Having no clear memory of lost family members does not mean that the loss is not felt, and many adopted children have additional losses, such as relationships with foster parents, birth or foster siblings, schoolmates, and neighborhoods. Birthparents lose a child to whom they are genetically connected and the ability to parent the child, even when there is some ongoing contact. Adoptive parents may experience the losses of infertility, the opportunity to parent this child from the child’s creation, and a genetic relationship with the child. They also may grieve the child’s losses and their inability to protect the child from insults the child may have experienced before joining the adoptive family.

Loss is healed through grief, a process that is revisited again and again over time. Developmental changes or tasks as well as new losses will trigger grief. Sometimes feelings of rejection are connected to loss, particularly for adopted children who wonder why they were not able to grow up in their birth families.

**Attachment (Belonging, Claiming & Entitlement)**
Members in adoptive families may confront challenges in achieving secure attachments within the adoptive family, particularly when a child joins the family who has experienced separation from previous caregivers and/or maltreatment. Even in adoption of newborns, adoptive parents may struggle with feeling a lack of entitlement to be parents of this child. Adopted children may at times question whether they truly belong within their families, whether the relationship would be different if they were born into this family, or whether their parents love them as much as birth children within the family. Also they may experience divided loyalties between birth and adoptive families, particularly when they developed an attachment within their birth family. Often with older child adoption, parents need to demonstrate claiming the child as their own and as a full member of the family in concrete ways, such as having a new family portrait made with the child. In addition the extended family needs to claim the child as one of its own.

**Identity**
All members of the adoption triad must incorporate their role in adoption into their sense of self. Birthparents may feel stigmatized for relinquishing a child for adoption and experience a loss of self-esteem. Adoptees may struggle with making sense of why they were not raised by the parents who created them and with questions of who they are and who they will become. Likewise adoptive parents may be assuming a role that diverges from the norm and for which they have few if any role models.

**Mastery and Control**
Center for Adoption Support and Education © 2012
It is a basic human desire to feel a sense of competence and personal power in one’s life. Adoption often involves obstacles to the fulfillment of this desire, such as a lack of capacity to parent a child you conceived (birthparents) or having to surrender control to professionals in order to have a child placed with them (adoptive parents). Adopted children typically had no control in the sequence of circumstances that led to their placement with this family, in the maltreatment they may have experienced, or often in their ability to obtain satisfactory answers to the questions they ask.

**Developmental Tasks and the Adoptive Family Life Cycle**

Adoption scholars have identified critical developmental tasks confronting adoptive families as they work through core adoption issues at each stage of psychosocial development (Hajal & Rosenberg, 1991; Brodzinsky, Schechter, & Henig, 1992; Brodzinsky, Smith, & Brodzinsky, 1998; Schooler & Norris, 2002). These are overlaid with the usual developmental tasks of life stages for individuals and family stages. Developmental tasks for adopted children include:

- Learning one’s adoption story
- Coping with loss
- Searching for answers about one’s origin and the reasons for relinquishment
- Coping with adoption stigma
- Integrating adoption into one’s identity
- Validating affiliation with two families
- Consideration of searching for one’s birth family

Related tasks for adoptive parents include:

- Gathering information about the child’s history
- Open discussion of adoption with the child
- Helping the child cope with loss
- Providing realistic but positive information about the adoption story
- Coping with adoption stigma
- Integrating being an adoptive parent into one’s identity
- Supporting the child’s dual family membership
- Supporting the adoptee’s search for birth family members

These are not all of the developmental tasks faced by adoptive children but the central ones in adjusting to adoption. There are additional tasks for children who have experienced deprivation, maltreatment, and interrupted attachments.

In addition, other adoption-related issues such as coping with infertility for some or issues related to transracial and/or transcultural adoptions add additional layers of complexity to the developmental tasks that adoptive families may confront. For example, an adopted child typically confronts identity-related issues in different ways at different ages – the preschool child learns his or her own adoption/birth story; the elementary-age child begins to struggle with feelings of rejection, recognizes the loss aspects of adoption and experiences peer reactions to adoption; the adolescent seeks a deeper understanding of who he/she is in relation to both adoptive and birth families and may struggle with...
independence; the young adult adoptee comes to terms with genealogy in making choices about marriage and parenthood and in deciding whether or not to search for birth parents if they are not known. Sometimes life events such as a divorce or death of a parent can trigger resurfacing of certain adoption-related issues.

**The Adoption Life Cycle**

The concept of the family life cycle was developed to describe the changes that family systems experience over time (Carter & McGoldrick, 1980), and adoption scholars have identified additional adoption-related tasks that emerge over time and interact with the more universal tasks of family life (Hajal & Rosenberg, 1991; Brodzinsky, 1998). These models incorporate a pre-adoption period which includes tasks for adoptive parents such as coping with infertility and accepting the need for social service scrutiny. The handout, “Life Cycle Development and Adoptive and Guardianship Families,” integrates the traditional individual cognitive, emotional, and social developmental processes with the related developmental tasks of adoption across the following stages: pre-adoption, infancy, toddlerhood, early childhood, middle childhood, early adolescence, late adolescence, young adulthood, middle adulthood, and later adulthood Center for Adoption Studies, 2004).

While most adoptive families navigate these normative challenges without seeking professional help, they all can benefit from pre-adoptive preparation and post-adoption education about adoption. Also studies show that adoptive families are much more likely to seek professional help than are birth families with odds ranging from 2-5 times more likely to seek counseling (McRoy, Grotevant, & Zurcher, 1988; Howard, Smith, & Ryan, 2004; Keyes, Sharma, Elkins, Iacono, & McGue, 2008) to 4-7 times greater odds of seeking residential treatment (McRoy, et al., 1988; Landers, Forsythe, & Nickman, 1996; Elmund, Lindblad, Vinnerljung, & Hjern, 2007).

**References**


Center for Adoption Support and Education © 2012


Handout #9.3 Principles for Adoptive Parents on Communicative Openness about Adoption

1. **Create an environment of communicative openness**: give the child permission to find answers and acknowledge the difference of adoption.

2. **Start talking about adoption from a young age and initiate ongoing opportunities**: just because a child is not talking about adoption does not mean she is not thinking about it. For example, an adoptive father asked his 9-year-old son if he ever thought about adoption, and the boy answered “not really”. He then asked if he ever thought about his birthmother, and his son replied, “All the time!” Parents should not wait for a child to bring it up but should initiate discussions about these issues and take advantage of opportunities that present themselves. They should also use positive adoption language.

3. **Be honest in a developmentally appropriate way** *(never lie and share all by age 12)*: A great resource for parents to learn how to talk with children about complicated issues such as maltreatment and others is *Telling the Truth to Your Adopted or Foster Child*, by Betsy Keefer and Jayne Schooler. They advocate that children should be told everything that is known about their history, and that this should be shared incrementally and in a manner that they can understand. They believe that even the most negative aspects of their history should be shared with them by age 12 so that they have a chance to integrate and come to terms with this information prior to the tumultuous time of adolescence.

4. **Empathize with feelings without being judgmental or always trying to fix it**: Parents should first empathize with painful feelings that their children express or facilitate the expression of these feelings, without trying to sugar coat or negate these feelings.

5. **Help the child “grow” her adoption story and control telling it outside the family**: Children’s questions about adoption will increase in complexity as they grow up, and it is important for the preschool adoption story to grow with the child. Parents also need to prepare the child for the kinds of comments or difficult confrontations they may run into outside the family. CASE’s WISE-UP curriculum for children is a resource for parents in addressing these issues.
6. **Honor the birth family:** It is important for adoptive parents to communicate respect and value of birth family members and to validate the gifts the child received from their original family whether they are physical traits and talents or evidence of caring for the child. This may involve valuing the culture that they came from as well.

7. **Use tools-story books, Lifebooks, movies, family traditions:** Parents can use a range of resources to assist them in talking about adoption with children including storybooks, helping children construct Lifebooks, or developing commemorative rituals or traditions such as celebrating the child’s adoption day.

8. **Provide opportunities to interact with other adopted children and adults:** Adopted children often feel different from other children and may know few if any children whom they know are adopted. Finding opportunities for them to be involved with other adopted children and adults is very normalizing and facilitates their processing of feelings about adoption.

9. **Address parents’ own feelings and barriers to communicating openly and positively about adoption:** Adoptive parents’ own issues may pose barriers to healthy communication with their children about adoption, including their feelings about infertility, anger toward or fear of birthparents, their fear of losing their child’s love if they feel too positively toward their birth family, and others. They need a resource for processing and coming to terms with these feelings in order to be able to support their child’s adoption adjustment.
Handout #9.4: Factors Shaping Adjustment in Adoptive Families
By Susan Livingston Smith

There is a range of factors pertaining to adopted children themselves, their families, and the environments they live within that shapes their adjustment. For adopted children, their genetic histories, prenatal experiences, circumstances of birth, pre-adoption experiences and individual characteristics such as temperament or gender contribute to their adjustment after adoptive placement. Likewise characteristics of the adoptive parents and families help to shape children’s adjustment to adoption – qualities of the emotional health of the parents and their marriage relationship, parental expectations for their children, the social support system that surrounds adoptive families, the style of discipline and communication within the family, family structure including sibling relationships, and others. And of course, the communities and society that individuals live within shape their adjustments -- the values and beliefs, the adoption service system and the adequacy of its services and preparation of families, the supportiveness of social institutions for adopted children and their families, and the services available to them.

Risk Factors in Children

In order to understand the nature of challenges and needs in adoptive families, it is important to review the body of knowledge on risk factors associated with adjustment in both adopted children and their families. There are also protective factors that buffer the impact of negative influences. For most children, adoption itself is a huge protective factor, bringing permanency and a nurturing environment to children who have generally been in less than adequate situations. It is necessary to understand the complexity of factors shaping adoption adjustment prior to any consideration of finding solutions to problems or challenges.

Range of Resiliency

While risk factors are associated with lower levels of functioning; they do not necessarily predict problems for all who experience them. Rather the presence of a risk factor increases the probability of a certain outcome. There is a broad range of outcomes among children experiencing the same risk factor. For example, in a longitudinal study of children adopted from very deprived institutional conditions in Romania, the researchers found that at age 6, children leaving institutions after the age of 2 had IQs that were on average 25 points lower than those who left by 6 months of age; however even among the late-adopted group, IQs ranged from mental retardation to superior (Rutter, O’Connor, ERA Study Team, 2004).

Also, many children may have the same condition and come from very different background situations, with some having no apparent risk factors identified. For example, while domestic infant adoptees generally have been assumed to have the fewest risk factors for developmental problems, recent studies have not always corroborated this conclusion. A University of Minnesota study of the mental health of U.S. adolescents adopted in infancy (placed by age 2), using community-based samples, found that relative to nonadopted adolescents, domestic adoptees had 3.25 the odds of having an externalizing disorder while international adoptees had 1.7 odds of having such a disorder. The 178

Center for Adoption Support and Education © 2012
domestic adoptees had a mean placement age of 2½ months as compared to a mean of approximately 5½ months for the 514 internationally adopted children (Keyes, et al., 2008).

Primary risk factors that have been linked to developmental challenges in adopted children and research findings associated with these risk factors are summarized below.

**Prenatal Malnutrition and Low Birth Weight**

Malnutrition in mothers during pregnancy, other maternal health conditions, and poor prenatal care can lead to problems in fetal development, premature births and low birth weight; for example, insufficient protein and iron in the mother’s diet is linked with problems in brain growth and later cognitive development. Premature birth or intrauterine growth deficiency, particularly in less than optimal medical environments, may compromise the infant’s immune system, ability to take nourishment, healthy brain development, and increase other health and developmental risks. Low birth weight poses some longer-term risks for cognitive impairment and learning problems (Gunnar & Kertes, 2005).

Prematurity and being small for gestational age are more common in some regions of the world, particularly in Asian countries. These conditions also are widespread among children adopted from orphanages in Russia and eastern Europe and can have long-term impact on adjustment. For example, in a longitudinal study of 105 children adopted from the former Soviet Union, the average birth weight of children was 5.8 pounds, and low birth weight (defined as less than 5.5 pounds) had a large negative impact on children’s adaptive behavior scores at two evaluation times (at 7.7 years on average and again as adolescents). In fact, during adolescence low birth weight was the only pre-adoptive risk factor of the three examined (also looked at age child entered orphanage and length of time in the orphanage) that significantly predicted higher behavior problem scores. Also those who were premature had lower school competence scores (McGuiness & Pallansch, 2000; 2007).

**Prenatal Exposure to Toxic Substances**

Prenatal exposure to alcohol, drugs, tobacco, and other substances that have toxic effects on fetal development has increasingly become a focus of research, beginning with investigations of fetal alcohol exposure in the early 1970s. Pre-term birth, restricted fetal growth, and lower birth weight are common effects for many of these substances, including alcohol, cocaine, marijuana, nicotine, amphetamines, and opiates such as heroin. Researchers have quantified these risks through sophisticated research designs -- for example prenatal cocaine exposure poses 3.6 times the odds of low birth weight, and with exposure to multiple drugs these risks escalate exponentially (Bada & colleagues, 2005).

The chronic impact of heavy alcohol consumption during pregnancy results in some of the most devastating long-term challenges, including the severe, irreversible neurological and physical abnormalities diagnosed as fetal alcohol syndrome. Low to moderate maternal drinking also poses higher risks for a range of symptoms, such as inattention and hyperactivity, learning problems, memory deficits, and mood disorders (Freundlich, 2000; Sokol, Delaney-Black, & Nordstrom, 2003). Children adopted from Russia and eastern Europe countries, where alcohol consumption is very common, have a higher than average rate of fetal alcohol exposure (Aronson, 2000); for example, the study of 105 children adopted from the former Soviet Union found that despite unknown prenatal histories for over Center for Adoption Support and Education © 2012
half of the children, 41 percent were known to have mothers who abused alcohol during pregnancy (McGuiness & Pallansch, 2000).

Longitudinal studies have been conducted that get detailed histories at several points during pregnancy and follow children for many years to investigate the long-term consequences of exposure to a range of drugs, while controlling for many other variables. For example, prenatal marijuana use has been linked with increased hyperactivity, impulsivity, attention problems, learning and memory deficits, and externalizing behavior problems of children at age 10 (Goldschmidt, Day, & Richardson, 2000; Richardson, Ryan, Willford, Day, & Goldschmidt, 2002). The long-term impact of some drugs, such as cocaine, has not been evidenced by research to be as severe as originally thought. For example a review of 36 studies on early childhood outcomes of prenatal cocaine exposure did not find significant differences in child behavior (Frank, Augustyn, Knight, Pell, & Zuckerman, 2001).

For adopted children, prenatal exposure to drugs and alcohol is associated with an increased rate of externalizing behavior problems, particularly hyperactivity. The California Long-range Adoption Study compared the adjustment of children known to experience prenatal drug exposure (cocaine, marijuana, or heroin) with those known to not have such exposure at 2, 4, 8 and 14 years after adoption (Barth & Needell, 1996; Barth & Brooks, 2000; Crea, Barth, Guo, & Brooks, 2008). In the original data collection, the 1396 adopted children were classified as drug-exposed (23%), not drug-exposed (33%), and unknown (44%). Those with known drug-exposure were compared to those not drug-exposed, and at the 4 year follow-up the two groups were alike on most measures, including parental satisfaction with adoption and closeness to child; however drug-exposed children were more likely to demonstrate hyperactivity. The 14-year follow-up compared the two groups at each wave of data collection finding that drug-exposed children had slightly more behavior problems at baseline and largely remained that way across time.

In the authors’ own study of outcomes in over 1300 foster care adoptions (Howard & Smith, 2003), 60 percent of the children were known to have been exposed to drugs or alcohol before birth. Prenatal substance exposure was associated with increased behavior problems, although it did not predict that parents were more likely to rate these children as very difficult to raise.

A special program in California, TIES, which assists families adopting children from care who have been prenatally exposed to substances, collected data from the adoptive families of 16 children several months after placement and again about a year later (McCarty, Waterman, Burge, & Edelstein, 1999). They found that parents’ appraisal of their overall adjustment improved significantly from Time 1 to Time 2, and their concerns about prenatal substance exposure lessened over time. (These parents received significant preparation and ongoing support.) On the Parenting Stress Index, almost half of parents reported clinically significant distress caused by the child’s mood or a mismatch in the child’s behavior and their expectations at Time 1. The authors concluded that the period following adoptive placement is a particularly vulnerable time and they need support services from the time of matching to help them adjust.

**Older Age at Adoption**

For many years, older age at placement has been identified as a risk factor for adjustment difficulties, particularly in relation to risk for adoption disruption and behavior problems (Festinger, 1986; Barth & Berry, 1988, Berry & Barth, 1989; Sharma, McGue, & Benson, 1996). For example, the latter study by Center for Adoption Support and Education © 2012
Sharma and colleagues compared adopted teens in four groups by age at adoption: 0-1, 2-5, 6-10, older than 10, finding that infant adopted youth were most similar to the non-adopted controls and those adopted above age 10 had the lowest levels of adjustment. The middle two age at adoption groups were generally between the infant-placed and older than 10 adoptee groups. However, surprisingly, some studies have found no convincing evidence of a relationship between age at adoption and behavioral problems (Juffer & van IJzendoorn, 2005). A meta-analysis of research on attachment in adopted children found that those adopted before age 1 were as securely attached as non-adopted peers, but those adopted after 12 months of age showed less attachment security (van den Dries, Juffer, van IJzendoorn, & Bakermans-Kranenburg, 2009).

Many studies do not find a linear relationship between age at placement or adoption and later difficulties, but report differences among some groups. For example the Dutch longitudinal study described previously found that overall, those adopted after age 2 demonstrated a gradual increase in risk of later maladjustment; however infants adopted between 7-24 months of age had fewer behavior problems than did those adopted at 0-6 months (Verhulst, Althaus, Versluis-den Bieman, 1990; Verhulst, 2000). In addition, Howard and Smith’s (2003) study of children adopted from foster care found that children removed from their original families between ages 1-3 years and those placed for adoption between ages 4-6 had the highest behavior problem scores—higher than those removed or placed at ages 7 or older.

Some researchers have argued that it is not age per se but experiences of adversity children placed at older ages often incur that increases their risk for problems. Howe’s (1997) research in England separated late-placed adopted youth into groups of children with a “good start” and those with adverse early beginnings, finding good start/late adoptions had a lower incidence of problem behaviors in adolescence than the infant-adopted group; whereas the late adoptions with adverse beginnings had many more problems than those adopted in infancy. Also, in the Dutch longitudinal study of internationally adopted children, the older the age of the child at placement, the greater the probability of experiencing early maltreatment. Age at placement did not contribute to the increase in maladjustment independently from the influence of early adverse experiences (Verhulst, Althaus, & Versluis-den Bieman, 1992). The body of adoption research clearly demonstrates that it is the impact of early adverse experiences prior to adoptive placement that is most clearly linked with increased risk for adjustment difficulties.

**Early Deprivation, Including Institutionalization and Serious Neglect**

Adequate nurture of children is the foundation of all areas of child development—physical, intellectual, social, and emotional. When children’s basic needs are not met, all areas of their development suffer, with more extreme deprivation leading to more severe and long-lasting effects. A review of 29 studies on children adopted from orphanages in Romania, Russia and China found that the most consistent predictor of ongoing problems is the length of time spent in orphanage care, with those in care a year or more having the highest risk for chronic problems (Meese, 2005).

Studies of children adopted from Eastern European orphanages have documented the enduring impact of profound deprivation for children spending over 6 months in institutions characterized by severe neglect. A longitudinal study led by a team of British researchers has followed over 150 children adopted from Romania into English families, with their age at adoption ranging up to 3 ½ years, and has Center for Adoption Support and Education © 2012.
compared these children to domestic adoptees. Children were assessed at ages 4-6 years and again at ages 11-12. This longitudinal study has used sophisticated methodologies to explore the underlying causes of the effects of institutionalization on children. Some of the primary findings of this series of studies include:

- Children adopted from Romania by 6 months of age were comparable to domestically adopted children in cognitive development, language development and attachment; however the majority of those institutionalized more than 6 months showed deficits in one or more of these areas (Rutter, 2005).
- At age 11, children spending 6-24 months in institutions had IQ scores, on average, 15 points lower than peers with less time in institutions, but were not significantly better off than those institutionalized for 2+ years. Also there was marked heterogeneity in children’s cognitive functioning which was not associated with the educational background of the adoptive families (Beckett, Maughan, Rutter, Castle, Colvert, Groothues, Kreppner, Stevens, O’Connor, & Sonuga-Barke, 2006).
- Children in institutions longer than 6 months were more likely to show a pattern of “disinhibited attachment,” characterized by the relative failure to develop normal attachment relationships rather than insecurity in an established attachment. (Children would act silly, attention-seeking, and would readily go off with strangers.) The 98 children institutionalized 6-42 months were assessed as having: no (30%); mild (44%), or marked (26%) disinhibition. Disinhibited attachment was associated with other types of psychopathology and a marked increased in service usage (Rutter, O’Connor, ERA Study Team, 2004; Rutter, Colvert, Kreppner, Beckett, Castle, Groothues, Hawkins, O’Connor, Stevens, & Sonuga-Barke, 2007).
- A pilot study investigating the impact of early deprivation on brain development through the use of MRIs found that Romanian adoptees when compared with non-adopted adolescents had significant differences in their brain structures. The primary difference that related to time spent in institutions was in the amygdala, which plays a role in basic emotional processing and guiding social behaviors, supporting their conclusion that early global deprivation affects brain development (Mehta, Golembo, Nosarti, Colvert, Mota, Williams, Rutter, & Sonuga-Barke, 2009).

For children adopted internationally, the level of deprivation varies across institutions within the same country and across caretakers. Some have toys to promote stimulation and a lower caregiver-child ratio to permit more interaction, but it is difficult for them to provide the quality of experiences needed to support optimal child development. One group studying the caregiving environment across six Romanian orphanages found that individual differences in the caregiving environment (such as the extent to which a caregiver was available and interacting with a child) was associated with cognitive development, competence and negative behavior in infants and toddlers (Smyke, Koga, Johnson, Fox, Marshall, Nelson, Zeanah, & BEIP Group, 2007). Even after controlling for age at adoption, early neglect impacts children’s adjustment years after their adoption. For example in Tan’s (2006) study of 115 girls adopted from China, he asked parents whether their daughters experienced neglect prior to their adoption and to provide their basis for this assessment. For the girls known to have been neglected, 42 percent scored below average on a social competence scale, as compared to only 14 percent of girls not known to have experienced neglect. Not every study of international adoptees has found a long-term impact of institutionalization on child behavioral adjustment, for example one study of 695 girls

Center for Adoption Support and Education © 2012
adopted from China found that they had slightly fewer problems than those in the normative comparison group on all scales of the Child Behavior Checklist except for the Anxious/Depressed subscale (Tan & Marfo, 2006).

Another problem found more frequently among children experiencing institutionalization or deprivation/neglect is sensory integration difficulties -- a condition in which the brain cannot analyze, organize, and integrate sensory messages efficiently. For example, a study comparing 73 Romanian adoptees and a comparison group of American children found greater problems among the adoptees in five of six sensory-processing domains -- touch, movement-avoids, movement-seeks, vision, and audition, as well as four of five behavioral domains -- activity level, feeding, organization, and social-emotional (Cermak & Daunhaurer, 1997). Children with sensory integration problems may demonstrate a range of behaviors including oversensitivity to tactile sensations such as a label rubbing their neck or defensiveness to being touched, hypersensitivity to noises, an aversion to many tastes or food textures, being distractible or whiny, clumsiness, and others (Purvis & Cross, 2007).

Also, neuroendocrine imbalances, such as abnormally high or low cortisol levels (a hormone produced by the adrenal glands) may be associated with profound deprivation and other traumas, with studies finding differential effects (Gunnar, Morison, Chisholm & Schuder, 2001; Gunnar & Vazquez, 2001; Gunnar & Kertes, 2005; Bruce, Fisher, Pears, & Levine, 2009). Gunnar and her colleagues (2001) found that 6 ½ years on average after their adoption, children who spent 8 months or more in a Romanian orphanage showed higher cortisol levels than two comparison groups of children. Cortisol is one of two major stress-related hormones, and having too much or too little cortisol for an extended period can cause a range of developmental problems. Also the Dutch longitudinal study described earlier assessed cortisol levels in 623 young adult international adoptees, finding that those who had experienced severe neglect or abuse had lower morning cortisol levels than non-neglected adoptees. Those reporting moderate early maltreatment had higher cortisol morning levels (van der Vegt, van der Ende, Kirschbaum, Verhulst, & Tiemeier, 2009).

For children in foster care or adopted from the child welfare system, neglect is the most common type of maltreatment experienced (USDHHS, 2007; Howard & Smith, 2003). However there is a broad range of conditions classified under neglect ranging from profound inattention to the child’s basic needs to unsafe living conditions and inadequate supervision. A cluster analysis of 160 substantiated neglect cases found that about 20-25 percent of these cases pose a high level of risk to the child (Chambers & Potter, 2009). Severely neglectful mothers interact minimally with their children, provide less affection,

---

1 Chronic stress during institutionalization or prolonged periods of trauma affects the limbic-hypothalamic-pituitary-adrenocortical (LHPA) system. Both cortisol and another, corticotrophin releasing hormone (CRH), operate in ways that suppress growth, resulting in growth retardation among some institutionalized children. Cortisol levels normally cycle throughout the day, peaking soon after waking and being the lowest in the evening. Elevated cortisol levels can contribute to negative emotionality and affective disorders and can also affect attention, learning and brain development. Elevated cortisol levels in early life are hypothesized to lead to the development of hypocortisolism or adrenal insufficiency in adults (Johnson, Kamilaris, Chrousos, & Gold, 1992; Gunnar, et al., 2001; Gunnar & Vazquez, 2001).

2 The sub-type of neglect cases presenting the highest level of risk involves many poverty-related needs and caregivers who also experience mental health problems and/or domestic violence and moderate levels of substance abuse (Chambers & Potter, 2009).
and give less instruction or encouragement, sometimes neglecting to even feed their children or tend to them for extended periods of time. It is this overall lack of involvement with their children which compromises normal child development in all its domains.

*Experiencing Physical, Sexual, or Emotional Abuse*

In addition to neglect or deprivation, many children adopted internationally and from foster care have experienced other maltreatment and trauma including physical, sexual and emotional abuse, witnessing violence, and others. One study found that children entering an orphanage beyond one month of age were more likely to have experienced some type of maltreatment than those placed there soon after birth (McGuiness & Pallansch, 2000), but children also may be abused in orphanages by other children or by caretakers. Also, some children experience multiple types of maltreatment as well as other types of trauma, such as witnessing violence and traumatic loss. Research has found that cumulative trauma experiences are associated with greater complexity and severity of symptoms (Briere, Kaltman, & Green, 2008).

The types of abuse experienced by children adopted from the child welfare system in the U.S. are not completely known. Often children are removed due to a single indicated allegation (most commonly neglect) but later other types of maltreatment they have experienced come to light. Indicated child abuse and neglect cases involve physical abuse (10%), sexual abuse (7%), psychological maltreatment (4%), or multiple maltreatments (13%) in a minority of cases (USDHHS, 2007). However, it is likely that some children entering foster care due to neglect may have experienced other types of maltreatment. In a study of over 1300 children adopted from foster care in Illinois, parents rated whether their children had experienced different types of maltreatment, including a category “unsure”. The incidence of various types of maltreatment reported were: serious neglect (63%), physical abuse (33%), and sexual abuse (17%), with another ¼ of parents stating they were unsure whether their child had been sexually abused (Howard & Smith, 2003).

Many of the behavioral symptoms of adopted children who are seen in mental health settings stem from the effects of trauma. In fact, a high percentage of children who have externalizing behavior disorders (attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), or conduct disorder) have a trauma history. One study reported that children diagnosed with externalizing disorders had more history of experiencing trauma than those with other diagnoses. In fact, 91 percent of children diagnosed with both ADHD and ODD were assessed as having a traumatic history, primarily physical or sexual abuse (Ford, Racussin, Ellis, Daviss, Reiser, Fleischer, & Thomas, 2000).

Externalizing behavior problems have been found to be more prevalent among adopted children, and a maltreatment history has been identified in a number of studies as contributing to such behaviors (Berry & Barth, 1989; Verhulst, et al., 1992; Smith & Howard, 1991; Rosenthal & Groze, 1994; Simmel, et al., 2001; Howard & Smith, 2003; Juffer & van Ijzendoorn, 2005). Also sexual abuse has been shown to be even more strongly associated with a high level of acting out behavior problems and adoption instability than has physical abuse (Rosenthal & Groze, 1992; Smith & Howard, 1991, 1994; Smith, Howard, & Monroe, 1998; Groza & Ryan, 2002; Howard & Smith, 2003; Simmel, 2007; Nalavany, Ryan, Howard, & Smith, 2008). In addition, the impact of maltreatment on the adjustment of adopted children has been found to persist into adulthood, especially when maltreatment is severe (van der Vegt, van der Ende, Ferdinand, Verhulst, & Tiemeier, 2009).
Emotional abuse is less commonly reported and investigated than other types of maltreatment, and it has been less investigated among adopted children as well. One English study has examined the impact of “preferential rejection” on children placed for adoption – a type of emotional abuse in which a child is singled out from siblings for negative parental attention in the birth family (Rushton & Dance, 2003). Those children experiencing preferential rejection had 8 times the odds of parents’ rating them as making unsatisfactory progress (both parents expressed concerns about parent/child relationship).

The impact of abuse on children is both psychological and physiological. The psychological impact can include pervasive fearfulness and anxiety, depression, low self-esteem, difficulties in self-regulation of feelings and behaviors, and PTSD- related symptoms such as hyperarousal, instrusive thoughts, and avoidance responses ranging from avoiding stressful situations and numbing of feelings to dissociation. Children experiencing complex trauma also may have a damaged world view involving mistrust of others, festering anger, aggression, and a strong need to control others to defend against feelings of powerlessness (Finkelhor & Browne, 1986; Terr, 1991; Ford, et al., 2000; Smith & Howard, 1999; Briere, Johnson, Bissada, Damon, Crouch, Gil, Hanson, & Ernst, 2001). Another line of inquiry related to the long-term impact of abuse and neglect on children is how such experiences alter the neurochemistry and physiology of the brain and can result in neurodevelopmental damage (Perry, 1998). One deficit in brain functioning linked with trauma relates to “executive functioning” or abilities located in the part of the brain associated with aspects of self-control, working memory, learning, attending, decision-making, and problem-solving (the pre-frontal cortex). A British study of foster and adopted children referred for a trauma-related assessment found that all of them had significant deficits in executive functioning and concluded that children’s oppositional responses to adult instructions often result from the brain’s difficulties in processing information – in other words it is related to the fact that the child can’t do rather than won’t do tasks. These researchers stated that “unless these difficulties are identified and addressed, these children get ‘left behind’ and a growing gulf develops between them and their peers” (Lansdown, Burnell, & Allen, 2007, p. 49).

An additional area of functioning challenged by child maltreatment is children’s emotional development, in particular their understanding of emotions and “theory of mind” abilities. “Theory of mind” is a psychological ability to understand that others may have differing perspectives than one’s own, and it is the foundation for empathy and social competence in children. Research has shown that maltreated children may have difficulty identifying their own and others’ feelings as well as in perspective-taking and responding to social cues (Rogosch, Cicchetti, & Aber, 1995; Pears & Fisher, 2005).

**Number of Placements Prior to Adoption**

A final factor in the pre-adoption history of children that has been linked with greater risk for ongoing adjustment problems is the number of placements that children experienced prior to their adoption. Experiencing multiple moves in care prior to adoptive placement has been linked with adoption instability and greater likelihood of adjustment problems (Festinger, 1986; Barth & Berry, 1988; Verhulst, et al., 1992; McRoy, 1999; Howard & Smith, 2003; Simmel, 2007; van der Vegt, et al., 2009). One study of moves in care among 415 foster children within their first 18 months in placement found a mean of 4 placement moves in this time period (ranging from 1-15). Behavior problems were both a cause and an effect of placement moves. Children with a high level of behavior problems were more
likely to be moved; however, for children who did not have elevated behavior problems upon initial placement, their number of moves in care consistently predicted increased internalizing and externalizing behavior problems (Newton, Litrownik, & Landsverk, 2000).

Research studies have found that placement instability has more of a negative impact on children than the fact of placement itself. For example, one study evidenced that adopted children with a history of multiple placement moves had poorer inhibitory control abilities and more oppositional behavior than adopted children who experienced only one foster placement prior to adoption, even after controlling for pre-adoption risk factors (Lewis, Dozier, Ackerman, & Sepulveda-Kozakowski, 2007). Similarly, another study of the relationship between placement instability and the risk of delinquency among foster youth found that male foster youth with only one or two placements had virtually the same risk of delinquency as those who were not placed; however male youth with 3 or more moves had a much higher rate of delinquency (Ryan & Testa, 2005).

**Emotional Conflicts Related to Loss and Identity Issues**

Over the course of their lives, adopted children and adults face the challenge of exploring the meaning of adoption and integrating this into their own identity. It is common for adopted children to struggle at times with their feelings related to being adopted, and studies have documented that emotional turmoil and difficulty related to adoption issues is associated with greater adjustment problems, including depression, lower self-worth, anxiety, and behavior problems (Smith, Howard, & Monroe, 2000; Smith & Brodzinsky, 2002; Juffer, 2006).

Generally, children do not become aware of the loss aspects of adoption until they are school age. During middle childhood, children’s understanding of the implications of being adopted grows at a profound rate, and at the same time there is a decline in positive attitudes related to adoption and an increase in behavioral problems (Brodzinsky et al., 1992; Juffer & Van Ijzendoorn, 2005). Adopted individuals fall along a continuum related to their interest in and involvement with adoption-related issues, and this varies in intensity at different times in their lives. Some show minimal interest in adoption, while others struggle and come to terms with issues, and still others remain unsettled (Dunbar & Grotevant, 2004). Smith and Brodzinsky (2002) examined the appraisals of birthparent loss of 82 adopted children between the ages of 8 and 12 as well as their coping strategies to manage related stress, their levels of depression, anxiety, and self-worth, and their parents’ ratings of behavior problems. They found that greater curiosity and preoccupation about birthparents as well as a coping pattern of behavioral avoidance (staying away from the problem, being mean to someone when upset about the problem, etc.) was associated with higher levels of externalizing behavior problems. Also, children who reported higher levels of negative emotions about birthparent loss also reported more depression and lower self-worth. Similarly, research with adopted adolescents has linked very high levels of preoccupation with adoption and significantly higher levels of alienation and lower levels of trust for their adoptive parents (Kohler, Grotevant, & McRoy, 2002).

In addition, Juffer (2006) studied the relationship between children’s feelings about adoption and behavior problems in 176 7-year old children who were transracially adopted into Dutch families. She found that 55 percent of these children had expressed the wish to be White and/or to be born into their adoptive families, and these feelings predicted higher levels of behavior problems according to
both mothers’ and teachers’ ratings. There was some variation according to the country children came from, with those children with dark skin reporting the greatest concern about difference.

Our own study of adopted children and adolescents whose families received therapeutic counseling services upheld the view that problem behaviors are often outward signs of underlying emotional struggles including separation/attachment conflicts, grief, identity issues, depression, and post traumatic stress symptoms (Smith & Howard, 1999; Smith, et al., 2000). The study explored the relationship of these issues to behavior problem severity and to whether the parents raised the possibility of adoption dissolution, finding that worker ratings of 5 of the 6 emotional issues examined (all but “need to search”) were associated with severity of behavior problems, and all except identity issues were associated with parents’ raising dissolution.

**Protective Factors among Adopted Children**

Resilience is the ability to overcome adversity and function better than might be expected. A number of protective factors – buffers that mediate the impact of stressful events – exist at a number of levels within children, families, and their environments. Of course, the absence of these factors might also be viewed conversely as a risk factor for poor adjustment. For example, whereas parental warmth and sensitivity are protective factors, the lack of these abilities can be viewed as a risk factor in adoption adjustment.

As discussed earlier, children can experience the same treatment or adversity and achieve different outcomes. Some of this difference in outcomes is due to protective factors and differential susceptibility. The body of research on risk and protective factors in child development has identified a range of factors fostering resiliency. On the individual level gender and temperament can make children more or less vulnerable to negative outcomes.

**Gender**

Generally, in the body of research on child development and in adoption research, being born female is a protective factor. For example, girls have a lower risk for developing externalizing behavior problems (Criss, Pettit, Bates, Dodge, & Lapp, 2002). Some adoption studies have found such differences by gender (Sharma, et al., 1998; Simmel, 2007; Verhulst, et al., 1990; Howard & Smith, 2003) while others have not (Juffer & van IJzendoorn, 2005).

**Child’s Temperament**

Children’s temperaments, which are both genetically and environmentally shaped, can be protective and moderate their susceptibility to negative experiences. Research has established that at birth children have definite temperaments that vary on factors such as irritability, emotional expression, activity level, fearfulness, adaptability, persistence, and others; these dispositions are relatively consistent over time even though they may be shaped through interactions (Goldsmith, et al., 1987). Children with easy temperaments elicit and reinforce nurturing responses from caretakers and peers and are less vulnerable to maltreatment and unhealthy attachment interactions (Wong, 2003; Flores, Cicchetti, & Rogosch, 2005). Therefore an infant who is cute, easygoing, and very responsive may receive more positive attention in an orphanage setting and therefore suffer fewer ill effects of Center for Adoption Support and Education © 2012
institutionalization. Research also has shown that children with difficult temperaments are more susceptible to negative discipline, resulting in more acting out, but they also were influenced more by positive discipline than children with relatively easy temperaments (van Zeijl, et al., 2007). Children with difficult temperaments may evoke maladaptive caregiving, and their parents may need support in maintaining effective discipline strategies.

**Ability to Develop Attachments**

A child’s capacity to give and receive affection or to attach is another protective factor. Attachment styles and capacities of young children are shaped through interaction with the environment. Also there is an emerging body of research indicating that there are genetic factors in children which make them more or less susceptible to inadequate caregiving and more or less responsive to positive changes in caregiving environments⁴ (Spangler, Johann, Ronai, & Zimmermann, 2009; Bakermans-Kranenburg, Van Ijzendoorn, Mesman, Alink, & Juffer, 2008). Once children are placed for adoption, the development of a secure attachment is a reciprocal process between the child and caregivers. Research indicates that the child’s ability to accept nurturance and develop an attachment to the parents, particularly the mother, is significantly linked with adoption outcomes. One study found that when an adoptive mother perceives a lack of attachment by the child, there is an eightfold increase in adoption disruption (Dance & Rushton, 2005). In our study of the adjustment of youth adopted from foster care, the child’s ability to give and receive affection (rating of very well or fairly well by parents) was the strongest protective factor in predicting fewer behavior problems. Being able to give and receive affection decreased a child’s Behavior Problem Index score (ranging from 0-28) by 5.5 points overall (Howard & Smith, 2003).

**Family-related Protective Factors**

The protective factors that contribute to positive outcomes and resiliency in adoptive families are primarily the same as in other families: 1) a stable marriage relationship with good communication; 2) a warm, cohesive pattern of family interaction; 3) an authoritative, nurturing parenting style; 4) openness in communication; and 5) good social support from outside the family. In addition, adoption experts stress the importance of realistic expectations and parental preparation for adoption as critical factors promoting resilience in their ongoing adjustment.

**Realistic Expectations and Thorough Parental Preparation**

Parents’ cognitive appraisal of their situation helps to shape their efforts to cope and their overall commitment to parenting. One major influence on their appraisal of their adoption is the expectations they had going into it and the congruence between their expectations and the child’s capacities. The importance of parents’ having realistic expectations for adoption is a recurring theme in the adoption literature and one that has been upheld by research (Barth & Berry, 1988; Groze, 1995; Pinderhughes, 1996; McRoy, 1999; Reilly & Platz, 2003). According to the latter study of 259 special needs adoptive

---

⁴ For example, in a study of 106 mother-infant dyads when the infants were 12 months old, attachment disorganization (present in 24%) was four times as high in those with a certain genotype. Attachment disorganization was assessed as 11% among infants with two long alleles, 26% among those with one long allele and 42% among those with two short alleles on the serotonin transporter gene (Spangler, et al., 2009).
families, parental expectations was the only one of five variables assessed that had a significant influence on all four of the adoption outcomes evaluated (parental satisfaction, quality of parent-child relationship, and impact of the adoption on the family and marriage). Also a qualititative study of 37 successful adoptions of teens from foster care found that a major key to success identified by parents and teens was having realistic expectations (Flynn, Welch, & Paget, 2004; Wright & Flynn, 2006).

Parents’ views of their children and any difficulties they may be having after adoptive placement are shaped by their expectations going into the adoption. A study of families adopting 15 older children concluded that parental perceptions were more important than child behaviors, and it identified specific parental perceptions that facilitated adjustment – finding strengths in the child overlooked by others, viewing behavior and growth in the context of the child’s history, reframing negative behavior, and attributing improvement in behavior to parenting efforts (Clark, Thigpen, & Yates, 2007).

One important means to achieving realistic expectations in parents and in older children placed for adoption is thorough adoption preparation. For parents, this includes provision of accurate and up-to-date background information on the child (Barth & Berry, 1988; Nelson, 1985; Rosenthal, 1993). However, after adoption families often report not receiving enough information; for example, in a study of 259 families adopting from foster care, 58 percent reported not receiving enough information on the child and 37 percent reported the child’s problems were more serious than originally described by the agency (Reilly & Platz, 2003).

Adoption preparation also includes in-person and online educational classes, reading, contacts with other adoptive families, and other methods (Brodzinsky, 2008). Several studies have linked parents’ perceptions of pre-adoptive preparation and their readiness for adoption with positive outcomes (Barth & Berry, 1988; Nelson, 1985; Paulsen & Merighi, 2009; Simmel, 2007). A recent British study of adopters’ evaluations of their preparation for adoptions from foster care found that while parents felt they had learned to understand children’s issues, they needed more on skills to manage difficult behaviors (Rushton & Monck, 2009).

Parental preparation to manage difficult behaviors is especially important when adopting children with oppositional or aggressive behaviors. Simmel (2007) concluded that the less prepared the family was to parent a child with externalizing problems, the less able they were to regulate the child’s behaviors. She compares this escalating dynamic to findings of another study in which the researchers observed that the child’s aggressive behaviors fueled coercive disciplinary practices by the parents, which in turn led to heightened aggressive behaviors in the child (Patterson, Reid, & Dishion, 1992).

**Positive Parenting Style**

In all families positive parent-child relationships promote secure attachments and contribute to positive outcomes for children. This is particularly true for children coming from high-risk situations, when parental sensitivity and responsiveness is essential to fostering a healing environment. Desireable qualities in parenting that research links with positive outcomes in children include warmth, sensitivity to children’s needs and feelings, responsiveness, positive disciplinary strategies, and active involvement (Benzies & Mychasiuk, 2008). A number of studies of adoptive families have established the importance of positive parenting aspects; some examples include:
• A study of 83 African American adoptive families found that qualities of the parent-child relationship, such as amount of enjoyable time spent together and how often the parent thinks of the child when separated are stronger predictors of child behavior problems than pre-adoption characteristics of the child or parent (Smith-McKeever, 2005).
• Positive scores on the HOME scale assessing parenting style (quality and frequency of stimulation, discipline style, and emotional support) was a significant predictor of fewer externalizing behavior problems in an analysis of 293 families who adopted from foster care (Simmel, 2007).
• Adoptive mothers with a high degree of maternal sensitivity and secure attachment styles are better able to respond to maltreated children’s past loss or trauma issues, and these placements are less likely to disrupt (Steele, Hodges, Kaniuk Hillman, & Henderson, 2003; Kaniuk, Steele, & Hodges, 2004).
• A longitudinal study of families adopting from Russia found that a cohesive family environment predicted higher child competence scores and lower behavior problem scores. Level of family cohesion as a protective factor had a greater impact than any pre-adoption risk factor on total behavior problem scores (McGuinness & Pallansch, 2007; McGuiness & Pallansch, 2000).

**Communicative Openness**

In all families, family communication patterns affect child adjustment, and communication is critically important in adoptive families (Steinberg, 2001; Brodzinsky, 2006). Research on adolescents from both adoptive and non-adoptive families indicates that children from families with “consensual” communication (high in frequent, spontaneous, unconstrained conversation and high in conformity orientation or maintaining harmony) have the fewest externalizing behavior problems (Rueter & Koerner, 2008). This study classified family communication patterns into one of four styles (consensual, pluralistic, protective, and laissez faire), finding that the percent of adolescents with high externalizing behaviors varied by communication pattern. They concluded that teens in families emphasizing conversation orientation were at lower risk for adjustment problems. Adopted adolescents had more externalizing behaviors than non-adopted adolescents, but this varied from 3 (consensual) to 27 percent (laissez faire) across the communication patterns. Adopted adolescents were at greater risk for problems compared to nonadopted peers in families that emphasized conformity without conversation and in families that emphasized neither conformity nor conversation.

Brodzinsky found that communicative openness in addressing adoption issues was a stronger predictor of children’s adjustment than structural openness (Brodzinsky, 2006). Adopted children experiencing more open adoption communication reported higher self-esteem and had lower parent ratings of behavior problems. Among adopted adolescents, those who perceive greater communication openness in their families report more trust for their parents, fewer feelings of alienation, and better overall family functioning (Kohler, Grotevant, & McRoy, 2002). Research on communication about adoption also indicates that parents often underestimate the difficulty their children have in talking about adoption, and the level of openness can vary between the same child and different parents as well as across different adopted children in the same family (Beckett, et al., 2008; Hawkins, et al., 2007; Wrobel, Kohler, Grotevant, & McRoy, 1998; Wrobel, Grotevant, Mendenhall, & McRoy, 2003)

**Environmental Protective Factors**
Family well-being is influenced not only by characteristics of children, parents, and their interactions but also by their social networks, organizations such as school and churches, and characteristics of their communities. Some environmental factors that have been identified through research that promote resilience include: 1) family involvement in the community through access to social networks and resources; 2) peer acceptance for children; 3) supportive mentors; 4) access to quality childcare and schools; and 5) access to quality health and mental health care (Benzies & Mychiasiuk, 2009).

**Sufficient Informal and Formal Social Supports**

A poignant response from a single adoptive mother who adopted a sibling group from foster care, reported by Groze (1996) in his longitudinal study of special needs adoptive families illustrates the critical importance of a supportive network, including adoption-sensitive professionals:

> I felt I was prepared for adoption, but I’ve been somewhat disappointed since. Yes, I am prepared to deal with the children’s problems on my own, with my family, or with a psychologist’s help. I was not prepared to deal with non-adjusting, non-understanding trained and untrained teachers, daycare and other so-called professionals (including some social workers)…Why can’t people be more tolerant-sensitive of adoptive…children and their parents’ problems? (p. 76)

For families adopting a child with many challenges, social support is particularly critical. The family impact resulting from caring for an individual family member with extraordinary health or mental health problems is far-reaching – economic cost, impact on family and other relationships, restrictions on personal and social activities, stigma, psychological overload, and others. When parents are experiencing chronic parenting stress, it can lead to smaller social networks (fewer friends), reduced feelings of competence, and restriction of their interactions outside the family (Armstrong, Birnie-Lefcovitch, & Ungar, 2005). For example, a qualitative study of challenges in international adoptive families reported that some families experienced a lack of support from friends or extended families that resulted in their feeling disconnected from others who did not understand their situation or expressed insensitive comments. One adoptive mother reported, “When we adopted, my parents treated our son noticeably different from the other grandchildren. It was like he was second class” (Reynolds & Medina, 2008, p. 87).

Adoptive families need support from many levels both within their own families, from friends and organizations with which they interact, and from professionals. What is most important is that the support is sufficient to meet their needs. The term “social support” is most frequently used to refer to informal support from unpaid individuals such as relatives and friends (Armstrong, et al., 2005). In addition, families need formal supports and responsive assistance from schools, day care, health, and mental health resources. When helping systems respond in an insensitive manner, it only increases families’ stress rather than helping to manage it. Research confirms that the amount and quality of support that special needs adoptive families receive contributes to family permanency and adjustment (Barth & Berry, 1988, Groze, 1996; Leung & Erich, 2002; Houston & Kramer, 2008).

A Texas study of family support and family functioning in special needs adoptive families found that a higher level of support overall and specifically from their spouse, other adoptive parents, physicians, and day care resources predicted a higher level of family functioning and fewer child behavior problems. However, families who were lower on family functioning were actually receiving more Center for Adoption Support and Education © 2012.
support from relatives, school, and professional helpers than those who were functioning well (Leung & Erich, 2002). A longitudinal study of the contribution of agency and non-agency supportive resources to the well-being of special needs adoptive families found that families’ contact and satisfaction with formal and informal helping resources declined from the pre-adoption period to 3 years later (Houston & Kramer, 2008). In this study, families who received more service from the adoption agency prior to finalization were more stable and experienced less family conflict 3 years later.

When families are unable to meet their needs for support within their informal social support system, they may seek out formal helping services. Adoptive parents may talk with their pediatrician or child’s school seeking advice, and many who are connected to a trusted adoption agency will contact them for suggestions.

References


Center for Adoption Support and Education © 2012


Center for Adoption Support and Education © 2012
Module #9  Adoptive Family Formation, Integration and Developmental Stages


sample of domestic and intercountry adolescent adoptees. *Adoption Quarterly, 10* (3-4), 131-156.


Lansdown, R., Burnell, A., & Allen, M. (2007). Is it that they won’t do it, or is it that they can’t? Executive functioning and children who have been fostered and adopted. *Adoption & Fostering, 31* (2), 44-53.


Center for Adoption Support and Education © 2012


Center for Adoption Support and Education © 2012


### Handout #9.5 Potential Risk Factors in Different Types of Adoption

<table>
<thead>
<tr>
<th>Risk Factors that Domestically Adopted Infants May Experience</th>
<th>Risk Factors that Internationally Adopted Children May Experience</th>
<th>Risk Factors that Children Adopted from Foster Care May Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range of resiliency</td>
<td>Range of resiliency</td>
<td>Range of resiliency</td>
</tr>
<tr>
<td>Prenatal exposure to toxic substances</td>
<td>Prenatal malnutrition and low birth weight</td>
<td>Separation from birth family</td>
</tr>
<tr>
<td>Emotional conflicts related to loss and identity</td>
<td>Prenatal exposure to toxic substances</td>
<td>Multiple placements</td>
</tr>
<tr>
<td>Genetic factors</td>
<td>Early deprivation/trauma, abuse physical/sexual</td>
<td>Prenatal exposure to toxic substances</td>
</tr>
<tr>
<td></td>
<td>Abuse and neglect</td>
<td>Older age at time of adoption</td>
</tr>
<tr>
<td></td>
<td>Many caretakers</td>
<td>Early deprivation</td>
</tr>
<tr>
<td></td>
<td>Emotional conflicts related to loss and identity</td>
<td>Exposure to physical, sexual or emotional abuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emotional conflicts related to loss and identity</td>
</tr>
</tbody>
</table>
Handout #9.6 Four Areas of Functioning Challenged by the Impact of Loss, Trauma, & Inadequate Nurture

**CAPACITY FOR RELATIONSHIPS**

Intimacy ........................................................ Isolation

**IDENTITY**

Self-integration ........................................... Identity Confusion

**SELF-EFFICACY**

Mastery ....................................................... Powerlessness

**SELF-REGULATION**

Self-control .................................................. Impulsivity

**Capacity for Relationships**

The ability to develop close relationships with others, to give and receive affection, is the foundation of development and supports the development of trust, positive expectations of others, and positive self-esteem. It also promotes the development of self-control, empathy, and a conscience. Deprivation and experiencing physical or emotional pain in early relationships leads to a fear of closeness, anger, and the development of defenses for self-protection, such as numbing and withdrawal. Well-nurtured children have the capacity for emotional connectedness, whereas children from adverse beginnings distrust others and learn to protect themselves from closeness. They may alternate between seeking closeness and distancing parents through irritating or hostile behaviors. They test their parents’ commitment in many ways. In order to overcome attachment problems children must learn to identify and express their own feelings and needs and to manage their fears related to closeness without pushing others away. Below are some tasks for children and parents in this work.

**Tasks for Children**

Learning to manage fear, accept comfort
Resolution of past losses
Grief work
Building on former attachments
Strengthening attachments in adoptive family

**Tasks for Parents**

Calming, redirecting, de-escalating
Work through own losses
Help child express grief
Honoring child’s previous attachments
Claiming child; positive interactions

Center for Adoption Support and Education © 2012
Module #9  Adoptive Family Formation, Integration and Developmental Stages

Identifying & expressing feelings
Help child to verbalize feelings

Experiencing safety and security
Responding to child’s needs at his/her developmental level – reparenting

**Identity**

Well-nurtured children receive positive external messages that become internal, leading to a sense of self-worth and an ability to incorporate many aspects of themselves into an integrated sense of who they are. Persons with a strong identity have a sense of wholeness, connectedness, and positive self-esteem. Their search for meaning has led to answers that do not devalue themselves. It is common for children who experience maltreatment or are removed from their birth family to see themselves as responsible for these events, bad, and unlovable. They may feel they must have done something bad to deserve maltreatment. Most adopted children ask themselves “Why didn’t they keep me?” and can struggle with feeling that they are not like everyone else, but are a second-class citizen who was “given away.” They are often missing essential elements (connection, history, information) from which to make sense of events and gain a positive sense of who they are and their place in the world. To come to terms with their history, children need to be able to connect their past, present, and future through reconstructing their life history and coming to terms with the meaning of these events in their lives. They need to be able to affirm the positives they have gained from others and their ability to survive difficult experiences. Tasks in this work include:

**Tasks for Children**

- Reconstruct life history
- Affirm the positives they received
- Destigmatize adoption
- Normalize adoption—know other adoptees
- Connect past, present, and future
- Recognize positives in self & talents

**Tasks for Parents**

- Share all information
- Demonstrate respect for birth family
- Able to communicate about adoption
- Affiliate with other adoptive families
- Maximize openness in child’s best interest
- Reinforce positive self-esteem

**Sense of Self-Efficacy**

Self-efficacy is best understood in relation to its antithesis – powerlessness. Children who have experienced interrupted attachments and other traumas have feelings of extreme vulnerability, fear and rage. Finkelhor and Browne (1985, p. 82-3) identify powerlessness as a primary impact of trauma and define it as “the process in which the child’s will, desires, and sense of efficacy are continually contravened.” One adopted child described, “I feel like a ball in a pinball machine.” Children who have
been unable to protect themselves may have a constant fear of impending doom, underlying feelings of anger and tension, and a strong need to control. They develop maladaptive behaviors to achieve a sense of power and mastery through asserting control over others, and their behaviors reflect this need. To avoid feeling helpless and vulnerable, they behave in negative oppositional ways to exercise power and control. Self-efficacy then is a sense of personal control and mastery (“I am the captain of my fate”) and the feeling that one can manage events in life. Children whose will is continually violated and believe their wishes do not matter need to learn positive ways to gain control, to achieve mastery in some areas of their lives, and to have an increased sense of personal choice and power.

**Tasks for Children**

- Getting in touch with feelings
- Healing from trauma
- Learning positive ways to gain control
- Achieving mastery in some areas
- Anger management
- Increase sense of power/choice

**Tasks for Parents**

- Encourage expression of feelings while limiting behaviors
- Tolerating children’s pain/healing work
- Unhooking from power struggles
- Providing opportunities; praise
- Managing own anger & teaching child same
- Empower child to make good choices

**Capacity for Self-Regulation**

The ability to regulate one’s own emotions and behaviors is an outcome of maturation processes stemming from a healthy parent-child attachment. The mastery of cause and effect thinking, the development of a conscience that depends on internalizing values and rules, and the capacity for empathy and motivation to adjust one’s behaviors to others’ desires are all founded on parent-child attachment. Mal-nurtured children struggle in these areas and may have effects of maltreatment that impair parts of the brain that control impulses and facilitate reasoning and consideration of consequences. They are not able to physically modulate tension in organize reasoned responses. They need help in identifying their feelings, finding ways to modulate and express them, and considering possible responses and their consequences.

**Tasks for Children**

- Linking feelings and behaviors
- De-escalating building tension/anger

**Tasks for Parents**

- Learning therapeutic parenting skills
- Recognizing/coping with triggers;
Module #9  Adoptive Family Formation, Integration and Developmental Stages

Learning acceptable ways to express feelings  Helping child to verbalize feelings
Developing problem solving abilities  Processing incidents
Developing internal controls  Letting child accept responsibility for behavior
Accepting control from others  Affirming child’s abilities; presenting united parental front

Behavior Problems and Adoption Instability

Research on adoptive families indicates that child behavior problems can threaten the stability of the adoption. Breakdowns in adoption either before the legal finalization (disruption) or after the child has been legally adopted (dissolution) are more common when children are adopted at older ages and after adverse early life experiences. While disruptions in infant adoptions are very rare (less than 1%), adoptive placements of older children with special needs have higher risks of failure, with reported disruption rates of large child welfare populations ranging from 10 to 15 percent (Urban Systems Research & Engineering, 1985; Festinger, 1986; Barth & Berry, 1988). A more recent study of disruptions occurring in approximately 16,000 child welfare adoptive placements in Illinois reported a rate of 9.5 percent, with a small percentage (3.6) of children still in non-finalized adoptive placements (Smith, Howard, Garnier, & Ryan, 2006).

As the number of adoptions of children from foster care increased in the 1970s and 80s, considerable attention was devoted in research to examining the risk factors associated with disruptions – factors such as older age at placement, child behavior problems, sexual abuse history, being a matched (stranger) adoptive parent, higher socioeconomic status, inadequate social support, unrealistic parental expectations, and others (USR&E, 1985; Festinger, 1986; Barth & Berry, 1988; Smith & Howard, 1991; McRoy, 1999).

Due largely to barriers in data collection, very little research has been carried out on adoption dissolution. One study of 516 children adopted from foster care in New York found that 3.3 percent had been placed out of the home within a four-year period following their adoption; however it was not known how many would eventually return home (Festinger, 2002).

In international adoptions, many children’s adoptions are finalized before they leave their home countries, and disruption and dissolution have been explored very little. One Dutch study examined 349 children in placement outside of their adoptive homes, which represented 5.7 percent of intercountry adoptions in Holland (Hoksbergen, 1991). About half of these children eventually returned home. Researchers in Spain have reported a disruption/dissolution rate of intercountry adoptions slightly less than 1 percent (Palacios, Sanchez-Sandoval, & Leon, 2005). The latter study noted that often there is not

Center for Adoption Support and Education © 2012
one risk factor that can be singled out as responsible for the breakdown of adoptions, but an accumulation of risk factors. Also adoption professionals often found out about conflicts or problems after it was too late to solve them. This difficulty in identifying high risk situations in a timely manner was echoed in other studies of foster care adoptions (McRoy, 1999; Smith, & Howard, 1991).

It is essential to recognize that it is not just the legal breakdown of the adoption or the placement of a child out of the home that is an important concern, but also the psychological cost of ongoing difficulty to the entire family. The impact of struggling over a period of many years to address a child’s needs and yet continuing in severe family turmoil leads to a sense of powerlessness, hopelessness, and failure in parents and to enormous stress throughout the family (Smith & Howard, 1999). More often families finalize their adoptions but continue to experience ongoing challenges. Some children are placed back into the child welfare system after adoption and for some, their adoptions were legally dissolved.

Very little research exists on post-adoption placement or adoption dissolution. Festinger (2002) reported that 3.3 percent of 516 adopted children in New York had been in foster care or other out-of-home placements within four years of their adoption; however many of these children were expected to return home. A recent study using FY2005 AFCARS data identified 2,642 children entering care during that year and 3,166 children exiting care who were previously adopted. Of those exiting care, 1,241 children (39%) were classified as legally dissolved adoptions, and the majority (59%) of the remaining children leaving care were reunified with their adoptive parents (Festinger & Maza, 2009). Shorter term psychiatric hospitalizations are likely more common than placement into the child welfare system.

Of course for every adopted child entering care, there are many others who continue to live with their adoptive families but experience intense, ongoing difficulties. These children comprise a minority of all children adopted from high risk situations but the human toll of severe, unresolved difficulties is hard for many to grasp. Studies of adoptive families served through adoption preservation programs indicate that over half of the children demonstrate the following behavior problems: lying/manipulation, verbal aggression, defiance, violation of family norms, peer problems, tantrums, physical aggression, and destruction of property (Smith, Howard, & Monroe, 1998).

Some specific behavior problems seem to threaten the stability of the adoption more than others – in the study mentioned above, 45 percent of parents served raised the possibility of dissolution at some point during services. Sexual acting out of the child greatly increased the likelihood of parents raising dissolution, as did running away, lying, defiance, and a few other behaviors. In addition, workers identified the emotional issues with which children were struggling, and all of these except the need to search were associated with a higher behavior problem score (Smith, Howard, & Monroe, 2000). The frequency of emotional issues present in approximately 275 children as assessed by workers included:

<table>
<thead>
<tr>
<th>Perception/attachment conflicts</th>
<th>75%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grief</td>
<td>71%</td>
</tr>
</tbody>
</table>

Center for Adoption Support and Education © 2012
Identity 64%
Depression 55%
PTSD Symptoms 36%
Need to search 32%

While severity of behavior problems is associated with dissolution, there are other considerations that affect a parent’s ability to continue parenting a child in a very difficult situation. Partridge, Hornby, and McDonald (1986) in their study of 235 adoptive placements of older, special needs children described the process of adoption breakdown as an ongoing emotional process in which the tensions build over time after parents’ unsuccessfully attempt to ameliorate the child’s negative behaviors. Based on interviews with parents and workers, they conceptualized six stages in the disruption process: 1) Diminishing Pleasures, the negatives begin to outweigh the positives; 2) Child Seen as Problem, time of acting out leads to child being defined as the real problem in the family; 3) Going Public, parents talk about the problem outside the family and alienation is hastened; 4) The Turning Point, a critical incident occurs and there is no return to happier times; 5) The Deadline or Ultimatum: parents set a timeframe for trying to resolve the problem or give an ultimatum to the child; and 6) The Decision to Disrupt. The unremitting, insurmountable problems and parents’ personalized interpretations of the meaning of child behaviors erode the parents’ ability to empathize with their child, weaken their attachment, and lead to a feeling of alienation or a point of no return.

References


Center for Adoption Support and Education © 2012
Module #9  Adoptive Family Formation, Integration and Developmental Stages


Center for Adoption Support and Education © 2012
Handout #9.7: Case Scenario: Jimmy’s Background and Reframing Behaviors

Jimmy was removed from his birth family at age 4 after an incident of abuse by his father. His father had threatened Jimmy that if Jimmy told anyone what he had done, he would kill Jimmy as well as himself. Jimmy’s father did indeed commit suicide while Jimmy was in the hospital. Jimmy left the hospital to attend his dad’s funeral and was placed into foster care around this time. Jimmy’s birthmother was heavily involved with drugs until her death when Jimmy was a teenager.

When Jimmy was placed with his adoptive family at age 6, he had many fears and nightmares. He thought he could be poisoned and would eat only white food, because he thought he could see the poison in white food. When he would see policemen, he would quickly hide. His adoptive mom went back to the agency and began to piece together the story that led to Jimmy’s original removal from home. After talking further with Jimmy, she learned that he thought he was responsible for his father’s death, that his father was going to come back from the dead and kill him, or that the police were going to arrest him for his father’s death.

Jimmy very much missed his birthmother, and his adoptive mom decided that he needed to see her. She was able to locate his birthmother and took him to visit her once or twice a year. Jimmy still struggled with grief and anger at what he perceived as rejection from his birthmother. In the early taping of his story at age 9 (which was on a training video produced by Spaulding), he stated: “I love my new mom and I love my old mom, but I kind of wish I was still with my old mom.”

Jimmy continued to have emotional struggles through most of his childhood and was involved with many counselors. As a young adult, his life seemed to become more stable.
REFRAMING SURVIVAL BEHAVIORS

Identify the survival behaviors which the child you are assessing displays. List each survival behavior in the left column. Identify the underlying emotional issues at the root of each survival behavior and list these issues in the next column.

<table>
<thead>
<tr>
<th>Survival Behaviors</th>
<th>Underlying Emotional Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
<td>4.</td>
</tr>
<tr>
<td>5.</td>
<td>5.</td>
</tr>
</tbody>
</table>

Treatment Strategies

<table>
<thead>
<tr>
<th>1.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
</tr>
<tr>
<td>5.</td>
</tr>
</tbody>
</table>
Handout #9.8  Lorna, Mike and Paul

Lorna and Mike, a couple with no children, adopted 10 year old Paul from foster care. They spent time together before the adoption which was supported by Paul’s foster mother, Marie, who at age 62 felt unable to adopt him. Marie remains in Paul’s life. Paul had experienced chronic neglect while with his birth parents – little food, often living on the streets, no medical care and very unpredictable events in his life from day to day. His birth parents left him at a bus station where a policeman found him. He entered foster care age 8 and his parents’ rights were terminated one year later.

For the first 6 to 8 weeks, Paul happily adjusts to his new family. Lorna and Mike are excited and hopeful and believed that their love and patience will overcome any initial challenges in helping Paul feel that he fully belongs in their family. Paul is caring and obedient and seems to enjoy every aspect of his life with Lorna and Mike.

What might be happening at this stage in the formation and integration of this adoptive family?

Within the next month or so, however, Paul begins to ignore his parents and what they say. He tells them that he does not want to do what they tell him to do. He begins to spend more time in his room and refuses to go to church with his parents or join them when neighbors come over for a visit. On one visit with neighbors and their children, Paul pushes a younger child who he says was trying to break one of his toys. The child begins to scream and Paul screams back at him. Lorna and Mike try to talk with Paul about what is happening but he either clams up or tells them to mind their own business. Lorna, in particular, is very hurt by Paul’s behavior. Mike reassures her that it is just a phase that Paul is going through.

What might be happening at this stage of the adoptive family’s formation and integration?

The “phase” however continues onward. Paul’s acting out behaviors escalate: he screams at his parents, refuses to go to school, stays on the computer when they tell him to sign off, pushes other kids at school and is suspended more than once; and after several unsuccessful attempts to connect with a therapist who can help the family, he refuses to go to any other counselor. Lorna and Mike feel they have tried everything and nothing works. They find that they are not enjoying parenting Paul – instead, it is becoming a more and more unpleasant chore. They begin to doubt whether they should have adopted him. They share their doubts and concerns with their pastor and with close friends.
What might be happening at this stage of the adoptive family development?

Ignoring his parents’ instructions that he is not to drive the family car without one of them in the car, Paul drives off in the car, and within a few blocks, runs a stop light and hits another car. He causes serious damage to both the other car and the family car and injures the other driver. Lorna and Mike are outraged and tell Paul that he cannot drive the car at all and will be responsible for paying them back for the costs of car repair and medical care for the other driver. They tell him that they will not accept one more episode like this. Paul says he understands and then sneaks out of the house and gets drunk.

What is happening at this stage in this adoptive family’s life?
Handout #9.9 Guiding Principles & Goals of Therapeutic Post-Adoption Services
Susan Livingston Smith

Based on the adoption literature related to struggling adoptive families and several evaluations of post-adoption programs, a number of principles and goals for working with struggling adoptive families have been identified. These are summarized briefly below.

Active Engagement: Empathic Listening & Accepting, Non-blaming Approach

Some adoptive parents not only blame themselves for their child’s difficulties but also feel that professionals have been judgmental toward them in the past. Adoptive parents’ comments such as, “Finally, there was someone who understood and didn’t see me as a bad mother” and “This was the first agency to not make us feel like it was our fault” illustrate the critical importance of acceptance and a non-blaming approach (Smith, 2006, p. 173). Also adoptive parents who are really struggling need to be able to tell their story and have their worker or other parents listen with an empathic connection. They may need to vent without being challenged and to have their feelings and efforts validated, as workers seek to help them understand that they are not the cause of many of their child’s difficulties, but that they can be a force for positive change (Smith & Howard, 1999; Zosky, Howard, Smith, Howard, & Shelvin, 2005; Hart & Luckock, 2006).

Flexible, Responsive Service Delivery Focused on Client Needs

Evaluations of post-adoption programs have emphasized that flexibility of service delivery to fit clients’ needs is extremely important. This includes scheduling appointments after school or in the evenings and going to the home if this is needed, responding promptly to families with crises or immediate needs, and the reliability of workers in returning calls and following through. Also being able to access help for as long as it is needed is linked with more positive outcomes than short-term or time-limited interventions (Atkinson & Gonet, 2007). Another element, described as “avoiding assessment paralysis,” involves not requiring an extended period of formal assessment and referring children for specialized evaluations prior to beginning working with the family toward change (Hart & Luckock, 2006). While comprehensive assessment is important, it may need to be spread over time and interspersed with solution-focused work.

Joining with and Supporting Parents: Increasing Parental Entitlement

Sometimes mental health professionals spend most of their time in individual therapy with the child, and parents may feel unsure of what is happening and how they can best help their child. In working with adoptive families, professionals must first form an alliance with the parents, recognize that the parents know their child better than anyone else, and join with and empower the parents to find solutions to their problems. When workers also work individually with children, parents should be kept abreast of the focus of the work and the child’s progress and should be involved in how they can be working on issues at home. Joining with parents also means recognizing their strengths and helping
them to see the positives in what they are doing well and in their child (Smith, 2006; Smith & Howard, 1999; Hart & Luckock, 2006).

**Helping Parents Understand Child in Light of Child’s History**

Often children served through post-adoption programs have been to many helping professionals and have had numerous evaluations over the course of their lives. Retrieving pieces of children’s history and helping parents understand how the child’s past experiences have influenced his or her current feelings and behaviors is a central piece of this work. For children whose behaviors are likely reactions to early life experiences, parents need to be helped to understand these behaviors as coping or survival mechanisms – a technique known as “reframing.” Educating parents also involves helping them to understand their child’s special needs and to have realistic expectations of their child (Smith, 2006; Smith & Howard, 1999; Hart & Luckock, 2004). For example, a special California program for serving families adopting children from care who were prenatally exposed to substances found that families benefitted greatly from helping them understand their child’s behavior in the context of the child’s previous experiences, including but not limited to substance exposure (McCarty, et al., 1999).

**Enhancing Therapeutic Parenting Skills While Supporting Attachment**

When parents are unable to modify difficult child behaviors, they often resort to more and more extreme means to manage them, and it is common to have escalating power struggles between parents and children. Parents may appear like a “jailer” to their child, and they may report feeling angry all the time and fear losing control themselves. Parents need to be assisted in establishing parental control and dealing with child behaviors in a way that is nurturing and supports attachment. This involves depersonalizing the child’s anger, responding in a rational, not angry manner to set limits, and learning therapeutic parenting skills. Therapeutic parenting shapes child behaviors both proactively (structured environment; emotionally available to child; promote child’s emotional regulation and reflective thinking) and reactively (holding child accountable for their own actions while addressing the root causes of behaviors) (Smith & Howard, 1999; Hart & Luckock, 2004).

**Exploring Adoption Issues and Honoring Previous Attachments**

It is paramount to achieve a sense of belonging for adopted children in their adoptive families while at the same time acknowledging and facilitating communication about the child’s birth family and other significant past affiliations. Children may be struggling with loss, grief, or adoption identity issues, and lifebook work is one means for helping them reconstruct the pieces of their history and fill in the gaps in their understanding. Adoptive parents may assume that because a child is not talking about birth family members, they are not thinking about adoption issues, and parents may wait for a child to ask questions before sharing critical information. Promoting open communication within the adoptive family and at times between adoptive family members and birth family or other attachment figures may be needed. Also adoptive parents sometimes need help in finding ways to honor children’s previous attachments.
and address their own fears or feelings about a child’s dual loyalties (Hart & Luckock, 2004; Smith & Howard, 1999).

**Listening to Children and Addressing Their Emotional Issues**

Accessing the inner life of the child may involve individual therapeutic work to help children become aware of and express their needs and feelings. These feelings may relate to adoption issues, such as loss, grief, and identity, but they may also relate to past trauma, depression or other emotional issues. In particular, children who have had traumatic experiences may need help in identifying situations where they do not feel safe or in expressing fears and perceptions. They may benefit from healing therapeutic work to process experiences and to develop feelings of mastery. It is important to involve parents in the therapeutic process and to help them develop strategies for addressing these issues with their children.

**Opening Family Communication**

Communicative openness is critically important in adoptive families, and both children and parents often experience difficulty in talking about aspects of the past, adoption issues, and their own feelings. Adopted children may fear hurting their parents’ feelings when they raise questions or painful feelings related to adoption. Sometimes birth children in adoptive families also have difficulty communicating about their needs and feelings with their parents. Also, spouses may not be able to communicate well about family stresses and their own needs. A core objective of therapeutic intervention is to facilitate communication throughout the family (Hart & Luckock, 2004).

**Strengthening Attachments**

Sometimes attachments within adoptive families are less than strong, particularly when children are older at placement and have complicated histories. Parents may have unrealistic expectations in this area and need to be helped to understand a child’s ambivalence and fear of trusting and losing again, resulting in a push-pull dynamic where the child seeks closeness and then pushes the parent away. Parents’ own anger at times interferes with their feeling empathy for their child. They need to find ways to initiate positive interactions with their child and to claim the child as their own through concrete evidence of belonging. For children who received very poor early nurture, interacting with a child in a way similar to parent-infant interactions that are playful and nurturing can help to promote healthy attachment. Theraplay (Booth & Jernberg, 2010) is a type of attachment therapy which uses these techniques (gentle tickling, nonsensical games, feeding the child, cradling or rocking the child in your lap, singing and gently talking to the child, making goofy faces at each other, etc.).

**Helping Parents to Address Their Own Issues and Access Support**

Center for Adoption Support and Education © 2012
It is important to identify and address issues of parents whether it is their own reactions to traumas their children have experienced, processing parents’ unresolved losses, helping parents support each other and present a united front in parenting, or self-care issues. Often parents whose children require an inordinate amount of care are emotionally exhausted and have become isolated themselves. Marriages, friendships, and connections to extended families may need to be strengthened, and parents may need support to take a break or spend time with one another away from their children (Hart & Luckock, 2004; Smith & Howard, 1999).

**Intervening on Multiple Levels**

Effectively addressing post-adoption needs of families requires multi-systemic interventions including working with multiple constellations of family members, coordination and advocacy with other systems such as schools and health or mental health providers, and linking families with a range of resources. It may require broader availability than the typical office-based mental health professional can deliver, such as responding to a crisis on a weekend, organizing a wrap-team, or attending an IEP conference at the school (Smith & Howard, 1999; Hart & Luckock, 2004). One mother served through a post-adoption program in Illinois described this aspect, “I really do believe it was the comprehensive nature of the whole aspect of the program that helped us the most. She did individual counseling with Lisa, family counseling with us all, and worked with my husband and I. She went with us when we had IEP meetings, brought my daughter to the school; she did a lot.”

**References**


Center for Adoption Support and Education © 2012


Handout #9.10
The Development of Post-Adoption Services, Models of Intervention and Evidence-Based Practices

Our understanding of the post adoption needs of families has grown dramatically over the past 25 years. No longer do most policymakers and practitioners believe that a permanent family is the only thing needed to enable children to recover from the losses and traumas they have endured. In addition, the need for specialized post adoption services for families after adoption is being recognized. Prior to the marked increase in special needs adoptions beginning in the 1980s, it was assumed that the usual array of community services existing for all children and families could meet any therapeutic needs of adoptive families. However, the unsuccessful experiences of many adoptive families in seeking help for their children have led to their seeking specialized services. The development of post adoption services is largely a response to their advocacy efforts.

The First Decade of Post-Adoption Services

Beginning in the late 1980s and early 1990s specialized post-adoption support and therapeutic services began development in earnest. A National Consortium for Post Legal Adoption Services, comprised of representatives from adoption and mental health systems in several states, was formed with Adoption Opportunities funding, and it developed a model for providing post adoption services, which is appended to this handout. A range of services tailored to the specific needs of adoptive families have been and continue to be developed in a number of states. These services include information and referral, education and training, support groups and mentoring, respite care, advocacy, crisis intervention, search and reunion services, and therapeutic counseling (Howard & Smith, 1997; Howard, Smith, & Oppenheimer, 2002).

In order to advance the development of therapeutic services for troubled adoptive families, research is critically needed. Evaluations of post-adoption programs began in the early 1990s, and a 2001 review (Barth, Gibbs, & Siebenaler) of research on post-adoption services to prevent disruption or dissolution found only five projects with formal assessments. Three of these served 50 or fewer families (Groze, Young, & Corcoran-Rumppe, 1991; Prew, Suter, & Carrington, 1990; Barth, et al., 2001). These evaluations are largely descriptive and do not have comparison group research designs. They do provide insights into the nature of this work and are summarized briefly below.

Oregon Post-Adoption Family Therapy Project. This project used co-therapists (an adoption worker and a family therapist, both LCSWs) who worked with families largely in their homes and focused largely on helping parents develop better ways of relating to their child’s confused belief system. Adoptions were not preserved in 8 percent of these families at the end of the service period, a median of 3.5 months (Prew, Suter, & Carrington, 1990).

Iowa’s PARTNERS Program & SNAFPTT Project (Quad Cities, Iowa/Illinois). The core of the PARTNERS program was the creation of a specially trained Clinical Review team of professionals representing a cross-section of the community. The team assessed cases and recommended one of three types of treatment – 1) referral to adoption-sensitive community professionals; 2) adoption counseling services for 3-6 months, approximately 2 hours a week, or 3) adoption preservation services with up to 10 hours of services a week for 45-90 days including therapy, parent training, crisis intervention, and safe care placements. Treatment utilized co-therapists in working on family integration, normalizing the Center for Adoption Support and Education © 2012
experiences of adoptive parents, re-parenting, and linkage with resources. Of the 39 families who participated, 29 percent of children were in placements at the end of the service period, however most placements were due to sexual offending by the child (Groze & Gruenewald, 1991; Barth, et al., 2001). The Special Needs Adoption Family Preservation Treatment Team Project was an extension of the previous project combining family-based mental health services and adoption practice and served 41 families. There was a significant decrease on children’s scores on the Child Behavior Checklist on both the internalizing and externalizing scales (Groze, Basista, & Persse, 1993).

Washington’s Medina Children’s Services. A collaborative project between Medina Children’s Services and HOMEBUILDERS of Tacoma, Washington provided 4 weeks of intensive in-home therapy (up to 10 hours a week) to 22 children and their adoptive families. A year later, only 9 of these 22 children were still living in the adoptive home (Barth, et al., 2001).

New England’s Casey Family Services Program. The Casey Family Services Postadoption Services program was established in 1991 in 6 New England states, and case data on over 400 families who had cases opened in the late 1990s (of which 293 were completed) were analyzed. These programs provided counseling, support groups for parents and children, educational workshops, and case advocacy. The types of adoptions served involved public agency adoptions for 62 percent of children and nearly all families served had used other services previously, including 60 percent who had received individual child counseling. The most common family concerns included child’s problem behavior (96%), balancing the needs of adults and children (96%), and the demands of caring for children (91%). The median length of case opening was 5 months and 3 Modules for families receiving family systems counseling. Counselors assess the greatest improvements in the areas of child behavior, understanding adoption issues, and effective communication, and gains were greatest for cases with more Modules and longer duration (Barth, et al., 2001; Lenerz, Gibbs, & Barth, 2006).

Illinois Adoption/Guardianship Preservation Program. In 1991, Illinois initiated an Adoption Preservation Project which expanded within a few years to a statewide program serving any type of adoptive family that is struggling. The initial evaluation of services to 234 children in 204 families found that 88 percent scored in the clinical range on the Child Behavior Checklist. Almost half of the families had considered adoption dissolution as an option, and about ¼ of children had been placed outside the home at some time prior to referral. Overall, there was a significant decrease in the children’s CBC scores from the beginning to the end of services, and 82 percent of children remained in their homes (Smith & Howard, 1994).

A later evaluation on data for 1999-2001 analyzed services and outcomes for 1,162 children in 912 families, finding that 80 percent of children served were public child welfare adoptions. Children had lived with their adoptive families for an average of 7.8 years, with most being placed at a young age (mean=3.6 years). Cases were served for a mean of 9.7 months, with an average number of 72 service hours. Workers rated 74% of families as somewhat to significantly improved on various aspects of family functioning and 70% of children as somewhat to significantly improved in their behavior problems. At the end of services 10 percent of children were in a placement, most often foster care or residential treatment. A case review of placed children revealed that approximately 2/3 of placements were the result of severe child behaviors, and approximately 1/3 were the result of parental inability to cope and their difficulty controlling the child. Children who were adopted from foster care were not more likely to be placed at the end of services (Smith, 2006).
Families who returned evaluations (58% of closed cases) were satisfied with services overall (92%), and rated outcomes slightly more positively than did workers. The outcomes reported by the highest percentage were feeling supported (92%), knowing where to get help (89%), and understanding child (87%). Seventy-four percent reported improvement in their child’s behavior (Smith, 2006). Another evaluation of a post-adoption program in British Columbia found that parents perceived a greater positive impact of services on their knowledge of where to get help and understanding adoption and their child than on children’s behaviors or their problems at school and with siblings (Dhami, Mandel, & Sothmann, 2007).

**Post-adoption Pilot Projects around the Nation**

The U.S. Children’s Bureau began supporting the development of innovative post-legal adoption services through Adoption Opportunities grants. Approximately 65 post-legal adoption projects beginning in the years 1989-1994 were funded. These related to training mental health professionals to serve adoptive families, education and support of families, therapeutic interventions, respite care, and resource development. A synthesis described knowledge gained from these projects (Howard & Smith, 1997). Adoption Opportunities grants continued to enable the development of post-adoption programs around the country; however many of these programs were not able to be sustained once the federal funding ceased. For example, in the synthesis based on the first six years of funding these grants, only a small minority of sites had been able to fully sustain these programs, primarily through state funding.

This pattern of three steps forward, two steps back has continued throughout the development of post-adoption services. Nevertheless many states have been able to establish some type of post-adoption services statewide. Some states offer primarily information and referral services, some a network of parent support groups, and some states have developed a broader continuum of many different types of services (Howard, Smith, & Oppenheim, 2002). Funding constraints in many states have made it difficult to sustain many programs and to provide these services to families who need them across the state.

In addition to public child welfare jurisdictions that have provided the impetus and leadership for development of these services, a number of private agencies and organizations around the country have maintained a focus on the development of post-adoption services. Organizations such as the North American Council on Adoptable Children, Casey Family Services, and the Annie E. Casey Foundation have consistently provided leadership in development of these services across the country. Some private agencies with adoption programs such as the Kinship Center in California, DePelchin’s Children’s Center in Texas, and others have continued in developing post-adoption services over the past two decades.

Also, a few unique agencies that do not do adoptions have focused on therapeutic services to members of the adoption triad and continue their development of post-adoption services and interventions. The Center for Adoption Support and Education (CASE) provides post-adoption counseling and educational services to families, educators, child welfare staff, and mental health providers in Maryland, Northern Virginia, and Washington, D.C. The Center for Family Connections in Cambridge, Massachusetts provides counseling, group work, and mediation services to families involved with both foster care and adoption.

Center for Adoption Support and Education © 2012
Since the beginning of the 21st century, only a few evaluations of post-adoption services have been published and only one of these used a randomized experimental design – the Maine Adoption Guided Services model (MAGS) (Lahti, 2006). Casey Family Services designed and implemented the services for this project, a family-centered case management and therapeutic model that was implemented statewide, beginning in 2000. Families who were finalizing adoptions were randomly assigned to either the Guided Services or Standard Services groups. Those in MAGS had access to an Adoption Guide, an adoption-competent social worker who could be called 24 hours a day by any member of the adoptive family, and who would meet with the family at least every 6 months. On average, the workers spent about 65 hours a year with each family in the Guided group (149 families). At baseline, there were no significant differences between this group and the 124 families in the Standard Services group on any child characteristics. However, after two years, the children in the MAGS group scored significantly lower on the Child Behavior Checklist. Also, after 5 years, Title IV-E costs for children in the Guided Services group were no greater than costs for children in the Standard Services group (Lahti, 2006; Lahti, 2005).

Evidence-Based and Promising Practices Applicable to Post-Adoption Services

While the evaluations described earlier offer insights into the nature of problems in families seeking services and factors associated with problem severity, more in-depth research is needed in order to develop a greater understanding of the dynamics of problems in these families, the types of changes occurring over the course of the intervention, and the types of children and families served whose situations improve or fail to improve.

There is considerable progress in research on specific models of intervention that are applicable to working with struggling adoptive families. Several are interventions with well-supported research evidence involving rigorous randomized controlled trials. While they have not been evaluated in work with adoptive families, there is limited research on the efficacy of some of these interventions with child welfare populations as well as other groups of at-risk youth. Some of these treatments include trauma-focused cognitive behavioral therapy, TF-CBT, (Weiner, Schneider, & Lyons, 2009) multisystemic therapy, MST, (Henegger & Lee, 2003) and two approaches to parent training – parent-child interaction therapy, PCIT, (Timmer, Urquiza, & Zebell, 2006) and the Triple P—positive parenting program (Prinz, 2009). However, some of these interventions have been used and tested more with maltreating families and as an alternative to child placement rather than directly with caregivers outside the birth family.

There are several other promising models of intervention focused on the types of challenges common among children and youth served through adoption preservation programs that have begun to build a research base, although none rises to the level of established empirically based practices with randomized control studies. The first noteworthy intervention, ARC: Attachment, Self-Regulation, & Competency, was recognized by the National Child Traumatic Stress Network as a promising practice for youth exposed to complex trauma. ARC focuses on building secure attachments, enhancing self-regulation capacities, and increasing competencies across several domains. It is founded in trauma-informed treatment methods and includes a range of therapeutic procedures including psychoeducation, relationship strengthening, parent training, social skills training, other CBT strategies, and psychodynamic techniques. This intervention targets the range of developmental capacities impacted by deprivation and trauma experiences in young children, and an evaluation of its use Center for Adoption Support and Education © 2012
reported a 50 percent reduction in PTSD symptoms (Kinniburgh & Blaustein, 2006). A workshop describing this interventive model is available online (Kinniburgh, 2008), and the next handout will go into more detail about this intervention.

ARC was implemented in the ADOPTS post-adoption program of Bethany Christian Services, beginning in Grand Rapids, Michigan in 2004 and after two years in 8 other sites, through the support of a 4-year grant from the U.S. Department of Health and Human Services. It was used with both pre- and post-adopt youth, ages 8-18, and with their parents in an 18-week course of treatment, after which families could continue to work on other issues if desired. The treatment included a 6-week group with children and another with parents. The evaluation reported significant improvement across all subscales of the Trauma Symptom Checklist, except the Sexual Concerns subscale, and gains were maintained after a year. This program was popular with families and clinicians and has been continued at all sites (Mark Peterson, personal communication, January 22, 2010).

Theraplay is an intensive, short-term treatment model for children and their parents based in attachment theory, developmental psychology, and pre-school educational practices and focused on enhancing parent-child attachment (Booth & Jernberg, 2010; Bennett, Shiner, & Ryan, 2006). It was rated by the California Evidence-Based Clearinghouse for Child Welfare as having promising research evidence. A major component of treatment is training parents to engage children through Theraplay activities that incorporate playful nurturing touch and self-esteem-building feedback to foster engagement—activities such as feeding each other, putting lotion on each others hands, thumb wrestling, and rocking a child in a blanket. Theraplay typically occurs in a comfortable room with floor pillows or a beanbag chair where the therapist, child, and parents can sit on the floor. The therapist takes charge of structuring the Modules and leading the direction of the play according to the goals of treatment. It has been used primarily with young children, although a recently published case study reported on very positive outcomes utilizing Theraplay in a residential treatment center with an adopted teen who had very limited ability for insight therapy (Robison, Lindaman, Clemmons, Doyle-Buckwalter, & Ryan, 2009). Theraplay has been used for many years with foster and adoptive families.

Developmental Dyadic Psychotherapy (DDP), developed by Daniel Hughes (2007), seeks to increase parent-child attachment while helping children to make sense of and accommodate their painful histories and the related feelings and behaviors. DDP involves children and parents in the physical proximity, playfulness, acceptance, and closeness typical of the healthy infant-parent relationship, enabling children to accept “affective attunement” from their parents and from the therapist. A critical component of this approach is reducing shame while enhancing the child’s capacity for guilt, which necessitates empathy and the desire to set things right. This therapy also focuses on helping the child gain emotional access to the most painful and difficult feelings and perceptions stemming from their early traumatic experiences and supporting the child in being able to think and talk about these experiences in a manner that detoxifies them and leads to a coherent narrative. A 2006 review (Craven & Lee, 2006) of the evidence base for 18 therapeutic interventions for foster children classified DDP at a category 3 (supported and acceptable) on a scale ranging from 1 (well-supported, efficacious) to 6 (concerning treatment). Subsequent to this review additional evaluative research extending follow-up to 4 years after treatment has been published (Becker-Weidman, 2006; Becker-Weidman & Hughes, 2008). In the latter report the 34 youth in the treatment group demonstrated significant improvements on all
scales of the Child Behavior Checklist that were sustained 4 years after treatment while the 30 subjects in the control group receiving other forms of treatment did not demonstrate sustained gains on any subscales.

The interventions above address trauma, attachment, and self-regulation issues of adopted children, but most do not directly address adoption concerns and issues that may be important to children. A primary intervention that focuses on adoption and identity issues is therapeutic lifebook work with children. Although lifebooks have been used with foster and adopted children for many years, unfortunately, there is no research on the efficacy of this intervention. Developing a coherent life narrative is an aspect of understanding and healing the impact of trauma, loss, and other difficult life experiences. Some resources that might be helpful in learning more about the use of lifebooks include an annotated bibliography of resources developed by Casey Family Services (2009) and a training DVD, “Putting the Pieces Together: Lifebook Work with Children,” developed by Lutheran Social Services of Illinois (Johnson & Howard (2008).

References


Center for Adoption Support and Education © 2012


Peterson, M. (January 22, 2010). Personal communication with Susan Smith.


Handout #9.11 Case Scenario: The Whitman Family

The Whitman family consists of Roger (age 64 & retired), Ellen (age 49 & a teacher), and Katie, age 15. Katie was placed with the Whitmans at age 5 from foster care. When Katie was 14, her adoptive parents sought help from an adoption preservation program due to Katie's violent and rageful behaviors. She rejected affection, destroyed property, and was verbally abusive. The last straw was two unfounded allegations of physical abuse, after which Ellen called DCFS and told the worker to come and get Katie—she had had it! They referred them to therapeutic post adoption services.

When the Whitmans married, Roger had already raised children in a previous marriage, and they decided that they would like to adopt a child age 3 or older. They attended an informational meeting at the child welfare agency and filled out an informational form. A few weeks later they received a call from a worker about a 4-year old girl whose foster-adoptive placement was disrupting. The reason was presented as Katie was having difficulty getting along with other children in the home, and they thought she would be ideal for the Whitmans because they had no other children. Very little was shared at this time about Katie's background, although they later learned that Katie had entered care at age 2 due to physical abuse and neglect.

The Whitmans decided to pursue this adoption opportunity and rushed through the home study process, although they received no training. They began weekend visits with Katie, who would seem reluctant to leave her foster family at the beginning and reluctant to leave the Whitmans at the end. During her fifth visit with the Whitmans just after Katie turned 5, her foster family called and said they would not meet the Whitmans to pick Katie up. So, abruptly and without good-byes, Katie became a member of her new family. Years later, Ellen learned from Katie that she did not know the foster family she left was not her birth family. She could not understand why her family decided to give her away.

Katie's behavior was challenging from early on. A social worker visited after the placement, but the Whitmans did not feel she was very helpful. Katie was hyperactive and didn't sleep. She had long tantrums and would scream for hours at a time. She destroyed clothes, curtains, and toys and was very attention seeking. Roger and Ellen took her to a psychiatrist who told them to lock their bedroom door at night so they could sleep. Katie would lie outside the door, screaming and kicking the door, which they were told to ignore. However she only seemed to get worse.

Over the years, the Whitmans sought help from many professionals and were advised to use behavioral approaches such as rewards, punishments, charting, and time-outs and to avoid talking about her past because it would just stir things up. The source of Katie's rage and fear was left unexamined. Her behavior problems continued and became so severe in the fourth grade that Katie was hospitalized based on her therapist's recommendations. She quickly learned to master the behavioral reward system, but made only superficial progress. She was "worse than ever" when she came home and also felt like she had been abandoned once again.
As she grew older, her difficult behaviors continued and she received a variety of drugs. She was placed in a range of special classrooms from learning disabled to emotionally disturbed. Katie would play her parents against one another and "carry tales" from one to the other. She was verbally abusive toward Ellen. When she made a second report against her parents for abuse, her parents saw this as the last straw. They felt like failures as parents. Ellen stated, "We were doing the best that we could, but nothing was working. I know we did damage to Katie in our frustration. We were so angry. We felt we didn't deserve this. We had saved her from a bad situation, so how could she treat us like this."