TAC (Training for Adoption Competency)
Module #9
Adoptive Family Formation, Integration, and Developmental Stages

Student Make Up Assignments

Please refer to the Student Packet for Module #9 for the learning objectives for this module and the handouts. In order to “make up” Module #9, please prepare the following written materials for your teachers’ review. The assigned presentation should be scheduled with your teachers.

Assignment #1: Read the following listed as pre-module assignments in the Student Packet and complete the written assignments:

✓ Read the selected excerpts from *Examining Adoption Outcome Research* and write down three key “learnings” from the research.

✓ Read the selected excerpts from *Normative Development Challenges in Adoption* that focus on the Adoptive Family Life Cycle and write a paragraph describing your reactions to the concept of the Adoptive Family Life Cycle.

✓ Read the selected excerpts from *Factors Shaping Adjustment in Adoptive Families* and develop a list of at least three “take aways” from these excerpts.

Assignment #2: Review the following information about the pre- and post-adoption developmental tasks of adoptive parents and write a short essay describing how you would use this information in your clinical work with prospective adoption parents (2 to 3 paragraphs)

Pre-Adoption Development Tasks of Adoptive Parents

- Tasks of Parents with Parenting Experience
  - Developing understanding of how adoption differs from other caregiving arrangements
  - Exploring and developing consensus with partner
  - Making the adoption decision
  - Accepting the need for social service scrutiny
  - Coping with uncertainty and anxiety about the placement process
  - Accepting psychological vs. biological parenthood

- Tasks of Parents without Parenting Experience
  - Mourning the loss of fantasized biological children
  - Same tasks as Parents with Parenting Experience plus:
    - Exploring the motivation to create a family through adoption

- Additional Tasks with Infertility:
  - Mourning loss of bloodline
  - Coping with infertility
- Accepting one’s own or spouse’s failure to reproduce
- Differentiating between reproduction, sexual adequacy and competence to parent
- Developing formal and informal support networks

• Additional Tasks with Transracial/Transcultural Adoption
- Learning to talk about race and racism, ethnicity and culture openly and honestly
- Developing multicultural awareness
- Examining motives for adopting a child of a race or culture different than one’s own
- Forming friendships with other transracial/transcultural families
- Understanding how where the family chooses to live will affect the child
- Confronting fears and stereotypes about the child’s community/country of origin

Post Adoption Development Tasks of Adoptive Parents

• Tasks of Parents with Parenting Experience
- Integrating new member into family
- Developing approach/language to inform family and friends about the adoption
- Dealing with others’ responses to adoption
- Realignment of relationships with extended family to accept non-birth child
- Creating and maintaining open communication about adoption
- Negotiating sibling rivalry and conflict
- Helping the child to adjust to new home, school and community

• Tasks of Parents without Parenting Experience
- Adjusting to instant parenthood
- Same tasks as Parents with Parenting Experience plus:
  - Seeking social validation of parenting competence

• Additional Tasks with Transracial/Transcultural Adoption
- Teaching child correct terms for heritage
- Becoming knowledgeable and respectful of child’s history, ethnicity and culture
- Demonstrating intolerance for racially, ethnically or culturally biased comments
- Understanding that the child may be treated unkindly or unfairly because of prejudice
- Validating the child’s feelings about prejudice/discrimination
- Helping child cope with bias through open and honest communication
- Develop support networks and mentors from the child’s community/country of origin
- Validating strengths and accomplishments of the child’s racial/ethnic/cultural group

Assignment #3. Read the following information about the central developmental tasks of adopted individuals and in a short essay, write about how you would share this information with prospective adoptive parents (2 to 3 paragraphs)
• **Learning one’s adoption story**: As they grow up, adopted children learn what it means to be adopted and with the details of their own personal history. This history may include difficult events such as abandonment or maltreatment. As youths’ cognitive abilities develop in middle childhood and adolescence, they will think about all of these aspects differently and will have new and different questions and feelings.

• **Coping with loss**: Every adopted person experiences loss in her own unique way and may experience emotions such as rejection, confusion, sadness, fear of loss or abandonment, shame, difference, and anger. A sense of loss emerges for children adopted in infancy as they develop the cognitive abilities to understand the loss aspects of adoption, around ages 6 to 8. Children placed at older ages have experienced the loss of attachment relationships with birth family or other caregivers and other meaningful connections as well, such as pets, foster sibs, orphanage mates, neighborhood and school contacts, and cultural connections.

• **Searching for answers**: All adopted individuals search for answers to the questions that arise from “Why did my birthmother not keep me?” to “What aspects of me are like my birthparents?” or “Do I have other siblings in my birth family?” Children who have experienced traumatic events search for answers as to why these things happen to them and what this means about who they are. Whether adopted individuals formally search for a reunion with birth family members, they all search for answers to the questions that come up over the course of their lives related to birth family connections and heritage. There may have many questions throughout their lives for which they cannot find satisfactory answers.

• **Coping with adoption stigma**: Adopted individuals may experience teasing or other forms of discrimination related to being adopted. A recent study by the Donaldson Adoption Institute of adopted adults found that among white adopted adults, 40 percent reported experiencing adoption discrimination from extended family members—the most common source of adoption bias.

• **Integrating adoption into identity**: While this task sounds very similar to learning one’s story and searching for answers, it involves integrating these aspects of self and other complicated or traumatic events in one’s life into one’s sense of self. For transracially or transculturally adopted individuals, it involves further complexities of figuring out what it means to be Korean or Mexican when you have no link to this culture in your adoptive family.

• **Validating affiliation with two families**: Adopted children need to incorporate their links to birth family into their identity and come to terms with what this connection means in their lives. It may involve a direct relationship with birth family members or claiming the gifts they received from birth family and birth culture.

• **Consideration of actively searching for birth family**: Adopted individuals who do not have an ongoing relationship with birth family will consider whether and when to actively search for them. This may be a continuing struggle over a period of many years and involve fears of hurting adoptive parents, fears of rejection by birth family or infringing on their privacy, and other complicated issues.
• **Coming to Terms with the Impact of Trauma.** Children who have experienced deprivation and maltreatment may have additional tasks of coming to terms with the impact of trauma or limitations that they experience as a result of adverse beginnings.

**Assignment #4.** One of the most important qualities that support positive adjustment in adoptive families is communicative openness. Communicative openness includes:

- Quality of communication with the adopted child about adoption
- Comfort with the child’s connections to another family
- Empathy with the child’s feelings
- Attitudes toward communication with the birth family
- Empathy with the birth family.

**Review Handout #9.3 Principles for Adoptive Parents on Communicative Openness about Adoption.** [These principles could be shared with parents on this or another handout, in trainings, or in your counseling sessions.] Select two of the principles and discuss how you would specifically work with adoptive parents around these principles. As an example: For the principle, “Create an environment of communicative openness”: How might you encourage the parent to help his/her child ask questions about his/her adoption? How might parents be helped to acknowledge the differences of adoption? For each selected principle of communicative openness about adoption, develop at least three specific clinical approaches you would use to help the parent understand and implement the principle.

**Assignment #5:** Read the following information on risk factors, stress and coping and complete the listed assignments:

- Most of the problems adopted children manifest probably have nothing to do with adoption *per se*, but they have to do with everything that preceded adoption—genetics, prenatal experiences, and pre-placement experiences and how well adoptive parents are able to help children address preexisting challenges after the adoption.

- Adoptive parents vary in their understanding of these issues and their resources to address them.

- In addition to pre-adoption factors, children and parents differ in the way they confront challenges after adoption, including those that are pre-adoption risk factors as well as salient adoption issues that emerge in different ways over time.

- In preparing adoptive parents for adoption, it is important to help them understand risk factors that are relevant to their children’s history. It is also important to help them understand that risk is only a probabilistic statement...the presence of this factor increases the probability for certain conditions but it does not mean a child will necessarily have the condition.
• Often, adoptive parents have the belief that if they are good parents, they should be able to handle things on their own. It is important for those preparing them for adoption to normalize help-seeking and to frame this as a strength for adoptive parents – seeking the services that their children need and advocating for their children.

One model of adoption adjustment builds on the “Stress and Coping Model of Adoption Adjustment” advanced by David Brodzinsky. Here are some key points about the model:

• The primary assumption is that children’s adjustment to adoption is determined largely by how they view or appraise their adoption experience and the type of coping mechanisms they use to deal with adoption-related stress.

• When children view adoption as stigmatizing, threatening, or as involving loss, a pattern of negative emotions associated with stress—for example, confusion, anxiety, sadness, embarrassment, anger—is likely to be experienced. When children experience these emotions, they consider various coping options and eventually choose one or more to reduce their distress.

In a paragraph or two, discussed your experience in working with children who are distressed by having been adopted? How have you seen them attempt to cope with being adopted?

• Although no one pattern of coping is necessarily associated with healthier adjustment, research generally suggests that overreliance on avoidance strategies is often tied to increased adjustment problems, both generally and specifically with regard to adoption.

• Adoption is assumed to involve loss and stigma and, hence, to be potentially stressful for children, even for those youngsters placed as infants. However, the degree to which children experience adoption-related stress and the success they have in coping with it are highly variable. Some children show very few indications of stress-related symptoms; others experience fully developed clinical symptoms. The link between stress and adjustment outcome is mediated by the range and effectiveness of coping behaviors and coping resources available to the youngster.

• It is not until children begin to understand the meaning and implications of adoption—around 5 to 7 years of age—that one expects to see increased sensitivity to adoption-related stigma and loss, as well as a shift toward more ambivalent feelings about being adopted.

In a paragraph or two, discuss the child characteristics or experiences that may make it more likely that children will have more negative views about being adopted.

• Genetic, prenatal, and birth factors also appear to play a role in children’s adoption adjustment. These biological factors are believed to influence the children’s well-being through their impact on cognitive, social, and emotional development.
In a paragraph, discuss why genetic, prenatal and birth factors might play such an important role in a child’s adoption adjustment.

- Finally, the model also recognizes the importance of societal, interpersonal, and familial factors in children's adoption adjustment, as well as the importance of the child’s pre-placement history. **Review the following chart:**

<table>
<thead>
<tr>
<th>Pre-placement Factors</th>
<th>Societal Factors</th>
<th>Interpersonal Factors</th>
<th>Familial Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fact of foster care placement</td>
<td>• Beliefs about how he/she is perceived as a “foster” child and as an “adoptive” child</td>
<td>• The child’s relationship with adoptive parents</td>
<td>• The child’s relationship with adoptive parents</td>
</tr>
<tr>
<td>• Age at time of foster care placement</td>
<td>• How the child is treated in social situations</td>
<td>• The child’s relationship with other children in the home</td>
<td>• The child’s relationships/connections with siblings</td>
</tr>
<tr>
<td>• History of abuse/neglect/abandonment (prior to foster care or while in care)</td>
<td>• Whether there are other adopted children in the family</td>
<td>• The child’s relationships/connections with birth parents/extended birth family members</td>
<td>• The child’s relationships/connections with birth parents/extended birth family members</td>
</tr>
<tr>
<td>• Length of time in foster care</td>
<td>• Whether there are other adopted children at school, in the neighborhood</td>
<td></td>
<td></td>
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<tr>
<td>• Number of foster caregivers</td>
<td></td>
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<td></td>
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<tr>
<td>• Type of foster care placement (kin, unrelated foster family, group, residential)</td>
<td></td>
<td></td>
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<tr>
<td>• Previous disrupted adoptive placements or dissolved adoptions</td>
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<td></td>
<td></td>
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<tr>
<td>• Sibling relationships and connections</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• For internationally adopted children: similar factors associated with orphanage or alternative caregiver</td>
<td></td>
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</tr>
</tbody>
</table>
In a paragraph or two, discuss your work with a child in which one or more of these factors impacted the child’s adjustment to the adoptive family.

**Assignment #6: Consider the following scenario:**

You are the therapist for Jarmon, a 15-year old who was adopted from foster care at age 12, and Carmen, his adoptive mother. I will provide Jarmon and Carmen with role play directions to follow in the role play. You are conducting an initial session with the teen and his mother and you want to learn as much as you can. Here is what you learn:

**Jarmon’s Viewpoint:** Jarmon is having a lot of trouble in school but he believes that it is the fault of his hard-nosed teachers and stupid people in his classes. Why should he have to listen to those teachers? They are a joke! Things are not much better at home. His younger brother, Trivon (who is age 6) is a pest and deserves to get a big swat when he messes with Jarmon’s things. His mother just doesn’t get it. Jarmon needs privacy to listen to his music and he doesn’t want to be bothered with her trying to get him to go to family stuff. Sure, he gets real mad at her but she asks for it.

**Carmen’s Viewpoint:** Carmen and her husband Hector adopted Jarmon at age 12 from foster care. He had been physically abused by his stepfather who also introduced Jarmon to drugs when the boy was only 10. His mother did little to protect Jarmon because her husband was physically abusive toward her as well. Jarmon came into foster care and quickly moved through multiple placements. He said that he wanted be adopted but now she is not sure. He lies to her about almost everything and always has an excuse for problems at school (blaming others). He is mean to Trivon and hits him. Carmen is at the end of her rope. Jarmon will not listen to her and seems to take pleasure in defying her.

In your essay (about a page), address the following questions:

- What maladaptive coping patterns do you believe that Jarmon is using? To what extent do you see the following maladaptive coping patterns that may be observed in adopted children?

  - Dishonesty – sometimes senseless lying, also stealing
  - Defiance – resists control, often severe power struggles result
  - Verbal and physical aggression – sometimes against younger children or animals
  - Destruction of property – may be sneaky in destroying prized possessions of others

In your essay (about a page), address the following questions:
• Peer problems – may play with younger children
• Anxiety – often unable to concentrate, restless, strong fears, nightmares
• Depression
• Self-harming
• Running away – usually in teens
• Passive resistance such as delaying tactics/ taking a long time for a simple activity
• Manipulating one authority figure against another (splitting)
• Uncomfortable with prolonged periods of calm – must do something to rock the boat
• Difficulty giving/receiving affection – vacillates between seeking and repelling affection
• Temper tantrums/rageful outbursts

What might be the underlying emotional issues behind these maladaptive coping strategies?

Assignment #7: Read the following information. Write a short essay (2 to 3 paragraphs) responding to these points in light of your own clinical experience with adopted children, youth and/or adults.

Children who are well nurtured develop a positive mental blueprint – a template for assessing the world and their place in it. Well nurtured children see the world as generally safe and adults as trustworthy. They believe that they have the capacity to exert their will and get their needs met.

Poorly nurtured children develop a different blueprint that profoundly colors their view of themselves and others – like goggles through which they view the world. Many adopted children have suffered significantly from adverse experiences prior to their adoptive placement, resulting in developmental deficits and emotional pain. Such children bring their lifeview and their way of coping with them into their new families – they see the world through the goggles of a maltreated child. The adaptations they have made to their previous environment are likely to create dysfunction in their new families, even with very experienced parents.

Frequently, adopted children coming from adverse situations demonstrate negative behaviors that are maladaptive coping patterns for defending against underlying emotional struggles. These behaviors also interfere with their ongoing development. In order to successfully modify these “survival behaviors” it is necessary to address the emotional issues that contribute to them. Children tell us what they have lived through by their behaviors. Never doubt that a maltreated child’s challenging behaviors mean something, even if it is impossible for the child to articulate that meaning.

Smith and Howard developed a framework for understanding the impact of loss, trauma, and inadequate nurture on children, identifying four critical areas of functioning that are affected. This model is useful in helping therapists and parents to understand their children’s behaviors in light of the child’s history. It is relevant primarily to adopted children with special needs who have had adverse early life experiences; however to some extent, these areas of functioning
may be affected by any child’s struggles to come to terms with adoption. The model addresses the following four critical areas of functioning:

- Capacity for Relationships
- Identity/Sense of Self
- Self Efficacy/Competence
- Self-Regulation

**Capacity for Relationships:** The ability to develop close emotional relationships with others...to love and be loved. As we learned earlier, attachment is the foundation for all development. Securely attached children have a sense of safety, the capacity for empathy, a sense of worth, and the foundation for a conscience. Children with dangerous or deprived beginnings distrust others and learn to protect themselves from closeness. Closeness may be associated with pain and loss, so that while a child craves closeness, it scares her. The child may alternate between seeking closeness and distancing parents through withdrawal or negative, hostile behaviors.

**Identity/ Sense of Self:** Also, as we learned earlier, our “sense of self” is derived from the messages we receive from the external world and our own inner interpretation of life events. A positive sense of self generally results in a positive feeling of self worth. Well nurtured children receive positive external messages that become internal; however children experiencing poor treatment often see themselves as responsible and are often missing essential elements from which to “build self” and make sense of who they are. Some adopted children struggle with feelings of rejection related to not being kept or protected by birthparents. They think, “If my birth mother did not want me, I must not be very valuable.” They also may feel a sense of stigma related to adoption or having been a foster child—that they are a second class citizen or fundamentally different from other children.

**Self-Efficacy/Competence:** A sense of personal control and mastery; the belief that one’s own efforts can make things better and that one is not simply a victim. Well-nurtured children have their needs met and build on achievements to develop a sense of impact on the world – “the master of one’s fate”. Poorly nurtured children learn that their wills are violated and their wishes don’t matter. They feel like “a ball in a pinball machine” and have been powerless to control the direction of their lives and sometimes to protect themselves. To avoid feeling vulnerable and helpless, they may behave in negative, oppositional ways to exercise power and control.

**Self-Regulation:** The ability to regulate one’s own behaviors and emotions is an outcome of maturational 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 the desires of others are all founded on parent-child attachment. Other maturational
capacities related to self-control are the development of language to express feelings, the
development of social skills, and healthy brain functioning and biochemistry. Well nurtured
children receive comfort and many cues about their emotions. They develop trust that
enables postponing gratification, thinking of others, and considering consequences. Poorly
nurtured children lack the emotional connection to others that is the foundation for the
development of empathy and self-control. They may have effects of maltreatment that
impair the parts of the brain that control impulses and allow for reason and consideration of
consequences. Deficits in self-regulation are a primary factor underlying emotional and
behavioral disturbances.

Aspects of parenting or therapeutic interventions can foster or further impair children’s
capacities in these areas. For children who have adverse beginnings, healing from the
psychological and neurobiological effects of deprivation, trauma, and interrupted
attachments is an ongoing challenge that reverberates over the course of their childhoods.
They have foundational holes in normal developmental achievements that need to be
addressed to help them realize their potential and to heal.

Assignment #8: Read the following about common dynamics in troubled adoptive families.

Common dynamics have been reported in the literature on adoptive families seeking therapeutic help.
Not all families who seek help are experiencing severe difficulties; however, these dynamics are
common in families who have children with a high level of behavior problems that they have not been
able to resolve despite repeated attempts. These dynamics include:

- Severe power struggles
- Differences in the way that parents and the child perceive their relationship
- Mother takes the brunt of child’s anger
- Marital tension
- Conflict throughout the family including between siblings
- Isolation
- Running on empty/exhaustion
- Parents feel like failures/hopeless
- Difficulty connecting or empathizing with child

Review Handout #9.8 and respond to each of the questions that follow each section of the case example
(about one page).

Assignment #9: Read the following information:

We know from various studies that a significant minority of adoptive parents seeking post
adoption therapeutic services may at some time think about and raise the possibility of ending
the adoption. In one Illinois study, 45% of the parents seeking these services did so.

However, most adoptive parents are truly committed to their children and are searching for
other solutions. In the Illinois study, approximately 10 percent of the adoptive parents were
actively seeking dissolution or seriously considering doing so. Many of these families had sought professional help many times over a period of years but had not found the right kind of help. However, many other parents had thought of this solution but truly wanted to find a way to keep their child in the family.

Adoptive parents’ accounts of their efforts to seek therapeutic services have identified many types of “unhelpful help” as well as important aspects of the helpful help that they received.

Based on the adoption literature related to therapeutic work with struggling adoptive families and several evaluations of post-adoption programs, a number of principles and goals for working with these families have been identified. Look at Handout #9.9 Guiding Principles and Goals of Therapeutic Post-Adoption Services.

I. Active Engagement: Empathic Listening & Accepting, Non-blaming Approach
   Joining with and Supporting Parents: Increasing Parental Entitlement

II. Helping Parents Understand Child in Light of Child’s History
    Enhancing Therapeutic Parenting Skills While Supporting Attachment

III. Exploring Adoption Issues and Honoring Previous Attachments
     Listening to Children and Addressing Their Emotional Issues

IV. Strengthening Attachments
    Helping Parents to Address Their Own Issues and Access Support

Review the following materials about each of the guiding principles and goals and write a two-page essay discussing at least three clinical implications of this information for your work with adoptive families.

I. Active Engagement: Empathic Listening & Accepting, Non-blaming Approach
   Joining with and Supporting Parents: Increasing Parental Entitlement

*Empathic listening and an accepting, non-blaming approach relate to engaging adoptive families.*

- Some therapists who work in therapeutic post-adoption programs have said that parents coming to them wanted to share all that they had been through and tried in their previous attempts to find solutions, and they often needed to vent their feelings of frustration and anger at the beginning and to be heard and understood.
- Sometimes they have strong feelings of anger or ambivalence toward their children, which they may need permission to express. It is important to listen to the family’s story for as long as they need to talk.
- Some of those seeking help have had difficult experiences with previous helpers, so that it would be good to find out about these experiences.
• Beyond allowing parents to vent, therapists seek to validate the efforts of parents and reduce their sense of blame for their children’s problems. The therapist might recognize the many positive steps that parents have taken to meet children’s needs and acknowledge that such efforts might have worked with another child but have not worked with this particular child.

• Often when adoptive families in crisis seek help, you are seeing them at their worst. Some therapists may think, “Who let this family adopt a child?” but in reality, this family may have looked very differently and much more functional and nurturing when they first adopted. It is important to remember this and not let judgmental attitudes or responses creep into your interactions with the family.

Joining with and empowering parents involves forming an alliance with the adoptive parents and including them in all aspects of treatment.

• Let parents know that they know their child better than anyone else and that you will work together with them in finding how they can best help their child.

• If children are seen individually, therapists should talk with parents about what issues they are working on with the child and how parents can reinforce this at home.

• Also, therapists should assist children in talking with parents about difficult feelings and issues.

II. Helping Parents Understand Child in Light of Child’s History
Enhancing Therapeutic Parenting Skills While Supporting Attachment

Helping parents to understand the child in light of the child’s history is a central component. We work to educate parents to understand their child, whether it is reframing behavior problems as survival behaviors or helping them to understand the needs of a child with FASD or ADHD. This helps to normalize their view of their children as does interacting with families in support groups who have similar experiences.

Teach therapeutic parenting strategies is another primary aspect of this work. We help parents to learn how best to respond to their child, both in managing behavior problems and in helping their children to resolve the residual impact of loss, trauma, and other issues. There are a number of parenting curricula and books that might be used in this work, such as Hage’s Therapeutic Parenting booklet or Parenting with Love and Logic. Therapists can help parents to help a child learn how to self-regulate and gain self-control by:

• Deescalating power struggles

• Setting up healing environment attuned to child’s needs and capacities; simple rules and regular schedule leads to sense of safety and predictability
• Establishing clear and sensitive parental authority-- balance of firm limits and warm, playful interactions, responses to negative behavior should be calm, rational and consistent, not out of anger

• Teaching prosocial behaviors and problem solving, coach child to make good choices

• Helping the child connect to own feelings

• Helping the child learn to release rage in acceptable way

• Enhancing self-concept--identify and praise strengths

III. **Exploring Adoption Issues and Honoring Previous Attachments**

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

*Exploring adoption issues, honoring previous attachments and listening to children and addressing their emotional issues* are all interwoven. They involve ongoing work to assess and address relevant adoption issues with children and parents as well as helping family members talk about issues with each other and work on addressing problems together.

*Exploring Adoption Issues*

• Work on adoption issues and related issues such as trauma resolution is interwoven throughout our work with adoptive families. It is important to elicit the adoption story and to explore adoption-related issues with both parents and children.

• Parents may need help in learning how to talk with their children about adoption, birth family, and loss. They may have important information about the child’s birth family that has never been shared with the child. Facilitating communication about these issues is important in promoting healing.

• Also, it is important to support the child in developing a coherent sense of their own history, and lifebooks are often a useful tool in working on this goal. You may work on these in groups, with parents, or with the child alone. Finally, it is important to address parents’ own adoption issues and facilitate communication with and between parents about these.

*Accessing the Inner Life of the Child*

• Children who have experienced loss and trauma often have difficulty identifying and expressing their feelings and may need assistance from the therapist to do so. A range of expressive therapies may be useful in this endeavor including:
  
  ▪ Beverly James’ work on treating traumatized children
  
  ▪ Debbie Riley’s “Loss Box” in *Beneath the Mask* that we worked with in an earlier Module
The trauma resolution scrapbook in the Lowenstein article on your reading list.

- Children’s issues connected to negative emotions are very individualized and are often not known to their parents. They may have strong fears which can trigger panic and lead to both internalizing or externalizing behaviors.
- Parents can help to identify situations in which children seem particularly stressed and work with the therapist on exploring children’s fears.
- Children who have experienced separation trauma from abrupt removal from placements and interrupted attachments may fear losing their adoptive parents. They may have fears of being kidnapped and an ongoing sense of vulnerability to additional loss.

IV. Strengthening Attachments

Helping Parents to Address Their Own Issues and Access Support

**Strengthening Attachments within the Adoptive Family:** There are a number of aspects that may need to be addressed in promoting more secure attachments in the parent-child relationship.

- Parents may not have realistic expectations for the child’s current capacity for attachment and may need to be helped to understand the child’s ambivalence based on the child’s previous history.
- It may be important to assess the child’s attachment history and to determine if the child ever had a positive attachment to a caregiver.
- Finding ways in which the parents can meet the child’s needs and initiate positive interactions with the child facilitates stronger attachment.

**Supporting Parents:** Parents in struggling adoptive families often have withdrawn from non-essential activities and become somewhat isolated. They may have few sources of pleasure in their own lives.

- Helping them to focus on taking care of themselves may involve a range of goals from working with the couple to increase their support of each other to linking them with outside supports or providing respite care.
- Parent support groups are invaluable resources for adoptive parents in helping them to gain social support and understanding.

A final principle is **multi-systemic interventions, collaboration and advocacy.** Helping to address families’ needs in relation to other systems with which they interact is an essential aspect of this work.

- Often there are ongoing problems at school and the therapist can assist parents both in communicating their child’s needs to school professionals as well as advocating for
needed services or the right type of school placement. Some programs may develop a “wrap” team to work with the family in finding solutions.

- Therapists also may work to obtain resources for specific needs, such as sending a child to a camp, finding respite or therapeutic daycare, or advocating for increased subsidies.
- Coordination of work with other professionals who are working with the family -- such as juvenile justice, mental health, or child welfare professionals – is important.

**Assignment #10:** Read the following materials about evidence-based interventions and complete the listed assignments.

There are a number of evidence-based treatment models that are applicable for children with internalizing and externalizing behavior problems. There are specific interventions that are relevant to therapeutic post adoption services work:

- Trauma-Focused Cognitive Behavioral Therapy – which we have previously discussed
- Parent-Child Interaction Therapy – also previously discussed
- Positive Parenting Program – which we will talk about today
- Multisystem Therapy – which we will also talk about today
- Attachment, Regulation and Competency (A.R.C.) – which we will also talk about today

1. **Positive Parenting Program (Triple P)** is a multilevel system of parenting interventions called “Triple P” that matches intervention intensities to the level of severity of problems.

   Triple P is a multi-level program to prevent and offer treatment for severe behavioral, emotional and developmental problems in children aged 0 to 16 years, through enhancing the knowledge, skills and confidence of parents.

   Review the following brief introduction to Triple P which is from Ontario, Canada but is equally applicable to the US: [http://www.youtube.com/watch?v=_pcsnCPpeGg](http://www.youtube.com/watch?v=_pcsnCPpeGg)

   Triple P incorporates five levels of interventions on a tiered continuum of increasing intensity. The rationale for this stepped-care strategy is that there are different levels of dysfunction and behavioral disturbance in children, and parents may have different needs and desires regarding the type, intensity and mode of assistance they require.

   - **Level 1** is a form of universal prevention and it delivers psycho-educational information on parenting skills to interested parents.
   - **Level 2** is a brief intervention of one or two Modules, for parents of children with mild behavioral problems.
• **Level 3** is a four-Module intervention, targets children with mild to moderate behavioral difficulties and includes active skills training for parents.

• **Level 4** is an intensive eight to ten Module parent training program for children with more severe behavioral difficulties or who are at risk of developing such problems, which can be offered either individually or in a group of parents. Parents are taught a variety of child management skills. This intervention is a form of selective or indicated prevention in that the children are at elevated risk levels of developing behavioral problems.

• **Level 5** is an enhanced behavioral family intervention program for families where parenting difficulties are complicated by other sources of family distress, e.g., marital conflict, parental depression, or high levels of stress.

**Triple P is based on:**
- Social learning principles
- Research in child and family behavior therapy
- Developmental research on parenting
- Social information-processing models
- Research from the field of developmental outcomes in children
- A public health perspective to family intervention

**Evaluation**
- There is evidence that Triple P is an effective parenting strategy.
- Several studies showed that parenting skills training used in Triple P produces predictable decreases in child behavior problems, which have typically been maintained over time.
- The program has been successfully used for several different family types including two-parent
- families, single parents, stepfamilies, maternally depressed families, maternally discordant
- families, and families with a child with an intellectual disability.
- In those studies the following variables were measured: child disruptive behavior, parent-child
- interaction, parenting style and confidence, parental adjustment (depression, anxiety, stress, self-esteem), parenting conflict and relationship satisfaction.

Watch the following video which illustrates how one parent is implementing Triple P. The mother is Scottish and her accent may present challenges but give it a try!
Write a short essay (2 to 3 paragraphs) discussing your impressions of Triple P as an intervention for adoptive families.

NOTE: More information on Triple P can be found at:

http://www.triplep-america.com/
http://www.triplep.net/cicms/assets/pdfs/pg1as100gr5so171.pdf

2. **Multisystemic Therapy (MST)** seeks to empower the family to influence the factors in a youth’s social network that promote positive functioning.

   There are nine principles of MST:

   **Principle 1: Finding the fit**
   An assessment is made to understand the "fit" between identified problems and how they play out and make sense in the entire context of the youth’s environment. Assessing the “fit” of the youth's successes also helps guide the treatment process.

   **Principle 2: Focusing on positives and strengths**
   MST Therapists and team members emphasize the positives they find and use strengths in the youth’s world as levers for positive change. Focusing on family strengths has numerous advantages, such as building on strategies the family already knows how to use, building feelings of hope, identifying protective factors, decreasing frustration by emphasizing problem solving and enhancing caregivers’ confidence.

   **Principle 3: Increasing responsibility**
   Interventions are designed to promote responsible behavior and decrease irresponsible actions by family members.

   **Principle 4: Present focused, action oriented and well defined**
   Interventions deal with what’s happening now in the delinquent’s life. Therapists look for action that can be taken immediately, targeting specific and well-defined problems. Such interventions enable participants to track the progress of the treatment and provide clear criteria to measure success. Family members are expected to work actively toward goals by focusing on present-oriented solutions, versus gaining insight or focusing on the past. When the clear goals are met, the treatment can end.
Principle 5: Targeting sequences
Interventions target sequences of behavior within and between the various interacting elements of the adolescent’s life—family, teachers, friends, home, school and community—that sustain the identified problems.

Principle 6: Developmentally appropriate
Interventions are set up to be appropriate to the youth’s age and fit his or her developmental needs. A developmental emphasis stresses building the adolescent’s ability to get along well with peers and acquire academic and vocational skills that will promote a successful transition to adulthood.

Principle 7: Continuous effort
Interventions require daily or weekly effort by family members so that the youth and family have frequent opportunities to demonstrate their commitment. Advantages of intensive and multifaceted efforts to change include more rapid problem resolution, earlier identification of when interventions need fine-tuning, continuous evaluation of outcomes, more frequent corrective interventions, more opportunities for family members to experience success and giving the family power to orchestrate their own changes.

Principle 8: Evaluation and accountability
Intervention effectiveness is evaluated continuously from multiple perspectives with MST team members being held accountable for overcoming barriers to successful outcomes. MST does not label families as “resistant, not ready for change or unmotivated.” This approach avoids blaming the family and places the responsibility for positive treatment outcomes on the MST team.

Principle 9: Generalization
Interventions are designed to invest the caregivers with the ability to address the family’s needs after the intervention is over. The caregiver is viewed as the key to long-term success. Family members drive the change process in collaboration with the MST therapist.

Review the following videos on MST:

A MST case study: http://www.youtube.com/watch?v=PqngEvu6PqE

Write a short essay (2 to 3 paragraphs) regarding your thoughts about MST.

In summary, here are resources on each of these evidence-based practices:

- Trauma-focused cognitive behavioral therapy http://tfcbt.musc.edu/
A Promising Practice: Attachment, Self-Regulation, & Competency (A.R.C.).

Recognized by the National Child Traumatic Stress Network as a promising practice, ARC is a comprehensive framework for intervention with youth exposed to complex trauma. Intervention is tailored to each client’s needs and may include individual and group therapy for children, education for caregivers, parent-child Modules, and parent workshops.

ARC is a framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. ARC identifies three core domains that are frequently impacted among traumatized youth, and which are relevant to future resiliency. ARC provides a theoretical framework, core principles of intervention, and a guiding structure for providers working with these children and their caregivers, while recognizing that a one-size-model does not fit all. ARC is designed for youth from early childhood to adolescence and their caregivers or caregiving systems.

These 10 building blocks depict the primary domains affected by complex trauma that are targeted by this treatment model:

- Attachment (the bottom green blocks)
- Self-regulation (the red blocks) and
- Developmental competencies (the top blue blocks)
The competencies targeted include interpersonal competencies; cognitive competencies such as the growth of executive functions (problem-solving, anger management, school performance), and intrapersonal competencies (positive self-concept and identity).

ARC seeks to build healthy attachments between children and their caregivers by attention to four goals:

- Creating a structured and predictable environment by establishing rituals and rules
- Increasing the parents’ capacity to manage their own intense emotions so that they can respond to the child in a rational, nurturing manner and not out of anger or impulsiveness
- Improving parent-child attunement so that the parent is able to respond to the child’s emotions rather than react just to the behavior
- Increase the use of praise and reinforcement to facilitate the child’s ability to identify with competencies rather than deficits

ARC involves considerable psychoeducation of parents to normalize their feelings and experiences and to teach them about the impact of trauma on their children. It assists them
in understanding the child’s reactions (reframing negative/oppositional behaviors) and in learning to self-monitor their own feelings and reactions to their child’s behaviors. It expands their capacity to empathize with their children’s feelings and to understand situations that will trigger children’s fear and anxiety.

A third intervention component of ARC relates to developmental competencies that need strengthening for children who have experienced complex trauma. There are four goals for addressing these competencies:

- **Create opportunities for children to gain mastery over their environment**

  This is done through identifying children’s interests and supporting them in experiencing success, helping them to set concrete goals and achieve them, supporting them in making their own choices, and other tasks.

- **Create opportunities for connection to peers and adults (including adults in the community)**

  This involves teaching children how to keep themselves safe and to negotiate healthy boundaries; teaching social skills and supporting them in building positive relationships with peers and adults. It involves work with school staff and adults in the community to facilitate the child’s integration into peer groups.

- **Identify and build on strengths to promote positive self-concept**

  This involves helping children to identify their strengths and to gain a sense of being a survivor rather than a victim of past adverse experiences; supporting children in building a sense of personal identity; and helping them find activities in which they can succeed and feel good about their accomplishments.

- **Teach the child to practice skills and evaluate outcomes in order to foster sense of control and self-efficacy**

  This involves teaching problem-solving skills and how to think through consequences and make positive choices and involving children in planning for activities and carrying them out.

More information on ARC can be found at:

http://www.traumacenter.org/research/ascot.php

Assignment #11: Review Handout #9.11 Case Scenario: The Whitman Family and develop a 15 minute presentation for your teacher that addresses the following questions:

- How will you engage this adoptive family in crisis?
- What goals will you work on with Katie?
- What goals will you work on with the parents and the family together?
- What specific treatment strategies will you use?

Here is follow up information on what happened in this particular case.

In this particular case, one important aspect of services was a parent support group that the Whitmans attended. The isolation and incompetence they had felt were diminished through contact with others who were struggling.

Tremendous progress was made in this case, but it was not all uphill. After about 6 months of services, the parents’ commitment was greatly strengthened, Katie made some progress in expressing her feelings, and the tensions at home were eased somewhat. However, a few months later, near her birthday, Katie became more violent, cutting herself and threatening greater injury. She was hospitalized for several weeks and her case with adoption preservation was reopened.

She also was re-hospitalized after another episode of self-injury a few months later. With the support of adoption preservation services, the Whitmans advocated for the hospital staff to address Katie’s early life experiences. A therapist at the hospital suggested that the Whitmans help Katie to find her birthmother. Katie did meet her birthmother, a struggling single mother to 3 children who brought her infant to the meeting and nursed her during their contact. The Whitmans believed that this helped Katie make sense of her feelings about her birth family and stop idealizing her birthmother. Mr. Whitman thought it helped Katie to accept her adoptive parents as her parents.

In addition to family counseling and support, advocacy was an important part of treatment. One goal that was addressed was an appropriate school placement for Katie. The worker helped the Whitmans advocate for a full educational assessment and for a placement in a therapeutic day school, where she ultimately was placed. Finding the right school placement for her made a big difference in her confidence and achievement. Her father later stated that Katie learned more in 2 years at this school than in all her previous years of school.

At the end of services, this family was in a much better place. The level of anger in their household was much reduced. Katie was doing well at school and was taking medication for ADD and depression. She no longer felt the need to injure herself. Katie could see a change in herself and her family and understood more about the roots of her feelings. The family was able to enjoy each other, taking trips, and having fun together.
The Whitmans believed that Katie still had a deep fear of abandonment. She had become much more affectionate with them, calling them mommy and daddy and seeking physical closeness. At first, Ellen was somewhat irritated at Katie’s following her around like a small child and wanting to be close to her all the time. The therapist had helped Ellen to see that this was a normal stage in young children developing attachment and was real progress for Katie. This intervention greatly fortified the Whitmans commitment to stick with Katie no matter what the future held. They stated that Katie’s last birthday was the first in which she had not been “out of control.”

Please provide all of your written assignments in one document to your teachers. Please schedule your presentation with your teachers.